VOLUME 57, NUMBER 10, OCTOBER 2022

AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

ISSN 0033-2704

# Women's Reproductive Mental Health: A Clinical Framework

***BY MARISSA BEAL, D.O., MARIKA TOSCANO, M.D., AND LAUREN M. OSBORNE, M.D.***

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SEE SPECIAL REPORT ON PAGE 17

# Stanford Ethics Team Examines Intersection Of Homelessness, Mental Illness, Police Conduct

*A team at Stanford University hopes to identify patterns of interactions and outcomes when police encounter people with mental illness with the goal of developing policies and best practices that can mitigate harm and avoid negative outcomes.* ***BY MARK MORAN***

In a searing essay titled "Living With Schizophrenia," written in 2012 for an adult education class, Deborah Danner—an African American woman with schizophrenia living in New York City—wrote something that would prove sadly prophetic: "*We are all aware of the all-too-frequent news stories about the mentally ill who come up against law enforcement instead of mental health professionals and end up dead.*"

Four years later, on October 18, 2016, Danner was shot and killed by a New York City policeman in her apartment in the Bronx after Danner's neighbors had complained that she was acting erratically. The officer who shot her was charged with second-degree murder but was later acquitted.

Tragedies like the shooting of Deborah Danner have become more common as law enforcement officers have increasingly become the first responders to mental health emergencies; in the decades since deinstitutionalization, homeless mentally ill individuals may have become especially vulnerable. Yet the scope and nature of encounters between police and those with mental illness—how often they happen and the variables that result in good or bad outcomes—are poorly understood.

According to Fatal Force, a *Washington Post* project to log fatal shootings by on-duty police officers in the United States, as of August 23, 1,624 individuals with mental illness had been killed by police since the *Post* began the project in 2015. That's 26% of all shooting deaths logged by Fatal Force, suggesting that people with mental illness are overrepresented. Of those, 255 have been African American. However, the number of victims with mental illness may be higher—the information is derived from media and police reports—and homelessness is not included as a variable.

Now, the ethics research team at Stanford University, led by Laura Roberts, M.D., M.A., is seeking to better understand the intersection between homelessness, mental illness, and law enforcement. Roberts is chair and the Katharine Dexter McCormick and Stanley McCormick Memorial Professor in the Department of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine. She is also editor in chief of books at APA Publishing.

With funding from the Elizabeth Dollard Charitable Trust, Roberts and her team hope to identify patterns in

*see* **Stanford Team** *on page 12*

PERIODICALS: TIME SENSITIVE MATERIALS

PSYCHIATRIC NEWS

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

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

# APA Participates in Government Roundtable To Address Our Major Challenges

***BY REBECCA BRENDEL, M.D., J.D.***

Over the last month, the national spotlight has continued to illuminate Americans' need for mental health care, the challenges in meeting that need, and the public and private attention and commitment to addressing mental health. Our nationwide response to the mental health pandemic is underway, and with it, APA's advocacy for psychiatrists, patients, and the integrity of our profession continues full force.

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 is a key federal law aimed at ensuring that Americans have access to mental health benefits in their health insurance plans on par with other medical benefits. Specifically, MHPAEA prohibits health insurance plans from imposing limits on mental health benefits that are more restrictive than those for other medical benefits. While MHPAEA does not apply to every health plan in the United States (notable exceptions include most Medicare plans), it applies to approximately 2 million group health plans covering roughly 136.5 million Americans.

Yet while MHPAEA is a key tool in fighting mental health stigma by legislating the end of discriminatory benefits determination for people with mental illness, the details are far more complicated. Progress has been slow in achieving the promise of the law. One clear example of the work left to be done occurred this past January, when the Department of Labor requested that more than 100 health plans provide information pursuant to MHPAEA's documentation requirements and found that not a single insurer's submission met the statutory requirements (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2016.11b8). This result is particularly concerning given that some version of MHPAEA has been in effect since 1996. We clearly have substantial work ahead in ensuring that every American has access to high-quality, evidence-based, and affordable mental health care.

Unfortunately, lack of compliance with required documentation is only the tip of the iceberg. APA, our members, and our patients are acutely aware of barriers to obtaining mental health care. Last month, Department of Labor Secretary Marty Walsh and Acting Assistant Secretary Ali Khawar invited APA representatives to participate in a roundtable discussion on mental health parity with representatives from sister mental health organizations. I was honored to represent APA at the meeting, especially given my personal experience with Secretary Walsh's commitment to mental health when he was the mayor of Boston. As mayor, Secretary Walsh was a key supporter of mental health and substance use treatment and was open about his own recovery journey. In his current position, he has continued his work to advance all Americans' access to mental health and substance use care.

The energy and spirit of collaboration at the meeting was palpable as leaders of mental health professional organizations and patient and family advocacy organizations shared their

*see* **From the President** *on page 29*

## IN THIS ISSUE






## DEPARTMENTS

# New ICD-10-CM Codes For Neurocognitive Disorders Effective October 1

*The coding changes for major and mild neurocognitive disorders represent the most consequential coding changes for* DSM-5 *disorders since the October 1, 2015, changeover from ICD-9-CM to ICD-10-CM.* **BY MICHAEL B. FIRST, M.D.**

Every October 1, the ICD-10-CM codes for all of medicine are updated, resulting in the addition of new codes and the revision or deletion of existing codes. Only a small fraction of the 68,000 codes are actually affected; last year, 159 new codes were added, 25 codes were deleted, and 27 existing codes were revised. Given that all HIPAA-compliant health care entities are required to use the most up-to-date ICD-10-CM codes, clinicians and institutions need to keep on top of these coding changes, especially since the addition of new codes usually results in some existing codes becoming obsolete.

This year the coding changes are largely confined to major and mild neurocognitive disorders, but they represent the most consequential coding changes for *DSM-5* disorders since the October 1, 2015, changeover from ICD-9-CM to ICD-10-CM.

Michael B. First, M.D., is a professor of clinical psychiatry at Columbia University in the Division of Behavioral Health and Policy Research. A nationally and internationally recognized expert on psychiatric diagnosis, First is co-chair of the Revision Subcommittee and *DSM-5-TR* editor, a member of the DSM Steering Committee, and the chief technical and editorial consultant on the World Health Organization's ICD-11 revision project.

### Changes for Major Neurocognitive Disorder

The first three characters that make up the ICD-10-CM code for major neurocognitive disorder depend on the type of etiological medical condition and are unchanged:

- F01 for major neurocognitive disorder due to vascular disease.

- F02 for major neurocognitive disorder due to other medical conditions (where the specific etiological medical condition is indicated by adding the ICD-10-CM code for the medical condition).

- F03 for major neurocognitive disorder when the medical etiology is unknown.

Although *DSM-5-TR* diagnostic criteria for major neurocognitive disorder include severity specifiers (mild, moderate, severe), there was no provision for indicating this clinically important information in the current ICD-10-CM code for major neurocognitive disorder. But this year, coding changes for major neurocognitive disorders taking effect include the provision of a fourth character code to indicate the severity of the major neurocognitive disorder and a combination of fifth and sixth characters to indicate the presence of an accompanying behavioral or psychological disturbance.

The fourth character in the code is designated for indicating current severity as follows: "A" indicates mild difficulties with instrumental activities of daily living (such as housework and managing money), "B" indicates moderate difficulties with basic activities of daily living (such as feeding and dressing), and "C" indicates severe (fully dependent).

In the late 1990s, it was brought to APA's attention that because Alzheimer's disease was classified in ICD-9-CM as a neurological condition, psychiatrists were having difficulty getting their services covered by insurers. Consequently, APA requested the addition of a fifth digit to the ICD-9-CM code for dementia due to a medical condition to indicate the presence or absence of a behavioral disturbance accompanying the dementia: 294.10 indicated dementia without behavioral disturbance, and 294.11 indicated dementia with behavioral disturbance.

To provide greater detail regarding the nature of the behavioral disturbance, this year new fourth and fifth character codes are available for indicating any accompanying behavioral or psychological disturbance. To accommodate these new codes, the "with behavioral disturbance" specifier in the *DSM-5-TR* diagnostic criteria for major neurocognitive disorder has been expanded to include the following: 11=with agitation, 2=with psychotic disturbance, 3=with mood symptoms, 4=with anxiety, 18=with other behavioral or psychological disturbance, and 0=without accompanying behavioral or psychological disturbance. (See Table 1 for definitions.)

Table 2 shows the combined coding

*see* **New ICD-10-CM Codes** *on page 9*

### Table 1. Expanded Behavioral Disturbance Specifiers

- **With agitation:** The cognitive disturbance is accompanied by clinically significant agitation.
- **With psychotic disturbance:** The cognitive disturbance is accompanied by delusions or hallucinations.
- **With mood symptoms:** The cognitive disturbance is accompanied by clinically significant mood symptoms (for example, dysphoria, irritability, euphoria).
- **With anxiety:** The cognitive disturbance is accompanied by clinically significant anxiety.
- **With other behavioral or psychological disturbance:** The cognitive disturbance is accompanied by other clinically significant behavioral or psychological disturbances (for example, apathy, aggression, disinhibition, disruptive behaviors or vocalizations, sleep or appetite/eating disturbance).
- **Without accompanying behavioral or psychological disturbance:** The cognitive disturbance is not accompanied by any clinically significant behavioral or psychological disturbance.

### Table 2. ICD-10-CM Codes for Major Neurocognitive Disorder

**F01 Major Vascular NCD**

*Codes sunsetted on September 30, 2022*

- **F01.50** Major vascular NCD, without behavioral disturbance
- **F01.51** Major vascular NCD, with behavioral disturbance

*Updated codes effective October 1, 2022*

- **F01.xy** Major vascular NCD

x=current severity, y=accompanying behavioral or psychological disturbance

- **F01.Ay** Major vascular NCD, mild...
- **F01.By** Major vascular NCD, moderate...
- **F01.Cy** Major vascular NCD, severe...

**.x11** ...with agitation
**.x2** ...with psychotic disturbance
**.x3** ... with mood symptoms
**.x4** ...with anxiety
**.x18** ...with other behavioral or psychological disturbance
**.x0** ...without accompanying behavioral or symptomatic disturbance

**F02 Major NCD Due to Another Medical Condition**

*Codes sunsetted on September 30, 2022*

- **F02.80** Major NCD due to AMC, without behavioral disturbance
- **F02.81** Major NCD due to AMC, with behavioral disturbance

*Updated codes effective October 1*

- **F02.xy** Major NCD due to [name of another medical condition]

x=current severity, y=accompanying behavioral or psychological disturbance

- **F02.Ay** Major NCD due to AMC , mild...
- **F02.By** Major NCD due to AMC, moderate...
- **F02.Cy** Major NCD due to AMC, severe...

**.x11** ...with agitation
**.x2** ...with psychotic disturbance
**.x3** ... with mood symptoms
**.x4** ...with anxiety
**.x18** ...with other behavioral or psychological disturbance
**.x0** ...without accompanying behavioral or symptomatic disturbance

**F03 Major NCD Due to Unknown Etiology**

*Updated codes effective October 1, 2022*
*(Note: R41.9 will continue to apply to unspecified neurocognitive disorder)*

- **F03.xy** Major NCD due to unknown etiology

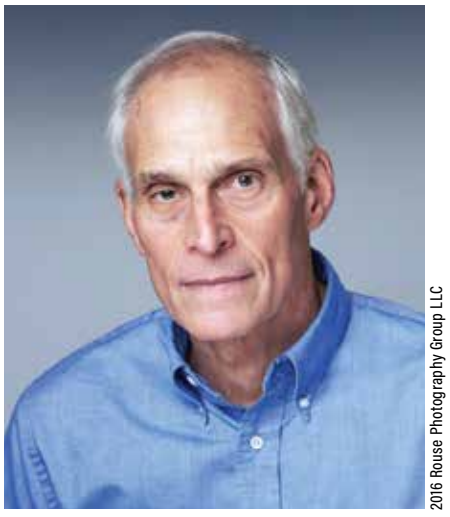
x=current severity, y=accompanying behavioral or psychological disturbance

- **F03.Ay** Major NCD due unknown etiology, mild...
- **F03.By** Major NCD due to unknown etiology, moderate...
- **F03.Cy** Major NCD due to unknown etiology, severe...

**.x11** ...with agitation
**.x2** ...with psychotic disturbance
**.x3** ... with mood symptoms
**.x4** ...with anxiety
**.x18** ...with other behavioral or psychological disturbance
**.x0** ...without accompanying behavioral or symptomatic disturbance

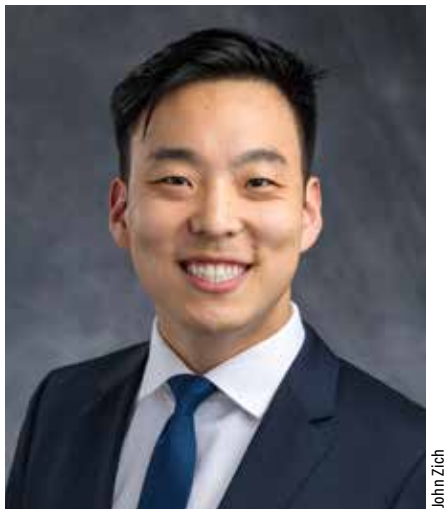
# Negative Language in Medical Records More Common for Black Patients

*Two studies reveal how implicit bias can rear its ugly head in the way health care professionals describe patients in electronic health records.* ***BY TERRI D'ARRIGO***



2016 Rouse Photography Group LLC

All health professionals should monitor themselves for the use of stigmatizing language and correct themselves accordingly, says Andrew Saxon, M.D.



John Zich

When use of negative descriptors such as "angry" is unavoidable, health professionals should take care to provide context so as not to promote bias, says Michael Sun.

Diana Lam

Terms like "drug-seeking" or "noncompliant" suggest negative intentions that patients may not have, says Gracie Himmelstein, M.D., Ph.D.

Stigmatizing language and negative descriptors appear more frequently in the electronic health records (EHRs) of Black patients compared with those of White patients, two studies have found. The first study, published in *Health Affairs*, revealed that Black patients had more than twice the odds of being described in EHRs with one or more negative descriptors—such as "agitated," "angry," "aggressive," and "not compliant"— compared with White patients. The second study, published in *JAMA Network Open*, found that stigmatizing language, such as "nonadherence," "belligerent," and "abuser" more often appeared in the records of Black patients compared with those of White patients.

These studies point to the need for health and mental health professionals to become aware of their own biases, said Andrew Saxon, M.D., the director of the Center of Excellence in Substance Addiction Treatment and Education at the VA Puget Sound Health Care System and a former member of APA's Council on Addiction Psychiatry.

"[Health professionals] need to be conscious of it, observe their own behavior, and correct themselves when they slip into stigmatizing thoughts and language," said Saxon, who was not involved in either study. "Oftentimes there is no conscious ill intent, and we're just mimicking the people who taught us this language at a time when society was much less conscious of how words matter."

Michael Sun, a medical student at the University of Chicago's Pritzker School of Medicine and lead author of the study in *Health Affairs*, agreed.

"We weren't born knowing how to write medical documentation. It's a learned skill. From a systems perspective, the way we have trained people to do medical documentation has an inherent bias," Sun told *Psychiatric News*.

Sun and colleagues used machine learning techniques to analyze health professionals' use of negative patient descriptors in the history and physical notes in the EHRs of 18,459 patients seen at a large, urban academic medical center in Chicago. These data included health records for patients who received treatment in an emergency department, inpatient setting, or outpatient setting between January 1, 2019, and October 1, 2020.

In total, the EHRs of 8.2% of the patients included negative descriptors. After controlling for sociodemographic and health characteristics, the researchers found that Black patients had 2.54 times the odds of being described with one or more negative descriptors in the EHR compared with White patients. Furthermore, Black race was associated with 5.6 additional negative notes per 100 patients relative to White race.

Sun said that neither he nor many of his peers found the results surprising.

"This is what we've been seeing for a while, but now we have data to show it and can find it objectively in the health care system," Sun said.

*continued on facing page*

ETHICS CORNER

# Ramifications of a Patient's Physical Assault On Inpatient Ward Psychiatrists

***BY CHARLES C. DIKE, M.D., M.P.H.***

Charles C. Dike, M.D., M.P.H., is chair of the APA Ethics Committee and former chair of the Ethics Committee of the American Academy of Psychiatry and the Law. He is also an associate professor of psychiatry; co-director of the Law and Psychiatry Division at the Yale University School of Medicine; and medical director in the Office of the Commissioner, Connecticut Department of Mental Health and Addiction Services.

A psychiatrist, who is also a U.S. military veteran, was seriously assaulted on her inpatient psychiatric ward by one of her patients whom she had been seeing in her office located on the ward. Staff members rescued her after being alerted by the loud commotion emanating from the psychiatrist's office. The psychiatrist was shocked and shaken by the assault, but soon thereafter, she vigorously advocated for the patient not to be transferred to another ward as the assault was psychotically motivated. However, after some reflection, the facility medical director separated the patient from the psychiatrist by moving the patient to another ward.

The risk of psychiatrists being physically assaulted by their patients is not minimal, with studies stating that psychiatrists have a 5% to 48% chance of being assaulted by their patients during their careers, according to a study in *Psychiatric Services*. The United States Department of Justice's National Crime Victimization Survey (1993-1999) found the annual rate of job-related violent crime among psychiatrists and mental health professionals to be 68.2 per 1,000, compared with 12.6 per 1,000 workers in all occupations and 16.2 among all physicians. Even psychiatry residents were not spared as reports suggest that 40% to 50% of them will suffer physical assault by a patient during their psychiatry training, also according to the *Psychiatric Services* study.

These rates of assaults are so common that psychiatrists have accepted them as the cost of working in this field. The ethics injunction that states that the physician-patient relationship is solely for the benefit of the patient is interpreted literally. Even in the face of a physician assault by psychiatrically ill patients, the physician believes the focus should be on treating agitated patients and making them comfortable rather than on the assaulted physician. However, these kinds of situations are not always that simple or straightforward. A patient assault on the ward psychiatrist affects the milieu, other staff members, and other patients. I am aware of a situation in which another patient on the ward went after the assaultive patient in retaliation to defend the honor of the beloved injured psychiatrist. Further, it would be naïve to believe that the assault did not affect the psychiatrist's view of the patient and that decisions regarding the patient's care are not consciously or unconsciously influenced by the assault. In my experience, a physically assaulted psychiatrist is less likely to acknowledge the trauma experienced from the assault and more likely to put up a brave face for other staff members and patients,

*continued from facing page*

In the *JAMA Network Open* study, Gracie Himmelstein, M.D., Ph.D., a resident physician at the University of California, Los Angeles, and colleagues analyzed 48,651 admission notes written about 29,783 patients by 1,932 health professionals at a large, urban academic medical center between January and December 2018. The admission notes included notes about patients with diabetes, substance use disorder (SUD), or chronic pain.

The researchers found that 2.5% of the notes contained stigmatizing language and that overall the notes of Black patients were nearly 1.3 times more likely to have stigmatizing terms than those of White patients. However, among patients whose notes were about SUD, the notes about Black patients were 1.7 times more likely to have negative terms than those of White patients.

"That only 2.5% of the notes have stigmatizing language shows that most [health professionals] are usually writing unbiased notes," Himmelstein told *Psychiatric News*. "On the other hand, there is still some stigmatizing language. Our results allow us to see who is affected most by it so we can change it and educate

*see* **Negative Language** *on page 10*

# Most OTC Cannabinoid Products Mislabeled

*More than half of over-the-counter (OTC) cannabinoid products have more cannabidiol than stated on the label.* **BY TERRI D'ARRIGO**

More than 3 in 4 topical hemp-derived cannabinoid products sold over the counter or online are labeled inaccurately regarding the amount of cannabidiol (CBD) they contain, a study in *JAMA Network Open* has found. Many of the products in the study also contained delta-9-tetrahydrocannabinol (THC), the psychoactive compound in cannabis, but this was not noted on the label. Furthermore, many of the labels made therapeutic claims about treating conditions for which the products are not approved by the Food and Drug Administration (FDA), such as pain and inflammation. (To date, the FDA has approved CBD to treat rare epilepsy disorders only.)

"It is obviously concerning that the vast majority of the products were inaccurately labeled. I assume many consumers of these products do not know they are potentially being exposed to THC," lead author Tory R. Spindle, Ph.D., told *Psychiatric News*. Spindle is an assistant professor in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins University School of Medicine.

"The other thing that stood out was the health claims being made. There is very little clinical research on these products so we don't have good evidence to back up claims that they are effective for pain."

Spindle and his colleagues examined the contents of 105 topical products that were purchased either in person from retail locations such as grocery stores, pharmacies, beauty and cosmetic stores, and health and wellness stores or purchased online. They considered the products to be accurately labeled if the amount of CBD in the entire product was within 10% of the labeled total amount. They deemed the products inaccurately labeled if the amount of CBD in the entire product was greater than 10% or less than 10% of the labeled total amount.

Johns Hopkins Medicine/Keith Weller

Cannabidiol products are not well regulated and may contain contaminants, says Tory R. Spindle, Ph.D.

Of the 89 products that listed a total amount of CBD on the label, only 24% were accurately labeled, 18% contained at least 10% less CBD than the label stated, and 58% contained at least 10% more CBD than advertised. Furthermore, 35% of all 105 products contained THC, although they contained less than 0.3% THC. Among all products, 28% made unapproved therapeutic claims, 14% made unapproved cosmetic claims, and only 47% noted that they were not approved by the FDA.

"These findings highlight the need for proper regulatory oversight of cannabis and hemp products to ensure these products meet established standards for quality assurance so that consumers are not misled by unproven therapeutic or cosmetic claims," Spindle and colleagues wrote. "These data also suggest that clinical studies are warranted to determine whether topical products with THC can produce psychoactive effects."

Spindle said that psychiatrists should discuss these products with their patients who may be using them and inform their patients that there is scarce research demonstrating that these products, especially topical ones, are effective treatments for pain or anxiety.

"I think it is also important to highlight that these products are not well regulated and therefore there is little quality control," Spindle said. "[Patients] may be using a product that does not contain the amount of CBD it says on the label or that contains other contaminents that would not be present in well-regulated drugs."

This study was supported by the Substance Abuse and Mental Health Services Administration. **PN**

**"Cannabinoid Content and Label Accuracy of Hemp-Derived Topical Products Available Online and at National Retail Stores" is posted at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794440.**

believing that to be what a leader does. It would, however, be important to acknowledge the psychiatrist's trauma response in the provision of care to the assaultive patient. In the psychiatrist's case described earlier, the assault triggered underlying posttraumatic stress disorder from the psychiatrist's days in the military. Therefore, the decision to keep the patient on the ward to be treated by the "victim" psychiatrist should be considered with much reflection.

The assaulted psychiatrist should explore the issues through an ethics lens—whether the patient can be treated fairly, to what degree would the patient's autonomy be further impacted, and would the patient's continued stay on the unit be helpful or harmful to the patient. Some of the specific questions that should be contemplated include the following:

- Would the patient receive the same care and attention from the psychiatrist and other staff members as other patients who are similarly situated on the ward?

- Would decisions about type and dose of medication be influenced consciously or unconsciously by the assault?

- Would the patient's privilege levels be negatively impacted for longer than necessary?

- Would the patient's freedom of movement be unnecessarily curtailed beyond what is customary for other aggressive patients? For example, would the patient be placed on special observation status complete with the associated stringent restrictions for an extended period? What about decisions regarding accessing hospital grounds or community trips?

- Would discussions about discharge placement be negatively influenced?

Most psychiatrists following an assault would reflexively respond to these questions in a favorable light and may not be aware of their unconscious biases.

A similar example is a psychiatrist whose patient died by suicide on the ward through no fault of the psychiatrist's care. However, over time, the psychiatrist became gradually more conservative such that patients who were deemed to have a slightly higher than average risk of self-harm or suicide were held on close observation status for extended periods and discharged to the community with much reluctance. The patients' unfair and sometimes harmful treatment was the direct consequence of the psychiatrist's trauma.

A patient's assault on a psychiatrist is not a trivial matter. Psychiatrists may not fully appreciate the impact of the assault when it occurs and may need a few days to process their feelings and reactions. While affirming our core ethics principle that the physician-patient relationship must be for the benefit of the patient, the emotional state of the psychiatrist should not be ignored. Hence, taking care of the psychiatrist's needs after a traumatic event ultimately benefits the patient. The psychiatrist may feel guilty or even ashamed for having negative reactions against the patient. The onus may fall on the facility medical director to relieve the guilt of the psychiatrist and encourage the healing process by overriding the psychiatrist's well-meaning but ill-conceived decision to continue treating the patient. Even a temporary separation from the patient may be necessary. It may be the most ethical response in some circumstances. **PN**

**"Assaults by Patients on Psychiatric Residents: A Survey and Training Recommendations" is posted at https://ps.psychiatryonline.org/doi/10.1176/ps.50.3.381.**

# APA Debuts Mental Health Innovation Exchange

*The two-day virtual event replaced the Mental Health Innovation Zone once held at APA's Annual Meeting. The sessions showcased the continuing advances in mental health technologies over the past few years and the importance of psychiatrists in leading this advance.* **BY NICK ZAGORSKI**

After a three-year hiatus, APA's premier showcase of technology and innovation returned this past August as a two-day virtual event. The Mental Health Innovation Exchange included presentations by nearly 40 leaders in digital psychiatry and mental health technology who provided a broad overview of how technology is shaping mental health care.

Following its launch in 2016, APA's innovation-themed event—then called the Mental Health Innovation Zone—quickly became one of the highlights of the Annual Meeting. The program featured engaging discussions and Q&As, product demonstrations, and a "Shark Tank"–style pitch contest, during which participants presented their creative ventures for improving—or perhaps even redefining—mental health care to a panel of experts.

The cancellation of in-person Annual Meetings in 2020 and 2021 led also to a break in the Mental Health Innovation Zone. Though APA returned to in-person meetings in 2022, APA's Committee on Innovation (a subset of the Council on Medical Education and Lifelong Learning) decided that the innovation program should be a standalone meeting and free to all APA members to maximize reach.

"COVID forced us to innovate as a profession," said Manu Sharma, M.D., an assistant professor of psychiatry at Yale University and a member of the Committee on Innovation. Over just a few months in early 2020, psychiatric practice converted to virtual-based care, Sharma noted, and based on physician and patient satisfaction, virtual care is here to stay. Sharma noted that the amount of venture capital invested in such mental health tools as digital phenotyping apps and AI-guided chatbots is "mind-boggling."

The program was rebranded as the Mental Health Innovation Exchange to acknowledge the transition from a physical space to a virtual one, but also to emphasize that innovation spreads through networking and the exchanging of ideas, said Steven Chan, M.D., M.B.A., the chair of the Committee on Innovation.

"Our goal was to make this event as accessible as possible, so each session was designed as a broad introduction into a certain facet of digital mental health," said Chan, who is also an addiction psychiatrist at VA Palo Alto Healthcare System and a clinical assistant professor (affiliated) at Stanford University. The sessions comprised interviews and conversations so that attendees could watch or listen at their own pace.

In addition to popular clinical topics such as telepsychiatry and mobile health apps, the Mental Health Innovation Exchange included sessions on the following:

*continued on facing page*

## APA'S GOVERNMENT, POLICY, AND ADVOCACY UPDATE

### HHS Proposes Rule to Strengthen Nondiscrimination in Health Care

The Department of Health and Human Services (HHS) proposed a rule to implement Section 1557 of the Affordable Care Act (ACA), which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities. HHS's new rule would extend the interpretation of Section 1557 to prohibit discrimination on the basis of gender identity, sexual orientation, and pregnancy status (including pregnancy termination).

The proposed rule reverses a rule issued in 2020 under the Trump administration, which interpreted Section 1557 in such a way that "on the basis of sex" did not protect patients based on sexual orientation or gender identity (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.7b23). In 2019, APA opposed the proposed rule change, citing the unnecessary barriers the rule would impose and the associated costs in allowing discrimination in health care.

More information on HHS's proposed rule is posted at https://www.hhs.gov/about/news/2022/07/25/hhs-announces-proposed-rule-to-strengthen-nondiscrimination-in-health-care.html.

### Inflation Reduction Act Aims to Reduce Health Care Costs

In August, President Joe Biden signed the Inflation Reduction Act into law, a sweeping package that, among its numerous provisions, addresses climate change and attempts to reduce prescription drug costs. Under the law, Medicare will be able to negotiate drug costs beginning in 2026, starting with 10 drugs and increasing each following year. The law also requires drug companies to pay rebates if their prices rise faster than the rate of inflation for drugs used by Medicare beneficiaries; limits monthly cost sharing for insulin to $35 for Medicare beneficiaries; and eliminates all cost sharing for vaccines for those covered under Medicare Part D.

The package also extends health care subsidies for those covered by an ACA plan for another three years. This amounts to savings of $800 a year, on average for 14 million Americans, according to a White House fact sheet.

More information on the new law's prescription drug provisions is posted at http://apapsy.ch/Inflation-Reduction-Act.

### APA Urges Senate to Support the Advancing Telehealth Beyond COVID-19 Act

APA issued an action alert encouraging members to urge their Senators to pass the Advancing Telehealth Beyond COVID-19 Act (HR 4040).

The legislation, which passed the House by a vote of 416-12, would address several of APA's top legislative priorities. It would extend multiple telehealth flexibilities that were implemented in response to the ongoing Public Health Emergency until January 2025, including Medicare coverage of audio-only telehealth. It would also delay the implementation of the six-month in-person requirement for coverage of behavioral health services. Without Senate action, these flexibilities are set to expire 151 days after the end of the Public Health Emergency (PHE). The current PHE is set to expire on October 13.

APA's Action Alert is posted at https://www.votervoice.net/AmericanPsych/Campaigns/96956/Respond.

### APA Supports Medicare Physician Fee Schedule Adjustments

APA joined the Conversion Factor Coalition in a letter to House and Senate leaders, thanking them for providing a 3% positive adjustment to the Medicare Physician Fee Schedule (MPFS) conversion factor. The letter was addressed to the chairs and ranking members of the House Ways and Means Committee, the House Energy and Commerce Committee, and the Senate Finance Committee.

The MPFS adjustment was used to partially offset a scheduled fee schedule reduction and avert an additional 4% Medicare payment reduction, ensuring "increased financial stability for Medicare clinicians," the letter stated. However, Medicare health professionals face another round of significant payment cuts on January 1, 2023, as the 2023 MPFS proposed rule would cut the Medicare conversion factor, the basic starting point for calculating Medicare payments, by 4.5%. "These cuts, combined with the pending threat of the [4% pay-as-you-go (PAYGO)] reduction, are simply not sustainable," the letter stated.

APA and the Conversion Factor Coalition urged Congress to mitigate the scheduled reductions and pass legislation that provides at least a 4.5% conversion factor adjustment for 2023 and waives the 4% statutory PAYGO requirement. "Millions of seniors rely on the Medicare program, and we must work to ensure it remains a robust and dependable option for those who need it the most, both in the short and long term," the letter stated.

The letter is posted at http://apapsy.ch/Conversion-Factor.

### APA Leads Letter in Support of Mental Health Parity Enforcement

APA led the Mental Health Liaison Group in a letter to Rep. Katie Porter (D-Calif.), Rep. Tony Cárdenas (D-Calif.), and Sen. Elizabeth Warner (D-Mass.) in support of the Behavioral Health Coverage Transparency Act (HR 8512/S 4616). The bill would strengthen enforcement of the Mental Health Parity and Addiction Equity Act of 2008, which requires insurance coverage for mental health conditions to be no more restrictive than coverage for other medical conditions.

Specifically, the Behavioral Health Coverage Transparency Act would require most plans and insurers to submit to federal agencies the analyses they perform in making their parity determinations, disclose data on their denial rates for mental health versus medical/surgical claims and the reasons, and provide information on network adequacy and reimbursement rates as a percentage of Medicare rates. It would also require federal regulators to conduct a minimum of 40 random audits of health plans a year and create a central online portal so consumers can easily access publicly available information, including their parity rights, results of audits, and guidance to submit complaints. Further, the legislation would establish dedicated funding for consumer assistance programs to help individuals navigate the complaint process.

The letter is posted at http://apapsy.ch/MHLG.

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- The role of technology in medical education (both teaching it and learning with it)

- Technology-oriented careers, including clinical informatics and medical officers at startups

- Cutting-edge neuroscience tools to identify biomarkers of brain health

- How technology can further diversity, equity, and inclusion (DEI) efforts

Importantly, most of the speakers were psychiatrists or mental health professionals, Chan said. "This conference was also an opportunity to highlight some of the amazing things APA members and other mental health professionals are doing with technology."

As several speakers noted during the innovation exchange, mental health technology is accelerating with or without psychiatrist input. While it's commendable that tech entrepreneurs are designing therapeutic apps and social media influencers are raising awareness of mental illness, "psychiatrists need to be more involved in these initiatives to make sure quality of care, privacy, and patient safety are paramount," Sharma said. The recent problems facing tele-mental health companies for unsafe prescribing practices or selling patient data represent one pitfall of technology gone awry.

"As the flagbearer for our profession, APA needs to educate psychiatrists and raise awareness on what the future will look like," Sharma said.

The 2022 Mental Health Innovation Exchange, which also featured online product demonstrations, proved a great success, organizers said, with hundreds logging in over the two days and many others catching up later (the discussions were made available on demand for 30 days after the event).

"It was wonderful to see the excitement on display from everyone involved and hear the diversity of ways our field is capturing innovation," said Luming Li, M.D., another member of the Committee on Innovation. Li serves as the chief medical officer at the Harris Center for Mental Health and IDD in Houston and is an assistant professor at Baylor, Yale, and UTHealth.

Li added that the innovation exchange served to support the importance of innovation across health systems and community practices, especially the need for tools and services that promote equitable, high-quality care for individuals in need.

"We need to ensure that innovations in care are safe and available to diverse populations receiving care," she said.

The committee is already discussing what shape the 2023 event will take. A live event at next year's Annual Meeting might be fitting, Chan said, given how San Francisco is a hub of technology and innovation and was the site of the last in-person Mental Health Innovation Zone back in 2019. **PN**

# New ICD-10-CM Codes

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for severity and accompanying behavioral or psychological disturbances for each of the three types of major neurocognitive disorders due to medical conditions: due to vascular disease, due to other medical conditions, and due to unknown etiology.

### Changes for Mild Neurocognitive Disorder

As part of the effort to make *DSM* more dimensional, *DSM-5* replaced the *DSM-IV* dementia category with major neurocognitive disorder and mild neurocognitive disorder. A longstanding ICD convention for coding mental disorders due to the direct physiological consequences of a medical condition is to employ two diagnostic codes: one code to indicate the symptomatic manifestations of the medical condition from a psychiatric perspective and a second code for the etiological medical condition (for example, F06.31 depressive disorder due to hypothyroidism and E03.9 hypothyroidism).

The only exception to this convention is the instruction in *DSM-5-TR* to use the single code, G31.84, for mild neurocognitive disorder due to a medical condition, regardless of the specific etiology (G31.84 is the ICD-10-CM code for mild cognitive impairment located in the "Diseases of the Nervous System" chapter). The October 1 update reflects the addition to ICD-10-CM of two new mental disorder codes, F06.71 and F06.70 for mild neurocognitive disorder due to a medical condition with or without a behavioral disturbance, respectively. As is the case with major neurocognitive disorder due to a medical condition, this diagnosis now requires a separate code for the etiological medical condition. **PN**

# APA Foundation Grant Supports MH Resource Translations in Ukraine

iStock/mammuth

*The APA Foundation awarded $20,000 to Languages of Care, which has been providing translated mental health resources to refugees and mental health professionals in Ukraine since the start of the war with Russia.* **BY KATIE O'CONNOR**

According to the United Nations, as of August 12, over 6.6 million people remained displaced within Ukraine due to Russia's invasion, and there are an estimated 6.3 million refugees across Europe.

"These are people who have had to leave their homes and everything behind in a desperate attempt to escape death and destruction," the United Nations said in a May news release. "They are traumatized and need urgent protection, including psychosocial support."

Since the beginning of Russia's invasion of Ukraine, the U.S.-based nonprofit Languages of Care has been working to support mental health professionals on the ground with translations of high-quality, evidence-based mental health and emotional wellness documents. The APA Foundation recently awarded Languages of Care a $20,000 multiyear grant from its Ukraine Disaster Relief Fund to support this work and ensure survivors have access to resources to support their mental and emotional well-being.

Languages of Care was launched in response to the uprising in Belarus two years ago, said co-founder, CEO, and Chief Medical Officer Sander Kofyman, M.D., M.B.A. Koyfman is also the chief medical officer at Athena Psych, a clinic in New York City, and is the immediate past president of Disaster Psychiatry Outreach, now a part of Vibrant Emotional Health.

When Russia invaded Ukraine, the organization jumped in to help. Koyfman and his team realized that there is a wealth of available information on trauma and disaster response in English from credible sources—such as the Centers for Disease Control and Prevention and the Center for the Study of Traumatic Stress at the Uniformed Services University—that can be translated into other languages to help people directly impacted by disasters. Languages of Care's volunteers began translating these vital documents into Ukrainian, Polish, Russian, and Romanian. Each document goes through a clinical review during the translation process, as well.

"Within three weeks, we grew from six volunteer translators to over 160," Koyfman said. "It has been an incredible response. Some of our volunteers are in Ukraine and other countries of former Soviet influence. They've done the enormous job of translating these materials and working with our clinicians to ensure the documents have the most accurate clinical and cultural representation possible."

Web links to the documents have been sent to thousands of therapists practicing on the ground, and printouts have been distributed to over 30,000 evacuees by Languages of Care's partner organization, Ukraine Friends.

Koyfman said that Languages of Care is working to expand, translating documents into multiple languages so the organization can pivot rapidly and respond wherever disasters occur. They are working on a "go kit," which will have a core set of essential documents available almost immediately when the need arises anywhere in the world. Recently, the organization partnered with Respond Crisis Translation Team to expand its language portfolio by adding French and Haitian Creole to respond to the need in Haiti.

Typically, in response to disasters, organizations work together to support victims and ensure they have housing, food, and other critical necessities, said APA Foundation Executive Director Rawle Andrews Jr., Esq. "But all too often, mental and behavioral health care are left out, even for those who are directly in harm's way." The APA Foundation is proud to work with organizations like Languages of Care to help to fill this gap and grow awareness to these critical needs in times of crisis, he said.

"I cannot emphasize enough how important and inspiring it is that the APA Foundation has recognized our effort and become the first foundation to support us," Koyfman said. "This grant is enormously impactful. It will help maintain our momentum and allow us to build this into something that we can sustain as we are building our team of multilingual clinical reviewers."

The APA Foundation was connected with Languages of Care through Joshua Morganstein, M.D., chair of the APA Committee on Psychiatric Dimensions of Disasters. Koyfman said the Committee on Psychiatric Dimensions of Disasters has helped Languages of Care identify the documents that should be included in the go kit, as well.

"Delivering mental health resources directly to the people of Ukraine in their own native language is tremendously important work," said Saul Levin, M.D., M.P.A., APA CEO and medical director and chair of the APA Foundation's Board of Directors. "The APA Foundation's grant to Languages of Care will have a direct impact on those in need and ensure they have access to evidence-based, culturally sensitive resources."

There are numerous ways psychiatrists can get involved with Languages of Care, Koyfman said. Donations are always needed, and clinicians with trauma and crisis expertise can also provide input on what documents should be included in the go kit. Additionally, anyone with college-level reading and writing expertise in a foreign language can contribute by proofreading documents that have been translated, as each document must be proofread by a practicing clinician. According to the Languages of Care website, there is an urgent need for clinicians with Polish/English and French/English proficiency.

"Trauma, isolation, and stigma are all worsened by the inability to communicate effectively," Andrews said. "When Languages of Care steps in with support from organizations like the APA Foundation, they're able to reach people who are directly impacted when they are experiencing the greatest need so they do not need a translator. They can receive help directly in a language they understand." **PN**

**"APA Foundation Awards $20K Disaster Relief Grant to Languages of Care" is posted at https://www.psychiatry.org/News-room/News-Releases/APA-Foundation-Awards-$20K-Disaster-Relief-Grant-t. More information about Languages of Care and how to volunteer is posted at www.languagesofcare.org.**

## Negative Language

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the people who are still using it."

Himmelstein said that health professionals should look at their EHR notes from the perspective of the next person who will read them.

"Read through what you write. Take a step back and read your notes as though you were someone who is meeting the patient for the first time. What do those notes tell you about the patient?" Himmelstein said. "Terms like 'drug-seeking' or 'noncompliant' paint an image of a patient that suggests the patient has bad intentions when that might not be true."

Saxon was particularly struck by the disparity in the use of stigmatizing language with reference to SUD.

"That particular finding highlights the intersection of structural racism and the stigma of SUD. It underscores the negative thoughts people may have about different groups who are already marginalized," Saxon said.

Himmelstein said that addressing bias and stigma in documentation begins in medical school.

"As a medical student, you're trained how to write these notes. It's a big part of the process of transferring from the preclinical years to the clinical years," she said. "It's important to understand early on that that [the EHR] is a guiding document that affects patient care. Every time you meet a patient, you pull up the patient's chart and read through the notes, and what is written there affects every patient encounter."

Sun said that medical school is a good start, but that addressing stigmatizing and biased language in the EHR is a lifelong process, especially because medical graduates may go into residencies in institutions that are unfamiliar with the issue. Therefore, avoiding using stigmatizing or biased language becomes a matter of individual vigilance.

"Think about what opportunities you may have to provide further context

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# Addressing Stress and Burnout: Faculty and Trainees Connect With Creativity

*A psychiatry resident at the University of Rochester spearheads a program showcasing the creative talents of trainees and faculty as a way to promote wellness.*

**BY GRACE RO, M.D., TOMOTARO MONTE, D.O., AND MARK W. NICKELS, M.D.**

As the summer comes to an end, resident physicians may be reflecting on the past year and recalling the stress and uncertainty of applying for training positions in the midst of an unprecedented global pandemic. Now many of us are finding that residency itself is just as stressful as we adjust to being physicians, dealing with long hours, inadequate resources, and restrictive administrative policies. Feelings of isolation may additionally perpetuate a sense of helplessness, further compounding our stress.

Grace Ro, M.D., and Tomotaro Monte, D.O., are PGY-2 psychiatry residents at the University of Rochester Medical Center. Mark W. Nickels, M.D., is the program director of the Psychiatry Residency Program.

To combat burnout among residents, there are increasing efforts to explore alternative methods to promote wellness and tap into the creative reserve that exists in many who pursue a career in medicine. Doing so is crucial to caring for patients: burnout and feelings of stress could certainly permeate our interactions with patients, potentially negatively affecting the quality of care provided, according to an article in the June 2020 issue of *Advanced Critical Care* by Katherine Reed, M.A., et al.

As one way to support residents, the Psychiatry Department at the University of Rochester Medical Center (URMC) hosted the first of an ongoing creative arts series this past spring called "Creatively Connecting." This series was spearheaded by one of the authors of this article—Grace Ro, M.D.—whose interest in the intersection between physician wellness and creative arts is rooted in her background in classical violin performance. Her efforts to utilize the arts to promote connectedness among the residents, the Psychiatry Department, and the local community were met with unwavering support from another author of this article—Mark W. Nickels, M.D., and the chair of the Psychiatry Department, Hochang Benjamin Lee, M.D.

This musical showcase featured performances by members of the Psychiatry Department at URMC. Attending psychiatrists, residents, social workers, and advanced practice providers shared their musical talents on a virtual platform. Utilizing the YouTube live premiere feature, viewers could interact with their peers and colleagues in real time via a live chat while enjoying music performed by familiar faces.


Above is a flyer for the "Creatively Connecting: Spring Showcase" designed by Amanda Lai, B.A.

To further promote a sense of connectedness with the community we serve at Strong Memorial Hospital, the Psychiatry Department provided funding to purchase gift vouchers from a locally owned smoothie shop. The business owner, also a poet and inspirational speaker, shared his poetry as one of the "Creatively Connecting" performances.

To study whether such events could have a tangible effect on well-being, Dr. Ro and her co-resident Dr. Monte sent out pre- and post-surveys using a modified version of the widely used Perceived Stress Scale (PSS) to the department trainees who watched the virtual showcase. The results revealed a decrease in stress levels and feelings of workplace isolation, and an increased sense of connectedness with one another.

Measuring changes in resident wellness is an ongoing challenge given the subjective nature of the data. Also, the types of events or modalities that may resonate with one resident may be different from another. Despite these limitations, residency programs can start by incorporating protected time for wellness activities and interventions. Based on residents' specific preferences, this time can be tailored to effectively promote their wellness and mental health.

It is no secret that a career in medicine is challenging and formative. However, as many of us would say to our own patients, we must first take care of ourselves to best take care of others. **PN**

**"Creatively Connecting" can be accessed at https://www.youtube.com/watch?v=XsZMWuIW4ps&t=546s. "Creative Arts Therapy as a Potential Intervention to Prevent Burnout and Build Resilience in Health Care Professionals" is posted at https://pubmed.ncbi.nlm.nih.gov/32526006/.**

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about the patient in the notes so as not to mislead or predispose other [health professionals] to bias," Sun said. "It may well be that the patient is angry. Anger is sometimes a symptom, and you have to include it in your notes. But why is the patient angry? It's not that we should never use negative words [like 'anger'], but that we need to provide context to better inform medical care."

The study in *Health Affairs* was supported in part by the University of Chicago Medicine's Center for Healthcare, Delivery Science, and Innovation; the National Heart, Lung, and Blood Institute; and the Chicago Center for Diabetes Translation Research as funded by the National Institute of Diabetes and Digestive and Kidney Diseases. The study in *JAMA Open Network* was supported by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and its publication was supported by the Princeton University Library Open Access Fund. **PN**

**"Negative Patient Descriptors: Documenting Racial Bias in The Electronic Health Record" is posted at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01423. "Examination of Stigmatizing Language in the Electronic Health Record" is posted at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788454.**


iStock/egdigital

# California Reporting Project Seeks Records Of Injury, Death in Police Encounters

*In a preliminary report aired on public radio in California this year, the California Reporting Project reported that in Bakersfield, 11 of 18 people who died during encounters with the police between 2014 and 2020 were believed to be mentally ill and/or intoxicated.* **BY MARK MORAN**

In 2018, the California legislature passed the "Right to Know Act," allowing access to reports of police internal investigations and officer disciplinary actions in the state.

The law made three categories of records available for public access: reports of use of force resulting in serious injury or death; reports of sexual assault by a California officer on the job; and instances of official dishonesty when it has been determined that an officer was dishonest on the job, affecting the reporting, investigation, or prosecution of a crime or the investigation of another officer's misconduct.

But as Lisa Pickoff-White, data journalist and senior producer for KQED (the public television and radio station in the San Francisco Bay Area), told *Psychiatric News*, the law made the records accessible only; it didn't make them public. "Someone has to ask for them," she said.

Enter the California Reporting Project (CRP), formed in 2019 when KQED joined five other media outlets in the state—the *Los Angeles Times,* the investigative reporting program at the University of California, Berkeley; CapRadio in Sacramento; and KPCC-Last—to begin requesting reports from the more than 700 police departments throughout the state. Today, more than 40 news outlets in the state are participating in CRP.

"We have received more than 100,000 reports, and some of these reports are extraordinarily long," Pickoff-White said. They contain voluminous notes, text messages, and other recordings from incidents involving death or serious injury. "And that's just the tip of the iceberg. We are able to request reports not just from police agencies but district attorneys, oversight bodies, and anyone who collects such records."

It is an enormous endeavor, and CRP has sought to partner with researchers who can help comb through the records for relevant information. CRP is also working with data technicians and engineers at Berkeley and Stanford to automate the extraction of information, creating open-source tools the public can use to access reports. Pickoff-White is also working with Community Law Enforcement Accountability Network (CLEAN) to do similar work nationwide.

The psychiatric ethics research team at Stanford University, led by Laura Roberts, M.D., M.A., is collaborating with CRP to look specifically at reports of injury or death by police involving people deemed to be mentally ill and/or intoxicated. She is chair and the Katharine Dexter McCormick and Stanley McCormick Memorial Professor in the Department of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine. She is also editor in chief of books at APA Publishing.

In a preliminary report aired this past March, CRP reported that in Bakersfield—a city of approximately 400,000 people north of Los Angeles in the southern part of the San Joaquin Valley—11 of 18 people who died during encounters with the police between 2014 and 2020 were believed to be mentally ill and/or intoxicated.

Pickoff-White said that the true status of an individual who is killed or injured is sometimes unclear. "One of the things we have found is that different officers at the exact same incident may perceive differently whether someone is mentally ill or intoxicated," she told *Psychiatric News*. "I have looked at a case where I have seen police reports from three officers who were there, and each person came to a separate conclusion about what they thought that person's mental status was at the time."

The collaboration with Roberts and her team at Stanford is crucial, Pickoff-White said. "It's been very exciting to see a group of people from so many disciplines work together. It has to be an interdisciplinary project because examining these cases really requires understanding a legal framework, a psychiatric framework, and a law enforcement framework." **PN**

**The CRP report on Bakersfield is posted at https://www.kvpr.org/local-news/2022-03-11/bakersfield-police-records-mental-health-substance-use-are-factors-in-serious-injuries-and-deaths.**

## Stanford Team

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policing when law enforcement officers encounter people who are mentally ill or who are unhoused, with the goal of developing policies and best practices that can mitigate harms.

Psychiatrist Stuart Yudofsky, M.D., a trustee of the Elizabeth Dollard Charitable Trust, told *Psychiatric News* that the foundation has provided Roberts' team with a two-year grant to pursue this work.

Yudofsky noted this issue has roots going back decades to the deinstitutionalization of people with mental illness and the failure to provide sufficient resources to treat people with severe and persistent mental illness in the community.

The result is that police are frequently the first responders to someone in crisis—a situation for which they are not always trained. "Laura's team will review the existing literature and know what questions to ask to get some data about where the flashpoints are" that lead to bad outcomes, he said.

Deborah Danner's death and the publication of her essay prompted a 2018 editorial by Roberts and colleagues in *Academic Psychiatry,* calling for evidence-based strategies to help law enforcement officers who have been forced to assume the role of first responders in difficult situations with individuals living with mental illness.

"Though I didn't know her, I carry the story of Deborah Danner with me every day, and I wish it were a rare story of tragedy," Roberts told *Psychiatric News*. "It is not. Many people with lived experience of mental illness have encounters with the criminal justice system and with members of law enforcement. Addressing challenges faced by people with mental illness or people in crisis situations is an undeniably difficult part of the work of members of law enforcement. Not all interactions between people with mental disorders and law enforcement are negative. But we have too many examples where encounters between law enforcement and people with mental illness have been mishandled—including situations with fatal consequences."

"Our ability to care for our patients, and our ability to support the broader public mental health of everyone in our society, is deeply wrapped up in how the criminal justice system treats people," says Laura Roberts, M.D., M.A.

### Team to Develop Case Studies

As part of the research effort to understand the intersection of mental illness, homelessness, and police violence, Roberts' team is collaborating with the California Reporting Project (CRP), a consortium of California journalistic outlets devoted to building a

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# ‘Socially Invisible’: Panel Raises Awareness For Missing Women of Color

*APA’s Area 4 Assembly hosted a panel highlighting the unrecognized trauma of missing women of color. Two Minnesota lawmakers emphasized the important role psychiatrists can play in raising awareness of this crisis.* **BY KATIE O’CONNOR**

In 2020, about 40% of the 250,000 women and girls who were reported as missing in the United States were people of color, even though they made up just 16% of the overall population.

“This is often referred to as a crisis hiding in plain sight,” said Dionne Hart, M.D., a member of APA’s Council on Advocacy and Government Relations and chair of the APA Assembly Committee on Public and Community Psychiatry. Hart moderated a conversation between two Minnesota legislators, Rep. Ruth Richardson and Sen. Mary Kunesh, which was hosted by APA’s Area 4 Assembly and titled “In Her Shadow: The Unrecognized Trauma of Missing Women of Color.” Hart said the program is part of Area 4’s efforts to increase awareness of the issues impacting the mental health of people of color and their communities. It was organized by Area 4’s Health Equity and Social Justice Workgroup, which Hart chairs.

Kunesh and Richardson were each successful in getting legislation passed to create, respectively, the state’s Missing and Murdered Indigenous Women Task Force and the Missing and Murdered Black Women Task Force.

“Belonging to a socially invisible community has consequences beyond being misunderstood and stereotyped,” Hart said. “It can lead to more dire outcomes, specifically the public disregard of the violence against Native American women and girls, which reflects a passive cultural genocide.”

Kunesh shared data from the Urban Indian Health Institute: In 2016, there were 5,712 reports of missing American Indian and Alaska Native women and girls, though the U.S. Department of Justice’s federal missing persons database only logged 116 cases. “I have on my desk back at the Capitol a list of over two dozen native folks who are currently still missing,” she said. “Their cases are wide open and information has been sought, but I can’t say that there are helicopters or thousands of people combing the grasslands and media [coverage] from coast to coast. That doesn’t happen for our women of color.”


Too often, psychiatrists underestimate the power of the pen and how influential it can be to communicate with their legislators and write letters to the editor. Doing so, however, can have an enormous impact, says Dionne Hart, M.D.

Psychiatrists can play a significant role in bringing attention to the thousands of missing and murdered women and girls of color, Kunesh and Richardson said. “There’s a lot of work that still needs to be done to ensure that this is not just looked at as a problem for the Black or Indigenous communities,” Richardson said. “This is something that impacts all of us.”

Sharing expertise about trauma, particularly generational trauma, and the supports that communities need is vital, Kunesh and Richardson said. Psychiatrists can have a powerful impact by writing letters to the editor of their local newspapers and articles for professional journals to raise awareness of this problem. In addition, speaking directly with lawmakers is also hugely important. “Bring your voices to the Capitol,” Richardson said.

The trauma within the Black and Indigenous communities leads to myriad negative psychiatric outcomes, and community-based strategies to ensure that there are no barriers to treatment are greatly needed, Richardson said. “We have to center patients so that we can build trust in these systems that haven’t always treated bodies that look like ours very well,” she said.

Education about trauma is an important first step, Kunesh said, “but also, we need to provide opportunities to collaborate with individuals within these cultures.” The American Indian community, for example, approaches emotional issues around trauma in a specific way, and including people from that culture in services can make a big difference in helping survivors heal.

Unless missing and murdered women and girls of color receive the attention they deserve, their stories will continue to be lost, Richardson and Kunesh said. “That’s why representation and centering their voices are so important,” Richardson said. “But we also need allies to be with us and ensure that we don’t just continue to turn away from this crisis.” **PN**

**The Missing and Murdered Indigenous Women Task Force report is posted at https://dps.mn.gov/divisions/ojp/Documents/missing-murdered-indigenous-women-task-force-report.pdf. Hart’s Twitter handle is @lildocd, Kunesh’s Twitter handle is @MaryKunesh, and Richardson’s Twitter handle is @RuthForHouse.**

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database of police misconduct in the state (see story on facing page).

The Stanford team is undertaking a systematic review of case files assembled by the CRP to identify individual cases in which law enforcement officers engaged with an individual who was, at minimum, perceived to be mentally ill and possibly homeless. “Reading and reviewing those case files and noting features and outcomes of those incidents allow us to better understand how police engage with these populations and to look at individual case studies when things went well or when things went poorly,” Roberts said.

For instance, Roberts’ team reported that a preliminary review of case files highlights instances in which the need of law enforcement to control or contain a situation is in conflict with best practices for dealing with people living with mental illness.

Ultimately, Roberts and colleagues hope to develop case studies that will be de-identified and published so that a variety of stakeholders—clinicians, law enforcement officers, policymakers, and individuals living with mental illness and/or homelessness themselves—can better understand the kinds of situations that end in use of force and develop best practices to avoid those outcomes.

## Honoring Deborah Danner

Roberts said that the effort should be of interest to psychiatrists everywhere. “Psychiatrists often work closely with law enforcement officers and engage with the criminal justice system,” she said. “In the decades since deinstitutionalization, the working relationship between psychiatrists and members of law enforcement has in many ways expanded, with the shared responsibility to determine if individuals are a danger to themselves or others.”

Deborah Danner’s essay is a harrowing account of her own travail as a person living with schizophrenia. It is also a deeply thoughtful meditation on the adversities confronting her brothers and sisters with serious mental illness—stigma, especially, but also the inadequacies that would contribute to her own death by police. Her essay included a “wish list” that called for better training of police officers, mental health care and housing support for people who are homeless and mentally ill, community support for mentally ill individuals after incarceration, and a system for identifying youth at risk for mental illness.

Today Roberts hopes that the effort to better understand what happens when police encounter people with mental illness will honor the memory of Danner.

“Our ability to care for our patients, and our ability to support the broader public mental health of everyone in our society, is deeply wrapped up in how the criminal justice system treats people. We hope our work on these questions can help shed some light on those dynamics and that the psychiatric profession can be an important part of meaningful solutions.” **PN**

**The Fatal Force database is posted at https://www.washingtonpost.com/graphics/investigations/police-shootings-database/. Deborah Danner’s essay was published in an editorial about her shooting in *The New York Times* posted at https://www.nytimes.com/2016/10/21/opinion/the-death-of-deborah-danner.html. Information about the California Reporting Project is posted at https://projects.scpr.org/california-reporting-project/. The 2018 *Academic Psychiatry* article is posted at https://link.springer.com/content/pdf/10.1007/s40596-018-0945-z.pdf.**

# Moynihan Report Still Connected to Racist Practices in Psychiatry

***BY ANUM IQBAL BAIG, M.D., M.B.A., AND IJEOMA IJEAKU, M.D., M.P.H.***

Daniel Moynihan, assistant secretary in the Department of Labor during the Lyndon B. Johnson administration, wrote a report in 1965 titled "The Negro Family: The Case for National Action," better known as the Moynihan Report. According to an article in the June 24 *Boston Review* by Stephen Steinberg, Ph.D., distinguished emeritus professor at Queens College and the Graduate Center of the City University of New York, the Moynihan Report was written during the critical period when President Johnson planned to progress into "the next and more profound stage of the battle for civil rights" after the passage of the Civil Rights Act of 1964 and Voting Rights Act of 1965. Those two pieces of legislation desegregated American society and granted Blacks both civil and voting rights. Some observers have viewed the Moynihan Report as claiming that dysfunctional family structure and culture are the roots of Black poverty. We suggest that racist policies and institutional racism are responsible for inequities in the distribution of wealth and other socioeconomic commodities. As a result, these pervasive racist policies continue to have adverse effects on Black mental health.

The Moynihan Report focuses on the "crumbling family structure and urban ghetto culture" in Black communities as fundamental causal factors of economic and health care disparities. While family structure can affect the economic status of Black households, it is only one of several social and political factors with such influence. Moynihan vaguely alludes to these factors by noting that "three centuries of injustice have brought about deep-seated structural distortions in the life of the Negro American." He then states that "a national effort towards the problem of Negro Americans must be directed towards the question of family structure." Thus, the report oversimplifies this explanation and shifts the focus away from continued racist policies and cultural practices, which were chiefly responsible for contributing to inadequate Black employment.

The Moynihan Report's findings are undermined by the flawed argument that the "tangle of pathologies" are direct consequences of dysfunctional family structure, rather than a contributing factor to Black poverty. He concludes the report by stating that the U.S. federal government can attempt to solve this problem by creating programs "enhancing the stability and resources of the Negro American family." According to an article in the June 30, 2015, *In These Times* by Daniel Geary, Ph.D., M.A., the ambiguous language used in the Moynihan Report allows its use by some to justify racism and its resulting economic inequalities, leading to damaging consequences. Geary is the Mark Pigott Associate Professor of U.S. History at Trinity College Dublin.

Anum Iqbal Baig, M.D., M.B.A., is a PGY-4 psychiatry resident and chief resident at the Charles R. Drew University of Medicine and Science. She is also a second-year APA/APAF Leadership Fellow and a member of the Southern California Psychiatric Society (SCPS) Diversity and Culture Committee. Ijeoma Ijeaku, M.D., M.P.H., is the immediate past president of the SCPS and chair of the Diversity and Culture Committee. She is also an associate clinical professor at UC Riverside School of Medicine.

The Moynihan Report is relevant today because of the continued presence of unresolved sociopolitical and economic issues mentioned therein. These matters continue to promote racism via racist policies that result in racial and health care disparities for Black people. Policies that perpetuate racial violence result in mistrust of the legal, political, and health care systems, thus leading to reduced access to mental health care. According to an article by Tahmi Perzichilli, M.S., L.P.C.C., posted May 7, 2020, in *Counseling Today*, the pervasive fear and mistrust of the health care system arise from historical reasons including the creation of "drapetomania" as a treatable mental illness that caused enslaved Blacks to want freedom, deinstitutionalization, use of the criminal justice system to control Blacks, and scientific racism. The unresolved sociopolitical and economic issues discussed in the Moynihan Report can be addressed through the enactment of anti-racist policies in every sphere of the American experience. Anti-racist policies are necessary to improve the overall well-being of Blacks as well as their access to mental health care. **PN**

**"The Moynihan Report: The Negro Family, the Case for National Action" is posted in BlackPast at https://www.blackpast.org/african-american-history/moynihan-report-1965/. "The Moynihan Report at Fifty" is posted at http://bostonreview.net/us/stephen-steinberg-moynihan-report-black-families-nathan-glazer. "The Moynihan Report Is Turning 50. Its Ideas on Black Poverty Were Wrong Then and Are Now" is posted at https://inthesetimes.com/article/moynihan-report-black-poverty. "The Historical Roots of Racial Disparities in the Mental Health System" is posted at https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/.**

# Outcome Data Trump Theory in Clinical Practice

***BY H. PAUL PUTMAN III, M.D.***

An article in July's *Molecular Biology* did not surprise most psychiatrists, but it was interpreted by some as proof that we are prescribing antidepressants without knowing what we are doing. The article, "The Serotonin Theory of Depression: A Systematic Umbrella Review of the Evidence," by Joanna Moncrief, M.D., et al., reported on a modified meta-analysis of existing systematic reviews and meta-analyses to determine whether the serotonin hypothesis of depression has been supported. The researchers concluded that it has not. Unfortunately, though, they also stated, "The idea that depression is the result of abnormalities in brain chemicals … provides an important justification for the use of antidepressants."

There are practitioners who see proposed mechanisms of action as support for therapeutic choices. This idea becomes difficult to sustain, however, when we acknowledge that disparate theories of mechanism are attributed to diverse treatments that share a common outcome: serotonin-norepinephrine reuptake inhibitors, selective serotonin reuptake inhibitors, norepinephrine-dopamine reuptake inhibitors, monoamine oxidase inhibitors, electroconvulsive therapy, transcranial magnetic stimulation, vagus nerve stimulation, N-methyl-D-aspartate antagonists, mood stabilizers, and psychotherapy. Our reductionist attempts to understand mechanisms too often suffer from errors conceptualizing across scales. We forget about emergent properties at higher levels of complexity and attempt to explain phenomena from the observable scales with which we are most familiar.

H. Paul Putman III, M.D., has a background in research and the private practice of psychiatry, lecturing, and consulting. He now writes full time and is the author of *Rational Psychopharmacology: A Book of Clinical Skills* from APA Publishing. Members may purchase the book at a discount at https://www.appi.org/Products/Psychopharmacology/Rational-Psychopharmacology.

Our interest in understanding mechanism of action isn't even peaked until we have observed that there is an *action* to start with: the *outcome* of a treatment. We can avoid teleological errors in clinical situations by sticking to outcome data. Once a successful treatment is replicated and standardized, it becomes its own indication. As I stress in *Rational Psychopharmacology: A Book of Clinical Skills,* we should always be making treatment recommendations based on the outcomes of randomized, controlled clinical trials, not the theories behind them.

We do yearn to know the processes behind successful treatment outcomes, out of intellectual curiosity and the hope that such knowledge may lead to new treatment options that can be investigated. As psychiatrists, though, we must remember that our hypotheses about cause are just that—educated guesses that must be tested, and not a substitute for reality. We best avoid reification by employing abductive reasoning in clinical practice: hypothesizing, testing, revising the hypothesis, retesting, and repeating this process until we have a supportable answer. We hypothesize about mechanisms, diagnoses, and the best treatment plans. Thanks to clinical trials, though, the treatments themselves are no longer hypotheses; they are supportable,

*see* **Outcome Data** *on page 22*

# Making Choices on a Journey

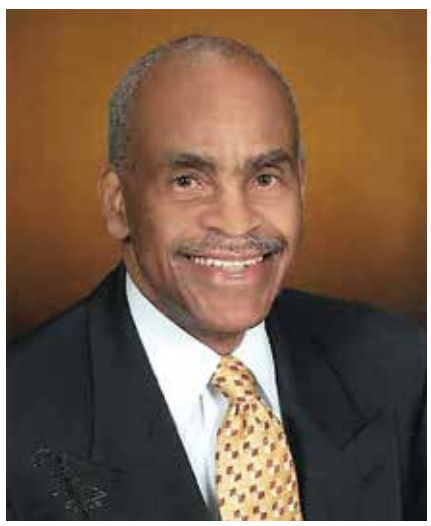
***BY EZRA E.H. GRIFFITH, M.D.***

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

On the last Sunday in July, I attended the 10 a.m. service at the Friendship Baptist Church in Atlanta. I was in the company of a longtime psychiatrist friend, Professor Quentin Ted Smith. It was a joyous reunion in the precincts of his home church. I had no idea that Morehouse and Spelman colleges took form in the basement of Friendship Baptist sometime in the 1860s. However, the faith group presently occupies an imposing multi-function modern structure dedicated in July 2017. Dr. Smith and I had become good friends over the years, and I was curious about his recent activities. I considered him one of the tranquil and effective sages in American psychiatry. He was neither garrulous about his talents nor his deeply generous spirit. He is vice chair of education in the Department of Psychiatry at the Morehouse School of Medicine. I believe that we first met years ago at a conference organized by the Black Psychiatrists of America. I had not seen him since I was the guest speaker at a white coat ceremony about 20 years ago at Morehouse.

I learned that Dr. Smith was a member of the choir slated to sing that Sunday. He was attired, like the other male singers, in a dark suit with a white silk tie and white shirt. Since he is still a half-marathoner and long-distance walker in his ninth decade, he fit into the suit with an understated elegance. He could gain admission to most church choirs anywhere because, as a college undergraduate, he sang first tenor with the Fisk University Jubilee Singers. That is a distinction few can claim. Later, at lunch, he explained that the Black church had long occupied a central space in his life. His music, he said, speaks to others, as does the calligraphy he employs in the letters he pens to members in his church who are grieving loss.

His parents raised him in Brooklyn, where he grew up in the Kingsboro projects. He attended Franklin K. Lane High School and then enrolled at Hunter College, one of the sections of the City University of New York. He felt a bit disheartened by the experience. He seemed to be missing the magic he wanted from the combination of home and school. The Yale psychologist Miraj Desai suggests that such feelings sometimes prompt us to renounce being sedentary and to travel outside our usual confines to seek change. By chance, friends who knew about Fisk University encouraged young Ted Smith to make the move, to take a different fork in the road and travel South. These unexpected encounters can produce decision-making that leads to the most special of places.



Quentin Ted Smith, M.D.

Quentin Ted Smith, M.D., is a professor of psychiatry and vice chair of education in the Morehouse School of Medicine Department of Psychiatry.

I did not ask him whether at that point he was familiar with Robert Frost's 1915 poem, "The Road Not Taken." However, his moving to Fisk turned out to make all the difference in his life. Others have also told me stories about how historically Black colleges enter people's lives and turn things around. He clearly appreciated the intellectual curiosity of this concentrated collection of Black people on a single campus. He was carried away by the wave of positivity and the constructive use of time, place, and energy. Everyone seemed focused, intent on

*see* **Making Choices** *on page 22*

# In 2020, Black Youth Experienced More Racial Discrimination Online

*Black youth reported a spike in experiencing discrimination online in 2020, as white nationalist and domestic terrorist groups responded to protests against racial injustice across the country.* **BY KATIE O'CONNOR**

Before the pandemic, adolescents were spending an average of four to six hours a day on screen-based devices. After the COVID-19 pandemic began in 2020, some studies estimate that youth started spending upward of eight hours a day in front of a screen.

That shift to greater amounts of time spent online coincided with heightened racial tensions in 2020, and a study published in the *Journal of the American Academy of Child & Adolescent Psychiatry* found that between March and November 2020, Black youth experienced increased online racial discrimination and reported poorer mental health immediately after.

"In 2020, the killings of Breonna Taylor, George Floyd, and other Black Americans at the hands of White civilians and law enforcement sparked an uprising against racial injustice that was met with fierce opposition from white nationalists and domestic terror groups in the United States," wrote Juan Del Toro, Ph.D., a research associate at the Learning Research and Development Center at the University of Pittsburgh, and Ming-Te Wang, Ed.D., a professor of psychology and education at the University of Pittsburgh. Those groups became more prominent in online spaces as youth simultaneously relied on those spaces to connect with peers during the pandemic.

Del Toro and Wang recruited 602 self-identified Black and White adolescents (58% Black, 42% White) between the ages of 12 and 18. For two weeks in March, April, May, and October 2020, the participants completed daily surveys to determine whether they had experienced online racial discrimination and to assess their mental health symptoms. Rates of participation varied from month to month, with 44% participating in the March surveys and 57% participating in the October surveys. The researchers collected a total of 18,454 daily assessments.

The authors included a single item from the Online Victimization Scale in the surveys to determine whether the participants experienced online racial discrimination: "Over the past 24 hours, did anyone say or post mean or rude things about you because of your race or ethnic group online?" Participants were also asked about symptoms of depression, anxiety, stress, and exhaustion/tiredness through the Profile of Mood States Questionnaire and a single item from the Daily Stress Scale.

Across all four survey periods, 45% of Black youth reported at least one instance of online racial discrimination, and on average, Black youth experienced two incidents of online racial discrimination. The percentage of participants experiencing online racial discrimination increased from 8% during the first survey period to 22% during the final survey period, and the authors noted that this increase was not solely explained by increased time spent online. In contrast, reporting of online racial discrimination by White youth ranged from 8% in the first survey to 11% in the last.

Black adolescents who experienced online racial discrimination also reported increased depressive symptoms, anxiety, and stress both on the day they experienced the discrimination and the next day, relative to days when they did not experience discrimination. No discernible effect of online racial discrimination emerged for White youth, the authors noted.

Even while working in a community or neighborhood to combat racism, parents and psychiatrists can encourage youth to give themselves space from difficult images and conversations online, says Michelle Durham, M.D., M.P.H. "We can teach our youth to advocate for change and protect their own well-being."

"This study compounds what we already know, unfortunately," said Michelle Durham, M.D., M.P.H., vice chair of education in the Department of Psychiatry at Boston University School of Medicine. "It is difficult even for adults to hear someone say negative things about you based on the color of your skin. If you are a young person who is already in the developmental stage of wanting to fit in, build identity, gain independence, and think about forming new relationships, it is extremely damaging to read those things about yourself and people who look like you."

Nicole Christian-Brathwaite, M.D., pointed out that a 2019 study in the *Journal of Adolescent Health* had similar findings. Among Latinx and African Americans aged 11 to 19 years old, more frequent experiences of traumatic events online (such as seeing a person of their ethnic group beaten, arrested, or detained or seeing a viral video of a Black person getting shot by a police officer) were associated with higher levels of posttraumatic stress disorder and depressive symptoms. Christian-Brathwaite is a child, adolescent, and adult psychiatrist and chief medical officer of Array Behavioral Care, which provides telehealth services.

"It is important to have a transparent conversation with youth and review what protections can be put in place to reduce those traumatic exposures," says Nicole Christian-Brathwaite, M.D.

"Often when we think about trauma, we associate it with physical, emotional, or verbal abuse. People don't always realize that racism is its own form of trauma," Christian-Brathwaite said. "Experiences of racism are stressful and, over time, become toxic stress." This impacts children's ability to cope and their developing brains, she said.

In working with youth, Christian-Brathwaite emphasized the importance of meeting them where they are and not minimizing or dismissing the importance of their virtual lives. "We can understand the important role social media has while giving kids the tools they need to navigate it," she said. "Give them the language they need to discuss what they are facing and acknowledge how painful some of their experiences have been."

Durham emphasized the importance of modeling behaviors for adolescents. "Parents are constantly modeling the behavior they want their children to have, and that is a really powerful tool to encourage the healthy use of screens," she said.

There is a variety of ways to minimize exposure to racism online, Christian-Brathwaite said, such as turning off the feature that automatically plays videos on social media websites to stop viral videos of police shootings, for example. Youth may also need help learning to become aware of how their minds and bodies are reacting to what they see, so they know when to take a break from the screen. "We have to be willing to give them some control and compromise while keeping them safe," Christian-Brathwaite said.

Finally, Christian-Brathwaite emphasized the need to screen for racial trauma. "We have the screening tools necessary to address a person's experience of racism, and we must use them," she said. "Avoiding race is avoiding a part of who that person is."

Del Toro and Wang's study was supported by grants from the National Science Foundation and the Spencer Foundation. **PN**

**"Online Racism and Mental Health Among Black American Adolescents in 2020" is posted at https://www.jaacap.org/article/S0890-8567(22)00361-6/fulltext#secsectitle0030. "Race-Related Traumatic Events Online and Mental Health Among Adolescents of Color" is posted at https://www.sciencedirect.com/science/article/pii/S1054139X19301648.**

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PSYCHIATRIC NEWS
*Special Report*

# Women's Reproductive Mental Health: A Clinical Framework

*The perinatal period is a time of increased risk for psychiatric illness. This article outlines fundamental principles of reproductive psychiatry to apply when treating perinatal patients, including screening recommendations, diagnosis, and treatment approaches.*

***BY MARISSA BEAL, D.O., MARIKA TOSCANO, M.D., AND LAUREN M. OSBORNE, M.D.***

Women develop mood and anxiety disorders at significantly higher rates than men. Psychiatric illnesses in women are most common during the reproductive years and frequently overlap with reproductive transitions, such as menarche, the perinatal period, and perimenopause. In fact, 10% to 15% of women and birthing persons will develop perinatal depression, making it the most common medical complication of childbirth. In addition, mental illness is uniquely comorbid in many gynecologic conditions, including chronic pelvic pain, endometriosis, polycystic ovarian syndrome, female sexual dysfunction disorders, and urinary incontinence. Some primary psychiatric diagnoses, such as premenstrual mood syndromes and postpartum psychosis, are present solely in patients with female reproductive organ systems.

The complex interactions among reproductive biology and physiology, biopsychosocial factors associated with reproductive transitions, and psychiatric illness have historically fallen into a gap in modern medicine. Obstetrician-gynecologists, psychiatrists, family physicians, and pediatricians are all involved in caring for women's physical and mental health, but because of varied training and scope of practice, a holistic approach to women's reproductive mental health is difficult to achieve by an individual in any of these siloed specialties.

The comprehensive *Textbook of Women's Reproductive Mental Health* is a much-needed new resource that general psychiatrists can consult to broaden

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their expertise and better improve short- and long-term health outcomes in their patients who undergo female reproductive transitions. (Note that while there are individuals with female reproductive organs who do not identify as female, the bulk of the research thus far concerns women, and we will therefore use that term throughout this article.)

The textbook is a foundational resource in the discipline of reproductive psychiatry—the branch of medicine that encompasses the science and practice of treating mental, emotional, and behavioral disturbances related to female reproductive transitions. This field has seen an exponential increase in interest and awareness in the past 15 years. General residency programs can now benefit from the free online materials offered by the National Curriculum in Reproductive Psychiatry, and there are now 16 postresidency reproductive psychiatry fellowships in the United States and Canada. There has also been a growth in funding opportunities for research related to reproductive women's mental health to fuel evidence-based practices, as well as a push for public policy growth and innovative collaborative care models. Hormonal fluctuation can trigger psychiatric illness in vulnerable women, and all psychiatrists should be educated in the risks that accompany the menstrual cycle and perimenopause. It is especially important for psychiatrists to develop skills for treating women in the perinatal period—a time when illness affects two generations and when many psychiatrists are reluctant to treat out of fear and lack of knowledge. This article will outline some important fundamental principles of perinatal psychiatry, including screening recommendations, diagnostic considerations, and treatment approaches.

## Screening for Perinatal Mood and Anxiety Disorders

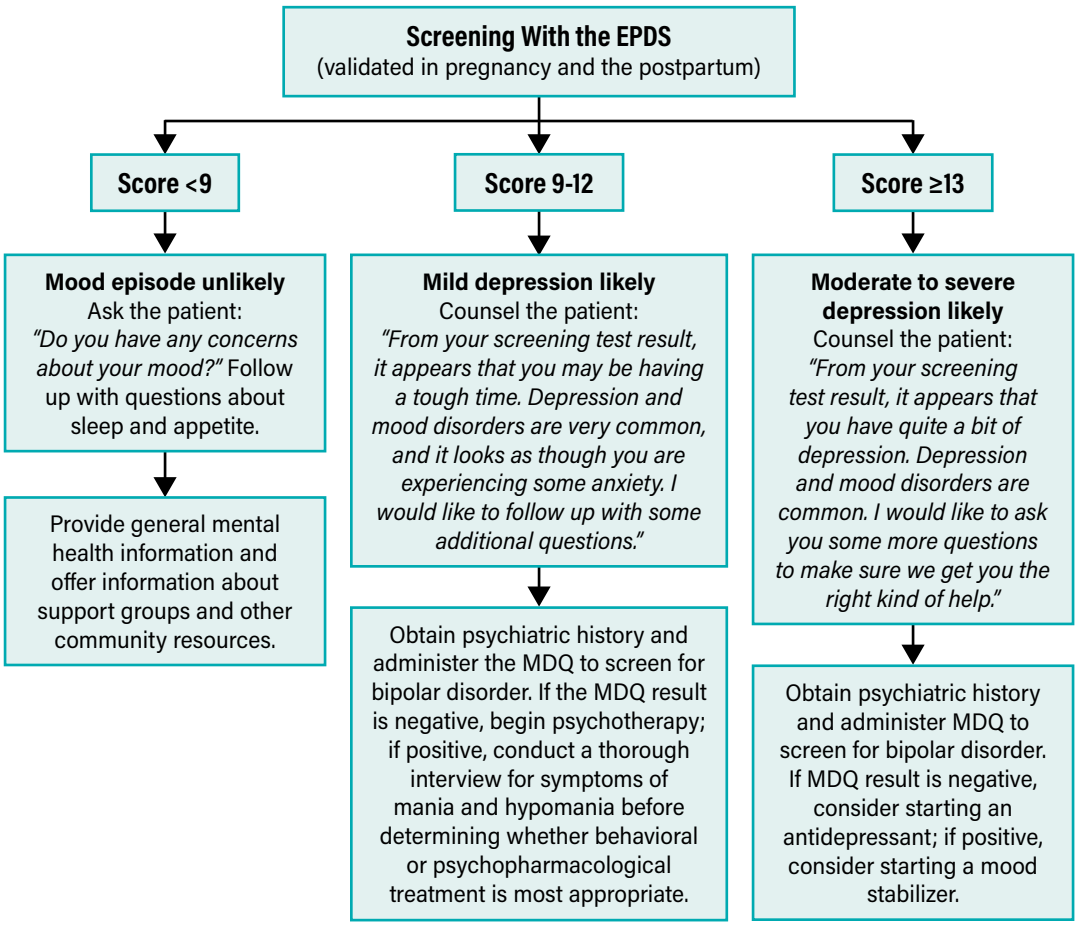
Any clinician who treats perinatal women, including obstetrical, primary care, and mental health professionals, should be screening for depression and anxiety. Major professional organizations including the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, U.S. Preventive Services Task Force, and others recommend universal screening for depression during pregnancy and postpartum, as this strategy has been shown to reduce prevalence of depression and increase remission rates in a large systematic review by Elizabeth O'Connor, Ph.D., and colleagues published January 26, 2016, in *JAMA*.

The most common screening tool is the Edinburgh Postnatal Depression Scale (EPDS), which is validated for pregnant and postpartum patients and available in over 60 languages. While the Canadian Task Force on Preventive Healthcare recently recommended *against* screening perinatal patients, their recommendation implies that health care professionals are routinely asking patients about their mental health during visits, which may not always be the case due to limited time, comfort level, and training. Their recommendation also highlights the gaps in access to psychiatric services in Canada. Most perinatal experts, however, believe that screening and identifying perinatal patients in need of psychiatric care is crucial not only to identify patients in need but also to further highlight the lack of infrastructure and encourage policy changes that may improve access.

Screening helps to identify patients at risk or with concerning symptoms who need further clinical evaluation (Figure 1). An elevated score alone does not indicate an underlying disorder, but rather provides information to detect, treat, and improve outcomes for women. While there are significant barriers to treatment, including transportation, child care needs, and stigma associated with mental health treatment during the perinatal period, screening may help to begin a conversation about maternal mental health, especially for members of racial and ethnic minorities who experience significant health care disparities.

**"Screening may help to begin a conversation about maternal mental health, especially for members of racial and ethnic minorities who experience significant health care disparities."**

**Figure 1. Using the Edinburgh Postnatal Depression Scale (EPDS)**




MDQ: Mood Disorders Questionnaire

## Risk-Risk Analysis: A Framework for Treating Perinatal Patients

Nearly all psychiatrists will treat patients prior to and during pregnancy and should be familiar with key aspects of treating women with perinatal mood disorders (Table 1). Ideally, psychiatrists and patients should collaborate to develop a treatment plan prior to conception, but because close to 50% of all pregnancies in the United States are unplanned, this is not always possible. Therefore, we recommend that psychiatrists begin discussions early about plans to become pregnant, re-address plans for pregnancy over time, inquire about contraceptive use, discuss medication safety and what steps to take regarding medication continuation/discontinuation, and err on the side of using medications with more reassuring safety profiles for women of childbearing age. During preconception planning or if the patient is already pregnant, the psychiatrist and patient must use shared decision-making, weighing the risks of untreated or undertreated psychiatric illness against the possible risks associated with psychotropic medications to the mother and the fetus. This is formulated

**Table 1. Key Points of Treating Perinatal Patients**

1. Times of reproductive change in a woman's life increase the risk for the onset and development of mental illnesses.
2. During pregnancy, mitigate both the risks of untreated or undertreated illness and the potential risks of treatment, including medication.
3. The safest medication to use in pregnancy is usually the one that is most effective and tolerated in treating a patient's illness.
4. Avoid undertreating the patient; remember that pharmacokinetic changes during pregnancy lead to lower plasma concentrations of all drugs.
5. Infant feeding and lactation and sleep preservation are important aspects of a treatment plan.

as a risk-risk analysis and is an important clinical tenet of reproductive psychiatry (Table 2). These discussions can be further augmented by consultation with a maternal-fetal medicine specialist obstetrician prior to or during pregnancy.

A risk-risk discussion includes a thorough diagnostic evaluation to ensure the validity of a psychiatric diagnosis. When patients present with preexisting diagnoses and medication regimens, it is important to obtain diagnostic clarity to have the most informed risk-risk discussion. Assessing the severity of illness and presence of residual symptoms may also inform the treatment plan and risk for relapse in the perinatal period.

The evidence regarding psychotropic medication safety relies mostly on observational data, as randomized, controlled trials have not been performed due to ethical concerns about randomizing vulnerable subjects. Early studies regarding the risks of antidepressants during pregnancy did not appropriately control for confounders or compared medication users with healthy controls, which is not an accurate comparison group. Since women with mood disorders (and psychotropic medication exposure) are more likely to have other medical and psychiatric comorbidities, as well as psychosocial contributors, these comorbidities need to be considered when assessing study outcomes. As study designs improved, including controlling for confounders and using appropriate control groups, most risks of psychotropic medications were determined to be lower than initially thought. There is clear evidence regarding the risks of untreated psychiatric illness during pregnancy, and this risk must be weighed against known risks of psychotropic medications.

Historically, because the risks of psychotropic medications were overestimated and the risks of untreated psychiatric illness underestimated, recommendations were to discontinue psychotropic medications during organogenesis in the first trimester or throughout pregnancy. This left women with a history of psychiatric illness at high risk for symptom relapse during pregnancy and in the postpartum period. Now, the increased volume of data related to the reproductive safety profile of psychotropic medications and outcome data for untreated psychiatric illness provide a framework for psychiatrists and patients to weigh the risks of both untreated psychiatric illness and psychotropic medication use in the perinatal period. We include a potential risk-risk analysis in Table 2 for a patient with depression, comparing data about untreated depressive illness versus treatment with selective serotonin reuptake inhibitors (SSRIs). However, each risk-risk discussion is patient-specific and may be affected by severity of psychiatric illness, socioeconomic status, racial disparities, psychosocial support, and/or access to treatment modalities.

**Table 2. A Sample Risk-Risk Discussion for Untreated Perinatal Depression Versus Treatment With Selective Serotonin Reuptake Inhibitors**

| Adverse outcome | Risks of untreated/ undertreated perinatal depression | Risks of treatment with selective serotonin reuptake inhibitors (SSRIs) during pregnancy |
|---|---|---|
| Congenital malformations | No association | Early studies showed a possible association between SSRI use and fetal congenital malformations (particularly common were mild cardiac lesions such as ventricular septal defect), but more recent, higher quality data do not show these associations when controlling for confounders, even with exposure in the first trimester during organogenesis. |
| Spontaneous abortion | Increased risk | No additional increased risk. |
| Preterm birth | Increased risk | Possible additional increased risk. |
| Low birth weight | Increased risk | No additional increased risk, or possibly low, clinically insignificant impact. |
| Short-term outcomes | Risk for impaired bonding, decreased length of breastfeeding, increased risk of postpartum depression | Studies have described an association with persistent pulmonary hypertension in the newborn period though the overall absolute risk of this is low (number needed to harm: 1,615) and usually mild (not requiring invasive ventilation); and neonatal adaptation syndrome (a brief [24 to 48 hours], self-limited period of infant restlessness, jitteriness, increased muscle tone, or rapid breathing requiring no medical intervention). |
| Long-term outcomes | Cognitive and behavioral problems | No additional increased risk. |

Source: *Textbook of Women's Reproductive Mental Health*, APA Publishing, 2022.

## Determining Etiology of New-Onset Psychiatric Episode

Ms. A is a 27-year-old woman with no prior psychiatric history presenting three weeks after the delivery of her first child. She is married with a supportive husband who works full time and has minimal family support outside of her husband. She noted some increased worry throughout the pregnancy, specifically related to the health of her baby, which affected her sleep. At 37 weeks, she was induced due to concern for preeclampsia and had an emergency C-section after her labor failed to progress and the baby was showing signs of distress. She now reports increased crying spells, low mood, and anxiety specifically related to the baby. She is sleeping one to two hours at night and waking up frequently to check if the baby is breathing or to clean bottles and pumping parts. Her partner reports that she is not acting like herself. She is attempting to breastfeed, but the baby had difficulty latching so she is mostly pumping breastmilk. She notes thoughts of harming the baby, such as dropping him from the changing table or falling down the stairs while holding him. She worries that she is a bad mother and contemplates whether her family may be better off without her.

To unpack the case study above involves consideration of a number of potential differential diagnoses. In addition to medical diagnoses associated with postpartum mood changes, such as new-onset hypothyroidism (arising from postpartum thyroiditis or from Sheehan's syndrome secondary to postpartum hemorrhage), a broad range of psychiatric conditions must also be considered, including postpartum depression, bipolar disorder, obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), and postpartum psychosis (PPP). It is vital to differentiate mood disorders in the perinatal period,

*continued on next page*

**"There is clear evidence regarding the risks of untreated psychiatric illness during pregnancy, and this risk must be weighed against known risks of psychotropic medications."**

*continued from previous page*

as symptoms often overlap and management varies depending on the underlying diagnosis, as summarized in Table 3. For example, intrusive thoughts, particularly of harm coming to the baby, can be nonpathological—most new mothers experience them. But they can also be present in depressive disorders, GAD, OCD, and PPP. Irritability is seen in baby blues, mania, depressive disorders, anxiety disorders, and posttraumatic stress disorder (PTSD).

For the case of Ms. A, we will outline the three most likely diagnoses—perinatal depression, OCD, and PPP—and cover diagnostic and treatment considerations for each.

**Figure 2. Elements of Case Study That Point to Each Diagnosis**

**Postnatal depression**
- Poor Sleep
- Low Mood
- Crying
- Anxiety
- Worries she is bad mother

**Obsessive-compulsive disorder**
- Worry about health of baby
- Frequent checking on baby
- Up in night cleaning pump
- Thoughts of harm to baby

**Postpartum psychosis**
- Anxiety
- Sleeping 1-2 hours/night
- Thoughts of harm to baby

**Perinatal depression**

Perinatal depression is common, affecting at least 15% of women, and encompasses both antenatal and postpartum symptom onset. (Pregnancy-onset depression is likely a biologically separate disorder from postpartum-onset depression, but *DSM-5* does not make this distinction.) The symptoms of perinatal depression are similar to the diagnostic criteria for major depressive disorder, including low mood, anhedonia, low energy and motivation, poor concentration, changes in sleep or appetite, and suicidal ideation when severe. Since fatigue and changes in sleep and appetite are common in the perinatal period, it is essential to discern a mood episode versus symptoms related to pregnancy. Anxiety and intrusive thoughts are more common in perinatal depression, with frequent ruminations related to the health of the mother or baby.

*Treatment*

Treatment includes SSRIs, serotonin and norepinephrine reuptake inhibitors (SNRIs), and tricyclic antidepressants (TCAs), all of which are compatible with pregnancy and lactation. Dosage increases may be necessary due to physiologic changes, and there is no evidence to support the practice of lowering or stopping medications in the third trimester to decrease the risk of neonatal adaptation syndrome.

**Unipolar versus bipolar perinatal depression**

A full discussion about the management of bipolar disorder in the perinatal period is beyond the scope of this article, though close to a third of women with bipolar disorder first present in the perinatal period. The majority of postpartum mood episodes experienced by those with bipolar disorder are depressive episodes. It is therefore important to screen for both postpartum depression and bipolar disorder to avoid misclassifying bipolar depression as unipolar depression. In fact, Lindsay Merrill, M.D., and colleagues, as outlined in the August 2015 issue of the *Archives of Women's Mental Health,* found that 21.4% of women who had a positive EPDS screen (score > 10) at their initial prenatal visit also had a positive Mood Disorder Questionnaire. Similarly, Katherine L. Wisner, M.D., M.S., and colleagues, reported in the May 2013 issue of *JAMA Psychiatry* that 22.6% of postpartum women with a positive EPDS screen were diagnosed with bipolar disorder upon structured clinical interview. Identifying an underlying bipolar illness greatly shapes management both in the short and long term and thus is essential not to miss during this period of increased vulnerability.

**"It is vital to differentiate mood disorders in the perinatal period, as symptoms often overlap and management varies depending on the underlying diagnosis."**

**Table 3. Brief Review of Differential Diagnoses for New-Onset Mood Symptoms In the Perinatal Period**

| Diagnosis | Onset | Symptoms | Treatment |
|---|---|---|---|
| "Baby blues" | Postpartum | Mild mood lability. | None, self-resolving in 14 days or less |
| Depressive disorders | Antepartum or postpartum | Sadness or a feeling of being numb or detached; neurovegetative symptoms, such as altered sleep, appetite, and energy; at times, the presence of hopelessness or suicidal ideation; anxiety often prominent. | CBT/IPT<br>SSRI/SNRI |
| Generalized anxiety disorder | Antepartum or postpartum | Thoughts focus on worry over routine events; apprehension and catastrophic thinking; in the perinatal period, many patients present with symptoms consistent with GAD but do not meet the time frame critierion. | CBT<br>SSRI/SNRI<br>Benzodiazepines (short term) |
| Obsessive-compulsive disorder | Antepartum or postpartum | Presence of compulsions; intrusive thoughts and images, often concerning infant harm (ego-dystonic). | CBT (ERP)<br>High-dose SSRIs |
| Postpartum psychosis | Postpartum | Waxing and waning symptoms; confusion, paranoia; thoughts to harm infant (ego-syntonic). | Hospitalization<br>Lithium<br>Antipsychotics<br>Benzodiazepines<br>Electroconvulsive therapy |

CBT: cognitive-behavioral therapy; IPT: interpersonal therapy; SSRI: selective serotonin reuptake inhibitor; SNRI: selective norepinephrine reuptake inhibitor; ERP: exposure-response prevention

Source: *Textbook of Women's Reproductive Mental Health,* APA Publishing, 2022.

**OCD**

New-onset or an exacerbation of OCD is common in the postpartum period, with higher rates than in the general population. Symptoms include obsessions (intrusive thoughts or images) and/or compulsions (repetitive behaviors completed to minimize anxiety) that are time consuming and affect functioning. During pregnancy, obsessions are often related to contamination or thoughts of infant harm. Compulsions may include excessive cleaning (such as sterilizing bottles/pumping supplies excessively) or checking behaviors (such as checking if the baby is breathing). The thoughts of infant harm are ego-dystonic and cause significant anxiety or distress for the mother; they may even lead to avoidance of the infant or environment where harm could occur. To ensure that unnecessary hospitalization and separation from the newborn are avoided, screening should further delineate intrusive thoughts of infant harm versus delusional thoughts (as discussed on facing page with PPP).

*Treatment*

As in the general population, treatment includes cognitive-behavioral therapy (specifically exposure-response prevention) and pharmacologic treatment with high-dose SSRIs as first-line treatment and TCAs or other antidepressants as second

line. Second-generation antipsychotics may be appropriate augmentation in treatment-resistant cases. Treatment considerations include dosage titration, as women may require higher doses as pregnancy progresses due to the physiologic changes of pregnancy. At this time, there are no data to suggest that higher doses of SSRIs are associated with worse maternal or fetal outcomes; fear or anxiety regarding increasing doses should be discussed with the patient.

**Postpartum Psychosis (PPP)**

When evaluating patients with new-onset postpartum mood symptoms, it is vital to rule out PPP. While rare, PPP is associated with an increased risk of suicide and infanticide and thus is considered a psychiatric emergency. The onset of symptoms typically occurs within the first four weeks after delivery, and they can include both mood (such as mania or depression) and psychotic symptoms (including delusions about childbirth or the infant). Symptoms wax and wane, and patients can appear delirious, with new-onset confusion, alterations in sensorium, and disorganized thought. PPP can also include delusions regarding infanticide, and thoughts of infant harm must be differentiated from intrusive thoughts related to OCD. As outlined in Figure 2, thoughts of infant harm in PPP include delusional content and poor insight and are ego-syntonic (congruent with personal beliefs), while in OCD thoughts are intrusive and ego-dystonic (incongruent with personal beliefs) with intact insight.

*Treatment*

Treatment consists of identifying PPP, assessing safety, ruling out medical causes of delirium or change in mental status, and inpatient psychiatric hospitalization. During hospitalization, lithium is the recommended first-line treatment, and studies have shown that the vast majority of patients respond to lithium. Benzodiazepines and antipsychotics are useful adjuncts, but they can usually be discontinued after the acute period. Electroconvulsive therapy can also be used when patients have severe symptoms, when rapid recovery is necessary, or when patients have not responded to other treatments. Treatment should be continued for at least nine months after an episode. PPP is closely linked to bipolar disorder and may represent a first episode or recurrence of an underlying bipolar illness, which may affect treatment decisions related to maintenance management. A minority of women who experience PPP have episodes only in the postpartum period and do not have an underlying bipolar disorder. After one episode, it is impossible to know whether women will go on to be diagnosed with bipolar disorder, but in either case, it is crucial to counsel all women who experience PPP about prophylactic treatment in subsequent peripartums. Lithium has the strongest body of evidence for prophylaxis against another episode of PPP.

## Perinatal Treatment Considerations to Remember

Here are some important perinatal treatment considerations to keep in mind.

- **Minimize the number of medications.**
  In addition to the "risk-risk" discussion, psychiatrists should consider minimizing polypharmacy and discontinuing medications that may not be necessary for maternal psychiatric stability. While there are now more data regarding outcomes for psychotropic medications, less is known about combinations of medications. (In other words, higher doses of fewer medications are preferable to lower doses of more medications.) However, the potential benefits of discontinuing medications must be weighed against the possibility of psychiatric relapse, leading to exposure to undertreated illness and possibly to even more psychiatric medications to achieve euthymia.
- **Use medications that work for the patient.**
  Medication history should be carefully reviewed to determine the medication that is most efficacious for the patient. While there are more safety data on older psychotropic medications, switching a woman to an older or possibly "safer" medication soon before or during pregnancy is not recommended if there is no information regarding the efficacy or tolerability for the specific patient. Switching medications may lead to symptom relapse and more medication changes and exposures if the patient doesn't respond to or tolerate the medication. Psychiatrists should counsel women regarding the lack of safety data for newer medications, and this should be included in the risk-risk discussion. Psychiatrists should also consider this when making treatment decisions for women of childbearing age. Prior to conception, it is reasonable to consider switching to an older medication with more reassuring data.
- **Don't undertreat.**
  Dosage considerations should be discussed, as physiologic changes in pregnancy, including increased blood volume, glomerular filtration rate, and liver metabolism, lead to decreased plasma blood levels for most medications. To avoid the possibility of exposing the fetus to both untreated/undertreated illness and medications, it is essential to optimize the medication dosage and possibly increase the dose throughout pregnancy, especially if symptoms begin to emerge. The goal is to use the lowest effective dose of medication while keeping the mother psychiatrically healthy to improve outcomes for both mom and baby. Furthermore, down-titrating medications such as SSRIs in the third trimester has not been shown to decrease the risks for complications, such as neonatal adaptation syndrome, and likely increases the risk of relapse.
- **Prescribe sleep and a plan for infant feeding.**
  A comprehensive treatment plan for perinatal patients should always include nonpharmacologic strategies, as these may offer additional benefit with minimal risk of harm. Psychosocial interventions and psychotherapy are essential aspects of a treatment plan to improve symptoms and reduce the medication burden throughout pregnancy. In addition, clinicians should discuss recommendations for sleep preservation and a plan for infant feeding throughout the pregnancy and postpartum. Sleep deprivation is a risk factor for psychiatric illness and can exacerbate perinatal mood and anxiety disorders. Protecting sleep and creating a postpartum plan for patients and their support system are important to ensure sleep is preserved.

  Discussions regarding infant feeding and parental goals related to breastfeeding should begin at preconception and continue throughout pregnancy and postpartum. Supporting a patient nonjudgmentally and providing information regarding options related to infant feeding is essential, as well as counseling regarding the risks of sleep deprivation, which is inherent in breastfeeding. Psychiatrists should discuss both the benefits of breastfeeding for the baby, as well as options for infant feeding, available resources, the benefits of consolidating sleep, and the importance of enlisting additional support to help with feeding. Regarding psychotropic medication exposure for the newborn while breastfeeding, a relative infant dose of less than 10% is generally considered acceptable per the American Academy of Pediatrics, and most common psychotropic medications are compatible with breastfeeding.

## Conclusion

Reproductive psychiatry is an emerging and urgently needed area of clinical interest, education, and research. The *Textbook of Women's Reproductive Mental Health* provides a guide and clinical toolkit for treating women during high-risk reproductive transitions. We hope that this book serves as a tool for trainees and psychiatrists when encountering women across the lifespan, including at menarche, across the menstrual cycle, in the perinatal period, and in perimenopause. As access to trained reproductive psychiatrists is limited, we hope that improved educational resources will reduce gaps in care and improve physical and mental health outcomes for women during these vulnerable time periods.

While this book and other similar efforts are a good start, there are still substantial gaps in knowledge in reproductive psychiatry. We need research on etiology and pathophysiology, and we especially need research that can inform diagnostic and treatment considerations for LGBTQ+ patient populations, transgender/genderfluid individuals, and women affected by racial and socioeconomic disparities. And, given the continued nationwide shortage of psychiatrists, funding for implementing evidence-based collaborative and integrated care models could vastly improve access to care and should be a priority for all health systems. **PN**

**"Primary Care Screening for and Treatment of Depression in Pregnant and Postpartum Women" is posted at https://jamanetwork.com/journals/jama/fullarticle/2484344. "Screening for Bipolar Disorder During Pregnancy" is posted at https://link.springer.com/article/10.1007/s00737-015-0527-y. "Onset Timing, Thoughts of Self-harm, and Diagnoses in Postpartum Women With Screen-Positive Depression Findings" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1666651.**

***Author Disclosure Satement***

*Lauren M. Osborne, M.D., receives royalties from APA Publishing and Elsevier, funding from the National Institute of Mental Health, and funding from the American Board of Psychiatry and Neurology for the development of the reproductive psychiatry curriculum. The other authors have no disclosures.*

# TMS Should Be Considered as First-Line Treatment For Moderate to Severe Major Depressive Disorder

***BY RICHARD A. BERMUDES, M.D.***

After incorporating transcranial magnetic stimulation (TMS) into my practice back in 2009, I anxiously awaited the release of APA's Practice Guideline for the Treatment of Patients With Major Depressive Disorder, which was published in 2010. I was concerned that the guideline would not mention TMS. The work group reviewed more than 13,000 articles published between 1999 (when the search from the previous edition ended) and 2006. The pivotal trial that led to the initial FDA clearance for TMS in October 2008 was published in the December 1, 2007, issue of *Biological Psychiatry*.

To my surprise, not only was TMS mentioned but a number of key guideline changes included recommendations for the following:

- Psychiatrists should present patients with information concerning the evidence for a broad range of treatment options, including somatic therapies and psychosocial interventions.

- Psychiatrists should use a clinician- and/or patient-administered rating scale for psychiatric symptoms to help with treatment strategies.

- ECT is indicated for treatment-resistant depression, but monoamine oxidase inhibitors, TMS, and vagus nerve stimulation are other potential options.

- Maintenance treatment should be considered after the continuation phase, especially for patients at risk for recurrence.

- There is currently insufficient evidence to support the use of TMS in the initial treatment of major depressive disorder.

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://www.appi.org/Products/Neuropsychiatry-and-Biological-Psychiatry/Transcranial-Magnetic-Stimulation.

As I read the guidelines recently and considered the number of new outcome studies conducted with TMS, I believe TMS should be considered in addition to pharmacotherapy and psychotherapy as a first-line treatment for patients with moderate to severe major depressive disorder.

There are a few key publications that highlight the growth in TMS over the last 10 years (see table). A relatively new systematic qualitative analysis published January 8, 2019, in *BMJ Psychiatry* indicates the sooner treatment-naïve patients start TMS in the current depressive episode, the better the outcome. Ten articles were included in the analysis (six high grade and four lower grade) that demonstrated a 95% response rate and 63% remission rate in subjects who received TMS as a first-line treatment in the current episode. Furthermore, discontinuation rates are lower with TMS compared with pharmacotherapy, and TMS has no systemic side effects such as weight gain, premature diabetes, and sexual side effects. TMS is cost-effective and leads to higher adjusted quality-adjusted life years.

Given the evidence, it may be considered unethical to *not* discuss TMS as a treatment option for patients who are treatment naïve or who have failed one antidepressant in the current episode. As ambassadors for recovery, psychiatrists should present patients with information concerning the evidence for a broad range of treatment options, including somatic therapies and psychosocial interventions. **PN**

**TMS Outcomes as First-Line Treatment for Nonpsychotic Major Depression**

| Diagnosis | Pharmacotherapy | TMS |
|---|---|---|
| Remission rates at 6 weeks | 36% | 63% |
| Maintenance of response/remission out to 1 year | 55% | 60% |
| Discontinuation rates within 4-6 weeks of acute phase | 16% | 5% |

Sources posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.10.8.27

**"Efficacy and Safety of Transcranial Magnetic Stimulation in the Acute Treatment of Major Depression: A Multisite Randomized Controlled Trial" is posted at https://www.biologicalpsychiatryjournal.com/article/S0006-3223(07)00146-1/fulltext. "A Systematic Literature Review of the Clinical Efficacy of Repetitive Transcranial Magnetic Stimulation (rTMS) in Non-treatment Resistant Patients With Major Depressive Disorder" is posted at https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-018-1989-z.**

## Making Choices

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achieving something. He could see it just in the way the students walked. And the professors took the time to be helpful and considerate. From his discourse, I could tell that he models some of his pedagogical style on what he witnessed at Fisk. After the first semester, he was awarded a scholarship. His performance earned him a place in Phi Beta Kappa in his senior year.

He graduated in 1961 and spent a year pursuing a Ph.D. at the University of Chicago in biopsychology. He missed the culture, the interactions, the spirit that had emerged so powerfully at Fisk. He took a year off and reoriented himself toward medicine. Robert Frost was right. It serves little purpose to stay on a disappointing pathway and brood. Alternatively, as a single traveler, he could not stay on more than one road at the same time. Frost makes clear that such simultaneity is not permitted: "Two roads diverged in a yellow wood, And sorry I could not travel both. …" So, Dr. Smith enrolled at the Howard University College of Medicine and found a new home. In it, he established the habits and rituals that Professor Devika Chawla says can restore a person into himself.

Professor Smith completed his medical studies in 1967, loving the experience and noting that his teachers were fantastic. By 1973, he completed specialty training in general and in child and adolescent psychiatry. He taught at Emory University School of Medicine before moving to Morehouse in 1984, where both he and his pathologist wife would build careers as celebrated master teachers and scholars. He modeled the physician role for his charges. Unlike many, he stayed away from administration because it often seemed to carry too much of a "misery index." He preferred the interactions with trainees curious about healing and caring for others.

He uses the solitude and isolation of his long walks and leisurely promenades around the city to think and recharge his energy. He has enjoyed remarkable privileges in life and has few regrets about his routine choices. Whenever presented with the dilemma of confronting two roads, he took one, recognizing that a choice is simply mandatory. I came away from our encounter repeating Walt Whitman's lines from "To Think of Time":

"Something long preparing and formless is arrived and form'd in you,

You are henceforth secure, whatever comes or goes." **PN**

## Outcome Data

*continued from page 14*

reproducible outcomes shown to be acceptably safe.

Just as *DSM-III* in 1980 abandoned the spurious value of presumed etiology of psychiatric diagnoses, we need to be ever vigilant to exclude presumed, unproven mechanisms from today's treatment plans. In the psychiatrists' office, outcome data matter and theories do not—the essence of evidence-based medicine.

The primary authors of an article posted July 19 in *Psychology Today* wrote that antidepressant use had reached "epidemic proportions" due to "the false belief that depression is due to a chemical imbalance." Dr. Moncrief is correct that we should not be telling our patients we recommend antidepressants because of a chemical imbalance—we should be suggesting they take them because we know that they help a large number of patients.

Psychiatrists offer patients a therapeutic alliance and our problem-solving skill, not just factual knowledge. To help them, we must know what works and how to use it effectively and safely. A proven mechanistic explanation, which might be reassuring to some, is still secondary; an unproven one, irrelevant. I have often admitted to patients that while we wish we knew why a treatment worked, I would rather be able to offer them options that we know help and are safe than understand completely the pathology of a disease or illness that we have no treatment for.

We must not be ashamed that we offer proven and safe treatments that may lack full explanation, nor be intimidated by the incomplete knowl-

*continued on facing page*

# FDA Clears Accelerated TMS Protocol for Depression

Magnus Medical

*The SAINT system uses functional MRI to map out an individual's brain connectivity to identify the optimal anatomic region for the condensed course of magnetic stimulation.* ***BY NICK ZAGORSKI***

The Food and Drug Administration (FDA) in September cleared the SAINT Neuromodulation System for the treatment of refractory depression in adults. SAINT is an innovative form of transcranial magnetic stimulation (TMS) that combines MRI-guided selection of the targeted brain region with an accelerated stimulation regimen involving multiple short TMS sessions every day for five days.

"This is more than just clearance of another device. This clearance expands the way we can use TMS to treat depression," Mark S. George, M.D., distinguished professor of psychiatry, radiology, and neuroscience at the Medical University of South Carolina, said in a media release from Magnus Medical Inc., the manufacturer of SAINT.

As George explained, older TMS protocols require six weeks or more of regularly scheduled stimulation sessions (three to five sessions a week). SAINT's five-day protocol might expand options for patients who are hospitalized and/or present to the emergency room, as well as outpatients unable to commit to a six-week treatment regimen.

Magnus Medical

One innovative element of the SAINT neuromodulation system (prototype on top) is its use of functional magnetic resonance imaging to identify the optimal brain region for focused stimulation (above), tailoring each treatment to a patient's brain connectivity profile.

The clearance of SAINT was based off multiple clinical studies that showed rapid, robust, and sustained improvements in depression symptoms in adults who had received SAINT. One of these studies was published last October in *The American Journal of Psychiatry*. The trial included 29 adults with treatment-resistant depression who were assigned to either SAINT or sham stimulation. Participants who received SAINT experienced on average a 62% reduction in their Montgomery-Åsberg Depression Rating Scale (MADRS) scores following five days of stimulation compared with a 14% drop in MADRS scores in those receiving sham stimulation. These mood improvements were maintained over four weeks. At the four-week follow-up, 69% of the participants in the SAINT group had a treatment response (at least a 50% improvement in the MADRS score) and 46% met the criteria for remission (MADRS scores of less than or equal to 10).

The FDA clearance of SAINT was groundbreaking for many reasons, explained Nolan Williams, M.D., the director of the Stanford University Brain Stimulation Lab, which developed the SAINT protocol. In addition to being the first rapid-acting neuromodulation commercially available, Williams told *Psychiatric News* that SAINT is also the first to use functional MRI to map out an individual's brain connectivity to identify the optimal anatomic region for stimulation.

"Because SAINT requires neuroimaging, this clearance marks the first official involvement of radiology in mental illness care," he said. (PET and other imaging tools are used to aid in some psychiatric diagnoses, but this marks the first use of imaging to treat patients with mental illness, according to Williams.) Williams, who is also an assistant professor of psychiatry and behavioral sciences at Stanford, said the arrival of SAINT may usher in a new medical subspeciality of psychoradiology.

Zafiris Daskalakis, M.D., Ph.D., chair of psychiatry at the University of California, San Diego (UCSD), told *Psychiatric News* this clearance could be transformative for psychiatry, though larger and more clinically diverse studies are needed (for example trials with depressed individuals with a comorbid personality disorder or substance use disorder).

In an editorial accompanying the *AJP* study, Daskalakis and UCSD colleague Cory R. Weissman, M.D., wrote that SAINT needs more testing in patients with severe depression who would currently be candidates for electroconvulsive therapy [ECT], such as psychiatric inpatients or patients with emergent suicidality; the existing clinical studies enrolled outpatients with moderate depressive symptoms. "If SAINT proves as efficacious as ECT it would offer a true alternative to patients and physicians who are worried about ECT's cognitive side effects," he said.

"I think it's also important to see studies where the novel innovations of SAINT [MRI targeting and multiple sessions per day] are separated," said Daskalakis. "Are the effects additive, synergistic, or is one element doing all the lifting." For example, if the MRI-based target selection is not essential, it might open up SAINT to clinics with limited MRI access and/or patients whose insurance will not cover the cost of imaging.

Williams thinks the MRI requirement for SAINT will not be a significant roadblock once clinics and payers see the long-term value of SAINT. He noted that the MRI assessment is only about 30 minutes and only needs to be done once per patient. "When you factor in the rapid and long-term benefits from finding that optimal location in a large group of patients, it becomes very cost effective," he said.

According to Brett Wingeier, Ph.D., co-founder and CEO of Magnus Medical, the SAINT system (which will include the magnetic stimulator as well as all the tools needed to analyze the MRI scans of patients using the company's cloud-based algorithm) will be available for purchase in 2023. Wingeier co-founded Magnus with Brandon Bentzley, M.D., Ph.D., a former member of the Stanford Brain Stimulation Lab. Williams is not employed by Magnus but is an advisor for the company. **PN**

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edge we share with those who would criticize our efforts. Adhering to the path of evidence-based medicine allows us to find answers through darkness and uncertainty, a journey we take with our patients for their benefit. **PN**

**"The Serotonin Theory of Depression: A Systematic Umbrella Review of the Evidence" is posted https://www.nature.com/articles/s41380-022-01661-0. " A Decisive Blow to the Serotonin Hypothesis of Depression: An Exhaustive New Review Debunks the 'Chemical Imbalance' Theory of Depression" is posted at https://www.psychologytoday.com/intl/blog/side-effects/202207/decisive-blow-the-serotonin-hypothesis-depression.**

**"Stanford Neuromodulation Therapy (SNT): A Double-Blind Randomized Controlled Trial" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2021.20101429. The editorial "Accelerated Intermittent Theta Burst Stimulation: Expediting and Enhancing Treatment Outcomes in Treatment-Resistant Depression" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2021.21121221. A perspective on SAINT from Nolan Williams, M.D., "New Stanford Protocol for TMS Found to Achieve Fast Remission," is posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.11.41.**

# Severe Grief Tied to Experiencing, Witnessing Overdose

*Repeated exposure to overdose events has a cumulative effect on how people who use illicit substances feel grief in response to loss.* **BY TERRI D'ARRIGO**

Repeated exposure to overdose events can shape how people who use illicit substances understand the world and violate their sense of safety, says Kathleen S. Kenny, Ph.D.

Experiencing or witnessing multiple overdose events is associated with severe grief among people who inject drugs, a study in *Drug and Alcohol Dependence* has found.

"We know that grief can have significant deleterious effects, and we wanted to understand how it was being experienced by people in the context of the opioid overdose crisis and its unceasing onslaught of overdose deaths and near deaths," lead author Kathleen S. Kenny, Ph.D., told *Psychiatric News*. She is a Canadian Institutes of Health Research postdoctoral fellow at the Manitoba Centre for Health Policy in the Department of Community Health Sciences at the University of Manitoba. "A main takeaway from the study is that cumulative, rather than single, overdose events were associated with severity of responses to grief and loss."

Kenny and colleagues examined data from a survey of 244 people who injected drugs in four community-based harm reduction programs in Toronto. Participants were 16 years of age or older and had injected drugs in the past three months. The researchers defined three types of overdose events: the participant's own overdose, an overdose witnessed by the participant, and the overdose death of a person important to the participant. They then asked whether participants agreed with seven statements about how they were affected by overdose-related losses. The statements included "I feel like I've lost parts of myself," "I feel like life has really changed," "I feel like things I use to cope don't help anymore," "I feel numbed out," "I'm not sure how to make sense of all the losses I've experienced," "I feel angry," and "I feel like I've lost a lot of my community." The participants who answered "yes" to a higher number of statements were considered to have more severe responses to grief and loss.

Among all participants, 28.7% reported two or more personal overdoses of their own, 70.9% witnessed two or more overdoses in other people, and 28.3% had experienced the loss of two or more people important to them in the previous six months. The researchers found that participants who experienced two or more personal overdoses,

*see* **Overdose** *on page 30*

# Drug Deaths Among Older Adults Rising

*Drug deaths among Americans aged 65 and older doubled over the last decade. Experts warn that unrecognized substance use disorders in older adults is a growing problem that can cause substantial harm.* **BY KATIE O'CONNOR**

Michael Fingerhood, M.D., has a patient in his 70s who has opioid use disorder. Usually alone when he uses, the patient told Fingerhood that he has started keeping naloxone in one hand so that as soon as he realizes he cannot handle the illicit drug he has just consumed, he can save his own life.

"Unfortunately, since the pandemic began, people are using alone, and older adults already deal with isolation and loneliness that make the problem only worse," said Fingerhood, director of the Division of Addiction Medicine and professor of medicine and public health at Johns Hopkins University School of Medicine. He added that fentanyl has also played a significant role in increased drug deaths, as people with substance use disorders (SUDs) are unknowingly purchasing drugs with large amounts of fentanyl.

In its 2022 America's Health Rankings Senior Report published earlier this year, the United Health Foundation reported that drug deaths among adults aged 65 and older doubled between 2008-2010 and 2018-2020, rising from 4.2 to 8.4 per 100,000, which corresponds to an increase of 8,620 deaths during this period. The report cited the Centers for Disease Control and Prevention's Wide-ranging Online Data for Epidemiologic Research (WONDER) database.

The death rate among older adults due to drugs rose significantly in 35 states, according to the United Health report. The states with the highest increases include Connecticut (352%), Maryland (323%), and New Jersey (222%). Further, the report highlights clear disparities. The drug death rate was 10.4 times higher among Black adults compared with Asian adults, the group with the lowest rate, and the rate was twice as high among males compared with females.

"For older adults, one of the challenges is that substance use disorders are oftentimes overlooked when patients present with depressive symptoms or other conditions," said Luming Li, M.D., M.H.S., an assistant professor adjunct in the Department of Psychiatry at the Yale School of Medicine and chief medical officer at the Harris Center for Mental Health and IDD (Intellectual and Developmental Disabilities).

She noted that the baby boom generation is more familiar with drug use and may be more likely to turn to drugs and alcohol to cope with symptoms of depression and loneliness compared with past generations of seniors. Further, the COVID-19 pandemic only worsened the problem, as public health measures cut off older adults from their social connections.

"This is a group that tends to be more isolated and have less social connectedness, whether from spouses and friends passing away or children moving away," says Luming Li, M.D., M.H.S.

In 2019, Li and colleagues published a review and synthesis of the available literature on SUDs in later life, which they called "an emerging public health concern," in the *American Journal of Geriatric Psychiatry*. They analyzed 124 documents, including government documents, studies, and review articles. "Evaluated studies and documents together suggest that older individuals are using illicit drugs and meeting criteria for SUDs at higher rates than previous geriatric cohorts, resulting in substantial negative impacts on medical and psychiatric conditions," Li and her colleagues concluded in the study. "Current treatment models are inadequate to address the new wave of older individuals with SUDs."

There are numerous biological factors that increase the odds of overdose among older adults, such as reduced metabolic clearance and the presence of a higher number of other medications in their systems due to comorbidities, explained Pallavi Joshi, D.O., a geriatric psychiatrist at Banner Alzheimer's Institute and a clinical assistant professor in the Department of Psychiatry at the University of Arizona College of Medicine.

Biases against aging can lead to health care professionals overlooking SUDs, as well. Joshi pointed out that SUDs among adults over 65 can be difficult to diagnose because symptoms can mimic cognitive impairment. "Pro-

*see* **Drug Deaths** *on page 31*

# Peer Specialists Can Aid in Suicide Prevention

*By sharing their own lived experience of suicidal ideation while assisting with a safety plan or following up with patients after discharge, peer specialists can establish social connections and offer hope, which both reduce suicide risk.* ***BY NICK ZAGORSKI***

Peer support specialists can be valuable members of mental health teams, using their lived experience with mental illness to serve as role models for patients and help them navigate the health care system. But can these specialists successfully work with patients who may be suicidal?

Some reports have cautioned that connecting people with a history of suicidal thoughts and/or attempts may be harmful for patients. Two recent studies, however, suggest that peer specialists can provide much needed support to patients at risk of suicide, both in the emergency setting and after hospital discharge, with minimal risks.

### Loss Sparks Fire for Change

In 2013, emergency physician Michael Wilson, M.D., Ph.D., had what seemed like a routine encounter treating an older patient with a toe injury during a night shift. However, the next day he was informed that the patient had died by suicide following discharge.

"That experience was both life and research changing," said Wilson, who is an associate professor of emergency medicine with a secondary appointment in psychiatry at the University of Arkansas for Medical Sciences (UAMS). He told *Psychiatric News* that since then, he has looked for ways for emergency departments to become more involved in suicide prevention.

One evidence-based way to reduce suicide among emergency patients who might be at risk is to have them complete suicide safety plans while in the emergency department, Wilson said. At UAMS, social workers or mental health specialists commonly work with patients on these plans, but these staff are busy and may not be available 24 hours a day. Additionally, the time pressures on emergency physicians can make it difficult to engage with patients for the 20 to 45 minutes needed for safety planning, he explained. Wilson believes trained peer specialists could help to fill this gap.

"Peers have a wealth of personal experience, and by acting more as friends and supports, peer specialists can develop a bond with patients that might engage them more in the safety planning process," he said.

Evan Lewis/UAMS

UAMS colleagues Michael Wilson, M.D., Ph.D. (top), Ron Thompson, Ph.D. (bottom left), and Angie Waliski, Ph.D. (bottom right), conducted a trial that found that peer support specialists could help patients at risk of suicide craft high-quality safety plans without extending patients' emergency department stay.

Along with UAMS research colleagues Ron Thompson, Ph.D., and Angie Waliski, Ph.D., Wilson compared how well peer specialists performed at safety planning relative to current UAMS practice. The study involved 31 patients aged 18 to 89 years who were admitted to the ED for suicidal ideation or suicide attempt; 15 completed a safety plan with the assistance of a mental health nurse or social worker, and 16 did so with the assistance of a trained peer specialist.

"Because peers had lived through personal trauma and had never held a similar role within the [emergency department], debriefing and supervision were paramount," Wilson and colleagues wrote in the *Psychiatric Services* article describing their findings. "Peers received biweekly feedback by the study team on the quality and completeness of the plans and adherence to study protocol. … The peers also received a weekly debriefing by a licensed clinical counselor throughout the study."

The researchers found that patient safety plans completed with help from peer specialists were more complete and of higher quality on average than those completed with help from mental health professionals. There was even some evidence to suggest that the patients who worked with peer specialists were less likely to return to the emergency department in the three months after creating a safety plan, but Wilson cautioned that the sample size of the study was small.

Still, the study suggests that peer specialists can fulfill this important role in the emergency department. "The specialists who participated all felt empowered and grateful that they could use their own life story to help another person in need," Wilson said.

Wilson hopes to now expand his work to determine if peer specialists can also help to follow up with patients.

"In rural settings like ours, it's vital to follow people after discharge because outpatient services are limited," Wilson noted.

### Peers Offer Long-Term Connection, Hope

Paul Pfeiffer, M.D., M.S., the Susan Crumpacker Brown Research Professor of Depression at the University of Michigan Medicine, has worked with peer specialists for many years and, like Wilson, believes they are well suited to engage with suicidal patients.

The interpersonal theory of suicide—a model developed by Thomas Joiner, Ph.D., of Florida State University—posits that suicidal ideation arises when people perceive themselves as a burden to others and not belonging anywhere, particularly when they have a sense of hopelessness, Pfeiffer said. A peer, who has experienced and overcome suicidal ideation, is in a unique position to provide social connection and hope to these patients.

Pfeiffer and colleagues developed and tested an intervention called PREVAIL (Peers for Valued Living). This intervention connects trained peer specialists with patients hospitalized following suicidal ideation or attempt multiple times over the course of 12 weeks (peers connect with patients one or two times at the hospital and follow up with the patients at postdischarge check-ins). During check-ins, the peers go over various suicide prevention strategies, such as reviewing the patients' safety plans, setting goals, and helping patients strengthen their social networks. Pfeiffer said that although there is a set of topics that peers are asked to cover, he wanted PREVAIL to offer enough flexibility so they could make use of their skills, such as active listening and being able to share their story of suicidal recovery.

"The peer specialists we have worked with have a range of opinions," Pfeiffer said. "Some wanted even more of a structured approach, while others wanted the freedom to do their thing." In the end, Pfeiffer noted this middle ground allowed for enough structure to ensure evidence-based suicide prevention skills are being taught while enabling peer specialists to be true to themselves as they offer support and hope.

In a pilot study involving 70 psychiatric inpatients with documented suicidal ideation or attempt at admission, Pfeiffer and his colleagues showed that peer specialists could reliably administer the PREVAIL intervention and were able to retain patients over the 12-week follow-up period. The participants also viewed the PREVAIL program favorably.

*see* **Peer Specialists** *on page 30*

# Sleep Experts Say Shift to Permanent Daylight Saving Time Would Have Adverse Health Effects

iStock/tarasov_vl

*Opponents of permanent daylight saving time cite numerous potential adverse health effects including disturbed sleep, mood disturbances, weight gain, and cardiovascular problems.* ***BY LYNNE LAMBERG***

Sleep deprivation and mood disturbances are likely to increase if proposed federal legislation calling for year-round, or permanent, daylight saving time (pDST), is enacted into law, said several speakers at the joint annual meeting of the American Academy of Sleep Medicine (AASM) and Sleep Research Society (SRS) this past summer.

In March, the U.S. Senate unanimously passed the Sunshine Protection Act in an unannounced voice vote, reportedly surprising many senators who later professed ignorance of the act's objective (*Washington Post,* March 17). The bill was introduced by Sen. Marco Rubio (R-Fla.).

The legislation would eliminate the twice-annual change between standard time and daylight saving time, permanently shifting the clock time of sunrise and sunset one hour later than standard time year-round. In standard time, clock time aligns with sun time. A shift to pDST would reduce sunlight in morning hours and increase it in evening hours.

If pDST were adopted, millions of Americans would have to awaken before sunrise and leave home for school or work in the dark several months a year, said symposium chair, Karin Johnson, M.D., a professor of neurology at the University of Massachusetts Chan School of Medicine-Baystate and medical director of the Baystate Regional Sleep Medicine Program.

Year-round DST would deny many Americans exposure to morning sunlight, the body's most important time-setting cue, lowering performance early in the day, said Johnson, who chairs the sleep section of the American Academy of Neurology. Further, pDST's longer, brighter evenings would make it harder to fall asleep, curtailing sleep.

AASM and SRS are among the nearly 80 medical, scientific, educational, and religious organizations that oppose the legislation. Opponents cite numerous potential adverse health effects stemming from pDST beyond disturbed sleep, including mood disturbances, weight gain, and cardiovascular problems; pDST might also lead to an increase of automobile accidents. They hope the bill will die in the House, where it will expire in December if not addressed.

Adopting pDST likely would exacerbate adolescent sleep deprivation, Christina F. Chick, Ph.D., an instructor in psychiatry and behavioral sciences at the Stanford University School of Medicine, said at the meeting. Changes in the biological clock that start at puberty prompt adolescents to prefer a later bedtime and waketime, she noted. Adolescents already are severely sleep deprived: The 2019 Youth Risk Behavior Survey by the Centers for Disease Control and Prevention found 78% of the nation's high school students averaged less than the recommended minimum of 8 hours of sleep on school nights.

Under pDST, adolescents still would have to get up at the same clock time when school is in session. The earlier their school start time, Chick noted, the larger the gap between their alarm time and biological wake time.

Many teens have later bedtimes and waketimes on weekends than on school days, Chick said. The discrepancy between the demands of their school and social lives and those of their biological clock leads to social jet lag, she said, a misalignment between internal and external clocks. This phenomenon is associated with daytime sleepiness, depression, and anxiety.

While social jet lag peaks in mid-adolescence, adults may develop it, too, Johnson said, since body clocks remain anchored to sun time. People living on the western edges of time zones, where the sun rises later, she noted, experience larger differences between their internal and external clocks than those living farther east. During DST, most time zones are misaligned with sun time by about one hour, and at their western edges, by about two hours.

Permanent Standard Time (pST) is the best clock for mental and physical health and safety, Jay Pea, founder of the nonprofit Save Standard Time, said at the meeting. It would be a public service, he told *Psychiatric News,* if psychiatrists and other health-focused individuals would share knowledge of pST's advantages with their state and national lawmakers. **PN**

**To see the impact of standard time, daylight saving time, and the spring/fall time shift on sunrise and sunset and daily activities over the year across the United States, see the interactive chart posted at https://savestandardtime.com/chart/.**

FIRST PERSON

# Remembering St. Elizabeths Hospital

***BY MARGARET ROBERTS, M.D.***

It is hard to move on from a career in a historic and hallowed place where you have worked for almost 20 years.

I didn't want to leave St. Elizabeths Hospital in Washington, D.C. The administrator at the time honored my passionate sentiments to remain—until he was overruled, of course. In preparation for my inevitable "eviction," I spent much time roaming among the cypress and oaks, cutting red holly berries at Christmas, studying the labels nailed on ancient trees of the West Campus, relaxing at the picturesque point overlooking the Washington Monument and the Potomac, and watching the helicopters from Bolling Air Force Base.

In late 2001, I was moved into the heart of Washington, D.C., near Union Station. My transfer followed the long-planned discharge of our patients into community residential facilities. I managed my separation by exploring any authorized occasion to visit the hallowed grounds: There were too few.

Margaret Roberts, M.D., retired from St. Elizabeths Hospital in Washington, D.C., in 2002. She then retired from part-time outpatient psychiatry in December 2020 (ACT at Catholic Charities and Umbrella).

My memories and nostalgia persisted. Thereafter, as if through a kaleidoscope, and with tenacity, zeal, sadness, and patience, I watched the campus undergo a metamorphosis as bulldozers and forklifts dug up the earth and razed buildings. I studied the promise of modernity through the black-iron railings along eight blocks of 2700 Martin Luther King Jr. Avenue. From that same stretch of road and over the high western stone-and-brick wall, I scanned the panorama of pagoda-like red tiled-roofs, the clocktower, and lofty turrets of architectural grandeur.

When the main gatehouse disappeared, so did the security guard and demand for identification. I was emboldened and walked onto the East Campus. An endorphin rush of pure joy surged at the encounter with the past. I claimed the acres again in silence, feeling victorious.

My pleasure continued at my sweet fortune to walk on Cypress and Oak again, past old and sublime buildings with rectangles of windows, rotten shingles, and some roof tiles still lined up in perfect symmetry. No one confiscated my camera, but I stayed vigilant for workers in hard hats and trucks. And suddenly I jumped for joy. I spied a plaque behind a delicate curtain of fresh greenery: A.P. Noyes Division Bldg. 7. The plaque was surrounded by five-leafed creepers spreading across the building's imposing green door.

*continued on facing page*

iStock/fotostorm

# Object Relations: How Early Relationships Create Map for Later Ones

*We begin interpreting our environment from the earliest moments of life, "locking in" a working understanding of ourselves and others.* **BY CHRISTOPHER MILLER, M.D.**

As the field of psychiatry has gained in sophistication and complexity, particularly with contributions from the neurosciences, what has been shown beyond any doubt is how early life experiences have a strong and lasting effect on adult life. This includes how early relationships influence later interpersonal templates. A child who grows up in a safe environment with loving, attuned caregivers may develop a sense of wonder and excitement, as well as the ability to be curious about self and others. A child who is abused or neglected can feel overwhelmed and confused, clinging to a harmful caregiver and distorting one's own thinking to make the abuser "good." In the latter case, the perception of relationships is already being distorted to allow for some sense of security to be held. Psychoanalytic literature, from Sigmund Freud's writings onward, has given pride of place to the internal world of the child. We begin "mapping" our environment from the earliest moments of life, "locking in" a working understanding of ourselves and others.

*continued from facing page*

Broken red tiles were scattered on the steps and the porch, fallen from the roof above. The Virginia creeper climbed upward.

I recalled this building primarily by its literary connection to the popular Noyes psychiatry textbook. Arthur Percy Noyes, M.D., worked on the medical staff in St. Elizabeths possibly from 1920 to 1929 under the enterprising William P. White as medical superintendent. Noyes' *A Textbook of Psychiatry* was first published in 1936, primarily for graduate nurses but also for medical students. Noyes served as APA president for the 1954-1955 term.

These scattered red buildings reflected St. Elizabeths' stubborn resilience and provided a time capsule of its history. Disparate fragments of its past came back to me as I left the grounds—Dorothea Dix, the carriage entrance at the Center Building, clay bricks made from the soil, the creamery, segregated wards, wounded Civil War soldiers, Blackburn Lab, the lodging of poet Ezra Pound: a complex history. **PN**

As the dialogue between neurosciences and psychotherapy has grown exponentially over the past three decades, many insights from psychoanalytic writers have come to life with objective findings from neuroimaging, neuroendocrinology, and genetics. This holds particularly true for the object relations framework, a model that outlines how interactions with "external objects" (that is, real-world people in one's life) will become registered in the child's mind and carried forward as "internal objects" (that is, the voice, image, and/or emotion stemming from those interactions). These "internalized relationships" from childhood will help pattern what to expect from others in future encounters, particularly those that remind us (consciously or unconsciously) of earlier interpersonal dynamics. On a brain level, working maps are patterned during sensitive periods of childhood. If events are associated with heightened emotional intensity and anxiety, higher cortical areas—used to "think through" matters—may be underused. This is especially true when early adversity is the norm, and a rigid, unchanging, *emotion-based* sense of self and others was laid down to allow for some sameness and predictability amid very confusing circumstances. Extreme forms of thinking about the world may be carried forward in adolescence and adulthood, since doing otherwise might reopen the "mental wounds" from early life, when there was no way of processing terrifying situations.

Christopher Miller, M.D., is an associate professor of psychiatry at the University of Maryland School of Medicine. He is the author of *The Object Relations Lens: A Psychodynamic Framework for the Beginning Therapist* from APA Publishing. APA members may purchase the book at https://appi.org/Products/Psychotherapy/Object-Relations-Lens.

Psychiatrists are becoming increasingly aware of the impact of trauma on early development. When we interact with patients who are viewing us in a skewed way, it is important to understand that such a lens likely derives from earlier experiences and that they are viewing us in accordance with what the world has taught them. Similarly, if we find ourselves feeling strong emotions toward our patients (for example, to rescue or reject them), we might imagine that we are identifying with an "internal object" trait that is being assigned to us (for instance, being an all-good or all-bad psychiatrist). Unless we take a step back to understand these pulls, we risk reenacting a harmful template the patient has internalized.

One way to understand the patient's past is to pay attention to the present, which is always rife with communicative richness on conscious and unconscious levels. We can always *think* about patients psychodynamically, even if the setting does not always allow us to *intervene* psychodynamically. We, too, will bring elements of our own internal worlds when we interact with patients, underscoring the need for personal supervision and therapy to address our blind spots.

Given its focus on the unique, personal, development-driven experience of each individual we treat, an object relations lens is, first and foremost, a humanistic one. It assigns major importance to the subjective experience of all our patients, beyond any diagnostic categories, and values the therapist-patient relationship over any other element. The relationship is the key both for understanding and for healing.

The object relations model is useful as we open our minds to the richness and dimensionality of patients across clinical settings, whether on an inpatient unit, in the emergency room, or in an outpatient office. There are exciting parallels between the object relations framework and our evolving neuroscientific understanding of early life development and of how successful psychotherapy can modify brain biology. Also, separation-individuation and attachment theories of development have significant areas of convergence with the object relations model. These considerations illustrate how critical it is for psychiatrists (whether established or in training) to have a working knowledge of object relations theory and practice. Such a foundation can help us attend to the "here and now" of the clinical encounter, bringing ourselves in as live, active co-participants in the dyad. By understanding how early life shaped our patients' challenges in navigating self and others, it is hoped that we can notice the pressures to re-create destructive templates; position ourselves differently from early, harmful individuals in patients' lives; and facilitate healthier relationship models to develop on the path to healing. **PN**

# Training That Challenges Cognitive Biases Reduces Symptoms of Psychosis, Study Suggests

*Cognitive biases, such as a bias against "dis-confirmatory evidence," are common among all people but are exacerbated in people with delusions associated with psychosis.* **BY MARK MORAN**

Metacognitive training helps people with psychosis realize that since everyone has biases, they must too, and that doubt can be cast on many conclusions about the world, including delusions, says Todd Woodward, Ph.D.

Metacognitive training (MCT) for psychosis—which helps patients learn to question unfounded assumptions known as cognitive biases that contribute to their symptoms—was associated with reduced delusions and hallucinations and improved self-esteem and functioning, according to a report in *JAMA Psychiatry*. Common cognitive biases in people with psychosis include jumping to conclusions, inflexibility about one's beliefs, and overconfidence in one's judgments.

"[T]he benefits of MCT were maintained up to one year after the intervention," said lead author Danielle Penney, a Ph.D. candidate at Douglas Research Center of McGill University, in a press release. "More generally, these findings support the utility of MCT as an effective tool that can be offered by mental health care workers across health care settings."

The researchers analyzed 43 studies of MCT involving 1,816 participants. Of the 43 studies, 30 were randomized, controlled trials (RCTs), 11 were non-RCTs, and two were quantitative descriptive studies. The researchers examined the effect of MCT on global symptoms, delusions, hallucinations, and cognitive biases. They also looked at the effect of MCT on self-esteem, negative symptoms, quality of life, well-being, and functioning.

MCT was associated with a reduction of all symptoms examined, with effect sizes that ranged from small (0.16 for cognitive biases, 0.17 for self-esteem, 0.23 for negative symptoms, and 0.26 for hallucinations) to medium (0.41 for functioning and 0.50 for positive symptoms) and large (0.69 for delusions). Moreover, analysis of RCTs found that both treatment and control groups maintained the therapeutic level reached at the end of treatment for all outcomes at the one-year follow-up.

MCT for psychosis was developed by Steffen Moritz, Ph.D., head of the Clinical Neuropsychology Working Group at the University of Hamburg, and Todd Woodward, Ph.D., a professor of psychiatry at the University of British Columbia.

In an interview, Woodward said he and Moritz began developing tests to measure the thought patterns that underlie delusions, and it was out of this effort that MCT was created. Woodward explained that these thought patterns exist to some degree among all people, though they are more pronounced in people with psychosis.

For instance, people in general have a bias against "dis-confirmatory evidence"—against evidence that runs counter to their beliefs; they may also experience uncertainty when reading facial clues or social situations to understand how someone else may be thinking or feeling (known as "theory of mind"). And all people tend to be confident in how they remember something even when, objectively, their memories are inaccurate.

"These are patterns of thinking that are exacerbated in schizophrenia," Woodward said. He and Moritz developed PowerPoint slides that introduced these common biases to individuals with psychosis through scenarios presented in a group format.

"We talk about how everyone has these biases in their thinking," Woodward said. "The important thing is that those with psychosis are able to eventually link these common biases to their own delusions. They start to realize that since everyone has biases, they must too, and that doubt can be cast on many conclusions about the world, including delusions. So, someone might be able to say, 'I'm not 100% sure my friend didn't show up at my party because he has it in for me, and there may be other reasons.' This bit of insight can be the foot in the door to developing healthier thought patterns."

Metacognitive interventions include, in addition to MCT, metacognitive therapy, metacognitive insight, and reflection therapy. MCT for psychosis delivered in a group format is the most widely investigated among these interventions and combines psychoeducation, cognitive bias modification, and strategy teaching.

In the *JAMA Psychiatry* study, the effects of MCT on symptoms in people with psychosis were similar to the effects reported in studies of cognitive-behavioral therapy for psychosis and cognitive remediation. Previous analyses of cognitive-behavioral therapy for patients with psychosis found small to moderate effects on delusions and small effects on hallucinations, negative symptoms, and functioning. Similarly, prior meta-analyses of cognitive remediation have reported small to moderate effects for negative symptoms, global symptoms, and functioning.

The researchers concluded, "These findings provide some evidence to consider MCT in international treatment guidelines, and the focus may now shift toward implementation and cost-effectiveness trials in real-world clinical settings." **PN**

**"Immediate and Sustained Outcomes and Moderators Associated With Metacognitive Training for Psychosis: A Systematic Review and Meta-analysis" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2790555.**

## LETTERS TO THE EDITOR

### APA Tool to Assess Community MH Needs Should Have Widespread Adoption

I was delighted to read about the report of the APA Presidential Task Force on Assessment of Psychiatric Bed Needs in the United States, appointed by then President Jeffrey Geller, M.D., M.P.H. (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.07.7.27).

As president of the New Jersey Psychiatric Association for the 2002-2003 term, I appointed a task force and, assisted by a number of colleagues, wrote a report on mental health needs and services in New Jersey, which was presented to the state legislature in May 2004. I discovered during that time that not only did the state have no way of making such an assessment, but also I could not even get a straight answer on how many state-supported psychiatric beds existed at the time—never mind other community resources. Sadly, little has changed.

Clearly, a tool to assess mental health resources and needs of any community on a continuous basis is essential to the task of creating and assigning them where they are needed. I encourage all district branches to prioritize advocating for their states to adopt such a tool and in the meantime urge community mental health organizations to participate in its testing. **PN**

NANCY T. BLOCK, M.D.
Berkeley Heights, N.J.

#### Letters to the Editor

Readers are invited to submit letters of not more than 350 words for possible publication. *Psychiatric News* reserves the right to edit letters and publish them in any of its formats. Letters should be emailed to cbrown@psych.org.

## MED CHECK

*BY TERRI D'ARRIGO*

### Dyanavel XR Available For ADHD

***Dyanavel XR (amphetamine)*** extended-release tablets are now available for treating attention-deficit/hyperactivity disorder (ADHD) in patients aged 6 years and older, Tris Pharma Inc. announced in August. The drug was approved by the Food and Drug Administration (FDA) in November 2021 based on data from a clinical trial in adults that found the extended-release tablets to be the bioequivalent of Dyanavel XR extended-release oral suspension.

The tablets are available in 5 mg, 10 mg, 15 mg, and 20 mg dosages. The 5 mg tablets are functionally scored and may be divided into equal halves of 2.5 mg. The recommended starting dosage is 2.5 or 5 mg once daily in the morning and may be increased in increments of 2.5 mg to 10 mg every four to seven days up to a maximum daily dose of 20 mg.

The label for Dyanavel XR extended-release tablets contains a boxed warning alerting prescribers that central nervous system stimulants, including Dyanavel XR, have a high potential for abuse and dependence. The warning also directs prescribers to assess the risk of abuse prior to prescribing and monitor patients for signs of abuse and dependence while on therapy. The prescribing information also notes that Dyanavel XR should not be substituted for other amphetamine products on a milligram-per-milligram basis because of different amphetamine salt compositions and differing pharmacokinetic profiles.

### Esmethadone Fast Tracked For Major Depression

The FDA has granted fast track status to ***REL-1017 (esmethadone)*** as a monotherapy for the treatment of major depressive disorder (MDD), Relmada Therapeutics Inc. announced in August. The FDA fast track is a process designed to facilitate the development of medications that treat serious conditions and fill an unmet medical need and to expedite their review.

In a phase 2 trial, 62 patients with MDD were randomized to REL-1017 (25 mg or 50 mg) or placebo daily for seven days. The primary endpoint was an improvement in the Montgomery–Åsberg Depression Scale (MADRS) score at day 7.

MADRS scores improved on day 4 in patients who took either dose of REL-1017 compared with those who took placebo. The improvement continued through day 14, seven days after the patients stopped taking the medication. From baseline to day 7, MADRS scores decreased a mean of 16.8 points in patients who took 25 mg and 16.6 points in those who took 50 mg compared with 8.8 points in those who took placebo. There were no serious adverse events while the patients took the drug, and there were no symptoms of withdrawal after patients discontinued the drug.

The phase 3 RELIANCE-III trial is evaluating REL-1017 as a monotherapy, while the phase 3 RELIANCE-I and RELIANCE-II trials are evaluating the drug as an adjunctive therapy.

### AD04 Promising for AUD In Patients With Certain Genetics

Adial Pharmaceuticals' genetically targeted serotonin-3 receptor antagonist ***AD04*** may help lower the number of days of heavy drinking in people with alcohol use disorder (AUD) who have certain polymorphisms in their serotonin transporter and receptor genes, the company announced in July.

In the ONWARD phase 3 trial, 302 adults with AUD were genetically screened and grouped according to how many drinks they drank on average a day: heavy drinkers who averaged fewer than 10 drinks a day or very heavy drinkers who averaged at least 10 drinks a day. Patients received either AD04 or placebo orally twice a day for 24 weeks.

At 24 weeks, the number of days of heavy drinking decreased significantly in heavy drinkers who took AD04 compared with those who took placebo. In the last month of the trial, heavy drinking decreased approximately 79% among heavy drinkers who took AD04. At the conclusion of the trial, patients in the heavy drinking group who took AD04 had a significant difference in the severity of their AUD diagnosis compared with those who took placebo.

However, when the results were analyzed for all patients in the study together, the reduction in heavy drinking days from baseline to 24 weeks did not differ significantly between those who took AD04 and those who took placebo. This result was influenced by a high response among very heavy drinkers who took placebo. **PN**

## From the President

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work, progress, challenges, and commitment to advancing the goal of providing mental health care to every American. Several themes regarding the work ahead for parity enforcement emerged. Stepped-up parity enforcement is possible, in part, due to funding appropriated by Congress as part of a large series of provisions on which APA members, including me, provided testimony this spring (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.06.6.24). There were several specific areas highlighted for stepped-up enforcement. For example, several organizations focused on work that APA and others have conducted through "secret shopper" surveys in which survey workers called psychiatrists listed on insurance panels to check for *actual availability* and found that in numerous geographical locations—including major cities—networks are inadequate.

On the APA front, I presented three issues of particular concern to our members' ability to provide care to patients: *low reimbursement rates* that cause network inadequacy, specifically asking whether insurers have been similarly reluctant to increase rates when networks are inadequate for other specialties; *facility-based concurrent review practices* by insurers that are often arbitrary, opaque, and divorced from transparent application of clinical progress metrics; and *retrospective review* of payments for office-based care that have left APA members—and their patients—facing uncertainty about payment for treatment long after appointments have occurred and even retroactive clawback of claims already paid.

The roundtable concluded with other measures that the Department of Labor could take through employers to advance mental health, including education about parity and the importance of mental health care to support the health and productivity of workers.

As we continue to advance our roadmap for the future this year at APA, there is no question that our focus on advocacy and interprofessional collaboration is making an impact. As always, please keep your ideas coming and join the conversation on Twitter, where you can follow me @Pres_APA! I'll be back next month! **PN**

## Overdose

*continued from page 24*

witnessed one overdose in someone else, or witnessed two or more overdoses in other people had the greatest likelihood of having severe responses to grief and loss. Severe responses were also more common among participants who were exposed to all three types of overdose events (their own overdose, overdose in other people, and overdose death in other people).

Kenny said that the results suggest that multiple, repeat exposure to overdose events may lead to a disrupted assumptive world among people who use drugs.

"People's core beliefs around everyday functioning, understanding of the world, and sense of safety are violated due to the continued, repeated experience of overdoses in their own lives, and the unrelenting loss of people in their communities to overdose," Kenny explained.

Frances R. Levin, M.D., the Kennedy-Leavy Professor of Psychiatry at Columbia University Irving Medical Center and chief of the Division on Substance Use Disorders at New York State Psychiatric Institute at Columbia, stressed the need for psychiatrists to create space in which patients who use drugs or have substance use disorder may grieve their losses.

Columbia University

Psychiatrists should be careful not to overlook a patient's grief, even as they seek to treat the patient's substance use disorder, says Frances R. Levin, M.D.

"When someone comes in for treatment, we tend to focus on treating the addiction, but it's important not to overlook the patient's grief," said Levin, who was not involved in the research. "Explore with them what they've experienced, how they've experienced it, and how they have tried to cope with it, and provide support in handling their grief."

This study was supported by funding from the Canadian Institutes of Health Research. One of the researchers is also supported by a postdoctoral fellowship from the Canadian Network on Hepatitis C. **PN**

**"Frequency of Fatal and Non-Fatal Overdoses and Response to Grief and Loss Among People Who Inject Drugs: An Unexplored Dimension of the Opioid Overdose Crisis" is posted at https://www.sciencedirect.com/science/article/pii/S0376871622002769.**

## Peer Specialists

*continued from page 25*

Pfeiffer and colleagues are now recruiting patients for a larger, multisite trial that will compare outcomes in patients hospitalized for suicidal ideation or attempt who receive 12 weeks of PREVAIL or enhanced usual care (which involves staff sending a brief supportive text a few days after discharge and links to mental health resources for patients who reply). The goal of the study is to both assess the effectiveness of PREVAIL and identify any barriers to implementing the program in hospitals.

Pfeiffer acknowledges that while many of the peer specialists find the work intensely rewarding, not every peer specialist is suited to work in suicide prevention. "Some people can find it too stressful, and there are potential downstream risks to peer specialists if patients experience an adverse outcome [like a suicide attempt]," he said. That's why it's important that the specialists be embedded within a clinical team that includes regular support and feedback from other peer specialists and mental health clinicians to help manage difficult or high-risk patient situations."

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Overall, though, the experience of building up PREVAIL has been tremendously positive for all involved, Pfeiffer said. "We had many patients tell us how the specialists brought them hope they didn't know was possible." **PN**

**"Feasibility of Peer-Delivered Suicide Safety Planning in the Emergency Department: Results From a Pilot Trial" is posted at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202100561. "Development and Pilot Study of a Suicide Prevention Intervention Delivered by Peer Support Specialists" is posted at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6494743/.**

## Drug Deaths

*continued from page 24*

viders may dismiss or mistake confusion, forgetfulness, or falls as a sign of memory loss. If providers assume that cognitive impairment is a normal part of aging, then a substance use disorder that mimics this can be more easily overlooked."

Nonetheless, there is hope for adults over age 65 who have an SUD, Joshi added. "Research shows that older adults respond well to SBIRT, or Screening, Brief Intervention, and Referral to Treatment," she said. "Brief interventions can be done by any provider in any health care setting, and research shows that even older adults who are accepting of SBIRT can reduce consumption and misuse."

She added that older adults are resilient, as evidenced by the COVID-19 pandemic: While the physical and social impacts were greater for older adults, they had better outcomes regarding suicide and other mental health metrics than younger adults, Joshi said. "We can use resilience to our advantage because a lot of these older folks have had to navigate difficult issues in the past."

"Older adults are not a homogenous group," says Pallavi Joshi, D.O. "Some 65-year-old adults may present like 50-year-olds and some may present like 85-year-olds, with more comorbidities, frailty, and prescription drugs. Those factors can seriously impact the severity of substance use."

Fingerhood noted that he has seen more older adults seeking treatment for the first time in recent years, which he takes as an extremely positive sign. He emphasized the importance of screening in various settings, including primary care and emergency departments.

Yet there are numerous barriers to screening, he continued. "Stereotypes feed the belief that addiction isn't a problem for older adults, and providers are less likely to screen them for substance use disorders," he said. Further, many older adults may feel shame about their substance use that can cause them to hide it from their physicians, Fingerhood said.

Physicians should look for signs of substance use in older patients, who may be less likely to share information about themselves, and ask such questions as "Do you have trouble falling asleep?" "What do you do when you are alone? With friends?", Fingerhood said. Additionally, he urged physicians to rescreen older patients following major life events, such as retirement or the death of a spouse.

Li emphasized the importance of connecting with older adults during treatment encounters. "In health care, especially hospital-based settings, you're often focusing on the checklist of things you need to talk to that patient about," she said. "But by not being present, you can miss important cues from patients. We need to approach [older] individuals with gentleness, care, and compassion to help them feel more connected so they are encouraged to develop healthy habits. A single good conversation can influence an older patient's entire week."

The 2022 America's Health Rankings Senior Report is funded by the United Health Foundation. **PN**

**United Health Foundation's 2022 America's Health Rankings Senior Report is posted at https://www.unitedhealthgroup.com/newsroom/posts/2022/2022-05-17-ahr-new-senior-report.html. "Substance Use Disorders in Later Life: A Review and Synthesis of the Literature of an Emerging Public Health Concern" is posted at https://www.ajgponline.org/article/S1064-7481(19)30401-4/fulltext.**