NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

JULY 2020

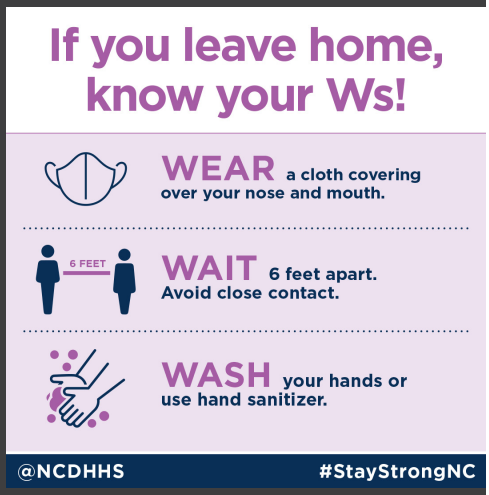


Image Credit: NC Department of Health and Human Services

IN THIS ISSUE

2020 NCPA Annual Meeting is Going Virtual!

In the interest of safety for all attendees, guests, and staff, this year's Annual Meeting will be held fully online from October 2-4.

For details and registration information, please visit: http://bit.ly/ncpsych20

President's Column: NCPA Adapting, Evolving

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

Typically, incoming NCPA presidents use this first column to introduce themselves and outline their plans and priorities for the coming year. The first part is straightforward: I am a child, adolescent, and adult psychiatrist in private practice at Raleigh Psychiatric Associates, where I have been for the last 10 years. I have lived in North Carolina for the last 20 years, as I attended medical school at Duke and completed my general psychiatry residency and child fellowship at UNC.

I joined NCPA as a resident, and I became more involved in my final year of training when I completed a year-long elective rotation in mental health advocacy. Since then, I have remained involved as a member of the Practice Transformation Committee and Chair of the EHR/HIE Task Force, then as Vice President and President-Elect. I took office as President at what would have been the conclusion of the APA Annual Meeting on April 30.

Over the past year, I thought about my plans and priorities for my term as President. Of course, those plans and priorities have shifted dramatically. In mid-March, almost overnight, all immediate priorities became centered around the pandemic. When North Carolina's first COVID-19 case was confirmed on March 3, it seemed as though contacts were traced and it was under control. However, within a week, North Carolina was under a State of Emergency. Within two weeks, college campuses were empty, schools were cancelled, and restaurants were closed.

We psychiatrists suddenly had to figure out how to care for our patients with different challenges in our practice settings. As an organization, NCPA was tasked with helping members navigate these challenges and advocating for effective policy changes. I am pleased that NCPA adapted with flexibility and resilience. Over the past year, Immediate Past President ***Dr. Jennie Byrne*** helped NCPA develop practices to effectively operate remotely, for which I am grateful.

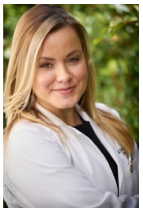
I have never been prouder to be an NCPA member than during the time this pandemic unfolded. Our Disaster Committee jumped to action, meeting daily at 7:30 a.m. Their tireless work, together with many other members and NCPA staff, accomplished more than I can outline in the space of this column. Our work has been shared with the APA's other district branches, often serving as a model for action.

continued on page 4...

2020-2021 Executive Council Takes Office

In March, NCPA members returned their election ballots, voting overwhelmingly to approve the slate of officers proposed by the Nominating Committee. The newly-elected officers began their terms at the end of April. Congratulations and thanks to the incoming officers and new Executive Council member for 2020-2021! Members with questions about the election process or interest in becoming more active in NCPA should contact NCPA staff, 919-859-3370 or info@ncpsychiatry.org.

President
Zachary Feldman, M.D., F.A.P.A.



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NORTH CAROLINA Psychiatric Association news

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From the Editor: A Book About a Surprising Way that Change Can Happen

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

My book recommendation for this issue is *The Great Pretender*, by Susannah Cahalan, a look back on events a half century ago that changed psychiatry. I offer this book now because I think that the COVID-19 pandemic will change psychiatry. I will say how I think it will change us later in this column, but first, the book.

In 1973, the distinguished journal *Science* published a paper called "On Being Sane in Insane Places." The underlying thesis was that psychiatrists could not tell the difference between those who were mentally ill and those who were not.

The article documented the efforts of David Rosenhan, Stanford professor of psychology and law, who recruited "normal" people to get themselves admitted to psychiatric wards with a simple complaint of auditory hallucinations. Once admitted, they were to act normally and declare the symptoms resolved. Nevertheless, the "patients" received significant diagnoses and were prescribed the current medications for a psychotic diagnosis, usually, schizophrenia. Rosenhan's conclusion was that psychiatrists could not tell the sick from the well.

I was a third-year medical student rotating on an inpatient psychiatric ward when *Science* published the article, and I remember the outcry. It was usually deemed "junk" or an "irresponsible" and methodologically flawed piece, but a few of my teachers nodded to the fact that the profession did have a problem with psychiatric diagnosis.

Cahalan's book, *The Great Pretender*, digs deeply into the facts of how the study came to fruition. She writes that it was not only a poorly designed study, but that Rosenhan presented only the data that supported his conclusion, and may have actually made some of it up.

Cahalan then offers a surprising opinion. While the psychiatric profession universally rejected Rosenhan's research, the informed general public endorsed the idea that psychiatry's diagnostic terminology and processes of the time were woeful, if not worthless. Cahalan concludes that this commonly held condemnation of psychiatry did something positive. It gave life-giving fuel to the efforts of Robert Spitzer and allies to create a more scientific diagnostic nomenclature.

Would DSM-III, with its descriptive nomenclature, have been delayed or rejected without Rosenhan? I will say this: one had to be there, including in training as a psychiatric resident, in the '70s to know how deeply certain factions were entrenched in their point of view. I watched "biological psychiatry" fight a war to be accepted by more traditional practitioners.

I remember a case conference where a professor (verbally) threw a resident out of the room for suggesting that a patient be prescribed a medication in lieu of psychotherapy alone. This was also a time when many if not most psychiatrists thought that the patient should not be informed of their diagnosis. The diagnosis was the property of the profession, and besides, the patient might go to the library and read about it. That could complicate treatment.

So, what does this have to do with COVID-19? I recently helped my psychologist wife, Lauren, set up the technology to convert her 25-30 hours per week psychotherapy practice to "teletherapy." She has lost no patients. Employee Assistance Programs are calling with new referrals requesting online help. She has not been to the office in several weeks.

I doubt that soon an all-clear whistle will blow and we will all go back to things as they were, either in the larger world or in the professional office. But I do not see the new world as two people staring into a computer monitor at head and shoulder shots of each other for 45 minutes to an hour. Lauren says there is something missing in translation.

I think the new telemedicine/telepsychiatry/teletherapy world will look very different in a decade and beyond. There will be an explosion of online mental health educational tools, interactive exercises with computer programs, group therapy through secure "Zoom-like" platforms, customized journaling and creative writing options and more. Some of this exists now, but increasing individualization for specific problems and populations will make it more attractive to third-party payers.

Somehow, we will figure out how to preserve the healing power of human relationships as it all plays out. And despite an "OMG" response by today's traditionalists, in the new world it will all seem obvious that this is the way you do it.

Just as Rosenhan's "junk" study propelled positive change, maybe the pandemic will do the same.

...“President’s Column,” continued from page 1

Some highlights include:

- Created a resource guide for members to distill information from innumerable sources and organize it into an easily accessible and searchable document
- Organized educational webinars for members and collaborated with other groups and organizations to reach a wide variety of audiences
- Created a Health Disparities Workgroup to assess longstanding health inequities made even more apparent by COVID-19
- Advocated successfully for Medicaid coverage of telemedicine, as well as for broader coverage of care delivered via telephone through the pandemic
- Created position documents on the use of long-acting injectable medications and ECT to maintain these treatments for patients that depend on them
- Created new forums for member communication, including a private, members-only NCPA Facebook Group and weekly informal “Living Room Chats”

These early morning Disaster Committee Zoom calls continued daily for eight weeks, and I would like to give special recognition to the “regulars”: ***Drs. Allan Chrisman***, ***Therese Garrett***, ***Harold Kudler***, ***Karen Melendez***, ***Kaye McGinty***, ***Siham Muntasser***, ***Nadyah John***, ***Nathan Copeland***, ***Nkechi Conteh***, ***Nikki Steinsiek***, ***Rick Weisler***, and ***Nerissa Price***, as well as NCPA Executive Director Robin Huffman. Dr. Kudler has also graciously taken on the role of co-facilitator for our weekly Living Room Chats together with ***Dr. Scott Klenzak***.

Then, on May 25, George Floyd was murdered by police in Minneapolis, and the wounds of racial oppression in this country were ripped open and laid bare. Not that the killing of a Black man by police was a new phenomenon, but Mr. Floyd’s murder occurred in the midst of a confluence of events such that the non-Black populace paid attention like never before. As a white male, I recognize that I did not previously think about or do enough to work toward racial equality, and I am sorry for that. I have pledged, and I continue to pledge, that I will do better by actively working to fight racism and to be an ally to those who are oppressed.

Many in NCPA have done this work all along. As an organization, however, NCPA recognizes that we have not done enough and will do more going forward. Toward that goal, we are forming a new Race, Ethnicity, and Equity Committee, chaired by ***Dr. Nadyah John***. We are also having difficult conversations in our Living Room Chats and in other forums to help all of us to better understand one another.

As we look ahead, we anticipate a surge in demand for mental health services, occurring as a result of trauma, anxiety about COVID-19, prolonged social isolation, loss of routine and sense of purpose, unemployment and economic consequences, and interruption in regular care. This surge is expected to be most pronounced in the minority groups that have been hit hardest by the pandemic, which also have the most difficulty accessing care.

Through our efforts as a field, in our various practices and systems of care, and individually as psychiatrists, we have worked, largely successfully, to decrease interruptions in care. However, we recognize we are certainly not reaching everyone, particularly those in underserved populations for whom we anticipate the greatest need. One priority for NCPA going forward is to continue to expand access to telemedicine through this pandemic and beyond, as appropriate use of this technology can break down barriers to obtaining care in terms of time, transportation, and stigma.

However, we continue to have the problem in North Carolina (as in the rest of the world) that there are not enough psychiatrists to treat all patients with psychiatric disorders, even under normal circumstances. With the looming surge in need for mental health services, this shortage will become even more pronounced. Therefore, a second priority is to implement evidence-based integrated models of care with the potential to expand the reach of psychiatrists to more patients. NCPA’s role in this is to educate and provide avenues to training for members, as well as to advocate for reimbursement of these services. A major victory has been Medicaid’s adoption of collaborative care codes. The next hurdle will be effectively advocating for private insurers to adopt these same codes.

As we work towards these goals and others, we continue to adapt and evolve as an organization. Due to uncertainties of the course of this pandemic, the Executive Council recently made the difficult decision to convert our Annual Meeting to a virtual event. For many of us, this meeting has become a time to learn, as well as to connect and reconnect with colleagues across the state. The Program Committee is working diligently to create a virtual event that captures both of these aspects.

We would love to get your input on our path forward, including advocacy, education, and how we can best serve your needs and those of your patients. Please join our private Facebook group, participate in a Thursday evening Living Room Chat, or email me personally at president@ncpsychiatry.org.

NORTH CAROLINA
Psychiatric
Association

Statement from the North Carolina Psychiatric Association

Approved by the NCPA Executive Council

June 8, 2020

"In the end, it is not the words of our enemies we will remember, but the silence of our friends."

-Dr. Martin Luther King, Jr.

The North Carolina Psychiatric Association (NCPA) strongly condemns the systemic, institutional racism that has infected America for centuries. NCPA supports the statement by the American Psychiatric Association. NCPA stands in solidarity with those demanding racial justice and the eradication of police brutality – and the societal indifference which perpetuates it – across the United States. In unequivocal terms, Black Lives Matter.

In a year marked by an endless stream of global crises, we recognize that Black Americans face disproportionate levels of trauma due to racial inequities and discrimination. Most recently, this has been documented by the disparate loss of Black lives to COVID-19. The toll of these disparities impacts all Blacks living in our communities, including Black physicians working in health institutions across the country.

NCPA understands it is not enough to simply offer support and declare we are against racism. Rather, we must be actively anti-racist in order to propel real, lasting change. In full transparency, NCPA does not currently have a Black psychiatrist on this year's Executive Council, and other minorities only hold a quarter of all voting positions. NCPA can and must do better. NCPA is committed to doing so by placing a greater emphasis on diversity in future nominations for leadership positions within NCPA. We intend to evaluate other immediate and long-term actions we can take to acknowledge white privilege, diversify our leadership, and demonstrate our commitment to actively combat racism.

These efforts will take place in all years ahead – not only this week or this month while wounds are still fresh in our collective hearts and minds. NCPA's hope is that this pivotal moment in history leads to greater peace, justice, and culturally competent mental health care for current and future generations.

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COVID-19 and Mental Health Resilience

Allan Chrisman, M.D., D.L.F.A.P.A. & S. Therese Garrett, M.D.
Co-Chairs, NCPA Disaster Committee

The speed at which our lives have been simultaneously disrupted – personally, professionally, and collectively – has left most of us reeling. Usually, we cope through social supports, which have been disrupted through the closure of businesses, schools, and nonessential services. The forced manner in which shelter-in-place orders occurred further exacerbated the political polarization impacting our communities, and this divide has led to increased stress and anger across the political spectrum. Confusion, uncertainty, and loss of control in our lives has been further fueled by misinformation and lack of personal protective equipment.

These impacts have been disproportionately felt by the health care workforce, other essential workers, and minority communities in ongoing ways. The anticipated reopening of our communities and beginnings of this process is now met with heightened anxiety from the uncertainty of exposure to infection and possible morbidity/mortality. The need for psychiatry and greater attention to the mental health needs of individuals and communities has never been so great as it is now.

Despite this disheartening characterization of our current state of affairs, we are pleased to report that our NCPA response has been robust. During the initial days and weeks of this pandemic, we quickly activated our previous disaster preparedness efforts and responses to meet this challenge.

Under the leadership of Executive Director Robin Huffman, President ***Dr. Zach Feldman***, and Immediate Past President ***Dr. Jennie Byrne***, a quickly assembled COVID-19 workgroup of Disaster Committee members and other volunteers has been engaged in assessment of needs and assertive advocacy for the safety and well-being of our members and their patients. We immediately created a "COVID-19 Resources for Psychiatrists" document and distributed a survey to determine the impact of the crisis on members' personal and professional lives.

The need for psychiatry and greater attention to the mental health needs of individuals and communities has never been so great as it is now.

Concurrently, in this first phase of response, we addressed the whirlwind transformation of practices from in-person to remote telehealth care. Simultaneously, we advocated for the continued practice of ECT as an essential procedure for urgent/acutely ill persons, as the state moved to stop all non-elective procedures/surgeries. In addition, the workgroup promoted the continued availability and prescription of long-acting injectable psychotropic medications with the appropriate State agencies and systems of care. Each of these initiatives prompted national support from the APA through the adaptation of NCPA statements into official APA briefs on ECT and long acting injectables.

Our work on telehealth prompted the development of a position statement co-authored with NCCCAP that was shared with legislators and policy leaders. We continue to work with focused briefs to assure the safety and wellbeing of psychiatrists returning to service from retirement through volunteerism or activation into direct service. Guidance on appropriate expansion of the scope of practice into active medical service has also been developed, along with two important documents addressing grief issues for health care workers and their families.

Participation in NCPA's longstanding network of advocacy, spearheaded by Robin Huffman, has emphasized our ability to be part of multiple coalitions and professional organizations throughout North Carolina. These include the NC Council of Child and Adolescent Psychiatrists, NC Medical Society, NC Pediatric Society, NC Academy of Family Physicians, NC Psychological Association, Disaster Response Network (DRN) Task Force, State agencies, NC commercial insurance companies, and others. Forums focused on direct contact and support of physicians have included the following:

1. NCPA's "What Psychiatrists Need to Know about Telepsychiatry: An Introduction to Virtual Care" webinar, led by Immediate Past President ***Dr. Jennie Byrne***, President ***Dr. Zach Feldman***, and NCCCAP President ***Dr. Therese Garrett***

2. AHEC/CCNC/NCPA coalition's "Navigating COVID-19" webinar series, including NCPA-led session, "You and Your Practice Resiliency - Protecting Your Practice's Human Capital"
3. NCPA's "Living Room Chats," co-facilitated by ***Drs. Harold Kudler*** and ***Scott Klenzak*** each Thursday evening
4. NCPA's Zoom chats with the academic psychiatry department chairs to share information and help sharpen our statewide focus on COVID-19 response
5. NC Medical Society's "Power Hour" weekly webinar series

As we move forward into the long-term work of dealing with this pandemic, we are focused on the well-being of the health care workforce through the advocacy of resilience measures on a local and national scale. Since the beginning of this crisis, training has been accomplished on disaster mental health, resilience, and crisis call work. As members of the North Carolina DRN Task Force, we collaborated with the Division of Mental Health to develop a crisis support hotline called Hope4Healers to support the acute mental health needs/questions of health care workers. This hotline, which is currently a 24/7 immediate answer service managed by a company out of Greenville, has recently expanded to include childcare workers and their respective families.

To expand efforts to address the stress of health care workers, Dr. Kudler arranged a consult with Dr. Marc Cooper from the Veterans Administration Hospital in Salisbury, NC on the topic of operational stress. Out of this presentation, ***Dr. Siham Muntasser*** is currently revising a U.S. Army pocket guide, "Guide to Coping with Deployment and Combat Stress." The targeted audience is health care workers who work within the Veterans Health Administration in various capacities and in different settings. This guide is an integration of the "Guide to Coping with Deployment and Combat Stress," published by the U.S. Army with the U.S. Department of Veterans "Affairs Whole Health for Life" model.

Additionally, we have had a presentation on Intimate Partner Violence Assistance Program by Kathy Williams-Brown, LCSW who directs and oversees the Intimate Partner Violence Assistance Program (IPVAP) at the Durham VA. This consultation will help strengthen the network of support for our patients and health care workers dealing with domestic violence. Meetings have also included discussions with NC Physician Health Program CEO Joe Jordan, Ph.D., and Victor Armstrong, the new Director of the NC DHHS Division of MHDDSAS.

Finally, we have also created a Health Disparities Workgroup to address the disproportionate impact of the COVID-19 public health crisis on minorities, especially African American, Latino, and immigrant communities. A separate column is presented in this newsletter (pages 8-9) to highlight their important work.

Editor's Note: Due to space limitations, this article with hyperlinks to mentioned resources is available at www.ncpsychiatry.org/covid-19.

What Psychiatrists Need to Know About...

COVID-19's Impact on Minority and Underserved NC Communities

J. Nikki Steinsiek, M.D., M.P.H. & J. Nathan Copeland, M.D., M.P.H.
Health Disparities Workgroup, NCPA Disaster Committee

In North Carolina, COVID-19 is impacting more than people's physical health. Numerous articles have been written on the social, financial, and mental health impacts across our country. Additionally, the way COVID-19 has hurt all Americans has been especially profound in minority and underserved communities and has further highlighted pre-existing health disparities.

While there are many similarities between what is occurring across the United States and in our state, the diversity within North Carolina communities lends itself to a similar diversity in experiences. We hope to share with you what has been shared with us – stories of hardship and perseverance from leaders of minority and underserved communities in our state.

Whether someone belongs to an African American, Latino/Hispanic, houseless (a term the community identifies with and we prefer given home is so much more than a physical space), or rural community, there are common themes in how daily stressors are exacerbated by COVID-19. Uncertainty and fear, while not new, are heightened. There is a tension between a fear of virus exposure and a fear of financial ruin. Unemployment benefits are available, but the barriers are many. Even if legal status is not a concern, the phone calls, the paperwork, the waiting, and the rejection are crippling. Rent and mortgages may not be due today, but in a month or two, how will that lump sum be repaid?

In the meantime, people need to eat and hold on to what remains of regular daily life. Food bank distributions are on the rise, but without reliable or safe transportation, access is again an issue. When food is received, people wonder when it is safe to consume expired products. Those who are undocumented hesitate before venturing out for food and other essential services, weighing the risk of deportation against potential benefits.

With regard to daily life, many families live in intergenerational households where, for some, tension grows because of increasing social contact for children, amidst concern for grandparents' safety. For the children, keeping up with school has been possible but difficult. Where there is broadband, there might not be a computer. Parents who are fortunate enough to be able to work from home struggle to provide the structure that many children need to complete their schoolwork requirements.

These pressing daily concerns are on the forefront people's minds. Access to psychiatric care, while important, is not yet center stage. When anxiety peaks and distress and despair take hold, what then? Again, there are issues and limitations related to internet access, literacy, and savviness with computers and other electronic devices.

We encourage you, our fellow psychiatrists, to consider how these factors may be impacting your patients. We encourage you to ask your patients about income, housing and food insecurity, barriers to transportation and reliable means of communication, intergenerational stressors, and ability to navigate federal and state resources. These social determinant questions will be critical for your patients and their mental health now and into the future. Several of these questions can be assessed using the newly developed Stoddard Kauffman Impact Scale: https://www.nlm.nih.gov/dr2/Coronavirus_Impact_Scale.pdf.

Additionally, during this time, there has been an increased focus on resource referral and management. For access and more information, please refer to the Community Care of North Carolina Triage Plus Line: https://www.communitycarenc.org/newsroom/ccnc-covid-19-triage-plus. Finally, in upcoming NCPA communications, please look out for other pieces from the Health Disparities Workgroup, which will continue exploring the impact of disparities on the mental health of our patients.

Special Considerations for Blacks/African Americans

Constance Olatidoye, M.D. & Nadyah Janine John, M.D., D.F.A.P.A.

Mortality rates of COVID-19 are disproportionately high for Blacks/African Americans. One must go beyond the social determinants of health to understand why. What are the unique aspects among Blacks/African Americans that result in this perfect storm? Here are some issues to consider and suggestions for how to "go-in" to address these issues with those you serve:

History

There can be a sense of distrust with the medical field, given the legacy of slavery in the United States and historical medical "trials" among Blacks/African Americans (e.g. the Tuskegee Study of Untreated Syphilis in the Negro Male: https://www.cdc.gov/tuskegee/timeline.htm). Even to this day, you may encounter individuals who can give you instances of Black/African American lives lost because physicians knowingly withheld treatment or undertreated.

You may sense some resistance from your Black/African American patients when you educate them on this virus. Consider asking your patient, "Is there anything you've heard from friends or family about COVID-19 that you'd like to ask my opinion on as your doctor?"

Current Realities

Some mistrust of the medical system by Blacks/African Americans can lead to conspiracies and "alternative truths." Well before the first documented U.S. case of death from COVID-19, social media posts circulated proposing that Blacks/African Americans were immune to COVID-19. This information, conveyed through joking posts and memes, spread quickly and extensively via likes, shares, and re-tweets. This myth, that Blacks/African Americans were immune to the virus, may have impacted the acceptance and implementation of mitigating efforts with Blacks/African Americans. You can inquire of your patients, "There is a myth that Blacks/African Americans are immune to the virus, what are your thoughts about that?"

Some Blacks/African Americans may not be wearing face masks despite the CDC recommendations. It is important to understand why wearing a face mask may not bode well for some. Blacks/African Americans have routinely been profiled as criminal or dangerous. Wearing a face covering, such as the suggested bandanas, scarves, and ski masks, is quintessential to a "bad guy." Among Blacks/African Americans, there may be a fear of being profiled, as opposed to a disregard for COVID-19 precautions. You may consider inquiring of your patients, "Do you wear a face mask? What face coverings do you have available? Any concerns about wearing a face mask?"

"Go-in" a Bit More

As of this writing, the infection rate of Blacks/African Americans in North Carolina with COVID-19 is 35%; the mortality rate is 34%. The likelihood that your Black/African American patient is directly affected by this disease is high. Ask your patients, "Do you know anyone diagnosed? Do you know anyone with symptoms? Do you know anyone who has died?"

As psychiatrists, our doctor-patient relationship has always been privileged by our ability to ask our patients for more personal information. Our patients are more comfortable hearing us ask about family dynamics, social stressors, and intimate details than hearing those questions from a helpline agent or an officiant at a public service office. We are in the unique position to inquire about things that really matter at this time to our patients. We have an obligation as health care professionals with this unique way of practicing to help flatten the curve for all citizens.

Pandemic Impacts Substance Use

Stephen Wyatt, D.O.
Chair, NCPA Addiction Psychiatry Committee

These are troubling times for all of us. The morbidity and mortality associated with the virus has been heartbreaking for many families and communities. Social distancing has created a variety of problems, many of which include behavioral health challenges. Financial stress, loneliness, and fear, just to name a few, are felt by many. These can create or exacerbate existing mental health disorders. One area of medicine that has not slowed during the crisis is psychiatry.

The use of alcohol and other drugs has often increased as people attempt to cope. We are seeing that currently. Though total sales of alcohol are down because of the discontinuation of on-premise sales, off premise sales have risen significantly. Online sales are up by 477% from a year ago. Restaurants and bars are trying to combat their losses by some creative offerings for takeout orders. Home delivery is legal in North Carolina, and this also contributes to the moderate increase in alcohol use and the stabilization of sales. Cocktail kits are being delivered all over the state, including airplane bottle size liquor selections.

The Alcohol Beverage Control (ABC) Commission charged with controlling the sale of liquor in the state is housed in the NC Department of Public Safety and is a direct report to the Governor's Office. There are 170 local ABC Boards across the state. Liquor stores are on the list of Essential Retail Businesses by emergency order. However, to be clear, each Board controls what is appropriate in terms of whether they stay open, for how long, and how it might be delivered. This is as the individual Board feels is most healthy for their community.

Under Governor Cooper's initial Executive Order, retailers were permitted to deliver beer and wine for off-premise consumption in the manufacturer's original container to vehicles at a curb or a parking space adjacent to their store without requesting approval of extension of premises from the ABC Commission. This emergency ruling was in part due to the social demand for alcohol and the clear danger prohibiting sales would pose for those physically dependent.

The use of alcohol and other drugs has often increased as people attempt to cope. We are currently seeing that.

As a sedative, alcohol is a drug often turned to relieve stress. For a short period of time, it can result in relaxation. However, with even moderate use, over one drink a day for a woman or person over 65 or two drinks for a man, there can be the opposite effect due to neurobiologic changes including tolerance and withdrawal. It can also alter our perception and decision-making abilities important in times of stress. Sleep, which is so important in managing stress, can be disrupted by alcohol. Sleep onset time can be shortened, but then alter sleep architecture, resulting in less healthy or reparative sleep.

For individuals with a history of alcohol use problems, these times can be problematic. They, too, frequently have been reliant on alcohol to help control their anxiety without recognizing it is only making it worse. Many have relapsed, resulting in a variety of health and social problems. These can be a result of the problems we are all dealing with but compounded by the lack of availability of face-to-face social supports that existed prior to the pandemic.

There are a variety of online AA meetings available across North Carolina (https://www.aa-carolina.org/aa_nc_city-county.html). For some people, these have been successful and even preferable. For others, especially those less comfortable with technology and reliant on the fellowship, this virtual format has been problematic. Anecdotally, I have had in the range of 20% of patients come into our hospital level withdrawal unit with a description of this playing a role in their relapse sometimes after months to a few years of sobriety.

Terribly, those fearful of COVID-19 are clearly making matters worse through alcohol misuse. Alcohol misuse results in greater susceptibility to viral infections by impairing the body's immediate immune response. Those with a long-term moderate to severe alcohol use disorder will have impaired respiratory immune cell function. Excessive alcohol use and the so often comorbid use of tobacco products will damage the cells lining the lung surface, which only becomes apparent when an infection occurs. This can also be associated with Acute Respiratory Distress

Syndrome (ARDS), resulting in the more frequent need for mechanical ventilation and more lengthy intensive care. Excessive alcohol use clearly increases the morbidity and mortality associated with the virus.

Beyond the negative physical effect, alcohol even when used episodically can impair judgement, putting a person at greater risk of not taking appropriate precautions and increasing the risk of infection. This contributes to troubling suicidality and suicide rates. It can also result in perpetration of violence through disinhibition and rageful behaviors. People most often lash out when they feel frustrated and unable to consider other solutions to a problem. This is associated with the rise in domestic violence we are now experiencing. This can, and often will, result in long-term harm to others, including children.

Though I have not found such data in North Carolina, there are reports suggesting significant increases in domestic violence, particularly among marginalized populations across the country and around the world. This has impacted gender violence, disproportionately impacting women. There are reports of spikes in calls to hotlines over the past two months. Compounding this are the movement restrictions on people. Clearly, there has been either inability to make formal complaints or hesitancy to make these reports due to isolation and the lack of alternative shelter.

We in the behavioral health field need to be on the lookout for how alcohol use may be contributing to a patient's complaints. Too frequently, if we don't ask or screen, we are not going to know when we should intervene. There are many ways we can help through evaluating and enhancing the patient's coping skills, considering the worsening or their underlying mental health problems, and considering the inclusion of psychotherapeutic or pharmacologic treatment of their alcohol use problem. But, we won't know unless we ask.

Not infrequently, patients are waiting for us to open that door. It can make a profound difference in the life of the patient and the lives of those around them.

Member Notes...

Kristin Baker, M.D., won her primary race for the NC House of Representatives District 82, representing Cabarrus County. Upon the death of Representative Linda Johnson, Dr. Baker was appointed to serve in the seat until the election in November. She is the first psychiatrist to serve in the NC House and is one of two physicians to serve in the NC General Assembly.

Jennie Byrne, M.D., Ph.D., D.F.A.P.A., Immediate Past President of NCPA, was recently appointed to the APA Council on Healthcare Systems and Financing for a two-year membership term.

Samantha Meltzer-Brody, M.D., M.P.H., Chair of the UNC Department of Psychiatry, received the 2020 Oliver Max Gardner Award, the highest honor conferred by the University of North Carolina system. Dr. Meltzer-Brody is the Assad Meymandi Distinguished Professor, as well as the director of the UNC Center for Women's Mood Disorders. In 2019, Dr. Meltzer-Brody received the APA's 2019 Alexandra Symonds Award in recognition of outstanding contributions and leadership in promoting women's health and the advancement of women. She was also recipient of the Psychiatric Foundation of NC's 2016 Eugene Hargrove Award for her exceptional contributions in the field of mental health research.

We want to hear from you... please don't be shy about sharing your news or your colleagues' news!

To submit an item for Member Notes, please email the NCPA member's name and details to info@ncpsychiatry.org.

Psychiatrists as Physicians and Psychotherapists: Advocacy in APA Caucus & NCPA Committee

Seamus Bhatt-Mackin, M.D., D.F.A.P.A.

My goals for this article are two-fold: to inform the NCPA membership about the work of the APA Psychotherapy Caucus and to invite NCPA members to join a newly forming NCPA Psychotherapy Committee. As I know a fraction of the people who may read this, I will start by saying a few things about my perspective.

When I finished my psychiatry residency – 12 years ago! – I believed myself to be a pretty solid psychiatrist and psychotherapist. I accepted a staff position at the Durham VA Medical Center, where I practiced emergency psychiatry and general outpatient psychiatry, including individual and group therapy. I was also developing as a clinician educator working with medical students and psychiatry residents in the Duke programs. I had acquired a strong foundation in the theory and practice of psychotherapy, for which I am grateful to teachers and mentors ***Drs. Phil Spiro***, Roy Stein, ***Harold Kudler***, Grace Thrall, ***Ron Vereen***, Russell Hopfenberg, and ***David Hawkins***, but I knew my experience was limited. I had so much more to learn! Fortunately, I was able to parlay self-advocacy, personal commitment, timely support from my clinical leadership – and good some luck – to additional professional opportunities, which furthered my development as a group therapist, a trauma therapist, and a cognitive-behavioral therapist.

At the time, I believed the deck was stacked against psychiatrists seeking to practice psychotherapy in organized health care settings. Nowadays, as I look around to the modern health care environment, I see even more barriers in the way of psychiatrists who seek to develop as psychotherapists and practice psychotherapy. For example, models of care delivery increasingly distinguish "prescribers" from "therapists" in the name of cost effectiveness, despite a lack of evidence to support improved outcomes or decreased costs (Gitlin and Miklowitz, 2016).

It turns out, I am not alone in my passion for psychotherapy! Psychiatrists across the country are getting active in advocating for our profession and for our patients with regard to the provision of psychosocial treatment by psychiatrists. For the last year, I have had the distinct honor and great pleasure to join the APA Psychotherapy Caucus Steering Committee in working on advocacy projects related to the practice of psychotherapy by psychiatrists.

The APA Psychotherapy Caucus: Taking a "Big Tent" Approach

The APA Psychotherapy Caucus was started in 2014 by a small group of APA members who shared a commitment to psychosocial treatment in the formation, identity, and skillset of psychiatrists. From the beginning, the Caucus was intentionally inclusive with regard to theoretical tradition – taking a "Big Tent" approach by welcoming psychoanalysts, CBT therapists, and psychotherapy-inclined psychiatrists who work in a variety of settings including inpatient wards, consult services, emergency rooms, and residential treatment centers.

The Caucus also included psychiatrists who practiced psychotherapy regularly in the past but who have fallen away from that work. Dr. Eric Plakun was the founding Chair of the Caucus Steering Committee, and Dr. David Mintz has served as Chair for the past two years. We are presently working on a number of short- and long-term projects, including developing additional useful content for the APA webpage related to psychotherapy, addressing the image of psychiatric identity, supporting early-career psychiatrists interested in psychotherapy, bolstering the education and training of psychiatrists in psychotherapy, and growing the caucus through outreach.

Psychiatric Identity and "Practicing at the Top of Our License": Integrated Care by Prescribing Medications and Providing Psychotherapy

In most health care systems, physicians are encouraged to "practice at the top of their license." Psychiatry is the only mental health discipline with the comprehensive training to allow practitioners to both prescribe medications and provide psychotherapy. This approach – one that is truly integrated across the biopsychosocial formulation – includes consideration of medical comorbidities, a knowledge of neuroscience, recognition of expanded options in psychopharmacology, as well as practice and continued training in core psychotherapy knowledge, attitudes, and skills. Prescribing medications while providing appropriate psychotherapy is described as truly "practicing to the top of the license" (Mintz, 2019; Welton, 2019).

In addition to the possibility of higher quality of care and better

outcomes with integrated treatment in clinically-indicated situations, and contrary to commonly-held assumptions about cost effectiveness of split treatment, empirical evidence suggests that integrated treatment (both medications and psychotherapy provided by a single clinician) is more cost-effective than split treatment (medications and psychotherapy provided by different clinicians) (Goldman et al., 1999; Dewan, 1999). To date, no studies provide evidence of improved clinical outcomes or cost-effectiveness from split treatment (Gitlin and Miklowitz, 2016), though there may be situations in which split treatment is the best or only available option.

Attending to Our Future: Early Career Psychiatrists Seeking to Practice Psychotherapy

The 2020 National Residency Match Program recorded the eighth consecutive year of an increase in the number of U.S. allopathic and osteopathic seniors matching to psychiatry residency positions (Moran, 2020). At the same time, as health systems increasingly recognize the importance of behavioral health as a part of overall wellbeing, there is great need for psychiatrists to join the field. In this climate of interest and need, graduating psychiatry residents are in an empowered position to negotiate arrangements with health care employers to include work descriptions and projects that fuel their passion, such as having appointments long enough to incorporate psychotherapeutic observations and interventions.

Despite increased interest in psychiatry and evidence for benefit from an integrated approach to patient care, many psychiatric residents do not encounter psychiatrist-psychotherapist role models in academic medical centers. Early Career Psychiatrists (ECPs) can have difficulty navigating – or even imagining – a career that includes continued psychotherapy practice and training. Thinking back on my own situation and factors that helped me forge my own career, I am eager to help more junior psychiatrists advocate for their own professional development and identity formation as psychotherapists. The APA Psychotherapy Caucus is developing resources for ECPs to access available information on training options, negotiating with potential employers, and providing a community of role models and mentors.

Outreach and Invitation: Newly Forming Psychotherapy NCPA Committee

The APA is composed of district branches (DBs), which are most often defined by state boundaries. At present, only a few DBs have local Psychotherapy Committees. In North Carolina, we are on the cusp of forming a Psychotherapy Committee with a goal of educating NCPA members on the provision of a variety of treatment modalities in psychiatric practice; supporting and encouraging medical students, psychiatry residents and ECPs with regard to psychotherapy; and coordinating with other NCPA committees on areas of advocacy around the funding of these treatments. Optimally, committee membership will be diverse, including representation of a wide variety of psychotherapy disciplines (psychodynamic, cognitive-behavioral, and other approaches) and clinical practice settings (private practice, community mental health clinics, health care organizations, and academic medical centers).

My own work in psychotherapy as a practitioner, a teacher, a supervisor, and even a client has been and remains rich, complex, meaningful, and deeply valuable. I am a passionate advocate for the benefits of psychotherapy, and I will do what I can to keep our profession involved in it. I know the effort will be more successful with more people involved, and I hope you will join us! We've got to get connected, get organized, and get to work.

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

How to Get Involved

Join the APA Psychotherapy Caucus:

1. Email Lisa Greiner: lgreiner@psych.org; or
2. Sign into the APA website, click "Member Profile" (upper right), select "Specialty Interests, Caucuses and Listservs," and check the box next to "Psychotherapy"

Express Interest in Joining the Newly Forming NCPA Psychotherapy Committee:

1. Email Dr. Seamus Bhatt-Mackin: seamus.bhatt-mackin@va.gov and the NCPA office: info@ncpsychiatry.org

Resident Spotlight: Perspectives on COVID-19

Nkechi Conteh, M.D., M.P.H.
2020 Graduate, Duke University Psychiatry Residency

In many ways, it has been a surreal experience to graduate from residency in the midst of a pandemic. One moment, we were preparing for the APA Annual Meeting, finalizing employment contracts, and compiling lists of patients to be transferred over the next two months. The next moment, activities had been canceled, job negotiations had been suspended, and clinics were closed. Hospital and State leadership appeared to be as shaken by the dizzying turn of events as we were.

After the initial shock, residents began with the struggle to make sense of the changes. That struggle was exacerbated by the loss of social support, which is a well-known factor in promoting resilience. We no longer had access to the usual support structures we so firmly relied on. Travel restrictions meant that family members could not return to Durham, and weddings and vacations were postponed. Moreover, the increased exposure risk meant that we had to keep our loved ones at arm's length, physically and sometimes emotionally.

There was the physical toll, as well. Continuous use of PPE left peeling skin and hands rubbed raw. Shifts became harder to complete due to the extra time spent donning and doffing clothing. It seemed that we were being spread thin across multiple roles: doctor, therapist, caregiver, lab assistant, volunteer. Furthermore, we felt that this disruption to our learning program meant that we would always have a lingering sense of being "incomplete." On the whole, the mental stress of residency significantly increased. The stakes had become higher. Living wills and anticipatory anxiety became hot topics of discussion.

Thankfully, we now have firmer footing as we navigate this experience. My residency program responded very quickly by reorganizing the curriculum to include disaster-related material. This may be recall bias, but I have never paid so much attention to a lecture this year as I did when listening to ***Dr. Allan Chrisman*** teach disaster psychiatry. We learned psychological first aid. We conducted a literature review of the mental health consequences of COVID-19 and impact on health care workers. We gained telehealth experience. On the informal side, new virtual connections were made for social engagement, such as poker teams and online yoga sessions. New skills were learned, like languages, sewing, and baking.

On my individual level, it has helped to focus on the positive side of things. I learned to disengage from conversations with well-intentioned friends who touted conspiracy theories as indisputable facts. I cut down on my news consumption. My mother joined Facebook. (I choose to view that as positive.) And the deeper understanding of the precarity of life made each moment spent in conversation with friends and family more precious.

Overall, there has emerged a sense of fulfillment in the realization that this is why we became physicians in the first place. It is not so much a matter of heroism, rather it is about achieving our purpose in life and being all that we can be. We have been tested beyond our expectations, and not only are we surviving, we are evolving. But this evolution is not restricted to physicians, nor is it one in which only the fittest survive. It is one where the beauty of humanity has shone within the darkest of shadows. The kindness we have shown to one another, the heartwarming gestures expressed across countries speaks to the indefatigable spirit of humankind. I am certain I am not alone in my belief that we have become better doctors and better persons since COVID-19. It is a privilege to serve in these trying times. May the lives lost and the lessons learned never cease to hold dear in our memories.

Nkechi Conteh, M.D., M.P.H. recently graduated from psychiatry residency at Duke University. During Dr. Conteh's residency, she served as Chair of the Duke Hospital-wide Resident Council. She is a former Association of Women Psychiatrists International Fellow and is currently a Group for Advancement of Psychiatry Fellow and an American College of Psychiatrists Laughlin fellow. Her interests include reproductive psychiatry, disaster psychiatry and global mental health.

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Calendar of Events

Every Thursday Evening, 6:00-7:00 p.m.
NCPA Living Room Chat
What's on your mind? Join Drs. Harold Kudler and Scott Klenzak for this friendly and informal conversation with your colleagues from across the state. Check email for Zoom link.

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