VOLUME 58, NUMBER 11, NOVEMBER 2023

AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

PSYCHNEWS.ORG

ISSN 0033-2704

Movement Emerges to Include Green Space as a Social Determinant Of Mental Health

BY MARK MORAN

SEE STORY ON PAGE 16

Mark Moran

DEA, HHS Extend Telemedicine Flexibilities Through 2024

The purpose of the second temporary rule is to ensure a smooth transition for patients and qualified health professionals who have come to rely on the availability of telemedicine for controlled medication prescriptions, the agencies say. ***BY JENNIFER CARR***

The Drug Enforcement Administration (DEA) and the Department of Health and Human Services (HHS) in October announced the extension of COVID-19 telemedicine flexibilities for prescription of controlled medications through December 31, 2024. These telemedicine flexibilities authorize qualified health professionals to prescribe to patients Schedule II-V controlled medications via audio-video telemedicine encounters, including Schedule III-V narcotic-controlled medications approved by the Food and Drug Administration for the treatment of opioid use disorder via audio-only telemedicine encounters. The extension is the latest in a series of efforts that began in February aimed at the creation of a final set of regulations for prescribing controlled substances via telemedicine appointments.

Ahead of the expiration of the COVID-19 Public Health Emergency earlier this year, the DEA proposed two new regulations: "Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation" and "Expansion of Induction of Buprenorphine Via Telemedicine Encounter."

While the proposed rules did not fully reverse course on the telemedicine flexibilities allowed during the Public Health Emergency (PHE), many saw the regulations as a step in the wrong direction by re-instituting in-person care requirements for the prescription of controlled substances.

APA filed two letters with the DEA in response to these proposed rules in March, urging that the DEA balance common-sense safeguards for DEA enforcement without decreasing access to lifesaving treatment.

APA's comments were among the more than 38,000 that the agency received on the proposed telemedicine rules during the 30-day public comment period. The day before the public health emergency was set to expire, the DEA and Substance Abuse and Mental Health Services Administration issued a temporary rule extending the full set of telemedicine flexibilities adopted during the Public Health Emergency for six months.

In September, the DEA held two days of public listening sessions related to the rules. Psychiatrist Shabana Khan, M.D., chair of the APA Committee on Telepsychiatry, spoke on behalf of APA at the meeting.

"Rather than a mandatory blanket requirement [for an in-person visit], the need for an in-person examination of a

see **Telemedicine** *on page 34*

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.

SUBSCRIPTIONS
U.S.: individual, $176. Single issues: U.S., $30. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.

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FROM THE PRESIDENT

Addiction Psychiatry Presidential Theme: Opioids

BY PETROS LEVOUNIS, M.D., M.A.

I am delighted to report that our first addiction psychiatry presidential theme campaign, which focused on vaping, has been concluded with great success. My thanks go to Dr. Smita Das, Dr. Tauheed Zaman, Bob Ensinger, Kristin Kroeger, and the incredible APA administration for spearheading this multiprong effort that is making a real difference. The focus of our yearlong campaign on addiction psychiatry in this quarter of my presidency is opioids.

As psychiatrists, we understand that opioid addiction has been one of the most devastating and persistent public health crises of the 21st century, and one that has exacted an immense cost in lives lost. According to estimates from the Department of Health and Human Services (HHS), more than three-quarters of a million people have died from opioid overdoses since 1999. Those sobering numbers make it even more urgent that we increase public education around opioids, including (1) the availability of safe and very effective treatments; (2) how doctors (not just psychiatrists) can be encouraged to use them; and (3) how patients, their families, and their friends can find the best way to access them. That is why the focus of our campaign

is on socializing the message that the diagnosis and treatment of opioid use disorder (OUD) is simple and works wonderfully when our patients can access it.

We are lucky to live in a time of incredible advancement in psychopharmacology that has established the safety and effectiveness of medications like naloxone and buprenorphine. These agents are lifesaving: naloxone for reversal of opioid overdose and buprenorphine (methadone or naltrexone) for treatment of OUD. Regardless of whether medication is paired with counseling and psychotherapy, they reduce the risk of relapse and take patients on the path to lasting recovery.

What's heartbreaking is that although OUD is one of the most treatable illnesses, only 1 in 4 people with OUD receives treatment.

We are working to confront the systemic barriers and knowledge gaps that prevent people from being able to access the care they need. Not nearly enough Americans know what treatments are legal and available to them to reverse overdoses and treat opioid addiction. Perhaps most importantly, they do not know how straightforward and effective they are. This includes physicians, many of whom are still unsure of their potential liability in administering buprenorphine despite a recent regulatory change that allows all practitioners with a current DEA Schedule III registration to prescribe treatment for OUD. (See pages 23 to 26 for an in-depth report on OUD, which includes information about this change.)

One of the results of convening our partner organizations for a major meeting at APA headquarters this past July was a commitment to promote resources from our various organizations and work collaboratively on messaging to the general public. The first example of this is a "Top 10 Things Everyone Should Know About Addiction" infographic, which is set to be released later this month.

Collaboration has been a central focus of these addiction psychiatry campaigns. Our efforts to educate the public and our lawmakers around the risks of opioid use have the best chance at success by APA and our partner organizations speaking with one voice. With our combined efforts, and by leveraging the expertise and passion of our members, I know we will move the needle on the U.S. opioid epidemic. **PN**

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DEPARTMENTS

Federal Government Takes Parity Discussion to States

After meeting with Department of Labor representatives, psychiatrists in Connecticut are encouraging their colleagues in other states to work with their district branches, report problems they have with insurers, and raise public awareness about parity issues.

BY KATIE O'CONNOR

Craig Norton

Tichianaa Armah, M.D., speaks at a meeting in August about the importance of enforcing the federal mental health parity law. She is flanked by Rep. Joe Courtney (D-Conn.; left) and Mike Finley (right) of Mental Health Connecticut.

For about 15 years, federal law has required insurance companies to cover treatment for mental disorders at the same level as medical/surgical care. Yet Tichianaa Armah, M.D., still has patients who must call a laundry list of psychiatrists before they find someone who is in network, even though the lists were provided by their insurance companies.

In August, Armah was joined by other psychiatrists and mental health advocates to describe examples like this directly to the people who have taken up the fight to crack down on insurers that are not complying with the federal parity law. Members of the Connecticut Psychiatric Society (CPS) and representatives of other mental health advocacy organizations met with Lisa Gomez, assistant secretary of the Department of Labor's Employee Benefits Services Administration (EBSA), to discuss parity. Armah is chief psychiatry officer with Community Health Center Inc. and president of CPS.

EBSA started cracking down on insurance companies due to parity violations a few years ago (*Psychiatric News*, http://apapsy.ch/parity_1). This year, the Biden administration proposed new rules that would strengthen the federal parity law even more (*Psychiatric News*, http://apapsy.ch/parity_2). The comment period for the proposed rules ended October 17.

EBSA was a core part of those new rules and continues its push to hold insurance companies accountable for mental health parity (*Psychiatric News*, http://apapsy.ch/parity_3). Part of that push is meeting with psychiatrists and hearing how the failure to enforce parity impacts them. APA helped coordinate the meeting with CPS, Rep. Joe Courtney (D-Conn.), and EBSA.

During the meeting, Armah introduced the attendees and set up a roundtable discussion during which all were able to share their experiences. Mental health advocates like NAMI Connecticut and Mental Health Connecticut explained that patients cannot access the evidence-based mental health care they need, and psychiatrists from various practice settings explained how psychiatrists are often prevented from practicing the specialized care they were trained to provide.

"Patients who need higher levels of care like residential or inpatient treatment are subjected to what I would frankly call discrimination because it is impossible for them to afford the evidence-based care that professional organizations recommend," said Andrew Gerber, M.D., who attended the meeting. Gerber is president and medical director of Silver Hill Hospital in New Canaan.

Living without parity isn't sustainable, Armah said. "It doesn't help us as a society to keep pushing people out of care," she said. "It creates a snowball effect that nobody seemed ready to address."

But that's what is so exciting about the work that Gomez and her agency are doing, Armah continued. "We're finally seeing someone say, 'O.K., we've seen this over and over again. Let's make mental health parity a reality, not just pretty words on paper.'"

see **Parity** *on page 13*

APA'S GOVERNMENT, POLICY, AND ADVOCACY UPDATE

APA Provides Feedback on Government's Role in Regulating Artificial Intelligence

Incorporating artificial intelligence (AI) into mental health care requires unique considerations, APA told Sen. Bill Cassidy, M.D. (R-La.), in a letter. Cassidy, who is ranking member of the Senate Committee on Health, Education, Labor, and Pensions (HELP), requested feedback from stakeholders on the role that the government plays in regulating the AI industry, as well as ensuring AI technology is designed, developed, and deployed in a responsible manner.

"The presence of AI-driven tools in clinical care carries unique opportunity and risk for the treatment of mental illness and substance use disorder," APA's letter, signed by CEO and Medical Director Saul Levin, M.D., M.P.A., stated. The opportunities include allowing physicians to focus on patient engagement rather than clerical work and reducing administrative burden.

However, AI technologies also carry unique risks for people with mental illness, including enhancing avoidant behavior, paranoia, or discomfort, as well as exposing patients to untested interventions. Patients with limited access to care could be shunted into lower-quality, automated care rather than having their psychiatric needs addressed using evidence-based medicine, the letter stated. "As such, these technologies risk worsening health disparities, particularly if they are insufficiently tested."

The letter is posted at http://APAPsy.ch/Cassidy-letter.

Group of Six Urges Congress to Strengthen, Diversify Physician Workforce

APA and its partner organizations, collectively known as the Group of Six, urged House and Senate leaders in a letter to act before the end of the year to advance policies aimed at strengthening and diversifying the physician workforce. The Group of Six is made up of APA, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American Osteopathic Association.

The letter was addressed to then Speaker of the House Rep. Kevin McCarthy (R-Calif.), House Minority Leader Rep. Hakeem Jeffries (D-N.Y.), Senate Majority Leader Sen. Chuck Schumer (D-N.Y.), and Senate Minority Leader Sen. Mitch McConnell (R-Ky.). The organizations urged the leaders to focus on several pieces of legislation, including reauthorizing vital programs that expired September 30: The Conrad State 30 program and the Teaching Health Center Graduate Medical Education Program.

They also noted additional pieces of legislation that would address challenges facing the physician workforce, including the following:

- Resident Physician Shortage Reduction Act of 2023 (HR 2389/S 1302), which would gradually raise the number of Medicare-supported graduate medical education positions by 2,000 a year for seven years.
- Mental Health Professionals Workforce Shortage Loan Repayment Act of 2023 (S 462), which would make mental health professionals eligible for the loan repayment program passed in the SUPPORT Act five years ago.
- Resident Education Deferred Interest Act (HR 1202/S 704), which would allow borrowers to qualify for interest-free deferment on their student loans while in a medical or dental internship or residency program.
- Rural Physician Workforce Production Act (S 230/HR 834), which would lift the current cap on Medicare reimbursement payments to rural hospitals that cover the cost of taking on residents, helping to alleviate the disadvantage that rural hospitals face when recruiting new medical professionals.

"The shortage and maldistribution of adult and pediatric primary care, psychi-

see **APA's Update** *on page 12*

CMS Approves Payment for Coordinated Specialty Care of First-Episode Psychosis

The new reimbursement codes, which are the result of advocacy by a subgroup of the Psychosis Risk and Early Psychosis Program Network, will expand access to the evidence-based treatment. **BY MARK MORAN**

The Centers for Medicare and Medicaid Services (CMS) has established new billing codes for payment of the array of services included in Coordinated Specialty Care for First-Episode Psychosis (CSC-FEP).

The codes will make it easier for private and public insurance programs to pay for these services and for community-based mental health programs to offer CSC-FEP to people who need it.

CSC-FEP had its origins in the landmark National Institute of Mental Health (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) study, which demonstrated the success of team-based care and shared decision-making offering psychotherapy, medication management, family education and support, case management, and work or education support. According to the 2021-2022 State Snapshot of Early Psychosis Programing Across the United States from the Early Psychosis Intervention Network (EPINET), the number of CSC-FEP programs has grown from 59 in 2014 to 353 in 2021.

The new reimbursement codes will increase access to a valuable, potentially lifesaving service, said Lisa Dixon, M.D.

The new codes are the result of advocacy by a subgroup of the Psychosis Risk and Early Psychosis Program Network (PEPPNET), which is focused on financing the array of services that are needed to make CSC-FEP successful. APA is one of the participating members in PEPPNET.

"CMS recognition of CSC-FEP as an effective team-based approach for serving persons with first-episode psychosis is a game changer," David Shern, Ph.D., a co-chair of the PEPPNET subgroup on financing, told *Psychiatric News*.

Shern explained that existing Medicaid and fee-for-service commercial insurance codes did not cover the full range of services. "The lack of an identified reimbursement code for these team-based services was an impediment," Shern said. "States and community-based programs were forced to come up with ad hoc coding conventions to cover all of the CSC services. Having recognition by the major payor in the American health care system of CSC as an evidenced-based model for care of early psychosis is a big deal."

He added, "What is exciting about this is that as a system we are moving 'upstream' to get care to people more quickly than we have traditionally."

The codes authorized by CMS are Level II Healthcare Common Procedure Coding System (HCPCS) codes. According to CMS, Level II HCPCS codes are used primarily to identify products, supplies, and services not captured by Current Procedural Terminology (CPT) codes (the numerical coding system maintained by the AMA). Level II HCPCS codes are used for billing such forms of health care as "ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office."

Shern likened coordinated specialty care to Assertive Community Treatment, which involves multiple components of care as well as involvement of community members and institutions. "This is a community-based service with outreach to people in the family and to other components of the community," he said. "In order for it to be successful, the full cost of it needs to be covered."

Lisa Dixon, M.D., director of OnTrackNY, one of the first and most well-developed early psychosis treatment programs, agreed. "This is going to increase access to a valuable, potentially lifesaving service," she said. "There are states that have led the way and really invested their dollars in this model of care. But in order to really make this stick, we need a way to pay for it that cuts across the different states."

"With these codes, CMS is saying it understands that coordinated specialty care is a multi-element service, and all of the elements are important," said Robert Heinssen, Ph.D.

She is also editor of the APA journal *Psychiatric Services*.

Dixon said the codes may help improve and standardize CSC-FEP. "We have a very complex and inconsistent health care system, but we have a reasonable description of what [coordinated specialty care] entails, and theoretically now we can look at these programs and evaluate the nature of the services provided. This is a really important first step in expanding access and, I hope, to improving care."

Robert Heinssen, Ph.D., senior adviser for learning health care research and practice at NIMH and the NIMH scientific officer for the RAISE study, agreed. He said that health services researchers can now evaluate the impact of the codes: Do they increase access to care? Do they improve quality, effectiveness, and sustainability of care?

"NIMH is thrilled with this development and is eager to work with researchers interested in exploring these issues," he said.

Heinssen noted that in 2015, when CSC-FEP was first being promoted as an evidence-based treatment, NIMH, CMS, and the Substance Abuse and Mental Health Services Administration developed guidance for states and community-based programs on how to finance CSC-FEP services—using Medicaid waivers and money from state mental health block grants. That guidance helped fuel the growth of the programs.

But it remained a tricky task to cobble together dollars for all services provided by CSC-FEP. "Analyses of current programs suggest that only about 50% of the direct costs of furnishing these services are covered by conventional fee-for-service insurance," Heinssen said. "It required a lot of ingenuity on the part of states to 'braid' multiple federal, state, and private funding mechanisms to cover the full costs of CSC. The solutions were often idiosyncratic and year to year because they rely on monies appropriated on an annual basis, which impedes long-range planning.

"With these codes, CMS is saying it understands that coordinated specialty care is an integrated, multi-element service, and all of the elements are important."

He noted as well that one development in CSC-FEP since the RAISE study has been the incorporation of people with lived experience of mental illness as peer support specialists. "These services will be covered by these omnibus billing codes," Heinssen said. **PN**

Information about OnTrackNY is posted at https://ontrackny.org/. "New Network Collects Real-Time Data to Improve Treatment of Early Psychosis" is posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.5.25.

Dionne Hart, M.D. (left), interviews Diana E. Ramos, M.D., M.P.H., M.B.A., surgeon general of California, at APA's MOORE Equity in Mental Health roundtable on the mental health impact of severe maternal morbidity and mortality on families. The program was held at APA headquarters in July.

Ensuring Women's Right to Full Spectrum Of Reproductive Care: We Must Do More

Psychiatrists must work to ensure social justice for women and protect their reproductive rights. ***BY DIONNE HART, M.D.***

In 1994, in Chicago, a group of Black women launched a movement focused on reproductive justice. These women recognized the necessity of supporting women's right to have autonomy over their bodies and to affirm their reproductive rights. They defined reproductive justice as a human right to control their sexuality, gender, work, and reproduction.

On June 24, 2022, the Supreme Court overruled *Roe v. Wade*, ruling the Constitution does not confer a right to a medically induced abortion. It was a political decision with immediate direct and indirect consequences. The decision ironically was made two years after many loudly voiced their rights to have control over their bodies to object to "jabs," referring to the COVID-19 vaccination. As physicians specializing in brain disorders with treatments that are often teratogenic, it is vital that psychiatric physicians educate ourselves and our patients about reproductive health.

This year, I twice had the opportunity to discuss this important topic alongside California Surgeon General Diana Ramos, M.D., an OB-GYN physician who is also a mental health advocate. Our first opportunity was in January when we discussed the legacy of Martin Luther King Jr., a 1966 recipient of Planned Parenthood's Margaret Sanger Award in Human Rights, and the second was during the Bebe Campbell Moore National Minority Mental Health Awareness Month kickoff event in July, where Dr. Ramos and I discussed the need for collaboration and advocacy. On both occasions, we emphasized the benefits of collaboration and leading "head first," in other words, to focus on scientific facts.

Dionne Hart, M.D., is an adjunct assistant professor of psychiatry at the Mayo Clinic Alix School of Medicine. She provides clinical care services in multiple community settings including an emergency department at an urban tertiary medical center, a state-operated community behavioral hospital, a correctional medical facility, and a short-stay withdrawal management center. She can be reached on X (formerly known as Twitter) at @lildocd.

Here are just a few take-home points from my discussions with Dr. Ramos:

- The Turnaway study found that electing to have an abortion does not harm the health and well-being of women but restricting access does.
- Both psychiatrists and OB-GYN physicians may discontinue psychotropic medications during a pregnancy due to concerns about the fetus experiencing adverse effects but often do not consider the benefits to the mother's health. This practice may contribute to maternal stress and increase risk of decompensation.
- Some psychotropic medications are teratogenic.
- Psychiatrists and primary care physicians, including OB-GYN physicians, play a vital role in educating women about birth control options (including abstinence) and side effects.
- 23% of pregnancy-related deaths up to one year postpartum are secondary to a mental disorder including suicide and overdose.
- Regardless of socioeconomic status or education level, Black women have a four to six times greater risk of maternal mortality.
- About 10% of fathers experience paternal perinatal depression; however, most perinatal mental health services solely focus on women.
- Women are one of the fastest-growing cohorts in the U.S. carceral system. Among female state prisoners, two-thirds are mothers of a minor child. Parental incarceration is a recognized adverse childhood experience.
- When adverse childhood effects are adequately addressed before age 18, 44% of youth with symptoms of depression improve.
- Experts predict the United States will face reproductive health care deserts in the near future as physicians and medical trainees choose to work and train in areas where women have complete autonomy over their reproductive choices and the opportunity to be trained in all appropriate treatment options.

An African proverb says that if you educate a woman, you educate a nation. APA is dedicated to collaboration to improve mental health access. By increasing advocacy efforts focused on reproductive justice at the bedside, in the clinic, and beyond, psychiatric physicians have an opportunity to not only improve the mental health of individual women, but also the health of communities. **PN**

Information on the Turnaway Study is posted at https://www.ansirh.org/research/ongoing/turnaway-study.

APA's Update

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atric, and other high-need specialties limit patient access to cost-effective, preventive care, and these problems will become even more acute in the coming years if no action is taken," the organizations wrote.

The letter is posted at http://APAPsy.ch/G6-Workforce.

APA Emphasizes Importance of Suicide Screening in EDs

In a letter to the Centers for Medicare and Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure, M.P.P., APA advocated for universal suicide risk screening for all patients in emergency departments (EDs). The letter was written in response to proposed rules that CMS issued related to its Hospital Outpatient Quality Reporting program.

Universal suicide screening of ED patients is "both clinically appropriate and logistically feasible," APA's letter, signed by Levin, stated. "However, many practitioners and facilities are currently reluctant or unwilling to expand suicide risk screening, for several related reasons." Those reasons include the challenges around hospitalization when most of the country is experiencing a shortage of psychiatric beds, as well as concerns about the harm of involuntary hospitalization.

These challenges underscore the urgency of expanding the availability of evidence-based interventions, as well as adequately funding crisis stabilization facilities. "[C]risis facilities vary widely in scope, capability, and populations served," APA wrote. "This is because they are not currently reimbursed by Medicare and most private insurance plans but instead financed and regulated at the state level via Medicaid and [Substance Abuse and Mental Health Services Administration] block grant funds. We urge CMS to develop standard definitions for facility-based crisis care and payment for these services."

APA's letter is posted at http://APAPsy.ch/CMS-suicide-screening.

Parity

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Psychiatrists are faced with numerous disincentives for taking insurance, the greatest being inadequate reimbursement. During the meeting, Lisa Harding, M.D., explained that she took a whole year before starting her private practice, Depression MD, so she could negotiate coverage rates with health plans to ensure she was paid fairly. She teaches a class on the business of medicine to students in the Department of Psychiatry at the Yale School of Medicine because so few psychiatrists know how to effectively advocate for themselves on the business side of private practice.

She pointed out that many psychiatrists are reimbursed less for providing care to patients than physicians in other specialties, even when they use the exact same billing codes. "How do you expect psychiatrists to pay their office staff, have an electronic health record, and pay their own salaries when they're only getting about $90 per patient?" Harding said.

The meeting with EBSA was incredibly helpful because Gomez was able to explain the steps psychiatrists can take when they're having issues with payers. Any psychiatrist who suspects that a health plan is not in compliance with the federal parity law can call EBSA at 866-444-3272. Further, Harding encouraged psychiatrists to get to know their regional EBSA offices.

"EBSA is on our side," Harding said. "Get to know who you should call depending on what state you're in. You have to let them know you exist and use them as a resource. They understand the rules that insurance companies have to play state by state, and hearing about the rules for payors in Connecticut was incredibly helpful."

In fighting for parity, Harding, Armah, and Gerber urged psychiatrists to be organized in their approach, both at the state and national levels, and work to raise awareness about the issues.

Public opinion can be a powerful force, possibly even powerful enough to force insurance companies to change their policies, Gerber said. "We have to start to speak out with a unified voice and use our authority as a profession to make people aware of the injustices going on here," he said. **PN**

Any physician who suspects that a health plan is not in compliance with MHPAEA can call EBSA at 866-444-3272 or visit EBSA's website http://apapsy.ch/EBSA. APA members who need assistance with practice-related issues may contact APA's Helpline at practice management@psych.org or (800) 343-4671.

Craig Norton

From left: Connecticut state Rep. Anthony Nolan speaks with Lisa Harding, M.D., and Tichianaa Armah, M.D., following a meeting on parity. All agreed that it is urgent to educate the public about their rights under the parity law.

AI in Psychiatry: What APA Members Need to Know

BY DARLENE KING, M.D.

Psychiatrists have been inundated with ideas and information about how artificial intelligence (AI) is going to impact—even revolutionize—the future of psychiatry. To help members understand AI better, APA hosted a webinar on the subject in August. Here, I am going to discuss some of the material presented as well as answer questions about AI that we have received from APA members.

APA uses the term "augmented intelligence" when referring to AI to focus on AI's assistive role in augmenting human decision-making, not replacing it. Augmented or artificial intelligence (AI) has been proposed for a variety of clinical uses: assisting with documentation, automating elements of billing and prior authorizations, detecting potential medical errors, supporting literature reviews, and more. Clinicians wonder whether the technology is already available to support these tasks and how to harness it to improve their patient care and workflows. However, generative AI and other large language models (LLMs) can also propagate biased or substandard care and pose new challenges to protecting patient privacy.

The webinar was led by me; Khatiya Moon, M.D., an assistant professor of psychiatry at Zucker Hillside Hospital and a member of APA's Committee on Mental Health Information Technology; and Abby Worthen, APA's deputy director of digital health. In the webinar we addressed clinical, ethical, and legal considerations for AI, specifically LLMs such as ChatGPT and Google's Bard. Here are the main takeaways from the webinar:

Darlene King, M.D., is an assistant professor in the Department of Psychiatry at UT Southwestern Medical Center, deputy medical information officer at Parkland Health, and the chair of APA's Committee on Mental Health Information Technology. She graduated from the University of Texas at Austin with a degree in mechanical engineering prior to attending medical school and residency at UT Southwestern.

Clinical Considerations

- Output from AI can be misleading or incorrect. It can draw conclusions that may lead to bias-related harm.

- Knowing tech sources, algorithm features, and training methods may provide some insight into the accuracy of output and what biases may exist, but this information is often not disclosed by tech companies.

- New evaluation metrics and benchmarks are needed to assess generative AI performance and utility of specific models in psychiatry.

- We need to educate patients on the risks of using LLMs to answer personal health questions and share that LLMs do not maintain confidentiality.

- If AI is used to make clinical decisions, patients must be informed.

Ethical and Legal Considerations

- APA urges caution in the application of untested technologies in clinical settings.

- Clinicians should approach AI technologies with caution, being aware of potential biases or inaccuracies and ensure that they are continuing to comply with HIPAA in all uses of AI.

- Physicians remain responsible for the care they provide and can be liable for treatment decisions they make relying on AI that result in patient harm. As such, physicians should always carefully review any output guided by AI before implementing it into a treatment plan.

- Physicians should ensure that they are transparent with patients about how AI is being used in their practice, particularly if AI is acting in a "human" capacity.

- Regulatory guardrails and best practices exist to protect patient privacy (that is, HIPAA best practices), including informed consent, data minimization, data security, and accountability. To utilize LLMs or generative artificial intelligence, health care entities generally need to enter into business associate agreements with technology companies to safeguard protected health information.

- Prompts entered into LLMs are stored on company servers and subject to the company's privacy

see **AI** *on page 22*

Transforming Mental Health Care: The Rise of VR/AR Applications in Psychiatry

BY ELEANOR ADAMS AND SHRUTI ARORA

Amid the ever-changing landscape of mental health care practice, virtual reality (VR) and augmented reality (AR) have finally made their debut after waiting for many years in the wings. What do experts and critics have to say?

At APA's 2023 Mental Health Innovation Zone (MHIZ), the applications, challenges, concerns, and future prospects of using VR/AR in psychiatry were discussed by key players in the field including Kim Bullock, M.D., a practicing neuropsychiatrist at Stanford and the founder of its Neurobehavioral Clinic and Virtual Reality & Immersive Technologies laboratory; Omer Liran, M.D., a psychiatrist at Cedars-Sinai Medical Center and co-director of its virtual medicine program; and Mark Zang, D.O., a palliative care physician and the associate chief medical information officer for digital innovation at Brigham and Women's Hospital.

Eleanor Adams and Shruti Arora are third-year medical students at UC Davis. They are both mentees of Steven Chan, M.D., M.B.A., a clinical informaticist, addiction medicine psychiatrist, and a member of APA's Telepsychiatry Committee.

The applications for VR in psychiatry are broad. Common uses include immersive exposure therapy for post-traumatic stress disorder, social anxiety, and phobias. Patients can be exposed to both visual and auditory environments to feared stimuli, confronting and managing their fears safely. VR can also aid clinicians in interactive diagnostics by simulating scenarios and analyzing patient reactions. These applications are just the tip of the iceberg; other uses include immersive environments for cognitive-behavioral therapy, therapist training, remote care appointments, and even research for new therapy techniques. To start, the panelists recommended using commercially available tools such as a MetaQuest or Google headset. Alternatively, a Google Cardboard device can transform 3D videos into a VR experience for under $10. They also suggested the Amelia Virtual Care app for clinicians as a helpful guidance point in psychotherapy practice.

Nonetheless, this ever-evolving technology comes with challenges, a few of which include the following:

- **Skepticism around use:** As Bullock stated, for many prospective users, "getting over that skepticism and giving education about how the reptilian brain [the basal ganglia] works, especially with exposure therapy," becomes a barrier to potential therapeutic use.

- **Regulatory pathways that lack support to keep up with the rate of changing technology:** Liran said that he would like the Food and Drug Administration (FDA) to permit the updating of already approved apps without having to obtain the FDA's re-approval each time.

- **Heterogeneity of VR technology:** Zang emphasized that a lot of this technology has not been built specifically for health care use, and adapting it for such use may be like fitting a square peg into a round hole.

- **The lack of regulatory pathways:** This is a major concern within the VR community. Bullock is "quite concerned that the rate of technology innovation is outpacing our regulatory processes and oversight." There are also concerns about potential ethics issues in the absence of strong regulatory foundations. Fortunately, Vang is collaborating with other leaders in the field to establish the American Medical Extended Reality Association (AMXRA), aiming to work with regulatory bodies like the FDA to address some of these safety concerns and regulation pathways in this new field of medicine.

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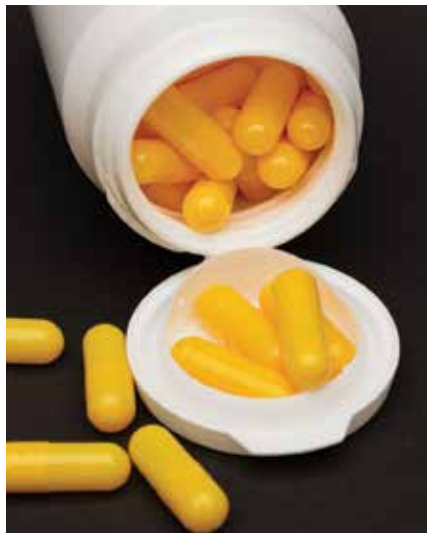
Before You Prescribe Gabapentin, Consider These Risks

Gabapentin was initially marketed as medication with low potential for abuse. A growing body of evidence highlights the potential risks of overprescribing the medication. **BY DONALD EGAN, M.D., M.P.H.**

Prescriptions for the anticonvulsant gabapentin have been steadily rising for more than a decade, primarily due to off-label use of the medication for a variety of conditions including pain, substance use disorder, and more. In 2021, gabapentin was ranked among the top 10 most prescribed medications in the United States.

Though gabapentin was initially marketed as medication with low potential for abuse and is commonly thought to be safe and effective, a growing body of evidence highlights the potential risks of overprescribing the medication. Here are several factors to keep in mind when considering gabapentin for your patients or working with patients who have been prescribed gabapentin by another doctor.



Getty Images/iStock/Ijachens

Donald Egan, M.D., M.P.H., is a third-year psychiatry resident at the University of Texas Southwestern Medical Center. He is the vice chair of APA's Diversity Leadership Fellowship and serves on the Council on Addiction Psychiatry.

Why So Popular?

Gabapentin (Neurontin) and pregabalin (Lyrica) are both gabapentinoids—psychotropic medications that cross the blood-brain barrier and mimic the inhibitory neurotransmitter gamma-aminobutyric acid (GABA). Gabapentin was first approved by the Food and Drug Administration (FDA) in 1993 as an adjunctive treatment for partial seizures. In 2002, the medication was approved for the treatment of postherpetic neuralgia, a painful complication of shingles.

Since these FDA approvals, the off-label use of gabapentin for other conditions has risen steadily. A report in *JAMA Internal Medicine* found that as U.S. prescriptions for gabapentin prescriptions climbed from 2006 to 2018, prescriptions for opioids leveled off before eventually beginning to fall over this time frame. Another study found that nearly 1 in 5 adults with chronic pain was prescribed gabapentinoids in 2018.

In addition to being used to treat pain, gabapentin is used off label to treat anxiety, alcohol use disorder (AUD), alcohol withdrawal, depression, substance use disorders (SUDs), sleep problems, and more. However, the data to support these off-label uses of gabapentin are mixed, especially for long-term use.

The rise in gabapentin prescribing is multifactorial but thought to be due in part to efforts by the pharmaceutical industry to promote the use of the medication for off-label uses. (In 2004, the manufacturer of Neurontin, Pfizer, pleaded guilty to multiple counts of illegally promoting the off-label use of gabapentin, resulting in nearly $430 million in fines.) Additionally, gabapentinoids are still considered relatively benign medications and safer alternatives to controlled substances such as opioids for pain or benzodiazepines for sleep or anxiety.

What Are the Risks?

The rising use of gabapentin in combination with the ongoing opioid crisis has contributed to a surge of negative health outcomes including hospitalizations and death.

In 2019 the FDA issued a warning about the potential risks of respiratory depression in patients taking gabapentin or pregabalin in combination with central nervous system (CNS) depressants such as opioids, antidepressants, and benzodiazepines. The FDA also warned the medication could increase breathing difficulties in patients with underlying lung disorders, such as asthma or COPD, as well as the elderly.

Despite this warning, gabapentin prescribing has continued to increase in the United States. According to IQVIA National Prescription Audit, total prescriptions dispensed for gabapentin were approximately 68.3 million in 2019, 69.0 million in 2020, and 70.9 million in 2021. At least 40% to 65% of individuals with prescriptions for gabapentin and roughly 20% for individuals who misuse opioids report gabapentin misuse.

Gabapentin misuse may in part be driven by dependence and withdrawal symptoms. Studies have demonstrated that patients who have taken as little as 400 mg daily for three weeks may experience withdrawal symptoms—including anxiety, pain, nausea, fatigue, and restlessness—that can begin within 12 hours of stopping the medication and can last up to 10 days.

Such misuse can quickly turn deadly: The U.S. Centers for Disease Control and Prevention (CDC) in 2022 issued a report that found the number of overdose deaths involving gabapentin approximately doubled from 2019 to 2020.

What Can Psychiatrists Do?

There are actions psychiatrists can take to reduce the use of gabapentin:

- **Educate patients:** Engaging in open and honest discussions with patients about the risks and benefits of gabapentin is essential. Patients should be made aware of the potential for abuse, dependence, and overdose. They should also be educated about proper medication storage and disposal.

- **Screen patients for substance use disorders and other medications:** Before prescribing gabapentin, psychiatrists should routinely screen patients for substance use disorders and reconcile any medications patients may be taking that may lead to deleterious interactions.

- **Prescribe first-line medications:** Before prescribing gabapentin, psychiatrists should prioritize the use of evidence-based first-line medications for specific symptoms and conditions. Superior agents exist for managing common issues such as anxiety, sleep disturbances, pain, and mood disorders, and they should be considered as primary treatment options.

- **Consider alternative pain management strategies:** Psychiatrists should consider adopting multimodal pain management strategies, especially for chronic pain conditions. Combining nonopioid medications, physical therapies, and psychological interventions can often lead to better outcomes while minimizing reliance on a single medication.

- **Regularly evaluate the effectiveness of gabapentin:** Psychiatrists should periodically assess the effectiveness of gabapentin treatment. If the desired outcomes are not achieved within six months, alternative treatment options or adjustments to the treatment plan should be explored.

- **Report adverse events:** Psychiatrists should report adverse events related to gabapentin. Such information will contribute to a better understanding of the safety profile of the medication and help regulatory agencies take appropriate measures if needed.

Amid the emerging evidence of the adverse consequences of the overprescribing of gabapentin, a pressing need exists for medical professionals to discuss the prescribing practices involving these medications. These conversations should focus on evidence-based interventions over unsupported off-label applications that do not have data to support their efficacy and may lead to long-term impacts on health. This is not to say that gabapentin has no role in modern medical practice, but rather a need to reevaluate prescribing practices to maximize patient care as well as prevent the potential development of a medication-related crisis. **PN**

Dr. Egan would like to thank Smita Das, M.D., Ph.D., M.P.H., and Michael Ostracher, M.D., for their assistance with this article.

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Liran's lab is developing VR applications specific to health care. The staff write scripts, create storyboards, and review patient feedback. Feedback is taken to the experts and evaluated for possible implementation. This iterative process informs app development, involving continuous consultation with patients and design changes.

Future prospects of VR development for medical applications are broad. Bullock said she imagines something futuristic like the holograms in "Star Trek" and admits it's almost impossible to predict what our future holds regarding technology expansion into medicine. Liran sees the future of VR in medicine as "revolutionized telehealth with physiological markers integrated with headset technology," and Vang emphasized that we are moving toward "a world where digital integrates into our reality and becomes the new normal."

Whether practitioners engage with this technology or not, its impact on medicine is inevitable. Panel discussions like this one at the annual APA Mental Health Innovation Zone provide the perfect space to learn, question, and discuss the progress of these technologies. **PN**

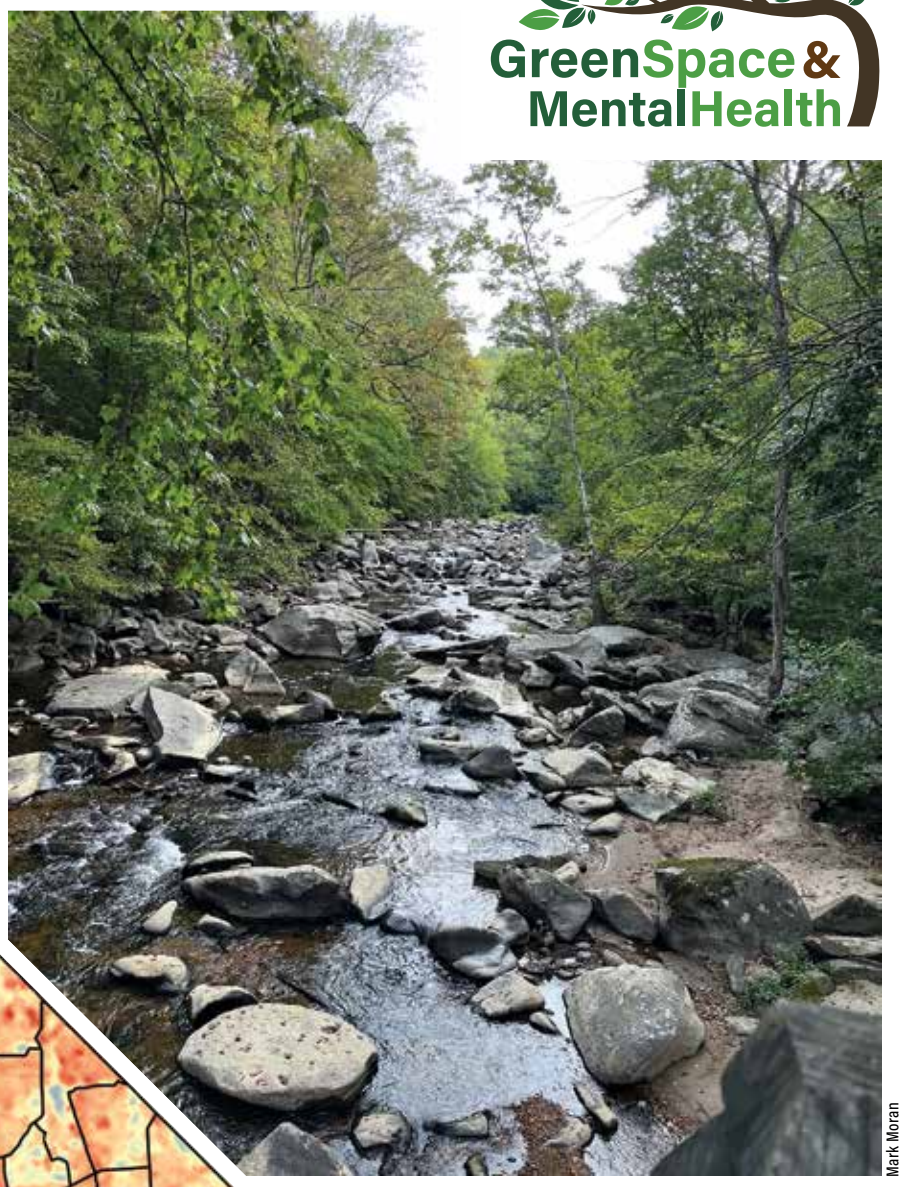
Movement Emerges to Include Green Space As a Social Determinant of Mental Health

A rich and growing literature shows that immersion in nature and exposure to green space has a measurable impact on health and mental health. This is the first in a three-part series. **BY MARK MORAN**

On a recent Saturday in Rock Creek Park in Washington D.C., Sarah Dewitt, a certified forest therapy guide, led a handful of people in the ancient Japanese practice of "Shinrin-yoku"—forest breathing or forest bathing.

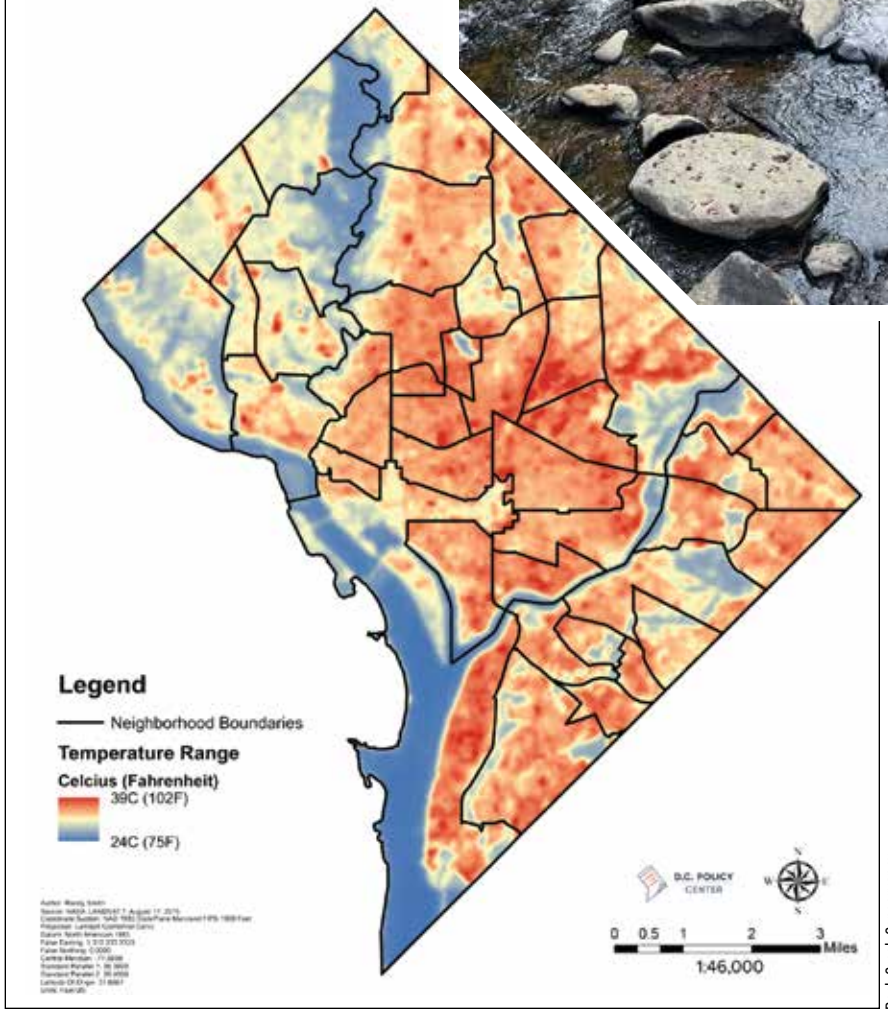
"Forest bathing is a very slow and mindful walk in nature," Dewitt told *Psychiatric News*. "It starts with a warm-up in which I invite participants to tune into each of their senses one at a time. Then I might invite them to wander out in the woods and pay close attention to all the things that are in motion."

It is customary to end a forest bathing walk with a tea service. This offers participants a chance to "taste" the forest, after tuning into their other four senses during the walk: sight, sound, smell, and touch. Traditionally a small amount of tea is poured back to the land as a gesture of gratitude and reciprocity before participants taste the tea and share reflections of their experience in the forest, Dewitt said.



Mark Moran

Rock Creek Park's nearly 1,800 acres of forest are the heart and lungs of the Washington, D.C., region, serving as a climate oasis and storing 100,000 tons of carbon above ground.



Rock Creek Conservancy

This heat map displays the range of temperatures in Washington, D.C., on August 17, 2015. The blue areas, including the Potomac River and also Rock Creek Park in the upper Northwest section of the city, are 15 degrees cooler than the hottest parts of the city.

In a city overheated in more ways than one, forest bathing is a welcome retreat, and Rock Creek Park is an oasis—33 miles of meandering creek and 1,800 acres of forestland administered by the National Park Service (NPS). The park serves as the city's heart and lungs: On the hottest summer days it may be as much as 15 degrees cooler in the park than in the hottest parts of the city (see map). And it serves as an important carbon capture, storing more than 100,000 tons of carbon above ground, according to Rock Creek Conservancy, a nonprofit partner to the NPS dedicated to preserving the park.

To follow the creek and wander the forest paths at any time of year is to experience a little bit of what the poet Mary Oliver meant when she wrote: "It is a serious thing just to be alive on this fresh morning in this broken world."

But forest bathing is more than an esoteric exercise of the spiritually or aesthetically inclined. There is a rich and growing literature showing that immersion in nature and exposure to green space has a measurable impact on health and mental health, and there is an emerging movement in some quarters of medicine to incorporate this research into clinical practice.

Still, the concept of proximity to greenspace as a social determinant of health and mental health—similar to access to food, housing, and health care—remains still slightly out of the mainstream, at least in the United States.

"In psychiatry we tout exercise, collaboration, and connection as important to mental health, but not enough people are talking yet about green space as a social determinant of health," said child and adolescent psychiatrist Sara Anderson, M.D., M.P.H., a member of the APA Caucus on Social Determinants of Mental Health and the APA Caucus on Climate Change.

Anderson said she works with children and teenagers with significant anxiety about being outdoors, a fear exacerbated by COVID-19. And public green space is very inequitably distributed: Children in lower socioeconomic neighborhoods are far less likely to have access. "We talk about adverse childhood experiences, but we don't talk about the environment and how that may contribute to or undermine resilience."

Anderson asked: "How can we create a passion to connect people to nature as an adjunct to developing connection and a locus of control in a world where we all feel out of control?"

Green Space Affects Population Health

If green space as something to incorporate into treatment has not quite made it to center stage, there is no lack at all of research on the subject.

"There is a strong and growing body of research showing that exposure to green space is related to better mental health, better cognition, higher levels of physical activity, lower cardiovascular disease, and lower mortality," said Peter James, Sc.D., an associate professor of environmental health at the Harvard T.H. Chan School of Public Health and an associate professor of population medicine at Harvard Medical School.

"The strongest lines of research are randomized trials showing short-term improvements in mood and cognition after exposure to nature because they are experiments designed in such a way as to control for potential confounders."

see **Green Space** *on page 37*

Psychiatrist Helps Students Create Film On Postpartum Psychosis

Hoping to educate and spur advocacy, two high school students worked with an expert in perinatal psychiatry to make a film on postpartum psychosis and how the American justice system responds to it.

BY KATIE O'CONNOR

Nirmaljit Dhami, M.D. (center), worked with high school students Amar Sandhu (left) and Mehr Dhami (right) as they developed a film on postpartum psychosis, which they presented at El Camino Health's symposium on mental health.

Many Americans do not know that women can develop postpartum psychosis, and those who do are often misinformed by inaccurate media portrayals. This past summer, two high school students in California embarked on a project to educate the public and begin sparking change.

"It was shocking to me when I first read about it," Amar Sandhu said of learning about postpartum psychosis. A senior at Menlo-Atherton High School in Atherton, Calif., he and Mehr Dhami, a senior at St. Francis High School in Mountain View, Calif., created a film about the illness. The film explores postpartum psychosis, the challenges faced by women with the illness who are in the criminal justice system, and what could be changed to better support these women.

Mehr Dhami's mother, Nirmaljit Dhami, M.D., suggested that the students make the film, titled, "Behind Bars: Innocent Yet Guilty." Nirmaljit Dhami is the medical director of inpatient perinatal psychiatry at El Camino Health in Silicon Valley. El Camino's perinatal psychiatric unit is one of less than a handful of such units in the country, Nirmaljit Dhami said. The film was featured at El Camino's Sixth Annual Maternal Mental Health Symposium in September.

Each year, high school students reach out to Nirmaljit Dhami at El Camino seeking internships, but few opportunities are available to them. She thought creating the film would be a way to involve local high schoolers while meeting another urgent need: education about postpartum psychosis and the need for greater specialty care for these patients. Often, the public hears only about women with postpartum psychosis after an incident of infanticide, which is rare but often highly publicized.

"We offer high-level services for a lot of moms, but many patients don't get any care at all, often simply because of lack of information," she said.

Education about postpartum psychosis is vital, she said, not only to educate women and their families about the illness, but also to support women who find themselves entangled in the criminal justice system. "The media focuses on the incidents of suicide or filicide, but they forget about the women who had a treatable illness and may now

see **Film** *on page 20*

North Carolina's Telepsychiatry Program Expands Reach, Saves on Costs

Since its launch in 2013, the North Carolina Statewide Telepsychiatry Program (NC-STeP) has saved the state millions of dollars and prevented more than 8,500 unnecessary involuntary hospitalizations. This year, it secured a $3.2 million grant to expand into pediatric clinics. **BY KATIE O'CONNOR**

A patient who had an appointment at her obstetrician-gynecology (OB-GYN) practice was struggling. A Marine spouse in her early 20s, she did not have a support system at home. While at her OB-GYN, she was able to speak with a licensed clinical social worker with the North Carolina Statewide Telepsychiatry Program (NC-STeP) virtually. On that call, the patient admitted what she hadn't told her OB-GYN: She had thoughts of suicide, had a history of self-harm, and had written a suicide note the week before.

The social worker immediately contacted staff at the OB-GYN's office, who reached out to a mobile crisis unit, which helped secure the patient a bed at a mental health facility. Ryan Baker, M.H.A., NC-STeP's administrator, said that the patient is now doing well. "These are the success stories that policymakers, politicians, and the public need to hear," he said.

NC-STeP Founder and Director Sy Saeed, M.D., M.S., started the program in 2013 because North Carolina was experiencing a problem also faced by many other states: Patients were spending huge amounts of time in the emergency department (ED) because they had nowhere else to go and no psychiatrists to see them. NC-STeP connects patients in EDs across the state with psychiatrists and other behavioral health workers virtually.

Saeed is a professor and chair emeritus of the Department of Psychiatry and Behavioral Medicine and founding director of the Center for Telepsychiatry and e-Behavioral Health at the Brody School of Medicine at East Carolina University. He is also a member of APA's Committee on Telepsychiatry.

Before NC-STeP started, the average length of stay for psychiatric patients in the ED in North Carolina was 72 hours. Within the program's first year, that length of stay was cut in half, and the program has maintained that reduction since, Saeed said. It has also expanded outside the ED, most recently to provide care to kids.

Expanding to Address Needs of Special Populations

One of NC-STeP's goals is to ensure all patients have access to evidence-based mental health services, Saeed said. In 2018, it expanded into community-based health care settings for patients in crisis. In 2021, it launched a collaborative care model with OB-GYN offices, connecting nurses, diabetes educators, behavioral health managers, nutritionists, obstetricians, maternal fetal medicine specialists, and psychiatrists together to care for patients. This grant-funded project also screened patients for food insecurity and offered a medically tailored food bag, nutrition education handouts, and links to existing community resources for emergency food to those who screened positive for food insecurity.

This year, NC-STeP received a three-year, $3.2 million grant from the United Health Foundation to expand into six pediatric and primary care clinics to provide services to youth. The goal is to collaborate with pediatricians and provide psychiatric expertise, as well as to address stigma around receiving mental health care, Saeed said.

The grant will also fund the development of a virtual reality game through which children and their families can learn about mental health and receive peer-to-peer support. The game will include a 3-D community house on the Roblox platform called "NC Kids Get Well."

Earlier this year, East Carolina University's Center for Telepsychiatry and e-Behavioral Health held a competition for children and adolescents aged 5 to 18 in which they could submit their own designs for the community house. "It warmed our hearts to see their entries," Saeed said.

A Model for Other States

Several states have reached out to NC-STeP, seeking guidance on building similar programs, including Vermont. The Vermont Emergency Telepsychiatry Network (VETN) launched in October of 2022 after Saeed gave a presentation to a group focused on telehealth. Ali Johnson, M.B.A., VETN's project lead, said the goal is to help Vermont EDs provide timely psychiatric care via telehealth for people with mental health needs.

Because Vermont is such a small state, the program looks different from

ETHICS CORNER

Ethics and the Law: What Is the Difference?

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

Section 3 of the *APA Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* states, "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." The requirement to respect the law has increasingly come under serious scrutiny in recent years with the enactment of laws by some states that are clearly contrary to the health and best interests of patients. Striving to uphold APA ethics principles, which apply to all APA members, psychiatrists must now confront additional challenges posed by these oppressive laws. In this climate, knowing what is legal versus ethical can be confounding. For example, is illegal behavior also unethical or, conversely, is unethical behavior also illegal? In other words, would breaking these laws constitute unethical behavior? Where should we draw the line?

The Merriam-Webster Dictionary defines "laws" as "a binding custom or practice of a community: a rule of conduct or action prescribed or formally recognized as binding or enforced by a controlling authority." "Ethics" is defined as "a set of moral principles: a theory or system of moral values."

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 a 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.

Unfortunately, these definitions do not help in answering the questions I have raised. Section 3 of the *APA Principles* states, "It would seem self-evident that a psychiatrist who is a lawbreaker might be ethically unsuited to practice his or her profession," especially when such illegal activities bear directly upon his or her practice. However, breaking the law by protesting social injustice may not be unethical. Likewise, breaking the law regarding speed limits and getting speeding tickets does not equate to unethical conduct. Therefore, illegal activity is not always unethical. The reverse is also true. For example, while being disrespectful and demeaning to patients are unethical, they are not necessarily illegal. That said, when unethical behavior negatively influences the care received by a patient, it could lead to a malpractice claim in civil court. Thus, unethical behavior can cross legal boundaries.

Malpractice is defined as **D**ereliction of **D**uty that **D**irectly leads to **D**amages, the so-called four Ds of malpractice. Unethical behavior that negatively impacts the duty of care that the psychiatrist owes the patient and directly causes harm to the patient can result in malpractice claims. However, ethics complaints differ significantly from malpractice claims in several ways.

Malpractice claims specifically allege that a psychiatrist's failure to provide proper care directly resulted in patient harm, while ethics complaints allege that a psychiatrist has engaged in unethical conduct, regardless of whether harm has occurred. Therefore, investigations in malpractice cases are confined to the specific intervention/behavior that caused harm, whereas ethics investigations may go beyond the substance of the original complaint if an investigation reveals other unethical conduct. Further, ethics complaints can be filed by an individual with direct knowledge of the unethical behavior, while the harmed patient, the patient's legal guardian, and/or the patient's surviving next of kin—that is, only those who have standing in court—may bring malpractice claims.

Importantly, standard-of-care concerns differ between malpractice cases and ethics complaints. In the former, the standard is what the "average prudent psychiatrist" would do in similar circumstances, whereas ethics complaints refer to violation of APA's ethics code. While a patient's desire to raise malpractice claims may be impeded by the availability of financial resources to retain legal representation, filing ethics complaints has no cost. In both cases, however, the psychiatrist may

continued on facing page

NC-STeP, Ali explained. Several hospitals in Vermont already provide telepsychiatry services, while others have none. VETN has an advisory board of experts who regularly meet to understand the state's needs, demonstration projects currently underway in two EDs, and a training program in development that will disseminate telepsychiatry best practices. While VETN isn't statutorily required to collect data like NC-STeP, Johnson said VETN has still implemented an evaluation component to ensure it also has robust data.

VETN is an example of how similar approaches can be adjusted to meet the needs of different states. Ultimately, regardless of the state, the goal has remained the same: Ensure all patients in crisis have access to quality psychiatric care. "Someone living in rural North Carolina should have the same access to care as someone in a suburban or urban area," Baker said. "This program actually fulfills that goal."

Program Often Overturns Involuntary Hospitalizations

As of June 2023, NC-STeP had provided 59,216 telepsychiatry consultations and saved the state more than $54 million. Further, over 32% of the patients it has served did not have insurance.

A significant factor in NC-STeP's cost-savings estimate is the involuntary hospitalizations that were overturned

see **North Carolina** *on page 21*

continued from facing page

incur various types of costs. The outcome of a successful malpractice claim is financial compensation to the harmed patient at the expense and reputation of the psychiatrist, and an ethics investigation can be financially and emotionally taxing, including concerns about potential loss of license or income for serious ethics violations.

The distinction between ethics and the law is not completely clear-cut. They both hold people to account, one to members of an association (ethics) and the other to members of society (laws). Patients reserve a right to sue their psychiatrist, even for what might seem like a mild unethical behavior. Whether they prevail in court is irrelevant. Consequently, I take an extreme view when I caution myself to strive to avoid all unethical behaviors by seeing them as (potentially) illegal. I am certainly not advocating the same to all psychiatrists, but I strongly urge you to consider this view. **PN**

***The APA Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* is posted at http://apapsy.ch/Principles_of_Medical_Ethics.**

Youth Guidance

Students share their stories and connect during a Working on Womanhood group session.

Group School Intervention Helps Girls Cope With Internalized Trauma

The Working on Womanhood program combines elements from multiple evidence-based therapies to help girls in at-risk neighborhoods develop healthy habits and healthy relationships. **BY NICK ZAGORSKI**

In September 2016, following a spike of gun violence in Chicago, Mayor Rahm Emanual announced a new public safety plan that featured a three-year, $36 million initiative to provide mentoring and psychological support to middle- and high school–aged boys in at-risk neighborhoods.

U Chicago /Jason Smith

With a cost of just $2,300 per student per year, Working on Womanhood is a cost-effective group intervention for reducing trauma and depressive symptoms in girls, said Monica Bhatt, Ph.D.

The mayor's plan was met with a mixed response, with some community advocates and researchers wondering why the program shortchanged programs for girls.

"Girls are absolutely overlooked in school and community settings," said Nacole Milbrook, Psy.D., the chief program officer at Youth Guidance, a Chicago-based nonprofit that creates and implements school-based programs to help students succeed in school and life. "Girls affected by violence and trauma tend to act *in* as opposed to act *out*; if you are not creating a problem, the perception is you don't need intervention."

That perception could not be further from the truth, noted Monica Bhatt, Ph.D., research director at the University of Chicago's Crime Lab and Education Lab. "We did surveys of 9th, 10th and 11th grade girls in schools [from neighborhoods] experiencing high rates of gun violence and found that nearly 40% had symptoms of distress consistent with probable PTSD," she said. "That is twice the rate seen in veterans returning from Iraq or Afghanistan, which is very sobering."

To offer support to these and other girls, Youth Guidance created a program called Working on Womanhood (WOW). WOW is a school-based, trauma-informed group counseling program designed by Black and Latinx women for Black and Latinx girls. The program serves students in schools in Chicago, Boston, and Kansas City, but the results of a recent feasibility study showcase a broader potential.

Students Experience Mental Health Improvements

Working on Womanhood—which was created in 2011 by a team of social workers at Youth Guidance—is shaped by principles taken from cognitive-behavioral therapy, acceptance and commitment therapy, and narrative therapy. The weekly group sessions are led by master's-level counselors, who offer

see **School** *on page 39*

Doctor Henderson's Trumpet Recalls an Echo of Two Worlds

Despite the obstacles he faced, Eddie Henderson, M.D., persevered to become a successful physician and jazz musician. **BY AARON LEVIN**

There are lots of musicians named "Doc"—Doc Severinson, Doc Pomus, Doc Cheatham, Doctor John the Night Tripper—but not too many are genuine, M.D. doctors.

Today, at 83, Eddie Henderson, M.D., is a master of the jazz trumpet, but he arrived at that peak with a detour through several side gigs, including psychiatry.

Henderson, born in New York, was introduced to music and medicine early. His father sang with the Charioteers, a famous Black vocal group in Ohio and later New York, and his mother was a friend of Billie Holliday and Lena Horne. Dizzy Gillespie and Duke Ellington visited his parents. Once, Sarah Vaughn took young Eddie to New York's Apollo Theater to see Louis Armstrong play. It was his first exposure to the trumpet. Backstage, Armstrong taught him how to make a sound on the instrument.

After a year of lessons, he played the "Flight of the Bumble Bee" for Armstrong, who gave him a book of his transcribed solos inscribed "To Little Eddie. You sure sound good. Keep playing. Love, Satchmo."

"I didn't know it was going to turn into the rest of my life," he recalled in an interview after playing at Baltimore's Keystone Korner jazz club just before COVID-19 upset the world.

After his father died, his mother married the most prominent Black physician in San Francisco, necessitating a move across the country. Henderson took lessons from the first chair in the San Francisco Symphony, gaining a firm grounding in the instrument, he recalled. "I could play the trumpet, but I knew nothing about jazz."

Nevertheless, he met leading lights in the jazz world as a high school junior when he shuttled Miles Davis, John Coltrane, Canonball Adderly, Philly Joe Jones, Wynton Kelly, and others to and from a local music festival.

His stepfather did not support his musical interest, however. He even told Henderson that he would end up as a "bum on the waterfront," but one of his great strengths was taking such disparagement as a challenge.

Others threw up roadblocks, as well. A teenage fascination with ice skating was briefly stymied by the unwillingness of the San Francisco skating club to admit a Black skater. But during a later stint in the Air Force, he was stationed in Colorado and joined the less-prejudiced Denver Figure Skating Club, under whose aegis he earned a bronze medal at the 1960 Midwestern Figure Skating Championships in Minneapolis.

Henderson aced high school; studied hard at the University of California, Berkeley; and was accepted at Howard University's medical school. "I had to fill my commitment of spite to my stepfather just to prove him wrong," he said.

Discipline got him through. "I never missed a class in my life. I took exceptional notes." He'd spend 8 to 5 at school, absorbing the pearls of wisdom in class; went home and studied for four hours; and then head to the local clubs and play jazz to relieve the tension and make a few bucks. On weekends, he would dash up to New York to listen to the jazz greats.

His decision to enter a psychiatry residency after graduation in 1968 came with an advantage at the time—he'd have more time to follow his musical muse. Back in California, he was assigned to the Clinical Research Ward, an inpatient service at the Langley-Porter Institute at UC Berkeley.

Jim Bourne

"It was unusual to have an African American in the residency at that time," recalled Ira Glick, M.D., who was head of the residency program then. "Eddie was a very interesting guy, very smart. He worked all day as a resident and played nights in the Fillmore district."

Glick and Henderson lost touch until 2019 when Glick was in New Orleans to give a lecture. He strolled over to a jazz festival just in time to hear the announcer introduce "Doctor Eddie Henderson." Glick stuck around until the end of the show. When Henderson came out, he spotted his old mentor and said: "You saved my life!"

Minimal night call gave Henderson the same opportunity he had in medical school at Howard—medicine by day and music by night. After a year and a half, pianist Herbie Hancock came to town and needed a trumpeter for a week, a week that would last to the present day.

Henderson left the residency and spent three years on the road with Hancock's group, then three months with Art Blakey, the legendary drummer and bandleader known for nurturing young talent. But after his pay with Blakey mysteriously diminished, Henderson returned to San Francisco and a clinic in Haight-Ashbury, this time as a general practice physician. The doctor who hired him had no qualms about encouraging Henderson's musical career over the next 10 years.

"He let me go on tour and paid my salary anyway," he recalled. "It was an ideal situation. I never wore a suit. A lot of patients were street people."

People knew he was a musician, and he often went to work with his trumpet, all the better to spend his nights playing at local clubs. Occasionally, the two worlds of Eddie Henderson intersected, or maybe collided, like the night when Thelonius Monk, the jazz piano legend, arrived as a patient in the clinic.

Eventually, Henderson was able to put down his stethoscope and make a full-time living with his horn. The path has taken him through 26 albums as a bandleader, dozens more as working with other musicians, and uncountable gigs in clubs and concert halls. He still fronts his own group and often joins an all-star band, The Cookers, on the road. He also passes along his experience to a younger generation of trumpeters as a member of the jazz faculty at Oberlin College's Conservatory of Music.

Yet those long ago echoes of his life as a physician and a psychiatrist in training still resonate, just like the notes emanating from his trumpet over the years.

"I couldn't be a good doctor unless I was healed, and music is the thing that heals me," he said. "Music is like therapy—it puts me at ease with who I am. Then I can relate to other people and spread the joy." **PN**

Film

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be stuck in the legal system, perhaps for the rest of their lives, because they couldn't get help," she said.

While making the film together, Sandhu and Mehr Dhami spent countless hours doing research. They read papers not just about the diagnosis of postpartum psychosis, but also about the criminal justice system. They interviewed forensic experts, psychologists, psychiatrists, public defenders, authors, and experts on reproductive mental health, as well as numerous other experts on this topic.

The film explains why women with postpartum psychosis may not always be able use the insanity defense. "If jury members have never been educated about mental illness, it's incredibly difficult for them to empathize or understand a person who pleads not guilty by reason of insanity," Mehr Dhami said.

The film is meant to be a piece of advocacy for the women who find themselves in the grips of postpartum psychosis and the justice system, raising awareness about the issue and encouraging compassion. "We're hoping that the film can have an impact on changing the law and prompting a reconsideration of how we address individuals dealing with postpartum psychosis," Sandhu said.

Mehr Dhami said she hopes the audience walks away from the film with newfound empathy for women who experience this disease. "It's hard to empathize with the women we hear about in the news because we don't understand the severity of the disease," she said. "I hope people will try to understand and get them help, rather than viewing them immediately as murderers."

Now, Nirmaljit Dhami said she has a pool of high school students interested in working on another film, which she intends to help them make for next year's symposium. She said she hopes to continue doing this work, as it is not only a great way to advocate for patients, but it also includes the community in advocacy and education.

Already, Nirmaljit Dhami said that she and the students have spoken with California lawmakers about potentially introducing legislation to better protect women who experience postpartum psychosis.

"We definitely want to create change with the film, and we often think about change on a big scale, but I think change also can start small," Mehr

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Mandatory Reporting Obligations: A Risk Management Perspective

Psychiatrists need to be clear with patients about their legal and ethical responsibilities regarding their duty to report patients who may be a danger to themselves or others or who may be at risk for harm. **BY ALLISON FUNICELLI, M.P.A., C.C.L.A., A.R.M.**

Psychiatrists, like most health care professionals, are bound by confidentiality under HIPAA and privacy laws. Patients share very personal information, and breaking confidentiality can negatively impact the psychiatrist/patient relationship and impede patients' ability to seek the care they need. But what happens when patients share information requiring psychiatrists to report under the duty to warn/protect requirements in their state? Psychiatrists may find themselves in an ethical dilemma and unsure how to proceed.

Each state has its own duty to warn/protect criteria, which fall into one of three categories: mandatory reporting; permissive reporting, meaning a psychiatrist *may* report under the statute without negative repercussions; or no duty to report.

Examples of Mandatory Reporting

- The patient deemed a danger to self or others.
- Suspected or evidence of abuse to elders, vulnerable adults, and minors.
- Lack of capacity or impairment to drive safely.
- Extreme Risk Protection Orders (red flag laws).

What happens when a patient tells his or her psychiatrist of threats or potential threat of harm or abuse sustained by third parties? If a patient reports crimes or potential threats made by a third party to others, not involving the patient, typically there is no duty to report. This information may be deemed hearsay since the patient is relaying information from or about a third party. However, if the psychiatrist has a concern for public safety, such as a patient's reporting a relative who may be planning a mass shooting, it is best to consult with an attorney immediately in the interest of public safety.

If the patient reports that a friend or family member was the victim of abuse as a child (for example, a patient reports that his or her spouse was the victim of child abuse), the psychiatrist may recommend that the patient encourage the friend or family member to report the abuse; however, it is unlikely that the psychiatrist has a reporting obligation. Again, when a psychiatrist is unsure about what to do under the circumstances, consulting an attorney or risk management professional is best.

Risk Management Considerations

Psychiatrists must be upfront with their patients regarding the legal and ethical duties they are required to follow, including situations involving a duty to protect/warn. Patients should understand that conveying certain information may trigger a duty to report per state/federal statutes and ethical obligations under medical licensure regulations and to alert others to a potential harm to the patient or others the patient may harm. As a result, here are risk management considerations in reducing the risk when considering reporting under the duty to warn laws.

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

- Consult an attorney, risk management professional, or Ethics Committee of APA or the AMA for guidance on reporting obligations.
- Use good documentation techniques for memorializing the information in patients' records. For extremely sensitive information, consider documenting it in a psychotherapy note kept separate from the medical record.
- Consider the policy of "do no harm." Will reporting the event create an increase in mental stress to your patient? Will reporting create a potential threat by a third party for injury to your patient? Is there a public safety concern?
- Does the actual or potential harm involve a child or vulnerable adult?
- Consult federal, state, and local statutes for guidance within your state. **PN**

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Dhami said. "The more people who see the reality of these cases and the way the justice system has treated some of these women, the bigger impact we will have over time." **PN**

North Carolina

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after patients were evaluated by an NC-STeP psychiatrist or behavioral health worker. Since the program began, it has resulted in over 8,500 involuntary hospitalizations being prevented.

"In the very first year of the program, we saved the sheriff's department approximately $500,000 just by cutting down on their transportation costs," Saeed said.

Because a substantial part of NC-STeP's funding comes from the state, Saeed regularly provides updates to the legislature on the program's value. It's easy and straightforward to explain the benefit to North Carolina residents in terms of dollar amounts, but Saeed also emphasized what is saved on behalf of the patients: Time away from their homes and involuntary transportation to an unfamiliar treatment center.

"We are able to provide high-quality, evidence-based care to patients closer to their home and, at the same time, cut down on costs in a lot of different ways," he said. "We help in delivering what science has promised: access to effective care." **PN**

More information about NC-STeP is posted at https://ncstep.ecu.edu. More information on VETN is posted at http://APAPsy.ch/df.

APA Virtual Program to Explore Impact Of Opioids on Communities of Color

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Studies show that African Americans are being hit particularly hard by the current opioid crisis. An upcoming webinar by APA's Division of Diversity and Health Equity will explore how psychiatrists can help to mitigate the devastating effects of this crisis.

BY FÁTIMA REYNOLDS, M.P.H., AND JORDAN WHITE, DR.P.H., M.S.

The opioid epidemic has impacted communities across the United States, transcending boundaries of race, age, and socioeconomic status. The rise of overdose deaths from prescription opioids in the 1990s and heroin in the 2010s has now given way to a synthetic opioid epidemic.

According to the Centers for Disease Control and Prevention (CDC), overdoses involving opioids killed more than 80,000 people in 2021. Synthetic opioids, particularly illicitly manufactured fentanyl, were responsible for 88% of these deaths.

Overdose deaths involving synthetic opioids have impacted communities of color and urban populations, particularly African Americans, at alarming rates. Experts believe that multiple factors, including easy access to the less expensive drugs, are likely fueling the synthetic opioid epidemic hitting Black and urban communities.

Psychiatrists at the forefront of research on opioids will examine these topics and more on Thursday, December 7, at 7 p.m. ET as part of APA's next "Looking Beyond Series" webinar. Topics for discussion will include the complex intersection of race, socioeconomic status, and systemic disparities in health care that are contributing to the disproportionate burden of the opioid epidemic on the African American community.

Fátima Reynolds, M.P.H., is a senior manager in APA's Division of Diversity and Health Equity (DDHE) and the founder of a grassroots artistic collective aimed at increasing diversity and gender parity in the music industry. Jordan White, Dr.P.H., M.S., is DDHE's director of social determinants of mental health and an adjunct faculty member at Morgan State University School of Social Work.

Role of Social Determinants of Mental Health

Disparities in mental health care result from a combination of factors rooted in social determinants of mental health. These factors may include structural and systemic biases; unequal distribution of public resources; and the impact of violence, stigma, and racism.

Historically excluded and marginalized populations, such as those from communities of color, are more likely to experience poverty, unemployment, and limited access to quality health care. People with substance use disorders have the additional hurdles of stigma associated with their disorder as well as a fear of legal consequences. Yet another barrier to care involves finding health care professionals who can provide affordable and culturally competent care to address the unique needs and challenges that patients of color face.

In a 2015 paper, psychiatrists Michael Compton, M.D., M.P.H., and Ruth Shim, M.D., M.P.H., described social determinants of mental health as being "underpinned by unequal distribution of opportunity and, more deeply, by public policies (e.g., legislation that may not specifically pertain to health but ultimately has far-reaching effects on health) and social norms (e.g., cultural opinions and biases that set the stage for poorer health among disadvantaged groups)."

Compton and Shim went on to describe the relationship between income inequality and substance use disorders and substance-related outcomes; for example, they noted, data show the risk of death from overdose is significantly higher in neighborhoods with greater income inequality.

"The social determinants of mental health represent modifiable factors that, if addressed, could lead to improvements in the mental health of our society and could even contribute to the prevention of mental illnesses and substance use disorders."

What Can Psychiatrists Do?

Opioid-related substance use and overdose deaths among African Americans is a critical issue that warrants the attention and intervention of psychiatrists and mental health professionals.

Even as overall opioid overdose death rates have leveled off, multiple studies suggest that opioid overdose deaths are continuing to rise for African Americans. For instance, a 2022 study conducted by researchers at Howard University in Washington, D.C., with the National Institutes of Health found that the opioid overdose death rates among African Americans rose four- to sixfold compared with opioid overdose deaths in White residents in areas identified as "hotspots" for opioid overdose deaths. (These areas included Maryland, Illinois, Michigan, Pennsylvania, and the District of Columbia.)

To address this crisis, it is essential to adopt a comprehensive approach that acknowledges the intersectionality of race, socioeconomic status, and mental health. Offering culturally sensitive care, increasing access to addiction treatment, and reducing stigma are crucial steps toward mitigating the devastating impact of the opioid epidemic on the mental health of African Americans. **PN**

Find more information and register for the webinar "The Unequal Impact of the Opioid Epidemic in the African American Community: Insights for Psychiatrists" at psychiatry.org/LookingBeyond.

AI

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policy. Prompts containing private health information could be leaked or sold to third parties, compromising patient privacy.

FAQs

Q *What are some available tools?*

A There are many LLMs available to the public. The most popular are ChatGPT, Google Bard, and Bing Chat powered by GPT-4. GPT-4All is an open-source ecosystem of chatbots that include uncensored models that can run locally and offline. Some LLMs focus on medical applications and include BioBERT, Clinical BERT, Med-BERT, and Google's Med-PaLM2. There are generative AI models that can create images, video, and audio as well. A multitude of apps and services utilize generative AI technology to offer specific functionalities such as editing photos, creating presentation slides, summarizing journal articles, and more. Regardless of which model you try or use, keep the privacy considerations in mind to avoid HIPAA violations. References provided by LLMs are often false and generated, so make sure to double check output for accuracy.

Q *How can we use AI to our advantage especially regarding documentation without violating HIPAA or patient trust?*

A While publicly available models have the capability to minimally assist with documentation, the risks of HIPAA violations and inaccurate output are too great. Entering into a business associate's agreement with a business focused on developing generative AI for clinical use may offer a HIPAA-compliant way to harness the technology as it continues to improve. **PN**

APA members who have questions about AI may send them to apatelepsychiatry@psych.org.

AMA Seeks Feedback on Physician Practice Expense

The AMA, with the assistance of Mathematica, is conducting a survey to better understand the costs faced by today's physician practices to support physician payment advocacy. Practices will be contacted by Mathematica via mail and email. Your response is critical to this effort. Learn more at http://apapsy.ch/AMA-survey.

PSYCHIATRIC NEWS
Special Report

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Opioid Use Disorder:
Treatment in an Ever-Changing Crisis

Faced with the loss of more than 100,000 Americans to drug overdose each year, the federal government has expanded access to an increasing number of medications to treat opioid use disorder, thus providing psychiatrists with a broad array of treatment options that one does not need to be an addiction specialist to offer. ***BY LIEF FENNO, M.D., PH.D., AND ROBERT KLEINMAN, M.D.***

Helping patients with opioid use disorder (OUD) is a core responsibility of psychiatry, but widespread treatment of OUD by our profession has been hampered by a complex legal patchwork of state and federal regulations. This has led to the creation of specialty clinics for providing medications for OUD, reducing opportunities for psychiatrists to provide safe, effective medical therapy to their patients and hindering access to treatment for those who seek it. In an era of unprecedented mortality and near-death resulting from a flood of illicit synthetic opioids such as fentanyl, it is critical that psychiatrists take part in providing treatment for patients with OUD and ensure that interventions that reduce harm to patients are widely available. Supporting this goal are numerous changes to federal laws governing the provision of OUD treatment and Food and Drug Administration (FDA) priority approval of new medications for OUD.

Recent Trends in Opioid-Related Deaths and Near-Deaths

In the United States, over 1 million people have died from drug overdose in the last 25 years. Accord-

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Lief Fenno, M.D., Ph.D., is a member of APA's Council on Addiction Psychiatry and an assistant professor jointly appointed in the Department of Neuroscience at the University of Texas Austin and the Department of Psychiatry at the University of Texas Austin Dell Medical School. Robert Kleinman, M.D., is a member of APA's Council on Addiction Psychiatry and a clinician-scientist and addiction psychiatrist at the University of Toronto.

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ing to the Centers for Disease Control and Prevention (CDC), annual overdose deaths have more than doubled in the last decade to over 106,000 in 2021. In 2021, opioids were involved in approximately 75% of drug overdose deaths, driven by the wide availability of potent, synthetic opioids such as fentanyl. Deaths involving heroin have decreased in recent years as fentanyl has displaced heroin in the illicit opioid supply. Many opioid overdose deaths involve co-exposure to stimulants such as methamphetamine. Methamphetamine and other stimulants may now be contaminated with fentanyl. In addition, fentanyl is also sometimes contained within "pressed" pills that appear similar to prescription medications, such as oxycodone or alprazolam. This means that individuals with occasional or exploratory use of illicit substances may be at risk of fentanyl overdoses.

Opioid overdose deaths vary by demographic. In recent years, approximately 70% of opioid overdose deaths have occurred in males. In 2021, opioid overdose rates were 38.0 among non-Hispanic American Indian/Alaska Native individuals and 34.7 among non-Hispanic Black individuals, compared with 26.9 per 100,000 among non-Hispanic White individuals. Although there is some geographic variation, overdose deaths increased in all but three states from 2019 to 2020, and most states had increases of over 30%.

Four Medication Classes for Treating Opioid Use Disorder

Medication	Methadone	Buprenorphine	Naltrexone	Naloxone
Treatment phase	Maintenance	Maintenance	Maintenance	Overdose reversal
Mu opioid receptor modulation	Agonist	Partial agonist	Antagonist	Antagonist
Legal restrictions	Must be dispensed by Opioid Treatment Program	DEA registration with Schedule III privileges	None	Over the counter
Formulations	Daily PO liquid, tablet	Daily SL film, tablet; weekly, monthly SQ	Monthly IM	Intranasal, various others
Potential for precipitated withdrawal	No	Yes	Yes	Yes
Long-acting formulation available?	No	Yes	Yes	No

Opioid use disorder is highly comorbid with other psychiatric illnesses. According to the 2021 National Survey on Drug Use and Health, among people who reported OUD, 60% also reported having a mental illness. Of those who reported having both OUD and mental illness, one-third reported having a serious mental illness. Roughly 25% of people with OUD have had a major depressive episode in the last year.

Providing effective psychiatric care to patients with comorbid OUD and psychiatric conditions involves treatment for substance use. Engaging patients in treatment for OUD also provides an opportunity to identify needle-borne illnesses, including HIV and hepatitis C (HCV). Ensuring that all patients have access to care, reducing barriers to treatment, and providing care in ways that are understandable and acceptable to all patients are critical. Every psychiatrist can provide care for patients suffering from OUD. Recent changes to federal laws and the approval of new medications for OUD provide us with new tools in our shared goal of providing comprehensive mental health care to our patients.

The X-waiver Has Been Xed

Buprenorphine is a semisynthetic opioid with high affinity for the mu-opioid receptor. Unlike most opioids, buprenorphine exhibits a ceiling effect on both euphoria and respiratory depression reducing the potential for fatal overdose with the medication. It also has a longer half-life than many other opioids, allowing longer periods of time without withdrawal symptoms. These properties make it an excellent medication for treating opioid dependence, and various buprenorphine formulations are FDA approved for treating pain or OUD.

The Drug Addiction Treatment Act of 2000 placed restrictions on the prescription of buprenorphine for OUD, requiring those who wish to prescribe it to take an eight-hour training course, register for a unique Drug Enforcement Administration (DEA) number known as an "X-waiver," and report the number of patients they treat each year. The law also capped the number of patients that each waivered prescriber could manage.

To reduce barriers to buprenorphine for OUD treatment, Congress eliminated the X-waiver requirement as of December 29, 2022. The Mainstreaming Addiction Treatment Act removed the previously mandated training, registration, patient cap, and reporting requirements. Now, from a federal perspective, any health professional (except veterinarians) who holds a DEA registration with Schedule III authority can prescribe buprenorphine for OUD where state law allows. There may be additional requirements at the state level, but the federal X-waiver is no longer required.

In lieu of the X-waiver, as of June 27, 2023, all health professionals renewing or applying for a Schedule II-V DEA license are required to attest to completing eight hours of treatment and management of patients with opioid or other substance use disorders. This may help address gaps in medical education about OUD treatments. For example, only a minority of psychiatry residency programs provide dedicated training in office-based OUD treatment with buprenorphine, despite a near-universal perspective of residency directors that this is an important training direction. Widening the available pool of health professionals who may prescribe buprenorphine should increase the office-based identification and management of patients using buprenorphine and reduce the stigma of receiving treatment for OUD.

Increasing the provider pool is a critical step in the widespread availability of buprenorphine for OUD, but additional barriers to universal access remain. Higher out-of-pocket costs are associated with buprenorphine discontinuation, and although Medicare has eliminated prior authorization requirements for buprenorphine products, most state Medicaid programs restrict the free prescription of buprenorphine, either through prior authorization, adjunct treatment requirements, or maximum daily limits. Beyond sublingual formulations of buprenorphine, long-acting injectables are not consistently covered by Medicaid formularies or private insurance.

Telehealth Buprenorphine and Prescribed Methadone

Telepsychiatry has the potential to further reduce barriers to treatment access and expand treatment opportunities to patients in rural locations or with limited transportation. The Ryan Haight Online Consumer Protection Act of 2008 has governed the prescription of opioids, including buprenorphine, by telehealth. In an effort to combat online "pill mills" that prescribe opioids outside of the course of regular care, the act requires "at least one in-person medical evaluation of a patient" before the initiation of an opioid, including buprenorphine treatment for OUD. On March 16, 2020, the DEA announced that it was suspending the requirement for an in-person evaluation of

"Ensuring that all patients have access to care, reducing barriers to treatment, and providing care in ways that are understandable and acceptable to all patients are critical."

patients with OUD in the context of the COVID-19 pandemic: Patients could be started on buprenorphine after only a telehealth encounter. This exception was intended to sunset at the end of the COVID-19 Public Health Emergency, but it is now under consideration as a rule change by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the DEA. The full set of telehealth exceptions enabling remote buprenorphine prescriptions for both new telehealth patient-health professional relationships and existing ones has now been extended through December 31, 2024. This second extension collapses into a single date the separate rules for new and established patients that had been set out in the first rule extension.

In parallel, early efforts are underway in Congress to change prescribing rules for methadone, a full opioid receptor agonist that is FDA approved and widely used for treating OUD. Its long but variable half-life requires careful management during the titration phase of treatment. Federal law and regulations require that methadone for OUD to generally be dispensed only from federally regulated Opioid Treatment Programs (OTPs). This requirement creates a highly controlled environment for methadone dispensing and reduces patient access. According to a study in *JAMA Psychiatry* in 2020, the estimated average travel time to a methadone clinic in the United States was more than 20 minutes one way, and 5% of the U.S. population had a drive time of greater than 60 minutes to the nearest OTP. Rural areas of the country had more limited access to these clinics, and certain areas had very limited access. For example, there were no OTPs in the entire state of Wyoming.

SAMHSA loosened rules for methadone prescribing during the COVID-19 public health emergency. On March 16, 2020, OTPs were informed that individual states were able to request blanket exceptions so that stable patients could receive a 28-day take-home supply of methadone and less stable patients could receive a 14-day take-home supply. Since then, SAMHSA has concluded that the benefit of liberalized methadone take-home dosing outweighs the increased potential for diversion and misuse. In states that concur, SAMHSA has extended the exemptions to federal regulation allowing increased take-home dosing flexibility. This new exemption allows patients to receive up to a seven-day take-home supply within their first two weeks in an OTP, up to a 14-day take-home supply in their next 15 days in the clinic, and up to a 28-day take-home supply at a time thereafter. This exemption will remain in place until whichever occurs sooner between (1) one year and the end of the COVID-19 Public Health Emergency or (2) the publication of a new federal rule revising the federal methadone regulations.

Finally, a bipartisan effort by Congress, the Modernizing Opioid Treatment Access Act, is now under consideration. If passed, this legislation would enable pharmacy dispensing of methadone for the treatment of OUD as prescribed by board-certified addiction specialists, rather than limiting dispensing to OTPs. As currently proposed, this legislation would require a provider registration process and would enable telehealth methadone maintenance for some patients.

Opioid Overdose Reversal Agents

Most opioid overdoses occur outside of a medical setting and immediate intervention can be the difference between life and death. Community-based, immediate response by civilian bystanders is therefore critical to reducing overdose mortality. Intranasal naloxone, typically available as a single-use, 4 mg dose, represents the mainstay of treatment. As nearly half of opioid overdose deaths have potential bystanders present, improving access to naloxone for patients, family, friends, and first responders can save lives.

In March 2023, the FDA approved naloxone nasal spray for over-the-counter (OTC) sale without a prescription, and the first OTC naloxone sprays became available at pharmacies in August. However, OTC naloxone carries a price tag of around $45 for a package of two nasal sprays. (Sometimes both sprays are needed to reverse an opioid overdose.) It is critical to share with patients that they are unlikely to be able to give themselves naloxone. Patients should involve individuals who would likely be bystanders in case the patient has an overdose, such as family, friends, roommates, and neighbors. These individuals should be taught how to administer naloxone, be able to provide CPR to the patient if necessary, and be willing to call 911 after administering naloxone.

With the increasing prevalence and use of illicit synthetic opioids such as fentanyl, additional medication options for the treatment of opioid overdose are needed. The FDA recently approved nalmefene nasal spray as a prescription medication for opioid overdose reversal. Nalmefene is a molecule closely related to naloxone, but with a substantially longer half-life.

Harm Reduction Tools and Financing

A core tenant of treatment for any substance use disorder is reducing the harms experienced by patients in the course of substance use. Harm reduction is an evidence-based approach that is effective in reducing substance-related morbidity and mortality and a key pillar in the Federal Overdose Prevention Strategy. Needle exchanges to reduce the transmission of human immunodeficiency virus, HCV, and other diseases transmitted by shared needles among those who use intravenous drugs is an example of an effective, low-cost harm reduction approach.

In addition to these more established harm reduction strategies, there has recently been increasing interest in the use of fentanyl test strips (single-use lateral flow immunoassays similar to

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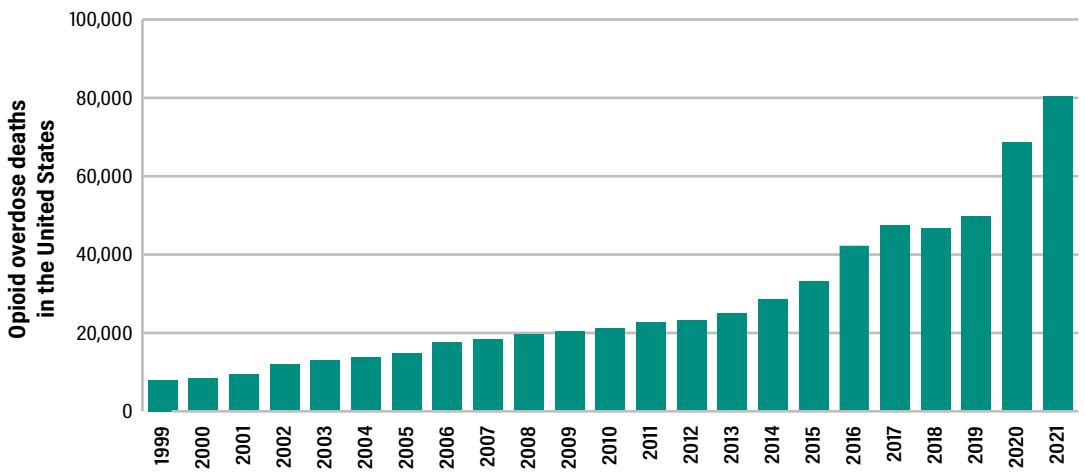
"Harm reduction is an evidence-based approach that is effective in reducing substance-related morbidity and mortality and a key pillar in the Federal Overdose Prevention Strategy."

Opioid Overdose Claims More Than 1 Million American Lives Between 1999 and 2021

Overdose deaths from any opioid, including prescription opioids, heroin, and synthetic opioids other than methadone, primarily fentanyl, nearly doubled between 2017 and 2021, rising from 47,600 to 80,411.



Among deaths with drug overdose as the underlying cause, the "any opioid" subcategory was determined by following ICD-10 multiple cause-of-death codes for natural and semi-synthetic opioids, methadone, synthetic opioids other than methadone, and heroin.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC Wonder Online Database, released January 2023.

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home COVID and pregnancy tests) to reduce accidental exposure to fentanyl. The individual puts some of the substance in water and dips the test strip in the water, and the test strip will reveal whether—but not how much—fentanyl is in a substance. It is critical to note that fentanyl may not be evenly distributed throughout a substance (such as a pressed pill) and so the absence of a positive fentanyl testing strip result does not guarantee safety.

As of April 7, 2021, federal grants from SAMHSA and the CDC for relevant programs can be used to purchase fentanyl test strips for community distribution. Despite the support of the federal government and the critical need to provide point-of-use information to people who use substances, many states still classify test strips and needle supplies as drug paraphernalia, a holdover from the "War on Drugs." This makes the possession of these items illegal and impedes organized efforts to distribute them.

Although fentanyl test strips provide information to people who use substances and to law enforcement officers regarding the presence of fentanyl in a substance, there remains a diagnostic gap in screening individuals for substance use. There is now a single point-of-care, FDA-approved test product for urine fentanyl testing, but it requires a stand-alone device that is not CLIA waived. There is no FDA-approved point-of-care stand-alone test for fentanyl approved for home use and standard drug screening panels may not detect widely used synthetic and semisynthetic opioids such as tramadol, methadone, and fentanyl. This limits the majority of health professionals to sending out a laboratory test for mass spectrometry urine analysis, which has a multiday turnaround time.

Beyond fentanyl, the recent trend of mixing xylazine ("tranq") into illicit opioids has created a new challenge for both individuals who use opioids and health professionals who treat OUD. The same manufacturers that produce fentanyl testing strips now have xylazine testing strips.

You Can—And Should—Help Patients With OUD

The opioid crisis has taken a number of forms over the last few decades: prescription opioids, heroin, and now fentanyl and other synthetic opioids. Opioid use disorder and the tragedy of overdose have cut across all demographics, and many psychiatrists will have an opportunity to provide potentially lifesaving interventions for patients who have OUD. The good news is that there are more options than ever to provide this care. A changing federal perspective on OUD treatment has permitted more health professionals to prescribe buprenorphine, methadone take-home flexibilities have made this medication a viable option for more patients, and naloxone is available over the counter. Telehealth enables health professionals to treat patients who live far with limited mobility or who live in rural areas. Harm-reduction options enable patients to reduce the potential harm of opioid use.

The opioid crisis has been devastating to our patients, and it is important that psychiatrists learn about the interventions that can help patients who have OUD. All health care providers—not just addiction psychiatrists—can learn to use the effective tools that are available for the management of OUD and make a difference in their patients' lives. **PN**

This information is provided as general background and should not be construed as legal or clinical advice. Clinicians should consult with their jurisdiction's laws, regulations, and clinical practice guidelines when providing OUD related treatment.

"The opioid crisis has been devastating to our patients and it is important that psychiatrists learn about the tools that can help patients experiencing an OUD."

Resources for Psychiatrists

APA Resources

- In-depth information on opioid use disorder
  https://www.psychiatry.org/patients-families/opioid-use-disorder
- Resource Document on the Treatment of Opioid Use Disorder in the General Hospital
  http://apapsy.ch/resource-document

APA blogs

- How to Help Those with Opioid Use Disorder in Jails & Prisons
  http://apapsy.ch/OUD-incarceration
- Clinicians Resources Roundup: Opioid Use Disorder
  http://apapsy.ch/OUD-information-roundup

Animated explainer video

- English: What is Opioid Use Disorder?
  http://apapsy.ch/OUD-video-English
- Spanish: ¿Qué es el trastorno por consumo de opioides?
  http://apapsy.ch/OUD-video-Spanish

Other Resources

- DEA list of questions for health professionals who wish to prescribe buprenorphine
  https://www.deadiversion.usdoj.gov/faq/buprenorphine_faq.htm
- Resources from SAMHSA for health professionals interested in prescribing buprenorphine for their patients
  https://www.samhsa.gov/sites/default/files/quick-start-guide.pdfz
  https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act

Report References

- *Drug Overdose Death Rates*
  https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
- *SUDORS Dashboard: Fatal Overdose Data*
  https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html
- *2021 NSDUH Annual National Report*
  https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
- *Monthly Patient Volumes of Buprenorphine-Waivered Clinicians in the U.S.*
  https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769683
- *Training in Office-Based Opioid Treatment with Buprenorphine in US Residency Programs: A National Survey of Residency Program Directors*
  https://journals.sagepub.com/doi/10.1080/08897077.2018.1449047
- *Buprenorphine Out-of-Pocket Costs and Discontinuation in Privately Insured Adults With Opioid Use Disorder*
  https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2807855
- *Thematic Analysis of State Medicaid Buprenorphine Prior Authorization Requirements*
  https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806100
- *Comparison of Driving Times to Opioid Treatment Programs and Pharmacies in the U.S.*
  https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2768026
- *Harm Reduction:* https://www.samhsa.gov/find-help/harm-reduction
- *Toxicosurveillance of Novel Opioids: Just Screening Tests May Not Be Enough*
  https://www.tandfonline.com/doi/full/10.1080/00952990.2021.1917588

Psychiatrist Involvement in Capital Cases: A Need for Strong Ethical Leadership

BY DANIEL EDDINS, M.D.

Daniel Eddins, M.D., is the chief resident of psychiatry at MedStar Washington Hospital Center in Washington, D.C.

In light of Florida Gov. Ron DeSantis' decision earlier this year to lower the legal bar for executions, this is an appropriate time to reevaluate the role of psychiatrists in capital cases. Psychiatrists are involved in capital cases at several different points of the legal process. They can take on the role of clinician or forensic evaluator, with the former providing treatment to restore competency and relieve suffering and the latter assessing for competency or providing expertise regarding the insanity defense. Forensic psychiatrists have grappled with the ethics of their specialty for decades, with psychiatrists such as Alan Stone, M.D., Paul Applebaum, M.D., and Ezra Griffith, M.D., helping to create a distinct ethical framework to distinguish between physicians acting as forensic evaluators from those working as clinicians. While evaluating for competency for execution remains a contentious topic, restoring competency for execution presents a clearer ethical dilemma for physicians acting in the clinician role.

Common law has held for centuries that the state should not execute people who suffer from severe mental illness. This was solidified when the Supreme Court ruled on *Ford v. Wainwright* in 1986, concluding that the 8th Amendment barred states from executing prisoners who don't understand their punishment. In other words, condemned individuals need to be competent. Further cases have helped clarify the standard for competency to be executed, but the question of what to do once an individual on death row has been found incompetent remains contentious. Decisions in state-level cases in South Carolina and Louisiana have held that forced medications solely to make someone fit for execution are illegal, although higher courts have not weighed in. Also, providing such treatment remains ethically dubious even if patients voluntarily accept it.

From the standpoint of our traditional four pillars of medical ethics (autonomy, beneficence, nonmaleficence, and justice), clear ethical concerns arise. Autonomy is directly threatened when forcing medications on individuals who have been sentenced to capital punishment. Voluntary treatment is less problematic, although one wonders if someone facing life imprisonment can freely choose to accept a medication that would lead to an early death. Since temporary relief of symptoms cannot possibly justify the adverse effect of imminent death, the concepts of beneficence and nonmaleficence are at odds with restoring competency for execution. While the morality of the death penalty overall is beyond the scope of this article, the well-documented issues involving racial disparities in the application of the death penalty raise justice concerns for the treating psychiatrist.

The influential bioethicist Edmund D. Pellegrino, M.D., argued that medicine has an internal morality, not dependent on societal influence, with the primary moral end being "right and good healing action and decision." Healing with the goal of killing, rather than relieving suffering, cannot be thought to be healing at all. Further, he argued that treatment must aim for the "good for humans," which includes ideas such as maintaining dignity and treating people as ends rather than means. Since executions inherently treat people as means to the purported societal good, treatment that leads to executions would be at odds with the human good.

Both the AMA and APA have positions on capital punishment against restoring competency without a commutation to a lower sentence. In addition, APA addresses capital punishment in its *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* and the APA Commentary on Ethics in Practice. Section 1, Annotation 4, is clear: "A psychiatrist should not be a participant in a legally authorized execution." The commentary states: "Psychiatrists should not participate in a legally authorized execution and may not assume roles that lead them to facilitate, implement, develop or monitor any techniques involved in execution. When a condemned prisoner has been declared incompetent to be executed, psychiatrists should not treat the prisoner for the sole purpose of restoring competence unless a commutation order is issued before treatment begins. However, the psychiatrist may treat the incompetent prisoner, as any other patient, to relieve suffering."

A stance without consequences, however, is not enough. In 2010, the American Board of Anesthesiologists (ABA) approved a policy that physicians participating in lethal injections will face revocation of their board certification. Given the arguments above, there does not seem to be a significant moral distinction between delivering the injection and making the patient suitable to receive the injection.

A similar policy by the American Board of Psychiatry and Neurology may be difficult to enforce, given that incompetent patients on death row may require medications to relieve suffering and secondarily to improve competency. However, a policy stance would at least provide the national guidance that the courts have not given. To quote the ABA, physicians are "healers, not executioners." **PN**

APA's Position Statement on Issues Pertaining to Capital Sentencing and the Death Penalty is posted at http://apapsy.ch/capitol-sentencing. *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* is posted at http://apapsy.ch/Principles_of_Medical_Ethics. The APA Commentary on Ethics in Practice is posted at http://apapsy.ch/Commentary.

Movies Can Open Doors to Accepting People of Differing Sexual Identities

BY ANTOINE BEAYNO, M.D., AND YEKATERINA ANGELOVA, M.D.

Antoine (Tony) Beayno, M.D., is a PGY-3 psychiatry resident at Mount Sinai Morningside and West in New York City. He is also a member of the LGBTQ+ Mental Health Committee of the Group for the Advancement of Psychiatry. Yekaterina Angelova, M.D., is the director of Consultation-Liaison Psychiatry at NYC Health + Hospitals/Harlem and is involved in patient care, supervision and clinical teaching, and trainee and faculty wellness.

Research has shown that movies are capable of much more than entertainment; they can influence our attitudes, behaviors, and ideologies in positive (and negative) ways and trigger a multitude of emotions including happiness, sadness, and anger.

A landmark event in the history of moviemaking was the invention of animation, aimed primarily at a particular target audience: children. Walt Disney movies have long been a part of millions of people's lives and moved into other areas, such as television, theme parks, cruise ships, consumer products, publishing, and international operations.

The first full-length Walt Disney animated feature, "Snow White and the Seven Dwarfs," was released in 1937. The film culminates in the iconic kiss that awakens Snow White from her slumber and births the now familiar theme of the hopeful princess waiting for her prince and her undisputable "happily ever after."

During the near century that followed, Disney continued its legacy of quintessential movies featuring this overwhelmingly heteronormative model. Disney never included an LGBTQ+ identifying character until 2022, when "Strange World" was released, featuring Disney's first openly gay character.

A recent event involving the screening of "Strange World" in a Florida fifth grade classroom in May led to the public investigation of the involved teacher and an uproar in the debate about early educational introduction of sexual and gender identities to children in schools. As reported in the *Washington Post*, this event occurred amid ongoing politically charged anti-LGBTQ+ legislation and regulations including Florida's "Don't Say Gay" law, which bans instruction about gender identity and sexual orientation in public schools. The involved teacher stated that she had showed the movie to her students because it tells the story of a family of explorers and her class curriculum had been focusing on ecosystems and the environment. One of the parents complained that the gay character featured in the movie stripped her 10-year-old child of "innocence."

Florida's "Don't Say Gay" law is only one example of the many measures that have been implemented across the United States that are greatly harmful to the LGBTQ+ community, especially

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Too Little, Too Late: LAIs Remain Underused

Despite the growing number of options for long-acting injectable (LAI) antipsychotics, experts say the medications remain underused—especially earlier in the course of illness.

BY NICK ZAGORSKI

UCLA

By maintaining consistent levels of medication for weeks, long-acting injectable antipsychotics help reduce the risk of breakthrough symptoms or even relapse, said Kenneth Subotnik, Ph.D.

Long-acting injectable (LAI) antipsychotics have been available in the United States for more than 50 years. Though LAI options were limited for the first 30 years (fluphenazine became available in 1972, then haloperidol in 1986), nine more formulations have entered the market in the past 20 years. Today, physicians can choose to prescribe a range of LAIs that can be administered under the skin or into muscle in durations ranging from two weeks to six months.

LAIs help ensure that a steady level of medication remains in a patient's body for extended periods of time and remove the burden of daily pills on the patient. However, despite these benefits and the growing number of options for LAI antipsychotics, experts say the medications remain underused—especially earlier in the course of illness.

A study published in the *Journal of Clinical Psychiatry (JCP)* found that only 4% of people with schizophrenia received an LAI within the first few years of their diagnosis; another *JCP* report found that in most cases, the switch from an oral to LAI followed a patient's hospitalization or a trip to the emergency department.

While some patients may have concerns about the side effects of LAIs, Jose Rubio, M.D., an assistant professor at the Feinstein Institutes for Medical Research in Glen Oaks, N.Y., and co-author on the above reports believes the bigger issue contributing to the underuse of LAIs, especially in the earlier stage of illness, is hesitancy by physicians treating these patients.

Reasons for Hesitancy

The underuse of LAIs by physicians is likely the result of multiple factors, ranging from the logistics involved in administering LAIs (for example, ordering and storing the medications) to questions over whether LAIs are superior to oral antipsychotics, Rubio said.

A large European trial that was described in *Lancet Psychiatry* in March suggested that patients taking LAIs were about as likely to discontinue treatment as those taking oral medications.

That trial, known as EULAST, enrolled 533 adults who had experienced a first episode of psychosis within the last seven years. The patients were randomly assigned to receive monthly LAI paliperidone, oral paliperidone, monthly LAI aripiprazole, or oral aripiprazole. They were then followed for up to 19 months, and a variety of clinical outcomes were assessed.

"A lot of the evidence of LAI superiority comes from analyses of health databases from countries like Sweden or Finland," said study co-author Rene Kahn, M.D., the Esther and Joseph Klingenstein Professor and System Chair of Psychiatry at New York's Icahn School of Medicine at Mount Sinai. However, such studies tend to

see **LAIs** *on page 40*

For Success in SUD Treatment, Talk

Strategies that help patients become aware of their motivation, values, thoughts, and feelings enable patients to meet the curveballs life throws them and minimize their risk of substance use. **BY TERRI D'ARRIGO**

Nonpharmacologic therapies such as motivational interviewing and cognitive-behavioral therapy (CBT) are essential to treatment for substance use disorder (SUD) because they equip patients with the skills they need to manage the thoughts and feelings that promote substance use. That was the message Carla Marienfeld, M.D., had for attendees of APA's first meeting of @theAPA Educational Series, "Addictions Update," in July.

"Many interventions for treating substance use disorder are focused on medication, yet most addiction treatment uses evidence-based nonpharmacologic modalities," said Marienfeld, a health sciences clinical professor of psychiatry at the University of California, San Diego.

Marienfeld began her presentation with a description of motivational interviewing.

"Motivational interviewing is about arranging conversations so that people talk themselves into change based on their values and interests," Marienfeld said. She explained that motivational interviewing is built on an understanding of two fundamental ideas.

First, "if there are two sides to an issue, and you take up one, you are inviting the other person to take up the other," she said. Second, "in any conversation about something where there are two sides, we tend to remember and act on the things we hear ourselves say."

To that end, motivational interviewing leverages patients' own words to help them solidify their goals and prompt them to action in treatment.

"It is a guiding style to draw out, encourage, and motivate patients to help them figure out how they can be successful," Marienfeld said.

Terri D'Arrigo

Approaches such as acceptance and commitment therapy help patients develop psychological flexibility, said Carla Marienfeld, M.D.

She also discussed systems therapy, which focuses not only on the patient, but the environment in which the patient operates, such as within a family, social circles, and the community.

"The idea of this type of therapy is that it focuses on the interaction patterns between the patient and those in the relationships with the patient, and when one part of the system changes, like the patient, the whole system has to change as well," Marienfeld explained.

She added that system therapy often takes the form of family therapy, in which the impact of the patient's substance use on others in the family is considered. These impacts may include impaired attachment, economic hardship, legal problems, emotional distress, and violence.

Marienfeld also discussed behavioral couples therapy for alcohol use disorder (AUD).

"Typically this is a 12-session annualized support program that supports the relationship continuing throughout recovery," Marienfeld explained. "When couples increase their support for recovery, they can help reinforce abstinence, build trust, and minimize negative interactions in the relationship. This support can help to enhance commu-

see **SUD Treatment** *on page 37*

University of Michigan

University of Michigan Psychiatrist G. Scott Winder, M.D. (right), and colleagues (from right to left) Jessica Mellinger, M.D. (gastroenterologist), Kristin Klevering, M.S.W. (social worker), Anne Fernandez, Ph.D. (psychologist), and Jack Buchanan (medical student) use a multidisciplinary approach to care for patients with alcohol-related liver disease.

Researchers, NIAAA Look to Make Integrated AUD-Liver Care a Reality

Given the strong connection between alcohol use disorder and liver diseases, researchers believe that making it easier for patients to receive care for both conditions under one roof could increase long-term survival. **BY NICK ZAGORSKI**

Alcohol can adversely impact almost every organ in the body, particularly the liver—the organ tasked with metabolizing ethanol. For heavy drinkers, problems such as cirrhosis, acute hepatitis, and liver failure are increasingly common.

Yet historically, psychiatric screening and treatment have not been well integrated into alcohol-related liver disease care, according to G. Scott Winder, M.D., a clinical associate professor of psychiatry at the University of Michigan. Winder is also a transplant psychiatrist at Michigan Medicine's transplant center; he was recruited in 2014 by hepatologists and surgeons concerned about the prevalence and severity of alcohol use disorder (AUD) in their patients.

As a single embedded psychiatrist, he could not provide all the mental health and substance use disorder care his patients required. But as he tried to get them connected to outside resources, he was often informed that patients' severe physical illnesses meant they would not be appropriate for various clinics or hospitals.

"Several substance use treatment centers told me or the patients they were too sick to be admitted," he told *Psychiatric News*.

To address this glaring treatment gap, Winder and colleagues at Michigan Medicine in 2018 established an integrated hepatology clinic where psychiatrists, psychologists, social workers, and liver specialists work with patients with alcohol-related liver diseases.

Beyond their own walls, this Michigan team, as well as other like-minded psychiatrists and hepatologists, have been beating the drum for more studies that examine the benefits of integrated liver care. And the right people seem to be listening.

Bringing Two Treatments Together

"Alcohol misuse has such a prominent role in liver disease, it just makes sense that we should bring the treatment of these two conditions together," George Koob, Ph.D., told *Psychiatric News*. He is the director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Since taking the helm at NIAAA in 2014, one of Koob's imperatives has been to improve the screening and management of AUD across medical disciplines and settings. At the time, survey data indicated that only 1 in 6 adults had been asked by a doctor about their drinking, while less than 10% of those who had AUD received a prescription for an FDA-approved medication for treating the disease.

While attending a liver conference a few years back, Koob connected with many hepatologists who recognized the importance of screening patients for drinking problems and expressed an interest in incorporating AUD management into their clinics. "The doctors really took the initiative on this, and [NIAAA] worked to provide them the support they needed, such as grants, workshops, and other resources."

Though the onset of COVID-19 slowed the momentum on this integration initiative, studies examining the relationship between alcohol, liver disease, and treating one or both conditions have started to yield data, Koob noted.

A 2021 analysis conducted by Winder's colleagues at Michigan, for example, found that deaths due to alcohol-related liver disease are lower in states with more restrictive alcohol policies (for example, higher alcohol taxes, limited Sunday hours at liquor stores, and lower blood alcohol threshold for impaired driving). Also, a research team at Massachusetts General Hospital examined retrospective patient data and found that individuals with AUD who initiated medication therapy were over 60% less likely to subsequently be diagnosed with alcohol-related liver disease. Even among patients who already had cirrhosis, those who initiated AUD medication had a lower risk of liver decompensation (loss of functioning) than those who did not, the study found.

The findings "highlight that liver disease is not an unavoidable progression," Koob said. "There are various points where if you stop drinking, then your health can stabilize."

Abstinence or Stability?

Preliminary data from health centers that have developed integrated AUD-liver disease programs suggest that patients in these programs are receiving higher quality care (for example, more screening for substance use disorder, referrals for substance use therapy, and preventive measures such as hepatitis vaccines) than patients receiving usual care. In the short term, these integrated programs have also led to fewer hospital visits by the patients, but only time will tell if the integrated programs will help improve long-term outcomes for patients with AUD and alcohol-related liver disorders.

Integrating care for comorbid conditions does not always improve long-term outcomes, Winder acknowledged. For example, efforts to integrate depression care into cardiology clinics have found limited success at improving physical health outcomes for patients with heart disease. "But the link between AUD and liver disease is much closer than depression and heart disease, so I'm hopeful that this integrated model can succeed," he said.

Winder told *Psychiatric News* that finding continued funding for integrated AUD-hepatology clinics is necessary to keep these programs running. "Addiction care, unfortunately, is not lucrative," he said. One solution Winder proposed is to tie integrated patient care with liver transplants, which are a source of revenue for health care systems. If a hospital invests psychiatric resources for complex patients with alcohol-related liver disease and AUD, then they will have a more successful pool of transplant candidates and more opportunities to perform transplants.

A historical hurdle that people with AUD and liver disease face is that most hospitals follow a guideline that the transplant recipient must be abstinent from drinking for at least six months before becoming eligible for a liver transplant.

There are numerous factors that can trigger post-transplant AUD relapse beyond an arbitrary abstinence period, Winder said. "An individual with cirrhosis who has recently slipped back into drinking but otherwise has a healthy psychological profile, strong social support, and good insight could be a better candidate [for a transplant] than someone abstinent for a year but who frequents bars, has psychiatric comorbidities, and checks out of the hospital against medical advice."

Koob also believes that the time has come to revamp such transplant rules. "[W]hy are we making people wait six months when acute hepatitis might kill someone within three?" he asked. He noted that the NIAAA's definition of AUD recovery does not refer to abstinence. NIAAA has funded research to establish a large cohort of early transplant recipients and follow their outcomes over time.

Koob, like Winder, is optimistic that these efforts to change the clinical care of liver disease will bear fruit. "Integrating health disciplines is tricky, but I know the hepatology community is committed to this, and I think the psychiatrists are ready, too." **PN**

More information on the NIAAA's alcohol-related liver disease initiatives is posted at http://apapsy.ch/di.

Xylazine Presents Unique Challenges

Xylazine hinders opioid overdose reversal and is associated with soft tissue wounds. **BY TERRI D'ARRIGO**

The veterinary tranquilizer xylazine is increasingly present in illicit fentanyl and presents several unique clinical challenges that health professionals must be prepared to address. In his keynote address at the Johns Hopkins University's Road to Recovery virtual conference in September, Ashish Thakrar, M.D., M.S., discussed these challenges and presented an overview of the emerging threat of fentanyl mixed with xylazine.

Xylazine is an alpha-2 receptor agonist that decreases sympathetic activity, resulting in sedation, analgesia, and euphoria, explained Thakrar, who is an assistant professor of medicine in the Division of General Internal Medicine at the University of Pennsylvania.

Thakrar said that one of the main challenges with xylazine is that people who overdose on fentanyl or other opioids mixed with xylazine do not respond as well to resuscitation with naloxone as those who overdose on opioids alone. Yet naloxone should always be administered in cases of a suspected overdose, he added.

"The key thing to remember is that naloxone will reverse the effects of any opioids [in a person who overdoses], so administering naloxone is the most important thing we can do for someone who is experiencing overdose," he said.

Thakrar presented data showing that overdose deaths involving fentanyl with xylazine detected are concentrated in several hotspots in the mid-Atlantic and northeastern regions—notably Baltimore, Connecticut, Philadelphia, and Vermont. He noted that there are signs that these overdose deaths are increasing in other states as well. To that end, Thakrar emphasized the importance of testing substances for xylazine as a harm reduction measure, adding that test strips specifically for xylazine are now on the market.

"They don't require a lot of prep and there's very little training required, so you can use them at the point of care and distribute them out to people who use drugs or harm reduction organizations or clinicians," Thakrar said. The strips are able to measure xylazine levels as low as 2 micrograms per milliliter, he continued; however, lidocaine, diphenhydramine, and levamisole can all give a false positive.

Thakrar explained that because xylazine is an alpha-2 agonist, it would stand to reason that xylazine would have withdrawal symptoms similar to withdrawal from clonidine or dexmedetomidine, but there is no firm evidence for a distinct xylazine withdrawal syndrome. He described a study at the University of Pennsylvania where researchers reviewed 74 hospitalized patients whose urine tested positive for xylazine.

"We did see these reports of anxiety and restlessness, but then we did a chart review … to see if we could find evidence of withdrawal unique to xylazine, and by and large, that's not [what we found]," Thakrar said. Instead, in most cases the symptoms of withdrawal were that of withdrawal from mixed opioids and benzodiazepines that the patients had used. "We only found two patients who had symptoms that we could not explain, and they had asymptomatic hypertension with or without tachycardia."

The University of Pennsylvania

Xylazine may cause heavy sedation that is difficult to distinguish from opioid overdose, but naloxone should always be given in cases of suspected drug overdose, said Ashish Thakrar, M.D., M.S.

Xylazine use can lead to soft tissue wounds, but these wounds are different from those typically associated with intravenous drug use, Thakrar said. First, the wounds often occur far from the injection site, and they have been known to occur in people who do not inject substances. Second, the wounds have a different appearance and progression, starting with purple blisters or ulcers that coalesce into deep eschar (dry, blackened, dead tissue), often without infection.

Thakrar explained that the association between xylazine use and these wounds is unclear, but that it is possible that xylazine damages endothelial cells, which in turn damages blood vessels. Traditional wound care, such as cleaning and debriding the wound, applying topicals such as skin protectants and antibiotics, and applying two layers of dressing have been found to aid healing in people with soft tissue wounds from xylazine use.

"With the right kind of wound care, and consistent wound care, these wounds do have potential to heal," Thakrar said. The challenge is that it can be difficult for people who have chaotic or inconsistent substance use or who are homeless to access and maintain wound care, he added. **PN**

Eye Tracking Correlates With Clinical Assessments Of Autism, Study Shows

Getty Images/iStock/Carl Fourie

Objective biomarker tests could help reduce diagnostic delays and connect children with autism to services earlier. **MARK MORAN**

Use of an eye-tracking device to measure children's visual engagement appears to correlate with clinical assessments of autism, offering a potential aid in diagnosis, according to a report in *JAMA*.

"Most parents of children with autism report having had concerns before the second birthday, yet the median age of U.S. autism diagnosis is 4 to 5 years," wrote Warren Jones, Ph.D., and colleagues. Jones is the director of research at Marcus Autism Center and the Norman Nien Distinguished Chair in Autism and associate professor at Emory University. Objective biomarker tests could help reduce diagnostic delays and connect children with services earlier, according to the researchers.

For the study, Jones and colleagues recruited 475 children aged 16 to 30 months old who were enrolled at six U.S. autism specialty centers between April 2018 and May 2019. The cohort included a broad spectrum of children with autism—both with and without co-occurring intellectual and developmental delays—as well as many children without autism who nonetheless had significant speech-language and other developmental disabilities.

All participants were evaluated by autism experts who relied on such standardized assessments as the Autism Diagnostic Observation Schedule, Second Edition; the Mullen Scales of Early Learning; and *DSM*-5 criteria. In addition, clinical site staff used an automated device to track the children's eye movement as they watched short videos of social interaction (for example, children playing together). Those performing the eye-tracking tests and clinical assessments were blind to each other's results.

Eye tracking of social-visual engagement was highly sensitive, successfully identifying children who were diagnosed with autism by clinical assessment in 71% of cases. The technique was also highly specific, correctly identifying those children who would not be diagnosed with autism in nearly 81% percent of cases. The eye-tracking test results correlated with clinical assessments of the child's level of autism-related behaviors and verbal and cognitive abilities.

The study "represents a significant step forward toward developing more objective tools for early diagnosis of autism," wrote Geraldine Dawson, Ph.D., the William Cleland Distinguished Professor of Psychiatry and Behavioral Sciences and director of

see **Eye Tracking** *on page 32*

ON MENTAL HEALTH, PEOPLE, AND PLACES

A Migrant in the Midst of Mantuan Opulence

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.

Most of us have heard of the Italian city serving as an iconic symbol of high fashion, international sports, and world-class opera. Mantua, the English term for *Mantova*, located a mere couple of hours travel from Milan, is set in another world altogether. The taxi I boarded at the train station took me to the middle of a beautiful city square called Piazza Erbe and left me to walk about 50 yards to the hotel registration desk. Once done, I ambled over to the hotel room set up in another building. I paused on the ground floor to watch a couple of sous-chefs make pasta from scratch. Later in the evening, I would taste what they were making, the lightly sweetened pumpkin dish called *tortelli di zucca*.

From my room balcony, I could easily survey the Piazza Erbe, which remains the site of a weekly city market. The restaurants and cafes that delimit the periphery of the square were illuminated by lighted table candles as the sun went down. They also served as a backdrop for pedestrians strolling by on the cobbled streets. I felt I was somewhere special. Its 2,000-year history and place on the list of World Heritage Sites convinced me I was visiting Mantua much too late in life. In high school back in Barbados, I had translated simple Latin passages of Virgil, the Mantuan poet. I had also come across Monteverdi's music in my choral experiences. All that had happened, however, without my making a connection to this city renowned for its art and culture. When I joined friends later for dinner, we could not stop talking about the magical ambience around us. The usual urban rush of traffic was gone; car horns silenced. Our only urgent concern was deciding which pasta to select. Fifty yards away, people held hands as they strolled around. There was a hushed quiet; people seemed to be loving life.

My tourist visits started with a promenade through the San Lorenza Rotunda, an 11th-century circular church at one end of the city square. Across the street stood proudly the Basilica Sant'Andrea (Basilica of St. Andrew), with its imposing steps. The grandeur of the church has made it an outstanding example of Renaissance architecture constructed between 1472 and 1765. The striking front façade of the church sets a contrast with the internal flooring of white and red marble arranged in checkerboard fashion. There is a crypt, located below the mag-

see **Mantua** *on page 33*

Brigitte Griffith

Mantua's Piazza Erbe has a 15th-century clock that marks the phases of the moon and signs of the zodiac.

Brigitte Griffith

Above is a photo of the ceiling and doorway in a gallery of the Ducal Palace in Mantua, Italy.

R.C. Grantham AIA

The interior of the Basilica of St. Andrew in Mantua, Italy, is admired for its early Renaissance design.

Questions Remain About Benefits of Antidepressants For Bipolar I Depression

Though long-term antidepressant treatment did not lead to reductions of any mood outcome compared with placebo, there was a significant reduction in depression recurrence over 52 weeks with maintenance treatment. **BY NICK ZAGORSKI**

Many patients with bipolar disorder take antidepressants in combination with other medications to reduce recurring depressive episodes. While some guidelines suggest antidepressants may help with acute symptoms, there is less evidence to support maintenance therapy given limited data on long-term efficacy of antidepressants and their potential risk of triggering manic episodes.

A report published earlier this year in the *New England Journal of Medicine* aimed to address these questions about the risk-benefit profile of maintenance antidepressant treatment for patients with bipolar I disorder.

The study by Lakshmi Yatham, M.B.B.S., a professor and head of psychiatry at the University of British Columbia in Vancouver, involved 177 adults with bipolar I disorder who had experienced remission of depression after taking escitalopram or bupropion XL for two weeks. The participants were randomly assigned to continue taking antidepressants for 52 weeks (maintenance group) or switch to placebo (discontinuation group) after six weeks; the antidepressants were taken in combination with mood stabilizers and/or second-generation antipsychotics throughout the trial.

UBC

If a patient with acute bipolar depression responds to antidepressant therapy, it is reasonable to consider maintenance treatment to prevent relapse or recurrence, said Lakshmi Yatham, M.B.B.S.

The primary outcome of interest for the study was the occurrence of any mood-related event, such as the emergence of a new manic, depressive, or mixed-state episode; hospitalization for mood symptoms; the need for additional medications to manage symptoms; or any suicidal behavior. The researchers also examined the rates of some of these individual events.

After 52 weeks, there was no statistical difference between mood-related events between the two groups (31% of individuals in the maintenance group and 46% in the discontinuation group experienced a mood-related event). However, individuals in the maintenance group showed a 57% reduced risk of depression recurrence compared with those in the discontinuation group.

There were more manic episodes reported by participants in the maintenance group than in the discontinuation group (11 versus 5). Yatham noted that three of these manic episodes occurred within the first six weeks when both groups were on the same treatment, and all three happened to be participants in the maintenance group.

Yatham and colleagues also compared all mood-related events reported by the patients in the two groups from week 7 onwards (when the two groups had differing therapies). They found that people in the maintenance group were

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Eye Tracking

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the Center for Autism and Brain Development at Duke University, in an accompanying editorial. "Another possible future application of the findings ... is the use of eye tracking to identify infants younger than 1 year who have a higher likelihood of a later autism diagnosis."

Dawson said that demonstrating that an eye-tracking test improves diagnostic certainty requires following children whose diagnosis was uncertain to determine whether the test improves prediction of a later autism diagnosis. "Future studies will need to assess how feasible, acceptable, reliable, and efficient the eye-tracking test is when used by clinicians as an aid in autism diagnosis in practice," she wrote.

Eye tracking as a technology is not new in cognitive psychology, but a number of obstacles stand in the way of its use in clinical diagnosis and treatment, said Nadja Ging-Jehli, Ph.D., a postdoctoral researcher in computational psychiatry and cognitive neuroscience at Brown University. She has studied the use of eye tracking in patients with attention-deficit/hyperactivity disorder (ADHD), which is often comorbid with autism; as many as 50% of patients with autism may also have ADHD.

Principal among the obstacles to using eye tracking as a reliable diagnostic tool is the lack of an agreed-upon theory of how eye tracking correlates with specific neurocognitive measures and standardized protocols to test those correlates. That is, simply observing the pattern of eye movements may not reliably indicate something meaningful to clinicians.

"The technology has been used for quite a while, but it doesn't necessarily indicate how the subject thinks or makes decisions," she told *Psychiatric News*. "For a technology to really have a breakthrough in a clinical setting, there needs to be a strong foundation, a theory of what exactly we are measuring."

This is particularly so in the case of children and infants. "There are multiple reasons why a young child or infant might not engage with a video clip that is presented to them," she said; these include the setting in which the test occurs, whether parents are present, or what the child is told by parents or others. "There needs to be a standardized protocol and a standardized setting [in which eye tracking is conducted] so the findings can be replicated," Ging-Jehli said.

In her research, Ging-Jehli has used eye tracking in combination with electroencephalogram (EEG) measurements and "process-oriented computational modeling" to characterize neurocognitive processes in patients with ADHD. Process-oriented computational modeling is used to simulate and study complex systems by breaking these systems down into individual processes (which can include eye tracking).

"By using eye tracking in combination with computational modeling, we can predict what people are going to choose before they indicate their choices," Ging-Jehli said. "We can also understand how eye measures influence the decision process."

Her research on ADHD includes the entire spectrum of severity, including patients with comorbid autism. "What we have found is that people with ADHD show a different gaze pattern—and that pattern is also linked to how they behave or how accurately they can perform a given task."

In addition, patients with comorbid autism similarly show a distinct gaze pattern, often fixating on small details of an image presented to them but unable to see the larger picture, she said. These findings point to the potential of using eye tracking not just for diagnosis, but as an intervention. "Potentially we could use eye tracking to train children to draw attention to certain information they seem to be tempted to ignore," she said.

In the meantime, standardization of methods and replication of results are crucial. In a 2021 paper in the *Psychological Bulletin* reviewing neurocognitive testing for ADHD, Ging-Jehli and colleagues wrote: "[P]roblems arise because tasks differ, participant groups differ, and the degree to which data to all these aspects are available differs. Even when multiple studies use the same tasks, details in the procedures of these tasks differ to such a degree that often they cannot be directly compared unambiguously. ... To address this challenge, we might aim for standards that define the requirements on tasks and methods used to characterize mental health disorders such as ADHD." **PN**

"Eye-Tracking–Based Measurement of Social Visual Engagement Compared With Expert Clinical Diagnosis of Autism" is posted at http://apapsy.ch/eye-tracking.

INTERVENTIONAL PSYCHIATRY

Rapid Response Therapies for Major Depression Could Dramatically Reduce Societal Cost

BY RICHARD A. BERMUDES, M.D.

Richard A. Bermudes, M.D., is the founder of Mindful Health Solutions in San Francisco and a volunteer 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.

Major depressive disorder (MDD) persists as a significant health concern not merely for its debilitating individual impact but also its striking socioeconomic implications. Traditional methodologies for assessing the societal burden often do not account for several hidden-cost components, inadequately addressing the magnitude of the problem. To truly apprehend the societal toll of MDD, an integrated perspective is required—one that considers the disease prevalence, comprehensive cost implications, the effects of therapeutic interventions, and the rapidity of the response of the therapies.

Recent data indicate that, in 2019, nearly 8% of American adults, or approximately 19.8 million individuals, reported moderate to severe depressive symptoms with a PHQ score of 10 or greater and were diagnosed with MDD. (Implicit in this calculation is the possibly flawed assumption that those with mild depressive symptoms scoring less than 10 and a diagnosis of MDD do not contribute to the societal burden and do not have personal costs.)

Putting the economic impact into focus, MDD cost the American adult population a staggering $333.7 billion in 2019. Translated into 2023 figures, this constitutes a burden of approximately $382.4 billion. To further break down this cost per individual with MDD: Direct health care costs comprise 38.2% of the total, while indirect costs account for a more substantial 61.8%. Work-related indirect costs include presenteeism (13.0%), absenteeism (11.5%), unemployment (9.1%), all-cause mortality (2.9%), and disability (1.4%). Additionally, work-related costs for adults without MDD who live in a household with an MDD-affected individual contribute to 24.0% of the total cost. Therefore, almost two-thirds of the economic burden of MDD is attributed to indirect costs, underscoring the importance of understanding MDD's comprehensive socioeconomic impact. At an individual level, the total cost per individual in 2019 was $16,854.

A rapid-response MDD therapy, with a two-week response rate of 50%—a considerable improvement over current treatments—could theoretically mitigate the economic strain of MDD by $26 billion in 2019 or a more significant $29 billion in 2023.

These estimations are more than merely speculative. Rapidly acting treatments—such as accelerated transcranial magnetic stimulation (aTMS), electroconvulsive therapy (ECT), Stanford Intelligent Accelerated Neuromodulation Therapy (SAINT), and Ketamine Infusion Therapy (KIT)—already exist.

If health care payers embrace these interventions and physicians can agree on prescription guidelines, these once theoretical numbers could become real, substantially alleviating the economic pressure exerted by MDD. The potential is immense, and the psychiatric community must unite to turn the possible into reality. **PN**

Mantua

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nificent dome and at the intersection of the basilica's nave and transept, that holds vessels said to contain the blood of Christ. Reportedly, the Roman soldier who pierced the side of Christ on the cross collected the blood and transported it to Mantua. The relic is exhibited in an annual street procession through Mantua on Good Friday.

The wondrous beauty of St. Andrew's Basilica made me think again about how much pomp and majesty are required for the execution of sincere religious rituals. I recognize the complexity of my own question, calling to mind a long-ago conversation with a member of a church. She explained that the poverty of her church's members could not stop them from finding different articles with which to decorate their church's altar. That special sacred space in their church had to "look pretty." It made them feel good and confident that their generosity toward the Almighty would be repaid. In our exchange, we never got to the problem of how much decoration is sufficient for the task of praising and pleasing God.

Another day on a morning walk, I was mulling over the historic dominance of the Gonzaga family, who were so influential in the Renaissance extension of Mantua and its artistic flowering. They had caused exceptional artwork to be produced in the family's palaces (the Palazzo Ducale and the Palazzo Te). I encountered a young man who greeted me in halting Italian. For our mutual comfort, we soon switched to English. He asked for help to buy other food to supplement the bag of rice he was carrying. He was an African migrant who had come seeking employment, and he explained that although jobs were hard to come by, he hoped to find work soon. His hardship seemed to blight the value of the Gonzagas' contributions to the Italian patrimony. With the flamboyance of the Italian Renaissance, can we leave invisible the immigrant's plight in our midst? Is there a way for the financially disadvantaged among us to benefit from the Gonzaga beneficence?

Someone brought to my attention a report in *Le Monde* (September 25, 2023), written by Sarah Belouezzane and Gilles Rof ("L'Appel Vibrant du Pape en Faveur des Migrants" – "The Pope's Fervent Call on Behalf of Migrants"). On a recent visit to Marseille, France, the Pope seemed to respond directly to my reflections and concerns, making clear that the immigration problem is a major humanitarian and political quandary of the day. He recognized that seeking solutions with mere words is wasteful. People in the lower ranks of populations worldwide are seeking a better life, and that must be acknowledged. Underneath the search, which is sucking the life out of so many, is the quest for human dignity. This struggle, structured in modern terms by leaders of the developed countries, makes clear that we must ask how may everybody benefit from the advances made by the upper echelons? Leaving the lower classes to fend for themselves is unacceptable and undignified. Many of us understand that action is required, of course. Still, implementing solutions in this era of polarized political convention is a major task. **PN**

Movies

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youth. Amit Paley, CEO of the Trevor Project, an LGBTQ+ youth suicide prevention organization, stated that "when lawmakers treat LGBTQ+ topics as taboo, … it only adds to the existing stigma and discrimination, which puts LGBTQ+ young people at greater risk for bullying, depression, and suicide."

Although educational exposure may lead to earlier recognition of alternative sexual attraction and gender identification, there are no evidence-based studies validating direct alteration of either through exposure or education. This has been further supported by a position statement of the Association of LGBTQ+ Psychiatrists (AGLP) in 2023. The concern that the exposure of children to a homosexual character (or a heterosexual one for that matter) through movies might impact the prospective development of their sexual and gender identity is an entirely unfounded concept. Gender identity develops as early as age 3, and sexual orientation shapes mostly in early adolescence.

For nearly 100 years, Disney animated movies have been publicly broadcasting heterosexual love stories and relationships that most LGBTQ+ identifying people watched as children. It is clear that children's exposure to heteronormative concepts does not necessarily dictate their lifelong experiences with gender and sexuality.

We extrapolate two significant points thus far from evidence-based literature: (1) engaging with fictional characters' stories on the screen can trigger understanding and empathy in the viewer through mirroring, and (2) exposure of children to romantic relationships of any kind through film has no known effect on the development of their sexuality and gender identity.

As such, it appears that the benefits of representation of minoritized groups in movies far outweigh any potential risks. In fact, multiple studies have shown that representation of minoritized groups in movies increases acceptance and decreases stigma. Representation of LGBTQ+ individuals specifically has been linked to decreased homophobia, according to a 2018 study by Goran Madžarević and María T. Soto-Sanfiel in *Sexuality and Culture*.

Perhaps it is time we embrace movies as an avenue for empathy, understanding, and acceptance and depict couples of diverse sexual orientation and gender diversity whose love stories have their happy ending. **PN**

The references for this article are posted in its online version at http://apapsy.ch/sexual_identities.

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Pain and the Hospitalized Patient

Consultation-liaison psychiatrists can help primary care teams recognize pain's influence on patient behavior. This article is one of a series coordinated by APA's Council on C-L Psychiatry and the Academy of C-L Psychiatry. ***BY CORINA FREITAS, M.D., HELENA WINSTON, M.D., AND DEVINALINI MISIR, M.D.***

Consultation-Liaison PSYCHIATRY

Pain is omnipresent in the hospital, but its degree and presentation are variable. A consultation-liaison (C-L) psychiatrist can help identify how and why pain may be affecting a patient's medical illness and recovery.

Patients in pain whom a C-L psychiatrist may encounter in the hospital include the following:

- People who have difficulty expressing what they are feeling (children, the elderly, those with an intellectual disability or communication difficulties, etc.).
- People who have chronic pain in addition to acute pain.
- People who are behaving in a negative or difficult manner as a result of their pain.
- People who have substance use disorder, especially opioid use disorders, who now have acute pain.

Case Example

James is a 34-year-old man with a history of generalized anxiety disorder, fibromyalgia, and gout. Around age 25, he started using heroin in the context of pain due to repeated gout flares. He subsequently entered substance use treatment and was able to stop heroin use. At age 33 he started having what he thought were severe gout flares again and visited the emergency room multiple times for knee pain. Due to ongoing pain, his friend offered him a fentanyl tablet. It helped the pain so much more than the methadone he had been taking as part of his heroin treatment that he stopped taking methadone and started taking fentanyl. Over the next year his use increased to 20 fentanyl tablets a day. Still, his knee pain worsened, and after coming to the hospital, he was found to have a septic joint necessitating an above-the-knee amputation. The primary team placed him on methadone 40 mg and as needed hydromorphone. After two days he started yelling at the team that he wanted to leave and was found with fentanyl tablets in his room. The C-L psychiatry team was consulted because of the patient's problems coping with his amputation, his anger, and his desire to leave against medical advice.

Discussion

A C-L psychiatrist aids the primary team in recognizing pain's influence on patient behavior by elucidating how pain can manifest as anger, acting out, entitlement, despair, and/or dependency, potentially mimicking new-onset personality disorders or even psychosis. Understanding patients' personality traits is crucial, as they significantly shape their response to illness and guide constructive engagement by treatment teams.

Patients with substance use disorders, especially opioid use disorders, often face undertreatment during acute pain episodes due to stigmatization and the misconception of

see **Pain** *on page 37*

Corina Freitas, M.D., is a clinical assistant professor at George Washington University School of Medicine and chair of the Department of Psychiatry and medical director at MedStar Southern Maryland Medical Center. She has contributed to research in a number of areas, including consultation-liaison psychiatry. Helena Winston, M.D., is an accomplished academician, having written book chapters and peer-reviewed articles that have appeared in such journals as the *Journal of Neuropsychiatry and Clinical Neuroscience*. Devinalini Misir, M.D., is a clinical assistant professor at the University at Buffalo School of Medicine and Biomedical Sciences with a wide clinical focus that includes addiction and behavioral pharmacology, substance use disorders, and maternal-fetal medicine.

Telemedicine

continued from page 1

patient really should be left to the clinical discretion of a practitioner who has the knowledge, skills, and experience to make that decision," Khan said. "Reducing flexibility in modalities of care increases inequity, forcing practitioners to cherry-pick patients that have the ability to travel to in-person care."

Khan, who is the director of child and adolescent telepsychiatry at NYU Langone Health and an assistant professor of child and adolescent psychiatry at NYU Grossman School of Medicine, noted that the existing standards and regulations around prescribing controlled substances provide a high level of oversight and accountability of prescribing practices.

"There is no evidence that telemedicine prescribing during the COVID-19 PHE increased diversion or negative outcomes associated with access to controlled substances," APA President Petros Levounis, M.D., M.A., told *Psychiatric News*. "In fact, initial data indicate that telehealth initiation in the care of patients with opioid use disorder increased retention in treatment."

The DEA hopes to have a final set of telemedicine regulations by the fall of 2024. "The purpose of this second temporary rule, like the one before it, is to ensure a smooth transition for patients and practitioners that have come to rely on the availability of telemedicine for controlled medication prescriptions, as well as allowing adequate time for providers to come into compliance with any new standards or safeguards," said DEA and HHS in the temporary extension.

Since 2017, the U.S. opioid crisis has been categorized as a public health emergency, APA CEO and Medical Director Saul Levin, M.D., M.P.A., noted. According to the Centers for Disease Control and Prevention, overdoses involving opioids killed more than 80,000 people in 2021.

"APA appreciates the DEA's efforts to learn from the lessons of the COVID-19 PHE in maintaining access to critical, lifesaving care through technology," Levin told *Psychiatric News*. "The DEA has the opportunity to get the balance right by finalizing rules that facilitate, rather than prevent, access to high-quality care." **PN**

The rule "Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation" is posted at http://apapsy.ch/telemedicine. The rule "Expansion of Induction of Buprenorphine via Telemedicine Encounter" is posted at http://apapsy.ch/controlled-substances. The rule "Second Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications" is posted at http://apapsy.ch/dj.

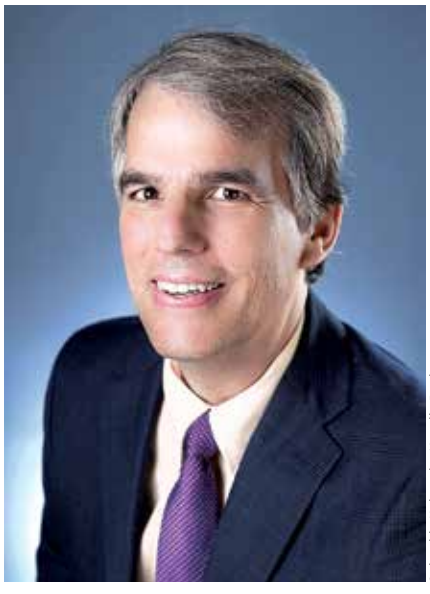
Overdose Death Risk Elevated in Many Health Workers

The risk is highest among counselors, social workers, psychologists, and other community and social service workers, but not elevated in psychiatrists and other physicians. **BY TERRI D'ARRIGO**

Counselors, social workers, psychologists, and other community and social service workers have more than twice the risk of overdose death as employed individuals who do not work in health care, a study in the *Annals of Internal Medicine* has found. Other health workers with significantly higher risk of overdose death include registered nurses and health care support workers such as home health aides. However, the study found no increased risk for physicians (including psychiatrists), health technicians, and other treating and diagnosing health care workers.

Mark Olfson, M.D., M.P.H., the Elizabeth K. Dollard Professor of Psychiatry, Medicine and Law and a professor of epidemiology at Columbia University Medical Center, and colleagues examined data from 176,000 health workers and 1,662,000 non-health workers aged 26 years or older. Participants were surveyed in 2008 as part of the American Community Survey and followed for cause of death through 2019. Health workers were categorized as physicians; registered nurses; other treating or diagnosing health care workers; health technicians; health care support workers, including home health aides; and social or behavioral health workers, including social workers, counselors, psychologists, and other community and social service specialists.

Among all participants, 0.07% died of overdose during the 10-year follow-up. Annual age- and sex-standardized rates of drug overdose death per 100,000 health workers ranged from 2.3 for physicians to 15.5 for social or behavioral health workers. Compared with non-health workers, social or behavioral health workers had 2.55 times the risk of overdose death during the study period. Registered nurses and health care support workers had 2.22 and 1.60 times the risk of overdose death, respectively, compared with non-health workers.



Columbia University/Amelia Panico

Psychoeducation could help health workers identify warning signs of problematic substance use in themselves and in their co-workers, said Mark Olfson, M.D., M.P.H.

"I was surprised that health care support workers were at such high risk of drug overdose death," Olfson told *Psychiatric News*. "When you think of national patterns of who is at risk for drug overdose deaths, the group at highest risk is typically young White unemployed men. In this representative study of working American adults, however, health care support workers, a majority of whom are middle-aged women and many of whom are people of color, stood out as a high-risk group."

Olfson added that health support workers, who frequently lift and move patients, have among the highest risks of injuries of all occupations, even higher than construction workers, according to federal statistics.

"Because painful musculoskeletal injuries can lead to opioid prescriptions and sometimes opioid misuse, enhanced training of health care support workers in safe patient lifting and transport techniques with adequate co-worker assistance could contribute to reducing upstream risks of opioid misuse and related complications," Olfson said.

The researchers noted that the higher risk of overdose death among registered nurses aligns with prior studies that suggest that nurses have a high rate of prescription drug misuse, which may be an indicator for substance use disorder and overdose.

"In their daily work, nurses routinely encounter controlled prescription drugs. Nurses who have greater exposure to these drugs at work are more likely to misuse them," Olfson explained. "For this reason, one strategy for reducing overdose risk among nurses might involve enforcing greater oversight concerning administration and disposal of controlled prescription drugs."

Olfson and colleagues noted, however, that the increased risk of overdose death in social and behavioral health workers had not been previously described in other research and is unlikely to be explained by physical pain or occupational access to controlled substances.

"Nevertheless, high rates of drug overdose deaths among social or behavioral health workers underscore a need to improve detection and management of drug use disorders in this health care worker sector," they wrote.

Olfson noted two challenges that health workers who have substance use disorder (SUD) may face.

"They may become too scared and too embarrassed to seek help. They may also become worried about confidentiality and think that if they seek help, they will lose their license or job," he said.

Olfson said that specialized programs for health care workers with SUD can help to reduce these barriers to care and contribute to earlier treatment. However, most of these programs have been limited to physicians and have not reached the health workers who are most vulnerable to overdose death, he said.

"New programmatic efforts are needed to reduce health care worker stress; prevent burnout; identify health care workers who are using drugs of abuse; and, as needed, increase their access to confidential substance use evaluation and treatment," Olfson said. "Psychoeducation could help health care workers identify warning signs of problematic substance use in themselves and in their co-workers. In addition to these general measures, consideration should be given to employee-specific strategies."

This study was supported by a National Heart, Lung, and Blood Institute interagency agreement with the U.S. Census Bureau. **PN**

"Fatal Drug Overdose Risks of Health Care Workers in the United States: A Population-Based Cohort Study" is posted at http://apapsy.ch/overdose.

Antidepressants

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40% less likely to experience any mood-related event and 59% less likely to experience depression recurrence than those in the discontinuation group.

"We did not hit the primary outcome, but I think many clinicians would say there is a signal indicating some benefit for longer-term antidepressant use," Yatham told *Psychiatric News*. "If a patient's acute depression symptoms improve with an antidepressant, I think it is reasonable to continue medication while being vigilant for a manic switch."

Nassir Ghaemi, M.D., M.P.H., a professor of psychiatry and pharmacology at Tufts University School of Medicine, warned that studies of maintenance depression care should always be examined with a critical eye.

He noted that maintenance trials like this one are biased because they assess patients who initially respond to the antidepressant for an acute depressive episode, after which the antidepressant is stopped 8 weeks later.

They relapse quickly, which proves nothing about long term efficacy. "What you have shown is people who responded in the short term may get worse in the short term once you take the medication away," he told *Psychiatric News*.

Additionally, he noted that the reported antidepressant responders for this *NEJM* study did not come from a randomized or blinded clinical study, and such trials of acute bipolar depression show that the apparent antidepressant benefit is equal to placebo.

"It ignores the important question of whether we should be prescribing antidepressants for bipolar depression in the first place; the preponderance of clinical data suggests they are not effective."

Joshua Rosenblat, M.D., an assistant professor of psychiatry at the University of Toronto and staff psychiatrist at the Mood Disorders Psychopharmacology Unit at Toronto Western Hospital, acknowledged that there is mixed evidence on antidepressant efficacy in patients with bipolar depression. But there is a clinical reality that these patients are seeking out and being prescribed antidepressants.

"Many patients I've seen … understand the risks [of antidepressants for patients with bipolar disorder]," Rosenblat said. "They tell me they their hypo/mania is not that bad, and they don't want to be taken off their antidepressant."

Rosenblat said the NEJM study offers some reassurance that antidepressants may offer some long-term protection for patients who want to continue taking the medication. He said he also prescribes antidepressants to patients experiencing bipolar depression with comorbid anxiety.

"We should try and limit antidepressants in bipolar but at the same time we should not kick them out of our armamentarium," he said.

This study was supported by the Canadian Institutes of Health Research. **PN**

"Duration of Adjunctive Antidepressant Maintenance in Bipolar I Depression" is posted at http://apapsy.ch/bipolar-depression.

MED CHECK

BY TERRI D'ARRIGO

FDA Seeks Fines Against Retailers Selling Illegal E-Cigarettes

In September the Food and Drug Administration (FDA) issued complaints for civil money penalties against 22 retailers for the illegal sale of Elf Bar/EB Design e-cigarettes, a popular brand that appeals to youth. The FDA previously sent these retailers a warning letter instructing them to stop selling unauthorized tobacco products. During follow-up inspections, the FDA observed that the retailers had not corrected the violations.

The complaints seek the maximum civil money penalty of $19,192 for a single violation from each retailer. Although the FDA has issued civil money penalty complaints to retailers for selling unauthorized tobacco products in the past, this is the first time it is seeking civil monetary penalties for the maximum amount against retailers for this type of violation.

The retailers can pay the penalty, enter into a settlement agreement, request an extension of time to file an answer to the complaint, or file an answer and request a hearing. Companies that fail to act within 30 days of receiving the complaint risk a default order imposing the full penalty amount.

The FDA has also sent an additional 168 warning letters to other brick-and-mortar retailers for illegally selling Elf Bar/EB Design Products.

Karuna Therapeutics Submits NDA For Schizophrenia Drug

Karuna Therapeutics Inc. has submitted a New Drug Application (NDA) to the FDA for ***KarXT (xanomeline-trospium)*** for the treatment of schizophrenia, the company announced in September.

The NDA submission includes data from the EMERGENT-1, EMERGENT-2, and EMERGENT-3 trials, which evaluated the efficacy and safety of KarXT compared with placebo.

In all three placebo-controlled trials, KarXT met its primary endpoint, demonstrating a statistically significant and clinically meaningful reduction in Positive and Negative Syndrome Scale (PANSS) total score compared with placebo. For example, in the EMERGENT-3 trial, 256 patients with schizophrenia who were experiencing psychosis were randomized to receive either KarXT or placebo twice daily for five weeks. The patients' symptoms were assessed with the Positive and Negative Syndrome Scale (PANSS).

At the end of five weeks, PANSS total scores dropped a mean of 20.6 points in patients who took KarXT, compared with a mean reduction of 12.2 points in those who took placebo. In addition, scores in the PANSS positive subscale dropped 7.1 points for patients who took KarXT compared with 3.6 points for those who took placebo.

The most common adverse events, reported in at least 5% of patients who took KarXT, were nausea, dyspepsia, vomiting, constipation, headache, hypertension, diarrhea, and insomnia, all of which were rated mild or moderate in severity.

Two additional trials of KarXT, which are evaluating the long-term safety of the medication, are currently underway.

Phase 3 Trial Suggests Efficacy of REL-1017 for Major Depressive Disorder

In September Relmada Therapeutics Inc. announced that patients in a phase 3 trial who took its investigational monotherapy ***REL-1017 (esmethadone)*** for major depressive disorder for up to one year experienced sustained reductions of depressive symptoms and functional impairment.

A total of 627 patients with major depressive disorder were enrolled in the trial, named REL-1017-310. These patients included 423 who rolled over from placebo-controlled trials of REL-1017 and 204 de novo patients who had not previously participated in trials with REL-1017. In the de novo patients, the mean Montgomery–Åsberg Depression Rating Scale (MADRS) total score was 33.8 at baseline. Treatment with REL-1017 in these patients resulted in mean improvements in the MADRS total score of 11.3 points at day 7, 16.8 points at month 1, 19.9 points at months 3 and 6, and 22.5 points at month 12. When treated with REL-1017, 26.6% of de novo patients achieved clinical response by day 7, 51.0% by month 1, 60.7% by month 3, 63.4% by month 6, and 77.2% by month 12.

Orexo Submits NDA for High-Dose Opioid Overdose Reversal Drug

Orexo AB has submitted an NDA to the FDA for ***OX124***, its high-dose nasal ***naloxone*** rescue medication for opioid overdose, the company announced in September.

The submission includes data from a study in healthy volunteers, OX124-002, where OX124 showed a significantly faster and higher absorption of naloxone compared with intramuscular dosing with an injection reference product.

Orexo previously submitted an application that the FDA rejected because of technical issues with the packaging process. **PN**

JOURNAL DIGEST

BY NICK ZAGORSKI

Getty Images/iStock/Dragos Condrea

Many ACOs Don't Offer Medication for OUD

The percentage of accountable care organizations (ACOs) that began offering medication for opioid use disorder grew between 2018 and 2022, but nearly half of them still do not offer this treatment option. This survey data was described in a report in *Psychiatric Services.*

"Health care organizations with accountable care organization (ACO) contracts hold provider networks responsible for meeting quality and spending benchmarks for a designated patient population, which may provide motivation to prioritize population health goals," wrote investigators at the University of North Carolina School of Medicine and colleagues. "Thus, ACO participants are well positioned to improve opioid use disorder prevention and treatment in primary and specialty care settings within their networks."

The researchers surveyed all ACOs that had a Medicare or Medicaid contract in both 2018 and 2022. About 55% of organizations surveyed submitted responses to three separate questions that asked whether clinicians in the ACO provider network offered buprenorphine, naltrexone, and/or methadone; they were also asked whether the organization included outpatient substance use disorder treatment facilities in its provider network.

Between 2018 and 2022, the number of accountable care organizations offering at least one OUD medication increased from 39% to 52%. Of the three medications for OUD, buprenorphine was the most commonly available, offered by 51% of organizations in 2022.

Organizations with in-network, outpatient substance use disorder treatment facilities were much more likely to offer these medications compared with organizations with no in-network facilities (80% vs. 33%, respectively). ACOs in states with high opioid overdose mortality rates were not statistically more likely to offer these medications than ACOs with low opioid overdose mortality rates (54% vs. 50%, respectively).

"Despite modest advancement, the lack of [OUD medication] availability among ACOs (which have led population health initiatives for more than a decade) shows that even strong ACO performers may need more support (or scrutiny) to increase access to evidence-based opioid use disorder treatment for their patient populations," the investigators wrote.

Newton H, Miller-Rosales C, Crawford M, et al. Availability of Medication for Opioid Use Disorder Among Accountable Care Organizations: Evidence From a National Survey. *Psychiatr Serv.* August 24, 2023. Online ahead of print. http://apapsy.ch/dm

Getty Images/iStock/JazzIRT

Dexmedetomidine During Surgery May Reduce PTSD

Patients who need emergency surgery following a trauma may be less likely to develop posttraumatic stress disorder (PTSD) if they receive dexmedetomidine during the operation, a study published in *JAMA Network Open* has found. Dexmedetomidine is an alpha-adrenergic agonist that has sedative, analgesic, and anxiolytic properties.

The study, by researchers at Suzhou Xiangcheng People's Hospital in China, involved 310 adults aged 18 to 60 years with trauma who were undergoing emergency surgery at one of four tertiary hospitals in China's Jiangsu Prov-

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Green Space

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Some of this research goes back decades. A foundational 1984 study by R.S. Ulrich in *Science* found that 23 surgical patients assigned to rooms with windows looking out on a natural scene had shorter postoperative hospital stays, received fewer negative evaluative comments in nurses' notes, and took fewer potent analgesics than 23 matched patients in similar rooms with windows facing a brick wall.

James has specialized in observational epidemiology using satellite images and Google street views to connect geographic areas of green space to population health and mental health outcomes. "There is a really robust literature showing that people who live in greener areas have better mental health and lower depression and anxiety, even adjusting for lots of other factors," he told *Psychiatric News.*

He cited a remarkable 2019 study from Denmark in *PNAS* (*Proceedings of the National Academy of Sciences*). Researchers used longitudinal health data from more than 900,000 Danish citizens coupled with high-resolution satellite images to show that greater exposure to green space during childhood was associated with lower risk of a wide spectrum of psychiatric disorders later in life. Risk for subsequent mental illness among those who lived with the lowest level of green space during childhood was up to 55% higher across various disorders compared with those who lived with the highest level of green space. The association remained even after adjusting for urbanization, socioeconomic factors, parental history of mental illness, and parental age.

Greenspace Integral to City Infrastructure

How might exposure to green space influence health? The dominant hypothesis is that of "biophilia"—a love of living things—a term coined by the naturalist E.O. Wilson. As James explained it, "We like being in nature because we *are* nature, we evolved in nature. This is the setting we were meant to be in. So, when we are stressed, we recover best in natural settings."

Anyone who takes a casual stroll in the woods after an argument can probably confirm this. But if the connection between nature and health is so intuitive, why is it not more widely adopted in clinical practice? Anderson said a principal obstacle is the lack of succinct and shared terminology of what green space means. "It is unclear what the right 'dose' is or what the type of environment should be that makes a difference—city park, forest, small backyard, plants in your home," she said.

"Not enough people are talking yet about green space as a social determinant of health," said Sara Anderson, M.D., M.P.H.

Answering that is key, said James. "What is the active ingredient in nature?" he asked. "What is the specific component of nature that influences our health? That's a complex question, but it's not just an academic exercise; it's crucial to determining what an intervention would look like and how we would administer it."

More generally, he believes that kind of evidence of how exposure to green space impacts individual and population health would help to transform the way we think about public infrastructure, with benefits for a warming planet.

This means advocating for the planting of trees and the creation of small, local parks—not just maintenance of the grand national parks for which the U.S. is famous. "There is a huge win-win to the planting of trees in cities," he said. "We can sequester carbon, cool urban areas, decrease health disparities, and improve health outcomes."

James added, "The shift we need is to view landscape architecture and greenspace as a fundamental component of city infrastructure for everyone, not a perk or amenity for the wealthy." **PN**

"View Through a Window May Influence Recovery From Surgery" is posted at http://apapsy.ch/window. "Residential Greenspace in Childhood Is Associated With Lower Risk of Psychiatric Disorders From Adolescence Into Adulthood" is posted at http://apapsy.ch/green-space.

Pain

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"drug seeking." In reality, individuals on maintenance therapies like methadone or buprenorphine, as well as those using illegal opioids, may require higher opioid doses to achieve adequate pain control due to cross-tolerance. Undertreated pain and not appropriately managed pain fuel addiction and raise the risk of patient attrition and posthospital discharge opioid overdose. The need to consult psychiatrists, pain specialists, or palliative care experts and consider augmentation modalities including patient-controlled analgesia pumps, diphenhydramine, or ketamine become pertinent. Exploring nonopioid avenues such as scheduled oral acetaminophen, anti-inflammatory medications, topical agents, gabapentinoids, antiepileptics, serotonin-norepinephrine reuptake inhibitors, and tricyclic antidepressants, should be prioritized based on pain type and comorbidities. In chronic pain scenarios, initiating nonopioid strategies alongside opioids at the onset is recommended due to their slower onset.

A C-L psychiatrist's role extends to comprehending patients' external opioid use reasons (pain, withdrawal, craving) and advising against retaliatory responses. Communication of procedure or boundary changes should occur calmly and nonpunitively. Ethical considerations and guidelines should be kept in mind to prevent a paternalistic approach, particularly with regard to patients not inclined to quit illegal substances.

Despite disagreements, the C-L psychiatrist's primary role remains treating the patient for the present ailment and preventing harm, including withdrawal. Educating patients and treatment teams about opioid-induced hypersensitivity, particularly in chronic opioid users, is vital. In some instances, reducing the use of opioids and increasing augmentation strategies might be the answer.

Outcome

In the case presented here, the C-L psychiatry team assessed James and concluded that due to fentanyl addiction, his pain was undertreated, and the team recommended an increase in methadone. They also determined that his untreated anxiety and fibromyalgia were worsening his ability to cope and started him on extended-release venlafaxine. James was also fearful that the team was going to judge him and treat him differently because he had used fentanyl in the hospital, and that is why he wanted to leave. Working with the team on addressing this concern allayed his fears, and medication changes allowed him to stop using fentanyl in the hospital; improved his anger, pain, and anxiety; and enabled him to commit to staying in the hospital for treatment. **PN**

Additional reading: "Chronic Pain and Mental Health Often Interconnected" is posted at http://apapsy.ch/pain-mental-health. "Taking Care of the Hateful Patient" by James E. Groves, M.D., is posted at http://apapsy.ch/hateful-patient.

SUD Treatment

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nication and relationship satisfaction."

She added that behavioral couples therapy focuses on establishing shared goals, maximizing the rewards of not drinking, stopping behaviors that enable, and focusing on problem-solving.

Then there is the community reinforcement approach and family training intervention, which Marienfeld said shares several strategies with behavioral couples therapy for AUD, except that the others involved are not romantic partners of the person with SUD and are instead "concerned significant others." This approach teaches the concerned significant others to modify their usual behaviors toward, reactions to, and expectations of the person who has SUD. Marienfeld explained that the concerned significant others learn how to use positive reinforcement but also to allow the person with SUD to suffer the natural consequences of substance use.

Marienfeld also described acceptance and commitment therapy, which highlights the context in which behavior or distress occurs as opposed to the form it takes. Acceptance and commitment therapy focuses on mindfulness practices, such as embracing thoughts and feelings without attempting to change them and creating space between experiencing a thought or feeling and the thought or feeling itself (for example, "I am having a thought that I am no good" instead of "I am no good").

"Once we recognize negative thoughts, we can work on challenging them, which then impacts how we feel," Marienfeld said. The focus of this approach is to develop "psychological flexibility" so that patients may process their thoughts and feelings and meet the challenges of life in an empowered way, she said.

Marienfeld rounded out her presentation with a discussion of CBT.

"Substance use is reinforcing," she said. "It interacts with psychological or behavioral coping deficits to increase substance use." For example, the patient may think "I can't cope with anxiety without [the substance]" so the patient uses the substance. "Substance use disorder develops when this pattern is repeated over and over," Marienfeld said.

CBT helps patients recognize critical or exaggerated thoughts or assumptions about themselves, the world, and others, so they can more effectively work on coping with the thoughts that lead them to substance use, Marienfeld said. **PN**

Journal Digest

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ince. The patients were allocated to receive either intravenous dexmedetomidine (at 0.1 µg/kg hourly) or saline throughout the surgery and from 9 p.m. to 7 a.m. for the first three days following surgery.

One month after surgery, the researchers evaluated the participants using the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5). The researchers also assessed the participants for other symptoms such as postoperative pain, delirium, nausea, sleep quality, and anxiety in the days after surgery and as well as at one month.

There was a lower incidence of PTSD in the dexmedetomidine group compared with the placebo group. CAPS-5 scores were also significantly lower in patients given dexmedetomidine relative to patients given placebo (17.3 vs. 18.9, respectively). Patients who received dexmedetomidine also reported better sleep and less anxiety in the days following surgery, and rates of delirium, pain, or nausea did not increase.

"The release of norepinephrine during or shortly after stressful and traumatic events can increase the formation of event-related fear memory, thereby inducing PTSD," the researchers wrote. As an adrenergic agonist, dexmedetomidine "can reduce the consolidation, reinforcement, and formation of conditioned fear memory in the early stage of trauma by reducing the important source of norepinephrine in the central nervous system, so as to prevent the development of PTSD."

Yu Y, Li Y, Han D, et al. Effect of Dexmedetomidine on Posttraumatic Stress Disorder in Patients Undergoing Emergency Trauma Surgery: A Randomized Clinical Trial. *JAMA Netw Open.* 2023; 6(6): e2318611. http://apapsy.ch/dn

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Sleep Restriction Therapy May Improve Insomnia Symptoms

Cognitive-behavioral therapy (CBT) is a proven treatment for insomnia, but access to trained therapists is limited. A study published in *The Lancet* suggests that patients with insomnia may experience benefits from a brief intervention involving one component of CBT.

Investigators at the University of Oxford and colleagues conducted a pragmatic study to test the efficacy of a sleep restriction therapy—which teaches people to set regular sleep hours and limit their time in bed to those hours.

The researchers enrolled 642 adults with diagnosed insomnia from 35 primary care practices across the United Kingdom. These participants (97% of whom were White) were then assigned to receive sleep restriction therapy along with a sleep hygiene booklet or a sleep hygiene booklet only. Sleep restriction therapy was provided by a primary care nurse over four 15- to 30-minute weekly sessions—two in-person and two over the phone.

At enrollment, the average Insomnia Severity Index (ISI) score among the participants was 17.5; after six months, ISI scores dropped to 10.9 in the sleep restriction group and 13.9 in the sleep hygiene group, which was a statistically significant difference.

In addition, 42.0% of the participants in the sleep restriction group met the criteria for a clinically significant response (ISI improvement of 8 points or more), compared with 16.8% of those in the sleep hygiene group. The participants receiving sleep restriction therapy also reported better mood, quality of life, and (among workers) less absenteeism.

"Our findings create a new pathway for the treatment of insomnia disorder, an area where current practice is deficient and guideline-recommended treatment is rare," the investigators wrote.

Kyle SD, Siriwardena AN, Espie CA, et al. Clinical and Cost-Effectiveness of Nurse-Delivered Seep Restriction Therapy for Insomnia in Primary Care (HABIT): A Pragmatic, Superiority, Open-Label, Randomised Controlled Trial. *Lancet.* 2023; 402(10406): 975-987. http://apapsy.ch/do

Getty Images/iStock/MJ Prototype

Long-Term Use of Acid Reflux Meds May Increase Dementia Risk

Individuals who take proton-pump inhibitors (for example, the acid reflux medications Nexium or Prilosec) over longer periods of time may be at a greater risk of developing dementia, suggests a report in *Alzheimer's and Dementia*.

"In this real-world population-based case-control study nested in a nationwide cohort of individuals aged 60 to 75 years in 2000 to 2018, PPI [proton-pump inhibitor] use was associated with an increased rate of all-cause dementia before age 90 years," wrote the authors from Copenhagen University Hospital and colleagues.

The researchers examined associations between cumulative use of PPIs and dementia in a nationwide Danish cohort of 1,983,785 individuals aged 60 to 75. These individuals were then followed for up to 19 years until the first onset of dementia, emigration, death, or December 31, 2018, whichever came first.

During the follow-up period, there were 99,384 incidences of all-cause dementia.

"Exposure to PPIs was found to be associated with an increased rate of all-cause dementia occurring before 90 years of age regardless of time of treatment initiation according to the diagnosis. Longer cumulative duration of PPI use yielded higher risk estimates," the authors wrote. "Further studies are warranted to determine if these findings represent a causal effect of PPIs on dementia risk and to explore risk differences according to age at dementia diagnosis and dementia subtypes."

Pourhadi N, Janbek J, Jensen-Dahm C, et al. Proton Pump Inhibitors and Dementia: A Nationwide Population-based Study. *Alzheimers Dement.* 2023 October 5, 2023. Online ahead of print. http://apapsy.ch/dq

Getty Images/iStock/3D Horse

TMS Found Not Harmful For Fetuses and Newborns

Peripartum depression—the onset of depressive symptoms during pregnancy or the first month after giving birth—can have devastating effects on mothers and infants. A meta-analysis published in *Psychiatry Research* suggests women with peripartum depression may experience benefits from transcranial magnetic stimulation (TMS) without causing harm to their offspring.

Researchers at D'Annunzio University of Chieti–Pescara in Italy and colleagues compiled 23 articles that examined TMS in the treatment of perinatal or postpartum depression

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and included health data on fetuses or newborns. These studies included two randomized, controlled trials; five open-label trials; one nonrandomized case-control study; and 15 case reports/case series. Most of the studies involved conventional repetitive TMS (rTMS), though two (both case series of five women) involved the intermittent theta-burst stimulation (iTBS).

Overall, the data identified no significant health concerns in newborns. All 10 studies that conducted Apgar tests (Appearance, Pulse, Grimace, Activity, and Respiration) after birth showed normal results (average scores at least 8 out of 10).

Three studies of patients with postpartum depression found no effects of rTMS on lactation or maternal bonding. The two iTBS case series identified one infant that was large for gestational age and a second with meconium in the amniotic fluid, but no other complications.

"In light of the complex clinical management of pharmacological treatment during the peripartum period, rTMS represents a valid treatment option for [peripartum depression], even while breastfeeding," the authors concluded.

They acknowledged that more randomized trials are necessary to understand optimal TMS protocols for this patient population.

Miuli A, Pettorruso M, Stefanelli G, et al. Beyond the Efficacy of Transcranial Magnetic Stimulation in Peripartum Depression: A Systematic Review Exploring Perinatal Safety for Newborns. *Psychiatry Res.* 2023; 326: 115251. http://apapsy.ch/dp

School

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lessons centered around one of five core values: self-awareness, emotional intelligence, healthy relationships, visionary goal setting, and leadership. The counselors can provide individual therapy and/or refer students for additional services, if needed.

The program is offered as a class once a week onsite at participating schools during the school day throughout the academic year (39 sessions total).

Milbrook told *Psychiatric News* that a big part of the program's success comes from the counselors. "What we are looking for is the right combination of passion and skill; we want counselors with training and knowledge, but also some lived experience with these neighborhoods."

The success of WOW also stems from Youth Guidance's commitment to regularly evaluating the effectiveness of the program and taking steps to strengthen it, said Bhatt, who has been involved in studying the impact of the program on the adolescent girls it serves.

"The organization took the time to create a clinical intervention that was responsive to the needs of girls, adapted it to be delivered in a school setting, and then worked with the Education Lab as external evaluators to understand whether or not the model worked to reduce PTSD, anxiety, and depression," Bhatt explained. The results of this evaluation were published earlier this year in *Science Advances.*

As part of a randomized trial, Bhatt's team worked with Chicago Public Schools and Youth Guidance to identify 10 public high schools located in communities experiencing high rates of gun violence across Chicago. Selected schools agreed to provide WOW beginning in the 2017-2018 academic year. These schools then used a lottery to offer spots in the WOW classes to 50 students in grades 9 through 11 per school. Girls who attended school at least 75% of the time during the prior year and did not have intellectual disability disorder or signs of aggression, self-harm, or suicidal ideation were eligible for the WOW class. Overall, 1,232 girls were offered access to WOW while 2,517 peers had access to standard school services and electives. About 85% of the students in the study were Black and/or Hispanic, and about 95% were eligible for free or reduced lunch.

Prior to the school year, 626 students—equally divided between WOW and control—were randomly selected to fill out a comprehensive baseline survey on mental and physical health measures (55% responded); about 2,000 girls were then randomly selected for a follow-up survey sometime between May and November 2018 (84% responded).

At the start of the study, many of the participants reported, on average, at least two serious traumatic experiences: nearly 30% had personally witnessed someone being attacked, stabbed, shot at, hurt badly, or killed, and more than 45% had someone close die suddenly or violently.

Bhatt and colleagues found that relative to their student peers, girls who participated in WOW experienced a 22% drop in PTSD symptom severity, a 14% drop in depression severity, and a 10% drop in anxiety severity from baseline to follow-up. WOW did not appear to have any effects on the girls' academic or disciplinary outcomes, but Bhatt said that this was not surprising.

"On average, these girls were coming in with solid attendance and a B average, which is admirable considering the high rates of trauma exposure we found," Bhatt said.

The overall cost of WOW at these schools was calculated at $2,300 per participant. Based on quality-of-life measures, an analysis showed that the program was highly cost-effective.

"Of course, something may be cost-effective, but if it requires a large percentage of a school's yearly operating budget then it's still cost-prohibitive from a district's perspective and not likely to be implemented," Bhatt noted. "One challenge now is how to lower the cost [of WOW] even further without compromising its effectiveness to make it available to more students."

Program Looks to Expand

For those intimately involved with Working on Womanhood, the findings of Bhatt's study were hardly surprising.

"I would not be where I am today without WOW's help," said Precious Omomofe, a senior and neuroscience major at Pomona College in Claremont, Calif. Omomofe, who started the program as a sophomore in high school, had to deal with the dual difficulties of living in a community experiencing gun violence while also attending a school with a small Black student population, thus feeling like an outsider.

"I would have never even thought about such counseling resources if they weren't so readily available," Omomofe continued. "In my family, mental health was not a topic of discussion." She recalled one of her early sessions with WOW when she broke down crying as she realized how overwhelmed she felt. "The staff were all so amazing and helped me succeed," she said.

Milbrook said that she is elated to see the positive outcomes on mental health that the Chicago program seems to be having on girls in the city now backed by scientific evidence. And while WOW programs have since expanded to schools in Boston, Dallas, and Kansas City, Milbrook hopes more schools will soon follow.

"Now is the time to act," she said. "Remember, the stark data in the study came from 2017 and 2018; since COVID hit mental health issues among high schoolers have only gotten worse."

The Science Advances study was supported by the AbbVie Foundation; Arnold Ventures; Paul M. Angell Family Foundation; Edna McConnell Clark Foundation; Logan; MacArthur; Polk; and a grant from the U.S. Department of Justice. **PN**

"Randomized Evaluation of a School-Based, Trauma-informed Group Intervention for Young Women in Chicago" is posted at https://www.science.org/doi/10.1126/sciadv.abq2077.

United States Postal Service

Statement of Ownership, Management and Circulation
(All Periodicals Publications Except Requester Publications)

1. Publication Title	2. Publication Number	3. Filing Date
Psychiatric News	4 4 8 5 8 0	09/28/2023
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$176.00

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4)
Addr 1: APA, Suite 900
Addr 2: 800 Maine Ave SW
City, State ZIP: Washiington DC 20024-2812

Contact Person: Brian Cole
Telephone: 202-459-9750

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not Printer)
Addr 1: 800 Maine Ave SW
Addr 2: Suite 900
City, State ZIP: Washiington DC 20024-2812

9. Full Names and Complete Mailing Addresses of Publisher, Editor and Managing Editor (do not leave blank)

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Name: Simone Taylor
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City, State ZIP: Washiington DC 20024-2812

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Full Name	Complete Mailing Address
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11. Known Bondholders, Mortgagees and Other Security Holders Owning or Holding 1 Percent or more of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → X

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PS Form **3526**, July 2014

13. Publication Title: Psychiatric News	14. Issue Date for Circulation Data Below: 09/01/2023	
15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to filing Date
a. Total Number of Copies (Net press run)	26,511	25,397
b. Paid and/or Requested Circulation (1) Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	26,118	26,129
(2) Mailed In-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	0	0
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(4) Paid Distribution by Other Classes of Mail Through the USPS (e.g. First-Class Mail)	0	0
c. Total Paid Distribution [Sum of 15b. (1), (2), (3), and (4)] ▶	26,118	26,129
d. Free or Nominal Rate Distribution (By Mail and Outside the Mail) (1) Free or Nominal Rate Outside-County Copies Included on PS Form 3541	0	0
(2) Free or Nominal In-County Copies Included on PS Form 3541	0	0
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(4) Free or Nominal Rate Distribution Outside the Mail (Carriers or other means)	88	50
e. Total Free or Nominal Rate Distribution (Sum of 15d. (1), (2), (3) and (4)) ▶	88	50
f. Total Distribution (Sum of 15c. and 15e.) ▶	26,206	26,179
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))		
h. Total (Sum of 15f. and g.) ▶	26,206	26,179
i. Percent Paid (15c. Divided by 15f. Times 100) ▶	99.66%	99.81%

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c. Total Print Distribution (Line 15F) + Paid Electronic Copies (Line 16a) ▶	26,206	26,179
d. Percentage Paid (Both Print & Electronic Copies (16b divided bt 16c x 100) ▶	99.66%	99.81%

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17. Publication of Statement of Ownership
[X] Publication required. Will be printed in the **11/01/2023** issue of this publication. [ ] Publication not required

18. Signature and Title of Editor, Publisher, Business Manager, or Owner	Title	Date
Brian Cole	Senior Publishing Systems Manager	09/28/2023

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LAIs

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combine different LAIs and oral medications in their analysis. "It's not a direct apples-to-apples comparison; this study compared outcomes between people taking two forms of the exact same molecule."

The primary outcome of interest in EULAST was medication discontinuation for any reason, which tried to capture the broad problem of medication adherence: "We let the participants vote with their feet; if they ask to stop their medication or they never show up again, then something went wrong with the treatment."

Overall, 71% of the participants taking oral medications discontinued treatment by 19 months compared with 64% of those taking LAIs—which the authors noted was not statistically different. There were also no differences in treatment discontinuation when comparing the individual medications (aripiprazole or paliperidone).

Kahn cautioned that any one study is not definitive, but "in regard to the claim that LAIs are superior at keeping patients engaged in treatment, the jury is still out."

Adherence Issues

Kenneth Subotnik, Ph.D., an adjunct professor of psychiatry and biobehavioral sciences at the University of California, Los Angeles, said that the EULAST study's focus on numerous treatment discontinuation events allows for a high-level overview of whether patients with schizophrenia can be better managed on LAIs than on oral medications. However, he noted, the design of the trial may have overlooked important advantages of LAIs.

Subotnik led one of the seminal clinical trials that found patients taking LAIs experienced fewer breakthrough symptoms than those taking oral antipsychotics. In that randomized trial of 86 adults with schizophrenia, those who received LAI risperidone were less likely to experience reemergent psychosis symptoms or have a relapse over 12 months compared with adults who took oral risperidone. The participants were assessed every two weeks and pill counts were carefully monitored for the oral group. The results were published in *JAMA* in 2015.

Subotnik noted that since breakthrough symptoms can often be controlled with a dose adjustment or adding another medication, such symptoms may have been missed in the EULAST study.

"I think psychiatrists may overestimate how adherent their patients are to oral medications, which can contribute to some problems," Subotnik suggested. Therein lies another advantage of LAIs, he said. "The injections maintain consistent and persistent levels of the medication in the blood, which makes it easier to differentiate a lack of drug efficacy from a lack of medication adherence."

LAIs: Preventive Tool

The thorniest barrier hindering physicians from prescribing LAIs as an early schizophrenia treatment option may be that "LAIs have been traditionally used for chronically ill patients who have recurrently demonstrated non-adherence, when it might be too late," Rubio said.

Breaking down this barrier may require systems-level changes, he continued. "We need to get physicians to stop thinking of LAIs as a reactive tool and start seeing them as a proactive intervention to prevent relapse and other bad outcomes."

Rubio noted that population data from Finland and Canada have shown that the effectiveness of antipsychotics drops dramatically after each relapse of psychosis, so it's critical to step in early.

Subotnik, who is also associate director of UCLA's outpatient clinic for patients who are in the early course of schizophrenia, agrees that LAIs need to be reframed as a preventive tool. "Studies have shown that there are so many neurochemical changes going on in the first few years after schizophrenia onset, and effective early treatment is the key to preventing further neurocognitive decline," he said.

"Most patients do not view LAIs as a form of punishment or coercion," he continued. "With oral antipsychotics, people with schizophrenia are reminded of their disorder every time they need to take their pill. This no longer becomes an issue with long-acting medications."

The EULAST study was funded by Lundbeck and Otsuka. Subotnik's clinical study was funded by the National Institute of Mental Health with supplementary funding from Janssen Scientific Affairs. Rubio's analysis was supported by Teva Pharmaceuticals. **PN**

"Efficacy of Oral Versus Long-Acting Antipsychotic Treatment in Patients With Early-Phase Schizophrenia in Europe and Israel: a Large-Scale, Open-Label, Randomised Trial (EULAST)" is posted at http://apapsy.ch/EULAST. "Long-Acting Injectable Risperidone for Relapse Prevention and Control of Breakthrough Symptoms After a Recent First Episode of Schizophrenia" is posted at http://apapsy.ch/risperidone. "Predictors for Initiation of Atypical Long-Acting Injectable Antipsychotic Agents in a Commercial Claims Cohort of Individuals With Early-Phase Schizophrenia" is posted at http://apapsy.ch/early-phase-schizophrenia.