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AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

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Christopher Brown, M.D.

SEE STORY BELOW

Psychiatrists throughout the country have provided invaluable services by taking care of current and new patients during this unsettling time and putting their own lives at risk by caring for COVID-19 patients. At the same time, they are caring for colleagues who are experiencing burnout and mental health issues from treating very ill patients, dealing with numerous deaths, and helping grieving families who could not say goodbye to loved ones in person.

5

COVID-19 exposes the need to address U.S. health disparities.

7

SAMHSA Disaster Helpline experiences jump in COVID-19 calls.

21

How to ensure the safety of people with SMI from COVID-19.

Psychiatrists Support Those Working To Save COVID-19 Patients

Over the phone or in person, U.S. psychiatrists have stepped up to help their fellow clinicians in the fight against COVID-19. ***BY AARON LEVIN***

As hospitals and medical centers geared up to manage incoming waves—or floods—of patients infected by the coronavirus, their departments of psychiatry deployed their own expertise to support their colleagues through what often became an unrelentingly stressful ordeal.

"We had a virus coming to an aging population with no immunity and with no specific treatments," said Ed Pontius, M.D., a semi-retired consultant and legislative affairs chair for the Maine Association of Psychiatric Physicians.

"We can only hope that the frontline people can keep up with the numbers of people who get sick, and so we're crucially dependent on the health of those frontline people," Pontius told *Psychiatric News*. "Only a single moment of loss of concentration can result in transmission of the virus and illness."

To help those frontline health care workers cope with that stress, some sites extended existing employee assistance programs, others developed similar models on the fly, while still others wheeled into place the results of longstanding thinking about the particular stressors that accompany the advance of contagion.

Beginning April 1, Maine Medical Center launched two weekly virtual support groups for physicians and nurses.

"The goal of these groups is to offer a confidential time and place to come together with colleagues who are facing the same challenges and find support

see **COVID-19 Patients** *on page 19*

PERIODICALS: TIME SENSITIVE MATERIALS

Psychiatrists Express Concerns Over MH Care During Pandemic

Psychiatrists perceived that the quality of and access to mental health care have been negatively impacted by the COVID-19 pandemic and worry about patients contracting the coronavirus.
BY KATIE O'CONNOR

Quality of and access to mental health treatment have been negatively impacted by the COVID-19 pandemic, according to psychiatrists surveyed in a study posted April 9 in *Psychosomatics*.

Scott Simpson, M.D., M.P.H., medical director of psychiatric emergency services at Denver Health and an associate professor of psychiatry at the University of Colorado Anschutz Medical

see **MH Care** *on page 20*

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

COVID-19 and Advocacy—The Good and the Unacceptable

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

During this time of the COVID-19 crisis, many activities by advocacy organizations for individuals with disabilities, inclusive of mental and substance use disorders and developmental disabilities, are concordant with APA's mission and should receive APA's support. Others are not.

The Good

APA should support the following:

- Calling for new funding initiatives and additional funding or redirecting resources for in-home supports; addressing the critical shortage of personal protective equipment and other medical supplies; establishing paid time off for family caregivers of individuals with disabilities; and appropriating emergency funding for organizations providing treatment to people with mental illnesses, especially programs at risk of being shuttered.

- Pressing for changes in policy to end the Medicaid institutions for mental diseases (IMD) exclusion and

to eliminate the 190-day lifetime limit for care in psychiatric facilities for Medicare beneficiaries; expediting reviews of Supplemental Nutritional Assistance Program (SNAP) COVID waivers; increasing flexibility for using the Temporary Assistance for Needy Families (TANF) funds; and limiting the CMS waiver that allows, at the time of an emergency or disaster, acute care hospitals with psychiatric patients in a separate unit or building to relocate only those patients who might benefit from placement in the general hospital.

- Ensuring enforcement of federal and state statutes banning discrimination in providing health care to individuals with disabilities. On March 31, the *New York Times* reported that "almost all plans give priority to otherwise healthy people who are most likely to fully recover." The biggest stage upon which the nondiscrimination issue is playing out is states' crisis standard-of-care plans that address the rationing of health care. These plans are rooted in formulations by faculty of medical schools and law schools, professional societies, the National Academies of Sciences, and state governments.

A state can be in a position of not intentionally discriminating against people with serious mental illness (SMI), but nonetheless find that these individuals are at the end of the line for treatment. I will address this complicated topic in a subsequent column.

The Unacceptable

There is one facet of advocacy that APA must vigorously oppose and invite other professional organizations to join us in doing so: Recommended responses to the current pandemic should not be used as a subterfuge to advance an organization's long-standing agenda of downsizing or closing public hospitals under the misinformed view that (1) every person with a psychiatric disorder can be treated without any degree of coercion and (2) the psychiatric inpa-

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IN THIS ISSUE

DEPARTMENTS

APA's COVID-19 Resource Center

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

Fourth COVID-19 Spending Bill Includes Funding for Hospitals, Testing

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Although primarily focused on replenishing the Small Business Administration's Paycheck Protection Program, the bill also adds to a provider relief fund originally created by the CARES Act. **BY MARK MORAN**

President Donald Trump last month signed the fourth emergency COVID-19 spending bill, a $484 billion package.

Approved by Congress and signed into law in the last week of April, the spending package was mainly intended to prop up the Small Business Administration's Paycheck Protection Program, which ran out of money earlier in the month following a run on claims for assistance.

But the Paycheck Protection Plan and Healthcare Enhancement Act (HR 266) also provides $100 billion in supplemental appropriations to the Department of Health and Human Services (HHS) for the Public Health and Social Services Emergency Fund. This includes $75 billion to reimburse health care providers for health care–related expenses or lost revenues that are attributable to the coronavirus outbreak in addition to the $100 billion approved in late March under the Coronavirus Aid, Relief, and Economic Security (CARES) Act; and $25 billion for expenses to research, develop, manufacture, administer, and expand capacity for COVID-19 tests to effectively monitor and suppress COVID-19.

In the run up to the bill's passage, APA and 11 other mental health and substance use treatment organizations sent a statement alerting Congressional leadership to the urgent need for direct funding to behavioral health and substance use treatment programs from the provider relief fund enacted under the CARES Act. While the spending bill approved last month did not specifically include funding for behavioral health, some mental health and substance use treatment programs may benefit from the funding.

HHS posted a fact sheet about the provider relief fund. APA has also posted guidance to practitioners regarding provider relief and other practice issues related to COVID-19 on the APA website (see end of article for links).

Meanwhile, APA and other medical and mental health specialty groups continue to work with Congress and the Trump administration to maintain and increase support for community behavioral health programs.

"Before the pandemic broke out, there was bipartisan consensus that addressing mental health, substance use, and suicide were urgent national priorities. Congress took preliminary steps to increase funding for mental health and addiction services, but these investments may soon be lost because of the financial strain COVID-19 has taken on our mental health and addiction system," the coalition said in a statement sent to Congressional leaders last month.

Citing a survey conducted by the National Council for Behavioral Health (see story on page 6), the coalition noted that many behavioral health organizations "don't have the funds they need to ride out this crisis." The survey of 880 behavioral health organizations across the country revealed that 62% believe they can survive financially for only three months or less under current conditions. "Organizations have canceled, rescheduled, or turned away 31% of patients, and 92% have reduced their operations," they wrote.

The statement noted that the CARES Act included funding to health care professionals, with a priority on paying hospitals through Medicare. However, community behavioral health organizations rely primarily on Medicaid and have largely been left out of critical emergency funding. "We urge Congress to dedicate significant resources specifically to supporting community behavioral health programs during the crisis," the coalition stated. **PN**

The text of the Paycheck Protection and Healthcare Enhancement Act is posted at https://www.congress.gov/bill/116th-congress/house-bill/266. Guidance from APA regarding the provider relief fund and other COVID-related practice issues is posted at https://www.psychiatry.org/psychiatrists/covid-19-coronavirus/practice-guidance-for-covid-19. The HHS fact sheet about the provider relief fund established by the CARES Act is posted at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html.

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tient setting is not the most integrated setting appropriate for anybody.

Advocacy organizations calling for the wholesale discharge of patients, even with new funding (which isn't going to happen when states are cutting budgets), still haven't learned the harmful consequences of discharging patients who still require hospitalization. National advocacy organizations are apparently so far removed from contemporary community practices that the services they say will meet the needs of discharged patients are not functioning in any way that would allow them to take on new referrals. It's unfortunate that these advocacy groups have yet to learn it takes more than good will and money.

There is no doubt that there are risks in having a large number of people with SMI in a hospital. In an article that I wrote with Margarita Abi Zeid Daou, M.D., published in *Psychiatric News* last month (https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2020.4b39; see follow-up article on page 21), these dangers were fully laid out. For a national advocacy group to point out only the downsides of patients staying in the hospital and be silent on both the benefits of hospitalization and the liabilities of being discharged is terribly irresponsible. And the peril is compounded because, as has already happened, state-level advocacy groups take up the call and potentially lead an unsuspecting governor, trying to take the right action, to further compound the state's problems regarding ill-served people with SMI on the streets, in shelters, in front of a judge, in jails/prisons, or in a morgue as an unclaimed body after a premature death.

The benefits of hospitalization during this pandemic include not being alone, getting daily psychiatric and medical care (much of it face to face), eating nutritional meals (and having staff to assist you if you choke), having someone to pick you up if you fall because you can't get up on your own, engaging in social activities, having suicide risks mitigated, staying out of homeless shelters and jails, being able to visit with family electronically through video chats, having quick access to testing for COVID-19, being nursed by trained staff when you feel awful because you have symptoms of COVID-19, not being afraid to take a walk outside (because the hospital has areas where you can safely do that), having someone to talk with you in the middle of the night because you can't sleep and your anxiety is worse than ever, having proper medication available without interruption, having toilet paper and hand sanitizer. ...

An Example

I am ending this column with a description of what is happening at one state hospital during the COVID-19 pandemic so those who advocate that now is the time to protect the lives of people with SMI by releasing them from the hospital might realize the error of such thinking.

On April 15 the census of this hospital, which is usually at or near 100%, was at 84% due to fewer admissions from courts and discharges following the normal course of business. Thus, there has been a little more room on the unit to distance patients farther from each other. Only staff are permitted to enter the building and only if they have no positive response to screening questions and no elevated temperature as determined by measurement taken in a tent at the front door. All staff are required to wear masks; staff who refuse are sent home.

On April 15, all patients were tested for COVID-19 (only three refused to be tested), and all patients started to wear masks. Patients stay on their units, where rehabilitation activities and leisure activities occur. These procedures have gotten results. At the same time that the hospital tested all its patients, the homeless shelter in the city, which like any such shelter does not have an insignificant number of residents with SMI, tested all its residents. The percentage of the 114 shelter residents who tested positive for COVID-19 was 43%; the percentage of the 243 hospital patients who tested positive-positive for COVID-19 was less than 1%.

Every Friday afternoon I co-lead a dance party on a unit where I am an attending psychiatrist. One of my patients, who has very serious social inhibitions, is my co-leader. Neither of us dances very well, but a social worker who moonlights as a dance instructor helps us out. Both staff and patients participate, and we follow social-distancing rules. It's a raucous time. Does anyone know any individuals with SMI living in the community who are going to a weekly dance party during the COVID-19 pandemic? **PN**

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Experts Warn Efforts to Contain COVID-19 May Increase Risk of Suicide

Social isolation reduces the risk of infection, but it also reduces contact with friends, family, community support, and health care services—all of which can increase risk of suicide. **BY NICK ZAGORSKI**

The rapid spread of COVID-19 has led officials across the country to enact measures aimed at reducing contact with other people and slowing virus transmission. Dramatic actions can have unintended consequences, however. In an article published in *JAMA Psychiatry*, mental health experts described one such consequence of extended social isolation—an increased risk of suicide.

"Concerns about negative secondary outcomes of COVID-19 prevention efforts should not be taken to imply that these public health actions should not be taken," wrote Mark Reger, Ph.D., the chief of Psychology Services at the Veterans Affairs Puget Sound Health System, and colleagues. "However, implementation should include a comprehensive approach that considers multiple U.S. public health priorities, including suicide prevention."

The authors highlighted nine broad areas where the pandemic and subsequent social isolation measures may increase the risk of suicide:

- Job loss and economic stress.
- Isolation from friends/family, including those in the hospital.
- Decreased access to churches and community centers that provide social support.
- Additional barriers to mental health services, including the restriction of visitors accompanying patients.

Though stress and anxiety are commonly mentioned as triggers for suicide risk during COVID-19, feelings of guilt may also contribute to suicide risk. —Maria A. Oquendo, M.D., Ph.D.

- Worsening medical problems due to stress and other factors.
- Increased stress and burnout among health care professionals.
- National anxiety from 24/7 news coverage of the pandemic.
- Increased sales of firearms, the most common method of suicide in the United States.
- Seasonal late-spring/early summer convergence of peak COVID-19 prevention efforts and peak rates of suicide in the United States.

"We should also not overlook that in addition to stress and anxiety, many people are struggling with guilt, which is known to have toxic effects on mental health," added suicide expert Maria A. Oquendo, M.D., Ph.D., the Ruth Meltzer Professor and Chair of Psychiatry at the Perelman School of Medicine at the University of Pennsylvania and past president of APA. Such guilt can include worries that one is not doing enough to help care for others or fears over potentially exposing others to the virus, she told *Psychiatric News*. There is so much uncertainty about how this virus spreads and who might be infected (increasing analyses suggest that there are a high number of asymptomatic COVID-19 cases) that some people feel guilty even doing necessary activities like grocery shopping, she said.

Despite this endless barrage of stressors, there are opportunities to improve suicide prevention efforts during the pandemic, Reger and colleagues noted. They recommended that health professionals take steps now to determine ways to incorporate mental health screening into COVID-19 screening and prevention efforts and look for additional ways to reach patients using tele-mental health services. They also noted the value of social media to help patients maintain social connections despite physical restrictions.

Professionals can also show support to patients through brief, supportive letters or emails, the authors noted. This concept of "caring letters" has been around for decades, and some studies have shown these letters to be an effective tool to prevent suicide.

"There may be a silver lining to the current situation. Suicide rates have declined in the period after past national disasters (for example, the September 11, 2001, terrorist attacks)," Reger and colleagues wrote. "One hypothesis is the so-called pulling together effect, whereby individuals undergoing a shared experience might support one another, thus strengthening social connectedness."

Oquendo agreed that it is not uncommon for suicide rates to recede in the context of a major crisis, "but we cannot be complacent; the entire population is going through a period of heightened stress right now. In the next few months, we will see the psychiatric [aftereffects] of this crisis emerge." **PN**

"Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm?" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2764584.

Black Community Especially Vulnerable to COVID-19

Higher rates of hospitalization and death among black people cast health disparities in the United States in stark relief.

BY TERRI D'ARRIGO

The COVID-19 pandemic is disproportionately affecting black people, according to a study in the *Morbidity and Mortality Weekly Report* published online April 8.

Shikha Garg, M.D., and colleagues at the Centers for Disease Control and Prevention (CDC) analyzed data from the COVID-19–Associated Hospitalization Surveillance Network, which collects information about laboratory-confirmed COVID-19 hospitalizations in 14 states. Of the 1,482 patients in the network who were hospitalized with COVID-19 in March, the race or ethnicity of only 580 were known. Among those, 33.1% were black, whereas only 18% of the people who live in the areas surrounding network hospitals are black. In contrast, 45% of those hospitalized were white, more on par with the 59% of local residents who are white.

Racism affects health outcomes through close alignment with socioeconomic status, says Morgan M. Medlock, M.D., M.Div., M.P.H.

As individual states have begun to compile and post COVID-19 statistics, the disparity becomes more apparent.* In Michigan, blacks account for roughly 14% of the population but 30% of COVID-19 cases and 40% of COVID-19 deaths. In Louisiana, blacks account for 33% of the population but 56% of COVID-19 deaths.

The disparity has also played out in cities. According to figures posted by the city on April 21, 593 Chicago residents had died of COVID-19, and 323 of those deaths—54.5%—occurred in blacks, yet current U.S. Census figures suggest that blacks make up only 30% of the city's population. In Milwaukee County, nearly 50% of confirmed COVID-19 cases and more than 50% of deaths from COVID-19 have occurred in blacks, who make up just 27% of the population.

The federal government should seek input from minority experts to address health disparities, says APA CEO and Medical Director Saul Levin, M.D., M.P.A.

Underlying conditions that are more prevalent in blacks, such as diabetes and hypertension, may be contributing to the substantially higher COVID-19 hospitalization and death rates in the black community. However, there are social factors at work as well, said Morgan M. Medlock, M.D., M.Div., M.P.H., an assistant professor of psychiatry at Howard University Hospital in Washington, D.C. She is the immediate past vice chair of APA's Council on Minority Mental Health and Health Disparities.

"We need to name racism," Medlock told *Psychiatric News*. "Racism impacts health outcomes through close alignment with socioeconomic status in this country. It is a structural entity that operates on institutions and in interpersonal dynamics, and it operates through internal mechanisms where a person who is subjected to an oppressive system may internalize the message 'you are not valuable.' Racism, operating on these three levels, has devastating effects on mental and physical health.

"As we think about solutions, we must think about why the statistics are so devastating for minorities living in cities," Medlock added. "Many are locked out of access [to health services] due to segregation, marginalized to inadequate employment, and exposed to poverty and other stressors. City governments need to think about policies that protect these communities."

Medlock said the Coronavirus Aid, Relief, and Economic Security (CARES) Act could serve as a model for similar legislation to address these issues.

"The CARES Act provides concrete mechanisms for how we can address the economic factors that are interwoven with this crisis," she said. "Why not pass something similar in Congress that also acknowledges the devastating effects of structural racism [and] addresses wealth inequality and access to health care?"

In a statement last month, APA CEO and Medical Director Saul Levin, M.D., M.P.A., called for government action and pledged APA's assistance.

"It is time that the Trump administration convene a group of minority experts to create implementable steps to abolish health inequities in African American, Native American, and Hispanic communities," Levin said. "We stand ready to help." **PN**

"Hospitalization Rates and Characteristics of Patients Hospitalized With Laboratory-Confirmed Coronavirus Disease 2019—COVID-NET, 14 States, March 1–30, 2020" is posted at https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm.

**Data on COVID-19 infections, hospitalizations, and deaths change daily. These figures were current as* Psychiatric News *went to press.*

APA Suspends In-Person Meetings for Rest of 2020

APA CEO and Medical Director Saul Levin, M.D., M.P.A., has announced that the Executive Committee of the Board of Trustees has voted to hold all of APA's scheduled meetings for the rest of the year on virtual platforms. The decision is based on the uncertainty surrounding the COVID-19 pandemic. The meetings include those of the Joint Reference Committee, Board of Trustees, Assembly Executive Committee, components in September, Assembly, and Area Councils. In addition, Levin and the Executive Committee have restricted all business travel for the remainder the year.

"We have had success with virtual meetings while under 'stay-at-home' orders and hope to continue to improve the ability to use technology during this crisis so that we can protect the safety of members and the administration while also conducting business as usual," said Levin.

Behavioral Health Organizations Struggle Financially During Pandemic

Many behavioral health organizations reported in a survey that they may be able to keep their doors open only a few months longer due to the financial impact of the COVID-19 pandemic. **BY KATIE O'CONNOR**

"People have ongoing mental illness needs," says Joe Parks, M.D. "Pandemics and economic crises don't mean people with schizophrenia or bipolar disorder get better. They still need follow-up visits and refills, psychosocial support, and help to maintain their housing."

Almost two-thirds of community behavioral health organizations (CBHOs) believe they can survive financially only for three months or less under the economic conditions resulting from the COVID-19 pandemic, according to an online survey.

The survey was conducted April 6 to 12 by the National Council for Behavioral Health and ndp | analytics, an economic and communications research firm. It included responses from 880 CBHOs located all over the United States and revealed that organizations have had to turn patients away, close programs, and generally reduce their operations as the economic realities of the current pandemic climate have set in.

Over 60% of CBHOs across the country have closed at least one program due to COVID-19, according to the survey, while 31% of organizations have canceled or rescheduled appointments or turned away patients. The impacts have been more severe for smaller organizations that serve 2,000 patients or fewer annually.

Nineteen percent of CBHOs believe they could survive only one month or less under the current COVID-19 conditions, the survey found. Only 9.4% of organizations believe they could survive a year or more.

Throughout the COVID-19 pandemic, APA has urged Congress to provide funding to behavioral health organizations.

"The COVID-19 pandemic could cause mental health care capacity to diminish across the country, just when communities need care the most," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "If behavioral health organizations are forced to close, tens of thousands of patients will find themselves without necessary and life-saving mental health and addiction treatment."

Losing access to care at CBHOs could force patients to turn to emergency departments (EDs) because they have nowhere else to go, which is not ideal in the era of COVID-19, pointed out Joe Parks, M.D., medical director of the National Council for Behavioral Health. People with mental illness have two to three times the rate of medical illness compared with the rest of the population, he said, as well as other risk factors that make them especially vulnerable to COVID-19.

CBHOs often serve as the vital link between patients with mental illness and primary care so they can get treatment for both their physical and mental illnesses. In addition to physical and mental health services, CBHOs also provide patients with community supports, from job training to housing services and food assistance.

CBHOs don't just have an impact on patients, they also provide employment opportunities for providers and many other support staff in the community. In terms of the impact on employees, 46.7% of all CBHOs have had to, or plan to, lay off or furlough employees, according to the survey results. More furloughs and layoffs have taken place, or are planned, at organizations serving 8,000 patients or more.

CBHOs do not have regular or widespread use of personal protective equipment (PPE) normally, so most centers had limited PPE stock to begin with. But now, these CBHOs have also been dealing with a significant lack of PPE, with 82.9% reporting that they don't have enough PPE for two months of operations.

"Behavioral health organizations need equal priority with the rest of health care," Parks said. Just like other health facilities, CBHOs need access to PPE and testing capabilities so they can provide in-person care when necessary, and they need to be reimbursed for telemedicine services when in-person care is not an option, or is easier and clinically appropriate. "If we want our EDs to function well, we need our behavioral workforce to be strong throughout this pandemic," he said.

Parks said there will likely be a surge of need for mental health services soon, as the country reels from the economic and social impacts of the pandemic. "We should anticipate the next surge and ensure we have the mental health capacity and workforce to meet the need.

"We need to get our priorities straight," he added. **PN**

"COVID-19 Economic Impact on Behavioral Health Organizations" is posted at https://www.thenationalcouncil.org/wp-content/uploads/2020/04/NCBH_COVID19_Survey_Findings_04152020.pdf?daf=375ateTbd56.

ETHICS CORNER

Getting Paid by Patients During the Pandemic

BY CLAIRE ZILBER, M.D.

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

Now that many of us have adapted to telehealth and electronic prescribing, the next hurdle is getting paid. If your practice, like mine, has been limited to cash and checks, your patients may be asking whether you accept any of several money transfer apps, credit cards, or other electronic forms of payment. This column is not an endorsement of any product. It merely reports on what I've learned as I researched the question: Which electronic payment system is most confidential with the least hassle?

Credit cards are certainly the most familiar. With an app like Square, you can enter a patient's credit card information and have the money deposited directly into your bank account. You are charged 3.5% plus 15 cents per transaction for a manually entered credit card number (less if you swipe the card, but that's not available via telehealth). Many medical practices accept credit card payments for copays, so this will feel familiar to patients. Some health care professionals record the patient's credit card information and automatically charge the card for each appointment. If you're planning to do this, you should have a written contract in which the patient agrees to the charges, including for late cancellations and no shows (if you have a policy about charges for these situations). Furthermore, it is imperative that you store the credit card information in a secure manner.

Many telehealth platforms include a payment feature. For example, DoxyMe displays a payment button to patients while they are in the virtual waiting room and during the session. Patients may enter a credit card number, which is processed through Stripe, an internet-based payment platform. Similar to other credit card payments, the charge is 2.9% plus 30 cents per transaction. Risk management advisors approve of this modality because the payment occurs through a HIPAA-compliant platform with which you already have a Business Associates Agreement (BAA).

Alternatively, you could choose one of a number of payment apps, such as Venmo, PayPal, or ApplePay. Each of these systems encrypt their data, but each can be hacked. They charge fees similar to credit cards for payments to businesses. For example, Venmo charges 2.9% plus 30 cents per transaction. Venmo advertises smaller fees for person-to-person transactions, but our practices are businesses. An additional concern with these platforms is their connections to social media accounts or other "outward-facing" connections on the internet. There is real concern that these companies scrape and sell transaction informa-

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SAMHSA Disaster Helpline Sees Increase In COVID-19 Related Outreach

SAMHSA plans to analyze data from its crisis helpline calls to better understand which individuals have an increased need for mental health services and the concerns that led them to seek help. **BY EMILY KUHL, PH.D.**

The Substance Abuse and Mental Health Services Administration (SAMHSA) has seen an 890% increase in the number of people calling its Disaster Distress Helpline, a subnetwork of the national Suicide Prevention Lifeline.

According to Richard McKeon, Ph.D., M.P.H., chief of the Suicide Prevention Branch at SAMHSA's Center for Mental Health Services, the jump in crisis calls to the Disaster Distress Helpline began when awareness of the COVID-19 pandemic intensified in the United States (approximately early March). And although many of the network's 170 local crisis call centers have also reported increases in call volume, McKeon noted that calls to the national Suicide Prevention Lifeline have not changed dramatically.

"The response to COVID is the largest-scale response in the Disaster Distress Helpline's history," he said.

Some states, such as Maine, also have implemented warmlines—telephone lines for mental health support and needs that have not yet reached a crisis stage—for frontline emergency and medical staff and other first responders to access support for job-related stress, anxiety, depression, trauma, sleep disturbance, substance misuse, and other psychiatric symptoms. These warmlines were not developed in response to the COVID-19 pandemic. Nonetheless, they represent an important pathway to mental health services for clinicians and other professionals struggling with concerns about the virus and its effects (for example, social isolation, job loss, and family separation).

McKeon said that SAMHSA has plans to analyze in greater detail the content of and patterns among COVID-19 calls (for example, geographic origin, and caller demographics) to the Disaster Distress Helpline with the goal of better understanding which individuals are expressing an increased need for mental health services stemming from the pandemic as well as the nature of their concerns (for example, isolation and job loss).

"Everything that is happening now just underscores the importance of the availability of these services—both the national Suicide Prevention Lifeline and the Disaster Distress Helpline," explained McKeon. "In a time when face-to-face services are not always possible, having the availability of these services—remotely and around the clock, without charge—is more important than ever."

Lifeline Boosted by Local Centers

Since 2001, SAMHSA has provided infrastructure funding to the Suicide Prevention Lifeline network crisis call centers in all states and the District of Columbia. The Lifeline answers an average of about 2.2 million calls annually, two-thirds of which are directed to one of the local crisis centers. The remaining are military-related calls routed to the Veterans Administration hotline.

"The national Lifeline effort really rests on the shoulders of the local crisis centers that answer these calls," said McKeon. "These local community crisis centers need all the support they can get moving forward in their mission. Although SAMHSA tries to provide what support we can to their efforts, some receive very limited, if any, [local] government funding."

Local crisis centers engage in a variety of tasks. They first work to calm the caller, as described in the Lifeline's Guidelines for Callers at Imminent Risk; use mobile outreach teams when available; and dispatch police or ambulance assistance only as a last resort. Ensuring caller safety and welfare is also imperative. Although dissemination of mental health information and mental health service referrals are not their core responsibilities, they do perform these duties.

"About 25% to 30% of callers are actively suicidal at the time of the call," said McKeon. "Other calls might be family members concerned about someone or a person thinking about suicide not on that day but maybe recently. So, there's a certain diversity to the calls on the Lifeline."

Call centers are also diverse in their capabilities. For instance, unlike the Veterans Crisis Line, most local crisis centers do not have access to callers' electronic medical records and thus do not have their medical and psychiatric histories on hand. However, some call centers do have expanded capabilities for individualized service. For instance, Georgia's Crisis and Access Line is run by Behavioral Health Link service, which allows dispatchers to make real-time appointments for callers in the state's community mental health system.

Although some local crisis centers have seen a growing influx of calls since the COVID-19 crisis began, McKeon emphasized the significance of psychiatrists' involvement in these centers year round, whether as volunteers or as sources for follow-up treatment and service provision.

"Every crisis center needs places to refer to. And there may be other kinds of consultation that psychiatrists could provide or relationships that could be established, and that varies from center to center," he stated. "But if psychiatrists are willing to accept referrals from a crisis center in their area, that would be most welcome."

Interested psychiatrists should contact their local crisis center to ask how they can best serve the hotline and its callers. Local crisis center contact information is posted at https://suicidepreventionlifeline.org/our-crisis-centers (scroll down to "Find Your Center"). **PN**

The Disaster Distress Helpline can be reached by phone at (800) 985-5990 or by text at 66746 and enter "TalkWithUs." The National Suicide Prevention Hotline's phone number is (800) 273-8255.

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tion. You can set your Venmo account to be private, but what if patients fail to do that and their payment for psychiatric services is able to be viewed? To what extent is the psychiatrist responsible for ensuring confidentiality despite patient error in the way patients use the app? The risk management advice I received from my malpractice carrier was to avoid these systems.

Another option is Zelle, a bank-to-bank money transfer system. According to my banker, all major banks participate in Zelle, but the individual customer must sign up to use it. I already use Zelle personally to receive rent payments. For transfers to a business account, Zelle charges a 2.5% fee, with a minimum of 25 cents and a maximum of $15 per transaction. Large transactions (that is, over $750) may not go through initially, but will be approved after a few smaller payments have been accepted. The transaction limit may depend on the payee's bank policy. My banker assures me that data from Zelle are not sold. Although my risk manager expressed concern about Zelle, it does seem equivalent in privacy loss to writing a check: a patient's name, address, and bank information are on checks, and that information goes to my bank. It isn't automatic for a bank or Zelle to sign a BAA, without which this is not a HIPAA-compliant payment method. You may be able to get away with it during the pandemic while HIPAA rules are relaxed, but you shouldn't continue to use Zelle once business practices return to normal.

It will be interesting to see which of the many ways we are adapting our practices will lead to permanent changes in the business of psychiatry and which are merely temporary adjustments. If you choose to use an electronic form of payment, consider whether you will continue after the pandemic subsides and the relaxed HIPAA restrictions are lifted. If so, you must be sure to present patients annually with a HIPAA notice of privacy practices and receive their signed acknowledgement of receipt. If not, how do you plan to get patients to revert to the old ways of doing business?

While reviewing this topic in a recent district branch meeting, one colleague wryly suggested an additional payment option: Barter for toilet paper and hand sanitizer. Let me know how that goes. **PN**

APA Member's Gift to Fund Psychiatric Neuroscience Lecture

Henry A. Nasrallah, M.D., and Amelia Nasrallah, M.A., wanted to give back to APA and increase knowledge and awareness of the latest psychiatric neuroscience research. **BY KATIE O'CONNOR**

A generous donation to the APA Foundation from long-time APA member Henry A. Nasrallah, M.D., and his wife, Amelia, will fund the Nasrallah Family Award for Advances in Psychiatric Neuroscience.

Nasrallah, a professor of psychiatry, neurology, and neuroscience at the University of Cincinnati College of Medicine, has supported APA for over 40 years as a member and distinguished life fellow, as well as an active attendee and presenter at APA's Annual Meeting and member of APA committees.

The winner of the annual award, which includes a $5,000 honorarium, will present a lecture at APA's Annual Meeting detailing the latest developments in psychiatric neuroscience.

"APA is the most important psychiatric organization in the world," Nasrallah said. "I thought the time was right to give the Foundation a gift that would make a difference."

Amelia Nasrallah, M.A., Nasrallah's wife, is a psychologist who previously served as director of clinical research management in the Department of Psychiatry and Behavioral Neuroscience at the University of Cincinnati and currently works as senior managing editor of *Schizophrenia Research* and *Biomarkers in Neuropsychiatry*. Brain research in psychiatry is important to them both, Henry Nasrallah said.

"Neuroscience is a very important part of psychiatry, and as a psychiatric neuroscientist, I wanted to promote neuroscience literacy among my APA colleagues," he said. Psychiatry is rapidly becoming a clinical neuroscience discipline, in addition to being a psychosocial discipline, he added. "By establishing a lectureship about psychiatric neuroscience at the Annual Meeting, I hope it will be a tangible way that we can transmit that message and help bring world-class psychiatric neuroscientists to speak," he said.

Henry A. Nasrallah, M.D., and Amelia Nasrallah, M.A., value brain research as an important aspect of psychiatry. "Everything psychiatrists and psychoanalysts do is actually based in neuroscience," Henry Nasrallah, M.D., says.

Separating psychiatry and neuroscience has created the misconception among the public, and sometimes among professionals, that the mind and brain are somehow separate entities, Nasrallah said. But the most important job of the brain is to generate the mind, he pointed out.

Bridging the gap between psychiatry and neuroscience would help patients who suffer from the stigma that surrounds mental illness. Many mental illnesses are thought to be the fault of the patient or a sign of weakness.

"Nobody stigmatizes someone with stroke or Parkinson's disease," Nasrallah said. "Actually, those patients receive a lot of compassion. I want the same thing for people with schizophrenia or bipolar disorder. We must erase the stigma that harms our patients, makes them feel miserable, and discourages many psychiatric patients from seeking potentially life-saving medical care." **PN**

RESIDENTS' FORUM

Medical Training, Teamwork Counter Fear, Anxiety on COVID-19 Floors

BY ALEXANDER LEGGE, M.D.

As a psychiatry intern at Montefiore Medical Center, I finished my internal medicine rotations in December. For three months this year, I rotated on an adult inpatient psychiatric unit. During March, the spread of COVID-19 throughout New York City resulted in several sequential changes to the unit, including a system whereby half of the interns would work from home to maintain social distancing. Daily activities on the unit, including therapy groups, became progressively more restrictive as COVID concerns grew.

On Sunday, March 29, my intern class had an emergency Zoom meeting during which we learned that deployment to COVID floors was imminent for all of us, part of a coordinated institutional effort to handle the COVID surge. Just three days later, I was notified of my deployment to an inpatient medicine unit. While I was among the first psychiatry residents to be deployed, many others have joined me at different times and locations (including all able PGY-1 and PGY-2 trainees). As of the last week in April, all inpatient units at Montefiore were

Alexander Legge, M.D., is a first-year psychiatry resident at Montefiore Medical Center in the Bronx, N.Y.

equipped to manage all or mostly all COVID-positive patients. Even the inpatient psychiatry unit, which remained COVID-free until recently, now has several COVID-positive patients with psychiatric disorders. Montefiore also strategically created several temporary units using a variety of spaces, such as lecture halls and outpatient clinics.

Deployed psychiatry residents are considered "allied" specialists, meaning we are always partnered with internal medicine residents. We are also strictly assigned to inpatient medical floors, *not* to emergency departments or intensive care units. Shifts for most of us are 12 hours (7 a.m. to 7 p.m.) and arranged in alternating blocks of seven days "on" and seven days "off" (including possible "jeopardy" days when we may be called in to relieve sick colleagues).

There is a substantial amount of fear and anxiety involved in COVID work. However, in many ways my deployment experience has been relatively straightforward. My assigned unit is small, and my team has consistently covered fewer than 10 patients, so I typically carry only three to five patients at a time. I feel very fortunate in this regard because fewer patients mean limited exposure. Some of my colleagues deployed elsewhere are carrying more patients and sicker patients.

"Pre-rounding" is done exclusively via chart review, so the first bedside encounter for each patient is usually during attending rounds. Later in the day, we avoid reentering rooms unless a patient requires urgent bedside assessment, perhaps due to a declining oxygen saturation level (the most common reason for reentering a room). Sometimes we can monitor patients from the hallway, thanks to newly installed windows on each door. There is also a constant effort to minimize exposure for other team members. For instance, blood draws are typically limited to once daily, and timing of medication is adjusted to minimize the frequency of nurses having to enter the room.

Other medical specialists can often perform consultations remotely, assessing the patient based on chart review before providing recommendations. Overall, this approach to inpatient care minimizes exposure risks for everyone. It also creates more reliance on the medical chart. At times, it feels as though we are working remotely from the proximity of the nursing station.

Visitors are typically forbidden, so it is crucial to call families on a daily basis. Fortunately, my training in psychiatry has already been a boon to my phone communication skills. Our psychiatry department also distributed several scripts to help navigate difficult conversations. Personally, I feel extremely fortunate in that I have not needed to have the *most* difficult conversation with any family member. Despite the disturbing volume of patients who are very sick, there is a larger volume of patients

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How Are OCD Patients Coping With COVID-19?

The responses of patients with OCD to COVID-19 appear to be as varied as their symptoms of the disorder. **BY NICK ZAGORSKI**

PortraitPro 12

Eric Storch, Ph.D., says concerns over COVID-19 have led to worsening of symptoms in some OCD patients, including symptoms that are not primarily driven by contamination/cleanliness obsessions.

As COVID-19 continues its spread, most Americans are adapting to a new normal that includes increased hand washing, actively thinking about not touching one's face, and avoiding close physical contact with others. For some patients with obsessive-compulsive disorder (OCD), these are familiar practices.

For the mental health professionals who treat OCD patients, the COVID-19 pandemic has led to interesting questions: How are patients managing their symptoms in a time when ritual cleaning is encouraged? And, should therapists adjust their strategies in this unusual time?

"Interestingly, many of the patients in our clinic have not experienced worsening OCD symptoms during this crisis," said Eric Storch, Ph.D., a professor and McIngvale Presidential Endowed Chair in the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine. "They may experience some stress and anxiety, but the levels are on par with the levels most people without OCD will exhibit," he told *Psychiatric News*.

As Storch explained, OCD symptoms largely fall into four broad domains: contamination/cleaning obsessions and compulsions, intrusive thoughts related to taboo subjects (typically sex, religion, or harm), obsessions/compulsions with symmetry and order, and ritualized checking (for example, turning a door lock a certain number of times before going to bed each night).

"Even among people with contamination fears, it's not always germaphobia; it's whatever a patient perceives as excessively disgusting," noted Allen Weg, Ed.D., a psychologist and director of Stress and Anxiety Services of New Jersey.

There are signs that some patients with OCD, whose anxiety revolves around germs and infection, are struggling with the COVID-19 outbreak, Weg continued. "I have had patients tell me that their worst fears have just been realized," he said.

Storch added that patients exhibiting other OCD symptom types can also be affected by COVID-19. He described a patient with harm-related worries who believes he is an asymptomatic COVID-19 carrier, which has worsened the patient's avoidance behaviors.

Working with OCD patients to modify their behaviors may be complicated by COVID-19. The cornerstone of OCD treatment is exposure and response prevention therapy, an approach in which patients confront their compulsions in a safe setting and then try not to conduct their typical ritualized response.

During the pandemic, Weg said he is being cautious about using direct exposure techniques, especially around hand washing or home cleaning rituals, with his patients. "It is somewhat risky for us to discourage these behaviors given the reality of this pandemic," he said. "But we still can employ other principles of exposure therapy to help patients change their habits, while also managing general anxiety levels to prevent an exacerbation of symptoms."

see **OCD Patients** *on page 11*

continued from facing page

who rebound, sometimes dramatically, with the help of inpatient medical support.

Because of a possible exposure during my last week on psychiatry, I underwent mandatory COVID testing after my third deployment shift. The test was negative, and I continue to remain asymptomatic. This is an encouraging sign that my personal protective equipment (PPE) has been effective. Throughout each day, I wear both N95 and surgical masks (provided daily in the hospital lobby). Whenever I enter patient rooms, I also wear a face shield, two gowns, and two pairs of gloves. Importantly, I sanitize and/or wash my hands obsessively throughout the day.

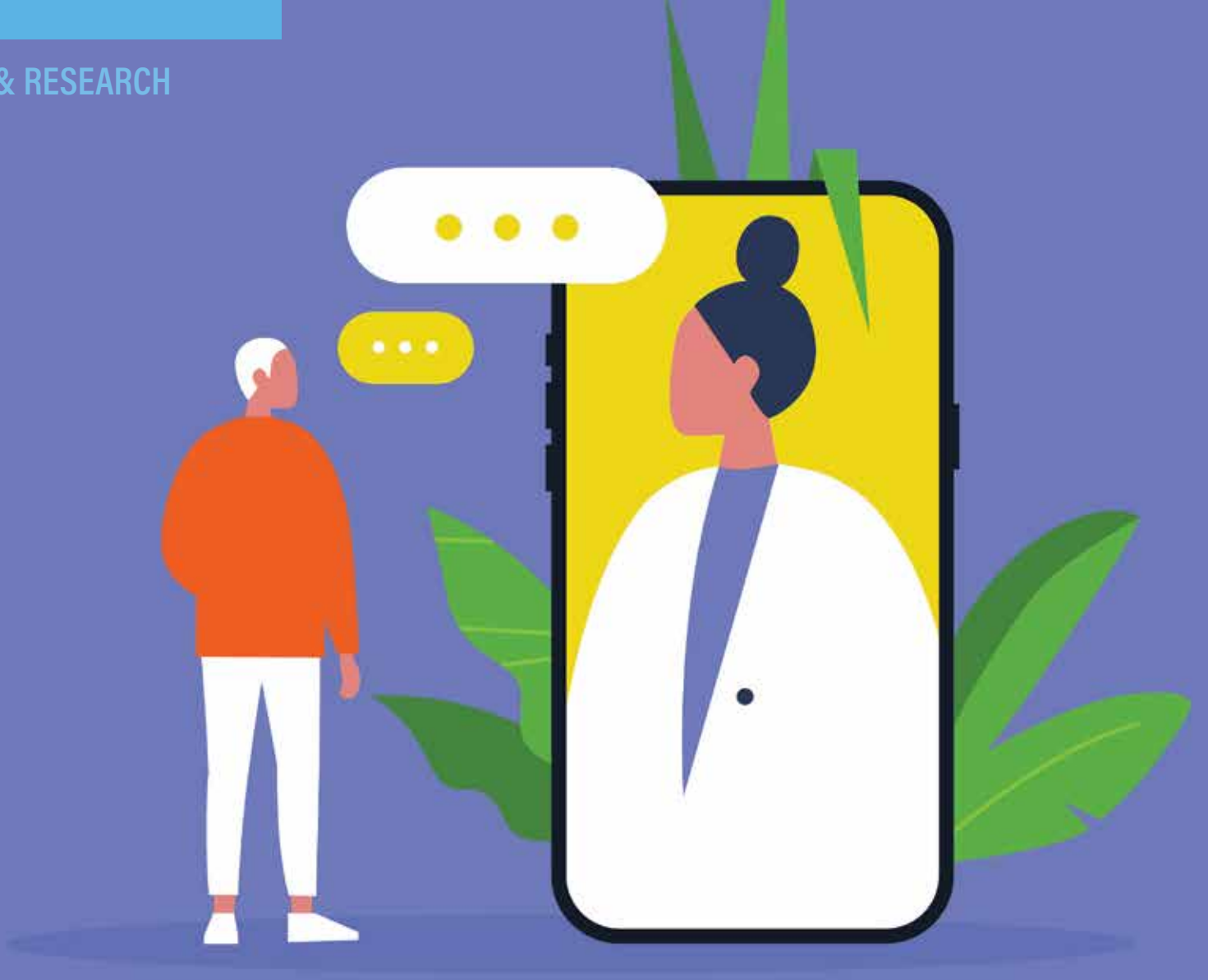
A recurring theme of the pandemic continues to be the omnipresent uncertainty about how everything will unfold. Uncertainty regarding individualized medical decisions poses frequent challenges during deployment. Team-based support has been especially helpful when facing these challenges. My team seemed to develop a sense of mutual respect and camaraderie almost instantaneously. We have also been fortunate to have downtime during most afternoons, making it easier to provide personal support to each other. Meanwhile, we try to expand our understanding of COVID together by looking over new data and sharing resources. Montefiore's institutional policies for COVID management, which are updated daily, have also illuminated a few "high-yield" knowledge gaps to review. Overall, I feel prepared by my ongoing medical education.

In closing, I want to emphasize the following to psychiatry colleagues elsewhere:

- Consistent and vigilant use of PPE helps prevent exposure to the virus. There has been an adequate supply of PPE at Montefiore throughout April.

- The fear and anxiety, in my opinion, are not only to be expected, they also serve as healthy motivators to be hypervigilant about handwashing and use of PPE.

- Finally, my medical knowledge base after completing the medicine rotations required by the Accreditation Council for Graduate Medical Education in December has been appropriate. When coupled with ongoing learning and the invaluable support from a great team, I have been able to fulfill my deployment responsibilities. **PN**



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We're All Telepsychiatrists Now

Telepsychiatry has shown its value and effectiveness for certain populations. Now suddenly many of the barriers that prevented its widespread adoption have been lowered, and it's going to be hard to "put the genie back in the bottle." **BY ROBERT CAUDILL, M.D.**

"Boy, that escalated quickly," said Ron Burgundy in the movie "Anchorman." On February 18, Dr. Shabana Khan and I were invited to participate in a congressional briefing titled "Improving Access to Telemedicine." The briefing was moderated by then APA President Bruce Schwartz, M.D., and included a panelist representing the patient perspective (https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.3b3). It was a standing-room-only audience consisting mostly of congressional aides and staffers.

As we say it, the charge was to lay out the administrative and regulatory impediments to more widespread adoption of telemedicine as an option for treatment delivery. Kudos to members of the APA Government Relations team who had gotten up to speed in a hurry and helped us to lay out the case.

Audience members reacted positively to our message, and a few people related their own experiences of seeking care through telemedicine outlets along with recognizing the great potential for doing much more.

Advocacy to Ease Telehealth Rules

We observed that Congress' landmark opioid legislation (the SUPPORT Act, PL 115-271) eliminated the geographic requirements pertaining to "originating sites" for Medicare coverage of treatment of people with substance use disorder and co-occurring mental health disorders. While the law went so far as to allow such treatment to be provided to patients at home, the law did *not* waive these coverage restrictions for patients strictly receiving mental or behavioral health treatment. While a potential boon for those with addictive disorders, the law failed to address the lack of care for those with distinct or even co-occurring psychiatric conditions.

Robert Caudill, M.D., is a professor of psychiatry, residency training director, and director of Telemedicine and Information Technology Programs in the University of Louisville Department of Psychiatry. He is a founding member of APA's Committee on Telepsychiatry and past chair of the Telemental Health Special Interest Group of the American Telemedicine Association.

To help remedy this coverage gap, we emphasized APA's support for the CONNECT for Health Act (HR 4932/S 2741), the EASE Behavioral Health Services Act (HR 5473), and the Telemental Health Expansion Act (HR 5201). Each of these bills proposed to eliminate the geographic requirements and allow Medicare coverage of in-home telepsychiatry.

The uniting theme for the briefing was to allow for expanded access to mental health and substance use disorder treatment by eliminating unnecessary barriers to telepsychiatry. We noted that the complex web of state licensure laws often served as an insurmountable barrier when trying to bring the most appropriate clinician into direct contact with a patient in need. Some states have yet to enact parity bills to assure that health care professionals delivering telemedical services will not be disadvantaged in terms of reimbursement. We spoke of clinicians who were hesitant to engage in telemedicine due to uncertainties about prescribing issues and how the Ryan Haight Act, while well intentioned and generally successful at helping to rein in rogue internet pharmacies, was still incomplete, and the Drug Enforcement Administration (DEA) had already missed a congressionally

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mandated deadline to delineate the telemedicine special registration provision of that law.

One cannot ignore the fact that the major federal payer, Medicare, has built-in disincentives against telemedicine including but not limited to origination-site disparities and practical prohibition against services delivered into inpatient settings. At the time of the briefing, rural sites were covered while most urban sites were not. Inpatient services were covered in an inconsistent and impractical fashion, and this further disadvantaged rural hospitals in need of access to specialty services. The Centers for Medicare and Medicaid Services (CMS) had earlier rejected the addition of initial inpatient hospital care as a covered telehealth service; however, CMS said it would cover certain subsequent hospital care services delivered via telemedicine. Unfortunately, the frequency limits around such services (once every three days for hospital inpatients, and once every 30 days for skilled nursing facility residents) were highly unrealistic and rarely if ever used. Had the goal been to limit utilization, the regulations made perfect sense. As it was, they remained yet one other significant barrier to telemedicine adoption.

Electronic Medical Record Problems

We noted several other concerns while acknowledging these might go beyond the scope of the presentation. Certainly, the appalling state of current electronic medical records systems has done nothing to inspire physicians to feel more favorably about employing optional technologies. The shameful lack of interoperability that continues to plague the electronic medical record world has mercifully been mostly solved in the world of videoconferencing. Due to the broad base of users (think non-medical business applications), methods can generally be found to connect most interested users. Similarly, some of the earlier barriers to access are rapidly being solved through other means. The improvements in videoconferencing technology along with the expansion of bandwidth, even into most rural areas, have been phenomenal. The advent of portable devices and smartphones has given rise to a generation of digital natives and well-acclimated digital immigrants. The acceptance of videoconferencing as a modality of providing and receiving care is widely accepted by both clinicians and patients in the younger cohort.

HIPAA continues to haunt the intersection of medicine and technology. This law was passed for a different day and world. It has been a barrier to the flow of information between clinicians despite that not having been the intention. In a day when people are posting things to social media that they would have been embarrassed to tell a priest when HIPAA was enacted, this law seems anachronistic. Patients can speak to us (audio only) on an iPhone, yet the same device using its native videoconferencing app software (FaceTime) is not universally considered HIPAA secure. If that sounds confusing to us, you can trust that patients are baffled as well.

Progress Linked to COVID-19 Pandemic

Like most things involving government controls, we were prepared for a long and drawn-out process. After all, the Ryan Haight Act was enacted in 2008, and 12 years later we were still waiting on regulatory language for the telemedicine special license it described. That being said, it was an amazing sequence of events that began transpiring on March 17. Seemingly (if only temporarily), there came many favorable responses to items that had long been on our wish list.

First, CMS released guidance that allowed patients to be seen via live videoconferencing in their homes, without having to travel to a qualifying "originating site" for Medicare telehealth encounters, regardless of geographic location.

Next we learned that, for the duration of this emergency declaration, the Department of Health and Human Services (HHS) had indicated that it was waiving HIPAA penalties for using non-HIPAA compliant videoconferencing software, allowing for popular solutions, such as Skype (basic) and FaceTime, to be used to conduct telehealth sessions.

While not explicitly requested initially, some relief was provided for telephone (audio only) communications with patients. As the public health crisis unfolded, CMS began allowing reimbursement (though a token amount) for patient-initiated "brief check-ins" via telephone (lasting around 5 to 10 minutes). Even this seemed to represent a new view of an old premise. Fortunately, on April 30 (retroactive to March 1) CMS announced that audio-only telephone services between patients and their physicians now include behavioral health services and that payments for these telephone visits are being increased to match payments for similar office and outpatient visits; however, given the newness of this policy change, it is unclear how it will specifically affect psychiatrists' reimbursement rates.

Another relaxation of rules was the DEA's suspension of the in-person exam requirement for telehealth-controlled substance prescription. This essentially provided to all DEA-registered clinicians the benefits long sought through the special registration and removed the roadblock created by the Ryan Haight delays. This step, along with the preceding one, is sufficient to allow any technologically capable practice to transfer its work to a telemedicine environment. Through a waiver or Modification of Requirements Under Section 1135 of the Social Security Act, the "requirements that physicians or other health care professionals hold licenses in the State in which they provide services, if they have an equivalent license from another State (and are not affirmatively barred from practice in that State or any State a part of which is included in the emergency area)" were waived as well.

These long-sought changes that we had expected to take years to enact went into effect in a matter of several hours. The underlying reason behind these sudden changes remains sad and potentially tragic. Nevertheless, having these much-wanted modifications go into effect is a very positive development on balance. There are, of course, practices that will struggle to make the transition, but without a doubt, the capability of seeing more of our "socially distanced" patients in their own homes (potentially from ours) protects not only our patients but also the larger medical workforce. Much work is yet to be done to fully realize all of the benefits in these changes. APA, the American Telemedicine Association, and other forward-thinking organizations have done their part to help get the word out, as have the various state medical associations.

Future Looks Bright for Telehealth

It is naive to say that things are forever changed, but it is hard to see how practices will ever return to their pre-COVID-19 routines. In-person care, of course, is not going away, but virtual care until now has been clearly underutilized. Alas, it has required a crisis of pandemic proportions to drive home that point. Nevertheless, the "genie is out of the bottle," and patients and clinicians who have learned it is not only possible, but sometimes even preferable to receive and deliver care from their homes are unlikely to want to go back to the old ways. We're pulling for the genie on this one. **PN**

References and links to telepsychiatry resources, including APA's, are posted at the end of the online version of this article at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.5b33.

OCD Patients

continued from page 9

Weg said that the heart of exposure therapy is to have patients accept a lack of total control, which most can do in areas not involving their compulsion. An individual who may be afraid of any contact with germs has no concerns about slipping in the shower or falling downstairs, for example, which are both possible accidents but relatively improbable under normal circumstances.

"People with OCD mix up possibility and probability in relation to their obsession," he said. "If we can get them to accept uncertainty, we can change their relationship with their object of fear and empower them."

Storch also acknowledged that exposure therapy is complicated in the current times. "The goal of therapy is to expose a patient to an ordinary level of risk and show that it's not dangerous," he said. "Right now, though, the standard risk level is elevated and increasingly uncertain." Still, he thinks there are ways for therapists to safely implement exposure techniques, so long as they raise the bar on what are considered normal cleanliness behaviors.

"It will be important to return to gold-standard exposure and response prevention therapy once the COVID-19 crisis resolves," he added. "Do we risk diluting the effectiveness of exposure therapy if we keep the thresholds of normal behavior unnecessarily high after the risk returns to pre-COVID-19 levels?"

Both experts agreed that the COVID-19 pandemic has created one net positive for OCD therapy: increased tele-mental health services. "There are some factors, like closely reading body language, that are better face to face, but being able to talk to patients in their homes has opened up new aspects of treatment," Storch said. "For one, we can engage with the patient's family more successfully."

"Telehealth also has an advantage in that the source of a person's OCD stress is often in the home," added Weg. "Now we can visibly see what patients are experiencing when they interact with their anxiety triggers, and we can better guide them through the therapeutic process."

Weg said he is hopeful the pandemic leads to a greater understanding of people with OCD. "The average person now has gotten a small experience of life with OCD," he said. "They live with elevated anxiety and repetitive thoughts about what they touched or if someone got too close to them."

This pandemic will eventually subside, and routines will go back to normal for most people, Weg said, "but imagine if it didn't. Having this routine go on for months or years is difficult and emotionally exhausting. Hopefully others can now have more awareness and empathy for these patients." **PN**

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Do Not Forget Delirium During the COVID-19 Scramble

Reduced oxygen to the brain and social isolation may increase the risk that some patients with COVID-19 will experience delirium. **BY NICK ZAGORSKI**

As U.S. hospitals continue to be inundated with COVID-19 patients, much media attention has been given to shortages of critical resources such as ventilators and isolation facilities. Less well publicized is another complication resulting from this surge of patients requiring emergency or intensive care: increasing numbers of patients with delirium.

Delirium is an acute state of confusion characterized by delusions, poor awareness, restlessness, and/or agitation, among other symptoms. If left unattended, it can lead to severe outcomes such as bodily injury, cognitive impairment, and death. Delirium is triggered by biological stress that affects the brain. Reduced oxygen to the brain caused by lung damage, for instance, can interfere with brain function, resulting in delirium.

This novel coronavirus also has characteristics that make delirium even more likely, noted Jo Ellen Wilson, M.D., M.P.H., a consultation-liaison psychiatrist and assistant professor at Vanderbilt University Medical Center. One trait is the virus's predilection to lead to more severe infections in older adults and adults with existing medical problems, both of whom are already at higher risk of delirium. Wilson told *Psychiatric News* there is some evidence that the coronavirus, like SARS and MERS viruses before it, may be able to invade the central nervous system and directly damage the brain.

Jo Ellen Wilson, M.D., M.P.H., says that delirium is a concern with COVID-19 because social isolation may increase confusion and the virus tends to cause severe infections in at-risk populations such as older adults and adults with other medical problems.

The social isolation of patients may also increase their risk of delirium, Wilson noted. "You can imagine someone waking in a hospital room alone, sick and confused, and the only people they see are completely covered in protective equipment," Wilson said. Such experiences can be extremely disconcerting to sick patients already in a semi-confused state and may exacerbate their condition, she said.

"[During this pandemic,] we will see a spike in delirium incidents, especially among older, vulnerable patients," said Kevin Biese, M.D., co-director of geriatric emergency medicine at the University of North Carolina School of Medicine. "But with overall hospital volume also increased, it's more likely that busy staff will forget about screening for delirium."

Screening patients with validated assessments is important, noted Ula Hwang, M.D., a professor of emergency medicine and geriatrics at the Icahn School of Medicine at Mount Sinai, since delirium can be hard to detect in the majority of patients. According to Hwang, only 25% of patients with delirium appear visibly agitated.

"Everyone in the [emergency department] rushes to give medication to the clearly agitated patients, but the quiet and sleepy patients whose delirium is growing worse are left unattended," she said. "But if we can plan ahead and take a few simple steps, we can identify at-risk patients and prevent a lot of bad

see **Delirium** *on page 25*

Top 10 Tips for Delirium Care in COVID Settings

1. Treat delirium as an emergency.

2. Be aware that viral infections can trigger delirium. Acute confusion may be a sign of COVID-19 in older adults, even before fever and cough.

3. Maintain calm, clear, and comforting communication, particularly if personal protective equipment (PPE) is needed for patient interaction. This reduces the risk of patients becoming confused.

4. Understand that being isolated from family and surrounded by people in PPE is stressful for patients and can worsen disorientation and agitation.

5. Recognize that confusion may be present upon admission, but it is not normal. Do not treat it as such.

6. Be aware that hypoactive delirium (sleepy, withdrawn, "pleasantly confused") is more common than hyperactive delirium (agitation and anxiety) in older adults.

7. Know your delirium risk factors: History of dementia, sensory impairment, older age, nursing home resident, and severe infection.

8. Identify and address reversible causes of delirium, such as immobility, dehydration, fever, pain, hypoxia, nausea, constipation, and psychoactive medications.

9. Stop delirium before it happens. Mobilize patients, try to keep them oriented to surroundings, and ensure physiological needs (food, drink, warmth, bowel and bladder) are met.

10. Understand that treatment with antipsychotics is not supported as best practice and may even worsen delirium. If severe agitation develops, use reduced doses such as risperidone ≤1 mg (oral), olanzapine 2.5 mg-5 mg (oral or intramuscular), quetiapine 25 mg-50 mg (oral), haloperidol 1 mg-2.5 mg (intramuscular) or 0.25 mg -1 mg (intravenous).

More details can be found at https://gedcollaborative.com/article.covid-19-delirium-care.

FIRST PERSON

COVID-19 Crisis Provides Opportunity for Reflection

BY ROBERT MCALLISTER, M.D., PH.D.

Robert McAllister, M.D., Ph.D., is a retired private practitioner in psychiatry and author.

It's my 17th year of living in a retirement facility. My life partner, Jane, died 13 years ago. I'm "alone." I am currently isolated not just from the rest of the world but from the "others" who live in the 200-plus apartments in this building and 90 more beds in three nursing units. There are no meetings, no gatherings, no visitors. Masks are worn by all employees and recently by all residents. We have to maintain six feet between people even on the elevator.

This experience is not new for me. I worked in a world where I was "alone," and there were "others." It was a world of doubts and fears, real and pretend tears, mysteries and mistakes, losses and findings, and continued searching. What can I tell you about those who came through my psychiatrist door? Each had his or her own mask of life's history.

The year 1918 marked the end of World War I, and the Spanish virus was conquered. Millions died during those times. In 1919 the census increased by one person I know—it is I, Robert McAllister, age 100 and doing well so far. (Thank you, I knew you would ask.) Every day I thank the Lord for my health of body, mind, and spirit. My motto is: Maker provided; owner maintained. I exercise in a 6-by-6-foot space in my living room each morning (some furniture stands on end) and take a walk in the afternoon (weather permitting).

I began a psychiatric practice in 1966 in a suburb of Washington, D.C. I later became superintendent of the state hospital in Reno, Nev. Then to Grants Pass, Ore.; Spokane, Wash; Taylor Manor Hospital in Ellicott City; and then a private practice in Maryland. You ask: What was I looking for?

Psychiatrists are always looking for something, searching the words, watching the expression, speculating what thoughts and feelings are behind the facial mask. The office life is gone, but the patients are still here—in my thoughts, in my prayers, in my reveries. I pray for them all; I read about them in some of the books I've written. I remember the girl who was an addict and came for a Social Security evaluation. It still brings tears to my eyes as I read about our meetings. Or the woman I saw in the Reno jail who wouldn't talk to me when I visited her at the request of Judge Craven. After a half hour, I needed to leave, and as the guard came to open the door, she spoke. Her story lives in my mind. Or the woman arrested at a local grocery store, threatened with jail. My letter to the judge changed his mind for this proud Native American who spoke with the God of the Night Skies.

Patients hid behind the masks of childhood, of married life, of conflicts, of sadness, of excess activity, of strange happenings in their lives. I sat behind my mask (a desk) and ever so gently and thoughtfully removed the pieces of their mask as we explored the virtues and benefits of reality. My mask faltered at times as tears came to my eyes, the fault of my ears unable to shut out the sadness of shattered lives in need of mending.

Am I tired? Yes. Am I grateful for my life? Yes, every bit of it. Three years in the seminary. Left: a life too alone. Over two years in the infantry, France, Germany, Austria. Camp Mauthausen—the Nazi goal was to kill the intelligentsia among the Jews. Much to look back on, much to ponder and to pray about. I have a former patient in the Southwest with whom I correspond. She was planning suicide the first time she came to my office. She was a nun, now happily married. One life is worth my 56 years in psychiatric practice. **PN**

IN MEMORIAM

The names of APA members whose deaths were reported to APA from January 1, 2020, to March 31, 2020, are posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.5b50.

Survey Reveals Gender Gap in COVID-19 Stress

Women are more likely to report worsening mental health due to the COVID-19 pandemic than men, a survey finds. **BY KATIE O'CONNOR**

Women are experiencing greater stress due to the COVID-19 pandemic than men, a trend that appears to be worsening, according to a Kaiser Family Foundation (KFF) survey.

The survey was conducted via telephone from March 25 to 30 with 1,226 adults aged 18 and older. Women surveyed were more likely than men to say that they've stayed home instead of going to work or doing other activities; changed or canceled travel plans; or sheltered in place. Forty-nine percent of women said their lives had been disrupted "a lot" by the outbreak, compared with 40% of men.

Most strikingly, 53% of women said worry or stress related to the pandemic has had a negative impact on their mental health, compared with 37% of men. This difference was even larger between parents, with 57% of mothers reporting worsening mental health compared with 32% of fathers.

KFF first noted the divergence between men's and women's responses in a poll conducted March 11 to 15. The gap between men and women's worsening mental health grew in just the two weeks between the surveys.

Maureen Sayres Van Niel, M.D., who is the APA Assembly's representative to the Caucus of Women Psychiatrists and chair of the Assembly Committee of Representatives of Minority/Underrepresented Groups, said that, while the survey's sample size is small, it points to important trends that she is also seeing in her clinical practice.

Clinicians should ask patients about the balance of household burdens and how that may be impacting their stress and mental health, says Maureen Sayres Van Niel, M.D.

"Women of all economic classes reported that they're at a tipping point," Van Niel said. "They're trying to be the teacher, the cook, run the household, do a full-time job, and be the chief comforter to worried family members, all during a time when the usual help and personal time they might have, such as going out to exercise or visit friends, is no longer available."

Van Niel noted that differences between men and women in terms of their mental health existed before the COVID-19 pandemic began and may impact the survey's results. Women are more likely than men to report their mental health symptoms to clinicians, and the incidence of anxiety and depressive disorders in women is twice that of men.

There is also a greater burden on women in the home, which may be exacerbating their stress because of stay-at-home orders. Data from the Bureau of Labor Statistics show that, even if women have full-time jobs, they continue to carry twice the load that men do in the care of children and elderly relatives and have two-thirds more of the responsibility for household chores than men, Van Niel pointed out.

Furthermore, 23% of households are headed by single mothers, many of whom live in poverty. "Studies of the mental health of those living with food, shelter, and financial insecurity reveal a high level of mental health symptoms, and the quarantine amplifies this, leading to an overwhelming strain for some," she said.

About a fourth of all women will experience intimate partner violence during their lifetimes, as well. "If women happen to be home now with someone who is abusive, their stress level will be immeasurably higher," Van Niel said.

Psychiatrists should proactively ask their women patients about the balance of family burdens in their lives, if they have enough food and shelter, and if abuse is taking place, she said. Given how significant these stressors can be on a woman, it's important to include such questions.

Considering that men are less likely to share their mental health symptoms, psychiatrists should also take care to illicit that information from men as well, she said.

"It's incumbent upon us to continue research to determine why women have twice the rate of depression and anxiety disorders than men," she said. "How much of a role do correctable stressors falling disproportionately on women contribute to that?" **PN**

"Is There a Widening Gender Gap in Coronavirus Stress?" is posted at https://www.kff.org/coronavirus-policy-watch/is-there-widening-gender-gap-in-coronavirus-stress/.

PSYCHIATRY & PSYCHOTHERAPY

Psychotherapy in the Time of COVID

BY HINDI MERMELSTEIN, M.D.

Hindi Mermelstein, M.D., is a board-certified psychiatrist with qualifications in both geriatric and consultation-liaison psychiatry. She has been involved in telepsychiatry for nearly 30 years.

A crisis, defined by the Oxford English Dictionary as a "time of intense difficulty, trouble, or danger," can disrupt normal defense mechanisms, threatening our ability to return to our "before" functioning. The COVID-19 crisis exacerbates the stress for those with and without preexisting conditions, while impeding the means and methods used to assess and treat psychiatric illness. What role can psychotherapy play in managing this increased level of distress?

The COVID-19 world is one of parallel vulnerabilities—the "fear of contagion" versus the "contagion of fear." At its core, fear creates anxiety and hinders our reasoning ability. The explosion of need, limited resources, and conflicting information lead to mistrust, which adds to the feelings of uncertainty. Furthermore, stay-at-home orders and the closing of schools, businesses, and so on have greatly altered the general structure of our lives. At a time when we feel most overwhelmed, we cannot "borrow" from our everyday routines for stability. Social connections are still possible but at a distance or through a video screen, which creates a sense of separation from the outside world. Absent our normal outlets, amid the extraordinary medical and psychological stress inherent in the COVID-19 pandemic, the number of people in need of psychiatric services has grown exponentially.

For our chronically ill patients, the need is even greater. The loss of regular treatment can destabilize symptoms that were previously under control. Patients with depression are more vulnerable to the losses that have occurred. Patients who already struggle with posttraumatic disorders are at greater risk, as are those who rely on a social "herd effect." A socially anxious patient excitedly stated, "Social distancing—I am an expert! I could teach social distancing!" More recently, however, he became clinically depressed because he had relied on the social structures around him to feel connected. Now he feels neither the attachment to nor encouragement from others. The unpredictable chaos of the pandemic has worsened anxiety for patients who struggle to defend against the chance of the always possible versus the likelihood of the probable. As a result, overwhelming anxiety has mushroomed, magical thinking has prevailed, and panic may ensue.

During times of crisis, psychotherapy is generally supportive, using varying approaches that incorporate support, education, symptom relief, and "level setting." Although this treatment tends to be time limited with short-term goals, in today's continually shifting landscape and its uncertain time frame, end dates cannot be predetermined. Cognitive-behavioral therapy may be particularly useful in helping reset distorted schema while interpersonal therapy can focus on the role of confusion and diffusion, which are unavoidable at this time. Group therapy allows for the sharing and normalization of experience while recreating social networks that have been lost.

The core process of psychotherapy is essentially unchanged regardless of approach. The primary element is the establishment of a therapeutic alliance allowing the story to unfold and the process to go forward. Telepsychiatry provides access to care that would otherwise not be available, with numerous studies reporting outcomes equal to face-to face encounters. For telepsychiatry, there are specific ways to optimize reaching psychiatric treatment goals:

- **Create the frame:** It is critical that the "frame" established in person (for example, professional workspaces, documentation of

continued on facing page

Pandemic Creates Challenges, New Opportunities For Treating Patients With Substance Use Disorder

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People with substance use disorders may be particularly vulnerable to COVID-19, and loss of peer support can be dangerous. Psychiatrists and addiction specialists are finding new ways to engage with individuals to help them progress in their recovery and in treatment. **BY MIRIAM E. TUCKER**

Treatment of addiction often involves encouraging patients to develop positive relationships and engage in prosocial activities with those contacts. —Kenneth Bruce Stoller, M.D.

The current social distancing requirements of the COVID-19 pandemic present unprecedented and worrisome challenges to the delivery of treatment to people with substance use disorders (SUDs). But the situation may also create some positive opportunities, including the embrace of new technologies that could ultimately improve access and delivery once the pandemic ends.

People with SUDs who smoke may be particularly vulnerable to the coronavirus that causes COVID-19 and to respiratory complications if they contract it, warned National Institute on Drug Abuse Director Nora Volkow, M.D., in an article in the *Annals of Internal Medicine*. Additionally, the social distancing rules have cut off in-person group meetings and other social support systems for people with SUDs and made it more difficult to obtain medications, potentially placing individuals in recovery at greater risk for relapse.

Addiction is often viewed as a disease of isolation, Kenneth Bruce Stoller, M.D., director of the Johns Hopkins Broadway Center for Addiction in Baltimore, told *Psychiatric News*.

"As addiction takes hold, people turn more inward and become isolated from social contacts," he said. "Part of treatment is to open the patient to developing more positive social contacts and specifically doing more prosocial activities with those contacts to build up a social support system. … These are all things that are affected now by COVID-19 in terms of people being forced to isolate."

Losing access to peer support groups can also lead to a worsening of SUDs, American Society of Addiction Medicine (ASAM) President Paul H. Earley, M.D., told *Psychiatric News*.

Therefore, Stoller said, "it becomes very important for programs and addiction psychiatrists and addiction medicine physicians to find creative ways to engage with individuals to help them progress in their recovery and in treatment."

Some adaptations have helped. Residential treatment programs have developed protocols for safety during this time. Most remain open with some changes, such as COVID-19 testing of new patients and social distancing of residents. Many outpatient programs have moved to virtual platforms, as have Alcoholic Anonymous and Narcotics Anonymous, with some success.

Federal rule changes have also eased conditions on the outpatient side. In March, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidance allowing stable patients receiving medication treatment for opioid use disorder to take a 28-day supply of their medication home. Patients considered less stable but who a clinician believes can safely handle some take-home doses may receive up to 14 days of their medication (*Psychiatric News*, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.4b14).

The Department of Health and Human Services also announced in March waiving HIPAA penalties for use of noncompliant technologies, such as Skype and FaceTime, for telehealth encounters with patients during the COVID-19 emergency. And, the Drug Enforcement Administration (DEA) now allows use of telephone evaluations to initiate buprenorphine prescribing.

With New Rules, New Dilemmas

Stoller said that while the SAMHSA rule change has helped a great deal, it has also created new challenges.

On the one hand, "we've been able to provide a larger number of take-homes to patients. This was a huge relief knowing patients wouldn't have

see **Substance Use Disorder** *on page 26*

continued from facing page

sessions, and office policies) be established equivalently in telepsychiatry. Despite current modifications to standard telemedicine, such as not having a staff member present at the exam, mimicking the in-person structure supports the psychiatrist-patient relationship, provides reassurance through consistency, and protects against the risk of informality that can distort how treatment is conducted.

- **Establish the treatment relationship:** In telemedicine, the first conversation for both new and established patients demands the quick establishment or re-establishment of a relationship, obtaining important information such as an emergency contact, explaining the treatment, and inviting questions. Discomfort in the transition from in-office visits may result in initially devaluing telepsychiatry and inappropriately justifying a pause in treatment. Creating or recreating the therapeutic environment can restore the trust in psychotherapy.

- **Listen with the third (or fourth) ear:** The nonverbal cues that inform us about the person we are treating, sometimes more profoundly than verbal cues, are vital for successful treatment. Ideally, telehealth should be practiced with videoconferencing, but during this crisis, many patients engage, by choice, telephonically. However, even without video access, asking patients to describe their setting and environment and acknowledging periods of silence can inform the nonverbal elements. The loss of the visual cues demands a much higher level of focus, but the anonymity can help foster the psychotherapeutic process.

Telepsychotherapy has unique advantages that enhance treatment for people coming into our virtual offices. The screens allow for a protective distance potentially encouraging patients to speak more freely about difficult subjects they feel too ashamed about to share in person. Moreover, each person chooses the place, which can help empower individuals who feel more stigmatized in the traditional office hierarchy.

The ferocity of the COVID-19 crisis, the rapidly evolving knowledge base, and ever-shifting treatment paradigms make it harder to assess risk while the unexpected change from normal health care arrangements hampers the ability to plan. Through implementation of the basic elements of good psychiatric practice while simultaneously embracing the unique elements of telemedicine, we have the ability and opportunity to provide the care that our patients—new and established—so desperately need.

On a final note, from one practitioner to another, take care and be mindful of an important air travel rule: In the event of disaster, put on your oxygen mask first before helping others put on theirs. Be aware of your "mask"; if you are having trouble managing in any way, seek help. You are essential, and your personal "mask" and need for "oxygen," whatever forms they take, are paramount. **PN**

More Studies on Duration of Untreated Psychosis Needed

Early interventions for patients with psychosis may be helpful, but more research is needed to determine the best ways to preserve the initial benefits of treatment over the lifespan.
BY KATIE O'CONNOR

Early intervention treatments, while still important for patients, may not have the long-term impact researchers formerly assumed, says Katherine Jonas, Ph.D.

Numerous studies have suggested that patients with longer periods of untreated psychosis tend to fare worse than those who begin treatment earlier. Some evidence suggests this may be because longer duration of untreated psychosis (DUP) leads to irreversible damage to neurons; other research suggests people with longer DUP may have a more severe form of schizophrenia.

The authors of a study in the *American Journal of Psychiatry* have proposed an alternative reason why those with longer DUP may have worse long-term outcomes than those with a shorter DUP: Their illness may be more advanced.

"Studies that assess outcomes for a short period after first admission [for psychosis] may identify protective effects of early diagnosis or treatment that actually reflect differences in illness stage rather than changes in illness course," wrote Katherine Jonas, Ph.D., senior postdoctoral fellow and research assistant professor in the Department of Psychiatry at the Renaissance School of Medicine at Stony Brook University, and colleagues.

The study suggests that future research on the course of illness in schizophrenia should examine outcomes relative to the first clear symptom of psychosis, as well as when the individual initially receives treatment.

Jonas and colleagues studied data from the Suffolk County Mental Health Project, which recruited hundreds of individuals with their first episode of psychosis between 1989 and 1995. A total of 287 of these patients were later diagnosed with schizophrenia.

Interviews occurred at participants' first psychiatric hospital admission and again at six months, 24 months, 48 months, 10 years, and 20 years. The researchers assessed participants' premorbid psychosocial functioning at baseline and after six months. After the first hospitalization, symptoms and functional impairment were assessed using the Global Assessment of Functioning Scale.

The authors defined DUP as the length of time between the onset of the first psychotic symptom and the first psychiatric hospital admission. The date of symptom onset was determined through interviews with the participants and their parents, as well as medical and school records. Participants' DUP ranged from zero days to 24 years.

DUP was not associated with differences in either premorbid or long-term psychosocial function, the authors wrote. Patients with long and short DUP experienced declines in functioning, but most of the declines experienced by patients with long DUP occurred prior to their first hospital admission, while declines experienced by patients with shorter

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Telephone Counseling May Offer Needed Boost to Veterans With Depression

Adding telephone-based counseling to an integrated care program at the VA increased employment productivity and reduced depression symptoms at relatively low cost. **BY NICK ZAGORSKI**

Adding a work-focused intervention to integrated depression care can lead to better employment and psychiatric outcomes in veterans, according to a study in *JAMA Network Open*.

Researchers tested a telephone-based work intervention called "Be Well at Work." This counseling program, which teaches stress reduction and coping skills for work-related challenges, is relatively inexpensive and has been shown to reduce employee's depression and absenteeism in traditional work settings. This study was the first to assess whether Be Well at Work could add value to an already proven model of depression care—the Veterans Health Administration (VHA) integrated care program.

The VHA's multidisciplinary integrated care model includes comprehensive depression screening, regular assessments, brief behavioral therapy, medication, and referral to specialists if symptoms become severe. The VA system also offers vocational rehabilitation services, but this is geared toward placing veterans in jobs and not necessarily ensuring productivity and well-being while at work.

"There are so many younger veterans from today's wars who are looking to assimilate back into society," said lead study author Debra Lerner, Ph.D., a senior scientist and director of the Program on Health, Work, and Productivity at Tufts Medical Center. She co-developed Be Well at Work with David Adler, M.D., a senior psychiatrist at Tufts Medical Center. "The topic of employment is front and center at the VA."

"There are so many younger veterans from today's wars who are looking to assimilate back into society." —Debra Lerner, Ph.D.

Lerner and colleagues enrolled 253 veterans (average age of 46) from the Philadelphia region who had been diagnosed with depression and reported at least a 5% drop in work productivity in the previous month. The participants were randomly assigned to receive either standard integrated care at the VHA or participate in the Be Well at Work program in addition to receiving integrated care. Participants in the Be Well at Work group received eight, biweekly 50-minute telephone calls for four months—led by trained counselors—as well as one follow-up session four months later.

After four months, the veterans who received the telephone intervention reported 17% greater improvements in work productivity and a 26% greater reduction in their depression symptom severity relative to veterans receiving only integrated care. These differences between the two study groups were still evident at the eight-month follow-up visit. The researchers estimated that the productivity increase saved employers about $1,800 per participant over one year, whereas the cost of the Be Well at Work intervention was $690 per participant—a 160% return on investment.

"The big question we have not answered yet is, What is the best strategy in the long run?" Lerner said. "Undoubtedly some people will want to sign up for this program a second time, so we have to find the best way to integrate new and returning patients." That would be one of the key items that can be addressed in implementation trials—studies in which new programs are set up and run in other settings to test their viability.

The researchers just launched a small pilot program to implement Be Well at Work for employees at Tufts Medical Center and are looking for additional ways to expand the program. "If there are interested academic or community mental health centers, then reach out to us," she said.

"We often don't deal directly with work issues in depression care, but depression affects job security and quality of life for many workers, including veterans," Lerner continued. "I hope this study encourages more veterans to seek care because programs like Be Well at Work can help."

This study was supported by an award from the U.S. Department of Veterans Affairs, with additional support from researchers with the Corporal Michael J. Crescenz VA Medical Center in Philadelphia. **PN**

"Effect of Adding a Work-Focused Intervention to Integrated Care for Depression in the Veterans Health Administration: A Randomized Clinical Trial" is posted at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762017.

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DUP occurred after their first admission.

"In this way, lead-time bias [in which early detection appears to improve outcomes] creates the illusion of a treatment effect attributable to early intervention," the authors wrote.

The findings show that researchers should think about lead-time bias in their studies, either in the study design or in the interpretation of the results, explained study co-author Laura J. Fochtmann, M.D., distinguished service professor of psychiatry at Stony Brook University and the medical editor of APA's clinical practice guidelines. "We want to give patients treatments that are truly going to be effective," she said. "This speaks to the rigorousness needed in study designs."

The researchers emphasized that the results should not be interpreted as evidence that early intervention is ineffective or that schizophrenia results in an inevitable decline.

"Some of our participants were untreated for a year or two years, and had negative things happen to them in those years," Jonas explained. "Some dropped out of school. Even if early treatment doesn't mean that at some future point they'll be better off, it might still avert some of those negative consequences associated with going untreated."

William Carpenter, M.D., agreed, noting that a patient's social pathology is quite different from psychotic symptoms. Carpenter is a professor at the University of Maryland School of Medicine and the Maryland Psychiatric Research Center, and editor-in-chief of *Schizophrenia Bulletin*. "Even if early treatment of positive psychotic symptoms does not affect long-term course, early intervention may help patients in relation to social impairments if intervention precedes a breakdown in social and occupational function," he said.

In an accompanying editorial, Donald C. Goff, M.D., a professor of psychiatry at New York University, and colleagues, called the report by Jonas and colleagues a "valuable and provocative new perspective on the relationship between duration of untreated psychosis and clinical course in schizophrenia."

They noted, however, that "the great heterogeneity in symptoms and clinical course" of schizophrenia complicates research of the illness. "Until we better understand the biological and environmental factors that moderate clinical course, we must exercise caution in making predictions about prognosis or decisions about optimal treatment approaches based on the analysis of heterogeneous populations," Goff and colleagues wrote.

"The current focus of research and allocation of clinical resources to the early stages of illness may have minimal impact on the dispiriting downward trajectory identified by Jonas and colleagues, unless late-stage deterioration is also addressed and high-quality treatment is provided beyond the early years of illness," they continued. "Although the potential relationships of DUP, early intervention, and longer-term outcomes remain unclear, Jonas and colleagues have called attention both to a potential bias in current analytic approaches to the study of DUP and to the importance of considering the long-term course of illness when evaluating interventions that we hope will change the trajectory of illness."

The study was funded by the National Institute of Mental Health. **PN**

"Lead-Time Bias Confounds Association Between Duration of Untreated Psychosis and Illness Course in Schizophrenia" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2019.19030324. "Does Early Intervention Improve the Long-Term Course of Schizophrenia?" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.20020111.

COVID-19 Patients

continued from page 1

through honest sharing and reflecting on our experiences," said Daniel Price, M.D., residency training director for psychiatry. The sessions are not overtly therapeutic. Instead, they're intended to allow participants to process their worries and how they're coping with the stresses they're experiencing.

"There is no curriculum for this group other than creating a place that encourages sharing our experiences," continued Price. "This is a place to tell our stories, both external—what we're doing or witnessing—and internal—what we're experiencing, thinking, and feeling."

The pandemic arose with unexpected intensity.

"None of us was prepared for this," said consultation-liaison psychiatrist George Nasra, M.D., chief of collaborative care and wellness at the University of Rochester. "When the pandemic began, we saw an increase in referrals from employees—but not the usual request for mental health or psychiatric care. Rather, people just needed support and someone to talk to."

Eventually, Rochester created an emotional support helpline, available from 7 a.m. to 8 p.m. available 7 days per week for all of the university's 40,000 employees and their families, said Nasra. The helpline is staffed by about 15 university workers displaced by the pandemic from their regular jobs in the medical center. They transfer callers to a list of over 80 faculty and staff in the psychiatry and psychology departments, who seek to normalize the experience of callers, avoid pathologizing, encourage self-care, and offer a list of resources for those who need more help.

Unexpected Education for Residents

One group that required some extra attention were psychiatry residents, said Nasra. Like their peers around the country, many stepped forward to volunteer as the pandemic struck their training sites. Rochester already had in place a once-a-week coaching program for residents. When the pandemic arrived, the focus shifted to COVID-19, discussing and processing cases.

"Residents have less experience with patients and are still in training mode," said Nasra. "They feel less equipped and need more support. They have to juggle the clinical needs of patients with their program requirements."

In Washington, D.C., residents and fellows at George Washington University (GWU) also volunteered to help, aware that their formal education was disrupted. The pandemic was not only a crisis but an opportunity, they soon learned.

"The COVID crisis is not getting in the way of your education," James Griffith, M.D., the Leon M. Yochelson Professor and chair of the Department of Psychiatry and Behavioral Sciences at GWU, reassured them. "This *is* your education, and you'll be better physicians for it."

Griffith also led grand rounds on resilience at the invitation of colleagues across medical specialties. He couched his lectures in terms familiar to each audience. To neurologists, for instance, he spoke about brain networks and how to protect executive function. He emphasized building relationships and adopting assertive coping as an approach to the stresses of caring for patients rather than withdrawal.

"Fear is not a problem; panic is," said Griffith. "The pandemic is characterized by intensity and uniqueness. No place seems safe, and there is great anxiety and self-blame about carrying the virus out of the hospital to family members or friends."

In a proposal to the dean of the medical school, Griffith suggested three levels of response to COVID-19 stressors among hospital staff. The first level emphasizes that individuals can show symptoms like insomnia or lack of concentration that are normal responses to stress. Support for this group includes psychoeducation and referral to web-based wellness resources. A clinician who requests help for emotional distress or is encouraged by colleagues to do so is considered to be at Level II. Those individuals are referred to peer support groups or the Physician Support Line. Level III covers those who have overt symptoms of depression, anxiety, or posttraumatic stress; they are invited to seek more intensive help from the GWU psychiatry faculty.

The Physician Support Line sprang up soon after the pandemic reached this country, said co-founder Smita Gautam, M.D., a child and adolescent psychiatrist at the Family Institute at Northwestern University in Chicago. Gautam and four colleagues around the country put together a group of hundreds of volunteer psychiatrists to provide telephone support. The group, now numbering about 500, includes a mixture of clinicians ranging from PGY-4s to retirees.

"We're offering peer support but not doctor/patient therapy or medication, although we do provide referrals as needed," said Gautam in an interview. "So far, people are telling us they're experiencing anxiety, grief, loneliness, insomnia, relationship issues, and fear of loved ones dying, among other problems."

Immediate Deployment of Help Advised

In New York City, the hardest hit area in the United States, frontline physicians, nurses, technicians, and others quickly reached the emotional brink because of the sheer volume of patients and subsequent mortality, said Vicente Liz, M.D., vice chair of psychiatry at BronxCare Health System and president-elect of the New York County Psychiatric Society. "There was a sense of frustration. People felt, 'We gave our best efforts, and it didn't work.'"

One night, 15 people died, Liz recounted in an interview.

"The next day we came in, and we knew we had to check on our people," he said. "Our team went floor by floor, engaging nurses and patient care technicians. We just asked how they were doing, how they were holding up. There was a sense of impotence because they weren't getting positive outcomes. But each interaction can be therapeutic. It doesn't need to be a formal encounter. The important thing is to be able to deploy quickly, right in the hospital."

The only constant about COVID-19 is the continued uncertainty surrounding its clinical and epidemiological course. That only underscores the continued need to support those who care for patients.

"This is not just a test of skill and endurance for frontline people," said Maine's Pontius. "The surge we anticipated this month in Maine has not struck us as hard as we'd feared it might, but we've had losses, and it seems likely that we will lose more during an eventual second wave." **PN**

The phone number of the Physician Support Line is (888) 409-0141. Its website is https://www.physiciansupportline.com.

MED CHECK

BY TERRI D'ARRIGO

DEA Ups Production Quotas For Controlled Substances In Response to COVID-19

In April the Drug Enforcement Agency (DEA) increased production quotas 15% for controlled substance medications that were in high demand because of the COVID-19 pandemic. These include medications such as ***codeine***, ***ephedrine***, ***fentanyl***, ***hydromorphone***, ***morphine***, and ***pseudoephedrine***.

In a statement, the agency also said it was increasing the authorized amounts of certain schedule III and IV controlled substances that may be imported into the United States, including ***diazepam***, ***ketamine***, ***lorazepam***, ***midazolam***, and ***phenobarbital***, which are used to treat patients on ventilators. The agency added that it would increase the quota for ***methadone*** to ensure that opioid treatment programs have enough to treat patients with opioid use disorder.

DEA Removes Epidiolex From Schedule of Controlled Substances

The DEA has removed ***Epidiolex*** (***cannabidiol***) by GW Pharmaceuticals PLC from its list of substances subject to the Controlled Substances Act.

The agency had originally placed Epidiolex in Schedule V of the law in September 2018, three months after the medication was approved by the Food and Drug Administration. Epidiolex is approved for the treatment of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in patients aged 2 years or older.

As the medication is no longer a controlled medication, physicians may prescribe it without adhering to the requirements of state prescription drug monitoring programs, prescriptions will be valid for one year, and prescriptions can be transferred easily between pharmacies.

Epidiolex's effectiveness was studied in three randomized, double-blind, placebo-controlled clinical trials involving 516 patients with either Lennox-Gastaut syndrome or Dravet syndrome. When taken along with other medications, it was shown to be effective in reducing the frequency of seizures compared with placebo.

SEP-363856 Shows Promise For Schizophrenia

In April Sunovion Pharmaceuticals Inc. announced that ***SEP-363856***, an investigational medication for schizophrenia, improved positive and negative symptoms in patients in a four-week study. SEP-363856 is a novel trace amine–associated receptor 1 agonist with serotonin 1A agonist activity.

In the trial, which was published in the *New England Journal of Medicine*, 245 adults with schizophrenia were randomly assigned a daily dose of 50 mg to 75 mg of SEP-363856 or placebo. After four weeks, scores in the Positive and Negative Syndrome Scale dropped an average of 17.2 points in the treatment group compared with 9.7 points in the placebo group. The treatment group also experienced similar improvement in scores on the Clinical Global Impressions Severity scale and the Brief Negative Symptom Scale.

Side effects in the treatment group included drowsiness and gastrointestinal symptoms, and there was one sudden cardiac-related death.

"A Non–D2-Receptor-Binding Drug for the Treatment of Schizophrenia" is posted at https://www.nejm.org/doi/full/10.1056/NEJMoa1911772.

Combination Drug for Refractory Depression Gets Mixed Results

In March Axsome Therapeutics announced mixed results from a phase 3 trial of its investigational combination drug ***AXS-05*** (45 mg ***dextromethorphan***/105 mg ***bupropion***) for treatment-resistant depression.

AXS-05 did not meet its primary endpoint of a statistically significant reduction from baseline in the total Montgomery-Åsberg Depression Rating Scale (MADRS) score at week 6 compared with bupropion alone. However, the drug did meet secondary endpoints by rapidly and statistically significantly improving symptoms of depression as indicated by changes in MADRS scores as early as the first week.

In the STRIDE-1 trial, 312 adults with treatment-resistant depression who had failed two or three prior treatments received either AXS-05 or 150 mg bupropion twice a day for six weeks. At the sixth week, patients who took AXS-05 had a mean MADRS score reduction of 11.6, compared with a mean reduction of 9.4 among those who took buproprion alone. However, this was not considered statistically significant.

For the secondary endpoints, patients who took AXS-05 had a mean MADRS score reduction of 5.2 at the first week, compared with a mean reduction of 3.6 among those in the buproprion-only group. At the second week, those who took AXS-05 had a mean MADRS score reduction of 8.0 versus 6.1 for those who took buproprion only. Overall, patients who took AXS-05 had a mean MADRS score reduction of 8.6 for the entire six-week trial, compared with a mean reduction of 6.7 in those who took buproprion alone. **PN**

MH Care

continued from page 1

Campus, and colleagues surveyed psychiatrists from March 19 to 30 and received responses from 101 psychiatrists in 29 states. They grouped the respondents by practice setting, including outpatient, hospital based, and "other" for those in forensic care and training programs.

"We used a narrow time frame, realizing it would result in a smaller sample size, but that will allow us to go back to this respondent set over time and watch how things change," Simpson said. "We had to work quickly because things are changing so fast."

Fifty-eight percent of respondents said the community response, such as stay-at-home orders, has negatively impacted the quality of mental health treatment, while 71% said the response has negatively impacted access to treatment.

Psychiatrists reported concerns over quality of and access to mental health care even as 91% said they have increased their use of telemedicine.

Respondents reported differences in how they're getting information about COVID-19, as well. Many of those working in hospitals reported primarily getting information from their employers, while those in outpatient settings are relying on websites run by the government and professional organizations like APA.

At 95%, nearly all the respondents said they were somewhat or very worried about patients contracting and becoming ill with coronavirus.

"This was a very heartening finding to me," Simpson said. "This is evidence that psychiatrists are dialed into a significant medical concern facing their patients."

Few respondents reported interactions with COVID-19. Only 19% said they, friends, or family members have been tested for the virus. About a quarter said they had treated a patient with suspected COVID-19, and 3% had treated a patient who had a confirmed case. "The low observed contact rate may suggest that COVID-19 is not widely present among these clinicians' patients, is not associated with significant psychiatric morbidity, or that mental health systems are not identifying patients at risk," the authors wrote.

Simpson cautioned that the survey was conducted in late March, and with the fast-paced spread of the pandemic, perceptions may already be changing. Researchers plan to conduct a follow-up survey with the same respondents to see how views of the pandemic's impact on mental health care evolve, particularly as people's exposure to COVID-19 and interventions change, Simpson said.

Patricia Westmoreland, M.D., president of the Colorado Psychiatric Society and an author of the study, said she suspects the follow-up survey will show significant changes to psychiatrists' perceptions of mental health care during the pandemic. "Even just a few weeks feels like a lifetime in the COVID era," she said.

Some concerns about access to and quality of mental health care may be mitigated, she said, as psychiatrists previously unfamiliar with telemedicine become accustomed to the care delivery format.

But she is concerned with how the need for mental health treatment may rise acutely as the pandemic continues. "I think we are about to face a tsunami of mental illness from the effects of people being quarantined and isolated," she said. "The social divides are also presenting a greater problem. It's much easier if you're wealthy to stay at home and access technology for the delivery of medical care, groceries, and meals. People whose incomes are lower don't have that luxury."

"Coronavirus and its ongoing public health response will carry lasting implications for psychiatric care," the authors wrote. "The time to begin studying and anticipating those impacts is now."

The survey was supported in part by an NIH/NCRR Colorado CTSI Grant.

Contents are the authors' sole responsibility and do not necessarily represent official NIH views. **PN**

"Novel Coronavirus and Related Public Health Interventions Are Negatively Impacting Mental Health Services" is posted at https://www.sciencedirect.com/science/article/pii/S0033318220301146.

Special Supplement to
PSYCHIATRIC NEWS

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COVID-19 and People With SMI: New Notes From the Field

By adhering to a strict set of safety guidelines and procedures during the COVID-19 pandemic, people with serious mental illness (SMI) and those caring for them can stay safe regardless of setting.

BY JEFFREY GELLER, M.D., M.P.H., AND MARGARITA ABI ZEID DAOU, M.D.

It's been four weeks since our first article on COVID-19 and people with serious mental illness (SMI) appeared in *Psychiatric News* (see https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2020.4b39), and in the world of the COVID-19 pandemic, that's more than enough time for lots to change. In this article we present updates, highlighting what's been done to help people with SMI stay safe at this time and drawing on our own experiences and those of many colleagues. The ideas here are just that—they are neither guidelines nor standards of care. They allow you to see what others are doing and to modify and mold these practices to meet the needs of your facility, community, and staff.

Inpatient Care

Who comes into the hospital?

Only hospital staff enter the building. If state law requires it, patients' attorneys may enter. But there are alternative ways to exercise a patient's right to see his or her attorney.

No one enters the hospital without answering a screening questionnaire based on guidelines from the Centers for Disease Control and Prevention and having his or her temperature taken. An affirmative answer to any of the screening questions or a temperature above 100.4 F precludes entrance until the staff person gets a negative COVID-19 test result.

Jeffrey Geller, M.D., M.P.H., is president of APA. He is also a professor of psychiatry at the University of Massachusetts Medical School and sees patients daily at a public psychiatric hospital in Massachusetts. He serves on the boards of Clubhouse International and the Treatment Advocacy Center. Margarita Abi Zeid Daou, M.D., is an assistant professor of forensic psychiatry in the Law and Psychiatry Program at the University of Massachusetts Medical School. She provides clinical care to patients in the largest state hospital in Massachusetts, Worcester Recovery Center and Hospital.

All who enter the hospital must do the following:

- Wear masks throughout the hospital unless alone in his or her own office.

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- Use alcohol-based hand sanitizer at the entrance and repeat sanitizer use or thorough handwashing multiple times a day.

- Go directly to his or her work area and stay there unless the job requires the person to go to other places in the hospital.

Monitoring patients and patient self-monitoring

Place visual reminders on the units for symptoms to be recognized and reported. Patients frequently forget, misattribute, or ignore symptoms. Remember that some patients do not read English; they should have equal access to the information through pictograms.

Talk to patients during daily/weekly meetings about COVID-19, symptom recognition, and their fears and concerns or lack thereof. Encourage patients to describe their understanding, ask them questions, and educate them about what they miss. This will decrease anxieties, allow otherwise undetected symptoms and concerns to surface, and especially make nurses' tasks somewhat easier.

Nurses check for symptoms daily. Nurses obtain a full set of vital signs, including measures of temperature, oxygen saturation, respiration, and heart rates daily. They do this two or three times a day if warranted by particular vulnerabilities and if nursing is reasonably well staffed.

Establishing COVID-19 unit(s)

The freestanding psychiatric hospital uses subsections of a larger unit or separate units if the hospital has small units to create (1) an admission unit, (2) a unit for suspected COVID-19 cases, and (3) a unit for confirmed cases. All patients who enter the hospital, including those sent elsewhere for medical emergencies, go to the admission unit and then are transferred to other units as soon as they test negative and it is thought to be safe to do so.

Patients within the hospital who have suspected signs and symptoms of COVID-19 are moved to the suspected-cases unit. If they test negative, they return to the unit from which they came. If they test positive, they move to the confirmed-cases unit. Thus, all confirmed cases are isolated in one area of the hospital. Patients must remain in their own rooms on these units. The hospital must have the capacity to lock patients in their rooms if necessary, even if the hospital would never do so under ordinary circumstances. This includes ensuring rooms do not have blind spots that could be missed by staff conducting safety checks and informing patients ahead of time (and repeatedly as needed) of those measures to minimize negative affects and reactions to "more confinement."

Be prepared that asymptomatic spread may happen on any unit, turning it into a seed for the virus and potentially a self-designated COVID-19 unit. Keeping both staff and patients informed and equipped is essential to avoid reactive measures and further surprises.

All staff who work on the COVID units do not work anywhere else in the hospital. Staff from other units never float or do overtime on these units. If there is a code, staff from other units do not go to these units; the units must be staffed to meet their own code needs. Staff enter the building at the closest entrance to the unit where they work and go directly to the unit; they stay on that unit for their entire shift. If a nearby breakroom is not used by anyone else, staff can go there. The hospital provides meals to the staff on the unit. Staff who need nicotine replacement should obtain gum, lozenge, or patch as off-unit smoking breaks should be eliminated. Staff leave the building at the end of the workday by going directly out of the building.

If the hospital does not have enough psychiatrists or nonpsychiatric physicians to devote them solely to one unit, these individuals must have head-to-toe personal protective equipment so as not to spread COVID-19 throughout the hospital. Hospitals that have the ability to split their psychiatric and other medical staffing should resort to a rotating part-time off-site work schedule. They should improve use of VPNs, shared calendars, and remote communications.

What staff is on a unit?

Nursing staff must be on units to manage patients. The other clinical disciplines have some discretion. These professionals need a schedule designating who is at an in-person meeting and who is there by other means. If a discipline has more than one member on a unit, the members should be rotated. This should allow those in the room to be sitting six feet apart, including when the patient is present. Patients are informed who is participating remotely even if the patient cannot see staff's images.

Teleconferencing and videoconferencing

Technology can provide a wide set of players equal access to patients, but this requires—at least at the front end—significant coordination and mastery of devices that many staff may have never used. The hospital gives each unit a dedicated tablet with a videoconferencing account. Attorneys, outside evaluators, family members, and friends can connect remotely (by appointment only) to speak with patients after obtaining the account link for the unit.

Psychiatrists and other team members should also be accessible remotely—whether working on-site or off-site—especially since they are less present on the units than they usually are, leaving a higher burden on nursing staff to manage patients.

Interpreters

Psychiatric assessments are particularly reliant on proper communication, more so than other medical specialties. Patients with Low English Proficiency (LEP) may be at a further disadvantage if not provided with the appropriate language assistance, especially during those times of rapidly evolving news and recommendations. If interpreters are not considered essential enough to be allowed in-person access to the hospital, videoconferencing (even more than telephonic interpreting) should be accommodated whenever possible. Interpreters not only communicate verbal messages between languages, but also visual cues that may be culturally bound and that culture-discordant health professionals may misinterpret or miss. Deaf patients must have interpreters in the room.

COVID-19 testing of all patients in a free-standing psychiatric hospital

In the case of a public psychiatric hospital, the state Executive Office of Health and Human Services sends members of the National Guard in hazmat suits to test all patients in a single day. This was successfully done in one state hospital with 250 patients.

At unit-based, group, or individual meetings, patients are informed the test will be done by swabbing through the inside of the nose with a long cotton swab—a small amount of cotton attached to a stick. Patients are given notice that the test may be uncomfortable but will not cause harm.

Patients are told that the test results don't all come at once and that it is not significant whether their results come sooner or later. Staff tell patients they will learn the results when they become available.

For those patients who have guardians, guardians are notified before the testing. This is a notification contact, not a contact requesting authorization to do the test. Messages are left if the guardian is not reached.

Patients are asked to agree to the testing and are told staff want to know whether each patient needs more medical help because they test positive. Patients are informed, prior to testing, that those who refuse the testing will be sent to the COVID-19 unit and quarantined for 14 days. Their accepting of the test is voluntary, and they can reconsider their choice either way.

This model can be used at VA hospitals, private hospitals, and psychiatric units in general hospitals with variations as to who does the initial testing.

Informing inpatients what they can do to further decrease risk

Patients are told to spend more time in their bedrooms. This has to be explained to each patient, providing as much explanation as each patient can comprehend. For weeks, months, or years, patients have been told not to stay in their rooms and isolate. Now patients are being told exactly the opposite. Group attendance and milieu activities that used to be one measure of patients' engagement in treatment are now canceled to avoid patient and staff gatherings. That can be confusing as well.

Masks are provided to all patients. Each mask is labeled with the patient's name. Patients are told how to store their mask when they are in their room (if they have a single room). Each patient is given a paper bag with his or her name on it, and the bag is stored in the same location in every room. Patients are told to wear their own mask only and absolutely not to trade or share masks.

Patients are told to handle the mask by the ear loops because the front or back may be contaminated. Patients are told when they receive the mask to keep their hands away from their face and to wash their hands after taking off their mask (this is only possible in hospitals where patients have bathrooms connected to the bedroom).

The masks can be purchased, but they can also be made. In one hospital, the rehabilitation staff took the lead on making masks of different materials (see photos on page 24). Special masks, using short pieces of cloth, are made for patients whose risk assessment indicates they would be a suicide risk.

When masks are distributed by the nurse, the nurse reminds each patient of risk-mitigation efforts that the patients have heard again and again since precautions began—those related to social distancing, hand washing, and the proper way to cough.

Suicide and self-injury

Greater vigilance needs to guide the care and treatment of patients thought to be at risk for suicide in the hospital and even some patients not usually thought to be at risk. Hospital-wide restrictive measures can further impact some inpatients whose world may now be limited to a room. Confinement, lack of agency and helplessness, anxiety, poor sleep, insecurity, and isolation are all COVID-imposed suicide risk factors. Keep a closer watch. Talk about it.

As usual, the psychiatrist and nurse decide whether to put a patient at a higher level of observation for suicide risk. The COVID-19 precautions introduce a new environmental risk factor—the availability of other patients' masks.

Transforming what are usually group activities into solitary activities

Classes, rehabilitation groups, and leisure groups are suspended. In their place, staff who ran groups have schedules to meet with patients individually.

Meals eaten in dining rooms are replaced with meals eaten in scattered areas or even in patients' rooms. Since it is likely patients have been told again and again not to eat in their rooms, they need to be told doing so is an emergency measure and not a change in hospital policy. Patients at risk for dysphagia should be identified and allowed to eat only in an open area with staff supervision to minimize risk of choking.

Large groups are no longer allowed in outdoor spaces. Schedules are coordinated so that small groups may use these spaces for recreation or other purposes. Each time a small group goes outside, the patients are reminded about staying six feet apart. Equipment, like a basketball, that would be handled by multiple patients cannot be used.

Staff burnout

Staff burnout needs to be recognized as a risk factor for the spread of COVID-19 as well as for bad outcomes from myriad other sources, like the psychiatrist's missing a patient's change in symptoms or a nurse incorrectly administering a medication. Nursing staff are particularly burdened by the added duties with which they are tasked during this pandemic. Sometimes understaffed, often working longer shifts, largely unable to use vacation and personal time, nurses and mental health aides are the frontline workforce on psychiatric units. The nurses are now expected to check vital signs more frequently, keep educating patients on-the-go about safety and hygiene measures, coordinate meetings and appointments requiring the use of teleconferencing, and operate the dedicated tablet for remote encounters to take place. They, and the mental health aides they supervise, are the first to receive and handle patients' anxiety, anger, need for extra support, and refusal to cooperate. Nurses, and especially mental health aides, respond to patients' potential and actual violence, which may increase with all patients in such close quarters. For their safety and that of patients, nurses are strictly confined to their unit throughout their shift, and they may not always be updated in a timely fashion about hospital policies before they are asked to implement them and accommodate their practices to them. As flexible, healthy, and well-adjusted as they may be, nurses now face the same insecurity and powerlessness as our patients while carrying more risk than team members on the front line.

What is the role of the psychiatrist? Start with what we do best: supportive listening. Step in where we can to help, even if it's usually the nurse's or the mental health aide's job. Educate and share information about new developments in the hospital and in the field. Use the flexing of HIPAA restrictions to share information that may save lives. Feed the staff. Bring in individually wrapped candy or other goodies and casually leave them in the nursing station. Ask a nurse or aide how his or her family members are doing. If you know, tell them where to buy toilet paper!

Downstream of COVID-19, the surge of mental health needs for people with SMI and those with less severe mental illness will increase. Having *mentally* healthy and capable staff ready to continue providing psychiatric care is more crucial than ever.

Community Residential

Group living environments (GLE)

Residents are not permitted to leave the residence and its property. If the residence has grounds, then residents can exercise on those grounds.

Residents cannot congregate in common areas of the residence.

The number of residents allowed in the kitchen, living room, and other common areas at one time is designated with signage on the walls for each area.

Residents do not eat meals sitting together at one table. They eat in shifts or spread throughout the common areas of the house.

Food shopping is done online.

Prescriptions are delivered if possible. If not, staff pick up prescriptions at the end of a workday and bring them to the GLE the next morning when they come to work.

No matter how many sinks and toilets are in a bathroom, only one resident uses the bathroom at a time. All residents must keep all toiletries in their own room.

Staff and residents develop learning objectives for each resident that involve online tasks, reading, artwork, puzzles, word games, or any activity that one can do on one's own. If the GLE has a yard, these tasks can involve outdoor, solo activities.

All appointments with primary care providers, psychiatrists, and therapists are done virtually. This should be no hardship as most of these appointments are being done virtually in all sectors—except that they may require further staff

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involvement and assistance for people with SMI.

One exception to consider involves residents who work in health care settings—or other truly essential jobs—where they are needed on-site. GLE staff should do their utmost to accommodate these individuals by establishing a way for them to go to work and to be isolated at all times from all other residents when they are in the house. If this is not possible, staff should look into alternative temporary living situations for these residents.

Independent living

People with SMI living independently or with various forms of support, such as Programs of Assertive Community Treatment (PACT), intensive case management, or cluster apartments pose a tremendous challenge.

Long before the COVID-19 pandemic, many people with SMI were struggling with isolation and loneliness; this problem is now amplified. After years of being taught skills and encouraged not to isolate, all of a sudden the same staff are saying, "Stay home. Don't go out. Don't get closer than six feet to anyone." Outreach workers who have shown up reliably for face-to-face meetings don't come anymore. The psychiatrist these individuals have seen every month, perhaps for decades, is only a voice on the phone. People with SMI who worked so hard to be able to enter a supermarket and shop on their own are told to stay home and order online. The ritualistic cup of coffee at the corner diner can't happen because the diner is shut down.

To avoid two bad outcomes—significant increase in psychiatric symptoms due to increased isolation and enduring the risk of COVID-19 infection because being trapped in a room or an apartment alone is just too hard to do—PACT staff, outreach workers, and outpatient therapists must increase (not decrease) contact. Have virtual meetings, more frequent phone contact with those who don't have a computer, and use more "brief" check-ins. Depending on the level of restrictions and the safety of being outside in one's area, while staying at least six feet apart, meet the person with SMI in a park, take a walk together, go together to the ATM machine, go on a local hike in the woods, take a bike ride, and so forth.

Clubhouses have set up virtual events and call-in lines. Some drop-in centers and peer-run services have reconfigured themselves into virtual services. Hotlines are geared up for more calls.

The essence of these interventions is to help people with SMI not feel alone and not feel scared.

Crisis Services

Depending on where one is located, crisis services have operated under one of several models: (1) mobile crisis intervention, (2) mobile only to emergency departments (ED), (3) ED services, (4) police-behavioral health specialist partnership, (5) police crisis intervention team, (6) police to lockup to mental health court, and (7) others.

A paradigm shift in crisis intervention is in place now. Whereas the ED was seen as a safe and effective locus for dealing with psychiatric emergencies in the past, the ED is now the last place anyone wants to see a psychiatric emergency end up.

The problem is that many of the crisis services that kept individuals out of EDs are not operating.

Masks: Kathryn Price, O.T.R.

At Worcester Recovery Center and Hospital in Massachusetts, rehabilitation staff created masks made of different materials. Special masks with shorter loops were made for patients assessed to be at high risk for suicide (see third photo from top).

So, while the psychiatric service system wants to keep psychiatric patients out of EDs, the tools to do this have evaporated. Even the last resort of arresting individuals and taking them to the state hospital for a forensic evaluation is now harder because the courts are operating on very limited schedules. And jail is no place for an individual with SMI to be, even without the COVID-19 threat, much less now where many of the COVID-19 precautions are not possible in the large, crowded setting of many jails.

The best approach to this dilemma is upstream interventions to avoid the crises. Jurisdictions can increase their use of assisted outpatient treatment (AOT) or the Sequential Intercept Model (SIM). Technical assistance in pursuing such interventions can be obtained from the Treatment Advocacy Center (https://www.treatmentadvocacycenter.org).

Correctional Services

Although not an appropriate place for people with SMI to be, correctional settings in the United States house more mentally ill individuals than psychiatric hospitals. Often, the same individuals with SMI circulate between jails/prisons, state hospitals, and the community. People with SMI also include those with addiction, trauma, poverty, and relatively poor health conditions, further overwhelming the limited services and resources and overcrowded and unsanitary conditions in jails and prisons. This is, basically, the perfect combination of factors for ravaging devastations by COVID-19, unless rapid and strict measures are taken to prevent and limit the spread.

Similar COVID-19 safety rules to those implemented in psychiatric hospitals are to be considered. Additionally, it has never been timelier than now to decrease crowding by releasing low-level offenders whose crimes were clearly a function of their mental illness. As hard as it may be at this time, these individuals must be released to at least circumstances that can keep them safe. While we're setting up tents or taking over hotels or convention centers for temporary hospitals or to house the homeless, perhaps we can do the same for people released from jails and prisons.

Safety for Victims of Abuse

The group at-risk for abuse is large and includes children, individuals (mostly women) in abusive relationships, vulnerable elderly people, and mentally ill individuals living at home. Increased and prolonged confinement with abusers is accompanied by fewer avenues for help: No playdates, no school personnel or neighbors to witness and report; no in-person doctor or ED visits to screen and report. Thus, there is no protective services involvement. Since it's more difficult to call for help in the abuser's presence, alternate means are desperately needed: safe words to use in supermarkets, phone apps that connect to local agencies or police departments where victims can silently seek help, and designated hotels where victims can go for assistance and shelter.

Psychiatrists should be on heightened alert for indications of abuse when interacting with patients. Many patients are connecting with their psychiatrist from the patient's home. The background sounds of threats, fighting, or crashing furniture should not be ignored.

Conclusion

The COVID-19 pandemic is a struggle for us all. For a significant percentage of individuals with SMI, it is even more of a struggle, as many of the tools that those of us without an SMI use to cope are not available to individuals with SMI. Severe depression, little tolerance for stress, and paranoid thoughts before the pandemic are all magnified in the face of this coronavirus attack. To save lives, we who provide care and treatment to these individuals need to use whatever resources we can, in as creative ways as possible, without worrying about whether it's been done exactly this way before. One resource to draw on is the SMI Adviser, an APA and SAMHSA initiative that provides clinical support and consultation for treating people with SMI (see https://smiadviser.org/clinicians). When dealing with this population, it's worth remembering that we are providing care in an environment with no precedent—there are no evidence-based practices. If the risk is low, don't wait to try something that just might work. **PN**

LETTERS TO THE EDITOR

Psychotherapy Subspecialty Ill Advised

In response to the *Psychiatric News* article "Should Psychotherapy Be a Psychiatric Subspecialty?" (https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.3b6), supporters of subspecialization are motivated by a laudable enthusiasm for maintaining psychotherapy as a core function of psychiatry. But for many reasons, creating a subspecialty will undercut, not support, this goal.

British psychiatry is not a model for American psychiatry. As a senior medical student nearly 60 years ago, I spent three months at the University of Edinburgh. Psychotherapy was not a major component of British psychiatry, and it still is not. It was created as a supspecialty there precisely because it is not a major part of British psychiatry and never was.

Subspecialties struggle to attract trainees. There is no indication that a significant number of psychiatrists would extend their training for a new subspecialty. Moreover, psychotherapeutic skills take time to develop. In a one-year subspecialty training program, the longest one could see a patient is for one year—hardly long enough to develop skills as a psychotherapist. A residency provides enough time to develop psychotherapeutic skills over three and a half years.

Advanced postresidency training in psychotherapy is already available at any number of psychoanalytic institutes, which have psychotherapy training programs. A psychiatric subspecialty uses resources to create what is already available.

Finally, the decline in interest in psychotherapy by psychiatrists is partially related to economics. A psychiatrist can earn more seeing four medication-management patients in an hour than one patient in psychotherapy. Subspecialization does not address this reality.

Although we have focused on the need for substantial psychotherapy training, a more important need may be to ensure psychiatrists learn how to assess our patients' complex psychology. We cannot effectively treat our patients by simply matching a patient's behaviors and symptoms to those of the *DSM*. We must fully understand the psychology and biology of our patients before we can decide on a patient's treatment. Without this understanding, one cannot learn to be a psychiatrist, let alone a psychotherapist. **PN**

SIDNEY WEISSMAN, M.D.
Chicago, Ill.

Dr. Weissman is a clinical professor of psychiatry at the Northwestern University Feinberg School of Medicine and a faculty member of the Chicago Institute for Psychoanalysis.

Letters to the Editor

Readers are invited to submit letters of not more than 350 words for possible publication. *Psychiatric News* reserves the right to edit letters and publish them in any of its formats—print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be emailed to cbrown@psych.org. Clinical opinions are not peer reviewed and thus should be independently verified.

Delirium

continued from page 12

outcomes."

In addition to robust screening, Hwang recommended that health care workers ensure patients with breathing problems are receiving oxygen therapy and receiving acetaminophen for fevers and pain; this could prevent many cases of delirium before they happen, she said.

Delirium Screening Is Critical

Nidhi Rohatgi, M.D., a clinical associate professor of medicine at the Stanford University School of Medicine, agrees that comprehensive patient screening for delirium is critical. As part of an initiative on optimizing delirium care that she helped spearhead at Stanford, nurses in the medical and surgical wards screen all patients for delirium using a scale known as the Confusion Assessment Method (CAM). The scale assesses attention, disorganized thinking, acute onset, and more.

The nurses also screen all patients for delirium risk. "Preventing delirium is everyone's responsibility, not just the psychiatrist's, because once medications [that increase risk of delirium] have been administered or delirium has lingered on for some time, it is a much tougher job for the psychiatrist to reverse or resolve delirium, and it is more likely the patient may be left with long-term cognitive impairment," Rohatgi said.

"One of the issues with predicting delirium is that the risk factors are different for the various patient subgroups across our hospital," she said. By working with physicians across specialties, Rohatgi's team came up with a short list of 10 common risk factors, such as older age or hearing/vision problems, that was broadly applicable if not perfectly accurate. Both the CAM screening and screening for patients at risk of delirium can be completed by nurses in two to five minutes, which is useful as staff may not have the luxury to conduct thorough risk assessments during a patient surge.

Regardless of the screening tool used, establishing a written plan for screening and treating patients with delirium is key to patient care, so all members of a health care team are on the same page.

"This is not something you should be doing on the fly," said Biese, who along with Hwang helped write up a brief tip sheet highlighting key principles of delirium care during the COVID era (see box on page 12). Though intended primarily for geriatric patients, many of these tips are applicable for all ages.

Delirium Care Complicated By COVID-19

Most delirium protocols involve identifying delirium, identifying the cause of delirium (for example, infection or low oxygen), and then treating the underlying cause of delirium as well as delirium symptoms.

Treating delirium in COVID-19 patients is a complicated matter. Studies have shown that the most effective measure to prevent or treat delirium is a tool known as the ABCDEF or A2F bundle. This tool encourages health care providers to work with patients to orient them to their surroundings, encourage movement, and engage with family and/or friends. For isolated COVID-19 patients recovering in crowded hospitals, implementing A2F care may be difficult. Also, a lot of skilled nursing facilities are not able to accept patients with COVID-19, so these patients must stay in the hospital environment much longer.

Difficult but not impossible, Wilson and others stress. "ABCDEF was designed to be flexible," Wilson said. If a center doesn't have available physical therapists to mobilize patients, for example, patients can at least be repositioned periodically. Other simple preventive measures include keeping blinds open during the day and ensuring patients are not retaining urine or constipated. "Staff should try to do what they can and get creative when needed."

Sikandar Khan, D.O., M.S., a research scientist at the Indiana University Center for Aging Research at the Regenstrief Institute, has turned to music as one potential creative solution for delirium. He recently led a pilot study that showed that a few hours of slow, rhythmic music each day might reduce delirium severity in ICU patients on ventilators. What's more, patients found the slow-tempo music as enjoyable as playlists suggested by family. "This is beneficial since it doesn't put extra burden on bedside staff. … [J]ust place the headphones on patients and press play," he said.

Khan, who has started another pilot study using virtual reality headsets to help ICU patients get exercise in bed, thinks technology can offer a low-cost/low-risk delirium interventions during this ongoing pandemic.

Biese agreed. "I can see a future where it's standard practice to put an iPad in every hospital room," he said. "It's an easy way to ensure isolated patients are always close to social support."

Rohatgi also emphasized the importance of empathy when working with patients who may be experiencing delirium. "[W]hen you do an in-person evaluation, just take two minutes to ask the patient some questions not related to the diagnosis, like what they like to do in their spare time or how they are really feeling." Just because physicians have a covered face does not mean they cannot exude empathy.

"Health care workers are rightfully afraid of exposing themselves and their families [to COVID-19]," Wilson said. "But despite our fears, we have to slow down and remember to practice evidence-based medicine. The guidelines we had in place a few months ago are still the best approach today. It's important that we continue to provide rigorous, patient-centered care even in these taxing times."

She cautioned that if health care professionals "go soft" and default to using antipsychotics or benzodiazepines for agitation in patients instead of taking time to assess patients for delirium, it could lead to "an avalanche of delirium cases today and new-onset dementia cases tomorrow."

Hwang predicted that COVID-19 is likely to lead to lasting changes in emergency medicine. She said she hopes one of these changes might be a better system of emergency care, which treats delirium as a priority. "I've had many colleagues from other specialties ask how they can help us. I think raising awareness about delirium and how to spot it is something psychiatrists can do during this current epidemic." **PN**

More information on Rohatgi's delirium program is posted at https://www.amjmed.com/article/S0002-9343(19)30516-9/fulltext. More information on Khan's music therapy trial is posted at https://aacnjournals.org/ajcconline/article-lookup/doi/10.4037/ajcc2020175.

continued from page 15

to travel back and forth to the program as many times a week and potentially be exposed to people who are infected or infecting others unknowingly. And then there are those who are quarantining and wouldn't otherwise be able to get their meds."

On the other hand, he pointed out, "a lot of patients don't reach the level of stability that we would typically feel comfortable giving them take-homes," so now the decision of how many take-homes to give an individual patient is far more complicated. "I have to think 'OK, if this person is still using cocaine on a regular basis but is no longer using heroin because the methadone has been effective, how many take-homes is safe to give the person?' … We have to use our best judgement, and frankly it's been somewhat of an educated guess lately as to what to do. … The risk-benefit ratio has really shifted, and it's not based on any data."

Another issue, Stoller said, is that although SAMHSA and the DEA now allow for doorstep delivery of medications for people who are quarantined at home, the structure of programs doesn't support staff being out in the field delivering medications all day. So now, opioid treatment programs (OTPs) are working with states and localities to try to design systems that would enable that delivery.

Examples being explored in Baltimore include use of a core group of city OTP staffers, use of existing delivery services, or dedicated funding for use of bonded courier services.

Technology Facilitates SUD Management

Despite the many challenges, technology is proving extremely useful in the SUD treatment world. Earley runs several group sessions a week, both support groups for people in recovery and psychotherapy sessions, all now through telemedicine. "People are joining these groups who wouldn't normally join groups for support and psychotherapy. … The upside is people are saying 'Wow, this is really helpful. I don't have to drive somewhere. It feels a little odd looking at each other on a computer screen or on my phone, but I'm getting some help.'"

This new reality, Earley said, "is forcing us to consider telemedicine as an industry. I think [telemedicine] is going to help extend the efficacy of addiction treatment in a significant way long after COVID-19 is gone."

Earley uses both Zoom and UberConference for group sessions with patients. He said he prefers the latter for smaller meetings, but feels Zoom is better for larger groups.

Stoller is also using Zoom and sometimes FaceTime for individual therapy. In addition, Doximity now has a video platform whereby the physician can send the patient a link to click on and go to a video chat. The service also has a dialer function where the physician can call the patient from home, but the number that shows up is the physician's office number. In hospitals, electronic health record systems such as EPIC also have their own audio and/or video platforms to connect with patients, he pointed out.

Another type of technology that may help resolve the take-home dilemma is an automated electronic pill dispenser called MedMinder (https://www.medminder.com). Stoller's OTP and two others in their collaborative have begun using it to dispense methadone. "Rather than simply giving a large number of take-home medication doses to patients in whom we may not have a lot of confidence in their long-term stability yet, we're able to load those doses into a pill dispenser that unlocks each day's dose one at a time at a pre-programmed time of day."

"A pandemic like this … brings out the patients who may [have been] reluctant to talk about their addiction disorder." —Paul H. Earley, M.D.

The boxes are leased at about $60 to $65 a month. The monthly fee is waived for patients who obtain their medications from a pharmacy that uses MedMinder boxes; patients pay only the medication copay.

Stoller is working with Behavioral Health Systems Baltimore and the Maryland Behavioral Health Administration to identify state and local funding to enable pilot testing of the boxes in a few OTPs in Baltimore City. His faculty group is also working on setting up a multisite clinical trial to "add to the evidence base for this technology when used in OTPs."

"So if there's any silver lining here, I think this situation is driving a lot more development of technologies that can be used to provide other methods of patient care and safety," Stoller said.

Additional Resources

Earley said that since the COVID-19 lockdown began, he's been receiving "more and more calls from psychiatrists and colleagues in other areas of medicine" seeking assistance with how to treat patients with SUDs.

There are several resources psychiatrists who may be seeing new or established patients with SUDs but who aren't addiction specialists might find useful:

- **Providers Clinical Support System** (https://pcssnow.org/): The site provides evidence-based training and resources for treating opioid use disorders. These include trainings to prescribe buprenorphine (https://pcssnow.org/medication-assisted-treatment/waiver-training-for-physicians/) and COVID-19 resources (https://pcssnow.org/resources/covid-19-resources).

- **ASAM COVID-19 Resources** (https://www.asam.org/Quality-Science/covid-19-coronavirus): Resources on the site include information about access to buprenorphine, opioid treatment care, and telehealth; adjusting drug testing protocols; inpatient and outpatient infection mitigation; medication formulation and dosage guidance; and national and state guidance. The site also has a searchable member database to find an addiction medicine specialist for consults or referrals.

- **APA Practice Guidance for COVID-19** (https://www.psychiatry.org/psychiatrists/covid-19-coronavirus/practice-guidance-for-covid-19): APA has created a webpage of the latest guidance from the government at both the federal and state levels. The page includes information about working with patients with substance use disorders.

Earley said that one thing he's noticed is that "a pandemic like this also brings out the patients who may [have been] reluctant to talk about their addiction disorder … I don't quite know the causation, but people are talking more about their stressors and being a bit more open about what's troubling them. SUDs are diseases that live in secrecy and shame. If we can eliminate that, to even a small degree, we're going to get more people accessing needed services, which is a win." **PN**

Volkow's editorial, "Collision of the COVID-19 and Addiction Epidemics," is posted at https://annals.org/aim/fullarticle/2764313/collision-covid-19-addiction-epidemics. An editorial co-written by Stoller, "An Epidemic in the Midst of a Pandemic: Opioid Use Disorder and COVID-19," is posted at https://annals.org/aim/fullarticle/2764311/epidemic-midst-pandemic-opioid-use-disorder-covid-19.