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AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

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David Hathcox

Area 4 Trustee Cheryl D. Wills, M.D. (second from left), is presented with a plaque at the Board of Trustees December meeting for becoming a lifetime member of APA by paying her dues through APA's lump-sum dues payment program. With her are (from left) APA President-elect Bruce Schwartz, M.D., APA Medical Director and CEO Saul Levin, M.D., M.P.A., and APA President Altha Stewart, M.D. Information on Board actions taken at the meeting is on page 14. Information about the lump-sum dues program is posted at http://apapsy.ch/dues.

8

APA takes issue with Texas court's latest action on death row case.

9

Register now for courses at APA's Annual Meeting in San Francisco.

22

Promoting heart health can help patients with bipolar disorder.

AJP Editors Select 2018 Favorites

Studies that highlight the potential of propranolol for PTSD, a networking approach to find new schizophrenia medications, and how trauma accelerates biological aging were among those that stood out most from AJP*'s 175th edition.* **BY NICK ZAGORSKI**

The end of 2018 marked a big year for the *American Journal of Psychiatry* (*AJP*), with the completion of the journal's 175th volume and the tenure of editor-in-chief Robert Freedman, M.D.

As is tradition, the editors of *AJP* used an editorial in the December issue to offer their personal selections for the articles they found particularly interesting or relevant in the past year. Eight articles covering a range of topics were highlighted as top picks in 2018; a selection of these is included below.

Daniel Pine, M.D., selected as his favorite article a clinical trial that showed that propranolol—a beta-blocker used to treat high blood pressure—can improve the effectiveness of memory reactivation therapy in patients with posttraumatic stress disorder (PTSD). Pine wrote that he enjoyed this article by Alain Brunet, Ph.D., of McGill University in Montreal and colleagues because the clinical potential of propranolol was discovered through both basic and clinical research into the role of memories in PTSD. "Thus, clinical observations on traumatic memories inspired basic science researchers, who generated the idea of using propranolol to inhibit retrieval of traumatic memories."

The top pick of Carol Tamminga, M.D., was a study that combined genetics and computational biology in search of antipsychotic drug targets. Karolina Kauppi, Ph.D., of Umea University in Sweden and colleagues looked for gene-gene interactions between 108 schizophrenia risk loci uncovered by the Psychiatric Genomics Consortium and the known gene targets of 64 antipsychotics. They found

see **2018 Favorites** *on page 25*

PERIODICALS: TIME SENSITIVE MATERIALS

FDA Downgrades Risk Category For Certain Indications of ECT

The FDA downgraded the risk classification of electroconvulsive therapy (ECT) devices to Class II when used for treatment of catatonia or a severe major depressive episode, but manufacturers must undergo premarket approval for all other indications. **BY LINDA M. RICHMOND**

The Food and Drug Administration (FDA) issued a final order last month downgrading the risk category of electroconvulsive therapy (ECT) devices for the treatment of catatonia and major depressive episodes, but for all other uses, it is requiring the agency's most extensive review process prior to approval.

see **ECT** *on page 26*

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

IPS: Where We Connect, Equip, and Inspire

BY ALTHA STEWART

If you joined APA before 1995, you probably remember when the Institute on Psychiatric Services (IPS) was known as the Institute on Hospital and Community Psychiatry. In 2015, it was renamed IPS: The Mental Health Services conference. Regardless of its name, since its beginnings 70 years ago, it has been the meeting where many APA members who work primarily in publicly funded settings connect with their colleagues, gain the latest knowledge and skills to maintain the highest standards of care, and are inspired to continue doing this work and encourage others to join them.

More than just a feel-good meeting, the IPS has, from its inception, been driven by the core values and mission of APA: "to improve access to and quality of psychiatric services" for "individuals with mental illnesses, including substance use disorders, and their families." Held each fall, it is designed to be a smaller, intimate experience different from the Annual Meeting and serves as APA's tangible commitment to supporting the work of psychiatrists on the frontline who are committed to ensuring that as many people as possible, regardless of their circumstances, have access to high-quality mental health care.

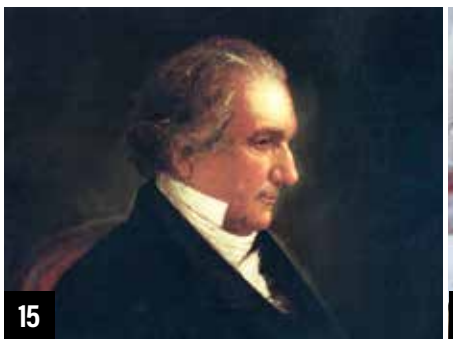
This commitment to community psychiatry is also apparent in other areas of the organization, notably the $14.2 million grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to create the Clinical Support System for Serious Mental Illness (*Psychiatric News*, http://apapsy.ch/SAMHSAgrant). We have also increased our focus on training and developing public sector psychiatrists, thanks to APA's taking the lead in the SAMHSA-funded Recovery to Practice Training Curriculum. Today, community psychiatry is being called "the third psychiatric revolution," and as this nation's oldest medical association with roots deeply embedded in providing public-sector care, APA is uniquely positioned to provide the support and educational programs that community psychiatrists need to continue their work and move it forward.

Unfortunately, the IPS has floundered over the last few years because of increasing expenses associated with hosting meetings in major cities and decreasing revenue from registration and exhibitors. As a part of our fiduciary responsibility to the organization, Dr. Anita Everett appointed and I have continued the IPS Strategic Planning Work Group, charged with conducting a situational analysis of the meeting (examining its structure, duration, location, and timing) and making recommendations for enriching the meeting over the next three to five years.

As with other areas of the Association, we are looking at ways to improve operations while providing high-quality member benefits to our growing organization. The work group submitted its initial recommendations to the Board of Trustees at its December 2018 meeting (see page 14), and after accepting the work group's initial report, the Board requested that the work group continue and work with APA staff to evaluate the feasibility of a revised format for future IPS meetings. They will report back to the Board in March. The

see **From the President** *on page 7*

IN THIS ISSUE



DEPARTMENTS

Early Bird Rates in Effect!

Register now for APA's 2019 Annual Meeting in San Francisco and take advantage of the meeting's lowest registration rates. A gala to celebrate APA's 175th anniversary will be held in San Francisco City Hall. For meeting and gala details, see the ad on page 16.

Access to Pharmacy-Provided Naloxone Remains a Challenge

Research suggests that pharmacists need, and would like, more education and training before feeling comfortable dispensing naloxone without a prescription. **BY TERRI D'ARRIGO**

Trained pharmacists have been allowed to furnish naloxone without a physician's prescription in California since January 2016, yet as late as February 2018, pharmacist-furnished naloxone was available at only 23.5 percent of the state's pharmacies, according to research published in the November 13, 2018, *JAMA*.

In the study, 30 trained interviewers posed as potential customers and used a standardized script to ask staff at 1,147 pharmacies whether it was possible to get naloxone without a prescription at the pharmacy. They found that pharmacist-furnished naloxone was available at less than a quarter of pharmacies, and only about half of those pharmacies had nasal naloxone in stock.

These findings are the latest to suggest a need for greater access to naloxone in community pharmacies. A paper published online in *Drug and Alcohol Dependence* in April 2018 noted that only 58 percent of pharmacies in Indiana stocked naloxone, and only 23.6 percent of pharmacists dispensed it in 2016 following a statewide standing order issued in 2015. An article published in the *New York Times* that same month suggested that only 37.5 percent of pharmacies in New York City stocked and would dispense naloxone under the state's standing order.

"The numbers that were quoted in California and New York are very concerning," said Elie Aoun, M.D., a general addictions and forensic psychiatrist at Columbia University and vice chair of APA's Council on Addiction Psychiatry. "I'm based in New York. The neighborhoods that have the worst access to naloxone are some of the most underserved and where fatal overdoses are most likely to happen."

There are several possible reasons pharmacists are reluctant to stock and dispense the drug, and the most likely is a need for more naloxone education. A study in the July-August 2018 issue of the *Journal of the American Pharmacists Association* found that only 49.2 percent of community pharmacists in North Carolina felt comfortable dispensing naloxone, and 53.7 percent cited inadequate training as a barrier to dispensing the drug. A study in the March-April 2017 issue of the same journal found that only 20.4 percent of community pharmacists in West Virginia—the state with the highest rate of opioid overdose deaths in the nation according to the Centers for Disease Control and Prevention—felt comfortable dispensing naloxone without a prescription. A vast majority, 77 percent, agreed with the statement, "I do not feel I am adequately trained in the use of naloxone over the counter."

Talia Puzantian, Pharm.D., B.C.P.P., says that prescriptions for naloxone can prompt more pharmacies to stock it.

Talia Puzantian, Pharm.D., B.C.P.P., an associate professor of clinical sciences at Keck Graduate Institute School of Pharmacy and Health Sciences and a researcher in the California study, said that she and her colleague were able to identify knowledge gaps among pharmacists.

"Some said naloxone is a controlled substance and that it requires a prescription. Some said that if someone came in having an overdose, they would give it to them. But if you're having an overdose, you wouldn't be walking into a pharmacy—you would be unresponsive and barely breathing," Puzantian said.

Puzantian noted that the knowledge gaps she and her co-author identified prompted them to develop a training webinar that meets California's requirements. The California State Board of Pharmacy offers the training at no cost, and in the first three weeks of availability, roughly 500 pharmacists completed the free one-hour webinar.

Research suggests that a sense of moral hazard may be a second reason that some pharmacists hesitate to dispense naloxone. In North Carolina, 15.4 percent reported ethical and moral concerns with dispensing naloxone, and in West Virginia, 38 percent felt that letting patients purchase naloxone over the counter would increase opioid overdosing.

It would be a mistake to think that way, said Puzantian. "At least two studies I've seen showed that [providing naloxone] does not promote opioid use. It makes people more likely to take action and call 911."

As for stocking naloxone at the pharmacy, that's often a matter of real estate, Puzantian said.

"You put things on the shelves that move, like Lipitor and Viagra. If physicians aren't writing prescriptions for it, you're not going to have it," Puzantian said. "I'm not trying to relieve pharmacists of blame, [but] if physicians prescribe it more and the public is more aware and asking for it, that initiates stocking with pharmacies."

Aoun is on board with prescribing naloxone, even when state regulations do not require a prescription for pharmacists to dispense it, because it may help patients and caregivers remember to get it.

Elie Aoun, M.D., gives every patient he sees a prescription for naloxone, regardless of whether he is seeing that patient for a substance use disorder.

"I've made it part of my regular practice to give any patient I see a prescription for naloxone regardless of whether I am seeing the patient for a substance use disorder or not," Aoun said. "Patients who don't have an addiction are always surprised, but it opens the door for a productive conversation. I say, 'People are dying of opioid overdoses right and left, and you might see someone on the

see **Naloxone** *on page 16*

Patient Characteristics Should Determine Response to Threatening Behavior

Confronting patients directly may backfire depending on the patient's motivation and diagnosis. **BY TERRI D'ARRIGO**

The most effective responses to stalking, threatening, or harassing behavior (STHB) directed toward mental health professionals depend on the patient's motivation and personality organization, suggests a study published in the *American Journal of Psychotherapy.*

In the study, researchers at the University of Indianapolis School of Psychological Sciences analyzed data from a questionnaire completed by 112 board-certified psychologists who had experienced at least one episode of STHB. The questionnaire covered the types of STHB the psychologists had experienced, the risk management strategies they used, and whether they felt those strategies had been effective in addressing the behavior.

"Our participants defined 'effective' based on their subjective sense that their response had improved the situation. This could mean a complete cessation of the STHB, but not necessarily," lead author Aaron J. Kivisto, Ph.D., H.S.P.P., co-director of doctoral programs in psychology and an associate professor of clinical psychology told *Psychiatric News*. "One could imagine, for example, a situation where a patient continued to engage in harassing behavior, although the clinician felt the situation had improved as a result of improving her office security."

The questionnaire also covered the primary psychiatric diagnoses of the patients who engaged in the STHB, what their motivations were (resentment or infatuation), and whether the patients had higher- or lower-level personality organization. Patients who had internalizing personality disorders, neurotic personality disorders only, or no personality diagnosis were coded as having higher-level personality organization. Those who had externalizing, borderline, or dysregulated personality disorders were coded as having lower-level personality organization.

Upon reviewing the data, the researchers found that the most common strategy, seeking assistance from colleagues or supervisors, was also deemed most effective by the respondents regardless of patient characteristics. However, the effectiveness of the second most common response, confronting the patient directly, was deemed effective by only about half of respondents, and in many cases it backfired.

"For patients motivated by resentment, direct confrontation made the situation worse in nearly two-thirds of cases," Kivisto said. "By contrast, direct confrontation with [patients] with higher-level personality organization was perceived as improving the situation in about two-third of cases."

Conversely, when addressing STHB by patients with lower-level personality organization, protective strategies like increasing workplace security and seeking assistance from an attorney were seen as especially effective.

The bottom line is that risk management is not one-size-fits-all.

> Direct confrontation can make the situation worse if the patient is motivated by resentment.
>
> —Aaron Kivisto, Ph.D., H.S.P.P.

In the paper, the researchers offer possible reasons why.

"The perceived effectiveness of these strategies may reflect these higher-functioning clients' ego strength, which allowed them to tolerate direct conversations about the psychologist-client relationship and modify their behavior in response to minimally intrusive limit setting," they wrote.

"Our study suggests that risk management responses should take into account patients' motivations for engaging in STHB and level of personality pathology. There's no single response likely to work for all patients all of the time, but the likelihood of responding productively might be increased when clinicians are sensitive to these contextual factors," Kivisto said.

Prior research by Kivisto and others suggests that most mental health professionals, including psychiatrists, will be subjected to STHB at some point in their careers.

"Where the differences [among mental health professionals] likely emerge is in the variation in risk management resources available … in different settings. It's one thing … to experience STHB in a secure inpatient setting, and another thing altogether in a home office," Kivisto said.

To that end, Kivisto encourages all mental health professionals to be proactive in reducing risk.

"This includes seeking out training on managing potentially dangerous patients; developing a network for consultation that includes clinical, legal, and law enforcement professionals; and developing clinic policies that facilitate clear limit setting to protect clinicians confronted with patients engaging in STHB," he said.

This study was funded by the University of Indianapolis. **PN**

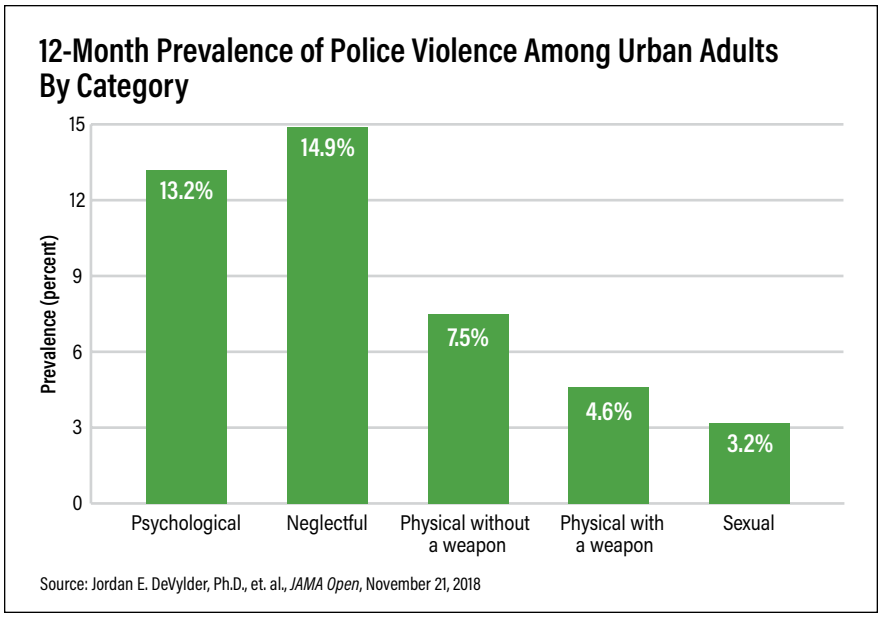
"Risk Management With Clients Who Stalk, Threaten, and Harass Mental Health Professionals" is posted at https://psychotherapy.psychiatryonline.org/doi/10.1176/appi.psychotherapy.20180034.

Exposure to Police Violence Linked To Suicide Risk, Psychosis

People of color and members of sexual minorities are more likely to experience police violence.
BY TERRI D'ARRIGO

Experiencing police violence is associated with a higher risk for suicide attempts, suicidal thinking, and psychotic experiences, according to a study published in *JAMA Network Open*. The study, which was based on a cross-sectional, general population survey of 1,000 residents of Baltimore and New York City from October through December 2017, also suggests that people of color and sexual minorities are more likely to experience police violence.

In their research, Jordan E. DeVylder, Ph.D., an associate professor in the Graduate School of Social Services at Fordham University, and colleagues evaluated data from the Survey of Police-Public Encounters II. This survey asks about experiences with police violence over the past 12 months. The types of police violence included physical violence with a weapon, physical violence without a weapon, psychological violence (threats, intimidation, and more), sexual violence, and neglect (not responding to calls for assistance, responding too late, and more) (see chart). The survey respondents were also asked to report psychological distress (including feelings of hopelessness, agitation, and depression), suicidal thinking, suicide attempts, and psychotic experiences.



In addition, the researchers determined risk according to race/ethnicity, sexual orientation/identity, and age. Compared with non-Hispanic whites, people of color had more than a fourfold increased risk of experiencing police violence with a weapon and more than a threefold increased risk of experiencing the other forms of police violence. Those who identified as homosexual or bisexual had nearly a twofold increased risk of psychological violence. Most exposures occurred among people aged 44 years or younger.

DeVylder told *Psychiatric News* that some of the data surprised him.

"There is a narrative in the media that [police violence] affects a lot of urban communities, especially those of color, so we did expect the data to reflect that. [But] the prevalence of police vio-

see **Police Violence** *on page 27*

APA Wins Government Grant to Develop Quality Measures for Behavioral Health

APA invites new and existing members of its PsychPRO mental health data registry to contribute to the initiative.

BY SAMANTHA SHUGARMAN

APA members Jerry Halverson, M.D., and Anna Ratzliff, M.D., Ph.D., are co-chairs of the Technical Expert Panel for the Quality Measure Development Initiative. The panel consists of stakeholders and experts who contribute direction and thoughtful input in every phase of the measure-development process.

Under a cooperative agreement with the Centers for Medicare and Medicaid Services (CMS), APA was awarded $5.38 million over three years to develop meaningful quality measures for behavioral health under the Medicare Access CHIP Reauthorization Act of 2015 (MACRA). These measures are intended for use by a wide range of health care providers, including psychiatrists, social workers, and other behavioral health providers, as well as primary care providers.

The quality measures will focus on measurement-based care, evidence-based care, and care experience. Major diagnostic categories include opioid use disorder, first-episode psychosis, and suicidality, but they do not exclude other psychiatric conditions.

The measures developed under APA's Quality Measure Development Initiative will fill CMS's designated priority gap areas of mental and substance use disorders. In collaboration with the National Committee on Quality Assurance, the initiative places quality measure development in the hands of psychiatrists, other health providers, and stakeholders and will focus on improvements in quality care and burden minimization for individuals with mental and substance use disorders and providers alike.

The initiative will "engage consumers, technical experts, and a Learning Collaborative of 20 to 25 diverse behavioral health practice sites, involving 400 clinicians," according to Philip Wang, M.D., Dr.P.H., APA's director of the Division of Research. Learning Collaborative sites will be recruited from practices that are members of APA's national mental health registry, PsychPRO. Data from participating sites will inform various aspects of the initiative.

"Each proposed quality measure will undergo rigorous development, employing established methods for measure specification," noted Wang.

APA members Jerry Halverson, M.D., and Anna Ratzliff, M.D., Ph.D., will co-chair the initiative's multi-stakeholder Technical Expert Panel. The panelists, composed of behavioral health care experts, were selected at the close of a 30-day nomination period and represent the various perspectives of those involved in the care of individuals with mental and substance use disorders. This includes individuals and family members of those with mental and substance use disorders, behavioral health providers, facility administrators, health plan leaders, researchers, and other advocates.

Halverson and Ratzliff, both experienced in the development and use of quality measures, spoke with *Psychiatric News* about their involvement in this national quality enterprise. Halverson has been highly engaged in producing and using quality measures for psychiatric treatment following his completion of intensive training at the Intermountain Healthcare Delivery Institute.

Since then, Halverson explained, "Much of my work has been through my employer, Rogers Behavioral Health (a national, private, not-for-profit behavioral health system), and other national organizations like APA, the AMA, and PCPI [formerly the Physician Consortium on Performance Improvement]. I was also on the Technical Expert Panel for CMS's Measure Development Plan."

Ratzliff described her psychiatric and academic career as one spent "delivering and implementing the Collaborative Care Model." One of the core principles of this behavioral health integrated care model is accountability for the quality of mental health care delivered by a team imbedded in a medical setting. "This work has allowed me to explore patient and provider experiences, [clinical] processes, and outcome measures of quality in a wide variety of settings," she said.

Most recently, Ratzliff served as a national faculty member for APA's Transforming Clinical Practice Initiative and noted that she "had the opportunity to support transition of practice to value-based contracting."

Under Halverson and Ratzliff, APA's Technical Expert Panel will be prepared to inform on the development of behavioral health quality measures that influence high-quality, patient-centered care for use in value-based payment programs.

As Ratzliff explained, "Measuring health care quality is important for multiple reasons, including informing on gaps and variation in care delivery. These findings tell us how the health system is performing and will ultimately lead to the opportunity to improve care."

Clinicians who treat patients in the various outpatient settings for mental and substance use disorders and who join the Learning Collaborative will have a valuable opportunity to advise

see **Grant** *on page 20*

Samantha Shugarman is APA's deputy director of quality reimbursement policy.

VIEWPOINTS

Call to Advocacy: End Discrimination Against Health Care Professionals With Substance Use Disorders

BY MATTHEW GOLDENBERG, D.O.

As you well know, this country is in the midst of an opioid epidemic. However, there is also a hidden epidemic involving physician suicide. Various sources estimate that hundreds of physicians die by suicide annually; one can only guess at how many hundreds of thousands of patients are affected by this loss.

We know that fear and stigma are two of the major barriers that keep health care professionals from getting help when they suffer from mental illness and addiction, and untreated mental illness is one of the major causes of suicide among health care professionals.

Unfortunately, a new California law likely makes the situation much worse in our state for both health care professionals and public safety. With the supportive testimony from, among others, patient-victims of USA Gymnastic's Larry Nassar and former USC gynecologist George Tyndall, Gov. Jerry Brown signed into law the Patient's Right to Know Act (SB 1448) last fall.

Matthew Goldenberg, D.O., is board certified in general and addiction psychiatry. He is an experienced evaluator and treatment provider of professionals working in safety sensitive positions (that is, health care professionals and pilots). He is chair of California Public Protection and Physician Health.

Under this law, health care professionals who are under probation by the California licensing boards must ask patients to sign a disclosure at the first visit following the imposition of probation pursuant to several circumstances, including drug or alcohol abuse resulting in harm to patients or to the extent that such use impairs the ability to practice safely. Addiction is now categorized and handled in the same context as criminal behavior like sexual abuse and convictions related to harming patients. This law could lead to more suicides among physicians and other health care professionals.

About 10 percent to 12 percent of health care professionals will suffer from addiction in their lifetime. That is the same prevalence rate as the general population. It has been established that rehabilitation rates for physicians are much higher than those of the general population, between 78 percent and 86 percent.

This law further stigmatizes addiction and increases fear among health care professionals who might be thinking about reaching out for help. Health

APA Applauds New Opportunity for States To Use Medicaid for Inpatient MH Care

As part of an overall plan to improve the continuum of care for patients with serious mental illness, states may now apply for waivers from CMS to begin receiving federal Medicaid financing for short-term stays in larger residential facilities. **BY LINDA M. RICHMOND**

APA is applauding a Trump administration guidance encouraging states to improve community-based mental health care that would also allow federal Medicaid financing for short-term residential care for serious mental illness (SMI).

The guidance, mandated by the 21st Century Cures Act, was written by the Centers for Medicare and Medicaid Services (CMS) and issued in a letter to state Medicaid directors. It offers a new opportunity for states to apply to use federal Medicaid financing for patients aged 21 to 64 who have SMI and need residential treatment in a facility with more than 16 beds (known as institutions for mental disease, or IMDs).

"We applaud the administration for encouraging states to strengthen their community-based and inpatient residential treatment options to provide a continuum of care for individuals with serious mental illness," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "Nearly 4 in 10 adults with serious mental illness do not receive care. APA is also pleased that CMS is seeking state expansion of evidence-based treatments, such as telepsychiatry, the collaborative care model, and early intervention for psychosis."

At the same time, Levin expressed concern about another Medicaid demonstration project approved by CMS: Medicaid work requirements. "These limit access to care for those most in need," Levin said.

> "We applaud the administration for encouraging states to strengthen their community-based and inpatient residential treatment options."
>
> —Saul Levin, M.D., M.P.A.

Seven states had obtained waivers from CMS to implement work and work-reporting requirements as of January 5 (Arkansas, Indiana, Kentucky, Maine, Michigan, New Hampshire, and Wisconsin). Arkansas was the first state to implement work requirements, which took effect in June of last year. Since then, nearly 17,000 of the state's most vulnerable residents have lost their health coverage as a result. Another eight states have requests to add work requirements pending with CMS.

Medicaid is the single largest payer of mental health services, and more than a quarter of adults with SMI rely on Medicaid coverage for their care. States are barred from using federal Medicaid financing for treating most adults in IMDs in a provision of the Social Security Act known as the "IMD exclusion." However, one year ago, CMS began allowing states to apply for exceptions known as "Section 1115 waivers" to cover short-term treatment of people with substance use disorders (SUD) at such facilities as part of a state's overall plan to address the opioid epidemic. To date, 17 states have been granted such waivers by CMS. About 3.4 million nonelderly Medicaid beneficiaries have a substance use disorder.

Early results are promising: since implementing its program, the state of Virginia has seen opioid-related emergency department (ED) visits drop 39 percent and substance-use related ED visits drop 31 percent.

The guidance outlines initiatives states may use to expand and improve service delivery systems for adults with SMI and children with serious emotional disturbance (SED). These include telepsychiatry, the Collaborative Care Model, and the coordinated specialty care model, which helps identify and engage individuals with psychosis early in the course of their illness.

States that wish to participate by expanding mental health care are expected to take a number of steps: improve community-based care, ensure good quality of care in IMDs, improve handoffs to community-based care following acute care stays, ensure a continuum of care is available to address the chronic needs of individuals with SMI and SED, provide a full array of crisis-stabilization services, and engage beneficiaries in early intervention treatment. At the same time, state plans must be budget neutral, CMS advised.

CMS will allow states that gain approval under these new waivers to begin receiving federal financing for short-term residential care for patients with serious mental illness in IMDs. Such patients must have a primary mental illness diagnosis and be hospitalized for treatment purposes. The guidance gives a path forward for the 12 states that have shown interest in expanding access to both community-based and residential mental health and substance abuse treatment.

The guidance also identifies ways states can improve crisis-stabilization services, care coordination, and services to address social risk factors, such as housing and supported education and employment. **PN**

The CMS press release is posted at https://www.cms.gov/newsroom/press-releases/cms-announces-new-medicaid-demonstration-opportunity-expand-mental-health-treatment-services. The CMS letter to Medicaid directors is posted at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

care professionals with substance use disorders often rely on self-treatment, fearing that reaching out for help will destroy their careers.

When health care professionals in other states become sick, they have access to physician health programs that provide easy access to professional interventions, evaluation, treatment, and monitoring. The services and oversight provided by these programs have been shown to be extremely effective and prevent harm to patients. Health care professionals, with a simple phone call to a confidential program, are immediately connected to the help that they need. California is one of the only states in the country that does not have a physician health program.

How can you help promote health and wellness among health care professionals?

- Please email me if you are interested in getting involved in organized efforts to improve physician health or if you would like to receive email updates about issues related to physician health. My email address is docgoldenberg@gmail.com.

- Email me your story of recovery, or the story of a colleague, regarding a struggle with addiction, experience receiving treatment and safely returning to work, and the positive impact this had on the community and patients.

- If your hospital or medical system has a well-being committee, become a member or find out whether there is another form of peer support to assist health care professionals in your area of practice.

- If you are a California member and are concerned about this new discriminatory law and the negative impact on patient safety, please contact your legislators and/or local professional organization (California Medical Society, California Psychiatric Association, California Society of Addiction Medicine, etc.) and share your opinion. **PN**

From the President

continued from page 3

Board also voted to not hold the IPS in 2020 (the APA administration reported that there were some challenges with contracting with a hotel for the 2020 meeting), and the Board felt that suspending the meeting for one year would give APA additional time to examine the feasibility of the meeting.

Finally, APA leaders were asked to host a town hall meeting at APA's 2019 Annual Meeting in San Francisco to further discuss the future of the IPS. Primary issues will include the value of a smaller meeting, opportunities to change the program format, and possible strategies for increasing the attendance of APA members as well as more of our partners in the public sector. The preliminary report presented to the Board last month indicated that approximately 50 percent of IPS attendees also attend the Annual Meeting, so we're hoping that members who value the IPS will come to the town hall.

It is important that we continue to have high expectations for this meeting, and it is equally important that we establish realistic approaches to meeting both our fiduciary and professional-development responsibilities. Losing sight of either could change the course of our profession in ways that impact our service, training, and research goals for generations to come. As always, we look forward to hearing what you think! More information on the town hall will appear in a future issue of *Psychiatric News*. **PN**

iStock/schankz

APA Files Brief Supporting Defendant In Long-Running *Moore* Case

To the extent that adaptive capacities are taken into account, they should be those acquired and demonstrated in a typical environment rather than a controlled environment, such as prison, APA argues. **BY MARK MORAN**

Adaptive strengths, especially those acquired and demonstrated in a controlled environment, are not sufficient to exclude a diagnosis of intellectual disability.

That's what APA wrote in an amicus brief to the U.S. Supreme Court on behalf of Bobby James Moore, who has been on death row in Texas since his conviction for the murder of a store clerk in 1980. It is the latest in a long legal saga centering on whether Moore is intellectually disabled and therefore exempt from capital punishment, as well as the means for determining a diagnosis of intellectual disability.

Last June, a Texas Court of Criminal Appeals (CCA) ruled that Moore could not be found intellectually disabled because of certain adaptive strengths he demonstrated. In a new appeal to the Supreme Court last November, APA argued that reliance on evidence of adaptive strengths is misleading and that there is sufficient evidence of intellectual deficits that Moore should be exempt from execution.

"The CCA opinion focused at length on Mr. Moore's adaptive strengths in the areas of communication and language skills," APA wrote. "However, it is inappropriate to focus exclusively on individual adaptive strengths or to conclude that the presence of such strengths precludes a finding of intellectual disability. Instead, evidence of a person's deficits should be the focus when diagnosing intellectual disability.

"Mental health professionals agree that intellectual disability should be diagnosed whenever there are sufficient deficits in adaptive functioning. That remains true even if the individual has relative strengths in other areas. Phrased differently, the presence of relative strengths in some spheres of behavior is not conclusive evidence that a person does not have intellectual disability."

Moreover, APA argued that to the extent that adaptive capacities are taken into account, they should be those that are demonstrated in a typi-

see **Moore** *on page 21*

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Why a Course?

BY ERIC WILLIAMS, M.D.
University of South Carolina
Course Subcommittee Chair, Scientific Program Committee
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Inova Fairfax Hospital Department of Psychiatry and Behavioral Sciences
Course Subcommittee Co-chair, Scientific Program Committee

Have you ever attended a session at APA's Annual Meeting and wished you could learn about the topic presented in more depth, had more opportunity to interact with presenters, ask questions, receive educational handouts, and perhaps learn in a more intimate learning environment? If so, you might want to consider registering for a course at this year's Annual Meeting. Courses consist of 4- , 6- , or 8-hour in-depth learning sessions with experts in the field on a wide range of topics including suicide risk, acute brain failure, street drugs, CPT coding mastery, eating disorders, perinatal mental health, understanding QT prolongation and risk mitigation, positive psychiatry across the lifetime, motivational interviewing, and sexual disorders. There are also Master Courses in transcranial magnetic stimulation, psychodynamic therapy for personality pathology, pediatric psychopharmacology, buprenorphine and office-based treatment of opioid use disorder, and essential psychopharmacology. Take a look at the offerings and consider a course as a way to complement your continuing medical education experiences and options! **PN**

HOW TO REGISTER

Because most of the spaces in APA's courses fill early, you are encouraged to enroll in advance to ensure you get a space in the course or courses of your choice. Meeting registration and enrollment forms can be accessed at **www.psychiatry.org/annualmeeting.** Only those who have registered for the meeting may purchase course seats. The deadline for advance registration is **April 9;** save even more by registering before the early-bird deadline of **February 12.** The on-site course enrollment area will be located in the Moscone Convention Center.

There are three easy ways to register for APA's 2019 Annual Meeting and courses.

- **Register online:** Go to psychiatry.org/annualmeeting and click on "Registration."
- **Fax registration form:** Fax your completed registration form with credit card information to (202) 380-0676.
- **Mail registration form:** Mail your completed registration form and payment (by credit card or check made payable to APA) to American Psychiatric Association—Registration, P.O. Box 896656, Charlotte, NC 28289-6656.

To obtain a form to register by mail or fax, call (202) 559-3900. There is a $25 processing fee for mailed or faxed forms. After **April 9,** you may register online only; faxed and mailed registration will not be accepted (on-site fees apply). You can also register on site.

MASTER COURSES

SATURDAY, MAY 18 | M8044

Buprenorphine and Office-Based Treatment of Opioid Use Disorder

Director: John Renner, M.D.

Educational objectives: (1) Discuss the rationale and need for medication-assisted treatment (MAT) of opioid use disorder; (2) apply the pharmacological characteristics of opioids in clinical practice; (3) describe buprenorphine protocols for all phases of treatment and for optimal patient/treatment matching; (4) describe the legislative and regulatory requirements of office-based opioid pharmacotherapy; and (5) discuss treatment issues and management of opioid use disorder in adolescents, pregnant women, and patients with acute and/or chronic pain.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $74; advance: $74; on site: $74. Nonmember: early bird: $74; advance: $74; on site: $74. Spaces available: 180.

SUNDAY, MAY 19 | M8027

Update on Pediatric Psychopharmacology

Director: Karen Wagner, M.D., Ph.D.

Educational objectives: (1) Demonstrate knowledge of current clinical guidelines for the use of pharmacotherapy in pediatric psychiatric disorders; (2) identify practical knowledge gained in the use of psychopharmacology and management of adverse effects; and (3) Utilize recent research on pharmacotherapy in common psychiatric disorders of childhood.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $390; advance: $420; on site: $450. Nonmember: early bird: $490; advance: $520; on site: $550. Spaces available: 132.

MONDAY, MAY 20 | M8045

Transcranial Magnetic Stimulation: Clinical Applications for Psychiatric Practice

Director: Richard Bermudes, M.D.

Educational objectives: (1) Explain the mechanism of action of TMS; (2) identify appropriate patients for TMS; (3) understand the efficacy of TMS for the treatment of major depression, OCD, and other psychiatric disorders; (4) identify the risks and side effects of TMS; and (5) review the specifications of FDA-cleared TMS systems.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $390; advance: $420; on site: $450. Nonmember: early bird: $490; advance: $520; on site: $550. Spaces available: 132.

TUESDAY, MAY 21 | M8042

Essentials of Clinical Psychopharmacology

Director: Alan Schatzberg, M.D.

Educational objectives: (1) Provide an update on major classes of psychopharmacological agents; (2) review recent data on drugs under development—both positive and negative data; (3) provide a framework for integrating multiple modalities of treatment; and (4) review recent data on devices to treat major disorders.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $390; advance: $420; on site: $450. Nonmember: early bird: $490; advance: $520; on site: $550. Spaces available: 500.

WEDNESDAY, MAY 22 | M8005

Psychodynamic Therapy for Personality Pathology: Transference-Focused Psychotherapy — Extended

Director: Eve Caligor, M.D.

Educational objectives: (1) Apply recent developments in our understanding and classification of personality disorders to clinical practice; (2) perform clinically meaningful assessments of personality functioning and pathology; (3) understand the general clinical principles organizing psychodynamic therapy of personality disorders; (4) establish a treatment frame and contract with patients presenting with personality pathology at different levels of severity; and (5) understand the role of countertransference management in the treatment of patients with personality pathology at different levels of severity.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $390; advance: $420; on site: $450. Nonmember: early bird: $490; advance: $520; on site: $550. Spaces available: 500.

SATURDAY, MAY 18

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Course Code: C1652

Good Psychiatric Management for Borderline Personality Disorder

Director: Brian Palmer, M.D.

Educational objectives: (1) Diagnose borderline personality disorder correctly, including differentiating from mood disorders and explaining the diagnosis to a patient; (2) articulate principles for management of safety issues in patients with borderline personality disorder; (3) describe the course and outcome of BPD and the impact of BPD on mood disorders and vice versa; (4) explain key principles and evidence in the pharmacological treatment of BPD; and (5) understand the role of split treatments and family involvement in the treatment of BPD.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 120.

Course Code: C1064

Functional Neurological Disorder (Conversion Disorder): Update on Evaluation and Management

Director: Gaston Baslet, M.D.

Educational objectives: (1) Perform a comprehensive assessment in patients with functional neurological disorder (FND)/conversion disorder, incorporating input from test and exam results and other collaborating disciplines; (2) communicate the diagnosis to the patient, his/her family, and collaborating clinicians in a way that reinforces engagement in treatment; (3) recommend, seek advice, and/or execute the most appropriate treatment plan based on the current evidence from the medical literature; and (4) understand the complexity and heterogeneity of this patient population and recognize various modifiable risk factors that should be considered targets for treatment.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1476

Advanced Pharmacological Management for Depression: Applying the Latest Evidence-Based Treatment in Clinical Practice

Director: Roumen Milev, M.D.

Educational objectives: (1) Use clinical tools and algorithms to support measurement-based care for major depressive disorder; (2) select an optimal antidepressant based on the latest clinical, biomarker, and pharmacogenetic guidelines; and (3) use evidence-based strategies for the pharmacological management of treatment-resistant depression.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1129

Talking With and Listening to Your Patients About Marijuana: What Psychiatrists Should Know

Director: Henry Levine, M.D.

Educational objectives: (1) Review limitations on current scientific knowledge of marijuana; (2) review history of marijuana use in medicine; (3) review biochemistry of exogenous and endogenous cannabinoids and their unique biological actions, receptors, approved cannabinoid preparations, metabolism, and routes of administration; (4) review clinical research data on the effects of marijuana upon psychiatric and nonpsychiatric conditions and upon behaviors such as violence, as well as its potential hazards; and (5) Discuss how to address providers' legal/ethical/documentation and history-taking issues and patients' questions, concerns, and educational needs regarding marijuana use.

8 a.m.-3 p.m.; 6 hours; Moscone Convention Center. Member: early bird: $250; advance: $285; on site: $320. Nonmember: early bird: $300; advance: $335; on site: $385. Spaces available: 316.

Course Code: C1033

Updates in Geriatric Psychiatry

Director: Rajesh Tampi, M.D.

Educational objectives: (1) Discuss the epidemiology, neurobiology, assessment, and management of neurocognitive disorders; (2) describe the epidemiology and management of behavioral and psychological symptoms of neurocognitive disorders; (3) elaborate on the epidemiology and management of substance use disorders in late life; (4) enumerate on epidemiology and management of anxiety and mood disorders in late life; and (5) define the epidemiology and management of psychotic disorders in late life.

8 a.m.-3 p.m.; 6 hours; Moscone Convention Center. Member: early bird: $250; advance: $285; on site: $320. Nonmember: early bird: $300; advance: $335; on site: $385. Spaces available: 132.

SUNDAY, MAY 19

Course Code: C1036

Risk Assessment for Violence

Director: Phillip Resnick, M.D.

Educational objectives: (1) Specify four types of paranoid delusions that can lead to homicide; (2) identify the relative risk of violence in schizophrenia, bipolar disorder, and substance abuse; and (3) indicate three factors that increase the likelihood that violent command hallucinations will be obeyed.

8a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 316

Course Code: C1730

Mean Girls (and Boys): A Clinician's Guide for Addressing School Violence

Director: Anne McBride, M.D.

Educational objectives: (1) Recognize the hallmark features of hot and cold aggression; (2) summarize static and dynamic risk factors pertaining to school violence; (3) distinguish the salient features of structured professional judgment and actuarial violence risk assessment measures; and (4) characterize approaches to addressing school violence at the individual, school, and community levels.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1072

Street Drugs and Disorders: Overview and Treatment of Dual-Diagnosis Patients

Director: John Tsuang, M.D.

Educational objectives: (1) Know the emerging data for prevalence of opiate abuse and other drugs of abuse; (2) know the new street drugs and club drugs; (3) know the available pharmacological agents for treatment of co-occurring disorder patients; and (4) learn the psychosocial treatment for co-occurring disorder patients.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 120.

Course Code: C1609

Imminent Suicide Risk Assessment in High-Risk Individuals Denying Suicidal Ideation or Intent

Director: Igor Galynker, M.D.

Educational objectives: (1) Appreciate the difference between long-term and imminent suicide risk; (2) learn the nuts and bolts of MARIS- and NCM-based approaches to the assessment of imminent risk; and (3) apply the MARIS- and NCM-based approaches to assess imminent suicide risk in test cases.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1134

Eating Disorders for the General Psychiatrist

Director: Evelyn Attia, M.D.

Educational objectives: (1) Learn about evidence-based medication treatments for eating disorders; (2) learn about medical management for adolescents and adults with eating disorders; (3) learn about family-based

treatment (FBT) for adolescents with eating disorders; (4) learn about psychological and psychiatric issues associated with obesity; and (5) learn about case management for complex patients with eating disorders, including those with co-occurring psychiatric conditions.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 120.

Course Code: C1035

The Psychiatrist as Expert Witness: The Ins and Outs of Being a Forensic Consultant

Director: Phillip Resnick, M.D.

Educational objectives: (1) Give more effective expert witness testimony; (2) understand rules of evidence and courtroom privilege; and (3) understand issues of power and control in the witness/cross-examiner relationship.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 316.

Course Code: C1160

Neuromodulation Essentials: ECT, TMS, DBS, VNS, and Other Innovative Techniques

Director: Richard Holbert, M.D.

Educational objectives: (1) Describe the indications, techniques, neurobiology, adverse effects (including cognitive side effects), and neurobiological changes associated with electroconvulsive therapy; (2) explain the indications, techniques (including motor threshold determination), adverse effects, contraindications, and efficacy of transcranial magnetic stimulation; (3) explain the role of vagus nerve stimulation in treatment-resistant major depressive disorder; (4) summarize the current use of deep brain stimulation in psychiatry; and (5) recognize innovative neuromodulation techniques such as FEAST, tDCS, tACS, MST, CES, and micromagnetic stimulation.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

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Course Code: C1163

Neuropsychiatric Masquerades: Medical and Neurological Disorders That Present With Psychiatric Symptoms

Director: Jose Maldonado, M.D.

Educational objectives: (1) Understand the incidence, epidemiology, and clinical features of the most common CNS disorders masquerading as psychiatric illness; (2) integrate knowledge of current psychiatry into discussions with patients; and (3) apply quality improvement strategies to improve clinical care.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $295; advance: $345; on site: $365. Nonmember: early bird: $395; advance: $445; on site: $465. Spaces available: 180.

Course Code: C8074

First-Episode Psychosis for the General Clinician: From Assessment to Treatment

Director: Steven Adelsheim, M.D.

Educational objectives: (1) Document the key components of appropriate assessment for early psychosis; (2) list the components of the Coordinated Specialty Care model; (3) have a strong understanding of the core workup and treatment components for a person with early psychosis; and (4) explain the different approaches to assessment and treatment for the adolescent with early psychosis symptoms.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 120.

MONDAY, MAY 20

Course Code: C1536

Positive Psychiatry Across The Lifespan

Director: Rama Gogineni, M.D.

Educational objectives: (1) Develop a working knowledge of the principles underlying positive psychiatry and its relevance across the lifespan; (2) gain an understanding of the application of positive psychiatry interventions in the treatment and prevention of mental illness in adults; (3) learn about resilience-building mind-body interventions in older adults; (4) learn positive psychiatry approaches to children and adolescents; and (5) discuss and practice new skills using clinical examples and case studies.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1331

Emergency Psychiatry: The Basics and Beyond

Director: Kimberly Nordstrom, M.D.

Educational objectives: (1) Understand "medical clearance" and why universal labs are not helpful; (2) have tools to engage agitated patients; (3) have a better understanding of when to (or not to) start medications on someone in an emergency or crisis setting; and (4) have good working knowledge on nonpharmacological and pharmacological treatments for agitation.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 120 .

Course Code: C1347

Psychiatric Care for Transgender and Gender Non-Conforming (TGNC) Youth and Young Adults

Director: Shervin Shadianloo, M.D.

Educational objectives: (1) Understand gender development and its variance among youth and young adults; (2) evaluate and provide gender-affirming care for TGNC youth and young adults; (3) treat co-occurring mental health conditions in TGNC youth and young adults; (4) advocate for mental health care of TGNC youth and young adults; and (5) refer TGNC youth and young adults to appropriate services and specialties in their course of transitioning.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1034

The Clinical Assessment of Malingered Mental Illness

Director: Phillip Resnick, M.D.

Educational objectives: (1) Detect clues to malingered psychosis; (2) identify factors that distinguish genuine from faked hallucinations and genuine from faked delusions; and (3) be more skillful in detecting deception and malingering, especially in defendants pleading not guilty by reason of insanity.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 316.

Course Code: C1298

Psychiatric Disorders in Pregnancy and Postpartum: An Update

Director: Shaila Misri, M.D.

Educational objectives: (1) Identify risk factors for perinatal mood and anxiety disorders and be familiar with individualized treatment interventions; (2) recognize effects of anxiety on fetus/developing child and review clinical presentations and treatment options; (3) understand how perinatal mood/anxiety disorders affect mothers, fathers, and children and learn about nonpharmacological treatment interventions; (4) understand the impact of untreated maternal illness on fetus, child, and family and recognize evidence-based treatment guidelines, including pharmacological treatments; and (5) understand the principles of

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pharmacotherapy in bipolar disorder I and II in perinatal women.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 316.

Course Code: C1264

Treating Narcissistic Personality Disorder: Transference-Focused Psychotherapy

Director: Frank Yeomans, M.D.

Educational objectives: (1) Understand and appreciate the range and types of narcissistic pathology; (2) recognize and work with the pathological grandiose, the psychological structure that underlies the symptoms of narcissistic personality disorder; (3) acquire treatment techniques that address narcissistic resistances and that help engage the patient in therapy; (4) acquire treatment techniques that help patient and therapist work with the anxieties beneath the grandiose self; and (5) work with the typical attachment styles of narcissistic patients.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1344

Become a CPT Coding Master: Avoiding Hazards, Maximizing Opportunities, and Anticipating Changes

Director: Gregory Harris, M.D.

Educational objectives: (1) Determine the correct CPT code to use in a variety of practice settings; (2) understand the necessary documentation required for these CPT codes; (3) identify areas that are scrutinized closely by third-party payors; and (4) understand the use of CPT codes in special circumstances such as prolonged care, telemedicine, collaborative care, and the use of screening tools.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1228

Clinically Relevant Forensic Psychiatry: A Practical Review

Director: Tobias Wasser, M.D.

Educational objectives: (1) Appreciate the significance of forensic issues in the everyday practice of clinical psychiatry; (2) demonstrate knowledge of clinically relevant topics and principles in forensic psychiatry; and (3) apply forensic knowledge to clinical encounters with patients.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1199

Mind-Body Treatments for Global Mental Health Issues, Mass Disasters, Refugees, and PTSD: Lecture and Experiential

Director: Patricia Gerbarg, M.D.

Educational objectives: (1) List four advantages for using simple, effective, evidence-based mind-body programs to support the emotional recovery of populations affected by mass disasters; (2) apply polyvagal theory to understanding how voluntarily regulated breathing practices (VRBPs) help shift the organism from states of defensive disconnection toward a state of safety and connectedness; (3) describe initiatives using mind-body techniques to relieve stress and trauma among survivors of war and terrorism in Africa, Asia, and the United States; (4) experience coherent breathing for stress reduction and learn how VRPs can be used to reduce anxiety, insomnia, depression, and symptoms of PTSD; and (5) acquire tools and resources to integrate breath and movement techniques experienced in this course into clinical practice.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $295; advance: $345; on site: $365. Nonmember: early bird: $395; advance: $445; on site: $465. Spaces available: 180.

TUESDAY, MAY 21

Course Code: C1219

Evaluation and Treatment of Sexual Dysfunctions

Director: Waguih Ishak, M.D.

Educational objectives: (1) Acquire practical knowledge and skills in evaluation of sexual dysfunctions; (2) acquire practical knowledge and skills in treatment of sexual dysfunctions; and (3) apply gained knowledge/skills to real-world examples of sexual dysfunctions in men and women.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1711

Integrating Neuroscience Into the Clinical Practice of Psychiatry: A Hands-on Practicum From the National Neuroscience Curriculum Initiative (NNCI)

Director: Ashley Walker, M.D.

Educational objectives: (1) Appreciate the value of incorporating a neuroscience framework into the everyday clinical practice of psychiatry; (2) feel confident and empowered that, with or without a neuroscience background, participants can integrate cutting-edge neuroscience knowledge in routine clinical settings; and (3) access and use new and innovative methods to educate patients, relatives, and trainees about clinically relevant neuroscience findings.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1098

Identifying and Helping Older Adults with Mild Neurocognitive Disorder

Director: James Ellison, M.D.

Educational objectives: (1) Learn to detect and assess *DSM-5* mild neurocognitive disorder; (2) understand the clinical and prognostic significance of MiND, which lies between normal cognitive aging and major neurocognitive disorder; (3) become familiar with evidence-based interventions that can delay or mitigate cognitive decline; (4) understand the role of neuropsychological assessment in the evaluation of mild neurocognitive disorder; and (5) become

acquainted with current and evolving neuroimaging techniques used in assessing mild neurocognitive disorder.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 120.

Course Code: C1248

Integrating Technology and Psychiatry

Director: John Luo, M.D.

Educational objectives: (1) Utilize online resources for lifelong learning, patient care, and collaboration; (2) integrate electronic practice management tools in education, communication, documentation, screening, and evaluation; (3) monitor and maintain professional identity and privacy; and (4) assess novel technologies such as smartphone apps and predictive analytics to determine their role in patient care.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 120.

Course Code: C1800

These *Are* the Droids You're Looking For: An Expert Course on QTc, ECG, Psychotropic Medications, and Other Jedi Mind Tricks

Director: Margo Funk, M.D.

Educational objectives: (1) Confidently measure the QT interval, choose the most appropriate correction formula, and calculate the QTc; (2) list medications and common drug interactions that confer high risk of torsades de pointes; (3) correlate components of the 12-lead ECG with cardiac electrophysiological mechanisms; (4) describe high-yield strategies for various practice settings and populations, including the intensive care unit, substance use disorders, and resource-poor clinics; and (5) describe an approach to comprehensive risk-benefit analysis in patients who require control of high-risk psychopathology and may be at risk for torsades de pointes.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1399

Motivational Interviewing: A Stepped-Care Approach to Advanced Skills

Director: Steven Cole, M.D.

Educational objectives: (1) Review and explain core MI concepts, including the four phases of MI, the four domains of spirit, and use of OARS to work through ambivalence; (2) explain step one of advanced skills: respond to distress/dance with discord; (3) describe step two: respond to sustain talk; (4) discuss step three: work through ambivalence/develop the discrepancy; and (5) use four global measures of the MI Treatment Integrity Code (MITI) to assess one's own and others' competence.

1 p.m.-5 p.m.; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1815

Sleep Issues and Psychiatric Disorders: What Should Mental Health Professionals Know?

Director: Karim Ghobrial-Sedky, M.D.

Educational objectives: (1) Understand and know types of sleep disorders; (2) appreciate the bidirectional relationship between sleep disorders and psychiatric disorders; (3) understand the neurobiology of sleep disorders and its overlap with psychiatric disorders; and (4) articulate the treatment options for sleep disorders (both psychopharmacology and psychotherapy), with a special focus on problems of using non-approved medications to treat insomnia.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $295; advance: $345; on site: $365. Nonmember: early bird: $395; advance: $445; on site: $465. Spaces available: 132.

WEDNESDAY, MAY 22

Course Code: C1584

Disaster Psychiatry Review and Updates: Mass Violence, Climate Change, and Ebola

Director: Joshua Morganstein, M.D.

Educational objectives: (1) Review critical principles in disaster psychiatry, including behavioral and psychological reactions; preparedness, response, and recovery; early interventions; and crisis and risk communication; (2) discuss the mental health effects of mass violence and disruption, with special consideration of mass shootings in "safe havens," such as churches, schools, and health care settings; (3) describe the impacts of climate-related disaster events on human health and how to apply critical principles in disaster psychiatry to enhance community preparedness and resilience; and (4) understand unique psychological and behavioral responses to pandemics and important aspects of preparation and response to these events using contemporary media content.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 96.

Course Code: C1137

Acute Brain Failure: Pathophysiology, Diagnosis, Management, and Sequelae of Delirium

Director: Jose Maldonado, M.D.

Educational objectives: (1) Identify the strengths and weaknesses of various screening and diagnostic instruments used for the detection of delirium; (2) recognize the main risk factors for the development of delirium in the clinical setting; (3) describe the evidence regarding the use of nonpharmacological techniques (e.g., light therapy, early mobilization) in delirium prevention and treatment; (4) define the evidence behind the use of antipsychotic agents in the prevention and treatment of delirium; and (5) recognize the evidence behind the use of non-conventional agents (e.g., alpha-2 agonist, melatonin, anticonvulsant agents) in the prevention and treatment of delirium.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 120.

Course Code: C1488

Autism Update for the Clinician: From Diagnosis to Behavioral and Pharmacological Interventions

Director: Gagan Joshi, M.D.

Educational objectives: (1) Understand the diagnostic evolution for autism spectrum disorder (ASD) and the evaluation strategies for arriving at an appropriate diagnosis; (2) discuss current evidence-based guidelines for genetic testing in ASD; (3) review the latest evidence for behavioral interventions in ASD across the lifespan with a particular focus on the integration of technology interventions; (4) appreciate the burden of psychopathology associated with psychiatrically referred populations with ASD; and (5) demonstrate the unique considerations in recognition and psychopharmacological management of psychopathologies frequently associated with ASD.

8 a.m.-5 p.m.; 8 hours; Moscone Convention Center. Member: early bird: $295; advance: $345; on site: $365. Nonmember: early bird: $395; advance: $445; on site: $465. Spaces available: 96

Course Code: C1403

Evidence-Based Psychodynamic Therapy: A Pragmatic Clinician's Workshop

Director: Richard Summers, M.D.

Educational objectives: (1) Become aware of the substantial evidence base supporting psychodynamic psychotherapy; (2) improve treatment selection by applying a contemporary and pragmatic framework for delivering psychodynamic therapy; (3) diagnose core psychodynamic problems and develop a psychodynamic formulation for appropriate patients; and (4) understand how to develop an effective therapeutic alliance and employ techniques for facilitating change.

8 a.m.-noon; 4 hours; Moscone Convention Center. Member: early bird: $190; advance: $210; on-site: $235. Nonmember: early bird: $215; advance: $235; on site: $260. Spaces available: 132.

iStock/ronniechua

Board Approves Statement Against Separation of Migrant Children

Addressing the plight of migrant children was just one of many actions taken by APA's Board of Trustees at its December meeting. **BY MARK MORAN**

No child should be forcibly separated from parents or caregivers as a consequence of the federal government's immigration policies, declared APA's Board of Trustees as it approved a position statement on the issue at last month's Board meeting in Washington, D.C.

APA had earlier this year issued statements and joined other medical organizations in condemning the practice of separating migrant children from parents, a practice undertaken as part of the Trump administration's "zero tolerance" policy regarding immigration. The action followed the Assembly's approval of the statement at its meeting a month earlier.

APA President Altha Stewart, M.D., referenced the death of a 7-year-old girl in comments before the vote. The girl, a migrant from Guatemala, was reported to have died of dehydration and shock after being taken into custody by American border patrol. "We need to be on the record speaking out against this policy," Stewart said. "This atrocity must be stopped."

The AMA approved similar policy at the Interim Meeting of the AMA House of Delegates (*Psychiatric News*, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.12a12).

The APA position states the following:

David Hathcox

Ned Kalin, M.D., the new editor of the *American Journal of Psychiatry*, tells Trustees that he plans to invest great energy into how issues of the journal are put together—for instance, by grouping seemingly disparate studies into one issue and showing that they actually share genetic, molecular, neuroanatomical, or behavioral underpinnings.

- Children should not be forcibly separated from their parents or caregivers as a consequence of immigration policies. For children who undergo forcible separation, qualified health professionals should be available who can provide trauma-informed, culturally, linguistically, developmentally, and structurally competent care.

- All children must have the right to live in a healthy environment free from violence and with access to evidence-based, trauma-informed, physical, and mental health care services.

- Effective partnerships between APA and immigration agencies and affiliated relief and aid organizations should be developed to address gaps in providing trauma-informed, culturally, linguistically, developmentally, and structurally competent care for these children.

- Immigration agencies should collaborate with medical societies and with key stakeholders to address gaps in providing trauma-informed, culturally, linguistically, developmentally, and structurally competent care for these children and their parents or caregivers.

- There must be development of resources that promote best practices in prevention and early

see **Board** *on page 24*

David Hathcox

Ayana Jordan, M.D., Ph.D., the early career psychiatrist trustee-at-large, comments on the report of a work group on the future of IPS: The Mental Health Services Conference.

Lewis Judd, M.D., APA Leader and NIMH Director, Dies

Lewis Judd, M.D., a former vice president of APA and director of the National Institute of Mental Health (NIMH), died December 16, 2018. He was 88 years old.

Judd was a neurobiologist and expert in psychopharmacology who was a pivotal figure in helping psychiatry move toward a more neurobiologically informed understanding of mental illness. He was chair of the Department of Psychiatry at the University of California, San Diego (UCSD), from 1977 to 2013, taking a leave of absence to serve as director of NIMH from 1988 to 1992.

In an interview published in *Psychiatric Services* in January 1988, just after becoming director of NIMH, Judd summed up the optimism that preceded the "Decade of the Brain." That designation was given to the 1990s by President George H.W. Bush in a collaborative effort between the Library of Congress and the National Institutes of Health to better inform the public about brain research.

"There is an accumulation of evidence that many mental disorders emanate from dysfunctional brain mechanisms that can be identified and described and, when fully understood, rather specifically and precisely ameliorated and treated," Judd said in the interview. "We are, I believe, on the threshold of a golden era that will result in the amelioration of suffering for millions of people."

Past NIMH Director Lewis Judd, M.D., was a pivotal figure in advancing the neurobiological understanding of mental illness.

Igor Grant, M.D., who is the Mary Gilman Marston Distinguished Professor and chair of the Department of Psychiatry at UCSD, said Judd's leadership laid the groundwork for today's BRAIN (Brain Research through Advancing Innovative Neurotechnologies) Initiative, begun under President Barack Obama.

"Besides contributing to our understanding of the lifelong course of mood disorders and their treatment, as NIMH director, Lew Judd was instrumental in proposing the Decade of the Brain, which was the foundation of today's NIH brain initiatives," he told *Psychiatric News*. "Passionate about educating the next generation of mental health professionals, he established training programs at UCSD not only for psychiatry residents and child fellows but also for clinical psychologist trainees."

Although widely acknowledged for his role in advancing the neurobiological understanding of mental illness, Grant said that Judd did not reject psychotherapy or psychodynamic approaches to treatment.

"He understood that when you talk to people, you are talking to the brain," Grant said. "Lew's contribution was the centrality of the brain, but he knew there were multiple ways to access it."

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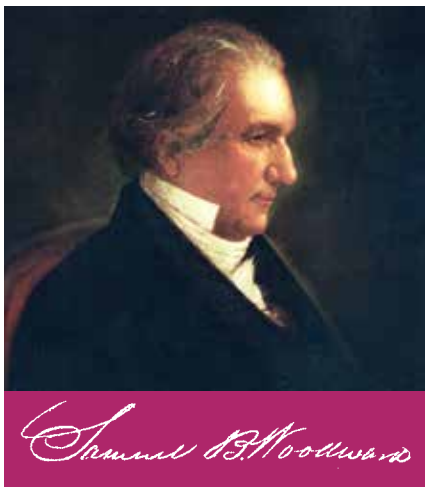
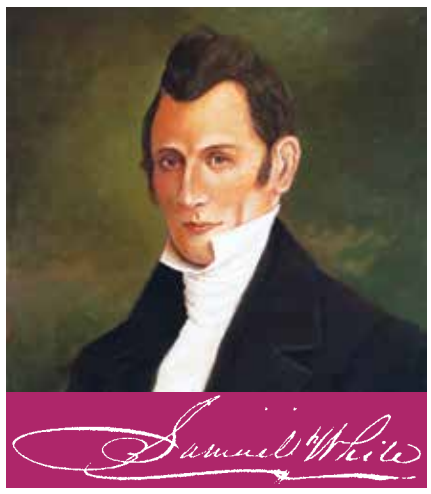
APA's 13 Founders Were Dedicated to Specialty Still Trying to Find its Way

APA's modest beginnings were driven by a desire to share knowledge on improving care for people with mental illness as the United States developed in its early years. This article is part of a yearlong series marking APA's 175th anniversary. ***BY AARON LEVIN***

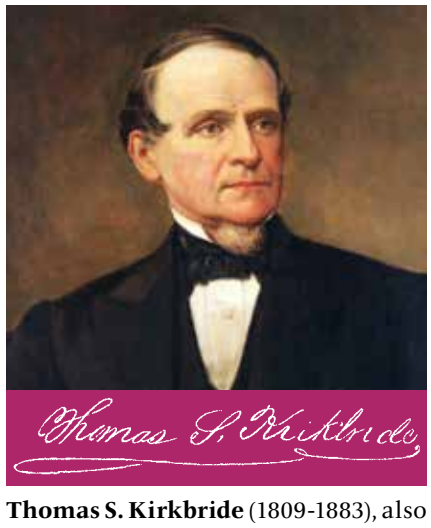
The Association of Medical Superintendents of American Institutions for the Insane, the forerunner of APA, began its organizational life in Philadelphia on October 16, 1844. In the room were medical leaders from 13 of the nation's 31 public and private hospitals for people with mental illness. All had trained as physicians, in some combination of apprenticeships or medical schools, but had only on-the-job experience in what today would be called psychiatry. Who were these men who were driven to create the country's first medical organization?



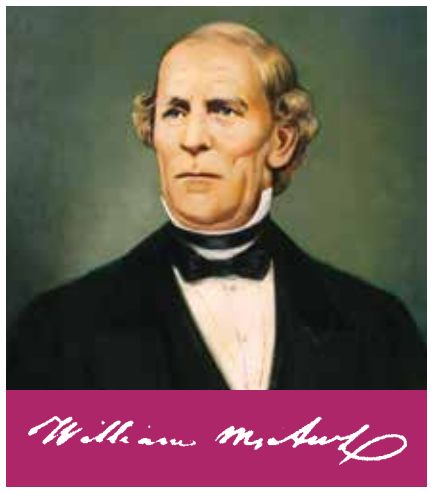
Samuel Woodward (1787-1850) was the first president of APA and head of the Worcester Lunatic Asylum in Massachusetts. Woodward believed that insanity was a somatic disorder, a disease of the brain with natural causes, and that the stresses of life could induce insanity in vulnerable individuals. He also helped establish the Hartford Retreat and was an early proponent of specialized medical treatment of alcoholics.



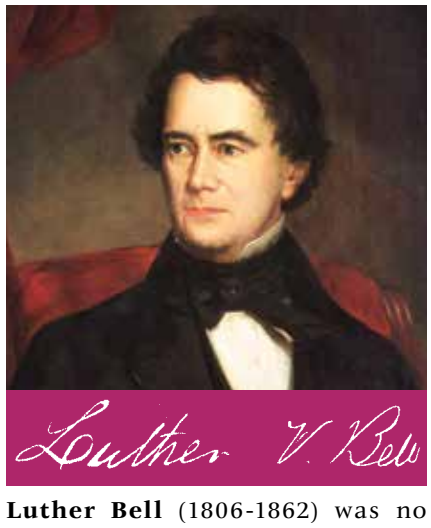
Samuel White (1777-1845), a surgeon, was APA's first vice president. In 1830 he established the private Hudson Lunatic Asylum near Poughkeepsie, N.Y. In an address on insanity to the New York State Medical Society in 1844, White argued for humane treatment and minimal restraint of patients. White was the oldest of the founders and died just four months after the association's first meeting.



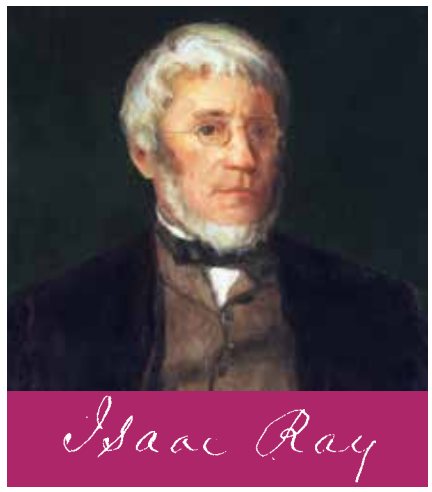
Thomas S. Kirkbride (1809-1883), also a surgeon by training, was the first secretary-treasurer of the Association. In 1840 he was named physician in chief of the Department of the Insane at Pennsylvania Hospital in Philadelphia and never left. He is best known for popularizing the standard architectural design for psychiatric facilities in the 19th century. The Kirkbride Plan called for a central building with wings to house patients stepping backward on either side.



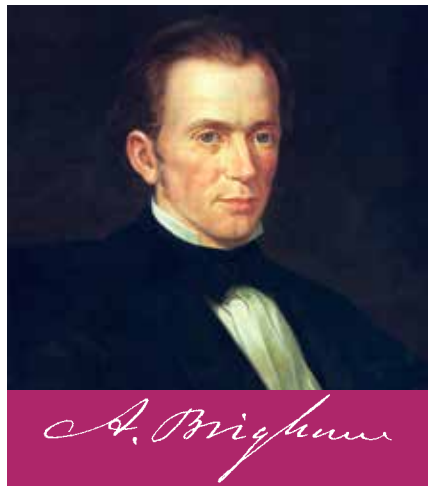
William Maclay Awl (1799-1876), APA's second president, walked from his native Pennsylvania to Columbus, Ohio, in 1826. He was the first superintendent of the Ohio Asylum in Columbus. He later worked at the Ohio Institute for the Blind and helped organize the Ohio State Medical Society. Typifying one of the chief problems on the founders' minds, Awl was forced out as superintendent for political reasons.



Luther Bell (1806-1862) was no stranger to the political system. He served as a state legislator in New Hampshire before establishing the State Asylum at Concord. Bell was also superintendent of the McLean Asylum in Massachusetts from 1837 to 1856. He volunteered as a surgeon in the 11th Massachusetts Regiment during the Civil War and died in 1862 while serving as medical director of General Hooker's division. He was the Association's third president from 1851 to 1855.



Isaac Ray (1807-1881) was the Association's fourth president. In 1838, while practicing in Eastport, Maine, he published *A Treatise on the Medical Jurisprudence of Insanity,* the first book in English on forensic psychiatry and one that remained a standard for decades. He served as medical superintendent of the State Hospital for the Insane in Augusta, Maine, beginning in 1841 and became head of the Butler Hospital in Providence, R.I., in 1845.



Amariah Brigham (1798-1849) was the founder and first editor of the *American Journal of Insanity,* predecessor of the *American Journal of Psychiatry.* Brigham emphasized early detection and treatment of mental illness and development of occupation skills among patients. He was skilled enough in general medicine that he taught anatomy and surgery at the College of Physicians and Surgeons in New York City. In 1842, he became superintendent of the State Lunatic Asylum at Utica, which under his leadership became a training ground for superintendents.

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APA leaders said Judd's contributions to psychiatry are lasting. "APA mourns the passing of Dr. Judd, a true giant in the clinical and research aspects of psychiatry," said APA President Altha Stewart, M.D. "He was an early champion of moving the field to the empirical evidence-based science we know today and leaves a legacy that successfully shows the blending of psychiatry, neuroscience, and psychology. His career is an excellent model for our path to the future of the field."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., recalled Judd as a colleague during Levin's service as a special advisor to Frederick Goodwin, M.D. Goodwin was the director of the Alcohol, Drug Abuse, and Mental Health Administration, which oversaw NIMH at the time. "Lew Judd was a great researcher, leader, and visionary thinker," Levin said. "He also was a terrific mentor to me during those years. I honor and thank him for all he did for psychiatry, our APA members, and our patients."

Judd received his medical degree and training in adult and child psychiatry from UCLA. He was a founding member of the Scientific Council of the Brain and Behavior Research Foundation. **PN**

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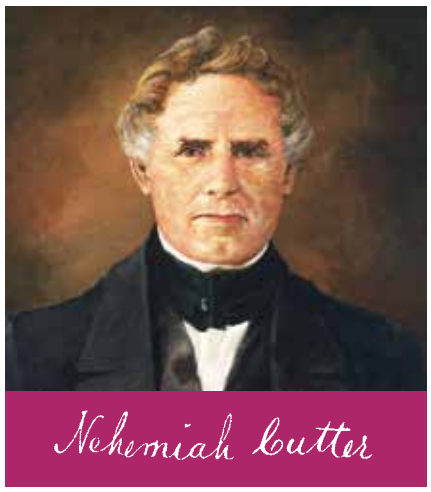
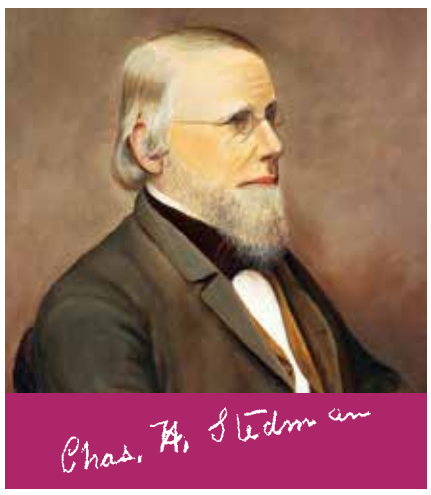
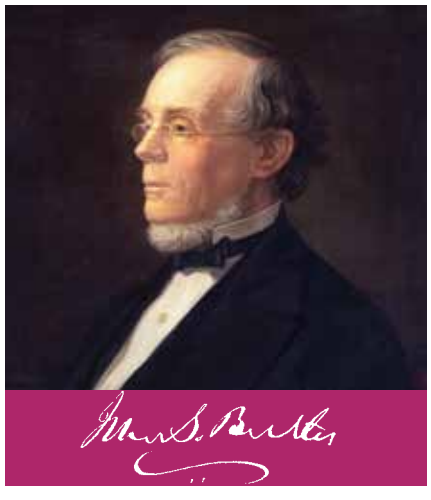


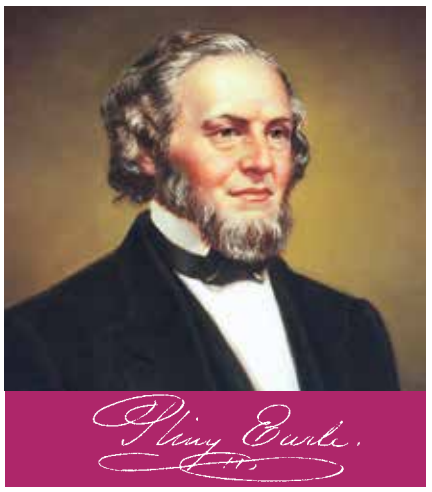
Nehemiah Cutter (1787-1859) ran the Cutter Retreat, a private asylum in Pepperell, Mass., starting in 1834. The asylum was demolished by fire in 1853, and Cutter returned to private practice. He held no office in the Association and left no published works; however, his death notice in the *Journal of Insanity* noted that he was an active discussant of papers presented at annual meetings.



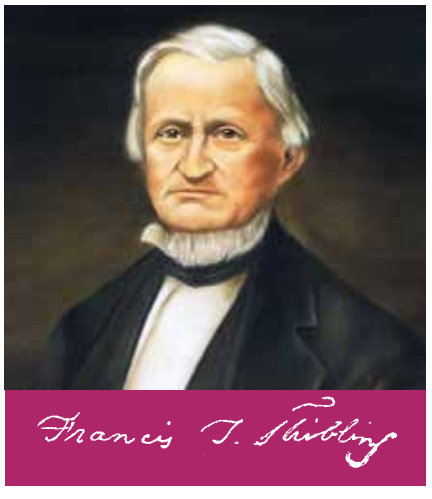
Charles H. Stedman (1805-1866) was an accomplished surgeon, honored as the translator of a standard German text on brain anatomy. Perhaps that's why he was appointed superintendent of the Boston Lunatic Hospital in 1842. The foray into psychiatry lasted nine years, until 1851, when he resigned to return to surgery and serve in the state senate.



John Butler (1803-1890) served as vice president of the Association from 1862 to 1870 and president from 1870 to 1873. A Massachusetts native, he practiced for 10 years in Worcester before being named superintendent at the Boston Lunatic Asylum in 1839. He resigned in 1842, disgusted with the politics that governed hospital leadership. However, he soon found a position at the Hartford Retreat, where he stayed for the next 40 years. During his time, the Retreat shifted to caring for wealthier, private patients rather than those whose care was supported by the state.



Pliny Earle (1809-1892) served as Association president in 1884-1885. He was superintendent of the Bloomingdale Asylum in New York City from 1844 to 1849, and spent brief tours in Washington, D.C., at the forerunner of St. Elizabeths Hospital. Earle was skeptical of claims by Woodward and others of high rates of curability of mental patients, saying they had ignored readmission numbers. He also noted that increasing numbers of long-term, custodial patients were consuming space and staff time that might have been more productively spent on patients who might indeed get well enough to live on the outside.



Francis Stribling (1810-1874) was the first graduate of the University of Virginia Medical School in 1830. He became superintendent of the Western Lunatic Asylum in Staunton, Va., in 1836, serving until his death in 1874. He worked closely with Dorothea Dix to advance humane care for people with mental illness, but he was also well known for rejecting racial integration of his asylum.

John Galt (1819-1862) was the first superintendent of the Eastern Lunatic Asylum in Williamsburg, Va. He was only age 22 at the time, and, at age 25, was the youngest of APA's founders. Galt was a voluminous writer. He read several languages and synthesized much European research in his 1846 book, *The Treatment of Insanity*. He advocated for moral treatment, as well as occupational, recreational, and music therapy. He also thought patients could benefit from spending time outside the institution. Unlike Stribling, Galt accepted a small number of free black patients in his asylum across the state. He is buried in the Bruton Parish Church in Colonial Williamsburg. **PN**

Naloxone

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street or have a family member or friend who [needs it one day].' "

Aoun believes that all clinicians should work together to make naloxone available in their communities. "We're spending a lot of money, effort, and resources to treat people with opioid disorders. But we can't treat people if they're dead." **PN**

"Provision of Naloxone Without a Prescription by California Pharmacists 2 Years After Legislation Implementation" is posted at https://jamanetwork.com/journals/jama/fullarticle/2714519. "Predicting Pharmacy Naloxone Stocking and Dispensing Following a Statewide Standing Order, Indiana 2016" is posted at https://www.sciencedirect.com/science/article/pii/S0376871618302321. "Overdose Antidote is Supposed to Be Easy to Get. It's Not," is posted at https://www.nytimes.com/2018/04/12/nyregion/overdose-antidote-naloxone-investigation-hard-to-buy.html."Identifying Barriers to Dispensing Naloxone: A Survey of Community Pharmacists in North Carolina" is posted at https://www.japha.org/article/S1544-3191(18)30198-5/fulltext."Pharmacists' Readiness to Provide Naloxone in Community Pharmacies in West Virginia" is posted at https://www.japha.org/article/S1544-3191(16)31010-X/fulltext.

Common Dementia Screening Tests Often Misclassify Patients

The findings might help guide physicians to the most appropriate cognitive tests for their patients based on age, ethnicity, and education level. **BY NICK ZAGORSKI**

Brief cognitive tests that take a few minutes to complete can be useful for screening patients for dementia in busy settings. But, new evidence suggests that such brevity may come at the cost of accuracy.

In a study published November 28, 2018, in *Neurology: Clinical Practice*, researchers examined the error rates of three commonly used cognitive screening tools: the Mini-Mental State Examination (MMSE), which tests memory skills including proper orientation of time and place; the Memory Impairment Screen (MIS), which tests the ability to remember words; and Animal Naming (AN), a verbal fluency test that involves naming as many animals as possible in 60 seconds. They found about a third of the patients who were screened for dementia by at least one of the three short cognitive assessments were misclassified.

"Our study found that all three tests often give incorrect results that may wrongly conclude that a person does or does not have dementia," study author David Llewellyn, Ph.D., a senior research fellow at the University of Exeter Medical School, said in a press release. "Each test has a different pattern of biases, so people are more likely to be misclassified by one test than another depending on factors such as their age, education, and ethnicity."

The study authors hope that the findings might help guide physicians to the most appropriate cognitive tests for their patients.

Llewellyn and colleagues analyzed data from 824 older adults (aged 70 and older) who had participated in a population-based study looking at risk factors for dementia. All participants received a three- to four-hour neuropsychological exam. A panel of experts then used the neuropsychological data to diagnose the participants' dementia status. The comprehensive exam included the MMSE, MIS, and AN; this enabled the investigators to see how the results of the brief screening tests compared with the final diagnosis.

Of the 824 participants, 291 (35.3 percent) were diagnosed with dementia. The researchers found that the MMSE, MIS, and AN misclassified 21, 16, and 14 percent of the participants, respectively. The study revealed that 35.7 percent of the participants were misclassified by at least one assessment, 13.4 percent were misclassified by at least two, and 1.7 percent were misclassified by all three.

The MMSE errors were overwhelmingly false-positives (that is, a patient without dementia was screened as having dementia), whereas the MIS and AN were more evenly split between false-positives and false-negatives (a patient with dementia being screened as not having dementia).

The researchers identified multiple patient characteristics that contributed to a risk of being misclassified by these tests, though most were specific to one or two of the assessments. For example, African Americans were more likely to be mischaracterized by the MMSE, people with depression were more likely to be mischaracterized by the MIS, and people in nursing homes were more likely to be misclassified by the AN. People with less education and those with heart problems were more likely to be misclassified by both the MMSE and AN.

The study findings also revealed that stroke, which has been previously reported to affect cognitive screening accuracy, did not increase the risk of misclassification in any three of the studied tests.

"Currently, there is not strong evidence to suggest any one particular cognitive test is right for everyone," said lead study author Janice Ranson, a Ph.D. student in Llewellyn's lab. She told *Psychiatric News* that the research group is now using information from the study to find practical ways to improve the accuracy of these cognitive assessments.

In the meantime, she said that knowing which patient variables can influence test results can guide physicians to pick the measurement with the least risk of bias. Or, if test options are limited, physicians can adjust the cutoff scores used to delineate probable dementia versus no dementia for the test. Though the standard cutoff scores of each test are based on clinical consensus, they can be adjusted to factor in such factors as less formal education, she explained.

"It is also important to note that the tests should be only one part of an initial assessment," Ranson said. "They need to be interpreted alongside a full history, and consideration of any symptoms and difficulties with everyday life, including information from a close family member if available."

This study was supported by The Alan Turing Institute, Halpin Trust, Mary Kinross Charitable Trust, and National Institute for Health Research. **PN**

An abstract of "Predictors of Dementia Misclassification When Using Brief Cognitive Assessments" is posted at http://cp.neurology.org/content/early/2018/11/28/CPJ.0000000000000566.

Patient Traits That Contribute to Errors for Brief Cognitive Assessments

	False Positive	False Negative
MMSE	Nursing home resident, lower education, African-American ethnicity, visual impairment, APOE4 gene carrier	Higher education
MIS	Older age	Older age, APOE4 gene noncarrier, depression, absence of patient or family member report of poor memory
AN	Older age, nursing home resident, African-American ethnicity, Hispanic ethnicity	Not residing in a nursing home, high physical activity, absence of patient or family member report of poor memory

MMSE: Mini-Mental State Exam; MIS: Memory Impairment Screen; AN: Animal Naming Test

Source: Janice M. Ranson, M.Sc., et al., *Neurology: Clinical Practice,* November 28, 2018

PSYCHIATRY & INTEGRATED CARE

Partnering With Community-Based Organizations to Improve Collaborative Care for Late-Life Depression

BY THERESA HOEFT, PH.D.

Collaborative care can go a long way toward improving access to care for common mental health problems. This month's author, Theresa Hoeft, Ph.D., describes how partnerships between clinic-based collaborative care programs and community-based organizations can further enhance depression care for older adults.

—Jürgen Unützer, M.D., M.P.H.

Despite recent advances, older adults with depression often do not seek or receive effective treatment. One of the most promising approaches to improving the reach and effectiveness of depression care in older adults is the systematic involvement of community-based organizations (CBOs) or family care. In 2014, the Archstone Foundation launched an initiative known as Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care. It supports partnerships of primary care clinics and CBOs and/or family members as care partners to enhance collaborative care for depression.

Some CBOs offer home visits that, similar to working with family members as care partners, can give providers a more intimate sense of patient needs. These connections can enhance care when community partners with a more complete picture of the patients' lives in the community are connected with the patients' providers and health record.

CBOs can also enhance care for depression by increasing the reach of mental health programs through interactions with people where they live and socialize and by increasing connections to community services to address unmet needs. Programs like the PEARLS model of collaborative care

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Theresa Hoeft, Ph.D., is a research assistant professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington. She is co-principal Investigator of the Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care study funded by the Archstone Foundation. Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington and founder of the AIMS Center, dedicated to "advancing integrated mental health solutions."

Sleep Apnea Linked With Hard-to-Treat High Blood Pressure in Blacks

As black people have a higher risk of hypertension to begin with, the added presence of sleep apnea could pose a significant health burden to this population. **BY NICK ZAGORSKI**


iStock

Blacks with moderate or severe sleep apnea are much more likely to have resistant hypertension compared with those who do not have sleep apnea, according to a study published December 10, 2018, in the journal *Circulation*. Resistant hypertension—blood pressure that remains high even when a person takes three or more hypertensive medications—is the most severe category of high blood pressure.

Lead study author Dayna Johnson, Ph.D., an assistant professor of epidemiology at the Rollins School of Public Health at Emory University, said these findings illuminate a critical but underrecognized risk factor for hypertension. Obstructive sleep apnea is a common sleep disorder in which a person's airways become transiently blocked during the night, resulting in fitful sleep and daytime drowsiness.

"Traditionally, researchers have focused on factors like diet and exercise, or comorbidities like depression, as reasons why people cannot control their hypertension," Johnson said. "But some people remain resistant, despite improvements in their lifestyle or mood, and this study provides one reason why."

Recent data suggest that about 75 percent of blacks will develop hypertension by age 55. Johnson's research has shown that about 25 percent of black adults have sleep apnea.

For the current study, Johnson and colleagues assessed data from the Jackson Heart Study (JHS), a large population study investigating the causes of cardiovascular disease in blacks. A portion of the participants in the JHS were given sleep apnea tests that provided objective respiratory measures including nasal pressure. The researchers then grouped the participants into several sleep apnea categories (none, mild, moderate, or severe).

The analysis included 664 black adults (average age of 64) with hypertension. Of these participants, 38 percent had hypertension that was controlled by medication, 48 percent had uncontrolled hypertension (blood pressure remained high despite taking one or two hypertensive medications), and 14 percent had resistant hypertension (blood pressure remained high despite taking three or more hypertensive medications).

The researchers found that nearly 26 percent of these participants had moderate or severe sleep apnea, and in almost every instance, the condition had gone undiagnosed. Compared with participants with mild or no sleep apnea, those with moderate or severe sleep apnea were twice as likely to have resistant hypertension. Those with severe sleep apnea were 3.5 times as likely to have resistant hypertension.

Charles Reynolds III, M.D., the University of Pittsburgh Medical Center Endowed Professor in Geriatric Psychiatry, told *Psychiatric News* that mental health professionals should consider these findings important, as breathing-related sleep disorders are included in *DSM-5*.

"Obstructive sleep apnea has been linked with a host of medical and psychiatric problems, including depression, anxiety, and memory difficulties," he said. "Sleep apnea also makes these conditions harder to treat." Reynolds was chair of the *DSM-5* Work Group on Sleep-Wake Disorders.

Reynolds said that psychiatrists should pay attention to sleep apnea as a possible comorbidity in their patients, especially people in at-risk groups, including those who are older, black, obese, and/or hypertensive. He noted that it is important to distinguish sleep apnea from insomnia, as sedatives can make sleep apnea worse. He suggested that psychiatrists ask spouses or other bed partners about snoring or gasping, as these are hallmarks of sleep apnea.

"Once identified, sleep apnea is very treatable, and the best approach is a coordinated effort between psychiatrists and pulmonologists," Reynolds continued. He added that just as sleep apnea makes depression worse, untreated depression reduces the likelihood of patients getting treatment for their sleep apnea.

Johnson also stressed the importance of screening for and treating sleep apnea. "Sleep apnea can be described as a condition in which you stop breathing for a few seconds several times a night, and that's scary when you think about it," she said. "In our study 94 percent of the people with moderate or severe sleep apnea had never been diagnosed, and that is troubling to think about as well."

The study was supported by grants from the National Heart, Lung, and Blood Institute (NHLBI). The Jackson Heart Study is supported and led by Jackson State University, Tougaloo College, and the University of Mississippi Medical Center, with additional support from NHLBI and the National Institute on Minority Health and Health Disparities. **PN**

"Association Between Sleep Apnea and Blood Pressure Control Among Blacks: Jackson Heart Sleep Study" is posted at https://www.ahajournals.org/doi/abs/10.1161/CIRCULATIONAHA.118.036675.

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were designed to reach older adults in their homes and can help engage patients who may be less likely to engage in care with a primary care provider (PCP). PEARLS providers offer home visits and can enhance connections to primary care for those with PCPs and create linkages to clinics for those without a medical home. Additionally, the relationships between some larger CBOs and other agencies, like Adult Protective Services, can facilitate patients reaching these agencies and needed services. Follow-up with the patient on whether they connected with the referral is also critical. Such follow-up can be designated to a provider in the clinic, but this important step often falls lower on the list of competing priorities and may get more attention from a CBO partner.

When sharing care activities with CBOs or family care partners, you need to establish a clear understanding of the roles for each member of the extended collaborative care team or the family care partner. Outlining these roles can also highlight the value that the CBO or family member brings to the team. These new roles, for example, may offer eyes and ears in the home, enhanced referrals to social services, or improving engagement in care. Also, some CBOs that employ lay health providers (for example, community health workers or peers) may accomplish such goals at a lower overall cost.

Clinics and CBOs face several barriers to collaboration, perhaps most notably separate financing streams, but valuing services offered by each organization is a sound starting place for working together. Clinics and CBOs differ in organizational culture and pace of operations, and they also do not typically have a shared communication infrastructure in place. Establishing communication strategies and necessary access to electronic health records for CBO staff and clinicians often requires strong champions at each organization. Champions can remove barriers to collaboration and convince their organizations that patient needs often cannot be completely met by the health care system alone.

Building bridges to CBOs and family care partners can enhance clinic-based collaborative care when such partnerships are thoughtfully developed. Working with these different partnerships on the Care Partners project and learning with them as they navigate strong working relationships across systems has been a rewarding experience. As a researcher trained in population health, I find it exciting to watch many of these organizations engage patients in care and address social determinants of health as shared goals, challenges that the health care system cannot fully address alone. Several Care Partners partnerships were sprung from these common goals.

For patients with complex needs in particular, having a diverse team with differing strengths in terms of outreach, engagement, rapport building, and connecting patients to needed social services has turned out to be a powerful way to enhance the care of older adults with depression. **PN**

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Understanding the Breadth and Depth of C-L Psychiatry: Perinatal Psychiatry

This article is one of a series coordinated by APA's Council on Consultation-Liaison Psychiatry and the Academy of Consultation-Liaison Psychiatry.

BY NANCY BYATT, D.O., M.B.A., JANNA GORDON-ELLIOTT, M.D., AND PRIYA GOPALAN, M.D.

Consultation-Liaison PSYCHIATRY

Perinatal psychiatry is a rapidly evolving field requiring specialized knowledge and skills. The consultation-liaison (C-L) psychiatrist often provides psychiatric care for pregnant and postpartum patients in inpatient and outpatient settings. This requires the ability to navigate the field's ever-growing literature and to negotiate and manage complex clinical situations in multidisciplinary care settings. The following case illustrates the role that C-L psychiatrists can play in perinatal care.

Case Study

Ms. A is a 26-year-old woman who has had three pregnancies and two live births. She was admitted at 32 weeks gestation for management of influenza. The C-L psychiatrist was called because of signs of benzodiazepine withdrawal and recommended symptom-triggered medication. Ms. A disclosed a history of bipolar I disorder and postpartum psychosis after her second delivery. She reported that she was less symptomatic during treatment with lithium, which she stopped when she became pregnant.

The C-L psychiatrist recommended restarting lithium, discussing the risks/benefits and alternatives as they relate to maternal, fetal, and child health and postpartum risk. The patient was also counseled about the use of benzodiazepines during pregnancy. Ms. A declined lithium and accepted referrals for outpatient substance use and mental health treatment. At 38 weeks, Ms. A presented with preeclampsia, undergoing emergency caesarian section. The obstetrical team called the C-L psychiatrist for "postpartum psychosis." The patient was confused and inattentive, with visual hallucinations. Laboratory studies indicated a sodium level of 125 mMol/L. She was diagnosed with delirium, which resolved with sodium correction.

Discussion

The risks of untreated mood disorders in pregnancy include limited prenatal care, substance misuse, severe postpartum depression or psychosis, and impaired mother-infant attachment. Risk of psychotropic medications to the fetus must be weighed against the risks of untreated maternal psychiatric illness. As exemplified by Ms. A, C-L psychiatrists who have limited comfort in treating pregnant patients may automatically avoid lithium or other psychotropic medications. When treating pregnant women, the C-L psychiatrist must consider whether organogenesis is complete and whether exposure to untreated mental illness may pose a higher risk to mother and baby than exposure to medication.

C-L psychiatrists are also commonly asked to evaluate patients for postpartum psychiatric syndromes. They need to understand the role of prophylaxis in a high-risk but otherwise asymptomatic patient and know indications for continuation or re-initiation of medications. Familiarity with the presentation of postpartum syndromes and an understanding of the use of medications during lactation are imperative. As Ms. A's case highlights, the C-L psychiatrist must continue to think broadly, even in the narrow context of the obstetrical setting—in this case, by identifying delirium, which improved with medical management.

Obstetrical risks associated with substance use include serious adverse events for mother and baby. C-L psychiatrists may be asked to assist with the management of substance use disorders and withdrawal, to provide brief motivational interventions, and to discuss relapse prevention. Their role may involve management of the teams' discomfort and countertransference around the psychiatric diagnosis and substance use and detoxification with benzodiazepines from alcohol and benzodiazepine misuse. Medication-assisted treatments (for example, methadone and buprenorphine) are preferred over detoxification to manage perinatal opioid use disorders.

The field of perinatal psychiatry is a highly specialized one that requires up-to-date knowledge and the ability to manage and collaborate effectively in high-acuity interdisciplinary situations. The combination of the high stakes of pregnancy, the complex psychosocial issues that women may be facing during pregnancy, and the uneasiness that can arise when managing pregnant patients with psychiatric issues all contribute to the challenges faced by the C-L psychiatrist working in obstetrical settings. As the field evolves, C-L psychiatrists with perinatal expertise are increasingly finding themselves leading integrated care initiatives in obstetric outpatient settings to address these needs. **PN**

Nancy Byatt, D.O., M.B.A., is an associate professor of psychiatry, obstetrics/gynecology, and quantitative health sciences at the University of Massachusetts Medical School, the founding medical director of the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms, and the founding executive director of Lifeline4Moms. Janna Gordon-Elliott, M.D., is an assistant professor of clinical psychiatry at Weill Cornell Medicine/New York-Presbyterian Hospital. Priya Gopalan, M.D., is an assistant professor of psychiatry at the University of Pittsburgh Medical Center (Western Psychiatric Institute and Clinic) and the medical director of consultation-liaison services and chief of psychiatry at Magee-Women's Hospital.

Grant

continued from page 6

the Technical Expert Panel and Consumer and Family Panel on the utility of these new measures. The feedback loop between the panels and Learning Collaborative participants ensures that the quality measures developed under the initiative will be meaningful to patients and can help health care professionals improve the care they provide. **PN**

Those interested in participating in the initiative's Learning Collaborative can learn more and sign up at psychiatry.org/registry. Those who qualify will receive a tablet computer for easy access to the PsychPRO online portal to complete required assessments and earn an honorarium, as well as acknowledgement of support in journal and white paper publications.

Moore

continued from page 8

cal setting, not in a controlled setting such as a prison.

"Reliance on adaptive strengths developed in the controlled setting of a prison should be limited, especially when other information is available," according to the APA brief. "It is widely accepted that people with intellectual disability can learn and that they are more likely to do so in a structured environment with clear rules—like a prison. Thus, the fact that an individual is able to develop relative strengths in prison is of limited utility when assessing that individual's *typical* adaptive functioning."

Marvin Swartz, M.D., chair of the APA Committee on Judicial Action, said *Moore* is "an important case about competency to be executed in a man with IDD [intellectual and developmental disabilities]." He added, "While there is broad consensus among experts that no precise numeric threshold or IQ score should be used to determine intellectual disability, the Texas courts have continued to use antiquated and idiosyncratic definitions."

Moore's claim to be exempt from execution rests on the landmark 2002 Supreme Court ruling in *Atkins v. Virginia* in which the court ruled that execution of intellectually disabled individuals violates the Eighth Amendment.

However, *Atkins* left open the question of how a state would determine whether someone was intellectually disabled. In 2004, the Texas Court of Criminal Appeals adopted its own idiosyncratic standards (known as "Briseno factors," for the case *Ex parte Briseno*) for determining intellectual disability that were regarded by APA and other professional groups as unrelated to clinically accepted standards (*Psychiatric News,* http://apa-psy.ch/Standards). The *Briseno* decision was appealed to the Supreme Court.

Last year the Supreme Court vacated the Court of Appeals' judgment, stating that adjudications of intellectual disability should be "informed by the views of medical experts." Moreover, the court said that the several factors set out in *Briseno* as indicators of intellectual disability are "an invention of the [court] untied to any acknowledged source."

The court remanded the case back to the Court of Appeals. The Texas court applied the framework in *DSM-5* for determining intellectual disability but still found Moore did not meet the criteria for intellectual disability, citing evidence of some adaptive learning the defendant has demonstrated during his time in jail.

Debra Pinals, M.D., chair of the APA Council on Psychiatry and Law, said the principles in the brief are important with regard to diagnostic issues for intellectual disability.

"The APA brief spells out the problems of limiting information for diagnosis to certain adaptive skills or those solely examined in a highly structured prison environment," she told *Psychiatric News.* "The stakes in this case are obviously high, and we hope this brief from several key organizations will help the Court be better informed for its deliberations."

Joining APA in the amicus were the American Psychological Association, the American Academy of Psychiatry and the Law, the National Association of Social Workers, and the Texas chapter of the National Association of Social Workers. **PN**

Amicus curiae briefs filed by APA are posted at https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/amicus-briefs.

Psychiatrist Wants to Increase Awareness About Bipolar, Cardiovascular Disorder

By putting more clinical focus on the numerous cardiovascular problems associated with bipolar disorder, including premature death due to heart disease, Benjamin Goldstein, M.D., Ph.D., thinks more can be done to help patients. **BY NICK ZAGORSKI**

While manic and depressive states are well-known symptoms of bipolar disorder, often overlooked heart problems also put this patient population at great risk. Benjamin Goldstein, M.D., Ph.D., a professor of psychiatry and pharmacology at the University of Toronto, hopes to change all that.

For over a decade, Goldstein has been conducting research to understand why bipolar disorder and heart problems seem so closely connected, as well as raising public awareness about this connection. His goal is to reframe bipolar disorder as not only a psychiatric illness, but also a cardiovascular one.

Kevin Van Paassen/Sunnybrook

Among the findings of Benjamin Goldstein, M.D., Ph.D., has been that adults with bipolar disorder typically develop heart disease in their mid-40s—about 17 years younger on average than people in the general population and 10 years younger than adults with major depressive disorder.

Interest in Childhood Bipolar Reveals Early Emergence of Heart Problems

Goldstein became interested in the connection between bipolar disorder and heart problems about 12 years ago, after starting a postresidency training in child and adolescent mood disorders at the University of Pittsburgh with Boris Birmaher, M.D.

At that time, the diagnosis of bipolar disorder in children was an area of vigorous debate. Many psychiatrists questioned the existence of bipolar disorder before adolescence, believing that children diagnosed with early-onset bipolar disorder had some other conduct or behavioral disorder common in children.

David Kupfer, M.D., who was then chair of psychiatry at the University of Pittsburgh and also a mentor to Goldstein, was one of the first psychiatrists to advocate for a better appreciation of the physical health problems facing adults with bipolar disorder. Goldstein figured that if children diagnosed with early-onset bipolar disorder had similar types of medical problems as adults with bipolar, then that would support the validity of a bipolar diagnosis. He decided to examine weight in the children with bipolar disorder and found that about 40 percent of the youth were overweight or obese. What's more, obesity correlated with worse psychiatric symptoms in these pediatric patients. Both findings were similar to what had been seen in adults.

Goldstein began studying the frequency and age of onset of heart disease among adults with bipolar disorder in large epidemiologic studies. His research led him to the discovery that people with bipolar disorder are about three times more likely to develop heart disease than the general population. Adults with bipolar disorder developed heart disease in their mid-40s—about 17 years younger than people in the general population and 10 years younger than adults with major depressive disorder, a group also known to be at risk of cardiovascular problems.

Some studies have suggested that manic symptoms create additional cardiovascular stress. Others have suggested that the higher risk of cardiovascular problems is the result of bipolar depression being generally severe and difficult to treat. Goldstein believes that it is the overall burden of depressive and manic symptoms that creates this greater risk of heart disease.

Cardiovascular Deficits Start Early

Goldstein said that while it is possible that medication side effects, limited physical activity, and/or smoking by patients with bipolar disorder may heighten the risk of cardiovascular problems, "there are biological connections above and beyond these expla-

see **Bipolar Disorder** *on page 26*

FROM THE EXPERTS

Suicidal Behavior and the Three I's

BY JOHN CHILES, M.D.

The treatment of patients exhibiting suicidal behavior utilizes a spectrum of therapeutic approaches. I'd like to advise you to keep two points in mind:

First, suicidal behavior co-occurs with a variety of mental illnesses, and your approach needs to be tailored to the diagnosis with which you are dealing. Also, patients with chronic suicidal behavior may carry more than one diagnosis, for example, a personality disorder, depression, a substance use disorder, and a significant nonpsychiatric medical problem. In contrast, a suicidal patient may have no discernible psychiatric diagnosis at all. It is best to treat suicidal behavior as a distinct problem occurring in the context of other treatable disorders.

Second, when you are evaluating suicidal behavior, view the behavior not as a problem but as a solution to a problem. As my coauthors and I describe in the book *Clinical Manual for the Assessment and Treatment of Suicidal Patients, Second Edition,* there are three key characteristics to the problems driving suicidality, which we call the three "I's." The problem can be seen as *intolerable* (I can't stand it), *interminable* (it will never end), and/or *inescapable* (I cannot get away from it). If your work can produce a nonsuicidal approach to the pertinent problem or problems, you are on the road to success.

John Chiles, M.D., is professor emeritus in the Department of Psychiatry and Behavior Science at the University of Washington School of Medicine in Seattle. He is the coauthor of *Clinical Manual for the Assessment and Treatment of Suicidal Patients, Second Edition,* from APA Publishing. APA members may purchase the book at a discount at https://www.appi.org/Clinical_Manual_for_the_Assessment_and_Treatment_of_Suicidal_Patients_Second_Edition.

Evaluation is part of the treatment process. The first minute, and every minute thereafter, should be conducted in a treatment framework. Focusing primarily on assessment and management of suicidal risk can be a missed opportunity at best and counterproductive at worst. Perform due diligence in meeting your risk management criteria, but do your best to leave your patient with the sense that suicidality is a legitimate but quite costly form of problem solving and that, between the two of you, you can come up with positive and effective ways to deal with whatever life has thrown your patient's way.

Suicidal behavior almost always occurs in the context of distressing and unwanted mental pain that occurs in a variety of states—sadness, guilt, anxiety, grief, fear, loneliness, boredom, shame, anger—to name the most common. Your patient is suffering and doing so in a culture that places emphasis on feeling good all the time and is quite happy to sell you a quick fix if you don't. While pain is an inevitable part of life's journey, prolonged suffering is not.

In our book, we detail techniques to move your patient from the emotional avoidance and passivity that are the core factors in suicidality to the use of active and positive problem-solving techniques accompanied by the ability to accept and move on from residual mental suffering. The basic task is to destabilize your patient's belief that mental pain is *inescapable* (show that the problem can be solved), *interminable* (show that the negative feeling will end), and *intolerable* (show your patient that he or she can stand negative feelings).

Stress that suicide is a permanent

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Having a Sibling With ADHD or ASD Increases Risk for Both Disorders

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Overall, about 15 percent of later-born siblings in the ADHD and ASD risk groups were diagnosed with ADHD or ASD, compared with about 2 percent of children whose older siblings had neither disorder. ***BY NICK ZAGORSKI***

Autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD) are distinct childhood conditions, but they share many traits. Children with both disorders often display impulsivity, difficulties with social skills, and repetitive behaviors. A study published December 10, 2018, in *JAMA Pediatrics* identified a hereditary overlap as well. Children who have an older sibling who has been diagnosed with ASD are not only at an increased risk of ASD themselves, but also at an increased risk of developing ADHD. Similarly, children who have an older sibling diagnosed with ADHD are at an increased risk of being diagnosed with ADHD or ASD.

"[L]ater-born siblings of children with ASD and ADHD appear to be at elevated risk within and across diagnostic categories and thus should be monitored for both disorders," wrote lead author Meghan Miller, Ph.D., an assistant professor of psychiatry and behavioral sciences at the University of California, Davis, and colleagues. "Practitioners may wish to share such information with families given the potential relevance of monitoring social communication, attention, and behavior regulation skills in later-born siblings of children with ASD or ADHD."

Miller and colleagues analyzed medical records from two large U.S. health care systems: Wisconsin's Marshfield Clinic and Kaiser Pacific Northwest, which covers Oregon and Washington. They looked for families who had at least one more child after having a child diagnosed with ADHD or ASD. The authors did this to overcome the effect of "reproductive stoppage," in which parents decide to stop having children after one is diagnosed with a developmental disorder. Family analyses that look only at the total number of siblings with or without a disorder likely underestimate the true inheritance risks, the authors wrote.

The final dataset included 15,175 non-firstborn children; of these, 730 had an older sibling diagnosed with ADHD (the ADHD risk group) and 158 had an older sibling diagnosed with ASD (the ASD risk group).

Compared with children whose older siblings had neither disorder, children in the ASD risk group were about 30 times more likely to also be diagnosed with ASD and 3.7 times more likely to be diagnosed with ADHD. Children in the ADHD risk group were about 13 times more likely to be diagnosed with ADHD and 4.4 times more likely to be diagnosed with ASD than children whose older siblings had neither disorder.

Overall, about 15 percent of later-born siblings in the ADHD and ASD risk groups were diagnosed with ADHD or ASD, compared with about 2 percent of children whose older siblings had neither disorder.

Miller told *Psychiatric News* that the analysis could not rule out that some of the increased prevalence of ADHD and/or ASD among the siblings in the ASD and ADHD risk groups was due to shared environmental factors. However, she said there is a lot of evidence that shows these two disorders are highly heritable.

As expected, the odds of ASD or ADHD in later-born siblings increased even more if the child was a boy. In the ADHD risk group, the odds of an ADHD diagnosis in a later born sibling also increased if the older diagnosed sibling was a girl.

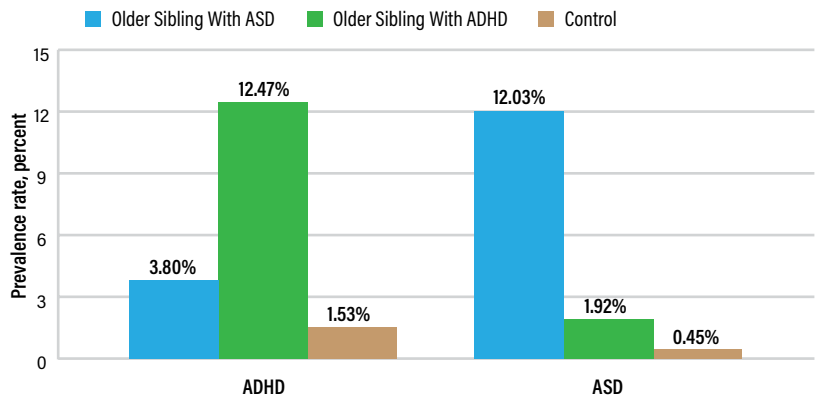
"Some studies have suggested that there may be a 'female protective effect' for male-predominant disorders like ASD and ADHD," Miller told *Psychiatric News*. That means females need to inherit a greater amount of genetic risk factors before they manifest a disorder. Therefore, if a daughter develops ADHD, it suggests the parents are carrying a greater genetic burden, which would make ADHD in boys more likely. The authors did not observe this same trend with older female siblings in the ASD risk group, which they suggested may have been due to the smaller number of diagnoses in the dataset.

This study was supported by grants from the National Institute of Mental Health. **PN**

An abstract of "Sibling Recurrence Risk and Cross-Aggregation of Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder" is posted at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2717035. An accompanying editorial, "Later Sibling Recurrence of Autism Spectrum Disorder and Attention-Deficit/Hyperactivity Disorder: Clinical and Mechanistic Insights," is posted at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2717031.

Sibling Diagnosis of ADHD or ASD Increases Risk for Both Disorders

Rates of a diagnosis of attention-deficit/hyperactivity disorder (ADHD) or autism spectrum disorder (ASD) are dramatically increased in children with an older sibling with either disorder.



Source: Meghan Miller, Ph.D., et al., *JAMA Pediatrics,* December 10, 2018

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solution to what is most often a temporary problem. Suicidal behavior increases mental pain and creates new problems producing more mental pain. At the same time, acknowledge that suicidal feelings are a valid and understandable response to this pain. Show empathy and understanding of your patient's pain, and dignify the pain by portraying it as a reflection of your patient's values and intentions. Things are not going the way they should; it's not right, and it hurts. Stress that it is OK to talk openly and honestly about suicide and be direct and matter of fact in your comments and demeanor. Consistently assess for suicidal ideation comments and demeanor and self-injurious behavior. Do not make value judgments about the act of suicide. For many of your patients, friends and family have done plenty of that already. Acknowledge that such behavior is one of several options for dealing with problems and mental pain but that other options may well work more effectively: "Let's take a look at them." Your approach should be collaborative, not confrontational.

Avoid power struggles over behavior. Your value comes from offering effective solutions to life's problems and showing that mental pain can be accepted in a way that allows life to have meaning and be enjoyed. Identify specific skill sets that can be developed through structured behavioral training—mindfulness and acceptance skills, detachment skills, problem-solving skills, and self-compassion skills.

Treatment of suicidal behavior is rewarding work, but it can be difficult. Acquiring the necessary skills and the right therapeutic demeanor can be hard. Know your limitations. Know your own hot-button emotional issues. Have colleagues available who are happy to talk things over with you. Last, know how many suicidal behavior patients with whom you are comfortable treating at any given time, and stick to that number. **PN**

MED CHECK

BY TERRI D'ARRIGO

FDA Names Companies For Innovation Challenge

The Food and Drug Administration (FDA) in November 2018 announced that eight companies were selected as beneficiaries in the Center for Devices and Radiological Health's (CDRH) Innovation Challenge. The CDRH launched the challenge in May 2018 to spur the development of medical devices that could provide new solutions for detecting, treating, and preventing opioid addiction; addressing diversion; and treating pain.

The companies and products chosen were as follows:

- Brainsway Ltd. (deep transcranial magnetic stimulation device)
- Avanos (pain therapy device)
- iPill Dispenser (tamper-resistant locked pill storage unit that dispenses medications at predetermined times)
- Masimo Corporation (overdose detection device)
- ThermoTek Inc. (devices for pain management)
- Milliman (opioid prediction service)
- Algomet Rx Inc. (rapid drug screen)
- CognifiSense Inc. (virtual reality neuropsychological therapy)

The device developers will receive increased interaction with CDRH experts, guidance for clinical trial development plans, and expedited review. They will not automatically receive marketing authorization from the FDA.

Phase 2a Treatment Shows Promise for Cannabis Use Disorder

A long-acting fatty acid amide hydrolase (FAAH) inhibitor, ***PF-04457845***, appears to help men with cannabis use disorder, according to a study in the January issue of the *Lancet Psychiatry*.

Deepak Cyril D'Souza, M.D., of the VA Connecticut Healthcare System in West Haven and colleagues randomly assigned 46 men with cannabis use disorder to receive the treatment and 24 men to placebo, stratified by severity of cannabis use and desire to quit. Participants were admitted to a hospital for five to eight days to achieve abstinence and start cannabis withdrawal, then discharged for the remaining three weeks of treatment.

After four weeks, the men in the treatment group reported smoking a mean of 0.40 joints per day compared with 1.27 joints per day for men in the placebo group. The men in the treatment group also had significantly lower urinary tetrahydrocannabinol carboxylic acid concentrations than those in the placebo group. There were no serious adverse events in either group.

"PF-04457845, a novel FAAH inhibitor, reduced cannabis withdrawal symptoms and cannabis use in men, and might represent an effective and safe approach for the treatment of cannabis use disorder," D'Souza and colleagues wrote.

This study was funded by the National Institute on Drug Abuse.

D'Souza DC, Cortes-Briones J, Creatura G, et al. Efficacy and Safety of a Fatty Acid Amide Hydrolase Inhibitor (PF-04457845) in the Treatment of Cannabis Withdrawal and Dependence in Men: A Double-blind, Placebo-Controlled, Parallel Group, Phase 2a Single-Site Randomised Controlled Trial. *Lancet Psychiatry.* 2019;6(1):35-45.

Bedtime Prazosin May Worsen Nightmares In PTSD Patients

Taking ***prazosin*** at bedtime may worsen nightmares in patients with posttraumatic stress disorder (PTSD) and suicidal thoughts, according to a study published in the *Journal of Clinical Psychopharmacology* in December 2018.

In the study, 20 patients with PTSD and mild to moderate suicidal ideation were randomized to bedtime-only dosing of either prazosin or placebo for eight weeks. Participants had weekly visits to receive the following week's medication. Although treatment effects were not significant during the first four weeks, by the study's end those in the prazosin group scored significantly higher than those in the placebo group on the Disturbing Dreams and Nightmare Severity Index. Similarly, people in the prazosin group showed less improvements on the Insomnia Severity Index and the Hamilton Rating Scale for Depression. Their scores also rose for the Scale of Suicide Ideation, although not as much as they did for the other indices. Suicidal ideation and daytime-only PTSD symptoms were similar in the prazosin group and placebo groups.

"The results do not support a larger study of nighttime-only prazosin in suicidal PTSD patients but leave open the possibility of benefit from daytime administration of prazosin," the authors wrote.

McCall WV, Pillai A, Case D. A Pilot, Randomized Clinical Trial of Bedtime Doses of Prazosin Versus Placebo in Suicidal Posttraumatic Stress Disorder Patients With Nightmares. *J Clin Psychopharmacol.* 2018;38(6):618-621.

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Board

continued from page 14

intervention for immigrant children and adolescents by making relevant screening instruments and other resources publicly available.

The Board also approved a resolution condemning "the brutal treatment of black males, the use of excessive force against black males, and the use of unwarranted and unnecessary deadly force against black males by law enforcement agencies and police departments."

The position statement encourages initiatives that foster direct collaboration between law enforcement and black communities "in order to engender trust, cooperation, and understanding."

Additionally, APA encourages the development of novel approaches and strategies to address the unique mental health needs of black males who have either directly or indirectly experienced police brutality and/or the use of unwarranted excessive/deadly force by law enforcement, as well as the mental health needs of their families and community members.

APA Joins Coalition Against Gun Violence

Additionally, the Board officially accepted an invitation to join the medical consortium of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM). APA joins a number of other organizations participating in the consortium including, among others, the AMA, American College of Physicians, American Academy of Pediatrics, American College of Emergency Physicians, and American College of Surgeons.

AFFIRM's mission is to eliminate the epidemic of gun violence through research, innovation, and evidence-based practice. The group will raise money privately to fund research on gun violence as a public health problem. Since 1996, congressional spending appropriations bills have prohibited funds allocated to the Centers for Disease Control and Prevention from being used for research on gun violence as a public health problem. While Congress clarified in an omnibus continuing resolution last March that the CDC can conduct research on gun violence, it also stated that government funds cannot be used.

AFFIRM takes no position on an individual's right to firearm ownership and eschews a policy agenda. According to the organization's website, AFFIRM's goals are the following:

- Raise research funds among diverse private-sector financial resources.
- Create infrastructure with expert leadership. The organization will identify and score health and research priorities and select project proposals to address the highest-ranking health priorities in this field.
- Provide funds to qualified researchers through their respective academic and/or professional medical organization, and through an open and competitive process.
- Sponsor professional working groups for the development of best practice recommendations, related educational resources, and training curricula with evidence derived from completed research.
- Cooperate with academic and professional medical standards organizations to integrate research evidence into medical education and health practices.
- Conduct quality assurance of completed research and educational materials.

Other Actions

In other news, trustees accepted the report of the IPS Strategic Planning Work Group, a group looking at various proposals affecting the future of APA's fall meeting focused on public psychiatry (see page 3). The Board voted to request that the APA administration work with the current IPS work group to examine the feasibility of a revised format for future IPS meetings and report back to the Board of Trustees in March. The Board also voted to suspend the 2020 meeting because there were some challenges with contracting with a hotel for the 2020 meeting. The 2019 IPS, which will be co-branded with the World Psychiatric Association, will be held in New York City. **PN**

APA members may access archived summaries of Board actions at http://apapsy.ch/Archives.

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Phase 2 Results for PTSD Combo Therapy Suggest Efficacy

Patients with posttraumatic stress disorder (PTSD) appear to experience greater symptom improvements when taking a combination of ***brexpiprazole*** and ***sertraline*** than those taking either medication alone, suggest the findings of a phase 2 trial. H. Lundbeck and Otsuka Pharmaceutical Co. Ltd. announced the results last November.

The trial, which involved 321 patients, assessed the efficacy, safety, and tolerability of monotherapy with brexpiprazole, sertraline, or a combination of the two agents compared with placebo for 12 weeks. The patients were evaluated using the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5) at the beginning and end of the trial. Those treated with both agents experienced improvement in their PTSD symptoms over time compared with those in the placebo group. Treatment with either agent alone did not demonstrate clinically meaningful differences compared with placebo.

According to a press statement by Lundbeck, the companies plan to discuss the results of the trial with the Food and Drug Administration (FDA) and to evaluate, with FDA, the continuation of a trial program.

Schizophrenia Drug Had Favorable Weight Profile In Phase 3 Trial

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

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

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

Alkermes plans to submit a New Drug Application to the FDA later this year. **PN**

2018 Favorites

continued from page 1

that most of the genes in the two groups overlapped and were part of the same biological pathways. But Kauppi and colleagues also identified several genes among the schizophrenia risk loci that had no connections to any current antipsychotic targets. "The article represents a novel alternative strategy for drug discovery," Tamminga wrote. "The availability of large datasets makes this approach an early example of new computational strategies for drug discovery."

A study on how depression may affect aging was a favorite of Susan Schultz, M.D. Laura K.M. Han, M.Sc., of VU Medical Center in the Netherlands and colleagues found that people with depression had accelerated DNA methylation activity, especially those who had experienced childhood trauma. DNA methylation is a process by which cells regulate gene expression; it normally occurs at a regular rate, making it a good biological clock. "This finding offers perspective into how we miss opportunities to understand aging by focusing only on middle to later adulthood," Schultz wrote.

Oliver Glass, M.D., editor-in-chief of the *AJP Residents' Journal*, selected an article by Somya Abubucker, M.D., a resident at Johns Hopkins University, on the deaths by suicide of celebrities Anthony Bourdain and Kate Spade. "Although some may argue that progress has been made, mental health stigma continues to linger deep in our culture," Glass wrote. "As trainees, psychiatrists, and health professionals, we must lead the effort to dismantle this stigma so that individuals who struggle with psychiatric crises can obtain immediate support."

Freedman picked a fitting article for his final editor's selection: a review from John Rush, M.D., and Michael Thase, M.D., titled "Improving Depression Outcome by Patient-Centered Medical Management." This piece was part of a series of articles that looked at the past and considered the future as a nod to *AJP's* 175th year. The article also discussed findings from the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study, the first major clinical trial published in *AJP* during Freedman's tenure.

"The Rush and Thase article struck me because it re-examines the fundamental issue in patient care, how doctors work collaboratively with patients," Freedman wrote.

As described in the editorial, STAR*D showed that many patients with depression become frustrated and display poor medication adherence when they don't experience immediate symptom improvements. Psychotherapy can be an effective adjunct treatment, but it is often not well coordinated with pharmacotherapy.

To overcome this challenge, Rush and Thase proposed a new system called patient-centered medical management. Under this system, patient care is divided into four clinical tasks: (1) engaging and retaining the patient in treatment; (2) optimizing symptom control; (3) restoring functioning and quality of life; and 4) mitigating the risk of relapse. Psychiatrists work with patients to systematically address each task, tailoring the behavioral strategies used to the strengths and limitations of each patient.

"The *Journal* is a vast collaboration, with thousands of colleagues interested in mental disorders, from genes to the community, and infants to the aged," wrote Freedman in an accompanying farewell letter in which he thanked the *Journal*'s editors, authors, reviewers, and APA staff for working tirelessly and usually anonymously to keep *AJP* running smoothly. "I look forward to reading this coming year's issues and the next phase in the progress of the *Journal*." **PN**

"2018 in Review" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.18091065. "A Farewell" by Freedman is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.18091108

List of *AJP's* 2018 Editor's Picks

- Sit DK, McGowan J, Wiltrout C, et al. Adjunctive Bright Light Therapy for Bipolar Depression: A Randomized Double-Blind Placebo-Controlled Trial. February 2018. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2017.16101200
- Wang Q, Roy B, Turecki G, et al. Role of Complex Epigenetic Switching in Tumor Necrosis Factor-α Upregulation in the Prefrontal Cortex of Suicide Subjects. March 2018. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2017.16070759
- Brunet A, Saumier D, Liu A, et al. Reduction of PTSD Symptoms With Pre-reactivation Propranolol Therapy: A Randomized Controlled Trial. May 2018. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2017.17050481
- Kauppi K, Rosenthal SB, Lo M-T, et al. Revisiting Antipsychotic Drug Actions Through Gene Networks Associated With Schizophrenia. July 2018. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2017.17040410
- Han LKM, Aghajani M, Clark SL, et al. Epigenetic Aging in Major Depressive Disorder. August 2018. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.17060595
- Jennissen S, Huber J, Ehrenthal JC, et al. Association Between Insight and Outcome of Psychotherapy: Systematic Review and Meta-analysis. October 2018. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.17080847
- Rush AJ, Thase ME. Improving Depression Outcome by Patient-Centered Medical Management. December 2018. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.18040398

From the *AJP Residents' Journal*:

- Abubucker S. Reflections on the Spade and Bourdain Suicides. September 2018. https://psychiatryonline.org/doi/10.1176/appi.ajp-rj.2018.130904

NEJM Journal Watch Psychiatry Recognizes *AJP* For Top Psychiatry Stories of 2018

In addition to being recognized as a top article by *AJP* editors (see story beginning on page 1), the study by Alain Brunet, Ph.D., and colleagues revealing the benefit of the beta-blocker propranolol for patients with PTSD was selected by *NEJM Journal Watch Psychiatry* as one of the top psychiatry stories of 2018.

"Propranolol presumably acts by altering the amount of emotional fear associated with the reconsolidation of activated memory traces," Joel Yager, M.D., associate editor of *NEJM Journal Watch Psychiatry* wrote in comments reflecting on the study. "The simplicity of the intervention is noteworthy, but currently its routine employment would be premature," he added. Yager is a professor of psychiatry at the University of Colorado.

The *NEJM Journal Watch Psychiatry* editorial board also recognized APA's Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder (AUD), released in January 2018. The editors acknowledged APA's efforts at educating physicians about the benefits and risks of approved AUD medications, which are simple to provide yet greatly underutilized.

"NEJM Journal Watch Psychiatry Top Stories of 2018" is posted at https://www.jwatch.org/na47953/2018/12/21/nejm-journal-watch-psychiatry-top-stories-2018. "The American Psychiatric Association Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2017.1750101.

ECT

continued from page 1

APA had strongly advocated for a broader reclassification of ECT devices, saying it could greatly expand access to safe, effective treatment for individuals with serious and persistent psychiatric disorders.

"APA is very pleased that the FDA has finally given ECT devices a lower-risk classification for certain indications," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "The extensive body of evidence for safe and effective use of ECT is well established. Although the new classification will help decrease the unfortunate stigma that surrounds this life-saving treatment, it will be important to ensure and expand patients' access to it. We are disappointed, however, that the FDA did not follow our full recommendation, but we will continue to work with the FDA on the issue. APA member experts will also be developing a resource document for members on how these changes may affect their practice."

First, the FDA's final order reclassified ECT devices from Class III (higher risk) to Class II (moderate risk) for the treatment of catatonia or a severe major depressive episode associated with major depressive or bipolar disorder. The order applies to ECT use in patients who are treatment resistant or who require a rapid response due to the severity of their condition.

In addition, the FDA lowered the minimum age for whom these ECT devices are considered Class II devices to 13 years, from its originally proposed 18 years of age.

At the same time, the order requires ECT device manufacturers to go through the FDA's most rigorous process for marketing known as a premarket approval application for all other uses of ECT devices, such as for schizoaffective disorder and bipolar manic states. The agency noted that this is because the FDA is unable to identify sufficient information to ensure the safety and effectiveness of ECT for such indications.

"This will give physicians more information on the safe and effective use of these devices and ultimately better protect patients," said Carlos Peña, Ph.D., director of the Division of Neurological and Physical Medicine Devices in the FDA's Center for Devices and Radiological Health, in a statement. The FDA regulates medical devices and categorizes them into one of three classes (I, II, or III) based on their level of risk and the regulatory controls necessary to provide a reasonable assurance of safety and effectiveness.

"ECT is an important part of the medical toolbox," Sarah Lisanby, M.D., director of the Division of Translational Research at the National Institute of Mental Health, told *Psychiatric News*. The published medical literature strongly supports the safety and effectiveness of ECT for use in major depressive disorder, she said. Because of its rapid action, ECT is among the most effective treatments for preventing suicide, she added.

Lisanby added that there have simply been fewer studies involving other indications, such as schizoaffective disorder. While the biggest risk posed by ECT is memory loss, recent research innovations have significantly reduced that risk, particularly the move toward unilateral lead placement and the use of ultrabrief pulses, allowing it to be used safely in outpatient centers, Lisanby said. However, more research is needed on ECT so scientists can better understand its mechanism and improve its safety. Such research may also provide clues to better understanding these illnesses and illuminate other pathways to recovery that could prove even safer and more effective.

For years, APA has strongly supported the reclassification of ECT devices as Class II. APA submitted formal comments to the FDA after the agency last proposed the reclassification in late 2015. APA cited numerous studies supporting the safety and effectiveness of ECT for patients with treatment-resistant major depressive episodes. APA had also recommended that the FDA designate ECT devices as Class II for use in mania in bipolar disorder, schizophrenia, and schizoaffective disorder, as well as for use in children and adolescents who meet the criteria for treatment resistance and who are in need of a potentially lifesaving intervention.

APA had encouraged members to submit comments to the *Federal Register* explaining the potential benefit of the reclassification. A similar effort was initiated years earlier when the FDA first invited public comments on how ECT devices should be reclassified.

The reclassification of ECT devices is part of the FDA's 515 Program Initiative, which it began in 2009 to address some 26 devices that were issued "temporary" Class III designations some 40 years ago and had never been required to go through premarket approval. ECT devices were one of the last medical devices awaiting reclassification. **PN**

The FDA's final order is posted at https://www.federalregister.gov/documents/2018/12/26/2018-27809/neurological-devices-reclassification-of-electroconvulsive-therapy-devices-effective-date-of. APA's comments in response to the FDA's 2015 proposed reclassification are posted at https://www.psychiatry.org/File%20Library/Psychiatrists/Advocacy/Federal/APA-FDA-ECT-reclassification-comments-03102016.pdf.

Bipolar Disorder

continued from page 22

nations." He pointed out that some of his research has shown that even in teens recently diagnosed with bipolar disorder, cardiovascular deficits are already evident.

One example of the differences seen in youth with bipolar disorder is in cerebrovascular reactivity—or how well the many tiny blood vessels in the brain dilate and contract in response to biochemical signals. Using brain scans, Goldstein and colleagues have found that youth with bipolar disorder have less cerebrovascular reactivity than healthy teens. If these blood vessels do not respond to biochemical signals properly, the health of surrounding brain tissue can be impacted. This, in turn, may contribute to both the mood symptoms associated with bipolar disorder and to future risk of stroke, he said.

Goldstein has also shown that among youth with bipolar disorder, those with higher triglyceride levels have more problems with executive function, and youth with hypertension have higher levels of impulsivity. While Goldstein noted these are only associations between poor cardiovascular health and worse mood states, the findings point to a connection between the mind and the heart.

Promoting Heart Health Can Help Patients With Bipolar Disorder

Understanding the connections between bipolar disorder and heart problems may assist with early interventions, Goldstein said. He and other researchers have found that aerobic exercise—even just a single session—can temporarily normalize blood flow and improve brain function in youth with bipolar disorder.

"When physicians discuss the importance of heart health with young or middle-aged patients, they usually do so with an eye to the future—highlighting the lower risk of heart disease in 20 or 30 years," Goldstein told *Psychiatric News*. "But for young people with bipolar disorder, being heart healthy can help the mind in the here and now."

To help drive home the message that bipolar disorder impacts the cardiovascular system, Goldstein and several colleagues worked with the American Heart Association (AHA) in 2015 to put forth an official statement that bipolar and other mood disorders in young people are significant and independent risk factors for early atherosclerosis and

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heart disease. "That recognition by the AHA was rewarding as it added a lot of legitimacy to my team's work," Goldstein said.

"There is no question that Benjamin, who was terrific while at Pittsburgh, has continued to function at a high level in both academics and research," said Kupfer of his former mentee. "Working with both adults and children, his work has established this important interface between bipolar disorder and cardiovascular disorders.

"Does every pediatrician or primary care doctor know about this interface? Probably not, and they should," Kupfer continued. "It makes early intervention for either disorder that much more important." **PN**

Police Violence

continued from page 5

lence was [still] higher than I expected it to be, especially among the subgroups," DeVylder said. "One group that stood out that I want to research further is transgender people. They were a small subset of only six, but four of the six had some kind of victimization with a weapon by a police officer."

Physical violence with a weapon and sexual violence were associated with the greatest increase in risk for suicide attempts, suicidal thinking, and psychotic experiences. Physical violence with a weapon was associated with more than a sevenfold increase for suicide attempts, nearly a threefold increase in risk for suicidal thinking, and more than a fourfold increase in risk for having psychotic experiences. Sexual violence was associated with more than a sixfold increase in risk for suicide attempts and psychotic experiences and nearly a fourfold increase in risk for suicidal thinking. Physical and sexual violence were associated with greater distress than the other forms of police violence.

DeVylder noted that police neglect may also take a toll on mental health.

"If you're living in a place perceived as unsafe, and [you feel that] when you call for help, it might not come, it's distressing," DeVylder said.

In their paper, DeVylder and his colleagues called attention to the broad effects of police violence in the United States.

"Police violence constitutes a public health problem that is important to address because of the expanse of its potential mental health consequences and the limited attention it has received from policymakers and researchers. [Our] findings suggest the need for clinicians to be attuned to the prevalence of police violence among patient populations, especially racial/ethnic minorities, males, young adults, and economically disadvantaged individuals."

DeVylder encouraged psychiatrists to consider whether their patients have been affected by police violence.

"Along with all the other social and environmental risks you think about, keep in mind that this could be happening to the people you work with and it's affecting their mental health. It's a problem that needs to be addressed in a way that's sensitive to the difficult nature of these experiences," DeVylder said.

This study was supported by the University of Maryland School of Social Work and Fordham University. **PN**

Jordan DeVylder, Ph.D., noted that four of the six transgender people in the study had experienced police violence with a weapon, indicating a need for further study of police violence against them.

"Association of Exposure to Police Violence With Prevalence of Mental Health Symptoms Among Urban Residents in the United States" is posted at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2715611.