Dr. Lisa Dixon 0:07
Welcome to our podcast psychiatric services from pages to practice. In this podcast, we highlight new research in the columns published this month in the journal psychiatric services. I'm Lisa Dixon, editor of psychiatric services. And I'm here with podcast editor. And my co host, Josh Barisan. Hi, Josh. Hi, Lisa. Today we are going to talk about a paper that focuses on the extent to which psychiatrists accept insurances of different types and how psychiatrists compared to non sick. Very interesting.

Dr. Josh Berezin 0:39
We are very happy to have Dr. Andrew Carlo here to talk about his in his co authors paper titled acceptance of insurance by psychiatrists and other physicians 2007 or 2016. Dr. Carla was the vice president of health system integration at Meadows Mental Health Policy Institute, and also part time clinical faculty at Northwestern University Feinberg School of Medicine. So Dr. Barlow, thank you so much for joining us.

Dr. Andrew Carlo 1:03
Thank you very much for having me. I wanted to start actually, by thanking a number of individuals for helping me with this project was a long, long project, it took about three to four years to complete. So I want to thank my co authors, Dr. Neil Jordan, from Northwestern doctors, you're gonna get sir and honorable and Basu from the University of Washington. And then also wanted to thank NCHS research data center, the US Census Bureau and all and AcademyHealth for their for their support with this project, which were instrumental in getting it to this point. Great.

Dr. Josh Berezin 1:29
So maybe you could set the stage a little bit for us. So I think there's this kind of like general idea amongst the public and physicians and psychiatrists that psychiatrists don't accept insurance. But what does the sort of existing data tell us going into the study? And what were some of the gaps in that data that you are we're wanting to address here?

Dr. Andrew Carlo 1:50
That's a great question. So there is a lot of evidence that already has shown that psychiatrists do not participate in insurance networks at the same rates as other physicians. And a number of the studies have been very impactful. In fact, they influenced me and really got me to the point where I wanted to do this additional study, I think, where there were gaps is there was a number of years that had gone by where there hadn't been an update, essentially, in terms of whether things had changed. And there had been some major changes, like the Affordable Care Act, for example, people were wondering, did that have an impact on whether physicians including psychiatrists would participate insurance network, so I wanted to update the literature to an extent also, I wanted to see if we could get some additional perspectives by using restricted data. And the restricted data allowed me to access some additional variables, which could maybe better characterize this problem and maybe provide a higher resolution take on it, essentially, that was my those are my main goals.

Dr. Josh Berezin 2:46
So tell us a little bit about the dataset, those is publicly available version, there's a restricted version, what what did you use to look at this question about insurance acceptance among psychiatrists and not psychiatrist.

Dr. Andrew Carlo 2:57

So we use NAMCS, the National ambulatory medical care survey, which is done annually. And it's a rigorously designed complex survey, it is given to physicians around the country. And when the data is published, every year, there's a public version that anyone can access by going to the website, and then there's a restricted version. And to get the restricted version, you have to apply, you have to have a specific reason why you want to access that data. And you have to access the data at a specific center that's designated by the federal government.

Dr. Lisa Dixon 3:27
Who does this? Is this the federal government that collects these data?

Dr. Andrew Carlo 3:31
Yes, yeah, the US Census is involved. In this particular case, NCHS, is also involved. And then the Research Data Center is where you access the data.

Dr. Josh Berezin 3:40
Like, you have to physically go yes, they do, you can't do it, just get like a token or something of that, like you have to be physically in the building?

Dr. Andrew Carlo 3:48
Yup, you have to be physically in the building. So I think there may be some exceptions, where you can get a token or some type of device to use it outside of the outside of one of these designated centers. But I think in most cases, you do have to go to one of these designated senators, and I started this project in 2019, in Seattle, when I was a postdoc fellow at the University of Washington, and so I had access to the center there. Then, of course, COVID happened may make it very complicated to access these centers. And then I moved to Chicago to accept a job at Northwestern. And I had to get access to the center here, which happened to be the Federal Reserve Bank of Chicago, which is kind of interesting place to do a data analysis, but um, yeah, so so I didn't have to physically go there. And that that created some challenges, especially during the pandemic. Also, the other thing that was interesting is I wasn't able to, none of my co authors were able to see the data or work directly with the data. So it was only me that was able to do that. I had to get approval, I had to get a special status. With the US Census, I had certain badges and access privileges. It was an interesting process.

Dr. Josh Berezin 4:46
Thissounds like a spy movie.

Dr. Andrew Carlo 4:47
Yeah.

Dr. Josh Berezin 4:49
Do you know why like, is there so we'll get into the specific questions you're asking but just sort of the data that was released for your study doesn't seem like it would be super sensitive, right? There's no Like patient identifying information in at least what you are looking at. So what are they? Is there other in the restricted dataset? Is there more sensitive information or?

Yeah, the concern with this particular dataset, because it's a survey of physicians that you'll be able to identify a specific position using the variables that are available in the restricted version, whereas in the public version, they deemed it virtually impossible to identify a specific position. And that's the main concern, I think, to be honest, the data that I requested specifically, I think it would have been virtually

impossible to identify any specific position, even if I had access this data, you know, outside of the the premises of the data center, but I do understand why they have those policies in place. It's for data, privacy and security.

Maybe you could tell us a little a little bit about what actual variables you were looking at what your sort of broad scope study questions were going into the Federal Reserve Bank to get, get to collect all your your top secret data.

Dr. Andrew Carlo 5:57
So we wanted to see if, between 2007 and 2016, there were trends and insurance acceptance among psychiatrists and non psychiatrist physicians. And then because we could access additional variables, and the restricted version of this dataset, wanted to see if we could identify certain trends and that are related to certain physician characteristics that might be associated with insurance acceptance, or non acceptance for psychiatrists, and psychiatrists. So those were our primary trends. Like I said, before, we wanted to update the literature, because the literature had really stopped around 2010. And there were a couple of smaller studies that had looked beyond that, but wanted to get some more current data, because the Affordable Care Act had happened and there been other changes that could have impacted it. And then to use those restricted variables to see if we could better characterize the situation maybe provide higher resolution in terms of what what's been going on, and trends acceptance among psychiatrists and other physicians.

Dr. Josh Berezin 6:50
So we'll get to this with your findings. But what were some of those other variables that you were were looking at?

Dr. Andrew Carlo 6:54
Yeah, so we had access to, to sex, age, regional practice urbanicity, meaning whether they were in a metropolitan statistical area, or a non metropolitan statistical area, as defined by the US Census, we also had access to another urban rural variable that was very detailed, but we ended up not using that because the sample sizes were too small. At each level, we had access to the race of the physicians, which we also ended up not using in our final analysis, because there was so much missing data with that variable. And then we had access to whether the physician trained in the United States or abroad, and whether they worked in a group practice or solo practice. So some of those variables are also very available in the public version. Some of them are only in the restricted version.

Dr. Josh Berezin 7:38
So very basically, you're looking at this data set has all this information about both psychiatrists and non psychiatrists and tells you whether or not they accepted various types of insurance, but Medicare, Medicaid, and commercial insurance and you're looking for differences between psychiatrists and non psychiatrist and seeing how they relate to some of those variables, like what region of the country they're in for a short example. Is that kind of the basic set up?

Dr. Andrew Carlo 8:04
That's right.

Dr. Lisa Dixon 8:04
It's very interesting that all non psychiatrists are grouped together. And so I'm curious whether you thought about looking at smaller groupings or more uniform groupings of different types of physician.

And obviously, you know, it may be made may make most sense to discuss this after you presented the findings. But it seems peculiar to to groove every other type of physician, as just non psychiatrists when I think the practice it seems like the practices should bury?

Dr. Andrew Carlo 8:37
Yeah, that is a great question. We definitely consider that when we reviewed the previous literature that's already been published on this topic. Some studies had broken down by specialty and subspecialty. So you'd see psychiatrist compared to dermatologist, oncologists, cardiologists, pediatricians, etc. But we decided to just compare psychiatrists to non psychiatrists, because what is clear from those previous studies that psychiatrists really stand out from the pack, in terms of their insurance, acceptance, that's important, except perhaps compared to dermatology, I think dermatology is the one that's a little bit close. But psychiatrists really do stand up for the pack. So I think that it's simplified our analysis substantially in our interpretation, and I think it was warranted given the previous studies.

Dr. Josh Berezin 9:23
It's funny, because when I was reading the study, I had the same question. And the specialty that I had in mind was dermatology. So like, what about dermatologists? I bet you and also, you know, it's just just a reflection before you get into some of the data. It's like, it's so interesting thinking about this in terms of like the region's urbanicity because I'm sure that where you live also sort of affects your view of insurance acceptance, just in general. So in New York City, there's so many different kinds of like health care ecosystems that you can be a part of from like primarily public sector to sort of like the very, very high end boutique medical care. So it's just interesting to think about kind of the lens you take going into reading the study, which I am aware is very different coming from New York City, and that would be different coming from Chicago. And that would be different coming from Seattle and let alone all the other non urban areas like country. So let's dive in a little bit. What were some of your top line findings?

Dr. Andrew Carlo 10:21
So some of the main things we found psychiatrists were less likely than other physicians to take any insurance, Medicare, Medicaid capitated commercial insurance and non capitated commercial insurance. So capitated being like Kaiser, non capitated being like most examples of BlueCross BlueShield, for example, psychiatrists across the board were less likely to take insurance. We also found that the gap between psychiatrists and non psychiatrists was more pronounced for public than private insurance. So public meeting Medicare, Medicaid, the gap between psychiatrists and non psychiatrists was larger than in the commercial space. And we found that among all physicians, not just psychiatrists, among all physicians, those in metropolitan areas, as defined by the US Census, and solo practices were less likely to accept insurance. But those trends were more pronounced among psychiatrists than they were among physicians at large. And then we essentially felt that if we were going to try to tailor policy changes, to have a large impact in the mental health space, that maybe there is something to be said, for focusing on psychiatrists and solo practices and those in metropolitan areas. And we could talk more later about the limitations of our of what we can actually say from our data. But I think those were two things that we came to mind, my co authors and I had been thinking about, as we wrote this paper,

Dr. Josh Berezin 11:40
Did anything surprise you like about the public? This is very much in line with both public perception and also prior research that you're updated? Did anything surprise you in terms of either like the magnitude of the effects or like, you know, just the ACA happened and didn't make a difference in this at all? This

like huge overhaul of Medicaid in particular? Like, what did was this confirming things? Or did it? Were there anything that raised an eyebrow for you?

Dr. Andrew Carlo 12:11
I think the the fact that we found that it psychiatrists in solo practice, were less likely to accept insurance and those in group practices really just confirmed what was already known in the literature. When we looked at the Metropolitan Area data that was actually we couldn't find an example of that being evaluated using this dataset, because I don't know if anyone had looked at this question with the restricted version. So I think that was a novel finding. I wouldn't say it was surprising, but it was good to see it actually coming through as a six statistically significant finding. You mentioned before, Josh, that in cities like New York City, for example, there's tons of psychiatrists, there's way more than there are in almost any other region in the country. Maybe there's a couple exceptions, but virtually every other part of the country has fewer psychiatrists, so

Dr. Lisa Dixon 12:54
And some would, some would argue that there's a greater need in New York City, and there may be a great especially when there are a lot of psychiatrists needs Yeah. Yeah.

Dr. Andrew Carlo 13:03
So that's, that's a secondary could look at it in all these different ways. But yeah, of course, I think, what's the impact of having that concentration? And of course, every metropolitan, it doesn't have the same concentration of psychiatrists, but they definitely have more than a non metropolitan area. So what's the impact of that? I think it didn't surprise me necessarily, I think I think I would have expected that the. And we could talk like, I think we're gonna talk more about this later. But the market power of psychiatrists in urban areas is very high, they're essentially price makers, and set their own price, because the demand is so high, they can fill their practice by setting their own price, due to their market power in urban areas. That's, I think, particularly relevant. And that may be why one of the reasons why we have the finding that in metropolitan areas, psychiatrists are less likely to accept insurance. So I won't say was surprising. But it was good to get that finding and actually have kind of have a basis for it.

Dr. Lisa Dixon 13:54
Andrew, can you give some of the numbers like we're talking about more or less, but I think it might be useful to to just give some of the percentages so folks have an idea of what we're actually talking about?

Dr. Andrew Carlo 14:07
Absolutely. Yeah. So just like some some broad strokes, data for spawned non psychiatrists, any insurance, the acceptance rate, around 95%, psychiatrists, any insurance between 80% and 70%. Okay, so that's a big gap right off the bat. Now, if you look specifically at psychiatrists who accept public insurance, right, that is between 70% and 55%, depending on which year you look at, in 2007, it was around 70%. And then by the time we got to 2015 2016, it was closer to 60%. So it actually had decreased over the study period. Now, if you look at non psychiatrists with public insurance 90% And then psychiatrists in private insurance, you know, it's a little bit higher than than the public like it ranges from around 70% to like in the mid 60s. percent. And the analogous number for psychiatrists is between 85 and 90%. So we see a pretty big gap in all three categories.

Dr. Josh Berezin 15:09
So let's get into some of the you're mentioning earlier about some of the drivers of these gaps, and maybe some things that you and your group were thinking about in terms of potential. I'm not sure

solutions is the right. I'm not sure if we have a solution per se, but things that could definitely influence things and move things in a better direction.

Dr. Andrew Carlo 15:30
Yeah, thanks for asking that question. Definitely, when the reason we did this study is because we want there to be an impact on this problem, we know that people need to see psychiatrists, and it's a problem for so many people. So if we can use these findings to inform policy, that would be a big win for this study, I think I did want to say before answering the question, though, that we don't have any data on why any physicians did what they did in terms of insurance acceptance, the NAM C's survey is given to physicians, and the first thing they do is fill out this survey in the beginning of their observation period. And they answer a ton of questions about their practice. And some of those questions are related to them taking new patients, and did they take new patients with different insurances? You take new Medicare patients, you take new Medicaid patients, do you take new commercial insurance patients that are in a non capitated plan, whatever, stuff like that, and then they actually are followed? They actually input data for individual visits with patients as well. So there's a lot more data than just this and MCs, but essentially, there's nothing in there about why are you doing what you're doing that that's not a part of the MC. So we can't say anything about that we hypothesize why we thought some of these findings were the way they were, I wish we actually could and maybe someday, we can go back and do like a more qualitative study or more rigorous kind of a survey of our our own survey that would ask some of those specific questions. But we can't say anything about that with this data set. But some of the reasons why we hypothesized that these findings were the way they were, some mental health has been reimbursed, you know, fairly low rates for a long time. That's something that's well known. It's not a surprise. Oftentimes, non mental health physicians get reimbursed at higher rates, generally the mental health position so that that's one incentive that pushes psychiatrists out of insurance networks. Also, there has not really been good enforcement of mental health parity, the Mental Health Parity and Addiction Equity Act was passed in 2008. And that was a landmark piece of legislation that made it law insurances had to manage mental health benefits, no more stringently than they manage their physical health benefits. And of course, they put that into law in the first place, because obviously, there had not been parity. And that Act was amended in 2010, to make it apply to more insurance plans than it did initially. So since 2010, the parody act is applied to virtually all insurance plans. It's been enforced by HHS, and the Department of Labor, depending on the specific type of plan. Enforcement has, I think there's been earnest efforts to enforce parody, but it's extremely complicated to enforce parody. I've been involved in some of this work myself, and it's actually the responsibility of the insurance company to demonstrate that they're in compliance with the law. The regulators aren't the ones who are determining what they're making the judgment, but the insurance company, it's their responsibility to provide the data that demonstrates they're in compliance. But it's, it's very difficult, very difficult to prove that someone's not in compliance. And so I think because of that, there's been this kind of, there hasn't been a lot of movement in the way that parody Act has affected actual practice. And I think so there still is not parody in the way that mental health benefits are managed. And I think that also pushes psychiatrists out of insurance networks, I think it's also important to note the shortage of psychiatrists in so many areas, even in like to Lisa's point, even in New York City, where there are a lot of psychiatrists, the demand is still astronomical. And so there's a Hydras have a lot of market power. And I mentioned before their price makers, price makers, meaning they can set their own price, the demand is such that they can set their own price, and they will be able to fill their practice, even setting their price at an extremely high rate above the market rate, so to speak. And so that also is an incentive for psychiatrists not to be an insurance network, because they have this market power they can they can make their own price. So taking what the insurance company is willing to give them and and allowed amount may not really match up.

Dr. Lisa Dixon 19:08
Is that market power the case? Everywhere? Or just in certain, you know, urban, affluent areas?

Dr. Andrew Carlo 19:16
Well, yeah, I think I don't know that that's been rigorously studied. I think it's a great question. I think we could sort of say what I think, I would say, in in areas where there's a concentrations of wealth, which in this country is largely in urban areas, that market power is probably can wield more influence. But I do imagine it's true virtually everywhere, that psychiatrists have a lot of market power. If if you're in a place like New York City, where there's a lot of psychiatrist, there's also a lot of wealth. I think it matches, it still matches well, for psychiatrists, where, whereas if you're in a smaller population center, you might be the psychiatrist around so you obviously have market power just by virtue of being an n of one essentially, or maybe there's just a few. So I think that there's there's different ways to conceptualize it, but I don't I don't think we know the answer for sure because I don't think it's been rigorously evaluated, I think it should be. And then the last thing I wanted to mention is that psychiatry is unique in some ways among physicians, because we do not need a lot to enter the market. Right? It used to be that all you need is a studio apartment. And you know, a couch and like a quiet space. Now, you don't even need that you just need a secure video account. And you can have a practice, essentially, you need very little to enter the market. And the demand is so high that so it's just very easy for psychiatrists to enter the market, multiple markets and to become a part of the market. So because of that, you also don't necessarily need to contract with insurance companies to get your patients like you may have to do if you're just a different type of physician.

Dr. Josh Berezin 20:45
And I think something else you mentioned in the paper that rang true also is like even if you've got rates equal, like to the high rates that psychiatrists could charge because they have so much market power, there, they still have an incentive not to accept insurance, because it's a pain, right? Like you have to fill out paperwork you have there's a whole administrative burden associated with insurance that if you can, even if you're getting the same amount of money, I can see that being a big driver, like why would it be worth it to me to get paid an equal amount and have all this administrative overhead that I could just do completely without?

Dr. Andrew Carlo 21:21
That is very true. Yeah. And I think that gets back to the parody enforcement. So I think that psychiatrists are disproportionately burdened with some of that. So some of the quantitative and non particularly non quantitative treatment limitations, things like prior authorizations, utilization review, etc. Although, you know, those are supposed to be equal to the Parity Act. But like I said, it's hard, very hard to enforce that. So I don't think they really are, where the rubber meets the road. I don't think they're really equal at this point in time. There has been some progress. There's been some lawsuits that have been brought against insurance companies, and the plaintiffs have won those lawsuits in some cases. So there's some momentum growing for parody enforcement. But I don't think it's there yet. So there's a disproportionate burden that those things have on psychiatrists, also, because you don't need much to enter the market. In psychiatry. A lot of psychiatrists are just kind of one person businesses, right? They're, they're everything. And so that means all of that falls on them, where they don't have they don't have group practices can kind of come together and devote resources to administrative support, things like that. But a lot of psychiatrists are practicing on their own. So that all falls on them. So it disproportionately impacts them in that way as well.

Dr. Lisa Dixon 22:24
How does this characteristic of the market, in your view and you mentioned this in the paper, have it impact other mental health professionals and their availability, their participation? And sort of the system? For example, psychiatric nurse practitioners or psychologists?

Dr. Andrew Carlo 22:44
That's a great question. We did not evaluate that in this study. In particular, now, MCs does have other types of health professionals other than physicians, but we are sort of complicated reasons, we restricted our dataset to only physicians in this case, but I imagine a lot of the trends would be relevant for other types of mental health professionals as well. For example, I imagine the same is true of psychiatric nurse practitioners, I imagine the same is true of psychologists that some of those same factors are at play for them fairly low reimbursement, high market power, they have the ability to be price makers, they don't need a lot to enter the market, they often work by themselves. So a lot of the burden of the insurance, regulatory this insurance, things that come with accepting insurance and being in an insurance network are burdensome for them. And so they elect to essentially opt out of that whole system and just take cash, pay patients, or primarily cash pay patients. And then by doing that, they're able to fill their practice. And perhaps some of that is Sutala.

Dr. Josh Berezin 23:48
So as we come to a close, maybe you could just like how do you think about this in the big picture of things like why does this matter, either for the profession, or for people who are seeking mental health services? Like what's the, what's the impact of this? And then also, what are your next steps and your groups next steps in looking at the problem and thinking through solutions?

Dr. Andrew Carlo 24:13
Those are two great questions. So I think this is important because psychiatrists were not obviously not the only mental health professionals. We're one of many mental health professionals and we have our role. But our role is very important. We have training in certain types of mental health problems, we tend to prescribe most of the medications that are needed for people to treat their mental health problems. And if so many of us don't take insurance, it just makes it extremely difficult for people that don't have large amounts of money to see us. And that's a big problem. And it disproportionately affects communities of color. It disproportionately affects communities without generally low socioeconomic status or an average lower socioeconomic status are disproportionately impacted by these trends. And I think it's a big problem, something the field has to try its best to find solutions for me Make sure that our services are available to all to meet them.

Dr. Josh Berezin 25:03
And then in terms of what what's next for you and your group and looking at this and similar issues.

Dr. Andrew Carlo 25:08
So we did try to come up with some, I think you're right, the way you framed it before does not solutions necessarily, but things that can help mitigate some of these challenges, or what what are some things that could be tested policy changes that could be made or things that could be enforced differently? So I think clearly, competition for psychiatrists would have an impact here. Right? If we have, and you're seeing this already, right, you're seeing a very large growth of advanced practice nurses, nurse practitioners, working in a psychiatric prescriber role. And when there's more people in the role that psychiatrists traditionally held, then that would effectively to extent reduce the market power of psychiatrists and may compel psychiatrists to participate insurance networks, if they're not able to fill

their practice with extremely high cash rates, then maybe they'd have more of an incentive to participate in insurance networks. That's obviously not a guarantee, and the demand is extraordinarily high. So you wonder, like how much competition would have to be introduced into the market to actually make a dent in that trend. But that is one thing that could have an impact, I think on the regulatory side, is parody enforcement. And this gets to your point earlier, Josh, and Lisa about parody is that there's a disproportionate burden on psychiatrists to do things to be part of the insurance network. dealing with the insurance in one way or another, it disproportionately impacts psychiatrists. And it's a it's a heavy burden, especially for people who work in their own practice their own solo practices. So I think really, enforcing parity and making sure the insurance companies are not disproportionately saddling psychiatrists with paperwork and phone calls and prior authorizations and things like that might make it more palatable for psychiatrists to be an insurance that works. Because I think ultimately, a lot of us psychiatrists, we want to we went into medicine, because we want to serve our communities. And so I think a lot of people, all things being equal would want to be in insurance networks. But if it's going to mean that they have to be filling out tons of extra paperwork, you know, in the evenings on the weekends, or making time for phone calls with the insurance company or filling out prior authorizations over and over again, it just makes it that much harder for them. So I think that's another thing enforcing parody could make a difference. And I think you are seeing that if you look in the news, you know, every few months now you see there's a lawsuit that's being filed against insurance companies, and some of them are actually winning, some of the plaintiffs are winning, and that guy can make a difference.

Dr. Josh Berezin 27:33
Well, maybe we'll end on that hopeful note.

Dr. Lisa Dixon 27:35
Thank you.

Dr. Josh Berezin 27:36
Thank you so much for joining us, and really a lot of food for thought. And we encourage everybody to check out the paper.

Dr. Lisa Dixon 27:42
Absolutely. There's a lot of very interesting data that to sort of flesh out even some of the points that Dr. Carlo made.

Dr. Andrew Carlo 27:50
Well, thank you both for inviting me, I really appreciate the opportunity. And I wanted to thank my co authors again, and all those that helped support me in this it was a long journey, a four year journey of work that I have a lot of people to support, including my family for allowing me to go to the Federal Reserve Bank of Chicago on the weekends and in the evenings. Just not not easy.

Dr. Lisa Dixon 28:09
How long did you have to? You know, how many hours were you there?

Dr. Andrew Carlo 28:14
Oh, many, many hours? Yeah, I don't know if they track those types of thing. I hope they don't assume

Dr. Lisa Dixon 28:19
Too many to count. Yeah, you didn't bill for it.

Dr. Josh Berezin 28:21
Okay, one last question. Did you have like a minder? Was there somebody who was like watching you while you were like typing away on the on the Federal Reserve computers, or you left your own devices?

Dr. Andrew Carlo 28:33
There? Yeah, they watch, you know, I don't know who's watching them. And in theory, they monitor and everything, and you're not allowed to bring any data out of the center yourself. You're not allowed to write anything down. You can take pictures of anything. All data has to be sent to the federal government, who will then review it to make sure there's no disclosure risks, and then they email you a data file. So it's a very convoluted process. It's kind of something I'll always remember, mostly, you know, like, you go through your career, you have experiences, this is one that just stand out. It was just a very strange experience.

Dr. Josh Berezin 29:06
All right, well, thanks again. And all of those nights and weekends in a bit of an odd vocation for Psych researcher. So thanks a lot, and we'll be looking forward to seeing what comes next.

Dr. Andrew Carlo 29:17
Thank you both. Again, appreciate it was great being on here and I look forward to hopefully hearing some feedback and if anyone wants to have any questions about the paper, any thoughts or comments, I'd love to hear them.

Dr. Lisa Dixon 29:27
That's it for today. Thanks to Aaron Van Dorn for mixing and editing and denry Jackson for additional production support. We invite you to visit our website BS dot psychiatry online.org to read the article we discussed in this episode, as well as other great research. We also welcome your feedback, please email us at IES journal@site.org. I'm Lisa Dixon.

Josh Berezin 29:50
I'm Josh Berezin

Lisa Dixon 29:51
Thank you for listening. We'll talk to you next time.

Aaron van Dorn 29:55
The views and opinions expressed in this podcast are those of the individual speakers only and do not necessarily run Present the views of the American Psychiatric Association the content of this podcast is provided for general information purposes only and does not offer medical or any other type of professional advice if you're having any medical emergency please contact your local Emergency Response number