“Post COVID Era”

This is my fourth editorial about COVID-related issues in Psychiatry; it shows how much this pandemic is effecting our lives, and the mental health of our patients and population on the whole. Recently, I was giving a lecture on the opioid epidemic to a national forum, where we talked about the number of people who died with opioid overdose being around 47,600 every year, but this number looks dismal when we compare the death toll wreaked by COVID-19.

As the death toll from COVID-19 continues to rise, and the number of cases skyrockets in the U.S. and around the world, the sheer weight of concrete suffering, the strain on healthcare systems and the economy, and the disorganized response from government and community threatens to eclipse awareness of important mental health implications. The likelihood of long-range problems in mental health increases exponentially with every passing moment we do create change. Healthcare workers are thought to be at particular risk for mental health problems after COVID, including but not limited to PTSD. Furthermore, the effect on the general population cannot be overstated. The COVID-19 pandemic has likely brought many changes to how you live your life, and with it uncertainty, altered daily routines, financial pressures and social isolation. You may worry about getting sick, how long the pandemic will last, whether you'll lose your job, and what the future will bring. Information overload, rumors and misinformation can make your life feel out of control and make it unclear what to do.

During the COVID-19 pandemic, you may experience stress, anxiety, fear, sadness and loneliness. And mental health disorders, including anxiety and depression, can worsen. Surveys show a major increase in the number of U.S. adults who report symptoms of stress, anxiety and depression during the pandemic, compared with surveys before the pandemic. Some people have increased their use of alcohol or drugs, thinking that can help them cope with their fears about the pandemic. In reality, using these substances can worsen anxiety and depression. People with substance use disorders, notably those addicted to tobacco or opioids, are likely to have worse outcomes if they get COVID-19. That's because these addictions can harm lung function and weaken the immune system, causing chronic conditions such as heart disease and lung disease, which increase the risk of serious complications from COVID-19.

There has been an avalanche of research on COVID-19 addressing both physical and mental health consequences. While specific findings vary around the world depend on local factors and statistical variations, there is a clear consensus that mental illness is increased by COVID-19. The researchers said the mental health consequences of having COVID-19 have not yet accurately been measured - but have been widely predicted.

A new study published in The Lancet Psychiatry medical journal shows COVID-19 may be linked to an array of mental health effects in patients. According to the study, conducted by researchers from Oxford University,
a diagnosis of COVID-19 was associated with increased incidence of being diagnosed with several psychiatric conditions and disorders including anxiety, insomnia and dementia.

The researchers sought to answer this question by looking at the rates of psychiatric diagnoses in patients in the three months after they were diagnosed with COVID-19. The group used the TriNetX Analytics Network, which collects data from electronic medical records from 54 health care organizations in the U.S. This includes data on 69.8 million patients - 62,354 of whom were diagnosed with COVID-19 between January 20 and August 1. They then looked how many of these patients had been diagnosed with a psychiatric disorder. They found that first episode psychiatric illness was doubled in COVID survivors - 5.8 percent of COVID survivors, compared with 2.5 to 3.4 percent of patients with other illnesses, had a first diagnosis. The most common diagnoses were anxiety disorders, found in 4.7 percent of COVID survivors, including adjustment disorder, generalized anxiety disorder, PTSD and panic disorder.

The researchers looked for diagnoses of dementia, insomnia, anxiety and mood disorders in the COVID-19 patients as well as in those diagnosed with the six other health conditions, who served as a control group. "In the 90 days after diagnoses, about 18% or almost 1 in 5 of people who had COVID received a psychiatric diagnosis of one kind or another - the highest being an anxiety disorder," and about 6% of COVID-19 patients who had never been diagnosed with a psychiatric disorder before were diagnosed with one within three months of getting COVID-19. The most common, again, was anxiety. Researchers said there are two probable causes of psychiatric disorders associated with COVID-19. "One possibility is that there could be some direct effect of the virus producing the symptoms. Perhaps what the virus might be doing in the brain in some people, or the way some people's immune systems have responded to fight the virus,"

Another study published in The Lancet Psychiatry journal in June looked at 153 patients who were hospitalized with severe cases of COVID-19 to see if they experienced any neurological and psychiatric complications associated with the virus. The study found that 125 of the patients did. Over 60% of the patients had strokes, a majority of which occurred in patients age 60 or older. About a third of patients experienced "an altered mental state such as brain inflammation, psychosis and dementia-like symptoms," according to the June study. This includes signs of confusion or changes in behavior. Almost a quarter of patients with an altered mental state were diagnosed with psychiatric conditions, the "vast majority" of which were found to be newly developed. However, researchers say it is possible some may have been simply undiagnosed before the patient developed the virus.

The rates of new mood disorders (e.g. depression, bipolar disorder)
were 2 percent, significantly higher than after other illnesses, and rates of psychotic disorders were the same. Patients reported insomnia and dementia (among older adults) at higher rates than after other illnesses, at 1.9 and 1.6 percent, respectively.

The risk of any psychiatric diagnosis (versus new diagnosis) was significantly increased after COVID-19 as well, with over 18 percent of patients with documented mental illness. Anxiety was most common, at 12.8 percent, followed by mood disorders at nearly 10 percent. Psychotic disorders were present in almost 1 percent, higher than after other illnesses. Importantly, patients who had a psychiatric diagnosis in the prior 12 months had a 65 percent increased risk of catching COVID-19, a risk even higher for older patients.

Future research will look more closely at causal factors in larger patient populations, but it is clear that the psychiatric dimensions of COVID-19 are considerable, and likely to outlast other issues for years to come. From an advocacy point of view, it is imperative that resources be devoted to addressing the mental health impact of COVID-19 to prevent amplified future illness and loss of function.

Psychiatric leaders have called for action given high rates of psychiatric illness and suicide following COVID-19 based on earlier studies. Accumulating evidence suggests that COVID-19 may uniquely affect the brain and immune system to contribute to mental illness. One respected research group has suggested a unique constellation of problems related to the pandemic they have called “COVID Stress Syndrome.”

These efforts will be most effective when mandated by the highest authorities and supported on the level of local government, communities, and healthcare systems. Individuals can advocate for greater attention to COVID-related mental illness by reaching out to our elected officials, and sharing constructive information on social media—which can be leveraged for post-traumatic growth. I hope we will be looking at the effect of Vaccine and recovery from this pandemic in our next newsletter.

AZFAR MALIK, MD, MBA, DFAPA
President / CMO, Center Pointe Behavioral Health System
Assistant Clinical Professor, Department of Psychiatry
Saint Louis University

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**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
The General Election cemented Missouri solidly as a red state. This was generally understood but with the way polling was guiding the races it seemed like last night Democrats were poised to gain seats in the House and Senate and other than Democrats flipping one seat by a total of 34 votes the night belonged entirely to Republicans.

The House majority will be 115-48 which is still well over a veto proof majority for the Republicans. The House Republicans will meet today to elect their leadership team for the next General Assembly. The Speaker next session has already been determined. Rep. Rob Vescovo from Jefferson County will serve his final term in the House in that top spot. All other leadership posts, including Majority Floor Leader, will be determined today.

Polling indicated that the Senate could pick up possibly two seats from the Republicans last night but that didn’t end up being the case. Both Sen. Caleb Rowden, Boone County and Majority Floor Leader, and Sen. Andrew Koenig, St. Louis County, held onto their seats despite a fierce campaign from their democratic challengers. The Senate Republicans will again have a veto proof majority of 24-10 going into the next legislative session. The Senate Republicans will meet Thursday to elect their leadership for next session. Its unlikely there will be any major changes from last session that saw Sen. Dave Schatz as President Pro Tem and Sen. Caleb Rowden as Majority Floor Leader.

Statewide Republicans held onto their positions and President Trump won the state by 15 points.

Statewide/Congressional Races in Missouri
All incumbent Members of Congress running in the General Election won re-election.

In the only open congressional seat (CD-1) in St. Louis, Cori Bush, who upset Congressman Lacy Clay in the Primary was elected. In the only perceived serious challenge in the 2nd CD (St. Louis County) Congresswoman Ann Wagner defeated State Senator Jill Schupp 52-46%.

State races of significance
All statewide elected officials won re-elections – Governor Mike Parson (57-40%), Lt. Governor Mike Kehoe (58-36%), Secretary of State Jay Ashcroft (60-36%), Attorney General Eric Schmitt (60-38%) and State Treasurer Scott Fitzpatrick (59-39%).

Initiatives and Referendums
The statewide initiatives on the ballot were Constitutional Amendment #1 relating to Term Limits for all statewide elected official Failed 48-52% and Constitutional Amendment #3 relating to “Cleaner Missouri” which would reverse the “Clean Missouri” Initiative that was passed by the voters in 2018 Passed 51-49%.

Missouri State Senate Races
Seventeen of the 34 State Senate seats (odd numbered districts) were up in 2020. All six incumbents running for reelection won:

District #11 Rizzo (D)
District #15 Koenig (R)
District #17 Arthur (D)
District #19 Rowden (R)
District #21 Hoskins (R)
District #23 Eigel (R)

Eleven of the 17 senate seats were open seats. Six Republican winners in the heavily republican open

(Continued on page 5)
**2020 Missouri Election Report**

**General Election Results**


The Republicans will have a 24-10 Majority in the 2021 Senate.

**Missouri State House Races**

All incumbent House members running for reelection won their primary except Rep. Steve Helms, (R) from Springfield (lost by 34 votes). Forty-six incumbent Representatives were running unopposed in the primary and general. There will be 47 new freshmen in House of Representatives the 2021 General Assembly which will begin on January, 2021.

The republicans will have a 115-48 Majority in the 2021 House of Representatives.

**2021 Missouri General Assembly Leadership**

The respective Republican and Democratic caucuses in both the House and Senate caucused on November 4-5 to elect their leaders for the 101st General Assembly. They are as follows:

**Officers of the Senate**

*President Pro Tem*
- Sen. Dave Schatz (Sullivan)

*Majority Floor Leader*
- Sen. Caleb Rowden (Columbia)

*Assistant Majority Floor Leader*
- Sen. Bill White (Joplin)

*Majority Caucus Chair*
- Sen. Dan Hegeman (Cosby)

**Majority Caucus Secretary**
- Sen. Jeanie Riddle (Fulton)

**Majority Caucus Whip**
- Sen. Tony Luetkemeyer (St. Joseph)

**Minority Floor Leader**
- Sen. JJ Rizzo (Independence)

**Minority Asst. Floor Leader**
- Sen. Brian Williams (St. Louis County)

**Minority Caucus Chair**
- Sen. Karla May (St. Louis)

**Minority Caucus Whip**
- Sen. Steve Roberts (St. Louis)

**Officers of the House**

*Speaker of the House*
- Rep. Rob Vescovo (Arnold)

*Speaker Pro Tem*
- Rep. John Wiemann (O’Fallon)

*Majority Floor Leader*
- Rep. Dean Plocher (St. Louis)

*Asst. Majority Floor Leader*
- Rep. Hannah Kelly (Mountain Grove)

*Majority Whip*
- Rep. Allen Andrews (Grant City)

*Majority Caucus Chair*
- Rep. Sara Walsh (Ashland)

*Minority Floor Leader*
- Rep. Crystal Quade (Springfield)

*Asst. Minority Floor Leader*
- Rep. Richard Brown ((Kansas City)

*Minority Whip*
- Rep. Doug Clemens (St. Ann)

*Minority Caucus Chair*
- Rep. Ingrid Burnett (Kansas City)
Stimulant-Induced Appetite Suppression, Two Case Reports, and Clinical Pearls
Sultana Jahan, MD, University of Missouri–Columbia

Attention Deficit Hyperactivity Disorder (ADHD) is a very common clinical presentation at the child and adolescent psychiatric clinics. Often stimulant medications are prescribed to treat ADHD. One of the most common side effects of stimulant medications is appetite suppression. Frequently patients present not only with ADHD diagnosis but present with other diagnoses as well. Pertaining to the specific disorders, they have prescribed different medications while they are on stimulant medications. It is imperative to assess the appetite suppressant effect of the other medications, as well as the medical and psychiatric conditions.

Two cases are presented here for further discussion.
Case 1:
Patient X was a 14-year-old mixed-race male who presented to the child and adolescent psychiatry clinic for a follow-up appointment. He carried a diagnosis of ADHD and was prescribed Methylphenidate extended-release 54 mg in the morning. According to the mother as well as the patient, his ADHD symptoms were well controlled with his stimulant medication. He had been doing well at school, at home, and was maintaining good grades. He was having an adverse effect from the medication including appetite suppression and lack of weight gain. The patient’s mother reported that he had not been eating much at breakfast and at lunch. Upon further inquiry, it was found out that patient was taking his medication on an empty stomach in the morning, at least one hour before his breakfast. At that visit, he was instructed to take his medication after a full/big breakfast every morning. During the next follow-up appointment, his appetite improved and the patient was able to eat better at breakfast and at lunch, and he also gained a couple of pounds.

Case 2:
Patient Z was a 15-year-old Caucasian male who was given the diagnosis of ADHD, Generalized Anxiety Disorder, and Tic Disorder. He has prescribed Methylphenidate extended-release 18 mg in the morning and Zoloft 50 mg in the morning. During one of his follow-up appointments at a child psychiatry clinic, the mother was concerned about his poor appetite and the lack of weight gain. According to the mother, the patient was not eating well and not gaining weight. At that visit his weight was 103 pounds, height was 5 feet 6 inches. His BMI was 16.6. The patient was considered underweight. During that visit, it was noted that the patient was also taking Topiramate 100 mg in the morning for Tic Disorder. Topiramate was prescribed by his neurologist. The mother reported that his tics were under control for many months with Topiramate. As poor appetite and lack of weight gain were significant issues at that visit, it was recommended that the mother discuss these concerns with the neurologist to see whether or not Topiramate can be reduced or tapered off. Especially, since the patient’s tics were under control for months as he grew older. During a subsequent follow-up appointment, the mother reported that the patient’s Topiramate was gradually tapered off by the neurologist and the patient continued to stay tic free. At the same time, his appetite got better and he started to gain weight.

Discussion:
The following measures can be considered when patients present with decreased appetite while on stimulant medications and being treated for ADHD:
1. Thorough medical and psychiatric history should be assessed. There are many medical and psychiatric conditions that can cause decreased appetite, for example, hypothyroidism, depression, anxiety, and anorexia nervosa.
2. Detailed substance abuse history should be obtained, especially a history of misuse/abuse of stimulant medication, methamphetamine, and cocaine.
3. Appropriate treatment recommendation should be considered pertaining to the relevant medical/psychiatric diagnosis and/or substance use disorder.
4. Meticulous history of prescription medications

(Continued on page 7)
Stimulant-Induced Appetite Suppression, Two Case Reports, and Clinical Pearls

Sultana Jahan, MD, University of Missouri–Columbia

should be gathered, which also can suppress appetite other than stimulant medications, e.g. Topiramate, Wellbutrin, and Amantadine.

5. Careful history should be obtained to better understand how the patient is taking medications, with meals or on an empty stomach. The parents/caregivers should be advised to dispense medications with or after full meals.

6. Supper time can be delayed a little bit to give time for stimulant medications to wear off, to help improve the appetite at supper time.

7. Parents/caregivers may consider offering the patient a small snack at night prior to bedtime.

8. If the above steps do not work, the risk/benefit ratio should be assessed carefully based on the individual patient’s clinical presentation and situation.

If indicated, a different stimulant medication, preferable from the methylphenidate group, can be recommended. If appetite suppression and the lack of weight gain are significant, non-stimulant medications for ADHD can be considered.

REFERENCES:

“Finding Equity Through Advances in Mind and Brain in Unsettled Times”
American Psychiatric Association Annual Meeting

The 2021 Annual Meeting and Mental Health Services Conference (formerly IPS) will be held virtually

In consideration of the continued spread of COVID-19, the American Psychiatric Association's Board of Trustees determined that it would be unwise to hold a large in-person meeting in 2021 during these public health crises since the APA would not be able to ensure the safety of those participating. In reaching this decision now, the Board weighed multiple factors, including the health and safety of our members and staff, uncertainty about the future course of the pandemic, the availability of an effective vaccine, and the timing of contract deadlines. The Board has voted to hold the Annual Meeting and the Mental Health Services meeting (formerly known as Institute for Psychiatric Services) virtually. The Board and the APA Administration will work diligently to develop virtual meetings that will provide robust, meaningful experiences and high-quality educational programs for all participants while maintaining safety and public health.

Key Details About the 2021 Annual Meeting

- Approximately 135 sessions will be selected for inclusion in the 3-day live meeting, which will occur in May 2021. These sessions will feature live interactions with faculty.
- 400+ scientific sessions will be available as part of an additional APA OnDemand Product.
- There will be a virtual poster hall.
- Attendees will have opportunities to earn CME credits through APA OnDemand, the live 3-day meeting, and the Annual Meeting Self-Assessment activity.

More information will be forthcoming as planning for the online meeting progresses.

2021 Annual Meeting Submissions

The 2021 Annual Meeting submission site is currently open to submissions of New Research posters ONLY. The site will close on Thursday, December 10, 2020 at 5:00 p.m. ET. Learn more about guidelines for submissions at http://www.psychiatry.org/psychiatrists/education/meeting-submission-and-guidelines.
Joe Biden has won the 2020 Presidential election”, I glanced at this notification twice from the New York Times as I sat at a coffee shop in downtown Columbia, MO on a sunny Saturday morning. It was November 7th and like the rest of the country, I had been checking the poll results incessantly, following the vote counts in the swing states for the past 3 days, awaiting the results of the most anticipated presidential election in modern history. I felt a sense of relief, my eyes almost teary as I absorbed this news. As I walked back to my apartment, I danced to a happy tune. With my face mask on, I reflected on the extraordinary circumstances of a pandemic-era election, in a moment of catharsis, celebrating the president elect’s victory.

I moved to the US in late 2015, as a foreign medical graduate, with the hopes of pursuing my medical residency. A 24-year-old, only physician in my family with no close family member in the country, I left my parents baffled with my aspirations. As a teenager in India, I admired several Indian Americans who were recognized worldwide for their contribution to mankind; Kalpana Chawla, the NASA astronaut and the first female of Indian origin to go to space, Amartya Sen, Nobel Prize laureate in Economics, Jhumpa Lahiri, Pulitzer prize-winning author, Vivek Murthy, 19th surgeon general of the US and Satya Nadella, the CEO of Microsoft, to name a few. America to me was a land of possibilities and opportunities, where there were no limits to what you could become and achieve. A country of immigrants where everyone had a fair shot, despite their differences. A truly diverse nation where one could live to their highest potential through sacrifice, risk-taking, and hard work. This belief was enough to fuel my aspirations for the years to come.

“Are you sure you want to apply for residency here?” one of the Indian physicians warned me in 2016. “We don’t know what’s going to happen in the coming elections. The Republicans have catastrophic immigration policies. Canada is much safer.” I never let her words dissuade me. One of the positive things about being young and naive is the optimism and confidence that follows it. I spent 2016 in New York City and Miami, doing electives and research, building my contacts and my CV, and eventually interviewing for a residency spot in the country. I applied coast to coast to maximize my chances of securing a spot. In November 2016, Donald Trump was elected as the president of the USA, and immediately in the following months, he signed multiple executive orders to ban foreign nationals of certain Muslim countries from entering the US. He tightened the visa access for high skilled foreign workers as a way to protect the American jobs, not realizing that most of these jobs are filled by foreign workers when the employers are unable to find competitive Americans for such roles. In March 2017, I cried happy tears as I matched into a residency program in the USA. I needed one spot out of thousands, and I needed one program director to rank me high enough. However, it was not an easy ride for several of my friends who were aiming at a similar path as mine. According to the 2017 NRMP match results, only 137 (9%) of non-US IMGs (foreign-trained physicians like me who needed a visa) matched into the Psychiatry of a total (1500) applicants. In the hindsight, I had no idea that I was walking on fire but I was proud of myself.

In the next years, I immersed myself in the residency, learning medicine; exploring my roles as a teacher and a leader, and learning from some of the most brilliant minds. When Covid-19 hit us, I felt trapped. There was no way I could leave the country without jeopardizing my return to the USA. I watched my sister’s wedding on FaceTime and realized that there will always be repercussions to one’s decisions; positive or negative.

For an international medical graduate on a J-1 visa, a waiver is sought to bypass the rule that requires our presence in our home (Continued on page 9)
countries for 2 years after the completion of residency. This is achieved by working in locations for 3 years that are designated as medically underserved or physician shortage areas by the HHS and has to be approved by the State of practice location via the Conrad-30 program followed by the Department of State in Washington, DC. Eventually, by the United States Citizenship and Immigration Services. The process takes 6-8 months and is fraught with rejections. Last week, I received approval from the state of Virginia that granted me a waiver in the Commonwealth. The Virginia State Health Officer concluded that my service will improve access to healthcare and reduce health disparities in James City County. Ironically, this was also the first area of colonization by the British in the 1600s and the center of political events leading to the American Revolution.

I continued to scroll the news as I watched the country rejoice and protest at the same time. “Kamala Harris has made history as the first woman, the first Black person and the person of Indian descent to be elected as VP”. I realized how Harris’s triumph marked a new high point in a career of barrier-breaking accomplishments, from San Francisco district attorney to the first female VP, a testament to the dedication of generations before her. Her Indian mother, Shyamala Gopalan, followed an unconventional route of completing a Ph.D. at UC, Berkley in the 1960s, and marrying a black man from Jamaica. Speaking of her life motto during a lecture at Spelman College in 2018, Harris said, “My mother would look at me and she’d say, “Kamala, you may be the first to do many things, but make sure you are not the last.” “And that’s part of why breaking those barriers is worth it. As much as anything else, it is also to create that path for those who will come after us.” I wonder if Shyamala Gopalan had not been so brave and had the support of her family, there would not be a Kamala Harris today.

I am well aware that the nation’s deep problems won’t vanish. As the 46th president of the US prepares to enter the White House, he will have to work to tackle the dangers still posed by a global pandemic, an unequal economy, a crooked justice system, systemic racism, democracy at risk, safety of immigrants and a climate in peril. However, it will not just be up to Joe or Kamala to fix these, but each of us to do our part. If I continue to serve this country as a physician, I hope to continue to be acknowledged and respected as an essential member of the community. If I were to leave the US, I would always be grateful and cherish the opportunities I was given in this fascinating country.
Residency Application During the Pandemic
Jacob Lee, MD

The 2021 Psychiatry residency application cycle was always going to be a challenging experience. The annual scramble for psychiatry’s roughly 1500 residency slots can be an anxiety-provoking process in the best of years, and setting this event against the backdrop of a global health crisis adds further complexity and uncertainty. As the nation’s residency coordinators and program directors worked to quickly reinvent their application process with an eye towards safety, potential applicants were left with even more questions about the psychiatry programs they planned to apply for. Applicants faced reduced visibility into programs that were actively changing to accommodate social distancing, telepsychiatry, and other safety measures. Considerations including the possibility of “drafting” psychiatry residents to coverage of internal medicine, emergency, or pulmonology/critical care services were newly introduced into the residency selection process. The traditional interview procedure, which involved numerous cross-country flights, hotels, handshakes, and more, was soon realized to be incompatible with CDC guidelines. By spring, health organizations such as the American College of Physicians and the American Psychiatric Association began communicating internally to discuss recommendations to adapt to this process. By early summer, it was clear that virtual interviews were yet another adaptation expected of our current batch of medical students.

Helping medical students navigate these uncertain times, an Informational Webinar was held on August 27th. Hosted by Washington University’s Simone Bernstein, the event brought together representatives from the University of Missouri – Kansas City and Columbia, Washington University, and St. Louis University. Dr. Jacob Lee presented the viewpoints of the Missouri Psychiatric Physician's Association. Speaking on behalf of their programs were a number of residents and chief residents, who spent the evening answering questions from over 110 students from around the state, country, and world. By the end, medical students could feel more confident in their understanding of Missouri’s psychiatric residency programs heading into this unprecedented interview season.

APA Reasserts Support for Affordable Care Act as Supreme Court Hears California v. Texas

The Supreme Court is hearing arguments today on California v. Texas, litigation challenging the constitutionality of the Affordable Care Act (ACA). The suit seeks to have the ACA entirely invalidated now that the so-called individual mandate has been essentially removed.

In May, the American Psychiatric Association joined with the American Medical Association and 20 other medical societies in an amicus brief in the case. The amici argue that the law as it currently stands should remain constitutional, and if the Supreme Court decides that the individual mandate no longer qualifies as a tax, it should leave the rest of the ACA intact.

“To disrupt the law governing the provision of health care in the middle of a pandemic would put everyone at risk,” said APA President Jeffrey Geller, M.D., M.P.H. “Overturning the entire Act would mean nearly 21 million people would lose their health insurance. We urge the Supreme Court to preserve the entire Act, including the individual mandate.”

“If the Court overturns or dramatically alters the Affordable Care Act in the middle of a pandemic and the growing mental health crisis created by the outbreak, people most in need will not have access to care,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A. “APA is extremely concerned about the lives of those with mental health and substance use disorders who are covered under ACA. Now more than ever access to health care is essential, and we should be doing everything possible to make it available.”
Impact of Racism Across Generations Discussed at APA Town Hall

The adverse effects of structural and interpersonal racism persist across generations, said panelists last night in the third online town hall meeting hosted by APA’s Presidential Task Force to Address Structural Racism Throughout Psychiatry.

“This is a period of turbulence in our country, and we are all being forced to confront the disparities in the treatment of Black, indigenous, and people of color,” said moderator, task force member, and APA Trustee-at-Large Michele Reid, M.D. She is a clinical assistant professor in the Department of Psychiatry and Behavioral Neurosciences at Wayne State University in Detroit and the chief medical officer of CNS Healthcare. “The COVID-19 pandemic has highlighted long-standing inequities caused by race, ethnicity, and income.”

Chuan-Mei Lee, M.D., an assistant clinical professor in psychiatry at the University of California, San Francisco (UCSF), and a child and adolescent psychiatrist at UCSF Benioff Children’s Hospital, spoke about the long-term, epigenetic effects of adverse childhood events (ACEs) that may occur as the result of structural and interpersonal racism.

“Experiences of discrimination produce the type of chronic stress that increases allostatic load, sets off cortisol production, shortens telomeres, and methylates DNA,” Lee explained.

Ebony Dix, M.D., an assistant professor in the Department of Psychiatry at Yale University School of Medicine and an inpatient geriatric psychiatrist, discussed how structural racism affects Black adults on a daily basis. She cited differential treatment of patients in the emergency department due to their race, as an example.

“Take an African-American male who is 50 years old and a white female who is 50 years old presenting to the same ED with the same psychotic symptoms,” Dix said. “I’ve seen time and time again that the full … work-up will be given to the white woman, but for the Black man the first things at the top of the differential is substance abuse or schizophrenia.”

Peter Ureste, M.D., an assistant clinical professor in the UCSF Department of Psychiatry and Behavioral Sciences, discussed how structural racism affects Latinx and LGBTQ populations, including transgender people of color.

“Transgender and gender nonconforming individuals face extraordinarily high rates of social and health inequalities, including poverty and discrimination by employers. They are [more likely to be] victims of violence, and they face higher rates of family rejection and homelessness than their cisgender peers. I would say this is even more so for transgender people of color,” Ureste said.

At the end of the discussions, Reid gave an update on the task force’s work. Highlights include the following:

- A website resource, psychiatry.org/TaskForce, that offers a recommended reading list, educational content, and a glossary of terms approved by the APA Board of Trustees.
- Three mini-surveys issued to guide the task force’s work and engage APA’s membership.
- A report by the task force’s Assembly work group that outlined eight actions to improve diversity and inclusion and reduce structural racism in the Assembly, actions that have since been approved by the Board of Trustees.
- Feedback sessions with APA councils and committees.
- Presentations made at the Kentucky, Missouri, North Dakota, Ohio, Utah, and Virginia district branches.

The next town hall will take place on February 8, 2021, from 8 to 9:30 p.m. ET.

APA Psychiatric News Alert, 11/16/2020
NAMI St. Louis 2020 Year-to-Date Impact Report

16,384
Individually and families impacted Jan. - Oct. 2020

Our Mission
Through our education, advocacy, support, leadership and customer-centered services, we will improve the quality of life of persons experiencing mental illness and that of their families, caregivers and friends.

More than 1,005
HelpLine calls, up 68% from 2019

68%

96 Virtual presentations serving 890 people since mid-March

88 Virtual Family & Peer Support Groups serving 413 individual and family members since mid-March

Reached 70,000+
persons on social media, providing messages of hope, information and resources while earning 6,172 followers

Reached 21,000+
people through the NAMI St. Louis website

Trained 32
new NAMI St. Louis education leaders in Family-to-Family, Family & Peer Support Groups, In Our Own Voice, or ETS

Trained 265 new CIT Officers during 13 in-person and virtual trainings

"Thank you for your help. I didn’t know where to start because I’ve never experienced anxiety before COVID-19...”
- HelpLine Caller

"During my first support group, I became aware that I am not alone in my fight with mental health and that there are others who have had similar experiences who want to support me. It made me feel valued and gave me clarity on issues I have been struggling with.”
- Peer Support Group Participant

"You guys did an amazing job! I don’t personally have a mental health condition, but I have a close friend with depression and this really helped me learn how to make sure she’s doing okay.”
- ETS Participant

NAMI St. Louis 1810 Craig Road, Suite 124, St. Louis, MO 63146
www.namistl.org (314) 962-4670
You are NOT ALONE

1 in 5 U.S. adults experience mental illness

1 in 25 U.S. adults experience serious mental illness

17% of youth (6-17 years) experience a mental health disorder

12 MONTH PREVALENCE OF COMMON MENTAL ILLNESSES (ALL U.S. ADULTS)

1% Schizophrenia
1% Borderline Personality Disorder
4% Dual Diagnosis
3% Bipolar Disorder
19% Anxiety Disorders
7% Depression
1% Obsessive Compulsive Disorder
4% Post-traumatic Stress Disorder

12 MONTH PREVALENCE OF ANY MENTAL ILLNESS (ALL U.S. ADULTS)

19% of all adults
15% of Asian adults
16% of black adults
17% of Hispanic or Latinx adults
20% of white adults
22% of American Indian or Alaska Native adults
27% of adults who report mixed/multiracial
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Implementing Suicide Screenings in VHA Settings Can Help Identify Veterans at Risk

When incorporated into Veterans Health Administration (VHA) medical settings, a population-level, suicide-risk screening may help identify veterans at risk of suicide who may not be receiving mental health treatment, according to a study published in *JAMA Network Open*.

“Emerging evidence suggests that suicide risk screening in AC [ambulatory care] and ED [emergency department] or UCC [urgent care center] settings may provide critical opportunities to identify risk among patients who are not receiving or seeking mental health treatment,” wrote Nazanin Bahraini, Ph.D., of the Rocky Mountain Regional Veterans Affairs Medical Center in Aurora, Colo., and colleagues. “Although the feasibility and utility of screening in the ED or UCC setting and medical settings [have] been demonstrated in community hospitals, it has yet to be examined in the VHA, the country’s largest integrated health care system.”

The researchers analyzed data from the VA Suicide Risk Identification Strategy (Risk ID), a screening and evaluation process that includes three stages: the primary screen (Patient Health Questionnaire-9), the secondary screen (Columbia Suicide Severity Rating Scale Screener), and the VHA’s Comprehensive Suicide Risk Evaluation. Individuals who screen positive at one level move into the next level of screening or evaluation.

Risk ID was implemented throughout all VHA facilities from 2018 to 2019. Patients were screened in ambulatory care settings if they had at least one outpatient visit and they did not have an existing diagnosis of depression, bipolar disorder, or posttraumatic stress disorder. All patients visiting an emergency department or urgent care center were also screened.

During the first year of Risk ID’s implementation (from October 1, 2018, to September 30, 2019), 4.1 million veterans in ambulatory care and over 1 million veterans who visited emergency departments or urgent care centers received the primary screening. The prevalence of suicidal ideation was 3.5% for primary screenings and 0.4% for secondary screenings in ambulatory care, and 3.6% and 2.1%, respectively, in emergency departments or urgent care centers. Those screened in emergency departments or urgent care centers were more likely to endorse suicidal ideation with intent, specific plan, or recent suicidal behavior during the secondary screening, compared with those screened in ambulatory care.

“The higher acuity of risk among veterans presenting to ED or UCC compared with AC settings highlights the importance of scaling up implementation of brief evidence-based interventions designed for ED or UCC settings to promote treatment engagement and reduce suicidal behavior,” the authors wrote.

Earlier this year, President Donald Trump signed the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (S 785), and the House passed the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020 (HR 8247). The bills both focus on preventing veteran suicide and address a range of issues related to veterans’ mental health care, including ensuring veterans can access the care they need.

“APA was pleased to see Congress focusing on veterans’ suicide prevention and mental health, and we are encouraged that lawmakers have recognized the importance of addressing this urgent issue,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A. “We will continue our work with the VA, Congress, and partner organizations to improve the mental health and substance use care available to our veterans through the VA and beyond.”

Reprinted from *Psychiatric News*
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Show-Me Psychiatry
The stress of health care professionals (HCPs) is surging during the COVID-19 pandemic. We need resources for our own care so we can perform well in our care of patients. It is a painful irony that, at this time of surging HCP distress, the Colorado Physician Health Program (CPHP), the peer assistance organization to which Colorado physicians have turned for 34 years for confidential assessment and treatment monitoring, is under serious threat.

As early as this past March, we were seeing reports about mental health outcomes among health care workers in Wuhan. In June, the published results of a survey of HCPs in New York demonstrated that psychological symptoms were common, with 57% of respondents reporting acute stress, 48% endorsing depressive symptoms, and 33% acknowledging anxiety symptoms. Lack of control, fear of transmitting COVID-19 to family, and fear for the health of family and friends were the most upsetting stressors, each endorsed by over 70% of respondents. The survey found that, while physical exercise was the most common coping strategy (59%), the majority of participants (51%) expressed interest in one or more proposed mental health wellness activities, especially online self-guided counseling with access to an individual therapist (33%) and individual counseling (28%).

Reports of HCP distress highlight the difficulties of working with critically ill and dying patients who are isolated from the support of their families, the fear of becoming ill or transmitting the virus to loved ones, concerns about access to personal protective equipment (PPE), and a sense of lack of control or uncertainty. An additional concern has been moral injury, which comprises the feelings of anxiety, helplessness, or outrage that occur when HCPs feel unable to surmount inequities or deficiencies in the health care system, such as when shortages of PPE or other resources force HCPs to make decisions that are contrary to their commitment to healing and awareness of how the deeply rooted structural racism in our society has made people of color especially vulnerable to the pandemic.

A pre-pandemic video from Dr. Z, who is best known for his satirical raps about health care, is a profoundly serious six-minute lesson that defines moral injury and its roots in a broken health care system. The problems discussed in the video have been amplified during the pandemic. A guidance document on moral injury in the pandemic by APA’s Committee on the Psychiatric Dimensions of Disaster is a must-read for physicians, administrators, and other leaders. It asserts, “Moral injury is associated with strong feelings of shame and guilt and with intense self-condemnation and a shattered core sense of self.” It highlights the circumstances in the current crisis that may lead to moral injury and introduces three tiers of interventions that health care systems may implement to reduce risk for such injury.

Although the literature on moral injury is primarily focused on situations in which HCPs must make treatment decisions that are counter to their moral commitment to provide the best possible care to patients, it is showing up in a unique way right now in Colorado health care. The Colorado Department of Regulatory Agencies (DORA), the state entity that oversees all the licensing boards including the medical board, has awarded the peer health contract to Peer Assistance Services instead of CPHP. For background about CPHP and the importance of a confidential peer health program for physicians, physician assistants, and medical trainees, please read my Psychiatric News column “ ‘Safe Haven’ Is Integral to Physician Wellness”

At the time of this writing, CPHP has appealed DORA’s decision and is simultaneously encouraging a public education campaign about the vital importance of confidential treatment of physicians by other

(Continued on page 17)
Physician Mental Health During COVID-19: A Call to Action
Claire Zilber, MD

Physicians in order to keep the medical workforce healthy and our patients safe. CPHP’s campaign includes a website that outlines key issues and calls us to action, www.PatientSafetyColorado.com. While the potential loss of confidential peer assistance is unique to Colorado at this moment, this may be the canary that warns other states about an erosion of protections for physicians who seek help for mental health issues. District branch leadership across the country would do well to monitor the situation in their own states.

In addition to protecting our physician health programs, there are other ways we can work to improve the mental health of our health care workforce during the pandemic. Some institutions, such as Rush University in Chicago, have responded by creating innovative pandemic wellness programs for their workforce. The Rush program includes Wellness Rounds, a Wellness Consult Service, onsite confidential counseling, and a crisis response algorithm.

As psychiatrists, we are in the best position to attend to the mental health of our health care colleagues. Whether through leadership in our institutions, our clinical activities, or activism to protect our physician health programs, we are the definitive spokespeople for the power of prevention and treatment of emotional distress.

Reprinted from Psychiatric News

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Patient’s Weight May Affect Response to Antidepressants

A patient’s body mass index (BMI) may play a role in the effectiveness of treatment with certain antidepressants for major depressive disorder, suggests a study published Thursday in the Journal of Affective Disorders.

Le Xiao, M.D., Ph.D., of Capital Medical University in Beijing and colleagues analyzed data collected in a clinical trial that included 202 adults with major depressive disorder at five hospitals from 2011 to 2016. Patients were 18 to 60 years and had scores of at least 20 on the 17-item Hamilton Rating Scale for Depression (HAMD-17) upon enrollment. All patients initially received paroxetine, and those whose symptoms did not begin to improve after two weeks were randomized to continue paroxetine, switch to mirtazapine, or take both paroxetine with mirtazapine for six weeks. BMI analysis revealed that 55% of patients had normal body weight, 35.1% were overweight or obese, and 9.9% were underweight.

The researchers found that patients who were normal weight or underweight were twice as likely to experience remission of their depression by the end of the eighth week, as defined by HAMD-17 scores of 7 or lower.

The researchers noted that one possible reason why people with a high BMI or excessive body fat may have a lower response to antidepressants compared with people with a lower BMI is that the drug must travel through more tissue and fluid in their bodies than in the bodies of people who are normal weight or underweight.

“The other potential mechanisms underlying the association between body weight and antidepressant response could be attributed to brain insulin resistance, inflammatory dysregulation, oxidative and nitrosative stress which is caused by obesity,” the researchers wrote. “Finally, decreased physical activity and obesity stigma can also contribute to poor response to antidepressants in patients with excess weight.”

Show-Me Psychiatry

What's Wrong With Health Care in the United States
Stuart Copans, MD; Mariam Rahmani, MD

There are 4 crucial failings in our current health care system, where the importance of relationships is ignored.

When a patient fails to improve with usual treatment, we begin a process of examining the causes of ineffectiveness: Is the medication dose too low? Is the patient’s body metabolizing the medication too quickly? Is the patient not following our directions? Is there a flaw in our understanding of the patient’s condition?

Health care in the United States is in poor health, its quality steadily declining since the 1960s. According to the World Economic Forum, in the 1950s the United States ranked first among the developed nations in the quality of health care. But now, despite enlisting renowned physicians, public health experts, economists, business leaders, and specialists in the treatment of ailing systems, we rank near the bottom.

What is the explanation? Is something being overlooked in the current effort to improve medical care? Do we not understand the cause of this fatal condition? The authors believe it is the importance of relationships that is being ignored; the physician-patient relationship, family relationships, and relationship systems in the community. Four key elements in our current health care system are responsible for this failure to acknowledge these critical relationships.

Interchangeability of parts
The foundation of the Industrial Revolution was the ability to create interchangeable parts. For example, workers on an assembly line build excellent automobiles cost-effectively. Health care administrators are using that model in medicine. The model of industrialized medicine works poorly when dealing with human beings, and is cost-effective only in the short run. Patients and practitioners are not interchangeable parts. Patients and their illnesses are too complex for a one-size-fits-all design. A health care model that does not recognize each patient as a unique person existing in a unique network of relationships—with medical practitioners, family, and community—results in increasingly poor outcomes, as the data demonstrate.

Systematic ignoring of the physician-patient and physician-family relationships
Treatment outcomes decline when patients see a different physician at each visit. The industrialized model excludes the importance of relatedness between physician and patient, losing the stabilizing relational linkages. For example, patients in hospitals cared for by their primary care physician are more likely to be discharged home and less likely to die within 30 days than those cared for by hospitalists who do not have an ongoing relationship with the patient and family.

The lack of sustained relationships between physicians and patients, and physicians and families, in the context of their community, impairs the effectiveness of treatment. It is costly to the physician’s sense that their work is meaningful, and thus costly to physician morale. Systems that fail to attend to the physician-patient relationship lead to decreased treatment effectiveness, physician burnout, early retirement, and increased rates of physician suicide.

Healing is more likely in the context of families than healing in isolation
Without attention to context, our words, actions, and experience have no meaning. Family and community relationships are the context of our patients’ lives. Strong social connections are associated with increased longevity. For example, marriage is a protective factor against cardiac disease and the death of a spouse is associated with increased rates of physical illness in the surviving spouse. For individuals with a chronic illness, treatment without consideration of family and community appears simpler and more efficient, but leads to sterile, out-of-context, uninformed treatment, blinding both the patient and the physician from seeing both the illness and the solution.

(Continued on page 19)
The undermining and erosion of family and community
Regulations and reimbursement systems that reduce the medical interaction to a specific procedure diminish the involvement of families and communities in a patient’s recovery. The Health Information Portability and Accountability Act (HIPAA), for example, which was established to protect patient confidentiality, immediately became an obstacle to communication with the people in the patient’s life who can help with follow-up appointments, medication adherence, continuity of care, and emotional support.

Treating the correct condition
The 4 elements described point to both the fatal condition and its solution. Attention to the whole person, focusing on relationships with physicians and nurses, patients and families, and the web of community relationships available in every community to every patient, helps people get and stay healthy. Any potential solution to the health care system that ignores relationships will always be ineffective. If industrial medicine worked, and at this point we’ve done that experiment, costs would not be rising, patients and physicians would not be dissatisfied, and health would be improving.

Dr Copans is Adjunct Associate Professor, Geisel School of Medicine at Dartmouth, Hanover, NH. Dr Rahmani is training director of Child and Adolescent Psychiatry at the University of Florida.
*Members of the Research Committee, Group for the Advancement of Psychiatry also include Dr John Beahrs, Emeritus Professor of Psychiatry, Oregon Health and Science University, Portland; Dr Allan Josephson, (Former) Professor and Chief, Division of Child and Adolescent Psychiatry, University of Louisville School of Medicine; Dr David Keith, Professor Emeritus, Department of Psychiatry and Behavioral Sciences, Upstate Medical Center, Syracuse, NY; Dr Patrick Malone (1944–2016); Dr Alan Swann, Professor of Psychiatry, Baylor College of Medicine, and staff psychiatrist, Houston VA Medical Center; Dr William Swift, Emeritus Clinical Professor of Psychiatry, University of Wisconsin School of Medicine and Public Health, Madison; Dr Johan Verhulst (1938–2019); and Dr Douglas Kramer, Emeritus Clinical Professor of Psychiatry, University of Wisconsin School of Medicine and Public Health, Madison, and Chair, GAP Research Committee.

Reprinted from Psychiatric Times, 11/5/2020

Luis Herman Schwarz, MD

Schwarz, M.D., Luis Herman at the age of 90, on November 10, 2020. Beloved husband of Rosa Ana Schwarz (1930-2018); loving father and father-in-law of Louis E. Schwarz (Elizabeth Palmieri) of University Park, MD; loving father of Luis Alonso and Elsa; dear grandfather of Stefan Schwarz, and Bruno, Federico, & Leonardo Raab; loving brother of Oscar, Guillermo, Rosa, Kristina, Josefin, Maria, Jorge, Otla, Martha, Romy, Inger Elizabeth, Patty, Elke, and Herman of Lima, Peru; brother-in-law, uncle, great-uncle, cousin and friend.

Luis was the son of Oscar Herman Schwarz, a German merchant marine captain from Hamburg who settled in Peru in the early 20th century. Luis was born in Lima, Peru, obtained his bachelor’s degree from the Universidad Nacional Mayor de San Marcos in Peru, and his medical degree from the Universidad Nacional Autonoma of Mexico. Luis completed his medical internship and medical residency in psychiatry at McGill University, Montreal Canada, while working as a research fellow. He immigrated to the United States with his wife Rosa and son Louis, and continued his residency in psychiatry and neurology at Washington University’s Malcolm Bliss Mental Health Center in St. Louis. During his tenure as Supervising Psychiatrist at Malcolm Bliss, he co-authored numerous research papers in a variety of psychiatric and neurology journals. His early interests in research and training others led him to become an Assistant Professor of Psychiatry at Washington University, and subsequently an Associate Professor of Psychiatry at St. Louis University School of Medicine. In 1970 he began his private practice, consulted at the Jefferson Barracks VA Hospital, and was a member of the hospital staff at St. Mary’s, Deaconess, St. Anthony’s, and Jefferson Memorial. At Jefferson Memorial he served as the Medical Director for their Behavioral Health Services department, and later as the Chairman of the Psychiatric Department. Luis served on a number of local medical societies, and was a distinguished 50 year member of the American Psychiatric Association. In his retirement years, Luis devoted much of his time to writing and publishing his poetry, engaging in spirited philosophical debates with his close circle of friends, and travelling the world with his wife Rosa.
Exercise can be a useful tool in managing symptoms of anxiety and depression. Learn how you can integrate exercise prescriptions into your treatment plans.

Over the past few decades, the level of sedentariness has increased and become a leading public health concern. Greater total sedentary time and longer sedentary bouts are associated with higher all-cause mortality risk.1 This is of even greater concern during the coronavirus 19 (COVID-19) pandemic, as the workforce has changed dramatically with various institutions attempting to maintain their workers remotely.

The access to recreation centers and fitness facilities has decreased significantly for public safety purposes. This has made it particularly difficult to advise patients on how to pursue exercise. Yet, in psychiatry, we all prescribe exercise as a natural therapy to improve mood and manage depression and anxiety symptoms. There is a large body of evidence to suggest its benefits.2

While most of us appreciate its importance, we also recognize that avoidance is exceedingly common. Too often patients hear the word exercise and develop an aversive reaction, as they anticipate that it involves intensive training reserved only for the athletically elite. So how can one simply and effectively counsel a patient on exercise to increase their chances of engagement?

The fact that exercise should be part of the treatment regimen for depression seems to be common knowledge, but it is important to emphasize studies from which this insight was formed. A large study of over 30,000 participants showed that 1 hour or more of exercise per week can prevent 12% of future cases of depression.3 Furthermore, 30 minutes of exercise on a stationary bike reduced depression symptoms 10 and 30 minutes post-exercise.4 Fascinatingly, these results are independent of the intensity of exercise.

While exercise has been reported to prevent depression and combat symptoms acutely, it has also been found to improve long term remission rates. One study found a reduction in depressive symptoms by 47% after 12 weeks of regular exercise.5 Another study showed that home-based exercise or supervised exercise resulted in statistically similar remission rates of major depressive disorder (MDD) as selective serotonin reuptake inhibitor (SSRI) use, albeit the sample size consisted more of those with mild depressive symptomatology.6 Even a year after study completion, the remission rates were correlated with the amount of regular exercise, with protective effects maximized at 180 minutes per week.7

While the above studies focused primarily on aerobic physical activity, strength and resistance training can provide similar reductions in depression symptoms. A large meta-analysis of 33 randomized controlled trials showed that regular resistance training significantly reduced symptoms of depression.8 There is substantial improvement in mood by combining both aerobic physical activity and strength training.9,10 Strength training can reduce depression symptoms by 2 to 3 times that of the control group while also reducing bodily pain and improving vitality and social functioning.11 Furthermore, it is important to prevent obesity as it is strongly linked to increasing anxiety symptoms.12 Indeed, it is clear that regular exercise, both aerobic and strength training, can reduce the risk of developing depression, treat depression symptoms acutely, and provide long-term remission.

The exercise programs used in the aforementioned studies often included cycling on a stationary bike or the use of a treadmill. The participants used the bike or treadmill for 30 to 45 minutes4-6,9 with 1 study requiring the heart rate to achieve 75% to 85% of maximum heart rate reserve.6 Other studies simply relied on patients self-reporting weekly exercise, which included activities such as walking and swimming.5,10 Strength training regimens targeted large muscle groups and included exercises such as (Continued on page 21)
Show-Me Psychiatry

How to Effectively Prescribe Exercise
Brad Bergin, Noel Amaladoss, MD, Antony Amaladoss, MBBS, D Psych, F Psych

Chest press, lat pulldown, leg press, leg extension, and knee flexion 2 to 3 times per week.\(^9,^{11}\) Regardless of the type of physical activity, all exercise sessions lasted 45 minutes or less. Results were often intensity independent, suggesting that even 30 to 45 minutes of mild to moderate intensity exercise a few days a week is sufficient to improve mood symptoms.

While there is strong evidence that regular exercise can improve one’s mood, the clinician must prescribe exercise in a way that promotes adherence. Practical strategies include being specific with exercise routines, but also to listen to the patient’s preferences and barriers to exercise. These strategies will help formulate a program that the patient can maintain.\(^{13}\) It is also helpful to construct goal-oriented objectives that a patient can successfully achieve.\(^{13}\) In addition, it is beneficial to break larger exercise requirements into smaller, achievable chunks. Finding motivation is crucial, which can be done through strategies such as stressing the mood elevating properties of exercise or by encouraging social workouts. It has been shown that those who exercise with others more or equally as often than alone report greater self-health.\(^{14}\)

After condensing the information in the literature and combing it with strategies for compliance, we feel it is possible to come up with sample exercise prescriptions. For example, a patient with low exercise tolerance and motivation could be prescribed 30 minutes of moderate walking. The patient could start by walking 1 to 2 days a week and gradually increase to up to 6 days, which would equate to 180 minutes per week. If the patient is having a particularly hard time with motivation, the clinician can encourage walking with a friend and setting goals. In a patient who is aversive to aerobic activity, the clinician can prescribe strength and resistance training that focuses on large muscle groups. These strength sessions can be prescribed 2 to 3 times per week and up to 45 minutes per session. Exercises should target large muscle groups and include activities such as chest press, lat pulldown, leg press, leg extension, and knee flexion. If a patient does not have access to a fitness center or prefers home workouts, then they can perform exercises at home such as push-ups, air squats, wall-sits, and abdominal routines. Since the mood benefits of exercise have often been shown to be intensity independent, it is more than possible to work within the patient’s exercise tolerance and physical limits.

In addition, it can be beneficial to discuss with patients the neurobiological changes seen during exercise that may contribute to elevation of mood and improved cognition. Aerobic fitness is associated with greater hippocampal volume and memory performance.\(^{15}\) Exercise also increases performance in the area of executive functioning, which is attributed to greater function of the anterior cingulate and prefrontal cortices.\(^{16}\) Moreover, aerobic exercising upregulates brain-derived neurotrophic factor (BDNF)\(^{17}\) and enhances dopamine\(^{18}\), serotonin\(^{19}\), and acetylcholine neurotransmitter release\(^{20}\), all of which play a role in mood and cognition.

Resistance training has been shown to improve memory performance and verbal concept formation potentially through increased insulin-like growth factor-1 (IGF-1).\(^{21}\) Additionally, exercise training has shown to improve regional cerebral blood flow in sedentary older men.\(^{22}\) Endocannabinoids also play a role, as there is an increase in release during exercise which may contribute to some of the mood elevating effects.\(^{23}\) Certainly reviewing the neurobiological and cognitive alterations seen in exercise may aid in further justifying to the patient that physical activity can be as efficacious as psychopharmacotherapy.

Read the rest of the article here:
http://www.psychiatrictimes.com/view/how-to-effectively-prescribe-exercise

Reprinted from Psychiatric Times, 11/10/20
A federal district court yesterday ruled that United Behavioral Health (UBH) must use medical necessity criteria and assessment tools developed by mental health and substance use disorder specialty organizations when making coverage-related determinations.

The ruling was part of a 10-year injunction against UBH issued by Judge Joseph Spero of the United States District Court for the Northern District of California in *Wit v. United Behavioral Health*. The injunction also includes a requirement that UBH personnel be trained in the use of the court-ordered medical necessity criteria and that UBH reprocess nearly 67,000 mental health and substance use disorder benefit claims over the next year. UBH is the country’s largest managed behavioral health care organization.

The injunction requires UBH to use the Level of Care Utilization System (LOCUS), Child and Adolescent Service Intensity Instrument (CASII), and Early Childhood Service Intensity Instrument (ECSII)—assessment tools developed by the American Association of Community Psychiatry (LOCUS) and the Academy of Child and Adolescent Psychiatry (CASII and ECSII)—as well as criteria developed by the American Society of Addiction Medicine.

Yesterday's ruling is the “remedy” phase of the case resulting from the court’s decision signed on February 28, 2019. The court held that UBH had illegally denied coverage for mental and substance use disorders based on flawed medical necessity criteria. Those denials impacted more than 50,000 UBH enrollees and involved 67,000 claims for coverage across four states: Connecticut, Illinois, Rhode Island, and Texas.

Reacting to the ruling, APA President Jeffrey Geller, M.D, M.P.H., said, “We applaud Judge Spero for holding this major insurer accountable for discriminating against patients with mental illness by denying them the care they need and are entitled to by law.”

He said APA will continue to be vigilant whenever insurers fail in their duty to abide by laws requiring parity between coverage of general medical care and coverage for mental illness and substance abuse disorders. “We hope insurers will take note of this ruling and stop the discriminatory practice of denying or limiting coverage of treatment for mental illness and substance use disorders.”

For further coverage of the *Wit v. UBH* decision, see upcoming editions of *Psychiatric News*. For background information, see the *Psychiatric News* article “UBH Internal Documents Show Focus on Short-Term Stabilization.”

Reprinted from *Psychiatric News*
The Missouri Psychiatric Physicians Foundation was established in 2018 by the MPPA as its IRS-approved charitable arm. The MPPF has its own officers and board and was organized exclusively in scientific, educational and charitable activities within the meaning of section 501(c)(3) of the Internal Revenue Code, including:

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.**

D. **RECOGNITION OF ACHIEVEMENT.** The Foundation may provide some recognition of achievement to individuals or groups who have excelled in advancing the purposes of the Foundation.

E. **SUPPORT OF MPPA.** The Foundation will provide support to the Missouri Psychiatric Physicians Association in its efforts to achieve the Foundation’s objectives such as education and research.

The Missouri Psychiatric Physicians Foundation is a 501(c)(3) exempt organization and all donations made to the MPPF are tax deductible under IRS Section 170.

Contribution Amount $ _____________________ Receipt Needed: ☐Yes ☐No

Name/Organization ________________________________________
Address ____________________________________________________ City State Zip ____________________________________________
Phone ________________________ Email ____________________________________________________________

☐Please send me a bill for the above contribution amount.

☐Check ☐Credit Card Card Number ____________________________________________________________
Exp. Date _____________ CVV Code _____________ Signature ____________________________________________

Donations payable to Missouri Psychiatric Physicians Foundation (MPPF)
722 E. Capitol Avenue, Jefferson City, MO 65101
573.635.5070 ~ visit www.missouripsych.org
Online Donations: https://missouri.psychiatry.org/advocacy/mppa-foundation
Missouri Psychiatric Physicians
Political Action Committee
Jo-Ellyn M. Ryall, MD

The election is over in Missouri and the PAC was successful in supporting several candidates who won their elections. We are limited to candidates running for office in the House of Representative or Missouri Senate and Chief Executive of Counties.

The committee of Jo-Ellyn Ryall and James Fleming was assisted by our Lobbyist Randy Scherr. Randy’s help was successful in all but one of the races we supported. We selected candidates of both parties and supported them with checks in March, July, and during the summer. Thank you so much to everyone who contributed.

Keri Ingle, D Lee Summit; Rory Rowland-D, Independence; Ian Mackey-D, St. Louis; David Gregory-R, St. Louis; Steve Helms-R, Springfield; Mike Stephens-R, Bolivar; Lisa Thomas, MD-R, Lake Ozark; all received our support for the House of Representatives. All were elected except Steve Helms. Barbara Washington-D, Kansas City was supported in her successful run for Senate. We also gave a contribution to Sam Page, MD before the Primary Election for St. Louis County Executive. He also won the General Election in November.

This was possible because of your contributions, but I am holding out the hat again. Our account balance is low and we need more contributions. We would like to cultivate new friends in the House and Senate. There were many freshmen in the House and several in the Senate. Please consider sending a contribution to MoPPPAC. If you would like us to consider your Senator or Representative for a contribution in the future please send your recommendation to Sandra Boeckman our Executive Secretary at the above address.

MARK YOUR CALENDARS FOR WHITE COAT DAY MARCH 2, 2021. May it be in person in Jefferson City.

Thanks again and have a healthy safe holiday season.
**Missouri Psychiatric Physicians Political Action Committee**

**MEMBERSHIP information**

**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
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, please contact Sandy Boeckman by email at missouripsych@gmail.com.
Calendar of Events

Executive Council Meeting
~ CONFERENCE CALLS ~
(7:00 pm)
January 19, 2021
July 20, 2021
September 24, 2021
November 16, 2021

American Psychiatric Association Annual Meeting
May 1—May 5, 2021

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