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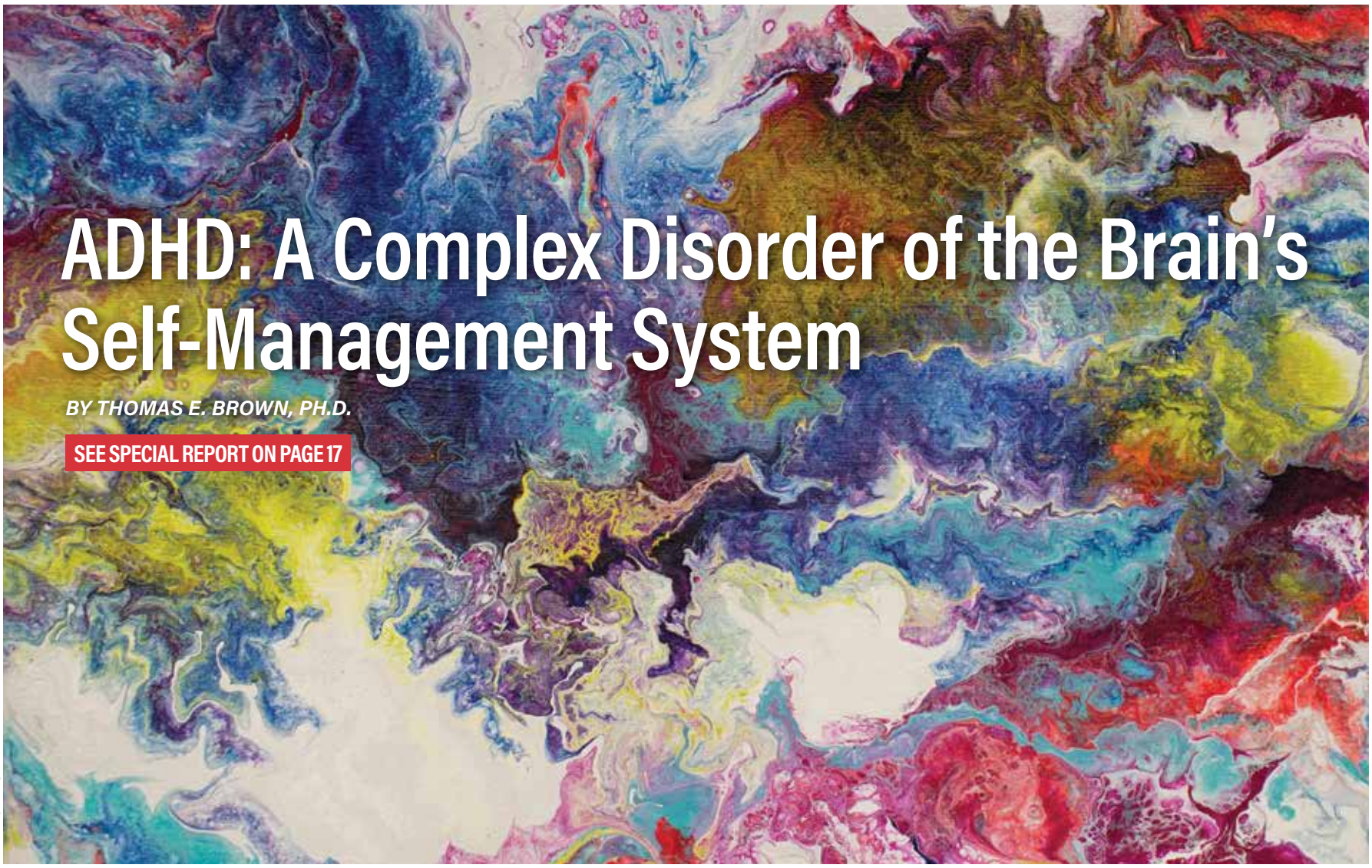

"reVeriE" by Tracey Messlein Newport

ADHD: A Complex Disorder of the Brain's Self-Management System

BY THOMAS E. BROWN, PH.D.

SEE SPECIAL REPORT ON PAGE 17

Medical Necessity Letters Written By Psychiatrists Can Be Decisive

A paper in the Journal of Psychiatric Practice *shows how a psychiatrist-written medical necessity letter—linked to the principles of effective care spelled out in the* Wit v. UBH *decision—can sway companies bent on denying care.* **BY MARK MORAN**

The authoritative voice of a psychiatrist, backed by the law, can push insurance companies to do the right thing.

Joe Feldman of Wilmette, Ill., a suburb outside of Chicago, found that out when his teenage daughter experienced a mental health crisis during her high school years requiring residential treatment. When the insurance company denied continued treatment, he set out to prepare an appeal. "In doing so, I realized that what was missing was the voice of my daughter's psychiatrist and another clinician involved in her care," Feldman told *Psychiatric News*.

Working together, he and his daughter's clinicians composed letters emphasizing the medical necessity of continued treatment. The insurance company pushed back.

After multiple denials, Feldman filed suit on behalf of his daughter, and in March 2019 a federal judge for the Northern District of Illinois ruled against the insurance company. The judge wrote that the company had failed to consider the clinician's assessment that Feldman's daughter was at "high risk" if forced into a lower level of care.

Feldman's story came to the attention of Eric Plakun, M.D., medical director of the Austen Riggs Center and Area 1 APA Trustee. Plakun was an expert witness in *Wit v. United Behavioral Health* in which he said he "got to see how the sausage is made in the world of access to care guidelines." That landmark case found that the largest managed behavioral health care company had inappropriately denied thousands of claims for mental health care (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.12a17).

The case is being appealed (*Psychiatric News Alert,* https://alert.psychnews.org/2021/05/court-ruling-in-wit-v-ubh-should-be.html).

Plakun also has a long view on the evolution of managed care from a movement to conserve finite medical resources for the greater good to a for-profit enterprise focused on cutting costs. "In the 90s after the failure of the Clinton health care reform effort, there were no rules on managed care," he said. "It became the Wild West and managed care limited treatment to

see **Medical Necessity** *on page 39*

PERIODICALS: TIME SENSITIVE MATERIALS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Why We Must Address Poverty

BY VIVIAN B. PENDER, M.D.

Poverty is one of the most destructive social determinants of mental health. Global forces such as the current pandemic, structural racism, climate change, and wars are contributing to a sense of future economic uncertainty. At the macro level, communities depend on government and public health measures to promote safety and well-being by providing financial resources.

A few weeks ago, I spoke with Benard Dreyer, M.D., a past president of the American Academy of Pediatrics, about poverty. He has spent years as director of the NYU Division of Developmental-Behavioral Pediatrics researching and reporting on the lifelong effects of child poverty. As recently as 2019, the National Center for Education Statistics reported that 16% of children under age 18 were in families living in poverty. Dreyer and his colleagues have demonstrated that poverty strongly reinforces adverse childhood experiences and how the cumulative toxic stress of adversity can change the developing brain of a child. Dr. Dreyer would like to see the payments to families provided by the American Rescue and Families Plans

Act of 2021 become part of the U.S. budget for at least five years to prove the beneficial effects of income support plans. On September 14, representatives of the Group of Six—APA, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Osteopathic Association, the American Academy of Family Physicians, and the American College of Physicians—engaged in discussions on Capitol Hill to provide our expertise on improving health and mental health.

Basic income programs have been around for a long time. Social Security became U.S. law in 1935 to pay retired workers and improve the general welfare of the public. In 1978, an experimental basic income program was introduced in Dauphin, Manitoba. It provided financial support that was marginally above the assistance rate to families. Mincome, as the government program was named, paid a stipend that over time was reduced as other sources of income increased. Mincome was remarkably successful. As poverty rates fell, physical and mental health improved, family violence and crime decreased, and the number of high school completions climbed. Participants reported less daily stress, and new mothers chose to use some of the stipend to take a longer maternity leave. Basic income experiments for families worldwide over the past four decades such as the one in Winnipeg have demonstrated similar positive results. Mitigating social determinants such as poverty were shown to ultimately reduce mental disorders (see https://www.facetsjournal.com/doi/10.1139/facets-2021-0015).

Compounding the effect of poverty is racism. The July issue of our own *American Journal of Psychiatry* contains several articles on the impact of structural racism on socioeconomic deprivation in communities. "From Womb to Neighborhood: A Racial Analysis of Social Determinants of Psychosis in the United States" by Anglin et al. elaborates a common (preventable) pathway to the diagnosis of psychosis in poor, minority, and immigrant populations (see infographic on facing page).

To take it a step further, socioeconomic disparity has been shown to have a pronounced effect on maternal health. The Momnibus Act (HR 959),

see **From the President** *on page 6*

IN THIS ISSUE

DEPARTMENTS

APA Board of Trustees Acts on Busy Agenda

A presidential task force and a new Board-appointed committee will be working on addressing social determinants of mental health and structural racism, respectively. **BY MARK MORAN**

APA President Vivian B. Pender, M.D., reported on the progress of the new APA Presidential Task Force on the Social Determinants of Mental Health (SDoMH) during her president's report at the July meeting of the Board of Trustees.

Pender told Trustees that the task force, chaired by former APA President Dilip Jeste, M.D., began meeting in June to develop policies and programs that will address the social and environmental factors that impact health and mental health.

Specifically, the task force will develop a strategic plan for implementing APA's 2018 Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health.

"This is a core objective of my presidential year," Pender said. "Lack of education, job insecurity, food scarcity, and structural racism—these and other social and environmental factors have a profound effect on mental health and on the ability of people, especially people of color, to access mental health care."

The 2018 position statement indicates that APA

- supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health and formally objects to legislation and policies that perpetuate structural inequities.

- advocates for the dissemination of evidence-based interventions that improve both the social and mental health of patients and their families.

- urges health care systems to assess and improve their capabilities to screen for, understand, and address the structural and social determinants of mental health.

- supports medical and public education on the structural and social determinants of mental health, mental health equity, and related evidence-based interventions.

- advocates for increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery.

The task force's work groups focus on four areas: clinical (chaired by Francis Lu, M.D.), policy (chaired by Allan Tasman, M.D.), public health (chaired by Kenneth Thompson, M.D.), and research/education (chaired by Dolores Malaspina, M.D.). A hub for information and resources has been established on APA's website at psychiatry.org/socialdeterminants.

Trustees also approved the creation of the Board of Trustees Structural Racism Accountability Committee. The committee is responsible for ensuring that the recommendations of the APA Presidential Task Force to Address Structural Racism Throughout Psychiatry are carried out. Established last year by then-APA President Jeffrey Geller, M.D., M.P.H., in the wake of the killing of George Floyd, the task force formulated a range of recommendations designed to address structural racism throughout the APA governance, staff, and membership (see "What Has APA's Presidential Task Force to Address Structural Racism Accomplished So Far?," posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.4.25).

The committee chair is Area 7 Trustee Mary Roessel, M.D. Members include Early Career Psychiatrist Trustee-at-Large Elie Aoun, M.D., Area 3 Trustee Kenneth Certa, M.D., immediate past APA President Jeffrey Geller, M.D., M.P.H., Area 2 Trustee Glenn Martin, M.D., Resident-Fellow Member Trustee-elect Urooj Yazdani, M.D., and Area 6 Trustee Mindy Young, M.D. Past APA President Altha Stewart, M.D., is a consultant.

Proposed MOC Standards

In other news, APA CEO and Medical Director Saul Levin, M.D., M.P.A., provided an update on proposed standards for maintenance of certification (MOC) issued by the American Board of Medical Specialties (ABMS) in April. APA submitted comments on the proposed standards in June; final standards are expected to be released next month. Coverage of the final standards will appear in a future

continued on facing page

From the President

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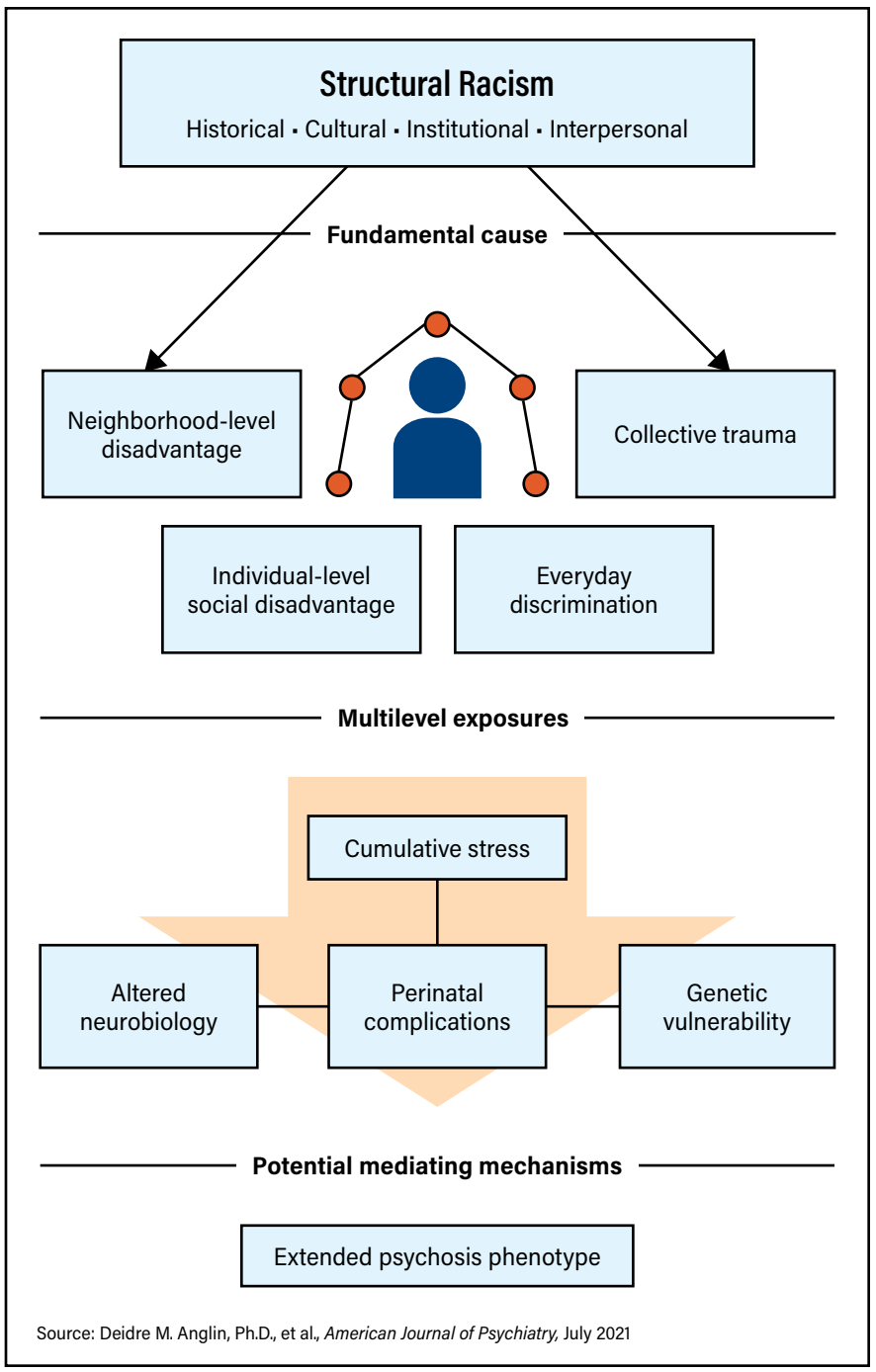
co-sponsored by U.S. Rep. Lauren Underwood (D-Ill.) and supported by APA, addresses racial inequity. The Black Maternal Health Act of 2021 is motivated by the high mortality rate among Black mothers—three to four times higher than that of White mothers. Hispanic and racially minoritized mothers have similar high rates of maternal mortality. HR 959 proposes critical financial investments in social determinants of health to community-based organizations, including incarcerated moms. It also highlights mothers with perinatal mental health conditions and substance use disorder. Most importantly, the Momnibus Act seeks culturally informed solutions.

Basic economic support for families could be construed as analogous to vaccination in the mitigation of poverty and its effects on mental health. *Psychiatry's role has generally been one of late intervention, rather than early preventative measures. Shifting the focus in this way may amplify the effect that psychiatry can have on the prevalence of mental illness.*

Just as vaccines are public health prevention methods, basic income programs, similar to other public health initiatives, have proven to mitigate social determinants by improving well-being, education, the environment, health, and ultimately mental health. Prevention and early intervention are the keys to decrease the rising need for an increased workforce.

Psychiatrists have a key role in promoting and advocating for mental health equity in clinical care, research, education, administration, and advocacy. Every psychiatrist and patient are part of one or several families, groups, cultures, races, religions, and communities. These connections are even more important in the context of isolation brought about by the COVID-19 pandemic. Perhaps by witnessing the devastation wrought by the pandemic, climate change, genocides, and discrimination, the public is becoming more aware of basic human needs. Amid the current multiple crises, psychiatry must realign itself with public health initiatives that focus on the economic needs of generations of children. The current U.S. government plan is projected to cut child poverty in half in one year; that may be aspirational, but if we all work together, it can happen The outcome is a better future for all. **PN**



Source: Deidre M. Anglin, Ph.D., et al., *American Journal of Psychiatry,* July 2021

continued from facing page

issue of *Psychiatric News*.

"We appreciate the overall emphasis of the proposed new standards on making continuing certification relevant to day-to-day practice of medicine, as well as affirming that ABMS needs to work with specialty societies to meet the needs of the diplomates," Levin said. "However, the new standards fail to address two important aspects—the lack of an evidence base informing several of the ABMS draft standards and the cost for physicians to participate in continuing certification."

Levin said APA incorporated comments from members. APA also shared its comments with the American College of Physicians and Council on Medical Specialty Societies.

Other Actions

Finally, the Board also approved these items:

- Formation of an ad hoc work group on APA and its district branches to explore their fiscal and administrative relationships, respective roles and responsibilities, and future strategic concerns (including but not limited to membership trends). The work group will report back to the Board with recommendations for operations and policy changes.

- Position Statement on Orchiectomy or Treatment With Anti-Androgen Medications as a Condition of Release From Incarceration. **PN**

APA position statements are posted in APA's Policy Finder at https://www.psychiatry.org/home/policy-finder.

Surgeon General: Physicians Can Help Combat Health Misinformation

Physicians have a key role in confronting health misinformation, according to a surgeon general advisory. An expert suggests ways to help misinformed patients. **BY LINDA M. RICHMOND**

The spread of health misinformation is not a new phenomenon, and false news stories on social media are 70% more likely to be shared than the truth, according to Vivek H. Murthy, M.D., M.B.A.

The first advisory issued by the 21st U.S. surgeon general asserts that health misinformation is an urgent public health threat that requires a "whole-of-society" effort to confront.

At a panel discussion, Vivek H. Murthy, M.D., M.B.A., said that the instinct to share health information with others "reflects the good in our humanity. … But that good instinct can be harmful when what's being shared is health misinformation—information that is false, inaccurate, or misleading according to the best evidence at the time."

During the pandemic, misinformation about masks, COVID-19 treatment, and COVID-19 vaccines has divided communities, led to threats against physicians and public health workers, and cost many lives, Murthy said. Polling by the Kaiser Family Foundation (KFF) suggests that this misinformation is fueling vaccine hesitancy, too: 67% of unvaccinated adults have heard at least one vaccine myth.

Murthy said health misinformation is not a new phenomenon. In the late 1990s childhood vaccinations dropped after a study—later retracted—falsely claimed that the measles, mumps, and rubella (MMR) vaccine caused autism. Pockets of measles outbreaks have occurred around the globe as a result. In South Africa, "AIDS denialism," a false belief denying that HIV causes AIDs, has cut access to effective treatment and has contributed to more than 330,000 deaths.

Murthy said that false news stories are 70% more likely to be shared by others than the truth, citing an analysis of millions of social media posts between 2006 and 2017 conducted by Soroush Vosoughi, Ph.D., M.Sc., and colleagues and published March 9, 2018, in *Science*. "Health misinformation causes everyday harm," Murthy said. "It causes people to turn down effective treatments for cancer, heart disease, and other illnesses. Health misinformation takes away our power to make the best decisions for our health and the health of our families."

Important Role for Psychiatrists

The advisory calls on physicians and other health care practitioners to leverage their role as highly trusted professionals by proactively addressing health misinformation with patients and the public. Clinicians are advised to "take the time to understand each patient's knowledge, beliefs, and values. Listen with empathy, and when possible, correct misinformation in personalized ways."

"The spread of health misinformation is an urgent and significant matter of

see **Misinformation** *on page 8*

APA'S GOVERNMENT, POLICY, AND ADVOCACY UPDATE

APA, Physician Groups Oppose Texas Ban on Reproductive Care

APA joined five other leading physician groups in opposing a Texas state law that took effect last month banning abortions, medical counseling, and support related to abortion after six weeks of pregnancy.

APA CEO and Medical Director Saul Levin, M.D., M.P.A., noted that APA opposes legislative interference in the doctor-patient relationship and laws that threaten the health and well-being of women. "Restrictive abortion and contraception policies have been shown to be related to an increased risk for a variety of mental health problems and may have a negative impact on the overall health of women, including physical, emotional, and social well-being," Levin said.

In a joint statement, APA and its five frontline partners wrote that the law, which bans all abortions after the first six weeks of pregnancy unless the mother's health is seriously threatened, limits the evidence-based practice of medicine; threatens the patient-physician relationship; and inhibits the delivery of safe, timely, and necessary comprehensive care. "This new law will endanger patients and clinicians, putting physicians who provide necessary medical care, or even offer evidence-based information, at risk by allowing private citizens to interfere in women's reproductive health decision making," the coalition wrote.

The Department of Justice filed suit against the state of Texas in federal court asking a judge to declare the abortion ban unconstitutional and block its enforcement. A lawsuit is also pending against the law in the Fifth Circuit Court of Appeals. Meanwhile, two other abortion laws are both slated to take effect in 2021: Oklahoma's six-week abortion ban and Montana's law criminalizing the provision of abortion care.

House Speaker Nancy Pelosi (D-Calif.) vowed to pass legislation establishing a statutory right for health care professionals to provide and patients to receive abortion care, free from medically unnecessary restrictions. Such a bill would face an uphill battle in the narrowly divided Senate, with Republicans expected to filibuster.

APA Helps Illinois, Oregon Pass Medical Necessity Statutes

APA's continuous advocacy helped lead Illinois (HB 255) and Oregon (HB 3046) to sign into law new medical necessity criteria statutes.

The new laws are similar to a bill enacted in California last year that requires insurers to use generally accepted standards of care when determining medical necessity. The aim of the laws is to prevent insurers from creating their own internal guidelines for determining medical necessity. APA worked closely with its district branches to support passage of the legislation.

APA Urges House Leaders to Pass MH/Substance Use Bills

APA pledged its support for a group of House committee-passed mental health and substance use (MH/SU) disorder bills and urged House leaders to move them to the floor.

The 10 bills would address the following: social determinants of health; ma-

see **Advocacy Update** *on page 38*

APA Kicks Off New MH State Advocacy Forum

Psychiatrists from state district branches will come together at monthly meetings to share best practices and lessons learned while advocating for mental health laws in their state. **BY LINDA M. RICHMOND**

At the inaugural session of the new Legislative Representatives Forum, more than half of APA's district branches (DBs) gathered virtually in June to share their experiences, tools, and tips for shaping mental health care legislation within their states.

The goal is to create a community of advocates. The forum came about because members noticed an uptick in legislation at the state level that impacted psychiatry, such as access to care measures, explained Debra Koss, M.D., a child and adolescent psychiatrist and clinical assistant professor of psychiatry at Rutgers Robert Wood Johnson Medical School.

"As legislators become more aware and interested in this work, it is critical that we as physicians are joining them at the table, lending our expertise and bringing the science to shape legislation. Without that expertise, the potential for unintended consequences with new legislation is high."

For example, many state lawmakers expanded access to telehealth during the pandemic and are now seeking to rescind those regulations out of concern that wider access could potentially increase costs. "This would put an abrupt halt to treatment for many patients," Koss said. Ultimately, physicians who are using telehealth to provide treatment are meeting the same standards of care and maintaining patients' continuity of care, thereby lowering costs by reducing emergency room and hospital utilization. "Yet those are not messages that lawmakers will hear unless we get involved."

Debra Koss, M.D., helped launch APA's Legislative Representatives Forum so district branches can share best practices for mental health advocacy at the state level.

The forum is intended for legislative representatives, DB presidents, and DB executive directors. "Certainly it's very exciting to see the turnout we've had, and we hope that all DBs will join us. I really appreciate the diversity of voices that is available to us in the forum," Koss said.

At that first meeting in June, participants found that although their local politics in each state differ, they share many of the same concerns. The most pressing issues among attendees were expanding access to telehealth and ensuring fair payment for it; increasing compliance with mental health parity; halting scope of practice expansion for nonpsychiatrists; and implementing 988, the three-digit hotline for suicide prevention and mental health crisis.

Katherine Kennedy, M.D., chair of APA's Council on Advocacy and Government Relations, said the goal of the forum is for state DBs to collaborate, harness new approaches, and share the tools and resources created by APA staff in the Department of Government Relations, such as model legislation.

"Being in a forum with others facing similar challenges helps energize you. We tend to live in our silos, and sometimes we are reinventing the wheel. The forum allows members to share the setbacks they've encountered—as well as effective approaches and best practices—so states can help each other succeed."

Kennedy said she sees legislative advocacy as a way to improve patient health outcomes at the population level and reduce the health disparities created by the social and structural determinants of health. For example, DBs that attend the forum might learn from other states how they are tackling opioid overdoses among people who have been recently released from incarceration. "You can save lives," she said.

"Imagine what we could accomplish if we had the collective wisdom of all our legislative representatives and could share with one another the lessons learned within each of our own states. Ultimately, it's a way to enhance our ability to be effective advocates for mental health care." **PN**

Misinformation

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health for the nation—as well as for communities around the world," Joshua Morganstein, M.D., chair of APA's Committee on Psychiatric Dimensions of Disaster, told *Psychiatric News*. "With this advisory, the surgeon general has chosen to elevate what is clearly an enduring and increasing barrier to health care."

Physicians may need to shift their approach to combat health misinformation. Morganstein said a growing body of evidence suggests that citing facts, figures, and statistics is not effective at changing people's minds. "In fact, when we spout data points, it may actually be increasing patients' mistrust in us," he said.

Some physicians, however, may believe it is not their job to try to change patients' minds and that their role is only to make recommendations, he added. However, "when we come from that perspective, we will miss a lot of opportunities to work with patients on many different aspects of their health. When we don't ask patients 'What are your concerns about my recommendations?' or 'What are the worries you have about this medication?,' we can be sure they will get the answers somewhere else, and most likely it will be from a far less informed source than we are."

Coaxing Patient Vaccination

Historically, people with serious mental illness (SMI) are an undervaccinated population: Only 25% of adults with SMI get a flu shot each year, compared with almost 50% of other adults. Earlier this year, APA urged states to prioritize coronavirus vaccination for people with SMI because of their increased risk of being hospitalized and experiencing serious complications including death.

"The spread of health misinformation is an urgent and significant matter of health for the nation—as well as for communities around the world."
—Joshua Morganstein, M.D.

"When it comes to willingness to accept the COVID-19 vaccine, a clear and unambiguous recommendation from a person's trusted health care professional remains a significant factor in moving people from hesitancy to willingness to accept vaccines," Morganstein said. "It is important that psychiatrists make those recommendations." (See "Vaccination Conversations: Influencing Critical Health Behaviors in COVID-19" at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.1.32.)

He prefers "nudging" patients toward gradual vaccine acceptance utilizing established principles of behavioral science. "The more precisely you understand what motivates a patient, … the more effectively you can tie any recommendations back to that." For example, he said, people who are motivated by social norms could be told, "Two-thirds of the people in your community have already been fully vaccinated," he said. Those who fear losing an opportunity could be warned, "As soon as boosters are required, it may become difficult for people to get their first series of shots."

According to polls done by KFF, some of the most pervasive myths surrounding the shots are that the vaccine can cause COVID-19 infection (36%) or infertility (31%). Other prevalent myths include that the vaccine can change an individual's DNA or that people who have had COVID-19 should not get vaccinated, KFF wrote. Also, more than half of unvaccinated adults (52%) aren't aware the vaccines are free.

Morganstein said, "People have stories about the vaccines that they're telling themselves if they haven't gotten vaccinated yet. For example, 'My mother had a terrible reaction to the vaccine' or 'I might be inserted with a microchip.' If we don't know what those stories are, then we can't help them." **PN**

The surgeon general's report "Confronting Health Misinformation" is posted at https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf. "The Spread of True and False News Online" is posted at https://science.sciencemag.org/content/359/6380/1146.

ETHICS CORNER

Philosophical Perspectives on Honest Speech

BY CLAIRE ZILBER, M.D.

Last month I wrote about the ethics of thruthfulness and honesty with patients and colleagues. I brought Aristotle into the discussion, but there are many other philosophical perspectives on this topic. In this column, I investigate contributions from Buddhist and Jewish traditions and suggest ways to incorporate this wisdom into our clinical and collegial interactions. Ironically, while writing this piece, I learned that I had unwittingly violated these concepts when discussing vaccination with colleagues.

Right Speech, Right Action, and Right Livelihood together comprise the three pathways to moral virtue taught by Buddha. Right Speech includes both abstaining from lying and being a reliable speaker of the truth. It also involves refraining from abusive or divisive speech, instead using polite speech to create harmony and affection. Finally, those who practice Right Speech avoid idle chatter and speak only that which is beneficial.

Claire Zilber, M.D., is a psychiatrist in private practice in Denver and a faculty member of the PROBE (Professional Problem Based Ethics) Program. She has served as a member of the APA Ethics Committee and chair of the Ethics Committee of the Colorado Psychiatric Society and is currently its immediate past president. She is the co-author of *Living in Limbo: Creating Structure and Peace When Someone You Love Is Ill*.

With our patients, this means being honest about how we are formulating their condition and the treatment plan and being careful to not waste their time with small talk that is irrelevant to their treatment. With colleagues, it means having the courage to speak truthfully and constructively about workplace problems and to decline participation in gossip.

The philosophy of Right Speech is strikingly similar to the Jewish ethical concepts of l'shon hara and l'shon hatov. L'shon hara means "evil tongue" and includes derogatory speech that emotionally, financially, or socially harms a person. L'shon hara can include truthful speech as well as lies if the speech is intended as gossip or defamation rather than to correct a wrong. Although a simple way to avoid l'shon hara is silence, the 12th century scholar Maimonides encouraged the alternative of l'shon hatov, which means "good tongue" and entails speaking kindly through focused praise and speaking for the benefit of others through anecdotes that show others in a good light. Focused praise involves pointing out specific strengths rather than making sweeping generalizations. This has relevance to our patients, who may yearn for our feedback about what they are doing well and exactly how they might try things differently. Although they need to be able to tell us how they have been harmed by others, it isn't especially helpful for us to speak harshly about the bad actors in their lives. Rather, they are helped by our empathic listening and our noting of the ways in which they have been resilient. With trainees, comments like "you're a star" or "you're brilliant" don't offer growth-promoting feedback. Instead, pointing out specific strengths such as their attention to detail or patience during a challenging interaction will help shape them toward further mastery.

While Right Speech and l'shon hatov may seem obvious and easy, I recently received a lesson in the double-edged nature of honesty. A long-standing study group has been meeting virtually since March 2020, and several of us have been outspoken about our fear of contracting COVID-19 and our dismay at those who aren't vaccinated. I assumed that everyone in this study group of highly educated professionals was eager to get jabbed. Only when we decided to hold a meeting in one of our backyards this past summer did one member of the group, I'll call him Sam, reveal that he wasn't vaccinated. He volunteered not to attend the garden meeting because he could tell from earlier conversations that his presence would make some of us uncomfortable. Although I don't remember all my comments about the unvaccinated in

see **Honest Speech** *on page 16*

Managing Outpatient Behavioral Health Risks

This convenient checklist will help you address important practice management issues and reduce your liability risk.

BY ALLISON M. FUNICELLI, M.P.A., C.C.L.A., A.R.M.

Understanding the risks associated with practicing in an outpatient behavioral health care environment can go a long way toward avoiding a medical malpractice lawsuit or licensing board complaint. While psychiatry is one of the least sued medical specialties, the risk is not zero.

Below are some points that psychiatrists should consider while treating their patients.

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

Prescribing

When prescribing or monitoring patients, consider the following questions:

- Which medications are best suited for the patient based on age, comorbidities, and drug-disease interactions?
- Is there a black-box warning and written informed consent?
- Is there evidence supporting prescribed medication if used in an off-label manner?
- Are there contraindications with other supplements, street drugs, or medications?
- Was the Prescription Drug Monitoring Program reviewed before prescribing an opioid or controlled substance medication?

Children of Separated, Divorced, or Unmarried Parents

Determine decision-making authority prior to treating a minor or releasing records.

- Do you have a copy of the current custody agreement or parenting plan?
- Does one of both parents have medical decision-making authority?
- Is the child of an age that allows him or her to consent to the release of information?
- What are the expectations in co-parenting if one parent decides to change his or her position?
- Do the parents understand that refusal of treatment or noncooperation by one or both parents may lead to the child's being terminated from the practice?

Telepsychiatry

- Are you using a HIPAA-compliant platform and secure internet connection?
- Do you have a Business Associate Agreement with the telehealth vendor?
- Are you licensed in the state or country where the patient is physically located for services?
- Will the patient consent to providing an emergency contact?

Patient Confidentiality

- Does your consent-to-treat policy include your obligations for mandatory reporting or duty to warn/protect in compliance with state regulations?
- Do you obtain the patient's written informed consent for release of his or her mental health records?
- Do you have written informed consent for the use of unencrypted email for electronic communication with the patient?

Misdiagnosis/Incorrect Treatment

- Do you review the patient's prior medical information when evaluating and treating patients?
- Is your communication with patients timely and relevant?
- Do you have a tracking system when ordering tests and labs to ensure they were completed and followed up?

Boundary Issues

- Do you have a policy that you and your staff do not accept "friend" requests from patients?
- Do you have a policy addressing treating multiple members of the same family?
- Are you engaging in a dual relationship with the patient?

Noncompliant Patients

- Is there a reason the patient is refusing to comply with treatment, including taking medications as prescribed and attending regularly scheduled visits?
- Do you obtain a written informed refusal when the patient does not follow the treatment plan?

Termination

- Do you have a policy on circumstances that may lead to terminating the relationship with a patient?
- Does the policy include the state requirements to properly terminate the relationship?

Suicidal/Violent Patients

- Are you regularly screening your patients for risk of suicide and violence, and is your screening documented each time?
- Is it within the scope of your practice to provide the appropriate level of care for a suicidal/violent patient?

Documentation

- Does your documentation provide the information to support your evaluation and treatment of the patient?
- Are your documentation policies and procedures up to date?

While these questions are just some of the areas of vulnerability to consider, addressing these types of questions can go a long way to avoiding risk and assisting in one's own defense if a malpractice claim or licensing board complaint is brought. **PN**

World Network of Psychiatric Trainees Holds Forum on Psychiatry Trainee Mothers

The World Network of Psychiatric Trainees (WNPT), founded in 2018, is an international association comprising 348 members from 66 countries. Its executive leadership is presided by Victor Pereira-Sanchez, M.D., Ph.D., a resident-fellow member of APA, and Sanya Virani, M.D., M.P.H., APA's resident-fellow member trustee. The WNPT holds virtual forums regularly on topics of relevance for trainees and most recently conducted its third virtual forum on May 15 in commemoration of Mother's Day. This event was attended by 50 psychiatrists from more than 20 countries. Its recording, available on YouTube and across many social media platforms, has generated more than 280 views at press time. The panelists were nine women psychiatrists in training or recently graduated and mothers from seven countries (Indonesia, New Zealand, Nigeria, Sudan, Ukraine, United Kingdom, and United States). The special guest presenter was Prof. Norman Sartorius, former president of the World Psychiatric Association.

The panelists' stories highlighted many of the challenges that COVID-19 posed in their respective countries and their dedication as psychiatrists in the face of very limited resources. The panelists also engaged with the audience about the need for changes in the work culture to effectively support psychiatric trainees who choose to be mothers. The event elicited wide interest among the audience watching in real time and later through social media.

The recording of the forum is posted at https://www.youtube.com/watch?v=_8HddcLbvbM. More information about WNPT and becoming a member is posted at https://worldtrainees.org. An expanded version of this article is posted on the* Psychiatric News *website at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.10.38.

APA App Advisor: Working With Patients to Use Apps

This article is part of series to provide information from APA experts on the use of apps in psychiatry. Your questions are welcome! See information at the end of the article for submission information.

BY NATHAN TATRO, M.A.

Nathan Tatro, M.A., is deputy director of digital health in APA's Department of Practice Management and Delivery Systems Policy.

This series features members of APA's App Advisor Expert Panel who discuss the general use of mental health apps and answer APA members' questions. This group is composed of APA members and other subject matter experts in mental health from related professions (for example, social work, psychology, nurse practitioners, informaticists) and patients with lived experience of mental illness. The purpose of this panel is to maintain APA's App Evaluation Model and to provide resources for professionals and patients to give them tools they can use when deciding what app is appropriate. The articles will also explore clinical, research, and policy interests of the panelists around mHealth (mobile health).

This month's panelist is Darlene King, M.D. Dr. King works with APA's App Advisor Expert Panel and is a member of APA's Committee on Mental Health Information Technology. She is a fourth-year psychiatry resident at the University of Texas Southwestern Medical Center in Dallas. As a physician with an engineering background, Dr. King thinks in ways that link engineering, medicine, and information technology. She earned a biomedical informatics certificate from the University of Texas School of Biomedical Informatics at Houston in 2019.

Q *One part of APA's Evaluation Model prompts the user to consider whether the app comes from a "trusted source." What are some ways we can tell if an app is from a trusted source?*

A First, it's important to look at the developer's profile in the app store and see if you recognize the company and to look for a few key pieces of information. Does the developer fall into any of the following categories: government, academic institution, or private company? A private company may be more likely to sell information or be held to different standards from those for a government agency or academic institution.

You should also review other information available in the app store, including the privacy policy, to see how information collected by the app is handled. You also should consider what type of app it is—for example, is it categorized as a wellness app or a medical app? This is important, because medical apps must adhere to the Health Insurance Portability and Accountability Act (HIPAA).

Q *When patients approach you about using an app, what important information do you discuss with them?*

A It's a good idea to approach discussing apps with patients similar to how you would approach talking about medication: Go over the risks and benefits, certainly, and let them know that the app use is voluntary and that they are not being expected to adhere to app usage.

Using apps also prompts a different kind of risk/benefit conversation. In terms of risks, for the most part, apps do not have the same confidentiality restrictions and don't have to adhere to HIPAA. Personal information that patients share in the app and with others could be sold to third parties or not be as protected at the same stringent level as their medical information. Also, unlike medications, most apps are not FDA approved, and many are not evidence based. We still don't know how helpful many apps may be. Finally, the information collected by apps that offer peer support may not be confidential, and some apps do not have built-in safety or crisis features.

However, there are some benefits to using many types of apps. For example, apps that are used regularly could help with mood tracking; journaling; or a targeted symptom, such as poor sleep, with a CBTi (cognitive-behavioral ther-

see **App Advisor** *on page 12*

The Fight Against OUD Needs Academic Medicine

Decades of research has produced a plethora of treatments for diagnosing and treating opioid use disorder and overdose, but those interventions are worthless if health care professionals are not taught when and how to use them. **BY TERRI D'ARRIGO**

Opioid overdoses resulted in more than 24 million hospitalizations and have claimed the lives of more than 360,000 Americans in the last decade. Yet only about two-thirds of medical schools include lectures about opioids and addiction medicine in their curricula, representing a dearth of education that may leave physicians and trainees with a poor understanding of how to screen for and treat opioid use disorder (OUD) with evidence-based interventions. If the nation is ever to get a handle on the crisis and rein it in, academic medicine must step up and be more proactive, experts in addiction medicine wrote in a commentary in *Academic Medicine*.

"This is where academic medicine can be most influential in addressing this public health problem: by enhancing the preparedness of the current and future clinical workforce to treat substance use disorders (SUDs), including opioid use disorder (OUD), through increased attention to addiction medicine in medical and nursing schools and in residency training programs," wrote Nora Volkow, M.D., the director of the National Institute on Drug Abuse, and colleagues.

NIH

The growing awareness of health disparities and social justice issues may build support for giving substance use disorders more attention in medical and nursing schools, say Nora Volkow, M.D., and colleagues.

The authors wrote that the growing awareness of health disparities, social justice issues, and the needs of vulnerable populations can build support for increased attention to SUDs in medical and nursing schools, and added that more training in addiction medicine is part of a larger shift toward recognizing that behavioral health in general is key to the prevention, management, and treatment of many illnesses and conditions.

Harvard University

Didactic learning in medical school about substance use disorders should be coupled with clinical experience, says Amber Frank, M.D.

"By offering more training in behavioral health, medical and nursing schools will not only better equip current students to meet the needs of the communities they will serve but also attract premedical and prenursing students who are more interested in and motivated to address these concerns," they wrote.

Amber Frank, M.D., an instructor in psychiatry and director of the Cambridge Health Alliance adult psychiatry residency program at Harvard Medical School, who was not an author on the commentary, told *Psychiatric News* that medical schools can help equip all students for working patients with SUD by teaching them the following core skills:

- The ability to obtain a comprehensive substance history with respect and empathy.
- A basic knowledge of screening tools, diagnostic criteria, and evidence-based pharmacological and psychosocial treatments for SUD, including OUD.
- The ability to recognize SUD-related emergencies such as overdose or dangerous intoxication.
- A basic familiarity with levels of care from community supports through inpatient settings.
- The ability to conduct motivational interviewing.

"This may sound like a lot, but it is in alignment with what we would expect medical students to master for other medical and surgical conditions, and it is doable," said Frank, chair of the American Association of Directors of Psychiatric Residency Training's Addictions Committee. "At the same time, these didactic-based learning experiences should be coupled with actual clinical experience. We wouldn't expect our medical students to learn endocrinology only from preclinical coursework without associated clinical exposure. Similarly, we need to move toward addictions education that is robust in both classroom and clinical learning venues."

Frank said that patients with SUDs can be found across clinical settings.

"[They] are everywhere: in our primary care clinics, our medical specialty services, the OR and ED, in OB/GYN. It is essential that we train our future primary care physicians, surgeons, and other specialists to recognize and treat substance use disorders, as relying only on subspecialty-trained addictions experts will be insufficient to meet the health needs of the population," she said. "The responsibility for care of individuals with SUD is one we all share, whether we are in academic medicine and researching new treatments or training the next generation, or if we are in community practice and refining our own clinical skills." **PN**

"How Academic Medicine Can Help Confront the Opioid Crisis" is posted at https://journals.lww.com/academicmedicine/Abstract/9000/How_Academic_Medicine_Can_Help_Confront_the_Opioid.96614.aspx.

App Advisor

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apy for insomnia) app. Also, patients may have greater access to resources or help through an app than otherwise easily possible. Apps can be a convenient way to engage with a specific type of intervention.

Q *Once you and a patient have decided to use an app together, what are some strategies to get the patient to engage with that app as a part of therapeutic treatment goals?*

A As the research suggests, an app's effectiveness depends on consistent and appropriate use. So, it's important to help patients think about the benefits of using the app and consistently remind them to use it during check-ins. That said, you might also suggest that they set a timer or notification (another app available to them on their phone) to remind them to engage with the app. You might also consider having patients plan to reward themselves for using the app daily for the first week and then repeat that reward if it seems to be successful. Depending on the app and specific type of treatment, patients might also want to tell friends about it, engage with the app as a group, or ask for accountability from friends and family to check whether they are using the app regularly.

Q *Glancing at the app store shows that there are some apps that are specifically created for children. What questions might parents ask when you recommend using an app as a part of a child's treatment?*

A Of course, the first question parents are certain to ask is whether the app is safe for their child to use. A conversation about safety goes back to issues around risks and benefits (as we talked about earlier), but also some are related to basic usability: Is this an app specifically for children or one primarily for adults? Both? Will my child be talking to other children of the same age on the app or is there a peer or community chat aspect to the app that might include adults? Can I monitor my child's usage of the app? How will this app help my child? How often should my child use the app? Do we need to bring screenshots of results or exercises that are generated when using the app?

Q *Should psychiatrists obtain written informed consent from patients for the use of an app?*

A This may be a good idea in terms of providing patients with all the information they need to decide whether or not they want to use an app, but there are some downsides as well. As this area continues to evolve, there are a number of factors that a clinician should consider and discuss fully with patients in an informed consent process before engaging in the use of a mental health app in treatment. Several such factors are identified in opinion number 32 of *The Opinions of the Ethics Committee on the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry,* posted at https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/Opinions-of-the-Ethics-Committee.pdf. **PN**

Email questions for APA's app advisors to ntatro@psych.org for use in this series of articles.

ON MENTAL HEALTH, PEOPLE, AND PLACES

Stress in Athletes' Lives

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

In recent months, there has been intense discussion about the connection between competitive sport and mental health. The commentary, focused in large part on the stress endured by elite athletes, has coincided with major international sports events. We have had, almost in back-to-back fashion, the French Open tennis tournament, the Tour de France cycling event, the European 2020 soccer championship, and the Olympics in Japan. Naomi Osaka, a world-famous tennis champion, made the news because of her unwillingness to face the pressure of yet another news conference at the French Open. Some bystanders thought she should respect her obligation to face the public because she had committed to doing so. Others agreed the journalists were offensive. At the Tokyo Olympics, Simone Biles, the American star gymnast, evoked similar conflicting responses when she withdrew from events, citing health matters.

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

At the European soccer championship, France was eliminated by Switzerland. The match went into overtime and then to a penalty shootout. Kylian Mbappe, a superstar for France, missed his penalty. That outcome sent France's players to the showers and home in disgrace. Mbappe apparently apologized to his fans for what sports writers called a failure. More sympathetic supporters urged him to keep his head up, as the day after the match would mark the debut of a new season. The three athletes I have mentioned illustrate well the stress of competitive athletics.

We follow elite athletes and how they fare on the different terrains of performance. Their annual income and lifestyle, especially in major sports, always attract our attention. Their bodies and minds serve as models of biomedical wonderment for physicians like us. Their capacity for concentration, the sacrifices they make, and their commitment teach us much about what they endure daily.

There are other features of sports that put excitement in our lives. Some years ago, my hospital organized a tournament of bed racing. We closed a street. Different divisions in the facility took a bed, decorated it, named it, and oiled its wheels. An employee, not weighing too much, volunteered to ride in the bed. A team of amateur athletic runners pushed each bed. We all spread the word about the event. The bed-race tournament was on. Every bed had its supporters. I was amazed at how much organized effort was put into this event. We had so much fun that I forgot to ask where the idea had originated. Athletics, competition, and team spirit came together and reawakened the slumbering youth in all of us, even in the bystanders.

With these wonderfully positive notions about competitive sports so present in our culture, how did the idea take root that elite athletes are the very incarnation of perfection and are obliged to meet public expectations? We must know that they make mistakes from time to time in what they do, and anxiety haunts the best of them. While performances may be breathtaking, consistently flawless performance is hard to sustain. So, why this mourning and weeping over the mistakes of our athletes and their inability to cope well with stress at every event? Why not just console and encourage them when they are facing loss, injury, and disappointing performances?

I still recall the early years in elementary school running after a soccer ball on the playground without quite knowing what to do with it. Eventually, the running was accompanied by thoughtful preparation and strategy. I remember the contentment of belonging to a group, the sense of accomplishment, learning about leadership when I captained the team, feeling the admiration of bystanders when I scored a goal. I also learned about losing in the context of competition and about the pain of a torn muscle during excessive effort.

We should urge sports enthusiasts to stop pretending that the elite athlete owes them continual brilliant performances. We should remonstrate with coaches who never prepare a substitute for the day that the star center forward on the soccer team will be unable to play. We know that sports can be pleasurable enough to evoke a kind of loyalty from fans that borders on spiritual commitment. We recognize sports' service as antidote to the drudgery of daily life. Still, creating an idealistic vision of athletics misleads us all. There is risk in the act of living, and that includes sports. **PN**

Honest Speech

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recent months, I imagine Sam does. I am dismayed with myself for having spoken carelessly, possibly alienating a person I admire. At a time when I am paying more attention to potential bias and microaggressions, I was blind to how I was violating my own intention to be respectful and inclusive of people who are different from me because I incorrectly perceived Sam as being just like me. I did not refrain from divisive speech. My comments could have socially and emotionally harmed a colleague. I was truthful, relentlessly so, and this threatened the integrity of the study group. Fortunately, Sam and I have known each other a long time, and the deep well of our mutual respect allowed us to have a thoughtful, open conversation about the reasons he is not yet ready to get a COVID-19 vaccine.

Honesty is the best policy, but there's an art to how we share it. We know that when meeting with patients, it is important to listen more than speak and to use our observing egos to monitor our impulses to blurt something out. When we do speak up with patients, hopefully we first reflect about the best words to use to motivate the patient toward self-improvement. Similarly, with students and supervisees, our praise or criticism will be most effective if both are specific, constructive, and respectful of the recipient's capacity to take in the information. Finally, as I learned the hard way, even when talking with trusted peers, we must listen and reflect carefully before speaking lest we make harmful assumptions and damage relationships. **PN**

PSYCHIATRIC NEWS
Special Report

"reVeriE" by Tracey Messlein Newport. "When you can't pick a color or a subject ... paint anyway." Created for ADHD Awareness October 2021 (https://www.adhdawarenessmonth.org)

ADHD: A Complex Disorder of the Brain's Self-Management System

Assessment of ADHD requires collection of information about how the patient functions in a wide variety of complex daily tasks at different times of day in different settings relative to other individuals of similar age.

BY THOMAS E. BROWN, PH.D.

Thomas E. Brown, Ph.D., is director of the Brown Clinic for Attention and Related Disorders in Manhattan Beach, Calif., and served on the clinical faculty of Yale Medical School for 20 years. He taught CME courses on ADHD at APA annual meetings for 18 years and has lectured and taught workshops on ADHD throughout the United States and in 35 other countries. He is the author of *Outside the Box: Rethinking ADD/ADHD in Children and Adults: A Practical Guide* from APA Publishing. APA members may purchase the book at a discount at https://appi.org/Products/ADHD/Outside-the-Box-Rethinking-ADD-ADHD-in-Children-an.

The disorder currently known as attention-deficit/hyperactivity disorder (ADHD) has long been seen as simply a behavioral problem of young boys who are excessively restless and inattentive. Among much of the public and even among many medical and psychological professionals, it is often misunderstood. However, ADHD is gradually being recognized as a complex neurodevelopmental disorder of the brain's self-management system, its executive functions.

This syndrome affects not only young boys, but also young girls. It is no longer seen as a set of problems that remit in adolescence. Research by Barkley, Murphy, and Fischer (2008) has demonstrated that for 70% of those with ADHD, impairments persist into adolescence and often also into adulthood, impacting not only schooling, but also employment and social interactions.

I have proposed a model showing six executive

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functions impaired by ADHD: activation, focus, effort, emotion, memory, and action (see illustration). Here are some important points about this model:

- Demands on executive functions increase with age as the child's abilities increase. A 4-year-old is expected to be able to get dressed without constant parental assistance but is not expected to cross a busy street unassisted. Most 12-year-olds are expected to be able to ride a bicycle but not safely drive a car.

- Everyone has difficulty with these executive functions sometimes. It is not unusual, even for adults, to lose focus occasionally while listening in a meeting or reading a book or to forget what they were about to do. For those with ADHD, these functions are more often and more severely impaired than for most others of similar age.

- Executive functions operate very quickly, usually with automaticity and without much conscious thinking, except for unfamiliar situations recognized as requiring a slower, more thoughtful approach.

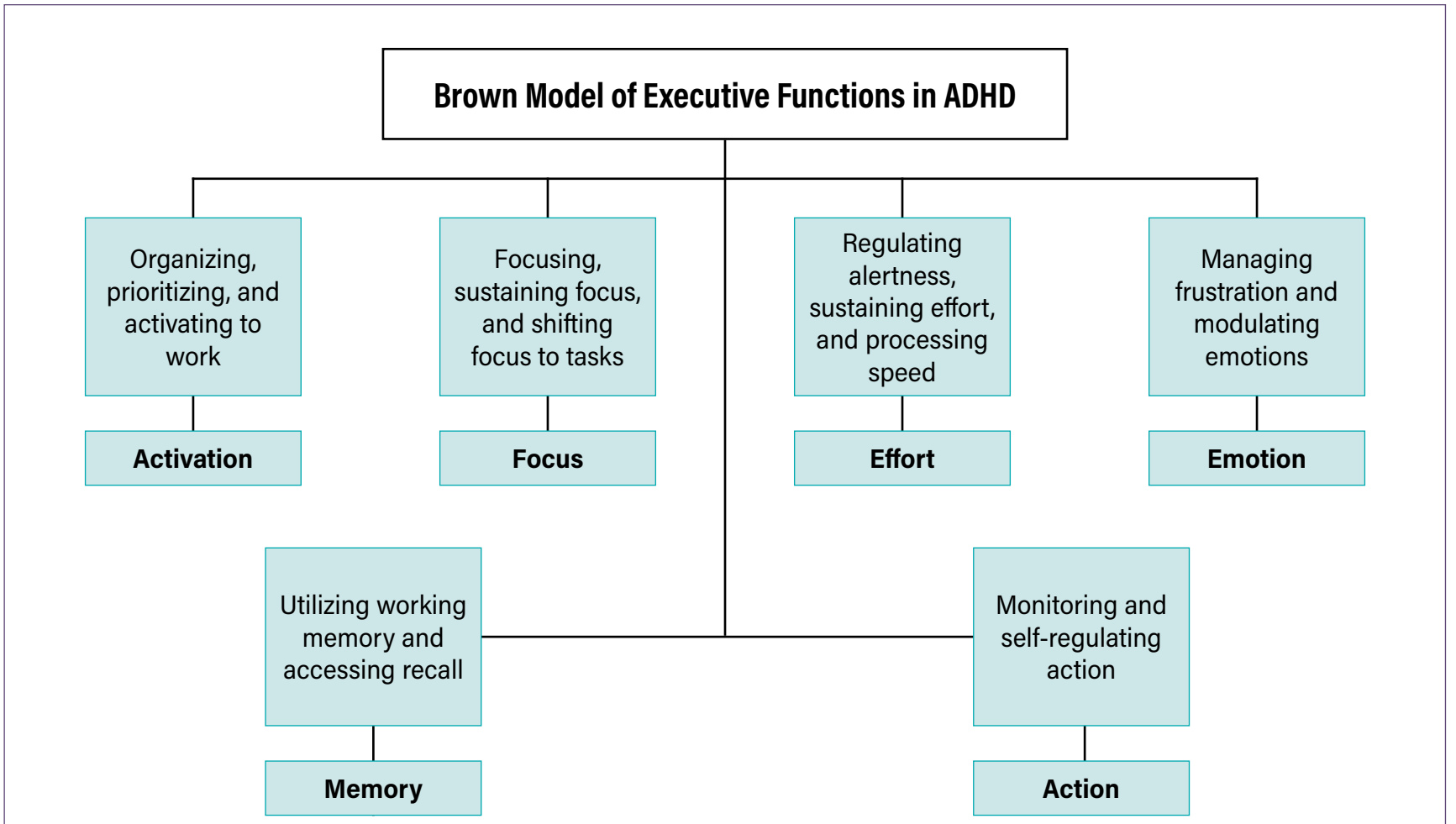
- Although ADHD was once seen as always involving hyperactivity and impulsivity, many with ADHD have never been hyperactive or impulsive. Some tend to be somewhat sluggish.

- ADHD has nothing to do with a person's intelligence. Some extremely bright and accomplished people suffer from ADHD despite a high IQ. Studies have shown that ADHD is found in people across the full range of intellectual abilities.

- Executive function impairments of ADHD are a very heritable syndrome. Among those diagnosed with ADHD, about 1 in 4 has a parent with ADHD. The remaining three usually have at least one other blood relative with ADHD, for example, a sibling, grandparent, uncle, aunt, or cousin. ADHD syndrome runs in families.

The Central Mystery of ADHD: Executive Functions of ADHD Are 'Situationally Variable'

All people with ADHD tend to have a few tasks or activities that strongly interest them and for which they do not experience executive function impairments. Because affected individuals can focus very well for a few specific tasks that interest them, it is often assumed that ADHD is simply a lack of willpower. People may say, "If you can do it here, you certainly should be able to do it for other tasks you recognize as important." Strong interest or strong fear about a task changes the chemistry of the brain instantly and mobilizes attention, but these changes are not generally under voluntary control.



Brown TE. *A New Understanding of ADHD in Children and Adults: Executive Function Impairments.* APA Publishing; 2013.

One of my patients compared ADHD to "erectile dysfunction of the mind." He said, "If the task you are faced with is something that turns you on, something really interesting to you, you're 'up for it' and you can perform. But if the task is not something intrinsically interesting to you, if it doesn't turn you on, you can't get up for it and you can't perform. It doesn't matter how much you tell yourself 'I need to! I ought to!' because it's just not a willpower kind of thing."

Assessment and Diagnosis of Executive Function Impairments

It was once assumed that a full neuropsychological evaluation involving "tests of executive functioning" was needed to adequately assess for ADHD. Such exams can be helpful for assessing physical damage from a brain injury or a stroke, but they are not usually helpful for diagnosing ADHD. There is no single test that provides an adequate assessment for the presence or absence of ADHD.

No EEG, no computer test, no neuropsychological test battery can capture the variety and complexity of functions involved in getting up in the morning and preparing to leave for school or work, riding a bike or driving a car in traffic, reading and comprehending papers or books, participating in social conversations, prioritizing a variety of tasks, and getting started on what is most important while avoiding distractions, yet shifting focus when needed.

Assessment of ADHD requires collection of information about how the patient functions in a wide variety of complex daily tasks at different times of day in different settings relative to most others of similar age.

The most effective way to determine whether a person may have ADHD is a well-conducted clinical interview with the patient by a clinician familiar with ADHD and, if possible, someone else who knows the patient well. Detailed directions for such an interview are included in my book *Outside the Box: Rethinking ADD/ADHD in Children and Adults.*

Initial evaluations should also include use of an age-normed rating scale for ADHD such as the Barkley Rating Scales, the Brown Executive Function/Attention Rating Scales, or the Behavior Rating Inventory of Executive Function (BRIEF).

These normed rating scales are helpful in compensating for the fact that *DSM-5* diagnostic criteria pick up some impairments of ADHD but do not include aspects of executive function impairments that are significant and occur commonly in many teens and adults.

Effective Treatment for ADHD in Children, Teens, and Adults

The most effective treatments for ADHD are carefully adjusted FDA-approved medications. For 8 of 10 persons with ADHD, stimulant medications significantly improve their impairments of executive functioning if the medication choice and dosing are carefully fine-tuned to adjust to that individual's body. However, these medications do not cure ADHD as an antibiotic may cure an infection. When effective, stimulant medications simply alleviate the symptoms of ADHD during the time the medication is active, in the same way that eyeglasses or contact lenses may improve vision while they are being worn.

The effect of medication is variable—some patients benefit enormously, while others experience more modest improvement. For about 2 of 10 patients, a given medication may cause unacceptable side effects or not be helpful at all.

Fine-tuning of stimulant medications for each individual patient is essential. The most effective dose of stimulant medication for patients with ADHD is not usually tied to the patient's height, weight, or symptom severity. Rather, the most important factor is how sensitive the individual's body chemistry is to the specific medication being taken.

Most very young children respond best to relatively small doses, but for some, it is necessary to titrate to a much higher dose. Similarly, most adults respond best to fairly high doses, but there are a few, including some who are quite tall and heavy, who will do best on a dose not much stronger than is used for most young children.

Fine-tuning of stimulants does not refer only to the size of the dose; it also is related to the timing of dosage in relation to the patient's daily activities. For example, many adolescents find that a morning dose of a long-acting stimulant like lisdexamfetamine dimesylate (Vyvanse), methylphenidate extended release (Concerta), or XR doses of other stimulants work very well for most of their school day. However, for many adolescents, these longer-acting medications taken in the early morning wear off at lunch or shortly thereafter, leaving no coverage for their afternoon classes.

Many who take longer-acting stimulant medications need a "booster dose" of an immediate release, shorter-acting version of that same medication to cover them for their afternoon classes. Some also need a "booster dose" in late afternoon to provide coverage for homework or other evening activities. There are significant differences in the rate at which even patients of similar age and size metabolize stimulant medications.

"Rebound" is another factor related to fine-tuning stimulant medications. This refers to the situation in which a given stimulant works without adverse effects during most of the time it is active, but then wears off too quickly causing the patient to experience restlessness, irritability, or blunting of emotion and the sensation of a "crash" that may last a couple of hours. Usually, such rebound reactions can be alleviated by adding a small dose of the short-acting formulation of that medication about 30 minutes before the crash tends to occur.

Medication Options Other Than Stimulants

In addition to stimulants, the FDA has approved several other nonstimulant medications as effective for treatment of ADHD. More than 30 studies have demonstrated the usefulness of atomoxetine (brand name Strattera) not only for ADHD, but also for ADHD accompanied by anxiety, tics, and some other comorbid problems. Unlike the stimulants, atomoxetine is dosed according to the patient's weight.

Other nonstimulant medications approved for treatment of ADHD include guanfacine (Intuniv) and clonidine (Kapvay). Both are α2-adrenergic agonists that act primarily on the norepinephrine system and have been used to reduce excessively high blood pressure in adults. They may be helpful for ADHD in combination with stimulants to reduce excessive restlessness, irritability, aggression, difficulty in falling asleep, and/or tics (vocal and/or motor). More detailed information about adjusting dosing for these medications appears in my 2017 book.

"The most effective way to determine whether a person may have ADHD is a well-conducted clinical interview with the patient by a clinician familiar with ADHD and, if possible, someone else who knows the patient well."

Nonmedication Interventions for ADHD

Education of Patient and Family

It is important for clinicians to provide accurate and understandable information about ADHD to patients and their families. There is a lot of misinformation about this disorder that may discourage them from utilizing effective appropriate treatment. Before information is provided, it is usually helpful to ask the patient and family members what they already know about ADHD and what questions they may have about the disorder, its course, and its treatment. This may reveal myths or misunderstandings that could undermine compliance with recommendations.

Guidance for parents of children with ADHD often involves addressing concerns such as the following:

- How can we resolve differences between us as parents about not only medication, but also how to deal with our child's behavior in ways that are not too harsh and not too lenient?

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- How can we prevent ADHD from becoming an excuse for laziness or unacceptable behavior?

- What should we tell the school? Should we ask teachers to make changes in how they deal with our child?

- Are our child's symptoms of ADHD likely to get better or worse as time goes on? What does this mean for his or her future education, relationships, and career?

Know the Laws Regarding Accommodations

For children or adults with ADHD, there may or may not be a need for accommodations in school or in employment. There are two levels of federal laws that provide for individuals with disabilities, including ADHD, who may need accommodations or supports not provided to other students or employees. Those laws include Section 504 of the Rehabilitation Act of 1973 and the Individuals With Disabilities Education Improvement Act of 2004, which was strengthened in 2006. Another applicable law is the Americans With Disabilities Act.

Examples of accommodations include the following:

- Extended time for completing timed tests or examinations.

- Reduction in the amount of written work required or extended time for completion.

- More frequent reports from school to home, possibly including daily report forms.

- Alternative seating of the student in the classroom.

- A peer notetaker for lecture classes to supplement notes taken by the student (for example, in college classes).

Details about regulations for accommodations and how to arrange for appropriate accommodations are also included in my 2017 book.

Other nonmedication treatments for ADHD may include supportive psychotherapy, couples therapy, or coaching by a trained ADHD coach.

Comorbidity in ADHD

In children and adults, ADHD is often comorbid with other disorders. One large study involving 61,000 children aged 6 to 17 years found that those children diagnosed with ADHD had much higher rates of other disorders than those who did not have ADHD. Among those children with ADHD, 33% had at least one additional psychiatric or learning disorder, 16% had 2, and 18% had 3 or more (see Table 1).

Co-occurring disorders are also very common among adults with ADHD. A nationally representative study of adults with ADHD aged 18 to 44 years who were not referred for treatment found that those with ADHD were 6.2 times more likely to have at least one additional psychiatric disorder at some point in their life than adults without ADHD (see Table 2).

In evaluations of children and adults with ADHD, it is not uncommon to have their comorbid disorder recognized and treated while their ADHD is overlooked or to have their ADHD diagnosed while a concurrent disorder is not recognized and treated. Detailed suggestions for adapting treatment for ADHD with various comorbid disorders are included in my 2017 book. **PN**

Table 2. Prevalence & Odds Ratios for Psychiatric Disorders in Adults With ADHD

	Lifetime Prevalence	Odds Ratio
Mood disorders	38.3	5.0
Anxiety disorders	47.1	3.7
Substance use disorders	15.2	3.0
Impulse disorders	19.6	3.7

Kessler RC, et al. "The Prevalence and Correlates of Adult ADHD in the United States: Results From the National Comorbidity Survey Replication." *American Journal of Psychiatry,* April 2006.

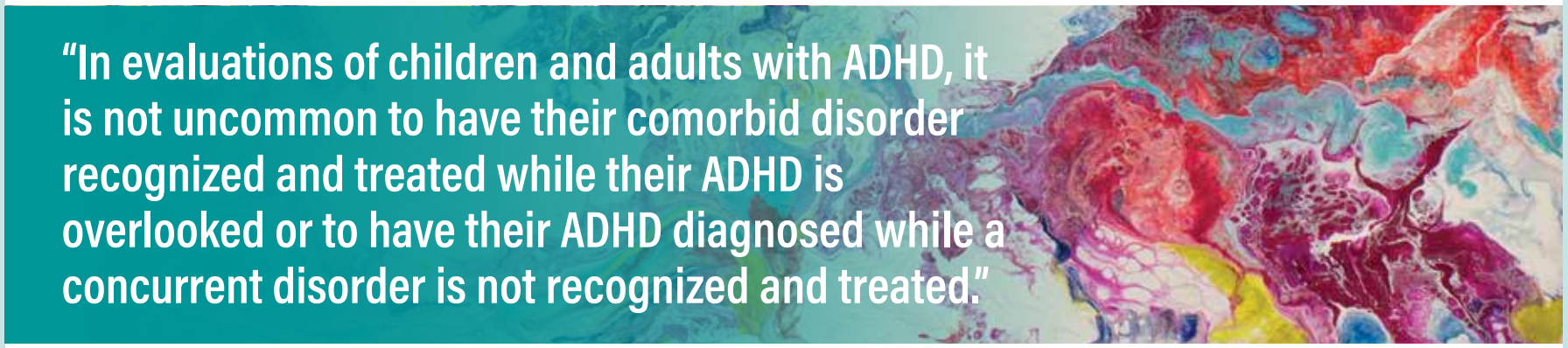

Table 1. Psychiatric Disorders Diagnosed in Children With and Without ADHD

	ADHD %	Non-ADHD %
Learning disorder	46.1	5.3
Conduct disorder	27.4	1.8
Anxiety	17.8	2.3
Depression	13.9	1.4
Autism spectrum disorder	6.0	0.6

Larsen K, et al. "Patterns of Comorbidity, Functioning, and Service Use for US Children With ADHD." *Pediatrics*, March 2011.

Additional Resources

- **Barkley RA, Murphy KR, Fischer M. *ADHD in Adults: What the Science Says.* New York: Guilford Press; 2018.**

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Guidance on Navigating Insurance Plans for TMS-Eligible Patients

BY RICHARD A. BERMUDES, M.D.

When should transcranial magnetic stimulation (TMS) be considered for patients with depression? Which patients are covered by insurance for TMS?

The answer to the first question is fairly straightforward; however, the answer to the second question is complicated. While all major commercial insurers cover TMS, the proper updated coverage policies can be difficult to find and navigate, and they have very difficult coverage criteria. This creates a confusing matrix of who is appropriate for TMS, who meets medical necessity criteria, and who has access to TMS therapy.

Several professional societies recommend TMS for adult patients with major depressive disorder who have failed to respond to one or two antidepressant medications trials (Table 1). In 2016, the Clinical TMS Society published its consensus review and treatment recommendations for TMS therapy for major depressive disorder. An expert panel of clinicians and academic researchers systematically reviewed over 100 peer-reviewed articles on TMS therapy and graded the strength of the evidence using the Levels of Evidence criteria published by the University of Oxford Centre for Evidence-Based Medicine. When the published data were deemed incomplete or insufficient, expert opinion was included as available. The results of the review and the coverage guidance recommend that left prefrontal TMS repeated daily for four to six weeks is an effective and safe treatment for depression in patients who have not responded to one or more antidepressant medications.

In 2017, "Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression" was published in the *Journal of Clinical Psychiatry*. Participants included a group of 17 clinicians and researchers with expertise in the clinical application of TMS, representing both the National Network of Depression Centers (NNDC) rTMS Task Group and the APA Council on Research (APA CoR) Task Force on Novel Biomarkers and Treatments. A total of 118 publications were reviewed for the consensus statement and were supplemented with expert opinion to achieve consensus on the administration of TMS for MDD in clinical settings. The expert opinion is that "TMS is appropriate as a treatment in patients with MDD even if patients are medication resistant or have significant comorbid anxiety."

Richard A. Bermudes, M.D., is the chief medical officer at Mindful Health Solutions in San Francisco and an assistant clinical professor of psychiatry at the University of California, San Francisco. He is also the co-editor of *Transcranial Magnetic Stimulation: Clinical Applications for Psychiatric Practice* from APA Publishing. APA members may purchase the book at a discount at https://appi.org/Products/Neuropsychiatry-and-Biological-Psychiatry/Transcranial-Magnetic-Stimulation.

With regard to commercial payers, coverage of TMS is less uniform (Table 2). For example, Optum considers patients eligible for TMS if they failed four antidepressant medication trials and a trial of psychotherapy in the current episode, while Cigna patients are eligible for TMS if they failed two antidepressant medication trials and a course of psychotherapy. Some insurance companies require patients to fail augmentation agents such as atypical antipsychotics in addition to antidepressants, while other insurers require failure on antidepressants from different classes. Some insurers cover TMS for patients with moderate severity, while others cover TMS for patients with severe symptoms. Different insurance companies require different depression rating scales and determine eligibility for TMS based on different cutoff scores. I have had patients who are eligible for insurance coverage of TMS one month but are suddenly ineligible when their benefits change. Unfortunately, the majority of insurance policies seem to select out the most ill and treatment-resistant patients who may have attenuated benefits from TMS due to the chronicity of the depression.

Here are my recommendations on the best way to align insurance coverage policies with the standards of professional societies.

For physicians referring or prescribing TMS therapy:

- Prescribe or refer patients for TMS when you consider them to be good candidates. If they are denied coverage, utilize your state's department of insurance, which should have a process for patients to appeal insurance denials.

- Per society recommendations, consider TMS for patients who have moderate or severe depression and have failed one or more antidepressant medications. In my clinical practice, I start to educate patients after one failed antidepressant and prescribe TMS after two failed antidepressants.

- There is only one absolute contraindication to TMS therapy—the presence of ferromagnetic metal in the head.

- Align with other mental health advocacy groups and lobby your state representatives to further extend parity for mental illnesses. Legislation (SB 855) was recently signed into law in California requiring health care plans to use utilization review criteria that are consistent with the criteria and guidelines set forth by nonprofit professional societies.

For commercial insurance medical directors/medical reviewers and companies:

- Meet with physicians who treat patients with TMS therapy. Consider their clinical experience when formulating coverage policies.

- Attend a CME course on TMS therapy.

- Review and align your company's insurance coverage criteria with professional society guidelines. **PN**

"Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression" is posted at https://www.psychiatrist.com/jcp/depression/consensus-recommendations-for-applying-rtms-in-mdd/.

Table 1. Guidance From Professional Societies, VA/DOD on When to Consider TMS for Patients

The Clinical TMS Society	NNDC rTMS Task Group and APA CoR Task Force on Novel Biomarkers and Treatments	Canadian Network for Mood and Anxiety Treatments	Department of Veterans Affairs and Department of Defense (VA/DoD)
TMS is a recognized treatment in routine clinical practice for patients who have not benefited from one or more antidepressant medications.	TMS is appropriate as a treatment in patients with major depressive disorder even if the patient is medication resistant or has significant comorbid anxiety.	TMS is considered first-line treatment in those individuals who have failed at least one antidepressant trial.	TMS should be offered for treatment during a major depressive episode in patients who have not responded to two antidepressant medications.

Table 2. TMS Insurance Approval Requirements

This is an example of an insurance grid that patients and physicians must navigate for TMS coverage. Insurers should be contacted directly for the most current policy.

Medication trials*	Covers moderate and severe depression	Covers only severe depression
4 ADMS + 2 Aug		Healthnet/MHN
4 ADMS + 1 Aug		Beacon (failure to respond)
4 ADMS	Optum	Magellan (failure to respond), Beacon (failure to tolerate), Anthem (failure to tolerate)
2 ADMS + 1 Aug		Aetna
2 ADM	TricareCigna	Anthem (failure to respond), Magellan (failure to tolerate)
1 ADM		Medicare (Noridian LCD)

*All payors require a failed trial of psychotherapy for TMS coverage.

ADMS = antidepressant medication; Aug = augmentation medication

Young-Onset Dementia More Prevalent Than Previously Estimated

A meta-analysis of 95 studies from around the world suggests that nearly 4 million adults globally may experience dementia before age 65. **BY NICK ZAGORSKI**

Though considered a disease of the elderly, dementia can strike younger adults as well (Alois Alzheimer's first patient was a woman who began experiencing memory loss and delusions in her 40s). Yet attention to patients with rare young-onset dementia—typically characterized as dementia before age 65—often pales in comparison to that given to the estimated 45 million adults living with late-onset dementia.

A large meta-analysis conducted by Sebastian Köhler, Ph.D., an associate professor of psychiatry and neuropsychology at Maastricht University in the Netherlands, and colleagues suggests young-onset dementia may be more common than previously estimated. Making use of data from 95 individual studies encompassing 2.7 million adults in more than 30 countries, the researchers calculated a global prevalence rate of 119.0 cases of young-onset dementia per 100,000 people. This figure is more than double that of previous estimates and equates to about 200,000 cases of young-onset dementia in the United States and nearly 4 million globally.

"Although this is higher than previously thought, it is probably an underestimation owing to lack of high-quality data," senior author Köhler and colleagues wrote in *JAMA Neurology*. They noted that data on adults under age 50 were sparse, as were data from low- and middle- income countries.

Age-Adjusted Prevalence of Dementia in Younger Adults

Though relatively small, the number of adults under age 65 with dementia is likely higher than previously thought.

Age	Number of cases
30-34	1.1 per 100K
35-39	1.0 per 100K
40-44	3.8 per 100K
45-49	6.3 per 100K
50-54	10.0 per 100K
55-59	19.2 per 100K
60-64	77.4 per 100K

Source: Stevie Hendriks, M.Sc., et al., *JAMA Neurology,* July 2021

The authors also excluded studies that focused on at-risk population groups like patients with HIV, noted Brian Draper, M.D., a conjoint professor of psychiatry at the University of New South Wales in Australia, who specializes in young-onset dementia. "The bulk of dementia research is related to diseases like Alzheimer's or frontotemporal dementia, but these secondary dementias that arise from other disorders that can impact the brain should not be discounted," he said. Draper has done a lot of work with alcohol-related dementia, which overlaps with Wernicke-Korsakoff syndrome, a condition in which chronic alcohol use leads to vitamin B deficiency and subsequent neurodegeneration.

Draper told *Psychiatric News* that the reduced attention to secondary dementias is not entirely from scientists or physicians. "There has been pushback from patients and advocacy groups for conditions like HIV to avoid associating these disorders with dementia due to stigma," he said. As a result, he said, places like alcohol treatment centers do not often provide dementia screening, which contributes to patients slipping through the cracks.

"From a personal management and clinical care perspective, it's imperative to diagnose young-onset dementia as soon as possible," Draper continued. "By and large, people who develop dementia earlier in life have a faster rate of cognitive decline, yet they live longer with the disease"—a factor that may be due to younger patients having fewer comorbidities at the time of dementia diagnosis.

In an editorial that accompanied Köhler's *JAMA Neurology* article, David Knopman, M.D., a professor of neurology at the Mayo Clinic, wrote: "Young-onset dementia is a particularly disheartening diagnosis because it affects individuals in their prime years, in the midst of their careers, and while raising families," he wrote. "Most dementia care is geared for older patients, and as a consequence, services are rarely available to address the needs of someone diagnosed with dementia in their 50s who has dependent children at home and a spouse who must continue working. Understanding the prevalence and incidence of [young-onset dementia] is a first step in addressing this challenge."

In comments to *Psychiatric News*, Knopman said that the results of the meta-analysis offered an important

see **Young-Onset Dementia** *on page 40*

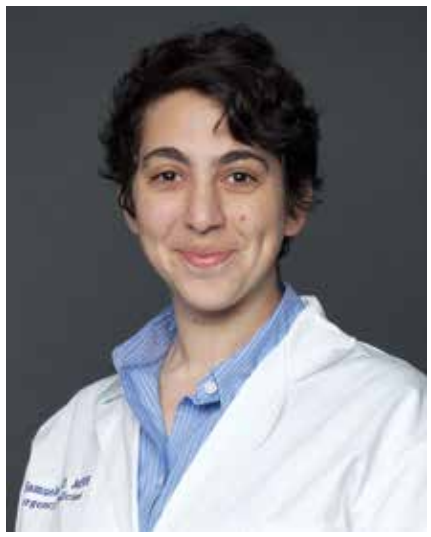
'Muslim Ban' Had Negative Impact on Health Care Use

Emergency department visits rose sharply among patients who were born in countries targeted by the ban. **BY TERRI D'ARRIGO**

Former President Donald J. Trump's 2017 executive order "Protecting the Nation From Foreign Terrorist Entry Into the United States" may have influenced the way people in the United States who were born in Muslim-majority countries used health care services, a study in *JAMA Network Open* suggests. The study found an increase in missed primary care appointments and increased emergency department visits among people in this population living in Minneapolis-St. Paul. The executive order, also known as the "Muslim ban," prevented citizens from Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen from traveling or immigrating to the United States.

Elizabeth A. Samuels, M.D., M.P.H., M.H.S., an assistant professor of emergency medicine at the Alpert Medical School of Brown University in Providence, R.I., and colleagues analyzed data from 252,594 adult patients who were treated at Minneapolis-St. Paul HealthPartners primary care clinics or emergency departments between January 1, 2016, and December 31, 2017. They grouped patients into three categories: those born in countries targeted by the Muslim ban (5,667 patients), those born in Muslim-majority nations not listed in the ban (1,254 patients), and those who were non-Latinx and were born in the United States (245,673 patients).

In the year after Trump issued the ban, there were 101 additional missed primary care appointments among patients from Muslim-majority countries not named in the ban compared with non-Latinx patients born in the United States. There were also 232 additional emergency department visits by patients from countries named in the ban compared with non-Latinx patients born in the United States, with the sharpest increase occurring in the first 30 to 60 days after the ban was issued. Emergency department visits for stress-responsive diagnoses such as acute coronary syndrome, suicidal attempts, and syncope increased among patients from countries named in the ban compared with non-Latinx patients born in the United States.



Brown University

Anti-Muslim and anti-immigration rhetoric during the 2016 U.S. presidential election season may have affected the use of health services by people in the United States who were born in Muslim-majority countries, says Elizabeth A. Samuels, M.D., M.P.H., M.H.S.

The researchers also found that after the beginning of 2016 but before the Muslim ban—campaign season and the election—primary care visits for stress-related conditions had been rising among people in the first two groups, those born in Muslim-majority nations. These primary care visits were for stress-related conditions in six categories: mental health, sleep disorders, gastrointestinal symptoms, neurologic symptoms, food-related disorders, and pain syndromes.

The study's results may reflect a phenomenon already set in motion before Trump was elected, Samuels told *Psychiatric News*.

"As we conducted this analysis, it became more and more apparent that it was difficult to isolate the effects of the 'Muslim ban' as a discrete event from the broader political context," Samuels said. "We think the changes observed are likely related to increasing anti-Muslim and anti-immigrant rhetoric in the public discourse throughout the 2016 election."

Samuels said that there is still a lot of work to be done to identify and understand the needs of different immigrant and refugee groups, including people from Muslim-majority countries.

"We studied a very heterogeneous group of people from different countries who arrived in the U.S. due to a variety of different situations and prior experiences," Samuels said, noting that none of the situations or experiences

see **'Muslim Ban'** *on page 27*

Antidepressants May Lower Heart Attack Risk in Diabetes

Diabetes is known to raise the risk of both depression and heart attack. How might antidepressants address both conditions? **BY TERRI D'ARRIGO**

Patients who have diabetes and depression and take antidepressants for at least six months may have a lower risk of heart attack than those who do not take antidepressants, a study in the *Journal of Affective Disorders* has found.

Alice Chun-Chen Chen, a statistician in the Department of Statistics at National Chengchi University in Taipei, Taiwan, and colleagues analyzed data obtained from the National Health Insurance Research Database (NHIRD) in Taiwan. The researchers focused on 287,350 patients who were at least 50 years old and had at least one inpatient or three outpatient diagnoses of diabetes between 1997 and 2010. Half of the patients took antidepressants and half did not.

The researchers then used data amassed from 2000 to 2013 to compare the risk of heart attack between both groups and found that 2.6% of those in the antidepressant group had been diagnosed with heart attack compared with 3.7% of those in the nonantidepressant group. Furthermore, those who took antidepressants had a 32% lower risk of having a heart attack.

"The results raise the issue of adequate screening for depression and appropriate use of antidepressants among patients with diabetes, especially for those with a high risk of myocardial infarction," Chen told *Psychiatric News*.

Among patients who had taken antidepressants for 180 days or longer, the risk of heart attack was 26% lower in those who took tricyclic antidepressants, 34% lower in those who took selective serotonin reuptake inhibitors (SSRIs), 33% lower in those who took serotonin and norepinephrine reuptake inhibitors (SNRIs), 29% lower in those who took trazodone, and 48% lower in those who took mirtazapine compared with patients who did not take antidepressants. However, patients who took bupropion did not have a lower risk of heart attack than those who did not take antidepressants.

Chen offered several possible reasons why taking antidepressants may lower risk of heart attack in people with diabetes and depression.

"Antidepressants have been suggested to have anti-inflammation effects, and some of them may have anticoagulant effects similar to aspirin," Chen said, noting that this may be particularly true of antidepressants that affect serotonin.

"Antidepressants can also increase compliance with treatment of diabetes in diabetic patients with depression," she added. She explained that depressive symptoms in people with diabetes have been linked to poor medication adherence and poor self-management of diabetes with respect to nutrition, physical activity, foot care, and blood glucose monitoring.

The study's findings bolster those of a previous study by several of the researchers in the October 2019 issue of the *Journal of Clinical Endocrinology and Metabolism*. In that study, the researchers used the NHIRD to analyze data from 53,412 patients who were diagnosed with diabetes and depression, beginning in 2000. Among those patients, 50,532 took antidepressants and 2,880 did not take antidepressants. To compare mortality rates between the two groups, the researchers then followed the patients from the date patients were diagnosed with diabetes until 2013 or until the patients died, whichever came first.

Patients who had taken the highest doses of antidepressants had a 35% lower mortality risk than those who did not take antidepressants. Among patients who had taken antidepressants, mortality risk was 37% lower in those who took SSRIs, 42% lower in those who took SNRIs, 80% lower in those who took norepinephrine-dopamine reuptake inhibitors, 40% lower in those who took mirtazapine, 27% lower in those who took tricyclic/tetracyclic antidepressants, and 48% lower in those who took trazodone compared with those who did not take antidepressants.

National Chengchi University

Antidepressants may have anti-inflammation and anticoagulant effects, says Alice Chen.

The study in the *Journal of Affective Disorders* was supported in part by grants from Cathay General Hospital and the Cathay General Hospital-National Taiwan University Hospital Joint Research Program. The study in the *Journal of Clinical Endocrinology and Metabolism* was supported by Changhua Christian Hospital and Chiayi Chang Gung Hospital, Taiwan. **PN**

"Antidepressants and the Risk of Myocardial Infarction Among Patients With Diabetes: A Population-based Cohort Study" is posted at https://www.sciencedirect.com/science/article/pii/S0165032721006649. "Antidepressants Reduced Risk of Mortality in Patients with Diabetes Mellitus: A Population-based Cohort Study in Taiwan" is posted at https://academic.oup.com/jcem/article/104/10/4619/5526757.

What Do American Indian Boarding Schools a Century Ago Have to Do With Dysregulated Children Today?

This article is part of a series on mental health issues related to Native Americans, Alaska Natives, Native Hawaiians, and Pacific Islanders. **GEORGE "BUD" VANA, M.D., AND DAKOTA LANE, M.D.**

When one of the authors of this article—George "Bud" Vana, M.D.—first started working as a psychiatrist at the Lummi Tribal Health Center, tribal members frequently mentioned boarding schools as one of the causes of mental health problems in the community and often applied it to the behavior problems he was seeing in young children. He had heard of these schools but had never made these connections to modern-day mental health problems.

The other author of this article—Dakotah Lane, M.D., also found that trauma from boarding schools continues to play out generations later in both medical and mental health issues. However, as he was growing up, he heard only silence when he asked his elders about boarding schools.

From the mid-1800s until the 1990s, as many as 100 American Indian residential schools operated in the United States, up to 80 in Canada, and many in Australia. Their purpose, as Richard Pratt, explained in 1892, was to "Kill the Indian, and save the man." Pratt was a former general who founded the first off-reservation residential school for American Indians. In practice, these schools did all that they could to prevent American Indian children from using their tribal language and observing cultural practices, instead using Christian Euro-American practices, ideas, and corporal punishment. In addition, there were reports of rampant physical and sexual abuse.

"Many who survived the ordeal returned home changed in unimaginable ways, and their experiences still resonate across the generations," Deb Haaland, President Joe Biden's secretary of the interior and a member of the Laguna Pueblo tribe, wrote in a memo earlier this year. Many other tribal members see a direct connection between the residential school experience and what has been termed Indigenous Historical Trauma (IHT), or intergenerational trauma among American Indians.

George "Bud" Vana, M.D., is a psychiatrist at the Lummi Tribal Health Center in Bellingham, Wash. He is triple boarded in pediatrics, adult psychiatry, and child and adolescent psychiatry. He helped develop a telehealth infrastructure at the center and a child psychiatry consultation service for other tribal health clinics. Dakotah Lane, M.D., is a member of the Lummi Tribe. As a Peace Corps worker, he was a high school teacher in Malawi, Africa, which led to his interest in becoming a physician. He is now medical director of the Lummi Tribal Health Clinic, where he and his team led a robust public health response against COVID-19.

How does this family and cultural separation and cultural reprogramming at least a generation ago (but sometimes as many as four or five) lead to dysregulated children today? Hillary Weaver, in her book *Trauma and Resilience in the*

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Early Psychosis Intervention Shows Robust Real-World Effectiveness

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Using data from medical registries in Denmark, researchers found that patients who received an intervention for first-episode psychosis had shorter and fewer hospital stays compared with patients who received the intervention in a controlled clinical trial. **BY NICK ZAGORSKI**

Health professionals know that the results of clinical trials—which often involve motivated patients and doctors—don't always translate when applied in real-world settings.

But a real-world test of OPUS, an intervention for people with first-episode psychosis, found it is as effective—and in some cases superior—as researchers had found when the intervention was evaluated in clinical trials.

The findings were a bit surprising to the study team from Copenhagen University Hospital in Denmark. "Early intervention services for psychosis are, by definition, a complex psychosocial intervention, and, once implemented, they may not be delivered with the same rigorous attention to program fidelity, low caseload, motivation … as they had in the controlled environment of a randomized trial," wrote Christine Merrild Posselt, M.Sc., a psychologist at the Copenhagen Research Center for Mental Health, and colleagues.

OPUS, developed at Copenhagen University Hospital, is a modified form of assertive community treatment for psychosis that includes family involvement and social-skills training provided by a multidisciplinary team of psychiatrists, psychologists, nurses, social workers, physiotherapists, and vocational therapists. A clinical trial of 547 adults conducted between 1998 and 2001 demonstrated that OPUS was superior to standard care in reducing psychosis symptoms and substance use and improving functioning. The success of the trial led to the broad implementation of OPUS across Denmark in 2003, as well as making OPUS a model for early psychosis programs in other countries.

For the current study, Posselt and colleagues compared the five-year outcomes of 3,328 patients who had received OPUS between 2003 and 2014 (after the national implementation) with those of 545 of the original clinical trial participants. Data for all patients was obtained from Danish medical registers. This period included two years of OPUS intervention followed by three years of standard care for all patients.

The researchers found that patients receiving OPUS after implementation (known as OPUS-real world) had about 30% lower odds of a psychiatric hospital admission than the clinical trial participants across the five-year time span. Among patients who were hospitalized, OPUS-real world patients had fewer and shorter hospital stays on average than their clinical trial counterparts. The authors noted this difference might be partially attributed to broader policy shifts seen in Denmark aimed at reducing inpatient stays. "However, it is reassuring that the departure from the constraints of a randomized trial, as well as an increase in caseload, has not led to an apparent increase in psychiatric admissions," they wrote.

OPUS-real world and clinical trial patients took similar amounts of antipsychotics and other psychotropics during the first four years of the study, but by year five, real-world patients used fewer medications than the clinical trial participants. Likewise, by year five, the OPUS real-world patients were more likely to be employed and/or attend school and more likely to be in a relationship than the clinical trial participants; the real-world cohort was also less likely to have been diagnosed with a substance use disorder.

There were no differences between the groups in terms of suicide, death due to any cause, non-psychiatric hospital visits, or use of outpatient mental health services.

Posselt and colleagues noted that as with psychiatric admissions data, broader changes in Denmark may have contributed to some of the improvements seen among the OPUS-real world patients; for example, employment services may have improved since 1998. But they also suggested that over time, as clinical staff become more experienced with the intervention, they may have found ways to deliver early psychosis services more efficiently and flexibly, which could improve patient outcomes even as caseloads increase.

This study was funded by the Lundbeck Foundation. **PN**

"The Danish OPUS Early Intervention Services for First-Episode Psychosis: A Phase 4 Prospective Cohort Study With Comparison of Randomized Trial and Real-World Data" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2021.20111596. The original OPUS trial, "A Randomised Multicentre Trial of Integrated Versus Standard Treatment for Patients With a First Episode of Psychotic Illness," is posted at https://www.bmj.com/content/331/7517/602.long.

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Lives of Contemporary Native Americans, summarizes Maria Yellow Horse Braveheart's work describing IHT and enumerates various mechanisms by which researchers have proposed that this process occurs across generations including epigenetics, adverse childhood experiences, and disrupted parenting skills. The Swinomish Tribal Health Center worked with many partners to write the textbook *A Gathering of Wisdoms—Tribal Mental Health: A Cultural Perspective*, which describes an interconnected triad of depression, behavioral acting out, and substance use problems—all of which derived from cultural identity problems. A recent systematic review of IHT by Joseph P. Gone and colleagues in the January 2019 *American Psychologist* shows that these connections are complicated and will benefit from more research.

Dr. Lane has also seen both the trauma and cultural resiliency play out through generations in his own family. His great-grandmother, Dora, refused to speak the Lummi language to her 12 children and spoke only English to help protect them from abuses at boarding schools. She also never gave any of her children traditional Indian names. For the many Pacific Northwest tribes, each Indian name represents a way for their ancestors to protect and guide them as they go through life as well as a way to remember who their ancestors are.

Years later when the threat of boarding schools had receded (1960s), Dr. Lane's grandmother Nancy (one of Dora's children) became concerned that her first-born daughter, who was 16 years old at the time, would not be protected when she would be leaving the reservation for a long trip to Europe. Nancy, who never had an Indian name herself, decided her daughter would need an Indian name and provided her daughter with one to help protect her throughout her trip in Europe.

Today all of Nancy's children and the majority of her grandchildren have Indian names, including Dr. Lane (his name is "Me-Musia"). While the boarding schools clearly achieved some of their objectives by wiping out the Lummi language from the Lane family, the story also serves as a reminder of how powerful cultural traditions can be in healing.

IHT and residential school attendance by distant and close relatives cannot explain all of the dysregulation indigenous children experience, and the boarding schools are not the only governmental injustices committed against tribal communities—that list is long. But a better clinical understanding of the historical cultural wound of the boarding schools has helped both Dr. Lane and Dr. Vana communicate with and be of service to their patients and to understand their individual resilience and their culture's resilience. **PN**

"The Impact of Historical Trauma on Health Outcomes for Indigenous Populations in the USA and Canada: A Systematic Review" is posted at https://doi.apa.org/fulltext/2019-01033-003.html. References appear in the online version of this article at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.10.40.

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was measured directly in the study. "Researchers, health care professionals, and public health workers need to work in collaboration with community-based groups serving these communities to assess and attend to the needs of these populations more fully."

The researchers did not report any study-specific funding for this work. **PN**

"Health Care Utilization Before and After the 'Muslim Ban' Executive Order Among People Born in Muslim-Majority Countries and Living in the US" is posted at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2782563.

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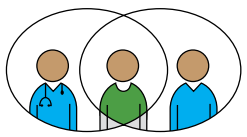
Psychiatry Patients With Long COVID-19 Need Team-Based, Coordinated Care

This article is one of a series coordinated by APA's Council on Consultation-Liaison Psychiatry and the Academy of Consultation-Liaison Psychiatry.

BY SANJEEV SOCKALINGAM, M.D., FARAH TABAJA, M.D., AND KATHLEEN SHEEHAN, M.D., D.PHIL.



Consultation-Liaison
PSYCHIATRY

Since the onset of the COVID-19 pandemic, there has been a significant focus on the psychiatric and neurological complications of SARS-CoV-2 infection. Although recent data suggest that approximately 18% of patients who had a SARS-CoV-2 infection develop a psychiatric diagnosis between 14 and 90 days after infection, long-term data show that approximately 1 in 3 COVID-19 patients experience either a neurologic or psychiatric disorder six months after infection. The postacute sequelae of SARS-CoV-2 are increasingly recognized and include both physical and mental health symptoms, as well as the impact on quality of life and functioning, according to Ani Nalbandian and colleagues in an article posted March 22 in *Nature Medicine*. While those with more severe initial COVID-19 infection may be at higher risk of postacute sequelae, individuals with more mild to moderate initial presentations can also experience prolonged symptoms.

The increasing awareness of long COVID symptoms has significant implications for consultation-liaison psychiatrists working in integrated care models within primary care and specialty settings. The following case summarizes the complexity and the important role of psychiatrists in the assessment, support, and long-term management of long COVID symptoms.

Sanjeev Sockalingam, M.D., is a professor and vice chair of psychiatry education at the University of Toronto and vice president of education at the Centre for Addiction and Mental Health in Toronto. Farah Tabaja, M.D., is the chief resident in psychiatry at the Institute of Living/Hartford Hospital and a first-year APA/APAF Diversity Leadership fellow. Kathleen Sheehan, M.D., D.Phil., is an assistant professor of psychiatry at the University of Toronto and clinician-investigator at the University Health Network in Toronto.

Case Study

Ms R was a 30-year-old teacher with a history of major depressive disorder that had been in remission for the past three years. She was referred to outpatient psychiatry by a local COVID-19 recovery clinic. Ms R was infected with COVID-19 three months prior to the referral and had moderate flulike symptoms and did not require hospitalization. Ms R reported that she never fully recovered following her acute illness and continued to have lingering symptoms of extreme fatigue, muscle aches, palpitations, and shortness of breath on exertion. Because of her protracted symptoms, multiple referrals had been made including pulmonology, cardiology, neurology, physiatry, and behavioral health.

On evaluation via telemedicine, she described functioning poorly and being mostly homebound since her infection and unable to return to work. Her psychiatric symptoms of low mood, anhedonia, poor concentration, low motivation, psychomotor retardation, poor appetite, and sleep disturbances were consistent with a relapse of major depressive disorder. Ms R also described significant cognitive symptoms including inability to focus, forgetfulness, headaches, and feeling "out of it." She did not report any drug or alcohol use and was not taking any psychotropic medications at the time of evaluation.

After initial evaluation, Ms R was started on a selective serotonin reuptake inhibitor to target her depressive symptoms, and this was titrated to a therapeutic dose. Psychotherapy and physical therapy were also recommended. She continued to follow up with the different specialists, and extensive workup by the cardiology, neurology, and pulmonology services was unremarkable. Over the next several months, Ms R showed slow but steady improvement in mood and overall functioning. With the help of intensive physical therapy, Ms R's exercise tolerance improved, and she was able to resume most of her daily activities. She continued to follow up regularly with outpatient psychiatry for ongoing support.

Psychiatry's Role in Long COVID Care

Recently published guidelines and literature highlight the importance of a patient-centered approach to care for those with long COVID, according to Robin Gorna and colleagues in the February 6 *Lancet* and Alice Norton and colleagues in the May 1 *Lancet*. This includes assessment of psychological and psychiatric symptoms, connection with appropriate community resources for mood and anxiety issues, and involvement of C-L psychiatric services for more complex presentations with co-occurrence of both mental and physical health symptoms.

Numerous mental health symptoms are associated with long COVID-19, and our understanding is evolving as we learn more about this condition. These include depression, heightened anxiety, fatigue, poor concentration, and insomnia. While some of these may be related to direct neurological impacts of the SARS-CoV-2 infection, others may be more related to the stress and isolation associated with the pandemic and having prolonged, severe illness. Attempting to parse which symptoms are "organic" and which are "psychiatric" risks further siloing and separation of physical and mental health. Instead, it is important to take an integrated and holistic approach to supporting patients with these issues, using our full repertoire of appropriate biopsychosocial interventions.

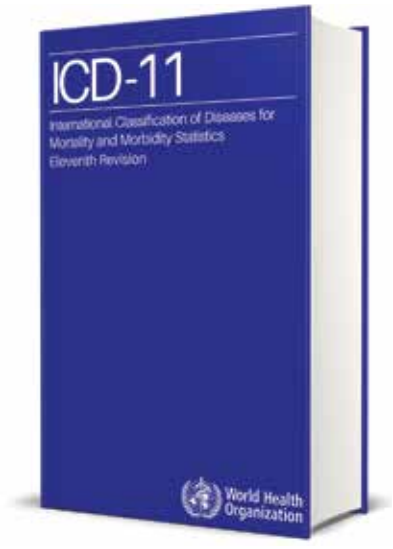
Because of the long-term functional impairment and complexity of long COVID-19 symptoms, patients with these persistent symptoms require a team-based approach with clear care coordination and planning, outlining interprofessional team members' roles and responsibilities. Psychiatrists and mental health clinicians need to work collaboratively with patients, primary care professionals, specialists, and other health care professionals to ensure that care is integrated and focused on rehabilitation and functioning. **PN**

"Post-Acute COVID-19 Syndrome" is posted at https://www.nature.com/articles/s41591-021-01283-z. "Long COVID Guidelines Need to Reflect Lived Experience" is posted at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32705-7/fulltext. "Long COVID: Tackling a Multifaceted Condition Requires a Multidisciplinary Approach" is posted at https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00043-8/fulltext.

Dimensional Model of Personality Disorder Incorporated Into ICD-11

The field of personality disorders is moving inexorably toward more dimensional conceptualizations of personality pathology, but clinicians need to be on board for this important shift to finally take hold.

BY ANDREW E. SKODOL, M.D.



More than four decades after first being proposed for *DSM* by Allen Frances, M.D., a dimensional model for personality disorder assessment and diagnosis will become part of an official classification of mental disorders—the International Classification of Mental Disorders, 11th Revision (ICD-11), when it becomes official in 2022.

A hybrid dimensional-categorical model of personality pathology was developed for *DSM-5,* called the Alternative *DSM-5* Model for Personality Disorders (AMPD), but it was placed in Section III of *DSM-5*. The *DSM-IV* chapter on personality disorders was left unchanged in Section II of *DSM-5*.

In this article, I will introduce readers to the new ICD-11 model and compare it with the AMPD. There are striking similarities, but also some critical differences. I will also briefly review the uneven empirical bases for each model. Finally, see the end of this article for links to papers that illustrate how each model is likely to be applied to patients who might have a personality disorder or have at least some clinically relevant personality problems.

Although the ICD-11 model is described as dimensional, it is in reality a hybrid dimensional-categorical model with some resemblance to the AMPD. By a dimensional-categorical hybrid, I mean that patients are evaluated on a dimensional scale, but categorical judgments are made by the application of diagnostic thresholds akin to how hypertension is defined by cut points on scales of systolic and diastolic blood pressures. For the ICD-11, there is a scale of the severity of personality pathology that ranges from "personality difficulty" to "mild," "moderate," and "severe" personality disorder, which represent the only personality disorder "diagnoses" in the system. The designation of "personality difficulty" (subthreshold for a personality disorder), as well as the three levels of personality disorder, can all be amplified by these trait specifiers: negative affectivity, detachment, dissociality, disinhibition, or anankastia. A categorical "borderline pattern specifier" is also available, but no other diagnostic subtypes of personality disorder are included in the ICD-11 model.

The *DSM-5* AMPD was developed nearly 10 years before the ICD-11 model, although it was not in final form until 2012. Because severity of personality pathology has been widely recognized as its most important aspect, associated with concurrent impairment and predicting many future negative outcomes, the AMPD has at its core the Dimensional Level of Personality Functioning Scale (LPFS). Impairment in self (identity, self-direction) and interpersonal functioning (empathy, intimacy) is rated on a 5-point scale from 0 (little or no impairment) through 4 (extreme impairment). A score of 2, or moderate impairment, indicates the presence of a personality disorder, based on a sample of 337 patients, with maximum sensitivity and specificity.

The AMPD also includes a five-domain, 25-facet pathological personality trait rating system to describe the myriad stylistic ways personality pathology may be expressed. AMPD definitions of negative affectivity, detachment, and disinhibition are equivalent to their ICD-11 counterparts. ICD-11 dissociality mirrors AMPD antagonism, and a domain of psychoticism is included in the AMPD to capture schizotypal personality disorder, which is not classified as a personality disorder in the ICD. Anankastic traits (that is, compulsivity) in the ICD-11 model are conceptualized as low disinhibition in the AMPD. Two critical differences between the two approaches to personality traits are that ICD-11 describes personality only at the broad five-domain level, while the AMPD has a more fine-grained, 25-trait facet method. Also, whether rated by clinical interview or assessed using the self-report Personality Inventory for *DSM-5* (PID-5), traits in the AMPD model are measured dimensionally according to the degree that each describes the patient, while the ICD-11 trait modifiers are essentially categories that either describe the patient or do not.

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Another major difference between the two systems is that the AMPD retains six specific personality disorders for which empirical support or clinical utility was deemed sufficient: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal. ICD-11 has only the borderline pattern specifier, which was added to the model reluctantly by its creators after strong negative feedback from some professional quarters. The six personality disorders in the AMPD are defined by criteria including disorder-specific impairments in personality functioning ("A criteria") and selected personality trait facets ("B criteria") that were found empirically to be most correlated with the *DSM-IV* personality disorders they were intended to replace. Diagnostic algorithms for each personality disorder also were determined to maximize correspondence with *DSM-IV* personality disorders, minimize co-occurrence with other personality disorders, and maximize relationships to functional impairment. If a pattern of personality pathology does not correspond to one of the six personality disorders prototypes, a diagnosis of PD-trait specified (PD-TS) may be assigned. The ICD-11 borderline pattern is defined by the nine *DSM-IV* borderline criteria with a threshold for diagnosis of five, as in *DSM-5* Section II.

There is evidence to support the validity of hybrid models of personality pathology in that both indicators of disorder and personality traits have been shown to increment each other in predicting important outcomes. Personality experts preferred an unspecified hybrid model over either purely dimensional or categorical models as a replacement for *DSM-IV* in 2007. In 2019, a repeat survey of experts continued to prefer a hybrid model, this time the AMPD. Since the publication of *DSM-5* in 2013, the AMPD has been widely embraced by large segments of the academic personality field in countries around the world.

A comprehensive review of the research literature published in 2019 found 237 research publications on the AMPD and concluded that the AMPD severity ratings and maladaptive traits had acceptable interrater reliability, high internal consistency and consistent latent structures, substantial convergence with a broad range of clinically relevant indicators, and some evidence of incremental validity over existing PD categories.

Few studies have addressed the ICD-11 model, and many of these are based on archival data and use earlier iterations of the model. As a consequence, the ICD-11 developers have had to rely on data based on the AMPD and the well-established five-factor model of personality, with large unfilled gaps in knowledge about the actual final ICD-11 model. For example, the final ICD-11 personality severity measure has not been the subject of any reliability studies, despite its complex format, which combines 15 to 20 personality disorder features into the rating, and research on the five ICD-11 trait domain definitions has been inconclusive in confirming the proposed five-domain structure.

Although these dimensional-categorical models (especially the AMPD) have spurred much new research on personality pathology, they are intended to replace the flawed categorical approaches of *DSM-IV/DSM-5* Section II and the ICD-10 for clinical purposes. Both models have been rated as having greater clinical utility than the standard approaches to describing, communicating about, and treating patients for personality pathology. The AMPD has been shown to predict important clinical needs and outcomes, such as impaired functioning; risks for self-harm, violence, and criminality; optimum treatment intensity; and prognosis.

The personality field is moving (as is most of psychopathology) inexorably toward more dimensional conceptualizations of personality pathology, but clinicians need to be on board for this important shift to finally take hold. **PN**

To learn more about the application of the ICD-11 and AMPD models in everyday practice, see the following articles: "Application of the ICD-11 Classification of Personality Disorders," posted at https://bmcpsychiatry.biomedcentral.com/track/pdf/10.1186/s12888-018-1908-3.pdf; "Clinical Utility of the *DSM-5* Alternative Model for Personality Disorders: Six Cases From Practice," posted at https://journals.lww.com/practicalpsychiatry/Abstract/2015/01000/Clinical_Utility_of_the_DSM_5_Alternative_Model_of.2.aspx; and "The Alternative *DSM-5* Model for Personality Disorders: A Clinical Application," posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2015.14101220.

Lifeline Mobile

Mobile clinics in the INTEGRA study will be staffed by health professionals and peer navigators and offer primary care services as well as comprehensive services for treating patients with OUD and preventing and treating HIV.

Five Cities Launch Mobile Health Units For Treatment of OUD, HIV Patients

The INTEGRA study will compare the feasibility, impact, and cost-effectiveness of delivering care via mobile health units compared with referring patients to community-based agencies. ***BY TERRI D'ARRIGO***

Substance use disorders (SUDs) that involve injection drugs carry a high risk of infection with human immunodeficiency virus (HIV). According to the Centers for Disease Control and Prevention, nearly 1 in 10 new HIV diagnoses in the United States is at least partly attributable to the use of illicit injection drugs, and sharing needles is the second riskiest behavior for being infected with HIV. Yet many people who need treatment for either SUD, HIV, or both face multiple barriers to care such as a lack of health insurance, a lack of transportation, and homelessness.

This summer five cities launched one-stop mobile clinics to address the needs of this vulnerable population as part of INTEGRA, a study funded by the National Institute on Drug Abuse and sponsored by the National Institute of Allergy and Infectious Diseases. The mobile clinics, brightly colored RVs staffed by health care professionals and peer navigators, will offer integrated health services to patients in Houston, Los Angeles, New York City (the Bronx), Philadelphia, and Washington, D.C., with opioid use disorder (OUD) who inject drugs.

"The benefit to having a mobile unit is that you can move services to where the people are and go home at the end of the day, as opposed to making people go to where the services are, where they may congregate and local businesses and neighborhood groups may feel they are a problem," INTEGRA protocol chair Steven Shoptaw, Ph.D., told *Psychiatric News*. Shoptaw is the director of the Center for Behavioral and Addiction Medicine at the University of California, Los Angeles.

The study aims to enroll 860 people who will be randomly assigned to one of two groups, the control group or the treatment group, for 26 weeks.

Patients in the control group will receive peer navigation to connect them to health services available at community-based agencies. The agencies offer services such as harm reduction; testing for COVID-19; and testing for HIV, sexually transmitted infections, and hepatitis A, B, and C. However, many of these agencies are located in downtown and commercial areas that may be difficult for people with limited transportation options to access.

The treatment group, via the mobile clinics, will be offered the same services available at community agencies, but with the addition of medication treatment with buprenorphine for OUD, naloxone, syringe services where available, pre-exposure prophylaxis (PrEP) for HIV prevention, antiretroviral ther-

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VIEWPOINTS

We Need to Find Right Balance Between Telehealth, In-Person Care

BY ALAN ROSEN, A.O., M.B.B.S.

Many community-based mental health practitioners have welcomed the focus on telehealth in response to the COVID-19 pandemic by governments around the world, yet there has been little or no focus on enhancing face-to-face and home-visiting services when needed, with appropriate safety precautions.

In a recent article in *Psychiatric News*, James Shore, M.D., and Peter Yellowlees, M.D., correctly noted that the much wider psychiatric use of telehealth in response to the COVID-19 pandemic has been transformative (https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.5.30). We need to ensure, however, that this transformation doesn't also overextend to replacing in-person care almost completely with telepsychiatry for mental health assessments; reviews; and crisis and disaster interventions, especially in community, regional, rural, remote, indigenous, and forensic settings, as detailed in an international review published in the July 20, 2020, *Current Opinion in Psychiatry* by me and my colleagues, Luis Salvador-Carulla and Gill Neeraj.

Alan Rosen, A.O., M.B.B.S., is a fellow of the Royal Australian and New Zealand College of Psychiatrists and is affiliated with the Brain & Mind Centre at the University of Sydney. He is also a Professorial Fellow at the Australian Health Services Research Institute, University of Wollongong, New South Wales. He is also chair of Transforming Australia's Mental Health Service System. He has led and researched integrated community and university hospital mental health services in Sydney and has served Aboriginal communities in the remote outback of New South Wales for more than 35 years, as an early adopter of telehealth enhanced practice and teaching.

The needs of people with moderate to severe mental illness were often poorly served prior to the pandemic. This represents a pre-existing crisis as the mental health systems in many countries were already broken, depleted, or under extreme strain. In addition, many people living with mental illness and psychosocial disabilities were already existing on the margins of society, and so they have been extremely vulnerable to the pandemic and its associated economic recessions and high levels of unemployment. Many are isolated, homeless, and at risk for suicide, and others may be living at close quarters with families who are critically in need of support themselves.

In the shock of the initial phases of the pandemic, public, private, and many non-governmental organizations (NGOs) that provide mental health services saw a sharp drop in face-to-face care and a withdrawal from home-based and assertive outreach modes of providing such care, just when it was greatly needed for a wider range of people who were more isolated than ever. In part, this was related to justifiable concerns about patient and staff safety, often including deficiencies of personal protective equipment, explicit procedures and training for safe home visiting, and community transport of patients and their caretakers.

While many clinicians have put their own health at risk to care for their patients, others have shown poor leadership. Some senior clinicians, even those not in designated vulnerable health or age categories, have withdrawn

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apy for HIV treatment, and primary care services. Mobile clinics will be placed in residential areas determined to be accessible for those affected by HIV and those who inject opioids.

"We wanted to provide simple interventions—primary care, testing, treatment, medications, and referrals to psychiatrists and other mental health professionals. We wanted to have everything Beny Primm said patients should have," Shoptaw said, referring to the late Beny Primm, M.D., a physician who started several of New York City's first methadone clinics. He later rose to prominence for his expertise in addiction treatment and HIV/AIDS and served in the presidential administrations of Ronald Reagan and George H. W. Bush.

At weeks 26 and 52, the researchers will evaluate both groups' use of medications for OUD; rates of viral suppression among participants with HIV; use of PrEP among HIV-negative participants; use of opioids and other substances based on participant self-report and urine screenings; drug overdose events; and new diagnoses of HIV, COVID-19, hepatitis C, and sexually transmitted infections. They will also analyze the cost-effectiveness of delivering care through mobile clinics compared with community-based agencies. The researchers hope to have results from the study in 2025. **PN**

Details of the study are posted at https://clinicaltrials.gov/ct2/show/NCT04804072. "HIV and Injection Drug Use" is posted at https://www.cdc.gov/hiv/basics/hiv-transmission/injection-drug-use.html.

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Lyme Disease Increases Risk For Mental Illness

Lyme disease, an infection caused by the bite of a tick, significantly raises the risk of mental illness, particularly affective disorders, and suicidality. **BY LINDA M. RICHMOND**

For Colleen Eve Fischer Hoffman, her symptoms started with debilitating fatigue. She began falling asleep at work and in class, and some days she was so tired she couldn't drive. She began experiencing leg pain and numbness in her hands. Her primary care physician ordered a battery of tests, even a sleep study, yet no answers were found.

After years of symptoms, Hoffman said one night she reached "rock bottom" and began to explore ways of taking her own life, she told *Psychiatric News*. Instead, she reached out to a therapist friend who saw her immediately and helped redirect her to a new game plan. Eventually she was diagnosed with Lyme disease, began seeing an infectious disease specialist, and found treatment.

Hoffman may not be alone in her experience: A study published July 28 in *AJP in Advance* found that patients who suffered severe Lyme disease infection were 28% more likely to develop subsequent mental disorders—and twice as likely to attempt suicide—than those without the vector-borne disease. The analysis also revealed such patients also had a 42% higher rate of affective disorders and a 75% higher rate of death by suicide. "Notably, the rate for affective disorders was highest during the first year after diagnosis and highest for completed suicide during the first three years after diagnosis," authors wrote.

"Clinicians should include Lyme disease in the differential diagnosis of individuals with a psychiatric disorder associated with multi-system symptoms," study author Brian A. Fallon, M.D., M.P.H., director of the Center for Neuroinflammatory Disorders and Biobehavioral Medicine at Columbia University, told *Psychiatric News*. "Sometimes mental health professionals are the first to consider Lyme disease, and that attentiveness can lead to diagnosis and appropriate antibiotic therapy."

For the study, researchers analyzed 22 years of medical records for the nearly 7 million people living in Denmark; it is believed to be the first large population-based analysis examining the relationship between Lyme disease and psychiatric outcomes. About 12,600 individuals had received a hospital-based diagnosis.

"Our results are not surprising, given that individuals with hospital-based diagnoses of serious infections are known to have an increased risk of subsequent affective disorders and suicide," Fallon said. The study results may not

see **Lyme Disease** *on page 32*

to work only digitally from their homes and offices. Severe losses of in-person crisis backup by mental health clinicians has been experienced by NGO community support workers. In addition, telehealth is still too expensive and inaccessible for many vulnerable or marginalized people, and many still lack the connection costs, skills, hardware, or privacy to use digital devices to benefit from telehealth services.

We can no longer put off prioritizing care for people with moderate to severe, persistent, and complex mental illnesses and suicidality, whose numbers will only continue to swell as further climate-related domino adversities unfold. We need to find an optimal balance between digital and face-to-face and outreach services for these patients. A call to action to this effect was directed to the Australian federal government in mid-2020, co-signed by many leading psychiatrists, other clinicians, and academics, including practitioners who provide both in-person and telehealth services.

There are increasing numbers of published studies on telehealth systems used in recent disasters, but they are predominantly descriptive. They tacitly or explicitly encourage public mental health teams to "pivot" (in contemporary management jargon) almost completely to telehealth provided by hospitals and clinics, without providing rigorously controlled evidence of telehealth's comparative or equivalent effectiveness. Telehealth suits some clientele but not others, and some expert U.S. "hybrid" (combined telehealth and in-person care) clinicians suspect that such "pivoting" solely to telehealth consultations can often be much more safe, convenient, and lucrative for practitioners than it is effective for many of the individuals and families who need to be served.

One key solution is to deploy more evidence-based assertive mobile community-based mental health teams integrated with and augmented by telepsychiatry services. However, we need an optimal and adjustable "hybrid" mix of both face-to-face and digital services and to encourage the use of digitally enhanced in-person and home outreach services in all regions.

The legacy of lessons from previous disasters and the likely exponentially increasing demand for mental health services due to climate change crises suggest that we need to develop and stabilize this balance for the future, making these arrangements more equitable and ongoing. Government responses to addressing the continuing mental health impacts of trauma and prolonged economic consequences of environmental disasters need to be sustained on an ongoing basis, not for just a few months at a time. These problems may ultimately affect not only those with the greatest disabilities and socioeconomic disadvantages, but ultimately all of us.

Ample subsidies for adequate digital equipment, network access, and training to use digitally enhanced services must be made available to patients and their families who need them. Service managements must ensure the availability of personal protective and other safety equipment and procedures and pastoral support for patients, health care personnel, and support workers.

Both during and beyond this pandemic, we must call on all governments and mental health service systems to ensure that an optimal range and balance of telehealth, person-to-person, and mobile outreach community services, including inpatient care and residential alternatives to hospitals, are accessible to all populations in need. **PN**

"The Future of Community Psychiatry and Community Mental Health Services" is posted at https://journals.lww.com/co-psychiatry/Abstract/2020/07000/The_future_of_community_psychiatry_and_community.13.aspx. Other references for this article are posted in its online version at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.10.8.

CLIMATE CHANGE & MENTAL HEALTH

The Ministry for the Future: Climate Change and the Human Psyche

BY MICHAEL A. KALM, M.D.

Michael A. Kalm, M.D., is a clinical assistant professor of psychiatry at the University of Utah and past president of the Utah Psychiatric Association. He maintains a private psychiatric practice and has provided demonstration psychotherapy to University of Utah residents for 30 years.

"You can't change human nature." We psychiatrists know that thanks to the complexity of human nature, we don't have to change it. We just have to strengthen human nature's better aspects.

Kim Stanley Robinson's magnificent book *The Ministry for the Future* begins starkly in the very near future with a catastrophic heat wave in India, leaving 20 million dead. The novel highlights the UN's Ministry for the Future, which is dedicated to the health of future generations.

In a story that spans several decades, we are exposed to the struggles that we all must inevitably face. The process presents myriad economic, sociopolitical, environmental, and geoengineering solutions, all of which are feasible and which humanity ultimately adopts. It is ultimately an optimistic novel that unflinchingly presents unimaginable suffering and trauma, with enormous mental health implications.

The novel depicts the potential human responses to crisis and trauma: severe responses to extreme disasters; despair and disengagement in response to overwhelmingly complex challenges; and robust and resilient recovery of stability as communities and societies develop effective solutions to these crises.

The horrific opening event has the immediate response of posttraumatic stress disorder (PTSD) associated with trauma and survivor guilt and profound rage with a desire for revenge. Robinson has his main character describe PTSD—"Mary, empathizing with others and tapping her chest, says, 'Eight billion people, all stuffed in here. No wonder it feels so crowded. All smashed into one big mass. The everything feeling.'"

Robinson also has Mary experiencing Stockholm syndrome. Frank, another main character, initially kidnaps and terrorizes Mary, but eventually they become friends and mutual caretakers. He galvanizes her to act on key issues, vital for her success as director of the Ministry.

Robinson explores rage and the need for revenge as a common reaction to devastation and trauma. He notes how rage can provide energy to take corrective action to repair and restore homeostasis. Thus, India's government acts unilaterally to cool the Earth by altering the atmosphere. This action, opposed by many other nations, is an example of what family systems pioneer Murray Bowen called "self-differentiation." In sick family systems (whether families of individuals or our collective "family" of nations), one member of the family goes through "self-differentiation" and refuses to maintain assigned roles in the family script. When the individual makes and sustains such disruptive change, other family members eventually find the courage to change. In Robinson's compelling tale, India maintains its stance against international opposition until other countries follow suit.

Robinson also explores deeper rage in the emergence of extremist groups that channel their rage into catalyzing constructive, transformative activities, such as repeated sabotage of persistently inefficient and harmful energy and transportation systems, ultimately leading to positive global changes in those industries.

As we are confronted with the immediacy and overwhelming challenges of the climate crisis, we risk falling into despair, demoralization, and dissociation. This derives not only from facing loss and trauma from lived experiences, but also the anticipation of such experiences, so-called pretraumatic stress disorder. Such despair appears throughout the book, especially in the conditions and experiences of the inhabitants of the many refugee camps for people from uninhabitable areas of the world. When political and other influential leaders deny or disavow the reality of climate change, usually to further their own ends, they increase the sense of hopelessness in many people.

The callousness of the powerful, a pathological narcissism, is described by Robinson: "The Götterdämmerung Syndrome, as with most violent pathologies, is more often seen in men than women. It is often interpreted as an example of narcissistic rage. Those who feel it are usually privileged and entitled, and they become extremely angry when their privileges and sense of entitlement are taken away. If their choice gets reduced to admitting they are in error or destroying the world, … the obvious choice for them is to destroy the world; for they cannot admit they have ever erred."

The pathological narcissism of white supremacy exploded in its fury at the U.S. Capitol on January 6. This was not a new phenomenon. Heather McGhee, in her book *The Sum of Us: What Racism Costs All of Us*, describes self-defeating public policies targeted at Black people but led to hurting Whites as well.

Ultimately, structural racism, income inequality, and other social determinants of health are key barriers preventing meaningful action on climate change. Environmental justice factors are potent and ubiquitous, contributing greatly to the despair and disengagement of many members of our communities and nations.

It is encouraging that Robinson's book goes on to describe in compelling detail the robust resurgence of social and mental health functioning and hope as positive solutions to the crisis are developed and implemented. These solutions emerge over time and range from the geoengineering efforts to stabilize melting glaciers, to the stabilizing economic tactic of the creation of the "carbon coin" as a way to reinforce decarbonization on a global scale, to developing humane solutions of mass migration issues.

These events occur in the context of what appears to be a cross-cultural acceptance of the Inuit philosophy of "facing up to Nartsuk," which is laughing at whatever the world throws at you, and a conscious decision to "change everything." In the book, as racial, social, and economic justice increase, allowing most people to feel part of their community, a sense of togetherness emerges that allows for feelings of empowerment and community action and a growing belief in the positivity of small and large steps to deal with meaninglessness, pessimism, and cynicism. The success of such collective efforts not only lifts the spirits of all involved, it also raises optimistic expectations for future efforts of this kind. Robinson deems it achieving a state of grace, the effect of being truly present.

Now is the time for us to care for and rescue future generations. My Jewish heritage instilled in me the concept of "Tikkun Olam," or the obligation to repair the world. Robinson and now the Biden administration provide the blueprint. It is up to all of us, especially psychiatrists, to use our skills and knowledge about the human psyche to help people move from fear and inaction to hope, positive incremental decisions, corrective actions, and a sense of community that leads us all into a healthy, livable future. **PN**

Lyme Disease

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be generalizable to potentially less severe cases of Lyme disease that were handled outside the hospital.

In the United States, the Centers for Disease Control and Prevention estimates that nearly half a million people a year are treated for Lyme disease (also known as Lyme borreliosis), which makes it the most common vector-borne disease. Due to climate change, the areas where Lyme disease is common are expanding.

Despite the link between Lyme disease and mental disorders, the absolute population risk is low: just under 7% of patients in the Denmark study diagnosed with Lyme in the hospital went on to develop new onset mental disorders requiring hospital contact, amounting to 831 patients.

"These absolute numbers would be larger if it had been possible to include in the analysis mental health issues not requiring hospital contact," Michael Eriksen Benros, M.D., Ph.D., head of research and a professor of immuno-psychiatry at the Copenhagen Research Centre for Mental Health in Denmark, told *Psychiatric News*.

According to the Global Lyme Alliance (GLA), which funded the study, Lyme disease cases in Europe are caused by *Borrelia garinii* and *Borrelia afzelii*. However, the *Borrelia burgdorferi* strain that dominates in North America is associated with greater inflammation, so it may be possible that the risk of mental disorders and suicidality is greater in the United States than that observed in Denmark, according to the GLA.

As for Hoffman, she is now doing better. She credits her psychotherapist, in part, with her recovery. "It's been a long haul," she said. "What really helped me was talking about it with people who got me."

The study was funded by GLA and an unrestricted grant from the Lundbeck Foundation. **PN**

"Lyme Borreliosis and Associations With Mental Disorders and Suicidal Behavior: A Nationwide Danish Cohort Study" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2021.20091347. The statement from the Global Lyme Alliance is posted at https://www.globallymealliance.org/blog/lyme-disease-and-mental-disorders-its-all-in-your-head-and-now-in-a-study.

JOURNAL DIGEST

BY NICK ZAGORSKI

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Two-Hour Class Helps Participants Manage Pain-Related Emotions

Adults with low back pain who received a single pain management class showed similar improvements in their emotional and cognitive responses to pain as those who participated in eight sessions of cognitive-behavioral therapy (CBT), a study in *JAMA Network Open* has found. The two-hour class, called Empowered Relief, is based on CBT principles and incorporates pain education, self-regulation skills, and mindfulness techniques.

Researchers at Stanford University and colleagues randomized 263 adults who had been experiencing chronic low back pain for more than five years to one of three treatments: Empowered Relief, a two-hour back pain health education class (content included warning signs of back pain, when to speak with a physician, and general nutrition), or eight two-hour sessions of CBT for pain. The participants were evaluated using the Pain Catastrophizing Scale—which assesses the frequency of various cognitive or emotional responses to pain—and other pain measures at baseline and three months after treatment.

After three months, pain catastrophizing scores significantly improved in participants in the Empowered Relief and CBT groups; average Pain Catastrophizing Scale scores dropped by 10.94 points for CBT and 9.12 for Empowered Relief—improvements that the authors noted were comparable. Empowered Relief was also comparable to CBT in terms of reducing pain intensity, sleep disturbances, depression, and anxiety. Empowered Relief was inferior to CBT at improving participants' physical functioning.

"[E]mpowered Relief is not meant to replace the longer-course CBT, which offers extended therapist contact, peer support, and didactic content (e.g., functional goal setting and mood management)," the researchers wrote. "Rather, a range of behavioral treatment options is needed to meet the diverse needs and wants of patients."

Darnall BD, Roy A, Chen AL, et al. Comparison of a Single-Session Pain Management Skills Intervention With a Single-Session Health Education Intervention and 8 Sessions of Cognitive Behavioral Therapy in Adults With Chronic Low Back Pain: A Randomized Clinical Trial. *JAMA Netw Open.* 2021; 04(8): e2113401. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783047

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Side Effect Burden Predicts Response To Antidepressants

The burden of antidepressant side effects as early as four days into treatment may predict how effective the treatment will be at reducing depressive symptoms, a study in *Translational Psychiatry* has found.

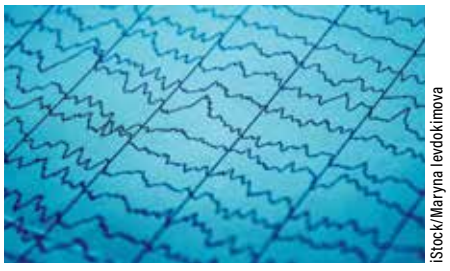
Researchers at the University of Sydney and colleagues analyzed data from more than 1,000 adults with depression who participated in the international Study to Predict Optimized Treatment for Depression. This study was designed to look for biomarkers of treatment response to escitalopram, sertraline, and extended-release venlafaxine. Among numerous measures, participants filled out the Frequency, Intensity, and Burden of Side Effects Rating (FIBSER) scale at Day 4 as well as two, four, and six weeks after starting treatment.

The researchers found that the frequency, intensity, and burden of side effects all increased over the first two weeks of treatment; side effect frequency and intensity began to decline over the next four weeks while burden level remained stable.

At each time point, higher scores for side effect burden were associated with lower odds of depression remission, defined as a score of 5 or less on the 16-item Quick Inventory of Depressive Symptomatology–Self-Rated (QIDS-SR16). High side effect burden was also associated with reduced odds of antidepressant response (50% or greater decrease in QIDS-SR16 scores) at all points except week 4. A greater intensity of side effects at week 2 was also associated with poorer remission.

"Given that burden of side effects not only predicted poorer treatment outcome but also failed to decrease throughout the course of treatment, a specific focus for future research should also be into the impacts of side effects causing enduring versus transient burden," the researchers wrote.

Braund TA, Tillman G, Palmer DM, et al. Antidepressant Side Effects and Their Impact on Treatment Outcome in People With Major Depressive Disorder: An iSPOT-D Report. *Transl Psychiatry*. 2021; 11(1): 417. https://www.nature.com/articles/s41398-021-01533-1



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Brexanolone Shifts Neural Rhythms In Basolateral Amygdala

Brexanolone—approved by the Food and Drug Administration to treat postpartum depression—is known to act on GABA-A receptors, but scientists do not fully understand how the medication exerts persistent antidepressant effects. A study by researchers at Tufts University School of Medicine and colleagues provides evidence that brexanolone and related neurosteroids operate by modifying neuronal activity in the basolateral amygdala, a region known to be involved in emotional processing.

These findings were published in *Biological Psychiatry*.

The investigators first used electroencephalography (EEG) to monitor brainwaves in people administered oral samples of brexanolone (22 mg or 55 mg) or placebo. The researchers found that the people administered brexanolone had elevated frequencies of several brainwaves compared with those given a placebo. Follow-up studies in rodents using a brexanolone analog called SGE-516 produced similar results, and the researchers were able to pinpoint the brainwave changes to the basolateral amygdala.

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APA'S GOVERNMENT, POLICY, AND ADVOCACY UPDATE

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ternal mortality and morbidity, particularly among minority and ethnic populations; substance use disorders/drug policy; and Medicaid in the U.S. territories.

"Given the exacerbation of MH/SUD conditions during the COVID-19 pandemic, it is urgent that the House move these bills to the floor for passage expeditiously to ensure that Americans receive access to vital MH/SUD treatment," Saul Levin, M.D., M.P.A., APA's CEO and medical director, wrote in a letter to House leaders urging movement on the bills.

APA Asks Congress to Boost GME Funding

APA is pushing for more graduate medical education (GME) training positions supported by Medicare in the budget reconciliation package.

As a member of the GME Advocacy Coalition, APA urged congressional leaders to pass the APA-endorsed Resident Physician Shortage Reduction Act of 2021 (HR 2256/S 834) to promote a more robust and diverse physician workforce. The bill would provide 14,000 new Medicare-supported GME positions targeted for rural teaching hospitals, hospitals in health professional shortage areas, and other critical need areas. The legislation would also commission a study of ways to create a more diverse clinical workforce.

In a letter to House leaders, the coalition urged leaders to "build upon last year's historic investment in the health care workforce." In the FY 2021 spending bill, Congress provided 1,000 new Medicare-supported GME positions. The United States will face a shortage of 124,000 physicians by 2034, which will likely be exacerbated by early retirement due to the COVID-19 pandemic, according to the letter.

Federal Government Invests $19 Million in Telehealth Services

The Biden administration is investing more than $19 million in telehealth services for rural and underserved communities.

As part of the effort, $3.9 million will be directed to help health networks increase access to telehealth services in primary, acute, and behavioral health care and to assess their effectiveness; $4.3 million will be directed to building telementoring programs and providing training and support for primary care providers to treat complex conditions, including substance use disorder.

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To confirm this region was important, the investigators injected SGE-516 into the basolateral amygdala of mice who exhibited anxious behaviors due to induced stress and found that the animals' symptoms improved. They were also able to mimic the anti-anxiety effects of SGE-516 by stimulating the basolateral amygdala with light energy. SGE-516 had no effect in mice lacking GABA-A receptors in basolateral amygdala neurons, supporting the critical role of these receptors.

The investigators suggested that brexanolone may shift basolateral amygdala brainwave rhythms to a more stable state that is resistant to chronic stress.

"Our findings demonstrate a novel molecular and cellular mechanism mediating the well-established anxiolytic and antidepressant effects of neuroactive steroids," the authors concluded.

Antonoudiou P, Colmers PL, Walton NL, et al. Allopregnanolone Mediates Affective Switching Through Modulation of Oscillatory States in the Basolateral Amygdala. *Biol Psychiatry*. July 27, 2021. Online ahead of print. https://www.biologicalpsychiatryjournal.com/article/S0006-3223(21)01470-0/fulltext

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THC-Lipid Combo Helps Reduce Symptoms Of Tourette's

Small clinical trials have shown that Δ9-tetrahydracannabinol (THC)—the psychoactive component of cannabis—can improve tic symptoms associated with Tourette's syndrome. However, the high doses used to treat tic symptoms can lead to unwanted side effects. A pilot study appearing in the *Journal of Neuropsychiatry and Clinical Neurosciences* reports that combining THC with the lipid compound palmitoylethanolamide (PEA) can improve the benefits and safety profile of this chemical in people with Tourette's syndrome.

Researchers at Yale University enrolled 16 adults with Tourette's and significant tic symptoms (defined as a Yale Global Tic Severity Scale, or YGTSS, score of 22 or higher); the average YGTSS score of the group was 38.1. The participants were given THX-110, a combination of up to 10 mg THC and 800 mg PEA, once daily for 12 weeks.

After 12 weeks, average YGTSS scores improved by about 20%, with four participants experiencing a 35% or greater improvement. THX-110 also worked rapidly, with visible improvements emerging after just one week. Several patients experienced improvements with 5 mg THC or less.

Though most participants experienced mild, transient side effects such as fatigue, dizziness, or dry mouth, only two left the study early—one due to drowsiness and fatigue and a second because the medication was not improving symptoms.

The findings raise "questions of whether use of PEA may allow for a reduced dose of Δ9-THC to be effective in the treatment of tics, and if combination Δ9-THC/PEA or Δ9-THC alone could be used not only as a chronic medication to help tics (as studied in this trial) but also as an acute short-term medication to be used during symptom exacerbation," the researchers wrote.

Bloch MH, Landeros-Weisenberger A, Johnson JA, Leckman JF. A Phase-2 Pilot Study of a Therapeutic Combination of Δ9-Tetrahydracannabinol and Palmitoylethanolamide for Adults With Tourette's Syndrome. *J Neuropsychiatry Clin Neurosci*. August 3, 2021. Online ahead of print. https://neuro.psychiatryonline.org/doi/10.1176/appi.neuropsych.19080178

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Medical Necessity

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crisis stabilization.

"But now the Wild West is being tamed by the parity law and by litigation. *Wit* determined that insurance companies could not decide that treatment was only about crisis stabilization and nothing more."

When Feldman contacted Plakun with his story about the effort to appeal the insurance company's denial with a medical necessity letter from his daughter's clinicians, Plakun knew that what was missing was language in the letter linking the clinicians' assertions of medical necessity to the imperatives spelled out in the *Wit* decision. Especially important in that decision are the eight principles of effective evaluation and treatment of mental and substance use disorders that meet generally accepted standards. Those principles stipulate that effective care does the following:

- Treats underlying problems and not just the current presenting problem.
- Treats co-occurring conditions.
- Uses a multidimensional assessment to determine level of care such as those developed by professional organizations.
- Is individualized and without arbitrary limits on duration.
- Maintains functional capacity or prevents deterioration.
- Should be both safe and effective.
- Addresses special needs of children and adolescents when making level of care decisions.
- Errs on the side of caution by using a higher level of care when there is ambiguity about the appropriate level of care.

Now Feldman and Plakun—along with attorney Mark DeBofsky, J.D., and Cheryl Potts, M.B.A., executive director of The Kennedy Forum-Illinois—have published a paper in the *Journal of Psychiatric Practice* (edited by past APA President John Oldham, M.D., M.S.) about the power of a clinician-written medical necessity letter backed by the imperatives of the *Wit* decision and the eight principles of effective care.

> "What we have to do is find ways to extend the impact of *Wit* beyond UBH to all commercial insurers and to Medicare and Medicaid."
>
> —Eric Plakun, M.D.

The paper includes a description of the current managed care landscape, common reasons for denial of care, and the elements of an effective medical necessity letter. The paper also includes three appendices—a template for a medical necessity letter, suggested text for inclusion in a medical necessity letter derived from the *Wit* decision, and a patient handout that explains the value and importance of a medical necessity letter.

"Medical necessity letters are powerful tools in your clinical practice," the authors wrote. "They do require some time and effort, but, having mastered the skill and designed a template for reuse, they are worth the effort. Individual patient letters may vary in length depending on complexity and circumstances, as well as the rationale for the recommended course of treatment. Keep in mind that a submission to an insurance entity generally requires consent of the patient, which should be noted early in the letter. Review of the letter with a patient is often a helpful step in strengthening the therapeutic alliance."

Plakun said that the medical necessity letter can be decisive and a tool for psychiatrists to put the principles of the *Wit* decision to work for individual patients and to improve access to care for all.

"Whether we are talking about how to advance treatment for an individual or how to make a real difference in access to care and a reduction of health disparities, what we have to do is find ways to extend the impact of *Wit* beyond UBH to all commercial insurers and to Medicare and Medicaid." he told *Psychiatric News*. "When those elements of effective treatment identified in *Wit* become accepted across the board and influence all insurance, that can really make a difference in reducing health disparities."

UBH also settled two other lawsuits charging the company with violation of the federal parity law. One is a class action suit brought by the office of the New York State Attorney General (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2015.10b22). And in August, the U.S. Department of Labor announced that UBH had agreed to pay $13.6 million to affected participants and beneficiaries and $2 million in penalties in settlement of the department's lawsuit charging violation of the parity act; for further reporting, see the next issue of *Psychiatric News*.

Today, Feldman's daughter is pursuing an associate's degree and doing well. He said that the medical necessity letter is a tool of empowerment—for psychiatrists and patients. "Clinicians don't have to wish their patients 'good luck' when dealing with an insurance company denial but can change the expectation to one that, in fact, the insurance company will pay for necessary care," he said.

"It's a gift from a psychiatrist to the patient because it is information that patients can't possibly be aware of on their own. They are already struggling, and insurance companies are opaque. This is a gift that says, 'This treatment should be covered.' " **PN**

"Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients" is posted at https://journals.lww.com/practicalpsychiatry/Fulltext/2021/07000/Providing_a_Routine_Medical_Necessity_Letter_to.7.aspx.

Journal Digest

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Low Cortisol May Help Predict PTSD After Heart Attack

Low levels of the stress hormone cortisol in the blood following a heart attack may predict those at higher risk of posttraumatic stress disorder (PTSD) over the next 12 months, reports a study in the *Journal of Affective Disorders*. As blood tests are routinely taken for heart attack patients, this finding offers another potential biomarker to identify patients at risk of PTSD early.

Researchers at the University of Zurich and colleagues examined data from a clinical study exploring whether early psychological counseling could prevent PTSD in patients who experienced a heart attack and were considered at high risk of developing PTSD. As part of the study, the participants received clinical assessments and provided blood samples after hospital admission and again three and 12 months after discharge. For this analysis, the researchers assessed the 106 study participants who completed the 12-month follow-up.

The researchers found that patients with lower levels of cortisol after their heart attacks were more likely to have elevated PTSD symptoms (measured with the German version of the Clinician Administered PTSD Scale, or CAPS) at three and 12 months. Patients who were younger and reported worse sleep before being hospitalized also had higher CAPS scores at three and 12 months.

The researchers suggested that future work should try to identify specific cortisol cutoff levels to delineate heart attack patients at high risk of PTSD.

Schaffter N, Ledermann K, Pazhenkottil AP, et al. Serum Cortisol as a Predictor for Posttraumatic Stress Disorder Symptoms in Post-Myocardial Infarction Patients. *J Affect Disord*. 2021; 292: 687-694. https://www.sciencedirect.com/science/article/pii/S0165032721005097

Young-Onset Dementia

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perspective on the rates of dementia over time and the relative risks in older versus younger adults. Overall, the study suggests that about 3% of all dementia cases in the United States are in adults under age 65. However, most of these cases were in adults aged 55 to 64.

"Among the really young, where the burden would be greatest, dementia is exceedingly rare," Knopman said. In the age range of 30 to 34, for example, Köhler's meta-analysis calculated a prevalence of 1 case of dementia per 100,000 people. "At that level, routine screening is out of the question," he said. "So, on a practical level, how can physicians identify a problem they might encounter once a decade?"

It's a pertinent question for psychiatrists, Draper said, since work by him and others has shown that chronic, treatment-resistant depression can be an early symptom of young-onset dementia. "If you have a middle-aged patient with treatment-resistant depression who begins complaining of memory problems, you should entertain [underlying] dementia as a possibility," he said.

Draper noted that Alzheimer's disease—which is the most common cause of dementia in older adults—is less dominant in young-onset cases. More commonly, younger patients may experience Disorders like frontotemporal dementia and Huntington's disease are more common. This is why psychiatrists need to look at more than just cognition in younger people, as behavioral (personality changes) and/or physical symptoms (such as gait disturbances) are most likely to emerge first, he said.

"There is no specific pattern that can help diagnose patients at an individual level," Knopman said. "But if physicians keep an open mind that dementia exists before 65, that can help awareness."

Firsthand clinical experience is also valuable, Knopman continued. "Once you have seen one patient with dementia, it helps make future diagnoses much easier. If more clinicians could do a geriatric rotation, that would help diagnosis tremendously."

The meta-analysis was supported by the Gieskes-Strijbis Foundation, Alzheimer Netherlands, and the Dutch Young-Onset Dementia Knowledge Centre. **PN**

"Global Prevalence of Young-Onset Dementia: A Systematic Review and Meta-analysis" is posted at https://jamanetwork.com/journals/jamaneurology/fullarticle/2781919.