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AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

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Wright State University

SEE STORY ON PAGE 14

Students at Wright State University Boonshoft School of Medicine share thoughts and ideas during "Peer Instruction," a lecture-less, "flipped classroom" format. It is one component of a comprehensive curricular reform reflective of a wider effort at medical schools and residencies to modernize the way future physicians learn.

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Podcasts offer a new way for psychiatrists to reach the public.

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Incoming AMA president will address Annual Meeting attendees.

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Physical activity drives improvements in mood.

APA Opposes Trump Administration Plan Targeting Psychiatric Drugs in Medicare

The proposal would erode the protections now granted to most psychiatric medications in Medicare Advantage and Part D drug plans, subjecting them to prior authorization, step therapy, and exclusion from formulary lists. ***BY LINDA M. RICHMOND***

APA strongly opposes a Trump administration prescription drug proposal aimed at patients in Medicare Advantage and Part D plans, saying that it would "impede patients' access to life-saving medications."

The rule (CMS-4180-P), issued late last fall by the Centers for Medicare and Medicaid Services (CMS), would allow Medicare Advantage plans and Part D plans to reduce costs by adopting various new "utilization management tools."

The proposal is a dramatic departure from current policy, which requires Part D plans to include on their formularies all drugs within six "protected classes," including antidepressants, antipsychotics, and anticonvulsants.

Specifically, the proposed rule would allow Part D plans to implement prior authorization and step therapy, as well as determine the indications for which certain drugs could be prescribed. Part D plans could also exclude a protected class drug from their formularies in certain cases. As for Medicare Advantage plans, they would be permitted to apply step therapy for Part B drugs.

"The need for patients to have access to the medications is crucial, with suicide rates rising across the United States and emergency room boarding of patients with serious mental illness becoming a crisis for many hospitals," APA CEO and Medical Director Saul Levin, M.D., M.P.A., wrote in formal comments that APA submitted to CMS in response to the proposed rule. "This

see **Medicare Plans** *on page 12*

PERIODICALS: TIME SENSITIVE MATERIALS

APA Releases New Statement On Perinatal Disorders

The psychiatrists who developed the position statement want physicians to know the seriousness of these disorders and how they should be identified and addressed.

BY LINDA M. RICHMOND

To improve outcomes for women and their families, APA issued a new position statement to encourage physicians across all specialties to better detect, diagnose, and treat mood and anxiety disorders in pregnant and postpartum women.

The "Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum" was approved by APA's Board of Trustees at its December 2018 meeting.

see **Perinatal Disorders** *on page 22*

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

APA = Advocacy: More Reasons We Must Be in the Room Where it Happens!

BY ALTHA STEWART, M.D.

In my last column, I shared some of the important initiatives in which I have been involved over the past year as part of the strong advocacy push under way in psychiatry. In this column, I'd like to talk about how we get the job done. In addition to joining other leaders of the Group of Six—a coalition representing more than 560,000 physicians and medical students—to visit legislators last month to discuss health care reform issues, I had the privilege to represent APA at a recent hearing about the negative impact of the administration's policy regarding separating children from their families at the border (see next issue of *Psychiatric News*). In addition, I recently traveled to Chicago for the annual meeting of the Illinois Psychiatric Society and learned of the challenges its members are facing with regard to safe-prescribing legislation being re-introduced in the state legislature this session. I also hear regularly about the work of members in other states to prevent passage of legislation allowing unsafe prescribing practices, for example, in Hawaii, Connecticut, Florida, Montana, and elsewhere.

For us to work for the passage or defeat of legislation or engage in other kinds of advocacy work, it takes a team of highly knowledgeable and dedicated professionals to support us, and we are very fortunate to have such a team at APA in the Division of Government Relations (DGR). Unless you are serving nationally on an APA component, involved in APA-PAC, or active at the district branch/state association level, you may not be aware of the wide range of work in which the DGR staff are involved on our behalf. I have had the opportunity over the past year to work very closely with the chief of DGR, Craig Obey, and his team in Washington, D.C., and regional directors throughout the country. On a daily basis, they are identifying issues in which psychiatry needs to have a voice and connecting with legislators and their staffs to educate them about mental illness, the need for increased access to safe and effective treatment, professional issues that impact the practice of psychiatry, and much more. They also provide staff support to the Council on Government Relations (CAGR), the APA component charged with helping to prioritize our legislative agenda and promoting advocacy to achieve our goals.

DGR will have a booth at APA's 2019 Annual Meeting in May. If you are attending the meeting, introduce yourself to the staff and find out the many ways you can become involved in advocacy at the local, state, or national level. If you haven't already, check out our advocacy website at https://www.psychiatry.org/psychiatrists/advocacy. Plan to attend national and state advocacy meetings. As I noted in my last column, one of the most powerful advocacy tools we have is *you* and the stories you can share with legislators about your patients' struggles. They help move the conversation from a general, impersonal discussion of policies and

see **From the President** *on page 4*

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See You in San Francisco!

APA's 2019 Annual Meeting will be held in San Francisco from **May 18** to **22**. Register now to take advantage of the advance registration fees. For more information about the meeting, see pages 9 and 10. To register, go to psychiatry.org/annualmeeting/registration.

Physicians Say Health Plans' Prior Authorizations Distract Doctors, Cheat Patients

Psychiatrists said insurance companies' use of prior authorizations are erecting barriers to patient care and circumventing mental health parity laws. ***BY LINDA M. RICHMOND***

More than nine out of 10 doctors recently surveyed reported that prior authorizations have had a negative impact on patient clinical outcomes, but psychiatrists are especially impacted by this burden posed by insurance companies.

Health plans and benefit managers contend that prior authorization requirements are needed to control costs and ensure appropriate treatment. But in psychiatry, patient advocates say these requirements are a way for health insurance plans to supplant the role of the psychiatrist, circumvent mental health parity laws, and cheat patients.

Among psychiatrists, prior authorizations are common when patients switch psychiatrists or health plans, after they have been treated for a certain number of visits, when their medication type or dosage prescribed is changed, and when they are prescribed an expensive name-brand or off-formulary drug. Other significant problems include prior authorization criteria that do not allow for clinically based exceptions, especially regarding step therapy requirements and continuation on the same drug or drugs after hospital discharge. The Trump administration has proposed a rule that would substantially increase the use of prior authorization for psychiatric drugs in Medicare Part D plans (see story on page 1).

When prior authorization requirements are imposed, less than one-third of patients end up with the originally prescribed medication—and 4 out of 10 patients end up abandoning therapy altogether, according to a report by PharmExec. Every week a medical practice completes an average of 31 prior authorization requirements per physician, using nearly two business days of physician and staff time to complete, a recent survey of 1,000 physicians by the AMA found.

Psychiatrist Elie Aoun, M.D., said he sometimes must wait on hold for more than an hour to secure prior authorization approvals from an insurance company. In psychiatry, medication options are relatively limited, he said. "It adds a lot of hurdles. We're fighting so hard to access treatment for our patients," he said. When he finally gets through, he is "speaking to a representative with no clinical training or experience who is just going through a checklist."

The AMA's survey found that more than one-third of physicians employ staff members to work exclusively on prior authorization tasks. Like many psychiatrists, Aoun has had to subscribe to a monthly service to help him manage the myriad prior authorization forms. "It's absurd that we're paying a service to help our patients receive the medications we're prescribing for them."

"Basic medical services in other specialties don't require prior authorization, but in psychiatry, they do," said Jacques Ambrose, M.D., chair of the APA/APAF Leadership Fellowship and a clinical fellow in child psychiatry at Harvard Medical School and Massachusetts General Hospital. "For example, if a patient with chronic heart disease needs to be hospitalized for monitoring, it's no problem. In psychiatry, if a patient with suicidal ideation needs to be admitted for monitoring, suddenly prior authorizations are needed."

Psychiatric patients from lower socioeconomic classes are more greatly impacted by prior authorization denials and other utilization management practices because they are not able to pay out of pocket or seek care elsewhere, Ambrose said. "In low-income clinic settings, the level of care is drastically limited. If I'm able to prescribe only medication X, Y, and Z, what does that mean for my patients? It's very unfair for already vulnerable populations."

Part of the problem is that there is no government agency that regularly monitors prior authorizations or investigates

see **Prior Authorizations** *on page 13*

Delays in Prior Authorizations Lead to 'Serious Adverse Event' For One-Quarter of Physicians

Other findings from AMA's survey of 1,000 physicians include the following:

- One-quarter of physicians said that delays caused by prior authorization requirements have led to a serious adverse event.
- Three-quarters of physicians reported the wait can sometimes lead to patients abandoning a recommended course of care.
- Most physicians reported that burdens associated with prior authorizations were "high" or "extremely high" (86 percent), and a similar percentage reported that those burdens have increased during the past five years.
- More than two-thirds reported waiting at least one business day for prior authorization decisions from insurers, and one-quarter reported waiting three business days or longer.

"Basic medical services in other specialties don't require prior authorization, but in psychiatry, they do." —Jacques Ambrose, M.D.

From the President

continued from page 3

legislation to poignant descriptions in real-life terms of people who are suffering because of the deplorable inadequacies of the current health and mental health system.

We will never stop fighting for what we need, and the DGR staff will not stop working on our behalf. I encourage you to devote even a small of amount of your time to becoming involved in APA's advocacy efforts—you might just be surprised how powerful your voice can be (see story on page 13). As Mahatma Gandhi said, "You must be the change you wish to see in the world." And we'll help you do it. **PN**

Opioid Prescribing in Rural Areas Far Outpaces Urban, CDC Finds

Nearly 1 in 10 adults in rural settings receives opioid prescriptions from primary care health professionals.

BY TERRI D'ARRIGO

Adults living in rural areas are 87 percent more likely to receive an opioid prescription than their urban counterparts, according to a study in the January 18 *Morbidity and Mortality Weekly Report* of the Centers for Disease Control and Prevention (CDC).

Macarena García, Dr.P.H., senior health scientist at the CDC's Center for Surveillance, Epidemiology, and Laboratory Services, studied electronic health record prescription data from 31,422 health professionals in primary care. The records, part of Athenahealth, spanned 2014 to 2017. The researchers found that although the overall rates of prescribing had dropped, the percentage of patients with opioid prescriptions remained significantly higher in rural counties, where 9.6 percent of patients had received opioid prescriptions. In contrast, 5.3 percent of patients in large metropolitan counties had received opioid prescriptions. Fourteen of the 15 counties with the highest opioid prescribing rates were rural.

Opioid prescribing may be more common in rural areas because residents there are more likely to have physically demanding work, says Mark Faul, Ph.D., M.A.

"We expected to find some differences in prescribing, but the reported differences were larger than expected," said Mark Faul, Ph.D., M.A., a researcher in the study.

Faul, a senior health scientist in the Health Systems Branch of the CDC's National Center for Injury Prevention and Control, suggested possible reasons for the geographic differences in prescribing.

"The literature on this topic suggests that the types of work that people do in rural areas are more physically demanding and may result in more pain due to injury compared with urban areas. In addition, access to medication-assisted treatment facilities and alternative therapies may be limited in rural areas," Faul said.

The study noted other possible reasons, including variations in the implementation of state-run prescription drug monitoring programs, the higher proportion of older adults living in rural areas and their higher rate of conditions associated with pain, and prescribers' individual relationships with patients.

Robert Pack, Ph.D., M.P.H., associate dean for academic affairs and a professor of community and behavioral health at East Tennessee State University College of Public Health, noted that the study focused on prescribing in primary care, couching his discussion in terms of the dearth of rural mental health care.

"There could be—and this is speculation—a number of conditions for which patients are seeking opioid pain relievers that could be better addressed using different medications, medications that a psychiatrist might be better to prescribe, like antidepressants. If patients had prior experience with [using opioid pain relievers for those other conditions], they may present to primary care seeking that medication,"

see **Opioid Prescribing** *on page 23*

Number of Opioid Prescriptions Declines From 2014 to 2017

Researchers used prescription data from 31,422 primary health care providers serving approximately 17 million patients. Patient-level data were aggregated by week over the 166 weeks from January 5, 2014, through March 11, 2017. The percentage of patient-weeks during which an opioid prescription was written was considered equivalent to the percentage of patients receiving an opioid prescription during that time.

Urban-rural category*	No. of patient-weeks	No. receiving opioid prescription	Percentage receiving opioid prescription			
			Overall	Period 1†	Period 2†	Period 3†
Noncore	8,979,403	864,364	9.6	10.3	9.9	9.0
Micropolitan	16,342,824	1,532,747	9.4	9.4	9.6	9.1
Small metro	18,860,569	1,443,246	7.7	8.0	7.7	7.4
Medium metro	32,045,592	2,158,111	6.7	7.3	6.9	6.2
Large fringe metro	31,430,958	1,753,802	5.6	6.4	5.8	5.0
Large central metro	20,535,145	1,057,967	5.2	5.4	5.2	5.0
All counties	**128,194,491**	**8,810,237**	**6.9**	**7.4**	**7.0**	**6.4**

* National Center for Health Statistics urban-rural classification scheme for counties. https://www.cdc.gov/nchs/data_access/urban_rural.htm.

† Period 1: January 5, 2014–January 3, 2015; period 2: January 4, 2015–March 19, 2016; period 3: March 20, 2016–March 11, 2017. Period-specific percentages are based on raw counts rather than statistical models.

Source: Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, January 18, 2019

Past APA President Wins Leadership Award

Former APA President Paul Summergrad, M.D., was presented with the Leadership Award for Outstanding Leadership, Mentorship, and Guidance to the Field of Psychiatry at a recent meeting of the American Association of Chairs of Departments of Psychiatry (AACDP). The award was presented by past AACDP President Mark Rapaport, M.D., chair and chief of psychiatric services at Emory University School of Medicine, and AACDP Secretary/Treasurer Britta Ostermeyer, M.D., M.B.A., the Paul and Ruth Jonas Chair in Mental Health and chair of the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma College of Medicine.

Summergrad is the Dr. Frances S. Arkin Professor and chair of the Department of Psychiatry and professor of medicine at Tufts University School of Medicine and psychiatrist-in-chief at Tufts Medical Center. He is also a past president of the AACDP.

In his award lecture, Summergrad discussed the central characteristics of an effective leader, including the importance of character, vision setting, value articulation, clear message communication, and tolerance to adversity. He emphasized the critical importance of a leader's interest in "the common good" and in taking pleasure in the accomplishments of others. He warned about a number of elements that can lead to leadership fatigue, including repetitive challenges, faculty division, and inadequate resources.

Alonso Nichols

Email Communication: 'Pause Before You Hit Send'

Engaging with patients via email is acceptable under certain conditions, but protect yourself and your patients by following a few simple rules. ***BY ANNE HUBEN-KEARNEY, R.N., B.S.N., M.P.A.***

When emailing with patients, psychiatrists may encounter unique challenges in trying to protect patient confidentiality and ensure appropriate patient and psychiatrist use of email. The following steps can help you evaluate the measures needed to protect patient confidentiality, minimize liability exposures, and engage in appropriate email communication with patients.

Appropriate	Inappropriate
Prescription renewals	Urgent or time-sensitive information
Scheduling appointments	Confidential information on symptoms or lab results
Brief nonclinical updates, such as "started new medication, doing well."	Complex clinical complaints or concerns that require multiple emails

First, obtain your patient's written informed consent to use email communication. Document the patient's informed consent, including acknowledgment of the security and risks associated with the use of email. When using email, the psychiatrist and the patient both have responsibilities.

Psychiatrist Responsibilities

- Use a secure, encrypted email communication system. Encryption software protects messages during transmission and storage by requiring user authentication and linking the person's identity to the email address.

- Clarify the permissible purposes for your practice of email communication with patients, such as prescription renewal requests and appointment scheduling. Consider providing a table listing appropriate and inappropriate topics for email communication (see example at left).

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

- Consider using a practice-dedicated email address with an automatic response indicating email response time (generally within 24 to 48 hours) that instructs patients to seek immediate help for urgent matters.

- Inform patients that all email communication is part of the medical record.

- Advise patients of staff who may view the email.

Patient Responsibilities

- Use email solely according to the practice's defined purposes.

- Acknowledge in writing that emails are not to be used for urgent or emergency situations.

- Use a personal and not a work email address, given that work email may not be afforded confidentiality protections.

Again, encrypt all email communications. Although patients can request unencrypted communications, if you send unencrypted emails, advise the patient of the risk to privacy and confidentiality. If a patient still prefers the use of unencrypted email, document that you advised the patient about the potential for unauthorized access to the information and obtain consent to proceed with sending the email unencrypted.

As with all patient communication, keep email communication professional. Thus, avoid using slang, medical jargon, and abbreviations and making typographical errors that give the impression of sloppiness. In addition, be mindful of the following questions:

- Who is reading the email? How do you know that the patient is the only one reading the email?

- How do you ensure that the patient actually received the email? Consider adding the tag "Request a

continued on facing page

ETHICS CORNER

Ethical Dilemmas Surrounding Expert Witness Requests

BY CLAIRE ZILBER, M.D.

Few clinical psychiatrists relish serving as expert witnesses. Forensic psychiatrists receive additional training in court testimony and may actually enjoy the process and remuneration involved; however, the majority of psychiatrists probably prefer to avoid the adversarial nature of legal disputes.

In addition to the confrontational tone of court proceedings, they are also stressful because they disrupt clinical and personal schedules, often with little advance notice. Although it is understandable that many psychiatrists want to avoid providing court testimony if possible, it may not always be ethical to do so. The following case example presents a dilemma and a solution that helps to balance a psychiatrist's competing duties to the court (which represents society), the patient, the psychiatrist's other patients, and the psychiatrist's other responsibilities (to colleagues, practice group, and self).

Case Example

A patient who was involuntarily hospitalized on a certification because of catatonia and who received court-ordered ECT is discharged to a mental health center that assumes responsibility for her ongoing involuntary treatment. She continues to receive maintenance ECT from the same hospital psychiatrist and has a new outpatient psychiatrist. When it's time to renew her certification, the court asks both the outpatient psychiatrist and the ECT psychiatrist to provide expert testimony at the hearing because the court has questions about the ongoing need for ECT and the need for continued involuntary treatment in general.

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.*

Court appearances are disruptive to everyone's schedule, and the ECT psychiatrist communicates to the outpatient psychiatrist that he won't be there to testify. On the one hand, the outpatient psychiatrist has met this new patient only once and feels unduly burdened since the ECT psychiatrist has known this patient longer and is more familiar with her response to ECT. On the other hand, the outpatient psychiatrist is a full-time employee of a mental health center and will be paid for his time in court, whereas the ECT psychiatrist is paid only for direct patient care. Furthermore, his hospital-based practice group is reluctant to cover for him when he makes court appearances. Both psychiatrists would have to cancel patients with short notice to attend the hearing, which may cause distress for those patients.

What Is a Physician's Duty Regarding Expert Witness Testimony?

The section on expert witness testimony in the recently revised *American College of Physicians Ethics Manual* recognizes that providing this testimony is time consuming and unfamiliar, yet without it, the court may not appreciate the patient's illness, treatment, and prognosis. Absent this information, legal decisions are made without the benefit of relevant medical understanding. The manual states, "Although physicians cannot be compelled to participate as expert witnesses, the profession as a whole has the ethical duty to assist patients and society in resolving disputes" (*Annals of Internal Medicine,* January 15, 2019).

How Might the ECT Psychiatrist Meet His Duty While Respecting His Other Obligations?

The ECT psychiatrist in this case has specialized knowledge of the patient that is not available to the outpatient psychiatrist. He could offer a written summary to his colleague of how the hospital's treatment team arrived at the determination that ECT was necessary, how the patient has responded to the treatment, any complications that arose and how they were handled, the current plan for maintenance treatment, and the prognosis with and without maintenance ECT. This would facilitate the outpatient psychiatrist's ability to respond to the court's questions. Although it would take time to prepare this summary, it would require less time than canceling half a day to appear in court, thus causing less dis-

see **Ethics Corner** *on page 9*

continued from facing page

Read Receipt" as a means to ensure that the patient received the email.

- Are safety protocols in place? Consider using an "out of office" message when you are away so your patients know you are not available. Ensure that the message includes how to contact your covering practitioner and what to do in case of an emergency (similar to the message you would use on your voicemail system).

Be aware that using email communication with patients can be a slippery slope. For example, while you may permit using emails for appointment scheduling purposes, the patient might begin emailing more frequently and for more involved clinical questions. Should this occur, do not ignore the email. Respond to the patient and remind him or her of the permissible information that can be shared via email and ask the patient to schedule an appointment to see you in the office or to telephone you. Address the authorized use of email communication directly with the patient at the next treatment session. Document the conversation.

Use emails to supplement face-to-face encounters, not to establish a physician-patient relationship. Beware of inadvertently establishing a physician-patient relationship by answering specific clinical questions via email with individuals not in your care.

Another precautionary measure is to confirm that you are sending the email to the patient's correct email address. Sending confidential information to the wrong person could lead to a breach of confidentiality and/or allegation or complaint to the state Board of Medicine. Consider sending an email to the patient to confirm the address prior to sending any email containing patient health information.

Treat email communication as a helpful and critical means of patient engagement and always ascertain that your email communications are appropriate, confidential, and professional. **PN**

iStock/Bet_Noire

Psychiatrists Join the Podcast Revolution

Many psychiatrists are using their communication skills to help educate the public about a range of topics including medical cannabis, wellness initiatives, and new innovations in psychiatry research. **BY NICK ZAGORSKI**

Shaka Smart, head coach of the University of Texas men's basketball team, is used to giving interviews—it's part and parcel with leading a nationally followed athletic program. Today's talk is a bit different though. Rather than talk about an upcoming game or his team's recent performance, Smart will discuss student-athlete mental health with Austin psychiatrist Gregory Scott Brown, M.D.

The conversation is one installment of Brown's weekly podcast, titled "This Is Mental Health." The series features conversations between Brown and people outside the psychiatric profession who are advocates for mental wellness. Brown has found these podcasts to be a valuable platform for fostering positive discussions about mental health. "I hope to show that people from all walks of life are thinking about improving mental health," he said.

Janet Taylor, M.D., prepares to record a program in her podcast series that takes an in-depth look at medical cannabis—a topic that has proven educational to many listeners as well as herself.

Brown is just one of many psychiatrists who are creating podcasts to communicate with the public. From a pure metrics perspective, it makes sense. Podcasts are exploding in popularity: between 2013 and 2018, the percentage of Americans who listened to a podcast at least once a month more than doubled from 12 percent to 26 percent. Moreover, the average listener tunes in to about five podcasts a week.

"In our profession, we spend a lot of time talking with patients, avoiding down time, and following stories to see where they lead," said Jessica Gold, M.D., an assistant professor of psychiatry at the Washington University School of Medicine in St. Louis and a member of APA's Council on Communications. She co-hosts a podcast called "Psyched!" "Once you understand some of the basics of the technology, it can be an easy transition," she continued.

In her case, Gold learned the technology side from co-host David Carreon, M.D. The pair started "Psyched!" in 2017 when they were both residents at Stanford University. The program covers various topics in psychiatry and neuroscience that are both engaging and informative, Gold told *Psychiatric News*.

"Some people may do podcasts for recognition, but I think you have to really like the stories you are doing in order to thrive, since recording and editing are time-consuming processes," she said.

Gold added that working with a partner helps divide the work while also making the process richer by having someone to riff off with.

"Podcasting is a commitment, but in the grand scheme, I have found the time to be worth it," Brown agreed. "I'm hearing lots of positive feedback from folks in the Austin community about how my discussions helped them think about, and talk about, wellness more."

Brown has said that podcasting has also been a tremendous learning experience. "I have the chance to interact with all these amazing people—one week it's a yoga instructor who is helping people deal with trauma, and the next I'm speaking with the head of a chamber orchestra about the role of music in improving mental health," he said.

"Podcasting has definitely allowed me to grow as a psychiatrist," said Janet Taylor, M.D., M.P.H., a community psychiatrist in Sarasota, Fla., and a member of APA's Council on Communications. She hosts the podcast "Sex, Lies, and Medical Cannabis With Dr. Janet" and covers a range of topics from how to properly read the label on cannabidiol extract to–yes—how cannabis affects sex.

Taylor started her podcast a few months back after taking a course on medical cannabis when she moved to Florida, where medical cannabis is legal. "It dawned on me how little I knew about this subject," she told *Psychiatric News*. "And if I didn't know anything, what did the average consumer of medical cannabis understand?"

Gregory Scott Brown, M.D. (left), prepares to interview University of Texas men's basketball coach Shaka Smart (right). Brown's podcast series features profiles of people outside the psychiatry profession who have taken an interest in mental health.

Because of federal and state rules, she cannot discuss medical cannabis at her community clinic. A personal podcast offered a workaround.

With previous media experience, including radio spots, Taylor was familiar with the production side of podcasting. For her, the learning curve has been marketing. "Once you have a product, you have to get out there and sell your brand," she said. "That not only attracts listeners, but also guests for the show."

While it may seem daunting for some psychiatrists, Taylor added that marketing oneself is not difficult; psychiatrists are already engaging in "marketing" activities but may simply not realize it. **PN**

Most podcasts can be downloaded from the Apple store or Google Play.

AMA's Incoming President to Deliver Distinguished Psychiatrist Lecture

Psychiatrist Patrice Harris, M.D., will tell meeting attendees why they shouldn't settle for being onlookers in organized medicine.

BY MARK MORAN

From serving as a member of APA's Board of Trustees to president-elect of the AMA, Patrice Harris, M.D., has been a force in organized medicine.

She will assume office in June as the first African-American woman president of the AMA. And just weeks before that, Harris will deliver a Distinguished Psychiatrist lecture at the APA Annual Meeting in San Francisco. Her address, titled "Psychiatry's Seat at the Table of Organized Medicine," will be presented Tuesday, May 21.

Harris will share her leadership journey in medicine and the lessons she has learned along the way. She also will share the AMA's strategic priorities and how they relate to the practice of psychiatry, with a particular focus on achieving greater equity within the health care system and fighting the nation's opioid epidemic.

Active in organized medicine her entire career, Harris was a member of the APA Board of Trustees from 1994 to 2004. The AMA Board of Trustees appointed her to the AMA Council on Legislation in 2003, and she was elected by the council in 2010 to serve as its chair.

David Hathcox

Patrice Harris, M.D., was elected after last year's AMA House of Delegates meeting to be president-elect of the AMA. She assumes the presidency in June.

In 2011, she was elected to the AMA Board of Trustees. Four years later she was re-elected and was chosen by her fellow Board members to be chair-elect, a position she assumed in 2016. At last year's meeting, the AMA House of Delegates elected her president-elect of the Association.

Harris has also been chair of the AMA's Task Force to Reduce Opioid Abuse. In an address to the APA Assembly last year, Harris said the opioid epidemic was initially driven by overprescription of opioids, but it is now increasingly related to use of heroin and fentanyl. "We need to bring down the number of prescriptions for opioids, and the AMA strongly urges physicians to make use of state prescription drug monitoring programs [PDMPs]," she told representatives.

Harris said physicians' increasing adoption of PDMPs is a success story, noting that participation has increased in states that do not mandate participation as well as those that do. "If PDMPs are user friendly, physicians will participate," she said.

But while the use of PDMPs is a necessary tool for decreasing the opioid crisis, it isn't sufficient. "We are trying to broaden the conversation to get policymakers to consider a range of options, especially policies that make medication-assisted treatment accessible and affordable." That includes access to the three medications approved for the treatment of opioid dependence: buprenorphine, methadone, and naltrexone.

APA President Altha Stewart, M.D., said Harris is a role model for using the power of organized medicine for the benefit of patients and public health. "Patrice's commitment to leadership within APA and the AMA is an example of how physicians who work together with fellow physicians can make extraordinary things happen," Stewart said. "I urge Annual Meeting attendees to come and hear what she has to say."

In addition to her roles at APA and the AMA, Harris has held many leadership positions at the state level as well, including serving as a member of the board and president of the Georgia Psychiatric Physicians Association and the founding president of the Georgia Psychiatry Political Action Committee. The district branch honored her as Psychiatrist of the Year in 2007. Harris has also served on the Medical Association of Georgia's Council on Legislation, Committee on Constitution and Bylaws, and Membership Task Force.

Children's health has been a motivating passion throughout her career. At Emory, where she trained in psychiatry and completed a child and adolescent and forensics fellowship, she addressed public policy for abused and neglected children before the Georgia legislature and in public education programs.

As past director of Health Services for Fulton County, Ga., which includes Atlanta, Harris was the county's chief health officer, overseeing all county health-related programs and functions, including a wide range of public safety, behavioral health, and primary care treatment and prevention services. She spearheaded the county's efforts to integrate public health, behavioral health, and primary care services. Harris also served as medical director for the Fulton County Department of Behavioral Health and Developmental Disabilities. **PN**

"Psychiatry's Seat at the Table of Organized Medicine" will be held Tuesday, May 21, from 10 a.m. to 11:30 a.m. in the Moscone Center.

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Take advantage of advance registration fees by registering by **April 9**. To obtain a form to register by mail or fax, call (202) 559-3900. There is a $25 service fee for processing mailed or faxed forms.

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

After April 9, you may register online only (late advance fees apply); faxed and mailed registration forms will not be accepted. You can also register on site.

Ethics Corner

continued from page 6

ruption to his clinical schedule. It would also provide valuable information and show respect for the outpatient psychiatrist, the court, and, most importantly, the patient.

Avoid Combining Roles of Expert Witness and Clinician

Except in testimony involving court-ordered treatment, psychiatrists should be careful about serving as an expert witness for their clinical patients. A patient may ask his or her treating psychiatrist to serve as an expert witness in a divorce, lawsuit, or criminal case. The patient may feel that the psychiatrist is the best person to explain his or her point of view, and the psychiatrist may feel protective and want to help advocate for the patient. What the patient may not understand is that once the psychiatrist's veil of confidentiality is lifted, all of the psychiatrist's knowledge about the patient is open to scrutiny. The patient can't pick and choose what will be revealed. In most cases, it may be preferable for the patient to hire a different psychiatrist to serve as expert witness and to preserve the confidentiality and sanctity of the treatment. At the very least, the patient should be fully informed of the risks of having the psychiatrist serve in a dual role.

Serving as an expert witness may be a stressful and time-consuming process for psychiatrists who are not trained in forensics or haven't chosen to orient their careers toward this activity. It is often preferable for psychiatrists to decline to be an expert witness in cases involving their patients, except when a case concerns involuntary treatment. In those situations, treating psychiatrists must appear in court; otherwise, the certification will be dropped. Psychiatrists must balance their duty to the patient with all other competing duties but keep in mind that the patient's needs are primary. As with all dilemmas, consultation may be helpful to discern the best course of action. **PN**

***The American College of Physicians Ethics Manual* is posted at https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-seventh-edition-a-comprehensive-medical-ethics-resource/acp-ethics-manual-seventh-edition. "Building on the American College of Physicians Ethics Manual" is posted at https://annals.org/aim/article-abstract/2720874/building-american-college-physicians-ethics-manual.**

Neurobiological Impact of Child Abuse to Be Discussed

Charles Nemeroff, M.D., will delve into how childhood maltreatment causes structural changes in the brain and affects genetic expression well into adulthood. **BY TERRI D'ARRIGO**

The consequences of child abuse and neglect can extend far across the lifespan, resulting in increased vulnerability to mood and anxiety disorders in adulthood. The increased risk may stem from the brain and changes in stress response. Yet these changes do not occur in all people who experience childhood abuse and neglect, suggesting that genetic variation plays a role in the psychiatric consequences of early life trauma. Charles Nemeroff, M.D., Ph.D., director of the Institute of Early Life Adversity Research and a professor of psychiatry at Dell Medical School at the University of Texas at Austin, will present the latest data on this phenomenon in a Distinguished Psychiatrist Lecture on Saturday, May 18, titled "Paradise Lost: The Neurobiology of Child Abuse and Neglect."

Nemeroff, who has published more than 1,000 research reports and reviews on the pathophysiology of mood and anxiety disorders, said that childhood maltreatment sets the stage for a plethora of mental illnesses.

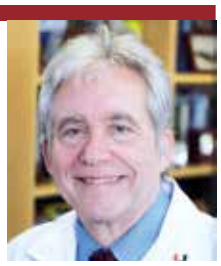
"These individuals are particularly at risk for depression, PTSD after [subsequent] trauma, and bipolar disorder. Individuals who have sustained childhood maltreatment have an earlier age of onset for these conditions, a more severe course, and relative treatment resistance compared with individuals without a history of childhood maltreatment," Nemeroff told *Psychiatric News*. He added that this population is also at higher risk for suicide, substance and alcohol abuse, and eating disorders.

"The developing brain is very vulnerable to insult. It's very slow to develop and doesn't mature till about age 24 or 25. These kinds of early life events have definite consequences on the brain and body," Nemeroff said.

Imaging studies have revealed changes in the brain after childhood maltreatment, he added. "There is some specificity to the findings that certain forms of childhood maltreatment result in certain forms of brain changes, and other forms of childhood maltreatment result in other forms of brain changes."

see **Child Abuse** *on page 23*

Imaging studies have revealed changes in the brain after childhood maltreatment.
—Charles Nemeroff, M.D., Ph.D.



Got Questions About CME and APA's Educational Programs?

The APA Education Center will provide attendees a one-stop-shop for all their learning and certification needs. Nina Taylor, M.A., APA's deputy director of education, describes the Education Center as having the feel of an Apple Store, where members can browse available resources in a relaxed and comfortable setting while having an opportunity to have their questions answered by the APA Education team. Here are just some of the things you can do at the center:

- Claim CME credit.
- Get assistance with the APA Meetings App (see page 18).
- Check in and learn more about the Resident/Fellow Scholars Program.
- Learn about and purchase APA OnDemand, which offers more than 350 hours of sessions from APA's 2019 Annual Meeting.
- Learn about the APA Learning Center, the online platform to earn CME credits, meet MOC requirements, and learn a new skill.

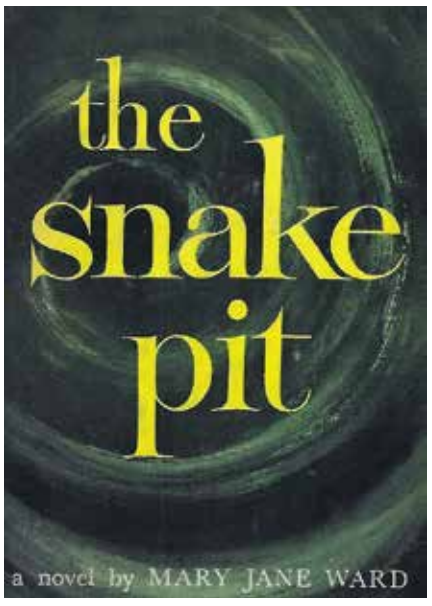
The Education Center will be located on the Upper Mezzanine Level in the Moscone Center.

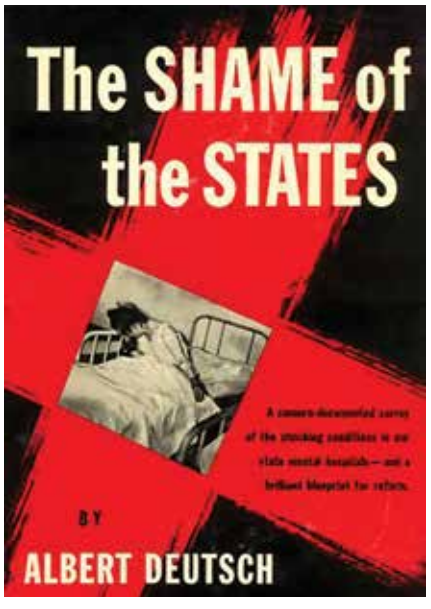
The Rise and Demise of America's Psychiatric Hospitals: A Tale of Dollars Trumping Sense

This is the second of a two-part series. **BY JEFFREY GELLER M.D., M.P.H.**

The 20th century contains dramatic changes in the roles played by psychiatric hospitals. From 1900 to 1955, the peak year-end census in state and county hospitals, public psychiatric hospitals were provided minimal resources to meet the needs of huge patient populations. Subsequently, as these hospitals were progressively eviscerated, the hospitals and those who worked there were vilified, perhaps as a way to assuage the guilt of what happened to their former residents. The asylums of earlier days became popularly known as the snake pits of the 1940s and 1950s and abandoned shells in our lifetimes. How did this happen?

In 1955, 50 percent of all hospital beds in the United States were psychiatric beds, a fact made infamous by Mike Gorman in his book, *Every Other Bed*. The rise in census did not occur because "nobody ever got discharged from a state hospital" between 1900 and 1955, but rather because public hospitals admitted more patients than they discharged for many years. For example, in Fiscal Year 1925 Worcester State Hospital (WSH) started with a census of 2,523 patients (almost exactly 50 percent of each sex), admitted 643 patients, discharged 427 patients, and ended the year with 2,739 patients. Over a decade, following this pattern, a hospital's census could increase by 2,000 patients.





These two books, published in the late 1940s, exposed the deplorable conditions of this country's public psychiatric hospitals.

Jeffrey Geller, M.D., M.P.H., is a professor of psychiatry at the University of Massachusetts Medical School and a member of the APA Foundation Library and Archives Advisory Committee. Geller will become president-elect of APA at the end of APA's 2019 Annual Meeting.

The ever-increasing population of public psychiatric hospitals from 1900 to 1955 was largely due to these facilities' becoming the destination for those with syphilis and for the elderly. The change from an agrarian to an industrial society meant the large multigenerational family was dissolving. This change left no one to take care of elderly family members, who, unfortunately, then became the responsibility of the state. For example, there were 183 deaths at WSH in Fiscal Year 1925; thus, 43 percent of the discharges were through death. One might say this was indicative of fairly poor medical care, but 47 percent of those who had died were aged 65 years and older (males 66 percent, females 34 percent). The principal diagnoses among those who had died were, in descending order, senility (33 percent), dementia praecox (14 percent), and syphilis (14 percent). Of the 18 patients who died from alcoholism, 75 percent were aged 65 years and older. Individuals were sent to the state hospital in the last stages of life: 16 percent were at WSH less than one month, and 13 percent one to three months; thus, 29 percent died within three months of admission.

Public hospitals became overwhelmed by the sheer numbers of patients. In the 1950s, there were only 26 U.S. cities whose population exceeded the aggregate population of public psychiatric institutions. The two largest hospitals each had a census that exceeded 16,000 patients. Never able to keep up with the needs of their patients, the hospitals went from awful to appalling when their workforce—from the farmer to the doctor—was pulled away to meet the manpower demands of World War II. The population at large learned of the horrors of their public psychiatric hospitals, tragedies long hidden away, through exposés such as *The Snake Pit*, Mary Jane Ward's fictionalized account of her hospitalization at Rockland State Hospital (book, 1946; movie 1948); author Albert Q. Maisel's article in *Life* magazine (1946) accompanied by some of the most painful pictures the American public had ever seen from Pennsylvania's Byberry and Ohio's Cleveland state hospitals; and *The Shame of the States* (1948), *New York Post* reporter Albert Deutsch's opus based on research from 1944 to 1947.

Perhaps the most dramatic shift in the use of psychiatric hospitals, and the most misunderstood, is "deinstitutionalization." First, deinstitutionalization was not a thought-out policy shift, not a movement, and not even labeled until considerably after the relocation of psychiatric patients from hospitals to settings outside of hospitals had begun. The depopulation of America's public hospitals occurred due to a confluence of factors including exposés and reports by conscientious objectors working in these hospitals in lieu of combat in World War II, the introduction of chlorpromazine (1954), a new breed of activist attorneys, and the naissance of the disability rights movement.

In numerous public institutions, especially in the 1950s, the sleeping arrangements for patients with mental illness or mental retardation lacked any semblance of privacy or dignity. The above photo is from the June 1961 issue of APA's journal *Mental Hospitals,* now *Psychiatric Services.*

On October 31, 1963, President John F. Kennedy signed what would turn out to be his last major bill, the Community Mental Health Centers Act. While Kennedy was extolled for this legislation, the bill turned out to be not much more than a hiccup, and Kennedy actually had little interest in it.

None of these factors, however, was as important as the passage of Medicaid. States realized that through Medicaid they could shift significant percentages of their expenditures for people with serious mental illness to the federal government by moving them out of large institutions and into facilities of 16 or fewer beds due to payment limitations imposed by the Institution for Mental Disease (IMD) exclu-

see **Hospitals** *on page 23*

Purchase Tickets for 175th Anniversary Gala Today!

With a history spanning 175 years, APA has a lot to celebrate. Join your colleagues and friends for an evening of music, dancing, and good food at APA's 175th Anniversary Gala. The celebration will be held at the city's crown jewel, San Francisco City Hall, on Monday, May 20, from 7 p.m. to 10 p.m.

Tickets for the event are $225 per person, with special pricing for APA/APAF fellows and resident-fellow members. Purchase your tickets at https://apafdn.org/gala or call (202) 559-3888. For information about Annual Meeting registration, see box on page 9.

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HHS's Proposed Drug Rebates Rule Would Raise Premiums; Benefits Unclear

A prescription drug rule proposed by the Trump administration would bar drugmakers from giving rebates to plans, resulting in higher premiums for Medicare Part D enrollees across the board. The ultimate impact on prices at the pharmacy counter remains unclear. **BY LINDA M. RICHMOND**

The Trump administration has proposed a controversial plan aimed at lowering prescription drug prices that would put an end to the practice of drugmakers giving rebates to certain health plans and their pharmacy benefit managers (PBMs).

The rule would affect enrollees in Medicare Part D drug plans and lower-income individuals enrolled in Medicaid managed care plans. If finalized as expected next year, the rule would raise monthly premiums in Medicare Part D drug plans by as much as 22 percent but would provide uncertain benefits at the pharmacy counter. Analysts say the plan would likely trickle down to the rest of the health insurance marketplace.

The proposed rule would legally bar rebates that drug manufacturers now pay to health plan sponsors—and the PBMs under contract with them—driving a certain volume of sales or providing a certain market share. The rebates are based on the list price of drugs, so when prices go up, the rebates are larger.

These arrangements may create a perverse incentive for drugmakers to raise their list prices—and for plans to favor these more expensive drugs—to obtain higher rebate payments, according to the proposed rule, published by the Department of Health and Human Services in the February 6 *Federal Register*.

Drug companies announced large list price increases for 2019, by one analysis, about 6 percent per drug, according to the proposed rule. However, these price increases are not supported by inflation, increased costs of goods, or increased demand, but they instead "reflect significant distortions in the distribution chain." Nearly every drug company reporting a price increase in January said that most or all of the increase reflected the cost of rebates being paid to health plans or their PBMs, according to a fact sheet issued by the administration.

Under the current system, patients pay a share of their medication cost based on the list price of the drug at the point of sale. The health plans or their PBMs later receive rebates on those medications, but that discount is not passed along to patients.

The proposed rule would end the safe harbor arrangement that shields drugmakers paying these discounts from anti-kickback statutes. The proposed rule would also establish a new safe harbor for drugmakers that choose to give rebates directly to consumers at the point of sale.

"There is tremendous uncertainty about how this rule would work and how it would affect beneficiaries in terms of out-of-pocket costs and program spending," said Juliette Cubanski, Ph.D., M.P.H., M.P.P., associate director of the Program on Medicare Policy at the Kaiser Family Foundation. "This is a bold experiment, but it's also a very risky experiment in terms of the potential impact on the prescription drug marketplace. What's unequivocal is that everyone enrolled would see an increase in premiums."

An analysis by Milliman of the potential impact of the proposal commissioned by the administration projects premium increases of 12 percent to 22 percent per member per month. Cubanski pointed out that the proposed rule provides no guarantee that drugmakers will choose to lower list prices or provide rebates to consumers, although all patients across the board will see their premiums go up.

Regardless, not all patients take rebate-eligible medications, which are typically reserved for expensive brand-name drugs that have several competing medications, Cubanski pointed out. Under the Medicare Part D plan, antidepressants, antipsychotics, and anticonvulsants are part of the so-called "protected classes" drugs for which plans are required to cover all or substantially all of them. As a result, rebates for these drugs for psychiatric conditions tend to be lower, if they are offered at all.

The drug rebate system is somewhat of a mystery, since discount arrangements for specific drugs are considered proprietary information that drugmakers are not required to disclose.

"There's some level of uncertainty as to whether patients would see any savings if you take away rebates for plans," Cubanski concluded. "Because the rule does not change drugmakers' fundamental ability to set list prices wherever they want them."

APA has been advocating to make prescription drugs affordable and accessible to those who need them and is reviewing the proposal, along with a coalition of medical organizations, and will be filing comments by the April 8 deadline.

Stephen J. Ubl, president and CEO of Pharmaceutical Research and Manufacturers of America (PhRMA), applauded the administration's proposal and said these types of reforms will especially help patients with chronic diseases who are often not benefitting from the current rebate system.

"We need to ensure that the $150 billion in negotiated rebates and discounts are used to lower costs for patients at the pharmacy," he added. **PN**

Comments on the proposed rule, "Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees (42 CFR 1001)" may be submitted at https://federalregister.gov/d/2019-01026.

Medicare Plans

continued from page 1

proposal would exacerbate these issues without achieving the financial benefits expected."

APA opposes the proposed rule because of the potential harm to patients and increased costs that come from patients being denied the medication that can best treat their symptoms due to the inherent complexity of psychotropic drugs and because no two psychotropic drugs are the same, Levin wrote.

"On average, plans currently cover just over two-thirds of drugs across all six of Medicare's protected classes, and this incentivizes plans to further limit the availability of lifesaving medications," he wrote.

Other concerns expressed by APA in its formal comments were the increased burden on physicians that the proposal would create as well as its interference with the doctor-patient relationship.

The American Psychiatric Institute for Research and Education of previously stable Medicaid conducted a study in 2011 of patients who were forced to switch to a Medicare drug plan and had to change medications because their refills were not approved. The study found that nearly two-thirds experienced adverse events, including emergency room visits, hospitalizations, homelessness, and incarceration.

"Having to clear the numerous administrative hurdles to deliver quality care takes valuable time away from patients," Levin added. CMS considered implementing significant changes to Part D's six protected classes in 2014 but ditched the plan due to overwhelming concern by physician, patient, and other advocacy groups.

Also critical of the CMS proposed rule were the National Kidney Foundation, the American Cancer Society Cancer Action Network, Biotechnology Innovation Organization, the Partnership for Part D Access, The AIDS Institute, and the Community Oncology Alliance. **PN**

Levin's letter to CMS is posted at http://apapsy.ch/cms-part-d. CMS's proposed rule, "Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses," is posted at https://federalregister.gov/d/2018-25945.

New Congress Offers Wealth of Opportunity For Psychiatrists to Speak Out

Health care was a prominent issue in the 2018 elections. The time is ripe for psychiatrists to speak up on behalf of their profession and their patients. **BY TERRI D'ARRIGO**

With a new Congress getting down to legislative business, there is no time like the present to get involved in advocating for the profession. The 116th Congress has a freshman class of 10 senators and 101 representatives, representing 111 potential new allies for psychiatry.

As lobbyists from all areas of health care jockey for position on Capitol Hill, it's vital that psychiatrists forge relationships with legislators and add their voices to the discussion, said Dora Wang, M.D., a clinical associate professor and historian at the University of New Mexico School of Medicine.

"Our health care system won't be reformed until the time-tested ethics of physicians are once again at the center of American medicine rather than the ethics of profit. It's of utmost importance that physicians are involved in politics," Wang said.

Wang has long been active in the political arena, supporting U.S. Sen. Martin Heinrich (D-N.M.) since he became a member of the Albuquerque City Council 20 years ago, and New Mexico Gov. Michelle Lujan Grisham (D) since the first time she ran for Congress in 2008. Wang has raised money to help candidates get elected, and she's not afraid of doing the labor herself: She once spent an entire weekend cooking for a fundraiser for Heinrich, raising $15,000 for his campaign.

"I encourage psychiatrists to know their senators, representatives, and local politicians. They want to know what's happening in mental health and in health care. By informing our politicians and working with them toward a better health care system, we are helping our patients," Wang said.

Meeting with elected officials is crucial to success. A 2017 report by the nonpartisan, nonprofit Congressional Management Foundation noted that 94 percent of respondents in a survey of congressional staff said that in-person visits from constituents would have some or a lot of influence on an undecided lawmaker. In that same survey, 98 percent of congressional staff said that meetings between the representative or senator and constituents were either very important or somewhat important, and 99 percent said that meetings between congressional staff and constituents were either very important or somewhat important.

Calling with a quick, direct introduction is an effective approach, Wang said. "State you are a psychiatrist. Let them know that the perspective of psychiatrists is important, and make an appointment to talk with them."

Wang also suggested seeking out local legislators or potential legislators, as they represent the future of politics and potential allies down the road.

"There may be legislators in your social circle or someone who you feel would be a good lawmaker. Encourage them to run for office," Wang said. **PN**

Dora Wang, M.D., is photographed with Sen. Martin Heinrich (D-N.M.) at his office in Washington, D.C. She encourages psychiatrists to become politically active at both the local and national levels.

Together, We CAN

Psychiatrists who are interested in advocating on issues related to the psychiatric profession and the care of patients are encouraged to join APA's Congressional Advocacy Network (CAN). The network's goal is to pair every member of Congress with a psychiatrist to serve as a key contact when health and mental health issues come before Congress. APA's Department of Government Relations helps congressional advocates build relationships with their lawmakers and educates the advocates on federal policy matters affecting their profession and patients. Information about CAN is posted at https://www.psychiatry.org/psychiatrists/advocacy/congressional-advocacy-network.

Prior Authorizations

continued from page 4

complaints about them, Ambrose pointed out. "There's a lack of transparency about the process, too, which allows insurance companies to dictate care."

APA is a member of the AMA's prior authorization coalition, a group of some 17 medical societies focused on reducing the negative impact that utilization management has on providers, patients, and the health care system. The coalition is working to encourage health plans—as well as the organizations that provide them with accreditation—to adopt their reform principles, which focus on clinical validity, continuity of care, transparency and fairness, timely access, and administrative efficiency.

APA and its district branches, along with other state medical organizations, have had some success tackling a related utilization management process deployed by insurance companies known as step therapy, also called "fail-first" practices. In January, Ohio became the latest state to sign step therapy reforms into law, joining at least 18 other states.

> The prior authorization process makes for a "dangerous distraction from providing safe medical care."
> —John Bailey, D.O.

Pharmacists don't typically advise patients when prior authorizations pop up that they can purchase their medications "out of pocket"; rather, they are simply told their insurance plan "denied" their prescription, said psychiatrist John Bailey, D.O., who is a Florida Psychiatric Society Assembly representative and member of the Florida Medicaid Pharmaceutical and Therapeutics Committee. "Within the past month, I've had patients who were told that their insurance company denied their sertraline, so they stopped taking it rather than calling me. They were so surprised on follow-up when I told them they could have bought the medicine outright for about $10 a month."

Bailey said the prior authorization process makes for a "dangerous distraction from providing safe medical care," taking up to two to three days at times to secure an approval. "There is no way for a physician to spend two to three days persistently pursuing a prior authorization for a single patient's medicine—and to also keep up with the many other responsibilities of providing care to other patients."

"Because of the insurance company practices," said Aoun, "we end up adapting the type of care we are providing to our patients. Rather, it should be the other way around." **PN**

The 2018 AMA Prior Authorization Physician Survey is posted at https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf. The Prior Authorization and Utilization Management Reform Principles are posted at https://edhub.ama-assn.org/data/Multimedia/10.1001ama.2018.0080supp1.pdf.

Wright State University

Wright State Adopts Curriculum Without Lectures

The reforms at Wright State are part of a wider trend across medical schools and residencies to modernize the way future physicians learn medicine. **BY MARK MORAN**

Mark Crager and Fatima Bensabeur, second-year students at Wright State University Boonshoft School of Medicine (BSOM) in Dayton, Ohio, are learning medicine along with their fellow students at BSOM in a fashion that perhaps no American physician in preceding generations ever has.

Consider the class "Host and Defense," an introduction to the principles of immunology, bacteriology, and virology as they apply to human disease. Crager and his classmates are expected to read texts ahead of time—like the dense, foundational *Robbins' Pathologic Basis of Disease*—with only a study guide to help students focus on the core material.

Then, rather than sitting through a lecture, reading notes, and regurgitating information in a test, Crager, Bensabeur, and their peers work with each other to discern what is relevant in the material in one of BSOM's "flipped classroom" formats, such as Peer Instruction (or PI). They are quizzed on the core material using electronic devices for recording their answers; if 80 percent of the class answer correctly, they move on. If less than 80 percent answer correctly, the students and faculty discuss, using problem-solving and critical-thinking skills to arrive at a common understanding.

"In PI, all of the students bring their unique background to the subject matter," Crager said. "Any one of your peers can explain something in a way that makes it very clear. In this way, the material takes on a new meaning—it's not just this massive textbook. You might come into it feeling overwhelmed, but when you sit down with your peers and work it through, you get a vision of what's really important."

Similarly, Bensabeur recalled a first-year pharmacology session in which she and her peers were given a lengthy list of drug names. As for Crager and his pathology text, it was up to Bensabeur to research how the drugs worked and what they treated, then join her fellow students in PI and refine her knowledge.

"I vividly remember my heart rate going up as anxiety started to set in," she told *Psychiatric News*. "I was given only the drug names and nothing else. I immediately started looking up ways that other students use to memorize drugs online and decided to go with flashcards. One day I would need to use this very information to save someone's life, so the better I learn it, the better physician I will be. I felt empowered. I was not told what to do or where to look. I was treated as a future physician who needed to make her own decisions. That's why our program is different."

Wright State University

WrightCurriculum will be refined over time, and the students and educators at Wright State BSOM are "learning about learning" as they go.

Educators Seek to Modernize Medical Education

Crager's and Bensabeur's novel learning experiences are components of the WrightCurriculum, an innovative educational model that was five years in the making before being rolled out at BSOM in 2017.

Psychiatrist Brenda Roman, M.D., associate dean for medical education at BSOM, said that the curriculum is based on state-of-the-art "science of learning." (Peer instruction, for instance, was developed by Eric Mazur, Ph.D., a Harvard physics professor dissatisfied with the traditional model of "read, lecture, memorize, regurgitate.")

Roman said that she believes the curriculum is the first in the nation to be entirely without lectures. "We expect students to read the material prior to class and come to class sessions to solve problems and think critically about the content that they should have already learned," she told *Psychiatric News*.

Teaching by the faculty becomes focused on probing for deeper understanding and clarifying misconceptions, and classroom time is intended to be highly interactive. "It results in a much richer conversation than typically happens during a lecture. The science of learning has taught us that learning from lectures is in fact highly inefficient. People retain only 5 to 10 percent of what they are told."

Rather, she said, evidence from cognitive psychology has shown that people learn best through "retrieval-based learning." "Every time you are forced to retrieve something from your brain, you strengthen the neural connections associated with memory, so that the next time you are expected to retrieve it, it should be easier."

Other innovative aspects of learning at Wright include an "interleaved" curriculum in which disparate topics (say, anatomy and the pathophysiology of a particular disorder) are woven together, switched between, and revisited at intervals throughout the year. Another is "distributed practice" in which learning about a particular topic or aspect of medical practice is spaced out over time. Both of these replace the traditional method of block learning, in which students cover one topic at a time, and the time-honored practice of "cramming" to memorize blocks of material—now regarded by

see **Curriculum** *on page 25*

Postpartum Anxiety, Depression Raise Risk Of Developmental Delays

Data from the All Our Families study show increased risk of personal-social delays and communication delays at age 3 years. **BY TERRI D'ARRIGO**

Children born to mothers who have persistent anxiety from late pregnancy to three years postpartum have an increased risk of delays in communication and personal-social development, according to a study in the *Journal of Affective Disorders*. The findings highlight the importance of early detection and support for mothers experiencing distress during pregnancy and the postpartum period and their offspring.

Muhammad Kashif Mughal, M.B.B.S., Ph.D., a postdoctoral fellow at the University of Calgary, and colleagues evaluated data from the three-year follow-up to the All Our Families study, an ongoing study of mothers and children in Calgary, Canada. The study, begun in 2008 as the All Our Babies study, includes self-reported assessments of mothers' distress (including depression, anxiety, and stress) at multiple time points ranging from before the 25th week of gestation up to three years postpartum. Also included are parent-reporting tools to measure child development at age 3 years across five domains: communication, gross motor, fine motor, problem solving, and personal-social. For the current study, the researchers analyzed data from 1,983 mother-child pairs.

Overall, 4.7 percent to 6.4 percent of the mothers reported depressive symptoms at four time points: less than 25 weeks gestation, 34 to 36 weeks gestation, four months postpartum, and one year postpartum. Also, 13.8 percent to 18.5 percent of mothers reported anxiety symptoms at six time points: less than 25 weeks gestation, 34 to 36 weeks gestation, four months postpartum, one year postpartum, two years postpartum, and three years postpartum.

Statistical analysis revealed that mothers with persistent high anxiety symptoms and early postpartum depression were more likely to report personal-social delays in their children at age 3 years compared with those mothers without such symptoms. The researchers also found that persistent subclinical and high anxiety symptoms were associated with an increased risk of communication delay at age 3 years. Furthermore, the relationship between maternal anxiety and risk of child communication delay was dose-dependent.

"The proportion of children with risk of communication delays were highest in children of mothers experiencing clinical anxiety symptoms, followed by the subclinical, and the lowest for minimal symptoms," Mughal told *Psychiatric News*.

Muhammad Kashif Mughal, M.B.B.S., Ph.D., says the population of at-risk women needs to be redefined because women with subclinical symptoms, which are associated with increased risk, are often "off the radar" of health professionals.

Mughal said that the results carry important implications for both practice and research, in which physicians and researchers traditionally rely upon clinical cutoffs to identify patients for intervention and follow-up.

"The mothers experiencing subclinical symptoms are usually off the radar of health care professionals and are not identified by traditional cutoff approaches," Mughal said. "The study highlights the importance of redefining 'at-risk' populations and moving from established cutoff approaches to ones that capture the chronicity and severity of symptoms during pregnancy and the postpartum period."

No statistically significant associations were found between maternal depression, anxiety, and stress symptoms over time and children's gross motor, fine motor, and problem-solving development at 3 years. However, the researchers identified other risk factors for these domains, such as maternal age greater than 35 years, male sex, and preterm birth for gross-motor delays; low maternal education and male sex for fine motor delays; and low family income and preterm birth for problem-solving delays. Having a family with two or more children was a protective factor for fine motor development.

"We need further studies to investigate the impact of these risk factors on child delays," said Mughal.

Mughal added that the findings call for a shift in perinatal health care to a model that emphasizes multiple perinatal screenings for maternal distress using validated tools and chronicity of symptoms.

"Ultimately, improving processes for routine, timely, and appropriate maternal mental health assessment, treatment, and referral at multiple time points during the perinatal period will increase the quality of life in pregnant women and will help reduce the likelihood of adverse birth outcomes, postpartum mental health concerns, and adverse effects on offspring," Mughal said.

This study was supported by funding from Alberta Innovates, the Alberta Children's Hospital Foundation, and the Maxbell Foundation. **PN**

"Trajectories of Maternal Distress and Risk of Child Developmental Delays: Findings From the All Our Families (AOF) Pregnancy Cohort" is posted at https://www.sciencedirect.com/science/article/pii/S0165032718304543.

PSYCHIATRY & PSYCHOTHERAPY

Canary in the Coal Mine Fights Back: What Access to 'Intermediate Levels of Care' Says About Managed Care

BY ERIC PLAKUN, M.D.

In the early 20th century, coal miners carried caged canaries into mines to detect dangerous levels of coal gas. A dead canary was an early warning of danger in the mine. Today, in mental health and substance use (MH/SU) treatment, access to care criteria for treatment at so-called intermediate levels of care (intensive outpatient programs, or IOPs; partial hospital programs, or PHPs; and residential treatment centers, or RTCs) are canaries in the coal mine. Problems accessing these levels of care should alert us to a pervasive problem with managed care criteria that tend to view psychiatric treatment as focused on crisis stabilization rather than on recovery. In this instance, though, the canaries are not willing to die quietly.

Our training and experience as psychiatric clinicians ground us in knowledge of the appropriate interventions for MH/SU treatment, yet few of us use related terms like "medical necessity" and "generally accepted standards" in our day-to-day clinical work. Medical necessity arises when dealing with insurance companies or managed care entities claiming authority to define generally accepted standards for MH/SU treatment. Based on the frequency with which clinicians face denials of requests for treatment at a given intensity or level of care, insurance companies and managed care entities appear to define medical necessity differently from us. To understand what this means, we need to understand terms like "medical necessity," "generally accepted standards," and aspects of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

Eric Plakun, M.D., is the medical director and CEO of the Austen Riggs Center in Stockbridge, Mass., and Area 1 trustee on APA's Board of Trustees. The opinions expressed in this article are solely the author's. The column is coordinated by the Committee on Psychotherapy of the Group for the Advancement of Psychiatry.

Medical Necessity and Generally Accepted Standards

The 2014 MHPAEA Final Rules state that parity applies to access to intermediate levels of care for MH/SU disorders (IOPs, PHPs, and RTCs are specified), just as in medical and surgical treatment. Intermediate levels of care are recognized as part of the continuum of care available when "medically necessary." The medical necessity of medical-surgical and MH/SU treatment depends on whether the treatment in question meets generally accepted standards.

There is no one source of generally accepted standards. Instead, they are a set of clinical practices based on (1) research evidence, (2) professional society perspectives (for example, APA clinical practice guidelines), (3) practice patterns, and (4) other potentially relevant sources, like the Medicare Manual, since it addresses treatment issues for large numbers of patients.

Although there is no formal list of such generally accepted standards, the knowledge and training we receive as clinicians enable us to identify treat-

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Punitive Discipline May Work in Short Term But May Cause Long-Term Emotional Damage

A new population study sheds light on the link between two parental discipline styles and later child aggression and less prosocial behaviors.

BY LINDA M. RICHMOND

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Young children whose parents employed harsh punitive discipline styles tended to behave better in the short term, but it came at a high cost: more emotional problems and less prosocial behaviors at age 11, according to a population study published in the January *Journal of the American Academy of Child and Adolescent Psychiatry*.

This long-term study of nearly 5,000 mothers pulled data from the U.K. Millennium Cohort Study, a national longitudinal study monitoring the lives of children born in 2000 and 2001 in the United Kingdom. The mothers took a questionnaire on their parenting styles when their children were 3 years old, which quantified their use of "active punishment," such as smacking, shouting, and telling off as well as their use of "withdrawal of reward" styles of discipline, such as removal of treats or attention, withdrawing privileges, or ignoring the children. The mothers also completed assessments of the emotional and behavioral difficulties in their children at ages 3 and 11 years. At age 11, children also completed a six-item questionnaire measuring their own mood.

Researchers found that the more frequently mothers used either discipline strategy—withdrawal of rewards or actively punitive approaches—the more emotional problems their children displayed at 11 years of age, wrote Priya Rajyaguru, M.R.C.Psych., of the Centre for Academic Mental Health at the University of Bristol in the United Kingdom, and colleagues.

While children subjected to the active punitive parenting approaches had fewer conduct and hyperactivity problems, this came at a high cost: more emotional problems and more problems relating to peers later in childhood. These problems were not seen among children subjected to the withdrawal of rewards discipline style, who also had fewer conduct problems but not less hyperactivity.

The muted nature of withdrawal approaches "is perhaps less likely to result in disruption of the parent-child bond, producing better child mental health outcomes," the researchers wrote. The findings offer yet another example of why parents should avoid spanking or harsh verbal discipline that causes shame or humiliation, as was recently emphasized in an updated policy statement against corporal punishment by the American Academy of Pediatrics (AAP).

"Aversive disciplinary strategies, including all forms of corporal punishment and yelling at or shaming children, are minimally effective in the short term and not effective in the long term," AAP wrote the December issue of *Pediatrics*. "With new evidence, researchers link corporal punishment to an increased risk of negative behavioral, cognitive, psychosocial, and emotional outcomes for children.

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ments as being within or outside the boundaries of generally accepted standards. Bleeding for pneumonia and prefrontal lobotomy for schizophrenia are outside generally accepted standards, while antibiotics and neuroleptic medications are within generally accepted standards for these disorders.

It is understood that many patients with MH/SU disorders have complex comorbid presentations; early adversity or recent trauma and losses and their sequelae have an enduring impact on lifetime course of illness; a combination of medications and psychotherapy is often superior to either alone; many patients struggle with recurrent or chronic disorders; and our treatments, though effective, leave many patients without much benefit. Given these realities, generally accepted standards call for treating MH/SU disorders in an integrated, biopsychosocial approach that typically includes medications and psychotherapy.

Role of Intermediate Levels of Care in Treatment and Recovery

Recovery—achieving a self-directed life as a member of society—is the principal long-term goal of MH/SU treatment. Although most treatment occurs in outpatient settings, effective outpatient treatment depends on patients having two skills.

First, they need the capacity to use the sessions, face the affects and dilemmas that emerge, and engage in an outpatient treatment process. Second, patients must have the capacity to function adequately between sessions in terms of work or school and interpersonal functioning.

If crises emerge that are associated with imminent risk of harm or major impairment in self-care, acute inpatient treatment focused on crisis stabilization with prompt return to outpatient treatment is within generally accepted standards. However, many outpatients lack the capacity to function adequately between sessions—even with medications, more frequent sessions, and the like. These are patients for whom generally accepted standards support treatment in intermediate levels of care—IOPs, PHPs, and RTCs. Intermediate levels of care look beyond acute crises. They are designed to help patients grapple with the impact of underlying comorbidity, adversity, trauma, chronicity, or risk of recurrence. They target these underlying issues that drive repeated crises or interfere with adequate use of outpatient treatment to achieve recovery. It's the difference between taking the lid off a boiling pot or turning down the flame. Intermediate levels of care offer this extra support long enough to help patients return to outpatient treatment better equipped to use it productively.

Intermediate levels of care in MH/SU treatment are comparable to intermediate levels of care in medical and surgical care. They are not simply an alternative to acute hospital treatment, but a differentiated, subacute level of care intended to improve functional capacity for those not needing acute inpatient treatment. An example is the stroke patient who no longer needs inpatient care but cannot yet function adequately as an outpatient because of impaired ability to walk, talk, and do self-care. An intermediate level of care offers such patients the opportunity to improve functional capacity in the same way an IOP or RTC might improve the functional capacity of patients with MH/SU disorders.

Generally Accepted Standards for Assigning Level of Care

There are instruments for determining the appropriate level of care congruent with this model and recognized as within generally accepted standards, such as the Level of Care Utilization System (LOCUS) developed by the American Association of Community Psychiatrists. The LOCUS assesses patients' needs for outpatient, IOP, PHP, RTC, and inpatient treatment across six domains that include risk of harm and functional capacity, but also include the impact of comorbidity, past treatment response, readiness to change, and the supports or stresses in a patient's environment. However, requests for access to intermediate levels of care—even in patients who meet LOCUS criteria for them—often lead to denials or authorization of very brief lengths of stay from insurance utilization reviewers.

There is a worrisome reason for this. Despite the 2014 Final Rules of the MHPAEA stating that obstacles to access to intermediate levels of care in MH/SU treatment should not be substantially different from those to gain access to intermediate levels of care in medicine and surgery, many insurance plans do not offer this kind of access. Many insurers view the focus of intermediate levels of care in MH/SU treatment as limited to crisis stabilization followed by prompt return to outpatient functioning or the end of treatment. This insurance perspective is illustrated by a white paper on the website of America's Health Insurance Plans (AHIP), a trade group of about 175 insurance plans that works to "improve and protect the health and financial security of consumers, families, businesses, communities, and the nation."

The AHIP white paper (https://www.ahip.org/wp-content/uploads/2017/06/MCG-White-Paper-Mental-Health-Parity.pdf) addressing challenges in implementation of the parity law for intermediate levels of care is written not by a psychiatrist but by an internist

see **Managed Care** *on page 21*

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Physical Activity May Lower, Prevent Depression

While there is a lot of research to support the association between physical activity and mental well-being, two studies provide evidence that activity may have a causal role in achieving a better mood. **BY NICK ZAGORSKI**

Numerous lines of research have shown a connection between mood and physical activity—someone who is depressed is also more likely to be less active and feel less energetic. Researchers have been unsure about which of these traits exerts more influence in the relationship. Two studies in *JAMA Psychiatry* now strengthen the notion that physical activity is the driving force; people who become more active can reduce depression symptoms or maybe even avoid depression altogether.

In the first study, published December 12, 2018, researchers at the National Institute of Mental Health (NIMH) and colleagues assessed real-time activity, energy, and mood data in 242 adults. The group included 24 individuals with bipolar I disorder, 29 with bipolar II disorder, 91 with major depressive disorder (MDD), and 97 people with no lifetime history of a mood disorder.

Over the course of two weeks, the participants wore special wrist devices (actigraphs) that tracked movement and sleep patterns. They also completed an electronic diary four times a day (8 a.m., 12 p.m., 4 p.m., and 8 p.m.), in which they detailed their mood and energy levels.

The researchers found that more physical activity in the participants was associated with greater positive changes in mood, energy, and sleep duration at later timepoints. That is, more physical activity in the afternoon was associated with better mood and energy later in the day. This was a one-way relationship; adults who reported better mood in the afternoon did not necessarily have more activity or energy in the evening.

The relationship between activity, mood, energy, and sleep was especially strong among people with bipolar I disorder compared with the other groups, said lead study author Kathleen Merikangas, Ph.D., chief of the Genetic Epidemiology Research Branch at NIMH. She noted that there was even a large difference in the influence of activity on mood between people with bipolar I and bipolar II disorder.

"This is an important finding that further suggests bipolar I and bipolar II are not merely progressive iterations of the same underlying disorder," Merikangas told *Psychiatric News*. (The primary diagnostic difference between people with bipolar I and bipolar II disorders is that people with bipolar I dis-

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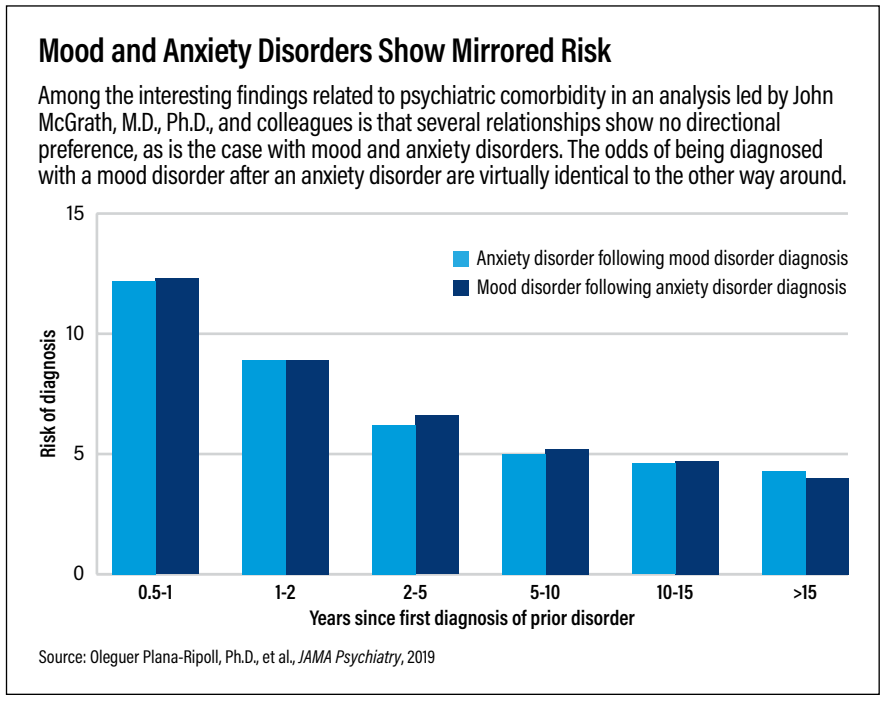
Co-Occurring Mental Illnesses May Be More Pervasive Than Previously Thought

An analysis of medical data from nearly 6 million Danes also found that in most cases, random chance may dictate which disorder people with co-occurring illnesses will develop first. **BY NICK ZAGORSKI**



Using the robust medical data available in Danish health registries, a team of researchers has developed the most comprehensive map of psychiatric comorbidity (the occurrence of more than one mental illness in an individual) to date.

The notion that a patient can have multiple mental illnesses is not new. Research has shown that similar disorders such as depression and anxiety often co-occur, due to both genetic and environmental factors. However, this new study, published January 16 in *JAMA Psychiatry,* has taken this knowledge to the next level.

The researchers found that psychiatric comorbidity is more widespread than previously appreciated and is not restricted to closely related psychiatric disorders. In addition, the study found psychiatric comorbidity is often bidirectional; for example, the risk of being diagnosed with major depression after an anxiety disorder is about the same as the risk of being diagnosed with an anxiety disorder after being diagnosed with depression.

"We wanted to provide clinicians, researchers, and patients with the most detailed atlas possible about which psychiatric disorders might occur together," said senior study author John McGrath, M.D., Ph.D., the Niels Bohr Professor at the National Centre for Register-based Research at Aarhus University in Denmark. "We have a good roadmap now, but we wanted to create the 'Google streetmap' version."

McGrath and his colleagues combed the health registry data of all individuals born in Denmark who resided in the country between 2000 and 2016; this encompassed almost 6 million children and adults and about 84 million years of medical data. They checked for all psychiatric diagnoses, but rather than focus on individual disorders, they grouped mental disorders into 10 categories, as described in ICD-10: behavioral disorders, such as attention-deficit/hyperactivity disorder; developmental disorders, such as autism; mood disorders, such as depression; neurotic disorders, such as anxiety; organic disorders, such as dementia; eating disorders; intellectual disability; personality disorders; schizophrenia; and substance use disorders. Next, the researchers calculated the risks of an individual with one type of disorder getting a second mental illness diagnosis within 15 years.

They found that comorbidity was pervasive, with some categories of disorders having exceptionally strong odds of occurring together. For example, compared with an individual not diagnosed with a mental disorder, an individual diagnosed with a mood disorder was 30 times more likely to be diagnosed later with a personality disorder or a developmental disorder, and 20 times more likely to be diagnosed with schizophrenia or a substance use disorder. The younger the age a person was at the time of the first diagnosis, the greater his or her risk of a second diagnosis.

The risk of the second diagnosis was also higher within the first six months after the first diagnosis, which McGrath attributed in part "to doctors doing a thorough job." A patient comes in and receives a psychiatric diagnosis, which raises the doctor's attention to other possible symptoms, which may lead to a second diagnosis at a follow-up visit. Therefore, McGrath explained, it is possible that the patient had already developed both disorders, and it just took a little time to uncover both. McGrath added that the risk stayed high for 15 years, though.

Another new discovery from this analysis was that many instances of psychiatric comorbidity were bidirectional. "In some cases, like mood dis-

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order typically have full manic episodes while those with bipolar II have more subtle periods of hypomania.)

From a clinical perspective, Merikangas said her study's findings suggest that medications that boost activity or energy could be useful in treating depression in bipolar I disorder. She noted that the antidepressants known as monoamine oxidase inhibitors (MAOIs) may be one such treatment, as studies have shown that they can boost both energy and mood.

Merikangas acknowledged that some physicians might be wary about providing MAOIs or other energy-boosting medications to people with bipolar disorder for fear of triggering mania, but she said that she believes such medications would be safe if given after a patient is stabilized with lithium or valproate.

Physical activity may not only help reduce existing depressive symptoms, but also help prevent depression from manifesting, according to a separate study published January 23 in *JAMA Psychiatry*.

For the study, Karmel Choi, Ph.D., a clinical fellow of psychiatry at Massachusetts General Hospital, and colleagues collected data from two large genetic analyses: a U.K.-based study that identified genetic variants associated with greater physical activity (measured with actigraphs) and a multinational study led by the Psychiatric Genomics Consortium that identified genetic variants linked with depression risk. They picked the top 10 genetic variants in each group and examined how they correlated with the other group.

They found that the variants associated with "being active" had similar and proportional effects on lowering depression risk. That is, a larger effect on activity correlated with a larger effect on depression. Though a real-world extrapolation is difficult to calculate from genetics data, Choi and colleagues estimated that if a sedentary person adds one hour of moderate activity or 15 minutes of intense activity to his/her daily routine, the risk of depression lowers by about 25 percent.

As with Merikangas's study, the study by Choi and colleagues revealed a one-way genetic relationship; genes strongly associated with depression risk had no influence on how physically active people were.

Chad Rethorst, Ph.D., an associate professor of psychiatry at the University of Texas Southwestern who studies the mental health benefits of exercise, said these findings offer yet another strong reason for people to become more active.

"Unfortunately, we all know that behavioral change is hard, even when there are compelling motivators," Rethorst said. "People who might have some added risk of depression probably have characteristics that would make behavioral change even harder."

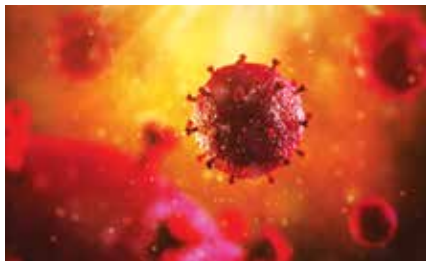
Understanding why some people are more predisposed to exercise or engage in other physical activities could help guide interventions aimed at promoting wellness, he added.

The study by Merikangas was supported by an NIMH Intramural Research Program grant, with additional support from the Johns Hopkins Bloomberg School of Public Health, Rubicon Fellowship, and the European Union Seventh Framework Programme. Choi's study was supported by grants from the NIMH, with additional support from the Tepper Family Massachusetts General Hospital Research Scholar program and the Demarest Lloyd Jr Foundation. **PN**

"Real-Time Mobile Monitoring of the Dynamic Associations Among Motor Activity, Energy, Mood, and Sleep in Adults With Bipolar Disorder" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2717967. "Assessment of Bidirectional Relationships Between Physical Activity and Depression Among Adults: A 2-Sample Mendelian Randomization Study" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2720689.

JOURNAL DIGEST

BY NICK ZAGORSKI



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Exposure to Efavirenz In Utero May Slow Development

Despite the antiretroviral efavirenz being recommended as the first-line choice for women with HIV who may have children, few studies have looked at the long-term effects of exposure to the medication on offspring. A study appearing in *Translational Psychiatry* now suggests that animals exposed to efavirenz in utero may experience changes in brain structure and developmental delays.

Researchers at Radbound University in the Netherlands treated pregnant rats with either 100 mg/kg of efavirenz or placebo (four animals in each group) throughout pregnancy and the first seven days after birth of their pups. The male offspring from each group of mothers were then tested on various physical and behavioral tasks during their youth, adolescence, and adulthood.

The various test results showed that while rats exposed to efavirenz perinatally had reduced body weight and delays in the development of their reflexes and motor skills, anxiety and depression behaviors were similar between the two groups. Brain tissue samples taken from the offspring when they were adults revealed that efavirenz-exposed animals had fewer neurons in regions involved in motor development compared with control animals.

The researchers noted that the mother rats given efavirenz did not show any reduced quality of maternal care, so this was not a factor in the developmental delays.

"Our findings underline the need for long-term clinical studies in children that are perinatally exposed to EFV [efavirenz], as well as more detailed studies on the underlying neurodevelopmental mechanisms," the researchers wrote.

Wijer LV, Garcia LP, Hanswijk SI, et al. Neurodevelopmental and Behavioral Consequences of Perinatal Exposure to the HIV Drug Efavirenz in a Rodent Model. *Transl Psychiatry*. 2019; 9(1): 84. https://www.nature.com/articles/s41398-019-0420-y

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Nut-Rich Diet Linked To Lower Depression Levels

People who consume a diet rich in tree nuts, particularly walnuts, may have lower levels of depressive symptoms compared with those who do not consume nuts, according to a report from researchers at the University of California, Los Angeles.

The researchers analyzed data from the National Health and Nutrition Examination Survey (NHANES) from 2005 to 2014. For NHANES, participants provided detailed dietary intake information and were also assessed for depressive symptoms with the nine-item Patient Health Questionnaire (PHQ-9). The researchers focused solely on adult NHANES participants (aged 18 and older), resulting in a sample size of 26,656 participants.

On average, the PHQ-9 scores of participants who consumed nuts were 3.82 while those who did not eat nuts had scores of 4.15—a statistically significant difference between the groups. Further analysis showed that people who included walnuts in their diet had PHQ-9 scores of 3.28, whereas people who ate nuts other than walnuts had scores of 3.83. The association between nut consumption and lower depression scores was stronger for women than men.

In looking at responses to individual PHQ-9 questions, the main reasons that contributed to lower depressive symptom scores were that nut consumers reported higher energy levels, had greater interest in activities, and better concentration.

As with any large data analysis, the researchers tried to adjust for other possible contributing factors but acknowledged that other dietary traits of people who eat nuts might help lower depressive symptoms. They also noted that the average scores indicated mild depressive symptoms, so it is unknown whether nuts are protective against major depressive disorder.

The findings were published in the journal *Nutrients*.

Arab L, Guo R, Elashoff D. Lower Depression Scores Among Walnut Consumers in NHANES. *Nutrients*. 2019; 11(2): E275. https://www.mdpi.com/2072-6643/11/2/275

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LETTERS TO THE EDITOR

We *Are* 'in Our Lane'

In her president's column in the December 7, 2018, issue, Dr. Altha Stewart employs the phrase "staying in our lane" and the term "biopsychosocial." These have important connotations and associations.

The National Rifle Association, adjuring physicians to "stay in their lane", used the phrase as a warning to those ostensibly straying, often dangerously, from paths defined by rules and common agreement. "Biopsychosocial" is a term more honored in usage than definition. It has been attacked as a "there is not there, there" concept.

Psychiatry suffers from the lack of a unifying theory (our "lane"). The widely used biopsychosocial concept has been put forward as providing this. Human beings function in a nexus comprising the soma (biology), psyche (mental states, normal and abnormal), and the social. Psychiatrists are specialist physicians who research, teach, train, and treat patients using this perspective. It can therefore be well said, and Dr. Stewart does so, that psychiatry is indeed "in its lane" when it addresses "psychological trauma and senseless tragedies." The biopsychosocial concept and approach defines "the lane" down which disturbed people (biologically and psychologically) are impelled toward the tragedy of violence to others (the social aspect). And recent scientific discoveries in all three biopsychosocial domains are increasingly elucidating the mechanisms that weave them indissolubly together, thus forming this "lane."

Demands for an "integrated," "collaborative," "biopsychosocial" approach are increasingly heard from many sides. I submit that satisfaction of these demands (by "staying in our lane") are crucial for patient satisfaction, improved outcomes, and reduced stigma on the part of the public, as well as for the recruitment and retention of psychiatrists.

J. PIERRE LOEBEL, M.D.
Seattle, Wash.

Letters to the Editor

Readers are invited to submit letters of not more than 350 words for possible publication. *Psychiatric News* reserves the right to edit letters and publish them in any of its formats—print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be emailed to cbrown@psych.org. Clinical opinions are not peer reviewed and thus should be independently verified.

Punitive Parenting

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"The AAP recommends that adults caring for children use healthy forms of discipline, such as positive reinforcement of appropriate behaviors, setting limits, redirecting, and setting future expectations," the policy statement concludes.

Both punitive and withdrawal-type approaches increased child-reported emotional symptoms, suggesting that they might both negatively influence children's mood as they approach adolescence.

The U.K. researchers noted that older mothers used relatively less discipline overall, whereas mothers with more education and higher socioeconomic status used relatively more withdrawal of rewards and less actively punitive approaches, the study found.

The study results suggested it could be particularly problematic for children when mothers with psychosocial distress, such as depression, take active discipline approaches, the researchers wrote. In mothers with high distress, the researchers reported a stronger association between active punitive discipline and the child's Total Difficulties Score on the Strengths and Difficulties Questionnaire. Researchers hypothesized that "the mothers' emotional tone could further heighten the emotional reaction to active discipline."

"This study demonstrates that for those mother-child dyads in which discipline is frequent, the type of approach used appears important with distinct later childhood mental health outcome," the researchers wrote. "[I]f mothers adopted more withdrawal and less active approaches, then later emotional and behavioral problems might be decreased."

Rajyaguru received funding from the National Institute of Health Research. **PN**

"Disciplinary Parenting Practice and Child Mental Health: Evidence From the UK Millennium Cohort Study" is posted at https://www.jaacap.org/article/S0890-8567(18)31897-5/fulltext.

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Chronic Inflammation Increases Risk of Cognitive Problems

Middle-aged adults with chronic inflammation are at greater risk of cognitive problems as they age compared with those without chronic inflammation, suggests a study published in the journal *Neurology*. Chronic inflammation is a persistent state of pain and stiffness seen in disorders such as arthritis and multiple sclerosis.

These findings were uncovered as part of the Atherosclerosis Risk in Communities (ARIC) Study. For this large study, all participants had blood tests taken that measured the following inflammation biomarkers: factor VIII, fibrinogen, von Willebrand factor (vWF), and total white blood cell (WBC) count. Three years later, the researchers measured levels of C-reactive protein (CRP), another blood biomarker of inflammation. The participants received cognitive assessments at the beginning of the study, six to nine years later, and at the end of the study.

The participants whose inflammation biomarker score (compiled by adding the values of factor VIII, fibrinogen, vWF, and WBCs) was in the top quartile had a 7.8 percent steeper decline in their cognitive ability over the 20-year period than those in the lowest quartile. The participants in the top quartile of CRP levels had an 11.6 percent steeper decline compared with those in the lowest quartile of CRP levels. Elevated midlife inflammatory markers were most consistently associated with declines in memory.

"Overall, the additional change in thinking and memory skills associated with chronic inflammation was modest, but it was greater than what has been seen previously associated with high blood pressure in middle age," said lead author Keenan Walker, Ph.D., of Johns Hopkins University in a press release.

Walker KA, Gottesman RF, Wu A, et al. Systemic Inflammation During Midlife and Cognitive Change Over 20 Years: The ARIC Study. *Neurology*. February 13, 2019. [Epub ahead of print] http://n.neurology.org/content/early/2019/02/13/WNL.0000000000007094

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School Exclusion More Predictive of Substance Use Than Juvenile Arrests

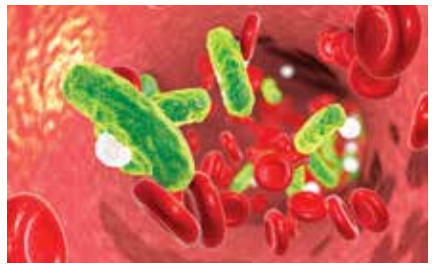
Research has shown that youth with legal/disciplinary problems are at elevated risk of substance use disorders later in life. A study appearing in the journal *Justice Quarterly* suggests youth who are suspended or expelled from school may be at greater risk of later substance use than those who are arrested.

A pair of researchers from George Mason University and the University of Florida examined data from the Rochester Youth Developmental Study—a long-term study of youth examining the causes and consequences of delinquency and drug use. The study sample included 960 adolescents who were all enrolled in school at baseline; among this group, about 55 percent were at some point suspended or expelled from school, 18 percent were arrested as adolescents, and 30 percent used drugs during adolescence.

The researchers found that in both the short term and long-term, only school exclusion practices, and not teen arrests, were statistically associated with subsequent substance use. There was a cumulative effect, in that each additional school exclusion increased the likelihood of drug use by about 14 percent. This association was slightly higher in minority students.

"Our findings have important implications for school policies regarding the use of exclusion from school as a disciplinary measure," the authors wrote. "While no one would deny the need to protect other students and the general academic setting from disruptive and potentially violent behavior, excluding the child from school, even on a temporary basis has been shown to have unintended problematic consequences."

Dong B and Krohn D. Sent Home Versus Being Arrested: The Relative Influence of School and Police Intervention on Drug Use. *Justice Quarterly*. February 5, 2019. [Epub ahead of print] https://www.tandfonline.com/doi/full/10.1080/07418825.2018.1561924



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Fluvoxamine Reduces Sepsis Symptoms in Mice

The antidepressant fluvoxamine may be able to reduce symptoms of sepsis (an inflammatory overreaction to infection that starts damaging the host's body), according to a recent animal study. Sepsis is currently treated with antibiotics to halt the underlying infection, but there are no treatments that directly target the problematic inflammation.

Researchers from the University of Virginia hypothesized that the endoplasmic reticulum (ER)—a component of cells known to affect inflammation—might play an important role in sepsis. They selected an ER protein called the sigma-1 receptor (S1R) as the likely mediator; S1R regulates the production of inflammatory chemicals called cytokines and this receptor is a known target for many drugs. Mice genetically modified to lack S1R were more vulnerable to developing sepsis and more likely to die from septic shock.

The researchers next gave normal mice an acute infection to trigger sepsis and then injected them with either fluvoxamine or saline after they showed signs of sickness; fluvoxamine was selected since this drug binds S1R and stimulates its activity. The animals given fluvoxamine had lower inflammatory cytokine production and had increased survival compared with the animals given saline.

The researchers also found that fluvoxamine could inhibit cytokine production in human blood cells. While additional studies are needed, the findings "suggest that repurposing fluvoxamine to enhance sigma-1 activity may be beneficial for treating sepsis," the authors wrote.

This study was published in *Science Translational Medicine*.

Rosen DA, Seki SM, Fernández-Castañeda A, et al. Modulation of the Sigma-1 Receptor-IRE1 Pathway Is Beneficial in Preclinical Models of Inflammation and Sepsis. *Sci Transl Med.* 2019; 11(478): eaau5266. http://stm.sciencemag.org/content/11/478/eaau5266.short

Managed Care

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described as responsible for establishing behavioral health criteria for her insurance plan. The white paper describes intermediate levels of care in MH/SU treatment as focused primarily on crisis stabilization and as an alternative to brief inpatient treatment. Non-AHIP insurance plans often share the same stance about intermediate levels of care. Insurance companies and managed care entities apparently do not agree that generally accepted standards for intermediate levels of care are comparable for MH/SU treatment and medical-surgical care. Instead, they refocus MH/SU intermediate levels of care on crisis stabilization, not on addressing underlying issues that interfere with adequate use of outpatient treatment to achieve recovery. Intermediate levels of care are a canary in the coal mine here.

Why do insurance plans and a group like AHIP promulgate a flawed understanding of generally accepted standards for intermediate and other levels of care? Why do many insurers cite the LOCUS, an instrument solidly within generally accepted standards for determining level of care, as a source for their criteria but then develop criteria markedly at variance with the LOCUS? Why are nonpsychiatrists defining MH/SU access-to-care criteria? Does this reflect mere ignorance or, more cynically, a willfully shortsighted approach that limits MH/SU treatment to crisis stabilization at all levels of care to cut costs, with the assumption that those for whom such treatment fails will soon move to another insurance plan or to taxpayer-funded plans like Medicaid or Medicare?

The Canary in the Coal Mine Fights Back

Recognizing the implications of this approach explains the common experience of denials of medical necessity in the treatment of MH/SU disorders. Many insurance plans and their reviewers interpret generally accepted standards in ways that misrepresent the nature of MH/SU treatment—and rely upon nonpsychiatrists to do so! One response to recognition of this approach has been patients and their attorneys filing class-action lawsuits against some of the nation's largest insurance companies. These suits allege breach of contract by insurers for issuing insurance policies guaranteeing access to medically necessary care, but then using flawed medical necessity criteria that are outside generally accepted standards to determine access to intermediate levels of care. This time, the canaries are fighting back!

As clinicians, we, too, should be responding to this problem both as individuals and through professional societies. When it comes to determining appropriate levels of care, the American Association of Community Psychiatrists leads the way with its development of the LOCUS. We should work toward defining generally accepted standards that go beyond the managed care focus on crisis stabilization for all kinds of MH/SU treatment. Addressing comorbidity, chronicity, and the impact of trauma or early adversity are essential to maximizing a patient's capacity to use outpatient treatment. If we are serious about helping our patients achieve recovery, we clinicians cannot abdicate the role of defining generally accepted standards to insurance companies and managed care entities. **PN**

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Jennifer L. Payne, M.D., and Maureen Sayres Van Niel, M.D., were among the psychiatrists who took part in drafting APA's position statement on screening and treatment of antenatal mood and anxiety disorders.

KEY POINTS

APA's "Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum" strongly recommends the following actions:

- Assessing all pregnant and postpartum women for the presence of—and risk factors for—a psychiatric disorder.
- Educating perinatal women on how to recognize the symptoms of depressive, anxiety, and psychotic disorders.
- Screening pregnant women with a validated screening tool twice during pregnancy and again during pediatric visits throughout the first six months postpartum. Physicians should also put in place a systematic response to ensure that psychiatric disorders are appropriately assessed, treated, and followed.
- Educating patients about the risks posed by untreated psychiatric illness during pregnancy and lactation, as well as the risks and benefits for both the woman and her baby of using psychotropic medications while pregnant or breastfeeding.

Perinatal Disorders

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"Perinatal depression is one of the most common complications of giving birth," said Jennifer L. Payne, M.D., director of the Women's Mood Disorders Center and an associate professor of psychiatry at Johns Hopkins School of Medicine. As many as 1 of 7 pregnant women and as many as 1 of 5 postpartum women develop depressive or anxiety disorders, according to the position statement.

More serious mental health problems are associated with the perinatal period: 1 of 1,000 such women develops a psychotic disorder, and maternal suicide is the second-leading cause of death among postpartum women. The incidence of perinatal psychiatric disorders is highest in women from lower socioeconomic backgrounds.

"We want to make abundantly clear the seriousness of these disorders and explain how we must address them to avoid deleterious effects on infant development, including preterm birth, low birth weight, lower IQ, slower language development, and more child behavioral problems," Payne said. "It impacts more than just the mom. It really becomes a public health problem in a way—it becomes about the whole family."

A blue-ribbon panel of 12 reproductive psychiatrists, including some of the top research psychiatrists in the country, began working together on the position statement two years ago. They drew from more than 450 reference materials, including their own research articles.

"We discovered there were so many untreated and undiagnosed cases of antenatal and postpartum psychiatric disorders," explained Maureen Sayres Van Niel, M.D., president of the APA Women's Caucus and a member of the Steering Committee of the Women's Preventive Services Initiative, who spearheaded APA's effort.

"A number of major medical organizations had already developed position statements and were looking to APA for guidance," Sayres Van Niel explained. "APA wants to be a leader in educating physicians in finding and diagnosing these disorders and helping providers to establish some sort of mechanism for following up when a screening comes back positive."

Formal Screening Tools Boost Detection

Recent studies of obstetrician/gynecologists have found a significant improvement in the detection rates of depressive and anxiety disorders for this patient population—in some cases more than 20 percent—when they use formal assessment tools. "But most ob-gyn and primary care physicians rely solely on a clinical interview and their own judgment," Sayres Van Niel said.

"Many of the women who suffer from these disorders feel shame and guilt. They think that with a pregnancy or new baby, they're supposed to feel only happy and positive about the experience, so they don't tell people," Sayres Van Niel said. "But with a screening tool, women can complete it in the waiting room, in privacy, and they may be more forthcoming."

Among free screening tools with good sensitivity and specificity, Payne and Sayres Van Niel recommended the one-page Edinburgh Postnatal Depression Scale (EPDS) accompanied by an anxiety screening tool, such as the Generalized Anxiety Disorder 7-item scale (GAD-7).

Payne pointed out that when it comes to treating this patient population, women are often advised when they are pregnant to give up coffee, alcohol, and their antidepressants.

"This is due to a misunderstanding of how serious psychiatric illnesses are," she said. "Antidepressants are not a 'luxury' medication."

Most Antidepressant Use Safe in Pregnancy

Some studies have associated pregnant women's use of antidepressants with higher rates of infant heart defects, hypertension, and autism, Payne explained. But when studies were well controlled for the health risks associated with depression (women with depression have higher rates of smoking, substance use, diabetes, obesity, cardiovascular disease, and use of other medications), antidepressants were not associated with increased risks for the infant.

"It's incredibly reassuring to know that most psychotropic medications are reasonably safe during pregnancy and lactation," Payne said. "But I think a lot of psychiatrists have not gotten that message, and we need to be talking more about that. When you look at the literature as a whole, it is clear there are abundant risks of having moms psychiatrically ill during pregnancy and postpartum, while the risks of antidepressant use during pregnancy is controversial."

Ultimately, the position statement was needed given how common these disorders are, Sayres Van Niel said. "A woman experiencing mental health issues during pregnancy or after the birth of a baby should be educated that her condition is a medical illness—and that there are good treatments for it and that she is no less of a mother for experiencing it." **PN**

APA's "Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum" may be accessed at https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Screening-and-Treatment-Mood-Anxiety-Disorders-During-Pregnancy-Postpartum.pdf.

APA Educates Public About Postpartum Depression

APA's new position statement on pregnancy and postpartum depression and anxiety will supplement other recent APA initiatives in this area, including the following:

- The APA Women's Caucus designed a durable take-home card for new mothers called "Moms: Be Sure to Take Care of Yourself, Too!" to educate them about the signs and symptoms of perinatal mood, anxiety, and psychotic disorders. The Healthy Start Initiative distributes the cards to the women in the program on the first home visit following the birth of their child. It is also available for general distribution to other organizations on the Healthy Start website.
- Two members of the APA Women's Caucus, Glenda Wrenn, M.D., and Maureen Sayres Van Niel, M.D., collaborated on an episode of the PBS television program "Healthy Minds" on postpartum depression in 2018. The segment is intended to increase awareness of the importance of mental health education, screening, and treatment during the perinatal period. It has been used by health care professionals, organizations who support women with postpartum disorders, and the general public.

Hospitals

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sion. The states had been impatiently waiting for federal participation in funding the care of people with serious mental illness since 1854, when President Franklin Pierce vetoed a bill that would have made the federal government responsible for those who were poor and had a mental illness. The slope charting the rate of depopulation of the public hospitals became steeper after the passage of Medicaid. The cost-shifting race was on.

Whether deinstitutionalization has ever occurred remains a matter of debate. While the number of current public hospital psychiatric beds represents about 3 percent of the 1955 peak, people with serious mental illness are found in many locations providing 24-hour care, including nursing homes, jails, prisons, general hospital psychiatric units, private psychiatric hospitals, contracted intermediate and long-term care psychiatric facilities, community residences (including some with locked doors and some where a person who leaves is shadowed by staff), crisis beds (often locked), and respite beds. Some who live "free" in the community are under the supervision of mental health courts or experience Assertive Community Treatment teams as unduly interfering in their lives or feel intensive case managers run their lives. Counted among those who may be totally unfettered by the mental health system are shelter residents and the homeless. This has led the critics of deinstitutionalization to instead label it "transinstitutionalization."

AP Photo/Bill Allen

President John F. Kennedy signs the Community Mental Health Act into law on October 31, 1963.

Over the past 60 years, many with serious mental illness have led and are leading self-directed, highly productive, meaningful, and satisfying lives. Many are not. The sad part of the history of public psychiatric hospitals over the past 118 years is that very few in government really cared how they could best be used. Of greater importance has been how much will any service for a person with serious mental illness cost and how can we get someone else to pay for it. **PN**

Opioid Prescribing

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said Pack, who was not involved in the research. "If we have better rural psychiatric reach, or greater adoption of telehealth programs for rural psychiatry, we may do a better job of more accurate prescribing for patients who might have conditions that are not just chronic pain."

Overall, the percentage of patients receiving opioid prescriptions dropped from 7.4 percent to 6.4 percent over the years studied, with most of the decrease occurring after the release of the *CDC Guideline for Prescribing Opioids for Chronic Pain*.

Faul said the response to the guideline was encouraging and called for additional measures to bolster appropriate prescribing. "Continued efforts to ensure safe prescribing practices by following [the guidelines] are enhanced by access to nonopioid and nonpharmacologic treatments for pain. Other important activities include increasing naloxone availability, expanding access to medication-assisted treatment, enhancing public health and public safety partnerships, and maximizing the ability of health systems to link persons to treatment and harm-reduction services."

Robert Pack, PhD., M.P.H., calls upon physicians and pharmacists to do more due diligence when working with patients who are dependent on opioids.

Pack agreed but cautioned health professionals to consider each patient individually and encouraged key players to take more responsibility in addressing the opioid crisis.

"The CDC guidelines are very important, but in some cases they may swing too far the other way," Pack said. "We need to get back to the place where physicians are doing their due diligence, … and pharmacists are doing their due diligence with triaging with prescribers and patients on what to do [for patients] dependent on opioid pain relievers." **PN**

"Opioid Prescribing Rates in Nonmetropolitan and Metropolitan Counties Among Primary Care Providers Using an Electronic Health Record System—United States, 2014–2017" is posted at https://www.cdc.gov/mmwr/volumes/68/wr/mm6802a1.htm.

Child Abuse

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Nemeroff noted the impact of early life trauma on how adults respond to stress.

"These individuals do not have a normal response to stress. Depending on when the abuse occurred and the current trauma [causing stress], they will have either a hyperactive response including cortisol secretion or a hypoactive and sluggish response," he said.

Nemeroff's presentation will delve into how this occurs and how certain genetic variants interact with adverse early environmental factors to predict risk for stress-related psychiatric disorders. From there, he will review therapeutic options, including conventional treatment with psychotherapy and medication, and conclude with an exploration of potential new avenues of treatment. **PN**

"Paradise Lost: The Neurobiology of Child Abuse and Neglect" will be held on Saturday, May 18, from 1 p.m. to 2:30 p.m.

Co-Occurring

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orders and neurotic disorders, it was startling how similar the risks were of getting one or the other first," McGrath said. "This is a signal that there are shared genetic risks for these disorders, and that which one manifests first might be purely chance."

Steven Hyman, M.D., director of the Stanley Center for Psychiatric Research at the Broad Institute in Boston, told *Psychiatric News* that these findings reinforce other recent research that has shown a lot of genetic overlap among psychiatric disorders.

"There is probably no single risk gene or genes shared across all psychiatric disorders, but the data are suggesting that there are clusters of disorders with similar genetic risk factors," said Hyman, who wrote an editorial that accompanied this study.

"For the research community, these findings provide a strong take-home message," Hyman continued. "We won't understand the biology of mental illness if we only study these disorders in individual silos."

To make these findings more widely accessible, McGrath and his team used data from the study to create interactive charts (available online at no charge at https://holtzyan.shinyapps.io/the-nb-como-project/) detailing age- and gender-specific risks of psychiatric comorbidity. For example, the risk charts show that a woman diagnosed with depression before age 20 has about a 40 percent chance to also be diagnosed with a neurotic disorder within five years, and a 50 percent chance to be diagnosed within 15 years.

"We hope that doctors will make use of these charts to help guide treatment discussions with their patients, and perhaps steps to reduce the risk of psychiatric comorbidity," McGrath said. "There is always some potential danger for putting risk data out there; it may cause stress in some cases. But I think knowledge is better than ignorance, and if used properly, this information can help in disease prevention."

This study was supported by the Danish National Research Foundation. **PN**

"Exploring Comorbidity Within Mental Disorders Among a Danish National Population" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2720421. The editorial, "New Evidence for Shared Risk Architecture of Mental Disorders," is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2720420.

Curriculum

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cognitive scientists as an especially bad way to retain information.

WrightQ is the school's version of "problem-based learning," in which a clinical case is discussed in small groups with a faculty facilitator. Students develop their own objectives for the case, research those objectives, and then present to each other a week later. "This form of learning requires that the students research the literature to find evidence-based treatments," Roman said.

Multiple-choice exams throughout a course are taken by students individually, followed by students working in the team-based learning groups and taking the same exam again. "We use scratch-off cards—kind of like lottery cards—in which students, after discussion, scratch off as a team what they feel the best answer is," Roman said. "If they don't get it the first time, they try again, receiving partial credit for a correct answer."

The innovations at BSOM are part of a trend in which traditional medical learning—based largely on an educational model more than a century old—is being reexamined. "The reforms at Wright State BSOM are reflective of a wider movement across medical schools and residencies to modernize the way doctors are trained," said APA Director of Education Tristan Gorrindo, M.D. "Cognitive science is informing the way we approach learning throughout higher education. This kind of innovation is exciting, and the continued study of these approaches will help us understand the impact of this learning on the wards and in residency."

WrightCurriculum will be refined over time, and the students and educators at Wright are "learning about learning" as they go. "We are the first class to experience this new model of medical education," said Crager. "There have been some challenges, but the nice thing is that the administration and faculty are recognizing the challenges as they come up and are willing to make adjustments. Within five years, the program should be streamlined, and they will have a good sense of what really maximizes learning."

Certainly, the medical education that Crager and Bensabeur are experiencing is a departure. Said Roman, "This is a very different experience from the one with which practicing physicians today are familiar." **PN**

Information about the WrightCurriculum is posted at https://medicine.wright.edu/student-life/curriculum/teaching-learning-feedback-assessment.