VOLUME 55, NUMBER 18, SEPTEMBER 18, 2020

AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

ISSN 0033-2704

AP Photo/Charles Krupa

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The U.S. presidential election is only weeks away. Where do candidates President Donald Trump (R) and former Vice President Joe Biden (D) stand on mental health and health issues?

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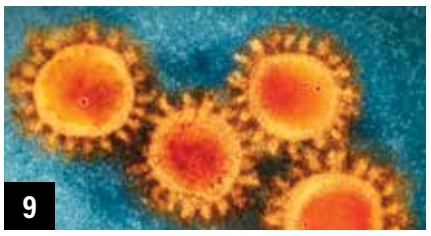
CMS accounts for pandemic in Quality Payment Program proposals.



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APA releases guideline on treating patients with schizophrenia.

Black Psychiatrists Link History of Structural Racism to Current Outcomes

Panelists in APA's second town hall discussed how racist policies put into place generations ago continue to harm Black people.

BY TERRI D'ARRIGO

Just a few days before the 57th anniversary of the civil rights March on Washington, where the Rev. Martin Luther King Jr. gave his "I Have a Dream Speech," APA hosted the second in a series of town hall meetings to address structural racism in psychiatry. A distinguished panel of two Black psychiatrists and a physician spoke to approximately 425 people about how the Black Lives Matter movement is an outgrowth of the civil rights initiatives of the 1960s, the effects of racist policies on Black people and their families, and the impact of racial injustices within the organization and the profession.

APA President Jeffrey Geller, M.D., M.P.H., who hosted the town hall, described how the actions and ideals put forth in the March on Washington are not only relevant, but necessary today.

"The tradition of advocacy and organizing continues because racial injustices are very much alive in the United States," Geller said. "Beyond the appalling scenes of police brutality and the deaths of innocent Black people, the systemic impact of racism hits home in the house of medicine and psychiatry as health inequities and racism impact Black people, Latinos, indigenous people, Asian Americans, and others."

Geller called upon the APA Board of Trustees to address racism within APA and psychiatry. He noted that Board members are predominantly white and that they must take the initiative and be proactive in confronting and dismantling structural racism.

"We cannot turn to the Black members of the Board to guide us. That would

see **Black Psychiatrists** *on page 12*

PERIODICALS: TIME SENSITIVE MATERIALS

APA Meets With ABPN to Press for MOC Reform

Early results from a pilot project using a journal-article approach to testing that might replace the 10-year exam have been promising. But future reforms await new guidance from the ABMS next year.

BY MARK MORAN

APA leaders, including members of the APA administration, Board of Trustees, and Assembly, continued to press for changes to how psychiatrists are assessed for continuing certification during a meeting in July with leaders of the American Board of Psychiatry and Neurology (ABPN).

ABPN President Larry Faulkner, M.D., said at the meeting that the American Board of Medical Specialties (ABMS) is revising its standards for

see **Certification Reform** *on page 19*

PSYCHIATRIC NEWS

Psychiatric News, ISSN 0033-2704, is published biweekly on the first and third Friday of each month by the American Psychiatric Association. Periodicals postage paid in Washington, D.C., and additional mailing offices. Postmaster: send address changes to Psychiatric News, APA, Suite 900, 800 Maine Avenue, S.W., Washington, D.C. 20024. Online version: ISSN 1559-1255.

SUBSCRIPTIONS
U.S.: individual, $164. International: APA member, $223; nonmember, $247. Single issues: U.S., $28; international, $49. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Structural Racism in American Psychiatry and APA: Part 6

BY JEFFREY GELLER, M.D., M.P.H.

This article describes the desegregation of all-Black U.S. state hospitals.

In his Special Message to Congress on November 19, 1945, President Harry Truman restated his belief that every American citizen has "the right to adequate medical care and the opportunity to achieve and enjoy good health." He advocated for more hospitals and more medical professional staff to serve in them. He said:

> *The States, localities and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation, and should make sure that Federal funds are allocated to those areas and projects where Federal aid is needed most.*

He believed that prevention should be an important function of these hospitals, including the prevention of mental disorders.

In 1946 Congress passed the Hill-Burton Act to support the building and expansion of hospitals through federal grants and loans. The law posed problems for poor and minority communities. While facilities receiving the funds could not discriminate based on race, color, national origin, or creed, they could have separate but equal facilities in the same area. Hospitals were required to provide a "reasonable volume" of free care each year, but no regulation defined that volume. The state and municipality where the hospital was located each had to put up one-third of the costs for construction and have the resources to maintain and operate the hospitals. Thus, low-income areas did not get much of the funding, but middle-class areas did.

In 1962, a black dentist, George Simkins; a black surgeon, Alvin Blount; and others sued two North Carolina hospitals in Greensboro that had received a considerable amount of Hill-Burton funds, claiming the hospitals denied "the admission of physicians and dentists to hospital staff privileges, and the

admission of patients to hospital facilities, on the basis of race." They also sought a ruling that the Hill-Burton Act's provision for separate-but-equal facilities and services was unconstitutional. The plaintiffs won the case on appeal in the U.S. Court of Appeals, Fourth Circuit. The *Simkins v. Cone* decision marked the first time that federal courts applied the Equal Protection clause of the 14th Amendment to prohibit racial discrimination by a private entity and set the stage for Congress to pass the 1964 Civil Rights Act the next year, which prohibited using federal funds for racial segregation.

The major force for the integration of hospitals, it turns out, was President Lyndon Johnson through Medicare. In a bold move, the Johnson administration made it clear that no segregated hospital would receive federal Medicare dollars. This precipitated a truly amaz-

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APA's COVID-19 Resource Center

This regularly updated site brings together a number of resources from APA and other authoritative sources to help members stay informed of changing government regulations and other practice-related news and care for their patients and themselves. It can be accessed at psychiatry.org/coronavirus.

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ing turnaround. In January 1966, no less than two-thirds of Southern and border hospitals were out of compliance, and many Northern hospitals operated as de facto segregated facilities. By June 15, more than 80% of hospitals were complying, and by June 30, the number had risen to 94%. By January 1967, there were very few hospitals not in compliance.

In December 1963, APA approved a position statement on the desegregation of hospitals for the "mentally ill and retarded." There is no record of what exactly this position statement said.

The sequence of and some perspectives on the desegregation of the all-Black state hospitals follow.

State Hospital Desegregation

- **West Virginia, 1954:** A few state hospitals desegregated before the Civil Rights Act of 1964. The Lakin Hospital for the Colored Insane was one of four state facilities for Blacks with special needs in West Virginia, the others being the Lakin Industrial School for Colored Boys, West Virginia Industrial Home for Colored Girls, and the West Virginia School for the Colored Deaf and Blind. Larkin opened in 1926 and became integrated in 1954. It was unusual in its time in that all the staff were Black. The staff and patients lived together at the hospital because local housing was practically nonexistent for Blacks, and they operated a self-sufficient community. The quality of care was said to be good, and Lakin has been described as "a serious attempt to accomplish the 'equal' portion of the separate-but-equal doctrine."

- **Maryland, 1963:** Maryland also initiated its state hospital desegregation plan prior to 1964. In 1963, Maryland's health commissioner ordered the desegregation of all Maryland state hospitals. The all-Black facility was Crownsville State Hospital. The initial push for desegregation at Crownsville was started by the National Association for the Advancement of Colored People and Black community leaders in the 1940s. Up until 1948, all of the hospital staff were white. Knowing integration would someday occur, members of the Black community, worried what would happen to Black patients when white patients were admitted and there were no Black staff. The first Black employee was a psychologist and others followed—the first Black social worker was hired in 1950 and the first Black aide in 1952. The first Black superintendent was hired in 1962. An issue arose with on-campus housing, a benefit of the job. White staff did not want to live with the Black staff. The superintendent told the white staff they could live in integrated housing on campus or at their own expense off campus. The first white patient was admitted January 1, 1963. Also in the 1960s, the hospital started an outpatient clinic in Baltimore, because Johns Hopkins and other facilities—by practice but not by policy—would not treat Black patients.

- **Oklahoma,1964:** Taft State Hospital was an all-Black facility, with an all-Black staff, located in an all-Black town. In 1940 its 738 patients were cared for by three psychiatrists (including the superintendent), three nurses, and an unknown number of direct care staff, who apparently all lived in one room. In 1949, Oklahoma consolidated the state hospital with the Institute for Colored Blind, Deaf, and Orphans and the Training School for Negro Girls, creating one large facility for Blacks with all manner of clinical needs. Oklahoma desegregated its public facilities in 1964. Rather than admit white patients to its state hospital for Black patients, as most of the other states would do, Oklahoma transferred the Black patients to its two other (all white) state hospitals. Taft was closed in 1970 and converted into a correctional facility, thus confounding in the public's mind people with mental illness and criminals. (Some state hospitals have converted some of their units into correctional facilities, leading some people to think that psychiatric patients are being held behind multi-layered, barbed wire, razor-topped fences.)

The Mount Vernon Hospital for the Colored Insane near Mobile, Ala., was a 19th century arsenal and a barracks and prisoner of war camp before it was opened in 1902 for the care of Black patients.

- **North Carolina, 1965:** Cherry Hospital, one of the state's all-Black state hospitals, admitted its first white patients in 1965 following years of clear health care inequities between its white and Black state hospitals. In 1957-1958, the state spent $886 per patient per year at Cherry Hospital, while per capita expenditures at the all-white state hospitals were about twice as much. While cotton was not raised on the farms of Cherry Hospital, Black patients were routinely leased to local white farmers to pick their cotton. The hospital was paid a fee for the patients' labor; the patients received nothing. An employee who had joined the hospital staff in the 1960s said in an interview in the 21st century that he thought integration had been easier at the hospital than it had been in the community outside the hospital. The integration of North Carolina's state hospitals and the shift to a regionally based system of state hospital admissions occurred simultaneously, but it's not clear if one drove the other.

- **Virginia, 1965:** In the 1950s, overcrowding was an increasing problem at Central State Hospital in Petersburg: One ward had 300 patients in a single large room, and patients in the forensic building were sleeping on the floor. The hospital constructed a maximum-security forensic unit and a geriatrics unit, and its patient population reached almost 5,000 in the 1950s. In the 1960s, in a run-up to the admission of whites, Central State Hospital upgraded its physical plant, started treating adolescents, and opened an alcohol abuse treatment program. The first admission of a white person to Central State Hospital, on August 27, 1965, was a matter of happenstance. A sheriff whose jurisdiction was near Petersburg was supposed to take a white patient to the forensic unit at Southwestern State Hospital. To avoid the trip of about 300 miles, he brought the patient to the Black forensic unit at Central State Hospital. A hospital employee at the time later recalled the confusion when the medical records department wanted to process this patient as a light-skinned Black patient. Other white people were admitted soon thereafter. The first Black superintendent/director was Olivia Garland. Hired in 1985, she stayed at Central State Hospital until transferred to Eastern State Hospital in Staunton, Va., to clean up scandalous conditions there. By the 1990s the Central State Hospital census included about 50% Black patients and 50% white patients. Other races totaled less than 1%.

- **South Carolina, 1966:** In South Carolina, William S. Hall, the state commissioner of mental health from 1963 to 1985, was concerned that too rapid desegregation of the state's all-Black facility would be dangerous: "Long-term mental wards are more like Barracks or dormitories than hospital wards. Most of the patients are ambulatory; a great many are quite able bodied. Massive forced racial mixing very possibly would provoke bloodshed, especially if it were done overnight." Political pressures caused Hall to revise his desegregation plan from five years to two years. Desegregation started with the opening of an integrated admissions building in February 1966.

- **Alabama, 1969:** Mt. Vernon Hospital for the Colored Insane (subsequently Searcy Hospital) in Alabama was the last of the segregated hospitals to integrate. While serving only Black patients since it opened in 1902, it was staffed predominantly by white staff. During the period 1964 through 1969, Alabama was engaged in a battle with the federal government regarding compliance with the Civil Rights Act of 1964, a struggle led by Alabama Gov. George Wallace. When sworn in as Alabama's governor, he had proclaimed, "In the name of the greatest people that have ever trod this earth, I draw the line in the dust and toss the gauntlet before the feet of tyranny, and I say segregation now, segregation tomorrow, segregation forever." There do not appear to be records of how the hospital achieved integration in 1969.

Conclusion

Some authorities would like to believe segregation in health care ended in the 1960s. Others point out that it hasn't ended yet. In the May 18 *Atlantic*, staff writer Vann R. Newkirk wrote:

> *The sweeping tide of Civil Rights papered over the fissures that were built into Jim Crow-era health care, but progress was slow and proved*

see **Structural Racism** *on page 9*

Remember Your Colleagues

APA has launched a new feature on its website for the publication of member obituaries. If you would like to write an obituary for an APA member, find out how to do so at psychiatry.org/obituaries. Member obituaries can also be read at this site.

Trump, Biden Differ on Approach to MH Policies

Trump wants to cut drug prices and end the Affordable Care Act. Biden plans to push for mental health parity and increased access to care. **BY KATIE O'CONNOR**

Symptoms of psychiatric disorders have soared since the COVID-19 pandemic began, with rates of anxiety, depression, and suicidal ideation increasing, among others.

The pandemic's mental health ramifications will be far reaching and long lasting, raising the question of how each of the two candidates running in the 2020 presidential election—Republican President Donald Trump and former Democratic Vice President Joe Biden—plans to respond to the mental health crisis should he win on November 3. **PN**

Trump's second-term agenda is posted at https://www.donaldjtrump.com/media/trump-campaign-announces-president-trumps-2nd-term-agenda-fighting-for-you. Biden's plan for health care is posted at https://joebiden.com/healthcare/#. Biden's interview with the Mental Health for US initiative is posted at https://www.mentalhealthforus.net/candidate/joe-biden/. "COVID-19, Mental Health, and the 2020 Election: A Review of Candidate Platforms" is posted at http://apapsy.ch/PresidentialCampaigns.

President Donald Trump

AP Photo/Charles Krupa

At press time, Donald Trump's plans to address mental health issues in a second term were unclear. His campaign website largely outlines what he has completed in his first term, including allowing short-term health plans to be extended up to 12 months, repealing the individual mandate of the Affordable Care Act (ACA), and declaring the opioid crisis a public health emergency.

The website notes that in 2019, Trump signed an executive order calling on his administration to develop a comprehensive strategy to end suicide among veterans and establishing a task force to do so. His administration also expedited the release of emergency grants to states to improve access to treatment for substance use disorder (SUD) and other mental illnesses during the COVID-19 pandemic.

He also signed the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, which expands access to treatment for people with SUD and other mental illnesses.

Shortly before the Republican National Convention last month, Trump's campaign team posted his second-term agenda on his website, which outlines 10 goals but does not provide details on how he would achieve them. The agenda does not list any specific policy goals related to mental health, but a news release notes that he will outline additional policies as he continues on the campaign trail.

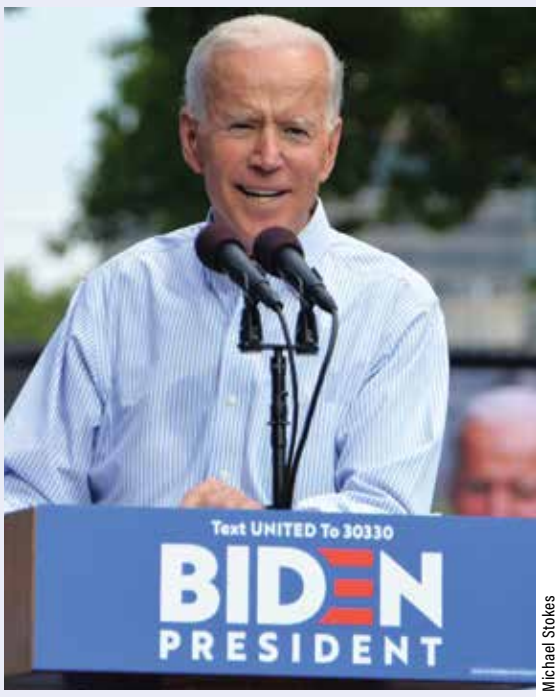
Under health care, the agenda lists seven goals, including cutting prescription drug prices and putting patients and doctors back in charge of the health care system. The goal of eradicating COVID-19 is also listed as a second-term priority, and bullet points include developing a vaccine by the end of 2020 and returning to normal in 2021.

"Mental health has remained a priority for President Trump, both throughout his Administration and the coronavirus pandemic," said Courtney Parella, the Trump campaign's deputy national press secretary, in an email. "President Trump has expanded critical telehealth technology to reach Americans in every corner of the nation, and because of his Administration's continued focus on this issue, Americans have never had more access to mental health resources than they do today."

In a comprehensive comparison of Trump and Biden's campaign platforms, the Kaiser Family Foundation (KFF) noted that Trump's 2021 budget includes an increase in funding for suicide prevention programs in the Substance Abuse and Mental Health Services Administration (SAMHSA).

With regard to mental health parity, KFF also noted that the Trump administration joined the case now before the Supreme Court that would invalidate the ACA, "an outcome that would substantially limit the scope of parity rules and eliminate the essential health benefit requirement," according to the analysis. KFF also pointed out that Trump's 2021 proposed budget would decrease total funding for SAMHSA, though the budget also includes a small increase in grants to address opioid use disorder.

Former Vice President Joe Biden



Michael Stokes

Joe Biden's campaign website states that, as vice president, he was a champion of efforts to implement the federal mental health parity law, improve access to mental health care, and eliminate the stigma of mental illness.

The website adds, "As President, he will redouble these efforts to ensure enforcement of mental health parity laws and expand funding for mental health services." The website notes that enforcement of the Mental Health Parity and Addiction Equity Act has been insufficient. "As President, he will finish the job by appointing officials who will hold insurers accountable, enforcing our parity laws to the fullest extent," the website states. "He will also direct federal agencies to issue guidance making clear how state officials and the public can file a complaint when their insurers—or Medicaid—are not living up to their parity obligations."

Biden says he will protect and build on the ACA and create a public health insurance option for Americans, similar to Medicare. Additionally, he would "redouble efforts to ensure insurance companies stop discriminating against people with behavioral health conditions and instead provide the coverage for treatment of mental illness and substance use disorders that patients and families need," according to his website.

Biden further promises to double funding for community health centers and expand the supply of health care professionals through efforts such as expanding the National Health Service Corps.

In a series of questions Biden was asked by the Mental Health for US initiative, Biden responded that his first step to tackle the opioid crisis and reduce SUDs in general is to build on the ACA as well as the 21st Century Cures Act. The law provides $1 billion in grants to states for substance use disorder prevention, treatment, and recovery efforts. The campaign website expands on his plan, noting that he would "dramatically scale up the resources available, with an unprecedented investment of $125 billion over ten years."

Biden proposes to ensure that his new public option, as well as public insurers such as Medicare and Medicaid, integrates SUD care into standard health care practice.

His website also notes that Biden will call on Congress to invest $50 million to accelerate research into the causes and prevention of gun violence at the Centers for Disease Control and Prevention and the National Institutes of Health.

In terms of the COVID-19 pandemic, Biden would ensure that health care workers and first responders have access to prevention and early intervention mental health services, including emotional health support and psychological first aid. He would also expand "immediate access to telemental health services by requiring all carriers—not just Medicare—to pay for telemental health services," according to the campaign website.

Bill Aimed at Replicating Oregon Mobile Crisis Program

The CAHOOTS program works within the local public safety system to provide interventions to individuals experiencing mental health crises.

BY KATIE O'CONNOR

Bill Holderfield

Sen. Ron Wyden (left) speaks with CAHOOTS staff, who run a mobile crisis intervention program. Wyden is hoping other states will be able to start similar programs thanks to legislation he has introduced.

According to a database compiled by the *Washington Post* and regularly updated, as of press time, 5,598 people have been shot and killed by a police officer in the line of duty since January 1, 2015. Twenty two percent, or 1,254, of those individuals were experiencing a mental health crisis.

Psychiatrists and mental health professionals have long pushed for policies and programs that would create alternatives to law enforcement when someone experiences a mental health crisis. For decades, the White Bird Clinic in Eugene, Ore., has been running one such mobile crisis intervention program, called CAHOOTS, or Crisis Assistance Helping Out on the Streets.

In the hopes of making the CAHOOTS model easier to replicate across the country, Sens. Ron Wyden (D-Ore.) and Catherine Cortez Masto (D-Nev.) have introduced the CAHOOTS Act, which will grant states enhanced Medicaid funding to provide community-based mobile crisis services. The White Bird Clinic's CAHOOTS model can be "a guidepost for other communities around the country," said Wyden, a ranking member of the Senate Finance Committee, during a press conference call on the legislation. "I want programs like CAHOOTS all across the country to become a part of Medicaid's DNA."

White Bird Clinic was established in 1969, and through the years, it has developed strong relationships with the community and local public safety system, explained Tim Black, director of consulting with White Bird Clinic. In 1989, White Bird Clinic launched CAHOOTS using a retired ambulance and police radios.

When it first started, CAHOOTS operated a 24/7 crisis hotline and a walk-in center on evenings and weekends. Now, it has expanded to provide 24-hour coverage to the cities of Eugene and Springfield. "We're perceived by the community on the same level as law enforcement, fire, and [emergency medical services]," Black said.

The CAHOOTS response team, consisting of a mental health crisis worker and an emergency medical technician, are embedded within the local public safety system. When dispatch centers receive emergency calls, the dispatcher determines if the situation requires police, emergency medical services, or CAHOOTS.

Sometimes, the CAHOOTS team will respond to a crisis alongside police officers, but in those situations the officers are there only to maintain safety so that CAHOOTS can provide the primary intervention, Black explained.

Bill Holderfield

CAHOOTS worker Sara Stroo prepares for a shift.

Those interventions include crisis counseling, suicide prevention, conflict resolution, substance use intervention, and transportation to services.

Since the death of George Floyd in May in Minnesota, movements across the country have advocated for a national reckoning with how law enforcement agencies operate, pushing to "defund the police" or reallocate law enforcement funds to community services, such as mental health care (see *Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.8a17).

"Across the U.S., you hear police departments and union leaders saying that officers don't want to be mental health workers," Black said. "The CAHOOTS program provides an alternative to traditional public safety responses. It's really about sending the right first responder to the right call."

Stephanie Maya Lopez, M.D., an associate professor of psychiatry at Oregon Health and Science University, noted that carrying out a deinstitutionalization policy without adequate investment in community services in the United States has resulted in increasing numbers of people with severe symptoms of mental illness.

Too often, people who are severely symptomatic end up in the public eye, particularly if they are experiencing homelessness. When law enforcement gets involved, Lopez explained, the best-case scenario is that the officer has some background in social work or crisis intervention to help the individual access services. "But law enforcement officers are not well trained to do that, and it's not the role they're meant to play," she said.

More often, those interactions result in the officer carrying out his or her duty of enforcing the law. "That may mean the person is arrested and put into jail, which during a pandemic, of course, has an added risk," Lopez said. "There's also a risk of injury to both the individual and the law enforcement officer if there is a physical component to the interaction. Tragically, it can even lead to death because these situations can escalate very rapidly."

Wyden and Cortez Masto's legislation would provide a 95% match in Medicaid funding to states to run programs similar to CAHOOTS, as well as $25 million in planning grants to help states get the programs established. In addition to crisis services, the programs are required to provide individuals with referrals to follow-up care.

Lopez emphasized that providing strong crisis response interventions is only one piece of the puzzle. "We have to look at the whole system and make sure that people are getting the services they need when they need them," she said. "But when we're talking about the interaction with law enforcement, anything we can do to reduce that contact and make it safe, person centered, and recovery oriented, the better it will be for people in crisis and law enforcement officers." **PN**

More information about the CAHOOTS Act is posted at https://www.finance.senate.gov/ranking-members-news/wyden-cortez-masto-propose-bill-to-reduce-police-violence-during-mental-health-crises.

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Pandemic Puts Hold on Major Changes To Medicare Quality Payment Program

CMS is proposing to adjust the weights applied to the Merit-based Incentive Payment System's cost and quality performance categories in determining incentive payments, raising the weight for the cost category and lowering the weight for quality. **BY MARK MORAN**

In recognition of the global public health crisis caused by COVID-19, the federal government is offering few major changes to the Medicare Quality Payment Program in the proposed rule for the 2021 Medicare Physician Fee Schedule released in August.

However, the Centers for Medicare and Medicaid (CMS) *is* proposing to increase the weight assigned to the cost category and decrease the weight assigned to the quality category within its formula for incentive payments in the Medicare Quality Payment Program. That means that high-cost services provided by participating physicians will weigh more heavily in whether they receive an incentive payment.

The proposed rule encompasses recommendations regarding physician payment—including proposed changes to the 2021 conversion factor for determining reimbursement for evaluation/management (E/M) office visit services, and telehealth. Those proposals should result in an increase in the overall payment to clinicians designated as "psychiatrists" (see *Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.9a21).

The proposed rule also includes updates to regulations governing the Medicare Quality Payment Program, which encompasses the Merit-based Incentive Payment System (MIPS). That system, implemented in 2017, seeks to reward high-value, high-quality Medicare clinicians with payment increases while reducing payments to those clinicians who aren't meeting performance standards.

In MIPS, performance is measured through the data clinicians report in four areas: quality, improvement activities, promoting interoperability (formerly known as "advancing care information"), and cost.

Importantly, CMS is proposing to raise the percentage weight given in

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formulating incentive payments to cost to 20% (it is now weighted at 15%) and lower the weight given to quality to 40% (it is now weighted at 45%).

The categories of promoting interoperability and improvement activities would remain at 25% and 15% of the MIPS final score, respectively.

Only one episode-based cost measure—the Medicare spending per beneficiary measure—applies to psychiatrists. That measure looks at Medicare Part A and Part B claims submitted for services from three days prior to 30 days after an inpatient hospitalization.

The minimum number of patients needed for the measure to be calculated is 35 patients with inpatient charges. (For those who are under the minimum number of patients to report on this measure, the cost category would have no weight, and quality would be weighted at 60%.)

The proposed rule would not add any new "quality" measures specific to mental or behavioral health for the 2021 performance period.

For reporting purposes, CMS is invoking an "Extreme and Uncontrollable Circumstances" policy to allow clinicians to request to have one or more MIPS performance categories re-weighted due to the COVID-19 pandemic public health emergency.

Additionally, CMS is proposing to adjust its approach to establishing benchmarks for rewards and penalties. Usually, a historic benchmark is used—that is, performance thresholds for penalties and rewards are based on data about overall physician performance from a previous year. However, due to concern that the COVID-19 emergency could skew results, benchmarks for 2021 performance will instead be set using data from the 2021 period itself.

Also related to COVID-19, CMS proposes a more gradual increase in the performance threshold needed to avoid a penalty in 2021: the 2019 final rule would have increased the threshold from 45 points to 60 points, but CMS proposes to hold the increase to 50. CMS also proposes to maintain the exceptional performance threshold at 85 points in 2021, the same threshold as in 2020.

Finally, CMS is delaying implementation of a new MIPS program, the MIPS Value Pathway initiative, originally planned for 2021. That initiative intends to establish specialty-specific sets of performance measures that better assess the "value" of clinician activity across the four domains. **PN**

Information about the Medicare Quality Payment Program is posted on the APA website at https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/overview-of-quality-payment-program.

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Judge Blocks HHS Rule Permitting Discrimination Against LGBTQ Patients

The rule is contrary to the Supreme Court's recent decision that Title VII of the Civil Rights Act applies to LGBTQ employees, the judge wrote in his preliminary injunction. ***BY KATIE O'CONNOR***

A federal judge blocked a Trump administration rule that would have eliminated protections against health care discrimination for lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) people.

On June 12, the Office of Civil Rights (OCR) in the Department of Health and Human Services (HHS) revised an Obama-era rule that interpreted discrimination "on the basis of sex" to include discrimination due to a person's sexual orientation or gender identity. Under the change, the definition of sex discrimination referred solely to a male or female, "as determined by biology," HHS stated in a press release (see *Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.7b23).

HHS announced the change just days before the Supreme Court ruled that Title VII of the Civil Rights Act of 1964—which prohibits employee discrimination based on race, religion, national origin, and sex—applies to LGBTQ employees as well (see *Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.7b5).

Several lawsuits were filed challenging HHS's rule, arguing that it would threaten the ability of LGBTQ individuals to access medical care and that the rule is incompatible with the Supreme Court's decision against employee discrimination. In the first ruling in these cases, Judge Frederic Block of the U.S. Eastern District of New York issued a preliminary injunction in which he agreed that the rule is contrary to the Supreme Court's decision and found that HHS acted arbitrarily and capriciously in enacting the rule.

"When the Supreme Court announces a major decision, it seems a sensible thing to pause and reflect on the decision's impact," Block wrote in his ruling. "Since HHS has been unwilling to take that path voluntarily, the Court now imposes it."

The rule change would have gone into effect on August18, but because of Block's injunction, the original definition of "on the basis of sex" will remain intact, pending further actions by the court.

At least four other legal challenges to the rule are pending before courts across the country, said Katie Keith, J.D., M.P.H., in a blog for *Health Affairs.* Other lawsuits challenge additional provisions in the rule, such as the elimination of language-access protections and addition of religious exemptions. "Each lawsuit asks the court to vacate all or parts of the Trump-era rule and prevent OCR from implementing or enforcing its provisions," Keith wrote.

The case in which Block issued his ruling was filed by two transgender women who have serious medical conditions, Tanya Asapansa-Johnson Walker and Cecilia Gentili. Both require ongoing medical care, Walker for her HIV-positive status and prior experience with lung cancer and Gentili for chronic obstructive pulmonary disease and emphysema.

Both allege that they have experienced discrimination based on their transgender status. Throughout her treatment for lung cancer, Walker "was subject to misgendering, the exposing of her genitals, physical abuse, and refusals to provide medications," according to Block's order.

Gentili has had similar experiences. During routine doctor visits, "doctors have mocked Gentili's body, refused to treat her, and used offensive language towards her after realizing she is transgender," the Block order states.

In 2018, APA issued a position statement that urges the repeal of laws and policies that discriminate against transgender and gender-diverse individuals and opposes all public and private discrimination against transgender and gender-diverse individuals. The Supreme Court's decision affirmed that position in its ruling, Jack Drescher, M.D., noted in an email. Drescher is a psychoanalyst and clinical professor of psychiatry at Columbia University and served on the *DSM-5* Work Group on Sexual and Gender Identity Disorders.

Block's ruling seems entirely consistent with the Supreme Court's ruling, Drescher continued. "What is truly sad here is how much wasted time and effort this administration has put into creating ways to exacerbate the distress of an already stigmatized minority group." **PN**

Block's order is posted at https://hrc-prod-requests.s3-us-west-2.amazonaws.com/123116892418.pdf. APA's Position Statement on Discrimination About Transgender and Gender Diverse Individuals is posted at https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Discrimination-Against-Transgender-and-Gender-Diverse-Individuals.pdf. "Court Vacates New 1557 Rule That Would Roll Back Anti-discrimination Protections for LGBT Individuals" is posted at http://apapsy.ch/1557_Rule.

Congress Considering Bills to Curb Black Youth Suicide

Informed by mental health experts, including former APA President Altha Stewart, M.D., federal lawmakers have introduced bills to provide more funding and resources to curb the disturbing rise in suicide among Black youth. **BY KATIE O'CONNOR**

First, Rep. Bonnie Watson Coleman (D-N. J.) realized there was a problem through her Facebook page. It was there that she began seeing more and more unsettling reports of Black youth dying by suicide.

So she told her aides, "I can't fix this, but I can elevate the discussion around it." Watson Coleman was tapping into a grim reality: The rate of suicide among Black youth has been increasing for years (see *Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.6b11).

In 2018, Watson Coleman convened a congressional hearing to discuss the problem, and last year the U.S. Congressional Black Caucus convened the Emergency Task Force on Black Youth Suicide and Mental Health, of which Watson Coleman is chair. The task force created a working group of Black mental health experts and advocates, and over the course of eight months the task force and working group held hearings, forums, events, and listening sessions to identify not only the causes of the crisis, but also potential solutions.

Altha Stewart, M.D., then the immediate past president of APA, was a member of the working group. "It was an honor to have been invited by the representatives," she said. "It was a once-in-a-lifetime experience, and I cannot stress enough how meaningful it was."

The task force released a comprehensive report, titled "Ring the Alarm: The Crisis of Black Youth Suicide in America" in December 2019. In conjunction with the report's release, Watson Coleman introduced the Pursuing Equity in Mental Health Act of 2019 (HR 5469). In July, Sens. Bob Menendez (D-N.J.), Cory Booker (D-N.J.), and Catherine Cortez Masto (D-Nev.) introduced companion legislation to Watson Coleman's bill, the Mental Health Equity Act of 2020 (S 4388). APA supports both pieces of legislation.

"If we fundamentally believe that today's youth are the future of America, then unmet mental health challenges, especially in minority communities, are putting that future at risk," Menendez said in a news release.

The working group, Stewart explained, offered numerous practical recommendations to address this problem through the report. "But we also laid bare some of the challenges that have impeded our ability to make headway in this area before."

The task force's report adds to the questions that need to be answered through research and those who fund research, says Altha Stewart, M.D.

The Urgency to Learn More

Very few research dollars have been dedicated to investigating mental illness and suicide among Black youth. "Black scientists—those most closely connected to this population—are 10 percentage points less likely than white scientists to be awarded [National Institutes of Health] research funding," the report stated. "[The] lack of evidence pertaining to Black youth mental health and suicide can be explained in large part by the documented disparities that exist in funding for Black investigators."

"Oftentimes, researchers focus on what the interest of the funder is," Stewart said. Yet the working group was composed of individuals dedicated to the interests of the community. "This is a group that has been trying for decades to make the case that funders need to expand the range of research topics they fund, and they've never been able to get a significant audience response from the funding community," she said.

A provision of the House and Senate bills seeks to increase the amount of funding related to Black youth mental health and suicide research through the National Institutes of Health (NIH) and National Institute of Mental Health (NIMH). "We haven't done enough research in this area, and to me, it is vitally important to understand this problem better," Watson Coleman said.

The bills would also call on the National Institute on Minority Health and Health Disparities (NIMHD) to research mental and physical health disparities and authorize $650 million to NIMHD annually for five years. Among other provisions, the bills would authorize $20 million annually for five years to community health clinics that predominantly serve people of color. The funds would

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VIEWPOINTS

The Weight of the White Coat

BY FRANK CLARK, M.D.

"It's cold outside. You might want to wear a coat." This is a familiar parental exhortation that remains embedded in our memory centers. Experience teaches us that coats function as armor to help shield the body from the deleterious effects of inclement weather. We develop an affinity for certain brands because of their durability to help repel the storms that have a proclivity to drench us even on the sunniest days. We marvel at their comfort and welcome effusive praise from spectators. However, even the most luxurious, embroidered, immaculate coat comes with a burden that is opaque even to the individual with 20/20 vision. It is the weight of the white coat worn by generations of physicians that warrants unequivocal attention if the health care system is to flourish.

Frank Clark, M.D., is medical director and division chief for adult inpatient and consultation-liaison services at Prisma Health-Upstate and a clinical assistant professor at the University of South Carolina School of Medicine-Greenville. He is also a member of the APA Presidential Task Force to Address Structural Racism Throughout Psychiatry and an APA delegate to the AMA's Section Council on Psychiatry.

The herd of white coats continues to lay footprints of discovery, compassion, mentorship, and sponsorship. They are the brotherhood and sisterhood who value integrity rather than hypocrisy. They serve as a moral compass to shepherd the young who have a voracious appetite for serving their communities. These are positive lightweight attributes that my colleagues and I welcome without trepidation. However, all white coats are susceptible to the infectious heavyweights that can dismantle the herd, resulting in a chronic pandemic: physician burnout. These heavyweights may masquerade themselves as imposter syndrome; depression; financial debt; and discrimination based on race, ethnicity, age, gender, sexual orientation, gender identity, and religion.

I have always considered it a privilege to be a member of the society of white coats. The journey to gain membership into this esteemed group has been arduous yet rewarding. I feel blessed each day to serve my community and to embolden the future leaders of tomorrow. My faith, family, and friends help restore my equilibrium when I am feeling weighed down by some of my acute and chronic heavyweights: imposter syndrome and depression. The ability to care for patients and teach learners of various disciplines rejuvenates my soul. It allows me to reenter the ring for another round with my nemesis. My therapist serves as the Jiminy Cricket who encourages me to find the silver linings, especially during these unprecedented times in our world. My feet hitting the pavement like a swift deer reminds me of the freedom that comes when I take off the cape weighed down with unrealistic expectations from others. It is during these enlightening moments that I feel like a weightless feather who can breathe comfortably.

The white coat saints who paved the way for our entry into medicine were resilient pioneers. We may never comprehend the heavyweights they endured while wearing the coat that pledges to do no harm. However, it would behoove us to learn how they continued marching on during times of trial and tribulation. We as physicians have the opportunity to be transparent and illuminate the weights that burden us throughout our career. We must remember that underneath the white coat is an individual who is the epitome of imperfection. The herd is only as strong as the individuals who form it. Let us bear one another's weights and love each other until our final day of rest. **PN**

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establish interprofessional teams to provide behavioral health care in primary care settings.

"Our nation must eliminate the pervasive structural inequities that are increasing suicides and mental health disorders among Black youth, including those in economically and socially disadvantaged communities," APA CEO and Medical Director Saul Levin, M.D., M.P.A., said in a news release. The legislation "can help to promote culturally competent, evidence-based mental health and substance use care while generating research designed to help us all better address existing disparities."

Pandemic Intensifies Urgency

The challenges that Black youth face are not new, Watson Coleman said. "I think the pandemic has created a greater sense of urgency," she added, by increasing isolation and depression.

Stewart emphasized how much is not known about how kids and families are faring during the pandemic. How are they coping with virtual learning, the loss of jobs, the loss of human life, and the inability to participate in cultural rituals around grieving and celebrating? "You can't have funerals, you can't have weddings, you can't have gatherings, and these things are known to be supportive psychological activities," she said.

"We're fighting the pandemic, we're fighting to try to retain some of our cultural identity and support system, and then we're fighting structural racism, discrimination, police brutality, and a whole lot of other societal issues," she continued.

The task force's report is not just a roadmap for legislators, Stewart explained. It contains actionable recommendations that anyone—particularly those who work with children or who are in the mental health field—can use to inform their everyday work.

As so much of the country's attention is focused on voting, Stewart recommended harnessing that momentum and talking to legislators about how they plan to curb the increasing rate of Black youth suicide.

"People who don't pay attention to keeping kids alive may not be the best people to represent you," she said. "We can't educate children who aren't alive, we can't house children who aren't alive. First, you've got to keep them alive." **PN**

"Ring the Alarm: The Crisis of Black Youth Suicide in America" is posted at https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf. More information about the taskforce is posted at https://watsoncoleman.house.gov/suicidetaskforce/.

Grants to APAF Fellows Will Foster Research On Pandemic's Effects on Psychiatry

Research projects should include a diverse sample of patients, clinicians, or practice types, depending on what the grantee is studying. ***BY MARK MORAN***

Seven young psychiatrists have received small mentored grants from the APA Foundation (APAF) to study the effect of COVID-19 on patients with mental and/or substance use disorders, the psychiatric workforce, and psychiatric practice.

All of the grantees are APA/APAF Fellows. They are Michael Mensah, M.D., M.P.H., APA's resident/fellow trustee and a PGY-4 psychiatry resident and co-chief of the residency program at the Semel Institute of Neuroscience of the University of California, Los Angeles; Anees Bahji, M.D., a PGY-6 addiction psychiatry fellow at the University of Calgary; Sebastian Cisneros, M.D., a PGY-5 child and adolescent psychiatry fellow at New York-Presbyterian Hospital; Devin Cromartie, M.D., M.P.H., a PGY-4 trainee at Boston University Medical Center; Juliet Edgcomb, M.D., Ph.D., a PGY-5 child and adolescent psychiatry fellow at the Semel Institute for Neuroscience and Human Behavior at UCLA; Youngjung Kim, M.D., Ph.D., a PGY-4 resident at Columbia University; and Tina Thomas, M.B.B.S., a PGY-4 psychiatry trainee at McGovern Medical Center, University of Texas Health Sciences Center.

Each grantee is receiving up to $15,000 to conduct a research project of his or her own design. According to the terms of the Request for Applications, issued in January by the APAF, research projects should include a diverse sample of patients, health care professionals, or practice types depending on the unit of interest. The fellows' research activities will be carried out under the supervision and guidance of a mentor at his/her primary institution in collaboration with mentors in the APA Division of Research.

"This initiative will enable APA and the APA Foundation to participate in enhancing the field's understanding of the impact of COVID-19 in diverse populations," says APA CEO and Medical Director Saul Levin, M.D., M.P.A.

"This initiative will enable APA and the APA Foundation to participate in enhancing the field's understanding of the impact of COVID-19 in diverse populations," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "It will also help in diversifying, sustaining, and strengthening a workforce of clinical investigators in psychiatry. This is an outstanding opportunity for APA and the Foundation to work with some of our most promising young psychiatrists in responding to the public health crisis."

Levin is also chair of the APAF Board of Directors and a former fellow of what is now the APA/APAF Leadership Fellowship.

In addition to the APA/APAF Leadership Fellowship, the other fellowships are the Child and Adolescent Psychiatry Fellowship, Diversity Leadership Fellowship, Edwin V. Valdiserri Correctional Public Psychiatry Fellowship, Jeanne Spurlock Congressional Fellowship, Public Psychiatry Fellowship, SAMHSA Minority Fellowship, SAMHSA Substance Abuse Minority Fellowship, and Psychiatric Research Fellowship.

APA/APAF fellowships provide psychiatry residents the experiential learning, training, mentorship, and professional development they need to be leaders in the field of psychiatry and psychiatric research. The fellowships offer such opportunities as working with Congress on health policy, conducting research, expanding services to minority and underserved populations, and focusing on child psychiatry or substance use disorders. Additionally, APA/APAF fellows get exclusive opportunities to serve on APA councils and network with APA members from around the country.

"A cornerstone of the APAF's mission is to support research that improves mental health care and contributes to public health," said Amy Porfiri, M.B.A., interim executive director of the APAF. "We are pleased to be a part of this effort with the APA Division of Research, and we look forward to seeing what these young researchers will accomplish." **PN**

Information about the APAF and the APA/APAF fellowships is posted at https://www.psychiatry.org/residents-medical-students/residents/fellowships.

Structural Racism

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> *much more difficult to assess than progress in education or housing. Generations of strict geographical segregation left hospitals that served Black people deeply segregated, understaffed, and under-resourced. … [T]here is no real high-water mark for the state of health-care integration.*

APA recognized that segregation in psychiatric hospitals, state schools for people with developmental disabilities, and related institutions did not end by 1970. In 1975, APA updated its Position Statement on Desegregation of Hospitals for the Mentally Ill and Retarded:

> *The American Psychiatric Association is in favor of desegregation of all hospitals for the mentally ill and retarded. This statement is offered as contributory to the national will to eliminate legal and social impediments to the extension of all services to all citizens. The acceptance of this principle and its translation into practice would remove the need to duplicate facilities to accommodate segregation. It would release all available resources in support of a wider range of treatment services for the benefit of all mentally ill citizens.*

In May 1969, a contingent of Black psychiatrists came to the Board of Trustees meeting demanding changes in how APA addressed—actually failed to address—the roles of Black psychiatrists and the treatment of Black patients. This position statement, which, oddly, partially justifies integration by indicating it will be a fiscally prudent change, was surely well intentioned. But in many respects, it was the easiest of the many actions Black psychiatrists of the era were pushing APA to take. It required no changes within APA itself. It did not address matters that could have led to changes for Black psychiatrists. **PN**

"America's Health Segregation Problem" by Ann R. Newkirk is posted at https://www.theatlantic.com/politics/archive/2016/05/americas-health-segregation-problem/483219/.

Winners of Resident/Medical Student Poster Competition Announced

The COVID-19 pandemic didn't stop one of APA's Annual Meeting's major events—the Resident/Medical Student Poster Competition.
BY CHRISTOPHER SALAZAR

The Resident/Medical Student Poster Competition is an APA Annual Meeting tradition that allows residents and medical students to attend the meeting, present their research, and be recognized for quality work. This year the competition was held virtually.

Eligible participants can submit abstracts for posters in five categories: Clinical Case Studies, Psychosocial and Biomedical Research Projects, Patient-Oriented Care and Epidemiology, Community Development and Service Projects, and Curriculum Development and Educational Projects. Submitted abstracts are evaluated by a panel of judges. All winners receive a medal and bragging rights for themselves and their institutions.

Here are this year's winners:

- **Apurva Bhatt, M.D.,** of the University of Missouri-Kansas City, Department of Psychiatry/Truman Medical Center/Center for Behavioral Medicine. Poster Title: "Adolescent and Young Adult Suicide Via Firearms in Missouri." Category: Patient-Oriented Care

- **Gabriela Marranzini, M.D.,** of the University of Virginia. Poster Title: "Climate of Fear: Diagnosis and Treatment of Specific Phobia of Climate Change." Category: Clinical Case Studies

- **Ki Hyeon Kwak, M.D.,** of Chung-Ang University Hospital, Seoul, Korea. Poster Title: "Comparison of the Changes in Psychological Status and Brain Activity Between Adolescent With IGD and Student Pro-Gamers in Internet Game School." Category: Psychosocial Research

- **Siddhi Bhivandkar, M.D.,** of St. Elizabeth's Medical Center, Boston, Mass. Poster Title: "Safety and Appropriateness of Micro-Induction of Buprenorphine/Naloxone" Category: Community Psychiatry

- **Thomas Roach, D.O.,** of the University of Toledo. Poster Title: "Tell Me About Yourself: A Residency Interview Preparation Seminar Directed by Psychiatrists." Category: Curriculum Development and Education **PN**

Christopher Salazar is coordinator of scientific programs in APA's Division of Education.

Brooklyn Psychiatric Society Celebrates Work of Residents

The Brooklyn Psychiatric Society celebrates the innovative work of residents in the Brooklyn area. **BY SANYA VIRANI, M.D., M.P.H.**

Each year the four residency programs in Brooklyn (Interfaith Medical Center, Maimonides Medical Center, Brookdale University Medical Center, and SUNY Downstate Medical Center) participate in a scholarly competition of poster and oral presentations. It was founded in 1992 by Ramaswamy Viswanathan, M.D., when he was president of the Brooklyn Psychiatric Society (BPS). The competition serves as a platform to exchange ideas and showcase projects that are the original works of residents produced during the course of their training.

Sanya Virani, M.D., M.P.H., is a fellow in addiction psychiatry at the Yale School of Medicine and is the resident-fellow member (RFM) trustee-elect on APA's Board of Trustees. She is also the past RFM Assembly representative for Area 2.

Because of the COVID-19 pandemic, the competition was held virtually this year. The event was hosted by Dr. Viswanathan, a professor at SUNY Downstate Medical Center, with the help of Linda Majowka, executive director of BPS. The judges were Dr. Jeffrey Geller, APA president; Dr. Gabrielle Shapiro, a clinical professor at Mount Sinai Icahn School of Medicine; and Dr. Daniel Chen, chair of psychiatry at Medisys Health Network.

Here are the competition winners:

Oral presentations

- **First Prize:** "Combating Modern Slavery: The Anti-Human Trafficking Project" by Dr. Rachel Varadarajulu of Maimonides Medical Center.

- **Second Prize:** "Where Did the Tryptophan Go? A Meta-analytic Journey Through the Kynurenine System in Major Depression, Schizophrenia, and Bipolar Disorder" by Dr. Paulo Sales of SUNY Downstate Medical Center.

Poster presentations

- **First Prize:** "Avoiding the Chill Pill—Verbal De-escalation Training for Residents in a Simulated Lab" by the author of this article.

- **Second Prize:** "Investigation Into Disparities of Opioid Use Disorder Between Sexual Minority and Sexual Majority Populations Using Population-Based, Publicly Available Data" by Dr. Lance Irons of SUNY Downstate Medical Center.

The other competition participants were Dr. Olayinka Olaniyi of Interfaith Medical Center; Dr. Sapna Jairath and Dr. Mahfuza Akhtar, M.D., of Brookdale University Hospital Medical Center; and Dr. Olusegun Popoola, M.D., of Interfaith Medical Center.

This annual competition allows residents in training programs across Brooklyn an opportunity to network with colleagues and potential mentors. It fosters a sense of community, celebrates academic progress, and reminds residents of the multiple opportunities and avenues that exist for growth and development.

Having served as the resident-fellow member (RFM) Assembly representative and deputy representative of Area 2 and now APA's RFM trustee-elect, I appeal to all trainees across the nation to find the time to come together and start events like these—they are not only rewarding and meaningful for growth, but also a symbol of unity within the profession. **PN**

Poussaint Honored for Lifetime Work to Improve Lives of Black Americans

Alvin F. Poussaint, M.D., holds the APA Distinguished Service Award after it was presented to him at a luncheon in his honor earlier this year. With him are Donna Norris, M.D., former speaker of the APA Assembly and past president of the Massachusetts Psychiatric Society (MPS), and Irving Allen, M.D., a member of the MPS. Poussaint is a professor of psychiatry, emeritus, and faculty associate dean for student affairs at Harvard Medical School.

Poussaint was scheduled to receive the award at APA's 2019 Annual Meeting by then APA President Altha Stewart, M.D., but was unable to attend the meeting. He was nominated by Patricia Newton, M.D., M.P.H., M.A., CEO and medical director of the Black Psychiatrists of America.

"It was an honor to select Dr. Poussaint for the Distinguished Service Award," Stewart told *Psychiatric News*. "For over five decades, Dr. Poussaint has worked as an outspoken advocate for the needs of those with mental illness from this nation's most disenfranchised and marginalized communities. In addition to his research on the effects of racism in the Black community, he has studied racism in medical and psychiatric treatment and its influence in the training environment. He has served on numerous editorial boards, and his 2000 book, *Lay My Burden Down: Suicide and the Mental Health Crisis Among African Americans,* was among the first to identify stigma of mental illness in the Black community as a major public health issue."

ON MENTAL HEALTH, PEOPLE, AND PLACES

Hate in the Context of Oppression

BY EZRA E. H. GRIFFITH, M.D.

Ezra E. H. Griffith, M.D., is professor emeritus of psychiatry and African American Studies at Yale University.

In an earlier column, I noted that the COVID-19 pandemic has stimulated my reflecting on articles published some time ago. Here I discuss a piece sent by a friend who has a deep interest in solving problems evoked by oppression and discrimination. The article, "Surviving Hating and Being Hated: Some Personal Thoughts About Racism From a Psychoanalytic Perspective," was written by the psychoanalyst Kathleen Pogue White and published in *Contemporary Psychoanalysis.*

Dr. White invites the reader to ponder "racial hatred." She does not define it crisply. However, the clinical vignettes she provides evoke intense animosity or hostility. She calls hatred a common human experience, one that we fear and forces us into a collusion of silence. It is understood that, while her focus is on the racial context, people experience hatred and hating on other bases like gender, religion, language, and disability. She exhorts us to tear the veil off this taboo, get it out in the open. Let fresh air into the space. Our clinical work might improve. I suggest that so may our social interactions and political discourse.

She sees three ways of thinking about racial hatred: being hated, hating the self, and hating the other. She emphasizes that her model derives from her experiences. For the first concept, she tells us about her kindergarten interaction with a nun. The nun asked whether anyone could read. Young Kathleen put her hand up to announce her achievement in reading. The nun replied that her pupil was not telling the truth. Dr. White goes through some psychoanalytic commentary before concluding that the nun had "spewed venom on a little person. …" The hatred continued as the teacher persisted in calling her "a rotten apple" throughout grade school. The analyst-author explains that there is a strategy for surviving this hatred: recognizing the projection from the nun, getting angry, and turning it back. So much for the problem of being hated.

White employs similar brief stories in talking about hating the self, which she defines as the internalization of "pernicious, destructive attributions and projections." Her explication of these processes is important. She wants to assure us that the psychoanalytic method may offer a pathway to healing. I reminded myself that there must be a role for positive experiences coming from others around us: at home, work, and leisure, for example.

White's third way of thinking about hatred has to do with hating the other: "re-externalizing malignant projections and regarding the projective source with extreme hostility." This response is variable, as we all know. It may take the form of a quiet rebuke, a serene sit-in, a rambunctious march, or a frightening manifestation of plundering and violence. She calmly wonders what internal pressures on whites colonizing America may have caused them to hate Blacks and other groups, with resulting revulsion and outright murder. She suggests the mayhem of those early colonizing years may have been produced by the toxicity involved in the colonizers' expulsion from their original countries. She invites white people to mull this problem over, as she lays bare her own pronounced hatred toward whites.

Kathleen White leaves the meaty challenges for last. She notes, "For blacks to come out of collusive racial self-hatred, we have to take back the good projections (white is good) and tolerate the experience of our own self-hatred (black is bad). For whites to break the collusion of racial hating, they have to take back the bad projections (black is bad) and tolerate the experience of whatever self-hatred they experience as a result." These recommendations are complicated by our traditions and habits, White points out. We are accustomed to reflecting on what it means to be Black. Now, how about considering the experience of being white?

Other scholars have been recognizing this new turn in our field, leading to a renewed exploration of "white privilege." My late colleague Professor Frederick Hickling had for some years been using the term "European-American psychosis." He raised questions about the birth of this delusional idea that whites are inherently superior to everybody else. In her Fanon-esque psychoanalytic model, White points out that both the oppressor and oppressed are caught up in a collusion related to racial hatred. Unraveling it

see **Oppression** *on page 18*

Phasing in Reopening Your Practice

Operating your practice during the pandemic requires the enforcement of safety measures, continued vigilance regarding confidentiality, and being aware of licensure and regulatory issues.

BY ANNE HUBEN-KEARNEY, R.N., B.S.N., M.P.A.

As physician offices are re-opening during the COVID-19 pandemic, there are questions and concerns about how to do so safely. This article is meant to provide ongoing support and risk management recommendations in addition to the previous *Psychiatric News* article on the nuts and bolts of reopening your practice, including obtaining consent from the patient returning to the office.

First and foremost, continue to follow the Centers for Disease Control and Prevention guidelines on social distancing, masks, and hand hygiene and your state and local restrictions. Take into consideration your health and that of your patients and whether to continue with telepsychiatry, reopen your practice to see patients in person, or have a hybrid practice (seeing select patients in person but continuing telemedicine sessions, especially with medically compromised patients or patients who take mass transit to travel to your office).

Be sure your office has masks for you, your staff, and your patients as well as an adequate supply of hand sanitizer. Demonstrate use of both, including using the hand sanitizer when your patient enters the session room. Avoid shaking hands with your patient and explain why.

Anne Huben-Kearney, R.N., B.S.N., M.P.A., is a risk management consultant in the Risk Management Group of AWAC Services Company, a member company of Allied World. Risk Management services are provided as an exclusive benefit to insureds of the APA-endorsed American Professional Agency Inc. liability insurance program.

Reorganize your office to allow for physical distancing, especially if you remove your mask to better interact with your patient. Try to avoid more than one patient in the office at a time, and allow enough time between patients to wipe down surfaces.

Questions on our Helpline have included whether sessions can be conducted at a public park or other public area. This decision needs to be made cautiously, with explicit arrangements made to address auditory and visual confidentiality and with written patient consent.

Consider the option of continuing with telepsychiatry services in the states where your patients are residing. Among the factors to consider are whether colleges and universities have reopened to on-campus education or students are splitting their time on campus and online; when and to what degree the state governors will be rescinding their executive orders, especially regarding licensure; and when the Drug Enforcement Administration resumes compliance with the Ryan Haight Act, which requires health care professionals to conduct an initial, in-person examination of a patient before electronically prescribing a controlled substance.

If you decide to continue with interstate telepsychiatry, initiate the application for permanent licensure in the relevant states where your patients are located. Check the status of COVID-19 state guidelines on APA's website at www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19?utm_source=Internal-Link&utm_medium=COVID-HUB&utm_campaign=Covid-19.

The Interstate Medical Licensure Compact (IMLC) is an agreement that allows states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. Information, including eligibility requirements, on the IMLC is posted at https://www.imlcc.org/. Of note, the State of Principal License, which is the state in which a physician holds a full and unrestricted medical license, must be a full and unrestricted medical license in a state currently participating in the IMLC.

Continuing with telehealth requires a HIPAA-compliant platform with a Business Associate Agreement to ensure your protection in case of a data breach. Psychiatrists should enable all available encryption and privacy modes when using all telehealth modalities.

Continue to ensure patient screening, both for in-person and telepsychiatry sessions. Ensure compliance with the standard of care, which is the same whether care is provided in person or via telemedicine.

When making reopening decisions, be sure to consider the appropriateness and safety of care whether provided in person or via telepsychiatry services. Safety for your patients and for yourself is paramount, now more than ever. **PN**

"Reopening Your Practice During Pandemic" is posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.7b20.

Black Psychiatrists

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take them out of the role of being Board members *with* us," Geller said. "It would signify our lack of understanding that racism is about us [whites]."

Aletha Maybank, M.D., M.P.H., the AMA's chief health equity officer and group vice president, discussed how the harmful legacy of segregation is evident today in the housing, health, and economic status of many Black individuals. She described how the COVID-19 pandemic has illuminated the disparity in life expectancy between Blacks and whites.

"Communities that had higher COVID rates also had higher poverty rates, higher household crowding, higher percentages of people of color, and higher racialized segregation," Maybank explained. "Why did they have higher poverty? Why were they more likely to die not just of conditions related to disease, but conditions related to the health care system [in their area]?"

Maybank attributed these phenomena to redlining, the discriminatory practice of denying financial and other services to residents of certain areas based on their race or ethnicity.

"The reality is that policy has dictated where people can live, especially as it relates to race and ethnicity over time," she explained. "It determines where people live, what kinds of investments are made in their neighborhoods [such as health care], and what people have access to in terms of jobs, transportation, and food."

Maybank also spoke of the importance of providing space in which young people can use their voices to propel societal change.

"I really don't feel we would be here today if it weren't for the young people of the Black Lives Matter movement," Maybank said. "The young people who speak … continue with the tradition of the civil rights movement, but in their own way because they're young [and] it's a new time. I feel they are leading with great power, great purpose, and great authenticity and truth. … We, as we get older, need to step aside and allow them to have that place of leadership."

Kevin M. Simon, M.D., the 2020-2021 Recognizing and Eliminating disparities in Addiction through Culturally informed Healthcare (REACH) scholar, described anti-racism as supporting anti-racist policy through action or the expression of anti-racist ideas.

"It has to be something that becomes part of your daily routine," said Simon, who is completing a fellowship training in child and adolescent psychiatry and addiction medicine at the Boston Children's Hospital/Harvard Medical School. "Much like we ask patients to practice behavioral techniques, we have to practice being anti-racist."

Simon discussed the importance of changing racist policies and explained the impact that some of those policies have had on Black children and families, building upon Maybank's discussion of redlining.

"There are places where if you are Black, regardless of how much money you have to put down for a home, there are realtors who will say, 'Well, I don't think you're putting down enough,' " he said. "Then when you see that the home is sold two weeks later for a lower price, [it is clear] there must be a policy that still exists, even though there [are laws] to say it is illegal to not sell a home to someone who is Black."

Black families are therefore more likely to rent, rather than own, a home. This then filters down into disparities in access to green spaces, because rents tend to be much higher where there are parks, which then affects Black children and their families, Simon said.

"There is evidence to show that green spaces improve mental health," he explained. "So we went from a policy regarding redlining to housing to green spaces to mental health. That is just one stream of connection [that shows] how policies impact individuals."

Former APA President Altha Stewart, M.D., discussed critical junctures in history when psychiatrists, as represented by APA and its precursor, the Association of Medical Superintendents of American Institutions for the Insane, failed to address racism. These touchpoints in history include the years before, during, and after the Civil War, the years of the "separate but equal" doctrine, and the Jim Crow era.

"[Now] we have this very important moment in time where what we do will be looked back upon by generations in the future," said Stewart, who is senior

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APA Releases Practice Guideline on Schizophrenia

The guideline emphasizes the need for comprehensive evaluations and getting patients involved in the treatment process. **BY NICK ZAGORSKI**

Michael McClain

The guideline includes tables about dosing considerations, metabolic properties, and potential side effects of antipsychotics so that physicians and patients can make informed treatment decisions together, says Laura Fochtmann, M.D.

Schizophrenia is a debilitating disorder that is associated with significant medical, social, and economic burdens for patients and their families. In particular, numerous studies have found that the average life expectancy of people with schizophrenia is about 20 years shorter than that of the general public.

To help psychiatrists and other mental health professionals provide the best evidence-based care to these patients, APA this month released the APA Practice Guideline for the Treatment of Patients With Schizophrenia.

The practice guideline represents APA's first schizophrenia guidance since 2009. Since then, numerous new antipsychotics have been approved as have medications to treat tardive dyskinesia, a common side effect of antipsychotics.

There have also been innovations in psychosocial care, including the rise of coordinated specialty care programs for early psychosis intervention, and more emphasis on getting patients involved in the recovery process. As such, the new guideline highlights the importance of a thorough diagnostic evaluation and treatment plan that factors in patient goals and preferences. The practice guideline on schizophrenia is APA's fourth to use standards set forth by the Institute of Medicine in 2011 to ensure clinical guidelines meet high standards of transparency, manage conflicts of interest, and are scientifically rigorous. It is APA's first guideline for an entire disorder to use IOM standards.

As with APA's previous guideline efforts, clinical recommendations were made by an expert work group following a systematic evaluation of relevant literature. All recommendations received two ratings: One assessed how likely is it that the benefits of the intervention outweigh the harms (rated on a scale of 1 to 3); the other assessed the degree of confidence in the supporting data (rated on a scale of A to C).

The expert work group made 24 recommendations, spread across the topics of patient assessment and treatment planning, pharmacotherapy, and psychosocial interventions. Of those, two received the highest rating of 1A: Patients diagnosed with schizophrenia should be treated with an antipsychotic medication; patients with schizophrenia whose symptoms improve while taking an antipsychotic should continue with maintenance antipsychotic treatment. The practice guideline also recommends that patients who have improved on an antipsychotic remain on that same antipsychotic during maintenance therapy, but this recommendation is supported only by moderate evidence (2B rating).

With the exception of clozapine—which the guideline recommends as the first choice for treatment-resistant schizophrenia, patients with high suicide risk, and patients with a high risk of aggressive behavior—the guideline did not make any recommendations about when to use specific antipsychotics.

"Although there may be clinically meaningful distinctions in response and tolerability of different antipsychotic medications in an individual patient, there is no definitive evidence that one antipsychotic will have consistently superior efficacy compared with another, with the possible exception of clozapine," the work group wrote.

The work group cited a comprehensive analysis conducted by investigators at the Oregon Health and Science University Evidence-Based Practice Center, which served as a principal source of data for the new practice guideline. This analysis suggested that the older second-generation antipsychotics olanzapine and risperidone might be superior for certain symptoms; however, given limited head-to-head comparisons, the work group could not make any strong conclusions (see story on page 17).

Likewise, the guideline does not offer definitive recommendations on the use of long-acting injectable (LAI)

see **Practice Guideline** *on page 20*

One in Five Say APA's Leadership is Not Diverse Enough

More than one-fifth of respondents in a recent survey by APA's Presidential Task Force to Address Structural Racism Throughout Psychiatry said that the organization's leadership is not diverse enough as reflected in the membership of its Board of Trustees, councils, executive committees, and other components or in general. The survey is the second in a series designed to inform the task force and APA of the work necessary to address structural racism in the organization and the profession.

The survey asked respondents, "What are the top three ways that institutional racism is reflected in APA as an organization?" There were 731 respondents who provided 1,588 answers, and 20.7% of the answers stated that APA's leadership was not diverse enough. Among those answers, 29.4% listed a lack of diversity in the organization's leadership first, over other areas that may reflect institutional racism such as the administration, advocacy efforts, recruitment of physicians of color, research, and education.

To that end, the task force has begun work to review the racial makeup of APA's leadership, Cheryl Wills, M.D., chair of the task force, told *Psychiatric News*.

"We have work groups that are looking at [the history] of the leadership and whether it has been diverse. If the claim [that leadership is not diverse] is supported by data, then we will turn that into actionable items for the Board to deliberate," said Wills, who is an associate professor pf psychiatry at Case Western Reserve University (Ohio) and APA's Area 4 trustee.

Wills explained that some of the work groups will conduct live interviews with survey respondents. "We want to get a multifaceted assessment and get input about their perceptions, needs, and recommendations."

Just over 9% of the survey answers indicated that the respondents did not see institutional racism at APA. Wills said that this is testimony to the need for the task force, because had institutional racism been apparent to all, the organization might have already addressed it.

Wills added that she reads every response to every survey. "We are a member-driven organization, so matters that pertain to addressing structural racism should also be member driven. Keep telling us what you think."

The next survey will focus on structural racism in psychiatric practice. It will be posted this fall at https://www.psychiatry.org/psychiatrists/structural-racism-task-force.

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associate dean for community health engagement at the University of Tennessee Health Science Center. "When they ask what did we do to move the needle, what did we do to improve the psychological well-being of [Black people] in this country, I'd like to say that we took the bull by the horns, addressed these issues head on, and did the hard work … that is emotional, that makes you vulnerable, that can be challenging, but that is not too difficult for psychiatrists."

She added that psychiatrists are primed for doing the work of dismantling racism both in the profession and in society at large.

"Our wheelhouse is in the difficult place. We are the people that people bring their most private, chaotic thoughts, and we help sort that out," she said. "We have to be on the front lines of doing that for psychiatry, for America, and for the American Psychiatric Association." **PN**

The next town hall will be held Monday, November 16. Archives of APA's town hall series on structural racism are posted for members at https://www.psychiatry.org/psychiatrists/meetings/addressing-structural-racism-town-hall.

Pandemic Has Compromised Mental Health of New Moms

Psychiatrists say there has been an uptick in the number of women seeking perinatal mental health services. **BY EMILY KUHL, PH.D.**

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Pregnant women and new mothers are increasingly seeking psychiatric services for mental health concerns related to the COVID-19 virus, according to maternal mental health experts.

"The volume of referrals to our Mother-Infant Psychiatry Program has appeared to fluctuate with the COVID-19 infection rates in our community," said Alison Hermann, M.D., a psychiatrist at Weill Cornell Medicine and co-author of a recent *JAMA Psychiatry* article about supporting maternal mental health in the context of COVID-19. "There has been a palpable level of distress amongst pregnant and postpartum women throughout this pandemic."

This trend of increased worry among perinatal women is understandable. Data from the Centers for Disease Control and Prevention published in June indicate pregnant women who contract COVID-19 are 50% more likely to need intensive care and 70% more likely to require ventilation care than nonpregnant women.

Leena Mittal, M.D., director of the Division of Women's Mental Health in the Department of Psychiatry at Brigham and Women's Hospital and associate medical director of MCPAP for Moms (Massachusetts Psychiatric Access Program for Moms, a statewide perinatal mental health resource in Massachusetts), also noted a clear uptick in COVID-related mood and anxiety symptoms among perinatal patients over the past several months.

"We hear from all different angles the ways in which perinatal woman are impacted," she said. "A lot of it is what you might expect—increases in distress and worry, which has been impactful in adding to the already higher risk of mental health complications during pregnancy and the postpartum period. But there have also been some unanticipated risks."

For instance, said Mittal, many women report experiencing trauma related to changes in the birth experience, like being separated from one's partner during delivery or being unable to have friends or family at home providing support for their newborn.

"Women are very concerned about COVID-19 exposure for themselves, their babies, and their adult family supports, such as grandparents. This often leads to strict isolating behaviors, which can further worsen psychiatric symptoms," added Hermann. "Worries about COVID-19 exposure, as well as the psychological effects of infection control practices, can lead to poor adherence to necessary medical care; rushed changes to birth plans; rejection of effective coping skills, such as behavioral activation practices; and missed opportunities for essential education and support."

Many women also may experience a type of grief reaction over the loss of what their idea of what labor would be like or what being a new parent would be like, which, in most cases, has profoundly changed due to COVID-19 and its countermeasures.

Another impact of COVID-19 that could place children at risk is an increase in substance use disorders during the pandemic, noted Mittal. "There have been more overdoses seen broadly and also the ongoing concurrence of substance use, especially while caring for children, resulting in increased levels of concern for being reported to Social Services," she said.

In response to these concerns, Mittal and Hermann encouraged psychiatrists to think not only about how to treat pregnant and postpartum women experiencing mental health problems during this time, but how to be proactive and identify strategies that could prevent new or worsening symptoms.

"Women with psychiatric histories or subsyndromal symptoms should participate in preventive psychotherapy. For the most part, women who have been stabilized on an effective medication regimen [during pregnancy or postpartum] should remain on that regimen, with few notable exceptions. They include valproate, which is contraindicated due to risk of congenital malformations," said Hermann. "All perinatal women who are in psychiatric treatment should have a strategy for effective symptom monitoring and a plan for responding to symptoms that might arise."

But due to COVID-19 infection control measures, such as limited in-person health care visits and shorter hospital stays, there are now fewer opportunities to screen perinatal and postnatal women for psychiatric symptoms. Thus, said Dr. Hermann, it is vital that psychiatrists know their local referral resources and have a way of referring patients quickly. There also should be a plan for contacting postpartum women for symptom screening and support soon after discharge.

Traditional interventions for anxiety, depression, trauma, and addiction can

see **New Moms** *on page 20*

APA Introduces Updated Evaluation Guide For Mental Health Apps

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Though the core design of APA's mobile app evaluation tool remains the same, the redesigned site includes many new features, including sample reviews of popular apps. ***BY NICK ZAGORSKI***

TECH TIME

Long before the emergence of GPS, the American Automobile Association (AAA)—with its maps, guides, and roadside services—was a vital resource for travelers navigating America's highways. APA now has its own AAA tool that the organization hopes will help psychiatrists navigate the complex world of mobile health apps.

The APA App Advisor is an outgrowth of a mobile app evaluator put forth by an APA work group in 2017. The original app evaluator was a five-tier screening tool that physicians could follow to systematically assess variables like an app's privacy policy, evidence base, data sharing capabilities, ease of use, and cost.

Last December, APA brought together a diverse expert panel to assess the evaluation tool and consider ways to enhance it. The panel included not just psychiatrists but also psychologists, social workers, nurse practitioners, medical students, and people with lived experience of mental illness.

"We wanted to make sure a lot of different voices were heard," said John Torous, M.D., director of the Digital Psychiatry Division at Beth Israel Deaconess Medical Center and chair of the expert panel. The panel recommended a few tweaks to material in each of the model's five areas of importance, but Torous noted that overall structure remained intact. "The core principles of the evaluator are the same: Is an app safe? Is it usable? Is it clinically actionable?"

The App Advisor includes several new features. For one, the panel developed an eight-question screening tool to complement the full evaluator. Torous likened it to the Patient Health Questionnaire-9 (PHQ-9), a brief screener to assess for possible depression. "It doesn't replace a full assessment, but the model screener can help practitioners quickly decide whether an app meets some basic standards to warrant further evaluation," he said.

The App Advisor website now includes written and video tutorials to discuss the pros and risks of using apps, familiarize users with the evaluation tool, and provide some basics on navigating it. Additionally, the site features example evaluations of 11 popular mental health and well-being apps, conducted by panel members. Torous said the panel plans to continually update the site with further evaluations of mobile health apps that might be relevant to APA members.

Torous emphasized that APA is not offering any endorsement of individual apps with these evaluations. "These evaluations are aimed at giving psychiatrists a sense of what to look for when reviewing an app so they can make the most informed decision for their patient and practice," he said.

"We hope that our updated App Advisor shows that APA is committed to staying active in the digital mental health space," Torous continued. "We want to be the trusted resource psychiatrists can turn to when they have questions about the ever-evolving digital health landscape." **PN**

The APA App Advisor is posted at https://www.psychiatry.org/psychiatrists/practice/mental-health-apps.

CLIMATE CHANGE & MENTAL HEALTH

Climate Anxiety From an Early Career Psychiatrist's Perspective

BY CHELSEA ANNE YOUNG, M.D.

Chelsea Anne Young, M.D., is a child and adolescent psychiatry fellow at Stanford University School of Medicine.

To be fair, I already disliked my therapist. As a psychiatry resident, I was strongly encouraged to undergo my own psychotherapy. This particular therapist came highly recommended, but I found his manner cold and removed. I worried that he could not empathize with my struggles to become pregnant. I resented his vagueness about his no-show and billing policies. I could forgive him for these demographic and stylistic differences, but he drove the nail into the coffin of our work together when I cried to him about climate change and he said nothing.

During Obama's presidency, although climate change registered for me as a serious threat, I had naïve confidence in our government's efforts to address it. The Paris Climate Accord felt historic. As with many of my fellow Democrats, the election of Donald Trump stunned me into a rude awakening. Not only would we no longer make incremental progress, I correctly guessed that we would now take steps backward with the rollback of environmental policies and reduced funding and incentives for green technology. I expected that life on our planet would suffer tremendously under Trump's administration.

Watching the election results on TV felt like a bizarre nightmare. Several days later, I sobbed in my therapist's office, overcome with despair, perhaps expressing real vulnerability to him for the first time. I worried about my own future and that of my future child. I worried about the fate of the coastal redwood forests that had defined my childhood. How long would they survive as California suffered longer and hotter periods of drought? I thought of the families most affected and the people who had contributed least to the problem and whose towns had been burned to the ground, washed away, or would become uninhabitable. I cried for my own isolation—I felt more anxious with each unseasonably warm day and no one close to me understood my distress.

In my memory of this event, my therapist remained silent, continuing to gaze at me in his typical aloof and quizzical manner. Given his psychoanalytic background, which emphasizes the therapist as a blank slate, I will never know if he remained mute because he did not understand my eco-anxiety or because silence is what his training required of him. As someone for whom the issue of climate change was real and terrifying, I felt abandoned, as if I had told him a family member had passed, and he failed to acknowledge it.

Needless to say, I switched to a therapist with a warmer, more approachable style. While I did connect with my new therapist and grew very attached to her as she guided me through my first pregnancy, I did not bring up climate change again in any meaningful way. I discussed plenty of other worries, most prominently the fear that my fetus could have been harmed by a brief exposure to environmental toxins, which in retrospect seems like an apt metaphor for my real concerns about our contaminated planet.

Not long after my son was born, I joined the climate movement, as many Americans have over the last couple of years. I marched in the streets, phoned my representatives, protested outside government offices, donated money to environmental causes, and talked to my friends and family about the cause. These small actions allowed me to get through each day with optimism.

I graduated residency and entered fellowship for the last stage of my training, specializing in mental health care for children and adolescents. One day, an intelligent, suicidal teenage boy sat in my office. I asked him what kinds of things worried him. He looked sheepishly at me and answered, "Fights with my family, and, you know, climate change." I stared at him silently, simultaneously stunned and impressed and grateful. "Yes, it's scary," I finally managed, "Tell me more." **PN**

Vitamin D3 Found Ineffective at Preventing Depression

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The trial involved over 18,000 middle-aged and older adults from across the country who took a high dose of vitamin D supplements or placebo daily for over five years. ***BY NICK ZAGORSKI***

High-dose vitamin D3 supplements do not appear to be effective at preventing depression in older adults, according to a large, placebo-controlled study published August 4 in *JAMA*.

Observational studies have suggested that people with lower blood levels of vitamin D are at higher risk of late-life depression, while other research has found that vitamin D deficiency may be involved in seasonal depressive disorder. But to date prospective studies of people taking vitamin D supplements have yielded little evidence that adding vitamin D protects against depression.

It is possible that previous supplement studies examined vitamin D doses that were too low and/or the studies were too short in duration. This new study addressed previous shortcomings by evaluating over 18,000 older adults across the United States for over five years.

The adults were participants in the Vitamin D and Omega-3 Trial (VITAL), a randomized study examining the effects of daily vitamin D3 and/or fish oil supplements on the prevention of cancer and cardiovascular disease. As an ancillary part of the study (VITAL-DEP), participants were also given the eight-item Patient Health Questionnaire (PHQ-8) during their periodic assessments to screen for depressive symptoms. Participants who were currently receiving treatment for depression or had another psychiatric or neurological condition were excluded from this ancillary analysis.

The final sample included 9,181 adults who took 2,000 IU/d of vitamin D3 daily for an average of 5.3 years and 9,172 adults who took placebo for the same average time. By the end of the study, 609 adults taking vitamin D3 and 625 taking placebo received a diagnosis of depression or developed clinically relevant depressive symptoms (a PHQ-8 score of ≥10)—which the authors noted was not a significant difference between the groups.

There was also no significant difference between the two groups in overall mood over time; average PHQ-8 scores rose by 0.20 points in the vitamin D3 group and 0.16 points in the placebo group.

"By no means is this study a verdict on vitamin D as a supplement in general," said study author Olivia Okereke, M.D., the director of geriatric psychiatry at Massachusetts General Hospital and an associate professor of psychiatry and epidemiology at Harvard Medical School. "This vitamin is important for bone health and immune health and potentially other conditions."

She continued, "The findings indicate that for an average adult, taking vitamin D3 supplements for the purpose of improving mood will provide no benefit."

Okereke and colleagues also looked at data on various subgroups in the study to see whether there might be a population that experienced a positive effect from vitamin D3. However, vitamin D3 did not appear to prevent depression in any of the tested subgroups, including grouping by sex, ethnicity, age group, and depression history.

"Now, there was one interesting signal that showed adults with normal body weight [body mass index score of 25 or less] might be gaining some protection from depression," Okereke noted. This signal mirrored some data seen in the main VITAL study, which was published last year in the *New England Journal of Medicine*. This study found that while vitamin D3 supplements did not prevent cancer or major cardiovascular events in the general population, the supplements did appear to reduce the risk of cancer in adults with low body mass index.

Okereke cautioned that the findings on obesity are still preliminary, but if there was one variable worth pursuing with further research, that would be it.

The VITAL-DEP researchers are reviewing data related to fish oil and depression and hope to release those findings soon.

VITAL-DEP was supported by a grant from the National Institute of Mental Health. The main VITAL study was supported by grants from the National Cancer Institute; the National Heart, Lung, and Blood Institute; the National Institute of Neurological Disorders and Stroke; the National Center for Complementary and Integrative Health; and the Office of Dietary Supplements. Pharmavite LLC and Pronova BioPharma/BASF donated the vitamin D3 and fish oil for the study, respectively. **PN**

"Effect of Long-term Vitamin D3 Supplementation vs Placebo on Risk of Depression or Clinically Relevant Depressive Symptoms and on Change in Mood Scores: A Randomized Clinical Trial" is posted at https://jamanetwork.com/journals/jama/article-abstract/2768978. The parent VITAL study, "Vitamin D Supplements and Prevention of Cancer and Cardiovascular Disease" is posted at https://www.nejm.org/doi/10.1056/NEJMoa1809944.

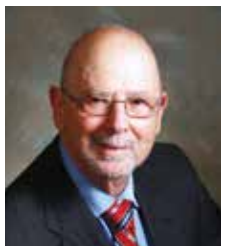
FROM THE EXPERTS

Psychotherapy for Stress Response Syndromes Can Be Adapted to Pandemic-Related Symptoms

BY MARDI HOROWITZ, M.D.

All people experience trauma and loss, and today they are dealing with unprecedented stress related to COVID-19, economic uncertainty, worry about friends and family, and increased strife around racial injustice. As mental health professionals, we have the responsibility to treat individuals who seek our services to help deal with symptoms related to these stressors. Although medications can ameliorate some symptoms, the main treatment for stress-related problems continues to be psychotherapy.

Brief psychotherapy can sometimes be effective for transient stress and trauma. Symptoms that do not resolve with brief treatments, however, often involve problems in relationships, disturbances in sense of identity, and diminished capacity for appraising meanings that require a longer-term therapy. I will describe a phased approach toward psychotherapy for stress-related symptoms that can be tailored to individual patients.



Mardi Horowitz, M.D., is a distinguished professor of psychiatry at the University of California at San Francisco and author of the 2020 second edition of *Treatment of Stress Response Syndromes*. APA members may purchase the book at a discount at https://www.appi.org/Products/Trauma-Violence-and-PTSD/Treatment-of-Stress-Response-Syndromes-Second-Edit.

In the initial phase of psychotherapy, the patient learns how to report events and personal experiences in relation to stressor memories and the symptoms that result. The therapist provides psychoeducation, when needed, and discusses treatment options and implications. The first aim is to restore equilibrium by providing support and hope. During the next phase of psychotherapy, the clinician shares with the patient how a different understanding of memory fragments can help to advance coping capacities and reduce uncontrolled states of dysphoria. As the patient develops increasing trust in the therapist, the patient experiences a feeling of safety during sessions, fostering openness and a willingness to progress in therapy.

In the middle phase of treatment, the patient and the therapist can explore the meaning of the patient's symptoms. Both parties engage in dialogue that connects current ideas and

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Which Antipsychotics Are Best for Your Patients?

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Researchers compiled data from 278 clinical trials of FDA-approved antipsychotics, comparing the effects of second-generation antipsychotics with other first- and second-generation antipsychotics. **BY NICK ZAGORSKI**

Psychiatrists in the United States currently have 12 second-generation antipsychotics (including some with multiple formulations) to choose from when considering treatment for patients with schizophrenia. Given these options, it is important that psychiatrists have updated information on how these medications stack up against each other.

A team of researchers at Oregon Health and Science University (OHSU) has conducted a meta-analysis comparing the efficacy and side effects of these U.S.-approved antipsychotics. Their findings reaffirm the current consensus that clozapine, olanzapine, and risperidone are generally the most effective treatment options for patients with schizophrenia. The report also provided new evidence that patients were more likely to stick with their recommended treatment if receiving long-acting injectable (LAI) formulations compared with oral formulations.

The analysis, published in *Psychiatric Research and Clinical Practice*, was part of a larger study carried out by OHSU's Evidence-Based Practice Center (EPC) comparing the effectiveness of both pharmacological and psychosocial treatments for schizophrenia. OHSU's center—which is one of nine in the country funded by the Agency for Healthcare, Research, and Quality (AHRQ)—is tasked with producing comprehensive evidence reviews on a range of medical topics. Stakeholders submit proposals to AHRQ for topics they believe need an evidence-based review.

APA submitted a proposal to AHRQ requesting a comprehensive review of schizophrenia treatments, since several new antipsychotics or new formulations of existing antipsychotics had been approved for use since APA's last schizophrenia practice guideline update in 2009. Marian McDonagh, Pharm.D., a professor of medical informatics and clinical epidemiology at OHSU and associate director of OHSU's Evidence-Based Practice Center, was lead author on the resulting report.

This systematic review as well other clinical studies helped to inform the development of APA's practice guideline on schizophrenia (see page 13).

McDonagh and colleagues compiled data from 278 clinical trials of FDA-approved antipsychotics, comparing the effects of second-generation antipsychotics with other first- and second-generation antipsychotics. The researchers then assessed a range of outcomes, including symptom improvement, quality of life, side effects, and mortality risk.

The data for oral medications showed that clozapine, olanzapine, and risperidone provided the strongest symptom response. Oral olanzapine also appeared to be the best option for preventing treatment discontinuation, while clozapine was superior to other medications in reducing suicide risk. There were no significant differences among the SGAs in the proportions of patients reporting any adverse event.

For most of the antipsychotic medications, particularly the newer ones, few or no comparative data were available, the researchers noted. This made it difficult for the researchers to make strong statements about LAIs or newer drugs such as cariprazine or lurasidone compared with the older medications.

Following their initial analysis, McDonagh and colleagues made the first draft of their review available for public comment. "We received a lot of comments that our analysis should have kept oral medications and LAIs in separate categories," she said. Ultimately, McDonagh and her expert panel considered all formulations together since APA had emphasized a desire to compare the benefits of all the available formulations.

The researchers found little evidence to suggest LAIs are superior to oral medications, as there are fewer clinical data on these newer injectables relative to more established oral drugs. The analysis did, however, reveal that LAI risperidone was superior to several oral antipsychotics in preventing people from stopping their prescriptions due to adverse events; LAI risperidone also scored well at improving quality of life relative to some oral antipsychotics.

"Looking ahead, there are so many other things to consider beyond schizophrenia symptoms," McDonagh said. "We need studies that address factors related to patient recovery, such as employment and independent living." She acknowledged studies like this are difficult projects that would take years. "However, this is a long-term disease, and we need long-term outcomes."

This study was funded by a grant from AHRQ. **PN**

"Updating the Comparative Evidence on Second-Generation Antipsychotic Use With Schizophrenia" is posted at https://prcp.psychiatryonline.org/doi/10.1176/appi.prcp.20200004. The full report, "Treatments for Schizophrenia in Adults: A Systematic Review," is posted at https://www.ncbi.nlm.nih.gov/books/NBK487628/.

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feelings to stressor events, their precursors, and their consequences. Irrational ideas are reappraised. As the patient gains capacities for reducing the frequency and intensity of intrusive ideas and waves of severe distress, the patient can increase coping skills and reappraise beliefs to change attitudes.

During the later phases of treatment, patients can learn how to integrate trauma and loss with preexisting schemas of their identity and attachments. Although patients may continue to have distressing and disturbed states of mind, they generally experience fewer intrusive flashes, socially impaired moments, and dissociative experiences. This provides incentive for continuing therapy to make more changes and improve self-regulation of emotional states. With successful assimilation and accommodation, past and current memory systems can be integrated. During the final phases of psychotherapy, the patient is better able to maintain a coherent autobiographical narrative of past, present, and future and integrate stressor memories into his or her new sense of identity. Mastery of stress and loss involves both conscious and unconscious mental processing.

As patients learn to modulate their emotional reactions to stressful events or situations, less adaptive responses—such as avoidance or phobia—will diminish. Difficult topics can be explored, leading to rational narratives about past, present, and future and a sense of meaning and purpose. The resulting improved coherence in sense of identity leads to tolerance for the unpleasant feelings and situations caused by the stressors. The patient can face the future making more rational rather than irrational choices.

Patients learn to anticipate that they may continue to experience states of mind in which traumatic memories are intrusive or avoided. But mastery of traumas and losses can increase a sense of self-efficacy; improve capacities for productive and satisfying work; and lead to more successful relationship coherence, constancy, and caring. In this way, optimum treatment can lead to personality growth in addition to a reduction in symptoms.

In the final sessions of treatment, the patient and therapist clarify gains, highlighting the useful new attitudes about self and others and the positive changes in self-control of emotions that occurred over the time together.

Psychotherapy can bring lasting change that transcends the time-limited stresses that provoke responses in our patients. The steps outlined here can be fruitfully employed to address the stress responses caused by the global pandemic. *Treatment of Stress Response Syndromes, Second Edition,* has chapters on each phase of psychotherapy from evaluation to support to exploration of meanings and to attitudinal change as well as termination. Each chapter has a decision tree to help clinicians, in collaboration with their patients, make decisions about the next focus of attention and treatment technique. These decisions, as treatment progresses, are based on augmenting and modifying individualized and trans-theoretical case formulations. **PN**

MED CHECK

BY TERRI D'ARRIGO

Esketamine Approved for MDD With Suicidal Ideation Or Behavior

The Food and Drug Administration (FDA) has approved ***Spravato (esketamine)*** CIII nasal spray to be used along with an oral antidepressant to treat depressive symptoms in adults with major depressive disorder with acute suicidal ideation or behavior, Janssen Pharmaceutical Companies of Johnson & Johnson announced in August. The approval is based on two identical phase 3 clinical trials in which participants who received esketamine plus comprehensive care demonstrated a significant, rapid reduction of depressive symptoms within 24 hours.

In the trials, adults with moderate-to-severe major depressive disorder who had active suicidal ideation and intent were randomized to receive either 84 mg of esketamine or placebo nasal spray twice a week for four weeks. After the first dose, a one-time dose reduction to 56 mg of esketamine was allowed for patients unable to tolerate the 84 mg dose. All patients received comprehensive standard of care treatment, including an initial inpatient psychiatric hospitalization and a newly initiated or optimized oral antidepressant treatment. At enrollment, all patients had Montgomery-Åsberg Depression Rating Scale (MADRS) scores higher than 28. The primary efficacy measure was the change from baseline in the MADRS total score at 24 hours after first dose.

In each study, MADRS scores dropped approximately 16 points for the esketamine group compared with roughly 12 points in the placebo group. Both the esketamine and placebo groups continued to improve between four hours and 25 days. In one study, 41% of the 111 patients in the esketamine group achieved clinical remission of depression compared with 34% of the 112 patients in the placebo group. In the other study, 43% of the 113 patients in the esketamine group achieved clinical remission of depression compared with 27% of the 113 patients in the placebo group.

BrainsWay TMS Device Gets OK for Smoking Cessation

In August, BrainsWay announced that its ***Deep Transcranial Magnetic Stimulation (TMS) System*** received clearance from the FDA for use as an aid in short-term smoking cessation in adults.

In a randomized trial, 262 patients received either treatment with the system or a sham treatment five days a week for three weeks, followed by an additional session once a week for three weeks. Patients had an average of 26 years of smoking, and none had been able to quit after multiple attempts.

The primary endpoint of the study was a comparison between the two groups of the four-week continuous quit rate. The continuous quit rate represents abstinence during a consecutive four-week period at any point between the start of treatment and the follow-up visit four months later. Patients kept a diary of their smoking habits and took urine tests to confirm whether they had smoked.

Among patients who completed four weeks of treatment, the continuous quit rate was 28.4% in the treatment group and 11.7% in the sham group.

FDA Grants Priority Review For Aducanumab For Alzheimer's Disease

The FDA has given priority review to the Biologics License Application for the investigational biologic ***aducanumab***, Biogen and Eisai Co. Ltd. announced in August. Aducanumab, an investigational human monoclonal antibody given as a monthly intravenous infusion, targets amyloid beta, a sticky compound thought to cause Alzheimer's disease by accumulating in the brain.

Biogen's application includes data from several clinical trials, including the phase 3 EMERGE trial. In EMERGE, 1,638 patients with early stage Alzheimer's disease were treated with aducanumab or placebo for 78 weeks. Those who received aducanumab experienced a reduction of 22% on the Clinical Dementia Rating-Sum of Boxes (CDR-SB) scores at 78 weeks compared with those who received placebo. They also experienced a consistent reduction of clinical decline as measured by the Mini-Mental State Examination, the Alzheimer's Disease Assessment Scale–Cognitive Subscale 13 Items, and the Alzheimer's Disease Cooperative Study–Activities of Daily Living Inventory Mild Cognitive Impairment Version compared with those who received placebo.

Patients received brain scans at 26 and 78 weeks. The scans revealed a reduction of amyloid plaques in the brains of those who received aducanumab compared with the brains of those who received placebo.

Phase 3 Data Positive For Insomnia Drug

In July Idorsia announced positive results in a second phase 3 trial of its investigational dual orexin receptor agonist ***daridorexant*** for insomnia.

In the trial, 924 adults with insomnia received daridorexant (10 mg or 25 mg) or placebo once in the evening for three months. Compared with patients who took placebo, those who took 25 mg of daridorexant experienced significantly improved sleep maintenance as measured by polysomnography in a sleep lab and as recorded in patient diaries. The results were statistically significant at the end of the first month and at the end of the third month.

In the first phase 3 trial, which Idorsia reported in April, 930 patients with insomnia received either 25 mg or 50 mg daridorexant or placebo once nightly for three months. Compared with patients who took placebo, those who took either dose of daridorexant fell asleep faster and experienced improved sleep maintenance as measured by polysomnography in a sleep lab and as recorded in patient diaries. Daridorexant 50 mg also significantly improved daytime functioning. All results were sustained over the entirety of the trial.

Idorsia plans to file a New Drug Application for daridorexant at the end of the year. **PN**

Oppression

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requires a joint agreement to self-examine. It is a tough assignment, as we are inclined to attack the blameworthy other. White wants more than that, although she concedes she may not see it in her lifetime. She urges us to end the bilateral self-hating legacy of racism. The crucial first step is for us to talk about it. **PN**

"Surviving Hating and Being Hated: Some Personal Thoughts About Racism From a Psychoanalytic Perspective" is posted at https://www.tandfonline.com/doi/abs/10.1080/00107530.2002.10747173.

Certification Reform

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what it is now calling "continuing certification" (replacing the term "maintenance of certification," a change that is intended to align with terminology used by the ABMS). The new standards are expected to be released in 2021, and the ABPN will be required to follow them.

Faulkner told APA leaders that the ABPN would consider a proposal from APA for an alternative to the current continuing certification program based on one created by APA. However, ABPN participants were noncommittal about approving it, Faulkner told *Psychiatric News*. "If the ABPN does receive a proposal, it will be given due consideration at that time."

The proposed program would need to meet all of the ABPN's and ABMS's MOC program requirements, including any new program requirements released in 2021.

"APA members have sent a message loud and clear that they want a lifelong learning and continuing certification process that is less burdensome, less expensive, and more relevant to their clinical practice," APA CEO and Medical Director Saul Levin, M.D., M.P.A., told *Psychiatric News*. "The APA administration, the Board, and the Assembly have heard that message, and we have brought it to the ABPN.

"We are encouraged that the ABPN is willing to work with us," Levin said. "The possibility of a certification program created by specialty societies is an intriguing one, but we will have to await the new ABMS program requirements. In the meantime, we are committed to improving the continuing certification process."

Levin also noted that on July 24, APA emailed a survey to 5,000 board-certified APA members to ascertain data on the burden imposed by the certification process. Survey results are being tabulated and analyzed.

In addition to Levin, present at the July meeting were APA President Jeffrey Geller, M.D., M.P.H.; APA President-elect Vivian Pender, M.D.; APA Secretary Sandra DeJong, M.D.; Mary Jo Fitzgerald, M.D., speaker-elect of the APA Assembly; Carver Nebbe, M.D., member of the Assembly Committee on MOC and Assembly representative from the Iowa Psychiatric Society; Ranga Ram, M.D., chair of the APA Caucus on MOC; Tristan Gorrindo, M.D., chief of APA's Division of Education; and Nitan Gotay, M.D., chief of APA's Division of Research.

Exam Costs in Thousands for Some

As mandated by the ABMS, the current continuing certification process includes four components:

- Part I: Professionalism and Professional Standing
- Part II: Lifelong Learning (CME), Self-Assessment and Patient Safety
- Part III: Assessment of Knowledge, Judgment, and Skills
- Part IV: Improvement in Medical Practice (also known as Performance in Practice, or PIP)

Diplomates must also sit for a certification examination at least once every 10 years unless they are enrolled in an alternative to the proctored 10-year examination, such as the three-year ABPN pilot project offering an open-book assessment based on reading journal articles (see *Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.9b23).

Ram told *Psychiatric News* that there were signs of progress at the July meeting, particularly in the ABPN's willingness to consider a program designed by a specialty society. "Members of the caucus hope that in ongoing negotiations with the ABPN, we can influence the board to move away from the 10-year exam to a more reliable assessment of continuing certification based on the education of psychiatrists in areas relevant to their everyday practice," he said.

He said caucus members ideally prefer an assessment based on reading journal articles and responding to questions generated by APA. He said the 10-year exam—a "high stakes" exam since candidates either pass or fail—includes questions that test candidates on information not relevant to their practice. Moreover, the costs of taking the exam—including time off from practice to prepare and take the exam and travel expenses for those who do not live near a testing site—can be in the thousands of dollars.

"I feel APA should push hard to be the professional society that provides all products for continuing certification, as long as the quality of the product is high," Ram said.

Faulkner said that the ABPN has taken a number of steps to minimize the burden on diplomates seeking continuing certification. "Options to fulfill Self-Assessment and Improvement in Medical Practice requirements have been expanded, and examination fees have been reduced over the last decade," he said.

Faulkner also pointed to the early success of the pilot project. "The vast majority of diplomates who have participated in the pilot project have indicated that they are pleased with it and find it to be 'helpful to [their] practice,' " he said. Based on this success, he said the ABPN asked ABMS for permission to convert the project into a permanent alternative for all ABPN primary and subspecialty certificates beginning in 2022.

"While early feedback from the relevant ABMS committees has been positive, a final decision about the ABPN request will be made by the ABMS Board of Directors later this fall," Faulkner said.

Other issues discussed at the July meeting included the following:

- The ABPN will begin including articles on structural racism in reading lists for the journal-based alternative.
- The ABPN is exploring the possibility of scholarships for psychiatrists who cannot afford initial certification fees or the annual MOC fee.
- APA has asked the ABPN to investigate options for home-proctoring of the initial certification exam so that examinees will not have to travel to testing centers, especially during the COVID crisis.

Additionally, APA reported at the meeting that it had completed its requirements as part of the ABPN's unrestricted educational grant to APA earlier this year. The grant was provided when the 2020 Annual Meeting could not be held.

The terms of this agreement required that APA allow ABPN diplomates free access to the virtual APA Spring Highlights Meeting, the APA's Annual Meeting self-assessment activity, and two online FOCUS Live events. The goal of the grant was to ensure that ABPN diplomates have access to high-quality CME and self-assessment activities to meet MOC requirements. Archived sessions of the Spring Highlights Meeting can still be accessed at https://www.psychiatry.org/psychiatrists/meetings/spring-highlights.

With the unrestricted educational grant from the ABPN, APA was able to make these activities available to all psychiatrists at no charge. **PN**

Information about APA's efforts on reform of continuing certification (or maintenance of certification) is posted at https://www.psychiatry.org/psychiatrists/education/certification-and-licensure/apa-and-moc-reform. APA members interested in joining the MOC caucus may do so at https://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/leadership-opportunities/join-a-caucus or through their membership profile.

Practice Guideline

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antipsychotics relative to oral medications, but noted moderate evidence to support the use of LAIs in patients who prefer this approach or have a history of poor medication adherence.

The guideline includes detailed tables highlighting dosing considerations, metabolic properties, and potential side effects of all approved antipsychotics. The work group wanted to ensure the inclusion of these tables so that physicians and patients could make informed treatment decisions together, said Laura Fochtmann, M.D., a Distinguished Service Professor of Psychiatry at Stony Brook University School of Medicine and vice chair of the guideline work group.

"Since we couldn't offer specific medication recommendations, we felt it was important for physicians to have that information in one place, since not everyone has access to all relevant drug databases," she told *Psychiatric News*.

The tables also emphasize the many differences between approved drugs, Fochtmann continued. "While we can't say that certain medications are superior or inferior, we want to stress that they are not all the same."

Given the many medications available for the treatment of schizophrenia, the APA Practice Guideline for the Treatment of Patients With Schizophrenia recommends that antipsychotic selection should be made with input from patients and their support circle as part of a thorough treatment plan that includes appropriate psychosocial therapies. The work group noted that cognitive-behavioral therapy for psychosis, education about schizophrenia, and supported employment programs all have strong evidence (rating 1B) of improving outcomes in patients. The guideline also strongly recommends that patients experiencing their first episode of psychosis should be treated in a coordinated specialty care program. If possible, patients should also receive interventions that improve their self-management skills.

Before any treatment plan can be tailored to the patient, the guideline recommends starting with a comprehensive patient assessment, preferably using elements in APA's Practice Guidelines for the Psychiatric Evaluation of Adults, published in 2015. Elements of a comprehensive evaluation include assessments of a patient's physical health, cognitive health, the risk of harming themselves or others, and substance use, including nicotine.

"The importance of the psychiatric evaluation cannot be underestimated because it serves as the initial basis for a therapeutic relationship with the patient and provides information that is crucial to differential diagnosis, shared decision-making about treatment, and educating patients and family members about factors such as illness course and prognosis," the work group wrote. **PN**

APA's practice guidelines are posted at https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines. More information on schizophrenia can be found in APA's Schizophrenia Resource Center at https://psychiatryonline.org/schizophrenia.

New Moms

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continue to be offered, but psychiatrists might have to think outside the box in terms of service delivery, said Mittal. Telehealth has been the most common workaround. But not all patients want to use or have access to telehealth technology, and psychiatrists should be mindful of this and plan accordingly.

Mittal also pointed out that medication prescribing may need to be restructured, such as extending the duration of prescriptions (when safe to do so), creating mail order prescriptions instead of having women go into the pharmacy, and—especially for substance use disorders—considering not making all prescriptions contingent on toxicological testing.

Unfortunately, any changes that psychiatrists make to perinatal screening, assessment, diagnosis, and treatment probably need to be feasible for the long term and not just as temporary solutions.

"We are all kind of stuck right now, as this has gone on for so long," Mittal said. "[Psychiatrists] have to figure out how to provide care for patients in this situation as our 'new normal' instead of looking at this as how to provide care during a crisis response." **PN**

"Meeting Maternal Mental Health Needs During the COVID-19 Pandemic" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2768028. The CDC report, "Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status—United States, January 22–June 7, 2020" is posted at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7316319/. More information on MCPAP for Moms can be found at https://www.mcpapformoms.org/.