NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SEPTEMBER 2024

"LA CULTURA CURA:" HISPANIC HERITAGE MONTH AS MENTAL HEALTH

Luke Smith, M.D.

Born in North Carolina and raised by Mexican parents, Deyanira is starting her first year at college. As a lead up, she recently attended a student conference in New Mexico where she was excited to meet with other Hispanic students from across the US. In particular, she looked forward to enjoying what she hoped would be authentic Mexican food. She reasoned that being closer to the Mexican border would afford her unfiltered tastes of her parents' homeland!

Unfortunately, it was a bit disappointing. Deyanira found hard shell tacos, pizza, and chain food restaurants. It was very different from the traditional Mexican food she's used to here in North Carolina where many small tiendas and Mexican restaurants sprouted up over the last two decades, serving authentic dishes very different from Taco Bell. When her mother told me of Deyanira's experience, she used the Spanish word "conquistador," likening the Americanization of cuisine in New Mexico to the cultural domination and purging of Latin-American traditions. In reality, cultural conquistadora activity is often subtle but very influential and at times may not even be intended. In her adolescence Deyanira grew up living in two worlds – at home with her Mexican parents and at school with her American friends, which was difficult to navigate culturally and socially. She often felt like hiding her Mexican identity and yielding to the dominant American culture. Sadly, this was because she experienced discrimination against her, many times overt and shaming.

Deyanira is not alone. North Carolina has seen unprecedented growth of the Latino community in recent years. The population surged to over a million residents, and now one out of every 10 North Carolinians identifies as Hispanic or Latino (actually, most will tell you they are neither Hispanic or Latino but instead will proudly say they are Mexican, Honduran, Colombian or wherever their country of origin is). One of every five students is Latino. The growth may be felt most in rural areas across North Carolina where Latino pop-

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The *NCPA News* is a publication of the NC Psychiatric Association, 222 North Person Street, Suite 012, Raleigh, NC 27601.
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PRESIDENT'S CORNER

Therese Garrett, M.D., F.A.P.A., NCPA President

Last year, NCPA implemented something new at the Annual Meeting, with our Pre-Conference focused on workplace violence within mental health settings. As there are multiple other areas of important clinical focus, the program committee has decided to continue this endeavor with our Pre-Conference program this year focused on High Suicide Risk. In 2022, visits to the ED for suicidal ideation topped more than 50,000 in North Carolina, with close to 15,000 visits for self-inflicted injuries.[1] Our Pre-Conference is focusing attention towards this topic, not just on assessment and treatment of patients with suicidal ideation, behavior and risk, but also on how suicide impacts us as psychiatrists.

The increased attention to suicidality and self-inflicted injury is happening in NC through the expansion and continued of the UNC Suicide Prevention Institute, with the first Statewide Suicide Prevention Summit in June of this year. NC DHHS continues to focus on supports to prevent suicide through increased crisis resources and the crisis service continuum, as well as 988 and the new NC Peer WarmLine (1-855-PEERS-NC). In its second year, NC's 988 has had a contact volume of 112,757, with 45% of callers as repeat callers.[2] This uptake of people calling for support demonstrates the level of previously unmet need, and the opportunities we have to continue to find more upstream support.

In April, the US Department of Health and Human Services announced a 10-year national strategy for suicide prevention, focused on four strategic directions: community-based suicide prevention; treatment and crisis services; surveillance, quality improvement and research; and health equity in suicide prevention.[3] From a suicide prevention strategic lens, a large percentage of psychiatrists sit primarily in the 'treatment and crisis services' area of suicide prevention. We join with our patients in a therapeutic relationship to build and maintain lives worth living. Depending on our job setting, we may have less line of sight into community-based prevention or population health research.

We can look towards opportunities for involvement in larger scale population-based work. The national strategy for suicide prevention calls us to action in addressing all four of their strategic directions through ***Care. Connect. Collaborate.***

- ***Care:*** *Caring about suicide prevention requires a thoughtful strategy and the intersection of prevention, intervention and postvention supports.*
- ***Connect:*** *Connecting to community and culture are key protective factors for health and well-being, including protecting against suicide risk. Connecting with data and research helps inform efforts and improve the ability for effective suicide prevention strategies.*
- ***Collaborate:*** *Carrying out a comprehensive approach relies on collaboration with public and private sector partners, people with suicide-centered lived experience, and people in populations disproportionally affected by suicide and suicide attempts. Everyone has a role to play in achieving meaningful, equitable and measurable advancement in suicide prevention.*[4]

Consider joining us this year to learn more during the High Suicide Risk Pre-Conference, or during any of the child plenary sessions also focused on youth suicide. Throughout the didactic portions as well as the social and networking events, you will have the chance to connect with others working in or passionate about suicide prevention. Beyond the Annual Meeting, I challenge you to go deeper through further exploration of local, state and federal priorities for suicide prevention. Consider seeking out opportunities for involvement in suicide prevention, whether through advocacy, community engagement, volunteerism or your professional clinical work or research.

Therese Garrett, M.D., F.A.P.A. is the Behavioral Health Medical Director at WellCare Health Plans, and a psychiatrist at the NC State University Counseling Center.

MORAL INJURY VS BURNOUT

Jennie Byrne, M.D., Ph.D., D.F.A.P.A.

In 2022, I wrote my first book, *Work Smart: Use Your Brain and Behavior to Master the Future of Work.* I wanted to share how we could use an understanding of the human brain and behavior as a guide to infusing more humanism and connectedness into the ways we work.

In the process of writing, I learned more about the concept of burnout. The literature showed that burnout makes workers feel terrible and dramatically worsens productivity. Worse, many workplaces harm the mental and physical health of its human workers.

Healthcare is no different from other toxic environments. In fact, healthcare workers, especially clinicians, are reporting record rates of burnout. As a psychiatrist, I was alarmed to learn that one 2020 survey showed that 78% of psychiatrists self-reported burnout (Summers et al. 2020).

Curious, I asked my physician colleagues about their experience with burnout. When I had a conversation with a fellow psychiatrist in North Carolina, **Dr. Warren Kinghorn**, what he said clicked.

Dr. Kinghorn shared the concept of "moral injury," a type of wound to the human soul, which immediately resonated with me. I personally do not feel burned out in my career. However, I do still bear the scars and some festering wounds from my decades as a practicing psychiatrist and a healthcare leader. Dr Kinghorn referred me to the moral injury literature, and I started educating myself about this topic.

One early leader in the field of Moral Injury in healthcare is Dr. Wendy Dean. She practiced as both a psychiatrist and an emergency room physician. In a seminal 2018 article, Dr. Dean and her colleague Dr. Simon G. Talbot clarified the difference between moral injury and burnout (Dean and Talbot 2018):

"Physicians on the front lines of health care today are sometimes described as going to battle. It's an apt metaphor. Physicians, like combat soldiers, often face a profound and unrecognized threat to their well-being: moral injury."

They went on to describe the difference between burnout and moral injury. Burnout is a "constellation of symptoms that include exhaustion, cynicism, and decreased productivity." Moral injury in healthcare "is not the offense of killing another human in the context of war. It is being unable to provide high-quality care and healing in the context of healthcare."

They made this salient point: "In order to ensure that compassionate, engaged, highly skilled physicians are leading patient care, executives in the healthcare system must recognize and then acknowledge that this is not physician burnout. Physicians are the canaries in the health care coal mine, and they are killing themselves at alarming rates (twice that of active-duty military members) signaling something is desperately wrong with the system."

The Industrialization of Medicine - The Factory Floor Model

I interviewed over 30 people for this book, including fellow psychiatrists and psychiatry residents. Time and time again I heard a similar refrain: Clinicians and patients alike feel like "cogs in a machine."

Many blame the for-profit corporate system, but others have a more nuanced view. They point to the complexity of medical care in our country today, the need for speed and efficiency, and the avalanche of data now available to guide care.

Burnout is an industrial term that imagines clinicians and patients as cogs in a machine. To fix burnout, you make the machine more efficient, and you recharge the energy level of the clinician. But despite solutions to be more efficient and effective, something is still deeply wrong.

I believe we are missing the point when we talk about fixing burnout. Fixing burnout implies that we, as psychiatrists, are a burned-out light bulb that needs to be recharged or replaced. As psychiatrists, we know that

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What Psychiatrists Need to Know About...

ADVANCEMENTS IN ADDICTION TREATMENT

Eric Morse, M.D., D.F.A.P.A.

In the past year, there have been some very important regulatory changes in the opioid treatment program/ methadone clinics (OTP) world. Medical providers working in OTPs an now admit teenagers using telemedicine regardless of trying/failing two detoxifications (now known as withdrawal management). Clinicians can now admit people who have been using opioids less than one year.

Medical providers can now use their best, individualized medical decision-making and give up to seven methadone take-homes on day one and new patients can be started on doses up to 50 mg of methadone (the maximum previously was 30 mg). Medication units and mobile vans have been encouraged by Substance Abuse and Mental Health Services Administration (SAMHSA) and North Carolina is working on the regulations and application process whilst I am writing this article. Mobile clinics will increase access to care. Mobile vans need to park for an hour or two every day at the same locations that are approved by the Drug Enforcement Administration (DEA), NC State Opioid Treatment Authority (NCSOTA) and NC Division of Health Services Regulation. They cannot drive to a patient's house and drop off.

OTPs and NCSOTA have worked hard to get NC county detention centers to follow federal law and allow our incarcerated patients to continue their methadone or buprenorphine treatment. The county-determined opioid settlement funds are helping with the added costs. This endeavor has not been easy. I have filed my fair share of Americans with Disabilities Act (ADA) complaints, spoken with their medical providers, sheriffs, jail captains, county managers, county attorneys, and jail nurses to make certain that my patients' rights are not violated.

The NC prison system is making changes too. Getting nursing homes to accept our patients on medications for Opioid Use Disorder (MOUD) seems to be improving as well. Many formerly abstinence-based rehabs are beginning to allow for MOUD so they can be eligible to receive opioid settlement funds as well. Money sometimes talks.

The other big change is that Brixadi has joined Sublocade on the market of injectable buprenorphine. Brixadi comes in three doses, in weekly and monthly options, and in a smaller bolus and needle. The Risk Evaluation and Mitigation Strategies (REMS) and NC Legislation have changed allowing NC pharmacists to order and administer these medications (once they have done the proper training). Previously Sublocade and Brixadi had to be ordered from specialty pharmacies and the clinician had to be present and sign for them at delivery. Now it is much easier. Any prescriber can prescribe them.

Most of the admissions that I see in my OTPs are not using pain pills or heroin anymore. It is mostly street "Fentalogs" (carFentanyl derivatives). Xylazine, medetomidine, and nitazenes are now in our fentalog street mixtures, making buprenorphine inductions and precipitated withdrawal more challenging. Methadone does not precipitate withdrawal. We have had success

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FILLING THE GAP

Vivian Campbell, M.D., L.F.A.P.A.

For the past year, I have been working exclusively by video telepsychiatry from home. It has been aconvenient alternative to traditional interim work, which I had done intermittently over the years, primarily by going physically to a location. We know there is a shortage of psychiatrists and other psychiatric prescribers. I was drawn to the opportunity for change that comes with working for different facilities every several months in addition to the flexibility of working from home.

I provide gap coverage, so usually, I see the patient because there is no one else to do so, and hiring is underway for a permanent provider. My role as the gap provider has a lot to do with the definition of "gap" by the person on the other side of the screen, whether that person is a facility staff person or the patient. As I enter my second year in this role, I am learning to explore these expectations with patients and the variety of clinical and administrative staff.

To quote Stephen Covey, I try to begin with the end in mind. I explain my role to the patient as being a Mary Poppins of sorts. If I know how long I will be helping their facility, I will share that information. This may be their first interim provider appointment as a new or established patient. For some, there may have been a few people who provided medication management over an extended period. Additionally, the use of telepsychiatry may not be the preferred modality for some people. I focus on how we can meet their needs and shorten their wait. I inquire about what brings them to the appointment and remain open to the fact that their response may be different from the response in their screening. In addition to addressing medication, they may want to express sorrow at the loss of their psychiatrist and talk about what the psychiatrist meant to them. I encourage optimism that they will be part of another good treatment relationship. If they just want to get the medication refilled and spend as little time as necessary with the person who is not going to be their permanent psychiatrist, then I respect that choice as well. Usually, the patient's chief concern starts with something about themselves, their lives, or their medication, but sometimes it starts with something about me, specifically my demographics.

I have learned there may be further renegotiation of the purpose of the appointment when my demographics matter. The experience with a recent patient was illustrative of what often becomes meaningful to the patient the moment my brown face appears on their screen. It has been a long time since I met a patient who told me they had never had a black doctor or therapist. I have been practicing in an urban southern city, so I was taken aback when I heard this from her. I was scheduled with an African-American patient whose doctor of many years had retired. In fact, she was satisfied with the medication she was prescribed for a thought disorder. A review of her record indicated her symptoms had been stable for an extended period of time. I expected the needed assessments would fit into the time allotted.

She raised a concern that seemingly she had not raised with her previous psychiatrist, that her family and religious community did not support her getting the mental health care that was effective for her. She felt emotionally isolated though she saw them regularly, and she wanted to talk about that.

Additionally, she quickly began to give me the rundown of her medical conditions and recent medications for non-psychiatric purposes that went beyond the usual review of systems.

While I was grateful for her trust, I obviously could not reassess her decades of health care in the 30 minutes I had to review her chart, interview her, write medication orders and complete her note. From the patient's perspective, the purpose of the appointment was a diagnostic reassessment from someone who looks like her. It is not surprising that a patient may seek a second opinion of sorts when seeing a new provider. My experience has been that this happens more often when we have this demographic concordance, and it is not reflective of the patient's diagnosis.

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MEMBER SPOTLIGHT
DONALD BUCKNER, JR., M.D., D.L.F.A.P.A .

In the rugged beauty of rural Appalachia, where rolling hills and tight-knit communities define daily life, **Donald Buckner, Jr., M.D,. D.F.A.P.A.** has spent his career weaving a tapestry of mental health care that has touched countless lives. With this member profile, Dr. Buckner highlights the needs and opportunities of practicing in rural communities as well as the challenges of delivering behavioral health care to western NC.

Dr. Buckner studied chemistry at North Carolina State University before completing his medical degree, residency and child and adolescent fellowship at the University of North Carolina Chapel Hill. Since that time, he has worked in many areas of psychiatry including college mental health, private practice, community mental health, and Indian health service caring for the mental health of western North Carolina as well as held many leadership positions including NCPA president (2017-2018). At this point, he is balancing his role as an educator as a community faculty for MAHEC, medical director for Meridian Behavioral Health Services-Blue Ridge Health, and an active member of his larger community.

For Dr. Buckner, the practice of mental health care in Appalachian communities is both rewarding and challenging. He fondly describes the adventures of being part of a rural ACT team, with long drives and beautiful landscapes to the encounters with uncommon pets and helping fix the concrete needs of patients, like a broken appliance. It is not uncommon to have patients drive across several counties to access care, and while

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Illustrations by Jenny Buckner

telemedicine has been able to improve some access, highspeed internet is not widely available and continues to be a barrier. Many areas are affected by the opioid epidemic and financial stressors, particularly as industrial closures can lead to loss of income and insurance for much of a community.

Rural practices can be professionally isolated compared to training with inherent community and mentorship. Dr. Buckner encouraged trainees and early career psychiatrists interested in rural practices to keep in touch with the NCPA committees that are actively working on practice issues in the state and engage with your local LME/MCO to be a clinical resource and advocate for the specific mental health needs of the communities served. One area that Dr. Buckner specifically worked on with NCPA was the development of "A Psychiatrist's Tookit: Supervising NPs and PAs." Dr. Buckner described the hiring and retention difficulties that plague rural mental health and how working with advanced practice providers improves rural access to care. With the seemingly rapid expansion of training programs, he highlights the importance of reviewing clinical experiences, competencies and weaknesses early, setting clear practice standards, and providing additional support and supervision than minimally required. He has found success with having trainees within his clinic to develop an appreciation for the mission and community, then hiring them after completing their clinical training to expand access to care.

Outside of his professional endeavors, Dr. Buckner has enjoyed being an active member of his community, coaching youth sports, and being active in his church. As we shine a spotlight on Dr. Buckner's remarkable career, we celebrate not just his professional achievements but also his profound impact on rural mental health, promoting best practices, and providing care where it's needed most.

DISASTER PREPAREDNESS & RESPONSE RESOURCES

View this resource to help understand how psychiatric care can be integrated into disaster response systems in order to effectively provide medical assessment, treatment, and consultation.

2024 Meeting Schedule

PRE-CONFERENCE

Thursday, September 26

Noon: Registration
1pm: Recent Developments in the Assessment of Suicide Risk *Nate Kimbrel, Ph.D.*
2pm: Our Primary Adverse Event: The Impact of Patient Suicide on Psychiatrists and Psychiatry Residents *Joan Anzia, M.D., D.L.F.A.P.A.*
3:15pm: Managing Post-Hospitalization for the Suicidal Patient *Danielle Lowe, M.D., Ph.D.*

ANNUAL MEETING

Thursday, September 26

2pm: Registration
6pm: Welcome Reception

Friday, September 27

7am: Breakfast with Exhibitors
8am: Fully Virtual Practice and Standards of Care *David Cash, J.D., L.L.M., Miriam Clarke, D.O. & Nate Sowa, M.D., Ph.D.*
9:30am: Cannabis Legalization in Canada: The Good, The Bad, and The Ugly *James MacKillop, Ph.D.*
11am: Fractured: Mental Health Crisis within the Criminal Justice Systems *Carrie Brown, M.D., M.P.H., D.F.A.P.A.; Dana Ervin; Brian Sheitman, M.D.; Sherif Soliman, M.D.; Warren Steinmuller, M.D., L.F.A.P.A.; & Marvin Swartz, M.D., D.L.F.A.P.A.*
12:30pm: Break with Exhibitors
12:45pm: Product Theater Dinner (Non CME)
2:30pm: Workshop by Practice (Choose One) .
Academic *Austin Hall, M.D., F.A.P..A & John Nicholls, M.D., J.D., D.F.A.P.A.*
Adminstration *Ish Bhalla, M.D. & Micah Krempasky, M.D*
Private Practice *Aarti Kapur, M.D. & Randie Schachter, D.O.*

Up to
16.75 *AMA PRA*
Category 1 Credit™

Saturday, September 28

7am: Breakfast with Exhibitors

General Psychiatry Sessions

8am: Alzheimer 's Disease Genetics and Research: The Need for Diversity, Equity, and Inclusion *Goldie Byrd, Ph.D.*
9am: Wise and Adaptive Use of AI and Technology in Mental Health *William Meyerson, M.D., Ph.D.*
10am: Break with Exhibitors
10:30am: Gambling & Other Behavioral Addictions *Tim Fong, M.D.*
11:30am: Diagnosis and Management of Autistic Adults in North Carolina *Linmarie Sikich, M.D.*

Child Psychiatry Sessions

8am: Best Practices and North Carolina Experiences in Safety Assessment and Planning *Danielle Lowe, M.D., Ph.D.*
9am: Preventing Suicide in Youth *Tatiana Falcone, M.D., M.P.H.*
10:30am: SAFETY-A: An Evidence Based Approach to Reduce Suicide Risk *David Goldston, Ph.D.*
10am: Break with Exhibitors
11:30am: Bringing Together Partners to Support Children at Risk of Self Harm *Tatiana Falcone, M.D., M.P.H.; David Goldston, Ph.D.; & Danielle Lowe, M.D., Ph.D.*

12:45pm: NCPA Business Lunch

5pm: Poster Session Reception
6pm: Dinner

Sunday, September 26

8am: Better Living Through Physics? *Perry Renshaw, M.D., Ph.D., M.B.A.*
9am: Schizophrenia (SCZ): Evidence-Based Approaches to Integrating Emerging Treatments Into Clinical Practice *Jose Rubio, M.D., Ph.D.*This activity is supported by an independent educational grant from Bristol Myers Squibb. Jointly provided by Global Learning Collaborative (GLC) and Total CME, LLC.*
10:30am: Top 10 Research Findings *Chris Aiken, M.D., D.F.A.P.A.*

YOU CAN STILL REGISTER
www.ncpsychiatry.org/annual-meeting

In support of improving patient care, this activity has been planned and implemented by American Psychiatric Association (APA) and North Carolina Psychiatric Association. The American Psychiatric Association (APA) is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

The American Psychiatric Association (APA) designates this live activity for a maximum of 16.75 *AMA PRA Category 1 Credit™.* Physicians should claim only credit commensurate with the extent of their participation in the activity.

2024 LEGISLATIVE UPDATE

Joshua Lanier, Director of Government Relations, CSHollis & Associates

After an unusual short session marked by much uncertainty in what would be accomplished, lawmakers adjourned on June 27, 2024. However, in keeping with the theme of the short session this year, the Adjournment Resolution still leaves much uncertainty about what lawmakers may try and resolve before the end of the year. The Adjournment Resolution provides for lawmakers returning to Raleigh at least once a month, should they decide to do so, to deal with a range of potential matters not addressed during the short session. One such item includes a short session budget. The budget is the overarching item that lawmakers have not yet passed this year, and questions remain if they will return to pass one at all.

Disagreements between Senate and House GOP leaders on budget provisions resulted in an impasse, not only in budget negotiations, but also held up other bills from passage as well. While the House had been proposing broader spending plans for an array of issues, the Senate had a much more conservative approach in their spending proposal. North Carolina has in place a permanent continuing resolution that keeps government funding in place if there is not a new budget passed before the start of the new fiscal year on July 1. Given this funding security measure, lawmakers knew they could go home without a budget, and there would not be the government shutdowns like those that often occur at the federal level. However, there were certain crucial funding measures lawmakers had to pass before leaving. Lawmakers were able to agree to a pair of stopgap spending bills to ensure that the state doesn't lose federal funding and that teachers get their scheduled raises from the long session budget bill. Additionally, the spending measures included about $68 million for childcare center grants, far less than the $130 million contained in the House and Senate's original budget proposals. Other significant spending measures, such as additional funding for opportunity scholarships, were not included in the spending bills and will remain in limbo until later this year, or until the 2025 long session. If lawmakers are to pass a short session budget, it would likely be in a November session following the election.

Another issue that may be addressed in a potential November session involves veto overrides. The Senate and House GOP currently hold veto-proof majorities. The House holds this majority by only one vote. Therefore, depending on if the House loses that one vote hold in the November elections, this may dictate what is taken up in November. Particularly as it pertains to budget overrides.

The week that lawmakers adjourned in June, they overrode three of the following bills:

- H 237, Various Criminal and Election Law Changes, which tweaks state law on face masks in public, allowing for medical grade masks to be worn. Further, the bill makes certain changes to campaign finance laws that will help keep certain donors identities hidden.
- H 198, Department of Transportation Changes, which is the annual omnibus bill put out by NCDOT. Cooper vetoed his agency's bill over a provision that would make it easier to cut down certain trees that are near highway billboards.
- H 834, Juvenile Justice Modifications, which modifies the definition of "delinquent juvenile" in the "Raise the Age" law which could lead to more prosecutions of 16 and 17-year-old offenders.

Another issue that might resurface involves medical marijuana. S 3, NC Compassionate Care Act, is a bill we have been closely monitoring throughout session. S 3 creates a framework that would legalize medical marijuana throughout the state, creating a review board comprised of various physician specialties that would determine what conditions can be eligible for medical marijuana. In one of the last-minute actions taken before adjournment, the Senate passed S 3 with a new provision that would prevent North Carolina from ever legalizing recreational marijuana. While the House de-

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SUPPORTING PEOPLE WITH SERIOUS MENTAL ILLNESS UPON RELEASE FROM INCARCERATION

Ted Zarzar, M.D.

Imagine living with schizophrenia along with the thought and perceptual disturbances that accompany it. Now, imagine this life in a jail or prison. You may be fearful around your peers and custody officers. You may be victimized or have difficulty following prison rules. You risk being placed in solitary confinement, spending 23-24 hours a day, potentially for months at a time, in a dark cell the size of a parking spot.

Around 40% of incarcerated Americans have a history of mental illness excluding substance use disorders. Community psychiatrists cannot escape the effects of mass incarceration. Of the 31,000 people in NC state prisons, about 20,000 return to the community each year, a substantial number of whom take psychotropic medications.

The reasons people with mental illness are overrepresented in our jails and prisons are complex. In one narrative, we have drastically reduced state psychiatric hospital beds, inadequately invested in community mental health infrastructure and treatment, and jails and prisons have assumed the role of safety net for people with serious mental illness (SMI).

In this "criminalization hypothesis," an untreated person with SMI is locked up for law violations partly related to psychiatric symptoms: for example, trespassing, resisting an officer, aggression, or failing to adhere to conditions of probation or parole.

However, providing community treatment alone does not reduce incarceration risk. More recent literature focuses on criminogenic risk – shared by people with and without mental illness – as a key area for intervention.

Criminogenic risks include antisocial characteristics and social determinants such as employment, education, housing, and income. In other words, receipt of an olanzapine prescription for a person who lacks housing, clothing, and food is an insufficient remedy.

People released from NC prisons receive a 30-day supply of medication along with the name and address of a follow-up provider. They may or may not have housing, transportation, health insurance, income, or food upon release. They must find a primary care provider on their own. Social or family support may be suboptimal or nonexistent.

One would not be surprised that in these circumstances, the risk of rearrest is high, as is emergency department and inpatient hospital use. The dismal revolving door of acute hospitalization, shelter placement, and incarceration, with which many community psychiatrists are familiar, rears its head.

In 2022, the UNC Departments of Psychiatry and Family Medicine piloted an intervention in Wake County aimed at breaking this cycle. The program, FIT (Formerly Incarcerated Transition) Wellness, provides comprehensive reentry support for people with SMI (defined here as schizophrenia, schizoaffective disorder,

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WE CAN ALL TAKE CARE OF OUR OWN

Nadia Charguia, M.D.

One Game Changing Week

Back in 2012, early in my faculty career, I had the privilege of being invited to work with my mentors, Drs. **Samantha Meltzer-Brody** and Theresa Raphael-Grimm, in what was then a newly founded initiative called Taking Care of Our Own (TCOOO). About one year in, I had an experience that became a career defining moment for me.

Over the course of one week, I met individually with five (out of six) first year fellows who were in the same medical subspecialty. A thoughtful faculty member in their division had recommended TCOOO following a challenging encounter.

Complying with HIPAA and promoting confidentiality, each fellow was unaware that their colleagues were also being seen. Although it was an acute event that led each to my office, it was years of challenges, burnout and associated difficulties that bubbled to the surface of our conversation. One theme in particular was most pervasive.

Without exception, each fellow stated that they were struggling in their current program, that they felt inadequate and saw their colleagues as being exceptional. Every single fellow I met with spoke of the difficulties they were having, stating that all others in their class were incredible clinicians, but they themselves felt inadequate, underprepared and as if they were imposters amongst the other first year fellows. Each of them existed collectively in a space, yet suffered in silence of the same affliction.

This moment paired with the thousands of others I've witnessed since that time continue to shape an understanding of just how significant the problem is that we are all facing.

How We Understand Well-Being

There has been an evolution in the collective understanding of how to move the needle on well-being within the healthcare industry. As Dr. **Jennie Byrne's** article demonstrates, the primary need to impact well-being is leading meaningful system change efforts. Root causes that lead to burnout and moral injury arise from systemic factors that beg to be understood and addressed. Equally needed are resources and approaches that raise awareness and provide support for the impact all can have upon our healthcare colleagues.

Calling Out Imposter Syndrome

Multiple studies over decades have highlighted that physicians have higher levels of resiliency and derive a greater sense of meaning from their profession when compared to our national workforce. This results in physicians tending to put others before themselves. What is a strength, however, also serves as a weakness as this tends to become internalized by a great number of physicians. Despite the high achievement and accomplishments attained, many are left with a sense of never being "good enough."

A large national study by Stanford Medicine researchers (Shanafelt, et al. Mayo Clinical Proceedings) was published in 2022 and surveyed approximately 3,000 physicians. This study determined that "one in four physicians experienced frequent or intense imposter syndrome symptoms…bringing greater risk of occupational burnout, suicidal thoughts and professional unfulfillment." When compared to 2,500 non-physicians, "physicians were at a 30% increased risk for reporting imposter syndrome compared to non-physicians and at an 80% increased risk relative to people with a doctoral or professional degree in another field."

How the physician is regarded has changed over time. Although there is no doubt that our healthcare work force are heroes for the work they do, it is imperative that we help change the narrative and let them be seen for the humans they are. We must help dispel the notion that we are meant to be super-human, that we can work no matter the circumstances or demands.

We can all lead with intention to raise awareness of the impact that is known to be the result of our stressed

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... "La Cultura Cura" continued from cover page

ulation growth steadily outpaced all other racial and ethnic groups over the past three decades (Lichter & Johnson, 2020).

Unfortunately, and ironically, linguistically appropriate mental health care and resources are on the decline: between 2014 and 2019, the proportion of mental health facilities in the United States offering treatment in Spanish declined by 17.8% (Pro et al., 2022). Additionally, Latino families have limited access to culturally responsive services that reflect an understanding of their cultural norms and attend to the history of stigma and mistrust of the mental health field among Latino communities (Ramos-Olazagasti & Conway, 2022).

The combination of larger populations with fewer culturally-responsive mental health resources has been compounded by a larger, national trend over the last decade: the adolescent mental health crisis. Some, such as Jonathan Haidt in *The Anxious Generation*, place blame on the overuse of screens and social media. Arthur Brooks, in a recent article in The Atlantic, posits that the underlying issue is actually a lack of a sense of meaning. For Latino adolescents, there is another significant player – the "conquistador" or meting out of culture, a loss that cuts the roots of heritage and ethnicity, leaving Latino youth adrift during a critical time when they are forming and consolidating their identity.

When cultural identity is forgotten or silenced, the psychological effects are profound. In her research among North Carolina Latinos, Rosa Gonzalez-Guarda, Ph.D., of the Duke School of Nursing, found that activities supporting ethnic pride are powerful ways to build resilience and strengthen the Latino community (Gonzalez-Guarda, 2023). When Latino youth feel the inevitable effects of acculturation stress, those who are connected to and proud of their culture exhibit less anxiety and depression. For adolescents like Deyanira, going to a quinceañera, enjoying traditional "comida tipica" food with family, celebrating the upcoming Hispanic Heritage Month proudly at school with friends, and cheering for Mexico during the World Cup, may be key ingredients to wellness and emotional health. Latinos in the US are affirmed and strengthened when they see members of the dominant culture celebrating with them at those times and acknowledging the rich cultural traditions they bring to our state. As we head into Hispanic Heritage Month, which begins on September 15, we can all play a part to boost mental wellness for our Latino neighbors in North Carolina by joining in the celebration!

Luke Smith, M.D. is a practicing Spanish-bilingual psychiatrist and Executive Director at Durham based El Futuro, a community-based nonprofit mental health and substance use service organization celebrating its 20th anniversary.

... "Moral Injury" continued from page 4

negative emotions and participating in a healthcare system that violates our personal and professional values creates profound suffering. This is not just an energy depletion issue.

For example, Dr. David Eisenberg told me about the difference between burnout and moral injury in his experience as a psychiatry resident.

"As a resident, sometimes I work many hours a week but feel energized. This happens when I like what I'm doing, and I'm having an impact. I'm contributing towards something bigger than myself. I feel the work aligns with my values, and I'm doing what is right for the patient.

"However, there are other times when I'm not working long hours, but I feel detached. These are rotations where I'm doing work that isn't what I trained for, or where I don't feel like I am having an impact. This negative feeling also happens when my contribution is not taken seriously, or when the leadership has no interest in change, and the broken system just continues to repeat.

"These situations are where I experience burnout - and it happens in a matter of hours, not days or weeks or years."

Dr. Eisenberg's story resonated strongly with me. There have been many times in my career where I was working hard, doing night shifts, or other work that should have depleted my energy stores. In contrast, at other times my work felt repetitive and efficient. My soul was full when the work had meaning, and on days where it felt meaningless, I suffered. This had nothing to do with my work hours nor my efficiency level. In fact, when I was more efficient, I was often more dissatisfied and filled with negative emotions.

The healthcare system's focus on efficiency and profit has profound consequences. Clinicians who start their careers with passion and dedication find themselves emotionally exhausted and detached. This not only affects their mental health but also the quality of care they provide to patients. When clinicians are burned out, their empathy diminishes, professionalism decreases, and job satisfaction plummets.

The problem isn't just about resilience. Clinicians are inherently resilient individuals who have endured rigorous training and high-stress environments. The issue lies in a system that depletes their mental and physical reserves to dangerous levels. Programs aimed at increasing individual resilience, such as yoga or meditation, are not enough to address the root cause.

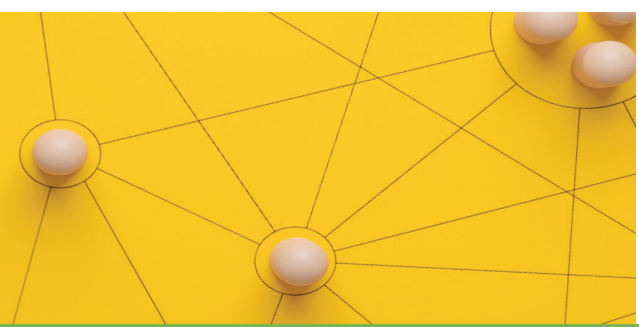
The Way Forward

To truly address burnout and moral injury, we need to shift our mental models and approach healthcare differently. This means recognizing the systemic issues and advocating for changes that allow clinicians to provide the high-quality care they are trained to deliver. It means fostering environments that support their well-being rather than adding to their stress.

By understanding the profound difference between burnout and moral injury, we can start to develop solutions that address the real issues at hand. It's about creating a healthcare system that values human connection and compassion over mere efficiency and profitability.

If you are suffering in silence, please reach out to me or a trusted colleague for help. Alternately, checkout my new book *Moral Injury: Healing the Healers* for a more detailed analysis and pragmatic solutions to heal moral injury in your psychiatry practice today. You are not alone, you are not helpless, and you can heal your moral injury wounds.

Jennie Byrne, M.D., Ph.D., D.F.A.P.A., is a past President of NCPA and a psychiatric entrepreneur. She is the author of two books: *Moral Injury: Healing the Healer* and *Work Smart*. Her practice, Constellation PLLC, is in Chapel Hill, NC.



... "Addiction Treatment" continued from page 5

getting patients on buprenorphine in our OTPs by using methadone as a bridge and then microdosing buprenorphine until they are just on buprenorphine. So OTPs can be used temporarily to get patients on buprenorphine and then transition them back to a doctor's office (the Hub and Spoke model).

There are some new technologies (DispenSecur, COPA, CHESS app) that the Morse Clinics have utilized and received patient feedback on (published articles pending) that may help prevent diversion of take homes with our new take home flexibilities and help with patient retention. Several new smart phone apps are being used. These may be exciting advancements in addiction treatment.

All anti-addiction medications for Medicaid recipients now have zero-dollar copays including nicotine replacement, bupropion, varenicline, buprenorphine, naloxone, and naltrexone. This change may really help with long-term adherence.

As new OTPs open to meet the needs in our communities, workforce shortages are a concern. However, for the first time, psychiatry, family practice and internal medicine residents have been doing elective rotations in the Morse Clinics. NP and PA students have been more recently training with us as well.

In the OBOT (office based opioid treatment) world, it appears that removing the X waiver has not increased buprenorphine prescriptions. Most people were hoping that all prescribers would prescribe buprenorphine when they identify OUD the way they would for most other prescription medications. Hopefully, with additional educational opportunities, like at our Annual Meetings, more NCPA members will prescribe buprenorphine.

Challenges remain. Recently, the NCPA Addiction Committee members were invited to NC Society of Addiction Medicine's annual meeting to join in on a lecture and subsequent discussion on new treatments of stimulant use disorders. There is further evidence for using long-acting stimulants, bupropion, naltrexone, mirtazapine, or modafinil in the use of stimulant use disorders, which have lower risk for abuse than short-acting stimulants. These options are few and not robust, but definitely worth a try. The vaccine technologies for opioids and cocaine, among others, have not worked as well in humans as in animal studies. Hopefully psychiatrists will continue to lead the way in trying to help people who suffer with substance use disorders. Thank you!

Eric Morse, M.D., D.F.A.P.A., is the founder and owner of the Morse Clinics which has nine locations in the Triangle area of NC. Dr. Morse is at the forefront of efforts to increase access to the medical treatment of substance use disorders in North Carolina.

... "Filling the Gap" continued from page 7

The assessment needed to complete what was necessary to assess the current diagnosis, safely prescribe medication, and address the psychosocial barriers to her finding more social support. I needed to connect her to her team for therapy and encourage her to feel confident she could continue the conversation no matter the ethnicity of the therapist. I recommended community-based peer-focused mental health organizations where she might find more information for herself and loved ones about living with mental health conditions and likely find a support group that included people of color. Lastly, as a temporary provider, I wanted to document her concern for the person who would be the incoming psychiatrist.

Usually, the patient seems indifferent to my demographics. Sometimes, a patient looks surprised that they are being seen by a Black woman. When I was in the office setting, there was a little pause at the door of the waiting room. I learned a lot in the moment when we made eye contact, they gathered their things, and we had the brief informal time walking back to the office or doing something medically ordinary together, such as going by the scale to weigh.

In the telepsychiatry environment, the collaboration over troubleshooting video connections is a similar experience to walking back to the office. Frequently, my camera is working so they can see me, but I cannot see them. I need to express hopefulness that I can assist them with getting their camera going and, importantly, that seeing them is really helpful to our communication. Most often, we are successful, but it does reduce the time available to "do the appointment." At the end of such problem-solving, we have done something successful together, and I give "us" a pat on the back for doing so. I learn a lot about frustration tolerance, self-confidence, cognition, and thought process. I learn about motivation and organizational skills. I meet family and pets. These can be good house calls.

For very underserved areas, psychiatry is not the only discipline in short supply. As psychiatrists, the patient may want us to do it all. Where there are interdisciplinary capabilities, a key role is to help the patient understand and use the treatment team model. Even if the patient only takes medication, it is important for the patient to know another treatment team members. Care managers or nurses are a crucial link. Though we are temporary providers, the patient's needs do not change. We may be getting the patient caught up on some metrics that are overdue. A colleague explained that when patients have waited a long time for follow-up care or if we are in the role at a single facility for over six months, we are functioning in the role of a permanent provider, checking labs, EKG, AIMS, of course, but also completing forms, setting new goals, and addressing psychosocial stressors that arise for the patient. At all times, we are still mindful that we are preparing for someone new to take over the care.

In the outpatient setting, the time frame for the appointment is relatively inflexible. It takes additional time to honor the desire for and expectation of someone to listen and have empathy for what they feel they have not been comfortable saying or what they feel has not be heard or properly interpreted, especially when patients feel it is important that they are seeing a provider of a specific background. I endeavor to communicate empathy and a desire to understand, and respectfully refocus the interaction on what we can do with our time.

What I can do is document additional shared details, commend the openness and encourage the patient to continue sharing with their next provider, make sooner follow-up appointments for further diagnostic reassessment when needed, and help the patient with clarifying questions they may ask other providers. Even though the role is to bridge the gap between two long-term treatment relationships, I seek to let them know they are being seen, acknowledge the limitations of our time together, and competently complete the medication evaluation and management. Candidly, it can add up to the investment of extra time. It can also add up to extra joy and a sense of purpose.

Vivian Campbell, M.D., L.F.A.P.A. is a board-certified general psychiatrist in Charlotte, NC. She serves on the Race, Ethnicity and Equity Committee.

... "Legislative Update" continued from 11

clined to take up S 3 before adjourning in June, there is the chance it may resurface again before the end of the year.

With a major election coming up this November, we are tracking all election activity throughout the state. Unfortunately, Dr. **Kristin Baker**, a child psychiatrist and member of NCPA, is not running for re-election for her House seat. However, there is another physician, Dr. Grant Campbell, running for Dr Baker's seat. Dr. Campbell is an OBGYN in Cabarrus County. We will be providing a full election update following November's election.

We continue tracking any intermediate legislative activity between now and November, and will be closely monitoring a November session, should lawmakers decide to return.

Joshua Lanier is the Director Of Government Relations at C.S. Hollis & Associates, lobbyist of NCPA.

.... "Incarceration" continued from 12

or bipolar disorder).

FIT Wellness grew out of the main NC FIT program, a member of the Transitions Clinic Network, which centers around a community health worker (CHW) with a lived experience of incarceration. The CHW serves as a health system navigator, advocate, and peer support for people reentering society.

FIT Wellness maintains this model while adding three additional features: 1) meeting with prospective patients before prison release to ensure a warm handoff, 2) access to prison health records, and 3) integrated and co-located psychiatric and primary care services.

Grant funds cover clients' basic needs including smartphones, phone plans, clothing, medications, and emergency housing if needed. CHWs assist with food, housing, and vocational resources. An eligibility specialist assists with Medicaid and disability benefits if applicable.

Between August 2022 and June 2024, 74 people enrolled in FIT Wellness. 80% were men and 73% were persons of color. Among those completing an intake survey, 37% had no high school degree, 33% had stayed in a shelter or were unhoused (e.g., "lived on the street"), 92% were unemployed, and 18% had health care coverage.

The program saw 228 clinic visits and 942 CHW contacts completed (by smartphone or face-to-face). The clinic retention rate, defined as multiple visits spanning ≥90 days, was 63%. Among clients surveyed at three months post-intake, 76% had not used an ED and 83% had not been hospitalized during clinic enrollment.

Preliminary data has been positive, and North Carolina is investing an additional $5.5 million into FIT Wellness over the next four years. Funds will cover expansion into Orange, Durham, and New Hanover counties, the inclusion of local jails as a referral source, and will support training of psychiatric residents.

Ted Zarzar, M.D. is a co-founder of NC FIT Wellness and associate professor of psychiatry in the UNC School of Medicine.

... "Take Care" continued from page 13

systems. Each of us can help facilitate conversations to cultivate a culture that fosters sharing of our vulnerabilities and honest experiences. Such steps can be taken without requiring formal settings, as these are conversations that can happen in a small group setting, over a cup of coffee or of course can be cultivated in a more purposeful environment, such as what we have built with the TCOOO program.

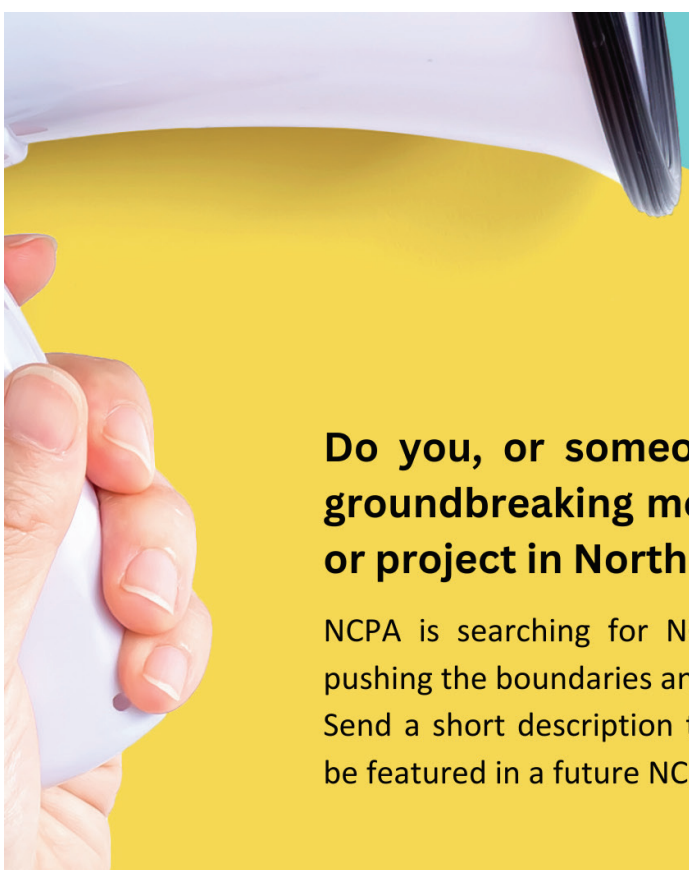
What is the Taking Care of Our Own Program?

The Taking Care of Our Own Program (TCOOO) has been a cornerstone resource at UNC School of Medicine since its foundation in 2012. Our mission has been to raise awareness about the unique challenges that come with working (and training) in healthcare. Through our program, we have provided outreach and psychoeducation across all the clinical departments that comprise the UNC School of Medicine (UNC SOM), highlighting common problems often faced by physicians, including burnout, imposter phenomena, anxiety, depression, and moral injury.

Simultaneously, we have worked to reduce stigma and barriers to seeking appropriate mental health care by providing timely access to tailored resources and referrals to convenient, confidential clinical services with expertise in well-being and mental health support for healthcare professionals. Our by-line has become "even if you don't know what you need, we are here to talk and help figure it out."

We started as three clinicians and have expanded to over fifty, some who have been hired fully to be a part of this incredible initiative, others who may offer an hour a week at a time. Every year, we continue to expand our reach and impact, currently averaging over 500 visits a month. Although we bill for services to support the time of our clinicians, we offer reduced fee options to those with varying degrees of coverage to ensure that no one is denied access. TCOOO serves as safe harbor and testament to barriers and stigma that have been reduced.

Nadia Charguia, M.D. is an associate professor and child psychiatrist with the Department of Psychiatry at the University of North Carolina at Chapel Hill. She is the Director for the Taking Care of Our Own Program. Dr. Charguia also serves as the Executive Medical Director for UNC Healthcare's Integrated Well-Being Program, leading well-being efforts systemwide.



CALLING ALL NCPA INNOVATORS

Do you, or someone you know, run a groundbreaking mental health program or project in North Carolina?

NCPA is searching for NCPA member-driven mental health initiatives that are pushing the boundaries and making a real difference. Share your program's story! Send a short description to info@ncpsychiatry.org. Your innovative project might be featured in a future NCPA newsletter!

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In support of improving patient care, this activity has been planned and implemented by American Psychiatric Association (APA) and North Carolina Psychiatric Association. The American Psychiatric Association (APA) is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

The American Psychiatric Association (APA) designates this live activity for a maximum of 16.75 *AMA PRA Category 1 Credit™*. Physicians should claim only credit commensurate with the extent of their participation in the activity.