NORTH CAROLINA Psychiatric Association news

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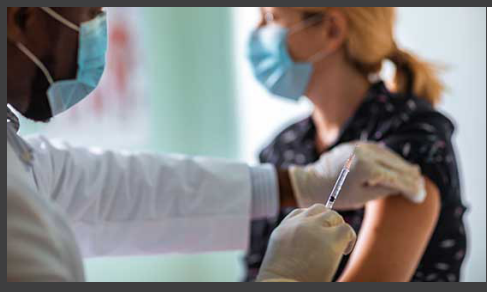
SPECIAL ISSUE | COVID: One Year Later



IN THIS ISSUE

Remember to Deduct Your 2020 Dues!

Remember that a portion of your NCPA and APA dues are tax-deductible as a business expense.

NCPA 2020 Dues: You may deduct 95 percent. (All but 5 percent of your NC dues are tax-deductible.)

APA 2020 Dues: You may deduct 96 percent. (All but 4 percent of your national dues are tax-deductible.)

For assistance determining the amount you paid in 2020 for dues, email info@ncpsychiatry.org.

Pandemic Poetry Reflections

Editor's Note: NCPA asked members to submit personal reflections on the past year, and we are honored to share the collection of poems we received. Due to space limitations, not all submissions have been printed. To view the full collection, please visit the NCPA website: www.ncpsychiatry.org/covid-reflections.

"2020 Eyes Shut Open"

I. Fear, panic;
runaway virus.

Riots, anger;
loss of control.

Disunity, frustration;
disarray nation.

II. Pain, loss;
death in the air.

Stress, distress;
overwhelms the senses.

Hopeless, futile;
steals the soul.

III. Lock, isolate;
change our practice.

Phones, videos;
steal the show.

Change, routines;
mars our sessions.

IV. Listen, caring;
rides the Zoom.

Dash, mash;
does what works.

Being, doing;
shows our concern.

V. Rising, lifting;
bringing light.

Fighting, dreaming;
never giving up.

Laughter, smiling;
rides the surf.

VI. Love, humility;
virtual hugs.

Peace, grace;
raising spirits.

Light, touch;
seeing freshness.

VII. Dawn, rising;
brand new day,

Mirth, play;
give us purpose.

Eros, whimsy;
shines so bright.

-John Shin, M.D., F.A.P.A.

continued on page 10...

From the Editor: Creativity in the Time of Covid

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

Considering creativity in the broadest "problem solving" sense, it's not hard to find examples of how professionals have to be creative to continue caring for their patients. But perhaps it is instructive, or at least inspirational, to consider creativity in the literary sense.

The story of Mary Shelley's novel-*Frankenstein* deserves reflection here. At age 18, she and poet Percy Bysshe Shelley visited Lord Byron at his home near Lake Geneva, Switzerland. The year was 1816, and the region was trapped in a "mini-ice age" due to atmospheric changes from the eruption of the volcano of Mount Tambora.

To pass the time during their confinement, Lord Byron proposed they each write an original story. The details of how this legendary story grew from the mind of young Mary Shelley are fascinating but beyond this writing. Rumors of what other activities Lord Byron suggested for passing the time will also not be repeated here.

The story *Frankenstein* was not the only remarkable act of creativity by the group during their isolation during that "volcanic winter." Lord Byron wrote a fragment of a story about vampires that others evolved to the modern version of the "romantic" vampire. (Polidori, The Vampyre: 1819.)

The changes in our lives due to the pandemic will be with us for a while. Challenges continue. Could there also be opportunities? Get creative.

NORTH CAROLINA Psychiatric Association news

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President's Column: Moving Forward

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

I recall that in my early days with NCPA, it was difficult to keep track of the organization's timing of election cycles and changes in leadership. For those of you not yet fully attuned to the workings of NCPA, let me offer a summary: Leadership changes over during the APA Annual Meeting, which is in late April or early May each year. Presidents and vice presidents serve one-year terms, so we annually pass on the gavel to the new president of the organization. This person had been elected the year prior and served on the Executive Council as president-elect throughout that time.

In the past, the changeover would typically occur during an in-person gathering at the APA Annual Meeting, but obviously that part changed in 2020 and will not occur this year either. As this year's APA Annual Meeting is fast approaching, we will soon be welcoming in new leadership, and this will be my final column as president of NCPA.

As I write this column, I am reflecting on where we have been over the past year. At this time last year, I was making my plans to attend the APA Annual Meeting in Philadelphia and planning my priorities as president for the upcoming year. Then the world changed, the APA Annual Meeting was cancelled, and all of those priorities shifted. This year was certainly not what I had envisioned or planned, but in many ways the organization was more prepared for the pandemic than we had realized. We were able to utilize remote working and videoconferencing quickly and effectively, and thereby able to continue to support our membership through that period of initial uncertainty.

Then came the horrific murder of George Floyd on May 25 by Minneapolis police officers. This was not the first time such an event had occurred, but between the widely seen video evidence, and the fact that so many Americans were at home and able to stop and think about what was happening, this event produced an awareness and a demand for change at a level not seen in many years. NCPA was spurred by these events to make changes to increase diversity in the leadership of our organization, to create more educational opportunities for our members, and to increase advocacy for policies to improve equitable access and quality of treatment for underserved groups.

We recognize that there is so much more to be done, and there should have been much more done over the last 60 years (and before). However, I do believe what we have started in the past year is an honest, concerted effort to make real change, and NCPA is committed to making this change an ongoing process. We have created the NCPA Race, Ethnicity, and Equity Committee, which organized our panel discussion on discrimination and equality for our Annual Meeting and has held subsequent meetings to "Continue the Conversation." The most recent of these featured a presentation and Q&A session with Regina James, M.D., Chief of Diversity and Health Equity for the APA. NCPA has taken the step to have this committee select a member to serve on the Nominating Committee each year to have a strong voice in ensuring diversity in the future of NCPA leadership.

As we look ahead to our population being vaccinated for COVID-19,

while also looking at the threats of new variants of the virus spreading throughout the world, there is much uncertainty going forward. It may be that we will be dealing with this novel virus in some form for years to come. Certainly changes in racial justice will need to be ongoing throughout our lifetimes and beyond. To me, these uncertainties only reinforce the value of this organization, which brings psychiatrists together from across the state to share ideas, provide resources, and advocate for our needs.

Looking ahead, NCPA is in a strong position with membership that has a strong representation from trainees to retirees, giving us a broad perspective and range of opinions. We also have an extremely strong leadership team on Executive Council that will be taking over in May. Our incoming leaders include ***Alyson Kuroski-Mazzei, D.O., D.F.A.P.A.*** as president, ***Michael Zarzar, M.D., D.L.F.A.P.A.*** as president-elect, and Constance Olatidoye, M.D. as vice president.

I look forward to our future as an organization, and I am optimistic that we will be able to help each other through the challenges we will face.

Notes From the Disaster Committee Co-Chairs

Part One: *Allan Chrisman, M.D., D.L.F.A.P.A.*

I am currently awaiting any side effects from the second shot of the Pfizer COVID-19 vaccine. Expectations of a "kick" from this second shot abound in my emotions and daily schedule, which has been cleared of any meetings or commitments. Being fully retired of any patient care has made this easier but not without some apprehension. A time for self-reflection about 2020 and the lost opportunities.

Listening to an NPR interview on my way home from the vaccination appointment with aspiring musician Madison Cunningham, whose song "Broken Harvest" (written specifically for NPR) about the silver linings of dashed plans, summed up my sense of what many young adults are experiencing.

"You had the initial momentum and there's no way to continue it because there's no road… us passionately, carefully planting our seeds so that they can grow in time for, you know, the harvest! And then, 2020 — the big fat hailstorm comes."[1]

Then at home as I sat going through e-mail, I came across a Working at Duke message about a poem for social justice by Trina Rodriguez who worked with a colleague to record "Who Could Understand the Plight of a Black Man."

This poem addresses and reflects on the struggles Black men continue to face in the United States. These two individual accounts of life in these times brings an enriched meaning to the studies and statistics about the dire struggles of life and death plaguing our communities.[2]

So, what about the vaccine? Is that the light at the end of the pandemic tunnel? Where are we now and how has the Disaster Committee continued to respond?

The Disaster Committee has continued weekly Tuesday 7:30 am Zoom calls, monthly Zoom calls with the academic Chairs of the major health systems, monthly Living Room Chat sessions, and twice monthly task force meetings on racial inequalities in health care. Our collective strategy has been to listen to our members and the communities with both a private and public health perspective on providing resilience support for the well-being of all.

The prominence of health care inequities suffered by historically marginalized populations has been both a challenge and call to action. How to prioritize our support through advocacy on a local, state and national level continues to drive our efforts.

Facilitating these efforts, NCPA Executive Director Robin Huffman has worked diligently with the NCPA Executive Council to ensure that we have a voice at the table of state agencies and the legislature. Getting and disseminating timely information on resource allocations – including testing, vaccine distribution, and financial support – continues to be an essential element of more recent initiatives.

Ensuring that individuals with Serious Mental Illness, along with children and persons with Intellectual and Developmental Disabilities, are not left out has been a major part of this effort. Monitoring the mental health crisis of this epidemic ebbs and flows and once again has become a prominent element of concern.

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Part Two: *Therese Garrett, M.D.*

In our clinical practices, many of us are continuing to see the impact of the pandemic on the mental health of our patients. There are the elderly who are isolated or living in nursing homes and have been unable to see their friends and family for a year. There are the young- and middle-age adults in the sandwich generation, concerned about their elders while also juggling remote and hybrid learning situations. There are the youth in our communities, some of whom with social anxiety are breathing ongoing sighs of relief at being able to stay home, while others are struggling with remote academic supports and limited peer interactions.

On our inpatient units, our psychiatrists are navigating the complexities of quarantine and isolation of positive patients and staff, while also dealing with the difficulties of finding placements for those patients with housing instability or in need of long-term care at nursing homes or group homes.

At the same time, we are seeing immense resilience. Parents are learning to accept Donald Winnicott's concept of the "good enough" mother by actively deciding which of the many juggled balls can be dropped. Children are settling into a new school routine and setting that none of us, nor our parents

or grandparents, experienced as youth. All of us are learning new ways to connect with our friends, colleagues, and families, along with new ways to celebrate and new ways to grieve our losses.

As we observe these challenges and successes, we are looking forward to the next step in the process: the vaccine. What is the role of psychiatrists in the vaccine rollout? How can we support, whether it is through volunteering at vaccination pop-ups or just keeping the discussion of the vaccine on our radar with our clinical interactions with patients?

Recent research has confirmed that individuals with schizophrenia are at high risk for COVID mortality. In our roles as psychiatrists, many of us have worked closely with our patients to allay concerns and fears they have about other treatments, including long acting injectables. Now is our opportunity to continue those conversations around separating fact from fiction about the vaccine, as well as working to allay well-deserved historical mistrusts of the systems for minority populations with whom we work.

At the present moment, the healthcare workers and older patients we work with are in the groups eligible for the COVID vaccine. Over the coming weeks and months, many of our patients – and our patients' parents, grandparents, siblings, and others – will become eligible.

Starting the conversation now, when patients bring up anxiety, stress, mood changes, fears, or obsessions about COVID and its impact on their mental health, allows us the opportunity to extend our reach as health educators not only to our patients, but to those in their inner circles.

In this role, we can combat misinformation and point North Carolinians to "Find your spot to take your shot." We can do motivational interviewing around vaccine hesitancy and discuss harm reduction for those who adamantly refuse the vaccine. We can continue to build on our relationships and alliances with our patients as we move into the second year of this pandemic to instill hope, advocate for our patients, and support our communities.

From 300 to 3,000: Nerissa Price, M.D. & "Sister Circle" Help Vaccinate Raleigh's Black and Brown Communities

300 doses. That was the vaccine allotment that WakeMed initially agreed to provide when the "Sister Circle," a group of five Black Raleigh physicians, asked administrators in January for help getting shots to more Black and Brown communities.

At first, there was some question of whether they could find 300 willing recipients. But by the end of February, the Sister Circle's efforts have vaccinated more than 3,000 people.

One physician in the Sister Circle is psychiatrist ***Nerissa Price, M.D.***, a Wake County native. She had witnessed how the pandemic disproportionately affected Black and Brown people – those who looked like her family members and even herself.

"I was disheartened a bit when I would hear some of our medical leaders and colleagues say, 'These deaths are due to healthcare disparities, and there's not necessarily a whole lot that can be done about it.'"

Dr. Price took that personally, knowing there was plenty to be done if she and others rolled up their sleeves. By partnering with churches, fraternities, sororities, and other leaders, the Sister Circle and other volunteers spread the vaccine message through the community's most trusted sources.

Dr. Price says that psychiatrists need to be reaching across to our physical health providers and seeking out opportunities to partner.

"We have a lot of work to do to help people with the mental health repercussions of the pandemic, but I think sometimes we have to break outside of our comfort zones and say, "Ok, I'm actually going to give out shots.'"

Whether it is vaccinating newly eligible groups or giving out second doses, Dr. Price says the Sister Circle and their partners are committed to helping until they are no longer needed. If you are available to lend a hand, please contact Dr. Nerissa Price at neprice@wakemed.org.

Race and Equality in Clinical Terms: How Can Psychiatrists Talk About Race?

Harold Kudler, M.D., D.L.F.A.P.A., NCPA Health Disparities Task Force

Unjustifiable killings of Black women and men, nationwide social unrest, and significant racial disparities in health outcomes during the pandemic place racial issues at the very top of the page for health professionals and the lay public, alike.

In reflecting on my personal responsibility as a psychiatrist, I'm reminded that I received little training on this issue during medical school and residency. That said, given the longstanding health inequities illuminated in high relief by COVID-19 and what I've learned (mostly outside of my formal education) about tragic miscarriages of Medicine across history, I can't escape the conclusion that these issues are an inherent and essential aspect of medical practice.

Examples include the Tuskegee syphilis study and the participation of physicians in the sterilization of nearly 7,600 women and men (including boys and girls as young as ten years of age) in North Carolina from 1929 to 1974. Non-whites (predominantly Blacks and some Native Americans) accounted for 40 percent of those sterilizations. With this in mind, I have a clear duty to inform myself about the intersection of race and medical practice and to share what I learn with colleagues and trainees.

Psychoanalyst Dorothy Holmes points out that clinicians trained to identify and respond to issues of developmental neglect and psychological trauma never-the-less remain blind to the daily impact of racial prejudice on their patients' health.

Holmes asserts that, "…the deep divides in our communities occasioned by our civilization's failures to deliver on its promises [of racial equality] have occasioned intrapsychic pain as well as social disruption… [and] this source of intrapsychic pain has been underrecognized and underutilized…" by clinicians.

In taking a clinical history, clinicians too often skim over the impact which systemic racism may have had on a presenting mental health problem.

I'm reminded of the work of a colleague, Maria Yellow Horse Brave Heart, Ph.D. Dr. Brave Heart, a social worker, is Associate Professor in the Department of Psychiatry and Director of Native American and Disparities Research at the University of New Mexico. A member of the Lakota people of the Sioux Nation, she developed the concept of historical trauma in the 1980s to understand social and health problems endemic among Native Americans. Historical trauma is understood as the cumulative effect of emotional and psychological wounding over the lifespan and across generations, rooted in massive group trauma.

My career as a Department of Veterans Affairs clinician, researcher, and advocate in the field of PTSD sparked an interest in the multigenerational effects of psychological trauma. These may be transmitted psychologically, socially and/or biologically. As an example of the latter, the new field of epigenetics demonstrates that, while a person's genotype remains constant over a lifetime, the way that code is transcribed can be altered by extreme psychological trauma resulting in phenotypic changes within a single generation which may then be passed down to descendants as a "fast track" adaptation to a hostile environment.

The recently established International Center for the Multigenerational Legacies of Trauma (https://icmglt.org/) provides a library of over 2,000 entries exploring the many ways in which trauma on the personal and/or population level can resonate across generations.

A few weeks ago, I was invited to address a group of psychiatrists on the issue of racial disparities in clinical practice and public health. In preparing that talk, I was tempted to fill the allotted time with demographic data and research findings from the burgeoning literature on race-based health inequalities. I also considered pointing listeners to a host of op-eds, documentaries, recorded professional town hall meetings, and several best-selling books.

Still, in thinking about my charge to facilitate a meaningful conversation with fellow clinicians, I realized that I'd be most effective if I tried to get to the heart of the matter with them in the same way that I've learned about racial disparities myself, through clinical experience.

The two cases which I chose to share were of veterans I got to know intimately through my VA clinic. In each case, these Black veterans identified racial prejudice as both a precipitating and a sustaining factor in their mental health problems.

Both faced the problem of how they could talk about these problems (much less overcome them) through their work with a White psychiatrist. I also did my best to describe my often-flawed efforts to meet their needs.

Their case histories were carefully disguised so that they could not be identified by my audience. Further, the small group of clinicians who I was addressing understood and agreed to respect the confidentiality of the clinical material which I shared. In preparing this article, I made the decision not to share these case histories here (not even in disguise) because there is no way to control where this article may circulate or to respond to conclusions which readers might (rightly or wrongly) make about the identities of my patients.

My main purpose in writing is to share what turned out to be an effective way to open a difficult conversation. Had I presented data, wise quotes, and abstract theories, I would have quickly lost my audience and failed in the mission which brought us together. Individual study and expert consultation are essential in preparing for clinical practice but speaking frankly with fellow clinicians about the challenges of clinical practice within a society which maintains distinct if often subconscious color lines is equally indispensable.

As psychiatrists, we have great respect for the intellect, but we also know that intellectualization can function as a defense against even being aware of concerns that make us anxious. By speaking about one's work with patients, there is a better chance of opening a deeper and more clinically useful exploration of the many ways in which systemic racism and historical trauma have impact on our daily work as psychiatrists.

I approached my task with humility because I had no answers to share. The clinical vignettes I offered illustrated my struggles in caring for (and about) people who I respected. I emphasized that my patients had been willing to take a chance in talking about racially charged issues with me and that we were all learning and growing in the process.

I'm pleased to report that this approach led to a thoughtful conversation among peers in which virtually every attendee contributed and which ran half an hour past the allotted time. We did not resolve all questions nor did we all achieve full enlightenment but I think we will be better prepared for future conversations with our peers and more thoughtful about interactions with our patients: I gauge that as a significant success!

Issues of race, disparity, and historical trauma relentlessly inhabit our professional lives. Patients tell us intensely personal stories which they may have never previously put into words, not even for themselves. It is essential that we tune our ears to what they are saying and equally important that we take our own pulse before responding.

As Dr. Holmes points out, we must apply skills we've built over a career to enhance our awareness of current events, personal histories, and the enduring effects of multigenerational legacies of trauma. It is precisely because of our core psychiatric values and skills that we have a special obligation to listen, respond, and lead in this.

Continuing the Conversation with Regina James, M.D.

NCPA continued the conversation with members by inviting the APA's Deputy Medical Director and Chief of the Division of Diversity and Health Equity, Regina James, M.D., February 4 for "Continuing the Conversation." This event, attended by almost 30 psychiatrists across the state, was the second in the members-only quarterly series planned by the NCPA Race, Ethnicity, and Equity (REE) Committee.

Dr. James gave a short presentation and then was interviewed by ***Constance Olatidoye, M.D., D.F.A.P.A.,*** a member of the REE committee, and took questions from the audience. She updated the group on the work of the APA's Presidential Task Force to Address Structural Racism Throughout Psychiatry and shared personal reflections.

The next "Continuing the Conversation" session is planned for Thursday, May 6.

What Psychiatrists Need to Know About... Methamphetamine

As Meth Use Rises Across NC, Treatment and Recovery Approaches Remain Challenging

Charles T. Browning, M.D., NCPA Addictions Committee

As a new decade begins, methamphetamines are poised to make a comeback. During the American Society of Addiction Medicine (ASAM) Virtual 2020 session, "Methamphetamine 2020: An Update," Richard Rawson, Ph.D., research professor at the University of Vermont and professor emeritus at the University of California, Los Angeles, said some are referring to the reemergence of methamphetamine and cocaine as the fourth wave of the 21st century opioid crisis.

"The dramatically increased availability and use of these psychostimulants poses numerous serious public health challenges," he said. "During the past five years, overdose deaths associated with cocaine and methamphetamine, mixed with fentanyl, have dramatically increased. Demand for effective treatments is currently a top priority."[1]

This ASAM Virtual 2020 session highlights a national trend emerging in more parts of North Carolina, although methamphetamine has been a presence for years in western parts of the state.

In the more central and eastern areas, where I work with Opioid Treatment Programs and crisis facilities that each do regular urine drug screens, we have seen methamphetamines go from a rarity to regular daily occurrences.

What does this "fourth wave" ushering in an increase in the use of stimulants alongside the continued use of opioids mean for North Carolina? It adds complexities to risks in overdose, changes in the types of comorbid medical and behavioral health conditions we will see in acute and chronic care settings, and presents us with more complex treatment situations and needs.

Nationally, there have been increases in methamphetamine and cocaine overdoses, as well as a sharp increase in overdoses related to a combination of stimulants and opioids. There are likely multiple factors for this, including:

- Purer forms of methamphetamine coming into the country;
- Greater availability of it in more markets due to supply/demand;
- New presence of synthetic fentanyl products in cocaine and methamphetamine, causing overdoses in opioid naïve populations.

Combinations of these drugs also create complexity and unpredictability in management of opioid overdoses in emergency settings.

Methamphetamine usage will also lead to a greater need for expertise statewide in managing the behavioral health needs of those who present for psychiatric and behavioral concerns for acute and chronic issues. At one of our crisis facilities in Arizona, the numbers of people presenting monthly with methamphetamine as a factor is in the hundreds, and it is the main presenting substance of use.

Many people present with homelessness, serious mental illness, and chronic use of high amounts of methamphetamine. They have higher risk of legal involvement and are much more likely to be violent and aggressive during their crisis stay (making up the majority of incidents that involve use of seclusion and restraint at this facility).

We have developed specialized protocols to help manage their crisis stay focused on creating a non-stimulating, supportive environment accompanied with principles of early intervention. The underlying themes are "calm, quiet, food, rest, and offering voluntary oral meds," for those presenting with acute intoxication.

For the majority of those presenting with acute agitation related to stimulants, the American Association of Emergency Psychiatry project BETA guidelines focus on oral benzodiazepines as frontline treatment, followed by parenteral benzodiazepines if needed for emergent safety issues.

When psychosis is present, add the use of oral SGA (second-generation antipsychotics). If no psychosis when the use of emergent forced meds is indicated, again use IM benzo first. If psychosis is present, then add IM SGA. The use of benzodiazepine (usually lorazepam) monotherapy minimizes oversedation, allowing the person to more quickly participate in their treatment compared to combining antipsychotics. This has some protective factor for seizure risk present with stimulant overuse. There are chronic cases of methamphetamine use involving psychotic symptoms with the agitation where combining antipsychotic treatment with benzodiazepines may be helpful.[2]

There are key physical health issues to be considered with the presentation of acute intoxication. Common dangers to screen for include rhabdomyolysis, renal failure, intracranial hemorrhage, cardiac effects (such as ventricular tachycardia), and seizure. Chronic conditions to evaluate in ROS and exam include dental, skin, cardiac, end organ damage, and psychiatric effects.

With the lack of medication-assisted treatment (MAT) options for opioid use disorder (OUD) and alcohol use, the longer-term recovery approach to the combined or sole use of methamphetamine is still a challenge. Some limited options are being mentioned in recent studies with limited benefits including mirtazapine, topiramate, a combination of injectable naltrexone and bupropion, and naltrexone as a sole agent. But the mainstay of treatment has been cognitive behavioral and contingency management therapies, motivational interviewing, and community management programs.

A focus on harm reduction aspects include promoting naloxone kits, even to those that use stimulants without intent to use opioids. Other harm reduction approaches focus on health consequences associated with methamphetamine use, including the specific harms caused by risky sexual behavior, fentanyl testing kits, and needle exchange programs.

Another treatment concern to be addressed is the disparities in care related to race and other demographics. A recent study (2019) in Boston looked at the breakdown of deaths related to opioids vs. opioids and other substances. They also evaluated the relations of social and other demographics. "City dwellers, non-Hispanic Blacks, people with a mental health diagnosis, and people with recent homelessness were all more likely to have died with opioids and stimulants in their system than with opioids alone."

A continued focus on evaluating systems and processes that create barriers of access and engagement for specific groups is also a necessity moving forward in evaluating and designing treatment continuum and approaches to care.

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...“COVID-19 Poetry Reflections,” continued from page 1

“2020”

On doing therapy
sitting barefoot
at home.
Anguish with a
backdrop
of domesticity.
Online schooling
in the next room.
White noise machine
hums in the hall.
A tangle of face masks
near the door,
next to
the hand sanitizer,
right by
the now seldom used
car keys.
The doorbell rings,
the blue van
with a swoosh on its side
drives off.
What will we have for dinner?
And who will do the dishes?
All blurs as I see the face on my screen.
I move back
into another world.
I am
present
in another’s life,
whose pain is clear,
even
on zoom.

-Samina Aziz, M.B.B.S., D.F.A.P.A.

“Six Feet Away”

For Ellen W. Huffman, 11/24/28-4/22/20

Condolences extended, flowers delivered six feet away.
Grieving without hugs or human touch.
Mourning alone.
No living room gatherings of families and friends.
No tables laden with food to nourish bodies bereaved.
No clutches of friends sharing long-ago stories and happy memories.
No laughter at her funny, silly ways and words.

No laughter.
Solitary tears.
Sobs unembraced.
Emptiness inside.
Grief in a vacuum.

When one dared to imagine such a day,
it would be tinged with great sorrow,
but comfort would be taken by the thousands of lives she touched,
jokes she’d made,
pews filled with those who came to pay their respect.

Instead, only family gather in graveside huddles.
Six feet away.
Six feet away.
Six feet away.

-Robin Huffman, NCPA Executive Director

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Resident Spotlight: Dr. Kulukulualani [Virtually] Goes to Washington, Part 3

Anthony Kulukulualani, M.D., PGY-3, East Carolina University Brody School of Medicine
APA Jeanne Spurlock Congressional Fellow

"5, 4, 3, 2, 1…Happy New Year!" We exclaimed in unison. Laughter and cheer filled the dark street that ran down the mountain into the valley. Debris from popped fireworks littered the roadway.

The New Year celebration is normally a big family event for us, but the pandemic curtailed many of those traditions this year. Still, I was happy to be home in Hawaii. I spent the next few days catching up and reminiscing with family members while we toured the scenic attractions of Oahu. The easy-going island lifestyle was a much-needed break from the "hustle and bustle" of work. I reluctantly packed my bags to return to my home in North Carolina. It was January 5.

"I hope you all are safe. We will reconvene tomorrow." The text in the group chat sent chills through my body.

The news coverage of the attacks on Congress on January 6 was broadcast from every television in the airport. Although my remote work on Capitol Hill has had disadvantages, I was grateful this time to be working from home.

We had a staff meeting the next day to process our feelings about the insurrection events. The mixed emotions expressed on the call were overwhelming for me, but the staff support was incredible. Eventually, everyone settled back into the normal "hustle and bustle." Fear and uncertainty turned into hope as we approached the inauguration of President Biden.

Working in a new Congress and with a friendly Administration has kept me quite busy this past month. Senator Smith's health policy team has reintroduced legislation on mental health, substance use disorders, social isolation amongst older adults, maternal health, and the social determinants of health. We have discussed the Senator's yearlong health priorities, met with constituents and advocacy groups, attended briefings, prepared hearing memos, worked on the next COVID-19 relief package, among many other responsibilities.

"I hope you all are safe. We will reconvene tomorrow." The text in the group chat sent chills through my body...

Although my remote work on Capitol Hill has had disadvantages, I was grateful this time to be working from home.

The legislative strategies used by both parties have also changed now that the Democrats are in the slim majority in the Senate. I have learned about and participated in different legislative processes, such as the vote-a-rama as part of the budget reconciliation process needed to pass the next relief package.

As a member of the Senate Health, Education, Labor and Pensions (HELP) Committee, Senator Smith has participated in the nomination hearings for Attorney General Xavier Becerra to be Secretary of the Department of Health and Human Services (HHS), Dr. Vivek Murthy to be the Surgeon General, and Dr. Rachel Levine to be Assistant Secretary of Health and Human Services.

Prior to this fellowship, I had no knowledge of these types of events. I now have a greater appreciation and insight into the impacts these types of appointments may have on health policy and legislation.

As the fly-in season of March approaches, I hope to continue learning and growing both professionally and personally through this fellowship experience.

When a Student-Run Clinic Goes Virtual

Enioluwafe Ojo, M.P.H., Fourth-Year Medical Student, UNC School of Medicine
2020 NC Council of Child and Adolescent Psychiatry (NCCCAP) Marc Amaya Award Winner

"Hey, are the student doctors back?" This was the fifth time Marlee* virtually reached out to me in three months. She had been receiving care with the Student Health Action Coalition (SHAC) Mental Health, a student-run free clinic (SRFC) affiliated with the University of North Carolina, for about three years. She was among 24 patients who suddenly lost a mental health provider amid the pandemic.

"I think so, but it will become a virtual clinic," I responded with apprehension. I had just started my second year with SHAC Mental Health, as the clinic director. The first thing on my agenda was addressing the four-month suspension of our services. The clinic's referrals were at an all-time high.

COVID-19 has a massive influence on the country's collective mental health. Psychological sequelae secondary to COVID include depression, anxiety, stress disorders, stigma, emotional outcomes, and insomnia[1]. With our inbox overflowing with requests, we had to come back. Providing care in a virtual setting was not something we ever envisioned.

SHAC Mental Health is a comprehensive, student-run mental health clinic covering Chapel Hill, Carrboro, Durham, and surrounding areas. Senior medical students, psychology graduate students, pharmacy students, social work students, residents, and attendings all come together to make this dream work. In general, SRFCs are becoming increasingly common. They provide incredible opportunities for students to practice medicine while exploring career options. Few of these clinics include in-depth opportunities to manage behavioral and mental health illnesses[2].

In fall 2017, fourth-year medical student Kate Dickerson envisioned this clinic. She hoped to provide quality mental health care to those without reliable health insurance. Dr. Dickerson, now a second-year psychiatry resident, reached that dream. Four years later, the program has become a haven for BIPOC (Black, indigenous, and people of color) individuals, low-income citizens, and the uninsured. The clinic partners with other SRFCs that target vulnerable populations, including SHAC Gender Affirming Clinic and Bridge to Care.

> *With our inbox overflowing with requests, we had to come back. Providing care in a virtual setting was not something we ever envisioned.*

As we started our telehealth adventure, we had one goal: provide high-quality care that met guideline standards. Six months later, we have successfully transitioned to virtually managing our patients. It has been challenging, but I am grateful for the experience. Personally, I have developed new leadership skills in health law and business management. As a whole, the clinic has gained new adaptation skills. Here are other key highlights from our reflections.

More Learners. Physical space was a significant barrier. In our new setting, there is more "office space." More space meant more potential for students and trainees to participate. We doubled the number of team members this year!

More Student Autonomy. Medical student providers have become the face of SHAC Mental Health. In a virtual setting, communication between patients and multiple providers can be circumlocutory and inefficient. It is also an administrative burden on the patient. Our medical student providers have transitioned to become the point person of individual patients. They serve as the primary communicator for individual patients and our large interprofessional group. Student providers report enjoying more autonomy and higher quality learning opportunities.

continued on next page...

...“When a Student-Run Clinic Goes Virtual,” continued from previous page

More Marlee.* Reviving our relationship with our long-term patients is the best part of our virtual clinic. A long-term relationship with a patient is a luxury in undergraduate medical education. Maintaining a consistent connection with the community is also one of our core values.

Telehealth care can give plenty, but it also takes. Significant clinical consequences exist with telehealth platforms[3]. We are unable to provide all our previous services in this setting. Our target population is less likely to have access to laptops or reliable phone service. We no longer feel comfortable managing complex patient cases, given the limitations of virtual care.

Going virtual has been the best, safest alternative for our clinic. We have learned new skills, met new people, reconnected with our patients, and expanded our team. I eagerly look forward to the day when SHAC Mental Health can resume in person. However, this time as a virtual clinic has positively reshaped us and will have a remarkable lasting influence.

**The name and other details have been changed to protect patient privacy.*

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Enioluwafe Ojo, M.P.H. is a fourth-year medical student at the UNC School of Medicine, applying to psychiatry. She completed her Master's of Public Health at the UNC Gillings School of Global Public Health, where she studied ethnic variation in mental health care pathways in the state. Her career interests include incarcerated populations, mental health policy, and DEI in medical education. In her free time, she loves to make ciders and pickle foods. She hopes to own chickens one day.

APA Announces 2021 Honorees

Congratulations to the following NCPA members who have achieved Distinguished Fellowship, Fellowship, and/or Life Member status! New honorees will be formally recognized at the APA Annual Meeting in May. *Please note, honorees listed below may hold additional distinctions other than those most recently awarded.*

Please let the NCPA Fellowship Committee know if you are interested in becoming a Distinguished Fellow or a Fellow by emailing info@ncpsychiatry.org.

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Calendar of Events

3rd Thursday of the Month
NCPA Living Room Chat
Join NCPA and your colleagues from 7:00-8:00 pm for support, advice, and camaraderie.
(Check Email for Zoom Link)

April 17, 2021
NCPA Executive Council Meeting
(Via Zoom)

May 1-3, 2021
APA Annual Meeting
"Finding Equity Through Mind & Brain"
(Online Only)