

# The Westchester Psychiatrist

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## President's Column: Thoughts on Covid-19

By: Richard McCarthy, M.D.



Over the past few days, I have been speaking with a number of my private practice patients. Most are taking clozapine, an extraordinarily effective but difficult to work with medication. In Psychiatry, especially with the more seriously ill, one develops a special relationship with long-term patients. I have worked with some of my patients from as far back as 1985, many more from the 1990s and most of the rest for at least 5-10 years. I have been there as they struggled to recover, something that was thought not to be possible in the DSM 3 era. Seeing them weekly for the clozapine blood test for years, and monthly now, I have watched as they have become "Regular People." I am a friendly Uncle to them instead of the Doctor that they must report to. They see me infrequently because now they have a life. We discuss what is going on in their lives, what problems they have and how they are trying to solve them. I am careful to not take away from them the credit they deserve for their recovery. I am not sure that I could have overcome the problems that they have faced and wrestled.

In the Covid-19 pandemic, it is entirely possible that I might contract the virus. As a 71-year-old male with some mild medical comorbidities, I am in the high-risk group. If ill, I would be low on the list for the few ventilators that might be available. Even if I were to get one, it is not likely that the outcome would change; rather it is quite likely that I would die.

Many of us and our Medical colleagues face the real possibility of death in a way that none of us really expected. As we try to come to terms with this, we also seek to wrap up any loose ends with our families. What I did or did not do that might have hurt them. What are my Advance Directives? Who is the Health care proxy? Where is the will, the Deed? What and where are the bank accounts and who should get what? This is something that we probably have thought about, and we have a general idea about how to go about doing it. But what of our patients? They will need a new physician to care for them. They will need to develop new relationships, something that many of them are not particularly good at.

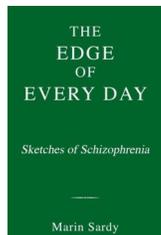
I began to speak with my clozapine patients about this in mid-March. These were difficult conversations. Most of them were stunned, some cried, others became angry. I made it clear to whom I would refer them, how to contact them and what they might expect. Then we discussed their lives, what they had been like, what obstacles they had overcome and how they had changed. I gave them my most recent avuncular thought, they thanked me for what had done for them and what I had meant to them. I reciprocated as best as I could. There was a Tom Sawyer watching his own funeral quality to it all.

I do not have a clever, thoughtful conclusion to this. The period of waiting for the "Peak" to hit is bizarre and completely removed from the oncoming tide. I worry about my family, myself and my patients. I also worry about my friends and colleagues. May we all be well. ■

## Book Review by Karl Kessler, MD:

### The Edge of Every Day: Sketches of Schizophrenia, by Marin Sardy

Pantheon (2019), 304 pages



Marin Sardy's book is a memoir of her growing up with her mother's mental illness and then dealing with the schizophrenia that her younger brother Tom developed in his 20s. Her mother had delusions and often lived impulsively, but she was the daughter of a wealthy father and her inheritance allowed her to indulge her compulsion to move from place to place. At some point in Sardy's childhood, her mother told her father to leave the home, and after that the author split her time between her two parents. She complains that her mother's illness was not adequately explained to her, as if she had known more about it, she would have been able to do more to help her mother or to distance herself from her mother.

The book then shifts to her relationship with her younger brother and his descent into schizophrenia. Tom had to leave college and was unable to work because of his illness, which became more and more psychotic. Because of Tom's illness, his father eventually had to refuse to allow him to live with him in his home

in Anchorage Alaska. Living on the streets of Alaska is an inhospitable climate for somebody with severe and persistent mental illness. This section of the book contains some excellent descriptions of how her brother was persecuted by his illness. He had the lack of insight (anosognosia) and a lack of willingness to accept help that is characteristic of many individuals with schizophrenia. Sardy describes the way her father and she tried to help Tom. At one point early in his illness, she invites Tom with her on a long vacation to Costa Rica, the better to observe and understand him. Later, she describes what it was like to get reports from her father about Tom's functioning while she was living far away and what it was like to see her brother living on the streets of Anchorage, after long periods of separation.

The book is very impressionistic and often not chronological. Although her brother's schizophrenia is well described, the nature of her mother's illness is less clear. In several places in the book she includes extraneous impressions of her own life, such as her practice of witchcraft, which could have been left out. ■

## JOINT DB MEETING – Bruce Schwartz, MD:

### Survey and Perspective on the State of Psychiatry in America

Reported by Jerry Liebowitz, MD

On March 10 at Carmines -UWS, the Bronx District Branch and the Psychiatric Society of Westchester jointly hosted a dinner meeting titled "Survey and Perspective on the State of Psychiatry in America." The speaker was Bruce Schwartz, MD, President of the American Psychiatric Association and Deputy Chair and Clinical Director of Psychiatry & Behavioral Sciences at Montefiore Medical Center in the Bronx.

Dr. Schwartz began his presentation by enumerating his two main objectives – understanding **the need for mental health treatment** in America and **the obstacles** to accessing such treatment. The first part of his talk focused on **clinical issues**.

He noted that the **prevalence of mental disorders** in U.S. adults aged 18 or older was 44.7 million (18.3%) in 2016, a slight increase from 2015 when it was 43.4 million (17.9%). There was a higher prevalence among women (21.7%) than men (14.5%). Young adults ages 18-25 years had the highest prevalence. He pointed out that 10-20% of children and adolescents have

mental health problems in the US and worldwide and that 50% of psychiatric disorders begin before age 14. One in seven U.S. children aged 2-18 have a mental, behavioral, or developmental disorder, of which 22% have severe impairment or 27.6% including substance use disorders. By comparison, about 8% of children under age 18 have asthma and 0.3% have Type 1 diabetes.

In a **comparison to common medical disorders**, Schwartz pointed out that mental disorders rank second (44.7 million), following cardiovascular disease and stroke (91 million). Half of all adults have at least once chronic disease and one quarter have two or more chronic diseases. For comparison, 18.3% had a mental disorder in 2016.

Regarding **mental health and disability**, Schwartz stated that psychiatric disorders are among the leading causes of disability

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## Psychiatric Society of Westchester's 33rd Annual Legislative Brunch

### Reported by Karl Kessler, MD, and Jerry Liebowitz, MD

Our 33rd Annual Legislative Brunch was held at St. Vincent's Hospital on January 26, 2020. Following introductions by PSW President Richard McCarthy and PSW legislative representative Susan Stabinsky, **Richard Gallo**, Government Relations Advocate for NYSPA (since 1973!) gave a **review of the 2019 legislative accomplishments and goals for 2020**.

He noted that his dual role reflected the main objective of our Legislative Brunch – to convey to legislators the concerns of psychiatrists and to convey to psychiatrists “the rigors that legislators go through.” They are working constantly and often struggle with each other, e.g., over the issue of legalizing marijuana. He pointed out that NYSPA represents more than 4,000 psychiatrists in New York State (including the 450+ members of PSW).

Before discussing NYSPA's priorities for this year, Richard Gallo celebrated the enactment of three of our previous legislative priorities:

1) **A law prohibiting “conversion therapy” for minors** was passed and signed into law last year. Chapter 7 of the Laws of 2019 prohibits licensed mental health professionals from engaging in efforts to change a minor's sexual orientation and defines such efforts as professional misconduct.

2) A bill initiated by NYSPA and passed in December 2019 requires a **parity report card** by insurance companies to see who is or is not in compliance. Implementation of The Mental Health (MH) and Substance Use Disorder (SUD) Parity Report Act, which requires insurers, health plans, and behavioral health management companies to submit key data and information to the Department of Financial Services (DFS), will be monitored by NYSPA in 2020. The first set of data has been posted on DFS's website at: [https://www.dfs.ny.gov/reports\\_and\\_publications/mhsud\\_reports](https://www.dfs.ny.gov/reports_and_publications/mhsud_reports).

3) After reviewing the history of medical insurance in NY going back to 1972, when mental health was initially not included, Gallo explained the components the **Behavioral Health Parity Reform Act (BHIPR)** that contains a series of historic reforms for MH and SUD, effective January 1, 2020. “Today we have the best parity laws in the country,” Gallo said proudly.

“Even with the best parity laws, ... they don't guarantee that anyone will get treatment,” Gallo noted, focusing especially on **out-of-network issues** that, he believes, must be addressed by

the Legislature. There are too many “hoops that mental health practitioners must jump through to see patients.” He pointed out how now it can take 14 days to get prior approval for an appointment and 28 days for SUD treatment.

NYSPA's focus for 2020, Gallo explained, is implementing **these laws to benefit our patients** (and other mental health providers).

Gallo then enumerated several of the **issues of concern to NYSPA for the 2020 Legislative Session**. He noted first that NYSPA has not taken a position regarding **legalizing marijuana**, whereas the Medical Society of NY has (against).

He noted that **the New York State budget** for fiscal year 2020-21 has an estimated \$6.1 billion shortfall, a large portion of which is attributed to Medicaid costs. One area of interest for NYSPA is the Governor's proposed relaunch of the **Medicaid Redesign Team (MRT II)** that is designed to save \$2.5 billion without raising taxes. Another is the **\$3,000 loan forgiveness for psychiatrists**.

Gallo concluded with the perennial **scope of practice concerns** and efforts to encroach on the practice of medicine. NYSPA continues to oppose attempts by psychologists to obtain prescribing privileges and having MA-level mental health providers being allowed to make diagnoses. He also brought up the issue of pharmacists seeking the authority to inject MH and SUD meds (in communication with prescribers).

Before asking the legislators for their comments and concerns, **Susan Stabinsky, MD**, PSW Legislative Representative, reminded everyone of the huge controversy at last year's Legislative Brunch about legalizing marijuana. She wondered where the legislators were on the topic this year. She then described with examples some of the **difficulties with obtaining prior authorization** that psychiatrists were experiencing.

The first legislator to speak was State Senator **Shelley Mayer** (37th District, from the Bronx to Bedford), chairperson of the Education Committee, was very pleased with the laws that were finally passed with a Democratic majority, even with the gerrymandering of districts that resulted in cities with divided representation. With a single focus on public education, she said that her number one concern is **the mental health of students** in

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New York State, especially younger children, and how this can be addressed. Saying that she was “thrilled” with parity legislation, she noted that access to mental health services is equally important to the new laws on the books. Pointing out that insurance companies have powerful voices in Albany, constituents must go through hurdles to get appropriate access. She recommended increasing insurance payments to mental health providers in order to **increase access to mental health care**. Many providers are in private practice and do not take insurance because the reimbursement rates are too low.

She expressed **concerns about legalizing marijuana**, including increasing marijuana use by young people and driving under the influence. “We don’t have enough evidence about its effects on young brains.” If marijuana is to be legalized, there should be funding for education, outreach, and a social-medical focus. “Edibles are a trap for children,” she stated, and a “driving force” for adults. She had personal experience with this, she explained, noting that three young people she picked for office ended up in psychiatric hospitals. This was “a game changer for me,” she concluded.

**David Buchwald**, State Assemblyman representing the 93rd A.D. (covering White Plains to North Salem) and a member of the Joint (Assembly and Senate) Budget Committee on Mental Health Issues, said he was concerned about the way that budget problems could affect mental health services. His office, with 130,000 constituents, helps patients with and without insurance – “a large part of the work for any legislator.” He highlighted a major concern: How to handle **the Medicaid deficit** in the State?! The governor, he explained, has reconstituted the Medicaid Redesign Team (MRT), which is tasked with proposals for cutting the Medicaid budget. However, the MRT report is expected to be released shortly before the State budget deadline of April 1, which would make it difficult for legislators and mental health professionals to adequately assess the proposals. Legislators “need to be generalists,” he explained, therefore “we rely on you [psychiatrists] to keep us informed” on areas that psychiatrists have expertise. He appreciates the **relationship with PSW**. “When we have a question, we know whom to go to.”

Regarding **marijuana legalization**, his sense of things is “not whether to move forward, but how to move forward.” He believes marijuana will be legalized in 2020 and wonders, what are the best practices to put in place? He noted that other states

did things in ways “not optimal,” and we should learn from that. We need to consider what will still be illegal – for example, sales to minors.

Buchwald is currently campaigning for Congresswoman Nita Lowey’s congressional seat because she is retiring from Congress after many years.

State Senator **David Carlucci** (38th senate district), Chairman of the Committee on Mental Health and Developmental Disabilities and Co-Chairman of the Senate Task Force on Addiction and Overdose and Veterans Mental Health, said one of his main issues of concern include **veteran’s access to mental health treatment** because of the difficulty they sometimes have in getting services through the Veteran’s Administration. “We want to end the stigma,” he emphasized, pointing out that **mental health care is medical care**. He wants to restore cuts that are in the governor’s proposed budgets. We should not be “penny-wise and pound foolish” when it comes to long-term prevention. Consideration should be given to having young veterans covered by New York State Medicaid. He noted that 22 veterans/day attempt suicide. He is working on legislation regarding suicide prevention and is a proponent of the FCC plan to designate 988 as a universal suicide hotline phone number, which he thinks will help reduce stigma.

Carlucci also supports **providers prevail** in medication authorizations, with no step-therapy lists, and he supports price restrictions or price controls to decrease the costs of prescription drugs. This will help make health care as efficient as possible. “It is becoming overwhelming,” he observed.

An important issue that should be examined, according to Carlucci, is whether to **reduce the division** (“the silos”) **between the three major mental health authorities in NY** – The Office of Mental Health, The Office of Alcohol and Substance Abuse Services, and The Office for People With Developmental Disabilities – and possibly merge the three. Nevertheless, he said, “New York State is head and shoulders above other states on mental health issues.”

He also wants to **expand judicial diversion** (from prison to mental health) by the creation of more mental health courts and domestic violence courts. This new law would allow the DA to refer a case to a problem-solving court (diversion court) in the county.

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James Kelleher, MD, a former PSW president, noted that New York has the lowest number of suicides per capita of any state. Carlucci added, "that's another reason we have to be leaders."

Carlucci then proposed that there be **loan forgiveness for mental health professionals**.

In 2019, Senator Carlucci was a co-sponsor of 36 bills that were passed in the State Senate, which was more than any other legislator. He is also campaigning for Congresswoman Nita Lowey's seat.

Several comments from the audience followed Senator Carlucci's remarks, leading to a very engaging discussion of the issues: the idea of integrating mental health, developmental disabilities, and substance abuse treatments by integrating the agencies; whether diversion programs are really meeting patients' needs; a call for an ombudsman to help address mental health and trauma needs; and encouragement to be proactive, not reactive. Robert Laitman, MD, raised concerns about legalizing marijuana, which he feared would lead to more people with psychoses, as has occurred in Canada and other states. He also raised the issue of supportive housing – "If you can't house, you can't treat."

**Steve Otis**, State Assemblyman from the 91st A.D. (New Rochelle, Larchmont, Mamaroneck, Portchester, Rye, and Rye Brook), highlighted some additional points. He was concerned about **budget cuts** that are needed because of the budget deficit and noted that new details needed to be deciphered. He wants us to help make the Board of Regents aware of the need for **mental health services in schools**. He expressed strong **opposition to psychologists prescribing** (scope of practice). He has many **concerns about legalizing marijuana** and believes that the legalization movement is driven in large part by non-medical issues – by a lack of equity in criminal prosecutions for possessing marijuana and by its legalization in some bordering states (VT and MA) and Canada. He urged caution. He is in favor of **stopping and restricting solitary confinement**. He noted the history of New York and Pennsylvania competing about what penitentiaries should look like, with Pennsylvania advocating for solitary confinement (where "a high percent went crazy") versus New York's cell block plan.

Assembly Member **Thomas Abinanti** from the 92nd District (Greenburgh and central Westchester) expressed concerns

about the **budget deficit** and the Governor's proposal to make an "artificial" 2% cap on increases in Medicaid spending. He noted that the **Medicaid Redesign Team (MRT)** is the Governor's means to circumvent the State Legislature. Previous actions by the MRT have been a "disaster for many people," he observed. He urged that future Medicaid Redesign Teams must include consumer representatives. He approves **legalizing marijuana** but prefers the **expansion of medical marijuana**. He sponsored the bill that **bans "undetectable" firearms**, which was enacted. These "ghost guns" are assembled from parts that are legally obtained, but they are not registered and have no registration number. He supports a mental health evaluation for everyone who wants to buy a gun.

**Michael Orth**, Commissioner of Westchester County Department of Community Mental Health and Co-Chair of the Suicide Prevention and Awareness Task Force, was concerned about the "silos" between State service agencies but stated that the Department of Community Mental Health is not such an organization. It serves adults and children and substance misusers and people with developmental disabilities. There are currently many County-funded mental health programs in Westchester and new ones are being considered and developed every year. There is an **Early Step Forward program** providing mental health services for children ages 0-5. There is **training for clergy** about mental health problems. There is an **educational program** about youth and adult mental health first aid given in schools. The County works with **diversion programs** for drug users in several communities. There is a **suicide prevention task force** that meets regularly. There is a state funded suicide review team to review suicides in the County to try to get more information on how to prevent future suicides.

**Robert Laitman, MD**, Chair of NAMI Westchester's Advocacy Committee, advocated for the passage of **Nicole's Law** (S06629), which would reform and improve the way hospitals and psychiatric facilities treat and discharge people admitted due to a self-inflicted, life-threatening injury. It is the first state legislation that has been inspired by NAMI's advocacy. ■

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in the US. Globally, he said, the top 25 leading causes of disability and injury between 1990 and 2016 include 9 mental, neurological or substance use disorders. "Cost is not inconsequential," he pointed out, with one third of all disabilities related to psychiatric disorders. The global costs of mental disorders, he noted, exceed the combined costs of diabetes, respiratory disorders, and cancer.

**Mental health and mortality** was another clinical issue Schwartz outlined. Of all deaths worldwide, 14.3% are due to mental disorders, with a median of 10 years of life lost. He compared this to 67.3% who die of natural causes and 17.5% of unnatural causes (suicide, injuries, etc.). In the U.S., he noted, individuals with a mental illness are more than twice as likely to smoke cigarettes and 50% more likely to be overweight/obese. Although the overdose death rate is leveling off and slightly decreasing, Schwartz emphasized, "We're not making a dent in the mortality associated with schizophrenia."

**Suicide is an epidemic**, Schwartz opined, with an increasing death rate, more than 30% over the past two decades, while others (including cancer, diabetes, heart disease, and stroke) are decreasing. Suicide is the ninth leading cause of death and the second leading cause of death among individuals aged 10-34 years. **Substance use** was the third largest contributor to suicide among people with and without known mental health conditions (28%) psychiatric disorders with the highest suicide mortality risk estimates are, in decreasing order: depression, bipolar disorder, schizophrenia, and anorexia nervosa

Sadly, "we are the only country in the world where the suicide rate is going up." In Russia, South Korea, Japan, India, and China there is "a happy decline."

Focusing on **mental health and homelessness**, Schwartz showed how they are inextricably linked. Approximately one third of the homeless population in the U.S. suffers from some form of severe mental illness (SMI). And having a severe mental illness increases the risk of becoming homeless by 10-20 times higher than those in the general population. Fifty percent of the homeless have a substance abuse problem and, he noted, substance use disorders are the single largest cause of homelessness for single adults. He pointed out that more than 50% of the chronically homeless were in three states: New York, California, and Florida.

Schwartz then discussed another serious issue, the **precipitous**

**decline of psychiatric beds** in the U.S., reflecting a 64% decrease in total psychiatric inpatients from 1970. State and County Hospital beds underwent a 96% decline from 340 beds/100,000 in 1955 to 11.7 beds/100,000 in 2016. The consensus, according to Schwartz, is that the safe minimum number of public beds for adequate psychiatric services per 100,000 population is around 50 beds. "We are significantly under-bedded" compared to Western Europe, he said. He explained how this shortage of beds, coupled with managed care, has affected our treatment. **Psychiatric readmission rates** are proportional to length of stay (LOS). Psychiatric patients in states with the shortest LOS were nearly three times more likely to be readmitted within 30-180 days of discharge than patients in states with the longest LOS. (Schwartz noted that in Japan the average length of stay is 6-9 months.)

Looking at the **trans-institutionalization of the serious mentally ill** in the U.S, he pointed out, reveals a decline from 88% in state hospitals in 1970 to 15% in 2007, but an increase in the **percent incarcerated** from 4% to 69% of the seriously mentally ill. "They didn't go away, the beds went away," he explained, pointing out that "prisons are now the largest mental health institution in the country." About 37% of prisoners and 44% of jail inmates had a previous mental health disorder, and many jail inmates with SUDs have co-occurring SMIs. And many of those without a mental disorder have a substance use disorder. More than 66% of jail detainees and half of prison inmates have a substance use disorder compared with 9% of people in the general population.

**The impact of psychiatric disorders on emergency departments** was the next topic Schwartz focused on, noting that more than 4% of all ED visits are attributable to psychiatric conditions: mental health 67%, substance abuse 24.4%, and co-occurring MH and SA 11.9%. Approximately 800,000 visits per year are for intentional self-harm, with the youngest adults disproportionately accounting for ED visits related to intentional self-harm and drug abuse conditions in 2007.

**Unmet behavioral needs** was another topic Schwartz highlighted, noting that in 2017 approximately 13,550 million adults reported a perceived unmet need for mental health services. About 20% of adults with mental illness reported that they were unable to obtain treatment because of barriers to getting the help they need. Approaches to addressing unmet behavioral health needs, he pointed out, include improving access to integrated behavioral health services and training primary

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care providers and others to screen patients for behavioral health needs.

Schwartz concluded the clinical part of his presentation focusing on **care disparities of the insured population**. He noted that there has been a 320% increase in seeking mental health services over last ten years, as reflected in private insurance claims for behavioral diagnoses, about one third of which was for out-of-network ambulatory behavioral care facilities (vs 5.5% for medical/surgical care), representing a doubling of access restrictions during three years of parity regulatory oversight. And almost one third was for out-of-network behavioral health office visits (vs 3.7% for primary medical/surgical). Regarding parity oversight nationally in 2017-2018, Schwartz pointed out, primary care and specialist physicians received 18-20% more in reimbursement for the same CPT codes than psychiatrists.

In the second part of his talk, Dr. Schwartz focused on **psychiatric research** in the U.S. Although the U.S. is one of the leading funders of mental health research in the world (through NIH, NIMH, NIDA, and NIA), the amount of federal research dollars spent on medical disorders far exceeds that for psychiatric disorders. “We are getting a much smaller piece of the pie,” he noted, less than 4%. And most of that is not for treatment. The amount of federal dollars allocated to research on psychotherapies is only a fraction of that spent on basic science and translational research. In 2014, for example, only 10% of the budget went to the division that supports studies on psychosocial, somatic, and rehabilitative interventions.

And, Dr. Schwartz noted, **psychiatric drug development** has stalled. This is due to several factors: disappointing results, gaps in our understanding of the etiology of mental disorders, and the very high cost of bringing a new medication to market.

In the third part of his talk, Dr. Schwartz focused on the **psychiatric work force shortages** in the U.S. Currently approximately 6,000 more psychiatrists are required to provide the minimum level of care that would de-designate the federally designated mental health professional shortage area. And the psychiatric workforce is predicted to decrease through 2024, with a shortage of between 13,280 and 31,091 psychiatrists. Then, starting in 2025, the workforce is projected to expand with estimates of a shortage between 3,400 to 17,705

psychiatrists in 2032.

In addition to the shortages, Dr. Schwartz noted the **workforce diversity problems**, with the numbers of minority psychiatrists trained in the U.S. estimated to be even lower than those in the overall U.S. physician workforce.

There is some good news, however, Schwartz pointed out, with an increasing percentage of U.S. senior medical students matching to psychiatry. In addition, psychiatry is one of the specialties that has a high percentage of physicians satisfied with work-life balance and a low percentage of burnout. And psychiatry ranked the highest (with cardiology) in the latest Medscape study of which young physicians would choose the same specialty again.

In the last part of his presentation, Dr. Schwartz discussed the **real progress** that has been made over the last several years:

- 1) The **Mental Health Parity and Addiction Equity Act (MHPAEA)**, although passed in 2008 to correct discriminatory health care practices, finally had rules issued in late 2013, effective for most policies and plans in 2015. “We lost seven years in the Obama administration,” he noted, but it is now the law of the land.
- 2) The **Medicare Improvements for Patients and Providers Act** eliminated Medicare’s discriminatory copayments for mental and physical health.
- 3) In 2009, the Patient Protection and Affordable Care Act (“Obamacare”) was passed and the MHPAEA was expanded to apply to health insurance plans offered to small businesses and individuals and to newly eligible Medicaid recipients.
- 4) The **21st Century Cures Act** (2016) created a high level Assistant Secretary for Mental Health and Substance Abuse in HHS, gave \$1.5 billion for the BRAIN initiative and \$1 billion for fighting the opioid epidemic, and expanded access to MH services for children through Medicaid and parity enforcement. Among its many other accomplishments, it gave SAMHSA grants for development of evidence-based interventions for psychiatric disorders and gave other grants to provide community mental health resources, suicide prevention and intervention programs, de-escalation training for law enforcement, and minority fellowships.

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5) The APA was given a five-year, \$14.2 million grant to create a **Clinical Support System for Serious Mental Illness (CSS-SMI)** that will help doctors and other health providers treat patients with SMI through consultation and education. Dr. Schwartz pointed out that this was **the first grant ever offered to a psychiatric organization.**

6) The APA was also awarded a new **CMS Quality Measure Development Grant** of \$5.38 million over three years to develop and test quality measures that are clinically relevant and capture the value of mental health treatment in high priority areas of MH/SUD for use in CMS's Quality Payment Program (QPP).

7) **The SUPPORT Act (HT6)**, the Substance Use Disorder Prevention That Promotes Opioid Recovery for Patients and Communities Act, was signed October 24, 2018, after passing with overwhelming bipartisan support in the House (393-8) and Senate (98-1). It provides , \$8 billion in spending for the opioid crisis and includes expansion of prevention programs and SUD treatment programs, increased funding for residential treatment programs for pregnant and postpartum women, grants to improve state prescription drug-monitoring programs, expanding the use of telehealth services and loan repayment, and provides funding for research and development of new non-addictive painkillers and non-opioid drugs and treatments.

He concluded by emphasizing that, despite the many obstacles, he is **optimistic** and sees **"the dawn of a new era,"** noting several important and positive developments. He explained that, although opiate overdoses, the suicide epidemic, mass shootings, veterans' mental health, and excessive and costly incarceration of the mentally ill are problems everywhere in the U.S., in "blue" and "red" states, his optimism comes from observing that these problems have attracted a **bipartisan political consensus and recognition that access to MH/SU services needs to be expanded. Parity Enforcement** is ramping up (e.g., the APA Model State Parity Law), and there is appreciation by our medical colleagues of the **benefits of integrated and collaborative care.** In addition, **population health initiatives** that focus on co-morbid depression, anxiety and substance use disorders are forming, which are essential **to managing health care costs.** Stigma, while still prevalent and problematic, is declining.

Dr. Schwartz, who created the APA Task Force for Continuing Care Guidelines for patients needing to be in the hospital, noted that "the New York State Department of Health is really incredible" regarding OMH guidelines, especially with a psychiatrist, Dr. Anne Sullivan, as its head.

He concluded by noting, "There is no health without mental health." ■

**We want to hear from our Members!**

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## TELEPSYCHIATRY CHECKLIST – MODIFIED PER CORONAVIRUS UPDATES (3/31/20)

Compliments of: PRMS, Inc.

1. I have reviewed my state's law on telemedicine, including, but not limited to:

- In-person examination requirements
- Prescribing requirements

**[3/19/20: States may be relaxing some of these requirements given the need for individuals to stay home.]**

2. If a patient will be treated in a different state:

- I am licensed in the patient's state, all state requirements are met (CME requirements, PMP requirements, etc...)

**OR**

- A license in that state is not required (3/9/20)

**[3/19/20: States MAY be relaxing licensure requirements, but it may be only in limited circumstances, such as only to treat patients in a hospital, or only if actually treating the coronavirus.]**

3. Law

- I have reviewed the law on telemedicine in the patient's state, including, but not limited to:
  - In-person examination requirements
  - Prescribing requirements

**[3/19/20: States have been slow to offer licensure waivers and even slower to address state treatment laws. The risk management advice is to do what you can. For example, a state may require written informed consent for the use of telemedicine. That may or may not be possible; if not possible, providers can obtain verbal consent and document that verbal consent to telemedicine]**

4. I am using HIPAA-compliant equipment

- If the equipment vendor stores any patient information, I have a Business Associate Agreement from the vendor

**[3/19/20: The federal government has exercised "its enforcement discretion and will waive potential penalties against health care providers that serve patients through everyday communication technologies during the COVID-19 nationwide public health emergency. This exercise of discretion applies to widely available communication apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of**

**whether the telehealth service is directly related to COVID-19."]**

<https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html>

5. I understand that services are considered rendered at the patient's location, not my location

6. I understand that the standard of care for telepsychiatry services is the same as for in-person visits

**[3/19/20: This is still true. So, for example, just as you need to get a patient in crisis to the hospital from your office, you would need to be able to call emergency services if a remotely treated patient is in crisis. Be sure to know the patient's exact location at the beginning of each session.]**

7. I understand that this treatment modality is not appropriate for all patients and I engage in careful patient selection

- I re-evaluate periodically the appropriateness of treatment

8. I require patient identification at the first session

9. I confirm patient location at the start of every session

10. I obtain informed consent to the use of telepsychiatry, in addition to informed consent to treatment

**[3/19/20: if written informed consent is not possible, at least document consent obtained verbally.]**

11. If I am prescribing, I am complying with:

- State law in my state and, if different, state law in the patient's state
- Federal law, if prescribing controlled substances, by:
  - Having a DEA registration in my state as well as each patient's state (if different from my state)

**[3/31/20: The DEA has temporarily waived the requirement to have a DEA registration in the patient's state.]**

- Seeing patient one time in person prior to prescribing controlled substances

**OR**

- Qualifying for one of the DEA's very limited

*(Continued on page 11)*

## TELEPSYCHIATRY CHECKLIST – MODIFIED PER CORONAVIRUS UPDATES (3/31/20)

(Continued from page 10)

exceptions to the one in-person visit rule

[3/19/20: The DEA has reminded providers of the public health emergency exception to the one in-person visit prior to prescribing controlled substances. [www.deadiversion.usdoj.gov/coronavirus/html](http://www.deadiversion.usdoj.gov/coronavirus/html)]

12. I provide appropriate patient monitoring, including follow-up on testing ordered
13. I provide appropriate follow-up care
14. I maintain appropriate documentation of all sessions
15. I have contingency plans for:
  - Clinical emergencies – including contact information for local authorities in the event of a crisis
  - Technical failures

[3/19/20: An example would be continuing the interrupted video session by telephone.]



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