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AMERICAN PSYCHIATRIC ASSOCIATION

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Troops are being treated for "shell shock" at Walter Reed Hospital in Washington, D.C., during World War I. The latest article in *Psychiatric News'* series celebrating APA's 175th anniversary takes a look at psychiatry's progress in understanding and treating military patients for the "invisible wounds of war" they experienced.

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HHS releases guidelines on tapering opioids after long-term use.

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Campaigning has begun for APA's 2020 election. Brush up on the rules.

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Baby teeth may hold clues about autism and ADHD.

Rise in Youth Suicide Rates Confounds Experts

More research is needed to understand what's behind the rising numbers of suicide among youth in the United States and how best to intervene, say psychiatrists. **BY LINDA M. RICHMOND**

The rate of suicide among youth aged 10 to 24 has climbed steadily over the past decade, increasing 56% from 2007 to 2017, surpassing the homicide death rate for this age group, according to a report issued last month by Centers for Disease Control and Prevention (CDC).

Deaths due to suicide and homicide, referred to as violent deaths by the CDC, have consistently been a major cause of premature death for individuals aged 10 to 24 in the United States. In 2017, suicide was a second leading cause of youth death, claiming the lives of nearly 6,700 individuals aged 10 to 24, while homicide ranked as the third leading cause of death for individuals aged 15 to 24 (and fifth leading cause of death for youth aged 10 to 24). In fact, the death rate for suicide exceeded that of homicide in youth for the first time in 2010, and it has done so every year since.

PERIODICALS: TIME SENSITIVE MATERIALS

Youth Suicide Research Urgently Needed

"The truth of the matter is we don't know what is causing this alarming rise in youth suicide rates," said Maria A. Oquendo, M.D., Ph.D., past APA president and professor and chair of the Department of Psychiatry at the University of Pennsylvania Perelman School of Medicine. Oquendo is also a director on the National Board of the American Foundation for Suicide Prevention.

"What is most disturbing to see is that the largest rate of increase in suicide deaths was in younger children, aged 10 to 14," Oquendo said. "The mean onset of mood, anxiety, or psychotic disorders is around age 15, so you don't expect to have children of that age dying by suicide."

see **Youth Suicide** *on page 24*

Supreme Court To Consider Civil Rights of LGBTQ Workers

Though the case centers on whether the Civil Rights Act prohibits the discrimination of LGBTQ employees, the decision could have wide-reaching implications for the community. **BY KATIE O'CONNOR**

Last month the United States Supreme Court heard arguments in a trio of cases with potentially sweeping implications for the LGBTQ population.

All three cases ask the justices to decide whether the protections under Title VII of the Civil Rights Act of 1964—which prohibits employee discrimination based on race, religion, national origin, and, particularly relevant in this case, sex—should apply to the

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Physician Heal Thyself?

BY BRUCE SCHWARTZ, M.D.

October 10 was both World Mental Health Day and National Depression Screening Day. To mark that day at Montefiore Medical Center, we were honored to have Susan J. Noonan, M.D., M.P.H., as our Grand Rounds speaker. Dr. Noonan, who is an emergency physician at Massachusetts General Hospital, has publicly discussed her struggles with depression and written books on depression for patients and family members. She is also a certified peer specialist and consultant at McLean Hospital.

There is much concern today about physician wellness, depression, and suicide. There are few medical schools, hospitals, academic medical centers, and residency training programs that have not suffered the loss of an esteemed and respected colleague, resident, or medical student. The problem, however, is much larger than that in the house of medicine. The United States is one of the few countries in the world experiencing an increase in suicides. It is now the second leading cause of death for youth and the tenth leading cause of death overall.

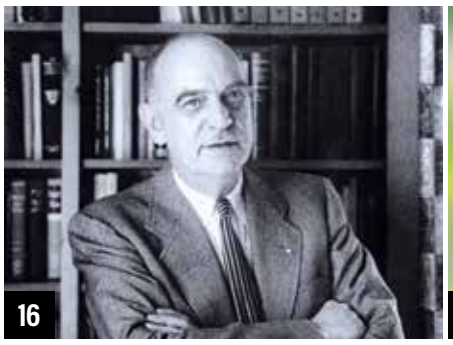
Hearing Dr. Noonan discuss her long-time refusal to seek treatment for her depression, the fear that her colleagues or superiors would learn of her mental illness and think less of her, and her concern that knowledge of her illness might negatively impact her career was a stark reminder about the stigma surrounding mental illness. Here was a highly educated, talented, and successful woman who despite working in a health care setting and experiencing great personal suffering was for too long unwilling to get care.

In the question-and-answer period that followed her talk, I asked her how we might change our environment and education so that other physicians would be more comfortable seeking treatment. She responded that the leadership in medicine must create an environment that encourages openness and wellness. I certainly agree that this is the minimum prerequisite for a health care setting. We have been struggling with stigma and discrimination in medicine for a long time. While stigma is diminishing among the general public, we still have a long way to go. But Dr. Noonan's talk was a reminder that perhaps in medicine—where we are especially competitive, driven, overly selfless, and devoted to others—self-stigmatizing beliefs may be even more of a problem than in society at large. How do we turn the corner and address the silent suffering, loss of talent, and lack of resources to better help our friends and colleagues get needed treatment?

Education on a broad range of mental health issues is limited by time in medical school and most residency programs. Although physician wellness, well-being, and prevention of burnout have been receiving much needed attention in the past few years, the effort has fallen short of effectively addressing severe depression and suicidality. All physicians should be exposed to colleagues, like Dr. Noonan, who have been treated for depression. They are role models and proof that our careers will not end if we take medication or are in psychotherapy. We have slowly—too slowly—come to learn that there is no need to hide these illnesses any more than we would want to hide having diabetes, breast cancer, or hypertension.

I believe that only when our colleagues who have faced and successfully gotten help for depression, suicidality, substance use, and other mental illnesses come forward to share their stories that more of us in need of psychiatric treatment will get that care. Recruiting such a cadre of physicians is not easy—there is stigma, after all—but our health and the long-term health of our profession depend on it. **PN**

IN THIS ISSUE



DEPARTMENTS

In Memoriam

The names of APA members whose deaths were reported to APA from July 1, 2019, to September 30, 2019, are posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.10a50.

New HHS Guide on Opioid Tapering Encourages Collaboration

The free, five-page downloadable publication covers the basics and emphasizes the need for behavioral health support. **BY TERRI D'ARRIGO**

In October the Department of Health and Human Services (HHS) published its "Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics." The guide, available as a PDF for download, offers evidence-based pointers and clinical pearls for determining which patients could benefit from reducing or tapering off opioid pain medications after long-term use and how to help them through the process.

The guide also includes the *DSM-5* criteria for opioid use disorder, emphasizes the importance of providing behavioral health support and encourages health care professionals to collaborate with mental health professionals and other specialists as needed.

"Psychiatrists, as physicians and mental health specialists, are best suited to provide care for the whole patient throughout the tapering process and, if necessary, through diagnosis and treatment of opioid use disorder," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "We welcome the opportunity to offer our expertise and are ready to answer questions, address concerns, and work together with both patients and health care professionals to ensure that patients receive the comprehensive care they need."

"Taking patients abruptly off high doses of opioid pain medication can cause negative consequences, including opioid withdrawal," said Elinore McCance-Katz, M.D., Ph.D., assistant secretary for mental health and substance use and head of the Substance Abuse and Mental Health Services Administration. "These guidelines offer an evidence-based approach to opioid tapering in a safe and effective manner for patients. Psychiatrists can play a key role because they have specialized training in this area that they can offer to their primary care colleagues."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., encourages both patients and health care professionals to reach out to psychiatrists to work together on opioid tapering.

The guide features a flowchart to help health professionals navigate the opioid tapering process and provides the following information:

- Considerations for deciding when to taper.
- Important steps to take before initiating a taper.
- Tips on shared decision making with patients.
- Pointers on individualizing taper rates.
- Background on opioid withdrawal.
- Ways of providing behavioral health support.
- Guidance on what to do when patients are unable or unwilling to taper.

The guide also includes links to helpful resources such as the Substance Abuse and Mental Health Services Administration's Buprenorphine Practitioner Locator and Opioid Treatment Program Directory. **PN**

"HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics" is posted at https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf.

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Multidisciplinary Teams Knock Down Barriers To Medication Treatment for OUD

Medication treatment for opioid use disorder is largely underused. The article below is the final in a series of four that explores the barriers to access and offers solutions to help ensure that patients who could benefit from the treatment both understand it and receive it. **BY TERRI D'ARRIGO**

Barriers to **Medication Treatment**

Each day, more than 130 Americans die of an opioid overdose, according to the Centers for Disease Control and Prevention. In 2017 alone, opioid overdoses claimed the lives of 47,600 people—enough to fill an entire baseball stadium. The need for accessible treatment for opioid use disorder (OUD) has never been so great, but those with the condition face barriers ranging from cost to a dearth of available health professionals who can offer them medications such as buprenorphine, methadone, and naltrexone.

Yet there is hope. Regardless of specialty, discipline, or care setting, health care professionals throughout the nation are coming together to find solutions. They are collaborating to design protocols, launch clinics, enhance training, and forge networks in an effort to increase access to medication treatment and save lives. In so doing, they are shining a light on what multidisciplinary teams can do.

"Improving access to medication treatment is crucial to addressing the opioid crisis, and it requires all hands on deck," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "I encourage psychiatrists to work with other mental health and health care professionals to treat patients with OUD. Multidisciplinary teams need our expertise in the treatment of not only OUD, but also other mental illnesses these patients often have."

In the Emergency Department

Seven years ago, as the opioid crisis grew and opioid-related visits to emergency departments (ED) began to soar, it seemed only logical to Gail D'Onofrio, M.D., M.S., chair of the Department of Emergency Medicine at Yale School of Medicine, to initiate buprenorphine treatment right there in the ED if patients agreed to it. She and her colleagues joined forces to create a protocol and conduct a randomized trial including 329 patients on the effectiveness of ED-initiated buprenorphine treatment.

They published their results in the April 28, 2015, issue of *JAMA*. They found that patients who received ED-initiated buprenorphine treatment were more likely to be in treatment at 30 days compared with those who received only information about local treatment options or who received a brief intervention and a referral for further treatment. In a follow-up study published in the June 17, 2017, issue of the *Journal of General Internal Medicine,* D'Onofrio and colleagues found that patients in the buprenorphine group were more likely to be in treatment at 60 days.

Now hundreds of EDs offer buprenorphine induction to patients with OUD, and D'Onofrio is inundated with requests from hospitals all over the country seeking information and guidance.

"We've learned a lot and are disseminating what we know via websites, webinars, grand rounds, and other avenues to try to get everyone up to speed," D'Onofrio said. "We know medication works, and at this point we don't consider it optional. The consequences of inaction are that 5% of patients who do not receive treatment after presenting to the ED with an OUD will be dead in a year, but if we give them the medication, they are much less likely to die."

Over the Miles

In 2015, Wells House Inc., a treatment center in western Maryland, found itself without someone who could write prescriptions for buprenorphine after its qualified health professional retired. The center reached out to the University of Maryland School of Medicine for help, and a telemedicine pilot program was born. From their offices in Baltimore, addiction psychiatrists in the university health system conduct full diagnostic patient evaluations, including medical, psychiatric, and substance use histories. They then provide diagnoses and treatment plans for patients that include the use of buprenorphine when appropriate.

In the December 2018 *American Journal on Addictions*, the Maryland team reported that 101 (54.7%) of the 177 patients initially enrolled in the program were still engaged in treatment at the three-month mark. Of those, 87 (86.1%) tested negative for opiates.

Since then the telemedicine program has expanded to roughly 450 patients in five counties, including the patients in the original program. So far, the retention rates are similar, said lead author Eric Weintraub, M.D., head of the Division of Addiction, Research, and Treatment and an associate professor of psychiatry at the University of Maryland School of Medicine. "There's about a 50% retention rate at three months, and of those, well over 90% are opioid-negative," he said.

He added that when patients leave the program, it's often because treatment is successful. "After a month or two they may leave because they go back to work or go back to their families."

More recently, the Maryland team received a grant from the Department of Health and Human Services Health Resources and Services Administration, to create a mobile unit in collaboration with the Caroline County (Md.) Health Department. Patients who come aboard a customized van and meet the criteria for OUD teleconference with Weintraub, who can evaluate them and send a prescription for buprenorphine or naltrexone to a nearby pharmacy.

"The data are just starting to come in, but when we ask [patients] if they would have sought treatment if the van hadn't been there, a lot of them say they would not have just because of difficulties in finding transportation," said Weintraub. (*Psychiatric News* will follow up on the mobile unit's progress in a future issue.)

Through Hubs and Spokes

At Penn State Health, interdisciplinary teams deliver medication treatment through a combination of models that connect primary care sites and hospital systems. One element, the hub-and-spoke model, includes a hub that serves as an intensive outpatient clinic that supports 12 surrounding primary care, ED, and primary psychiatric spoke sites. Patients may receive care across the continuum of the hub and spoke according to individual need. Some patients may start at a spoke and end up needing spoke-to-hub transfer for more intensive treatment. Others may initiate treatment at the hub and transfer to a spoke once stabilized.

Another element is Project Extension for Community Health Outcomes (ECHO), which uses videoconferencing as a platform for telementoring and collaborative care, the better to share

see **Medication Treatment** *on page 20*

APA to Offer 'Learning Collaboratives' on MAT

APA members are encouraged to take advantage of 32 virtual learning collaboratives on medication treatment for opioid use disorders to be offered over the next several months.

The learning collaboratives, combining self-paced activities and live interactions with fellow members and experts on medication treatment via conference calls, are being offered by APA as a partner in the Opioid Response Network, a coalition of organizations led by the American Academy of Addiction Psychiatry. The network is a project of the State Targeted Response Technical Assistance Project, funded by the Substance Abuse and Mental Health Services Administration. It provides local training and education free of charge for specific needs at a community level to address the opioid crisis.

Each collaborative is led by a faculty expert who guides participants and supports their efforts. Participants can earn up to 12 CMEs by completing various activities such as watching prerecorded webinars, calling in to office hours, participating in group discussions, and completing an individual project.

If you are interested in receiving information about the collaboratives, fill out the form posted at http://apapsy.ch/Learning_Collaboratives or contact Eunice Maize at APA at emaize@psych.org.

Youth Vaping Surges Unchecked, Survey Finds

Adolescents' use of e-cigarettes continues to surge, with more than 4 out of 10 high school seniors reporting in 2019 that they've tried vaping nicotine and nearly 1 in 8 reporting daily use.

BY LINDA M. RICHMOND

More than 25% of high school seniors reported past-month vaping of nicotine in 2019, and more than 40% have ever tried it, according to the latest data from the Monitoring the Future survey.

The researchers sought to assess whether U.S. secondary schoolers' vaping of nicotine continued to increase in 2019, after the previous year's record increase, the largest for any substance tracked in the 44-year history of the survey (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.1b22). In fact, the prevalence of nicotine vaping more than doubled across the board since 2017, with more than 20% of 10th graders and 9% of 8th graders reporting past 30-day use in 2019.

"I think it's important for psychiatrists and others to really drive home how debilitating addiction can be," Richard Miech, Ph.D., principal investigator of the Monitoring the Future survey and a professor at the University of Michigan, told *Psychiatric News.* "Many adolescents and adults believe that vaping nicotine poses little health risk, a belief promoted by the vaping industry. They tend to overlook that nicotine is still in there. Growing numbers of adolescents are getting suspended from school, kicked off high school sports teams, and are generally experiencing negative consequences because they are not able to control their cravings for nicotine."

Funded by the National Institute on Drug Abuse, the Monitoring the Future survey conducted by the University of Michigan tracks substance use annually among 8th, 10th, and 12th graders at hundreds of schools nationwide. The researchers issued the vaping results of the survey several months early this year, as the number of severe vaping-related lung injuries rose to 1,888 nationwide, with 37 reported deaths as of press time, according to the Centers for Disease Control and Prevention (CDC). Eight in 10 of those injured have been under 35 years old.

"Growing numbers of adolescents are getting suspended from school or kicked off high school sports teams because they are not able to control their cravings for nicotine." —Richard Miech, Ph.D.

As a new principal investigator of the Monitoring the Future project, Miech said one of his goals has been to get the most critical data disseminated more quickly. "Ideally, we want to get the information to policymakers as policy is being made," he explained.

The substantial levels of daily vaping reported by adolescents in 2019 suggests the development of nicotine addiction in a sizable number, Miech said. In fact, 12% of 12th graders, 7% of 10th graders, and 2% of 8th graders reported daily vaping. "New efforts are needed to protect youth from using nicotine during adolescence, when the developing brain is particularly susceptible to permanent changes from nicotine use and when almost all nicotine addiction is established," Miech and colleagues wrote in an article in the October *NEJM.*

The Food and Drug Administration (FDA) said it still intends to clear the market of e-cigarette products in flavors that appeal to kids, such as gummy worm, cotton candy, and cookies n' cream. "The agency intends to finalize a compliance policy in the coming weeks," Stephanie Thull, an FDA spokesperson, told *Psychiatric News.* "The FDA plans to share more on the specific details of the plan and its implementation soon."

Miech said he thinks banning all nontobacco-flavored vaping products would go a long way toward reducing teen vaping. "If teens' first experience with vaping was associated with tobacco flavor, I believe they would conclude that vaping is gross and not vape anymore," he said.

Miech also would like to see a tax on the vaping industry that is directly indexed to the prevalence of teen use, as indicated by the Monitoring the Future survey or another national survey, to remove the financial incentive of promoting teen vaping. The higher the teen prevalence of vaping products, the higher the tax. **PN**

"Trends in Adolescent Vaping, 2017-2019 is posted at https://www.nejm.org/doi/full/10.1056/NEJMc1910739.

ETHICS CORNER

When the Legal 'Floor' Doesn't Match the Ethical 'Ceiling'

BY CLAIRE ZILBER, M.D.

Ethicists sometimes distinguish between that which is *legal* and that which is *ethical* using the metaphor of a room. The law can be considered the floor, providing the minimum standard, and professional codes of ethics can be considered the ceiling, providing the aspirational goals. We usually work somewhere in between the two. And, occasionally, like an M.C. Escher print, the floor and the ceiling don't match because the law may be unethical. This column discusses two situations in which complying with the law may conflict with professional ethics.

Section 3, Article 1, of the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* exhorts psychiatrists to respect the law because "a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession." This article, however, also notes, "It is conceivable that an individual could violate a law without being guilty of professionally unethical behavior."

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

Presently, at least two situations demonstrate when compliance with a law may actually be less ethical than noncompliance with the law. First, in 18 states and territories, it is legal to discriminate against people based on their gender identity. Second, at least three states have tried to ban physicians from asking patients about gun ownership.

Transgender patients routinely experience discrimination in health care settings. As detailed in a previous column (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.3a18), transgender patients are harassed in medical settings, refused treatment, or avoid seeking medical care for fear of discrimination. According to findings from the 2016 National Transgender Discrimination Survey, 24% of respondents reported not receiving equal treatment, 25% reported being harassed or disrespected, and 2% reported being physically assaulted at a doctor's office or hospital. The corresponding rates of discrimination, harassment, and assault in mental health clinics are, respectively, 11%, 12%, and 1%. Due to discrimination, 28% of respondents reported that they postponed medical care, and 50% said they had to teach their health care providers about transgender care. Transgender patients may also face discrimination and harassment at pharmacies, where they encounter difficulty obtaining their prescribed hormone treatments.

Is this discrimination legal? Unfortunately, yes. The federal government does not offer legal protection from discrimination based on gender identity, which means that unless a state passes a protective law, it is legal to discriminate against people who identify as transgender or gender nonconforming.

According to the Transgender Law Center's National Equality Map, 20 states do offer robust legal protection against discrimination based on gender identity. While the particular laws vary from state to state, they generally extend the same protections against discrimination in housing, employment, and public services that are afforded to people based on race, ethnicity, age, gender, religion, and disability.

Is this discrimination ethical? Obviously not. It is a physician's duty to treat every patient with dignity and respect and to prioritize the patient's welfare even if the patient's appearance, identity, or diagnosis causes discomfort. Section 1, Article 2, of APA's *Principles* asserts, "A psychiatrist should not be a

see **Ethical 'Ceiling'** *on page 26*

Stigma Linking Mental Illness, Violence Has Increased, Study Finds

Over the past 22 years, the public perception that people with mental illness are potentially violent has increased, as has support for coercive treatment.

BY KATIE O'CONNOR

Rarely is the impact of stigma against people with mental illness more evident than when an incident of mass violence sparks assumptions about the perpetrator's mental health.

The public perception that those with mental illness are potentially violent has generally increased over the last 22 years, particularly for schizophrenia, as has support for coercive treatment, according to a study published in the October *Health Affairs*.

"If society does not attempt to counter the drift toward greater public stigma of dangerousness and support for coercion, the damage to people with mental illness, their families, the mental health system, and society can only worsen," wrote lead author Bernice Pescosolido, Ph.D., a distinguished professor of sociology at Indiana University, and colleagues.

The authors examined trends from three National Stigma Studies, which Pescosolido and her colleagues developed. The studies consisted of vignettes that described profiles of hypothetical people with symptoms or behaviors of psychiatric disorders meeting *DSM-IV* criteria. They were included in the 1996, 2006, and 2018 General Social Survey, which measures attitudes, beliefs, and behaviors in American society and is conducted by the National Opinion Research Center at the University of Chicago.

The vignettes were meant to test the respondents' ability to recognize mental illness and gauge whether they associated mental illness with danger, as well as their willingness to respond to it with coercion. In 1996 there were 1,444 respondents and a 76.1% response rate; in 2006 there were 1,522 respondents with 71.2% response rate; and in 2018 there were 1,173 respondents with a 59.5% response rate.

The vignettes described people with schizophrenia, alcohol dependence, and major depression. A fourth described nonclinical "daily troubles," which essentially involved a person who felt worried, sad, and had trouble sleeping at night but was "getting along pretty well," the vignette stated. Respondents were randomly assigned one vignette. An interviewer read them the vignette, and they received a printed copy. They then responded to questions.

Health Affairs/Nathan Mitchell Photography

It is especially important to understand how public discourse may be increasing stigma because it adds to the challenges of mental illness, says Bernice Pescosolido, Ph.D.

"The public perception of the likelihood that people with mental illness will be violent toward others was high, consistently approaching or exceeding 60% for both schizophrenia and alcohol dependence," the study found.

Other key findings include the following:

- Over 30% of 2018 respondents saw vignette characters with major depression as likely to be violent toward others.

- Respondents who reported that people with depression or daily troubles were more likely to harm themselves increased over all three years.

see **Stigma** *on page 14*

APA Joins Other Medical Groups to Call for Balance in 'Surprise' Medical-Billing Legislation

Proposed "surprise" medical-billing legislation may give insurers too much market power by allowing them to set out-of-network physician fees based on their own median rates. The AMA joined a physicians' coalition asking lawmakers to adopt a more balanced approach using commercially reasonable rates and independent dispute resolution. **BY LINDA M. RICHMOND**

APA signed onto a letter by the AMA to both houses of Congress last month asking for a more balanced approach to "surprise" medical billing that would not hand over power to insurance companies by allowing them to set reimbursement rates for out-of-network physicians.

The letter, which was signed by more than a hundred physician organizations, pointed out that proposed legislation could worsen staffing shortages in rural areas and other underserved communities. Unanticipated, or "surprise," medical bills happen when patients unknowingly or without other options receive care at an in-network facility from out-of-network physicians.

Legislation under consideration, both S 1895 and HR 2328, allow health plans to set rates for out-of-network physician payments, based on their own median payments to in-network providers, which would likely worsen access problems for patients seeking hospital-based care from on-call specialists, according to the letter. Median health plan payments are typically lower than average rates, Congressional Budget Office (CBO) research found.

The letter emphasized that patients should be held harmless for any costs above their in-network cost sharing and removed from payment disputes between their health insurance and out-of-network providers. At the same time, "it is essential that any legislation does not create new imbalances in the private health care marketplace," the letter urged. "The health insurance market is already heavily consolidated, which can result in artificially low payment rates and anticompetitive harms to both consumers and providers of care."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said that in light of the nation's increasing demand for behavioral health care and shortage of health care professionals, any solution to surprise medical billing must not further jeopardize the provision of care. "Health plans typically reimburse behavioral health care specialists 20% less than they pay primary care providers and offer 'phantom' networks to their subscribers with disconnected phones or physicians who are not taking new patients. We implore lawmakers to adopt a commercially reasonable payment rate and payment appeals processes, while requiring enforceable network adequacy standards and stronger enforcement of mental health parity."

About 1 out of 6 emergency visits or in-network hospital stays resulted in out-of-network billing, according to a 2017 analysis of large employer claims by the Kaiser Family Foundation. More than a dozen states have now passed comprehensive laws to address surprise medical billing in state-regulated health insurance plans.

However, most workers are covered by self-insured, large employer plans that are not subject to these state laws. Democratic and Republican lawmakers are vowing to pass federal legislation aimed at solving the problem of surprise billing, an effort supported by President Donald Trump.

The CBO found that the vast majority of health care is delivered by in-network providers, yet more than 80% of the estimated budgetary effects of S 1895 and HR 2328 would come from changes to reimbursement rates for in-network physicians. "In other words, in-network providers who have not contributed to the problem will bear the impact of the rate-setting scheme," the letter pointed out.

The letter calls for lawmakers to include the following provisions in legislation to address surprise billing:

- Set an initial payment for out-of-network physicians that reflects a commercially reasonable and fair rate in the private market, using an independent claims database (rather than relying on health insurance companies' median in-network rates).

- Establish an independent dispute resolution (IDR) process to settle payment disputes and give health insurers an incentive to offer fair initial payments for out-of-network care. In July, the House Energy and Commerce Committee adopted an IDR process in HR 2328 as a backstop measure.

- Lower the proposed threshold that would trigger the IDR process and allow for "batching" of claims that involve identical plans and providers and similar procedures.

continued on facing page

Federal Judge Rules Safe Injection Site Is Legal

Though the Justice Department said it plans to appeal, the case may open the door for other interested cities and states to open safe injection sites.
BY KATIE O'CONNOR

Vancouver Coastal Health

Injection booths have yellow boxes for disposing of used needles at Insite, a safe injection site in Vancouver, Canada.

Last month a judge issued the first federal ruling on the legality of safe injection sites, finding that a Philadelphia organization's plan to open such a site does not violate what is known as the "crack house" statute of the Controlled Substances Act.

Safe injection sites (also known as supervised injection or consumption sites) are designated spaces in which people can inject drugs under medical supervision. They're meant to connect people to treatment while also preventing overdoses and the spread of infectious diseases. Though numerous such sites have opened in Europe and Canada, none are operating legally in the United States.

Proponents of the sites argue that they are potential stopgaps to curtail the sharply increasing number of fatal drug overdoses. According to the National Institute on Drug Abuse, there were more than 70,200 drug overdose deaths in 2017, a twofold increase over the decade before.

"It's very clear that when these sites are available, they are utilized by a fairly substantial number of people," said Andrew Saxon, M.D., a professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine, director of the Center of Excellence in Substance Abuse Treatment and Education at the VA Puget Sound Health Care System, and a member of APA's Council on Addiction Psychiatry. He noted that available evidence largely relies on observational data. "These sites do seem to be a conduit for treatment for some people who are understandably leery about the health care system."

The Justice Department sued Philadelphia-based nonprofit Safehouse in February after threatening last year to take "swift and aggressive action" against localities that open safe injection sites. (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.10a12).

In his decision, Judge Gerald McHugh of the United States District Court for the Eastern District of Pennsylvania pointed out that there is no evidence that Congress intended to criminalize safe injection sites when it passed a statute of the Controlled Substances Act meant to outlaw houses and buildings where drugs are made, used, or distributed. "The ultimate goal of Safehouse's proposed operation is to reduce drug use, not facilitate it," he wrote in his order.

The Justice Department has signaled its intention to appeal the ruling. In a letter addressed to Ilana Eisen-

see **Safe Injection** *on page 23*

continued from facing page

- Require stronger enforcement of federal mental health and substance use disorder parity laws.

- Establish measurable and enforceable network adequacy standards for insurance companies, so patients are not routinely pushed toward out-of-network care.

The letter noted that New York's surprise-billing law took effect in March 2015 and saved patients more than $400 million in emergency services alone, reduced out-of-network billing in New York by 34%, and lowered in-network emergency physician payments by 9%. At the law's center is the IDR, which removes consumers from billing disputes and gives a process for settling billing disputes. Filing a dispute involves providers visiting a website and completing a two-page, online form.

"This contrasts with the often voluminous filing requirements necessary for physicians and other providers to obtain prior authorization … just to provide covered benefits to their patients, even for mental health and substance use benefits," the physicians' letter pointed out. **PN**

The physicians' letter is posted at http://apapsy.ch/Surprise_Billing. The CBO report on S 1895 is posted at https://www.cbo.gov/system/files/2019-07/s1895_0.pdf. "An Examination of Surprise Medical Bills and Proposals to Protect Consumers From Them" is posted at https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them.

Using Apps in Patient Care

Mental health apps are another tool that psychiatrists can use to help patients, but caution is needed to avoid patient harm and risk management issues. ***BY ANNE HUBEN-KEARNEY, R.N., B.S.N., M.P.A.***

Anne Huben-Kearney, R.N., B.S.N., M.P.A., is the assistant vice president of the Risk Management Group, AWAC Services Company, a member company of Allied World.

Apps designed to run on a mobile device, such as a smartphone, are available for just about everything these days, from shopping and weather to entertainment and travel. Health care is seeing a huge increase in the variety of apps to help manage patient care and provide physicians with valuable information. Use of apps for mental health care is no exception.

There are literally thousands of apps targeting mental health conditions, such as those to reduce anxiety, improve sleep, improve focus and attention, track moods, assess an individual's well-being, and screen for symptoms of depression. There are

apps that screen for suicidality by analyzing text message metadata as well as the content of conversations.

But what app is the best for your patient? How do you evaluate the app to recommend to your patient? What if the depression screening signals suicide risk? Does the response to suicidal ideation generate advice for the patient to call his or her psychiatrist or recommend local mental health resources? Does the response to a suicidal attempt trigger advice for the patient to call an ambulance? Based on the suicidal risk, is an alert sent to the psychiatrist?

Many of the mental health apps are challenged to assess the likelihood that patients will try to harm themselves—a challenge that psychiatrists know well. An algorithm in the software that determines that the suicidal score requires no response carries risk, but the decision to respond too aggressively also carries risk, as this may cause the patient to hesitate to seek help in the future.

Mental health apps are classified as wellness rather than medical apps, which means they are not regulated by the Federal Drug Administration and do not need to be compliant with HIPAA. One outcome is that the mental health apps may not be secure so information may be accessed and improperly disclosed. Based on an IP address or digital identifier, a data aggregator can pull information from the multiple apps a person uses and create a user profile that includes age, gender, geographic location, interests, and even income. The app developers can sell the information to other companies that are looking to appeal to a similar clientele. One risk is that some-

continued on next page

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one with an eating disorder could receive an ad for stimulants or laxatives or a person with a gambling disorder could be targeted for casino ads. In addition, many apps may sell patient-collected information to create products that have nothing to do with health care, without making this notice obvious in the "Terms of Service."

These are some risk management recommendations to consider:

- Determine whether the mental health app is appropriate for the specific patient condition and supported by evidence-based research. This reduces the risk that false or misleading information or ineffective therapeutic interventions are offered to patients.

- Check for HIPAA compliance, especially privacy and security.

- Evaluate concerns with therapeutic boundaries and billable time (for example, for data collection and interpretation of the information collected).

- Evaluate whether the app is customizable to the specific patient and is easy to use for both the patient and the psychiatrist.

- Decide how to integrate the apps into the clinical sessions, ideally for enhanced clinical communication.

- Develop a response plan in advance with the patient in case the patient expresses or scores high for

suicidal ideation. The response plan should include a clinical assessment and evaluation by the psychiatrist.

- Remind patients that mental health apps supplement, but do not replace, live support from their psychiatrist.

There are many mental health apps that provide information, help with daily life (especially with distress tolerance and physical activity), and support the care and treatment by the psychiatrist. Mental health apps can be useful if tailored to help meet the psychosocial needs of mental health patients. Psychiatrists need to assist their patients to adopt a responsible and balanced use of technology to avoid the use of social disengagement yet maximize the current tools (apps) available to promote patient engagement and support. **PN**

APA's App Evaluation Form is posted at https://www.psychiatry.org/psychiatrists/practice/mental-health-apps. The form assists psychiatrists in evaluating mental health apps for their patients.

Stigma

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- Between 40% and 60% of respondents supported all forms of legal forced treatment for schizophrenia in 2018.

- Between 1996 and 2018, support for coercive hospitalization for schizophrenia increased by over 10%.

The authors wrote that one of the most troubling findings was that nearly 20% of respondents in 2018 were willing to use the law to put a person with daily troubles in a psychiatric hospital. That was a significant increase over the 2006 and 1996 responses. "What it tells me is that right now we're living in a very fearful society," Pescosolido said.

"The myth of dangerousness is deep in our culture," she continued. She noted how, after a mass shooting, she usually hears comments that the perpetrator was "sick." "But 'sick' does not mean mentally ill," she said. "It's sort of our American metaphor for anybody who is outside the norm."

Some of the study findings, the authors noted, could be interpreted as encouraging, however. If more people understand the risk of self-harm for people with mental health issues, that "may suggest a greater openness to mental health care than in the past."

The authors described several limitations of the study. Vignettes cannot fully describe the spectrum of a person's symptoms or life situation. The National Stigma Studies have also been criticized, according to the authors, for not including cases of people in treatment or recovery; doing so could result in a lower rate of responses reflecting stigma.

Lloyd Sederer, M.D., an adjunct professor at Columbia University's Mailman School of Public Health and vice chair of APA's Council on Communications, said he was not surprised by the study's findings. They reiterate that no amount of data showing that people with mental illness are unlikely to be violent has an impact on the public's perceptions.

Integration programs (including in workplaces and housing) can substantially change people's beliefs about people with mental illness, he said. "It's about knowing somebody not by their illness but by their person," he said. However, implementing such programs on a large scale can be challenging.

"There have been longstanding problems with stigma related to mental illness for centuries, not just decades," said Carol Bernstein, M.D., past APA president and chair of the Council on Communications. "The fundamental issue of violence is that it's so scary and unpredictable that people look for easy answers."

The study was supported in part by research grants from the National Science Foundation (NSF) to the General Social Survey and an NSF supplement to the National Stigma Study. Additional funding was provided by the Brain and Behavior Research Foundation through a NARSAD Distinguished Investigator Grant, the Indiana Consortium for Mental Health Research, and the Indiana University Network Science Institute. **PN**

"Evolving Public Views on the Likelihood of Violence From People With Mental Illness: Stigma and Its Consequences" is posted at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00702.

With Changing Insights, Military Psychiatry Evolved Over Time

From "soldier's heart" to PTSD, the understanding of the effects of combat stress has grown and led to better insight into reactions that still mark the lives of soldiers. **BY AARON LEVIN**

The link between the stresses of military life and the mental health of soldiers has occupied poets, doctors, and veterans since the Bronze Age, as any reader of Homer will attest.

Understanding of that connection has deepened over the last century, pushed by the era's brutal, complex wars and greater insight into the experiences of those who fight them.

By studying this population over time, researchers have gained awareness of the long-term effects of wartime service on veterans. For instance, a 2006 study involving a random sample of 15,000 veterans of the American Civil War who applied for medical disability 40 years after the end of the war found that many of them had multiple cardiovascular, gastrointestinal, and/or nervous disorders.

"Nervous disorders" included what would be both psychiatric and neurological diagnoses today: psychosis, hallucinations, depression, mania, hysteria, suicidal ideation, and anxiety as well as aphasia, headaches, paralysis, epilepsy, and vertigo—symptoms that would not surprise today's veterans.

Wars Bring With Them New Insight Into Psychiatric Symptoms

The part of the body believed to react to the stress of war has changed since the American Civil War. Then, problems were ascribed to cardiovascular anomalies. The strain of carrying heavy packs led to "disordered action of the heart," it was believed, and a new diagnostic category, "soldier's heart," was created. More psychologically oriented physicians diagnosed "nostalgia," an acute form of homesickness.

These attempts at description reflected an increasing medicalization of war syndromes that took hold during World War I. The constant pounding of artillery was thought to disturb the neurons of the brain, inducing "shell shock," which left soldiers immobilized. Many were evacuated to hospitals behind the lines or back to Britain.

Most of those soldiers never returned to battle, so a new tack was chosen. Soldiers with psychological symptoms were kept close to the front, given immediate help, and counseled that their condition was a normal reaction and neither pathological nor a personal failing, said Matthew Friedman, M.D., the former director of the Department of Veterans Affairs National Center for PTSD. Friedman is now a professor of psychiatry and vice president for research at the Geisel School of Medicine at Dartmouth College in Hanover, N.H.

Psychiatrist Thomas Salmon, M.D., sent to France with the American Expeditionary Force in 1918, studied how the British treated psychiatric casualties. He concluded that "shell shock" was an acute response to combat stress that could be addressed with the PIE approach: addressing the individual's proximity (to the battlefront), immediacy (of care), and expectancy (of recovery), said Dale Smith, Ph.D., a professor of military medicine and history at the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Md.

Much of the knowledge in dealing with psychiatric casualties in World War I was forgotten by the time of World War II. One glimmer of history was preserved in the research and writing of Abram Kardiner, M.D., a psychiatrist who observed American veterans in the 1920s and 1930s. In *War Stress and Combat Neuroses*, published in 1941, Kardiner described the emergence of hyperreactivity, stress intolerance, dissociative reactions, and altered physiology as these men faced the threat of war.

"Kardiner did not let prevailing psychoanalytic beliefs obscure his observations," said Friedman. "I consider him the father of the psychobiology of PTSD and other stress-related disorders."

At the time of America's entry into World War II, the U.S. Army was determined to minimize the psychiatric casualties seen in the previous war. Vulnerable recruits would be screened out using the prevailing psychoanalytic model. The result was failure; far too many otherwise healthy young men were screened out until the program was stopped. Nevertheless, psychiatric casualties—now called "battle fatigue" or "combat fatigue"—again occurred in the course of the war, sometimes at rates as high as 25% to 40%.

Understanding of PTSD Emerges

The PIE approach was eventually rediscovered, and general physicians in military service were given psychiatric training. William Menninger, M.D., head of the Army's Neuropsychiatric Consultation Division, led the development of *War Department Technical Bulletin Medical 203* in 1943, a manual that provided a useful classification system of mental illness and was later incorporated into psychiatric training, said Smith. With some tweaking, it was adopted by the Veterans Administration and ultimately by APA in *DSM-I*, providing a link between military and general psychiatry, said Smith.

Rapp Halour/Alamy

In 1943 a committee headed by Brig. Gen. William C. Menninger developed *Technical Bulletin Medical 203,* a military-specific classification system of mental illness on which *DSM* was later patterned.

"The stigma attached to mental illness in the popular mind was not attached to a diagnosis of combat fatigue because the diagnosis had been 'earned' and thus conferred a measure of social protection," he said.

The *DSM-I* brought forth "gross stress reaction" to describe the response to combat; it was later superseded by the more familiar "neurosis." Gross stress reaction was not included in *DSM-II* in 1964, but the ensuing years saw two changes that focused and defined stress reactions. One was the growing body of literature based on careful observation of Holocaust survivors and rape victims, said Friedman.

"People working with different kinds of patients recognized commonalities in symptoms," said Friedman. "They began focusing on the reaction, not the cause. In a situation that overwhelms the individual's coping capacity, any person would have a similar pattern of symptoms."

The second event was the war in Vietnam. The war itself was amorphous, lacking in front lines and realizable goals. Veterans were vilified as they came home. Many found comfort only among their own, in informal gatherings and eventually in veteran centers where they could process their experiences among themselves. Posttraumatic stress disorder (PTSD) was named and defined as a neuropsychiatric condition characterized by dysfunctions in learning and fear extinction. Treatments developed by Edna Foa, Ph.D., Patty Resick, Ph.D., and others using prolonged exposure and cognitive-behavioral therapy were adapted for veterans.

Vietnam veterans weren't the first to experience PTSD, of course. "I've seen many World War II veterans," said Friedman. "We weren't asking the right questions [when they came home] because the PTSD construct hadn't evolved. Risking your life in a war that makes sense may offer some protection, but that's outweighed by the stresses of combat and the violent loss of friends."

Preventing Psychiatric Casualties in Changing Circumstances

An increased understanding of the stresses of military life grew in the decades after the Vietnam War, said Col. David Benedek, chair of psychiatry at the USUHS. By the time of the Gulf War in 1991, medical detachments included combat stress control personnel deployed with combat units. They were trained to recognize a range of diagnoses beyond combat stress and could call on psychological and pharmacological treatments. They had a preventive mission as well, offering psychoeducation and sleep-management techniques, and helping officers understand the critical value of group cohesion and the need for social support.

In the more recent conflicts in Iraq and Afghanistan, the model was pushed even further. Recognizing the value of

see **Military Psychiatry** *on page 22*

APA Election Guidelines: Know the Rules

The 2020 APA election cycle is now under way. Members are encouraged to participate in the election by voting and offering their support to the candidates of their choice. Governing the campaigning efforts of candidates and their supporters are guidelines that appear below. These guidelines are also posted on APA's election website at www.psychiatry.org/elections, where members will find additional information that will help them decide who they believe will best lead APA in the coming years: the candidates' names and contact information, the 2020 election schedule, and other information. Also, by January 1, 2020, the site will include links to the candidates' websites and video interviews with the candidates for president-elect, treasurer, and trustee-at-large.

Voting begins on January 2 and ends on January 31. **PN**

APA Election Guidelines for Candidates and Supporters

Based on guidelines approved as amended by the Board of Trustees in March 2015

A. OVERVIEW

The intent of the guidelines is to encourage fair and open campaigning by APA members on a level playing field by (1) specifying permitted and prohibited election-related activities, (2) fostering opportunities for candidates to educate their colleagues about the issues, (3) informing voters about candidate experiences and views (4) keeping costs down; and (5) maintaining dignified and courteous conduct appropriate to the image of a profession.

Campaigning is not permitted until after the nominations have been reported to the Board of Trustees by the Nominating Committee. Members should withhold commitments of their final support or votes until after all candidates are known. Members soliciting letters of nomination or circulating petitions to be nominated may not use the nomination process for campaign/electioneering purposes beyond asking for nomination letters or signatures on petitions.

Each candidate receives a copy of these guidelines and a statement to sign, certifying that he/she has read the guidelines; promises to abide by them; will immediately report any deviations of which he/she becomes aware to the Elections Committee; and will notify and try to correct any supporter upon learning of an actual or potential deviation. Candidates are to inform members they ask for support about the guidelines by sending a copy or calling attention to the guidelines on the APA website.

All APA members are expected to abide by the APA election guidelines in APA elections, including in their capacity as officers and members of other organizations. APA requests that other organizations adhere to the intent of the campaign guidelines and provide fair and equitable coverage of opposing candidates.

When candidates or their supporters are unclear about whether an intended campaign action is permitted, they should seek the opinion of the Elections Committee before taking action. The Elections Committee will respond with a ruling concerning the proper interpretation of the guidelines and inform all candidates in order to maintain a "level playing field".

The Elections Committee investigates any potential violation by a candidate or supporter of which it becomes aware and reports violations to the Board of Trustees. The procedures used by the Elections Committee to investigate and report campaign violations are in Chapter 2 of the Operations Manual and are sent to candidates with these Election Guidelines.

B. CAMPAIGNING

Campaigning is defined as any attempt to influence a potential voter's vote. Campaigning includes mentioning one's candidacy or making any statement that might be interpreted as a position statement reflecting what actions the candidate would take if elected. It does not include appearances made as part of one's normal work activities.

1. General

- Candidates are to state their own positions on issues and their own plans for the Association directly and positively.
- Candidates/supporters may not make personal attacks against other candidates.
- Members of the national Nominating, Elections, and Tellers committees, as well as the Board of Trustees, are not permitted to participate in campaigning and endorse/support a candidacy.

2. Resources

- Candidates and supporters may communicate with each other and coordinate campaign activities. However, formal campaign committees (entities that can make statements or take other actions on behalf of the candidate) are not allowed and candidates may not enter into agreements to campaign together. Merely endorsing a candidate is not a violation of the guidelines as long as there is not prior commitment or agreement in campaigning together.
- Fundraising is not permitted. A goal of these guidelines is to limit campaign activities to a level that all candidates can easily afford.
- Use of APA, Area Council/State Association, or District Branch resources or personnel is generally prohibited, except to support the election process, including communication of candidate statements to members.
- APA, Area Council/State Association, or District Branch funds, services, stationery, or staff may not be used to endorse, support or promote any candidate; however, Area Council/State Association or District Branch funds—not APA funds—may be used to support the expenses of candidates invited to the branch/area meeting for election purposes.

3. Campaign Communications

Permitted forms of campaigning include the following; all others are prohibited.

a. Electronic Messages (Email, SMS, etc.)
There are no limits on the number of campaign messages sent electronically. However, candidates and supporters are advised to use restraint with electronic messages of all kinds, as these are often ill received by voters, especially if voters perceive that they are being spammed. Beginning email messages with the conventional "APA Campaigning" in the subject line is a courtesy that can help recipients to quickly sort out campaign email messages. Obtaining email addresses is the responsibility of the candidates and their supporters; they are not to be provided by APA, Area Councils/State Associations, or District Branches.

b. Listservs
Candidates may create their own listservs to facilitate communication with and among their supporters.
- The APA Member-to-Member listserv may be used for campaigning, but no other APA listservs used for APA, Area Council/State Association, or District Branch functions.
- Listservs of other psychiatric organizations may be used for campaigning if permitted by those organizations.

c. Social Networking Sites, Blogs, and Homepages (Facebook, Twitter, etc.)
Candidates may use social networking sites, blogs, and homepages for campaign purposes.

d. APA Website
APA will include information on all candidates (the photos, biographies, statements provided forthe ballot booklet and links to candidate homepages) and on the election itself (campaign guidelines, ballot mailing and return dates, etc.) on its website. This election information can be accessed through the election logo and linked to other information as appropriate.

e. Candidate Homepage
Each candidate is responsible for setting up and financing his/her own homepage. There will be a disclaimer on APA's website stating that candidates' homepages are their own creation and responsibility and that APA takes no responsibility for information posted on them. APA reserves the right to cut the link between its web site and a candidate's homepage if a candidate violates the campaign guidelines.

f. Phone
Campaign-related phone calls (including calls made through services such as Skype) may be made from candidates/supporters to individual APA members. Use of automatic calling services (robocalls) or hiring personnel to make such calls is prohibited.

g. Letters and Handouts
There are no restrictions on the number of campaign letters, postcards, faxes, or handouts.

h. Private Discussion
Spontaneous private election-related communication with colleagues is permitted.

i. Invited Position Statements
Psychiatric organizations may request written position statements or answers to questions for publication in a newsletter or other written medium. Such publication requires that no candidate is endorsed or favored and that all candidates for a given office have been given equal opportunity to respond.

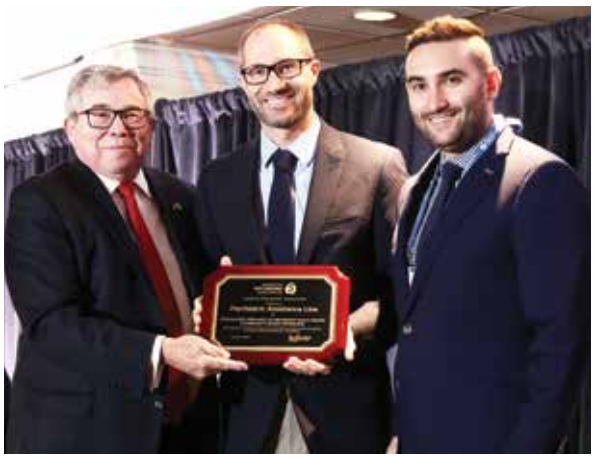
j. Area/State/District Branch Campaigning: Newsletters
Area Council/State Association or District Branch newsletters may announce as news items of up to 150 words per candidate the candidacy for national office or Area Trustee of member(s) of that Area Council/State Association or District Branch, with pictures. Editorial endorsement of candidates is prohibited, as are letters to the editor in support of (or opposition to) candidates. Newsletters may print other statements or materials by or about a candidate only if they give equal opportunity to opposing candidates. Newsletters may not be distributed beyond the usual newsletter distribution.

k. Mutual Campaign Presentations
A mutual campaign presentation is defined as an event where all candidates for an APA office appear together to acquaint voters with the candidates and/or to discuss campaign issues. Candidates may appear in person or through electronic media.
- If all candidates have been given equal opportunity to attend and one cannot attend, the other candidate(s) may present.
- Endorsement or favoritism of any candidate is prohibited.

l. Introduction at Professional Presentations
A candidate's candidacy may be mentioned when the candidate is introduced for the purpose of giving a professional presentation, provided that the candidate is not endorsed.

C. PROFESSIONAL PRESENTATIONS

There are no restrictions on professional presentations, defined as events where no campaigning occurs and a candidate participates in the dissemination of information through any medium. Running for office should not inhibit or prohibit candidates from conducting their usual professional business.


Photos: Oscar & Associates

Representatives of the programs winning this year's Psychiatric Services Achievement Awards are pictured above with APA President Bruce Schwartz, M.D. At left are the representatives of the winner of the Gold Award for an Academic Program, the Peer-to-Peer Depression Awareness Program. They are Lizelle Salazar, M.P.H., Stephanie Salazar, M.P.H., and Sagar Parikh, M.D., of the University of Michigan. In the center are the representatives of the winner of the Gold Award for a Community-Based Program, the Minnesota Psychiatric Assistance Line (PAL)—Todd Archbold, M.B.A., vice president of development with PrairieCare in Brooklyn Park, Minn., and Joshua Stein, M.D., a child and adolescent psychiatrist with PrairieCare. At right are Lori Wellman, practice management director at Banner-Whole Health Clinic, and Ole Thienhaus, M.D., of the University of Arizona College of Medicine, representing the Silver Award winner, Banner Health-University of Arizona Whole Health Clinic.

Achievement Award Winners Recognized For Innovations in Expanding Access to MH Care

This year's winners encourage students to talk to other students about mental health, extend psychiatric specialty care to primary care, and offer holistic care from a mental health clinic.

Three programs that use creative strategies to extend mental health care to communities were honored at APA's 2019 IPS: The Mental Health Services Conference in New York in October. At the conference's Opening Session, APA President Bruce Schwartz, M.D., presented two Gold Awards (one for a community-based program and one for an institutionally based program) and a Silver Award.

The Psychiatric Services Achievement Awards recognize innovative models of service delivery and programs for people with mental illness or disabilities. This year's winners are the following:

- **Gold Achievement Award for Academically or Institutionally Sponsored Programs: Michigan Peer-to-Peer Depression Awareness Program**. The Peer-to-Peer Depression Awareness (P2P) program was formed in 2009 as a collaboration between the University of Michigan Depression Center and the Ann Arbor Public Schools District. The P2P program is a student-to-student initiative that emphasizes early detection and prevention of mood disorders and anxiety through schoolwide intervention. Specifically, the program seeks to raise awareness of mental health conditions, fight stigma, and encourage help-seeking behavior to ultimately reduce the impact of mental illness on adolescents. Since its launch, more than 700 P2P team members have delivered awareness-themed events and projects to thousands of students. More information is posted at https://www.depressioncenter.org/p2p.

- **Gold Achievement Award for Community-Based Care: Minnesota Psychiatric Assistance Line.** The Psychiatric Assistance Line (PAL) is provided by PrairieCare Medical Group of Brooklyn Park, Minn., through a grant from the Minnesota Department of Health Services. PAL has provided more than 1,500 consultations with child and adolescent psychiatrists and other specialized mental health practitioners to health care professionals in Minnesota. Through these consultations, PAL delivers trainings to help educate and empower other health care professionals to treat mental health conditions in their own practice settings. These consultations include treatment plan support and feedback to help patients get better mental health treatment in a timely manner. PAL has created unprecedented access to psychiatry in the state in a cost-effective manner. More information is posted at https://www.mnpsychconsult.com/.

- **Silver Award: Banner Health—University of Arizona Whole Health Clinic.** The Whole Health Clinic (WHC) in Tucson, Ariz., provides integrated health and behavioral services from the departments of psychiatry and family medicine to people living in Tucson and the surrounding areas. The clinic's behavioral health and primary care teams work side by side to address the whole health needs of the people it serves. What distinguishes the WHC from other integrated clinics is the fact that it was conceived primarily as a mental health clinic and uses population health statistics as metrics to assess its success. The clinic's behavioral health and primary care teams work side by side to address the whole health needs of the people it serves. Services include individual, group, and family therapy; case management and referrals; peer support services; psychiatric evaluation; medication monitoring; comprehensive physical health assessment and care; lab and pharmacy services; vocational support; benefit-eligibility assessment and enrollment assistance; substance abuse services and referrals; court-ordered treatment monitoring; and family psychoeducation and support groups. More information is posted at https://www.bannerhealth.com/locations/tucson/banner-university-medicine-whole-health-clinic-wilmot. **PN**

More information on the Psychiatric Services Achievement Awards is posted at http://apapsy.ch/PS_Awards.

Affective Psychosis Common Among First-Episode Patients

Affective psychosis is significantly prevalent among first-episode psychosis patients but there is a dearth of research on this population and a need for development of standardized treatment guidelines. **BY MARK MORAN**

Clinicians should be alert to the prevalence of individuals with affective psychosis in first-episode psychosis clinics. The condition is characterized by mania and possibly presenting as a precursor to bipolar disorder, said Dost Ongur, M.D., Ph.D., in a keynote address at the Early Psychosis Pre-Conference at APA's IPS: The Mental Health Services Conference. The IPS was held last month in New York.

Ongur, the director of the Schizophrenia and Bipolar Disorder Research Program and chief of the Psychotic Disorders Division at McLean Hospital, said that more than 40% of early psychosis patients at McLean have affective psychosis.

"These people belong in our early psychosis treatment services," said Ongur, who is also editor of *JAMA Psychiatry*. "If you can recognize people with affective psychosis, you can do something about a potentially underserved population. Many of their needs are similar to those with nonaffective psychosis."

Ongur said there is a critical need for research on this population and development of standardized treatment guidelines.

He noted that there is no equivalent of the Recovery After Initial Schizophrenia Episode (RAISE) study on early treatment of nonaffective psychosis. "Evidence for early intervention is sparse compared with nonaffective psychosis, but there is research demonstrating that the long-term trajectory can be altered with good treatment," he said.

RAISE was a research project funded by the National Institute of Mental Health (NIMH) that provided much of the foundation for the effectiveness of coordinated specialty care of people with first-episode psychosis.

Ongur said a first episode of affective psychosis with mania may be the first presentation of bipolar disorder, with typically a long delay between onset of illness and the establishment of a bipolar disorder diagnosis. This delay is equivalent to the duration of untreated nonaffective psychosis; longer duration has been repeatedly shown to negatively impact long-term outcome in nonaffective psychosis, he said.

"We need to change that," Ongur said. "People are often going to the doctor for years, and bipolar disorder is never mentioned."

Characteristics of first-episode psychosis with mania include euphoria, reduced need for sleep, grandiosity, and racing thoughts. These are accompanied by a progressive loss of insight. "However, these symptoms may be frequently misinterpreted in the context of psychosis," Ongur said. "Some patients are diagnosed with schizoaffective disorder when the psychosis persists for a significant period outside of mood episodes or with schizophrenia when mood episodes are isolated and not clinically significant."

Mark Moran

Dost Ongur, M.D., Ph.D., says a major unresolved question in treatment of affective psychosis in first-episode psychosis clinics is whether first-episode patients with affective psychosis should be maintained on a mood stabilizer.

Ongur especially emphasized that extreme manic behavior often causes a great deal of damage to social relationships. A return to recovery and full functioning very often entail working through guilt and shame associated with behavior during the manic episode and making an effort to rebuild relationships.

Patients typically respond to treatment with a combination of the mood stabilizer lithium and an antipsychotic. There is also an important role for psychoeducation, cognitive-behavioral therapy, interpersonal and social rhythm therapy (IPSRT), and family focused therapy. (IPSRT is designed to help people improve their moods by understanding and working with their biological and social rhythms.)

Ongur said antipsychotic medication may be tapered six to 12 months following the first episode, but a major unresolved clinical and research question is how long patients should be maintained on mood stabilizer.

"The experience at McLean suggests that many individuals can tolerate tapering to lamotrigine monotherapy, but that all pharmacotherapy should not be discontinued," Ongur said.

Ongur's presentation was the second keynote address at the one-day conference sponsored by APA and SMI Adviser in partnership with NIMH, the Substance Abuse and Mental Health Services Administration, and the Psychosis-Risk and Early Psychosis Program Network. SMI Adviser is APA's Clinical Support System for Serious Mental Illness, established with a grant from SAMHSA.

The conference brought together more than 350 clinicians and researchers from around the country involved in early psychosis treatment. "When we ask APA members what areas in which they feel they need more education, management of early psychosis is near the top of the list," said APA Director of Education Tristan Gorrindo, M.D. "Programs such as this early psychosis conference and APA's SMI Adviser initiative help front-line clinicians implement evidence-based care for those with early psychosis." **PN**

More information on SMI Adviser and its new app is posted at smiadviser.org.

FDA Approves Daily Asenapine Patch

Among other benefits relative to oral medications, a transdermal application of asenapine enables easy visualization of medication adherence that may be useful in hospital settings. **BY NICK ZAGORSKI**

In October the Food and Drug Administration (FDA) approved Secuado—a once-daily skin patch containing the antipsychotic asenapine—for the treatment of adults with schizophrenia. This approval marks the first transdermal formulation of an antipsychotic medication in the United States. Secuado is manufactured by Noven Pharmaceuticals.

According to Noven, the efficacy and tolerability of Secuado was demonstrated in a six-week randomized, placebo-controlled study involving 616 adults with schizophrenia. The study found that both low-dose and high-dose patches (3.8 mg over 24 hours and 7.6 mg over 24 hours) were superior to placebo at improving schizophrenia symptoms, as assessed by the Positive and Negative Syndrome Scale (PANSS). After six weeks, patients in the groups that received low and high transdermal doses of asenapine experienced an average drop in PANSS scores of 22 and 20 points, respectively, compared with an average drop in PANSS score of 15 points in those who received the placebo patch. Patients who received transdermal asenapine also had greater reductions in the overall severity of their illness, as assessed with the Clinical Global Impression-Severity (CGI-S) scale compared with those who received placebo.

The patches were well tolerated, with the most common side effects being extrapyramidal symptoms, skin reactions around the application site, and weight gain.

"The optimal antipsychotic treatment is one that provides low-dose efficacy with minimal side effects and addresses the issues surrounding poor compliance among patients with schizophrenia," Leslie Citrome, M.D., a clinical professor of psychiatry and behavioral sciences at New York Medical College, stated in a recent commentary published in the *Journal of Clinical Psychiatry*. Citrome was an investigator on the Secuado trial and has received consulting fees from Noven. "[T]he development of novel transdermal treatments has the potential to fill some of these unmet needs."

Specifically, transdermal patches can provide a more consistent flow of medication at lower concentrations than can be achieved with pills, since potential metabolism in the gastrointestinal (GI) system is bypassed; this mode of delivery also leads to fewer GI-related side effects such as constipation, nausea, and vomiting. Though asenapine is available as an orally dissolving tablet (which is taken into the bloodstream, also bypassing the stomach), the sublingual formulation is known to produce unpleasant sensations in the mouth (numbness or tingling). If the sublingual formulation is swallowed early, the medication is broken down in the stomach and loses its effectiveness.

"Asenapine is a well-tolerated second-generation antipsychotic drug that also has a good efficacy profile," said Stephen Marder, M.D., a professor of psychiatry at the University of California, Los Angeles, and director of the Section on Psychosis at UCLA's Semel Institute for Neuroscience and Human Behavior. "I could see this transdermal application used in many settings."

Hospitals are one place where highly visible skin patches could help staff

see **Asenapine Patch** *on page 20*

iStock/Aleksandr_Kravtsov

Strategies for Reducing Cannabis Use By Patients With FEP

Coordinated specialty care for first-episode psychosis (FEP) can couple motivational interviewing techniques with cognitive-behavioral therapy to help patients stop using cannabis. **BY MARK MORAN**

Inquiring about cannabis use is critical when treating patients with first-episode psychosis (FEP), as such use is associated with a higher risk of schizophrenia and earlier onset of the disorder.

Yet these patients may be resistant to ceasing cannabis use. To overcome this resistance, mental health professionals must work together to inform patients about the risks associated with cannabis use and offer strategies to help young people "become ready" to quit.

Three researchers and therapists at APA's Early Psychosis Pre-Conference in New York last month outlined psychosis-related risks associated with cannabis use and strategies that coordinated specialty care (CSC) teams can use to help FEP patients to stop using cannabis. The preconference was held in conjunction with APA's IPS: The Mental Health Services Conference.

"CSC can improve individuals' lives in a broad range of areas, such as interpersonal relationships, work, school, and symptoms of depression and psychosis, even when substance use continues to be a problem," said Susan Gingrich, M.S.W., training coordinator with NAVIGATE, the model first-episode coordinated specialty care program developed with support from the National Institute of Mental Health. The program has been implemented at 20 sites throughout the United States. NAVIGATE was the intervention model used in the Recovery After Initial Schizophrenia Episode (RAISE) study, which helped to establish the effectiveness of coordinated specialty care for patients with FEP.

"The overall aim of the CSC program is helping people achieve goals and improve the quality of their lives," Gingrich said. "This does not absolutely require the person to stop using substances—although it is preferable if they do. … We need to continue to work on improving functioning and goal achievement even if the individuals are not ready to change their cannabis use."

Mark Moran

Cannabis use is associated with worse outcomes in patients with first-episode psychosis, says Eric Messamore, M.D., Ph.D.

She was joined by Erik Messamore, M.D., Ph.D., medical director of the Best Practices for Schizophrenia Treatment Center at Northeast Ohio Medical University, and Melanie Bennett, Ph.D., of the Maryland Early Intervention Center.

Motivational interviewing and enhancement—a counseling approach that aims to help people overcome their resistance to making changes—has been successfully employed to reduce cannabis use by patients with FEP, said Bennett, a training coordinator at Maryland Early Intervention Center.

Bennett said at the start of treatment for first-episode psychosis, mental health professionals can couple motivational interviewing with educational materials to begin a conversation about stopping or diminishing use of cannabis as the goal. For instance, the mental health professional might say the following: "In our work in this program, we have learned that not using cannabis is the best way for you to reduce your symptoms, achieve your goals, and feel good now and in the future. Different people do this in different ways and on different timelines. … There are many strategies to help you stop using and feel OK when you're ready to stop. There are many things we can do to help you prepare to stop using if you're not ready quite yet."

As treatment continues, mental health professionals should regularly check in with the patient about his or her willingness to quit with such questions as the following: "The last time we talked, you were thinking that maybe you would cut down during the week. How are you thinking about this these days?"

Bennett said motivational interviewing and enhancement can be coupled with cognitive-behavioral therapy to help patients prepare to change, even when they still may be reluctant to give up cannabis use. Working with patients to identify challenges that may arise when reducing or stopping cannabis use and discussing how best to cope with such challenges without turning to cannabis can help better prepare patients for the future.

Said Bennett, "As our clients move toward *wanting* to change, we can help by *preparing* them to change." **PN**

Medication Treatment

continued from page 5

best practices among health professionals and monitor outcomes. So far Project ECHO has provided two videoconferencing tele-education sessions on OUD treatment.

"We talk about [the topic] with multiple experts in the room. For OUD there are peer counseling and addiction medicine specialists, and we had psychiatrists come in," said Sarah Kawasaki, M.D., an assistant professor in the Department of Psychiatry and the Department of Medicine at Penn State. "[Participants] all feel that their type of medicine is supported, and it makes them feel more confident and competent in treating OUD."

Kawasaki and her colleagues discussed their preliminary results in a paper in the November 2019 *Journal of Substance Abuse Treatment*. As of April, the hub had treated more than 600 patients, including 352 in active treatment for OUD, and the 12 spoke sites had treated 306 patients. During the first six months of the hub program, 63% of patients who took methadone and 43% of patients who took buprenorphine remained in treatment. **PN**

"Drug Overdose Deaths" is posted at https://www.cdc.gov/drugoverdose/data/statedeaths.html. "Understanding the Epidemic" is posted at https://www.cdc.gov/drugoverdose/epidemic/index.html. "Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial" is posted at https://jamanetwork.com/journals/jama/fullarticle/2279713. "Emergency Department-Initiated Buprenorphine for Opioid Dependence With Continuation in Primary Care: Outcomes During and After Intervention" is posted at https://link.springer.com/article/10.1007/s11606-017-3993-2. "Expanding Access to Buprenorphine Treatment in Rural Areas With the Use of Telemedicine" is posted at https://onlinelibrary.wiley.com/doi/abs/10.1111/ajad.12805. "Multi-Model Implementation of Evidence-Based Care in the Treatment of Opioid Use Disorder in Pennsylvania" is posted at https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(19)30243-0/fulltext.

Asenapine Patch

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monitor treatment adherence, noted Marder, who was not involved in the development of Secuado. Such patches would likely not be useful in emergency situations, he continued, as the sustained release over 24 hours would be too slow in cases where patients become acutely agitated.

Even with a once-daily application, medication adherence can still be a concern, as symptoms can worsen if more than 24 hours has elapsed between applications.

"It would be even better if the patch lasted more than 24 hours," said Marder, noting that a long-acting transdermal application would be a noninvasive alternative to long-acting antipsychotic injections.

Aequus Pharmaceuticals is now testing a seven-day aripiprazole patch. **PN**

More information about Secuado, including prescribing information, is posted at http://www.noven.com/SECUADO_USPI.pdf. The commentary, "Patches: Established and Emerging Transdermal Treatments in Psychiatry," is posted at https://www.psychiatrist.com/JCP/article/Pages/2019/v80/18nr12554.aspx.

Baby Teeth May Offer Clues About Autism, ADHD

An analysis of metallic compounds present inside baby teeth reveals that children with autism spectrum disorder and/or attention-deficit/hyperactivity disorder have irregular metabolism of several metals including lead starting in early development.

BY NICK ZAGORSKI

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The tooth fairy may soon have some competition for unwanted baby teeth: Investigators at the Icahn School of Medicine at Mount Sinai and the Karolinska Institute in Sweden have found that the composition of lead and other metallic elements in the baby teeth of children with autism spectrum disorder (ASD) and/or attention-deficit/hyperactivity disorder (ADHD) differ from those of children without these disorders.

These study findings may help build a bridge between the genetic and environmental factors (such as lead exposure) that can contribute to ASD and/or ADHD, noted study co-author Paul Curtin, Ph.D., an assistant professor of environmental medicine and public health at Mount Sinai. "We are trying to understand the origins of these disorders, and it seems that irregular elemental metabolism may be involved," Curtin told *Psychiatric News*.

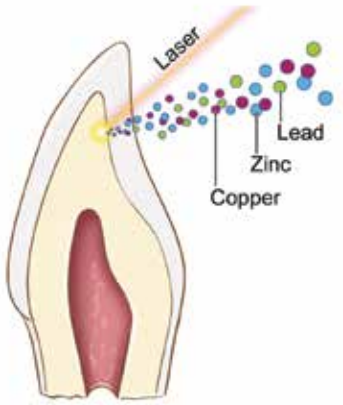
Elemental metabolism refers to how the human body processes metallic elements—both unwanted pollutants such as lead as well as essential trace nutrients such as copper and zinc.

With the use of precision lasers, the research team cut through baby teeth layer by layer and analyzed the composition of metallic elements at various points along the way. Just like an analysis of tree rings can provide important information about a tree's history, this analysis of the layers of tooth enamel can provide a snapshot of how metallic elements have been processed by the child over the course of early development. (Though baby teeth do not become visible until about six months of age, they form early in development and start hardening during the second trimester of pregnancy.)

The investigators analyzed baby teeth from 74 Swedish children who were part of a twin study on autism. The participants included 30 twin pairs, one set of triplets, and 11 single children. In this group, 13 children had ADHD, eight had ASD, 12 had both disorders, and 41 did not have either disorder.

Different Kind of Tooth Drilling

In a technique known as laser ablation, a precision laser cuts through the layers of tooth enamel, which releases trapped molecules such as metal ions. The composition and concentration of these ions provide a snapshot of the past and reveal how the body has metabolized these metals over time.



Source: Christine Austin, Ph.D., et al., *Translational Psychiatry,* 2019. Image: J. Gregory, Mount Sinai Health System

The researchers identified several differences in elemental metabolism among these four groups of children. For example, copper and zinc metabolism were significantly altered in children with ASD, whereas children with ADHD had altered metabolism of cobalt, lead, and vanadium.

When combining the metabolic profiles of all 10 elements analyzed, the researchers identified a unique global pattern for each of the four groups.

While Curtin noted analyzing teeth would not be a useful tool for diagnosing the disorders—ADHD and ASD are typically diagnosed before the age most baby teeth start to fall out—the findings may encourage more research into how elemental metabolism affects early development.

He noted that if researchers were to develop animal models with altered metal metabolism and ASD-like and/or ADHD-like symptoms, they might be able to test medications or supplements that can correct the altered metabolism to see if doing so might provide a therapeutic effect.

The study was published September 25 in *Translational Psychiatry* and was supported in part by the Swedish Research Council, Swedish Brain Foundation, and Stockholm Brain Institute. **PN**

"Dynamical Properties of Elemental Metabolism Distinguish Attention Deficit Hyperactivity Disorder From Autism Spectrum Disorder" is posted at https://www.nature.com/articles/s41398-019-0567-6.

Military Psychiatry

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unit cohesion as a protective factor, troops in platoons and companies trained together, deployed to the war zones together, and returned home together. Behavioral health clinicians again were pressed further forward. Mental Health Advisory Teams were sent into the field to assess risk, especially following a spate of suicides among service members.

During the wars in Afghanistan and Iraq, there has been an uptick in the number of suicides by troops. Military populations are younger and healthier than the civilian population, and their suicide rates were historically lower, too. Yet, suicide rates in the Army rose above civilian levels over the course of the wars, from about 12 per 100,000 people per year at the start of the wars to 25 per 100,000 people years later. (According to the American Foundation for Suicide Prevention, the U.S. suicide rate in 2017 was 14 per 100,000 people.)

The correlation between suicide and combat is not clear. Troops who serve in the war zones have the same rates of suicide as those who had been previously deployed and those who had never been deployed.

To tease out this puzzle, Congress authorized $50 million for a massive study of thousands of Army (and later Marine) recruits. The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) gathered a variety of demographic, medical, social, and genetic information from 100,000 individuals. The data were analyzed to chart servicemembers' passage through their military service.

"We set out to use machine learning techniques to create predictive algorithms and ultimately precision medicine," said Robert Ursano, M.D., director of the Center for the Study of Traumatic Stress at USUHS and a principal investigator on the project. As Army STARRS progressed, the researchers learned more about the soldiers as they entered the service. Many had experienced traumatic events in their lives prior to enlisting, including many with traumatic brain injuries.

This led to increased emphasis in the armed forces on how the environment affects individuals and their subsequent mental health, said Ursano. Such knowledge allows better calculation of risk and the potential to develop interventions and offer better care.

The study examined 600 suicides between 2004 and 2009 but also found 10,000 suicide attempts, a separate problem that the military health system must also address, said Ursano.

The all-volunteer U.S. armed forces added another dimension in the years since the end of the Vietnam War. Women today make up about 15% of military personnel overall.

Care for women's special medical needs—like menstruation or urinary tract infections in the field or pregnancy back in the United States—are a concern, said retired Army psychiatrist Elspeth Cameron Ritchie, M.D., M.P.H. The lack of front lines in the wars in Iraq and Afghanistan means that women, whether or not they are officially in combat units, are just as vulnerable to bullets, missiles, or roadside bombs as their male comrades. Those who work in medical units are exposed repeatedly to injured troops. The interaction of combat exposure with sexual trauma may exacerbate PTSD, although there are insufficient data so far to render a firm conclusion.

Psychiatrists who serve in military settings must learn the same things as their civilian counterparts, augmented by a military medical curriculum that includes battlefield training exercises for the days and months when they are working in combat. Finding a way to integrate those two streams is a key to future care for American troops during and after their service.

"American psychiatry underpins military psychiatry, but we haven't yet tapped the full potential of psychiatry in the United States," said Smith. "We need to create synergy between the two, and society needs people who will bridge that gap." **PN**

Gender-Affirming Surgery Linked to Positive MH Outcomes Over Time

Over a 10-year follow-up period, an individual's odds of receiving treatment for a mood or anxiety disorder decreased by 8% for each year since his or her last gender-affirming surgery. **BY KATIE O'CONNOR**

People who are transgender face a slew of challenges every day, including discrimination and difficulties accessing the health care they need to align physically with their gender identity. Though several professional organizations, including APA, recommend that physicians consider providing medical interventions for those who want them, cost is often an insurmountable barrier in the United States.

Yet research shows that people who are transgender benefit when they get the medical interventions they seek, and a study of the entire Swedish population published October 4 in *AJP in Advance* further reinforces that point. Among those in Sweden who received gender-affirming surgery, the likelihood of being treated for a mood or anxiety disorder decreased by 8% for each year since their last surgery over a 10-year follow-up period.

Richard Bränström, Ph.D., an associate professor at the Karolinska Institutet in Sweden and research affiliate at the Yale School of Public Health, and John E. Pachankis, Ph.D., an associate professor of public health at the Yale School of Public Health, collected health information from the 2,679 people diagnosed with gender incongruence (defined as a diagnosis of either transsexualism or gender identity disorder) in Sweden between 2005 and 2015. They used the Swedish Total Population register, which included 9.7 million people.

"We had a unique possibility with the registry that we have here in Sweden," said Bränström. "Most studies of this population have been quite small, often just samples collected in the clinic with short follow-up times, and it's unknown how representative those samples are of the transgender population overall."

To determine the mental health outcomes of Sweden's transgender population over 10 years, researchers first gathered data on the type and year of gender-affirming treatments obtained by those with gender incongruence diagnoses from 2005 to 2015. The study's outcome measures were psychiatric outpatient health care visits, antidepressant and anxiolytic prescriptions, and hospitalization after a suicide attempt.

"[W]e then investigated the odds of mood and anxiety disorder treatment and hospitalization following a suicide attempt as a function of years since initiation of hormone or hormone-suppressing treatment and since last gender-affirming surgery," the authors wrote.

Rebecka Uhlin

According to the study, transgender individuals were about three times as likely to have received prescriptions for antidepressant or anxiolytic medication and more than six times as likely to have been hospitalized after a suicide attempt. These findings were not surprising considering the challenges the population faces, said Richard Bränström, Ph.D.

The findings tracked a significant reduction in the odds of receiving treatment for a mood or anxiety disorder and hospitalization following a suicide attempt after the individual's last gender-affirming surgery. There was, however, no relationship between the years since initiation of hormone treatment and the likelihood of mental health treatment.

The findings align, on a larger scale, with those of many smaller studies: People who are transgender benefit when they are able to receive gender-affirming medical interventions. Over 70% of those diagnosed with gender incongruence during the study period received hormone treatment (including androgen-suppressing and -blocking medication), and 48% received gender-affirming surgical treatment (usually chest surgery or surgery of the reproductive organs).

The authors noted several limitations to the study, particularly that the criteria used to define the transgender population may not capture the full spectrum of those who identify as transgender. They also pointed out that those diagnosed with gender incongruence are naturally exposed to treatment settings that may predispose them to seeking mental health treatment.

That may be part of the reason why, Bränström noted, even 10 years after their last gender-affirming surgery, those with gender incongruence diagnoses were still significantly more likely to be treated for a mood or anxiety disorder than the general population. But that finding also likely reflects, Bränström added, that living as a transgender individual naturally comes with stigma-related stress or minority stress.

Eric Yarbrough, M.D., chair of APA's Council on Minority Mental Health and Health Disparities and past president of the Association of LGBTQ Psychiatrists, said that he believes the findings are applicable to the United States. "It's only going to give us more evidence to show insurance companies that these types of surgeries and treatments should be paid for," Yarbrough said.

"We are in a culture war right now," said Jack Drescher, M.D., who is a clinical professor of psychiatry at Columbia University and served on the *DSM-5* Work Group on Sexual and Gender Identity Disorders. He is also the author of *Psychoanalytic Therapy and the Gay Man* and emeritus editor of *the Journal of Gay and Lesbian Mental Health*. "There are still some who believe people should not be able to have those services, so for those of us who are treating people in these populations, a study that shows that people who get treatment feel better is no surprise. That we have to prove it today is the sad thing."

The study was supported by the Swedish Research Council and the Swedish Research Council for Health, Working Life, and Welfare. **PN**

"Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2019.19010080.

Safe Injection

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stein, an attorney representing Safehouse, U.S. Attorney William McSwain said he would "use all enforcement tools" at his disposal to shut Safehouse down if it opens its facility before such an appeal process takes place, reported *The Philadelphia Inquirer*.

The case is being closely watched as it could have far-reaching implications for other cities also considering opening safe injection sites, such as New York, San Francisco, and Seattle.

In an October op-ed published in *The Washington Post*, Safehouse's founders said, once it eventually opens, their facility will operate much like those in Canada, where there are numerous safe injection sites. People could come to the center and inject their own drugs with clean equipment while a health worker, who would neither touch nor distribute drugs, would be available to prevent overdoses or deaths. "This isn't a substitution for treatment," the founders wrote, "but it is safer than having people use drugs alone or on the streets."

At Insite, a safe injection site in Vancouver, Canada, operated by Vancouver Coastal Health and PHS Community Services Society, more than 3.6 million clients have injected illicit drugs under supervision at the facility since 2003, according to the facility's website. There have also been 48,798 clinical treatment visits and 6,440 overdose interventions without any deaths.

Saxon noted that, ideally, people who use injection drugs would get the highest-quality treatment available, but cost and workforce shortages are just two of the barriers to access. "But in the meantime, there's no reason we can't do the harm-reduction activities so fewer people die and fewer people get sick," he said. **PN**

McHugh's ruling is posted at https://www.documentcloud.org/documents/6444521-2019-10-02-Memorandum-on-Safehouse.html. The op-ed "We're Launching the Nation's First Safe-Injection Site. We Hope It Will Be One of Many" is posted at https://www.washingtonpost.com/opinions/2019/10/15/were-launching-nations-first-safe-injection-site-we-hope-it-will-be-one-many/.

JOURNAL DIGEST

BY NICK ZAGORSKI

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Smoking Ban in MH Settings Reduces Conflicts Between Staff, Patients

Adopting a comprehensive smoke-free policy in psychiatric hospitals may reduce conflict between patients and staff, according to a study in the *International Journal of Mental Health Nursing*.

Researchers at Kings College London and colleagues examined rates of smoking-related incidents at a psychiatric hospital in London in the 12 months before and after the facility became smoke-free in 2014. Prior to this, smoking was not permitted inside the hospital, but patients could take occasional smoke breaks outside.

They identified 61 smoking-related incidents in the year prior to the policy change, and 32 incidents in the year following the change. Reports of patients being confrontational with staff after being approached about the hospital's smoking policy rose slightly after the policy change; however, these incidents were offset by the elimination of confrontations during smoke breaks and a reduction in incidents when patients were denied a smoke break by staff.

"We have demonstrated that designated smoking breaks are a source of conflict … and for the first time shown that eliminating breaks as part of a comprehensive smoke-free policy may remove this source of conflict," the authors wrote.

Spaducci G, McNeill A, Hubbard K, et al. Smoking-Related Violence in a Mental Health Setting Following the Implementation of a Comprehensive Smoke-Free Policy: A Content Analysis of Incident Reports. *Int J Ment Health Nurs*. September 12, 2019. [Epub ahead of print] https://onlinelibrary.wiley.com/doi/abs/10.1111/inm.12659

Cristina Davis/UC Davis

Researchers Develop Opioid Analyzer Using Breath Collection

Scientists may be one step closer to identifying a noninvasive way to detect opioids in patients. A pilot study of patients with chronic pain at the University of California, Davis, suggests opioid metabolites can be detected and quantified from exhaled breath.

"Techniques that monitor exhaled drugs in breath are relatively new, and most of them are in the early stages of development. However, the use of breath drug-monitoring platforms is very attractive in terms of being noninvasive and useful in a variety of settings," the researchers wrote. "Exhaled breath collection represents a painless, easily available, and noninvasive technique that would enable clinicians to make quick and well-informed decisions."

For this pilot study, the researchers collected breath samples from 10 adults—seven patients undergoing pain management treatment with intravenous opioids and three controls not taking opioids. Six of the pain patients were also taking oral oxycodone, while one was taking oral methadone. The participants provided samples by exhaling into a dry ice–filled container that quickly condenses the breath for analysis. Each participant provided two breath samples about 60 to 90 minutes apart, with a blood draw taken immediately afterward.

Using mass spectrometry, the researchers were able to identify opioid metabolites that reflected the medication the patients were taking. Though the metabolites were present at lower levels than in corresponding blood samples, there was a correlation between the relative breath and blood concentrations of each patient.

"[T]he small number of subjects precludes any robust conclusions, and more subjects taking a specific opioid and at various times from opioid ingestion will be required," the researchers wrote. Additional studies with larger samples will also be needed to see how sex, weight, and metabolism influence the breath analysis, they added.

The study was published in the *Journal of Breath Research*.

Borras E, Cheng A, Wun T, et al. Detecting Opioid Metabolites in Exhaled Breath Condensate (EBC). *J Breath Res*. 2019; 13(4): 046014. https://iopscience.iop.org/article/10.1088/1752-7163/ab35fd

iStock/wundervisuals

Flibanserin Found to Be Safe When Taken Hours After Drinking

Flibanserin—a medication approved for some types of hypoactive sexual desire disorder (HSDD) in premenopausal women—is safe if taken two or more hours after drinking alcohol, two studies in the *Journal of Sexual Medicine* suggest. The findings support the recent decision by the Food and Drug Administration (FDA) to change the label of flibanserin from recommending women taking the medication avoid alcohol (due to the risk of low blood pressure and fainting) to recommending that women discontinue drinking alcohol at least two hours before taking the medication.

To assess the potential physiological interactions of alcohol and flibanserin, researchers at George Washington University and colleagues conducted two small clinical studies involving healthy premenopausal women (who were not assessed for HSDD). In one study, 64 women consumed either orange juice

continued on facing page

Youth Suicide

continued from page 1

Although the youth suicide rate was lowest among 10- to 14-year-olds in 2017 (2.5 deaths per 100,000), this group experienced the largest increase—with a suicide death rate nearly three times higher than in the prior decade (177%). Among 15- to 18-year-olds, the suicide rate rose 76%, and 36% for 20- to 24-year-olds.

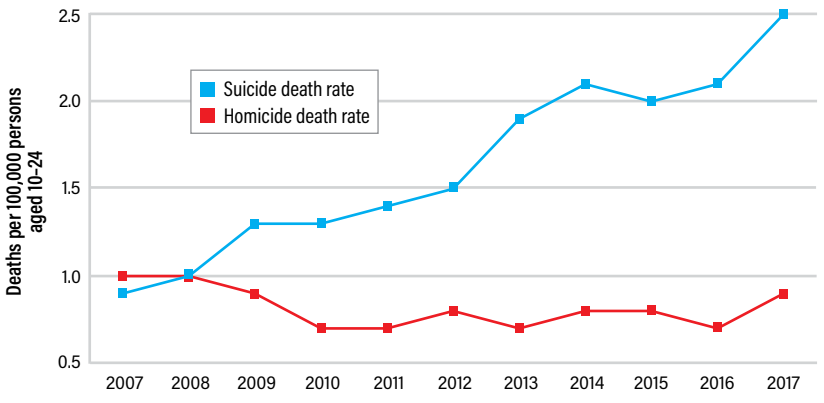
One possible explanation for the uptick in suicide among children may be that menarche and the onset of puberty is happening earlier, Oquendo said. Some studies have associated early menarche with higher rates of both depressive symptoms and antisocial behaviors. Psychological autopsies, which rely on extensive interviews with friends and family of the deceased to study suicide, have found that 95% of individuals who die by suicide had a mental illness, typically a mood disorder, she explained.

"More research is needed on what is driving the rise in youth suicides," said Eraka Bath, M.D., an associate professor of psychiatry and director of the Child Forensic Services Program at the University of California, Los Angeles. "Recent studies suggest the importance of examining the impacts of social media exposure on cyberbullying as well as on the development of anxiety and depressive disorders. Additionally, we need improved understanding of how excessive screen time may affect empathy and reward circuits in the brain."

Oquendo said that youth exposure to vaping is another major concern. "We know that youth exposure to nicotine is associated with increased risk for suicide, as is use of other substances, such as drugs and alcohol."

Suicide Rates of Youth Surpass Homicide Rates in Past Decade

After a stable period from 2000 to 2007, suicide rates for youth aged 10 to 24 increased from 2007 to 2017, while homicide rates increased from 2014 to 2017 but were still lower than suicide rates.



Source: National Center for Health Statistics, National Vital Statistics System, Mortality

Data Point to At-Risk Youth

Although the CDC report did not discuss race or ethnicity, a recent study in *Pediatrics* suggests that suicide attempts by black adolescents may be rising. The findings were based on data from the Youth Risk Behavior Survey (YRBS)—a national survey administered to high schoolers across the United States—from 1991 through 2017. As part of this survey, youth were asked to report

continued from facing page

or orange juice plus alcohol (the equivalent of two glasses of wine) prior to taking 100 mg flibanserin two, four, or six hours later or a placebo pill two hours later. Each woman participated in eight drinking sessions over two weeks, though the order was assigned randomly.

Overall, there was no statistical difference in the rates of hypotension (defined as systolic blood pressure <90 mm Hg and diastolic blood pressure <60 mm Hg) when women received flibanserin compared with when they received placebo. There was only one incident of fainting, and that was a participant who took placebo four hours after consuming alcohol.

In the other study, 24 women were assigned to receive either 100 mg flibanserin or placebo at bedtime 2.5 hours after consuming a three-course dinner and two glasses of wine. As with the other study, there was no difference in the rate of hypotension or adverse events such as dizziness or fainting in women who took flibanserin or placebo at bedtime.

These studies were funded by Sprout Pharmaceuticals, the manufacturer of flibanserin.

Simon JA, Clayton AH, Kingsberg SA, et al. Effects of Timing of Flibanserin Administration Relative to Alcohol Intake in Healthy Premenopausal Women: A Randomized, Double-Blind, Crossover Study. *J Sex Med.* September 12, 2019. [Epub ahead of print] https://www.jsm.jsexmed.org/article/S1743-6095(19)31365-7/fulltext

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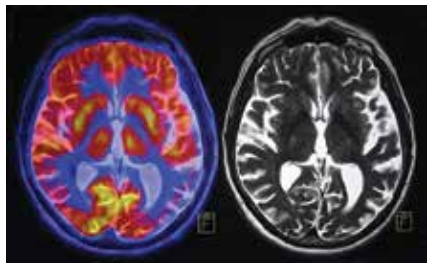
Light Flash Therapy Coupled With CBT Can Improve Sleep

Light flash therapy combined with cognitive-behavioral therapy (CBT) can improve sleep in adolescents, according to a study published in *JAMA Network Open*. Light flash therapy is a technique in which ultra-brief (millisecond) flashes of bright light are pulsed during sleep; these flashes can be processed by the retina, which in turn can adjust circadian rhythms.

In this two-phase study, researchers at Stanford University and colleagues enrolled 102 adolescents aged 14 to 18 who reported difficulty going to bed early and waking up early. In the first phase, 72 adolescents were assigned to receive either active light therapy (3 millisecond pulses every 20 seconds for three hours) or sham light (3 millisecond pulses every 20 seconds but only for one minute each hour) nightly for four weeks. The second phase was similar, but all 30 participants also received four weekly sessions of CBT. The light flash duration was also reduced from three hours to two hours, as some participants reported the lights to be disruptive.

There were no differences in sleep and wake times as reported in sleep diaries or subjective measures of sleep quality between adolescents who received active or sham light therapy in phase one. In the second phase, however, the adolescents receiving CBT in addition to light flash therapy reported getting to bed about 50 minutes earlier and sleeping for 43 minutes longer on average relative to those receiving sham light.

Kaplan KA, Mashash M, Williams R, et al. Effect of Light Flashes vs Sham Therapy During Sleep With Adjunct Cognitive Behavioral Therapy on Sleep Quality Among Adolescents: A Randomized Clinical Trial. *JAMA Netw Open.* 2019; 2(9): e1911944. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2751894



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Brain Imaging May Predict Exposure Therapy Response In OCD Patients

Brain imaging may be able to predict which patients with obsessive-compulsive disorder (OCD) will benefit from exposure therapy, according to a study published in *PNAS*.

Researchers at Columbia University and colleagues asked 36 adults with OCD and 33 controls without OCD to complete the Simon Spatial Incompatibility Task while receiving a functional MRI (fMRI) scan. This task involves identifying which way a left or right arrow that quickly appears on the left or right side of a screen is pointing. The task is designed to assess conflict control, as the participant must disregard the spatial direction and focus on the arrow direction. The researchers chose this task since it is believed that OCD symptoms reflect the brain's inability to resolve cognitive conflicts.

After completing the task, all OCD participants were offered 17 twice-weekly sessions of exposure therapy; 17 of the patients achieved remission following therapy.

The researchers identified a pattern of elevated brain activity in several regions among people who responded to treatment. These regions included the left pallidum (which controls voluntary movements), the visual cortex, and several small regions linked with the default mode network (which is active when people are daydreaming). By using this pattern as a template, the researchers could predict which patients responded to therapy with about 80% accuracy.

"[T]hese results represent an important step toward targeting treatment plans to specific patients, while suggesting that improving the capacity to resolve cognitive conflict may be a target for novel treatments," the authors wrote. **PN**

Pagliaccio D, Middleton R, Hezel D, et al. Task-based fMRI Predicts Response and Remission to Exposure Therapy in Obsessive-Compulsive Disorder. *Proc Natl Acad Sci USA.* September 23, 2019. [Epub ahead of print]https://www.pnas.org/content/early/2019/09/17/1909199116.long.

suicidal thoughts and behaviors.

While the analysis revealed that the rates of suicidal ideation and suicide plans by the adolescents trended downward over time across sexes and racial and ethnic groups, black adolescents experienced an increase in rates of suicide attempts, the authors reported. This trend was not seen in adolescents who identified as white, Hispanic, Asian American, Pacific Islander, or multiracial.

"These racial and ethnic nuances are important and need to trickle up to psychiatrists' awareness for improved training, better screening and assessment, and more robust prevention and intervention," Bath said. "Given that minority populations are particularly impacted by structural factors, such as racism and discrimination, lack of access to mental health care, poverty, and community violence, we need to think about elements of risk beyond what we traditionally learn about in our training, which prioritizes symptoms and specific disorders and overlooks these factors." She called for more research on racial and ethnic differences in youth suicide.

Another group of youth who may be at a higher risk of suicide are those whose parents are in treatment for psychiatric disorders and have a history of suicide attempt, Oquendo added.

"We should be treating these children the same way that we treat children of cancer patients: We need to alert these patients to the familial aspect of this illness and the importance of monitoring their children. But because of the stigma of suicide, the parents' history of suicide attempt is often hidden, and these opportunities for intervention are lost."

Screening Can Save Lives

"We are on the front lines of having an opportunity to intervene and hopefully stop this trajectory," said Gabrielle Shapiro, M.D., chair of APA's Council on Children, Adolescents, and Their Families and a clinical professor of psychiatry at Mount Sinai School of Medicine. With even the youngest patients at risk for suicide, screening and assessment for suicidality and depression should be frequent and routine, she said.

Another effective means of lowering youth suicide rates would be educating teachers and parents on how to recognize troubling behavior at home and in school, she said. The APA Foundation's Typical or Troubled school mental health education program has been successfully implemented in dozens of cities in the United States to do this.

Oquendo said treatment does make a difference in preventing youth suicides. Particularly effective are selective serotonin reuptake inhibitors as well as suicide-specific therapies such as cognitive therapy for suicide prevention and dialectical behavior therapy. Also proven effective is the use of safety planning interventions, which allow the patient to make a concrete plan for weathering a potential suicidal crisis. Safety planning can be provided in any setting, including schools or emergency rooms, and various professionals including teachers and mental health professionals can easily be trained to help patients complete these lifesaving plans, she said. **PN**

"Death Rates Due to Suicide and Homicide Among Persons Aged 10-24: United States, 2000-2017" is posted at https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf. "Trends of Suicidal Behaviors Among High School Students in the United States: 1991–2017" is posted at https://pediatrics.aappublications.org/content/early/2019/10/10/peds.2019-1187. For a patient safety plan template, visit https://suicideprevention lifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf.

LGBTQ

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country's millions of lesbian, gay, bisexual, transgender, and questioning/queer employees.

"We've taken it as axiomatic that gender discrimination is illegal, but the idea that those protections should also be extended to transgender individual or people of different sexual orientations would really broaden the protections," said Marvin Swartz, M.D., chair of APA's Committee on Judicial Action. "It would have widespread repercussions."

In *Bostock v. Clayton County* and *Altitude Express v. Zarda*, which have been consolidated, Gerald Lynn Bostock and the estate of Donald Zarda argue that both men lost their jobs due to their sexual orientation. *Harris Funeral Homes v. EEOC* involves Aimee Stephens, a transgender woman, who was fired after informing her boss of her gender transition.

Lawyers for the employees largely used textualism, a style promoted by Justice Antonin Scalia, to argue their case. They claimed that, regardless of what Congress intended when it passed the Civil Rights Act, discrimination against LGBTQ employees is ultimately discrimination based on their sex and thus prohibited under Title VII.

"When a[n] employer fires a male employee for dating men but does not fire female employees who date men, he violates Title VII," Pamela Karlan, Bostock and Zarda's lawyer, told the court on October 8. "The employer has, in the words of Section 703(a), discriminated against the man because he treats that man worse than women who want to do the same thing."

David Cole, a lawyer with the American Civil Liberties Union arguing on behalf of Stephens, made similar points. He told the justices that Harris Funeral Homes discriminated against Stephens because it "fired her for identifying as a woman only because she was assigned a male sex at birth. In doing so, it fired her for contravening a sex-specific expectation that applies only to people assigned male sex at birth."

The opposing side, however, argued that sexual orientation and gender identity are independent and distinct from a person's sex, and so Title VII does not apply.

At odds with the textualist argument is the question of Congress's intentions when it passed the Civil Rights Act. Justice Neil Gorsuch expressed concern about "the massive social upheaval that would be entailed" if the court rules in favor of the employees. He considered the possibility that the question before the court might be more appropriate as a legislative rather than judicial issue.

Justice Samuel Alito echoed those sentiments. He said whether Title VII should apply to sexual orientation "is a big policy issue, and it is a different policy issue from the one that Congress thought it was addressing in 1964." Since the Civil Rights Act was passed, there have been numerous attempts in Congress to expand Title VII to explicitly apply to LGBTQ workers, but to no avail.

Jack Drescher, M.D., who served on the *DSM-5* Work Group on Sexual and Gender Identity Disorders and is a clinical professor of psychiatry at Columbia University, said people within the LGBTQ community are worried. "They're afraid that the Supreme Court will decide that it is going to be OK to discriminate against LGBTQ people, not because it's fair but because the current makeup of the Supreme Court is not seen as favorable to the notion of rights for LGBTQ people."

Though many conservative judges advocate for textualism, after the oral arguments the justices appeared largely split on ideological lines. The three cases are the first involving LGBTQ rights since the retirement of Justice Anthony Kennedy, who was often the court's swing vote on gay rights cases and wrote the opinion in the case that guaranteed marriage equality. It's unclear if another justice will act as a swing vote in this case.

If the justices find that Title VII does not apply to LGBTQ workers, it could potentially impact health care access for the LGBTQ population as well. Such a decision might mobilize the community to advocate for anti-discrimination laws at the state level, Drescher said. According to the Human Rights Campaign, only 22 states, Washington, D.C., and two territories (Guam and Puerto Rico) have laws prohibiting employment discrimination based on sexual orientation and gender identity, and one state prohibits discrimination on sexual orientation only. **PN**

Transcriptions of the arguments are posted at https://www.supremecourt.gov/oral_arguments/argument_transcripts/2019/17-1618_7k47.pdf and https://www.supremecourt.gov/oral_arguments/argument_transcripts/2019/18-107_4gcj.pdf. Information on states with and without employment anti-discrimination laws is posted at https://www.hrc.org/state-maps/employment.

Ethical 'Ceiling'

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party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation."

At the moment, our *Principles* do not extend their umbrella of protection to people based on gender identity; however, APA has repeatedly spoken out against discrimination against trans individuals in the military and recently joined with other physician organizations to oppose weakening of federal protections for transgender patients. It is hoped that the APA Ethics Committee will revise Section 1, Article 2, to reflect this position.

Another area where the ceiling and floor don't match is gag rules about guns. Although struck down in the courts, several states have tried to prohibit physicians from asking their patients about firearms. For an excellent review, read "Law, Ethics, and Conversations Between Physicians and Patients About Firearms in the Home." Again, APA has joined with other physician organizations to defy efforts to silence physicians' voices in the national conversation about guns, for example, following the Marjory Stoneman Douglas High School shooting last year and the more recent shootings in El Paso, Texas, and Dayton, Ohio.

If the gag laws in Virginia and West Virginia had passed and if the Florida law had been upheld in the courts, it might have been illegal for a psychiatrist to ask a patient who is manifesting suicidal or homicidal behavior if they have access to a gun. All psychiatrists know that this question is absolutely critical to assessing patient safety and that failing to ask it and failing to document the answer is below the standard of care. Essentially, the laws would have mandated a form of malpractice. In this situation, the ethical course of action would have been to break the law to protect patients and public safety.

As psychiatrists aspire to ethical excellence—that is, reaching for the ceiling—awareness of ethical challenges posed by laws is important. APA has been responsive to recent cultural and legal shifts that create hazards for patients and the public. When individual psychiatrists recognize a dilemma posed by a mismatch between the law and professional ethics, they would do well to seek consultation from their malpractice carrier, an attorney, a colleague, the district branch ethics committee chair, or another trusted and knowledgeable adviser in order to thoughtfully determine the best course of action. **PN**

Links to the resources noted in this article are posted in its online version at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.11a4.