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Continue Telehealth Post-Pandemic

By Steven Madonick, MD, CPS President

2020 has proven to be a unique and vexing year. We have been confronted with Covid-19, an economic crisis and renewed evidence that inequality, discrimination and racism persist in our country. At least many Americans are more cognizant of these problems and perhaps more open to solutions.

In the year ahead, we also need to be more open to working on the unfairness, marginalization and stigma that impede the treatment of mental illness and substance use disorders. These shortcomings affect the health of more than 25% of the population of the United States. Psychiatrists have recently acquired improved technologies, methodologies and strategies to care for our patients. Let us find the will to use these advances to improve recovery from mental illness and substance use disorders and reduce the great suffering that they cause.

"The pandemic marked the first widespread use of Telehealth in Connecticut."

The pandemic marked the first widespread use of Telehealth in Connecticut. This is because during the emergency, full reimbursement was granted for the first time by the Department of Social Services and private insurers. The benefits of telehealth have greatly exceeded expectations. Patient satisfaction with telehealth has been high (Medalia et al, Nakagawa et al, Uscher-Pines et al).

Most outpatient clinics experience a no-show rate of 20% to 30% with in-person care. One patient missed 3 consecutive appointments. She could not get to her appointments because she could not afford $400 to repair her car on her limited income. With telehealth, she could see her psychiatrist without leaving home and she attended every subsequent appointment. The switch to telehealth has decreased no show rates of these patients to between 5 and 10%. More patients are getting treatment and they remain engaged with telehealth.

There are advantages of telehealth for providers. The reduced no show rate boosts revenue for chronically underfunded not-for-profit organizations that treat our sickest and most impaired patients. There is also the possibility of reducing expenses for scarce office space as many prac-

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Psychiatry, Racial Equity, and Vaccination

By Sheila Cooperman, MD

In order to better care for people in the United States and bring an end to the pandemic, it is important to be aware of what we are facing and evaluate where changes in the health care system need to be made and how we, as psychiatrists, can influence those changes. I want to review where we are, what can be encouraged on a large scale, and what psychiatrists can facilitate with individual patients to influence necessary changes.

"The pandemic has highlighted several vulnerabilities in our healthcare system."

The pandemic has highlighted several vulnerabilities in our healthcare system. The rising rates of diabetes, heart disease and obesity coupled with a reduction in life expectancy in marginalized populations, those with low socioeconomic status and those of color was identified prior to March 2020. In addition, these medical conditions are common in the seriously mentally ill and in patients who are taking psychotropic medications that increase the risk of some conditions. With increasingly available data on how these populations have fared during the Pandemic, the Kaiser Family Foundation and the Epic Health Research Network, using the Epic health record system, reviewed approximately 20 million medical records and divided them by race and ethnicity for hospitalizations and death per 10,000 due to COVID (1).

Unfortunately, the socioeconomic disparities along racial lines worsened during COVID as has the morbidity rate for those

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Race	Million	Hospitalizations	Deaths
Black	7	24.6	5.6
Hispanic	5.1	30.4	5.6
Asian	1.4	15.9	4.3
White	7.4	7.4	2.3

The Crown Act: Much Needed Legislation to Protect Black Hair

By Amanda Calhoun, MD, MPH, PGY-1
Assistant Editor

I cannot recall the moment when I realized that Black hair was not considered beautiful. As a young child, I wore my hair in long braids. I can think back to multiple moments when I sat on the floor, watching a movie as my mom braided my hair into intricate designs. When my family traveled to the Caribbean every year, my aunts and godmother would join us there and braid my hair too. Everyone's braiding style was a bit different. My aunt braided tightly, and I told her she should be in the "Braiding Olympics." My godmother would swat your hand with the comb if you tried to touch your hair to see how much remained to be braided. It was a bonding experience, a normalized experience. Braided hair is known as a protective style for Black hair because it is a style that keeps it healthy and vibrant. Straightening hair with chemicals or heat, on the contrary, is not healthy for Black hair.

I began to get messages, at a very early age, that braided hair, or my poofy, beautiful, thick hair as it grew out of my head, was "wild" or "ugly." I remember my little sister, talking with her friend about how their braids were ugly, and they wished it could be straightened. As a Black girl, you receive an onslaught of negative messages about hair all the time. You are told, in commercials, in movies, by peers, by society, that beautiful hair is Eurocentric hair—white-adjacent hair—straight, thin hair. Thick, poofy, kinky, curly hair is ugly. Braids are ugly. Locs are ugly. Black hair is ugly. This message is communicated daily to Black girls and they ingest it like poison.

As my sister and I grew older, we pushed against this white supremacist message and began wearing our hair in natural styles again. It was an intentional effort to push back and to love our hair again—something that society had taught us to hate. These anti-Black hair sentiments have been interwoven throughout U.S. society since slavery.

When I applied for psychiatry residency, I straightened my naturally curly and thick strands of hair. I was worried that wearing my hair in my natural state would keep me from getting residency interviews, and I wasn't alone. "What should I do with my hair?" was a common internet thread, with Black women and men convening to discuss how to wear their hair for their residency application photo and interviews. Black men cut off their locs for interviews and Black women took out their twists and braids, all in an attempt to conform with the Eurocentric ideal of what is professional. We knew that if we did not, it could have very real legal implications.

On March 10, 2021, Governor Lamont signed the CROWN Act, which stands for "Creating a Respectful and Open World for Natural Hair." This legislation expands civil rights protections by banning discrimination, in the

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Behind our Tears and Joy on this Monumental Inauguration Day

Maureen Sayres Van Niel, MD
President, APA Women's Caucus

When I witnessed the historic inauguration of Vice President Kamala Harris today, I surprised myself. Like the women psychiatry colleagues I spoke with from all over the country, I felt much more emotion than I had expected: So much joy and exhilaration and also tears—sometimes outright weeping—took us by surprise, arriving at the surface from a suppressed place.

"Like the women psychiatry colleagues I spoke with from all over the country, I felt much more emotion than I had expected…"

Maybe that's the place we keep hidden deep inside ourselves where we file painful things so that we can keep going—like when we realized that the "old boys' network" was working its magic for our male colleagues in their advancement but not for us or noticed the disregard for women's mental health in our medical school curriculum. It's the place that allowed us to keep going when we overheard our male fellow interns rank our looks on a one to ten scale. or when we put up with sexual harassment and innuendo from all directions because we thought we had to if we wanted to become a doctor, or when we looked around for women role models at the highest levels of our medical centers only to find the rare professor who had made it through. It's the place where we have filed away the many times someone asked women physicians of color questions that should have been directed at the housekeeping staff, and the place where we stored our disappointment when no one seemed curious or motivated to find out why women had twice the rate of depression and anxiety than men. And for some of us, it's the place where we filed away the painful feelings of impending separation when staring into the eyes of the

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Telepsychiatry: An Invaluable Tool

By Christopher Hammel, MD, MPH

**Details of this case have been altered to protect the patient's privacy, and the patient has consented to the inclusion of his case.*

When I first met Jason, he was suffering from such severe irritable bowel syndrome that he was nearly homebound.* He had quit his job, become socially isolated, and all but abandoned the outdoor activities he loved. He was also depressed, describing periods of being "near paralyzed, like a zombie," sleeping 14 hours daily and "living on the couch for the past 6-8 weeks and sleeping all weekend, almost literally." His troubles began after a hospital nurse made a serious medication error that stopped his heart and sent him to the intensive care unit. In short order, his support system was disrupted and he soon developed gastrointestinal symptoms, forcing him to leave his dream job as a firefighter. Prior to this, he had been a Navy SEAL and had worked successfully in several other careers. Jason had seen many doctors and came to believe there was a psychosomatic component to his illness, and he wanted my help in treating it. I explained that I was only offering televisits because of COVID-19. Jason said that, in fact, was one reason he called me—leaving the house had become so difficult that, although he had been interested in psychiatric care for some time, he was having trouble attending an appointment. I could hear his eagerness in his voice: Here was a patient who was motivated for treatment.

I had the strange experience of graduating residency and starting a private practice in July 2020, amidst the COVID-19 pandemic. When the first wave spread in February 2020, I was a fourth-year resident at the Institute of Living at Hartford Hospital, months from graduation and just starting my search for office space. I had volunteered to help set up the inpatient psychiatric units for remote visits, and I remember hearing one patient on the adolescent unit ask loudly, "What's that on his face?"—I was the first person he had seen wearing a mask. Certainly, though, I was not the last; it soon became apparent that it would be some time before I'd see patients in person, and I quickly abandoned my office search. When I hung my proverbial shingle, it was as a website on the Internet. I have since been seeing patients exclusively through telepsychiatry.

Working remotely has led me to build a modernized, efficient practice which is easy for patients to access. My patients can complete all their paperwork online via e-signature, pay by credit card, check their appointment times online, and enjoy the benefits of a paperless practice. Given my broad use of technology, I have made a concerted effort to develop some expertise in privacy, using only end-to-end encrypted services. These efforts have been successful, allowing me to reach my desired patient density in about two months. My experience with remote psychiatry has also left me well-acquainted with its advantages and disadvantages.

Over the past four months of providing Jason with remote psychotherapy and medication management, his condition has started to improve. His sleep schedule has largely normalized, and his outlook has brightened. He rediscovered activities he previously enjoyed with his wife: exercising together for an hour daily and joining a painting studio. He has begun facing a variety of personal demons, and he's making good strides in taming them. The best illustration of his progress is in his own words: "I wish I had done this years ago." All this work has been completed via telepsychiatry. Jason's case illustrates some of the benefits of remote care, including access to care for patients with difficulty leaving home due to medical and/or psychiatric conditions, safety for both patient and psychiatrist during a pandemic, and good efficacy.

I believe that a significant portion of my practice consists of patients who, like Jason, were previously unable to access care because telepsychiatry was simply not done. The pandemic, in bringing telepsychiatry to fruition in a matter of months, has allowed these patients to be seen. It provides that same access to patients who live in rural parts of Connecticut and have difficulty reaching psychiatric care, or to those whose work schedules are prohibitive. One of my patients, a busy physician who works hours far outside of my own and has young children, can still see me during her 30-minute lunch break only because she does not have to commute. I have several patients who are college students without easy access to transportation and, further, would be required to quarantine for 2 weeks if they left campus. Without access to telepsychiatry, they would be forced to switch back and forth between my office and the temporary coverage offered by their colleges. The medical literature on continuity of care is clear: The alliance between psychiatrist and patient is a key aspect of healing. Repeatedly interrupting that relationship for these students would represent a systemic failing resulting in substandard care. The cure is telepsychiatry. Another example: While I was writing this article, a father called me about his son. When I told him that I'm seeing patients remotely, he replied, "I know—he won't leave the house, even to go

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"Working remotely has led me to build a modernized, efficient practice which is easy for patients to access."

"Staying in our Lane:" Social Interventions Require Political Advocacy

By Zach Harvanek

Last September, I went to see a new patient in the emergency department. "New" is a relative term as this patient, like many others, is a frequent visitor to the hospital. These patients are sometimes in the emergency room nightly or even multiple times per day. This is often due to a combination of housing insecurity, substance use, and having nowhere else to turn for help. Surprisingly, this particular patient hadn't been to our emergency department in two months.

"Income inequality is but one instance of how politics affects mental health."

When I see him, I ask an unusual first question: "Where have you been the past couple months?" He had used his stimulus money to get an apartment over the summer. With stable housing, he was sober for two months. Then the stimulus money ran out, and with it, his place to stay and his sobriety. The night I saw him he was intoxicated, hopeless, and suicidal. In the morning he is sober, recants his suicidal statement and goes on his way. But given his circumstances, he will likely be back soon with similar complaints.

Consider a biopsychosocial approach to this patient. We didn't give him any medications or a new diagnosis. Waitlist and financial barriers prevent him from accessing substance use treatment programs or therapy. We have referred him to shelters and housing programs, but these have been unsuccessful in the past. Our healthcare system did nothing for him that couldn't have been better provided elsewhere. However, this patient's story offers a solution: giving him cold, hard cash.

Think about the stimulus payment as a social intervention: Giving him $1200 "treated" his substance use, depression, and suicidality for 2 months. This patient's true "diagnosis" was poverty, and it was addressed with his stimulus check. The prior available social resources were inadequate for him. Unfortunately, the one-time nature of these payments meant this patient relapsed, much like a psychotic patient without refills on his antipsychotic medication.

The recent COVID relief bill passed by Congress again includes one-time payments, which will only be a temporary fix for this patient. However, it also includes recurring payments directed to children. It is estimated that these recurring payments will cut the rate of child poverty by almost 50%, and even more amongst BIPOC (Black, Indigenous, and People of Color) communities. We know childhood poverty is related to multiple negative long-term physical and psychiatric outcomes, and in one year this "intervention" will have to be "refilled."

What is our role as psychiatrists here? Some argue physicians should "stay in their lane" and avoid publicly commenting on political issues outside of direct healthcare. This neglects one-third of the biopsychosocial model. Political interventions that impact our patients' mental health are as much "our lane" as prescribing medications or providing psychotherapy. If interventions like recurring payments will benefit our patients, it is as much our duty to advocate for them as it is our duty to refill our patients' medications.

Income inequality is but one instance of how politics affects mental health. Racial injustice is another timely example, with discrimination correlating with rates of depression, PTSD, and even mortality rates. To draw a parallel, the answer to the Flint, MI water crisis was not to only treat each individual case of lead poisoning, the government needed to act. Such societal issues are best addressed on societal and structural levels. So, write your members of Congress about income inequality. Thank them for passing recurring payments for children and encourage them to expand it to adults. Speak out yourself against racist legislation such as voter suppression laws. It's time to take back our lane and advocate for our patients.

Register today for the Women's Mental Health Conference (WMHC), the first academic and trainee-led conference on women's wellbeing in the nation. The conference is the APA SAMHSA Minority Fellowship Project of Drs. Sofia Noori and Stefanie Gillson, both PGY-4s at the Yale Department of Psychiatry and members of CT Psychiatric Society.

This year's free virtual conference (which offers CME credit) will be held on **April 23-24th**. It will feature #MeToo founder Tarana Burke as the keynote and panels on Black women's mental health, reproductive psychiatry, and mental health technology. Bestselling author Dr. Michele Harper and Native rights activist Dr. Sarah Deer will also lead sessions. The conference is free and open to the public.

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Legislative Update: Good Intentions are a Welcome Change

By Jacquelyn T. Coleman, CAE, Executive Director

The leadership of the Connecticut General Assembly are sending a strong signal that they are going to use their majority power to enact many reforms in the care and treatment of those with mental illness and substance use disorder.

They have created bills of major scope. They have given them names like Bill Number 1 and Bill Number 2, and they themselves have signed on to the bills for all to see. When leadership signs on to bills it is a strong indication that they expect them to pass.

Senate Bill 1, 32 pages in length, is called "An Act Equalizing Comprehensive Access to Mental, Behavioral, and Physical Health Care in Response to the Pandemic." Among its provisions are: requiring an exit interview when a student withdraws from school, citing 5 factors to be addressed, and mandating continued services for the student for a year after withdrawal; creating a mental health tool kit for employers; certification of peer support specialists; mandating a study of the State's COVID response; declaring that the policy of the state of Connecticut to recognize that racism is a public health crisis; establishing a Truth and Reconciliation commission to examine racial disparities in public health.

Other matters in the bill include breast cancer awareness, hospital staffing, demographic data collection, community building and establishment of a Uniform Emergency Health Practitioners Act.

And that is just one bill.

Bill Number 2 is Called "An Act Concerning Social Equity and the Health Safety and Education of Children," and contains 49 pages of proposed reforms.

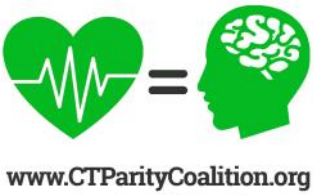
There have been three major telehealth bills, referred to three different committees. CPS has supported all of them. Their numbers are 5596, 1022, and 6472. Essentially their intent is to place into law the elements of the Governor's Executive Order.

Another bill of great interest to CPS (1045) disallows the use of step therapy for behavioral health conditions and provides a rebuttable presumption that each health care service under utilization review IS MEDICALLY NECESSARY if ordering by health care professionals acting within their scope of practice.

The Committee on Higher Education has raised a bill (6235) to provide a tax rebate to psychiatrists who work in the state to purchase their first home in the state within 10 years of graduation from medical school. This was the work of Representative Liz Linehan who met with us to explore this and other matters.

It is easy to find these bills online. Go to cga.ct.gov. At the very bottom there is a place to put in the bill number.

Given the legislative intent, we can hope these bills pass, but there may be some alterations along the way. We'll be watching. Such broad bills will obviously affect many constituencies.



News from the APA

APA Statement on the Shootings in Georgia

WASHINGTON, D.C., March 17, 2021 – Yesterday, eight people, including many women of Asian descent, were shot dead at spas in Georgia. During the COVID-19 pandemic, inflammatory language and violent acts have placed the Asian American and Pacific Islander (AAPI) communities and businesses at risk. While authorities are still investigating the motive, it comes at a time when anti-Asian American racism has swelled in the United States. The American Psychiatric Association (APA) issued the following statements.

"This year has seen a significant increase in racism and xenophobia against Asian Americans, and it is unacceptable and harmful," said APA President Jeffrey Geller, M.D., M.P.H. "This unspeakable tragedy can cause further fear for the AAPI community, which has endured so much already. We send our condolences to the victims' families and friends, and others who knew them. We stand in solidarity with our members in condemning it."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., noted that "the tragedy that occurred in Georgia is becoming far too familiar. We must be mindful that the mental health impacts of mass shootings are far reaching, touching families, communities, and the nation. If you are struggling to cope with these traumatic events, please reach out to family or friends for support. If you are overwhelmed, seek help from a psychiatrist, or your primary care provider."

Top Diversity and Equity Leaders in Psychiatry Offer Guidelines for Academic Medicine in New Article and Commentary from American Journal of Psychiatry

WASHINGTON, D.C., March 1, 2021 – Diversity, equity and inclusion (DEI) leaders in academic medicine are subject to increasing expectations with limited resources and there is an urgent need for psychiatry de-

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titioners of these organizations who use telehealth now work from home. Telehealth has led to positive, important changes in how we treat psychiatric patients and we must keep these very substantial gains.

There are patients who cannot benefit from telehealth due to even greater economic and social disparities. These are our most disabled patients. A patient living in a single room occupancy hotel had no access to a computer, a smartphone or broadband. He had only his state issued cellular phone. Fortunately, treatment by telephone was reimbursed under the COVID-19 emergency measures and he was able to get treatment using his state-issued cell phone. This allowed continuity of care and he remained stable during the pandemic (Batterson et al). We must reimburse telephonic care along with telehealth so our most impoverished and seriously ill patients like him may also receive care. We must not discriminate against them.

The pandemic, the economic crisis and recent social protests bring the marginalization of patients with mental illnesses and substance use disorders more clearly into view. Telehealth and telephonic care improve access, engagement, and outcomes. The implementation of these modalities has been a rare source of good news during this pandemic. Let us fully fund these important modalities and move treatment for mental health disorders and substance use disorders to a new level. This investment will position us to care for the increased prevalence of mental health disorders and substance use disorders projected from the pandemic.

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Telehealth Conversion of Serious Mental Illness Recovery Services During the COVID-19 Crisis. Alice Medalia, Ph.D., David A. Lynch, Ph.D., Tiffany Herlands, Psy.D. Published Online:1 Aug 2020https://doi.org/10.1176/appi.ps.71705

Rapid Conversion of an Outpatient Psychiatric Clinic to a 100% Virtual Telepsychiatry Clinic in Response to COVID-19, Peter Yellowlees, M.B.B.S., M.D., Keisuke Nakagawa, M.D., Murat Pakyurek, M.D., Angel Hanson, Jerry Elder, Helen C. Kales, M.D. Published Online:28 May 2020https: // doi.org/10.1176/appi.ps.202000230

Suddenly Becoming a "Virtual Doctor": Experiences of Psychiatrists Transitioning to Telemedicine During the COVID-19 Pandemic. Lori Uscher-Pines, Ph.D., M.Sc., Jessica Sousa, M.S.W., Pushpa Raja, M.D., M.S.H.P.M., Ateev Mehrotra, M.D., M.P.H., Michael L. Barnett, M.D., M.S., Haiden A. Huskamp, Ph.D.Published Online:16 Sep 2020 https: //doi.org/10.1176 / appi.ps.202000250

Advancing the Use of Telehealth Through Education and Advocacy. Bob Batterson, M.D., Moderator; Jay Shore, M.D., M.P.H.; Gregory Harris, M.D., M.P.H.; Kiki Kennedy, M.D. July, 8 2020

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who take public transportation, live in multigenerational households and must work outside of the home (1).

The opportunity for change exists to:

1. Expand access to care by supporting Federally Qualified Community Health Centers (FQHCs), safety net hospitals, and Medicaid expansion for those who lost their employer sponsored health insurance.
2. Develop equitable care models that are culturally sensitive in their delivery and outreach which includes community leaders to support vaccination.
3. Address the social determinants of health: housing, nutrition, transportation, finances, and legal assistance (1)

Psychiatrists may play a key role in ending the pandemic by encouraging their patients to be vaccinated. For those patients who are currently in treatment, their basic needs come first and especially for those who are seriously mentally ill, trust in vaccination may be a challenge. If those needs can be addressed, there is a greater likelihood that those patients will agree to get vaccinated. A Motivational Enhancement Therapy (MET) approach may also be beneficial.

Joshua Morganstein, MD in Psychiatric News (2), suggested approaching vaccination as an opportunity to apply three categories of the Transtheoretical Model of Intentional Behavior Change:

1. Pre-Contemplation: For those patients who refuse, recommend vaccination and leave the door open for continued, future discussion,
2. Contemplation: For those who are hesitant, explore the concerns, review the risks/ benefits of their choice,
3. Preparation/Plan: For those who are ready to act, provide them with the information about where to be vaccinated and answer their questions.

As psychiatrists, we have unique skills in being able to communicate and influence change, in this case we can make a critical contribution to ending the Pandemic by encouraging vaccination.

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Lopez L, Hart L, Katz M. Racial and Ethnic Health Disparities Related to COVID-19. JAMA. 2021;doi 10.1001/jama 2020.26443.

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Behind our Tears and Joy

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infant we had just given birth to or adopted, knowing that as mothers in this country we would get no guaranteed accommodation to return to work part time, no break on our academic tenure clock, and no appropriate paid leave to participate in the growth or care of our child.

Each of us woman physicians has had to fit into a system created for men and not designed with our beautiful biology in mind. To some degree or another, we have all had to take a journey that was harder for us than for the men who made the rules and were invested in keeping the system the way it was. Today one of us got through . . . she won one of the prizes she had dreamed of. This achievement is cause for great celebration. Just seeing a woman in the role of vice president will give our girls and boys a different world to look to for inspiration.

Amidst our joy is also the sad reminder that many women in our past, including our own mothers and grandmothers, and maybe even ourselves, were denied the opportunities we dreamed of to use our gifts to the highest levels of achievement. Many women psychiatrists have had their own dreams vanquished by just too much adversity.

Meanwhile, women have been tending to the heart of the world for a long time. While we have one eye fixed on the impossible challenges that society has presented to us, we can also acknowledge that some women psychiatrists have managed, in the midst of their zigzagging work and family responsibilities, to weave together a strong, resilient family life. They have helped create a home environment, whatever its composition, suffused with their own personal family values, launching their children into the world every day to face its challenges, bolstered by the love they have received at home.

Hallelujah, Vice President Harris! We are ecstatic that a woman has broken one more barrier. But we are also aware of how much more we must do to make real change for women in psychiatry and achieve equity. We need wholesale structural and institutional changes that will let us reach our full potential—including changes that will let us be promoted and paid equally with our male colleagues.

Let us now remember this day and let it motivate us. Join me in doing all that remains to be done, wherever you are working and whatever district branch you can work through. And remember to take care of yourselves and ask for help when you get overwhelmed.

My instinct was to invite my young grandchildren in the next room to watch the historic inauguration with me, but I thought better of it. What I want for them is a new normal: a world where the high achievements of women don't seem so unusual to young hearts and minds.

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to a doctor's appointment. That's why we called you." There can be no doubt that telepsychiatry improves both access to care and its continuity.

Once upon a time, doctors were able to provide home visits to these patients, something that both physicians and patients enjoyed as a unique, ancient, and warm version of healthcare. As managed care arose and costs expanded, we essentially lost the ability to make those visits. Now, with televisits, we can see patients in their homes again. Why would we willingly discard such an invaluable tool and return to that stunted interregnum? Some might argue that by allowing some patients to be seen at home, e.g. someone suffering from panic disorder with agoraphobia, we are reinforcing maladaptive behaviors. I believe this is a similar argument to expecting a person with opioid use disorder to "just stop using." The better option is to meet them where they are, form a relationship, and use that rapport as a scaffold for other interventions to help them get better. As a wise person once told me, often the most important goal of a first session is to have a second session. Let's not throw away an opportunity to have that first session.

Beyond those patients who are too impaired to attend an initial in-person visit, many patients are more comfortable at home and thus increasingly willing to connect. Seeing a patient's home can also provide useful information: Is their environment meticulously hygienic, or concerningly messy? Over the past year, I have seen everything from the precarious chaos of hoarding disorder, to the carefully-aligned room of obsessiveness, to a room designed around a Nazi memorabilia collection, an outdoor hot tub, and even the interior of a hearse. I have seen more bedrooms, basements, and car interiors than I can count. This is truly seeing the patient in the context of their natural environment—particularly now, when so many are working remotely and socially distancing. All of this is valuable information for a psychiatrist, and many of these experiences became the foundations for important conversations. Seeing patients in their homes has other advantages: When they forget the names or dosages of their other medications, they can walk to the bathroom to check the bottles. When a patient requires an urgent visit, scheduling is much easier

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for both patient and psychiatrist. On the other end of that spectrum, consider the case of a medical student with ADHD stabilized on a stimulant medication. Should we expect this person, who may be working 100-hour weeks, and who requires only a brief check-in and medication refill, to take an hour or two out of her day for driving round-trip and sitting in a waiting room, when she could just as well spend a fraction of that on a televisit? Time is our most precious resource and, if we have a way to better respect our patients' time, we owe it to them to do so.

It's worth noting that telepsychiatry did not begin last year. Patients have been able to access telepsychiatry through phone applications, such as Talkspace, since well before the pandemic. However, these psychiatrists are often out-of-state, raising concerns related to quality of care. As an established member of the mental health community in Connecticut, when I see a new patient, I call or request records from their primary care physician, therapist, prior psychiatrist, and other key clinicians, all of which I consider part of comprehensive, high-quality care. Often, I already know the patient's therapist and have established good communication and clear expectations for each other, allowing us to work in smooth parallel for the patient's benefit. I suspect that most out-of-state telepsychiatrists, who have no relationships with their patients' other doctors, have little interest in meeting this standard. Even from an exclusively financial perspective, maintaining telepsychiatry in Connecticut makes sense because patients' medical expenditures are recycled into our state economy.

The practical and logistical advantages of seeing patients remotely are myriad. Safety for both patient and psychiatrist are clear, as cloth masks are no replacement for remote care. As a solo private practice psychiatrist, if I fall ill or require quarantine, there is no coverage team to manage my patients until I return: While a trusted colleague would certainly assist with urgent cases, many of my patients would go unseen. Similarly, patients who are ill or quarantined would also go unseen without a telepsychiatry option. Patients who are high-risk because of medical comorbidities pose a particularly important consideration: In what way is denying them telepsychiatry, an accessible and effective alternative, not a form of discrimination? There is an argument to be made that we have an ethical obligation to protect these patients of ours by continuing to offer them a remote option.

Outside of the medical community, I believe there is an unspoken assumption—in fact, a fantastical wish—that COVID-19 will be the only pandemic we face in our lifetimes. If we could be assured of that, and if influenza and other endemic viruses vanished, then there would be less reason to maintain telepsychiatry after the pandemic settles. Unfortunately, that is not the case. For a moment, let's set aside COVID-19 and its potentially fearsome complications. Imagine that I have a patient who has bipolar disorder and takes lithium, and he falls ill with influenza. He calls to tell me he is experiencing a new-onset tremor, a worrisome early sign of potential lithium toxicity. Is it reasonable to force this patient to drive to my office and sit in my waiting room, causing him great discomfort and risking infection to my other patients, my staff, and myself, when I could just as well evaluate him remotely? Having used telepsychiatry over the past year, I find it hard to believe that we ever thought that the former was the best option.

Additionally, it seems likely that masks will remain part of our culture, e.g. during influenza season. We must consider the important diagnostic information and loss of rapport that occurs because of patient and psychiatrist wearing masks. While some psychiatrists lament the loss of body language in televisits, and while they are certainly no replacement for seeing patients in-person and unmasked, I suspect the available alternative is worse. So much of what we do relies on what is communicated through facial expression, including what is communicated unintentionally and therefore not subject to volitional compensation. In this manner, seeing patients in the office now, and in the future should mask-wearing be adopted long-term, poses a significant impediment to our work. From a purely clinical perspective, forced to choose between seeing a patient's facial expression or their body language, I choose the former. In some cases, such as with a patient who is potentially violent, facial expressions provide important clues to the patient's internal state, blocking of which could even compromise the psychiatrist's safety. There is no replacement in psychiatry for seeing someone's face. Masks are here to stay, and telepsychiatry should be too.

Despite meeting remotely, Jason and I have formed a strong therapeutic alliance. I've learned to read his facial expressions, which often provide important clues for our work together, and I'm sure he's learned mine, allowing him to feel comfortable and connected. Given his other medical problems which place him in the "high-risk" category for COVID-19, I believe that forcing him to choose between abandoning psychiatric care and exposing himself to this dangerous virus in my waiting room would be unethical. Telepsychiatry has allowed me to treat Jason in a safe, effective, and compassionate manner, and the results are evident in his progress. It is no secret that insurers have resisted enshrining telepsychiatry

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News from the APA

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partments to commit to fully supporting their efforts, according to an article now available in the American Journal of Psychiatry written by top DEI leaders in academic psychiatry from across the country.

The authors, representing prominent public and private institutions, include Ayana Jordan, M.D., Ph.D., Yale University, and current APA ECP Trustee-at-Large; Ruth S. Shim, M.D., M.P.H. University of California, Davis; Carolyn I. Rodriguez, M.D., Ph.D., Stanford University; Eraka Bath, M.D., University of California, Los Angeles; Jean-Marie Alves-Bradford, M.D., Columbia University; Lisa Eyler, Ph.D., University of California, San Diego; Nhi-Ha Trinh, M.D., Harvard University; Helena Hansen, M.D., Ph.D., New York University; and Christina Mangurian, M.D., M.A.S., University of California, San Francisco.

Dr. Jordan and colleagues describe, from their collective experiences, the growing expectations of people in DEI positions, in part resulting from the recent focus on racial justice and need to address structural racism. "DEI leaders are being summoned for one-on-one and programmatic consultation, anti-racist curriculum development, anti-bias training, and skill acquisition," they write. "However, many of these institutions do not provide the appropriate resources or support necessary to institute an effective response for cultural change….This lack of scaffolding leads to an exacerbation of the 'minority tax,' thereby placing more duress on the very same people adversely affected by structural racism." Notably, almost half of these DEI leaders have not received salary or compensation for the roles.

"It was not surprising to any of us that most DEI leaders were women of color," said Mangurian. "But what was surprising is that so many of us did not receive the support we deserved. Our work suggests that leadership in psychiatry — and across all academic medicine — should re-examine their current investments so they can provide sufficient financial and administrative support to these extraordinary DEI leaders. This will not only help ensure these women of color thrive and stay within academia, but will help move us closer to our shared goal of creating a more diverse, equitable, and inclusive environment."

In an accompanying commentary, Altha Stewart, M.D., APA past-president, notes that recent personal accounts by Black academics suggest the lack of leadership support on racism issues "is a major factor in departure from academic medicine by Black physicians (including psychiatrists)." Dr. Stewart discusses the historical underpinnings of structural racism in academic medicine and emphasizes the need for senior leaders to recognize and address the unintentional but well-institutionalized barriers in their systems and to work to create more balanced, equitable, and welcoming environments. "To retain BIPOC faculty, institutional leadership must believe, validate, and act on facul-

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The CROWN Act

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workplace and other public spaces, targeting natural hairstyles. In particular, the hair of Black individuals has been targeted for centuries in America. Black adults have been punished, reprimanded, and even passed over for promotion or fired based on their hair. Cases filed by Black workers against their jobs for discrimination based on their natural hairstyles have existed for more than 40 years.

Black children are no exception. Several high-profile cases documenting racism against Black hair exist, and to be sure, a myriad of others that never garnered public attention. A Black high school student was forced to choose between cutting off his locs or forfeiting his wrestling match. A Black girl was sent home from elementary school in Louisiana because of her braided hairstyle. The policing of Black hair is not new, but hopefully, this new legislation will help to crack down on it. Hopefully one day, all Black people can comfortably and happily wear their natural hair.

Telepsychiatry

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in legislation because increased access to care hurts their bottom line. But insurers are there to serve our patients, not vice versa. Our decision about whether we keep telepsychiatry as a permanent option must be based on what is in our patients' best interest.

I look forward to seeing patients in person again when we can do so safely and without masks. I will be glad to meet Jason face-to-face, shake his hand, and congratulate him on his progress. Even then, I hope to maintain telepsychiatry as part of my practice for the days when his symptoms prevent him from coming to my office. I want to be able to tell him that we don't need to cancel our visit because we can still meet virtually. We know that telepsychiatry is an effective delivery method, that it increases access to care, and that it provides numerous other benefits. Even in the absence of COVID-19, it was years overdue. Throwing it away would be regressive and, for those patients with other health problems, it would be discriminatory. We owe it to our patients to keep telepsychiatry as a permanent option.

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ty's experiences of racism," writes Dr. Stewart.

Jordan and colleagues offer a series of recommendations in the areas of financial, administration and structural practices to effectively support DEI leadership, including:

- Structural
  - Strategically elevate the title of the DEI leader to vice or associate chair in the department, to clearly state the importance of the role.
  - Include that person in the departmental cabinet, executive committee, and/or other leadership team.
- Administrative
  - The roles and responsibilities of the DEI position should be clear when the job description is first presented to potential candidates, with responsibilities commensurate with financial effort provided.
  - As with all leaders, term limits are recommended for this role with evaluation at 5 years and a 10-year maximum term.
- Financial
  - DEI efforts should receive financial support, including salary reflective of effort and expectations; discretionary funds to implement policies; and support staff.

"Real change will require that no one be exempt in demonstrating the organization's commitment to diversity and inclusion by creating the welcoming environments that will support institutionalization of this new culture," Jordan and colleagues conclude.

The paper is available here, and the commentary is available here. Drs. Jordan and Mangurian discuss this article in depth on the latest AJP Audio podcast. The American Journal of Psychiatry is the official journal of the American Psychiatric Association.

Connecticut Psychiatric Society

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