

## PSYCHIATRIC NEWS

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# Stigma, Misunderstanding Among The Barriers to MAT Treatment

*Medication treatment for opioid use disorder is largely underused. The article below is the first of four in a series that will explore the barriers to access and offer solutions to help ensure that patients who could benefit from the treatment both understand it and have access to it.*

BY TERRI D'ARRIGO



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In 2018, 4.2 million Americans had an opioid use disorder (OUD), and of those, 1.2 million received medication treatment with buprenorphine, methadone, or naltrexone, according to the Substance Abuse and Mental Health Services Administration's 2018 National Survey on Drug Use and Health. Although medication for addiction treatment (MAT) is neither sought by nor appropriate for every patient, that less than a third of people with an OUD receive it suggests an unmet need in public health despite the many studies that show it reduces illicit opioid use, improves retention in opioid treatment programs, lowers the risk of relapse and overdose, and improves patients' functioning and quality of life.

The roots of this phenomenon lie in the history of MAT, one that is rife with misunderstanding and stigma going back to the first government-run methadone clinics in 1972. Although the clinics were created with good intentions and offer valuable services, their requirements and logistics can make going to one feel like punishment, said Edwin A. Salsitz, M.D., an addiction medicine specialist at the Addiction Institute of Mount Sinai in New York.

"Some clinics are blocks, sometimes miles away from the hospitals they're affiliated with. They don't have the same look and feel as a hospital, and they're located in parts of the city or town that are not really desirable," Salsitz explained. "That created stigma.

People began thinking, 'Why go to a clinic every day? No other medication is handled that way. I want to be treated in a doctor's office like other people.'"

## Clashing Approaches Add to Stigma

Traditional abstinence-based treatment and therapies have added to the stigma associated with MAT, and thus its underuse, said APA President Bruce Schwartz, M.D., deputy chair and professor of psychiatry in the Department of Psychiatry and Behavioral Sciences at Montefiore Medical Center and the Albert Einstein College of Medicine. The Montefiore Department of Psychiatry operates one of the largest substance use treatment programs in the United States.

"The staff who work in those programs have usually attained abstinence without the use of medication treatment, so there's an antipathy against it. Their attitude is that 'This is the way I did it, so this is the way it should work for everybody,'" he said.

Schwartz added that there is a belief among many abstinence-based counselors that incorporating MAT into recovery is merely replacing one addiction with another.



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"It happens in the rehab dimension of these programs, but it also happens in detox. The detox programs aim to get people off of all drugs, so there's a disincentive to transition people to medication treatment," he continued. "That's partly because many nonphysicians who work in the programs don't have full knowledge of the nature of the underlying biology of these disorders."

Patients on MAT sometimes encounter pushback from counselors and members of abstinence-based groups, said Salsitz.

"They say you're not in recovery, which is hurtful to people who are doing well on medication treatment. Many of these patients like to be part of a group, and they don't want to lie and not [reveal that] they take medications." However, he noted, if the patients do tell, they'll be badgered with questions such as "When are you going to get off it?"

Misperceptions of medication treatment continue among abstinence-based counselors partly because the programs are undermedicalized, Schwartz said.

see MAT on page 20

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## FROM THE PRESIDENT

# What Is at the Heart of the Access Problem?

BY BRUCE SCHWARTZ, M.D.

There is a great deal of concern among our colleagues in psychiatry and primary care, the public, and health care experts regarding the shortage of psychiatrists in the United States. My office receives multiple calls each week from people seeking care for themselves or family members. All have insurance, have often checked online directories (un)maintained by insurers, and cannot locate a psychiatrist to see them.

Were those people seeking primary care or medical/surgical specialty care, there would be much less of a problem identifying a potential provider. While prospective patients might have to wait a few weeks for a primary care appointment or even several months for a specialist, they would be able to schedule an appointment. Not so for psychiatrists, especially in the greater New York area and probably in most major cities. In rural areas they would be completely out of luck.

The sources of these problems are well established. Insurers—especially managed care plans—have insufficient numbers of psychiatrists on their panels who actively see new patients. It is a form of rationing and reflects the discrimination and stigma that remain so much of an issue in our field. These same insurers have fee schedules that pay psychiatrists on average 21% less than primary care physicians. These fees are probably a fraction of the actual out-of-network fees that patients pay. The 2017 Milliman Research Report on analyzing disparities between coverage of treatment for mental and substance use disorders versus other medical conditions showed that insured patients seeking psychiatric care had to access services out of network three to almost six times more frequently than for medical/surgical care. This represented a doubling of access restrictions during the first three years of parity regulatory oversight.

These types of abuses by insurers would never be tolerated by private-sector employers or patients for medical/surgical care. Enforcement of the Mental Health Parity and Addiction Equity Act has been almost nonexistent. The Mental Health Parity Compliance Act, co-sponsored by Sen. Chris Murphy (D-Conn.) and Sen. Bill Cassidy (R-La.) and supported by APA, would tighten much-needed parity enforcement for these ERISA plans. At the state level, several states have enacted APA's model



parity legislation, while many other states either passed partial or more comprehensive versions.

But this is only part of the problem. Imagine if we actually had full parity as required by federal law and regulations. The demand for services would be even more overwhelming, and I fear the solutions that would come from our legislators would be ones in which the lowest level of care would become the norm. The fact with which we must grapple is that there are not enough psychiatrists in the United States.

The Association of American Medical Colleges reported there were about 38,000 practicing psychiatrists in the United States in 2017 (the year for which latest data are available), and 61.3% were 55 or older. Our workforce is rapidly diminishing despite an increase in psychiatry residents and renewed popularity of our field among graduating medical students. In comparison with Western European

nations, the supply of psychiatrists in the United States is far lower. Our country has about 14 psychiatrists per 100,000 population. Switzerland has 45; France, Sweden, Germany, the Netherlands, Norway, Finland, and the United Kingdom all have between 20 and 22 psychiatrists per 100,000 population. Our low number hardly reflects that our citizens are less in need of psychiatric care.

In fact, given the epidemics of death from opiate overdoses, suicide, and school shootings by young people with emotional problems, we need many more psychiatrists. Sen. Chuck Schumer (D-N.Y.) is advocating for legislation to add 15,000 residency positions under the so-called Physician Shortage Act of 2017. We can hope that a significant portion of any new graduate medical education funding will be allocated to psychiatry as there is bipartisan consensus that a mental health crisis exists in our nation. But we cannot train enough new psychiatrists fast enough to address the critical need for psychiatric care. My next column will address what I believe are workable and reasonable options. **PN**

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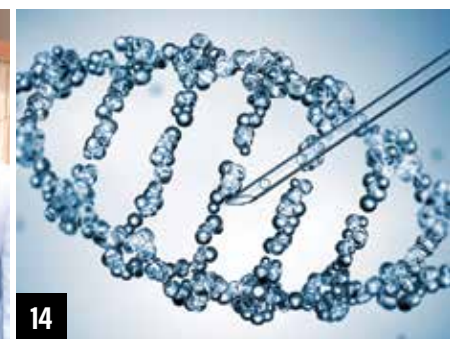


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# AMA Identifies Six State Strategies For Ending Opioid Epidemic

*The report highlights tools and strategies devised by states that have already achieved success in reducing opioid deaths and turning the tide of the epidemic.*

**N**etwork adequacy—whether health plans have enough health care professionals in their network to meet demand—and enforcement of parity laws are among the keys to addressing the opioid epidemic, according to an analysis by the AMA and Manatt Health, a health care consulting firm.

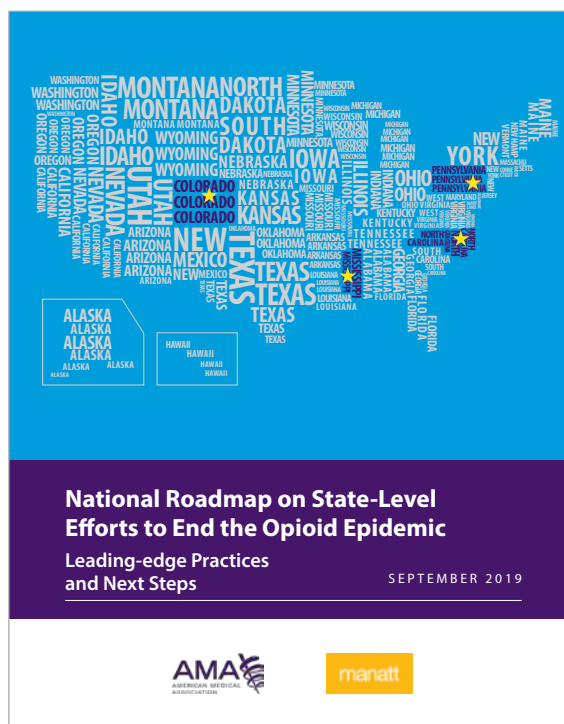
The “National Roadmap on State-Level Efforts to End the Opioid Epidemic: Leading Edge Practices and Next Steps” analyzes the response to the epidemic in four states—Colorado, Mississippi, North Carolina, and Pennsylvania—and highlights six strategies that appear to be critical to success. The two already noted—enforcement of parity laws and network adequacy—are also among APA’s top legislative priorities.

“States have to be willing to use their oversight to enforce parity laws,” psychiatrist and AMA President Patrice Harris, M.D., M.A., told *Psychiatric News*. “The work APA has been doing in this area to develop tools that physicians can use to evaluate whether states are complying with parity has been invaluable.” Harris is also chair of the AMA Task Force to Reduce Opioid Abuse.

Complementary to parity enforcement is ensuring that health plans have adequate numbers of mental health professionals in their networks. This is likely to require payment reforms, collaborative care models, and other efforts to bolster and support the nation’s treatment workforce for opioid use disorder (OUD), according to the report.

Four other effective strategies identified in the roadmap are the following:

- **Improving access to evidence-based treatment for opioid use disorder.** Remove prior authorization requirements and other barriers to medication for addiction treatment (MAT) for OUD—and ensure MAT is affordable.
- **Expanding pain management options.** Enhance access to comprehensive pain care, including nonopioid and nonpharmacologic options.



- **Improving access to naloxone.** Reduce harm by expanding access to the overdose-reversing drug and coordinating care for patients in crisis.
- **Evaluating policy success and barriers.** Evaluate policies and outcomes to identify what is working and build on successful efforts, and identify policies and programs that might need to be revised or rescinded.

“We are at a crossroads in our nation’s efforts to end the opioid epidemic, and states are being creative on how they respond,” Harris said in a statement. “It is time to end delays and barriers to treatment; time for payers, pharmacy benefit managers, and pharmacy chains to revise policies that restrict opioid therapy to patients based on arbitrary thresholds; and time to help all patients access evidence-based care for pain and substance use disorders. Physicians must continue to demonstrate leadership, but unless and until these actions occur, the progress we are making will not stop patients from dying.”

Joel Ario, managing partner at Manatt Health Strategies and former insurance commissioner in Oregon and Pennsylvania, added: “These recommendations are already proving effective in leading states. If state policymakers want to have a tangible impact on improving patient care, these are the

policies that are showing real promise. This is not hypothetical—this is what is needed to end the epidemic.”

The recommendations by the AMA and Manatt emerged from four key themes identified in an earlier analysis of strategies in the four states. The broad themes include the following:

- **Vigorous state oversight and enforcement.** State regulators can have a significant impact on reducing barriers and improving patient care, and some have used these tools to increase access to evidence-based treatment. Regulators have successfully held payers and others accountable for restricting access by using prior authorization for MAT. Additionally, states have found success by enforcing state and federal insurance parity laws, benefitting patients needing treatment for mental or substance use disorders.
- **Medicaid expansion.** Medicaid often provides more comprehensive care for substance use disorders

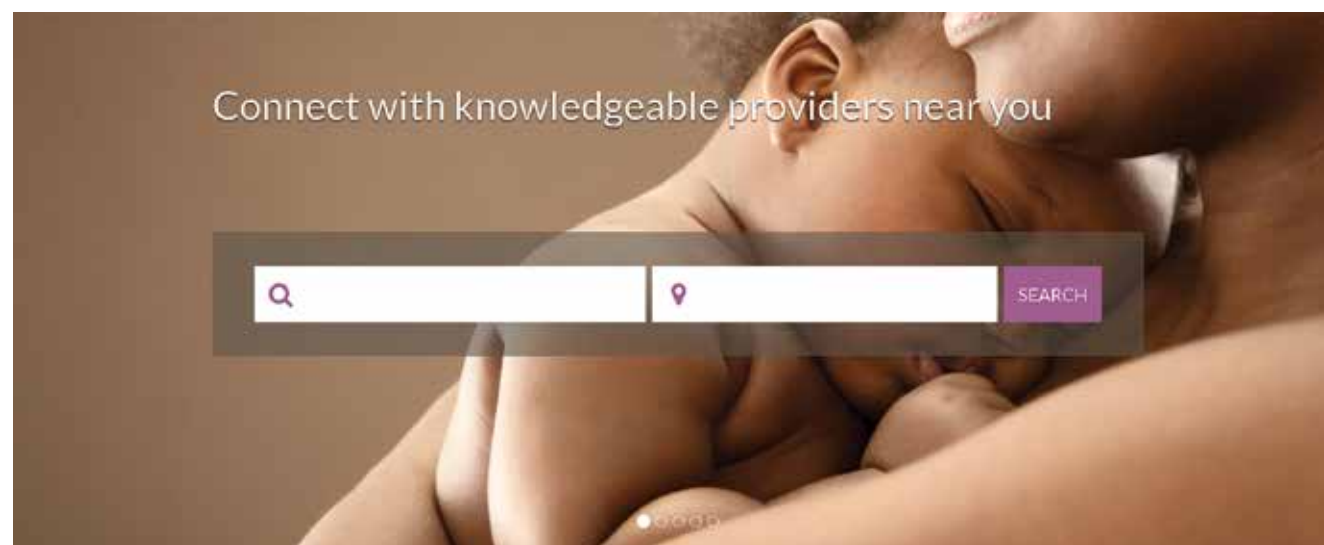
than the commercial insurance market, often by removing barriers to MAT and providing greater access to nonopioid pain care. Expanding Medicaid in states that have not yet done so would establish a strong foundation to help even more patients.

- **Long-term funding.** Grants are being used to advance many best practices, but to continue saving lives, states need long-term, sustainable funding. Without reliable funding streams, programs that are showing promise to reduce overdose and death—and to connect patients to treatment—might simply disappear.

- **Measuring success.** Some states are evaluating policies and programs to determine what works. Most of these evaluations are just beginning. Comprehensive analysis is essential to focus resources on successful interventions and to revise or drop policies that are having unintended consequences. **PN**

 The AMA report is posted at <https://www.end-opioid-epidemic.org/wp-content/uploads/2019/09/AMA-Manatt-National-Roadmap-September-2019-FINAL.pdf>.

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## Free Service Connects Clinicians With Perinatal Psychiatry Experts

Launched in 2018, the phone-based consultation service allows frontline physicians to discuss perinatal mental health issues with leaders in the field. **BY NICK ZAGORSKI**

As a community psychiatrist who travels between two rural clinics across southern South Carolina, Brittany Sauerborn, M.D., knows that the patients she sees have limited access to specialty health care. As such, she takes extra care when working with patients who may require additional health services beyond mental health, such as pregnant women. For example, she recently faced the difficult decision of whether to add a second medication for a pregnant patient taking an antipsychotic.

"She was over an hour away from the nearest high-risk OB-GYN, so I had to get this decision right," said Sauerborn, who is just a few years out of residency and still learning the special considerations of treating pregnant women. While researching online for guidance, she happened upon a phone consultation service offered by Postpartum Support International (PSI), which proved an invaluable assistance.

Two weeks later, she was discussing her patient with Jennifer Payne, M.D., director of the Women's Mood Disorders Center at Johns Hopkins University. After consulting with Payne, who is one of the leading authorities in perinatal psychiatry, Sauerborn felt much more confident about her treatment plan.

On top of that, Sauerborn recalled, "It felt like I had called up a friend; she was friendly, down to earth, and didn't make me feel unknowledgeable."

"It always feels great to educate other health care professionals," said Payne, who sets aside one hour each week to provide consultation services through PSI. "It may not seem like a big impact,

but everyone I can empower becomes someone else who can share knowledge; it becomes a domino effect."

### Filling a Pregnancy Care Gap

Stories like the experience between Payne and Sauerborn fill PSI Board President Ann Smith, C.N.M., with a great sense of pride. "This initiative is a baby of mine," she said of the consultation service, which launched in 2018.

"We know how difficult it is for women nationwide to access mental health care," Smith explained to *Psychiatric News*. What she found equally distressing is that pregnant women fortunate enough to get to a mental health care professional often receive inadequate care. "Though perinatal depression falls under the aegis of depressive disorders, there are many differences in how you screen and treat this disorder," she said.

Unfortunately, many mental health care professionals do not know how to treat pregnant women properly, Smith continued. "And I felt it was incumbent on us [PSI] to try and fix that."

Smith wanted to provide a free service so that any frontline physician could reach out and have a conversation with a nationally recognized



Jennifer Payne, M.D., sets aside one hour a week to volunteer as an expert for the PSI phone consultation service. "If you're not 100% sure about something, then call. That's what we are here for."

expert in perinatal psychiatry. Though an online forum was initially considered, Smith settled on a phone consultation service since live conversations can uncover nuances that might be overlooked in typed messages.

The process starts with an appointment call. The physician selects a time that works for him or her, and then an appointed expert calls the physician at that time. Anyone associated with the physician—an office manager or nurse—can make the initial appointment call, but the prescribing doctor has to take the consultation call personally.

### Residents and Fellows: Stay in Touch!

APA has launched a list serve for resident and fellow members (RFMs) so they can easily communicate with each other and create their own community. Those interested in joining can sign up via their member profile at [psychiatry.org](https://www.psychiatry.org) by navigating to "Specialty Interest Caucuses and Listservs" and checking the box for Resident-Fellow Members (RFMs).

Currently, 12 perinatal experts volunteer as PSI consultants, with several others who have indicated support once the call volume increases. "I have been thrilled with how energized the reproductive psychiatry community has been since we launched this service," Smith said, but added, "We are always happy to take more since we know the demand is out there."

There is no minimum time requirement expected of the volunteer experts. "Tell us what you can manage. If it's one hour a month, we will take it," said Smith. And though the work is pro bono, the consultants do receive "PSI Bucks," which provide discounts to services like online courses or the PSI annual meeting.

### Bridging Patients and Doctors

The key now is spreading the word to more people. Smith and other PSI leaders do their part by plugging the consultation service at meetings and events, but she said that mothers have been some of the biggest promoters to date.

"From what I hear, a lot of our consult calls start with the phrase, 'My patient told me ...,'" said Smith, which shows that patients often learn about the service first and then tell their doctors about it. She finds satisfaction in that patient initiative because it demonstrates PSI's success in supporting both patients and physicians—and acting as a bridge between the two—key PSI missions since it was founded in 1987.

Smith is keen to point out that PSI offers more than just consultations to psychiatrists and other physicians. Last year the organization also initiated a certification program in perinatal mental health with specialty tracks for psychotherapists, prescribing physicians, and support staff like nurses, doulas, and lactation consultants. PSI's current project is establishing a national directory of trained therapists and psychiatrists to help with referrals.

But the impact that the consultation service has made on patient lives cannot be understated. "In some situations, that one phone call can be a real game changer," Smith said.

Though Sauerborn has used the service just once, it was a valuable resource. "I do feel more comfortable now, even just knowing it's available," she said. "If an unfamiliar situation arises, I would definitely use it again."

"There is a lot of misinformation out there about pregnancy and mental illness," Payne said. "If you're not 100% sure about something, then call. That's what we are here for." **PN**

**More information about PSI is available at <https://www.postpartum.net/>. PSI's Perinatal Psychiatric Consult Line can be accessed at 800-944-4773, extension 4.**



# Assisted Dying Rises Over Time in States With Oldest 'Medical Aid in Dying' Laws

*Use of "medical aid in dying" in Washington and Oregon has occurred predominantly among white, college-educated, and insured individuals, suggesting the practice has not been pushed on marginalized populations as some have feared. BY MARK MORAN*

**T**he use of medical aid in dying (MAID) in Washington and Oregon has increased per 1,000 deaths since laws were passed in those states permitting the practice, according to a report in *JAMA Open Network*.

The majority of patients availing themselves of MAID in those states are non-Hispanic, college-educated, white individuals, and 88.5% had public or private insurance. In both states, slightly more than 72% of patients were over 65 years of age, more than 76% had cancer, and 4% received referrals for psychiatric examinations.

Those are among the findings from a study of trends in MAID (also known as medical-assisted death, physician-assisted death, and physician-assisted suicide) in the two states with the longest standing laws permitting patients with a terminal illness to receive a lethal prescription from their physician.

The increased use of MAID over time during a period when laws permitting the practice spread to other jurisdictions suggests it is becoming more acceptable, although the most recent data indicate it could be plateauing. Meanwhile, the demographics of MAID in the two states suggest that the practice has not been directed—as some have feared—at vulnerable populations based on age, race/ethnicity, educational attainment, or insurance status.

"Concerns that MAID would unintentionally target socially disadvantaged patients have not materialized," wrote Charles D. Blanke, M.D., of the Oregon Health Science University and colleagues. Blanke is also chair of the SWOG (Southwest Oncology Group) Cancer Research Network.

The practice of physician-assisted death is among the most contentious issues in contemporary American medicine; even the term is hotly debated, with opponents of the practice tending to prefer the term "physician-assisted suicide," while proponents insist that terminally ill patients seeking to end their lives with medical assistance should not be conflated with individuals who are suicidal when they have years of life yet to live.

Last June, the AMA House of Delegates approved a report by its Council

on Ethical and Judicial Affairs stating that the AMA's Code of Medical Ethics supports both opponents and proponents of what the council calls physician-assisted suicide (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.7b16>).

The Oregon Death With Dignity Act was approved by the state in 1994, permitting terminally ill adults (18 or over) who are residents of the state to voluntarily obtain a physician's prescription for a lethal medication. In 2008, Washington state approved leg-

(2,235, or 87.4%), decreasing ability to participate in pleasurable activities or impaired quality of life (2,203, or 86.1%), and loss of dignity (1,755, or 68.6%).

The rate of deaths by MAID per 1,000 overall deaths has risen steadily in both states (although there appears to be a drop in the last year of observation). "[W]ith the increasing age of legislation, there has been a corresponding increase in MAID use in both Oregon and Washington," Blanke and colleagues wrote. "We can hypothesize



**There are lots of unanswered questions in this field, and we need more controlled trials.**

**—Charles D. Blanke, M.D.**

islation largely modeled on the Oregon law. Today, MAID (or physician-assisted death or physician-assisted suicide) has been adopted in nine jurisdictions in the United States: California, Colorado, District of Columbia, Hawaii, Montana, New Jersey, Oregon, Vermont, and Washington.

## Reasons Patients Request MAID

In the *JAMA Open Network* report, Blanke and colleagues sought to characterize patterns of medically assisted dying in the two states with the longest standing laws permitting the practice. They conducted a retrospective observational cohort study of Oregon and Washington patients with terminal illness who received prescriptions as part of their states' legislation allowing MAID. They reviewed published annual reports from 1998 to 2017 in Oregon and from 2009 to 2017 in Washington.

Blanke and colleagues found that since the passage of the Oregon law, a total of 3,368 prescriptions were written in the two states, with 2,558 patients (76%) dying after they ingested the prescription. The distribution of diagnoses among patients requesting MAID is as follows: cancer (1,955, or 76.4%); neurologic illness (261, or 10.2%), lung disease (144, or 5.6%); heart disease (117, or 4.6%), or "other illnesses" (77, or 3%).

In comments to *Psychiatric News*, Blanke reiterated that he believes the most important finding from the comparison is the relative safety of MAID. "There is no evidence the practice is being forced on marginalized or vulnerable patients," he said.

Patients cited the following reasons for requesting MAID: loss of autonomy

Blanke told *Psychiatric News* he and colleagues plan to conduct a study assessing the effect of mandatory referral for treatment of depression on patients' decisions about following through with medical aid in dying. "I want to respect those who claim that if we treat depression in these patients, a smaller percentage will want to take their lives," he said.

Blanke said the field of end-of-life care and especially medical aid in dying needs more interventional studies—like the one he plans to conduct on the effects of mandated treatment for depression.

"There are lots of unanswered questions," he said. "It's frustrating that almost all of the research in this field has been descriptive. It's really time to do some more controlled trials, and I think we are on the cusp of doing that."

In the *JAMA Open Network* article, he and colleagues concluded: "There is significant room for further integration of palliative care, social support services, and case management in end-of-life decision-making with the intent of increasing the options available to those facing a terminal disease." **PN**

**▶ "Trends in Medical Aid in Dying in Washington and Oregon" is posted at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/72747692>.**

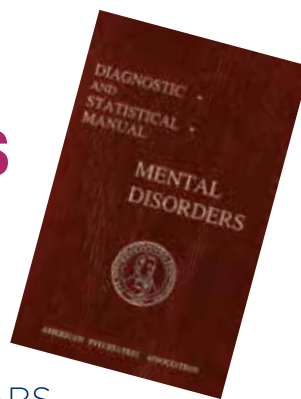
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# Efforts to Describe Mental Illnesses Continue to Make Progress

The long and challenging labor to bring psychiatric diagnostic standards into the modern world has improved patient care and made research more reliable and valid. **BY AARON LEVIN**



175 YEARS



For Hippocrates and Galen and their followers over succeeding centuries, the four humors explained the origins of human personality and behavior. By the mid-19th century, however, scientists sought anatomical clues for mental illness. That model had a promising start. The discovery that syphilis caused general paresis of the insane and Alois Alzheimer's recognition of neurofibrillary tangles in the brains of demented patients were valuable discoveries. But those observations were harder to extend to other disorders.

In Germany, Emil Kraepelin, in serial revisions of his textbook on psychiatry through the 1890s, abandoned any attempt at classification based on the anatomic characteristics of a given condition. Instead, he took meticulous notes on each patient and collated the accumulating evidence. He ultimately divided mental illnesses into the psychoses (dementia praecox, now termed schizophrenia) and the mood disorders (manic depressive [now bipolar] disorder).

In 1917, the Committee on Statistics for the American Psychiatric Association (then called the American Medico-Psychological Association), together with the National Committee on Mental Hygiene, formulated a plan for gathering uniform statistics across mental hospitals. This initiative resulted in the creation of the *Statistical Manual for the Use of Institutions for the Insane*, a first in the United States.

The next major step came after World War II. The war's psychiatric aftereffects on military personnel pushed the Veterans Administration to develop criteria to manage patients in its care. At the same time, the World Health Organization (WHO) set about revising the International Lists of Causes of Death to include causes of morbidity, culminating in the publication of ICD-6 in 1948, the first version of the ICD to include diseases.

In 1948 APA began work on a variant of ICD-6, which was published in 1952 as the first *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The "Diagnostic" element was descriptive, and the "Statistical" was a nod to the psychiatrists running America's mental asylums, said Darrel Regier, M.D., M.P.H., who served as vice chair of the DSM-5 Task Force and is a former director of APA's Division of Research. He is now a senior scientist and adjunct professor in

psychiatry at the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences.

The first *DSM* was heavily influenced by the dominant psychoanalytic paradigm of the day, as was its successor, *DSM-II*, in 1968. Freudian terms like "neurosis" and "reaction" remained, as well as an emphasis on the social and intrapsychic causes of mental illness.

The definitions in both *DSM-I* and *DSM-II* were brief and not well differentiated, said *DSM* expert Michael First, M.D. For instance, one well-known study found that the same set of patient descriptions presented to psychiatrists in the United States and Great Britain resulted in radically different sets of diagnoses. First is a professor of clinical psychiatry at Columbia University and a research psychiatrist at the New York State Psychiatric Institute. He was heavily involved in editing the text and criteria in *DSM-IV* and *DSM-IV-TR* and was an editorial consultant on *DSM-5* and is now a member of the *DSM* Steering Committee and co-chair and editor of the *DSM-5* text revision (*DSM-5-TR*).

Loose definitions of mental illness were not just a clinical problem. Researchers lacked consistent standards by which to recruit subjects and measure treatment effects. Insurance companies were increasingly cautious

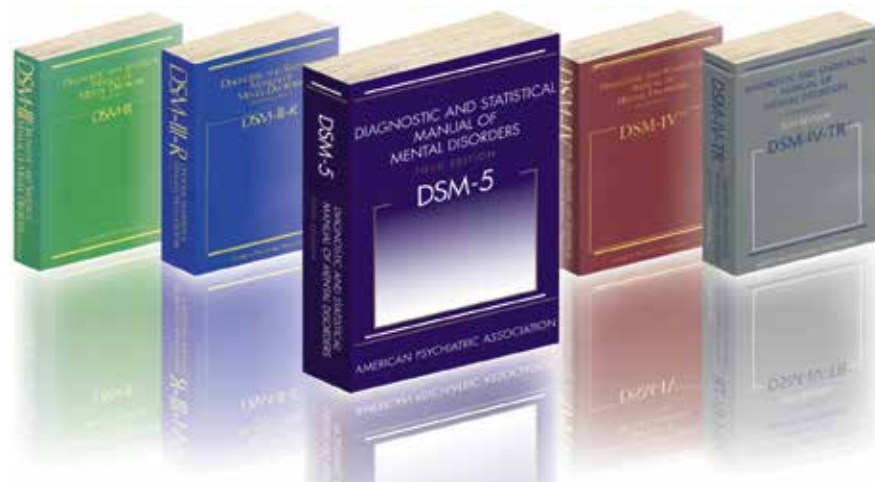
about paying for making a diagnosis and care they saw as ill defined.

In the 1950s, WHO sponsored a comprehensive review of diagnostic issues, conducted by the British psychiatrist Erwin Stengel, M.D. He called for explicit definitions of disorders as a means of promoting reliable clinical diagnoses.

"*DSM-I* and *DSM-II* had little impact on the mental health fields," said First. "They were mainly used for statistical purposes, especially in state systems, which needed a system for routine reporting on their patient populations.



Robert Spitzer, M.D., is recognized for pioneering a system of measurement and assessment for diagnosing mental illnesses that helped move American psychiatry toward a more evidence-based nosology.



As the knowledge about psychiatric illnesses has progressed, APA's *Diagnostic and Statistical Manual of Mental Disorders* has been updated regularly since the first edition was published in 1952. Here are the publication dates of later editions: *DSM-II*: 1968; *DSM-III*: 1980; *DSM-III-R*: 1987; *DSM-IV*: 1994; *DSM-IV-TR*: 2000; and *DSM-5*: 2013. *DSM-5-TR* is now in development.

The move to *DSM-III* in the early 1970s was motivated by a desire to tackle perceived problems with both the reliability and validity of psychiatric disorders. Both researchers and clinicians needed better definitions."

APA selected Robert Spitzer, M.D., to head up the development of *DSM-III*. He had worked on *DSM-II* and was instrumental in having homosexuality removed as a mental disorder from *DSM-III*. (An article that focuses on the removal of homosexuality from *DSM* will appear in the next issue.)

Spitzer wanted psychiatric diagnoses to be defined in terms of purely descriptive symptoms, without the implied etiology suggested by psychoanalytic language, said First.

Much of the groundwork for that had been laid by Eli Robins, M.D., and a group of other psychiatrists at Washington University in St. Louis, who focused on the biology of the brain, said Regier.

In 1972 John Feighner, M.D., of Washington University in St. Louis and colleagues published "Diagnostic Criteria for Use in Psychiatric Research" in the January 1972 *Archives of General Psychiatry*. The Feighner Criteria helped standardize the definitions of 16 disorders for use by researchers in recruiting subjects for research studies.

"The team that developed the Feighner Criteria made three key contributions to psychiatry: the systematic use of operationalized diagnostic criteria; the reintroduction of an emphasis on illness course and outcome; and an emphasis on the need, whenever possible, to base diagnostic criteria on empirical evidence," wrote Kenneth Kendler, M.D., Rodrigo Muñoz, M.D., and George Murphy, M.D., in "The Development of the Feighner Criteria: A Historical Perspective" in the February 2010 *American Journal of Psychiatry*.

Spitzer refined and expanded them into the Research Diagnostic Criteria (RDC) for an NIMH study on the psychobiology of depression, and they became the precursors to *DSM-III*. However, in developing diagnostic criteria for *DSM-III*, Spitzer went beyond both the Feighner and RDC criteria. His team put them into a consistent format and then used a system whereby a certain number of symptoms were required to make a diagnosis. The result, published in 1980, was groundbreaking.

"*DSM-III* took over the world of mental health practice—it's descriptive atheoretical approach and its precise definitions allowed it to be embraced by researchers and clinician across the mental health professions," said First.

Inevitably, such a major shift in approach would be imperfect. *DSM-III* was revised (as *DSM-III-R*) in 1987, the focus of which was correcting errors as well as reflecting the results of

see *DSM* on page 25



# APA Quality Measurement Initiative Needs You to Help Test Measures

*APA needs psychiatrists and mental health professionals to become a part of the Learning Collaboratives that will be testing preliminary measures developed under a grant from the Centers for Medicare and Medicaid Services.*  
**BY MARK MORAN**

**A**PA needs psychiatrists and other practicing behavioral health care specialists to contribute to a federally supported effort aimed at developing meaningful quality measures for behavioral health.

Last year, as part of a cooperative agreement with the Centers for Medicare and Medicaid Services (CMS), APA was awarded \$5.38 million over three years to develop quality measures for behavioral health. The measures are intended for use by a wide range of health care professionals, including psychiatrists, social workers, other behavioral health professionals, and primary care providers who treat indi-



Jerry Halverson, M.D., says that measurement-based care quality measures should not supplant clinical wisdom, but rather support and enhance it.

viduals with opioid use disorder, first-episode psychosis, and suicidality, among other psychiatric conditions.

The initiative is embarking on an important new stage in which preliminary measures will be tested by mem-

bers of a PsychPRO Learning Collaborative. (PsychPRO is APA's national mental health registry.) These preliminary measures focus on measurement-based care processes; Learning Collaborative members have agreed to

integrate the quality measures and assessment tools into their outpatient practice. There is still time for interested APA members to join the Learning Collaborative and become involved in the development of measures by contacting Debbie Gibson, APA's deputy director of mental health registries, at [dgibson@psych.org](mailto:dgibson@psych.org); or Barbara Casanova, APA's assistant project manager for PsychPRO, at [bcasanova@psych.org](mailto:bcasanova@psych.org).

The measure development team includes APA staff from the departments of Reimbursement Policy, Research, and the PsychPRO mental health registry in partnership with seasoned quality measure developers from the National Committee on Quality Assurance. Also consulting on the initiative are members of APA's Committee on Quality and Performance Measurement, as well as the initiative's volunteer technical expert panel (TEP).

The TEP is composed of psychiatrists, psychologists, social workers, other advanced behavioral health professionals, and primary care providers. Given the importance of capturing the value of these measures to patients and family members, the initiative also includes a separate consumer/family panel (CFP). The CFP is composed of individuals with

see **Measurement** on page 25

Advertisement

# Grassroots Movement of Psychiatrists Arises to Support Asylum-Seeking Families

*A psychiatrist takes matters into his own hands to join with like-minded individuals to train mental health professionals, lawyers, and others who want to help asylum seekers.* **BY SHAWN SIDHU, M.D.**

*"Our lives begin to end the moment we become silent about things that matter."*  
—Dr. Martin Luther King Jr.

I remember feeling so nervous and shaky the first time that I drove to the Immigration and Customs Enforcement (ICE) detention center in rural Grants, N.M. I made my way to the ICE checkpoint, eyeing the barbed wire fences, and soon passed through a metal detector. Entire families were waiting at the checkpoint to see detained loved ones.

An ICE officer led me back to an interview room where I met a transgender woman who reported some of the most horrific traumas I had ever heard. Her story was so graphic and terrible that it seemed completely surreal, as if such a story could exist only in fiction and not in the real world. She described things that seemed unimaginable for one human being to do to another and for no apparent reason. Her pain and tension were palpable as she trembled with fear and told her story through a shaky voice. She had to stop the interview several times as



University of New Mexico.

Shawn Sidhu, M.D., is training director of the Child and Adolescent Psychiatry Fellowship Program and an associate professor in the Department of Psychiatry at the

she sobbed into scarred arms. She looked me in the eye as she fought back tears and said, "If I go back, they will kill me and my family."

I remember dissociating for most of the drive home and just staring off into the distance to grasp what I had heard. I wrote the report and anxiously awaited any news. After what seemed like an eternity, I got a call from her lawyer, who informed me that our mutual client had indeed been granted asylum! It was one of the most exhilarating moments of my life. As physicians we often get to provide people with symptomatic relief, and if we're lucky, we can change a life trajectory, but seldom do we get to provide individuals with freedom!

A small group of us began doing asylum evaluations at the detention center in early 2018, but it quickly became clear that we would not be able to meet the exponentially increasing demand. I remember feeling stuck in that moment and reached out to national organizations to come to New Mexico for a large group training. We even offered to pay for such a training, but we were told that "New Mexico does not currently have the infrastructure to support this work."

With few other options, we decided to do the training ourselves. We applied for a small grant and were floored when 100 people signed up, and 71 came to the program. One of the attendees was from Texas Tech El Paso, and she invited me to do a similar training in El Paso. This training drew many more people, and the news media were present to spread the word about our movement and its building



Shawn Sidhu, M.D., poses with Fabiola Ekleberry (left), president of the Professional Counselors of El Paso, and Rep. Veronica Escobar (D-Texas) at one of the trainings for professionals who want to help asylum seekers.

momentum. I returned to El Paso several months later and was honored to have U.S. Rep. Veronica Escobar  
*see Asylum Seekers on page 21*



## PSYCHIATRY & INTEGRATED CARE

### Contouring a CoCM Program To Local Needs and Strengths

**BY JIM PHELPS, M.D.**

*Effective collaborative care programs share core principles such as patient-centered, measurement-based, and population-based care, and some of the most effective implementations of the model make smart adaptations based on available needs and resources. In this month's column, Jim Phelps, M.D., writes about how Samaritan Health Services in rural Oregon built an effective primary care psychiatric consultation program based on its unique situation and strengths.*

—Jürgen Unützer, M.D., M.P.H.

The waiting list to see a psychiatrist at Samaritan Mental Health had been lengthening for years. We used to joke, wryly, "Psychiatry here has two speeds: inpatient or six months." Our community, especially our primary care colleagues, desperately needed something in the middle.

Given its repeated demonstrations of improved access and improved outcomes, the collaborative care model (CoCM) was an obvious solution. Over more than four years, we've developed a 20-clinic primary care psychiatric

consultation program based on the core principles of CoCM, contoured to meet our local needs and build on local strengths.

#### Need 1: Access

The strongest need and principal driver of our efforts was the lack of access to psychiatric services, as manifest in our waiting lists. Because access to psychotherapy for patients with Medicare and Medicaid was similarly limited, primary care providers (PCPs) often prescribed multiple medications trying to help their patients with

depression and anxiety (an average of eight psychotropics before consult).

#### Strength 1: Multiple Willing Psychiatrists

Fortunately, one of the strengths we could build upon was a team of psychiatrists with primary care experience and a strong inclination toward a CoCM approach. Though short of psychiatrists for a traditional model of care, for a CoCM approach in a limited number of primary care clinics, we were relatively psychiatrist rich—including child/adolescent specialists.

We capitalized on this by designing in a psychiatrist's involvement in every referred case, enabling us to pursue differential diagnosis closely, particularly trauma and/or bipolarity.

#### Need 2: BHC candidates

We had difficulty finding strong candidates for the behavioral health consultant (BHC) role, especially in our more rural areas (Oregon coast and Cascade foothills). So we shifted to using bachelor's-level candidates, sometimes with little clinical experience, who then receive two months of on-the-job training: extensive "role



Jim Phelps, M.D., is emeritus staff psychiatrist with Samaritan Mental Health in Corvallis, Ore.; research editor for the Psychopharmacology Institute; and medical

director of PsychEducation.org. 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.

induction" instruction, then shadowing an experienced provider, then weeks of observed interviewing and documentation. They are then based in one or two primary care clinics where they receive warm handoffs and conduct a structured interview for our diagnostic database. These mental health consultants (MHCs), as we call them, do not receive the psychotherapy instruction that is part of the training of UW's behavioral health care managers and do not offer therapy per se. But they are part of the patient-centered team in their clinics, they maintain our registry, and their follow-up

*continued on facing page*



# Full-Time Telepsychiatrist Has Wide Reach To Patients Across Southwest U.S.

*In the days following the shooting in Odessa, Texas, telepsychiatrist Jenny Boyer, M.D., J.D., Ph.D., was able to connect with veterans who were witness to the event.*

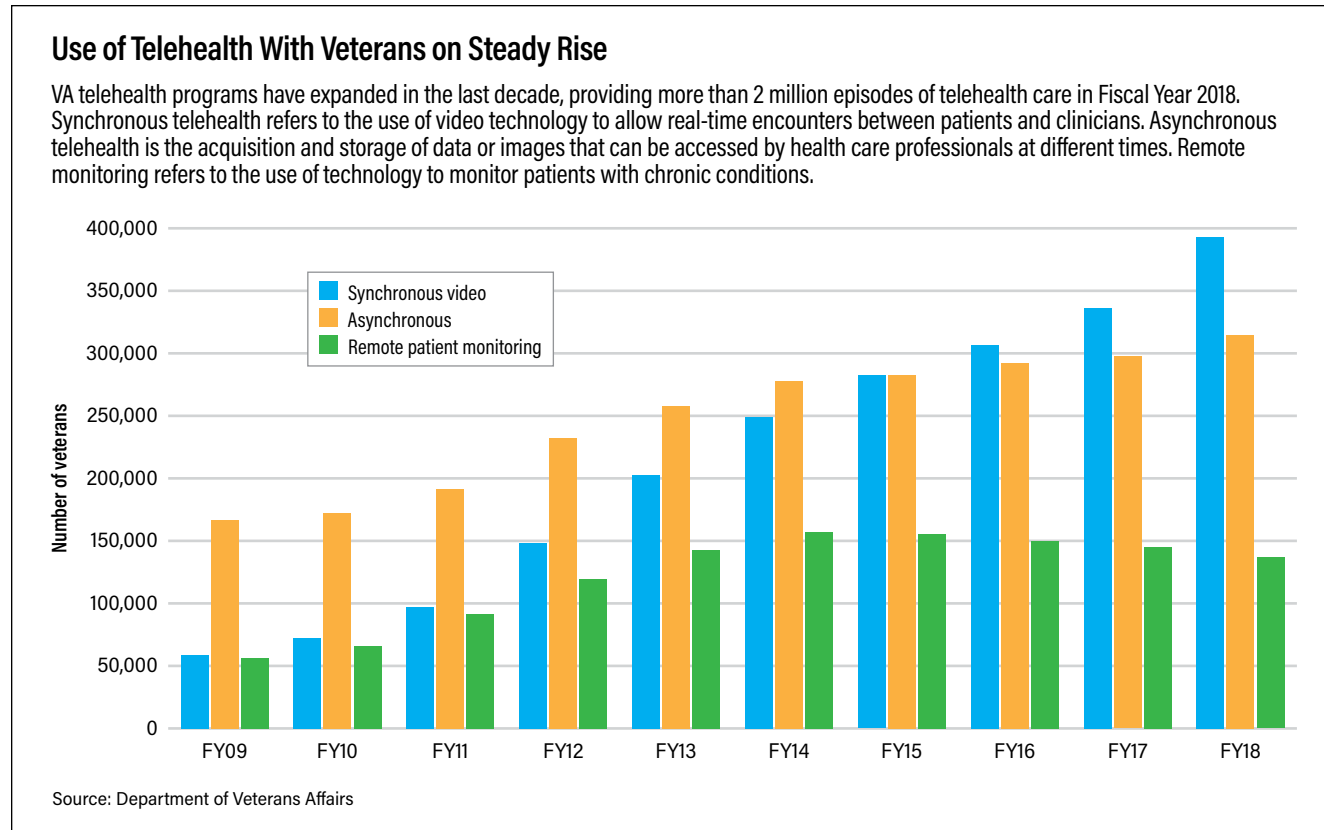
BY MARK MORAN

Jenny Boyer, M.D., J.D., Ph.D., covers a lot of ground as a full-time telepsychiatrist, working from her home for the Department of Veterans Affairs.

Her geographic area of clinical responsibility in West Texas includes Big Springs, Abilene, San Angelo, and Odessa. She has also connected with patients in Hobbs, N.M.

Last month her reach across the rural regions of the Southwest United States brought her into contact with survivors of, and witnesses to, the mass shooting in Odessa in August, in which eight people were killed and 25 injured.

A significant number of her more than 500 regular telepsychiatry patients are veterans who have seen combat, and they had a unique perspective on that event and a response shaped by their own historical experience. The shooting spree began after a routine traffic stop in which the perpetrator fired at police officers, then



drove through the Odessa and Midland areas of Texas shooting randomly. It ended when police killed the gunman outside a movie theater.

Describing her experience with patients in Odessa after the shooting—

and more generally as a full-time telepsychiatrist—Boyer emphasized that she was speaking on her own behalf and not for the Department of Veterans Affairs (VA).

“A couple of my patients reported that during the shooting, they were in combat mode, calling on their training to protect civilians and to face an enemy,” said Boyer, who is also APA’s Area 5 trustee. “The shooting was very loud, lasting a couple of hours, and the shooter was moving, which is like combat. They saw an active-duty colleague killed, and it caused them to relive their own combat experiences.

“Their training made them fearless, not thinking of themselves until it was all over,” Boyer told *Psychiatric News*. “But afterward, many were unable to sleep and avoided talking to anyone. They were waiting at the door [of the telepsychiatry clinic where they receive care] to try to see me the first day I was on duty after the shooting. These veterans were stalwart, then tearful, and afraid that our country is becoming a combat zone.”

The delayed traumatic response to a shooting is familiar to other psychiatrists who have treated survivors. “We psychiatrists are second-line responders in a disaster such as this, waiting for these symptoms to percolate over time,” psychiatrist Lesley Dickson, M.D., executive director and a past president of the Nevada Psychiatric Association, told *Psychiatric News* after the shooting at the Route 91 Harvest Country Music festival two years ago in Las Vegas. “We can expect these people to show up

weeks or even months after the event with a story to tell, one they need to tell.”

## A Long Reach

Boyer’s patients in Odessa and elsewhere throughout “Texoma” can thank the VA’s commitment to telemedicine and telepsychiatry. According to the VA, in Fiscal 2018 the Veterans Health Administration provided more than 2.29 million episodes of telehealth care to more than 782,000 patients; more than 45% of these veterans live in rural areas.

The VA has three programs that draw on information and telecommunications technology:

- **Synchronous telehealth** is the use of real-time, interactive videoconferencing, sometimes with supportive peripheral technologies, to assess and provide care to a patient remotely. Typically, the patient at a clinic is linked to a health care professional at another location.

- **Asynchronous telehealth** is generally defined as the use of technologies to acquire and store clinical information (for example, data, image, and sound), which is then forwarded to or retrieved by a health care professional at another location for clinical evaluation.

- **Remote patient monitoring** is a program in which veterans with chronic conditions (for example, hypertension or diabetes) can opt

see *Telepsychiatrist* on page 24

*continued from facing page*

patient interviews facilitate treatment to target.

We have a relatively ample supply of candidates for this position (having a local university helps). They are willing to work in our rural communities. But attrition is high: most last about two years in this role, often obtaining additional clinical training and degrees (we expect some to return!). A steady recruitment and training program is necessary. Fortunately, we have a superb director for this process, which is critical.

## Strength 2: A Common Electronic Health Record System

EPIC is used for electronic health records throughout our system, which enables extensive direct communication between our MHCs, consulting psychiatrists, and PCPs. MHCs write up their initial interview and send it to the psychiatrist. Based on that write-up, the scanned questionnaire, and further examination of the chart as needed (recent PCP visits, other medical problems, prior medications, labs, and so

on), the psychiatrist adds an impression and one to four recommendations. Further details are placed in appendices. PCPs appreciate the detailed guidance and its inclusion in the chart for review at the next appointment.

With this means of focused communication with our PCP colleagues, we’ve found another joy in this CoCM process (besides being able to shrink that wait list by 50%): Every case is an opportunity to teach, offering just a little concept and a little insight in each consult, specific to the PCP’s level of understanding. Routine recommendations can be stored as “dot phrases” and entered as appendices with a few keystrokes. With this guidance, our PCP colleagues’ reluctance has shifted to a solid team approach.

EPIC now includes our registries, both adult and child/adolescent. Our relationship with local psychotherapists (some are in-clinic) is an area for further development, with the hope of broadening access there. There is much more work to do, but we’ve gotten great gains so far, which have been almost universally appreciated in our clinics! We are extremely grateful to the UW team for leading the way. **PN**



# APA Joins New Brief Opposing Kentucky's Medicaid Waiver Requiring Work

*The new brief repeats the argument that the Kentucky Medicaid waiver proposal that requires beneficiaries to work will cause many to lose coverage.*

BY MARK MORAN

APA has joined a friend-of-the-court brief, filed with the United States Court of Appeals District of Columbia Circuit, urging the court to strike down a proposed Medicaid waiver by the Commonwealth of Kentucky requiring Medicaid beneficiaries to work in order to receive benefits.

The amicus brief, filed with 10 other organizations, repeats all of the substantive points raised in an earlier brief filed with the United States District Court for the District of Columbia. In March that court struck down the proposed rules in Kentucky and Arkansas requiring Medicaid beneficiaries to work, stating that the federal government's approval of those rules was "arbitrary and capricious."

After a second round of public comment, the Department of Health and Human Services (HHS) re-approved a nearly identical approach by the Commonwealth of Kentucky. As before, the program's proponents claim work requirements will lift beneficiaries out of unemployment, improve health outcomes, and strengthen social safety nets.

In the new amicus brief, APA and the other organizations make three overarching arguments. They are as follows:

- Conditioning eligibility for coverage on employment will lead to mass disenrollment and dramatically worse health outcomes. By the commonwealth's own estimates, this program will lead to 1.14 million lost coverage months—the equivalent of nearly 100,000 people losing coverage for a year. "HHS and Kentucky do not explain how often-insurmountable barriers to entering the workforce and remaining employed will go away just because the Commonwealth conditions health coverage on employment," according to the brief. "Many unemployed and underemployed beneficiaries will simply lose coverage."

- Kentucky HEALTH (the name of Kentucky's waiver program) imposes new burdens and penalties on beneficiaries that jeopardize coverage for the gainfully employed. It requires beneficiaries to report their work status monthly. Any reporting mistake could trigger disenrollment. Kentucky's program requires beneficiaries



"A work requirement is a considerable challenge for nondisabled individuals who have intellectual or mental health conditions that seriously interfere with the ability to work," says Marvin Swartz, M.D., chair of the APA Committee on Judicial Action.

to shoulder premiums, report any change affecting eligibility, and submit documentation for annual eligibility redeterminations. Under Kentucky HEALTH, failure to check these boxes can lock beneficiaries out of coverage

for up to six months. That would create a steady churn of people losing coverage, only to get it back months later, possibly after they become sick.

- Losing benefits exposes former

beneficiaries to the risk of medical bills they cannot afford and, in some cases, the threat of bankruptcy. Without a reliably insured patient population, rural providers could be forced to shut down. The program will create new administrative expenses and increase Medicaid costs when healthy beneficiaries lose their coverage only to re-enroll when their health worsens and their conditions are costlier to treat.

In comments to *Psychiatric News* preceding the earlier district court case, Marvin Swartz, M.D., chair of APA's Committee on Judicial Action, said that many individuals eligible for Medicaid may be unable to work even if the Social Security Administration has not officially determined them to be disabled.

"There are clearly documented gains in health outcomes resulting from Medicaid insurance coverage that will be lost, and predictably health will decline," he said. "Such a work requirement is a considerable challenge for nondisabled individuals who have intellectual or mental health conditions that seriously interfere with the ability to work. They will very likely lose access to general and behavioral health care." **PN**

The amicus brief is posted at <https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/amicus-briefs/amicus-2019-Stewart-v-Azar-No19-5095.pdf>.



## ETHICS CORNER

### Clinician or Evaluator? Know Your Role

BY CLAIRE ZILBER, M.D.

A 40-year-old pharmacist, whom you have been treating for five years for generalized anxiety disorder, has done well on escitalopram augmented with regular exercise and a men's support group. After a motor vehicle accident in which he sustains a moderate concussion, he complains of headaches, cognitive fogging, and diminished concentration while multitasking. Neuropsychological testing shows mild impairment of executive function, particularly with response inhibition and sustained attention during complex tasks.

He tells you that managing the details of a busy pharmacy for a full workweek is difficult and asks you to fill out a form stating that he can work only 30 hours a week. The form requires information about your patient's diagnosis, extent of impairment, and prognosis, as well as which work duties are affected. You want to help your patient, but you are uncomfortable completing



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

the form because you're not sure you know the answers to all of the questions.

The role of a clinician is to evaluate and treat the patient. In this capacity, the clinician has a fiduciary duty only to the patient, which means that the patient's needs are paramount. The word "fiduciary" derives from the Latin root *fiducia*, which means trust. Commonly used in the context of banking or other financial services, in which the financial agent places the client's interests above the company's own, it also applies to health care profession-

als. Patients trust that their physicians are making treatment decisions based on what is best for the patient, not what is most profitable or interesting to the physician. They also are assured of patient confidentiality.

The role of an evaluator is distinct from that of a clinician. An evaluator's task is to complete an assessment and provide a report on the findings, usually to a third party, such as an employer, insurance company, Social Security Administration (SSA), attorney, or court. The evaluator's fiduciary duty is divided between the patient and the third party.

The patient should be able to trust that the evaluation will be objective and complete, that the report will be delivered in a timely manner, and that the limits of confidentiality inherent in reporting to a third party will be respected. That is, the physician may share relevant information with the third party to complete the assessment report but will respect the patient's

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# Arkansas Medicaid Work Requirement Led to Coverage Losses, Study Shows

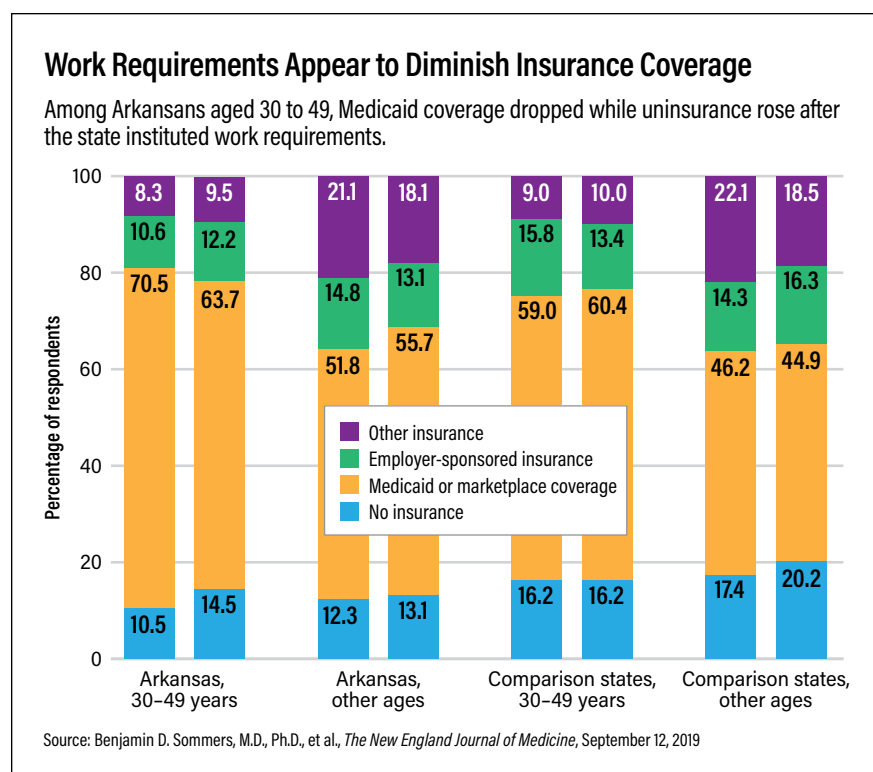
*There was no change in employment or community engagement as a result of the work requirement largely because nearly all of the targeted population had an exemption or was already meeting the requirements, according to the lead investigator.*

BY MARK MORAN

Medicaid coverage of low-income Arkansas residents between 19 and 34 years of age dropped by almost 7% after the state instituted work requirements for Medicaid beneficiaries, while lack of any insurance among the same group rose by 4%.

At the same time, there were no significant gains in employment or in community engagement by beneficiaries, and many beneficiaries were unaware of the policy or were unsure how to comply with the requirements.

These were among the findings of a telephone survey of 5,955 low-income individuals in Arkansas and three comparison states (Kentucky, Louisiana, and Texas) published September 12 in *The New England Journal of Medicine* (NEJM). Not all of the respondents were Medicaid beneficiaries; some may have



had Obamacare, another kind of insurance, or no insurance.

The survey results appear to support claims by APA and other health organizations that work requirements will lead to health coverage losses.

In June 2018, Arkansas became the first state to implement work require-

ments in Medicaid. The state notified beneficiaries aged 30 to 49 that they were required to work 80 hours a month, participate in another qualifying community engagement activity such as job training or community service, or meet criteria for an exemption such as pregnancy or disability.

*continued from facing page*

confidentiality in other domains.

The evaluator also owes a fiduciary duty to the third party. The employer, insurance company, SSA, attorney, or court rely on the assessment to be objective and unbiased. If the evaluator does not find the patient to have the extent of injury or disability that the patient would like to have represented, the evaluator is obligated by his or her duty to the third party and to society to be honest in the report, even though the patient may perceive this as unhelpful.

If a psychiatrist is both the patient's clinician and evaluator, there is potential for role confusion and harm to the psychiatrist-patient relationship. If the patient wants a certain outcome from the evaluation, the psychiatrist may feel subtle or overt pressure to please the patient and preserve the alliance. However, if the psychiatrist skews the report in favor of the patient, that could be considered fraud and an abrogation of the psychiatrist's duty as an evaluator for the third party. That said, if the psychiatrist reports objectively in the evaluation and the patient does

not get the desired outcome, the patient may feel betrayed, harming the treatment alliance.

Some invitations to serve in a dual role are clear and easy to decline. For example, if a patient is involved in a civil or criminal legal proceeding, the treating psychiatrist should not serve as an expert witness in the case. The complete loss of confidentiality inherent in testifying in a deposition or courtroom is destructive to the treatment relationship, and patients usually are able to understand and appreciate the psychiatrist's desire to protect the patient's confidentiality in this context.

Trickier are the requests to complete applications for disability, disability bus passes or parking permits, emotional support animals, and test accommodations. Some of these may be appropriate, but others may put the psychiatrist in the uncomfortable position of bending the truth to benefit the patient. There are no black-and-white rules on which to rely; rather, the psychiatrist must consider each request on a case-by-case basis.

Returning to the case of the phar-

macist with mild neurocognitive impairment, should the psychiatrist fill out the work accommodation form? It depends.

On the one hand, if the psychiatrist has significant experience in neuropsychiatry and feels confident in his or her ability to assess impairment and predict prognosis, it may be appropriate to complete the form. On the other hand, how does the psychiatrist know what work duties are affected other than through the patient's own report? What if the psychiatrist completes the form the first time, but then the form must be modified to support a change in the work position desired by the patient? Precedent has already been set with the patient that these forms are part of the service provided by the psychiatrist. At some point, even if initially comfortable with completing an evaluation, the psychiatrist may need to set a limit on what evaluative services he or she is willing to conduct. Explaining to the patient the tension between clinical and evaluative roles may help preserve the alliance when declining to complete any additional evaluations. **PN**

By December, nearly 17,000 adults were notified by mail that they had been removed from Medicaid. In March 2019, a federal judge halted the program owing to concerns about its effect on coverage (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.5a20>).

According to the Kaiser Family Foundation Medicaid Waiver Tracker, other states have submitted waivers to implement work requirements—Alabama, Mississippi, Oklahoma, South Carolina, South Dakota, Tennessee, and Virginia—and others have been approved for such changes: Arizona, Indiana, Michigan, Ohio, Utah, and Wisconsin. A work requirement waiver in Kentucky was also halted by the federal court in March; it is being challenged again in appeals court, where APA has joined in an amicus brief arguing that the waiver will be especially harmful to patients with serious mental illness (see facing page).

“More than a dozen states have proposed work requirements in Medicaid, but Arkansas is the only one that fully implemented them [before the court stepped in earlier this year],” Benjamin D. Sommers, M.D., Ph.D., lead author of the NEJM report, told *Psychiatric News*. “While advocates of the policy say it can increase employment, raise people out of poverty, and replace Medicaid coverage with private insurance, we don't find any evidence of those changes and instead see people losing their health insurance largely due to red tape.”

Sommers is a professor of health policy and economics at the Harvard T. H. Chan School of Public Health and Brigham and Women's Hospital.

The researchers conducted a random-digit dialing telephone survey to compare changes in outcomes before and after implementation of the work requirements in Arkansas among people aged 30 to 49, as compared with Arkansans aged 19 to 29 and 50 to 64 (who were not subject to the requirement in 2018) and with adults in the three comparison states.

Sommers and colleagues found that the share of Arkansans aged 30 to 49 who had Medicaid or marketplace coverage under the Affordable Care Act went from 70.5 percent in 2016 to 63.7 percent in 2018. Meanwhile, the percentage of uninsured respondents among Arkansans aged 30 to 49 increased from 10.5% in 2016 to 14.5% in 2018 (see chart).

In all groups and comparison states, employment declined between 2017 and 2018; among Arkansas residents aged 30 to 49, employment declined by 3.5 percentage points, from 42.4% to 38.9%.

“Implementation of the work requirements led to significant losses

see *Arkansas* on page 24



# Psychiatrists React to Genetic Study Of Same-Sex Sexual Behaviors

*Large genomic analysis strengthens the idea that sexual behavior is a complex trait governed by multiple genetic and environmental factors, but experts in LGBTQ psychiatry caution against focusing on why people are gay. BY NICK ZAGORSKI*

On August 30, an article in *Science* reported the findings of the first-ever large-scale genome analysis into sexual orientation. The study validates same-sex sexual behavior as a complex human trait influenced by numerous biological and environmental factors.

"We wish to make it clear that our results overwhelmingly point toward the richness and diversity of human sexuality," lead author Andrea Ganna, Ph.D., a geneticist at the Broad Institute of MIT, and colleagues wrote. "Our results do not point toward a role for discrimination on the basis of sexual identity or attraction, nor do our results make any conclusive statements about the degree to which 'nature' and 'nurture' influence sexual preference."

In brief, this study analyzed the genome sequences of nearly 500,000 people who provided DNA samples and completed surveys about their sexual

behavior. The samples came from both the national UK Biobank and the consumer genomics company 23andMe. The results showed that lots of genetic



**"This study is not going to change the problems that gay and lesbian people are facing now."**

**—Eric Yarbrough, M.D.**

variants likely contribute to sexual behavior, and this genetic variation accounts for between 8% to 25% of the differences in sexual behavior.

Large genetic analyses have typically been welcomed in psychiatry; studies that uncover genetic risk factors for depression or substance use help reduce stigma by validating the biological nature of these disorders

while also identifying new therapeutic drug targets. For many psychiatrists, exploring the genetic factors that influence sexuality is not as cut and dry.

"I was torn after reading about this study," said Eric Yarbrough, M.D., a New York City psychiatrist, chair of APA's Council on Minority Mental Health and Health Disparities, and past president

of the Association of LGBTQ Psychiatrists. On the one hand, he said he is glad that research like this is being conducted. The idea that sexual orientation has some hereditary basis is not new: studies have previously shown that same-sex sexual behaviors run in families. On the other hand, this analysis adds new context into some of the mechanisms involved. For example, the anal-

ysis strengthened a long-held idea that sex hormone regulation affects sexual orientation. The study also suggested that there may be a connection between same-sex sexual behavior and the olfactory system in men.

But while the study investigators were careful to avoid simplistic conclusions, especially discriminatory conclusions, the data are open to interpretations that might be disheartening to some in the LGBTQ community.

"Many gay advocates say they are born a certain way, and this study does sort of contradict that," said Yarbrough. "It doesn't mean they are wrong, but it does shed light on how complex sexual orientation and identity are."

The modest influence of genetics reported in the study might also be misrepresented by individuals or groups who believe gay behavior can be modified, noted Jack Drescher, M.D., a clinical professor of psychiatry at Columbia University. "Some on the religious right have equated being gay with alcoholism," he told *Psychiatric News*. "Even though there may be a genetic influence on sexual behavior, it doesn't mean you have to give in to the impulses. This study will probably not change any opinions in that regard."

Drescher and Yarbrough also noted that this study did not fully address

*see Genes on page 24*



## VIEWPOINTS

### Some Random Thoughts on 'Gay Gene' Studies

BY JACK DRESCHER, M.D.

A recent study in the journal *Science* claimed to "reveal insights into the genetic architecture of same-sex sexual behavior." Following the study's release, an above-the-fold, front-page headline in *The New York Times* declared, "Many genes influence same-sex sexuality, not a single 'gay gene.'"

This is not entirely news. A 1991 study examined the likelihood of both twins being gay. The chance of two identical twins being gay was 52%; the frequency of fraternal twins being gay was only 22%. If homosexuality resulted from genetic transmission, one might expect 100% gay identical twins. Yet, 52% for identical twins compared with 22% for fraternal twins suggests genetics play some role, although not entirely, in the development of sexual orientation.

This new study notwithstanding, today, the relative contributions of nature and nurture remain unknown.

#### Heterosexuality as Default

Although theorizing origins of both same-sex relations and other-sex relations are found in Plato's *Symposium*,



Jack Drescher, M.D., served on the DSM-5 Work Group on Sexual and Gender Identity Disorders. Among other positions, he is a Distinguished Life Fellow of APA and a clinical professor of psychiatry at Columbia University. He is the author of *Psychoanalytic Therapy and the Gay Man* and emeritus editor of the *Journal of Gay and Lesbian Mental Health*.

the terms "homosexuality" and "heterosexuality" were first coined in 1869—in fact, by a journalist—a time when scientific speculation about same-sex feelings, behaviors, and attractions flourished. Then and now, heterosexuality's origins were taken for granted, requiring no need for further study.

Sigmund Freud was an exception. Despite his own theorizing about "inversion's" etiology, a 1914 footnote to *Three Essays on the Theory of Sexuality* noted that "from the point of view of psychoanalysis, the exclusive sexual interest felt by men for women is also a problem that needs elucidating and is not a self-evident fact based upon an attraction that is ultimately of a chemical nature."

Freud's caveat notwithstanding, researchers often, and implicitly, treat heterosexuality—needed to propagate the species—as a default position requiring no explanation. Consequently, headlines trumpeting genetic "causes" of heterosexuality are unlikely as no one is looking for them.

#### Patients Ask "Why Am I Gay?"

In clinical practice, gay patients sometimes ask therapists "why" they are gay.

What motivates the question? When one has a stigmatized identity—and gay identities are still stigmatized today—perhaps a therapist can provide an etiological narrative that makes sense to the patient. However, depending on the therapist's training, beliefs, and biases, patients might conceptualize their homosexuality as good ("normal," "born gay"), bad ("mental disorder," "unforgivable sin"), or childish and immature ("infantile sexuality," "developmental arrest").

Occasionally, although less commonly than in the past, gay patients encounter therapists who introduce the issue of why the patient is gay. Of course, it would be highly unusual for a therapist to raise similar questions

with straight patients. Heterosexual patients rarely ask therapists why they are straight, and one would be hard pressed to find many heterosexual patients willing to spend time and money on such a "treatment."

#### Culture Wars

So why do "gay gene" studies make headlines? After APA removed "homosexuality per se" from *DSM-II*, mainstream mental health professionals moved away from pathologizing same-sex feelings and attractions. This eventually contributed to a cultural normalization of homosexuality.

However, speculation about homosexuality's origins persists as a culture wars issue in a political battle over whether society should accept gay relationships on an equal basis with heterosexual ones.

On one side are those who believe people are "born gay" (often synonymous with genetically determined). In arguments against discrimination, the modern LGBTQ civil rights movement often speaks to this implicit belief. On the opposing side are religious, social conservatives who say no one is born gay. They believe that being gay is sinful or immoral and that those coming out as gay are making a wrong choice. These

*continued on facing page*



# Anticholinergics Linked to Increased Risk of Dementia

*A study finds an association between anticholinergic antipsychotics and antidepressants and greater dementia risk, but should psychiatrists deprescribe these medications? BY TERRI D'ARRIGO*

The American Geriatrics Society's Beers criteria generally caution against the use of anticholinergic medications in older patients because of the risk of confusion and memory loss, yet many older people take these drugs to treat conditions ranging from depression to overactive bladder to seasonal allergies. Now a study published in *JAMA Internal Medicine* suggests another potential risk for certain anticholinergics: dementia.

Carol A. C. Coupland, Ph.D., a professor of medical statistics in primary care at the University of Nottingham, and colleagues compared the health records of 58,769 British adults aged 55 years and older who had dementia with those of 225,574 peers who did not have dementia. The team also analyzed anticholinergic prescriptions written over a 10-year span before the patients' dementia diagnosis or, for patients who did not develop dementia, an equivalent timeframe. They broke the patients' total number of anticholin-

ergic doses into five categories based on the number of doses taken over the 10-year span: 0, 1 to 90, 91 to 365, 366 to 1,095, and more than 1,095.

Patients who took the most doses of anticholinergics were roughly 50% more likely to develop dementia than those who did not take anticholinergics. The risk was greatest for those who took anticholinergic antipsychotics, followed by those who took bladder antimuscarinics, antiparkinson agents, antiepileptics, and antidepressants. Risk also increased for patients who took antivertigo medications, but only for those who took the second greatest number of doses (366 to 1,095). The associations were strongest in patients who were diagnosed with dementia before they turned 80 years old.

There were no significant increases in dementia risk associated with anticholinergic skeletal muscle relaxants, gastrointestinal antispasmodics, antiarrhythmics, antimuscarinic bronchodilators (used to treat chronic obstructive pulmonary disease [COPD] and asthma), or antihistamines.

The risks were generally higher for vascular dementia than for Alzheimer's disease, a finding not seen in other studies to date. The researchers said this raises questions about the ways that anticholinergics may increase risk.

"These may include vascular and inflammatory changes, as well as the more obvious mechanism of chronic cholinergic depletion," they wrote. "Perhaps the mechanism underlying the potential effects of anticholinergic drugs is not solely through blocking acetylcholine and causing an excess of Alzheimer disease, so future research

should give consideration to possible mechanisms."

The researchers acknowledged several limitations to the study, mainly that some patients may not have taken their medications as prescribed, so their exposure to anticholinergics may have been misclassified.

"This misclassification ... might explain the lack of association for antihistamines and the highest exposure category of antivertigo drugs," they wrote.

The researchers adjusted the results to account for factors known to increase risk for dementia, such as smoking and diabetes, and for the conditions for which the anticholinergics may have been prescribed, such as COPD or schizophrenia.

Regardless, the study should not be used to imply causation, said Tom Denning, M.D., a professor of dementia research at the Institute of Mental Health at the University of Nottingham and a researcher in the study. "Despite the long lead-in period in this study, we can't be totally confident that these drugs cause dementia, as there may still be mediating factors that we have not accounted for," Denning told *Psychiatric News*.

Yet, psychiatrists need to be aware of the findings and consider whether medications have anticholinergic effects before prescribing or deprescribing them, he added. "They will have anxious patients seeking advice as to whether to continue with medications, but of course they need to balance out future risks against current efficacy of treatment when having these discussions with patients," Denning said.



If patients are doing well on an anticholinergic, psychiatrists should be cautious about taking them off, says Maureen Nash, M.D., M.S.

"Deprescribing makes the most sense when someone has a small likelihood of benefiting from a medicine or never needed it to begin with," said Maureen C. Nash, M.D., M.S., a member of APA's Council on Geriatric Psychiatry. "If your life expectancy is less than five years, then many classes of medication will no longer benefit you."

Nash urged caution in deprescribing anticholinergic antipsychotics or antidepressants if a patient is doing well on them because there is no guarantee that restarting the medications will work as effectively if the patient relapses.

"This is a real risk that people with serious mental illness face and should always be a part of the discussion about risks, benefits, and alternatives," Nash said. "These are among the questions to ask before considering a change: How many medications did this person have to try before finding something that worked? How severe has the patient's illness been in the past? What is the family history of suicide or severe illness?"

Nash added that every treatment decision should be based on an understanding of not only the risks and benefits of treatment but also the risks of the patient's illness or symptoms.

This study was supported by the National Institute for Health Research, the University of Nottingham, Care East 15 Midlands, MedTech, and the In Vitro Cooperative. **PN**

**2** "American Geriatrics Society 2019 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults" is posted at <https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.15767>. "Anticholinergic Drug Exposure and the Risk of Dementia: A Nested Case-Control Study" is posted at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2736353>.

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religious beliefs underlie refusal to normalize homosexuality as well as efforts to change homosexuality through sexual orientation conversion efforts (SOCE).

Inevitably, differing interpretations of the new genetic study appeared quickly.

In *The Advocate*, Dean Hamer, author of a landmark 1993 "gay gene" study, remarked, "It's easy to confuse 'no single gay gene' with 'no genetic influence,' which in short order will be misinterpreted as 'it's a choice.' ... [J]ust because our sexuality is complex and individualistic doesn't mean that it isn't deeply ingrained as part of our identity."

In contrast, the Catholic News Agency quoted a theologian saying, "This is simply irrelevant to the analysis of the moral goodness or evil of homosexual acts, and of the ordered or disordered character of the homosexual tendency or disposition."

In the culture wars, each side gleans from science what it will, making it unlikely that scientific findings alone will decide when society will treat gay people as full citizens. **PN**

**2** References for this article are posted at <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.10a23>.



Although the study shows an association between dementia risk and anticholinergics, the results should not be interpreted to imply causation, says Tom Denning, M.D.

The University of Nottingham





With the help of sensors that track real-time data on the hits a football player receives (see image below) over the course of a season, Bradford Mahon, Ph.D. (left), and Adnan Hirad, Ph.D., found that impacts that cause head rotations are more responsible for midbrain damage than head-on collisions.

Carnegie Mellon University

## New Analysis Suggests There Is No Such Thing as Harmless Head Contact in Football

Using innovative helmet-based sensors, researchers have pinpointed the midbrain as a key marker of early sports-related brain injury. **BY NICK ZAGORSKI**

It may be cliché to term sports-related research as a “game changer,” but those words may accurately reflect the recent findings of investigators at the University of Rochester and Carnegie Mellon University (CMU) on the detrimental effects of sports-related head impacts.

With the help of specially designed football helmets with embedded sensors that monitor the speed and trajectory of incoming hits, this team found that just a single season of collegiate football results in damage to the brain’s white matter (nerve fibers that support the transmission of electrical signals throughout the brain)—even in the absence of a concussion or any outward symptoms of brain problems.

What’s more, the researchers found that it’s not head-on collisions that appear to be the main culprits of damage to nerve fibers; rather, hits that result in head twisting seem to cause the most nerve damage.

“Everyone interested in this area has focused on concussions, and that’s well and good,” noted lead investigator Adnan Hirad, Ph.D., an M.D./Ph.D. candidate at the University of Rochester who was a driving force behind the study. “But what about all these other repetitive hits sustained during games or practice. How bad are they [for the brain]?”

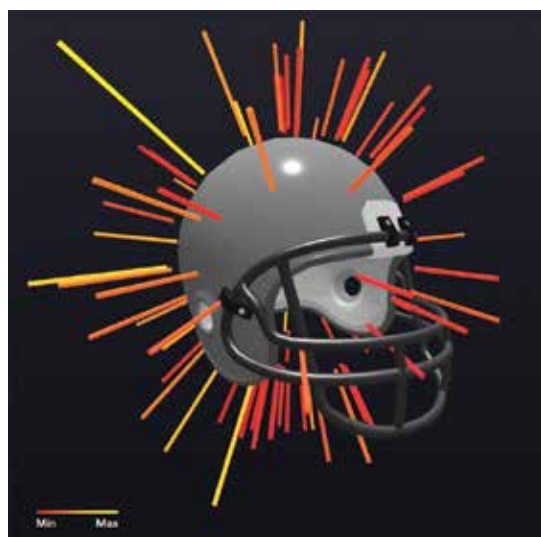
Based on the analysis of 38 University of Rochester football players who

participated in a head impact study, these seemingly innocuous hits are anything but. MRI scans of these players taken before and after one football season revealed significant white matter damage in the midbrain, even though only two of the 38 participants sustained a concussion during the season. (The midbrain is the topmost section of the brainstem that controls sensory functions like vision, hearing, alertness, and the sleep/wake cycle.)

The degree of white matter damage correlated with both the number and force of hits sustained, especially the amount of rotational force a player sustained.

Senior investigator Bradford Mahon, Ph.D., an associate professor of psychology at CMU (and previously at Rochester), told *Psychiatric News* these findings raise several practical considerations.

For one, the detailed sensor readouts obtained in the study might lead to improved helmet designs that can reduce some of the potential damage. “Football helmets are heavy, and while that weight and thickness can reduce the effect of a linear impact, that added



The sensors embedded in the helmet create a “spatial fingerprint” showing the direction and force of all sustained head hits. Over time, such information may help identify players at risk of clinical head trauma symptoms. See more at [openbrainproject.org](http://openbrainproject.org)

Adnan Hirad et al., Science Advances 2019

weight increases your susceptibility to a rotational shift,” he explained. “Developing lightweight helmets [using composite materials and force-absorbing foams or gels, for example] would help move the needle in regard to brain injury.”

These helmet sensors might also serve as an objective way to measure an athlete’s neurological injury prior to the emergence of any clinical symptoms.

“My goal when starting the project was to find a good biomarker for [subtle] head injury,” Hirad said. “Is there an equivalent in the brain to the canary in the coal mine?”

Hirad focused on the midbrain because this region has multiple characteristics that make it a good location to assess early neurological damage. First, it is centrally positioned in the brain and susceptible to injury from multiple directions. The midbrain also regulates behaviors like eye movement, which is known to be disturbed after a concussion, so damage to this region likely contributes to the symptoms of head injury. Third, midbrain damage has been implicated in neurodegenerative diseases, which suggests that short-term physical damage can lead to chronic effects.

The strong connection between rotational impacts and white matter damage seems to validate Hirad’s choice of the midbrain as the proverbial canary. For further evidence, he and colleagues examined MRI scans from 29 other Rochester athletes from a variety of sports who sustained a concussion and observed that these athletes also had midbrain damage.

Mahon said he envisions a future where a football player can be monitored in real time using helmet sensors to assess potential brain damage without requiring an MRI scan. With such information, team doctors might be able to better identify when a player who has not sustained a concussion should be taken out of a game to prevent serious injury.

Study co-author Jeffrey Bazarian, M.D., a professor of emergency medicine at the University of Rochester, is also looking for blood-based biomarkers that correspond to impact-related neurological damage. (This would be useful in medical settings and for contact sports that don’t use helmets.) His latest research suggests that serum levels of the Alzheimer’s-related protein tau might be a good proxy for brain injury.

“Right now, the only criterion for playing is whether an athlete is showing any symptoms of a concussion,” Mahon said. “But that is the equivalent of sending someone with radiation exposure back into a nuclear environment just because the individual has no outward signs of radiation poisoning.”

Mahon noted that more data need to be collected to assess questions like how white matter damage accumulates on a week-to-week basis or if the midbrain can repair white matter damage following an extended contact-free offseason.

“But what we would really hope to do is monitor football players at different ages and assess them over multiple years,” he said. “With that, we might be able to get a glimpse of what a lifetime of football does to the brain, not just one season.”

As researchers come to understand football’s long-term effects on the brain, Mahon believes the discussion over football will have to tackle exis-

see **Football** on page 20

**Advertisement**



# Study Finds Little Benefit of Adding Fluoxetine to CBT for Youth

*Though combination therapy did not reduce depressive symptoms in youth, youth with comorbid anxiety experienced greater symptom improvements relative to CBT alone.* **BY NICK ZAGORSKI**

An article published in the September issue of *Lancet Psychiatry* has brought the issue of antidepressant use in youth to the forefront again. A clinical trial led by researchers at Orygen, the National Centre of Excellence in Youth Mental Health in Melbourne, Australia, found that combining cognitive-behavioral therapy (CBT) with fluoxetine was not superior to CBT alone at improving depressive symptoms in teens and young adults with major depression.

This lack of effect was particularly noticeable for participants who were younger than 18, noted lead author Christopher Davey, M.B.B.S., Ph.D., the head of Mood Disorders Research at Orygen. For patients aged 18 and over, there was some indication that a combined approach was more effective than CBT alone, especially if the patients had comorbid anxiety symptoms.

The Youth Depression Alleviation–Combined Treatment (YoDA-C) study involved 153 participants aged 15 to 25 years with moderate-to-severe major depression (score of 20 or higher on the Montgomery-Åsberg Depres-

sion Rating Scale, or MADRS). All participants received weekly, 50-minute CBT sessions and either daily fluoxetine (up to 40 mg/day) or placebo pills for 12 weeks. The researchers evaluated the participants' depressive and anxiety symptoms, social functioning,

quality of life, and suicidal thoughts every four weeks.

After 12 weeks, there was no statistical difference between the two study groups in depression symptom improvement; MADRS scores decreased by 15.1 points among patients receiving CBT plus fluoxetine and 13.7 points among patients receiving CBT plus placebo. The rates of remission (achieving a MADRS score of 7 or less) were similar

in the groups: 24% of patients in the CBT plus fluoxetine group achieved remission, and 19% patients in the CBT plus placebo group achieved remission. Likewise, secondary measures such as improvements in self-reported depressive symptoms, social functioning, and overall quality of life were similar between the two treatment groups.

The one exception was anxiety, as measured by the Generalized Anxiety Disorder 7-item scale (GAD-7). GAD-7 scores decreased by 5.3 points in the fluoxetine group compared with 3.2 points in the placebo group, which was a statistically significant difference.

In looking at different age groups, the researchers found that participants aged 18 and older generally showed stronger responses to fluoxetine than those under 18. Though MADRS scores remained similar, older participants taking fluoxetine had statistically significant improvements in all the secondary measures (anxiety, self-reported depressive symptoms, social functioning, and quality of life) relative to placebo. Participants under 18 did not show significant improvements in any of these assessments.

The lack of any benefit of fluoxetine treatment for participants under age 18 is noteworthy since it stands in con-

see **Fluoxetine** on page 21

## KEY POINTS

The Youth Depression Alleviation–Combined Treatment study compared the effects of 12 weeks of cognitive-behavioral therapy (CBT) plus fluoxetine versus CBT plus placebo in 153 adolescents and young adults with major depression.

- Overall, CBT plus fluoxetine **was not** superior to CBT plus placebo at reducing depressive symptoms.
- Overall, CBT plus fluoxetine **was** superior to CBT plus placebo at reducing anxiety symptoms.
- Age-related analysis suggested that participants 18 and older are more likely to benefit from the addition of fluoxetine to CBT.
- There were no statistical differences in suicidal ideation or self-harm between the groups, though the number of incidents was small.

**Bottom Line:** This placebo-controlled study suggests adding fluoxetine to CBT provides minimal benefits for major depression, though it may be useful in participants 18 and older and/or those with comorbid anxiety.



## FROM THE EXPERTS

# Preventing and Treating Mood Disorders Starting in Childhood

**BY MANPREET KAUR SINGH, M.D., M.S.**

Youth around the world are increasingly being diagnosed with a spectrum of mood disorders. Improved awareness that mood disorders commonly start in childhood has decreased stigma and made treatment more accessible. With early identification comes the promise of reducing the silent suffering that frequently occurs when an accurate diagnosis or adequate treatment is delayed. Are we prepared and resourced to universally screen for and treat children and adolescents for mood disorders? Who is most at risk for developing lifelong recurrence of mood symptoms? Which interventions are readily available for youth who are at highest risk for developing intractable mood disorders? Let's briefly consider each question.

### Universal or Targeted Screening?

Many successful screening programs have been implemented in schools and in pediatric primary care settings. Depression screening pro-

grams based on comprehensive, multi-informant, and novel biological risk factors may improve the sensitivity and specificity of depression screening compared with programs limited to single self-report assessments. Screening during critical sensitive windows, such as during transitions between middle school to high school and high school to college, may also be valuable. Indeed, a lag between diagnosis and treatment can lead to illness progression and subsequent treatment nonresponse, so screening for early-onset mood disorders is imperative for clinicians working with youth, but also for working with adults.

### Which Children Are at Risk?

Children with a family history of mood disorders and exposure to early life stress are predisposed to developing a mood disorder compared with the general population. Emerging evidence suggests that children of parents with bipolar disorders are at an increased risk compared with the general popu-



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lation for developing mood and other psychiatric disorders and that there may be a differential response to psychotropic medications (toward increased side effects) based on this familial risk. Maternal depression also has received considerable research attention as a contributor to the onset and persistence of mood symptoms in children. For example, adolescents whose mothers experience moderate to severe and persistent symptoms of

depression have more relationship problems with peers and lower prosocial behaviors compared with children of mothers with low levels of depression, independent of socioeconomic or other characteristics.

### What Interventions and When?

We have many reasons to believe that we can make tangible differences in the lives of youth with or at risk for mood disorders through early identification of key risk factors and targeted treatment. For example, although sex, high polygenic risk scores for depressive symptoms, and maternal postnatal depression have been associated with persistent forms of depression, exposure to parental domestic violence and bullying seem to be associated with discrete and time-limited forms of depression that are highly responsive to early intervention. We have also learned that youth with pediatric-onset bipolar disorder spend most of their time in euthymic mood states and may

continued on facing page

# Verbal De-Escalation May Not Be Best For Children With Aggressive Behavior

*After switching from a program of behavioral modification to verbal de-escalation as a strategy for agitated pediatric patients, one hospital found the need for medications or restraints rose. BY NICK ZAGORSKI*

A comprehensive behavioral modification strategy that includes parental training, positive incentives, and limit setting (like “timeouts”) to change problem behaviors is more effective than verbal de-escalation for managing agitation in children with disorders like attention-deficit/hyperactivity disorder (ADHD) or oppositional defiant disorder (ODD). The findings were reported in the *Journal of the American Academy of Child & Adolescent Psychiatry*.

When staff at Stony Brook University Hospital’s 10-bed children’s psychiatric inpatient unit treated agitated children with behavioral modification, they prescribed fewer sedatives and antipsychotics and less frequently used physical measures, including seclusion or restraints, than when they used de-escalation strategies. De-escalation strategies include “talking down” patients

or diverting their thoughts away from the source of agitation.

This study was made possible by the fact that the inpatient unit has kept a database for many years examining temper outburst behavior in children. When the unit shifted from a behavioral modification-centered approach for managing patients to a de-escalation-based approach, it was possible to examine the impact of the change. Elimination of the behavioral approach was due to multiple factors, but in part reflected a belief that giving children “timeouts” for unacceptable behavior was a form of patient restraint and should be avoided.

The researchers, led by Gabrielle Carlson, M.D., a professor of psychiatry and pediatrics at the Renaissance School of Medicine at Stony Brook University looked back at the patient records of 510 children who had been admitted to the hospital for aggressive behaviors between 2008-2018. Of these, 347 children were admitted to the unit when the behavior modification program was the standard practice and 163 when verbal de-escalation was used.



Jeanne Neville

Though her new study provides some insight into managing emotion dysregulation in children, Gabrielle Carlson, M.D., notes that tremendous gaps in knowledge remain. As incoming president of AACAP, Carlson aims to focus her term on addressing these gaps.

The researchers compared how often these children were administered “pro re nata (PRN),” or as needed,” medications during their stay; the use of PRNs was a proxy indicating a severe temper outburst for which verbal efforts were ineffective. They found that more children on average needed PRNs and needed them more frequently when verbal de-escalation was the practice compared with when behavioral modification was employed. In addition, the need for seclusion or physical restraint was higher when de-escalation was used compared with when behavioral modification was the practice.

The differences in staff’s use of medication and restraints may have been the result of staff not receiving sufficient training in verbal de-escalation effectively, the authors noted. “However, the hundreds of hours of nurse’s notes we reviewed suggests they were doing the best they could in these situations,” Carlson told *Psychiatric News*.

She believes the findings point to a shortcoming with the use of verbal de-escalation in children with conditions like ADHD and ODD (many of whom also have listening comprehension problems). Verbal de-escalation by nature requires paying increased attention to children during an outburst by talking to them. “And when you see how much attention some of these children were getting, maybe it’s not surprising they continued to act out,” she said.

“I’m not saying behavioral modification would be valid for every child at

every age with every psychiatric illness,” she continued. “However, behavior modification with parent training has considerable evidence behind it in children with ADHD and ODD.

The results “highlight that success [when treating aggressive outbursts in children] depends on multiple interventions like behavioral therapy, education, and parental involvement,” Dan Conner, M.D., a professor of psychiatry and chair of the Division of Child and Adolescent Psychiatry at the University of Connecticut, told *Psychiatric News*.

Conner, who was not involved with the study, added “Wouldn’t it be nice if we could ... take these tools that work in inpatient settings and apply them elsewhere. Then we can reduce the number of children who need hospitalization. It’s not as easy as writing a prescription, but it does work.”

“There is so little information about the specific management of explosive temper outbursts in children in the literature,” noted Carlson. “[H]opefully, this study has helped advance our understanding of inpatient management, even if just a tiny bit.”

Carlson, who is the incoming president of the American Academy of Child & Adolescent Psychiatry (she will take over at AACAP’s annual meeting this month), plans to make emotion dysregulation in children the theme of her two-year term. Emotion dysregulation addresses children who get too angry too fast and for too long.

She told *Psychiatric News* that she will emphasize research, education, and advocacy to improve the diagnosis and treatment of children with emotional dysregulation. Items on Carlson’s agenda include the following:

- Improve how explosive outbursts are classified in the *DSM*. Currently, this problematic behavior is not well-represented in *DSM-5* outside of the newly defined in disruptive mood dysregulation disorder. These behaviors occur in several different disorders, and there is no way to identify them.
- Encourage the Food and Drug Administration to make this kind of pediatric aggression a priority treatment target. Some attempt has been made to address irritability in autism, but irritability may not always include explosive outbursts. Other conditions such as pain have received tremendous interest and research funding and might serve as a model on how to increase support for aggression.

- Develop measures that factor in all three important aspects of aggressive outbursts: How often the child gets angry, how angry the child gets, and how long he or she stays

see *De-Escalation* on page 24

*continued from facing page*

have better outcomes than those with adult-onset bipolar disorder. It turns out that rates of bipolar disorder are not higher in the United States than in other Western countries as previously thought and do not appear to be increasing over time, though prevalence rates of pediatric bipolar disorder vary due to inconsistent use of standard diagnostic criteria. These latest findings support leveraging early and preventive efforts for most youth, while concentrating advanced therapeutic efforts on youth who are at greatest risk for poorer outcomes and at critical sensitive windows in development.

There are a number of available evidence-based treatments for youth with and at risk for mood disorders, and the level of evidence is strengthening with controlled treatment trials, Food and Drug Administration–approved interventions (see the figure included in the online version of this article), and prospective follow-up studies to determine long-term outcomes. Family-based intervention strategies that directly target family history risk provide psychoeducation, communication skills building, and problem-solving

strategies to prevent mood disorder onset and recurrence.

Mechanisms underlying risk for developing a lifelong mood disorder or how a child responds to treatment for a mood disorder are emerging. A number of researchers are now conducting prospective, longitudinal studies of youth and families with or at risk for mood disorders to observe children through the course of their neurodevelopment and as they transition into adulthood. With a strong movement toward evidence-based practice, clinicians and patients alike are seeking guidance from the latest research on clinical best practices and the development of novel treatments that will outperform the current standard of care.

Our patients and families count on us to share advances on the horizon for the identification and treatment of mood disorders in youth. Sharing our efforts to learn from the past and innovate for better treatments conveys hope amidst the stressful contexts of their daily lives. **PN**

**References and related information for this article are posted at <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.9a22>.**



# How Accurate Is News Media Portrayal of MAT?

Local news coverage in states with high opioid overdose rates highlighted more negative than positive consequences of OUD medication use. **BY TERRI D'ARRIGO**

**N**ews media coverage of medication treatment for opioid use disorder (OUD) is increasing, but there is room for improvement in its accuracy, a study in *Health Affairs* suggests.

Researchers at the Johns Hopkins Bloomberg School of Public Health looked at news stories about medication treatment for OUD in national media outlets such as the *New York Times*, *Wall Street Journal*, *Washington Post*, and *USA Today*; television news programs on major networks such as ABC, CBS, and NBC; television news shows with high viewership such as CNN's "Situation Room," Fox News Channel's "Special Report," and the PBS "NewsHour"; and two local newspapers in each of nine states hit hard by the opioid crisis. The researchers found that 45% of 300 news stories included at least one accurate message about medication treatment (for example, medication treatment can help people function), but 16% of news stories included at least one inaccurate message about medication treatment (for example, people on medication treatment are high). Furthermore, 9% of news stories contained the inaccurate message that medication treatment is akin to replacing one addiction for another.

National news outlets tended to fare better than local ones: 67% of their news stories mentioned at least one positive consequence of medication treatment such as reduced harms to health, compared with 46% of local news stories. Similarly, 36% of national news stories mentioned at least one negative consequence of medication treatment such as misuse of the medications, compared with 51% of local news stories. But per-

## Barriers to Medication Treatment

haps most notable is that only 36% of all news stories noted that medication treatment is underused or that people faced barriers to accessing it.

"There's a real disconnect between what the public health and addiction communities know about treating OUD and the information news consumers receive. Misinformation can reduce investment in the infrastructure for delivering medication treatment and reduce interest in medication treatment among people who might benefit, which can be incredibly damaging," said lead author Alene Kennedy-Hendricks, Ph.D., an assistant scientist in the Department of Health Policy and Management.

"I was recently at a community meeting where a parent who had lost her child spoke about her daughter wanting treatment but not medication because she didn't consider it real recovery," Kennedy-Hendricks added. "That individuals who are rebuilding relationships, have a job, or are fulfilling other roles in society that are meaningful to them would be told that they are not truly in recovery because they are treated with medication is really harmful."

Kennedy-Hendricks added that inaccurate messages can contribute to stigma with respect to medication



Johns Hopkins University Bloomberg School of Public Health

There is a disconnect between what addiction professionals know about treatment of opioid use disorder and the information that news consumers receive, says Alene Kennedy-Hendricks, Ph.D.

treatment, leading to "not-in-my-backyard" attitudes toward establishing treatment centers in the community. This can, in turn, siphon support away from policies that would increase access to the medications.

"We've seen letters to the editor stating that [local residents] didn't want methadone or buprenorphine treatment providers in their community," she said.

Psychiatrists can help counter misinformation in the media, particularly at the local level. "Few local newspapers are able to devote a reporter to a particular health beat. Psychiatrists can

educate local news media [by discussing] the science of medication treatment and by sharing stories of people whose recovery from opioid use disorder has involved medication," she said.

The researchers received no outside funding for this study. **PN**

**News Media Reporting on Medication Treatment for Opioid Use Disorder Amid the Opioid Epidemic** is posted at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05075>. APA's media guidelines are posted at <https://www.psychiatry.org/newsroom/reporting-on-mental-health-conditions>.

## MAT

*continued from page 1*

"The physician comes in once a week or once a day for a couple of hours, so for many drug treatment programs, [recovery] has been the province of those who are abstinence based," he said. "[Physicians] should help educate staff about the advantages of medication treatment. There has to be some medical supervision as to what is the most appropriate treatment."

Another reason misperceptions persist is that historically, opioid use disorders did not figure prominently in treatment programs the way alcohol and other drugs have, said John F. Kelly, Ph.D., director of the Massachusetts General Hospital Recovery Research Institute in Boston.

"Now with the opioid epidemic of the last 10 or 15 years, OUDs have been thrust into the forefront. There has been a shift in how we approach substance use disorders [SUDs], and that's where there has been a culture clash with medications becoming a major player," Kelly said.

## Stigma Among Health Professionals

The culture clash has reared its head within the medical profession as well. Interviews with 47 addiction-treatment professionals summarized in *Social Science & Medicine* suggest that physicians who provide MAT may be subjected to stigma themselves, not only from nonphysician counselors in abstinence-based programs, but also from other physicians. This can occur because other physicians have outdated knowledge about MAT, believe that MAT is substituting one addiction for another, or advocate abstinence.

Such attitudes may take hold in medical training, where MAT is often passed over on rounds and medical students are not exposed to success stories involving patients who use MAT, said Salsitz. "For many medical students, a large part of their education takes place in large urban hospitals, where the methadone patients are admitted if they're not doing well. If that's all you see, that's what you expect."

Kelly agreed, noting that most of the stigma is directed toward people who use methadone.

"There's a sense of people just being

left to languish on methadone in the parking lot of life, where they don't do anything and don't seem to go anywhere. It's a cultural stereotype in the treatment sector," Kelly said, adding that buprenorphine has not been stereotyped this way.

Salsitz said that the way the medical community treats its own members who have OUDs exacerbates the problem.

"State-run Physician Health Programs generally will not allow physicians with an OUD to be treated with methadone maintenance, although some programs now allow the use of buprenorphine maintenance," Salsitz said. "Traditionally, Physician Health Programs have endorsed naltrexone for treating physicians with an OUD. Until recently the paradox has been that physicians were not allowed to be on opioid agonist therapy despite the evidence of its effectiveness."

## Education Counters Stigma

Stigma presents a hurdle in providing MAT to patients with OUD, but it can be overcome with a willingness to listen and educate others, said Kelly.

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## Football

*continued from page 16*

tential as well as practical questions. "At what point will there be enough data to consider making consequential changes to this sport, especially in regard to youth playing football?"

The study by Mahon and Hiras, which appeared in *Science Advances*, was funded by the NFL Charities, the National Institutes of Health, and the U.S. Army Rapid Innovation Fund. **PN**

**A Common Neural Signature of Brain Injury in Concussion and Subconcussion** is posted at <https://advances.sciencemag.org/content/5/8/eaau3460>.



## Interested in Buprenorphine Prescribing?

APA offers training and CME credit for physicians who wish to provide office-based treatment of opioid use disorder with buprenorphine. The training meets the federal training requirement of the Drug Addiction Treatment Act of 2000, and completing the training allows qualified physicians to apply for the necessary waiver to their Drug Enforcement Administration (DEA) license to provide this treatment. The training can be accessed at <https://www.psychiatry.org/psychiatrists/education/signature-initiatives/buprenorphine-prescriber-training>. The Substance Abuse and Mental Health Services Administration has also posted information on training and applying for the waiver at <https://www.samhsa.gov/medication-assisted-treatment>.

In addition, APA is a partner in the Providers Clinical Support System (PCSS), whose mission is to increase health care professionals' knowledge and skills in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorder. As a PCSS partner, APA offers free webinars presented by nationally recognized clinical experts, researchers, and government officials. Archived training webinars are available with or without CME credit and can be accessed at <https://www.psychiatry.org/psychiatrists/practice/professional-interests/addiction-psychiatry/pcss-webinars>.



"We as psychiatrists, and as physicians, have a responsibility to address the opioid crisis in our communities and help those with opioid use disorder, and we can do this by becoming qualified to prescribe buprenorphine," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "I urge you to take advantage of the resources that APA offers to help you obtain your DEA waiver as well as sharpen your skills for treating people with opioid and other substance use disorders."

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He suggests motivational interviewing and similar approaches when encountering resistance from counselors, physicians, patients, and others who may have misconceptions about MAT.

"We need to understand why they may have those beliefs and attitudes and see the world through their eyes. Where are they coming from?" Kelly said. "Listen, acknowledge, and validate why they might have those beliefs. Then show them the evidence, what the medications do, and how they reduce overdose and increase the chances of remission. We have a lot of data that support medication treatment."

"The more understanding people have about addiction and the science of the medication, the more they start to see how medication can help," Kelly added. "I liken medication treatment to nicotine patches for smoking. It takes away the nagging cravings of the addiction, so you can focus on your behavior and lifestyle changes to make them more conducive to sustaining long-term remission."

Because family members may be a source of misinformation or stigma, Sarah M. Bagley, M.D., medical director at Boston Medical Center's Center for Addiction Treatment for Adolescents/Young Adults Who Use Substances, engages them in the process. Last year, Bagley and her colleagues published a case series in *Addiction Science & Clinical Practice* about stigma associated with MAT for young adults with OUDs.

"We invite families to come visit. We ask them to have a family meeting

to listen to their concerns, and then share with them why medication treatment is the recommended approach," Bagley said.

She tells patients and family members that OUD is no different from other medical illnesses, such as diabetes, for which study after study shows there are effective treatments.

"If I didn't offer medication treatment, I would not be doing my job," she said.

To that end, Schwartz encourages all psychiatrists to be prepared to offer every available option to their patients who have OUD, including MAT.

"The reality is that you need everything," he said. "It's not one size fits all. It depends on the patient's history and how well the patient has done in terms of attempting recovery from their SUD." He emphasized that no one in practice should shy away from treating people with OUD or other SUDs, and he encourages all psychiatrists to become qualified to prescribe buprenorphine.

"We have medications that are helpful in the care of these patients," Schwartz said. "It's not a magic pill, but these patients are very treatable." **PN**

**2018 NSDUH Annual National Report** is posted at <https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report>. "Intervention Stigma: How Medication-Assisted Treatment Marginalizes Patients and Providers" is posted at <https://www.sciencedirect.com/science/article/pii/S0277953619302916>. "Stigma Associated With Medication Treatment for Young Adults With Opioid Use Disorder: A Case Series" is posted at <https://ascjournal.biomedcentral.com/articles/10.1186/s13722-018-0116-2>.

## Fluoxetine

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trast to the findings of the Treatment for Adolescents With Depression Study (TADS)—a large U.S. clinical trial conducted between 2000 and 2003 across 13 medical centers. This study found that combining CBT with fluoxetine led to greater improvements in depressive symptoms in adolescents up to age 17 compared with CBT alone.

These two studies featured one critical difference: The use of a placebo pill in the comparison group; YoDA-C included one, TADS did not.

While the use of a placebo pill helps to remove potential bias from both the patient and investigator perspectives, "[b]ecause of the high placebo effect seen in youth depression [studies], one cannot assume that CBT plus placebo has the same clinical effect as CBT alone," Benedetto Vitiello, M.D., a professor of psychiatry at the University of Turin, wrote in an accompanying *Lancet* editorial.

Vitiello added that much of the design of YoDA-C was intended to make it applicable to the real world: The participants included both teens and young adults, they were referred from local clinics across Melbourne, and there were minimal exclusion criteria (even youth with suicidal thoughts were included in this trial). But the inclusion of placebo pills somewhat undermines this goal of practicality, since doctors cannot ethically give a patient placebo pills in practice.

"These reported differences highlight the importance of nonspecific treatment factors that may influence a patient's response to medicine," said Joe Kossowsky, Ph.D., a psychologist and instructor of medicine at Boston Children's Hospital, who has exten-

sively studied placebo effects. Nonspecific factors include the hopes and expectations of patients when given a pill, as well as the therapeutic bond a patient develops with his or her doctor or therapist, Kossowsky said. Doctors therefore should not underestimate the impact they can have when prescribing an antidepressant.

Together, the results of both TADS and YoDA-C suggest that adding an antidepressant to CBT could improve symptoms, though it may be largely driven by nonspecific factors. The debate then becomes whether these improvements are worth the potential risks of using an antidepressant, which in youth include the black-box warning about potential suicidal ideation. Interestingly, there were fewer suicide attempts in the CBT plus fluoxetine group relative to the placebo group in the YoDA-C study, but participants in the fluoxetine group reported twice as many instances of nonsuicidal self-harm. In both instances, the total number of events was small and not statistically different.

YoDA-C was funded by a grant from the Australian National Health and Medical Research Council. **PN**

**2 "The Addition of Fluoxetine to Cognitive Behavioural Therapy for Youth Depression (YoDA-C): A Randomised, Double-Blind, Placebo-Controlled, Multicentre Clinical Trial" is posted at [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(19\)30215-9/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30215-9/fulltext). The accompanying editorial, "Youth Depression: Are Two Treatments Better Than One?", is posted at [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(19\)30281-0/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30281-0/fulltext). "The Treatment for Adolescents With Depression Study (TADS): Outcomes Over 1 Year of Naturalistic Follow-Up" is posted at <https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2009.08111620>.**

## Asylum Seekers

*continued from page 10*

(D-Texas) speak at our event.

We then took our training to the epicenter of the refugee crisis in the Texas Rio Grande Valley. Brownsville and McAllen are where many of the children were first separated from their parents this year. We then went to New Orleans, which is home to the largest Honduran population in the nation, and scheduled trainings in Arizona in November.

At press time, we had trained 325 mental health professionals along the U.S.-Mexico border about how to conduct mental health evaluations for asylum-seeking immigrants. Many of these professionals are from small border towns and wanted desperately to do something to help, but did not know what to do. Our training model involves not only training local mental health

professionals, but also inviting critical stakeholders such as immigration lawyers and community organizations to join in the training with us. By doing so, the mental health professionals, lawyers, and community organizations can meet one another and begin the process of creating long-lasting working relationships with one another. We also created a list serve that lawyers can use immediately to contact the mental health professionals who attended with requests for evaluations for their clients. In this way, we have been able to build local capacity to assist asylum-seeking families that will not rely on the assistance of outside experts in the future.

You've heard the adage, "Give a person a fish, and you feed them for a day; teach a person to fish, and you feed them for a lifetime." We've got a lot more fishermen now, and they're all going to be needed. **PN**



## MED CHECK

BY TERRI D'ARRIGO

### OTC Gel Now Available To Aid Pill Swallowing

**P**hasix—a gel designed to help patients older than two years swallow pills, capsules, and powders—became available over the counter in August.

Users place their medication on a spoon and cover it with a teaspoon of the gel. The product adheres to the medication from the mouth to the stomach. It works by moistening the mucous membranes in the mouth and throat cavity, so the medication does not get stuck on the way to the stomach. Once in the stomach, the gel breaks away from the surface of the medication so the drug can be digested, according to Arkray USA, the maker of the gel. Phasix does not affect the absorption rate of the drug, the company says.

### FDA Rejects Hetlioz For Treating Jet Lag

In August the Food and Drug Administration (FDA) rejected Vanda Pharmaceuticals' **Hetlioz** (*tasimelteon*) to treat jet lag. Hetlioz, a melatonin receptor agonist, is approved to treat non-24-hour sleep-wake disorder.

As part of the supplemental New Drug Application for Hetlioz, the company submitted data from a study of 25 patients who flew from the United States to London. In the study, those who took Hetlioz slept roughly three hours longer than those who took placebo. According to a statement issued by Vanda, the FDA asserted that the results "are of unclear clinical significance."

Vanda is currently testing Hetlioz for treating delayed sleep phase disorder; pediatric non-24-hour sleep-wake disorder; and Smith-Magenis syndrome, a developmental disorder that is characterized in part by sleep disturbances.

### Ecopipam Receives FDA Fast Track Designation For Tourette's Syndrome

**E**copipam, an investigational therapy for pediatric patients with Tourette's syndrome, received a "fast track" designation from the FDA in August. The FDA fast track is a process designed to facilitate the development of drugs that treat serious conditions and fill an unmet medical need and expedite their review.

Ecopipam, manufactured by Emalex Biosciences Inc., is a first-in-class therapy that selectively blocks the actions of the neurotransmitter dopamine at a different receptor than approved therapies for Tourette's syndrome.

The most common adverse events reported by patients taking ecopipam included sedation, insomnia, nausea, and vomiting.

Emalex recently began enrolling children and adolescent patients ages 6 to 18 years for a phase 2b, double-blind clinical study of ecopipam, according to the company.

### FDA Approves Wakix For Daytime Sleepiness Caused by Narcolepsy

In August the FDA approved **Wakix** (*pitolisant*) for the treatment of excessive daytime sleepiness in adult patients with narcolepsy, Harmony Biosciences announced. Wakix is a selective histamine 3 receptor agonist-inverse agonist that works to

increase the synthesis and release of histamine. It is a first-in-class oral medication that is administered once a day in the morning.

In two multicenter, randomized, double-blind, placebo-controlled studies, 261 patients with narcolepsy who took Wakix for eight weeks experienced a statistically significant improvement in excessive daytime sleepiness compared with those taking placebo, as measured by the Epworth Sleepiness Scale score. The most common adverse reactions reported by patients taking Wakix were insomnia (6%), nausea (6%), and anxiety (5%).

Wakix will be available in the United States later this year, the company said in a statement.

### Nourianz Approved as Add-On Therapy For Parkinson's Disease

**N**ourianz (*istradefylline*)—a selective adenosine A2A receptor antagonist—has received FDA

approval as an add-on treatment to **levodopa/carbidopa** in adults with Parkinson's disease who are experiencing "off" episodes. An "off" episode is an increase in Parkinson's symptoms such as tremor or difficulty thinking when a patient's medications are not working well.

Nourianz was studied in four 12-week, placebo-controlled trials totaling 1,143 participants with Parkinson's disease who were already being treated with levodopa/carbidopa and who were experiencing an average of roughly six hours of "off" time a day. Those who took either 20 mg or 40 mg of Nourianz daily experienced a statistically significant decrease from baseline in daily "off" time compared with those who took placebo.

The most common adverse reactions in those who took Nourianz were involuntary movements, dizziness, constipation, nausea, hallucination, and insomnia.

The maker of Nourianz is Kyowa Kirin. **PN**



## JOURNAL DIGEST

BY NICK ZAGORSKI



### Visual Marker May Help Identify Autism Severity

Individuals with autism are slower at switching their focus between two competing images (known as binocular rivalry), and the degree of this switching delay correlates with the severity of autism symptoms, according to a study in *Current Biology*. This finding may some day lead to an objective test for autism that does not require any verbal communication.

Researchers at Dartmouth University and Johns Hopkins University tested the binocular rivalry of 18 adults with autism and 19 age- and IQ-matched adults without autism. The participants looked through a special prism so that each eye saw a unique image, and an electroencephalography (EEG) device measured their brain waves as the two images flickered on and off at different frequencies, causing the brain to con-

tinually shift its attention.

The EEG readings showed that the adults with autism were statistically slower at switching their focus between competing images compared with controls (about 21 perceptual switches per minute versus 24 per minute). On average, the participants with more severe autism symptoms (as assessed by the Autism Diagnostic Observation Schedule, second edition) had slower switching. Perceptual switching rates were independent of IQ scores.

The researchers noted that the adults with autism understood the nature of the test as well as the adults without autism, so that did not explain the differences.

Using purely the EEG data, the researchers were able to distinguish the participants with autism from controls with 87% accuracy.

A perception-based biomarker could be useful in several circumstances, the researchers noted. "These include assessments of preverbal infants or adults with minimal communication skills, who are estimated to represent 30% of the autism spectrum but are rarely included in research," they noted.

**Spiegel A, Mentch J, Haskins AJ, Robertson CE. Slower Binocular Rivalry in the Autistic Brain. Curr Biol. 2019; 29(17): 2948-2953.e3. https://www.cell.com/current-biology/fulltext/S0960-9822(19)30871-1**



### Children With IBD Have Greater Risk Of Psychiatric Problems

**C**hildren who develop inflammatory bowel disease (IBD) are at an elevated risk for a range of psychiatric disorders and suicide attempts, according to a study appearing in *JAMA Pediatrics*.

A team led by researchers at Sweden's Karolinska Institute used Swedish health registry data to identify all children born in the country between 1973 and 2013 who received an IBD diagnosis (such as ulcerative colitis or Crohn's disease) before age 18. The analysis included 6,464 individuals with childhood-onset IBD, 6,999 siblings of these patients, and 323,200 unrelated individuals. (Children who had a psychiatric diagnosis prior to an IBD diagnosis and their siblings were excluded from the final sample.)

During the follow-up period (about nine years), 17.3% of the individuals with childhood-onset IBD received a diagnosis of a psychiatric disorder com-

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pared with 11.8% of the general population, corresponding to about a 60% increased risk of psychiatric disorders in individuals with childhood-onset IBD. A similar increased risk was seen when comparing the children with IBD with their siblings.

Risks of a psychiatric disorder were even higher for patients who received an IBD diagnosis before age 6 (140% increased risk), and those who required bowel or perianal surgery (100% increased risk). Individuals with childhood-onset IBD also had a 40% increased risk of suicide attempt.

“The highest risk of anxiety and mood disorders during the first year after a diagnosis of IBD suggests the need for psychological support for these patients,” the researchers concluded. “Particularly concerning is the increased risk of suicide attempt. Long-term psychological support should therefore be considered for patients with childhood-onset IBD.”

**Butwicka A, Olén O, Larsson H, et al. Association of Childhood-Onset Inflammatory Bowel Disease With Risk of Psychiatric Disorders and Suicide Attempt. *JAMA Pediatr.* August 19, 2019. [Epub ahead of print] <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2748635>**



## Weight-Loss Program Benefits Patients On Psychotropics

Individuals who are taking antidepressants and/or antipsychotics may benefit from participation in a weight-management program, according to a study published in *Obesity*.

Researchers at the University of Toronto and colleagues assessed the outcomes of 17,519 adults enrolled in a physician-guided weight-management program at the Wharton Medical Clinic (which has locations throughout Ontario) between July 2008 and July 2017. Of this group, 3,457 adults were taking an antidepressant, 172 were taking an antipsychotic, and 465 were taking both medications. The participants spent an average of 14 to 22 months in the program.

The researchers found that patients lost a significant amount of weight regardless of the psychiatric medications they were taking. Among men, those taking antidepressants lost slightly less weight in the program com-

pared with patients not taking either medication after adjusting for differences in age, starting weight, and treatment time (average weight loss of 7 pounds compared with 9.5 pounds). Men taking antipsychotics or both medications lost similar amounts of weight as men taking neither medication. Among women, there were no adjusted differences in weight loss (average 6.5 pounds) among any of the four groups.

The researchers also found that both men and women taking an antidepressant and/or antipsychotic lost an equal amount of weight regardless of whether their medication was considered “weight-gaining.”

**Wharton S, Kuk JL, Petrova L, et al. Effectiveness of a Community-Based Weight Management Program for Patients Taking Antidepressants and/or Antipsychotics. *Obesity (Silver Spring).* 2019; 27(9):1539-1544. <https://online.library.wiley.com/doi/10.1002/oby.22567>**



## Regular Physical Activity Lowers Risk of Postoperative Delirium

Add one more item to the list of health benefits conferred by regular physical activity: A study published in the *Journal of the American Geriatrics Society* found that older adults who are physically active prior to elective surgery are at reduced risk of postoperative delirium.

Investigators at the Albert Einstein College of Medicine in New York assessed 132 adults (aged 60 and older) without significant cognitive impairment who underwent elective orthopedic surgery. The participants completed a cognitive assessment and a physical activity questionnaire prior to the surgery.

Of this group, 41 patients developed postoperative delirium. Overall, the participants who reported engaging in physical activity at least six days a week prior to surgery were 74% less likely to develop delirium. Women were especially likely to benefit from physical activity; active women were 86% less likely to develop delirium. There was no significant effect of physical activity on delirium risk when looking solely at men.

The effects of physical activity were independent of the patient's cognitive scores. Thus, “[p]ersons with mild cognitive impairment or a relatively low level of participation in stimulating

cognitive activities will likely still benefit from exercise, if tolerated,” the investigators wrote.

There was also some suggestion that regular physical activity lowered the severity of symptoms among patients who did develop postoperative delirium, but these findings were not statistically significant. The investigators suggested that a follow-up analysis in a larger population is warranted.

**Lee SS, Lo Y, Verghese J. Physical Activity and Risk of Postoperative Delirium. *J Am Geriatr Soc.* August 1, 2019. [Epub ahead of print] <https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.16083>**



## More Evidence Supports Depression as Marker For Early Parkinson's

A retrospective analysis of people in Bologna, Italy, provides further evidence that depression may be one of the early symptoms of Parkinson's disease, prior to the more characteristic movement problems associated with this disorder.

A team at the Institute of Neurological Sciences in Bologna tracked a group of adults aged 35 and older from Bologna who did not have Parkinson's disease. The researchers compared Parkinson's disease diagnoses in study participants who took antidepressants for at least 180 consecutive days (considered a proxy for depression) with those who did not take antidepressants.

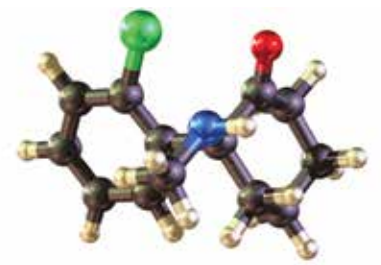
During roughly a decade of follow-up, 34,620 adults (totaling 199,093 person-years) were categorized as exposed to antidepressants, and 389,678 adults (totaling 4,286,470 person years) were considered not exposed.

The researchers found that patients exposed to antidepressants were 70% more likely to be diagnosed with Parkinson's disease than those not exposed to antidepressants, and the diagnosis was made an average of three years after starting the medication.

The risks of Parkinson's disease among individuals who took antidepressants were higher for men, for adults 65 and younger, and adults with fewer medical comorbidities. “[T]he fact that the risk of PD [Parkinson's disease] is higher among patients without other physical conditions favoring depression confirms the link between depression itself and subsequent PD,” the investigators wrote. The article

was published in the *Journal of the Neurological Sciences*.

**Zenesini C, Baldin E, Vignatelli L, et al. Use of Antidepressants and the Risk of Parkinson's Disease in the Local Health Trust of Bologna: A Historical Cohort Study. *J Neurol Sci.* 2019; 405:116421. [https://www.jns-journal.com/article/S0022-510X\(19\)30342-9/fulltext](https://www.jns-journal.com/article/S0022-510X(19)30342-9/fulltext)**



## Opioid Receptors May Mediate Ketamine's Antisuicidality Effects

Ketamine is known to reduce suicidal thoughts in people with severe depression. A study in *Molecular Psychiatry* now suggests ketamine's anti-suicidality effects may be dependent on activation of the opioid system.

The findings come from a secondary analysis of a 14-person clinical trial by researchers at Stanford University and Palo Alto University. Patients received either naltrexone (a strong opioid receptor blocker used to treat opioid use disorder) or placebo prior to receiving intravenous ketamine (though each patient completed both arms of the study). The study participants were evaluated with the Hamilton Depression Rating Scale (HDRS), the Montgomery-Åsberg Depression Rating Scale (MADRS), and the Columbia Suicide Severity Rating Scale (CSSRS) throughout the two-week study.

The researchers found that patients reported less improvement on measures of suicidality (HDRS item 3, MADRS item 10, and CSSRS total score) after ketamine if they had taken naltrexone before the infusion compared with when taking placebo before the infusion.

A previous article for this trial reported that ketamine's antidepressant effects were likely mediated by opioid receptors. The researchers noted that while the relative changes in patients' depression and suicidality symptoms were similar in the first 24 hours, they diverged over the remaining 13 days.

“Thus, similar to past reports, our current data support the hypothesis that the pharmacological mechanism through which ketamine reduces suicidality is partially independent from the mechanism through which it reduces depressive symptoms,” they wrote. **PN**

**Williams NR, Heifets BD, Bentzley BS, et al. Attenuation of Antidepressant and Antisuicidal Effects of Ketamine by Opioid Receptor Antagonism. *Mol Psychiatry.* August 29, 2019. [Epub ahead of print] <https://www.nature.com/articles/s41380-019-0503-4>**



## Telepsychiatrist

*continued from page 11*

to enroll in. The program applies care and case management principles to coordinate care through health informatics, disease management, and technologies such as in-home mobile monitoring, messaging, and video.

The VA's TeleMental Health program conducted about 473,000 consultations with more than 151,600 veterans in 2017. Services provided via the program reduced acute psychiatric VA bed days of care by 40% and VA hospital admissions by 34%, according to the VA.

Boyer works from her home in Norman, Okla., seeing patients in real time; her day begins at 6 a.m. when she makes sure she can connect to whichever clinic she is scheduled to see patients first.

The majority of her patients have major depression, bipolar disorder, sleep apnea, and/or substance use disorders. But many of her patients are also general medical patients with diabetes and orthopedic problems.

Boyer sees younger patients who

have traumatic brain injury and older veterans of Vietnam and Korea. As a woman, she is frequently in demand by women veterans.

"The pros of telehealth are that it really helps patients with a lot of complications save the time and trouble and travel of having to go to a big city center," Boyer said. "It helps to be able to not have to drive to Dallas or Houston if you live hundreds of miles away. Sometimes patients may not like [telepsychiatry] at first, but when they see that it works, they come around."

Boyer has a passion for public service psychiatry, and she said that the technology and distance involved in telehealth do not impede the forging of a relationship with her patients.

The strength of the relationships that Boyer has forged with her telepsychiatry patients was especially important to the veterans of Odessa, even those who were not witness to or directly affected by the shooting. "I had patients who could not make themselves come in [to the clinic], but I was able to call them after hours," Boyer said. "Some of these patients would not leave the house and wanted to avoid any kind of crowds. Others refused to

watch the news and avoided anyone who wanted to talk about the shooting, trying to fight off the effect it had had on them."

Boyer added, "My own heart is sad, but so proud of these good people." **PN**

## Erratum

An article in the September 6 issue incorrectly stated the effective year for two proposals outlined in the proposed 2020 Medicare Fee Schedule released by the Centers for Medicare and Medicaid Services. The following would be implemented in 2021:

CMS proposes requiring performance and documentation of a patient history and exam only as medically appropriate; further, the agency proposes allowing clinicians to bill the E/M visit based on either the level/amount of medical decision-making involved or on the amount of time spent providing care. (The latter proposal removes the requirement that—in order to bill by time—at least 50% of the time must be spent in counseling and coordination of care.)

The full article can be accessed at <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.9a26>. **PN**

## Genes

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sexual identity. The study participants all answered surveys about their sexual behavior (for example, "Have you ever slept with someone of the same sex?"). However, one's actions do not necessarily reflect their identity—there are those who might feel an attraction to the same sex but have not acted on it, for example. The analysis also did not factor in gender identity, which overlaps with one's sexual identity.

At the heart of Yarbrough's concern with the study—and the media attention it has drawn—is that he thinks there are more issues worthy of atten-


tion than trying to find genes associated with sexual behavior.

"This study is not going to change the problems gay and lesbian people are facing now—like lack of access to affirming health care or civil rights concerns," he said. "These findings reinforce that there are many pathways by which people arrive at their sexual identity," echoed Drescher. "However, there is a historical and lingering problem in the field [of psychiatry] in that therapists think all conversations with gay patients need to discuss the reasons they are gay."

Drescher noted that some patients grappling with their sexual identity may want to know more about the biology of sexuality, so psychiatrists are

welcome to highlight this study as evidence that same-sex sexual behavior is a normal behavior. As a result, it should not be overemphasized (a point he discusses in a commentary on page 14). "We do not routinely ask heterosexual patients why they think they're heterosexual. It should be no different for gay patients."

The *Science* study was supported in part by the Eunice Kennedy Shriver National Institute of Child Health and Human Development. **PN**

 **"Large-Scale GWAS Reveals Insights Into the Genetic Architecture of Same-Sex Sexual Behavior" is posted at <https://science.sciencemag.org/content/365/6456/eaat7693.long>.**

## Arkansas

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of Medicaid and an increase in the share of adults without any health insurance in the age range targeted by the policy," Sommers said. "There was no significant change in employment or any of the other community engagement activities that the policy requires—primarily because 97% of the target population already met the requirements, based primarily on working or having a disability."

Moreover, Sommers and colleagues also found that nearly a third of respondents aged 30 to 49 were unaware of the policy change, and more than half indicated they were unsure if it applied to them or not.

"Even those who knew about it were

often confused about how it worked or what they had to do to keep their insurance coverage," Sommers said. "This is the most likely reason why there were significant coverage losses even though most people were already meeting the requirements in one way or another."

He concluded, "These results should serve as a strong note of caution to states moving ahead with work requirements, which may not have their desired effects." **PN**

 **"Medicaid Work Requirements—Results From the First Year in Arkansas" is posted at <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772?query=TOC>. The Kaiser Family Foundation Medicaid Waiver Tracker is posted at <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2>.**


## De-Escalation

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angry. Such measures will improve diagnosis and create a reliable outcome measure for clinical trials.

Treating children with mood dysregulation goes beyond the hospital setting, Carlson emphasized. "We need to better identify, measure, and manage problem outbursts in settings like general practice, foster care, and our schools."

The authors reported that this study required no external funding. **PN**

 **"Behavior Modification Reduces Psychotropic Medication Use in Inpatient Children With Aggression: A Retrospective Cohort Study" is posted at [https://www.jaacap.org/article/S0890-8567\(19\)31435-2/fulltext](https://www.jaacap.org/article/S0890-8567(19)31435-2/fulltext).**

# DSM

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research that was sparked by the availability of the *DSM-III* diagnostic criteria. The next major revision came with *DSM-IV* in 1994. Its main innovation was the establishment of a three-stage empirical review process that involved literature reviews, MacArthur Foundation-funded reanalyses of existing datasets, and the conducting of disorder-specific field trials to test diagnostic proposals. Moreover, there was a concerted effort to harmonize with ICD-10, which was also in development at the same time and came out in 1992. In recognition of the fact that too-frequent changes to the diagnostic criteria sets are disruptive to both clinicians and researchers but also recognizing the important of keeping the information in the *DSM* text up to date, a text revision, *DSM-IV-TR*, came out in 2000.

Work on *DSM-5* began in 2000, when APA convened work groups to design the research agenda for the manual. That effort resulted in numerous monographs and articles, as well as one book, *A Research Agenda for DSM-5*. APA formed the *DSM-5* Task Force under the direction of David Kupfer, M.D., to commence the revision process in earnest.

The lack of discrete boundaries between disorders and between disorders and normality suggested the need for a dimensional approach, an idea developed into the spectrum model. New genetic research was revealing that hundreds, perhaps thousands of genes with small effects underlie most cases of disorders like autism and schizophrenia. Combined with environmental exposures, this led to disease presentations that varied in severity and course.


The Task Force on *DSM-5* adopted a new approach, identifying central tendencies of diagnostic categories but not narrowly limiting them, said Regier.

*DSM-5* entries not only included a diagnostic classification and diagnostic criteria sets but also extended discussions of prevalence, diagnostic features, course of illness, cultural and gender issues, and other matters.

Drafts were posted online to promote transparency and stimulate feedback during the process. Another innovation with *DSM-5* was the establishment upon publication of a “continuous improvement model” for the revision process. “APA invites proposals for changes to *DSM-5*,” says the manual’s website. “Changes will be made on a rolling basis, as warranted by advances in the science of mental disorders.”

The process of reviewing proposed

revisions is overseen by the *DSM* Steering Committee, chaired by past APA President Paul Appelbaum, M.D. (*Psychiatric News*, <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2017.9a4>) “It will be interesting to see how the *DSM* evolves now that we’re seeing more dimensional approaches and advances in the biology of mental illness,” said Regier. **PN**

 “Diagnostic Criteria for Use in Psychiatric Research” is posted at <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/490573>. “The Development of the Feighner Criteria: A Historical Perspective” is posted at <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2009.09081155>.

## Measurement

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mental and/or substance use disorders, their family members, and representatives from mental health advocacy organizations.

Anna Ratzliff, M.D., Ph.D., and Jerry Halverson, M.D., co-chairs of the TEP, emphasized that measurement-based care quality measures developed under the initiative will not diminish the importance of the clinical expertise of the behavioral health care providers,

but should support and enhance that expertise. However, it is essential to include as wide a variety of perspectives as possible in the development of quality measures. “Patients and providers want to know that the care administered yields positive health outcomes and is cost efficient for all stakeholders,” said Halverson.

“Behavioral health, as a clinical specialty across the different provider types, has not reached consensus on what constitutes patient-centered clinical or functional outcomes,” Ratzliff said. “Mea-

surement-based care enables clinicians to collect quantifiable data at intermittent and clinically appropriate time frames. This can be a major resource when caring for their patients.” **PN**

 Members can learn more about the quality measurement grant at [psychiatry.org/qualitymeasures](https://psychiatry.org/qualitymeasures). Additionally, at APA’s 2019 IPS: The Mental Health Services Conference in New York, the symposium “Meaningful Quality Measures: Using PsychPRO to Place Measure Development in the Hands of Providers” will be held on Thursday, October 3, from 1 p.m. to 2:30 p.m.

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