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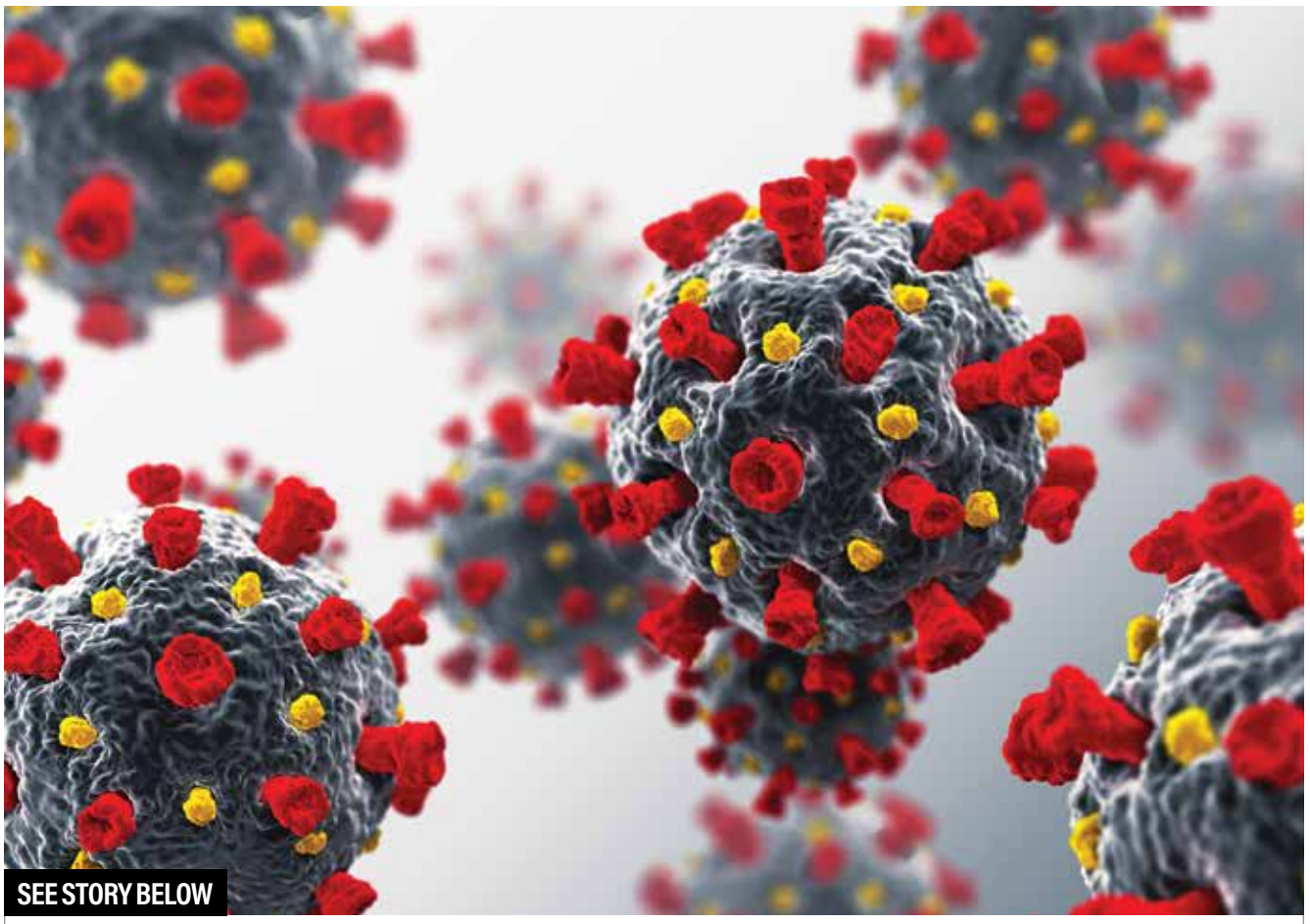

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SEE STORY BELOW

Psychiatrists are helping not only patients but also the public cope with the uncertainty caused by the COVID-19 pandemic. To assist in that effort, APA has posted a number of useful resources on its Coronavirus/COVID-19 Information Hub at psychiatry.org/coronavirus. See story below and stories on pages 4 and 18.

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Compassion and wisdom may reduce loneliness, experts say.

COVID-19: Psychiatrists in Battle Mode To Help Patients, Public During Crisis

Exposure to the disease and the ensuing quarantine or isolation can upend the lives of patients with existing psychiatric illness or generate new anxiety and distress. ***BY AARON LEVIN***

The onslaught of the COVID-19 coronavirus pandemic has caused an unprecedented disruption of life in the United States and around the world. Even as schools and businesses close, sporting events are cancelled, and entire industries are suddenly bereft of customers, the health care system is bracing for more waves of new patients.

The COVID-19 pandemic contains within it more than a respiratory infection. Infectious disease outbreaks also can have short- and long-term psychological effects on patients, their families, the health professionals who care for them, and communities where outbreaks are reported. Survivors of the severe acute respiratory syndrome (SARS) outbreak in Asia and Canada in 2003 reported elevated rates of psychiatric disorders both during the acute phase of the pandemic and up to four years later, according to several studies.

Psychiatrists and mental health professionals must be ready to care for those affected by the virus as well as patients with pre-existing psychiatric illness.

"In the context of the COVID-19 pandemic, patients with existing mood, anxiety, psychotic, or substance use disorders are at risk of worsening symptoms due to added stress and could benefit from extra attention as soon as possible," Jon Levenson, M.D., an asso-

see **COVID-19** *on page 28*

PERIODICALS: TIME SENSITIVE MATERIALS

APA to Offer Two Online CME Programs In Lieu of Annual Meeting

Even though they are virtual, the education and continuing medical education (CME) credits they offer will be as real as if participants had been in the room.

APA is offering two new educational programs this spring to help members earn the CME credits they need for licensure and certification and to sharpen their clinical skills.

The first program, called the APA Spring Highlights, will feature headline speakers, subject experts, and thought leaders, some of whom were slated to appear at APA's Annual Meet-

see **Online CME Programs** *on page 27*

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

COVID-19 and Mental Health: A Message That Needs to Be Heard

BY BRUCE SCHWARTZ, M.D.

As of March 23, the Centers for Disease Control and Prevention (CDC) reported 33,404 cases of COVID-19 in the United States, with confirmed cases in all states and the District of Columbia, and 400 deaths. The World Health Organization, which tallies international cases, reports 292,142 cases worldwide and 12,784 deaths as of March 21. The virus has affected nearly every country in the world. By the time you are reading this, these figures may have multiplied exponentially.

The speed with which the virus has spread is perhaps the most frightening aspect: Information from the World Health Organization on March 21 stated that 26,069 cases had been reported in the previous 24 hours.

We have entered an extraordinarily challenging period. Despite some exceptional public health agencies like the CDC, leadership was slow to recognize the seriousness of the outbreak earlier, failing to provide clear, consistent, and reliable information (to the extent it was available) and preparing a broad-based public health response (especially regarding the availability of tests for the virus). It's a difficult line to walk between encouraging protective behaviors and causing excessive anxiety or panic. The lack of preparation for a pandemic by federal, state, and local agencies is regrettable.

> "While we are rightly concerned about the safety of our family, friends, and communities, let us also use this extraordinary crisis to commit ourselves ever more earnestly to the task of building a system of care of which we can be proud, rather than ashamed."

The passage of the bipartisan $8 billion coronavirus relief package (including a relaxation of restrictions on telemedicine, which APA had called for) is an important step in the right direction—hopefully, one that will remain after the passing of the epidemic. Physicians at the state and local levels are working to combat and contain the epidemic, as have many other entities, including professional societies like APA. Amid all the noise, we are learning about protective steps we can take, and APA has posted useful information on its website (see box on page 28).

Using basic, common-sense hygienic practices recommended by the CDC, will help prevent the spread of infection. Among them: Wash your hands often with soap and water for at least 20 seconds; avoid close contact with people who are sick; avoid touching your eyes, nose, and mouth; stay home when you are sick; and use a tissue to cover a cough or sneeze and then throw it in the trash. Our CEO and medical director, Saul Levin, M.D., M.P.A., is a former health director and recom-

continued on facing page

IN THIS ISSUE

DEPARTMENTS

APA Member Testifies on Improving SUD Treatment Access

Smita Das, M.D., Ph.D., M.P.H., urged lawmakers to consider the impact of all substances, including opioids, methamphetamines, alcohol, and tobacco, when crafting legislation. **BY KATIE O'CONNOR**

Early during her testimony before a Congressional committee on March 3, Smita Das, M.D., Ph.D., M.P.H., stated a simple fact: "Addiction is a chronic brain disease; it is a chronic medical illness that can be treated effectively."

But to close treatment gaps for people with substance use disorders (SUDs), key investments in several areas are necessary, she continued, such as workforce capacity and alleviating barriers to care.

Das is a clinical assistant professor of psychiatry and behavioral health sciences at Stanford University School of Medicine, member of APA's Council on Addiction Psychiatry, and president of the Northern California Psychiatric Society. She testified before the House Committee on Energy and Commerce's Subcommittee on Health at a hearing titled "Combatting an Epidemic: Legislation to Help Patients With Substance Use Disorders."

"As a district branch president and an early career psychiatrist, I am well aware of the frustrations that my colleagues and patients have with mental health policy," Das told *Psychiatric News* in an email. "From reimbursement issues to access, there's a lot that we can contribute to the discussion about mental health policy."

The hearing was held to examine 14 bills related to the opioid crisis and the treatment of people with SUDs, including the Opioid Workforce Act of 2019 (HR 3414), which creates additional residency positions in addiction medicine, addiction psychiatry, and pain medicine, as well as the Medicaid Reentry Act (HR 1329), which would allow incarcerated individuals who are within 30 days of release to enroll in Medicaid, provided they meet eligibility criteria. APA has endorsed both bills through coalition letters.

"Using evidence-based, common-sense policies, like allowing incarcerated individuals to enroll in Medicaid prior to discharge, defragments care and coordinates support to allow patients to successfully re-enter their communities," Das told the subcommittee.

Das was part of a panel of experts who appeared before the subcommittee, including Michael P. Botticelli, executive director of the Grayken Center for Addiction at Boston Medical Center and former director of the White House Office of National Drug Control Policy under President Barack Obama; Patty McCarthy, chief executive officer of Faces & Voices of Recovery; Robert I. L. Morrison, executive director and director of legislative affairs at the National Association of State Alcohol and Drug Abuse Directors; Margaret B. Rizzo, executive director of JSAS HealthCare Inc.; and Shawn A. Ryan, M.D., M.B.A., chair of the American Society of Addiction Medicine's Legislative Action Committee.

Michelle Greenhalgh

"The crisis America is facing when it comes to substance use disorders is not going away," says Smita Das, M.D., Ph.D., M.P.H. "While there has been some progress and attention placed on the opioid crisis, it is important that lawmakers recognize that the fight for our patients is not over."

Das told lawmakers that psychiatrists are uniquely positioned to treat patients with SUDs and comorbid psychiatric disorders. "However, the shortage of psychiatrists and physicians trained in addiction medicine, addiction psychiatry, or pain management has created a long-standing acute treatment gap for those with or at high risk for substance use disorders," she said. Funding new residency positions, expanding loan repayment and forgiveness, and offering incentives to work in underserved areas could help mitigate the impact of the physician shortage.

SUDs and other psychiatric illnesses are not choices or moral issues, Das testified. There are evidence-based approaches to treat people with these disorders, yet access is severely limited. In response to a question from U.S. Rep. Anna G. Eshoo (D-Calif.), chair of the subcommittee, Das explained that before California's Medi-Cal program covered buprenorphine, she sometimes spent more time on the phone trying to get her patients access to the medication than she actually spent with the patient. "It's very frustrating," she said.

Lack of enforcement of the Mental Health Parity and Addiction Equity Act of 2008 also impedes access to care, she said. "Stigma in seeking help is already an enormous obstacle for our patients, but forcing both the patients and the providers to engage in bureaucracy to get coverage makes treatment that much more inaccessible," she said.

"We must treat substance use disorders as the chronic diseases they are and pursue solutions that address all substances, including opioids, methamphetamines, alcohol, and tobacco," she told the subcommittee. "I encourage the committee to look beyond opioids and ensure it is considering all substance use disorders as it considers legislation." **PN**

A copy of Das's testimony is posted at https://energycommerce.house.gov/committee-activity/hearings/hearing-on-combatting-an-epidemic-legislation-to-help-patients-with.

continued from facing page

mends these precautions as well: Do not make physical contact, including shaking hands; use disinfectant wipes and antibacterial hand gel; do not share pens or food plates; and avoid directly touching elevator buttons, ticket kiosk buttons in public garages, etc.

As psychiatrists we are especially aware of the mental health repercussions of the pandemic and the associated fear and panic. It is important that we help our patients, colleagues, friends, family, and ourselves maintain some perspective on the risks of infection. For many, their fears and anxiety will need to be addressed with supportive and cognitive interventions, and we can reassure them by citing similar past experiences through which we persevered, including the SARS, MERS, and swine flu outbreaks and the Y2K computer blackout scare.

We must do our best to minimize the burden of this contagion on the elderly and most vulnerable of our patients. The now urgent response to COVID-19 unfortunately contrasts with the failure of our mental health system.

There has been no comprehensive approach to the epidemic of suicide, providing resources and access to mental health care for people with serious mental illness, many of whom are left to languish on city streets or in jails and prisons. Only recently has the epidemic of opiate use and overdose deaths attracted federal funding. Research dollars to find new treatments and understand the underlying neurobiology of psychiatric disorders is wholly insufficient.

Even people with health insurance face barriers to getting mental health care. Despite the promise of mental health parity laws, enforcement has been slow, and beneficiaries still encounter a multitude of problems, such as care denials and "phantom" provider networks.

There is no question that we are in a period of great turmoil. The pandemic is liable to get worse before it gets better, and it will likely take longer to dissipate than any of us like.

But the truth is that this is going to pass. What won't pass, and will likely be made worse by the pandemic, is our broken mental health system where deaths from suicide, overdoses, and the associated higher mortality and morbidity of mental illness disability will remain. While we are rightly concerned about the safety of our family, friends, and communities, let us also use this extraordinary crisis to commit ourselves ever more earnestly to the task of building a system of care of which we can be proud, rather than ashamed.

Be well, and stay safe. **PN**

CMS Lifts Restrictions on Telehealth for Psychiatry, Other Services to Meet COVID-19 Challenge

The temporary emergency waivers were issued in the wake of a national emergency declared by President Donald Trump and the passage of an $8 billion COVID-19 spending bill. **BY MARK MORAN**

Medicare patients seeking certain medical services—including mental health services—can now be seen via live video chats in their homes. They do not need to travel to a qualifying "originating site" for Medicare telehealth encounters, regardless of geographic location, according to a guidance issued March 17 by the Centers for Medicare and Medicaid Services (CMS).

CMS is temporarily expanding Medicare telehealth services and waiving existing restrictions on those services under authority granted to the Secretary of Health and Human Services (HHS) in the bipartisan Coronavirus Preparedness and Response Supplemental Appropriations Act approved by Congress and signed by President Donald Trump on March 6. The new guidance is intended to protect patient health and slow the transmission of COVID-19 by allowing patients to receive care without leaving home.

One week following passage of the bill, President Trump declared the COVID-19 pandemic a national emergency. Under that emergency declaration, Medicare coverage will now include three types of virtual services: Medicare telehealth visits, virtual check-ins, and e-visits.

Additionally, for the duration of the emergency, HHS is waiving HIPAA penalties for using non-HIPAA compliant videoconferencing software. This will allow physicians and other health care professionals to use popular technology, such as Skype (basic) and FaceTime to conduct telehealth sessions. The federal Office of Civil Rights has released further guidance about the HIPAA penalty waiver.

When conducting a telemedicine encounter, health care professionals should use the same CPT codes as for in-person encounters, but with the Place of Service (POS) code 02 to indicate the care was provided via telemedicine. Psychiatrists considering transitioning patients to telepsychiatry in place of in-person appointments should consult APA's Telepsychiatry Toolkit, which includes videos and guidance on topics related to telepsychiatry, including clinical considerations, administrative and technical requirements for software issues, and reimbursement.

Physicians providing telepsychiatry services need a license in the state in which the patient is located at the time services are provided. However, many governors are declaring states of emergency, which may result in altering or waiving these restrictions. The Federation of State Medical Boards (FSMB) has posted a list of states that have declared emergencies and waived a variety of licensing restrictions. APA is monitoring state-level activities and will disseminate information as soon as there is definitive guidance for members in those states.

APA CEO and Medical Director Saul Levin, M.D., M.P.A., had urged passage of the telehealth provisions in a letter to Congressional leaders one week before the bipartisan vote.

Finally, the Drug Enforcement Administration lifted existing requirements that a health care professional conduct an initial, in-person examination of a patient—thereby establishing a doctor-patient relationship—before electronically prescribing a controlled substance. For the duration of the emergency, that requirement will not apply.

The emergency actions temporarily lift a number of restrictions that usually apply to where and under what circumstances patients can receive telehealth services. Generally, Medicare beneficiaries may receive telehealth services under Medicare only if they are located in a qualifying rural area and at one of eight types of qualifying originating sites. In 2018, Congress passed the SUPPORT Act, which removed the Medicare originating-site restrictions for patients with substance use disorders with or without a co-occurring mental health disorder. This change allowed patients to receive telehealth services at home. However, the telemedicine restrictions remained in place for patients with mental health disorders but no co-occurring substance use disorder.

The bipartisan bill granted authority to the HHS secretary to lift that restriction and others but did not actually do so. That was accomplished by HHS's March 17 guidance.

The $8 billion spending bill substantially exceeded the $2.5 billion originally requested by the Trump administration. It provided $7.76 billion to federal, state, and local agencies to combat the coronavirus—including more than $3 billion for vaccine research—and authorized an additional $500 million to meet the demand created by waiving the restrictions.

Prior to passage of the March 6 bill, APA CEO and Medical Director Saul Levin, M.D, M.P.A., had urged Congress to remove restrictions on using telehealth for mental health services in a letter to Congressional leaders. He and other APA leaders welcomed the Trump administration's actions.

"We are in an extraordinary crisis, and the administration has done the right thing," Levin said. "Now, Medicare beneficiaries who may be at risk of contracting COVID-19 can be seen in their homes via telepsychiatry and maintain their regular course of therapy without disruption. This will also minimize future infections."

APA President Bruce Schwartz, M.D., agreed. "Telehealth and telepsychiatry in ordinary times can help more people access services that are critical to their well-being," Schwartz said in a statement. "But it is especially important now, given the nature of COVID-19. Particularly for some groups, like senior citizens and other vulnerable populations, access to telepsychiatry and telehealth could be vital."

Members who have any questions about telepsychiatry are urged to send an email to the APA Helpline at practicemanagement@psych.org. **PN**

KEY POINTS

Under a declaration of national emergency and following passage of a bipartisan emergency COVID-19 spending bill, the federal government is waiving a host of restrictions on use of telehealth to help patients receive services, including mental health services, without leaving their homes. These are the key provisions:

- Medicare patients do not need to travel to a qualifying "originating site" for Medicare telehealth encounters, regardless of geographic location.
- Medicare will now cover three types of virtual services: Medicare telehealth visits, virtual check-ins, and e-visits.
- HIPAA penalties for using non-HIPAA compliant videoconferencing software are waived, and physicians and other health care professionals may use popular technology, such as Skype (basic) and FaceTime, to conduct telehealth sessions.
- Health care professionals should use the same CPT codes as for in-person encounters, but with the Place of Service (POS) code 02 to indicate the care was provided via telemedicine.
- The Drug Enforcement Administration will no longer require that a health care professional conduct an initial, in-person examination of a patient—thereby establishing a doctor-patient relationship—before electronically prescribing a controlled substance.

Bottom line: These temporary, emergency waivers are intended to help protect patients and health care professionals by allowing patients to receive services at home. Psychiatrists needing assistance with telehealth and other matters during the public health crisis should contact APA at practicemanagement@psych.org.

A fact sheet from CMS about the guidance is posted at https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. The Drug Enforcement Administration notice is posted at https://www.deadiversion.usdoj.gov/coronavirus.html. The FSMB list of states that have declared emergencies is posted at http://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declaration-licensure-requirement-covid-19.pdf. APA's Telepsychiatry Toolkit is posted at https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit. Additional resources are posted at https://www.psychiatry.org/coronavirus.

AP Photo/J. Scott Applewhite

President Barack Obama signs the Patient Protection and Affordable Care Act on March 23, 2010.

ACA Celebrates 10 Years: Despite Effectiveness, Law Has Been Target of Dismantling

A number of research studies have demonstrated a clear benefit of the Affordable Care Act for people with mental illness and substance use disorders. **BY MARK MORAN**

Ten years ago on March 23, health care history was made when President Barack Obama signed the Patient Protection and Affordable Care Act.

Two days before, the House had approved the bill by a vote of 219-212.

Debate leading up to passage of the ACA was contentious; the changes the new law required were dramatic, capping decades of debate and discussion about how to achieve universal access to health care while containing skyrocketing costs. The most prominent changes mandated by the law were these:

- Expanding insurance coverage to 30 million Americans, principally by extending Medicaid coverage (in states that chose to do so) to 133% of the federal poverty level, but also through the establishment of health insurance exchanges for individuals and small group coverage.
- Requiring employers to cover their workers, or pay penalties, with exceptions for small employers.
- Subsidizing insurance costs for low-income families.
- Permitting dependents to be covered on parents' insurance to age 26.
- Barring coverage exclusions based on pre-existing conditions.
- Preventing insurers from dropping enrollees who become ill.
- Banning lifetime coverage limits and strictly limiting annual coverage limits.
- Requiring individuals to have insurance, with some exceptions, such as financial hardship or religious belief.

The reform package also included a number of elements related to psychiatric care: coverage for treatment of mental illness, including substance use disorder (SUD), is required in the basic package of all plans marketed in the exchanges (as well as individual and small market plans outside of the exchanges), and federal mental health parity regulations apply to those plans. Medicaid expansion extended care to some of the most seriously mentally ill people while also closing (but not eliminating) the so-called Medicare Part D "donut hole." That term applies to the gap in Part D prescription drug coverage for those beneficiaries with very high prescription

see **ACA** *on page 24*

Substance Use Treatment Increases After Medicaid Expansion

Admissions to specialty treatment programs for substance use disorder (SUD) increased significantly in the period following state expansion of Medicaid under the Affordable Care Act (ACA), according to a report last month in *Health Affairs*.

"The ACA Medicaid expansion was designed to improve access to care for poor, uninsured Americans and to reduce financial barriers to care," wrote Brendan Saloner, Ph.D., of Johns Hopkins University and Johanna MacLean, Ph.D., of Temple University. "Our study suggests that the expansion achieved both of these objectives for people who received care in specialty SUD treatment programs."

They used national admissions-level data from 2010 to 2017 from the Treatment Episode Data Set: Admissions, a federally mandated database for all specialty health care professionals who accept public funding or are otherwise subject to state regulation.

There were 11,205,670 admissions overall. Saloner and MacLean calculated admissions per state population in several categories per 100,000 nonelderly adults.

They also calculated the population rate of admissions by treatment setting: residential treatment, intensive outpatient treatment, and nonintensive outpatient treatment (outpatient treatment that either lasts less than two hours a day or occurs on fewer than three days of the week). They excluded admissions to detoxification programs, as this modality is not considered treatment on its own. The primary outcome was differences in treatment utilization between expansion and nonexpansion states before and after expansion.

They found that admissions to treatment steadily increased in the four years after Medicaid expansion, with 36% more people entering treatment by the fourth expansion year in expansion states compared with nonexpansion states. Changes were largest for people entering intensive outpatient programs and those seeking medication treatment for opioid use disorder. The share of admissions paid for by Medicaid increased 23 percentage points in expansion states compared with nonexpansion states, largely displacing treatment paid for by state and local governments.

"Overall, we find that the ACA Medicaid expansion increased the number of people receiving any treatment for opioid use disorder," Saloner said in comments to *Psychiatric News*. "This occurred both for treatment that included and did not include medication. In some, but not all, years, we see faster growth in the expansion states in treatment with medications. An important caveat is that we do not know whether this was treatment that was comprehensive and whether it included other effective services such as counseling."

He said the study was confined to looking at Medicaid expansion but added that he believes the health exchanges and parity requirements in employer-provided insurance "have been an important pathway into service for privately insured patients."

Saloner also said that despite legal challenges, the Medicaid expansion has largely continued under the Trump administration. "It has actually grown, due to some more states joining the program since 2017, such as Maine and Idaho."

He concluded: "I think the ACA Medicaid expansion has been really important not only to patients but also to state and local governments. One of our main points is that we see a lot of reduced spending by these governments, because Medicaid is now paying for the care of many previously uninsured individuals."

Should Psychotherapy Be a Psychiatric Subspecialty?

Does the future of psychotherapy by psychiatrists lay in subspecialization? Supporters say it will help preserve psychotherapy within psychiatry. Detractors say the idea will further diminish the role of the general psychiatrist. **BY MARK MORAN**

Like many students who entered medical school in the late 1980s, just on the cusp of the advent of managed care, Robert Gregory, M.D., has watched a remarkable sea change in psychiatric practice.

Gregory said that as recently as 20 years ago, he could name 20 or 30 psychiatrists in upstate New York who identified strongly as psychotherapists and included psychotherapy in their practice. "Today I can name maybe two or three."

He sees a still more disturbing trend in education. "Training follows the realities of clinical practice," said Gregory, a professor of psychiatry at the State University of New York, Syracuse, and a former director of residency there. "There are fewer and fewer faculty mentors and role models for psychotherapy practice. Residents may come into training excited by psychotherapy, but it's hard for them to sustain that enthusiasm when they don't see it as an integral part of psychiatric practice and don't have mentors or role models.

The move toward value-based health care will benefit psychotherapy by psychiatrists, because it is cost-effective.
—Robert Gregory, M.D.

Christina Rahr Lane

David Mintz, M.D., chair of the APA Caucus on Psychotherapy, says he hopes the subspecialization concept will generate discussion about the importance of retaining psychotherapy by psychiatrists.

"We know from research that you need to learn psychotherapy by doing it. Seminars don't work. It's a skill set that can be expensive to teach because it requires one-on-one or small group work with lots of clinical supervision and feedback from someone with a great deal of experience."

The Accreditation Council for Graduate Medical Education (ACGME) requires "competency" in supportive, psychodynamic, and cognitive-behavioral therapy (CBT), but Gregory sees those requirements being crowded out over time.

"With increasing knowledge about neuroscience and genetics, there will need to be room in the curriculum," he said. "There are already calls for less training in psychotherapy because it is expensive and—in the minds of some—irrelevant to the realities of clinical practice. If current trends continue, it will be only a matter of time before those training requirements are dropped."

To counter this trend, last year Gregory and David Mintz, M.D., chair of the APA Caucus on Psychotherapy, floated a potential solution: certification in psychotherapy as a new subspecialty of psychiatry. In a paper published in *The American Journal of Psychotherapy,* they laid out the argument for subspecialization. They drew on the experience of the United Kingdom, where psychiatrists can subspecialize in "medical psychotherapy."

They wrote: "Bringing all psychiatrists with special interest and expertise in psychotherapy together under one umbrella may create opportunities for advocacy with a single unified voice, greater status and recognition of enhanced psychotherapy skills, provision of psychotherapy training for all psychiatrists, and the potential for enhanced insurance reimbursement for psychotherapy in recognition of a higher skill set through fellowship training."

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'Psychotherapy Is Undervalued'

Marshall Forstein, M.D., co-chair of APA's Council on Medical Education and Lifelong Learning, doesn't want to see a psychotherapy subspeciality. He wants to see psychotherapy by psychiatrists valued for what it is—a highly effective treatment by the only specialists who can bring a biopsychosocial perspective on patients with mental illness.

"The real issue is that psychotherapy is labor intensive and undervalued. If psychotherapy were reimbursed with parity, institutions would be able to invest more in providing psychotherapy and train residents to incorporate this skill into their armamentarium."

And he worries about what will happen to psychotherapy training in residency if a subspecialty is created.

"If a fellowship in psychotherapy is seen as the place to learn therapy, training programs will do the bare minimum to continue to focus on training residents for higher reimbursement services," said Forstein, who is director of residency training at the Cambridge Health Alliance. "Residents would still need to have some basic training in residency to know how to talk to patients and to perform complex diagnostic assessments of patients with comorbid medical and psychiatric disorders. Even prescribing medications requires a basic understanding of dynamics to enhance adherence to treatment."

Forstein added that it's unclear what level of competence is acceptable. "My residents at Cambridge Health Alliance treat patients for as long as three years and get to see the natural course of therapy and the dynamics that shift over time. How long would a fellowship have to be to make a graduate of such a certificate program competent? One year would hardly be enough. Two? Three?"

He said the ACGME requirements for psychotherapy training need to be more rigorous and focused. In addition, he suggested that providing more psychotherapy training during residency and decreasing the volume of patients managed with medication-only visits would provide the time within a residency, as has been done in his program. "Every one of our residents is supervised by an attending," he said. "But in some programs, residents carry over a 100 or more patients, some of whom are never supervised directly, thereby allowing residents to make mistakes or, worse, inculcate behaviors that are even dangerous."

David Hathcox

He added, "The bottom line is the devaluation of psychotherapy. Reimbursements are insufficient to cover the costs of treatment and training, and there aren't enough residency slots to increase the workforce, even as more medical students become interested in a career in psychiatry."

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Developing a Cadre of Specialists

Creation of a new psychotherapy certification would mark a dramatic and potentially disruptive change for educators and academic centers and could significantly alter the perception of the general psychiatrist. Nevertheless, it's an idea that is attracting supporters.

"It's a terrific idea and would help to develop a cadre of psychiatrist-psychotherapists for education, research, and specialty care," said APA Treasurer-elect Richard Summers, M.D., former chair of the Council on Medical Education and Lifelong Learning.

Summers says a subspecialty would help "embed" psychotherapy within psychiatry. "The purpose of a subspecialty is to create a pathway for training, research, and clinical specialty care that is necessary for the field. Subspecialists teach the rest of us, develop new subspecialty knowledge, and are the ones we call when we have a particularly complicated clinical problem. Every general psychiatrist needs to know the basics about psychotherapy, as they do about C-L psychiatry, addictions, and other subspecialties. In the future, only some psychiatrists will need to be subspecialty experts in performing psychotherapy."

But the idea also has detractors. Marshall Forstein, M.D., co-chair of the Council on Medical Education and Lifelong Learning and director of residency training at the Cambridge Health Alliance, said that subspecialization will only further diminish the role of general psychiatrists while creating a

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select subspecialty drawn from those with resources to pursue a fellowship. (see box on page 6).

"It will go the way of many subspecialties that can't fill their training slots," Forstein said. "Residents have enormous loans and can't take on another year of training. This will discourage those who are not on scholarship and bias people with money and resources." Meanwhile, he continued, if general psychiatrists are reduced to prescribing, they are at risk of being replaced by lower-cost mental health professionals.

Trends Create an Inexorable Slide

Supporters and opponents alike who spoke with *Psychiatric News* agreed about the economic and educational trends that appear to be working synergistically against a future for psychotherapy by psychiatrists.

"There is a lot more for psychiatrists to master today than there was when I was in training, and a lot of residents graduating today say they are uncomfortable with their training in psychotherapy," Mintz told *Psychiatric News*. He cited a 2010 survey of residents in the *Journal of the American Psychoanalytic Association* that found most residents rated their own skills in psychodynamic psychotherapy as "poor" or "very poor."

Mintz is director of psychiatric education at the Austen Riggs Center.

He said that the ACGME requirements for "competency" are thin gruel compared with the kind of immersive, experiential training necessary to become proficient at psy-

chotherapy, especially psychodynamic therapy. In another era, a program might develop its own identity for training in psychotherapy; it might not offer much CBT, for example, but it might have a great depth of faculty expertise in psychodynamic therapy. Or vice versa.

"Now, the training is spread so thin," he said. "To speak of 'competency' is almost Orwellian doublespeak, given the experience of graduating residents. On top of that, we have a treatment system that for cynical, economic reasons wants psychiatrists to do prescribing. The result is a slide toward psychiatrists increasingly being seen only as prescribers of medicine, neglecting the fact that psychotherapeutic skills often lead to more effective prescribing."

To this, Gregory added the possibility that in a health care system driven increasingly by treatment algorithms, the advent of artificial intelligence (AI) has the potential to render obsolete a psychiatry that is shorn of any function except dispensing medicine.

"If we continue to head in the direction we are heading, I worry whether psychiatry will even be a viable profession," Gregory told *Psychiatric News*. "A nurse practitioner with an AI software can run through the algorithm. And the AI software companies are already figuring this out."

Matching Patients to Psychotherapy Type

But there are some hopeful portents. Whether subspecialization is the answer to the future of psychotherapy by psychiatrists, there is agreement that value-based care and

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the harnessing of population data to better match individual patients to a particular treatment can be good for psychotherapy.

"I think population health and value-based medicine are going to drive better coverage for psychotherapy," Gregory said. "Psychiatrists are the unique specialists who are able to integrate biological, psychological, family, and sociocultural models of illness to see a person in front of them, instead of a diagnosis, and to focus on recovery, not just on stabilization of symptoms. In value-based population health, that's going to be valuable because it's cost-effective."

Forstein said Cambridge Health Alliance is planning an initiative using data to match patient characteristics to a psychotherapeutic modality. "One of the questions we have to answer is, Which patients would benefit from which form of psychotherapy? To date there hasn't been a good way to answer that."

Summers agreed that's just where psychotherapy needs to go. "The future of psychotherapy will involve much better data on matching patient needs and psychotherapy type. When patients get to choose whether they want psychodynamic or cognitive-behavioral treatment, I believe they will get better results." **PN**

"Can Psychiatry Residents Be Attracted to Analytic Training? A Survey of Five Residency Programs" is posted at https://www.ncbi.nlm.nih.gov/pubmed/21148130. "Should Psychotherapy Be a Subspecialty of Psychiatry" is posted at https://psychotherapy.psychiatryonline.org/doi/10.1176/appi.psychotherapy.20180044.

Be Prepared to Discuss CBD Products With Patients

Though cannabidiol (CBD) is generally considered to be a nontoxic and nonaddictive component of marijuana, a deluge of untested CBD products with dubious health claims could pose health risks.

BY NICK ZAGORSKI

The rising legalization, acceptance, and availability of marijuana (cannabis) receives the lion's share of attention in public health circles, but the past few years have also seen a marketing surge in cannabis-derived cannabidiol (CBD) products. CBD—one of the two principal chemicals in marijuana—is believed to be benign and potentially valuable pharmacologically since it does not produce a high like tetrahydrocannabinol (THC)—the other active ingredient in marijuana.

The research into the biology, medical benefits, and risks of CBD has not kept up with the commercial proliferation of this product. And that has left physicians, including psychiatrists, feeling ill prepared to discuss CBD with their patients, said Smita Das, M.D., Ph.D., M.P.H., an assistant professor of psychiatry and behavioral health sciences at Stanford University and a member of APA's Council on Addiction Psychiatry.

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"These products are readily available in chain drugstores across the country or online, and patients are talking about them," Das said. She explained that she's had several patients who are in treatment for opioid use disorder ask about CBD's pain-relief properties and whether CBD is a safer alternative to cannabis. The answer to that question and other psychiatric benefits of CBD remain unknown.

"Some small clinical studies have suggested CBD could be beneficial for anxiety and schizophrenia, but these findings are still preliminary," she noted.

The Food and Drug Administration (FDA) in 2018 approved a concentrated form of CBD for the treatment of two rare forms of childhood epilepsy, but that is the only medical indication to date.

While pure-grade CBD used in research studies has been shown to be safe, that is not always the case with commercial CBD products, noted Yasmin Hurd, M.D., a professor of psychiatry and neuroscience at the Icahn School of Medicine at Mount Sinai, in a *JAMA Psychiatry* editorial published in January. "Pesticide, mold, lead, and other adulterants including even synthetic cannabinoids, which induce marked psychosis, have been detected in [CBD sold in commercial] products," she wrote.

Even if a CBD-containing product is safe, it may not meet FDA guidelines. FDA rules prohibit the active ingredients of medications from being included in or marketed as foods or

dietary supplements. Cosmetic products with CBD can be sold, but these products cannot make any unproven health claims. Many companies flaunt these rules, and in November 2019, the FDA sent out a warning to 15 companies for illegally marketing CBD products against their guidelines.

"Wherever CBD is presented as a health benefit, we must ensure that existing rules and regulations are followed," Hurd wrote.

Das noted that while it is possible for physicians to prescribe purified CBD off label to patients who are currently taking over-the-counter CBD products to prevent them from ingesting adulterated products, the CBD medication (marketed as Epidiolex) costs about $30,000 a year.

"In many places, marijuana products are actually cheaper than CBD products," Das said. "I have had patients transition to marijuana because the CBD product became cost-prohibitive, as well as others who were curious to try marijuana because CBD was working for their condition." Such increased use of marijuana can come with increased risks, she noted, including cannabis use disorder or psychosis.

When Das is approached by patients about the possibility of using CBD to reduce psychiatric symptoms, she said that she first discusses with them alternative medications that have been approved for their conditions.

"We should not be afraid to have these conversations with patients and ask them openly about all the substances and chemicals they are taking or have taken," she continued.

see **CBD** *on page 26*

Nora Volkow, M.D., Receives AMA's Nathan Davis Award

Volkow's leadership at NIDA and her research have led to groundbreaking insights into the connection between neurobiology and critical elements of addiction.

BY MARK MORAN

Nora Volkow, M.D. (fourth from left), is joined by psychiatrists, AMA and APA leaders, and APA staff at a ceremony where she received the AMA's Dr. Nathan Davis Award for Outstanding Government Service. From left are Ken Certa, M.D., APA delegate to the AMA's House of Delegates; Raul Poulsen, M.D., of Key Biscayne, Fla.; Kristin Kroeger, chief of APA's Division of Policy, Programs, and Partnerships; Volkow; Patrice Harris, M.D., M.A., president of the AMA; Jerry Halverson, M.D., APA delegate to the AMA's House of Delegates; Jenny Boyer, M.D., J.D., Ph.D., APA trustee; Becky Yowell, APA director of reimbursement policy and quality; and Ray Hsaio, M.D., APA delegate to the AMA's House of Delegates.

Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA), is one of the recipients of the AMA's 2020 Dr. Nathan Davis Award for Outstanding Government Service.

At NIDA, Volkow has helped to foster groundbreaking research demonstrating the neurobiological basis of addiction. She has documented changes in the dopamine system affecting frontal brain regions involved with motivation, pleasure, decision making, and judgment, which are "hijacked" by addiction.

As a public spokesperson, Volkow has also fought stigma associated with substance use disorder. This has included ensuring that physicians and other health care professionals have easy access to science-based information and clinical resources to address substance use disorder via NIDAMED, an online portal on the NIDA website.

"Dr. Volkow's pioneering work as the nation's leading scientist on drug addiction has already translated into effective strategies to prevent and treat substance use disorders," said AMA Board Chair Jesse M. Ehrenfeld, M.D., M.P.H. "She has worked tirelessly to fight the stigma of substance use disorders, and thanks to her leadership, we are in a far better position today to combat complex public health emergencies like the challenging opioid crisis."

Volkow was one of eight honorees chosen this year to receive the Dr. Nathan Davis Award for Outstanding Government Service. The award, named after the founding father of the AMA, recognizes elected and career officials in federal, state, or municipal service whose outstanding contributions have promoted the art and science of medicine and the betterment of public health.

At a ceremony during the AMA's National Advocacy Conference in Washington, D.C., Volkow said that from an early age she had wanted to be a physician and was drawn to the challenge of understanding and treating addiction.

"I was struck by the loss that people with addiction experienced—loss of themselves, loss of their ability to make decisions, the degradation of their support networks—and by their isolation," Volkow said. "I saw these patients in medical school and in residency and when I was an attending psychiatrist. And no one was paying attention to them. That's when I decided I wanted to use science and knowledge to destigmatize addiction."

Born in Mexico City, Volkow earned her medical degree from the National University of Mexico in Mexico City. She completed her residency in psychiatry at New York University. She received the International Prize from the French Institute of Health and Medical Research for her pioneering work in brain imaging and addiction science and was awarded the Carnegie Prize in Mind and Brain Science from Carnegie Mellon University. She has been named one of *Time* magazine's "Top 100 People Who Shape Our World." **PN**

ON MENTAL HEALTH, PEOPLE, AND PLACES

Building Community: We Gatherin' Barbados

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.

It was a beautiful February morning. I had never witnessed a church ceremony like this one, whose objective was the solemnization of citizens' coming together and celebrating their national cohesion. The Barbados government called it a "gatherin'," dropping the last letter of the word to signify that the term was formulated in the people's street patois.

The government had begun this unique yearlong initiative a month earlier in St. Lucy, the most northern parish of this Caribbean country. A St. Lucy contingent was now passing the baton to the people in the neighboring parish of St. Peter. The country's governor general was in attendance, as were the acting prime minister, several parliamentary representatives, and individuals from all walks of Barbadian life. Tropical flora decorated the Anglican church, and the music was decidedly ecumenical. People were wearing outfits reflecting the melding of their British, African, and West Indian cultural heritage, as illustrated by the women's headwear in the photo on the facing page. There has been, of course, dynamic cultural change in their customs and rituals since Barbados obtained independence from its centuries-old British colonizers in 1966.

The government invited all Bajans, the diminutive name for Barbadians, to celebrate themselves throughout 2020. All 11 parishes of Barbados will in turn welcome residents from other parishes. Bajans throughout the diaspora have also been invited home to celebrate the island, its culture, and its people's achievements. The objective, given the symbolism of the year 2020, is to gather and simultaneously look back and forward.

The organizers of the gatherin' have been advertising a range of activities. For example, sports will be represented by dominoes and road tennis. Public lectures will focus on different aspects of the island's socioeconomic and infrastructural development. There will also be tours of the island's patrimony and discussions of the country's artists, economists, and health caregivers. Steel pan music and calypso singing will be juxtaposed against the island's heritage and traditions of classical and church music. Even genealogists

continued on facing page

Seven Actions to Ensure Safety In Psychiatric Office Settings

BY DENISE NEAL, B.S.N., M.J., C.P.H.R.M.

Denise Neal, B.S.N., M.J., C.P.H.R.M., is assistant vice president of the Risk Management Group, AWAC Services Company, a member company of Allied World.

Workplace violence can happen in any setting. The Centers for Disease Control and Prevention (CDC) defines workplace violence as "the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty."

The possibility of being verbally or physically assaulted, stalked, or threatened by a patient is not only a concern but reality for psychiatrists, especially those with limited resources and lack of on-site security. The following actions are recommended to improve safety and security in psychiatric offices and should be tailored to each individual practice.

1. Workplace violence assessment, response, and prevention plan

- Conduct a workplace violence assessment and create a workplace violence prevention and response plan regardless of the size or location of your practice.
- Assess for workplace hazards within and around the office and plan for the various types of violence that may occur, whether physical violence against staff or verbal violence/harassment/bullying.
  - Be sure to include, as appropriate, representatives from each discipline in your office.
  - If you sublet space, include the practitioners who use that space.
  - Consider involving law enforcement and risk management in your planning.
  - Review the plan with staff at least annually.

2. Office and physical safety

- Control/restrict access to the office by patients, visitors, and contractors by providing individual access card readers and/or locks to staff only or limiting access to restricted areas.
- Ensure patients, visitors, and contractors are escorted within the office and do not wander alone.
- Install video surveillance cameras at entrances and exits and post signs indicating their presence as a deterrent to violence.
- Employ an office "buddy" system—no one works alone, including after-hours, or goes to his or her car alone.

3. Social media: your patients are not your friends

- Don't accept "friend" invitations from your patients on social media, and do not look up your patients on social media (consider boundary issues and privacy).
- Be mindful of posting personal information about yourself, family, and friends that may reveal your habits.

4. Be aware of stalking behavior and boundary crossing

- Be aware of behaviors that are unwanted or distressing including threatening, harassing, and stalking behaviors.
- Develop policies and procedures to identify, communicate, document, and track concerning behaviors, boundary violations, boundary crossings, and patient stalking.
  - For each occurrence of workplace violence/behavior incidents, document it and discussions about behavior expectations in the patient's medical record.
  - Communicate concerning behavior to other multidisciplinary staff members.
  - Seek assistance from your risk manager, legal counsel, and security/law enforcement.

5. Communicate concerns and plan an escape route

- Avoid having your back to the exit, and turn your body sideways to allow a clear path to the exit if a quick escape is necessary.
- Install panic buttons in each office, at the reception desk, and in bathrooms.
- Wear an audible alarm.
- Designate a safe room within the office should an escape not be possible.

6. Call 911 if you fear for your safety or the safety of others

- There is a HIPAA exception for disclosure to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public. When disclosing the threat, limit the disclosure to nonclinical information.
- Terminate patients that display violent/aggressive/stalking behavior toward you or your staff and consider whether a restraining order/noncontact order is needed. (See "Risk Management Considerations When Terminating With Patients," which is posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2016.4b16.)

7. Education and Training

- Provide clinical and nonclinical staff interactive, site-specific education and training.
- Educate staff about the nonverbal cues of aggression, agitation, and behavior escalation that may lead to an assault.
- Provide de-escalation and response training.
- Consider self-defense/personal safety training. **PN**

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will be available to help in finding of one's roots.

There was little doubt the gatherin' was meant to be inclusive. That's why the activity venues extended into all the parishes, and the themes of the individual meetings covered the old, the young, males and females, and broad interests of the population. One could tell that there was a sense of healing in the air. Everybody was promoting interpersonal connecting, pride in self and country, awareness of what it means to be a Barbadian, and confidence in self and neighbors. The politicians had devised an ingenious way of inviting everybody to renew membership in the small country and contemplate ways of sharpening the connection to home. Added to that invitation was the prod to take some responsibility for the future of the island and its efforts to confront the growing drug problem, violence, and unemployment.

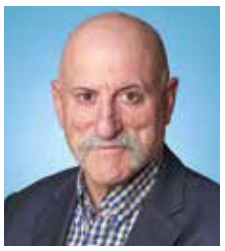
Brigitte Griffith

In the weeks following the Sunday service, I chatted with local and returning folk. I visited the countryside and sampled food in restaurants. I attended steel pan concerts and toured art museums. I even revisited museums and listened to the crashing of the waves at different beaches. I remembered Devika Chawla's advice (see *Stories of Home: Place, Identity, Exile* by D. Chawla and S. H. Jones) to monitor and untangle home's habits and its affective rhythms. There was also Chawla's mention of the personal restorative power of home's rituals and performances. I could see home in music, art, sports, religious ritual, and the smells and sights of Bajan life all around me.

There must be something good about celebrating one's self, one's roots, and the contributions of family to a firm developmental foundation. I liked the notion that home-space could symbolize achievement and promise. This was a Barbadian form (a we-gatherin') of civic engagement and community building, with significant implications for individual and collective well-being. **PN**

A History of the APA Assembly From A (Alabama) to W (Wyoming)

The APA Assembly was created in 1953 and through the years has become an important venue for ensuring that a wide range of voices and ideas are heard from APA members and allied organizations. **BY JEFFREY GELLER, M.D., M.P.H.**



Jeffrey Geller, M.D., M.P.H., is president-elect of APA. He is also a professor of psychiatry at the University of Massachusetts Medical School and a member of the APA Foundation Library and Archives Advisory Committee.

The history of the APA Assembly is a tortuous one, with APA Assembly members stutter stepping their way to the current purpose, makeup, and functioning of the Assembly. That's not a criticism but merely a description. Perhaps a series of metamorphoses was the only way the Assembly could have achieved the meaningful role it plays in APA today.

The first meeting of the Assembly of District Branches occurred on May 5, 1953, in Los Angeles, where the temperature reached 94 degrees, by far the hottest day that week. There were 16 district branches at the time (four from New York state), and all attended the meeting. But the Assembly did not actually start out this way.

Prior to the Assembly's formal formation, at each Annual Meeting there was a town-hall gathering where APA business was conducted and officers elected. Since 1892, APA had had an elected "Council" (now the Board of Trustees), who acted on behalf of the membership between meetings. In the 1940s dissatisfaction with the effectiveness of APA and its capacity to respond to the needs of the membership had become quite apparent.

The 1940s was not the first time APA wrestled with restructuring. William Allison White, in his 1925 presidential address, suggested forming "sections" and within them "district societies." This model was implemented. In a decision that would come back to haunt APA, membership in the independent sections and district societies did not require APA membership. Eleven years later, the sections were dispensed with, district societies became "affiliated societies," and "district branches" (DB) were created. APA decided then on a unified membership rule: If one is a member of a DB, one must be a member of APA, and if one is a member of APA, one must be a member of a DB.

This did not exactly fix the problem of non-APA members being actively involved in APA affairs. Since there were still affiliated societies that could include nonmembers, these grew in number, and not one DB was formed until 1949, or 13 years after the unified membership rule was established.

Emerging from this quagmire was another clarion call for change. The Council appointed the Reorganization Committee to look at reorganizing APA and appointed Karl Menninger as its chair. The outcome was a recommendation that APA function with a House of Delegates that made policy and a Council that carried out the policies (similar to the AMA model). As one can imagine, this was not popular with many APA members. Two camps emerged, fractious debates ensued, and this structure was rejected.

Some of the other committee recommendations were adopted, most notable of which was the formation of a central office under the direction of a medical director. The Reorganization Committee reorganized and recommended the creation of the Assembly of District Branches, whose representatives would meet and consider only those matters sent to it by the Council.

In 1949, there were 27 affiliate societies and no DBs. The first two DBs were approved by APA that year: the Pennsylvania DB (which included Delaware) and the Mid Continent DB (Missouri and Kansas). In the ensuing years, as DBs formed, they often included more than one state.

In 1952 the APA Bylaws were amended, and the Assembly of District Branches was official. By the first meeting in 1953, there were 16 DBs as already noted. The Assembly's first-year budget was $500. That's equivalent in purchasing power to about $4,830.92 in 2020. The Assembly's 2020 budget is $1,361,318.

Almost as quickly as a group can change its mind, the Assembly pushed back against the idea that it could consider only matters referred to it by the Council. Before the second Assembly meeting, the DBs suggested a change so the Assembly could also initiate recommendations to the Council. The Council approved this. It took until the third Assembly meeting for the members to do so. The Central California Psychiatric Society applied for membership at the 1953 meeting and was accepted, making it the first DB on the West Coast. Its annual dues were $1. At the 1954 meeting, the Assembly organized itself into five regions; from the outset, New York was its own region, but neither the Mid-Atlantic states nor California were regions at this point.

The Assembly grew quickly in the early years as members perceived the benefit of being in a DB so as to be able to influence the direction of APA: 1953, 16 DBs; 1954, 21 DBs; 1955, 23 DBs; 1956, 31 DBs; 1957, 35 DBs. One has to credit New York state* as figuring the Assembly out early on. New York added one DB per meeting in four of the first five meetings. By 1958, the Assembly had 45 DBs. At the meeting that year, the affiliated members category was designated to refer to nonpsychiatrist physicians with an interest in psychiatry.

At the time of the 1959 Assembly meeting, there were 48 DBs. Ninety APA members attended the meeting and decided this was about the maximum number the Assembly could have and function in an effective parliamentary fashion. At the most recent Assembly meeting in November 2019, there were 246 voting members.

The eighth Assembly meeting, in 1960, passed a noteworthy resolution: "The ancillary personnel in mental hospitals need some leadership, and APA should take responsibility for this leadership."

By the time of the ninth Assembly 1961 meeting, APA had 6,000 to 7,000 members and 53 DBs. Only two states were not represented by a DB, West Virginia and Alabama. But again, some DBs represented more than one state. For example, the Intermountain Psychiatric Association represented psychiatrists in Arizona, Idaho, Montana, Utah,

see **Assembly** *on page 25*

District Branch Assembly Formed: Sixteen District Branches formed themselves into the first A.P.A. District Branch Assembly, and selected Joseph L. Abramson Chm., and John R. Saunders Secretary. Unquestionably this new development in APA's organizational structure will tend to bring a wider representation of opinion to bear on the affairs of the Association. Rules and procedures under which the Dist. Brs. will operate will be published shortly.

This news item appeared in the May 1953 *APA Newsletter,* produced by APA's Information Service.

The Assembly of District Branches Comes of Age

On May 7, 1963, Assembly Speaker Robert Garber, M.D., presented Assembly delegates with a "Ten Point Program for the Assembly of District Branches." Garber told the delegates that "the District Branches have reached that point in their development where they are an indivisible part of the whole organizational structure of APA." The ten points were as follows:

1. Build branch membership. About 4,000 psychiatrists at that time were known not to hold APA membership. The branches were urged to undertake active recruitment.
2. Support your branch and your national Association. This would include, among other things, a lively newsletter, divisional meetings, and the establishment of chapters and/or regional groupings in appropriate cases.
3. Establish a staff facility for your branch.
4. Support adequate appropriations for public psychiatric hospitals.
5. Assume leadership in state and community mental health planning councils.
6. Expand and consolidate close working relationships with medical societies.
7. Develop and expand general and private hospital psychiatric services.
8. Redouble efforts to educate other physicians in psychiatry.
9. Actively support and work with the citizens' mental health movement.
10. Work to improve the public image of psychiatry.

**I acknowledge a potential conflict: I was born in New York and educated in its public school system grades K-12.*

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How Will Precision Medicine Advance Psychopharmacology?

Among the numerous goals of precision medicine is to identify biomarkers linked to disease vulnerability and tailor prevention strategies or treatments for each patient. **BY EMILY KUHL, PH.D.**

Certain areas of medicine—notably oncology—have successfully leveraged objective biomarkers to fuel the advent of precision medicine, helping clinicians tailor targeted treatments to a patient's genetic, cellular, or molecular profile.

To date, implementation of precision medicine in psychiatry (or precision psychiatry) has not yielded significant real-world clinical impacts. But some of the latest research reveals important clues about its potential to advance pharmacotherapy development and prescribing practices in the future.

Targeting Treatment Decisions

Precision medicine is an approach to research and patient care that incorporates individual differences in biology, lifestyle, environment, and social determinants of health with the goal of more effectively identifying what underlies an individual's illness.

"Many psychiatric conditions are very heterogenous, and the notion that depression, for instance, represents 'one' thing, I think we would all agree, is not accurate," said Jordan W. Smoller, M.D., Sc.D., Trustees Endowed Chair in Psychiatric Neuroscience at Massachusetts General Hospital, in an interview. "There are probably many forms of the disorders that we see in psychiatry, and by understanding and leveraging individual differences, we can [care for patients] better."

Among the numerous goals of precision medicine is to identify biomarkers linked to disease vulnerability, such as the *BRCA* gene variants for breast cancer or the *ApoE4* gene for Alzheimer's disease. A second aim involves tailoring prevention strategies or treatments for each patient to offer the intervention with the greatest likelihood of favorable response and minimal side effects. Numerous biomarkers may be involved in such tailoring and include findings from brain imaging, inflammatory markers, and more.

Jordan Smoller, M.D., Sc.D., says psychiatry is beginning to take advantage of the latest advances in genomics and large-scale data analyses to identify individual differences between patients that may one day guide treatment.

Momentschmiede

Immunotherapy in psychiatry is still nascent, says Andreas Menke, M.D., but it may play a role in depression and stress-related mental disorders.

"In cancer, precision medicine is pretty advanced compared with psychiatry because they have good biomarkers to differentiate subtypes of the same cancer and match patients to the right chemotherapy. This is what we want for psychiatry," Andreas Menke, M.D., senior consultant psychiatrist in the Department of Psychiatry, Psychosomatics, and Psychotherapy at University Hospital Wüerzburg in Germany, told *Psychiatric News*. "We want to find biomarkers that tell us, 'OK, this patient

see **Precision Medicine** *on page 29*

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Does Video Surveillance Help Psychiatric Patients?

In an age of constant vigilance, psychiatrists should consistently re-evaluate the efficiency of cameras on hospital units, according to experts.

BY KATIE O'CONNOR

The idea that people are safer if someone is watching has helped to fuel the boom in video surveillance around the world. According to some market estimates, there are more than 60 million security cameras in North America alone.

In psychiatric units, cameras are used to increase safety and security and to monitor patients who may present a suicide risk or require isolation or restraints. But how effective is video surveillance in terms of improving security, what other impacts do cameras have on patients and staff, and what ethical matters should be considered in their use?

"A lot of the discussion of video use in psychiatric settings has focused on practical questions: Do they work? Where should they be used? Less attention has been given to the ethical issues," said past APA President Paul Appelbaum, M.D. "That's in contrast to the use of video surveillance in public spaces in society at large, where there's been a great deal of discussion about the impact on privacy and related issues due to the proliferation of cameras."

Appelbaum and colleagues reviewed literature on video surveillance, and their findings were published last December in *Psychiatric Services*. They found a lack of evidence demonstrating effectiveness of video surveillance for increasing security. Yet, Appelbaum pointed out, the data are weak either way, as the few studies on whether cameras improve security have been small. "The absence of evidence is not necessarily evidence of absence," he said.

"We should always be thinking of whether any intervention, human-based or technological, actually serves the purpose we think it's going to serve," said Rebecca Brendel, M.D., J.D., chair of APA's Committee on Ethics and director of the master's degree program at the Harvard Medical School Center for Bioethics. "Then, if it doesn't have clinical utility, we should reconsider its use."

Creating a Sense of Safety

Charles Dike, M.D., vice chair of the APA Committee on Ethics and an associate professor of psychiatry in the Law and Psychiatry Division at Yale University, has worked on psychiatric units using video surveillance in multiple roles, most recently as the medical director of the Connecticut Department of Mental Health and Addiction Services. The question of the camera's impact comes up often, he said.

"My overall thoughts are that video surveillance can be very helpful in the right situations, but it should be used with caution in other circumstances," he said.

In common areas, such as hallways, shared spaces, and treatment rooms, the benefits of video monitoring outweigh the risks, he said, and he has found that patients and staff feel the same.

Patients can be nervous when they enter psychiatric hospitals, he explained, and cameras can help them feel at ease. "Some are worried about other patients with histories of violence," he said. "There's a tendency for patients to be really tense and worried about their own safety. But when you know that other people are watching through the cameras, it makes you feel as though you're not alone. You feel somebody is there to protect you if something were to go wrong."

Appelbaum cautioned that video surveillance can also create a false sense of security among staff, which in turn could lead to less use of other techniques to ensure safety, such as monitoring and engaging with patients in person.

"Although cameras are often typically installed for the purpose of altering patient behavior, it is possible that one of their major effects may be on staff behavior," he said.

Not all patients feel comfortable with video surveillance, either. "Patients often have a reduced ability to control their self-presentation, particularly in seclusion or restraint, and adding constant video monitoring can lead to a sense of shame, as aspects of self are exposed that the patient would rather have concealed," Appelbaum and colleagues wrote.

Giving Patients a Choice

Video surveillance may be helpful to avoid waking patients multiple times during the night when they are being regularly monitored, Appelbaum said.

"When patients are queried, some have said they like the notion of video monitoring so they can sleep without being disturbed, while others don't. It's not a universally accepted approach," he said.

"One of the major consequences of being hospitalized is losing choice. You tend to no longer get to decide what time you wake up, what time your lights have to be out, what time you eat, or how you

VIEWPOINTS

COVID-19 Guidance to Help Our Patients and Ourselves

BY SHAWN SIDHU, M.D.

Psychiatrists learn very early on in their training about the incredible and irreplaceable power of social support for all of our patients and their families. This social support is even more critical during disasters, catastrophes, and epidemics, and the ripple effect of this support can spread throughout an entire community. While mass impact events like the COVID-19 outbreak can be incredibly tragic, there can be a silver lining in communities coming together as a unified front to help one another in a showing of neighborly love, compassion, empathy, kindness, openness, and selflessness.

As of press time, the Centers for Disease Control and Prevention (CDC) is recommending social distancing to slow the spread of COVID-19. Yet, for psychiatrists, advocating social distancing during a global pandemic may seem akin to fixing a leaky boat with water. By removing social support and activity from our patients, we can expect that some may experience a worsening of their symptoms. Given the current climate, what are we to say to our patients when we have a proverbial hand tied behind our backs?

Shawn Sidhu, M.D., is training director of the Child and Adolescent Psychiatry Fellowship Program and an associate professor in the Department of Psychiatry at the University of New Mexico.

Here are some very practical tips that we can suggest to our patients and health systems, as well as follow ourselves:

- **Social distancing does not have to mean social isolation.** Yes, it may be difficult to take part in larger gatherings that can be incredibly inspiring and unifying, such as church services, concerts, and sporting events. However, this can be a time for connecting with loved ones. So many of us often think to ourselves, "I wish I had more time with my loved ones." This is a great opportunity to catch up with loved ones and have really meaningful conversations and experiences. It offers a chance to put cellphones and laptops away and break out the old board games and card decks. A very healthy use of electronics would be to video chat with loved ones and stay connected to real-world relationships.

- **Social distancing does not mean self-imprisonment.** Exercise and fresh air improve the immune response while boosting emotional and mental wellness. Going for a jog along a nature trail or playing ball with loved ones or pets in an open field are great ways to connect to nature and reduce stress. Even while indoors, keeping the windows cracked can keep fresh air moving, which helps to prevent the spread of viruses while pushing back against cabin fever.

- **Use this as a moment in time to connect to something deeper within yourself.** Many of our patients desperately want more time

continued on facing page

spend your time during the days. To the extent that they can be given choice, that seems to be a good thing."

Dike agreed that having a conversation with patients who require monitoring about their preferences can be empowering: "Would they prefer for this to be done through a camera system if available or would they prefer for staff to come in?" But at times, the notion of allowing patients a choice is unrealistic because installing cameras and hiring someone to continuously monitor them can be prohibitively expensive, Dike said, especially for state psychiatric hospitals.

Some patients, he continued, do prefer staff to come in and check on them during the night. "They feel safer," he said, whereas they're not always certain that someone is watching them through the camera. However, he continued, some patients would worry about someone coming into their room while they are sleeping, especially those with a history of trauma or of paranoid delusions who would be concerned about their safety.

Considering Importance of Human Interaction

Choice can also play an essential role when monitoring patients who are secluded or restrained.

"These are very difficult, traumatic situations for patients, and it's important to have staff be there to reassure the patient that everything is going to be OK," Dike said. "A positive human interaction is important."

But there are some patients for whom staff presence is agitating, he added. For such patients, video monitoring could be a better option.

In their study, Appelbaum and his colleagues suggest using psychiatric advance directives to ascertain a patient's preference for monitoring ahead of time if an emergency requires restraint or seclusion.

Increasing technology has allowed patients better access to care, Brendel said. Nevertheless, in times of acute distress, human interaction is hugely important. "We can't lose the simple act of caring and of a therapeutic presence," she said. "We can't replace that, at least not yet."

At minimum, she said, better data are needed to illustrate in which cases video monitoring effectively improves safety and patients' well-being. "Or, we should stop doing it, because it would be unethical to do something that is potentially harmful with no counteracting benefits," she said. **PN**

"Ethical and Practical Issues in Video Surveillance of Psychiatric Units" is posted at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900397.

continued from facing page

for self-care, reflection, mindfulness, and connectedness. Similar to family time, many people have "wellness bucket lists," so to speak, or lists of things that they would love to do but just never seem to find the time to do them. This could be a time for quiet reflection, journaling, thinking about where people are in their lives, appreciating the moment through mindfulness, catching a sunrise or a sunset, visiting a new hiking trail, or catching up with an old novel. It could also be a time for creative pursuits, such as dusting off the old guitar or art canvas or finding that creative-writing journal that is buried under medical journals and notes. It might also be a great time to share this creativity with others.

- **Check news once a day from a reliable source.** Watching the 24/7 news cycle will serve only to increase anxiety and/or paranoia. A healthy limit is to check updates once a day on reliable, authoritative sites, such as those of the CDC and World Health Organization.

- **Resist the urge to binge-watch Netflix.** Spending long hours indoors without fresh air and spending long stretches of time in dark isolation can be deleterious to both emotional and physical health.

Our patients are already at risk for social isolation as a result of psychiatric symptoms, and many of our patients have good reasons to feel anxious, mistrustful, or paranoid based on their life experiences. Pandemics can certainly increase all of these feelings, and people who are medically ill, have loved ones who are ill, or have experienced traumatic grief and loss are especially at risk for increased symptoms. We must ensure that all of our patients are safe and getting high-quality care at a time when there may be a shortage of health care professionals and patients may want to cancel appointments.

As a society, we have to be very careful to not fall prey to xenophobia or discrimination against those whom we deem ill or responsible for this pandemic. It is critically important to reinforce unity, togetherness, resilience, and hope during these times. Humans have withstood the test of many catastrophic events throughout history and have always overcome difficult odds by persevering and supporting one another. We can do the same. **PN**

History of Severe Infection Linked To Substance-Induced Psychosis

Hepatitis and sepsis are among the infections that may increase the risk of substance-induced psychosis. **BY TERRI D'ARRIGO**

People who have a history of severe infection such as hepatitis or sepsis may be more likely to develop substance-induced psychosis than people without such history, a study in *AJP in Advance* suggests. Substance-induced psychosis occurs during intoxication with drugs or alcohol and resolves after the person stops using the substance.

The results hint at the possibility of new treatments for psychosis, said lead author Carsten Hjorthøj, Ph.D., M.Sc., of Copenhagen University Hospital.

"We hope that it may be possible to treat at least some cases of psychosis using various immunotherapies, anti-infective agents, et cetera," Hjorthøj told *Psychiatric News*. "Imagine if it becomes possible to use such medications rather than the usual second-generation antipsychotics for even a fraction of patients with psychosis."

Copenhagen University

The study's results offer hope that one day immunotherapies or anti-infective medications may be an option for treating psychosis, says Carsten Hjorthøj, Ph.D., M.Sc.

Hjorthøj and colleagues analyzed data from nationwide Danish registers that included all people born in Denmark since 1981. The authors were able to obtain information about people who experienced substance-induced psychosis, infections, or schizophrenia, as well as information about parental substance use disorders and psychosis. The final sample included more than 2.2 million people, among whom there were 3,618 recorded cases of substance-induced psychosis.

The risk of substance-induced psychosis doubled for the first two years after a severe infection and remained elevated for 20 years. Overall, a history of severe infection increased the risk of substance-induced psychosis by 30%, although some types of infections appeared to incur greater risk than others. For example, sepsis, skin infections, and urogenital infections were associated with a 50% increase in risk. Hepatitis tripled the risk, even after the researchers accounted for substance use disorders, which carry their own risk of psychosis.

In a secondary analysis, the researchers sought to tease out whether severe infection increased the risk of converting from substance-induced psychosis to schizophrenia. They excluded 351 people from the primary analysis who had a diagnosis of schizophrenia before their substance-induced psychosis. Among the 3,267 remaining people, 813 converted to schizophrenia. Again, those who had a history of hepatitis appeared to face the greatest risk: After 20 years, 57.5% had converted to schizophrenia, compared with 37.3% of people without a history of severe infection.

Hjorthøj said the reasons for the link between hepatitis and both substance-induced psychosis and conversion to schizophrenia are unclear.

"It could be a case of severe substance use that hasn't been otherwise diagnosed, thus indicating some potential residual confounding. But at least one other study has found the same association for psychosis in general, so perhaps this also feeds into [an existing] gut-brain interaction hypothesis, which is also of much interest in studies on psychosis," Hjorthøj said. "However, I think that for now we should be cautious not to overinterpret this finding."

Hjorthøj noted a dearth of studies on substance-induced psychosis and called for further research.

"I think it has received so little research attention because the etiology seems so straightforward: Just don't use substances, and these disorders won't occur," he said. "But guess what? People will continue to use substances, and more research is needed both to prevent substance use leading to psychosis and to develop better treatments."

This study was supported by a grant from the Lundbeck Foundation Initiative for Integrative Psychiatric Research–iPSYCH. **PN**

"Infections as a Risk Factor for and Prognostic Factor After Substance-Induced Psychosis" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2019.19101047#d85793e1.

Secondhand Smoke May Raise Risk Of Depressive Symptoms in Adolescents

Adolescents exposed to secondhand smoke every day are 63% more likely to experience depressive symptoms than their peers who are not exposed. **BY TERRI D'ARRIGO**

Adolescents in low- and middle-income countries who are exposed to secondhand smoke may be more likely to develop symptoms of depression, a study in the *American Journal of Preventive Medicine* has found. The risk is also dose-dependent, with greater exposure associated with higher risk.

"Better implementation of smoke-free air policies and strategies aiming at reducing the number of smokers in low- and middle-income countries may lead to reductions not only in physical health problems such as lung cancer, cardiovascular diseases, and COPD at the population level, but also depressive symptoms among adolescents," lead author Louis Jacob, Ph.D., a resident in physical rehabilitation and medicine of the University of Versailles Saint-Quentin-en-Yvelines in France, told *Psychiatric News*.

The researchers analyzed data from the 2003-2008 Global School-Based Student Health Survey of more than 37,000 adolescents aged 12 to 15 years who had never smoked and who lived in 22 low- or middle-income countries. To determine participants' exposure to secondhand smoke, they were asked, "During the past seven days, on how many days have people smoked in your presence?" To determine whether participants had experienced symptoms of depression, they were asked, "During the past 12 months, did you ever feel so sad or hopeless every day for two weeks or more in a row that you stopped doing your usual activities?"

> Policies that promote smoke-free air may lead to reductions in depressive symptoms in adolescents.
>
> —Louis Jacob, Ph.D.

Overall, 53.6% of the participants had been exposed to secondhand smoke on at least one day in the past week, and 24.5% had experienced depressive symptoms in the past year. Nearly 29% of participants who were exposed to secondhand smoke every day over the past week had experienced depressive symptoms compared with 23% of those who were not exposed to secondhand smoke. Compared with those who were not exposed to secondhand smoke over the previous week, those who were exposed on at least three days were 48% more likely to have experienced depressive symptoms, while those who were exposed on all seven days were 63% more likely to have experienced depressive symptoms.

The results varied little from country to country, suggesting that they may be applicable to other low- and middle-income countries, but whether they apply to high-income countries remains to be seen, Jacob said. However, he noted that those who live in disadvantaged neighborhoods may be exposed to higher levels of secondhand smoke, regardless of country.

"Psychiatrists and other mental health professionals should be aware of this and may use this information to identify adolescents who are at increased risk for depression," Jacob said.

The researchers wrote that the increased risk of depressive symptoms in adolescents exposed to secondhand smoke may stem from increased levels of perceived stress because of physical discomfort, the association between secondhand smoke and chronic physical conditions in childhood and adolescence such as asthma, or the effects of nicotine on neurotransmitters and inflammation.

The work of one researcher in the study was supported in part by the ISCIII-General Branch Evaluation and Promotion of Health Research and the European Regional Development Fund. **PN**

"Secondhand Smoking and Depressive Symptoms Among In-School Adolescents" is posted at https://www.ajpmonline.org/article/S0749-3797(20)30032-5/fulltext.

Naloxone Prescription Fills Inch Upward, But Remain Low Overall

A mere fraction of patients at risk for opioid overdose obtain the life-saving opioid reversal drug. **BY TERRI D'ARRIGO**

The Centers for Disease Control and Prevention (CDC) recommends that physicians consider prescribing the opioid-overdose-reversal drug naloxone to patients at risk for opioid overdose, including those with a history of overdose or substance use disorder, those who take higher opioid dosages, and those who take both opioids and benzodiazepines. Yet less than 2% of patients in these populations fill prescriptions for naloxone, a study in the *Journal of General Internal Medicine* has found.

Lewei (Allison) Lin, M.D., M.S., a research investigator at the Center for Clinical Management Research at VA Ann Arbor, and colleagues examined claims data from a private health insurance database in six-month increments from January 2014 through June 2017. They compared the records of adults who received opioids and naloxone with the records of those who received only opioids, and looked at whether the risk factors for opioid overdose outlined in the CDC recommendations were associated with receiving naloxone.

By the end of the last six-month period in the study (January 2017 to June 2017), only 1.6% of patients who were taking high dosages of opioids (at least 90 morphine milligram equivalents per day) had filled a prescription for naloxone. Among those with a history of opioid overdose, only 1.6% had filled a naloxone prescription, followed by only 1.4% of those with a history of opioid use disorder. Less than 1% of those who were taking both opioids and benzodiazepines had filled a naloxone prescription.

> Psychiatrists should be aware of which of their patients are at risk for opioid overdose and discuss naloxone with them.
>
> —Lewei (Allison) Lin, M.D., M.S.

Lin, who is also an addiction psychiatrist and assistant professor in the Department of Psychiatry at the University of Michigan Medical School, said that although dispensing rates are slowly increasing, they are still inadequate.

"There is still a lot of work to be done in getting naloxone to the patients at highest risk, especially those with a history of overdose," she said.

In the study, Lin and her colleagues noted that they could not determine from the data whether patients had received prescriptions for naloxone but had not filled those prescriptions. However, Lin told *Psychiatric News* that health professionals who prescribe opioids may not know about a patient's risk, especially if the patient has undisclosed or undiagnosed substance use disorder.

"We saw the vast majority of people who received naloxone were people also receiving opioids. In recent years, many of those at risk for overdose are no longer being prescribed opioids. In particular, this includes people who use heroin, cocaine, or crystal meth. These groups are at very high risk because these drugs are often mixed with fentanyl," Lin said.

Lin pointed out that although psychiatrists generally do not prescribe opioid pain relievers, they work with patients with other risk factors for overdose, including patients with opioid use disorder, a history of overdose, or concurrent use of benzodiazepines.

"It's important to look at all of these risk factors and to talk to patients about naloxone. Or, if patients tell you they have family members who struggle with addiction, a discussion of naloxone can be part of the conversation you have with them," Lin said.

This study was supported by Precision Health at the University of Michigan, the National Institute on Drug Abuse, the Substance Abuse and Mental Health Services Administration, and the Michigan Department of

see **Naloxone** *on page 28*

Loneliness Persists Even When Older Adults Live in Social Environments

Even while living in an independent-living community with a bounty of social opportunities, residents reported loneliness, described as feeling empty or abandoned.

BY KATIE O'CONNOR

Stigmas, such as blaming loneliness on the person's behavior, sometimes prevents people from expressing their feelings of loneliness, says Dilip Jeste, M.D.

One resident of an independent-living community in San Diego described the feeling of loneliness as "Ugly. Just Ugly." To be lonely, another said, is like a "sudden loss of control over your life."

These residents all lived in a community with a plethora of activities designed to bring them together. Yet, as a study published on January 10 in *Aging and Mental Health* found, even older adults living in an environment meant to encourage socialization experience strong feelings of loneliness.

"We wanted to do a study in older people who had no social isolation," said past APA President Dilip Jeste, M.D., one of the study's authors. Jeste explained that loneliness and social isolation are related, but they're often confused with each other. "The difference is that loneliness is subjective," he said. "One feels lonely, whereas social isolation is objective and refers to the number of social relationships one has."

In the independent-living community, "we found loneliness was quite common," said Jeste, the senior associate dean for healthy aging and senior care, distinguished professor of psychiatry and neurosciences, and director of the Sam and Rose Stein Institute for Research on Aging at the University of California, San Diego. Two of Jeste's University of California, San Diego, colleagues were co-first authors of the study: Alejandra Morlett Parades, Ph.D., a research fellow, and Ellen E. Lee, M.D., an assistant professor in residence.

Between April 2018 and August 2019, Jeste and his colleagues assessed loneliness in more than 100 residents of the San Diego County independent-living community using version three of the UCLA Loneliness Scale, which is designed to measure subjective feelings of loneliness.

On the UCLA Loneliness Scale, the residents had a mean score of 39.3, which is considered moderate loneliness, with 15% reporting no/low loneliness, 63% reporting moderate loneliness, and 22% reporting high loneliness.

Primary care providers should be alert to the risks of loneliness because they see older patients more often than psychiatrists, says Robert Roca, M.D., M.B.A., M.P.H.

Researchers also conducted qualitative interviews with 30 residents between the ages of 67 and 92. The interviews included questions like "Do you ever feel lonely, and if so, how often and how would you describe the feeling?" and "What do you do, or think that others can do, to not feel lonely anymore?"

The authors separated the results of the interviews into three main themes: risk and protective factors for loneliness, experience of loneliness, and coping strategies to prevent loneliness.

"Many subjects described the subjective experience of loneliness such as feelings of sadness and hopelessness, while some non-lonely subjects perceived lonely people as lacking motivation," the authors wrote. Other participants attributed their loneliness to aging-associated losses, such as the death of partners, family, and friends.

"They felt empty," Jeste said. "They felt abandoned. They felt they didn't have anybody who cares for them. One person said she feels incarcerated when she feels lonely."

The study shows why solutions to loneliness such as increased engagement on social media or going into public spaces like libraries to encourage meeting new people does not work for everyone, Jeste said. "Even if people do those things, they may still feel lonely," he said. "We must stop thinking that we can cure loneliness just by increasing people's social relationships."

The study also illustrated an "inverse relationship between loneliness and wisdom." Jeste has studied the concept of wisdom closely, defining it as a personality trait comprised of emotional regulation, self-reflection, decisiveness, compassion, and spirituality. Some interviewees identified spirituality as protective against loneliness, for example, while other strategies to prevent or cope with loneliness included compassion, a key component of wisdom. (See *Psychiatric News*, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.7b1.)

"Loneliness is a red flag," said Robert Roca, M.D., M.B.A., M.P.H., an associate professor of psychiatry and behavioral sciences at Johns Hopkins University School of Medicine and chair of APA's Council on Geriatric Psychiatry. "The study's message for clinicians, and even for the research community, is that if you're going to understand loneliness, you have to understand the person, their circumstances, and what loneliness means for them."

Loneliness could be caused by a number of factors, continued Roca. It may be a result of acute bereavement, depression, or lifelong social anxiety, for example. "When you encounter loneliness as a clinician, you need to dig deeper to understand where it comes from," he said.

Social isolation and loneliness are associated with adverse health outcomes. "We don't want our patients to drink too much and we don't want them to smoke because these have adverse health consequences," he said. "But we've discovered that social isolation and loneliness are comparably potent risk factors, and they're being appreciated as public health problems."

see **Loneliness** *on page 28*

Resilience Program May Reduce Stress, Promote Wisdom

Resilience, defined as adaptation when faced with adversity, trauma, loss, or other stresses, is associated with improved well-being among older adults. Jeste and his colleagues wanted to see if a group intervention, dubbed Raise Your Resilience (RYR), would improve wisdom in senior living community residents.

The results of their trial were published in *International Psychogeriatrics* in February. The intervention involved 89 adults over 60 years of age in five independent living communities. Delivered in three 90-minute sessions at weeks one, two, and four by a trained residential facilitator, RYR focused on three topics: aging as a time of growth and enjoyment, small changes to increase positive emotions, and engaging in "values-driven activities." Participants reported their levels of resilience, well-being, perceived stress, and wisdom at baseline, after a one-month control period before the intervention, following the intervention, and in a three-month follow-up.

Compared with the control period, perceived stress and wisdom both improved between pre- and post-intervention, and resilience improved in the three-month follow-up.

"The pursuit of improving resilience is ultimately rooted in the goal of reducing stress and its widespread and deleterious impacts," the authors wrote. "Reduction of stress ... can boost older adults' health and help them function independently longer."

In an interview, Jeste stressed that the intervention was delivered by local staff within the senior housing communities. "They were not licensed clinicians or licensed therapists," he said. They were staff that the researchers had trained, suggesting that interventions such as RYR are easily applicable even while they have a significant impact on the lives of older adults.

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ACA

continued from page 5

costs; that gap has been narrowing each year since passage of the ACA and is scheduled to be eliminated entirely this year.

The ACA also increased funding for community mental health centers, ensured that patients with psychiatric illness could not be excluded from "medical home" demonstration projects, permitted demonstration projects for co-location of primary and behavioral health care services, and authorized grants to establish "depression centers of excellence."

Almost no one—including APA—was wholly satisfied with the law. One principal concern at the time was the law's creation of an Independent Medicare Payment Advisory Board, which would make recommendations about containing Medicare costs (it was repealed before ever taking effect). The law also left intact the Medicare Sustainable Growth Rate (SGR) formula for physician payment and the discriminatory Medicare copayment for psychiatric services. The SGR was repealed in 2015 by the Medicare Access and CHIP Reauthorization Act, and Medicare's discriminatory payment was eliminated entirely in 2014.

"The passage of health reform is an important event, but it is really a beginning, not an end," said APA Medical Director James H. Scully Jr., M.D., at the time. "Many critical details need to be addressed. … So while we are aware of the historic action that has occurred, there is now an enormous task ahead."

In a column in *Psychiatric News*, then-APA President Alan Schatzberg, M.D., wrote, "Is the new law perfect? Of course not, but no law is. … On balance, however, the positives far outweigh the negatives, which is why APA supported passage."

Law Increases Access to SMI, SUD Care

Imperfect as it was (and remains so to some people of all political persuasions), there is clear evidence that the law has been an enormous benefit to patients with mental illness—especially those with serious mental illness (SMI)—and more gradually, over time, to patients with SUDs.

A 2016 report in *Health Affairs* by Timothy Creedon, Ph.D., and Benjamin Le Cook, Ph.D., of the Cambridge Health Alliance found that mental health treatment rates increased significantly in 2014 compared with years prior to the implementation of insurance reforms in the ACA. The researchers looked at four time periods (2005-2007, 2008-2010, 2011-2013, and 2014).

"Among those meeting criteria for serious psychological distress in the past year, survey respondents in 2014 were significantly more likely to receive mental health treatment than respondents in any of the pre-2014 comparison periods," they wrote.

A troubling finding was that the racial and ethnic disparities in access to care and treatment utilization persisted; nonwhite respondents did not experience the same increase in utilization as did whites. But Creeden and Le Cook cited several mitigating factors, including a 2012 Supreme Court decision that made Medicaid expansion voluntary, and several states—including those with some of the poorest populations—did not opt to expand.

A Kaiser Foundation report found that as of February, 37 states and the District of Columbia opted to expand their Medicaid programs. Fourteen states have not: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming (see chart; Nebraska has opted to expand but has not yet done so).

Another 2016 report in the *Journal of Rural Health* found that among 39,482 young adults aged 18 to 25 years with psychological distress, adjusted insurance rates increased from 72.0% to 81.9% between 2008 and 2014, though a significant rural/urban difference remained in 2014. Treatment rates for those with psychological distress increased following 2010 reforms, from 30.2% to 33.0%. (Those treatment gains were not sustained into 2014.)

In an ACA anniversary edition of *Health Affairs*, Brendan Solaner, Ph.D., and Johanna Catherine MacLean, Ph.D., of Temple University found that admissions of individuals for treatment of SUDs steadily increased in the four years after Medicaid expansion, with 36% more people entering treatment by the fourth expansion year in expansion states compared with nonexpansion states (see box on page 5).

Challenges to the ACA

Since its passage, the ACA has been the target of Republican congressional attempts to scale back or eliminate the law entirely, court challenges to its constitutionality, and attempts by insurance companies to circumvent the parity requirements. A string of court rulings and settlements with state attorneys general or with state insurance commissions in Massachusetts, New York, and Pennsylvania has compelled health plans to comply with the law.

Most recently, five major health insurers and two managed care companies in Massachusetts agreed to reverse practices that discriminate against patient and mental health professionals and restrict access to care, following a landmark settlement with the Massachusetts attorney general (see *Psychiatric News*, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.3b31).

Court challenges to the ACA have focused especially around the "individual mandate." That provision in the original law levied a penalty on individuals who did not sign up for insurance in the exchanges; the mandate was designed to protect insurance companies against the enrollment of individuals who were sicker and were high service utilizers.

In December 2019 a panel of the U.S. Court of Appeals for the 5th Circuit, ruling in the case *Texas, et al., v. United States of America, et al., and California, et al.*, agreed with a district court in Texas that ruled in 2018 that the mandate was unconstitutional. That same district court also ruled that since the mandate was integral to the law, then the entire statute was rendered illegitimate; the court of appeals did *not* uphold that finding.

The case is before the Supreme Court, and Democrats in Congress and several states have asked the court to expedite review. Without comment, the Supreme Court declined to expedite, and any final ruling is likely to be months away (see *Psychiatric News*, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.3b5).

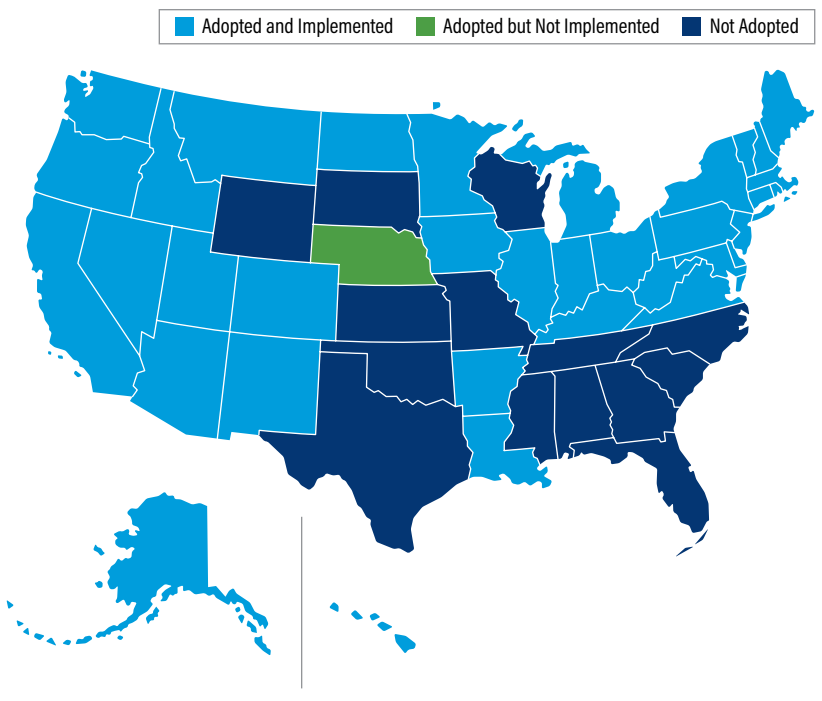
In the meantime, there is no question that the ACA has been transformative. Virtually the entire medical community has united behind its preservation. In December 2018, APA joined the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American Osteopathic Association in denouncing the Texas district court decision.

"As frontline physicians who care for patients in rural, urban, wealthy, and low-income communities, we call for immediate appeal of the decision," the organizations said in a statement. "In addition, we urge the U.S. Congress and states to stand in strong support of protecting patient access to comprehensive health insurance coverage and join us in advocating for swift appeal. Finally, we urge the administration to continue implementing the law so our patients can continue receiving the care they need. Our message is simple: No one should lose the coverage they have." **PN**

The 2016 report by Creedon and Le Cook is posted at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0098. The Kaiser Foundation report on state Medicaid expansion is posted at https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/. *The Journal of Rural Health* report is posted at https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12258. The March report by Saloner and MacLean is posted at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01428.

Majority of States Opt to Expand Medicaid Under ACA

State expansion of Medicaid to 133% of the federal poverty level, made possible by the ACA, is optional. As of February, 36 states and the District of Columbia had opted to expand.



Source: Kaiser Family Foundation

BY TERRI D'ARRIGO

FDA Issues Guidance On Clinical Trials During COVID-19 Pandemic

The Food and Drug Administration (FDA) in March issued guidance for researchers conducting clinical trials during the coronavirus (COVID-19) pandemic.

"Although the impact of COVID-19 on trials will vary depending on many factors, including the nature of disease under study, the trial design, and in what region(s) the study is being conducted, the FDA outlines considerations to assist [trial] sponsors in ensuring the safety of trial participants, maintaining compliance with good clinical practice, and minimizing risks to trial integrity," the agency stated in a press release.

Such considerations include evaluating whether in-person visits are necessary to fully assure the safety of trial participants or whether alternative methods for assessments, such as phone calls or virtual visits, can be made. Other considerations include offering additional safety monitoring for trial participants who may no longer have access to an investigational product (for example, withdrawal of an active medication) or the investigational site.

"With this guidance issued today, the FDA is helping industry and investigators navigate the COVID-19 pandemic and help assess how to move forward with critical clinical trials," said Anand Shah, M.D., FDA deputy commissioner for medical and scientific affairs. "The FDA released this guidance to emphasize that at all times, patients' safety should continue to be at the forefront of considerations."

More information on the FDA's guidance is posted at https://www.fda.gov/regulatory-information/search-fda-guidance-documents/fda-guidance-conduct-clinical-trials-medical-products-during-covid-19-pandemic.

FDA Bans Electrical Stimulation Devices For Self-Injury, Aggression

In March the FDA published a final rule banning electrical stimulation devices (ESDs) used for self-injurious or aggressive behavior, declaring in a statement that the devices "present an unreasonable and substantial risk of illness or injury that cannot be corrected or eliminated through new or updated device labeling."

The agency noted that several significant psychological and physical risks are associated with the use of these devices, including worsening of underlying symptoms, depression, anxiety, posttraumatic stress disorder, pain, burns, and tissue damage. In addition, many people who are exposed to these devices have intellectual or developmental disabilities that make it difficult to communicate their pain.

The ban is a finalization of a 2016 proposed rule and applies only to ESDs used to control self-injurious or aggressive behavior. It does not apply to aversive conditioning devices used for other purposes, such as those used for smoking cessation, or to FDA-cleared or approved technologies, such as cranial electrotherapy stimulators or transcranial magnetic stimulation.

According to the FDA, at the time of the announcement regarding the ban, it appeared that only one facility in the United States used ESDs, the Judge Rotenberg Educational Center in Canton, Mass., where between 45 and 50 individuals had been exposed to the devices.

Montelukast Gets Boxed Warning for MH Effects

The FDA is now requiring a boxed warning for ***montelukast***, which is sold under the brand name ***Singulair*** and in generic form to treat asthma and hay fever (allergic rhinitis). The boxed warning strengthens an existing warning about the risks of neuropsychiatric events with montelukast such as agitation, depression, sleep problems, and suicidal thoughts and actions, and it advises health professionals to avoid prescribing montelukast for patients with mild symptoms, particularly those with hay fever.

The FDA required the box warning after reviewing continued reports of suicide and other adverse events by patients taking the medication, including reports submitted through the agency's Adverse Event Reporting System (FAERS) and studies published in the medical literature. The FDA had also conducted its own study using data in the Sentinel Distributed Database, which is generated from patient interactions in the United States health care system through their insurers and providers, and presented the findings at an FDA advisory committee meeting in 2019.

"Based upon this assessment, the FDA determined the risks of montelukast may outweigh the benefits in some patients, particularly when the symptoms of the disease are mild and can be adequately treated with alternative therapies. For allergic rhinitis in particular, the FDA has determined that montelukast should be reserved for patients who have not responded adequately to other therapies or who cannot tolerate these therapies," the agency said in a March 4 Drug Safety Communication.

FDA Reviews NDA For Dermally Delivered Zolmitriptan

In March the FDA accepted a New Drug Application (NDA) for ***Qtrypta*** for the treatment of migraine. Qtrypta, manufactured by Zosano Pharma Corporation, delivers ***zolmitriptan*** through an intracutaneous microneedle system. The drug-coated microneedles are designed to penetrate the epidermis and dermis, where the drug dissolves and enters the bloodstream.

The ZOTRIP pivotal phase 2/3 clinical study evaluated the efficacy, safety, and tolerability of Qtrypta compared with placebo in 333 patients aged 18 to 65 years. Among those treated with a 3.8 mg dose of Qtrypta, 41.5% achieved freedom from migraine pain within two hours. In addition, 68.3% reported freedom from their most bothersome non-pain symptom within two hours, such as nausea, sensitivity to light, or sensitivity to sound.

In the phase 3 long-term safety study, the most frequently reported adverse event was redness at the application site. Fewer than 2% of patients reported neurological side effects typically found in the class, such as dizziness and paresthesia.

Deutetrabenazine Fails Trials for Children With Tourette's Syndrome

In February Teva Pharmaceutical Industries Ltd. announced that ***Austedo*** (***deutetrabenazine***) did not meet the primary endpoints of trials

see **Med Check** on page 29

Assembly

continued from page 16

Wyoming, and Nevada except for the Reno area. The total number of psychiatrists represented by this DB was 80.

New York state kept chugging along. By the end of the 10th Assembly meeting, the state had accrued three additional DBs. Other states were forming chapters, which was the Assembly's preference.

I'm going to stop this year-by-year analysis after covering the 11th Assembly meeting in 1963, as this was the watershed year for the Assembly. It was here that the Assembly decided it needed to meet twice a year. And it was here that Speaker Robert Gardner put forth his "Ten Point Program for the Assembly of District Branches" (see box on page 16). The Assembly has strayed very little from these admonitions.

The Assembly of today struggles with many of the same issues as it did during its first dozen years and has debated many times since: the relationship between the Board of Trustees and the Assembly; the role of the professionals "not holding M.D. degrees in allied mental health fields" (as they were referred to in 1964); the optimal size of the Assembly (once thought to be one-third of the current size of the Assembly); should a state have more than one DB or one DB with chapters; how many regions should there be; a recommendation that the Joint Commission (known at the time as the Joint Commission on Accreditation of Hospitals) re-evaluate its methods for surveying psychiatric facilities; recruitment of residents as members to increase membership; and how to deal with insurance companies (in 1965 the new UAW contract had a provision for psychiatric coverage of workers' dependents).

That's not to say the Assembly hasn't evolved. From an organization of older white men**, the Assembly has evolved into an APA operation as diverse as the membership it serves. The Assembly has not only diversity in those who represent DBs but now has 14 members designated as early career psychiatrists, 14 as minority and underrepresented psychiatrists, 14 as resident-fellow members, and 20 representatives of affiliate organizations of psychiatrists (ACROSS members). And the Assembly is modifying its activities, adapting to the need to be efficient and effective. Who would have thought on that hot day in L.A. in 1953 that someday the Assembly would have both a consent calendar and a reaffirmation calendar?

The Assembly faces a new challenge at this time. It's belt-tightening time at APA, and the Assembly, like the rest of APA, needs to figure out how to do at least what it's doing with fewer resources. The Assembly has been here before. Let's see what happens this time. **PN**

The author thanks the following individuals for providing written materials used in the preparation of this article: Deena Gorland, Jack McIntyre, M.D., and Allison Moraske.

*** I confess I am one of these.*

JOURNAL DIGEST

BY NICK ZAGORSKI

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Pregnant Women With Depression More Likely to Use Cannabis

Pregnant women with a history of depression are nearly four times more likely to use cannabis than those without a depression history, according to a report by researchers at the City University of New York and colleagues. The report, which was published in *Drug and Alcohol Dependence*, also identified much higher cannabis use among pregnant teens with depression.

"As brain development is ongoing until age 25, cannabis use in this group may increase risks for both mother and offspring," wrote the study authors. "Our results provide recent, nationally representative estimates suggesting that education and intervention efforts should be targeted at pregnant teens."

The researchers used data from the annual National Survey on Drug Use and Health (NSDUH) from the years 2005 to 2018. Their samples included 11,623 women aged 12 to 49 who reported being pregnant at the time they took the NSDUH interview.

Among this group of pregnant women, 6.8% reported a major depressive episode in the previous year; 12.7% of pregnant women with depression reported using cannabis in the past month, compared with 3.7% of pregnant women with no depression. Among pregnant women with depression, the rate of use decreased with age: 23.7% for women aged 12 to 17, 16.7% for women 18 to 25, and 8.0% for women 26 and older.

Pregnant women with depression were also more likely than those without depression to use cannabis even if they perceived such use as being risky, the authors noted. "This pattern appears similar to cigarette use among pregnant women with depression and may suggest that depression drives increased use, though other pathways are also possible," they wrote.

Goodwin RD, Zhu J, Heisler Z, et al. Cannabis Use During Pregnancy in the United States: The Role of Depression. *Drug Alcohol Depend.* February 24, 2020. [Epub ahead of print] https://www.sciencedirect.com/science/article/pii/S0376871620300466

CBD

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She noted that APA's Council on Addiction is working on some guidance documents for psychiatrists to help with these discussions. The American Academy of Addiction Psychiatry and American Academy of Child and Adolescent Psychiatry also have some cannabis and CBD-related resources available on their websites. **PN**

FDA information on cannabis and CBD is posted at https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd. Hurd's editorial, "Leading the Next CBD Wave-Safety and Efficacy," is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2758326 .

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Chronic Apathy Predictors Identified in Patients With Psychosis

Apathy is a common symptom of psychotic disorders and is associated with poor long-term outcomes for patients. Researchers at Oslo University Hospital in Norway have now tracked 10-year trajectories of apathy in people with first-episode psychosis and identified key predictors of elevated long-term apathy.

The researchers enrolled 198 adults aged 18 to 65 years with first-episode psychosis from inpatient and outpatient hospitals around Oslo and 198 people without psychosis. The participants were assessed seven to 10 years after enrollment; a subset of these participants was also assessed at six months or one year after enrollment.

Average apathy scores for first-episode psychosis patients were 28.7 at baseline (assessed with the Apathy Evaluation Scale self-report version, or AES-S). These scores dropped to 24.6 after one year of treatment, before remaining at about 24 for the study duration. Apathy scores for the controls were 17.6 at baseline and remained stable throughout the study. After seven to 10 years, 37% of first-episode psychosis patients had clinically significant apathy (AES-S score of 27 or higher), compared with 5% of controls.

Further analysis indicated that higher baseline apathy scores or a long period of untreated psychosis prior to diagnosis were associated with higher long-term apathy across the study duration; elevated depression at baseline was also associated with higher apathy, but not for the full 10 years.

"Considering the lack of evidence-based treatments for negative symptoms, efforts to reduce [duration of untreated psychosis] and to treat co-occurring depressive symptoms could help to prevent high levels of apathy in the long term and thus improve functional outcome," the authors wrote.

This study appeared in the *European Archives of Psychiatry and Clinical Neuroscience*.

Lyngstad SH, Gardsjord ES, Engen MJ, et al. Trajectory and Early Predictors of Apathy Development in First-episode Psychosis and Healthy Controls: a 10-year Follow-up Study. *Eur Arch Psychiatry Clin Neurosci*. March 4, 2020. [Epub ahead of print] https://link.springer.com/article/10.1007%2Fs00406-020-01112-3

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Community Treatment Orders May Increase Hospital Readmission

An analysis of postdischarge outcomes among people in South London who received inpatient psychiatric care suggests that community treatment orders are associated with increased risk of being readmitted to the hospital. The findings were published in *BMJ Open*.

A community treatment order, also known as assisted outpatient treatment, refers to a legal order in which a person with severe mental illness adheres to a mental health treatment plan and outpatient monitoring to enable a rapid response if relapse occurs. These orders are a subject of debate, and the data are mixed on their effects on hospitalization and health care costs.

For this latest analysis, researchers at King's College London and colleagues assessed 4,489 patients discharged from involuntary care between 2008 and 2014. Participants' outcomes were measured until 2016, enabling at least two years of follow-up for each patient.

Of this group, 830 (18.5%) were given a community treatment order at least once. Patients who were involved in the legal system were five times more likely to receive a community treatment order compared with patients who were not involved with the legal system. Patients taking a long-acting injectable antipsychotic were twice as likely to receive a community treatment order as those taking oral antipsychotics.

The researchers found that patients with a community treatment order were 1.6 times more likely to be readmitted to inpatient care during the analysis period. These patients were also more likely to come back to the hospital sooner (average readmission time of 4.0 years versus 5.8 years for patients without community treatment orders) and spend more time in the hospital (average of 178 days in the two years following first discharge versus 148 days for patients without community treatment orders).

"There are several possible explanations for why those on [community treatment orders] had higher rates of psychiatric hospital admission compared with controls in our study. One plausible explanation is that patients with more severe symptoms or a history of relapse were more likely to receive [community treatment orders]," the authors wrote.

Barkhuizen W, Cullen AE, Shetty H, et al. Community Treatment Orders and Associations With Readmission Rates and Duration of Psychiatric Hospital Admission: A Controlled Electronic Case Register Study. *BMJ Open*. 2020; 10(3):e035121. https://bmjopen.bmj.com/content/10/3/e035121.long

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Cognitive Assessment Tool Found Reliable for People With Intellectual Disability

The National Institutes of Health Toolbox Cognitive Battery (NIHTB-CB) is a reliable tool to assess cognition in most children and young adults with intellectual disability, according to a study in *Neurology*. Useful for research, the NIHTB-CB is a freely available set of seven tablet-based tests measuring executive function, memory, language, and processing speed.

Researchers at the MIND Institute in Sacramento, Calif., and colleagues

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tested the NIHTB-CB on 242 individuals aged 6 to 25 with intellectual disabilities such as fragile X syndrome or Down syndrome; all participants were tested twice, one month apart.

The findings revealed that many of the participants with intellectual disability successfully completed the tests, and the tests were reliable (test scores were similar on both occasions). Tests that involved crystallized intelligence (accumulated and fixed knowledge such as vocabulary and object recognition) were more feasible and reliable than those involving fluid intelligence (problem solving). Most of the variability occurred in participants whose intelligence was lower than a typical 5-year-old, suggesting these tests need to be adapted more for use in very low-functioning individuals.

"Besides evaluating the NIHTB-CB as an appropriate assessment for [intellectual disability] in general, the present results demonstrate the sensitivity of the battery to known syndrome-specific cognitive phenotypes," the authors noted. For example, individuals with fragile X syndrome performed worse on a card-sorting task (that measures executive function) than their overall cognitive level would suggest. This aligns with existing research showing that children with fragile X have more impaired attention and impulse control than children with other types of intellectual disability.

Shields RH, Kaat AJ, McKenzie FJ, et al. Validation of the NIH Toolbox Cognitive Battery in Intellectual Disability. *Neurology*. February 24, 2020. [Epub ahead of print] https://n.neurology.org/content/early/2020/02/23/WNL.0000000000009131.long

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Smokers Taking Varenicline At Lower Risk of Heart, Psychiatric Hospitalization

People taking the smoking cessation medication varenicline have lower rates of psychiatric hospitalization than those taking other smoking cessation products, according to a study in *Addiction*. They are also less likely to be hospitalized for cardiovascular problems compared with those taking nicotine replacement therapy (NRT), the study found.

Using the MarketScan database, which contains health insurance claims information on over 100 million people in the United States, the researchers identified 618,497 adults with no history of depression who received a prescription for a smoking cessation pharmacotherapy. This group included 454,698 varenicline users, 131,562 bupropion users, and 32,237 users of prescription NRT. (The researchers used NRT as the control group since it is considered the safest smoking cessation option.)

Compared with those who took NRT, people taking varenicline or bupropion were 20% and 25% less likely, respectively, to be hospitalized for a cardiovascular problem in the 12 months after starting their treatment. People taking varenicline were 35% less likely to be hospitalized for a psychiatric illness in the first year of taking the medication compared with those taking NRT. In contrast, patients taking bupropion had a 21% higher risk of psychiatric hospitalization compared with those taking NRT.

"Given the comorbidities associated with smoking, varenicline should continue to be considered a treatment option for smoking cessation," the researchers wrote. "These results also provide further support for the FDA's decision to remove the varenicline boxed warning for neuropsychiatric adverse events."

Carney G, Bassett K, Maclure M, et al. Cardiovascular and Neuropsychiatric Safety of Smoking Cessation Pharmacotherapies in Non-depressed Adults: A Retrospective Cohort Study. *Addiction.* February 19, 2020. [Epub ahead of print]. https://onlinelibrary.wiley.com/doi/full/10.1111/add.14951

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Online Mindfulness Program Effective for Students With Depression

An internet-based intervention that combines mindfulness techniques and cognitive-behavioral therapy principles can help reduce symptoms of depression and anxiety in college students, suggests a trial conducted by researchers at the University of Toronto.

"[S]tudents often experience difficulties in accessing [counseling] services, while counseling centers are overwhelmed due to limited resources," wrote the researchers in *JMIR Mental Health*. "New and accessible strategies are needed to address the students' mental health."

The research team worked with student focus groups to develop a web-based mental health intervention called Mindfulness Virtual Community (MVC). The MVC featured three components: youth-specific educational and mindfulness-practice videos; an anonymous, peer-to-peer discussion board; and short, group-based online conferences where participants remained anonymous, guided by a mental health professional.

The researchers evaluated the intervention in 113 University of Toronto students. The participants were given access to all of the MVC resources, a partial MVC that included only video modules, or a waitlist control for eight weeks. At the end of the study, students who had full or partial access to MVC interventions reported significantly reduced depression symptoms (assessed with the PHQ-9) and perceived stress compared with the control group. However, only students in the partial MVC group reported greater improvements in anxiety symptoms compared with the control group.

"Anxious subjects, avoidant of health professional contacts, might have responded more positively when assured that the entire program was web-based and did not involve any 'live' interactions," the researchers wrote. "[T]his finding has cost implications given that personnel costs often constitute the largest proportion of web-based intervention costs." **PN**

Ahmad F, El Morr C, Ritvo P, et al. An Eight-Week, Web-Based Mindfulness Virtual Community Intervention for Students' Mental Health: Randomized Controlled Trial. *JMIR Ment Health*. 2020; 7(2): e15520. https://mental.jmir.org/2020/2/e15520/

Online CME Programs

continued from page 1

ing in Philadelphia. The Annual Meeting, which had been scheduled from April 25 to 29, will not take place due to public health concerns around the COVID-19 pandemic.

APA's Spring Highlights is a two-day online event that will be held on Saturday and Sunday, April 25 and 26, from noon to 5 p.m. The program will begin on Saturday with an Opening Session that includes addresses by APA President Bruce Schwartz, M.D., APA President-elect Jeffrey Geller, M.D., M.P.A., and APA CEO and Medical Director Saul Levin, M.D., M.P.A.

That session will be followed by scientific sessions over two days offering 9 hours of CME content featuring experts in major areas of psychiatric diagnosis and treatment. Some of the sessions will focus on supporting clinicians during the current COVID-19 crisis with information about its impact on mental health treatment. APA's Business Meeting will end the program on Sunday at 4:30 p.m.

APA's Spring Highlights is free to APA members. At press time, the price for nonmembers had not been determined. A forthcoming all-member communication and *Psychiatric News Alert* will provide details about registration.

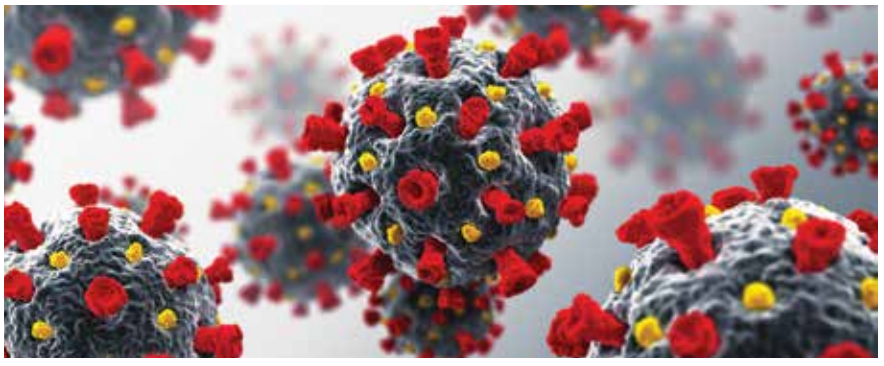
Additionally, APA is simultaneously developing the 2020 APA On Demand program. APA Annual Meeting On Demand historically has consisted of scientific sessions from the Annual Meeting with presenter slides synchronized with presenter audio. This year, in the absence of an Annual Meeting, APA On Demand will feature presentations that will be recorded remotely over the internet from speakers' institutions or homes. The presentations will cover emerging clinical topics, cutting-edge science, and new therapies and offers 75 hours of CME credit. It will include presentations and speakers originally planned for in-person delivery at the Annual Meeting.

Presentations will continue to be recorded over the coming months and added to the online library on a rolling basis within 24 hours of being recorded. Once all presentations are recorded, a USB will be shipped to those who selected this add-on option upon purchase. More information is posted at https://www.psychiatry.org/psychiatrists/education/apa-on-demand.

At press time, APA On Demand was scheduled to be released this spring, with registration fees similar to those of the Annual Meeting.

"Although the Highlights and APA On Demand cannot replace or substitute the Annual Meeting, we hope that these programs will offer the kind of essential education our members and mental health professionals have come to expect from APA," said APA Director of Education and Deputy Medical Director Tristan Gorrindo, M.D. "I urge everyone seeking the very best in psychiatric expertise to take advantage of these learning opportunities."

"A large number of our physician members are restricted by their respective institutions from traveling to conferences and meetings to help stop the spread of COVID-19 and provide patient care, making it impossible for lecturers and registrants to attend a spring medical conference," Levin said. "The latest information from the Centers for Disease Control and Prevention and Pennsylvania health authorities supported our judgment that travel restrictions, meeting restrictions, and social distancing are the required, safe, and responsible actions. Public health must come first." **PN**



COVID-19

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ciate professor of psychiatry at Columbia University and chair of APA's Council on Consultation-Liaison Psychiatry, told *Psychiatric News.* Ensuring that patients have continued access to their medications is equally important.

"Patients with COVID-19 may need a formal psychiatric consult and care for anxiety related to their isolation and uncertainty about the course of their illness," said Levenson, who usually works with cancer patients and others with serious physical illnesses.

Health care professionals should remind patients to obtain the latest information from reliable sources, such as the Centers for Disease Control and Prevention and the World Health Organization, and limit exposure to media coverage of the outbreak, Joshua Morganstein, M.D., chair of APA's Committee on the Psychiatric Dimensions of Disasters, said in an email. "It is essential to understand how any given patient will most effectively receive information and tailor communication and interventions using a patient-centered approach."

Prepare for the Long Haul

Psychiatrists must be up to date on all aspects of the coronavirus outbreak to combat the stigma associated with the disease, he added. (His hospital holds a daily briefing at 10 a.m. to keep staff current.) They may also need to learn some new skills, like how to use protective gear or treat patients via telepsychiatry over computers or cell phones.

Steps to reduce transmission, like personal hygiene measures, remaining at home, or keeping children away from the elderly might help slow the rate of new infections and avoid overloading the health care system.

However, social distancing measures like quarantine, isolation, and travel restrictions intended to limit the spread of the disease may also contribute to depression, anxiety, and distress, said medical anthropologist Monica Schoch-Spana, Ph.D., a senior scholar at the Johns Hopkins Center for Health Security and senior scientist in the Department of Environmental Health and Engineering at the Johns Hopkins Bloomberg School of Public Health.

"The pandemic will be protracted, so the psychological impacts will be long lasting," said Schoch-Spana in an interview. Much is still unknown. "This is a novel pathogen, with no specific medications for treatment, limited scientific knowledge about it, and lots of uncertainty as to its course, so it's no wonder there is much distress. Clinicians are learning as they go along."

Much of the advice to the public has been valuable but one sided, said Schoch-Spana. Promoting handwashing and advising the frail elderly to stay at home make sense, but such advice should be coupled with suggestions for social connection as well as social distancing. For example, family, neighbors, and friends can be urged to check in with people sequestered at home to see if they need help—or just a little companionship.

"Also, as people in health care work longer or extra shifts, they could ask neighbors to look in on their families while they are at work," she said. "Employee assistance plans in the health care sector should be sensitive to the extra stress during the epidemic. We need to get through the contagion together."

Getting through COVID-19 may be an uneven experience, said Judith Bass, Ph.D., an associate professor at the Johns Hopkins Bloomberg School of Public Health. "The current pandemic shines a light on the inequities in health care access and the urban/rural divide."

Nevertheless, lessons learned from the SARS and the Ebola outbreaks may help hospitals in the United States prepare for outbreaks, she said. Clinicians in those epidemics couldn't do much to help many of their patients, leaving them with a mixture of fear for their own infection and feelings of guilt. Many health care workers were also stigmatized as potential sources of infection in their home communities.

"Just being exposed to the virus puts you at risk for PTSD," said Damir Huremovic, M.D., M.P.P., in an interview. He is an assistant professor of psychiatry at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell in Manhasset, N.Y., and editor of *Psychiatry of Pandemics: A Mental Health Response to Infection Outbreak* (Springer, 2019). "We have good knowledge from SARS regarding the effects on staff, survivors, and families, but every disease is different, and you can't apply past experience as a blanket prescription."

Inpatients should be a major concern, given the experience of a nursing home in Washington state, where 20 residents died, said Huremovic.

Clinicians Need Care as Well

Besides working long hours, clinicians are also at high risk for infection.

"Psychiatrists can play an important role in supporting all the physicians, nurses, social workers, rehab specialists, and people in the emergency department who are directly caring for COVID-19 patients," said Levenson. He is already planning for a time when the number of those employees will be thinned by overwork or illness and is looking at ways to temporarily press psychiatrists from other specialties into working as C-L practitioners.

A massive onslaught of patients could lead to difficult clinical and ethical dilemmas, said Schoch-Spana. In Italy, which quarantined the entire country on March 9, the number of patients needing mechanical ventilators exceeded the number of available machines.

"Deciding who gets scarce resources will require making not just technical choices about who gets a ventilator, but moral choices as well," she said. "Then imagine the mental state of the clinician who has to make that decision."

Finally, public health experts fear that once the pandemic runs its course, urgency among the public and elected officials to prepare for the inevitable next outbreak will wane.

"When there's no epidemic, people don't want to be bothered. Then they panic when it arrives, and then they drift back into blissful amnesia," said Huremovic.

Time will only tell if the severity of the COVID-19 pandemic will overcome that cycle of concern and complacency. **PN**

APA's Resources on COVID-19

Since the start of the COVID-19 outbreak, APA has worked to keep members informed about mental health aspects of the pandemic and how psychiatrists can respond. A February 19 blog post by Joshua Morganstein, M.D., chair of APA's Committee on the Psychiatric Dimensions of Disaster, offered suggestions for patients and clinicians. That was followed by additional posts, including one on March 12 with numerous links to resources for psychiatrists from APA, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the World Health Organization, the Center for the Study of Traumatic Stress, and others. Frequent emails from APA's CEO and Medical Director Saul Levin, M.D., M.P.A., and *Psychiatric News Alerts* have also updated members.

As the crisis worsened, APA centralized this information in the APA Coronavirus/COVID-19 Information Hub at psychiatry.org/coronavirus. The site is being updated as new information becomes available.

Naloxone

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Health and Human Services. Lin's research was also supported in part by funding from the U.S. Department of Veterans Affairs Health Services Research & Development Service. **PN**

"Association of Opioid Overdose Risk Factors and Naloxone Prescribing in U.S. Adults" is posted at https://link.springer.com/article/10.1007/s11606-019-05423-7.

Loneliness

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Jeste argues that, just as society promotes physical activity and healthy nutrition in schools and workplaces, so too should it promote wisdom as a healthy behavior to prevent loneliness.

"Loneliness is becoming more common and can lead to depression and suicide," Jeste said. "We need to do something at a societal level: How do we spread compassion? How do we make people feel more self-reflective? How do we make people [better] regulate their emotions? These are things we need to start thinking about."

The study was supported, in part, by a NARSAD Young Investigator grant from the Brain and Behavior Research Foundation; the National Institute of Mental Health; the Stein Institute for Research on Aging at the University of California, San Diego; and the IBM Research AI through the AI Horizons Network. **PN**

"Qualitative Study of Loneliness in a Senior Housing Community: The Importance of Wisdom and Other Coping Strategies" is posted at https://www.tandfonline.com/doi/full/10.1080/13607863.2019.1699022. "A Pragmatic Trial of a Group Intervention in Senior Housing Communities to Increase Resilience" is posted at https://www.cambridge.org/core/journals/international-psychogeriatrics/article/pragmatic-trial-of-a-group-intervention-in-senior-housing-communities-to-increase-resilience/B0A9838146EED495E5EB770389FDBEF1.

Precision Medicine

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needs Antidepressant A, and that patient needs Antidepressant B, or this patient does not respond at all to antidepressants and needs ECT [electroconvulsive therapy] or psychotherapy.'"

So far, such breakthroughs have remained elusive. Large-scale research initiatives, like the National Institute of Mental Health's Research Domain Criteria (RDoC) project and the PsycheMERGE Consortium within the National Institutes of Health's Electronic Medical Records and Genomics Network, are seeking to identify neurobiological underpinnings and objective markers that portend psychiatric illness. But psychiatrists have grappled with translating results from studies into meaningful targets for treatment matching.

Smoller and colleagues from the PsycheMERGE Consortium found that among more than 100,000 patients, those in the top 10% of polygenic risk scores for schizophrenia were about 2.3 times likely to have schizophrenia compared with everyone else. The study was published last October in the *American Journal of Psychiatry.*

"That is more than a doubling of risk," he said. Still, more research is needed before researchers know how such information will translate to the clinic. "[W]hether we can use that diagnostically or prognostically yet is still unclear," he said.

One innovation that could impact prognosis and treatment selection is pharmacogenetics—or the ways in which genes affect medication efficacy and safety in an individual. In theory, knowing whether a patient is a poor, intermediate, rapid, or ultra-rapid metabolizer of a given enzyme in the cytochrome P450 system may inform selection and dosing of tricyclic antidepressants and selective serotonin reuptake inhibitors.

But theory and actuality often differ, as reflected in the findings of the Genomics Used to Improve DEpression Decisions (GUIDED) Trial. In this trial, researchers compared depressive symptoms in patients who were prescribed antidepressants based on their pharmacogenomic tests with those who received treatment as usual. While patients who received pharmacogenomics-guided care had an increased chance of achieving treatment response and remission by week 8 of the study, there were no significant differences between the groups in the trial's primary outcome—percent change in Hamilton Depression Rating Scale score—at week 8.

A recent meta-analysis of five randomized, controlled trials, including the GUIDED Trial, also found improved remission with pharmacogenetic-based antidepressant prescribing. There were numerous methodological limitations identified that possibly undercut this finding, such as recruitment bias and lack of generalizability across genders and ethnicities.

Several dozen commercial entities offer pharmacogenetic testing for depression in the United States, but Charles B. Nemeroff, M.D., Ph.D., a professor and chair of the Department of Psychiatry at the University of Texas at Austin Dell Medical School, cautioned that evidence, such as that from the GUIDED Trial, suggests this approach is not currently clinically useful.

"Part of the problem is that the commercially available tests do not include several candidate genes that have been reported to influence antidepressant response," Nemeroff explained to *Psychiatric News.* "Moreover, the companies do not provide 'proprietary' information on their algorithms, so the field cannot really assess their methods. I think that eventually this field will help predict antidepressant treatment response, but it's not ready for prime time."

Charles B. Nemeroff, M.D., Ph.D., says more research is needed before it is known how well pharmacogenetic-guided antidepressant therapy can improve patient outcomes.

Revolutionizing Drug Discovery

Along with treatment decision making, precision medicine may influence the drug development pipeline. In oncology, for example, the discovery of human epidermal growth factor receptor-2 (HER-2) mutations in people with breast cancer led directly to the creation of the chemotherapy drug trastuzumab (Herceptin). This medication is now a first-line treatment for patients with metastatic breast cancer whose tumors overexpress HER-2.

The discovery of innovative psychiatric medications over the last 50 years has been stymied in part by the field's inability to identify medications that exert their therapeutic effect in ways different from existing psychotropic medications (ketamine and esketamine are notable exceptions). Smoller told *Psychiatric News* that precision psychiatry may offer a pathway to changing that.

"Genomic studies that implicate specific genes or pathways offer the potential to identify novel biological mechanisms that were previously unsuspected," he said.

Smoller pointed to the discovery from genomewide studies that the complement pathway, known to be involved in immune response, may play a role in schizophrenia. "From that research, we then showed that [this pathway] may accelerate the pruning of synapses by marking synapses for destruction by microglia." Consequently, Smoller said, this has led to a new understanding of the biology of schizophrenia and offers new opportunities for therapy targets.

Such discoveries point to a need for pharmaceutical companies to change their approach to drug development so that investigatory treatments are better matched to individuals' unique biology.

"Previous drug development aimed at what we used to call 'carpet bombing,' where we tried to identify one drug for all people who suffer from a given disease. We now know that this is silly," Nemeroff said.

As medicine continues moving away from "one-size-fits-all" strategies, research on individual immune responses, such as the expression of certain tumor-specific antigens in oncology, has proliferated. Immunotherapy in psychiatry is still nascent and only speculative, Menke told *Psychiatric News*, but it may play a role in depression and stress-related mental disorders, especially given the known effects of trauma on the immune system and its functioning across the lifespan.

Beyond the future discovery of novel medications and immune-based approaches, precision psychiatry also may benefit clinical trial design and recruitment strategies. Biologically based stratification could help researchers better understand why a particular group of participants did or did not respond to an investigatory medication or better predict which participants might be placebo responders. Not only might this help detect an effect that otherwise could have gotten lost among a mixed group of responders and nonresponders, it could make clinical trials shorter, less costly, and more efficient, potentially increasing the speed at which regulatory approval is acquired.

"Psychiatry needs to and is beginning to move in the direction of taking advantage of the latest advances in genomics, large-scale data analyses, and integrating information from multiple streams to identify the key profiles or individual differences that matter," Smoller said. "We are at the very early stages of doing this, but the potential is large. And for a field that, in some ways, has not had transformative advances in treatment and in which identifying individuals at high risk for illness or predicting outcomes that matter has largely been beyond our capacity, it's exciting to be moving in this direction." **PN**

Smoller's study, "Penetrance and Pleiotropy of Polygenic Risk Scores for Schizophrenia in 106,160 Patients Across Four Health Care Systems," is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2019.18091085. "Impact of Pharmacogenomics on Clinical Outcomes in Major Depressive Disorder in the GUIDED Trial: A Large, Patient- and Rater-Blinded, Randomized, Controlled Study" is posted at https://www.sciencedirect.com/science/article/pii/S0022395618310069.

Med Check

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comparing the drug with placebo for the treatment of tics in pediatric patients with moderate to severe Tourette's syndrome. Austedo is approved for the treatment of chorea associated with Huntington's disease and tardive dyskinesia in adults.

The phase 2/3 ARTISTS 1 study evaluated the safety, tolerability, and efficacy of Austedo in 119 patients aged 6 to 16 years with moderate to severe Tourette's syndrome. Patients received either deutetrabenazine or placebo for 12 weeks. The primary endpoint was the change in the total tic score on the Yale Global Tic Severity Scale (YGTSS) from baseline to week 12.

In the phase 3 ARTISTS 2 study, 158 patients aged 6 to 16 years with moderate to severe Tourette's syndrome received either low-dose or high-dose Austedo or placebo over eight weeks. The primary endpoint was the change in the total tic score on the YGTSS from baseline to week eight in the placebo and active treatment groups. **PN**