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From Your Couch to Mine: From Virtual to In-Person

By Christopher Hammel, MD, MPH

For the first year of my private practice, I was a telepsychiatrist. I finished residency and began accepting new patients in July 2020, early in the pandemic, well before vaccines were introduced. The transition to physical visits has been a unique and peculiar career experience: some days, it feels prosaic; others are more Lewis and Clark.

Perhaps the most pervasive issue in seeing patients remotely was that I continually asked myself, "What am I missing?" I imagined that I might miss some subtle sign of psychosis, an obvious medical issue that was just off-screen, an anxious wringing of the hands in an otherwise-calm patient, or some scent that would have shifted my differential diagnosis: the odor of neglected personal hygiene; the acrid halitosis of alcohol. I worried that I would find a "tarantula on a slice of angel food cake," as the novelist Raymond Chandler put it—some critical finding that lurked just outside of the camera angle.

In July 2021, COVID-19 rates in Connecticut were at their lowest since the pandemic began; my tolerance for working from home, too, was at its nadir. I decided it was time to rent a long-term office. Because I provide medication management as well as psychotherapy, and some patients had difficulty checking their vital signs elsewhere, I asked my patients to be seen in the office. I provided them with the option to remain remote for 2 weeks, and invited them to discuss any concerns or special circumstances with me. Although I had arranged through a colleague for emergency office space during my remote year, I never had to use it. So, when I moved into my office, exactly one year after opening my practice, I had not yet met most of my patients in-person.

While some were eager to meet face-to-face, others demurred. Exploring the hesitation often had the same finding: convenience. Most of my patients are working adults, and being able to meet with me before work or during their lunch break was difficult to relinquish. Those who had special safety concerns all came in-person, but asked for even more stringent protective measures than CDC or state guidelines, which I obliged.

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President's Column

By Tobias Wasser, MD

I want to welcome all CT psychiatrists and trainees to another exciting year with CPS! I am delighted to begin my term serving you all as President of our organization. I have been so fortunate to be involved with CPS since my residency training and have benefited greatly from the collaboration, collegiality and mentorship of the many wonderful psychiatrists who make CPS a vibrant and impactful voice for our field and our patients. I recognize that one year is a short period of time in the lifespan of an organization, so one of my hopes for this year is that we can set realistic yet meaningful goals for how to make a significant impact on the lives of our patients, particularly the marginalized and underserved. I hope we can look back at this year and feel satisfied that we accomplished something meaningful for these patients. The CPS executive council is also going to begin the process of developing longer range planning to think about how we'd like to see our organization grow and develop over the next 3-5 years so that we can continue to build on our past successes and plan for the future of CPS.

None of this work can be successful, however, unless we hear and learn from all of you about the ways in which you'd like to see your CPS advocate for you and your patients! One of CPS's greatest strengths over the past few years has been our political advocacy and lobbying efforts. A major component of this success has been our collaboration with our phenomenal CPS lobbyist, Carrie Rand-Anastasiades. Carrie is committed to working on behalf of CPS and our patients and we need your help to decide how we concentrate our collaborative efforts with her in this upcoming year.

All of us do this work due to a dedication to helping patients – whether through direct patient care, teaching, research, advocacy or administration, we all have so much to offer. CPS offers an opportunity for all of us, whether seasoned psychiatrists or PGY1 residents, to come together to collaborate and build upon our individual strengths in moving toward this goal. One of my other goals for this year is to grow CPS' membership and the active participation of our members as a way of enhancing and ensuring our vitality. We need experienced psychiatrists so we can benefit

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My Experience as a Medical Doctor During the Pandemic

By Sheila Cooperman, MD

For nearly two years now the staff I work with have been delivering mental health care to the seriously mentally ill in the most challenging of times. My experience during the pandemic has been as a Medical Director of the Western Connecticut Mental Health Network. We provide services to people from the Massachusetts border to the New York border. We operate an interesting group of clinics in the Western part of the state. They are located in Torrington which is rural, Waterbury which is urban, and Danbury which is suburban. They are staffed by psychiatrists, APRNs, case managers, clinicians, social workers, psychologists and support staff. They are part of the Connecticut Department of Mental Health and Addiction Services. The Network has the support of the DMHAS Medical Director, Charles Dike, the Commissioner and other administrative aides who coordinated significant changes during the pandemic in how treatment was delivered with guidance from the Department of Public Health. The views I express here are my own and not of DMHAS.

The experience has been intense. I never imagined what it would be like to work through a pandemic. We had to adapt quickly to provide for the treatment needs of a vulnerable population. For me, the most successful breakthrough was the ability to have telephone sessions and video sessions, both for patients and staff. We have a number of patients who do not have computers or smart phones and reaching out to them with their basic cell phones has been a true lifeline. You probably will not be surprised to hear that a number of patients had said that they preferred to have staff call rather then come to the clinic or have staff come to check on them at their residence. That was honored unless there were safety concerns. As the months dragged on, patients were asking for their groups to start up again. The telephone conference calling lines were used and we did a survey monkey to check on how patients rated the group experience. The majority of people said it was helpful and near to the "in-person" experience. I hope the ability to maintain phone sessions continues. Many patients have said that they value phone sessions because they do not have cars and lack experience with technology. Also, they depend on public transportation and in times of inclement weather, can maintain and more easily access their appointments. This supports continuity of care.

As video capability was established, it became another life saving avenue for communication for patients who could access it. I was interested to see that some found it easy to use and others resisted. Practice and more practice made meetings and sessions smoother. It became almost second nature for some. The Network is spread out geographically and there were clear advantages to using video conferences.

This pandemic has been a learning curve in technology, infectious disease and adaptation for myself, my patients and my staff. I do think that one of the greatest challenges has been the misinformation regarding the

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Racial Trauma and Social Media

By Chidinma Okani, MD, PGY-3

According to the 2018 Pew Research Center survey on adolescent technology use, 95% of youth have access to smartphones and 45% say that they are online "almost constantly." Moreover, the survey revealed that African American youth report more frequent internet use than their white counterparts, with 34% reporting going online almost constantly in contrast with only 19% of their white peers. In recent years, social media has played a prominent role in widespread broadcasting of police brutality against African Americans, most notable the murder of George Floyd in 2020 which went viral after being captured on cellphone video. These viral tragedies beg the question: what are the long-term psychological effects of these tragedies on Black youth?

National-study findings indicate that African Americans have a 9.1% prevalence rate of PTSD, compared to 6.8% of their white counterparts (Himle et al, 2009). The DSM-5 definition of PTSD centers on direct experience of traumatic events, in-person witnessing of traumatic events, learning of the traumatic event occurring to close family or friends, and experiencing repeated exposure to aversive details of traumatic events (e.g., first responders). Some argue that this definition is limited in its exclusion of both media-induced secondary traumatic stress as well as stress caused by racial discrimination. Social media depicting racial acts of violence are unique in its implication of both of these factors.

Secondary traumatic stress has been studied in multiple national tragedies. Following the 9/11 attacks, researchers assessed PTSD symptoms in a sample of 2,273 individuals using the PTSD Checklist. The study revealed that there was sufficient evidence to suggest that repeated exposure to television coverage of 9/11

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Connecticut Psychiatric Society

Legislative Update

By Carrie Rand-Anastasiades

The 2021 fully virtual legislative session finally concluded on June 17th, which was the latest possible ending by calendar rules. Rebounding from COVID, CT was in the forefront with high vaccination rates, and the American Rescue Plan (ARP) funding injected an enormous amount of money into the economy that led to the passage of a bipartisan budget, the first in a number of years. The legislature also passed controversial issues such as the legalization of marijuana and sports betting that will hopefully help fill State coffers in the future. Medical issues on vaccination were first and foremost on the agenda. After much controversy, a bill was passed that removed the religious/non-medical exemption from vaccines for children attending school. Several other States have enacted similar legislation, including Maine and New York.

Due to the virtual session, CPS targeted several specific issues to work on. Ensuring that telehealth, including audio-only, was extended was our first order of business. HB 6470/Public Act 133 requires the Department of Social Services (DSS) commissioner to provide Medicaid reimbursement for telehealth services to the same extent as services provided in person. In addition, it requires DSS to cover audio-only telehealth services permanently. Audio-only services are provided to people who are unable to use or access comparable covered audiovisual equipment. This has been an extremely useful tool not only during the pandemic, but overcoming obstacles to technology and transportation for the State's most vulnerable residents. The act also expands the types of health care providers who can order home health care services to include advanced practice registered nurses (APRNs) and physician assistants (PAs). In addition, it establishes requirements for the delivery of telehealth services and insurance coverage of these services until June 30, 2023. Among other things, the law allows telehealth providers, regardless of any contrary state laws, to provide services from any location. We look forward to making the insurance component permanent as was done with Medicaid.

Another issue we focused on was a bill regarding psychotropic drugs and mental health services. HB 6855/Public Act 125 prohibits health insurance policies that cover outpatient prescription drugs from requiring a health care provider to prescribe a supply of outpatient psychotropic drugs greater than that which he or she deems clinically appropriate. In addition it prohibits imposition of a cost-sharing amount (i.e., coinsurance, copayment, deductible, or out-of-pocket expense) for a less than 90-day supply of these drugs. The provisions apply to individual and group health insurance policies. The law also establishes a 10-member task force to study ways to encourage mental health service providers to participate in provider networks. The passage of this bill was way overdue. CPS has been championing the initiative for several sessions. Steadfast determination to keep bringing the bill back to show the safety issues associated with it finally won the day.

As we head into the 2022 session, we have some uncertainty. It is a short session, beginning in February and ending in May, but we are not sure if the building will be open to the public as it had been pre-COVID. There could be a mixture of online and in-person, or it may be completely closed once again; forcing us into a virtual world for the second year in a row. CPS will be working with our coalition partners to tackle enforcement of parity in CT. Now that data has been released from insurers, per a bill passed two years ago, we will once again be looking at reimbursement rates and access. There will also be a focus on Medicated Assisted Treatment (MAT) to ensure all forms are covered and available to patients. Whatever the session brings, we look forward meeting the challenges and opportunities with a united voice that continues to bring success.

President's Column

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from your wealth of experience. We also need trainees so we can benefit from your energy, enthusiasm and connection to the future vibrancy of our organization So, if you are a psychiatrist or psychiatric resident practicing in the state of CT, whether you've never been to a meeting or haven't been in a while, I invite you to join us for at least one meeting this year to see what CPS has to offer you. If you are a regular attendee, I encourage you to bring at least one colleague who's never attended before to at least one meeting this year. This year we will be having meetings once every other month on Thursday evenings and will try to use this time as effectively and efficiently as possible to demonstrate to you all that your time is well spent!

Thank you for your commitment to CPS and to our patients. If you'd like to connect with me privately to share your ideas, please feel free to reach out to me at tobias.wasser@yale.edu. I look forward to seeing you at a meeting this year!

Save the Date
Open Council Meeting

1/20/22 at 7:00 p.m.
via Zoom

To register, email
CPS@ssmgt.com

Racial Trauma and Social Media

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rendered individuals vulnerable to the development of chronic PTSD (Schlenger et al., 2002). Another study of 141 fourth- through eighth-grade students in New Orleans found that the amount of time children spent watching Hurricane Gustav television coverage was significantly correlated with PTSD symptoms (and this was stronger for children with pre-existing symptoms). A survey of 2,381 middle school children (43% self-identifying as African American) found that watching coverage of Oklahoma City bombing was directly related to post traumatic stress symptoms of intrusion, avoidance, and arousal among youth.

These studies point to disturbing effects of consuming violent media, especially for Black youth. However, additional studies are needed to further elucidate the mental health effects of social media, in particular. Social media poses unique challenges when accounting for mental health. Unlike traditional media outlets, which present news in a more regulated manner, social media offers news in a more chaotic and unrestricted fashion with the help of algorithms that carry the user through an intricate web of links aimed at engaging users for multiple hours at a time. This increases their likelihood of unexpectedly encountering violent imagery (NYT: The Trauma of Violent News on the Internet). Regardless of whether the mental health effects of violent media, particularly media showing murders of Black individuals, qualifies under the strict DSM-V criteria for PTSD, it is an important issue we need to begin talking about and studying it, nonetheless.

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My Experience During the Pandemic

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masks and vaccines. As doctors, we have all needed to wear masks for many hours during surgery rotations or doing psych consults on patients with infectious disease or compromised immune system but others who have not worked in medical systems often see masking as a hardship.

I remember classmates having polio, rheumatic fever and the measles. I had been so relieved that there were vaccines available to spare children measles, mumps, rubella and polio. As doctors, we know what sequelae can occur as a result of these diseases. It has been both sad and frustrating for me to see the vaccine hesitancy and refusal that has led to the continuation of this pandemic. It is incredible to see scientific facts cavalierly dismissed.

The pandemic continues on with its ebbs and surges and I have found that the continued contact with my colleagues using all of the communication options available gives me hope that we will come out of this with new skills and avenues to treat vulnerable patients.

From Your Couch to Mine

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Although many of my patients wrung their hands or bounced their legs anxiously during our first in-person visit, most acclimated quickly. There were no "tarantulas." Some were less comfortable opening up than they had been in their homes, which was often dispelled by talking about it, and by the passage of time. My most dramatic discoveries were a couple of cases of high blood pressure. In short, what I really missed by doing remote visits was the obvious answer: the connection of sitting in a room with another person. Meeting these people who trusted me with their secrets, traumas, fears, and joys for face-to-face meetings was a pleasure. Some visits felt a bit like meeting an old pen-pal. In particular, I found that my hour-long psychotherapy visits were more enjoyable and productive in the office, perhaps because I myself found it easier to engage. Family visits also felt significantly better in-person: in remote visits, I often suspected that, when I met with one party individually, the other was still within earshot.

During this period, there was at least one experience which would have been challenging to manage remotely: an adolescent patient arrived for a visit with her parents, who had been noncompliant with her outside psychotherapist's instruction to bring her to the emergency department due to safety concerns. After evaluating the patient myself, I made the same recommendation, but her parents remained recalcitrant. Ultimately, I felt compelled to call an ambulance against their wishes and without their knowledge because I was fearful that they would leave with the patient. Had they been at home, navigating this process would have been even more difficult. However, after the patient was brought to the hospital, I invited the parents into my office to debrief. Afterwards, her father offered me a firm handshake and a genuine thank-you. I suspect that if this had occurred remotely, such repair would have been impossible.

It was also during this time that, as one of my sessions ran a few minutes over, my next patient invited himself into my office. The intruder's severe anxiety was exacerbated by our return to in-person sessions, leaving him wondering if I had forgotten him. Fortunately, I believe that I was more upset than the patient whose session was disturbed. I apologized profusely to that patient, had a thorough and firm talk with the intruder, and scheduled them apart going forward. It wasn't long after I moved into my office that infection rates began to rise again, and I returned to allowing patients the option for remote visits at their discretion, which remains my practice. I felt comfortable doing this because my caseload is fully vaccinated. As vaccines became available, I spoke with each of my patients to recommend they get vaccinated and, suspecting that boosters may eventually be necessary, documenting the dates of their shots in a portion of their note which is carried forward. Now, as patients become eligible for boosters, I'm able to easily check their vaccination dates and remind them. In my own judgment, the risk of meeting an unvaccinated patient in-person to my patients, my family, and myself, versus the benefit of doing so, does not weigh out favorably. Thus, it would require an unusual set of circumstances for me to meet an unvaccinated patient in-person. I shared this with my last unvaccinated patient a few months ago, and he informed me soon after that he was seeking care elsewhere for unrelated reasons.

Having returned to in-person visits, albeit in a stuttering fashion, I feel all the more strongly that telepsychiatry should remain an option for psychiatrists. The extent to which it might constitute a helpful option for a given patient should be a topic of conversation between patient and psychiatrist. Factors that predispose me to insist on an in-person visit might include: an initial visit, a patient I have not yet met in-person, a medically complex patient, or a patient prescribed a complex or higher-risk medication regimen. I may be less likely to insist on an in-person appointment if there are access-to-care issues, e.g. transportation limitations or a demanding work schedule; level-of-comfort issues, e.g. a patient who might discontinue therapy if I push too hard to meet in-person; vaccine hesitancy or refusal; or a high level of exposure, e.g. if the patient works as an ICU intensivist.
In summary, both in-person and virtual care were important to getting through several waves of the COVID-19 pandemic. Both modalities will remain important to psychiatric practice in the future.

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