



# PSYCHIATRIC NEWS

PSYCHNEWS.ORG

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**Fair Insurance Coverage: IT'S THE LAW**

Federal law prohibits your private health insurance plan from discriminating against you because you have a mental illness, including a substance use disorder. Coverage for a mental health concern now must be equivalent to coverage for physical health problems, like heart disease, diabetes and cancer.

**Under the federal "Mental Health Parity" law:**

- 1 You are entitled to the treatment your physician says is necessary for your mental health or substance use disorder. Your health plan cannot require you to fail first at less-expensive treatments if it does not have the same "fail first" requirement on all other illnesses covered by your plan.
- 2 With few exceptions your co-payment or co-insurance for your mental health benefit should not be higher than it is for other medical care, and you should have only one deductible and out-of-pocket maximum that covers all of your health care.
- 3 When you visit a psychiatrist for medication management and for psychotherapy on the same day, you should pay only one co-payment.
- 4 You should have access to an "in network" mental health provider who:
  - is qualified to treat your condition
  - can be reached in a reasonable manner
  - can be reached in a reasonable manner
- 5 You have the right to appeal your plan's decision about your care or your plan's decision to deny your claim.
- 6 The number of visits or hospital days should not be limited, unless similar limitations apply to most other medical illnesses under your plan.
- 7 Your health plan should pay even if you don't complete the treatment or a prior recommended course of treatment.
- 8 Your health plan is required to provide you with a written explanation of:
  - how it evaluated your need for treatment
  - why it denied the claim
  - the basis for its conclusion that the plan complies with federal law.
- 9 You have the right to appeal your plan's decision about your care or your plan's decision to deny your claim.

**SEE STORY BELOW**

**APA has devoted** much time and resources regarding the enforcement of the mental health parity law and conducted studies on health insurers' compliance. Studies revealed that one way insurers skirt the law is through inadequate provider panels (see story below). Above is a poster that APA produced for placement in high-visibility locations to inform patients of their rights under the law. The poster can be downloaded from [psychiatry.org/parity](http://psychiatry.org/parity).



**4** Adversaries around PAD find common ground on values of palliative care.



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**13** Alzheimer's biomarkers may vary depending on race.

## Aetna Settles With Mass. Attorney General On Network Adequacy, Directories

*The use by health plans of narrow or "phantom" provider networks has hindered access to care and the implementation of parity nationwide. BY MARK MORAN*

**A**etna, one of the nation's largest health insurers, agreed to a settlement last month with the Massachusetts Office of the Attorney General (AG) requiring the company to comply with state and federal laws by maintaining accurate,

updated provider directories and network adequacy.

The legal action brought by Massachusetts AG Maura Healey alleged that the health insurer violated state law because of inaccurate and deceptive provider directories and inadequate

provider networks. The legal action also alleged that Aetna violated state law by unfairly denying or impeding member coverage for substance use disorder treatments.

Since regulations regarding the Mental Health Parity and Addiction Equity Act (MHPAEA) were issued by the Centers for Medicare and Medicaid Services, APA has worked to educate attorneys general, insurance commissioners, consumers, state and federal legislators, and employers about MHPAEA requirements regarding network parity for mental and substance use disorders, both in consumer access and in provider payment.

APA has conducted "secret shopper" surveys in many states bringing to local authorities' attention the fact that insurers frequently misrepresent the depth and breadth of their networks in violation of consumer protection laws.

The surveys have also revealed that health plans violate mental health parity regulations by failing to pay psychiatrists the comparable rates for the same services as other physicians.

In 2016, for example, a team of researchers with the APA Foundation telephoned a randomly selected sample of psychiatrists publicly listed as network psychiatrists for the three largest health insurance carriers in Washington, D.C. They found that most of the network psychiatrists listed as practicing in the area either were not able to schedule an appointment or were not even reachable at the listed telephone numbers.

The analysis revealed that close to a quarter of the phone numbers for the listed psychiatrists were nonresponsive or were nonworking numbers. And only 15 percent of psychiatrists were able to schedule any appointment for callers; in one plan, only 4 percent were able to schedule an outpatient appointment.

The findings highlight a problem that has hindered access to care and

*see Aetna on page 18*

PERIODICALS: TIME SENSITIVE MATERIALS

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## FROM THE PRESIDENT

# Heading Into the Home Stretch

BY ALTHA STEWART, M.D.

Over the years, I've watched more than a few presidents as they set priorities; represented the organization at the local, national, and global levels; and worked through the challenges they faced during their terms. One of the things I noticed is the balance they struck between the priorities on which they campaigned and the challenges they faced in getting them done. I'm about two-thirds through my term, and I am pretty sure that I'm not the first president who has said around this time, "It's an interesting and challenging time to be president of APA!" So, as I am reaching this important milestone at the start of a new year, I thought I would share some of the reasons why I'm glad to be a psychiatrist and APA president right now.

I am extremely proud that we have continued to advocate on behalf of members on one of the most important issues faced by our members—maintenance of certification (MOC). As we enter the new year, we are focused on working to make sure that MOC requirements are not a barrier to med-

ical licensure, hospital credentialing, or joining insurance panels. And although we remain committed to lifelong learning and professionalism, we will continue to work on solutions that offer options for our members to demonstrate continued learning and competence in their specific area of work.

I will always be proud that APA was the first professional medical organization to speak out against the harm done to children and their families separated at the border based on national policies. We were soon joined by other associations, and ultimately the policy was reversed. However, the repercussions from that and related policies have created emotional harm about which we are still concerned. One of our own, Dr. Pamela McPherson of the Department of Homeland Security's Office of Civil Rights and Civil Liberties, brought the government's child detention practices to our atten-

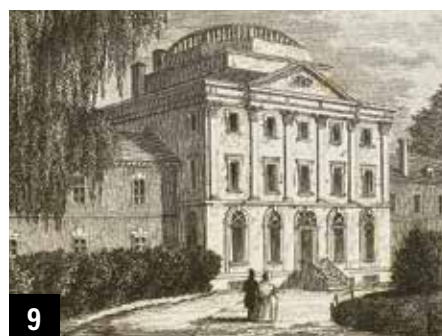


tion and represented the profession well in her appearance before a Senate committee and later on "60 Minutes." The story touched most Americans and, as I told her in a personal communication, made me proud to be president of an APA with members like her.

It was a year of ups and downs as APA continued to focus its advocacy efforts on the lack of full implementation of mental health parity and the ongoing challenges to the Patient Protection and Affordable Care Act (ACA). From the landmark case in Texas in which the judge ruled that the ACA is unconstitutional to the current efforts in the House to create legislation to save what is considered the most important overhaul to the U.S. health care system since the passage of Medicare and Medicaid in 1965, APA has consistently spoken in favor of what is in the best interest of our patients and our members. And while engaged in these advocacy efforts, we have continued to provide high-quality services, including in response to a variety of natural disasters, violent incidents in the commu-

see **From the President** on page 7

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### Early Bird Rates in Effect!

Register now for APA's 2019 Annual Meeting in San Francisco and take advantage of the meeting's lowest registration rates. A gala to celebrate APA's 175th anniversary will be held in San Francisco City Hall. For more information about the meeting and gala, see page 10.



# First Step Act Is Start Toward Meaningful Prison Reform

*Congress passes the most ambitious criminal justice and sentencing overhaul in decades, addressing some concerns of individuals with mental illness. Advocates hope reforms will trickle down to state and local prisons.*

BY LINDA M. RICHMOND

A bipartisan criminal justice reform bill signed into law late last month includes some provisions beneficial to individuals with behavioral health disorders.

The most ambitious criminal justice and prison sentencing reform in many years, the First Step Act (S 756) aims to cut recidivism and improve federal prison conditions while also reducing mandatory sentences. Prior to the enactment of the First Step Act, it had been several decades since Congress had made significant reforms to federal criminal justice and prison policies.

APA supported several of the provisions that passed, particularly prison staff training on how to handle incidents involving inmates with mental illness. However, APA and other organizations that advocate for mentally ill people are concerned that it falls short of the sweeping overhaul required to address the needs of the more than 2 million individuals with serious mental illness who are cycling in and out of jails and prisons.

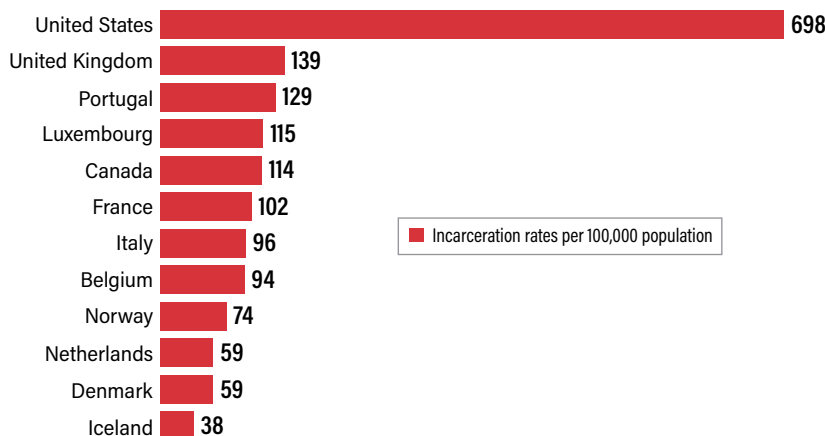
“APA members will see some benefit for their patients from this legislation, particularly those who work in the corrections sector or those working with individuals post-release,” said APA President Altha Stewart, M.D., an associate professor of psychiatry and director of the Center for Health in Justice Involved Youth at the University of Tennessee Health Science Center. “These types of systems improvements are very consistent with APA’s work to develop better treatment models for people with mental illness in jails and prisons.” For example, APA joined the Stepping Up initiative, a national effort to reduce the number of individuals with mental illness in county jails, in 2015.

Several years in the making, President Donald Trump embraced the measure last November, and with his support, the bill was approved by the Senate by a bipartisan vote of 87-12 on December 18, followed by a House vote of 358-36 two days later.

“[M]y job is to fight for ALL citizens, even those who have made mistakes,” Trump tweeted, congratulating the Senate for its passage of the historic measure. “This will keep our communities safer and provide hope and a second chance to those who earn it. In addition to everything else, billions of dollars will be saved.”

## Incarceration Rates of Founding NATO Countries

The United States incarcerates 698 individuals for every 100,000 (or 1 in 143). That translates to more than seven times the average incarceration rate of other founding NATO countries.



Source: States of Incarceration: The Global Context 2018, Prison Policy Initiative

The new law will do little to address that the United States is out of step with the rest of the developed world regarding incarceration rates. There is one person locked up for every 143 people in the United States, compared with 1 in 1,079 on average in other founding NATO countries, according to the Prison Policy Initiative (see chart).

As a federal law, the First Step Act applies only to the 225,000 individuals in federal prisons and jails, only a very small fraction—about 10 percent—of all those incarcerated in the United States. The majority are locked up in state prisons and local jails, more than 1.9 million people, to whom these reforms do not apply.

“If we can enact these reforms at the federal level, we can figure out a way to bring them about at the state and local levels,” Stewart said. “It is very disheartening that we imprison more of our citizens than any other developed country and that an overwhelming proportion of individuals incarcerated are actually mentally ill—and are incarcerated as a direct result. As a society, we can do better for them.”

APA supported the following provisions in the First Step Act:

- A requirement that staff training address how to identify and respond to incidents involving individuals with mental illnesses.
- An order for the federal Bureau of Prisons to report on the availability of treatment for heroin and opioid use disorders in prison through evidence-based programs, including medication-assisted treatment.
- A mandate to end juvenile solitary confinement, except as a last resort and as a temporary response to behavior posing an immediate risk of physical harm.

One goal of the law is to cut recidivism rates by helping prisoners better prepare to rejoin society. It requires federal prisons to determine each inmate’s “criminogenic needs” upon intake and tailor programs to them. The law also creates incentives for participants, including shaving time off sentences for those who take part. It reauthorizes reentry programs that promote transitional employment. The law also requires incarcerated individuals to be housed as close as practicable to their primary residence and allows for home confinement for low-risk prisoners.

“Now, the focus turns toward appropriations in 2019,” said Megan Marcinko, APA’s director of federal relations. “We hope to see reauthorization and expansion of Community Behavioral Health Clinics (CCBHCs), a demonstration project that treats individuals with mental illness earlier in the disease course and in their own communities, saving money that would be spent on criminal justice and hospital readmissions, while better utilizing emergency response resources.” **PN**

 The text of the First Step Act (S 756) is posted at <http://apapsy.ch/FirstStepAct>.

## Advertisement

# How Should Organized Medicine Respond to Physician-Assisted Death?



*Both proponents and opponents agree that wider access to high-quality palliative care and physician-patient communication about end-of-life options is the right response to the growing patient demand for control over the end of one's days. This is the third in a series of articles on physician-assisted death. BY MARK MORAN*

*"For some physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to abandon the patient preclude the possibility of supporting patients in hastening their death. For others, not to provide a prescription for lethal medication in response to a patient's sincere request violates that same commitment and duty."*

*—From a 2018 report by the AMA Council on Ethical and Judicial Affairs. The report was not adopted by the House of Delegates*

In November last year, the AMA debated the second iteration of a report by the AMA's Council on Ethical and Judicial Affairs (CEJA), which stated again that U.S. physicians come to the fraught issue of physician-assisted suicide (PAS) or physician-aid-in-dying (PAD) with "irreducible differences of opinion."

Debate about PAS/PAD at the AMA and in other venues has shown that divisions over the issue are, indeed, irreducible: opponents and proponents alike appeal to fundamental tenets of the medical profession—either the injunction to "do no harm" and to extend life or to honor patient autonomy and to diminish suffering.

The CEJA report, which was not adopted by the House of Delegates, asserted that the Code of Medical Ethics, as currently written, encompasses both positions—on the one hand, it asserts that "physician-assisted suicide is fundamentally incompatible with

the physician's role as healer," while on the other hand, it also preserves (in the so-called "conscience code"—Section 1.1.7) the right of physicians to practice according to their conscience in states where PAS/PAD is legal.

It was a difficult needle to thread. That the House of Delegates did not adopt the CEJA report is not surprising; CEJA renders opinions on some of the most difficult issues in medicine, and the council's reports often go through several iterations before being accepted. But PAS/PAD appears to be a uniquely fraught topic engaging the most fundamental questions of what it means to be a doctor. Even the term is hotly debated, with proponents insisting that patients with terminal illness seeking to end their lives with medical assistance should not be conflated with individuals who are suicidal when they have years of life yet to live. (This article uses PAS/PAD interchangeably.)

In comments at the House of Dele-

gates, psychiatrist Jim Sabin, M.D., the chair of CEJA, cited the potentially fractious nature of the subject. "This has been a long slog," he continued. "The debate has been civil, thoughtful, and respectful on a topic that, if not handled well, could split the association."

## A Return to 'Caring Over Curing'

How can organized medicine respond to a challenge that so deeply divides physicians? How can it answer the growing movement for patient autonomy and the demand—as reflected in the legalization of PAS/PAD in six states and the District of Columbia—for greater patient control over the end of one's days? And what about

concerns around the "slippery slope," that the practice could evolve, as it has in some countries, beyond patients with terminal conditions (see box)?

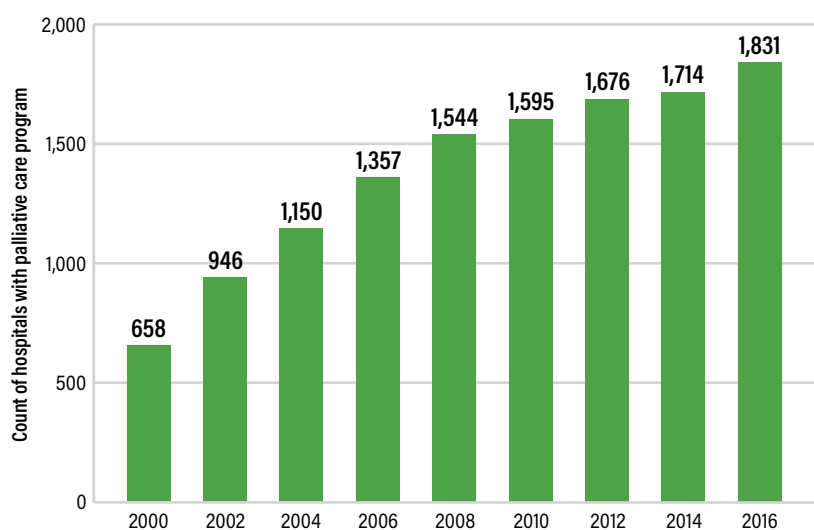
If there is one area of common ground shared by physicians on all sides, it is the need for wider access to palliative care and greater communication between physicians and patients about options for end-of-life care.

The 2018 Palliative Care Growth Snapshot by the Center to Advance Palliative Care reported that between 2000 and 2016, the number of hospitals with palliative care programs tripled (see chart). Yet availability is highly variable by geography and hospital size. Even in hospitals that report having palliative care services, only a small fraction of the patients that could benefit use the service, the center reported.

In comments to *Psychiatric News*, Joseph Rotella, M.D., chief medical *continued on facing page*

## Palliative Care in Hospitals Growing

In 2000, only 658 (25%) of all hospitals with more than 50 beds reported a palliative care program. In 2016, that number increased to 1,831 (75%). However, many programs remain understaffed and under-resourced.



Source: Center to Advance Palliative Care 2018 Snapshot (2000-2016). Data are based on the American Hospital Association Annual Survey Database.

## Is the Slope Always Slippery?

Among the prominent concerns about physician-assisted death (PAD) is the "slippery slope," the possibility that it will be extended to people whose illnesses are not terminal, including those with severe mental illness.

But cannot the stakeholders in this issue—especially organized medicine—build "guardrails" to prevent that from occurring? Is the slope always slippery?

Proponents of PAD in states where it is legal insist that the actual experience suggests that those concerns are unfounded. "I think there is enough accumulated experience in the states and other jurisdictions in which the practice of PAD is legally permitted to establish that the 'slippery slope' has not emerged nor does it appear to be emerging," said Oregon psychiatrist David Pollack, M.D.

Oregon enacted the Death With Dignity Act, in 1997, the first jurisdiction to legalize PAD. "The safeguards in the legislation or regulations in these jurisdictions have proven to be adequate to prevent

an ever-growing approval of requests for PAD for inappropriate or excluded reasons/criteria."

From a logical perspective, the slippery slope is not inevitable, said past APA President and ethics expert Paul Appelbaum, M.D. "Just because a policy or practice moves in a particular direction doesn't mean that it will necessarily continue moving in that direction. For example, policies to make it harder for people who shouldn't own firearms to purchase them, such as universal background checks (as some states have implemented), are not going to lead to a ban on anyone owning firearms."

Nevertheless, Appelbaum said that there is momentum behind expanding PAD. "Just because a policy is not compelled to continue moving in a given direction doesn't mean that in any given case it won't. Sometimes initial steps toward a particular end make it more likely—even if not inevitable—that policy will continue to evolve in that direction. I think that's the case for PAD. Does adoption of PAD for terminal con-

ditions necessarily lead to its extension to nonterminal, including psychiatric, disorders? No, I don't think so. Indeed, the experience in the United States to date suggests that at the very least it doesn't do so quickly.

"But I still think that adoption of PAD for terminal conditions in the U.S. will make it much more likely that we will see PAD for nonterminal disorders," he said. "There are several reasons for this—first implementation of PAD will desensitize policymakers, physicians, and the public to the practice of physicians giving their patients the means to end their lives or doing so directly; second, to the extent that PAD is justified on the basis of patient autonomy in the face of untreatable suffering, it is difficult to argue from an ethical perspective that only terminal patients have the right to exercise such autonomy. Finally, legally, implementation of PAD raises equal-protection issues related to affording a right to one group that is withheld from another (arguably similarly situated) group."



“The power of modern medicine is not the power to relieve humans of the human condition. ... Our charge is to use life-extending technology wisely.”

continued from facing page

officer of the American Academy of Hospice and Palliative Medicine (AAHPM), emphasized a point that both opponents and proponents of PAS/PAD would affirm: “No one should ever have to consider PAD because they cannot access palliative care.”

Rotella said the discussion about what quality of life means to people nearing the end of life presents an opportunity to advocate for palliative care and hospice. “Suffering near the end of life arises from many sources including loss of sense of self, loss of control, fear of the future, and/or fear of being a burden upon others, as well as refractory physical and nonphysical symptoms,” he said. “For the vast majority of patients living with termi-

nal illness, expert palliative care and hospice can help them maintain a quality of life they consider acceptable.”

He continued, “About half of dying patients never enter hospice care, and many get it only for the last days or few weeks of life,” he said. “A barrier to earlier access to hospice care is reluctance by patients, family members, and physicians to have the conversation about prognosis and adjusting goals of care when the illness is advancing. Other forms of palliative care are appropriate at any stage of serious illness and can be provided alongside active treatments for the underlying illness. Most hospitals have inpatient palliative care teams.”

Rotella added that access to palliative care is more limited in outpatient settings, primarily due to a lack of funding. “We’re seeing an expansion of



Jason Smith

Daniel Sulmasy, M.D., Ph.D., says physician-assisted death is “the wrong answer to the right question”: how can medicine respond to people’s concerns about dying a technological death?

community-based palliative care services as more payers are covering it as a benefit, but current reimbursement under traditional Medicare remains insufficient,” he said.

To address that barrier, AAHPM has proposed an alternative payment model for community-based palliative care that was recommended last year by the

see **Coda da Vita** on page 11

APA Among Top Medical Societies in Leadership Gender Equity

In a study comparing leadership equity among 39 organizations, APA stands out, with women elected president five times in 10 years. **BY TERRI D'ARRIGO**

APA is among the top professional medical societies in terms of gender equality in presidential leadership, according to a research paper in *JAMA Internal Medicine*. In fact, APA's current president is a woman, Altha Stewart, M.D.

Researchers led by Julie K. Silver, M.D., an associate professor and associate chair in the Department of Physical Medicine and Rehabilitation at

Harvard Medical School, identified one major physician-focused medical society for each of 39 specialties. They collected data on presidential leadership attributed to men and women from 2008 to 2017, for at least five election cycles for each society. To determine whether presidential representation was equitable, the researchers compared the percentage of years that women were president for each society with the percentage of women among that specialty's active physicians for 2015.

Fifty percent of APA's presidents in the study period were women. Of 37,717 active psychiatrists in 2015, 38 percent were women. This resulted in a 12 percent

positive difference between the percentage of women who were president and the percentage of women who were psychiatrists during the study years.

“The Society of Critical Care Medicine, American Society of Neuroradiology, American Psychiatric Association, and American Geriatrics Society had the highest number of years with women presidential leaders (4 to 6 of 10 years). In contrast, 10 societies had 0 of 10 years with women presidential leaders,” reported the researchers.

The researchers gathered their data on active physicians in each specialty from the Association of American Medical Colleges' *2016 Physician Specialty*

*Data Report: Active Physicians by Sex and Specialty 2015*. Gender was verified via publicly available online profiles.

“By electing as many women as men to serve as president in recent years, our members acknowledge and celebrate the qualities and strengths that women bring to our profession,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A.

Levin noted that APA has not only elected women but also women from different backgrounds. “I'm proud of APA's diversity and encourage physicians in every specialty to join us in electing to their professional leadership colleagues of every gender, race, ethnic-

see **Gender Equity** on page 14

Gender Disparities Remain in Leadership of Most Medical Societies

The table below shows the medical societies that were among those with the highest and lowest representation of women presidents in the period 2008 to 2017. Of the 39 societies studied, APA had one of the best track records. Positive values indicate equitable or better representation of women among years of presidential leadership; negative values indicate the opposite.

Specialty	No. of Active Physicians in 2015 <sup>a</sup>	Active Women in 2015, No. (%) <sup>a</sup>	Medical Specialty Society Assessed	Years With Woman President, % <sup>b</sup>	Difference, % <sup>c</sup>
Neuroradiology	3,289	642 (19.5)	American Society of Neuroradiology	40	20.5
Pulmonary disease	5,480	615 (11.2)	American Thoracic Society	30	18.8
Critical care medicine	10,143	2,588 (25.5)	Society of Critical Care Medicine	40	14.5
Psychiatry	37,717	14,335 (38.0)	American Psychiatric Association	50	12.0
Geriatric medicine	5,221	2,673 (51.2)	American Geriatrics Society	60	8.8
Neurology	13,378	3,760 (28.1)	American Academy of Neurology	0	-28.1
Pediatrics	57,491	35,573 (61.9)	American Academy of Pediatrics	30	-31.9
Endocrinology, diabetes, and metabolism	6,957	3,231 (46.4)	American Association of Clinical Endocrinologists	10	-36.4
Anatomic/clinical pathology	13,277	4,869 (36.7)	College of American Pathologists	0	-36.7
Obstetrics and gynecology	41,446	22,585 (54.5)	American College of Obstetricians and Gynecologists	10	-44.5

<sup>a</sup> Data from Association of American Medical Colleges. <sup>b</sup> From 2008 to 2017. <sup>c</sup> The % of years with a woman president vs the % of women among active physicians in 2015  
Source: Julie K. Silver, M.D., et al., *JAMA Internal Medicine*, January 7, 2019

# APA Participates in Policy Forum: Advancing Mental Health

*At the Advancing Mental Health Policy Forum held recently by Otsuka Pharmaceutical, speakers focused on mental health parity, care coordination and community supports, and incentives for high-quality care.*  
**BY LINDA M. RICHMOND**

Imagine this: you're at work and your cell phone rings. It's the school nurse summoning you because there's been an "incident" at your son Jeremy's school. You know he has been stressed and not sleeping well, preparing for his SAT tests and applying to colleges. Lately he's been saying things like his "teacher was trying to trick him with paradoxical exam questions." When you arrive at school, you learn your son threw a book at his teacher.

Now, imagine your family had no immediate association with a mental health clinic. What would you do? Rush him to the emergency room, in the hope that someone with psychiatric experience could see him? Have him hospitalized? Take him home and try to obtain an appointment with a psychiatrist or at a clinic? Would the teacher



Anita Everett, M.D., draws attention to the wide gulf between access to care in a general medical emergency versus a psychiatric one and calls for fully embracing the idea of mental health parity, not just in payment, but also in the mental health care delivery system.

press charges for assault, and would Jeremy now have a criminal record?

Now, imagine that your son instead had a sports-related injury and had broken a bone. He would be immediately stabilized by an emergency room physician, trained and experienced in this type of injury, and within hours he would be in an operating room being treated by an orthopedic surgeon.

"It's a very different situation than the wide unknown that can happen

with a mental health situation," explained Anita Everett, M.D., immediate past president of APA, who told the story at the Advancing Mental Health Policy Forum recently held by Otsuka Pharmaceutical.

"We have laws governing parity in payment, but we need parity in the mental health delivery system. Parity is a big idea that we need to embrace in its full extent," said Everett, who also serves as chief medical officer of the Substance Abuse and Mental Health Services Administration (SAMHSA) and director of its Center for Mental Health Services.

Over the last several years, SAMHSA has been sharply criticized for not addressing mental health service delivery as well as the needs of individuals with serious mental illness, Everett said. To move forward, the agency is following a blueprint drawn up by the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), a high-level committee created by the 21st Century Cures Act.

SAMHSA is focused on the five main recommendations made by ISMICC, which include the following: improving

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coordination across federal departments, boosting treatment access and engagement, focusing on evidence-based treatment and recovery, eliminating or reducing unnecessary involvement with criminal justice for children and adults with mental illness, and creating new financing strategies.

The Certified Community Behavioral Health Clinics (CCBHCs) is one model of care that embodies many of these goals and is being tested in eight states, Everett said. Now one-third of the way through its demonstration project, CCBHCs are beginning to show evidence of success. Whereas individuals in crisis have waited an average of six months to see a clinician, CCBHCs are required to triage such patients on the same day or by the next day, she said. In addition, CCBHCs' payment

mechanism covers the real cost for delivering such services, allowing clinics to offer a competitive salary and attract needed staff to provide the care that is needed.

### APA Helps Advance Parity, New Care Models

Although the Mental Health Parity and Addiction Equity Act was enacted 10 years ago, overall consumer awareness of the law remains low, explained David Lloyd, national senior policy advisor and Illinois director of policy at the Kennedy Forum, during a panel discussion on mental health parity. Its "Don't Deny Me" campaign is aimed at increasing provider and consumer awareness of the law. In addition, its "Parity at 10" is a three-year campaign now under way to unite advocates in several states—Illinois, Maryland, New Jersey, New York, and Ohio—to pursue

full enforcement of the federal parity law. The Kennedy Forum plans to develop effective models for implementing mental health and substance abuse parity and then disseminate those across the country.

Tim Clement, APA's Northeast regional field director of state government relations, said that a common parity concern of psychiatrists is the nightmarish prior-authorization requirements imposed by health plans. Such requirements can be a parity violation. "Psychiatrists are going to bat for their patients, who are oftentimes in desperate need of treatment. They cannot fight for themselves or navigate these complicated systems."

Boosting provider awareness of the mental health parity law is key, Clement said. "When an insurance company realizes that the provider on the front line is very knowledgeable about parity,

it sometimes backs off and approves the care. It can make the difference between someone getting the care they need or not."

Michelle Dirst, APA's director of practice management and systems delivery, participated in a panel discussion called "Incentivizing Quality Care." She explained how APA has helped expand adoption of the Collaborative Care Model, for which psychiatrists serve as consultants to care managers and primary care providers who treat psychiatric patients. With support from the Centers for Medicare and Medicaid Services and SAMHSA, this take on collaborative care that started in Washington state has now been expanded to 3,000 psychiatrists throughout the country. **PN**

**Information on the "Don't Deny Me" campaign is posted at <https://www.parityregistry.org/dont-deny-me/>.**



## ETHICS CORNER

# It's Not *Just* Semantics

BY CLAIRE ZILBER, M.D.

Linguistics and psychology intersect in the field of semantics. Derived from the Greek word *semantikos*, which means "significant," the study of semantics is concerned with the relationship between words and meaning. The words we use to describe ourselves and others are consequential, and the way we choose to communicate them can significantly impact how we think and feel. Many psychiatrists' first lesson in professional semantics concerns how we refer to patients, but there is a variety of other important ways we use language in clinical, administrative, and policy settings. This column will examine several of the ways language and word choice shape perceptions about our work.

Mental health advocates have endeavored for decades to get physicians and policymakers to call people with schizophrenia just that, rather than "schizophrenics." The difference, although superficially subtle, is profound. A person with schizophrenia is first a person, and as a person deserves to be treated with the same respect and dignity as any other person. Calling someone "a schizophrenic" reduces that person's identity to the diagnosis and has a dehumanizing effect.

Another semantic distinction comes from the psychoanalytic literature. As early as Freud, parents or other important figures in the life of the infant and child were referred to as "objects," eventually leading to Object Relations Theory. There is some utility in conceptualizing the



Claire Zilber, M.D., is a psychiatrist in private practice in Denver, a faculty member of the PROBE (Professional Problem Based Ethics) Program, and chair of the Ethics Committee

of the Colorado Psychiatric Society. She is the co-author of *Living in Limbo: Creating Structure and Peace When Someone You Love Is Ill*.

child's projections and experiences using this less personal vocabulary, to signify that it is the internalized representation of the parent, not the actual parent, that is the subject of interest. As valid as this justification may be, thinking about the parent as an "object" or "part object" reduces the humanity of the parent and semantically suggests a psychological experience of relative alienation for the developing child. This tension between psychoanalytic nomenclature and the mundane meaning of the word "object" primarily exists for readers of psychoanalytic theory and probably has little impact on patients or the public, except when they're also reading this literature.

A more prominent semantic tension is found in the different ways mental health professionals refer to the people they treat. Psychiatrists, by virtue of our training and identity as physicians, think of the people we serve as patients. Mental health professionals who are not medical doctors tend to use the word "client" instead of "patient." In some clinical settings, especially mental health centers and other multidisciplinary treatment

environments, calling patients "clients" is part of the institutional culture. Furthermore, in some contexts, the word "consumer" is preferred, especially in environments like mental health clubhouses or large health care systems. Those of us who think of our patients as patients may bristle at these other terms as they imply a different kind of relationship than the one for which we were trained.

Similarly, health care administrators and economists may lump all clinicians together as "providers." This may be an efficient linguistic trick to avoid listing all the disciplines in a particular institution or field, and it validates that other mental health disciplines contribute significantly to patient care, but it also subtly diminishes the identity of the health care worker. To refer to a psychiatrist as a mental health provider may suggest that our particular skills and training are not especially different or consequential compared with other mental health professionals. A person who is proud of his or her professional discipline as a nurse or psychologist or

social worker may have a parallel aversion to being lumped together with generic providers.

An implication of the patient/client/consumer and psychiatrist/provider dichotomies is that we may think of our work in a very different way than do administrators, insurers, and policymakers. Our vocabulary rests on the compassionate human interaction that is the historical basis of healing. The alternate vocabulary suggests the economics of commodities. Our ministrations are not mere economic transactions.

Although the comment "It's just semantics" is often used to soften an argument about the use of a specific term, in reality, at the center of semantics is the implication that the words we choose have precise and important meanings. Through careful choice of language, we can preserve the humanity of the people we serve, support the distinctions between the psychiatric profession and other mental health professions, and rekindle our focus on caring for patients rather than providing billable service units. **PN**

## From the President

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nity resulting in mass deaths, and attacks on the profession.

Finally, the ongoing initiative involving physician burnout, wellness, and resiliency continues to be an important member benefit. We understand from members that excessive productivity quotas and documentation requirements and limits on the time we spend with patients are significant factors contributing to dissatisfaction for psychiatrists and other physicians, and we

will continue to explore ways to promote the system changes needed to adequately address this problem.

These are some of the reasons that I believe that APA is a value-based, professional entity that asserts this identity every day as we advocate, champion, practice, research, and teach. I am looking forward to the final third of my term and pledge to continue to focus on maintaining that identity. May the new year allow each of us to do the same on an individual level in our roles as advocates, champions, practitioners, researchers, and teachers. **PN**

# FDA's Streamlined Health App Approval: Better for Patients or Companies?



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Companies that are “pre-certified” by the FDA will be given a fast and streamlined review process for all their digital health products. Some groups are concerned such a model is more beneficial to companies than patients. **BY NICK ZAGORSKI**



**T**he number of mobile health care apps is growing at a rapid pace. Recent estimates suggest there are now over 300,000 health apps available to download. This list includes more than 10,000 mobile apps related to mental health, including screening tools that assess mood, trackers that help people monitor their daily symptoms, and mindfulness-based activities to promote relaxation and wellness.

The Food and Drug Administration's ability to regulate the products in this vast and quickly evolving space using traditional models has proven

challenging. In response, the agency is looking to shift its oversight of individual apps to the companies that make them.

While such a model could enable trusted firms to quickly bring evidence-based medical apps to market, some groups—including APA—are concerned that this approach will benefit companies more than patients.

## Pre-Cert Could Streamline App Review

The new FDA model is called the Software Precertification Pilot Program, or Pre-Cert. According to the FDA, com-

panies that demonstrate “a robust culture of quality and organizational excellence and are committed to monitoring real-world performance of their products once they reach the U.S. market” will be “pre-certified” and given a fast and streamlined review process for all their digital health products.

These “pre-certified” companies will then be responsible for monitoring the effectiveness and user satisfaction of their products and providing periodic reports to the FDA.

The FDA spent 2018 hashing out the basic framework of the pre-certification process, which they refer to as Pre-Cert 1.0. The first real-world test of the program is occurring this year.

Nine companies have been selected to participate in the pilot and work toward Pre-Cert status. One of the companies involved is Pear Therapeutics, which has two FDA-cleared digital therapeutics: ReSET and ReSET-O. These prescription-only mobile applications are meant to be used in conjunction with standard outpatient treatments for alcohol, cocaine, marijuana, and/or stimulant use disorder (ReSET) or opioid use disorder (ReSET-O). Other participating companies include Apple, FitBit, Johnson & Johnson, and Roche.

## Will Pre-Cert Benefit Patients?

John Torous, M.D., co-director of the Digital Psychiatry Program at Beth Israel Deaconess Medical Center in Boston and a member of APA's Committee on Mental Health Information Technology (MHIT), said he appreciates the FDA's effort to “think outside the box.”

Historically, the agency has taken a hands-off approach to most mobile health apps; the FDA actively regulates only those apps that meet the agency's definition of a “medical device,” as defined in the federal Food, Drug, and Cosmetic Act. To be considered a medical device, a mobile app must claim that it can diagnose, prevent, treat, cure, or mitigate a disease or condition.

In some cases, an app can be easily categorized as a medical device; an app that turns a phone into a blood sugar meter so that people can monitor their diabetes, for example, serves a clear medical function. But, as Torous explained to *Psychiatric News*, most mental health apps “fall into a gray area.” Apps such as Moodkit and Happify, for instance, provide tools for people to track and manage their mood symptoms, but because these apps don't make specific medical

claims, they are exempt from FDA oversight.

While some app developers have put their mental health apps through rigorous clinical testing and review, many have not, Torous said.

With the Pre-Cert option, more companies might be willing to develop apps that meet FDA quality standards for medical devices. However, Torous and other MHIT committee members are concerned that the Pre-Cert model, as currently described, shifts too much regulatory oversight to the companies.

“It would be nice if the FDA had a clearer partnership with physician and patient groups,” Torous told *Psychiatric News*. “The criticism today is that industry seems to be driving the ship.”

## APA Committee Calls for Transparency

In October 2018, Torous and other MHIT committee members composed an official letter on behalf of APA that voiced these concerns. One of the concerns noted in the letter was that the Pre-Cert program does not require any pre-market evaluations to see if the apps can improve health outcomes. Rather, safety and effectiveness will be gauged through post-marketing surveillance done by companies themselves.

In the letter, Torous and the members of the committee urged the FDA to ensure transparency during both the certification process and during product surveillance.

A lack of transparency could jeopardize patient safety, the group wrote. This “is especially troubling considering that patients who utilize some of these apps by pre-certified vendors will be diagnosed with substance use disorders, mood disorders, and other mental health conditions that place them at risk for self-injurious behavior, suicidality, and overdose.”

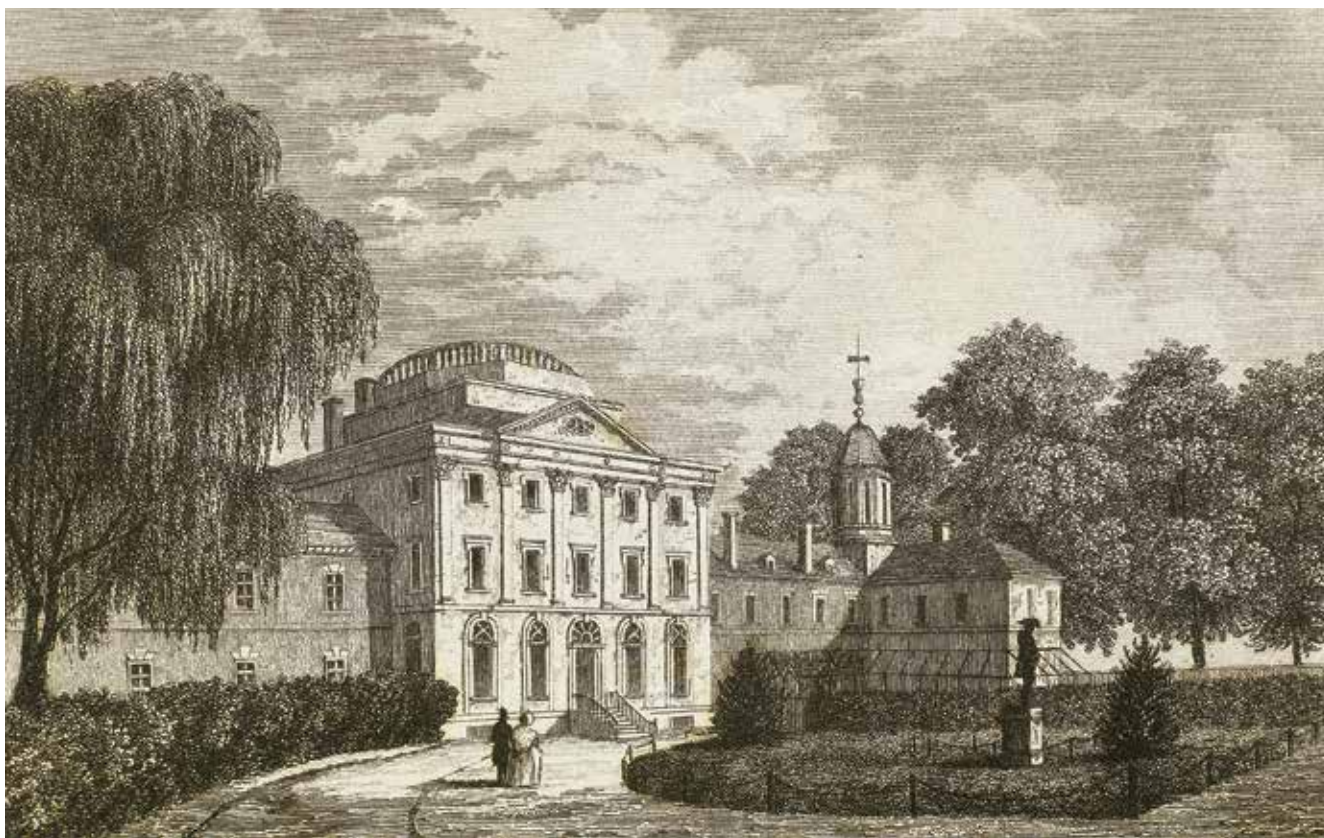
They added, “Medical specialty societies, like APA, can offer the FDA and participating vendors a wealth of guidance in this process, including expertise in measurement-based care, clinical content resources (e.g., clinical practice guidelines), and member experts.”

APA has not been the only group to voice concern about Pre-Cert. Industry groups (for example, the Medical Imaging and Technology Alliance) issued statements questioning whether the FDA has the authority to place mobile apps in a new regulatory category without congressional approval. They also noted the current model has not yet provided details on how companies that fail to meet standards lose certification status. **PN**

**More information about the FDA Pre-certification Program is posted at <https://www.fda.gov/medicaldevices/digitalhealth/digitalhealthprecertprogram/default.htm>.**

Advertisement





Benjamin Rush was elected to the medical staff of Pennsylvania Hospital in 1783 and worked there until his death in 1813. His classic work, titled *Medical Inquiries and Observations Upon the Diseases of the Mind*, was the first psychiatric textbook printed in the United States.

## The Life of Benjamin Rush Reflects Troubled Age in U.S. Medical History

*Benjamin Rush, considered the father of American psychiatry, helped usher in humane care for people with mental illness at the dawn of this nation, but his views on race had a negative impact on treatment.* **BY AARON LEVIN**

**I** have lately obtained the exclusive care of the maniacal patients in our hospital," wrote Benjamin Rush to a friend in the autumn of 1787. The appointment was a longstanding dream for Rush,

who had already spent 18 years as a physician in Philadelphia, and later earned him a place as the father of American psychiatry.

"Rush's most important contribution to the development of psychiatry



was his attempt to destigmatize people with 'insanity' by assuming that their treatment could be hospital based, just as with patients with other illnesses," said Jeffrey Geller, M.D., M.P.H., a professor of psychiatry at the

University of Massachusetts Medical School, in Worcester.

Rush was certainly not the only American of his day concerned with the care of people with mental illness. Over several generations, the Galt family of Virginia managed the Williamsburg asylum, which opened in 1773, for example.

Rush's interests went far beyond mental illness, and he wrote compulsively about them all. He produced a torrent of pamphlets, essays, letters, books, and articles and published lectures on general medicine, infectious disease, military medicine, politics, philosophy, criminology, mental health, education, and slavery.

Rush's path to becoming a leading figure in early American medicine and a signer of the Declaration of Independence began modestly. He was born in Byberry, Pa., just north of Philadelphia, on Christmas Eve in 1745, the fourth child of a blacksmith. The family moved to Philadelphia in 1751, but his father died soon after. Fortunately, young Benjamin was a good student. He graduated at age 13 from boarding school and entered the College of New Jersey (now Princeton University) as a junior, graduating just three months shy of his 15th birthday.

While Rush had initially planned to become a lawyer, his interest switched to medicine. From 1761 to 1766, he apprenticed with Dr. John Redman, a prominent physician in Philadelphia. (The first medical school in the 13 colonies wasn't founded until 1765 at what became the University of Pennsylvania.) Besides following the doctor on his rounds, young Rush also read deeply on medicine and bought tickets to anatomy lectures by Dr. William Shippen Jr., who had just returned from formal medical study at schools in London and

see **Benjamin Rush** on page 17

### Benjamin Rush: Slaveholder and Abolitionist

Rush's views on race were contradictory. On the one hand, he wrote many tracts opposing slavery and was a founder of the Pennsylvania Abolition Society. The "intellects of the Negroes [and their] capacities for virtue and happiness" were equal to that of Europeans. The racist "vices" attributed to blacks were not an excuse for slavery but were caused by it. He helped two black

Philadelphians, Absalom Jones and Richard Allen, when they started churches for African Americans. They later returned the favor by helping Rush treat patients during the great yellow fever outbreak of 1793. On the other hand, Rush wrote that "black skin was an indication of disease," a remnant of leprosy perhaps. Cure that "illness" and blacks would become white again.

He also owned a slave. Rush purchased William Grubber in the winter of 1779-1780. Grubber served at times in the Rush household, but Rush also let him hire out to work on ships, possibly to earn his free-

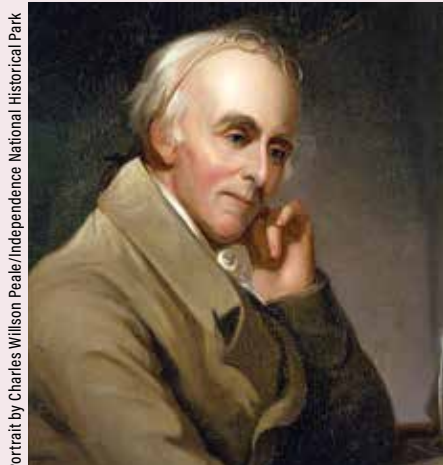
dom. Rush freed Grubber in 1788, and his voluminous writings do not address the apparent incongruity of being an antislavery slaveowner.

Rush was not alone, said King Davis, Ph.D., a professor of research in the School of Information at the University of Texas at Austin. Francis Fauquier, the royal governor of Virginia, also opposed slavery but held slaves. John Galt, one of the founders of APA, used slaves as attendants in his asylum or on the grounds at the Williamsburg Asylum but admitted some free blacks as patients.

Broadly speaking, said Davis, there were three eras with different hypotheses about African Americans and mental illness. Between 1750 and 1840, the prevailing thought was that "Africans lacked the ability to reason and so couldn't become mentally ill," said Davis. "Over the following century, it was believed that African Americans couldn't deal with freedom and so would develop mental illnesses once freed from slavery."

That period saw an "astronomical" number of African Americans admitted to psychiatric hospitals, he said. By the 1950s and 1960s, as the civil rights movement picked up steam, "urban living" was blamed for mental illness among blacks, and schizophrenia was seen as a "black" disease.

"This is an extraordinary contradiction," said Davis. "Rush's dualistic perspective on race influenced the content of psychiatric training, the focus on treatment, and the emphasis or absence of cultural diagnoses of mental illness."



Portrait by Charles Willson Peale/Independence National Historical Park



# Common Delirium Medications Found Not Effective in Critically Ill Patients

*A large clinical study shows that treating ICU patients with haloperidol or ziprasidone is no more effective than placebo at reducing duration of delirium.*

BY NICK ZAGORSKI

**D**elirium—an acute brain condition characterized by disturbed thinking, agitated behavior, and delusions—is one of the most common complications in patients with a critical illness. Despite limited evidence of the effectiveness of antipsychotics at reducing delirium, these medications are often prescribed to patients in the intensive care unit (ICU). The results of a large clinical trial now show that there is no evidence that either haloperidol or ziprasidone provides any benefit over placebo in ICU patients with delirium.

The small number of previously published studies on antipsychotics and delirium focused on whether these drugs can prevent or reduce the severity of delirium if given ahead of time (most have suggested no prophylactic

## KEY POINTS

The MIND-USA Study randomly assigned 566 ICU patients who developed delirium to receive up to 20 mg haloperidol daily, 40 mg ziprasidone daily, or placebo for 14 days.

- There was no statistical difference between the groups with regard to delirium duration. The average time patients spent without being in delirium or coma over the 14-day period was 7.9 days in the haloperidol group, 8.7 days in the ziprasidone group, and 8.5 days in the placebo group.
- There were also no statistical differences in other outcomes including amount of mechanical ventilation required, time to discharge from ICU or hospital, or time spent on opioids.

**Bottom Line:** There is no evidence to support use of antipsychotics to treat delirium in acutely ill patients.

benefit). The study, published in the December 27, 2018, issue of the *New England Journal of Medicine*, asked whether patients might benefit from antipsychotics administered soon after developing delirium.

Timothy Girard, M.D., a visiting associate professor of critical care medicine at the University of Pittsburgh and colleagues with the MIND-USA

(Modifying the Impact of ICU-Induced Neurological Dysfunction-USA) consortium assessed 566 patients who were admitted to one of 16 U.S. medical centers with acute respiratory problems or shock and subsequently developed delirium. At the onset of delirium, 192 patients received intravenous haloperidol (up to 20 mg daily), 190 received intravenous ziprasidone (up to 40 mg daily), and 184 received placebo infusions. Patients were kept on the antipsychotic medications or placebo for up to 14 days or discharge from the ICU, whichever occurred first.

The investigators found no significant difference between the three patient groups on any clinical outcomes. Compared with placebo, neither antipsychotic reduced the time patients spent without delirium and/or coma during the 14-day intervention; patients in all three groups spent between 8 days and 8.5 days delirium/coma-free. Patients who received antipsychotics also had similar outcomes to those receiving placebo in terms of 30-day and 90-day survival rates, the need for opioids or other sedatives, time spent on mechanical ventilation, or time until hospital discharge.

“One possible reason that we found no evidence that the use of haloperidol or ziprasidone resulted in fewer days with delirium or coma than placebo is that the mechanism of brain dysfunction that is considered to be targeted by antipsychotic medications—increased dopamine signaling—may not play a major role in the pathogenesis of delirium during critical illness,” Girard and colleagues wrote.

Another possibility, noted by Thomas P. Bleck, M.D., in an editorial accompanying the study, is that the current concept of delirium may be flawed.

“The neurochemistry of sudden alteration in mentation [mental activity] is complex and involves several neurotransmitters as well as structural, immunologic, and network alterations and possible brain infection that is not clinically evident,” wrote Bleck, a professor of neurological sciences at Rush Medical College in Chicago. “The investigators deserve credit for conducting a difficult trial, but it would have been astounding if there were a single magic bullet for the restitution of normal brain function in ICU patients with delirium.”

Girard and colleagues noted that while the findings did not show any evidence of a benefit of antipsychotics on delirium overall, there may be some subgroups of delirium patients who may benefit from these medications. These groups may include those with particularly hyperactive symptoms or patients also going through alcohol withdrawal, who might benefit from antipsychotic intervention.

This study was supported by grants from the National Institute on Aging, National Center for Advancing Translational Sciences, and the Department of Veterans Affairs Geriatric Research Education and Clinical Center. **PN**

➔ “Haloperidol and Ziprasidone for Treatment of Delirium in Critical Illness” is posted at <https://www.nejm.org/doi/full/10.1056/NEJMoa1808217>. The accompanying editorial, “Dopamine Antagonists in ICU Delirium,” is posted at <https://www.nejm.org/doi/full/10.1056/NEJMe1813382>.

## Advertisement

### Sign Up Now for APA's 2019 Federal Advocacy Conference

APA's 2019 Federal Advocacy Conference will be held in Washington, D.C., on March 11 and 12, and all APA members are invited to participate. Participants will have an opportunity to lobby members of Congress on issues that affect psychiatry and patients and help shape health care policy during the 116th Congress. Before meeting with federal legislators and staff, participants will learn about APA's 2019 federal legislative agenda and receive hands-on advocacy training to prepare for the Hill visit. The deadline to register is March 1, but space is limited, so register now at <https://www.eventbrite.com/e/apas-2019-federal-advocacy-conference-tickets-53299215388>.





# High Doses of Off-Label Antipsychotics Linked to Increased Death Risk in Youth

Youth prescribed high doses of antipsychotics off label were found to be at an 80 percent increased risk of death, including more than a fourfold increased risk of death from cardiovascular or metabolic causes. **BY TERRI D'ARRIGO**

**H**igher doses of antipsychotics raise the risk of death in youth aged 5 to 24 years who take the medications for conditions other than psychosis, when compared

with those who take other psychiatric medications, according to a study in *JAMA Psychiatry*.

This underscores the need for vigilance in ensuring the most appropriate medications are prescribed for each condition, lead author Wayne Ray, Ph.D., a professor of health policy at Vanderbilt University in Nashville, Tenn., told *Psychiatric News*.

"More than one million children and young adults receive antipsychotics, and most of them are for conditions for which other treatments are available. They are dangerous and carry cardiovascular, respiratory, and metabolic risks," Ray said.

In the study, Ray and his colleagues analyzed data from 247,858 patients who were enrolled in Tennessee's Medicaid program between 1999 and 2014. Of those, 30,120 began taking high doses of antipsychotics (more than 50 mg chlorpromazine equivalents), 28,377 began taking low

doses of antipsychotics (50 mg or less chlorpromazine equivalents), and 189,361 began taking other psychiatric medications including psychostimulants, antidepressants, and mood stabilizers (the control group).

Among all participants, 70.6 percent had a diagnosis of behavioral symptoms such as attention-deficit/hyperactivity disorder (ADHD), conduct disorder, or impulsivity. Only 28.1 percent in the high-dose group had diagnoses for which there is an FDA-approved indication for taking antipsychotics, such as bipolar disorder or autism spectrum disorder.

The researchers found that among patients without life-threatening somatic illness or psychosis who started antipsychotics, those in the high-dose group had an 80 percent increased risk of death, attributable to a 3.5-fold increase risk of unexpected deaths. After accounting for overdose, this increased risk for unexpected deaths persisted, with a 4.3-fold increased risk of death from cardiovascular or metabolic causes. Furthermore, when extrapolating the data out to death rates per 100,000 person-years, the researchers found a rate of 25.6 cardiovascular or metabolic deaths per 100,000 person-years in the high-dose group, compared with a rate of only 4.9 in the control group.

"The bottom line is that the findings reinforce existing guidelines for care and cautious use of antipsychotics in younger populations," said Ray. He noted the need to consider other treatments, provide pretreatment evaluations, identify patients with cardiac problems that might compound their risk, and ensure post-treatment monitoring for cardiac, respiratory, and metabolic effects.

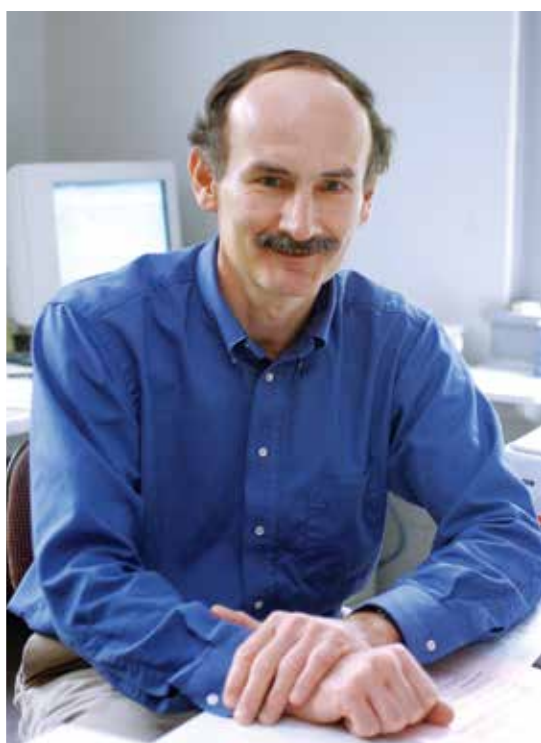
"These things are already in the recommendations, but we suspect that they are not followed in regular practice," Ray said.

"Most [high-dose antipsychotics] aren't prescribed by psychiatrists, and they are primarily written for behavioral symptoms and mood disorders for which there are other medications and psychosocial interventions," Ray added.

John Newcomer, M.D., president and chief executive officer of South Florida Behavioral Network in Miami and an adjunct professor of psychiatry at



Demands from parents and schools to quickly address certain disruptive behaviors may help drive off-label use of antipsychotics in children, says John Newcomer, M.D.



Wayne Ray, Ph.D., says that most of the antipsychotics prescribed to children and young adults are for conditions for which other treatments are available.

## Coda da Vita

*continued from page 5*

Physician-Focused Payment Model Technical Advisory Committee for limited-scale testing by the Centers for Medicare and Medicaid Services.

Beyond providing better palliative care and making it more widely accessible, Daniel Sulmasy, M.D., Ph.D., senior research scholar at Georgetown University's Kennedy Institute of Ethics, argues for a return to what the bioethicist Daniel Callahan 30 years ago called the priority of "caring over curing." He reminds physicians that the same Hippocrates who urged doctors to "do no harm" also cautioned against physicians attempting to treat patients who are "overmastered by disease."

An opponent of PAS, Sulmasy said it is "the wrong answer" to the right question: How can medicine respond to people's concerns about dying a technological death?

"The power of modern medicine is not the power to relieve humans of the

human condition. We don't make humans immortal. Our charge is to use life-extending technology wisely. I don't want to deny people access to chemotherapy that will allow them to live longer with a good quality of life. But I also know there are countless cases in which patients continue to get chemo when it has long outlived its usefulness, when they wind up on ventilators when they probably never should have been started on one to begin with."

He added, "That's not good medicine, and the answer to that problem is to stop using treatments that are more burdensome than beneficial, to treat symptoms, and to provide hospice and palliative care when appropriate. Then we can accompany patients through their last days, even as the bonds that keep us together are dissolving."

Sulmasy added, "At this stage, we are recognizing that they are overmastered by disease, and we are letting them go." **PN**

Washington University School of Medicine in St. Louis, noted potential barriers to more appropriate prescribing of antipsychotics.

"The logistics, needed training, and reimbursement structure for effective behavioral therapies that include CBT [cognitive-behavioral therapy] all present barriers to their increased use. This in combination with the perceived simplicity of antipsychotic prescription and perceived demands from parents and schools for a rapid fix for certain disruptive behaviors may be what contributes to higher off-label use of antipsychotics in children in the United States," said Newcomer, who was not involved in the research.

Ray agreed.

"Reimbursement drives medication over other approaches. We need options other than just trying to use medications. These [nonpsychotic] conditions are more complex than that. There are bad-home situations, the need for parental training, and other kinds of issues," said Ray. "There are nonpharmacologic interventions that can work. Psychiatrists have long been frustrated by a lack of resources for these, but it's a matter of life or death."

This study was supported by the National Heart, Lung, and Blood Institute and the National Institute for Child Health and Human Development. **PN**

**Association of Antipsychotic Treatment With Risk of Unexpected Death Among Children and Youths** is posted at <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2717966>.

# Survey: Teen Vaping Surges While Use of Most Other Substances Flat

While vaping among adolescents has experienced a record one-year rise, their use of most other substances is flat, a national representative survey shows.

BY LINDA M. RICHMOND

The rise in adolescent vaping remains the biggest concern when it comes to secondary students' use of substances: 21 percent of high school seniors reported vaping nicotine in the past 30 days in 2018, almost double the previous year's finding, according to the most recent Monitoring the Future survey.

The survey has tracked national substance use among 8th, 10th, and 12th graders at hundreds of schools annually since 1975. It is conducted by the University of Michigan and funded by the National Institute on Drug Abuse.

With 37 percent of high school seniors and 32 percent of 10th graders reporting vaping during 2018, the one-year spikes are among the largest in teen substance use recorded in the past 43 years. That translates into at least 1.3 million additional secondary students vaping nicotine last year as compared with 2017. Studies have shown that nonsmoking adolescents who vape are about five times more likely to have smoked a traditional cigarette one year later, lead study author Richard Miech, Ph.D., M.P.H., research professor at the University of Michigan, said at a press briefing last month announcing the results.

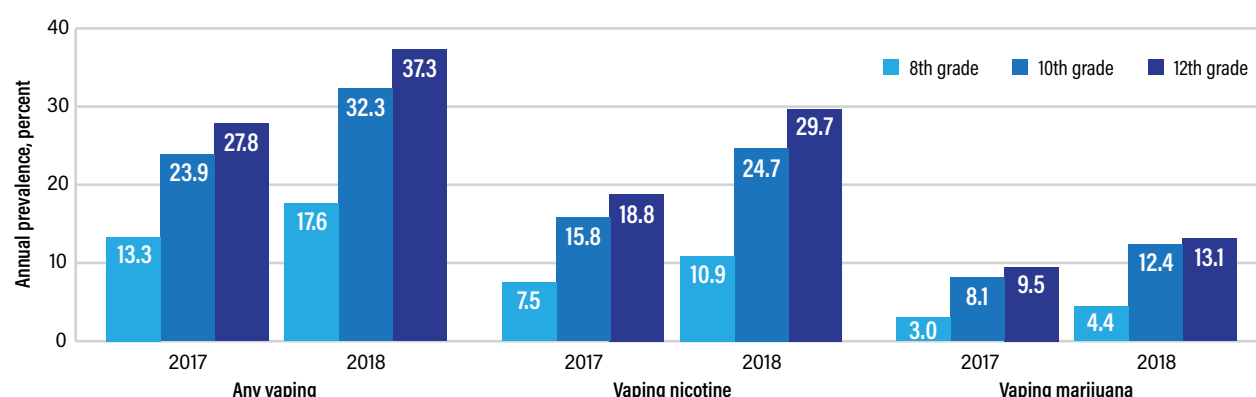
"The policies and procedures in place to prevent youth vaping clearly haven't worked," Miech said. "Vaping is reversing hard-fought declines in the number of adolescents who use nicotine. These results suggest that vaping is leading youth into nicotine use and nicotine addiction, not away from it."

Although nicotine remains the most common substance vaped by adolescents, vaping of the active ingredient in marijuana (9-THC) is also rising at proportionally record levels: nearly 8 percent of 12th graders vaped marijuana in 2018, up from almost 5 percent the previous year, according to the Monitoring the Future survey.

"Vaping is making substantial inroads among adolescents, no matter the substance vaped," Miech said. "In 2018, we saw substantial increases in vaping across all substances, including nicotine, marijuana, and adolescents who reported vaping 'just flavoring.' ... If we want to prevent youth from using drugs, including nicotine, vaping will warrant special attention in terms of policy, education campaigns, and pre-

## Vaping Rises at Alarming Rates Among Secondary Students

The increase in adolescent vaping in 2018 was the largest one-year gain in teen substance use recorded in the past 43 years, according to an annual survey of 50,000 secondary students across the country.



Source: 2018 Monitoring the Future Survey

vention programs in the coming years."

Other notable survey results were as follows:

- Teen opioid use is declining. Despite the nationwide opioid epidemic, adolescent misuse of

prescription opioids and tranquilizers dropped in 2018 to less than half the usage in peak years. Among 12th graders, less than 4 percent misused prescription opioids, less than 4 percent tranquilizers, and less than 1 percent heroin. These findings

indicate that the U.S. opioid epidemic of recent years is largely concentrated among adults.

- Past-year use of illicit drugs other than marijuana held steady at the

see **Vaping** on page 15



## RESIDENTS' FORUM

### Words From the Patient's Mouth

BY MATTHEW FADUS, M.D.

The use of quotations in electronic medical records can provide clarity in otherwise complex narratives provided by patients.

Direct quotations allow for a snapshot of the interaction between a patient and a provider and can enhance documentation in a way that a summary or commentary on the interaction may not be able to capture. For example, documenting a patient's concern that the "FBI is monitoring me through the Wi-Fi" helps other health care professionals understand the depth of the patient's psychotic symptoms and may be more useful than documenting experiences as paranoid delusions.

There is concern, however, that certain patient quotations may introduce bias by implying exaggerated or factitious histories or revealing low socioeconomic status. A study by A.P. Goddu et al. posted January 26, 2018, in the *Journal of General Internal Medicine* indicated that inclusion of certain patient quotations in the medical record can impact clinical evaluation and judgment. The study utilized a fictitious vignette of a patient affected by a sickle cell crisis, and respondents were asked to read documentation that



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included quotations from the patient describing his pain as "all up in my arms and legs" and "still a 10," acutely worsening after "wheeling himself all the way over to McDonald's to hang out with a friend." The authors hypothesized that quotations such as these had the potential to introduce biases, as they may cast doubt on the patient's level of pain or imply a lower socioeconomic status. The study found that the quoted patient was subject to more negative attitudes and less aggressive pain management than a patient whose documentation was more objectively summarized.

Although this study indicated how quotations can introduce bias, documentation of patients' own words can also help health care professionals contextualize the patient interaction. For example, the quotation from the patient above may help other health care professionals understand that the patient is wheelchair dependent and may not

have adequate means of transportation not only to meet a friend for lunch, but also to get to appointments for follow-up care. Information regarding structural factors and individual circumstances can arise from patient quotations, offering clues to help better understand the patient in a broader context.

The nuances of language, however, may limit the utility of some patient quotations. In the example above, very little is added to the narrative when the patient's pain is described as "still a 10." Using this direct quotation may lead other readers to be suspicious or mistrustful about the patient's level of pain and does not introduce any opportunities for advocacy or support in the evaluation and treatment plan. When health care professionals feel that a quotation may lend to bias, they can instead summarize the interaction and choose documentation that more objectively describes the situation ("the patient is experiencing 10/10 pain").

Quotations have also been used for patients who prefer to use a name other than their given name at birth, particularly those who may identify with a gender that is different from their assigned gender. Although efforts to include these preferred names in the medical record should be encouraged, putting the preferred names in quotation marks may lead some readers to

continued on facing page



# Race May Impact Expression Of Alzheimer's Biomarkers

*The findings that the levels of the protein tau differ between whites and African Americans serve as a reminder that diagnostic algorithms that incorporate Alzheimer's biomarker data must account for potential racial differences in how these biomarkers are expressed.* **BY NICK ZAGORSKI**

**T**he toxic buildup of the proteins amyloid- $\beta$  and tau is a hallmark feature of brains affected by Alzheimer's disease (AD). A study published January 7 in *JAMA Neurology* now reveals that the accumulation of tau may vary with race. A research team at Washington University School of Medicine in St. Louis found that African Americans, whether they have Alzheimer's or not, have about one-third less tau on average than whites.

"To our knowledge, our study is the first to examine racial differences in molecular biomarkers of AD in which the cohort contributed data for both amyloid concentrations as seen on PET [positron emission tomography] scan and CSF [cerebrospinal fluid] concentrations of [amyloid and tau]," wrote lead author John C. Morris, M.D., a professor

of neurology at Washington University's Knight Alzheimer Disease Research Center, and colleagues. "Understanding how race may modify the risk and expression of AD may yield new insights into race-dependent biological mechanisms that in turn can inform future diagnostics and therapeutic advances."

Morris and colleagues analyzed data from 1,255 adults aged 43 or older who were participating in Alzheimer's studies at the Knight Research Center; this sample included 173 African Americans and 1,082 non-Hispanic whites. As part of these studies, the participants received brain scans and provided CSF samples.

The researchers found no racial differences between African Americans and whites when it came to the average amyloid levels, whether measured in CSF or on PET scans. This was true even after adjusting for differences in sex, educational level, Alzheimer's family history, body mass index, and degree of cognitive impairment between the groups.

Compared with white participants, African-American participants were found to have significantly lower CSF levels of tau (brain scans of tau were not taken). Average CSF concentrations of tau were 294 pg/mL for African Americans and 443 pg/mL for whites. This discrepancy in tau levels was even greater among participants who had the Alzheimer's risk gene APOE $\epsilon$ 4. Among APOE $\epsilon$ 4 carriers, average tau concentrations were 270 pg/mL for African Americans and 464 pg/mL for whites.

Recent studies have shown that APOE $\epsilon$ 4 may influence tau-related neurological damage. Morris said that his group's findings suggest that APOE $\epsilon$ 4 and tau interact differently in African Americans and whites.

"Caution is needed in interpreting our results until they can be confirmed (or refuted) with subsequent analyses in larger cohorts to carefully explore the influences of socioeconomic status, comorbid diseases, and other factors that may contribute to racial differences," the researchers wrote.


Tau concentrations were not the only differences between the two groups that were uncovered by Morris and colleagues. Analysis of MRI scans of the participants revealed that African Americans had smaller hippocam-

see **Biomarkers** on page 16

*continued from facing page*

view the name in contempt, given that quotations (and how they can be interpreted as "air quotes") can imply expressions of irony, satire, or sarcasm, according to Martina Lampert in the December 2013 *English Today* from Cambridge University Press. LGBTQ advocacy groups discourage the use of quotations for preferred name, for example *Joseph* (preferred name: *Emma*) has a more affirming and inclusive tone than *Joseph* ("Emma").

The language in medical records can influence others in ways that many health care professionals may not be aware of. Quotations can add depth and context to the documentation of a clinical encounter, but they also carry a risk of introducing bias. Psychiatrists and mental health professionals should carefully consider the risks and benefits of using direct patient quotations, particularly when working with a mental health population that is susceptible to stigma and bias. **PN**

 **"Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record"** is posted at <https://link.springer.com/article/10.1007/s11606-017-4289-2>. **"Say, Be Like, Quote (Unquote), and the Air Quotes: Interactive Quotatives and Their Multimodal Implications: The 'New' Quotatives Remind Us of the Vocal, Verbal, and Gestural Dimensions of Speech"** is posted at <http://apapsy.ch/quotations>.

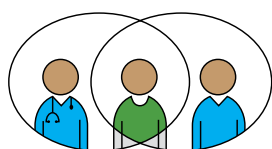
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## Understanding the Breadth and Depth Of the Subspecialty: Psycho-Oncology

*This article is one of a series coordinated by APA's Council on Consultation-Liaison Psychiatry and the Academy of Consultation-Liaison Psychiatry.*  
**BY KIMBERLY MILLER, M.D., AND MADELINE LI, M.D., PH.D.**



### Consultation-Liaison PSYCHIATRY

**A**mong subspecialties of consultation-liaison psychiatry, psycho-oncology is one of the most well established. The field originated out of the Memorial Sloan-Kettering Cancer Center in New York in the 1950s, growing to its current state with professional organizations in 30 countries comprising the Federation of Psycho-Oncology Societies and establishing and leading Screening for Emotional Distress, the sixth vital sign in medical populations. Psycho-oncology is a multidisciplinary specialty, and cancer psychiatrists are core team members whose role includes assessing a patient's psychiatric symptomatology; understanding how medical, psychological, and social factors affect the patients' ability to cope with their illness; and helping the oncology teams develop patient-centered management.

Cancer psychiatrists have expertise in distinguishing between distress that is normative versus maladaptive. They use the etiological approach for psychiatric diagnosis in the context of the somatic consequence of cancer or its treatment; manage psychopharmacology and oncology drug interactions; and psychotherapeutically explore changes in identity and relationships,



Kimberly Miller, M.D., is an assistant professor of C-L psychiatry at the University of Toronto and an attending psychiatrist and education coordinator in psychosocial oncology in the Department of Supportive Care at the Princess Margaret Cancer Centre. Madeline Li, M.D., Ph.D., is an associate professor of C-L psychiatry at the University of Toronto, a



psychiatrist in the Department of Supportive Care at the University Health Network, and a scientist at the Princess Margaret Cancer Research Institute.

meaning and purpose, and fears, hope, and mortality.

#### Case Study

Ms. JS was a 42-year-old single woman with metastatic breast cancer, referred by her oncologist when she declined chemotherapy and requested medically assisted dying instead. She described her cancer as her “way out” of a difficult life filled with trauma, abusive relationships, and loss. Her mother died of advanced cancer when

Ms. JS was 8 years old, and she was subsequently raised by an abusive uncle. She had a history of suicide attempts, the last one 15 years ago requiring psychiatric admission. She was lost to follow up after discharge. She described feeling chronically depressed since then, with a significant worsening since her cancer diagnosis two months ago.

After confirming there were no acute safety or capacity concerns, we began by conveying an understanding of how her mistrust had developed in the context of her abusive childhood and adolescence. We shared that our priority would be to develop a trusting relationship with her and to give her as much control over her care as possible. She preferred to avoid intravenous chemotherapy, which would feel intrusive to her and result in hair loss. This was communicated to her oncologist, and she was ultimately treated with tamoxifen, an oral endocrine therapy, and deferred her request for assisted dying. Due to the development of menopause symptoms, together with ongoing and worsening depressive symptoms, she was treated with venlafaxine after brain metastasis was ruled out. Venlafaxine was selected because it is known to alleviate hot flashes and does not interact with tamoxifen, which can occur with other antidepressants.

The scope of a psycho-oncologist includes helping patients with understanding their medical condition and supporting them in their capable treatment decision making. Since psychological suffering is the primary motivation behind assisted-dying requests, over 60 percent of which come from patients

with cancer, psycho-oncologists can play a critical role in helping patients explore their options during discussions of care goals. Maintaining communication with the primary oncologist, nurse, social worker, and pharmacist is vital in providing this patient-centered care.

Ms. JS was also engaged in end-of-life psychotherapy. This helped her connect feelings about her past losses to her cancer in the present, which she perceived as another trauma. Over time, she experienced the medical care she received as reminiscent of how her mother had loved her, with compassion and respect. She could recognize her resilience and success in having a stable job and deriving a strong sense of meaning through her work, which she was able to continue throughout most of her two-year illness.

After progression of her disease, the need to control her physical appearance remained very important to her as a way of maintaining a valued aspect of her identity. She agreed to treatment with capecitabine, an oral chemotherapy that does not cause hair loss, and continued on this until a few months before she died. In hospice, she continued to be followed by the psycho-oncology team that she had grown to trust, allowing herself to receive care and dying peacefully.

In addition to the core C-L psychiatric management of medical patients, psycho-oncology provides a unique opportunity to work longitudinally with patients facing life-and-death issues, exploring and responding to existential distress. This in turn requires psychiatrists to be mindful of their own countertransference and well-being in working with this population. It necessitates exquisite professionalism, but at the same time can be a deeply personal experience, both rewarding and poignant. **PN**

## Gender Equity

*continued from page 5*

ity, sexual orientation, and sexual identity to better reflect the rich variety of perspectives and backgrounds present in modern medicine,” he said.

“It speaks to the organization’s commitment to inclusiveness in leadership that five of APA’s 10 most recent presidents, including myself, have been women,” said Stewart. “To be sustained as APA moves forward, we will have to continue to focus on inclusiveness at all levels of membership, the better to guide our profession in providing care that is sensitive to our patients’ diverse perspectives and needs.” **PN**

**2** “Analysis of Gender Equity in Leadership of Physician-Focused Medical Specialty Societies, 2008-2017” is posted at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2720134>.



# Estimates of Adult Benzodiazepine Use Double

*Baby boomers match seniors in the use of benzodiazepines, while misuse is most common in those aged 18 to 25. BY TERRI D'ARRIGO*

Over 30 million U.S. adults took benzodiazepines in the past year, including 5.3 million who misused the medication, according to a study posted December 17, 2018, in *Psychiatric Services in Advance*.

The findings, which were based on an analysis of data collected as part of a national survey in 2015 and 2016, suggest that annual benzodiazepine use among U.S. adults may be more than double estimates based on data collected in 2013 and 2014. The findings also point to those most likely to take the medication without a prescription or in greater amounts or over longer periods of time than prescribed.

In the study, researchers analyzed data about adults age 18 and older who participated in the National Survey on Drug Use and Health (NSDUH) in 2015 and 2016. The data were extrapolated for the U.S. population. The annual NSDUH asks participants about substance use, mental health, and more. Overall, 30.6 million adults, or 12.6 percent, used benzodiazepines in the previous year. Other studies such as the 2013-2014 National Health and Nutrition Examination Survey and the Medical Expenditure Panel Survey suggested that between 4 percent and 5.6 percent of adults took benzodiazepines.

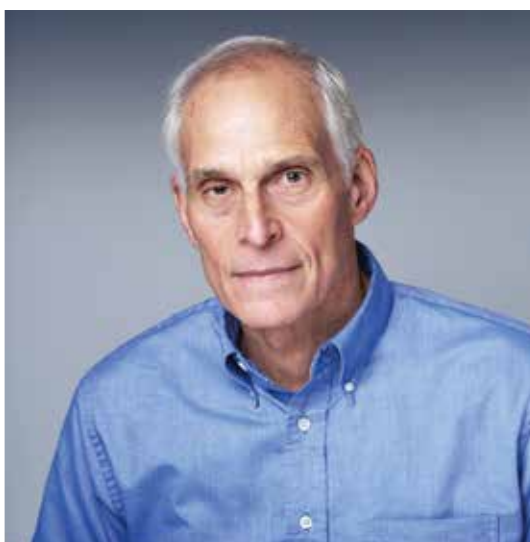
Differences in the survey design may account for the increase in use reported in the most recent NSDUH, said lead author Donovan Maust, M.D., M.S., an assistant professor of psychiatry at the University of Michigan and a research scientist in the Center for Clinical Management Research at the VA Ann Arbor Healthcare System.

“Beginning in 2015, the survey included questions about both as-prescribed use and misuse of prescription medications. This may partially explain why the NSDUH estimate is higher compared with other surveys that capture only prescription use,” Maust said.

Overall, 20 percent of benzodiazepine use was misuse. The most common form of misuse was use without a prescription, and the most common reasons for misuse were to relax or relieve tension and to help with sleep. Adults aged 50 or older were more likely than their younger counterparts to take benzodiazepines more often than prescribed and more likely to use them to sleep. However, misuse decreased with age, with adults over 65 least likely to report mis-

use. In contrast, 51 percent of participants aged 18 to 25 reported misuse, and they were more likely than older adults to misuse benzodiazepines to get high.

“Because benzodiazepines are so commonly prescribed to older adults, it was reassuring that misuse among adults over 65 was lowest of all the age



It is important to address concomitant use and misuse of other drugs while also taking benzodiazepine use into account, says Andrew Saxon, M.D.

“It really has no clinical advantages over safer benzodiazepines (for example, oxazepam and lorazepam) when prescribed for appropriate purposes, so it would be good to educate the physician workforce that when prescribing a benzodiazepine is indicated, alprazolam is not the best option,” said Saxon, who was not involved in the research.

The study also offered insight on concomitant use and misuse of other drugs. Opioid misuse and abuse or dependence were most strongly associated with benzodiazepine misuse. Use or misuse of marijuana or alcohol also increased the likelihood of misusing benzodiazepines.

“Alcohol, tobacco, heroin, other opioids, and stimulants probably confer much more risk than do benzodiazepines themselves. In that sense, it is probably more important to address the misuse of these other substances while taking into account the benzodiazepine use,” Saxon said.

Saxon added that although benzodiazepines should be prescribed carefully, they do benefit patients. “We shouldn’t overreact and start trying to take all patients off benzodiazepines. The study confirms that most benzodiazepine use is by patients with a prescription who do not misuse the medication.”

Maust said that the key to successful prescribing is to begin with the end in mind.

“Benzodiazepines should always be started at the minimum dose with a very clear expectation that it’s meant to be a short-term thing. Patients should understand the risks of the medication, the short-term plan for treatment, and the plan to end so that everyone is on the same page,” Maust said.

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



Donovan Maust, M.D., M.S., says that initiatives aimed at curbing misuse should focus on young adults.

groups. They generally take these medications as prescribed. For initiatives aimed at curbing misuse, you have to focus on younger adults because so much of their use is misuse,” Maust said.

Alprazolam was by far the most common benzodiazepine misused, the choice of 75.1 percent of those who misused benzodiazepines.

“Xanax is short acting and high potency. It brings a sense of relief but then has a strong on-off effect, which makes for greater misuse or abuse potential. When you take it and it wears off, you might be more inclined to take an extra dose,” Maust explained.

Andrew Saxon, M.D., chair of APA’s Council on Addiction Psychiatry, said the study’s results bolster the case for using caution when prescribing alprazolam.

**➔ “Benzodiazepine Use and Misuse Among Adults in the United States” is posted at <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201800321>.**

## Vaping

*continued from page 12*

lowest levels in two decades (ranging from 6 percent of 8th graders to 12 percent of 12th graders). That figure represents a 30 percent drop in the use of these drugs among 12th graders in the past five years.

- Adolescent use of most other substances held steady in 2018, with prevalence not significantly changing for the following: amphetamines, methamphetamines, alcohol,

“extreme binge drinking” (10 or more drinks in a sitting), flavored alcoholic beverages, cocaine, hallucinogens, heroin, inhalants, MDMA (Ecstasy or Molly), and marijuana use overall, the survey reported.

- Annual marijuana/hashish use dropped 1 percent among 12th graders to 36 percent in 2018, yet inched up among 10th and 8th graders to 28 percent and 11 percent, respectively. State marijuana laws have relaxed during the past five years, the researchers noted. Ten

states have now legalized recreational use of marijuana for adults over the age of 21.

- Nearly 6 percent of 12th graders continue to report “daily use” of marijuana. Daily marijuana use continues to hold steady yet outpaces daily cigarette use across all grades, reflecting a steep decline in daily cigarette use. Perceptions of harm and disapproval of marijuana use have trended down among adolescents, with only 1 in 4 seniors agreeing that regular marijuana use

poses a great risk—less than half of what it was 20 years ago.

- Use of synthetic cannabinoids (K2/Spice or sometimes called “fake weed” or synthetic marijuana) dropped significantly in the past five years in all three grades. Past-year use by 12th graders dropped to nearly 4 percent last year from more than 11 percent when it was first assessed in 2011. **PN**

**➔ The Monitoring the Future website is <http://www.monitoringthefuture.org>.**



BY NICK ZAGORSKI



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## Eczema Associated With Increased Suicidality

People with atopic dermatitis—also known as eczema—appear to be more likely to think about and attempt suicide than those without this condition, suggests a meta-analysis in *JAMA Dermatology*.

Eczema is an inflammatory disease characterized by dry, cracked, and scaly patches of skin. Previous studies have found patients with eczema are at a greater risk of anxiety and depression, but whether these patients are at an increased risk of suicide was unknown.

The meta-analysis by researchers at the University of Southern California incorporated 15 studies, which included over 310,000 eczema patients and 4 million control subjects. The analysis revealed that patients with eczema were 44 percent more likely to exhibit suicidal ideation and 36 percent more likely to attempt suicide compared with patients without eczema. There were not enough data to identify the increased risk, if any, of completed suicides. “In studies comparing patients with mild AD [atopic dermatitis] versus patients with moderate to severe AD, patients with moderate to severe AD were found to have a higher prevalence of suicidal ideation but not completed suicides,” the authors wrote. “Greater

disease severity of AD is associated with increased sleep loss, more severe pruritus, and higher depression and anxiety rates, which can all contribute to more suicidal ideation.”

However, the authors cautioned that there is a shortage of data on subpopulations, and more research is needed to better understand the associations between eczema and suicidal behaviors.

**Sandhu JK, Wu KK, Bui TL, Armstrong AW. Association Between Atopic Dermatitis and Suicidality: A Systematic Review and Meta-analysis. *JAMA Dermatol.* December 12, 2018. [Epub ahead of print] <https://jamanetwork.com/journals/jamadermatology/fullarticle/2717582>**



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## Possible Mechanism Identified for Cognitive Symptoms in Schizophrenia

Using positron emission tomography (PET) scans to image patient brains, researchers at Massachusetts General Hospital have uncovered molecular differences that may explain why people with schizophrenia have cognitive difficulties. They observed that key regulatory proteins known as histone deacetylases (HDACs) were present at different levels in the brains of patients with schizophrenia relative to healthy controls.

Reduced HDAC levels had previously been observed in postmortem brain

samples from patients with schizophrenia, but this is the first evidence of HDAC deficiency in living individuals. The findings were published in the *Journal of Clinical Investigation*.

The researchers scanned the brains of 14 individuals with schizophrenia or schizoaffective disorder as well as 17 healthy controls, using a specially designed tracer that radioactively tags HDACs. The scans showed that HDAC expression was significantly reduced in the prefrontal cortex (which regulates working memory, planning, and flexibility) of schizophrenia patients compared with controls. Patients who had less HDAC also had more severe cognitive problems on average.

Unexpectedly, the researchers found that HDAC levels in schizophrenia patients were higher than controls in other brain regions linked with cognition, such as the cerebellum. “These data may suggest that abnormal HDAC expression, in either direction, could have negative effects on cognition,” the researchers wrote.

**Gilbert TM, Zürcher NR, Wu CJ, et al. PET Neuroimaging Reveals Histone Deacetylase Dysregulation in Schizophrenia. *J Clin Invest.* December 10, 2018. [Epub ahead of print] <https://www.jci.org/articles/view/123743>**



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## Overdose Death Data Illuminate Toll of Opioids

Between 2011 and 2016 opioids, benzodiazepines, and stimulants dominated the list of top 10 drugs most frequently involved in overdose deaths, according to a *National Vital Statistics Report* published in December 2018.

While the ranking of the individual drugs changed from year to year, the top 10 drugs involved in overdose deaths remained consistent throughout the six-year period, according to the analysis conducted by investigators at the National Center for Health Statistics and the Food and Drug Administration. The top 10 drugs included alprazolam, cocaine, diazepam, fentanyl, heroin, hydrocodone, methadone, methamphetamine, morphine, and oxycodone.

Among this group, fentanyl-related deaths showed the most drastic rise, going from 10th most common cause

of overdose death in 2011 (about 1,600 overdose deaths) to the top spot in 2016. Over 18,000 overdose deaths in 2016 involved fentanyl—nearly 29 percent of all overdose deaths. The report also revealed that 69 percent of the time when fentanyl was involved in an overdose death, another drug was also found in the person’s system, most often heroin or cocaine.

Overall, the number of drug overdose deaths per year increased by 54 percent during the study period, going from 41,340 in 2011 to 63,632 in 2016. Methadone was the only drug for which total overdose deaths declined during the study, dropping from about 4,500 deaths in 2011 to 3,500 deaths in 2016.

**Hedegaard H, Bastian BA, Trinidad JP, et al. Drugs Most Frequently Involved in Drug Overdose Deaths: United States, 2011–2016. *Natl Vital Stat Rep.* 2018; 67(9):1–14. [https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67\\_09-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_09-508.pdf)**



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## Financial Difficulties Impacting Purchase of Food Linked to Binge Eating

People with limited finances can experience food insecurity—problems being able to afford enough food to support a regular, balanced diet. A study appearing in the *International Journal of Eating Disorders* reports that food insecurity is associated with higher rates of binge eating disorder (BED). This finding may help explain the observed links between food insecurity and obesity, the authors noted.

Researchers at Yale University surveyed 1,250 adults online about their weight, eating habits, and perceived food security.

They found that adults who reported having low food security (they had to adjust the quality, variety, or desirability of their food purchase to satisfy hunger) or very low food security (they had to adjust food purchases but still went hungry at times) were more likely to have BED symptoms than those with adequate food security. Among respondents who reported BED symptoms, 28.2 percent reported low food security, and 18.9 percent reported very low food security. Participants with very low food security were also more

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## Biomarkers

*continued from page 13*

pal volumes on average than whites. The hippocampus is a brain region that plays a key role in memory, and studies have found an association between smaller hippocampal volumes and Alzheimer’s risk. This difference was most pronounced between African Americans and whites who had a family history of dementia.

“Inclusion of African-American individuals and other minority populations in biomarker studies is challenging, even for research centers that do this work well,” wrote Lisa Barnes, Ph.D., the Alla V. and Solomon Jesmer Professor of Gerontology and Geriatric Medicine at Rush University Medical Center in an editorial accompa-

nying the study. “But as the field moves toward a biological definition of AD, the underinclusion of minority populations in AD research will significantly hinder our progress as a field, and the race to end AD will not be shared with our most vulnerable, at-risk populations.”

This study was supported by grants from the National Institute on Aging and the National Center for Advancing Translational Sciences. **PN**

**“Assessment of Racial Disparities in Biomarkers for Alzheimer Disease” is posted at <https://jamanetwork.com/journals/jamaneurology/fullarticle/2719700>. The editorial, “Biomarkers for Alzheimer Dementia in Diverse Racial and Ethnic Minorities—A Public Health Priority,” is posted at <https://jamanetwork.com/journals/jamaneurology/fullarticle/2719697>.**



continued from facing page

likely to be obese than those in the other two groups.

The “[r]esults highlight the need to devote resources toward policy revisions, preventative interventions, and psychiatric treatments aimed at decreasing the overall association of food insecurity with BED and obesity among low-income Americans,” the authors wrote.

**Rasmusson G, Lydecker JA, Coffino JA, et al. Household Food Insecurity Is Associated With Binge-Eating Disorder and Obesity. *Int J Eat Disord.* December 19, 2018. [Epub ahead of print] <https://onlinelibrary.wiley.com/doi/abs/10.1002/eat.22990>**



UI Southwestern

## DNA Vaccine Reduces Accumulation of Alzheimer's Proteins in Mice

Researchers at the University of Texas Southwestern Medical Center have developed a DNA-based vaccine that reduces the accumulation of two toxic proteins associated with Alzheimer's disease in mice.

Whereas traditional vaccines inject protein fragments (antigens) into the body so the immune system can make antibodies, a DNA vaccine injects pieces of DNA under the skin, which are then made into antigens inside the body.

For the study, the researchers injected either a DNA vaccine they created or a traditional amyloid vaccine into mice that were genetically modified to develop Alzheimer's disease. Beginning at four months of age through 20 months, the mice received 13 vaccinations.

An analysis of the mouse brain tissue showed that the DNA vaccine reduced amyloid- $\beta$  levels by up to 40 percent and tau levels by up to 50 percent, with no adverse side effects. The DNA vaccine removed about twice as much amyloid- $\beta$  and four times as much tau as the traditional vaccine, despite the traditional vaccine producing 10 times as many antibodies.

This study was published in *Alzheimer's Research & Therapy*.

**Rosenberg RN, Fu M, Lambracht-Washington D. Active Full-Length DNA A $\beta$ 42 Immunization in 3xTg-AD Mice Reduces Not Only Amyloid Deposition But Also Tau Pathology. *Alzheimers Res Ther.* 2018; 10(1):115. <https://alzres.biomedcentral.com/articles/10.1186/s13195-018-0441-4>**

## Benjamin Rush

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Scotland. The classes included occasional dissections of the bodies of criminals or people who had died by suicide.

To learn more, Rush sailed to Edinburgh in 1766 to study at that city's renowned medical school, graduating in 1769. He returned to become the colonies' first professor of chemistry at the College of Philadelphia. (Benjamin Franklin was the first president of the school's board of trustees.)

Less than three weeks later, he was called out on his first psychiatry case, a Capt. John Macpherson, who exhibited symptoms of what today would be called mania and paranoia. He also cared for Macpherson's distraught wife, thus learning a lesson about the need to care for the families of patients.

Rush argued for consideration of the whole person. “Knowledge of the mind opens to [the physician] many new duties,” Rush wrote. “It is calculated to teach him that in feeling the pulse, inspecting the eyes and tongue, examining the state of the excretions, ... he performs but half his duty in the sick room.”

Rush joined the staff of Pennsylvania Hospital in 1783. Besides the general medical patients, the hospital housed 30 people with severe mental illness in dank basement cells about 10 feet square. In 1787, he was formally given charge of the care of these patients. He installed stoves in the cells to keep the patients more comfortable and allowed them to take walks outside their cells and be treated by the doctors.

More broadly, Rush sought “a common underlying pathologic process” expressed as a “unitary theory of disease,” as one historian of medicine has written.

From Hippocrates on, medicine had cycled through a number of presumed biological options for the origins of mental illness, a source that might be the liver, the spleen, or the intestines. Rush's medical training in Edinburgh acquainted him with the latest theory,

a “vibration of the nerves.” Later, Rush came to believe that the flow of blood in the body was the source of all illness, mental or physical.

“I infer madness to be primarily seated in the blood-vessels, from the remedies which most speedily and certainly cure it, being exactly the same as those which cure fever or disease in the blood-vessels from other causes, and in other parts of the body,” he wrote. As a result, his prescription for psychiatric illness differed little from that for any other: bloodletting, emetics, wine, exercise, alternating warm and cold baths.

After seven years of urging, Rush finally won approval in 1794 for a new wing of the Pennsylvania Hospital to house patients with mental disorders. It was a watershed moment. That same year, Phillippe Pinel in Paris began publishing about *traitement moral*, the more humane, psychological approach to caring for people with mental illness and one that would have more influence over the next century than Rush's.

In his compendium on mental illness, *Medical Inquiries and Observations Upon Diseases of the Mind*, published a year before his death in 1813, Rush set forth his own diagnostic toolkit. “Amenomania” was a form of psychosis, characterized by delusions and hallucinations, he wrote. The patient “denies he has any disease,” may believe that he is “the peculiar favourite of heaven,” and is “now happy in the errors which accompany his madness.”

“Mania” was accompanied by “high or low spirits,” “great rapidity of thought,” “irritability of temper,” “instability in all pursuits,” and “unusual acts of extravagance,” among other symptoms.

“Manalgia” had symptoms that sound like depression: “taciturnity,



Everett Collection Historical/Alamy

Benjamin Rush developed the “tranquilizing chair” in 1810. At the time, “madness” was considered an arterial disease. The chair was supposed to control the flow of blood toward the brain and reduce the force and frequency of the pulse.

downcast looks, a total neglect of dress and person, long nails and beard, dishevelled or matted hair, indifference to all surrounding objects, insensibility to heat and cold.”

Approaching a patient afflicted with madness, he advised, the physician's gaze should be “mild and steady,” accompanied by a “harsh, gentle, or plaintive” voice (depending on circumstances) and “dignified” conduct. “A physician should treat his deranged patients with respect. ... Acts of justice and a strict regard to truth tend to secure the respect and obedience of deranged patients to their physician.”

If that didn't work, Rush suggested using straitjackets, strapping the patient in a special chair, “privation of customary pleasant food,” “pouring cold water under the coat sleeves,” or a 20-minute shower.

“If all these modes of punishment should fail of their intended effects, it will be proper to resort to the fear of death,” he continued, covering every possibility.

And, of course, active treatments usually included some combination of bleeding; purging the bowels; induced vomiting; blistering the skin; cold (air, water, or ice); and administration of mercury, antimony, quinine, opium, digitalis, and more.

Strange as they sound today, we should be careful of dismissing Rush's views on illness and cures, said Geller.

“Bleeding, purgation, and so on were simply the best practices of the day, and he believed them to be effective,” he said. “In 75 years, maybe people will be aghast at how we treat psychiatric patients in 2019. Rush used what was available and sometimes got results.” **PN**



Jack Boucher

Benjamin Rush was born here in Byberry, Pa., on Christmas Eve in 1745.

# Aetna

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the implementation of parity nationwide: the use by health plans of “narrow” or “phantom networks” that advertise to enrollees an ample selection of psychiatrists, but which in fact offer very few real options for timely care. In many cases, listed providers are not accepting new patients and others have moved out of the geographic area; in some reported cases, listed psychiatrists are retired from practice or deceased.

“Attorney General Healey is to be commended for acting on behalf of citizens in her state who need access to mental health and substance abuse treatment,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A. “APA staff were invited and spoke to state attorneys general, state insurance commissioners, consumer groups, legislators, and employers to explain the importance of network adequacy. The settlement by Aetna with the Massachusetts AG office shows that those efforts are beginning to produce results.”

In the settlement, Aetna agreed to pay \$75,000 to the commonwealth as a civil penalty and to cover attorneys’ fees and agreed to not engage in any unfair or deceptive acts or practices in



Office of the Attorney General

The office of Massachusetts Attorney General Maura Healey will continue to monitor Aetna’s compliance with the settlement.

violation of state law. The company further agreed to do the following:


- Comply with state and federal laws by maintaining accurate and updated provider directories and network adequacy, outlining detailed and specific information to be included and action that must be taken.
- Maintain an adequate behavioral health network in numbers and types

of providers so that services are accessible to members without unreasonable delay, with specific, detailed information that must be listed in directories and requiring periodic audits of provider networks.

- Conduct provider outreach quarterly to validate directory information and conduct monthly audits of its Behavioral Health Provider Directory.

- Track and monitor member complaints related to provider directories, network adequacy, timely access to care, and out-of-network claim disputes and clearly provide notice to members that they may file complaints about provider network inadequacy to the state Division of Insurance.
- Comply with state law by covering specific medically necessary substance use disorder services and not requiring members to obtain preauthorization for specific substance use disorder services.

As part of the settlement, the Massachusetts AG office will monitor Aetna’s fulfillment of the settlement. “Massachusetts patients face far too many barriers to receiving essential mental health and substance use treatment,” said AG Maura Healey in a statement. “With these commitments, Aetna is making it easier for patients to access the care they need.” **PN**

 The settlement between Aetna and the Massachusetts Attorney General is posted at [http://www.psychnews.org/pdfs/Aetna\\_AOD\\_201901.pdf](http://www.psychnews.org/pdfs/Aetna_AOD_201901.pdf).

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