In my first Editorial about Leadership in Psychiatry, I mentioned that we will be following others if we don't take ownership of all of the facets of patient care. I have always advocated for physician leadership in the realms of clinical care, population health, and resource allocation. In this article, I will discuss the involvement of private money pouring into psychiatry and how the future of clinical care will be driven by finances and financial outcomes only.

I am sharing some news from the business circles to emphasize how the world of business is following mental health and looking at financially-driven goals in different subspecialties of psychiatry. It is interesting to look at the world of private equity, which has recently been investing heavily in addiction centers, eating disorder centers, and autism clinics for no reason other than that they are profitable. As we clinicians are aware, these select illnesses have other comorbid disorders that would also benefit from investment. Ultimately, if we are to manage population health, financial outcomes, and maintain quality of clinical care, we must care for patients with all psychiatric disorders and control costs. This may be achieved by emphasizing outpatient care, continuity of care, and focusing on prevention and relapse prevention.

Behavioral Health Continues To Attract Private Equity

In 2014, Bain Capital acquired the largest chain of methadone clinics in Massachusetts, Habit OPCO, Inc. As the director of a substance abuse program at McLean Hospital in Massachusetts told the Boston Globe at the time, “[t]he problem I find with some of the for-profit clinics is the absolute minimum required by law becomes the absolute maximum they’re willing to do for their patient.” The Globe Noted that while staff at Habit OPCO said profits were not the priority, a patient-focused stance would be “an unusual position to take for executives at an enterprise owned by Bain.”

In early March 2020, before the COVID-19 pandemic struck the U.S., Vox ran a series called The Rehab Racket. They covered the shady underworld of addiction services brokers and the “shuffle” of patients going from one treatment facility to the next. Covering the strange world of addiction services in-depth is beyond the scope of this particular essay, but Vox’s work is worth reading—the gaps in patient care and the cyclical nature of most addiction treatments allow private equity firms to monetize patients’ confusion and addiction.

Today, private equity’s involvement in behavioral health services is beginning to taper off. While some private equity firms are still involved in previous investments or are trying to roll up portions of the industry, many are looking for the next revenue opportunity. “Behavioral health” has become a watchword for “solid investment.” As one industry website noted, “[i]n the fiercely competitive arena of healthcare investment, investors are under constant pressure to find the next ‘behavioral health’ – a healthcare subsector that experienced a significant increase in consumer demand and, in turn, significant investment starting about 10 years ago.”

(Continued on page 2)
The behavioral health sector is no better—and seemingly quite a bit shoddier and more fraudulent—than it was before the 2008 Parity Act triggered a flood of private equity investment. Patients with severe autism and addiction still struggle to find caring providers and safe group homes. But with only their stakeholders to please, private equity owners have made their money on the industry and can keep moving along. Some of the profit-takings can lead to more wastage of health care dollars.

Experts predict that this trend will continue into the year ahead, as does Burk Lindsey, managing director in the healthcare investment banking group at Raymond James & Associates. Lindsey, who was a panelist alongside Taggart on the recent BHB webinar, even theorized that PE’s interest in behavioral health could pick up in 2021.

COVID-19’s impact on the overall health care industry partially explains this trend. Not only did the pandemic exacerbate the nation’s behavioral health problems, but it also hurt other sectors of health care that have historically been considered recession-proof, such as dentistry and dermatology.

“As a result, companies in segments that were relatively unaffected by COVID — like home health and hospice — and those one could argue perhaps benefitted from COVID — like the vet space and behavioral health — are attracting greater interest than they otherwise might have,” Lindsey previously told BHB. “In essence, you have the same amount of capital chasing a smaller number of opportunities.”

But not every behavioral health opportunity is created equal. According to Lindsey, PE buyers are currently most interested in pursuing capital-efficient, balance sheet-light companies, such as autism providers, outpatient mental health companies, medication-assisted treatment (MAT) organizations and opioid treatment programs (OTPs). Lindsey has identified this as another trend that is likely to carry over from last year.

“There’s a lot more momentum and activity around models across behavioral health that have more of a lower-cost outpatient setting,” Lindsey said during the webinar.

LifeStance Health and Refresh Mental Health are two recent examples of such activity. Both national outpatient mental health providers scored huge PE investments last year, with TPG Capital putting $1.2 billion into LifeStance in April and Kelso & Company acquiring a majority stake in Refresh in December. While Kelso didn’t announce the terms of the Refresh deal, Taggart said the provider sold for “crazy multiples.”

As a consequence of these acquisitions, providers are leaving organizations as they are losing autonomy. These psychiatrist
shortages are then filled by Nurse Practitioners and Allied Mental Health providers.

Lindsey and Taggart predict 2021 could even see private equity firms start to build outpatient mental health businesses of their own from scratch if they’re unable to find attractive platform-sized companies to acquire. This is a strategy that PE firms such as KKR have previously deployed in the autism space, which is also expected to remain hot in 2021.

In terms of other M&A predictions for the year ahead, dealmakers said they also anticipate that the industry will see a growing number of behavioral health providers diversify their product offerings and expand their telehealth capabilities.

Despite a modest drop-off in the number of deals last year, behavioral health, in general, continues to entice investors. Bankers stated that sub-sectors with particularly strong traction include drug and alcohol addiction, as well as autism, brain injury, at-risk youth, and eating disorders.

Behavioral health issues are often accompanied by substance abuse problems. Wester explained that this makes for complicated cases that often require multiple stays in high-acuity residential treatment centers, as well as ongoing, long-term outpatient care.

One recent business conference reported, “As we look to rebuild from the COVID-19 pandemic, the business community must prioritize and invest in the mental health of all employees—this is not just a business initiative, but a social imperative that will drive positive and long-lasting effects for society. We invite other leaders of businesses – whether large or small – to join this global movement to advance the desperately-needed conversation around creating an open, welcoming, and supportive workplace environment for all when it comes to mental health in the workplace.”

As psychiatry and other behavioral health providers try to improve care for our patients, we need to get involved with the financial outcome to the health care systems. I have just given a small glimpse of the business activities in the recent months — you can expect a lot more mergers and acquisitions going forward.

Unfortunately, the direction of investment by profit-driven organizations will lead to more costly, siloed care, and will lead to greater fragmentation. This is what happens when clinicians are not in leadership positions or driving the care in these organizations. If psychiatrists do not get involved in creating treatment algorithms to help reduce the cost of healthcare and improve patient outcomes, we will be left behind. Without our input, treatment programs will be dictated by short-term gains and financial returns rather than what is ultimately better for the individual patient and the society in general.

To our young psychiatrists: we need to take clinical and financial ownership of not only patient care but also the health care system and population health along with our medical colleagues. If we fail to do so, both our field and our patients will suffer.

AZFAR MALIK, MD, MBA, DFAPA
President / CMO, Center Pointe Behavioral Health System
Assistant Clinical Professor, Department of Psychiatry
Saint Louis University
I was born in Chicago almost fifty years ago. At that time, the Chicago Cubs had not had a playoff appearance in several decades. My father emigrated from India in the early 1960s and married my mother who is a third-generation European. My maternal grandmother was a compassionate nurse who provoked a strong work ethic.

I completed high school at Loyola Academy in Chicago, and upon graduation, moved to Kansas City to attend Rockhurst College (now Rockhurst University). Rockhurst offered a strong science curriculum. I completed my studies and graduated with a BS in chemistry and a minor in philosophy. Despite their stark contrast to the natural sciences, philosophy and theology were some of my favorite classes at Rockhurst. Such studies certainly involve a different type of thinking, but still ultimately involved connecting principles and problems solving (like chemistry, at times). I think I enjoyed having a diverse curriculum, but when applied to my own faith, it also offered me an opportunity to challenge and ultimately, validate my beliefs.

While the first two years of medical school were a bit tedious and 95% of our instruction occurred in the classroom, the transition to 3rd year and the “short white coat” was genuinely exciting. Every rotation was more stimulating than the previous one. This represented not only the passion of the instructors but also the chance to apply many of the principles, algorithms, and knowledge that I had spent the last two years accumulating. During my medicine clerkship, I recall two patients, one with cirrhosis secondary to alcohol use disorder and another with myasthenia gravis. Both had a grave medical illness. Both had some needs that were unmet by the traditional doctor-patient relationship where the emphasis can be limited to the chief complaint and whichever medical issue is most acute. I recalled an earlier rotation where one of the physicians, a pediatric surgeon, reminded us that when a doctor takes care of a patient both of their names are at the header throughout the chart and written on a board at the foot of the patient’s bed is the physicians’ own name, often in all capital letters and in an even larger font than that of the patient.

I decided that I wanted to be a physician who would strive to apply a patient’s past and present social history into the context of their current medical and behavioral health needs. I completed medical school and started my psychiatric residency. I enjoyed psychiatric training even more than I had hoped. Chicago Medical School where I trained had a reputation as being a ‘neuropsychiatry program’. This was no doubt partly related to faculty that included Michael Taylor MD (extensively published in schizophrenia and other topics) and Richard Abrams MD who owned a company that manufactured the “Thymatron” ECT machine. In addition, there was excellent mentoring in psychotherapy with David Garfield MD and consultation liaison psychiatry with Amelia Erhardt MD. I was about to start “practicing” medicine and psychiatry formally. The joke I would hear went something like -- “all that school and training and you are still ‘practicing’—when does it really start...”. This made me think of another professor in medical school who would remind us “after all, we are all, students....”

Upon completion of residency, I took a job in Kansas City thinking that it would be fun to go back to the same town where I had spent four years of my life (in college) but had been too limited by time, finances, and transportation to explore many off-campus opportunities. The practice I joined, Midwest Psychiatric Consultants, offered an opportunity to explore a variety of behavioral health practice locations. The practice founder, John Pro MD, had an excellent reputation throughout Kansas City. Importantly, Dr. Pro had been a pioneer of Consultation-Liaison Psychiatry in Kansas City in the 1980s. Consultation-liaison psychiatry had been a favorite rotation in residency and since my partners, including Philip Khoury MD who remained with the corporation until we dissolved in 2020, all shared my interest—we were soon the consulting psychiatrist for nearly half a dozen med-Surg hospitals. Several of us ended up even becoming Board Certified in this specialty. Other experiences with research, nursing homes, forensic psychiatry, and the

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more traditional inpatient/outpatient psychiatry rounded out a balanced group practice experience.

During this time, my interest in addiction medicine was sparked by a new medication with a somewhat unique pharmacological profile. I had always had passionate regard for psychopharmacology and was fortunate enough to see a Dr. Stephen Stahl program and would study his publications. My wife who is a professor of pharmacy is an even bigger fan. Sarah has been a tremendous source of encouragement to me throughout my career, whether she was helping me study for an exam or driving two hours to have dinner with me when I was taking a test out of town. We met if you have not guessed in the mental health clinic, my second year of residency. Supportive relationships can certainly help one get over some of the mountains that life puts in our way, and I have been fortunate. Dr. Khoury was an amazing practice partner, and I am fortunate to have enjoyed his friendship and collaboration over the last two decades. Sarah would at times jokingly refer to Dr. Khoury as my “work spouse”.

I attended a program in Las Vegas to learn about opioid use disorder and Medication-Assisted Treatment (MAT). At the conclusion of the program, I had obtained a “buprenorphine waiver”. I returned to Kansas City to begin offering treatment with this new agent. At that time, there were less than a dozen providers in the Western Missouri region offering MAT. David Sternberg MD was among them. Dr. Sternberg was tremendous support and resource, and I did seek out his advice on several of my initial inductions. It was rewarding to see the rapid improvement that MAT can offer to an individual with opioid use d/o. So effective at times that one may even forget to emphasize psychotherapy, but I still sought to make counseling a component in the treatment plan. Having an appreciation of a patient's detailed life story is useful in weighing the risk of relapse, incorporating potential triggers and liabilities as well as assets. I became Board Certified in Addiction Medicine. It is important to note that in the last decade that thousands of physicians also became certified in this important field. I am pleased to report that in recent years Addiction Medicine has achieved formal recognition in the specialty society (ABMS).

After twenty years of psychiatric “practice”, I have confidence in my ability to help my patients. I look forward to the future.

### APA Coronavirus Resources

If you are a patient or family member or friend in need of immediate assistance:

- **Disaster Distress Helpline** Call 1-800-985-5990 or text TalkWithUs to 66746
- **National Suicide Prevention Lifeline** Call 800-273-8255
- **Physician Support Line** Call 1-888-409-0141
- **Crisis Textline** Text TALK to 741741
- **Veterans Crisis Line** Call 800-273-8255 or text 838255
Social Bots Represent a New Challenge to the Goals of Psychiatry
Dr. Jacob Lee

When former President Donald Trump enacted his controversial decision to pull out of the Paris Climate Agreement, social media accounts around the country engaged in a passionate debate about the merits of combatting global warming. Nearer the end of his term, dual waves of race and civil justice crashed through the virtual discussion across Twitter, Facebook and beyond. These conversations were nothing new; modern climate activism predates Twitter by decades and modern racial activism predates the internet by well over a century. Analysis from Pew Research found the #BlackLivesMatter hashtag has been a relatively consistent presence on Twitter for the last five years, with periodic increases in usage around key events. The nature of these discussions has changed and supposedly democratized in the era of mass social communications. As these long-overdue reckonings played out in this new virtual arena, they brought with them a new voice, often under-appreciated by those most involved.

Social media disinformation bots are computer programs that post autonomously on social media platforms, amplifying information or disinformation over hundreds of thousands of digital voices. “Astroturfing” or “Twitter bombing” can deploy these bots to post tens or hundreds of thousands of messages directly displaying false information, or directing to websites with fake news. Social media bots contribute as much as 19% of the content on platforms such as Twitter, and analysis shows they play a significant role in influencing decision making, including influencing the 2016 United States Presidential election.

Analysis from the Journal Climate Policy assessed 880,000 tweets in the 2 months following the US withdrawal from the Paris Climate Agreement, finding that bots are “not just prevalent, but disproportionately so in topics that were supportive of Trump’s announcement or skeptical of climate science and action.” Despite social media bots contributing as much as a quarter of the climate-related tweets, many users fail to recognize their prevalence, and no major medical organizations have publicly acknowledged their threat.

Another Bot Tracking project, Bot Sentinel, detected “an uptick in inauthentic activity by accounts that were already active and also new accounts created” to spread disinformation during the height of #BlackLivesMatter. Oumou Ly, a staff fellow at the Harvard Berkman Klein Center, observed that the majority of the disinformation seems to be coming from the far-right. “The online information environment is very asymmetric,” she told Digital Trends. “The right participates more often and in a more sustained way in spreading disinformation because they have more to gain politically from it. It’s part of their political strategy.”

In the past decade, the American Psychiatric Association has increasingly recognized the role civil rights activism, antiracism, and climate advocacy play in the overall health of our patients. Expanding our efforts into these areas opens a broader concept of what it means to be a psychiatrist or to advocate for psychiatric patients. This reconsidering of our role casts a spotlight over issues previously untouched by physicians as advocates, with social media increasingly a target. With these and other psychiatric advocacy efforts negatively impacted by social disinformation bots, we discover a broader risk to advancing the goals of American Psychiatry.

Americans, including our patients, increasingly utilize social media, with Pew Research finding 70% of Americans use social media to connect to each other, find news content, entertain ourselves, and exchange information. High-quality research increasingly ties social media to hyperpolarization, cyberbullying, depressive symptoms, addictive behavior, and more, suggesting social media bots are just one portion of a larger risk to mental health.

As American psychiatrists look to take on these and other challenges in an increasingly futuristic landscape, we must start by publically acknowledging these new threats. At the upcoming APA General Assembly meeting, I plan to introduce legislation that would call upon the American Psychiatric Association to recognize the role social media disinformation bots play in negatively impacting opinions on key psychiatric issues. Furthermore, I will call

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Social Bots Represent a New Challenge to the Goals of Psychiatry
Dr. Jacob Lee

for governing bodies and social media platforms to research and work to limit the damage these social bots can inflict.

Sources:

Researchers:
COVID-19 has added significant stress to our lives since March of 2020. So far, 27 million in the United States have been infected. Over 460,000 people have died. Travel restrictions, the limitations of structured activities such as games, sports, school, entertainment, and forced isolation in our homes to prevent the spread of the infection have changed our society’s very fabric. Unemployment has risen sharply, causing financial ruin for many families of some segments of our community.

Suicide Rate
During the pandemic, we have become more socially isolated, lonely, and in some cases more anxious and depressed, potentially precipitating suicidal behavior. It is not clear whether the actual incidence of suicide has increased during the pandemic. Systematic studies of suicide rates during the pandemic are sparse. Some suggest an increase in suicidal thoughts and self-harm. Reports show that the suicide rate fell in some developed countries (1). For instance, Japan had a decline during the early period of the pandemic but found that the rate increased significantly after August 2020. The suicide rate in Kollam, a medium-sized city in Southern India in 2020, was 45/100,000, a 400% increase from the previous year.

Based on the lessons learned during the Spanish flu of 1918–1919 in the United States (2) and the SARS epidemic in China (3), a rate increase worldwide can be expected during the COVID-19 pandemic. The United States’ comparative data are yet to be gathered once the pandemic is under control with vaccinations, which are underway.

Each year, roughly 12 per 1,00,000 people die by suicide. For every death due to suicide, there are 15 reported suicide attempts. In the United States, generally, White men over 55 years old are more at risk for death from suicide than any other ethnicity and gender, while Blacks between 25 and 34 show an increasing trend lately. Whether these are the same groups differentially affected by COVID-19 is yet to be determined.

Potential Causes and Effects
Suicidal behavior is one of the most challenging areas to study, due to the complex interaction of various psychosocial factors, mainly when interacting with a medical condition with its unique secondary effects.

In the initial stages of the pandemic in Italy, the United Kingdom, and New York, people were afraid of the unknown, as there was no treatment, and the medical community was ill equipped to deal with the infection. The intense anxiety and even phobia led to hopelessness and even helplessness, potentially causing suicidal vulnerability. As the pandemic settled in, financial ruin, economic setbacks, and unemployment for individual sections of the society impacted their very existence, which, coupled with social isolation and loneliness, likely increased suicidal behaviors.

A family member’s untimely death and lingering physical and mental symptoms among some who had the infection affect family income. Chronic fatigue, muscle weakness, joint pain, and brain fog with confusion and forgetfulness in “long haulers” impact employability and earning capacity.

While COVID-19 increased our sense of togetherness by improved parent/children interactions and intimacy between parents, paradoxically, it also increased domestic abuse and violence. Isolation, fear, income loss, financial ruin, and abuse cause severe anxiety, depression, panic attacks, post-traumatic stress disorder, and alcohol and substance abuse. They may aggravate psychiatric conditions among people who already suffered from them before the pandemic. For instance, people with obsessive-compulsive disorder may become increasingly obsessed with COVID-19 statistics of infection and death and will be glued to the TV or online pandemic news. A paranoid person may become more delusional and psychotic. All these conditions increase a person’s suicide risk.

Misinformation in social media and how a person interprets the data and personalizes it indirectly adds to the anxiety. Lack of reliance on scientific data is another matter of concern.
The Vulnerable Population
Who are the most vulnerable among us? The elderly, homeless, migrants, hospitality workers, and frontline health-care workers are particularly prone to suicidal behaviors. In the elderly, quarantine causes profound loneliness and isolation.

Banerjee et al. (4) reported that isolation, fear, stigma, abuse, and economic fallout caused by COVID-19 increase the risk of psychiatric disorders, chronic trauma, and stress, which eventually increase suicidality and suicidal behavior. Adolescents are forced into social isolation by virtual school. On January 24, 2021, the New York Times reported that Clark County in Nevada saw a twofold increase in student suicide from 9 to 18 during the last nine months. It is unclear whether this is a nationwide occurrence.

People with preexisting conditions, including substance abuse and mental disorders, and people with a family history of suicide and medical conditions such as diabetes and obesity, are also at risk. Some stable patients may begin to deteriorate with severe anxiety and depression. Many of them are already socioeconomically impoverished. Due to their exposure to deaths, morbidity among their patients, work pressure, and their relative helplessness to assist a dying person, frontline workers are particularly vulnerable.

While the risk factors increase the potential for suicidal behaviors, they are not always predictors and are not causative. Not every person who has some or all risk factors engages in suicidal behaviors, thanks to most people’s innate resilience. It is still unknown who ends up taking his or her life. Often suicide is an impulsive act, usually not well planned or well executed. However, having easy access to means such as a firearm or pills with lethal potential increases the chance of death.

What Can We Do About the Increased Risk?
The good news is that most suicides are preventable. Clinical experience and research show that asking a person about his thoughts will not plant any “bad ideas” and, in fact, has interventional benefits.

The World Health Organization (WHO) and Centers for Disease Control (CDC) recommend strengthening financial support, facilitating access and delivery of mental health care, improving social connection, educating the public on coping and problem-solving skills, and identifying risks early as effective ways to deal with suicidal behaviors.

The mentally ill should be encouraged to continue their mental health appointments, take their medications, and refrain from using alcohol and substances. Telehealth rules have been relaxed. Although some older adults are technologically challenged, telehealth is an effective way to maintain contact with mental health professionals.

Improving social connectedness is the most effective way to deal with the suicidality of the elderly and other people at risk. Family members and friends must maintain contact with the vulnerable via electronic media.

If you are having thoughts of suicide, contact the National Suicide Prevention Lifeline at 1-800-273-8255, available 24/7, or text 741741.

References

aedaniel@aol.com
Www.prisonsuicideextertwitnes.com
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Risk Management Resolutions for the New Year

Written by
Professional Risk Management Services (PRMS)

With the start of a new year, we can likely all agree that we were glad to say ‘goodbye’ to 2020 – a year that has, among so much else, upended healthcare, economies, and mental health. Not only has the pandemic changed the way you practice psychiatry, but it has also created new risks. So, as we begin a new year, our PRMS Risk Managers (or “Mayhem Managers” as they’ve become known) have a few key resolutions to consider in 2021.

Given these tumultuous times, we have reduced the number of resolutions this year. You may already be doing everything suggested below – if so, keep up the great work! And if not, you may find these resolutions useful to your practice – it is never too late to start implementing!

1. When treating patients remotely, I will check on licensure requirements in the state where the patient will be located at the time of the visit (if different from my state).

Resources:
• Preliminary Analysis Chart* to determine if state licensure is relevant
• Telespsychiatry Checklist*
• Other telespsychiatry resources, including state waiver information, planning for post-pandemic practice, FAQs, and more at PRMS.com/faq*

2. I will be proactive and create a plan for the unlikely event of my sudden unavailability or inability to practice.

Resource:
• PRMS Contingency Planning Tool*

3. I will continue to address cybersecurity to ensure the confidentiality, integrity, and availability of my patient’s health information.

Resources:
• PRMS Cybersecurity Booklet*
• Several practical resources in the Physician Cybersecurity Resources section* on the AMA’s Cybersecurity Webpage

4. I will consider using a suicide assessment tool when evaluating patients’ suicidality.

Resource:
• SAFE-T Card*

5. I will check the relevant state’s Prescription Monitoring Program when prescribing controlled substances.

Great work in 2020, despite the challenges and pivots the year has thrown our way. PRMS continues to be proud of the work psychiatrists and our partners do for the behavioral healthcare community, and we wish you a safe 2021!

*Website links for all resources can be found at www.PRMS.com/Resolutions

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The apology and historical addendum acknowledge that early psychiatric practices laid the groundwork for the inequities in clinical treatment that have historically limited access to quality psychiatric care for Blacks and other people of color.

Above are iron markers displaced in the 1960s from the graves of psychiatric patients at Milledgeville State Hospital in Georgia, now Central State Hospital. The markers are part of a memorial to the patients. The hospital started admitting Black patients in 1867 under a segregation policy with far different standards of care for patients based on race. For example, White patients were given light work and luxury goods, while Black patients endured discrimination and neglect, leading to poor health and death.

The APA Board of Trustees issued an apology last month for a history of racism in APA and psychiatry and for “enabling discriminatory and prejudicial actions within APA and racist practices in psychiatric treatment of Black, Indigenous, and People of Color (BIPOC).”

The statement of apology—issued on Martin Luther King Jr. Day and addressed to members, patients, their families, and the public—was accompanied by a document outlining specific practices and policies (including failures to speak out and protest racist practices) that have damaged Black and indigenous people and their families dating back to APA’s founding.

“The Board is issuing this document on Martin Luther King Jr. Day because we hope that it honors his life’s work of reconciliation and equality,” said APA President Jeffrey Geller, M.D., M.P.H., in a statement released that day. “We do not take that legacy or his call to action lightly.”

He added, “Many will argue this apology should have come sooner. That said, the events of 2020—the killings of Black people by police, the health inequities laid bare by the pandemic—were an eye-opener for many among our membership and a clarion call that it was past time to take action.

“We have made an investment this year in several ongoing strategies to ensure the APA moves toward greater accountability on race,” Geller said. “Ultimately it will fall to the leadership and member leaders to hold us accountable, but this year has changed everyone.”

In the statement, APA’s trustees acknowledged that early psychiatric practices laid the groundwork for the inequities in clinical treatment that have historically limited access to quality psychiatric care for Blacks and other people of color.

“The events of 2020 were an eye-opener for many among our membership and a clarion call that it was past time to take action.” — Jeffrey Geller, M.D., M.P.H

“These actions sadly connect with larger social issues, such as race-based discrimination and racial injustice, that have furthered poverty along with other adverse outcomes,” according to the statement. “Since APA’s inception, practitioners have at times subjected persons of African descent and Indigenous people who suffered from mental illness to abusive treatment, experimentation, victimization in the name of ‘scientific evidence,’ along with racialized theories that attempted to confirm their deficit status. Similar race-based discrepancies in care also exist in medical practice today as evidenced by the variations in schizophrenia diagnoses between white and BIPOC patients, for instance.”

The statement continues, “Unfortunately, APA has historically remained silent on these issues. As the leading American organization in psychiatric care, APA recognizes that this inaction has contributed to perpetuation of structural racism that has adversely impacted not just its own BIPOC members, but also psychiatric patients across America. ... We hope this apology will be a turning point as we strive to make the future of psychiatry more equitable for all.”

APA Past President Altha Stewart, M.D., a member of the Board and the first Black psychiatrist to be president of the Association, said the apology is a first step, but an important one. “The pandemic and the economic downturn have really highlighted disparities affecting people of color and indigenous people, and it is time for an acknowledgement of the role APA has played in building and sustaining structural racism that has created those disparities,” Stewart said.

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APA Board Issues Apology for History of Racism

“From the beginning of our country with its uniquely violent form of chattel slavery, the founders of APA began segregating treatment of mental illness according to race,” she said. “Mental health is critical to everything people strive to do—holding a job, building a career, raising a family and children, contributing to the community—and from the start of this nation, psychiatry has had a role in limiting the ability of people of color to achieve those things. In some cases, there is documented evidence of APA and psychiatry positively working against those goals.

“More often, APA has not spoken out and seized on the opportunity to raise its voice when a different policy choice could have been made that would have benefited Black people,” Stewart said. “The apology is a way to begin repairing that longstanding national wound.”

The apology is part of an initiative begun by Geller soon after he became president last April to address structural racism in psychiatry and eradicate it. Leading this effort is the 11-member APA Presidential Task Force to Address Structural Racism Throughout Psychiatry, chaired by Area 4 Trustee Cheryl Wills, M.D.

The task force has been charged with providing education and resources on the historical roots of structural racism within APA and the profession of psychiatry and how that history continues to affect patients and their families and contribute to inequities in mental health care for Black people and people of color generally. The task force was further charged with developing achievable recommendations for change to eliminate structural racism in APA and psychiatry and to provide reports with specific recommendations to the APA Board of Trustees at each of its meetings through May. This work will continue beyond Geller’s one-year presidency.

“This is an important milestone in APA’s progression toward fulfilling its strategic initiative of diversity and inclusion,” Wills told Psychiatric News. “Now that APA has formally acknowledged its history, there is more work to be done, and the task force, in collaboration with the Board, will continue to take an objective look at how race impacts psychiatric care and will make recommendations when they are deemed necessary.”

A fourth town hall led by the task force was held Monday, February 8, titled “Structural Racism and Psychiatric Residency Training: Recruitment, Retention, and Development.” A report on the town hall will appear in the next issue of Psychiatric News.

Wills urges members with questions or concerns to communicate with the task force by writing to srtaskforce@psych.org or visiting the task force microsite on the APA website.

The annotated document that accompanied the public apology is a more detailed description of events in APA’s history that have contributed to pervasive structural racism today.

“[W]hen the 13 founders of what is now APA met to discuss improvements in mental health care delivery, the treatment system they created and the organization they founded aligned with that era’s racist social/political policies,” the document states. “In this system, Black patients received psychiatric care separately from white patients. ... Additionally, prevailing Black stereotypes in psychiatry included fallacies that patients were hostile, unmotivated for treatment, had primitive character structure (i.e., not psychologically minded), and were child-like. These misconceptions were perpetuated by a now-debunked diagnosis, Drapetomania, centered around the idea that Black Americans who did not want to be slaves were mentally ill. During that time, APA chose to remain silent on these issues.”

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said the APA apology and accompanying historical context document were developed after lengthy discussion and deliberation. “The Board of Trustees of APA has taken an important first step in acknowledging the impact of structural racism on mental health inequities,” he said. “The APA administration is committed to working with our members to increase diversity and inclusion and being anti-racist in our approach to advance quality mental health care for all.”

Reprinted from Psychiatric News Alert
When Amazon Prime decided to stream selected stories from the Modern Love column of the New York Times, I was excited. I had been an avid reader of this section where people reflect on the intricate nature of human relationships. The episode that struck me was “Take Me As I am, Whoever I Am”, based on the essay written by author Terri Cheney in 2008.\(^1\) Terri then an entertainment lawyer, wrote about her struggles with Ultradian Bipolar Disorder, revealing how she hid her condition from her friends before ultimately going public.

Terri has been played by Anna Hathaway, the Oscar-winning actress who takes you through the roller coaster of highs and lows of the spectrum. The episode starts with Lexi (Hathaway) during her manic high at a supermarket in loud makeup, sequin, bright clothes. She is instantly drawn to a man named Jeff and lands herself a date with him that week. The scene breaks into a flash mob dance that reminds you of the movie “La La Land”. As soon as Lexi reaches home we see her transforming abruptly into depression as she curls up in a fetal position, almost catatonic in her bed. While she did manage to wake herself up for the date, she appeared slow, dysphoric, withdrawn, unkempt making Jeff wonder if she had a twin. A few mornings later, she woke up euphoric again, to the sound of birds chirping and called up Jeff for another date. However, by the time he appeared that night, she had flipped, going from dancing around her apartment to sobbing uncontrollably on the bathroom floor. When Jeff walked away, she decided that things needed to change and she needed to give people a chance to know the real her.

The episode illustrated how the stigma of mental illness keeps people from getting the help that they need. What was unique was the challenging portrayal of a high functioning lawyer with Ultra-Ultra rapid cycling (Ultradian) Bipolar Disorder, an uncommon diagnosis for even psychiatrists to make or witness. Lexi almost had no baseline or a euthymic phase. Mania is portrayed as a glamorous Hollywood movie where Lexi is super productive and euphoric with no impairment or mixed symptoms that some patients might not relate to. Depression does make you feel empathetic towards her crumpled to her bathroom floor in tears, hopeless and terrified, and is more realistic.

While 12-24% of patients experience Rapid Cycling where they have a total of four or more mood episodes in a year, ultradian is characterized by multiple episodes in a day that can often be confused with Borderline Personality Disorder (BPD) and might be a controversial diagnosis to make.\(^2\) Some would prefer to classify it as a mixed state. There might be perhaps some regularity to mood cycling if it were truly caused by some underlying chemical disturbance as in Ultradian Bipolar Disorder compared to more random mood cycling that is closely tied to events in patients’ emotional lives as seen in BPD. Post et al first described Ultradian in the 1980s.\(^3\) Anticonvulsants like Valproic Acid and Carbamazepine might be more effective for treatment than Lithium for these patients along with the reduction of triggering factors like antidepressants, drugs of abuse, thyroid abnormalities, and irregular sleep schedules. There are promising results from Calcium Channel Blockers like nimodipine.\(^4\)

In the ending scene, Lexi finally opens up about her condition to a coworker, a powerful moment where she described this cathartic experience as an elephant's taking one of its feet off her chest. After a trial of several meds and ECT, she found herself stable on a specific combination and was ready to begin a new chapter in her life. The show ends with realistic hope, "I've finally accepted that there is no cure for the chemical imbalance in my brain, any more than there is a cure for love."\(^5\)


(Continued on page 15)
Modern Love: A Portrayal of Ultradian Bipolar Disorder
Akriti Sinha, MD
PGY-4, Department of Psychiatry, Chief Resident for Academics, 2020-2021
University of Missouri Healthcare

Longitudinal Course of Affective Illness. British Journal of Psychiatry, 149(2), 191-201. doi:10.1192/bjp.149.2.191


Philip Joseph LeFevre III, M.D.
1935-2021

Philip LeFevre III, M.D., a former SLUCare psychiatrist and professor of psychiatry at Saint Louis University School of Medicine, died February 8, 2021, in a plane accident, he was 82.

LeFevre retired from SLU in July. He joined the University in 2012 after years in private practice. His daughter Cherie LeFevre, M.D., is a professor of obstetrics, gynecology and women’s health at SLU and a SLUCare urogynecologist.

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Dr. Philip Joseph LeFevre III of Glendale, Missouri, died February 8, 2021, in a tragic plane accident. His son, Philip Joseph LeFevre IV, also perished in the crash. Dr. LeFevre was born July 9, 1935 in South Bend, Indiana to Henry LeFevre and Agnes (Steinbrunner) LeFevre. He was married 54 years to Patricia (Adams) LeFevre, who preceded him in death on February 12, 2019. Dr. LeFevre is the father of five children and is survived by his four children and their spouses. He is the proud Pop-Pop of 17 grandchildren: Amanda and Jack (Michelle (LeFevre) and Alan Arbuckle), Elise, Joseph, Genevieve, and Cecilia (Cherie (LeFevre) and Matt Grahek), Michael Jr., Annabel, Augustine, and Gabriel (Christie (LeFevre) and Michael King), Eleanor, Catherine, Margaret, and Elizabeth (Julie (LeFevre) and Warren Nakatani), and Philip V, Patrick, and Colette (Philip IV (deceased) and Laura (Heinz) LeFevre). He is also the proud Great Pop-Pop to Adeline (Elise Grahek). Dr. LeFevre is survived by his siblings: Kathleen (Dan, deceased) Bohman, Cy (Helen) LeFevre, Larry (Kathy) LeFevre, and Marg (Dave) Brunswick. He is preceded in death by his parents and his brothers, Henry (Bud) and Joseph (Theresa, deceased).

In June 2020, Dr. LeFevre celebrated 50 years as a psychiatrist. He was in private practice for over 42 years and, during his last eight years in medicine, served as a professor at the St. Louis University School of Medicine, and as a practitioner with SLUCare Department of Neurology & Psychiatry.

A Requiem Mass was held February 15, 2021, at 11:00 a.m. at St. Mary’s Assumption Catholic Church, 1126 Dolman Street, St. Louis, MO 63104.

In lieu of flowers, the family asked that donations be made in his honor to organizations near and dear to his heart: Our Lady of Guadalupe Monastery https://www.ourladyofguadalupemonastery.com
In January 2021, I had the pleasure of attending a DBT training for providers titled "DBT - Making it Work in Our Communities," presented by Ronda Oswalt Reitz, Ph.D. The training was 13 hours, spread out over 4 Zoom sessions with over 100 participants joining from across Missouri. Participants were mostly licensed therapists and social workers, but even as a psychiatry resident I found the training very useful. I have summarized the training for our readers, starting with what is DBT, how it works, and finally why relentless compassion is effective for emotionally vulnerable and dysregulated clients.

Dialectical behavior therapy (DBT) is most often thought of when treating borderline personality disorder (BPD). However, other proven successful applications of this therapy have been for eating disorders, adolescents, and children as young as 6 years old. Specific types of DBT have been developed for special populations, including DBT-PE (Prolonged Exposure) for clients exposed to trauma, and DBT-SUD for clients with substance use disorder.

The goal of DBT is to help people find lives worth living through relentless compassion and effective behavior change strategies. This is done by accepting that "everything is as it should be, every day is a good day, and everything is caused." This radical shift accepts that there is a reason why a behavior occurred and helps teach skills so that next time there is a different outcome. DBT has been shown to save lives and reduce life-threatening behaviors in frequency and severity of self-harm and decrease inpatient psychiatric hospitalization.

Standard DBT include 4 components: individual DBT based treatment (individual therapy, 1 hr/week), group skills training (teach skills, mindfulness, assign and review homework, 2 hrs/week), skills coaching (24/7 therapist availability for a brief, focused coaching sessions), and consultation team (meeting of therapists, skills training staff, coaches, and anyone else involved in direct patient care, 2 hrs/week). All 4 components must be present for true DBT to occur. DBT approach to treatment focuses on contingency management: what is being reinforced and why? It does not dismiss or invalidate feelings, it does not rely on interpretation, and it does not reinforce escalation. The goal of DBT therapist it to remain neutral to warmly interested, but not to judge, not use "should" statements, and not get angry.

It is important to prevent further escalation or mirror aggression or anger because clients in DBT are often very emotionally vulnerable. There are 3 core features of emotionally vulnerable individuals. First, they have high emotional sensitivity, meaning that they have a low threshold for immediate, emotional arousal. Second, they have high emotional reactivity, so their reactions are intense and extreme. And finally, they have a slow return to baseline, evidenced by long-lasting reactions, and are known to "hold a grudge."

DBT is frequently used for individuals with borderline personality disorder. BPD has 9 criteria in the DSM-5, of which an individual must meet 5 or more to receive a diagnosis of BPD. An easier way to summarize the BPD criteria is by looking at the 5 areas of dysregulation.

1. Emotional dysregulation: rapidly shifting feelings and moods, problems with anger
2. Interpersonal dysregulation: chaotic relationships, fear of being alone or abandoned
3. Self-dysregulation: fluctuating or absent sense of self, sense of emptiness
4. Cognitive dysregulation: dissociation, paranoid thinking, over-personalization
5. Behavioral dysregulation: self-harm behaviors, impulsivity

DBT strives to promote compassion toward clients by validating feelings and acknowledging emotions. Clients are doing the best they can with the circumstances that they have. DBT assumes that if clients could do better, they would do better. Clients also want to improve and have a better life. Providers sometimes use derogative language when speaking about clients with BPD such as "attention-seeking," which should be replaced

(Continued on page 17)
with "belonging-seeking." Clients that didn't receive the appropriate love and connection from their parents growing up are using whatever skills they have acquired, regardless of how maladaptive, to find that belonging. If we as providers retain compassion for our clients, we can replace judgment-driven statements of "you knew better, why didn't you do better?" instead, with connection-driven statements such as "of course you did that behavior given your past, and now we are teaching you skills so next time you must do better."

If you are interested in further information about DBT in Missouri, please visit their website dbtmo.org. The site also has posted upcoming training and resources for providers. For DBT skills training group lecture materials, check out the original text by Marsha Linehan titled "DBT Skills Training Manual" and "DBT Skills Training Handouts and Worksheets." The must-have #1 recommended text for doing DBT is "Cognitive-Behavioral Treatment of Borderline Personality Disorder" by Marsha Linehan. And finally, for those interested in reading a memoir of Linehan's life and how DBT was created, check out "Building a Life Worth Living" by Marsha Linehan. I hope that this brief summary of DBT basics is a useful tool for psychiatrists that treat clients with BPD and refer them to DBT.

APA today denounced the treatment by Rochester, N.Y., police officers of a 9-year-old girl who was pepper-sprayed, pushed into the snow, and handcuffed when they responded to a family disturbance. The girl is believed to have been experiencing a mental health crisis at the time.

In a body-cam video released Sunday by the Rochester police department, the girl was calling for her father. According to a New York Times report, an officer told her, "You're acting like a child."

She responded, "I am a child." When she refused to sit inside a police car, an officer pepper-sprayed her.

"Children should never be treated like this," said APA President Jeffrey Geller, M.D., M.P.H. "People in psychiatric distress should never be treated like this. We condemn the appalling actions of the police on this video. The girl and her family have experienced this violence and are now dealing with trauma, and watching this video is distressing for many others."

According to the Times report, Rochester Mayor Lovely Warren said the officers involved in the spraying would be suspended until the conclusion of an internal investigation. She said state laws and union rules prevented her from taking more serious action, according to the Times.

"It is sad and deeply disturbing to see yet another example of police violence in this country, this time directly involving a young child," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "APA supports policies that train law enforcement to recognize and appropriately respond to a mental health crisis. The actions in that video underscore the need for that training as well as partnerships among local law enforcement and behavioral health systems."
Why Psychiatry Training Must Include Discussions on Structural Racism

Balkozar S. Adam, MD; Rameshwari V. Tumuluru, MD; Sarah H. Arshad, MD

The authors explore the impact of structural racism on psychiatry trainees and the patients they care for (and what can be done about it).

Psychiatry trainees work in a challenging world. Some have firsthand experience with bias, microaggressions, and racism, including in their training. For example, there are enormous challenges faced by Black trainees, with only 5% of American physicians identifying as Black. Underrepresented minority physicians have reported being questioned about their identity and are subject to discrimination, marginalization, and frank racism when patients or families refuse treatment by a minority physician. They often must accommodate racist comments without addressing them, ignoring their own emotional pain, focusing instead on placating patients and families and successfully completing their training. They work in a system in which the majority of department chairs, hospital CEOs, and medical school administrators are white.

Trainees may question the lag in recruitment of faculty and trainees of color by leaders of medical schools or academic institutions. They wonder about opportunities for mentorship offered by their educational institution to alike trainees or efforts to retain diverse faculty. The coronavirus disease 2019 (COVID-19) pandemic has exposed cracks in the system at a time when these leaders are being asked to focus on issues of race and health disparities.

When psychiatrists begin their training, they experience a myriad of unknowns, including internal conflicts about their abilities, the need to master their anxiety, and the push-pull of ensuring they pay due diligence to the issues facing their patients. As they negotiate the interpersonal issues related to dealing with the multidisciplinary team, their peers, as well as patients, they look to their supervisors and the training institution for guidance and support. They attend mandatory didactics and conduct literature searches for edification. In the absence of scientific literature and sparsity of information provided during didactics to address racism experienced by patients and trainees alike, supervision becomes the most important tool to address the trainees’ concerns.

Supervision is an expected part of psychiatric training. However, little attention is paid to training psychiatrists to be supervisors, let alone in addressing issues such as racism or discrimination during supervision. This issue is particularly important when we consider systems-based practice, a core competency for child psychiatry, and the need to plan treatment of psychiatric disorders in a larger context that includes the patient’s family, the community, society, and their cultural background. This required competency makes addressing environmental issues such as racism an important parameter that must be addressed effectively both in didactic education as well as in supervision.

Trainees must navigate the interconnected pandemics of COVID-19 and structural racism when caring for patients and families and look to their supervisors for support. In particular, they must consider structural racism, which is a “system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity,” taking into account historical and cultural perspectives in which certain populations have experienced privilege while others, often populations of color, experienced a hardship.

The system reflects a nation’s values and policies, and examining it often highlights clear social privilege which stratifies populations based on color and socioeconomic status. It is a complex system that has been “developed, maintained, and protected” with significant impact on variables influencing health, including social determinants of health, health care access, trust in a health care system, and the ability to navigate the health care system. The COVID-19 pandemic has shed a new light on the broken health care system, in which there are clear racial differences in the morbidity and mortality of this illness.

Within psychiatry training in general, there has been a shift from thinking about cultural competence to cultural humility, and recommendations for cultural psychiatry seminars and didactics alongside increasing cultural awareness in accordance with the Accreditation Council for Graduate Medical Education. (Continued on page 19)
Education (ACGME) requirement. However, although cultural psychiatry seminars have been taught for decades, there is scant evidence they have been effective in addressing systemic racism, in part because there is limited content related to structural racism in these courses. Furthermore, there has been little to no guidance on in-person learning experiences, or guidance for how supervisors could provide adequate mentorship to trainees on these issues, including how to mentor trainees when they experience discrimination and bias. In addition, these seminars are typically meant for trainees, when in order to enact greater structural change, they would have to be attended by the people in leadership who can affect structural racism, such as policymakers, CEOs, and admissions officers.

Examining Racism in Training Programs
Trainees, especially the Black, brown, and immigrants, have witnessed racism, and it is more pronounced now with escalating racial tension in this country. They have seen how marginalized patients and families are treated differently by clinical staff, subject to microaggressions and stereotypes, perhaps being labeled as “difficult” or having greater difficulty communicating with front desk staff. Clinically, trainees see minority patients misdiagnosed, or observe them dropping out of mental health care more often than their non-minority counterparts.

The effects of structural racism are seen when diverse families are more likely to experience unemployment or poverty, and have difficulty navigating insurance or accessing reputable medical facilities and treatment. In addition, these children are more likely to live in unsafe neighborhoods and are unable to access fresh produce or play outdoors because they feel unsafe. Lack of fair housing opportunities and clean and safe neighborhoods are additional factors in effectively removing the marginalized from having a mainstream experience. Trainees may witness the lack of quality educational opportunities in communities of color including access to needed electronic equipment (iPad/school-issued laptops) to access virtual learning during the pandemic. Besides, the lack of technology and spotty services (Wi-Fi, data, and internet services) limits their ability to participate in telehealth treatment. Lack of educational opportunities and individualized educational services for those in need further contribute to the downward spiral of ever-decreasing opportunities. In addition, trainees observe the increasing rates of unemployment, food insecurity as well as high rates of COVID-19 infections in communities of color.

Such experiences highlight the importance of considering systems of care issues such as culture and environment, as trainees observe disproportionate reporting of abuse and involvement with the welfare and justice systems in minority groups compared to others. Observing the disparities in all aspects of their patient’s lives, the impact of long-standing oppression and racism becomes increasingly relevant to the psychiatry trainee’s experience. Furthermore, such effects of discrimination may resonate with trainees who may have experienced similar deprivations in their own lives. They then begin to question their role and that of their training institutions in addressing such disparities as well as the efforts of national organizations such as the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and the American Medical Association in addressing disparities. While trainees feel at liberty to discuss other transference and countertransference issues with their supervisors, there is a hesitation in discussing issues related to racism and bias. In addition, supervisors, too, may lack guidance and experience similar discomfort discussing such issues with trainees during supervision.

The Role of Supervisors
In reviewing the extant literature, Hook and colleagues and Schen and colleagues make clear there are certain attributes necessary to provide good supervision specifically in addressing racial and cultural issues. These include adopting a stance of cultural humility, sharing of relevant experiences, accepting differences, and creating an atmosphere of openness that makes difficult dialogues, such as those related to racism and subsequent intergenerational trauma, possible. The literature is sparse in providing guidance to address the issues of racism including those (Continued on page 20)
Why Psychiatry Training Must Include Discussions on Structural Racism
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experienced in a dyadic situation, such as microaggressions experienced in clinical situations with patients or by colleagues and other team members. It is almost nonexistent in providing guidance to address the concerns related to structural racism.

Racism is experienced at various levels: internalized, interpersonal as well as institutional/structural. Just as supervision allows opportunities for trainees to discuss transference and countertransference experienced in clinical encounters, there is a role for supervision in navigating the emotions that arise as trainees navigate a racist world. Instructors should provide a venue to explore the perceived inadequacy as internalized by the trainee due to experiences with structural bias, and lack of personal opportunities as well as interpersonal experiences of microaggressions and invalidation in education and training.

The supervisor’s role should include an exploration of the trainee’s vulnerabilities and the impact of experienced structural racism, whether personally experienced or as witnessed in the patients and families they encounter, without crossing the boundary to provide therapy. Leaders and mentors need to validate these experiences, create a safe space for dialogue, and then provide guidance and advocate for action, supporting the trainee to confront microaggressions when they occur. Supporting trainees to become advocates for themselves, their peers, and their patients will be a priority in creating individual responses to structural racism.

While supervision of minority trainees can be crucial in developing individual understanding of racism and structural racism, a more seismic change will occur when the educator is able to inculcate such advocacy towards the elimination of biases with entire groups of trainees, not just those in the minority. Leaders can support the creation of a “cafe style” roundtable discussion where issues related to racism or bias are discussed. These conversations between and among trainees from different backgrounds, with different statuses of privilege themselves, can introduce personal or witnessed experiences to the greater collective. Ideally there can be non-confrontational dialogue focused on understanding each other’s experiences that can promote individual insight and growth.

As trainees further contemplate these issues, they will reconsider clinical encounters with diverse patients, enabling them to better empathize and care for patients and families. On a larger level, these dialogues can lead to changes in the institutional structure and response to racism. It is hoped that such education will combat microaggressions and increase bystander response through allyship to set the stage for a more robust response from all trainees.

In addition to providing guidance to the trainees, supervision will be a more meaningful experience when supervisors also examine their own biases that arise during the course of supervision and address them. This will be an enriching experience and enhance the supervisor’s ability to provide the necessary supervision. Such self-examination alongside peer supervision of the supervisors may guide the ability of the supervisee, supervisor, and ultimately the institution to make changes. They can also discuss historical traumas, the ongoing disparities in provisions of care, and the role of advocacy, as supporting patients and families who experience structural racism enhances health and minimizes disparities. In the case of child psychiatry, supervisors can help trainees think of how to make health care more equitable and available to all, and educate trainees on the impact of structural racism on the interaction and overlays of structural racism on the systems of care encountered by patients and families, including the juvenile justice system, public assistance and child protective services.

These actions can include discussions on neighborhoods in which clinics are located, availability of other resources such as transportation, food access, safe housing, and how institutions can partner with other systems and agencies to promote health care and more specifically mental health care access. With these dialogues and institutional involvements, there will be an onus on academic and health care institutions to do their part in battling structural racism and (Continued on page 21)
Why Psychiatry Training Must Include Discussions on Structural Racism

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involving in communities. The role of the supervisor is to not only help with clinical information but also consider the ethical principles behind health care delivery and advocate on multiple levels. Involvement in advocacy efforts is critical to reverse the historic exclusion from decision-making, which played a part in the existing structural racism. Such discussions will address cultural and environmental contexts of our patients and inculcate cultural humility in both the supervisor and supervisee.

Concluding Thoughts

Trainees navigate their personal and professional growth in a challenging world, and supervision is critical in dismantling and addressing structural racism. It enhances not only the educational experience by guiding the supervisee on the subtleties of managing patients, but also serves as a lightning rod for change to address often ignored issues related to racism. Supportive advocacy through education and supervision will pave the way for the individual supervisee to feel empowered to act as an advocate for themselves, and address interactional issues as they come up between provider and patients and families as well as among peers to dismantle the longstanding institutional "blind eye" which is structural racism.

Dr Adam is clinical professor of psychiatry, University of Missouri-Columbia, Columbia, MO. Dr Tumuluru is associate professor of psychiatry at the University of Pittsburgh and the medical director of the Southside Acute Partial and IOP Program part of Western Behavioral Health/UPMC, in Pittsburgh, PA. Dr Arshad is attending psychiatrist and assistant program director for the Post Pediatric Portal Program at the Children’s Hospital of Philadelphia. The authors report no conflicts of interest concerning the subject matter of this article.

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Reprinted from Psychiatric Times, 2/11/21
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A. **PROFESSIONAL EDUCATION.** The Foundation will develop and fund educational offerings and projects, including in collaboration with others, designed to improve and enrich professional knowledge and skills of psychiatrists and other medical and mental health professionals in the prevention, diagnosis and treatment of psychiatric brain disorders. This may include programs to encourage healthier personal and professional lifestyles.

B. **PUBLIC EDUCATION.** The Foundation will encourage and sponsor educational programs, including in collaboration with others, to increase awareness and advance knowledge of psychiatric brain disorders and effective treatments available today. The Foundation may support educational efforts aimed at employers, the media, persons living with a mental disorder and their families, to encourage a better understanding of the causes, treatment and prevention of psychiatric disorders and their treatment. The Foundation may also support efforts to remove barriers to access to psychiatric care.

C. **RESEARCH AND DISCOVERY.** Support of research projects by members of the MPPA which aim to advance the biopsychosocial understanding and management of psychiatric disorders. This will include identification and remediation of the social determinants of mental health.

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Psychiatric News reports, “Educating primary care physicians on depression management, increasing awareness about mental illness and suicide among high school students, and reaching out to previously hospitalized psychiatric patients after discharge represent several of the most effective and scalable approaches to suicide prevention,” investigators concluded after reviewing “97 clinical trials and 30 population-level studies published between 2005 and 2019 that explored interventions aimed at reducing suicides or suicidal behavior such as self-harm.” The findings of the systematic review were published online Feb. 18 in the American Journal of Psychiatry, a publication of the American Psychiatric Association.

Reprinted from Psychiatric News, 2/22/21

### Missouri Psychiatric Physicians PAC

Help elect candidates who will represent your interests in the Missouri General Assembly, and state and local campaigns. Join the Missouri Psychiatric Physicians Political Action Committee, MoPPPAC, the political voice of the Missouri Psychiatric Association.

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**MoPPPAC MEMBERSHIP form**

(Please type or print clearly)

Name* _______________________________________________________
Employer* ____________________________________________________
Street* _______________________________________________________
City, State, Zip* ________________________________________________
Phone _______________________________________________________
Email ________________________________________________________

*State law requires that we use our best efforts to collect and report the name, mailing address and employee of individuals who contribute to MoPPPAC.

Enclosed is my check or money order for: $ __________________________

Contributions to the PAC are not tax deductible. Make checks payable to MoPPPAC and return to 722 E. Capitol Avenue, Jefferson City, MO 65101.
What is the MO Psychiatric Physicians PAC?
MoPPPAC is an organization that accepts volunteer contributions to help strengthen the Missouri Psychiatric Physicians Association’s (MPPA) participation in elective processes at state and local levels.

Why does MoPPPAC exist?
1. State and local candidates who will advocate for Missouri Psychiatrists need the financial support of the medical community to win elections.
2. The Missouri Psychiatric Physicians Association advocates in the legislative arena with other organizations that have PACs. As long as organizations with interest adverse to those of the Missouri Psychiatric Physicians Association have PACs, the MPA needs one, too.
3. A PAC is part of a balanced strategy for legislative advocacy and political action.

How does your PAC investment affect your bottom line?
Lawmakers’ decisions in areas such as taxation, regulations and health care directly affect the profitability of your practice. Government policy affects not only your business; it affects your patients. MoPPPAC can contribute to a significant number of pro-medicine candidates. By pooling your political contributions with other Psychiatrists, you receive a greater return on your investment.

Who may contribute?
Anyone who wants to help elect candidates who support Psychiatry can contribute to the MoPPPAC.

Who directs MoPPPAC?
MoPPPAC operates under the direction of PAC officers and directors who are members of the American Psychiatric Association and the Missouri Psychiatric Physicians Association. The MoPPPAC Board of Directors may elect other members from time to time to serve as PAC officers and directors.

Who decides how MoPPPAC funds are spent?
The Board consists of officers and directors who serve on behalf of the Missouri Psychiatric Physicians Association. The Board approves all disbursements over $500. The PAC president approves disbursements of $500 or less.

What factors determine MoPPPAC’s support of a candidate?
- MoPPPAC membership input.
- A candidate’s strong voting record on mental health care and other issues affecting the practice of psychiatry and psychiatric patients.
- A candidate’s willingness to support the goals and mission of the Missouri Psychiatric Physicians Association.
- MoPPPAC funds are used for purposes that are consistent with the goals and missions of the Missouri Psychiatric Physicians Association and the American Psychiatric Association.

How to Join?
Complete and return the Membership Form to MoPPPAC with your contribution. Note: MoPPPAC can accept only checks and money orders at this time, no credit cards. Maximum contribution is $5,000. Contributions to the PAC are not tax deductible.
NEWSLETTER ADVERTISING ORDER FORM

Form and Payment must be received before the ad is placed in the newsletter.
Submission Deadlines are February 15, May 30, August 15 and November 15.

☐ Full Page (7.5” X 10”): $550.00
☐ Half Page (7.5” X 5”): $275.00
☐ Quarter Page (3.75” X 5”): $140.00
☐ Eighth Page (1.8125” X 2.5”): $75.00

Number of Ads: ________________________________________________
Total Price: ____________________________________________________

Company: ___________________________________________________________________________________________
Contact Name: ______________________________________________________________________________________
Address: ___________________________________________________________________________________________
City, State Zip: _______________________________________________________________________________________
Phone: _____________________________ Email: _________________________________________________________

Mail order form and payment to MPPA, 722 E. Capitol Avenue, Jefferson City, MO 65101
Make checks payable to the Missouri Psychiatric Physicians Association
Send ad submission to missouripsych@gmail.com
If you have questions, contact Sandy Boeckman at missouripsych@gmail.com or 573-635-5070

Show-Me Psychiatry

Missouri Psychiatric Physicians Association
Medical leadership for mind, brain and body.
Media Benefits for MPPA Members

Your membership in the Missouri Psychiatric Physicians Association entitles you to several key media benefits:

1. Free ad listings on the MPPA website. MPPA Members can post their research studies, job listings, events or books for 6 months on the MPPA website at http://missouri.psych.org. The listing can repost again after that period.

2. Reduced newsletter ad rates. MPPA members may place any size ad in Show-Me Psychiatry, MPPA’s quarterly newsletter, for 50% off the regular rate. Show-Me Psychiatry reaches nearly 500 MPPA members and associated healthcare professionals in the state and appears online at the MPPA website. It is the only publication dedicated to psychiatrists in the state of Missouri.

3. Free “Upcoming Events” listings. There is no charge for members to post upcoming meetings and special events of interest to the behavioral health community.

All ads must be camera ready in an electronic format and should include a link to the advertiser’s email address or website. Web ads may be submitted in color or black & white. Newsletter ads will print in black and PMS 294 Blue inks regardless of submission format.

Letters to the Editor

We invite readers to submit letters of not more than 500 words. Show-Me Psychiatry reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Letters should be sent by postal mail to Show-Me Psychiatry, Missouri Psychiatric Physicians Association, 722 E. Capitol Avenue, Jefferson City, MO 65101 or by email to adamb@health.missouri.edu. Clinical opinions are not peer reviewed and thus should be verified independently.

Newsletter Submissions

We strive to offer content in Show-Me Psychiatry that represents our membership and encourage members to participate in its creation. For communications regarding the newsletter or to submit articles, letters to the editor or upcoming events, please contact: Editor, Show-Me Psychiatry, 722 E. Capitol Avenue, Jefferson City, MO 65101, or missouripsych@gmail.com.

Newsletter Disclaimer: The opinions expressed herein are those of the authors and do not necessarily state or reflect the views of Missouri Psychiatric Physicians Association. Publication in this newsletter should not be considered an endorsement.

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Guidelines for Submission to Show-Me Psychiatry Newsletter

1. All submissions will be sent via email to Sandy Boeckman at missouripsych@gmail.com who will then forward the submission to the newsletter editor.

2. The length of the article should be between 600-1200 words. In addition to the article, up to five references may be added.

3. At the end of the article, the author should include a statement clarifying the presence or absence of a conflict of interest related to the article.

4. If the article includes clinical information, the author should make a statement that the identifying information of the patient has been changed and he/she has obtained the permission of the patient and/or guardian prior to publication.

5. The article will be edited by the newsletter editor. The author may be asked to clarify some information, and address comments made by the editor. The revised article will be emailed back to the editor for final review and approval.

Submission Deadlines

February 15
May 30
August 15
November 15

Advertisement Information

For advertisement information or questions, contact Sandy Boeckman by email at missouripsych@gmail.com.
Calendar of Events

Executive Council Meeting
~ ZOOM CONFERENCE CALLS at 7:00 pm ~
  July 20, 2021
  September 24, 2021
  November 16, 2021

MPPA Spring Meeting
~ Virtual ~
  April 10, 2021

APA Spring Assembly Meeting
April 24-25, 2021

APA Annual Meeting
May 1 - May 5, 2021

MPPA Fall Conference
~ Stoney Creek Inn, Columbia, MO ~
  September 25, 2021