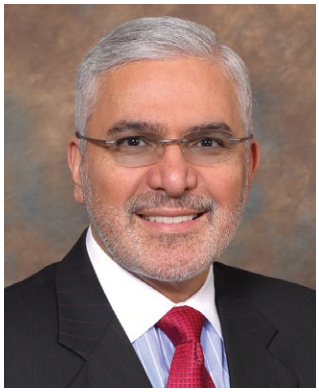

Henry A. Nasrallah, MD
Editor-in-Chief

Unmet needs and hassles of psychiatric practice

Few things are more aggravating than having to secure preauthorization from an insurance company to hospitalize an acutely ill patient or to prescribe a medication that is not on the insurer's restrictive formulary.

Recently, my umbrage at these practices soared to a new height when a colleague told me that he had to fight for, and then wait to receive, permission from an insurance employee to increase, by a notch, the maintenance dosage of a long-acting antipsychotic for his patient.

Can anyone justify why an absentee person who has never met the patient should, sight-unseen, second-guess our clinical judgment that a patient's symptoms are still not well-controlled and require upward adjustment of the dosage? Why are insurance companies allowed to micromanage clinical decision-making? Such outrageous intrusiveness is a signal that insurance companies have "jumped the shark" in their effort to push business interests ahead of the needs of their subscribers.

We've had it with the 'carve-out' status of psychiatry that allows insurance companies to treat reimbursement for our services more restrictively than for other specialties

Call to readers
Reader, I invite you to submit other frustrations and unmet needs that you've encountered in your practice, in the form of a Letter to the Editor that we'll consider publishing in an upcoming issue.

Send your contribution to: henry.nasrallah@currentpsychiary.com

Whose interests are being put first?

I recall instances when I refused to buckle to pressure from a patient's third-party payer to switch from 1 antidepressant to another, a move that would save the insurer money but put my patient at risk of relapse. I informed the insurance company representative that my attorney was going to file a lawsuit on behalf of my depressed patient if he were to relapse or attempt suicide because he had been switched from an antidepressant that was working to another that might not.

Fighting back paid off: In each case, I was told the payer would "make an exception" for that patient.

Frustrations of this kind have become commonplace in psychiatric practice. They tend to detract from the stimulating and gratifying aspects of the care we provide, and reinforce the perception that insurance companies' primary goal is to fatten profits, not facilitate patients' return to health.

Here are other reasons for chronic frustration in psychiatric practice. They reflect serious, unmet needs that we hope will be resolved soon.

Improved diagnostic schema. We need a valid—and more than simply reliable—evidence-based diagnostic system that is rooted in scientifically established pathophysiology. The basic clinical elements of DSM-5 should be gradually amalgamated with rapidly emerging genetics and biological endophenotypes. The continuum of and boundary between "normal" and "pathologic" human behavior should be further clarified.

Biomarkers. Our field eagerly awaits development of biomarkers (laboratory

tests) to bolster psychiatric practice in several ways, including:

- confirming the clinical diagnosis
- identifying biological subtypes
- monitoring response
- guiding selection of drugs
- predicting side effects
- measuring severity of disease.

Elusive parity. We've been patient, but we're tired and angry at empty promises of full parity for psychiatric care. We've also had it with the stigmatizing and discriminatory "carve-out" status that allows insurance companies to treat reimbursement for psychiatric services more restrictively than for other medical and surgical specialties. Policy makers must end the egregious discrimination that gives half a loaf to some brain disorders (psychiatric) and a full loaf to other brain disorders (neurologic).

Better medications. We need a stronger commitment from the pharmaceutical industry, on which we rely entirely for development of psychoactive drugs, to wage a relentless war on serious mental illness. The private sector should accelerate translation of groundbreaking neuroscientific discoveries—thanks to research funded by the public sector, such as the National Institutes of Health—into innovative new mechanisms of action. Patients who suffer from psychiatric brain disorders for which there are no approved treatments await that commitment and bold action.

Collaborative care. Psychiatry needs a more consistent, more productive bidirectional relationship with primary care. A stronger bond will improve the care of patients on both sides and would, I believe, increase the satisfaction of clinical practice for both specialists. Because structure can facilitate function, co-locating providers can help achieve this vision.

Legal entanglement. Psychiatry must be unshackled from an oppressive set of laws that tie our hands when we treat patients with brain pathology who are incapable of understanding their illness and their need to be treated. Those laws were imposed long before scientific advances showed that prolonged and untreated episodes of psychosis, mania, depression, and anxiety are associated with neurotoxic processes (neuroinflammation, oxidative and nitrosative stress). Medical urgency and patient protection must trump legalisms, just as unconscious stroke and myocardial infarction patients are treated immediately without filing multiple forms or waiting for a court order.

Another legal beef: We psychiatrists are exasperated with the expanding criminalization of our patients—hapless victims of brain diseases that impair their reality testing and behavior. Should a person who suffers a first epileptic seizure or a stroke while driving and kills the driver of an oncoming car be incarcerated with hardened murderers and rapists and treated for epilepsy in a prison instead of a neurology ward? Our patients belong in a secure hospital, a medical asylum, where they are given compassionate medical care, not the degrading treatment afforded to a felon.

More resources. There is a dire need for psychiatric hospital beds in many parts of the country, because many wards were closed and renovated into more profitable, procedure-oriented specialties. There also is a severe shortage of psychiatrists in our country, as I discussed in my editorial, "Signs, symptoms, and treatment of *psychiatrynemia*," (December 2014). The 25%

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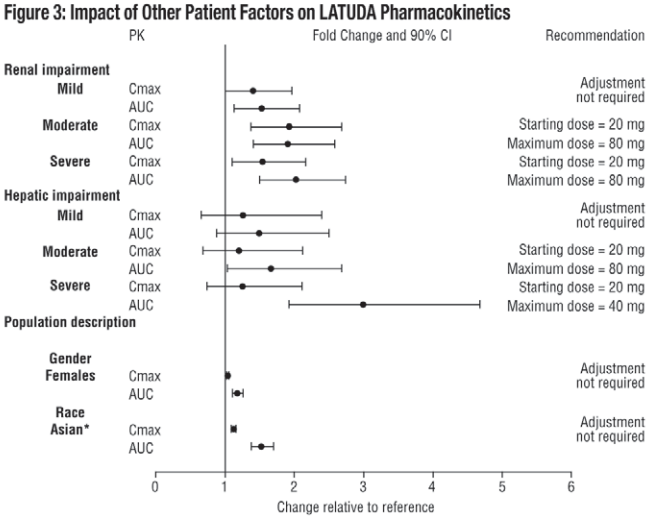
8.6 Other Patient Factors

The effect of intrinsic patient factors on the pharmacokinetics of LATUDA is presented in Figure 3.

Figure 3: Impact of Other Patient Factors on LATUDA Pharmacokinetics



*Compare to Caucasian

10 OVERDOSAGE

10.1 Human Experience

In premarketing clinical studies, accidental or intentional overdosage of LATUDA was identified in one patient who ingested an estimated 560 mg of LATUDA. This patient recovered without sequelae. This patient resumed LATUDA treatment for an additional two months.

10.2 Management of Overdosage

Consult a Certified Poison Control Center for up-to-date guidance and advice. There is no specific antidote to LATUDA, therefore, appropriate supportive measures should be instituted and close medical supervision and monitoring should continue until the patient recovers. Consider the possibility of multiple-drug overdose.

Cardiovascular monitoring should commence immediately, including continuous electrocardiographic monitoring for possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide, and quinidine carry a theoretical hazard of additive QT-prolonging effects when administered in patients with an acute overdose of LATUDA. Similarly, the alpha-blocking properties of bretylium might be additive to those of LATUDA, resulting in problematic hypotension.

Hypotension and circulatory collapse should be treated with appropriate measures. Epinephrine and dopamine should not be used, or other sympathomimetics with beta-agonist activity, since beta stimulation may worsen hypotension in the setting of LATUDA-induced alpha blockade. In case of severe extrapyramidal symptoms, anticholinergic medication should be administered.

Gastric lavage (after intubation if patient is unconscious) and administration of activated charcoal together with a laxative should be considered.

The possibility of obtundation, seizures, or dystonic reaction of the head and neck following overdose may create a risk of aspiration with induced emesis.

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of the population who suffer a mental disorder are clearly underserved at this time.

Furthermore, because today's research is tomorrow's new treatment, funding for psychiatric research must increase substantially to find cures and to thus reduce huge direct and indirect costs of mental illness and addictions.

Public enlightenment. A well-informed populace would be a major boon to our sophisticated medical specialty, which remains shrouded by primitive beliefs and archaic attitudes. For many people who desperately need mental health care, negative perceptions of psychiatric disorders and their treatment are a major impediment to seeking help. Psychiatrists can catalyze the process of enlightenment by dedicating time to elevating public understanding of the biology and the medical basis of mental illness.

All this notwithstanding, our work is gratifying

Despite the hassles and unmet needs I've enumerated, psychiatry continues to be one of the most exciting fields in medicine. We provide more therapeutic face-time and verbal interactions with our patients than any other medical specialty. Imagine, then, how much more enjoyable psychiatric practice would be if these pesky obstacles were eliminated and the unmet needs of patients and practitioners were addressed.

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