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SEPTEMBER 2020

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IN THIS ISSUE

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Why I'm Going to the NCPA Virtual Annual Meeting & You Should, Too

Mehul Mankad, M.D., D.F.A.P.A., NCPA Past President

Hello old and new friends. Here's a blast from the past—your old Past President here to shamelessly plug this year's annual meeting. For those of you who are regular attendees, the annual meeting serves as an enriching tradition that nourishes minds and hearts of psychiatrists in our state. The warm environment, top notch speakers, and opportunities to connect with colleagues are unmatched. As a member of this year's Annual Meeting Program Committee, I can assure you that NCPA has been working very hard to preserve the best elements of our meeting while catapulting us into new territory through a virtual format. I'd like to share three reasons why you cannot miss this year's annual meeting.

Convenient and a Bargain

Many of us pivoted to working from home offices this year. Others who are hospital-based are now wearing scrubs for the first time since medical school. Whatever your circumstance, you are free to don the "COVID mullet" (nice clothing on top, lounge pants or shorts on the bottom) and join us. The meeting has been condensed to primarily occur over Saturday and Sunday while providing the same number of CME hours as our traditional 3.5 day meetings. No travel. No hotel expense. Half the registration price. In total, I think I will be spending about 20% of my usual budget to attend this year. If I were you, I would register myself and talk some psychiatrist friends into attending.

Outstanding Speakers & Format

You might be thinking, "Mehul, I can find free online CME everywhere. Why should I attend this meeting?" You are correct. You can find free CME in many nooks and crannies of the internet. However, it's hard for me to tell if the material is sponsored, current, or relevant. Ours is a real meeting with synchronous components, not a generic website. Our Program Committee received enthusiastic support from our talented lineup of speakers when we converted the meeting to a virtual format. They are interested in providing current information and will include opportunities for two-way interaction. This meeting is designed from the ground up as a virtual meeting and makes the most of available technology and learning styles. It promises to have a very different feel than passively watching lecturers, whether they are in-person or on a screen.

Opportunity for Fellowship

I'll be honest. I do love the speakers. But I equally love the opportunity to see my psychiatrist colleagues. As with the in-person NCPA meeting, social events are encouraged but optional. This year, we are excited to continue the tradition of social programming for our meeting attendees and have some surprises in store. And when you are done in the evenings, you get to sleep in your own bed rather than a hotel! Looks like a winner to me, and I can't wait to see you the first weekend in October.

From the Editor: A Rare and Unusual Book

Drew Bridges, M.D., D.L.F.A.P.A.

For this issue, my book recommendation is the rare and unusual, *One for a Man, Two for a Horse: A Pictorial History, Grave & Comic, of Patent Medicines* by Gerald Carson (Bramhall House, NY, NY:1961).

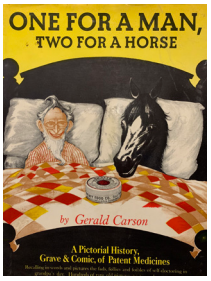
My background in medicine often led me to stories about how people treated illnesses before real science was enlisted. This book presents a delightful collection of pictures and stories of "cures" offered by all manner of entrepreneur.

Historical representations of pills, elixirs, devices, and salves are taken from original advertising sources, dating from shortly after the Civil War to the early 1900s. Most ingestible concoctions contained alcohol, but some included dangerous chemicals like mercury.

One section details how products were marketed. There were indeed covered wagon- style medicine shows, but advertisements were much more sophisticated. Efforts created "the public image of a trademark by using ideas, pictures slogans, and mnemonic devices to establish a product personality."

Free samples and billboards proliferated. H. H. Warner is credited with inventing the paid advertisement disguised as a news story.

Perhaps the most successful story of patent medicine branding goes to Lydia Pinkam, whose Victorian-era vegetable compound addressed the many ills of "weak women." She had even become popular with boys at elite colleges, who would write under female pseudonyms for advice on "intimate matters." Her product was so popular that when she died wealthy in 1883, her image graced souvenir china plates.



While the book is not still in print, copies can be found online. Mint condition copies are over $40. The book should be attractive as a colorful coffee table picture book or a well-researched source of history of early medicine treatments.

NORTH CAROLINA Psychiatric Association news

EDITOR Drew Bridges, M.D., D.L.F.A.P.A.
MANAGING EDITOR Robin B. Huffman, Executive Director
ASSOCIATE EDITOR Kelly Krasula, Communications Coordinator

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President's Column: Continuing to Adapt to the "New Abnormal"

Zach Feldman, M.D., F.A.P.A.

As 2020 rolls on, we continue adapting to the "new normal," or what some might call the "new abnormal." As psychiatrists, we have been fortunate that our work has adapted well to a virtual platform. While most of us agree something is lost without in-person contact, telemedicine is a reasonable stopgap for us to continue providing services while maintaining safety for patients and ourselves. We have gotten somewhat used to these online interactions as we became familiar with the format and worked out some early technical glitches.

Like many of us in practice, NCPA has also been operating remotely since March, and again, while we all miss seeing each other in person, the organization has continued to function amazingly well.

Our upcoming Annual Meeting has created an additional challenge. When the pandemic began shutting down our nation in March, we were hopeful the October meeting would still be held in person as planned. Over time, it became clear that would be impossible. Our challenge has been to transition the meeting online while replicating the best aspects.

What hasn't changed is we will still offer a great lineup of interesting and relevant lectures from expert speakers. (See the schedule on page 15 or visit the NCPA website.) I would like to thank our Program Committee for quickly developing a transition plan and our staff for making it happen.

Those who have attended previous Annual Meetings can attest that there is much more to these events than CME. They provide a yearly opportunity for psychiatrists, residents, medical students, and other mental health professionals to make and maintain personal connections. While this environment cannot be fully replicated online, we have selected a meeting platform and are utilizing a program format such that attendees will feel engaged through interpersonal interactions.

There will be a live Q&A with the speaker(s) at the conclusion of each lecture. Between sessions, there will be time to mingle with colleagues in a virtual lobby, where attendees can see who is in attendance, message other attendees, and even break out into private video chats. We have also added social activities, such as a virtual cocktail hour and morning yoga. (Feel free to turn off your video for yoga. I know I will!) Of course, this is new for us, and there may be some glitches at times. But I am confident that we will offer an experience where attendees feel like part of the event.

Even though it will not be quite the same without everyone gathering in one physical location, an online meeting offers some advantages, just as telemedicine offers some benefits over in-person patient care.

First, the conference is much more accessible and convenient. As the meeting commences on Friday evening, there is no need to take any weekdays off. Our hope is that more psychiatrists will be able to attend, including those out of state. This is a great opportunity for all of us to invite friends in other states, including former medical school and residency classmates. Wouldn't it be great if some of them were inspired to return to North Carolina?

Second, the total cost to attend is greatly reduced with a lower registration fee and no travel expenses. These savings may make it more feasible for medical students, residents, and fellows to attend.

Third, the lectures will be recorded so that attendees can go back and rewatch something they missed.

Finally, each attendee has control over the thermostat. No more freezing or sweating in a hotel conference room (though there may still be competition with family members/roommates)!

As the meeting goes on, I anticipate we will realize many more advantages and areas for improvement. Our Annual Meeting will be in person again one day. But in the future, we will likely continue to incorporate online aspects to augment the educational experience and reach a greater audience than those who can make the trip each year.

I hope you will join us for NCPA's first virtual Annual Meeting from October 2-4. Please also spread the word to your colleagues in and out of state. While it won't be the same, it will still be a lively experience!

A Point of Personal Privilege: Tell Me a Story

Robin B. Huffman, NCPA Executive Director

It has probably become invisible to you psychiatrists by now, but we typically include a line in most of our electronic and print newsletters and emails to you to "Let the NCPA office know…" or "Please reply to this email to share your thoughts!"

Why do we do that? Because we want to know if your employer suddenly announces that you are required to see the patient in person who refuses the telehealth appointment and refuses to wear a mask! Or that you will be required to take medical leave if you feel at risk for in-person rounding at the hospital and not be able to provide care using telehealth technology.

Hearing from members in every nook and cranny of our state about what is actually taking place as you practice medicine and care for patients is our office's way to take the pulse of the profession. From your phone calls, your inquiries, your emails, and even your faxes, we learn about how policies we have helped shape are playing out in the real world. We learn whether insurers are doing the things they say they are doing, such as paying telehealth claims at parity with in-person visits.

We also get vivid pictures from you about your patients' ongoing challenges. Telemedicine is great, but not if the patients don't have access to broadband internet, or they don't own smart phones, or they have limited data plans, or they have cognitive issues that make facility with telehealth possible. From your reports and stories from the field, we are able to share, advocate, and fight for policies that help improve the delivery of mental health services for your patients.

From you, we learn whether psychiatrists feel safe "seeing" patients in an office or whether they would prefer interacting with patients in a video session unmasked. We hear stories about employers trying to coerce physicians into postponing necessary ECT sessions or substituting oral medications for long-acting injections.

This is the feedback NCPA needs to act on your behalf. To create and distribute guidance documents to back you up. To lobby for your medical authority to determine how best to care for your patients.

From your reports and stories, we are able to share, advocate, and fight for policies that help improve delivery of mental health services for your patients.

From your stories about the inability to connect patients discharged from the hospital to appropriate outpatient services, we understand and can communicate to legislators and policy leaders the dearth of appropriate outpatient services.

From your private reports to me about abysmally low reimbursement rates (you can tell me, you can't discuss with other physicians!), NCPA can challenge insurers about the real causes for their network adequacy problems and about their lack of implementing federal parity requirements.

We also want you to share your stories with your elected officials. While your patients may be reluctant to share their personal stories with legislators, you are in a position to paint the picture for them about the mental health care needs of their constituents.

You can help illustrate – in ways lobbyists can't – the real impact of the lack of insurance coverage or broadband internet. Or you can convey how your treatment actually ended a person's frequent emergency room visits for symptoms caused by their mental illness. You are in a prime position to suggest successful solutions to health care problems that exist in our towns, cities, and counties.

So, tell us a story. Tell us what is going well in your practice. Tell us about problems you are experiencing. Send us an email to info@ncpsychiatry.org. Give us a call at 919-859-3370. Drop by for one of our weekly virtual Zoom chats. We would love to hear your story!

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Health Disparities and COVID-19: Interview with Jay Leggette of Robeson County

Health Disparities Workgroup, NCPA Disaster Committee

The Health Disparities Workgroup formed in April 2020 in recognition of the disproportionate impact that the pandemic was having on minority communities. The workgroup meets biweekly and invites members of the community to share their experience. At a recent workgroup meeting, Jay Leggette, Grassroots Community Health Coordinator and founder of The Stimulus, shared challenges and opportunities in Robeson County in the wake of COVID-19.

Mr. Leggette was born and currently resides in Robeson County. He has significant experience in organizing community health responses to disaster, including, but not limited to, Hurricanes Matthew (2016) and Florence (2018). He pointed out that the pandemic has called attention to several unique issues in Robeson County and the surrounding region. One example is that some migrant farm workers describe being turned away when seeking testing and treatment. This has been reported in other parts of the state, as well.

Over time, a series of collaborative initiatives have resulted in a testing ramp up in Robeson County, but the rate of positive cases reported on the NCDHHS Dashboard and CDC Dashboard indicates that a significant number of people in Robeson County continue to experience access barriers. Mr. Leggette highlighted that, according to the data released by NCDHHS and the CDC, the positive case rate per 10,000 and per 100,000 in Robeson County appears to be significantly higher than in some of the more populous counties across that state. By comparison, these other counties have reported a higher number of cases, but a lower positive case rate. *(See Figure 1.)*

Hurricane season is here. Given the county's horrific past experiences, this adds to people's anxiety. Referring to difficult (and often incomplete) recovery among vulnerable communities following Hurricanes Matthew and Florence, Mr. Leggette pointed out that, "We've seen two terrible federal government responses to disaster in the past."

He added that, "When a major disaster hits during a political cycle [such as the upcoming election in November 2020], there is a tendency to get misinformation from both left and right as the disaster itself becomes politicized."

He noted growing concern of an orchestrated effort to disenfranchise disaster survivors by downplaying the impact of COVID-19. The community recently struggled with Hurricane Isaias and is already bracing for more, potentially more powerful storms in what is expected to be a highly active 2020 hurricane season.

"Unlike other communities, we were already in 'the disillusionment phase' when COVID-19 hit, since many are exhausted from ongoing long-term recovery efforts from two previous major disasters in recent years," said Mr. Leggette. "We have a stressed hospital system, and Robeson County is the most unhealthy county in the state according to data released by the 2020 County Health Rankings."

He continued, "The public schools of Robeson County announced plans to reopen using a hybrid approach; the first nine weeks are virtual, and some in-person learning thereafter if feasible. We're fortunate because our School Superintendent has a master's in public

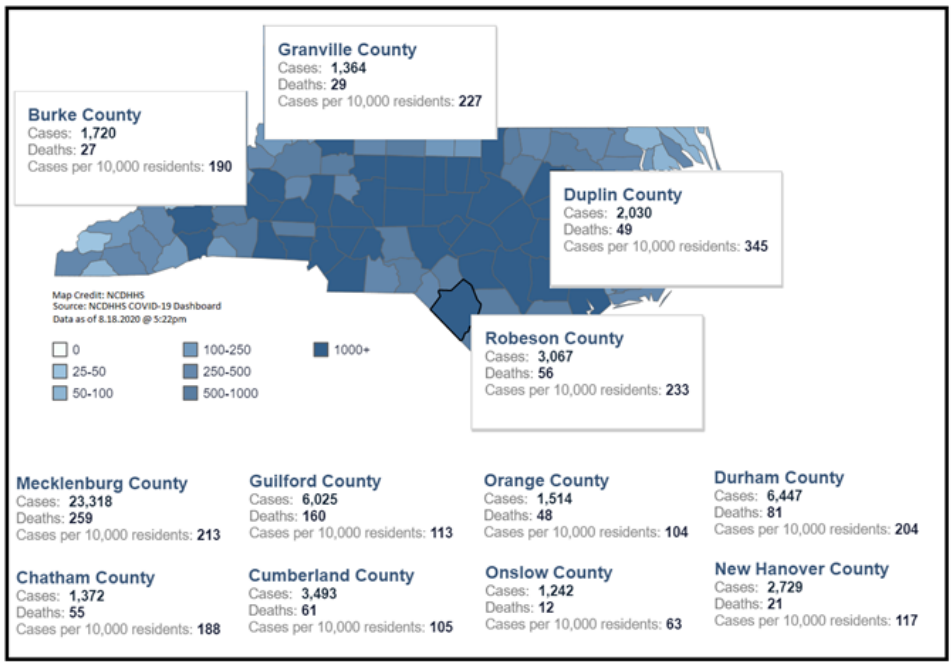

Figure 1. Map Credit: NCDHHS. Source: NCDHHS COVID-19 Dashboard. Data as of 8.18.20 @ 5:22 pm.

health and a doctorate in education, so she gets it. Virtual education is a challenge. In many parts of the county, some households essentially live in a 'technology desert' since accessing the internet is difficult and/or impossible due to limited service availability and bandwidth issues. They used school buses to provide Wi-Fi 'hotspots' last semester, but it's expensive."

There are some significant resources in Robeson County. One of them is UNC Pembroke (UNC-P), which has strong connections with the local community and the Lumbee Tribe. UNC-P has reported that more than 250 students at the university will become certified as national Mental Health First Aid trainers thanks to a grant from the UNC System Office. Following Hurricane Matthew in 2016, the Lumbee Tribe began collaborating with the county's official Long Term Recovery Group in order to increase local disaster preparedness, response, and recovery capabilities.

"As a community, we are coming together, but there's a lot of work to do," said Mr. Leggette.

The Department of Veterans Affairs (VA) is another resource with special ties to Robeson County. Native Americans serve in the United States military at the highest rate of any ethnic group. They also have the highest rate of PTSD of any ethnic group. For this reason, the VA's Vet Center program and the Lumberton VA Community Based Outpatient Clinic have been playing an important role in providing counseling, primary care, and mental health services across the community. The Vet Center also responds to disasters in the civilian community by deploying Mobile Vet Centers equipped with satellite communications systems. These can be set up as local clinical and communications hubs and provide face-to-face care on site or telehealth services in partnership with remote sites of care. The Lumbee Tribe, which is one of several tribes in Robeson County, has its own Veterans program with close ties to VA. This proves can be especially helpful in emergency situations.

"We need to build our capacity with local volunteers and build on the efforts of Veterans," said Mr. Leggette. "A lot of the time, volunteers from across the state show up to help, but they lack the cultural competence to be effective in working with our highly diverse community members."

A Veterans organization, Team Rubicon, which is composed of Veterans who have deployed to the wars in Afghanistan and Iraq, specializes in disaster response. The organization has been very effective in working with residents in Robeson County. Mr. Leggette also acknowledged that another Veterans organization helped distribute toys to disaster survivors with children in the wake of Hurricane Florence.

Mr. Leggette suggested that ROTC programs at local colleges, as well as Junior ROTC programs at local high schools, could be another valuable community resource because they have the capacity to field disaster responses conducted by highly cohesive teams composed of community members. Additional training and coordination with local community agencies could significantly enhance the effectiveness of such a response system.

Mr. Leggette emphasized that building diverse coalitions is essential for effective advocacy, and that several groups in the county need such advocacy.

"For example, some migrant farm workers are unemployed because of COVID-19, so by at least one agency's definition, they are not currently farm workers," said Mr. Leggette. "Therefore, they can't apply for funds meant to support farm workers during the current crisis."

He continued, "Similarly, right after Hurricane Matthew, funding was justified based on one definition of homelessness, but one organization responsible for dispensing those funds insisted on applying a different, more narrow definition. Although the organization later applied both definitions in order to determine eligibility, their initial response kept many people from receiving needed assistance. Therefore, all of us must work together to encourage organizations and agencies to advocate collaboratively, reasonably, objectively, and equitably in order to connect those in need with the funds and resources that are available during disasters."

In his closing remarks, Mr. Leggette noted that a key aspect of effective disaster response is matching available resources with the needs of community members in ways that complement their own strengths and support community systems. This is the time to advocate for migrant workers' access to COVID-19 testing and benefits, not only because this is the right thing to do, but also because this protects and promotes the health of the entire community.

"And, whatever we do needs to be culturally competent and sustainable," concluded Mr. Leggette.

Editor's Note: Due to space limitations, this article with hyperlinks to resources and cited references is available at www.ncpsychiatry.org/robesoncounty. You may also email info@ncpsychiatry.org for a copy.

What Psychiatrists Need to Know About...

Telepsychiatry Lessons in the Age of COVID from the NCPA Addictions Committee

Something New, Something Gained...

April Schindler, M.D., PGY-4, Atrium Health; NCPA Addictions Committee Member

The pandemic interjected upon my third year of residency training, the traditional outpatient year. I was settling into the flow of clinics, gaining confidence in my practice style, and learning the art of psychotherapy.

When suddenly, COVID-19 changed everything. Seemingly overnight, my clinic schedule converted to phone and video services. Green scrubs replaced business casual attire; face masks replaced makeup. I staffed cases with my attending by FaceTime and had limited contact with co-residents by group texts and Zoom. This was not how I imagined residency.

In the midst of shelter-in-place chaos, an unexpected feeling of loss crept into the therapeutic milieu. I spent each day alone in an office, my book bag now occupying the seat normally held by my patients. I was already familiar with telepsychiatry, as our program integrates virtual care from our first year of residency. Now, talking to patients by phone or video felt strangely different than sitting together in the same space. What drew my attention to this change was when patients began commenting on how much they missed in-person visits.

I began to question, "Is there actually something missing?" Before the pandemic, I embraced telepsychiatry as the way of the future. I believed I was learning to provide cutting-edge care in a convenient, cost-effective, and patient-centered manner. Certainly, there are numerous benefits – my dwindling no-show rate proves that patients value this service. I also gain a newfound glimpse into their world, families, and lives. As a telemedicine advocate, I recall myself convincing applicants to our program, stating, "It's the next best thing to in-person care!" That is, until it was all we had.

Training in psychotherapy can be demanding even under ideal face-to-face circumstances. However, nothing in my training prepared me to read the subtleties of verbal and nonverbal communication solely via video or phone. Trainees in psychiatry around the globe are facing similar dilemmas, and it feels as though we are living a real-world experiment in treatment outcomes. The techniques and interventions we were taught are based on classical interactions, and the modalities we employ were developed for real-world, dyadic relationships. In real time, I am teaching myself to assimilate traditional methods with technological advances. At times, it feels like driving blind.

In the first week of virtual-only visits, I began psychotherapy with a new patient. The difficulty of configuring her iPhone with our "user-friendly app" proved beyond her level of technological ability. We proceeded with weekly psychotherapy by phone over the next four months. For my new phone-only therapy patient, I was no longer the observing witness to her story. I noted how I missed the body language, facial expressions, postural changes, gestures, and physiological undertones that are so telling of unspoken thoughts and feelings. Likewise, she missed mine.

Recently, she connected to the video app with assistance from her family, and we finally met "face to face." A powerful human moment transpired that confirmed to me something had indeed been missing. Our eyes met, we smiled at each other, and tears began streaming down her face. When encouraged to comment on the tears, she said, "I finally feel known."

As I enter my fourth year of "virtual psychotherapy" training, I ponder the centrality of attachment formation between therapist and patient. I wonder if the strength of attachment and the therapeutic alliance are at all dependent upon face-to-face, real-time conditions. I speculate on what may be sacrificed in emotional fluency of patient interactions by phone or video visits. I question how the interpersonal neurobiology of therapeutic interactions may be altered by virtual interface. I contemplate whether or not our mirror neuron systems couple virtually as they do when sharing the same three-dimensional space.

This case convinced me that video interactions capture communication nuances. However, my experience throughout this pandemic leaves me feeling like there may still be something missing from video visits. Of all we stand to gain from telepsychiatry, I hope genuine human connection is not lost for the sake of convenience.

...Things Change, We Adapt

Steven Prakken, M.D., NCPA Addictions Committee Member

Global events always stand out in history, and the COVID-19 pandemic is no exception. While its full impact on politics, economics, and health care are not yet fully known, some early lessons are quickly emerging. One such major change is telehealth.

I have followed the progression of telehealth peripherally over the years. As a psychiatrist also boarded in pain management, I care for some of the most difficult patients in medicine and prescribe some of the most dangerous medications. Thus, I thought telehealth would never directly involve me. I knew that contact in the room was far too important. How could one fully evaluate pain and the subtle nuances of mood and personality, while also considering the impact of the use (and misuse) of opioids, in addition to considering underlying TBI, ADHD, SUD? Without being in the room together, how could Motivational Interviewing be used to move all of that in a more functional direction against the resistant winds of the patient's fears and fixed beliefs? No way! Telehealth might work for others, I thought, but not for my complicated practice.

Then, COVID flew into town and blew my fixed beliefs right out the window. In-person visits were suddenly discontinued, yet treatment needed to continue. I had to immediately adjust to working initially only with telephone connection because of the strictures of my institution, then transition to video. What transpired has been surprising and instructive.

I was certain that the relationship would be profoundly different. Connection is the foundation of all other elements of treatment. If missing, or substantially blunted, the treatment can't work. To my surprise, I quickly found that with patients I had seen before, the connection was unexpectedly solid. Even on the phone, I could "feel" their smile, anxiety, blunted emotions, or irritability quite similarly to if we were physically together. These patient-specific patterns and dynamics were a known entity, thus reproducible and understandable even with electronically filtered cues. Spontaneous conversations about how it felt on their side reinforced that this was a mutual perception.

As I was starting to feel more confident about my ability to master this brave new world, I saw on my schedule that new patient intakes had been scheduled. New intakes were not supposed to occur, as per COVID protocol. But there they were, and I decided to give it a try. Initial patient assessments are a challenge in Psych/Pain. Obtaining a detailed history, exploring personality elements, medications used and misused, along with their impact, is imperative. The real challenge and impact, however, comes from synthesizing data and clinical observations into a cohesive piece, reflecting it back to the patient, and moving in a direction they will likely be ambivalent about (e.g., decreasing opiate use) within a newly minted 45-minute long relationship. I was shocked it still worked. Even with a few cases of substantial TBI, habitual medication misuse, or even Opiate Use Disorder, I found that trusting connection could be made and movement initiated if I stayed in my usual mental framework of curiosity, non-judgment, dynamic thinking, and education.

It also turned out telehealth difficulties other than relational ones were manageable. It required some creativity, but it was possible. In Pain/Psych some common challenges actually became easier. Pill counts done on-screen in real time preclude a patient being able to say they forgot to bring the right pills from home. Obtaining collateral information is easier as family members are typically there in the background. Functional assessments are more robust when one can actually see the inside of the house, the chair the patient sits in too much, the domestic disarray caused by immobility. Urine Drug Screen (UDS) testing can even be done by local labs. Some UDS screening groups travel to a patient's home with 24-hour notice, a better set-up than UDS done in-clinic, which the patient knows about months in advance.

My current conclusion is that telehealth is about 80% as effective as face-to-face contact. The 20% loss is still within relationship nuances for which face to face contact is essential. Though not a perfect solution, telehealth permits contact with individuals who are not able to access effective treatment in other ways. It is absolutely crucial for Population Care models, which are currently growing exponentially, particularly for subspecialty treatment options.

The survival of telehealth is in the hands of the payors. To date, they have supported telehealth expansion through equitable payment policies. Hopefully, these policies will not change substantially, if at all, post-COVID. Some early data even implies that outcomes are better and total cost of care lower with the use of telehealth, seemingly related to improved patient access to care. Psychiatry may stand to benefit more than other specialties given the extent of underserved psychiatric patients in rural areas. However, telehealth psychiatry access will need to be consistently supported by pricing policy, or once again these patients will be without treatment.

Who says you can't teach an old dog new tricks? With the support of tech-savvy grown kids and a modicum of swearing at failed technology/poor internet connection/lack of institutional infrastructure, I made the leap into telehealth to diagnose, treat, and maintain relationships with even my most complicated patients.

Resident Spotlight: Jeanne Spurlock Congressional Fellow Brings Ohana Spirit to Washington

Anthony Kulukulualani, M.D., PGY-3, East Carolina University

"Ohana means family and family means nobody gets left behind or forgotten."

As I watched the movie *Lilo and Stitch*, memories of my home resurfaced. The chocolate melted in its box, exposing the macadamia nut. This traditional candy was my favorite on a hot summer day in Hawaii. I glanced inside the house from the porch steps for a sign of my grandmother. I knew she was scraping together change to give to the young lady who sold her cosmetics, but I never understood why at the age of sixty my grandmother still needed these things. She came out, grabbed a candy, and sat down. I decided to ask her about it and her reply was simple, "Because Keoni, everyone here is family, and we need to help each other out when we can. That is what family does."

In retrospect, my grandmother's explanation has been the cornerstone of my life. Her diagnosis of breast cancer inspired me to pursue a career in medicine, but being 4,500 miles from Hawaii has been a tough challenge. I moved from Hawaii to North Carolina as a child because my dad was in the military. It was a change that shaped the trajectory of my life. As a Native Hawaiian raised in the South by a Hawaiian mother and African American father, my cultural identities were virtually unknown to those around me. I was a minority among minorities, or as a friend once said, "You're an army of one." Not only was it extremely rare to encounter a fellow Hawaiian here, but it was nearly impossible to meet someone with my distinctive background. However, because of my grandmother, I recognize the importance of building connections with my surrounding community. I have pursued various leadership opportunities to achieve this. These experiences have taught me how to integrate my cultures into the mainstream. Despite obvious differences between myself and others, I can now find similarities so that I am able to better relate to people. This has helped me let go of that long-ingrained feeling of being different and narrow the cultural distance that I so often felt as a young man.

> *Diversity and leadership have played major roles in my life. I understand the importance of serving as a voice for diverse patients in a system that is complex and difficult to navigate.*

One of my current leadership positions is through the American Psychiatric Association's Jeanne Spurlock Congressional Fellowship, which provides psychiatry residents or early-career psychiatrists with an interest in child and/or minority mental health advocacy to work in a congressional office. I interviewed with several offices through the fellowship, and I decided that the office of Senator Tina Smith was the best fit for me based on similar interests in health care issues. Some of those issues include the COVID-19 pandemic and its multi-faceted impact, telehealth, health equity and the need for culturally competent care, rural health, and health care costs. I hope to learn more about these issues through the lens of federal legislation and advocacy while I immerse myself in the governmental process from within the system itself.

Diversity and leadership have played major roles in my life. I understand the importance of serving as a voice for diverse patients in a system that is complex and difficult to navigate. I began medical school wanting to support minority medical students, address health care disparities, and help augment the number of culturally competent and socially conscious physicians. I am excited that this fellowship will help me accomplish these goals. By doing so, I will ensure that with a strong conviction of the ohana spirit, no patient is left behind, or forgotten.

Concerns About Police Misconduct Should Spur Reform, Funding for Civil Commitment Process

Marvin Swartz, M.D., D.L.F.A.P.A.

Reprinted with Permission from NC Policy Watch *(August 19, 2020)*

The plague of police misconduct has rightfully been in the public spotlight in recent months, but an important aspect of this problem and source of frequent conflict still needs much more attention: the challenge of enforcing civil commitment laws.

http://www.ncpolicywatch.com/wp-content/uploads/2020/08/AdobeStock_mentalhealth-commitment.jpg

Involuntary civil commitment is a well-established and necessary system under which judges have the authority to order needed treatment for persons with mental illness who are considered dangerous to themselves or others.

Unfortunately, because of several factors, law enforcement encounters during involuntary civil commitment all too often lead to violence – especially for people of color.

To begin with, persons subject to civil commitment are often treated like persons accused of crime. They are typically taken into law enforcement custody and often handcuffed or restrained while in transit to treatment facilities and courthouses for commitment hearings. It's the rare person that doesn't find these custody and transport procedures disturbing and disrespectful of their dignity.

This situation is made even worse by the fact that police and other law enforcement officers typically receive limited training in working with persons with mental illness. The potential for injustice is further heightened by the endemic problems of racial discrimination, poverty and the social stigma associated with mental illness. In addition, persons of color are disproportionately subjected to involuntary civil commitment as a means to gain access to limited state-funded treatment because they often lack insurance.

Fortunately, reducing police encounters with persons in civil commitment is possible and can serve as an important step toward reducing potentially tragic law enforcement interactions. (As a corollary, reducing the rolls of the uninsured through Medicaid expansion would also greatly reduce the need for involuntary commitment when it's used as a mechanism to access state-funded care.)

Recall that in medical emergencies, the majority of patients are transported by trained emergency medical personnel. Unfortunately, most cities and counties in North Carolina still rely on law enforcement to transport persons with mental illness under civil commitment; at times, local governments even initiate involuntary commitment to provide "free" transport of individuals who otherwise would sign into treatment voluntarily.

Such transport and long waits during evaluations are a major and unwanted drain on law enforcement officers. Families and friends are also often disinclined to pursue commitment to help their loved ones, fearing it could cause more harm than good.

To their credit, the North Carolina General Assembly and Gov. Cooper enacted reform legislation in the involuntary civil commitment process to reduce law enforcement involvement in civil commitment via Senate Bill 630 [2] in 2018.

SB 630 sought to advance several critical innovations and to set another course while we await broader reforms. It asks counties to rethink their civil commitment

custody and transportation plans. It asks them to seek alternatives such as secure transport services or ambulances. It also actively discourages unnecessary use of restraints or handcuffs while the persons are in custody and offers de-escalation training to officers.

Finally, because most civil commitment hearings for individuals require transport to public courthouses, the law now promotes use of video evaluations of persons in crisis to reduce the need for law enforcement transport. This avoids the painful and embarrassing specter of transporting individuals with mental illness, especially persons of color, children and the elderly, in handcuffs for their day in court.

Unfortunately, for all of the good ideas in SB 630, the state has yet to provide the necessary funding to fully implement it. To date, few counties have implemented video for use across the commitment process. The COVID-19 epidemic alone offers important reasons to reduce unnecessary law enforcement custody and transport.

The heightened attention to racial justice and the COVID-19 epidemic offer compelling rationales to encourage these humane and just reforms. We can and should champion the use of video commitment examinations and subsequent court hearings to enhance the privacy and dignity of civil commitment while we await other needed reforms to improve access to voluntary treatment such as Medicaid expansion. Video offers greater safety, privacy and enhances dignity for persons in crisis. Such changes offer a solid first-step in reforming involuntary commitment. Now is the time to hasten these needed reforms.

Dr. Marvin Swartz is a professor of Psychiatry and Behavioral Sciences in the Duke School of Medicine and a faculty member of the Duke Law, Center for Science and Justice.

URL to article:

http://www.ncpolicywatch.com/2020/08/19/concerns-about-police-misconduct-should-spur-reform-funding-for-civil-commitment-process/

Classified Advertisement

Physician Inpatient Behavioral Health Opportunities:
Caldwell Memorial Hospital - Lenoir, North Carolina

Atrium Health is seeking a dynamic BC/BE Psychiatrist to join our thriving, inpatient behavioral health team at Caldwell Memorial Hospital, located amidst the beautiful foothills of the Blue Ridge Mountains in Lenoir, North Carolina. Our collaborative team model pairs Psychiatrists with an advanced practitioner to provide full coverage of the unit in a seven on/seven off schedule.

The call schedule for this unit is two weeks of the month with one week working as primary call and the other providing back-up for the advanced practitioner partner.

Schedule: 7 Days on/7 Days off BC/BE Psychiatrist

POC: timmy.coleman@atriumhealth.org

Atrium Health

Will the sessions be recorded so I can watch them again later?

We've got you covered! All 14 CME sessions will be recorded, including the live Q&A with each speaker. If you register to attend the live Annual Meeting from October 2-4, you will have access to the meeting platform for several months past October. Access includes the ability to watch the lectures again, download the PowerPoint slides and other materials, revisit the Virtual Exhibit Hall, and find your CME information.

Do I have to watch sessions at the scheduled times?

In order to claim CME credit, you must log into each session at the scheduled time during the weekend of the meeting. For CME purposes, we must keep record of who logged into each session at some point during the scheduled time. However, if you must step away from the computer for a brief moment, you will still receive credit. You will have access to rewatch the few minutes you missed (or the entire lecture) after the meeting ends.

Can I watch with my spouse or a small group?

Yes! Make it a (COVID-approved) party! If you'd like to view the meeting with another registered attendee — spouse, friend, or coworker — go for it! For CME purposes, please be sure to email info@ncpsychiatry.org to let us know which session(s) you watched and who was present. We will be sure those names are counted on the attendance log. Please note: Each person claiming CME must individually register for the meeting.

I miss social interaction! Can I mingle with attendees?

NCPA worked hard to select a virtual meeting platform with networking capabilities for attendees. The platform we have chosen is called PheedLoop, and registered attendees will receive an email with detailed instructions on how to set up your account and log into the platform. (Please take a few minutes to set up your account in advance so that you are familiar with the platform.) Once there, you will be able to see who else is logged into the meeting space. If you would like to start a conversation with that person, you can either send them a message or even invite them to join you in a one-on-one video chat!

How many CME credits can I earn this year?

The APA designates this live activity for a maximum of *12.5 AMA PRA Category 1 Credits™*. Our meeting platform, PheedLoop, will help you keep track of which sessions you attended so you know exactly how many credits you earned. At the conclusion of the meeting, you will receive further instructions on claiming credit.

Are out-of-state physicians and other non-physician mental health professionals welcome?

Of course! Please invite your friends and colleagues. Generally, the meeting is intended for psychiatrists, psychologists, primary care physicians, nurse practitioners, nurses, physician assistants, social workers, and administrators.

What about the Annual Business Meeting?

Glad you asked! Both NCPA and the NC Council of Child and Adolescent Psychiatry (NCCCAP) will still host Annual Business Meetings for members of their association only. The NCPA Annual Business Meeting will take place from 4:00-5:30 pm on Saturday, October 3. The NCCCAP Annual Business Meeting will take place from 8:00-9:00 am on Sunday, October 4. As these meetings will be held via Zoom, all members - regardless of conference attendance - will be able to participate. The Zoom meeting links that will be distributed at a later date.

What's a Virtual Exhibit Hall? Are any prizes up for grabs?

We know you'll miss taking home a tote bag stuffed to the brim with pens, koozies, candy, and business cards. But you will still get to network with our awesome exhibitors and sponsors. Looking for a new job? Interested in hearing about that new treatment center that just opened up? Want to say hello to a friend you've seen at every meeting for the past decade? Hop over to the Virtual Exhibit Hall! We're keeping the Exhibitor Bingo tradition alive, this year offering Amazon gift cards and free registration for next year's meeting as prizes!

How much is registration?

Due to the nature of a virtual meeting, we were able to significantly reduce the cost of registration. (Food is expensive!!) The quality of the meeting content and experience, however, will be comparable to our in-person events. The fee is $225 for NCPA/APA members and NCCCAP members; $275 for non-members; and $20 for psychiatry residents & medical students.

What a bargain! But come on, how fun could it really be?

You know it!! If you've ever been to a NCPA Annual Meeting, you know we're all about making the event feel special and different from other conferences throughout the year. Make sure you read this newsletter cover to cover to learn what you can expect.

We've got a virtual cocktail hour, morning yoga session, women in psychiatry lunch, and even a "Plague Doctor of Prague" virtual walking tour that you can enjoy with your family on Saturday evening. (Perfect if you're out of Netflix options!) Guided through Prague's cobblestone streets by a "Plague Doctor" in the original dress of those who fought the Plague in 1713, the interactive tour will cross the famous Charles Bridge, stop at the old St. Francis hospital, and conclude at the St. Agnes convent. The best part is all those activities and more are included in your registration fee!

Wow, that doesn't sound like a regular, old Zoom meeting! Where do I register?

We're so happy to hear that! You can register on the NCPA website or visit http://bit.ly/ncpsych20 to go straight to the registration page. If you have any other questions, give us a shout at info@ncpsychiatry.org!

Note: Program schedule subject to change at any time. Please visit http://bit.ly/ncpsych20 for the latest updates.

Friday, October 2

5:00-5:15 pm — ***Welcome Remarks***
Zach Feldman, M.D., F.A.P.A., NCPA President

5:15-6:15 pm — ***Top Research Findings of 2019-2020***
Chris Aiken, M.D., D.F.A.P.A.

6:15-6:30 pm — Break; Virtual Exhibit Hall

6:30-8:00 pm — Panel Discussion: ***A Conversation about Race, Trauma, and Resiliency***
Victor Armstrong, M.S.W. (Moderator); Karon Dawkins, M.D., D.F.A.P.A.; Constance Olatidoye, M.D.; Christina Cruz, M.D.

8:00-9:00 pm — Virtual Cocktail Hour & Exhibit Hall

Saturday, October 3

8:00-9:00 am — Morning Yoga, Sponsored by HopeWay; Virtual Exhibit Hall

9:00-10:00 am — ***Psychobiology of Insomnia***
Vaughn McCall, M.D.

10:00-10:15 am — Break; Virtual Exhibit Hall

10:15-11:15 am — ***10 Ways that Evidence Changes Practice: Updates from the Psychopharmacology Algorithm Project***
David Osser, M.D.

11:15-12:30 pm — Product Theater, Hosted by Sunovion (optional, no CME credit); Virtual Exhibit Hall

12:30-1:30 pm — ***The Psychiatric Toll of COVID-19***
Richard Weisler, M.D., D.L.F.A.P.A.; Allan Chrisman, M.D., D.L.F.A.P.A.

1:30-2:30 pm — ***New Approaches to Postpartum Depression***
Samantha Meltzer-Brody, M.D., M.P.H.

2:30-3:00 pm — Wellness Break: "Drawing Your Breath" Art Therapy Activity, Sponsored by HopeWay; Virtual Exhibit Hall

3:00-4:00 pm — ***Clozapine and Schizophrenia: Improving Outcomes While Managing Risk***
Fred Jarskog, M.D.

4:00-5:30 pm — NCPA Annual Business Meeting

5:30-7:00 pm — Dinner Break; Virtual Exhibit Hall

7:00-8:30 pm — "Plague Doctor of Prague" Virtual Walking Tour (Families Welcome!); Virtual Exhibit Hall

Sunday, October 4

8:00-9:00 am — NCCCAP Annual Business Meeting; Wellness Break: Metta Meditation, Sponsored by HopeWay; Virtual Exhibit Hall

9:00-10:00 am — **CONCURRENT TRACKS**

General Track: ***MDMA-Assisted Psychotherapy, a Novel Experimental Treatment for PTSD***
Michael Mithoefer, M.D.

NCCCAP Child & Adolescent Track:
Explosive Outbursts in Youth: Coming Together to Treat the Sickest Kids
Gabrielle Carlson, M.D., AACAP President

10:00-10:15 am — Wellness Break: "Mindful Eating" Nutritional Wellness Activity, Sponsored by HopeWay; Virtual Exhibit Hall

10:15-11:15 am — **CONCURRENT TRACKS**

General Track: ***Understanding & Treating Depressive Mixed States***
John Beyer, M.D.

NCCCAP Child & Adolescent Track:
An Uncomfortable Truth: Structural Racism and Dichotomy in Diagnosis and Treatment of Irritability and Outbursts in Youth
Lisa Cullins, M.D.

11:15-12:30 pm — Women in Psychiatry Lunch; Virtual Exhibit Hall

12:30-1:30 pm — ***Treatment of Sexual Dysfunction in Women***
Anita Clayton, M.D.

1:30-2:30 pm — ***Neural Mechanisms of Social Reward***
Robert Malenka, M.D., Ph.D., V. Sagar Sethi, M.D. Mental Health Research Award Winner

2:30-3:00 pm — Break; Virtual Exhibit Hall

3:00-4:00 pm — ***Collaborative Care to an SMI Population***
Michael Zarzar, M.D., D.L.F.A.P.A., NCPA Vice President

4:00-4:05 pm — ***Closing Remarks***

Meeting Adjourns

Accreditation: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and the North Carolina Psychiatric Association. The APA is accredited by the ACCME to provide continuing medical education for physicians. Designation: The APA designates this live activity for a maximum of *12.5 AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NORTH CAROLINA
Psychiatric
Association

North Carolina Psychiatric Association
A District Branch of the American Psychiatric Association

4917 Waters Edge Drive, Suite 250
Raleigh, NC 27606
P 919.859.3370
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All NCPA members are eligible for special discounts. Mention this newsletter for 15% off your next ad!

Calendar of Events

Every Thursday, 1:00-2:00 p.m.
NCPA Doctor's Lounge
After holding Thursday evening Living Room Chats since March, we are switching to a lunch hour to give more folks a chance to join us in the "Doctor's Lounge." Check email for Zoom link.

October 2-4, 2020
2020 NCPA Virtual Annual Meeting
Attend this year's Annual Meeting & Scientific Session from the comfort and safety of your own home! For registration information, please visit http://bit.ly/ncpsych20.