NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

JUNE 2016

IN THIS ISSUE

ATTENTION ALL NCPA MEMBERS:

Are you receiving our twice-monthly e-newsletters in your email inbox?

Generally, we send an e-newsletter during the 2nd and 4th week of the month to all NCPA members with an email address on file with us. If you are not receiving an e-newsletter, but you use email, please contact us at info@ncpsychiatry.org or 919-859-3370.

Also, please add us to your safe-sender/email white list.

Annual Meeting & Scientific Session Major Depression: A Closer Look at Current & Emerging Treatments

September 8-11 | Renaissance Asheville Hotel

The countdown is on – it's almost time for NCPA's Annual Meeting and Scientific Session. If you haven't already done so, get out your calendar and circle September 8-11 as "booked!" While you're at it, fill out the registration form on page 15 of this newsletter and make your hotel reservations for the conference. Online registration is also available: www.ncpsychiatry.org/annual-meeting

This year's Program Committee has put together a truly outstanding conference that features nationally known speakers—from across the country and from North Carolina! Here is a brief glimpse of what is in store.

NCPA and the Psychiatric Foundation of North Carolina are pleased to announce that the winner of the 2016 V. Sagar Sethi, M.D. Mental Health Research Award is Helen Mayberg, M.D.. Dr. Mayberg is professor of Psychiatry, Neurology and Radiology and the Dorothy Fuqua Chair in Psychiatry Imaging and Therapeutics at Emory University of Medicine. She heads a multidisciplinary research program studying depression patholphysiology in both psychiatric and neurological patients and will give the Sethi lecture at the conference.

NCPA is excited that, in conjunction with the APA, our Annual Meeting will include a total of 6 hours of CME related to integrated care. The 6-hour "Applying the Integrated Care Approach" curriculum will be introduced as a plenary session on Friday, and the remaining credit hours will be offered in Friday and Saturday afternoon workshops.

Other speakers include:

- Scott Leibowitz, M.D., *Today's 'Genderation' of Youth: A Developmental Approach to treating Transgender and Gender Diverse children and Adolescents* and *Gender and Sexuality Competence in Psychiatric Practice: An Field in Evolution and Relevance to Modern Day Clinical Practice*
- Michael Thase, M.D., *Contemporary Issues in the Psychotherapeutic and Pharmacological Management of MDD* and *Treatment Resistant Depression*
- Pierre Blier, M.D., Ph.D., *Update on Neurochemistry: Decision-Making for Clinicians* and *Beyond the Antidepressent Label: Neuroscience Based Nomenclature*

NCPA members and other in-state experts are also featured on the program this fall, including ***Sy Saeed, M.D., M.S., FACPsych, Stephen Wyatt, D.O., Eric Morse, M.D.,*** Samantha Meltzer-Brody, M.D., and ***Philip Ninan, M.D..***

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From the Editor

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

Reflecting on the fact that we are in the midst of a presidential campaign, my book recommendation for this issue is *Lincoln's Melancholy: How Depression Challenged a President and Fueled His Greatness*, by Joshua Wolf Shenk.

The work is a remarkable psychological biography that makes use of previously unexamined primary sources, private letters and other written documents. Read it not for his politics or the historical record of his presidency, but for the personal account of his depression.

Key sections of the book that should be fascinating to this newsletter's readership include a description of the primitive treatments to which he was subjected. In a more positive vein are the acts of human kindness by those who sheltered him at his most desperate hour, keeping him alive and allowing time for the deadly aspects of his illness to remit.

Lincoln used humor and a type of quiet reflection that today might be called meditation to fight his illness. Often suicidal, he rejected self-destruction holding on the belief that he may someday be in a position to do something of great value for others.

The reader of the book will be rewarded by this well written and researched book that carries lessons for patients and those who work with them.

NORTH CAROLINA Psychiatric Association news

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To update your mailing address or if you have questions or comments about NCPA News, contact NCPA Staff, 919-859-3370 or info@ncpsychiatry.org.

Lifting Up our Successes, Recalibrating for the Future

Tom Penders, M.D., D.L.F.A.P.A., President

With the spring season at its height and with the close of the Annual Meeting of our national organization, the staff and leadership at NCPA traditionally step back each year and evaluate progress toward meeting goals set to advance its mission.

Now in its 81st, year NCPA has had an outstanding record of success in its efforts to promote the highest quality of care for North Carolina residents with mental illness including substance disorders. We have also worked successfully in advancing and representing the profession of psychiatry and medicine and serving the professional needs of our members. Each spring it has become traditional to acknowledge and celebrate our accomplishments, renew our commitments and re-calibrate our efforts to advance this mission.

Each of us has become aware of the increasingly rapid changes in our environment of practice. Most psychiatrists in North Carolina and nationally have concerns about the uncertainty surrounding the consequences of these changes and what this could mean for our patient care priorities. It is critically important that any recalibration of our goals for this year be driven by these concerns.

NCPA has been most fortunate to maintain a highly effective staff, support from the APA, and a large and engaged group of highly committed volunteer leaders. NCPA has become an unusually influential organization. During the past year, guided by the wisdom and dedication of ***Art Kelley***, our immediate past president, and with the effort of over 153 members active in committees, NCPA has been a significant force for good in the often chaotic world of health care in North Carolina.

During the past year we have been able to influence state legislation that threatened to control important clinical discussions we have regularly with our patients. Here are some of the legislative battles waged last year:

- NCPA led the effort to remove language from an omnibus gun bill (H562) that passed last session that would have prohibited physicians from asking patients about gun ownership.
- NCPA advocacy and engagement prevented H847 (Medical Treatment for Minors) from moving forward with sections that would have eliminated minors' rights to seek mental health or substance use counseling without parental consent.
- NCPA was part of the coalition that helped pass S676, a bill to mandate insurance coverage for treatment of autism.

In sum, your NCPA has played an important role in the passage of legislation increasing access to care for individuals with psychiatric and addictive disorders.

NCPA has been an important voice for members and your patients through its committee work and several task forces that were initiated this past year. (In fact, the quick-acting, strategic work of the task forces was so successful for the association this past year, that Executive Council will be discussing transitioning from our traditional

"standing committee" structure to topic-specific task forces and work groups that will help NCPA take a more nimble approach to advocacy and problem solving for members.) The work of the task forces last year has been commendable:

- The ED Boarding Task Force, led by Past President ***Burt Johnson***, has worked to promote policies and direct resources toward addressing the problems of extended detention of patients with acute psychiatric disorders in Emergency Departments throughout the state. Its work and the documents produced have been recognized in state-wide meetings and have helped ensure psychiatry's voice at the table when solutions to ED boarding are being discussed.
- Another labor-intensive effort by our President-Elect, ***Don Buckner***, has produced guidelines for utilization and supervision of psychiatric extenders that may very well become a model for our national organization. This toolkit will be available for

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New NCPA Executive Council Begins Term

In March, NCPA members returned their election ballots (electronically for the first time, in most cases), voting overwhelmingly to approve the slate of officers proposed by the Nominating Committee. The newly-elected officers began their terms at the conclusion of the APA Annual Meeting in Atlanta, May 18. Congratulations and thanks to the incoming NCPA officers and new Executive Council member for 2016-2017!

Each year NCPA sends ballots and candidate information to all members for their review and anonymous return vote. From time to time, members ask about the nomination and voting processes. The NCPA Nominating Committee typically is comprised of two chairpersons and members who are representative of our membership and of each region of the state. (Our Bylaws define our regions based on the historical four geographical areas traditionally served by the state's four original mental health hospitals.)

The Nominating Committee then selects at least one candidate for each position open, reports its slate to the Executive Council and then the full membership. Nominations may be received from the floor during the Business Meeting, held during the Annual Meeting and Scientific Session in the fall. Nominations may also be received by petition of 25 members within six weeks following the Annual Business Meeting.

While the Nominating Committee has an official purpose of developing the slate for the next year's election, it also serves to help identify and encourage members to engage with NCPA in its other work. Sometimes new faces for Executive Council leadership are identified by their work on NCPA committees and task forces. We encourage members from every part of the state to let the NCPA office know of their interest in serving on task forces, committees, or representing your geographic region of the state on Executive Council.

The Tellers Committee is responsible for establishing an equitable voting system. Voting is done by secret ballot, and all slated officers must receive a majority of votes cast to be elected; there are procedures in place to address run-offs and reruns as well. NCPA's fiscal and operational calendar runs from May to April; officers on the slate typically are voted on during the months of January, February and March, depending on when the ballot information is mailed to members. The new officers and Executive Council members begin their official work at the first Executive Council meeting of the new governance year, typically in June. The detailed processes and procedures can be found in the Constitution and Bylaws.

For more information about NCPA's Constitution and Bylaws and a full list of Executive Council members, visit the "About Us" menu at www.ncpsychiatry.org. Further, members with questions about the election process or interest in becoming more active in NCPA should contact staff for more information, info@ncpsychiatry.org or 919-859-3370.

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Member Notes...

Ureh "Nena" Lekwauwa, MD retires June 30 as DMHDDSAS Medical Director/Chief of Clinical Policy, after serving almost six years. Prior to coming to the Division, Dr. Lekwauwa served as the Medical Director for Centerpoint Human Services for 13 years. She has also served on NCPA Executive Council.

Warren Pendergast, MD retires June 30 as CEO and Medical Director of the NC Physicians Health Program after serving 17 years. Dr. Pendergast served as the Director of the Psychiatric Consultation Services at Carolinas Medical Center in Charlotte for nine years before accepting his first NCPHP position as Associate Medical Director.

Khalil Tanas, MD was awarded the Governor's highest honor – Order of the Long Leaf Pine in January. The presentation was made during his retirement reception as Alliance LME/MCO Medical Director.

Laura Willing, MD has been awarded the APA's Jeanne Spurlock Congressional Fellowship, she will serve a 10-month fellowship in Washington, DC working with a member of Congress or congresionnal committee focused on minorities and children's issues.

Winfield Tan, MD has received APA's Child Adolescent Psychiatry Fellowship, designed to promote interest and a career in child and adolescent psychiatry.

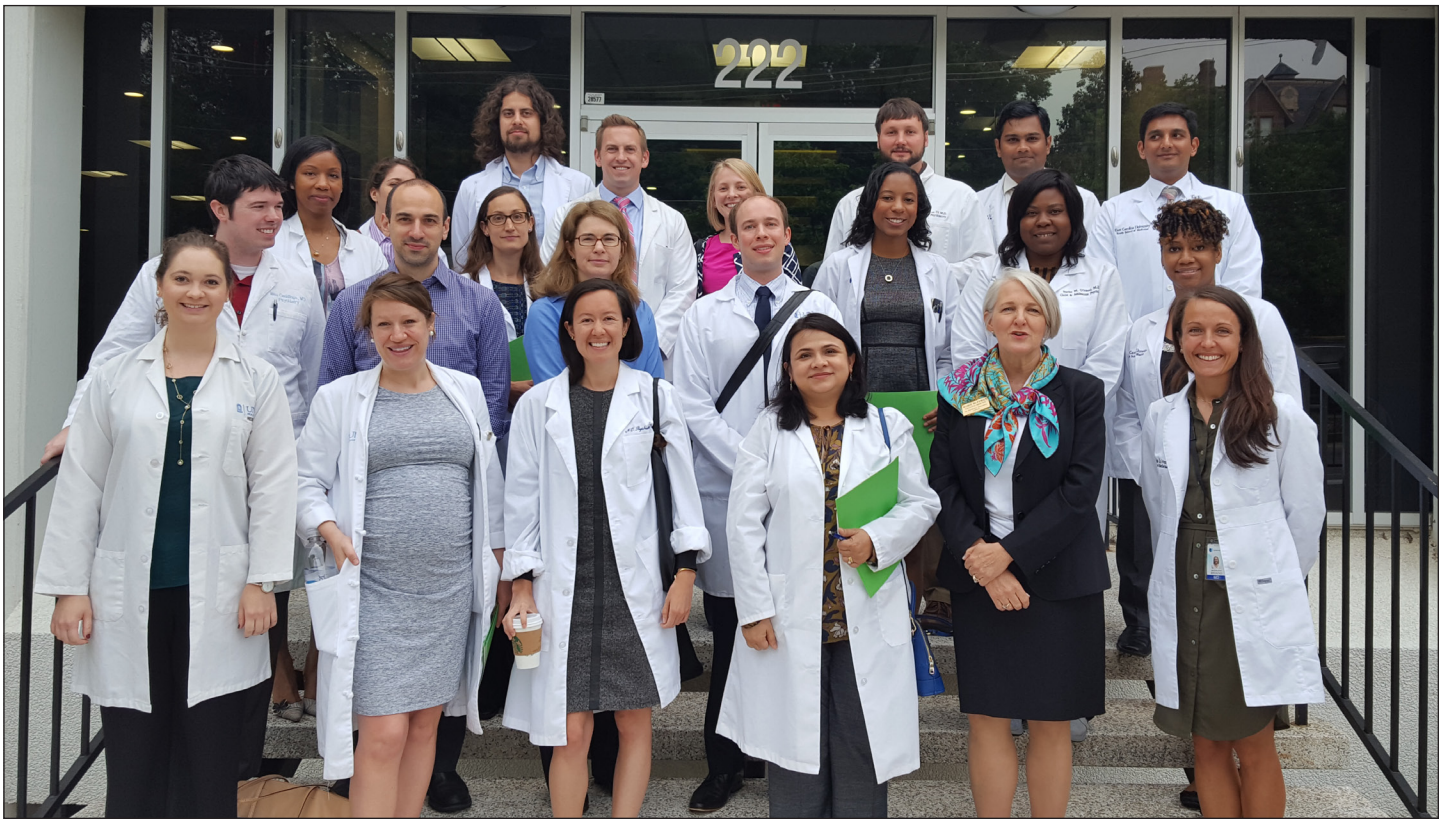
Christina Cruz, MD has received the APA/SAMHSA funded Minority Fellowship, designed to enhance the knowledge and capabilities of racial and ethnic minority psychiatry residents to teach, administer, and serve minority and/or underserved populations.

The N.C. Psychiatric Association, in conjunction with the N.C. Medical Society, held its annual "White Coat Wednesday" advocacy day May 11. Members attended advocacy training at the NCMS and then spent the day at the North Carolina General Assembly meeting with legislators and monitoring legislative meetings. Thank you to all our members (listed below in bold) who attended White Coat Wednesday!

Please send us your news!

Email your name, photo (if available) and details to info@ncpsychiatry.org.

Row 1: ***Laura Willing, MD,*** Morgan Patterson, MD, ***Winfield Tan, MD, Samina Aziz, MBBS,*** Robin Huffman, ***Magdalena Broszko, MD***
Row 2: Weston Geddings, MD, Gabriele Morosoff, MD, ***Patricia Knaudt, MD, Nathan Copeland, MD, Sarita O'Neal, MD, LeTonia Adams, MD***
Row 3: ***Jacqueline Smith, MD,*** Therese Garrett, MD, ***Lauren Isbell, MD***
Row 4: ***Liz Greene, MD,*** Christian Bjerre, ***Carson Felkel, MD,*** Katy Kranze, ***PG Shelton, MD, Purushothaman Muthukanagaraj, MD, Avinash Boddapati, MD***



Guidelines for Responsible Prescribing

Ted Zarzar M.D., served as the Chair of the Preferred Drug List/Prior Authorization Task Force. He is an Assistant Professor at UNC-Chapel Hill and is on staff at UNC Wakebrook.

NCPA's Executive Council convened a task force in 2015 on prior authorizations (PAs) and the Medicaid preferred drug list (PDL) in response to members' concerns about the ever-increasing number of prior authorizations being required by insurers. PAs have swelled to the point that several practices have hired additional staff to handle the paperwork and phone calls needed to ensure that patients do not go without necessary medications.

As many members are already aware, PAs can often be irrational, particularly with private payers, for example, that may require justification for generic medications for FDA-approved indications.

The PA/PDL task force was charged with taking members' feedback and developing recommendations on assisting clinicians with PAs (including appeals) and on guidelines for responsible prescribing. Early on, the task force decided to use the NCPA's response to the Medicaid PDL in fall 2014 as a guide for developing its new recommendations. This response focused on antipsychotic medications and provided recommendations on appropriate limits on PAs, focused on various quality of care and cost concerns.

Based on member feedback and medication costs, the task force decided to put an emphasis on stimulants as a drug category often subject to PAs. After several meetings, the task force recommended that PAs on stimulants be limited to certain clinical situations based on quality of care concerns such as efficacy and safety. For example, PA may be appropriate if dosing of medication is above the FDA limit, or if a nontraditional stimulant (e.g., modafinil) is utilized for ADHD before an FDA-approved medication is attempted. The recommendations acknowledged certain exceptions to these rules as well.

The document produced was approved by NCPA's Executive Council and was also reviewed by the NC Council of Child and Adolescent Psychiatry. It is intended to support NCPA members who may be called on to provide justification for clinical decision-making by insurance companies, or who are appealing PA decisions.

The document is available on the NCPA website (http://www.ncpsychiatry.org/pdl) along with other resources related to PA/PDL issues. On the site, members will also find a template provider complaint letter to the NC Department of Insurance for use following PA denials. The site also includes the 2014 PDL response that includes recommendations on PA limits for antipsychotic medications, and the Division of Medical Assistance (DMA) single-page form for completing PA requests for patients with Medicaid.

The PA/PDL task force concluded its work in April 2016. All members are encouraged to visit the NCPA website (http://www.ncpsychiatry.org/pdl) and utilize the aforementioned documents when communicating with payers in order to leverage the full weight of NCPA behind prudent, clinically indicated prescribing.

Principles of Prescribing for Substance Use Disorders

Cornel N. Stancui, M.D. is a Resident Fellow Member and PGY-IV at East Carolina University; Tom Penders, M.D., D.L.F.A.P.A., NCPA President, Past Chair NCPA Addictions Committee

This is the first in a series of articles by the NCPA Addictions Committee designed to address prescribing for patients with Substance Use Disorders. The series will include use of benzodiazepines, use of stimulant drugs, and opioids and chronic pain.

Introduction

Over the past five decades pharmaceutics have revolutionized the treatment of psychiatric disorders. A growing number of agents have been introduced for an increasing variety of psychiatric disorders. It is estimated that one in five Americans are currently prescribed pharmacologic treatment for a mental disorder.

In patients with chronic medical conditions, the proportion receiving medication for mental health disorders is much higher. Rates of psychotropic drug use are highest (23%) in the Southeast US, including North Carolina. These rates of psychotropic drug use confer an increasing responsibility for providers to be aware of the characteristics and interactions of psychotropics with increasing numbers of other agents prescribed for an aging population.

Despite advances in pharmacologic treatment, there are significant challenges for the many patients who are treatment resistant. It is common for prescriptions to go unfilled. Lesser degrees of non-adherence affect patient outcomes for anxiety and depressive disorders.

Substance use disorders commonly co-occur with psychiatric disorders, resulting in the potential for adverse reactions, exacerbation of addictive disorders and interactions between alcohol, drugs of abuse, and pharmaceutics prescribed for treatment of mental disorders. Clinicians need to adopt and adhere to principles of prescribing for patients with substance use disorders that are somewhat different from those governing use in populations not struggling with addictions.

In this series of papers we will describe some of the dilemmas frequently encountered by clinicians treating individuals with co-occurring psychiatric and addictive disorders. We offer recommendations for principles to address these dilemmas.

Opioids and Chronic Pain

The prevalence of chronic, non-cancer pain (CNCP) is rising dramatically in an aging population affecting hundreds of millions of individuals and resulting in significant loss of functioning and reduced quality of life. CNCP contributes to increased healthcare costs and premature death. CNCP is common in the general population as well as in those with substance use disorders (SUD).

Between a quarter to a third of chronic pain patients have been identified with comorbid addictive disorders. Many also suffer with co-occurring depressive disorders. The treatment of patients with painful conditions and co-morbid SUD is complex and often challenging.

Despite limited evidence for efficacy in long-term treatment, opioids are commonly employed in the management of CNCP, often for extended periods. There has been a 10-fold increase in prescriptions for opioids over the past two decades and prescribed dosages have also increased. Another source describes approximately one-third of patients admitted to inpatient psychiatric programs were on maintenance opioids for treatment of CNCP. A recent survey found 25% of those on long-term opioid therapy displayed aberrant use or misuse. Ten percent will develop moderate to severe opioid use disorder often together with affective disorders or PTSD.

Randomized controlled trials of efficacy for psychoactive agents often exclude those with SUD. Increasing use of opioids has resulted in diversion and increased prevalence of illicit use. Importantly, prescribing patterns have resulted in the, now well-documented, current epidemic of overdose deaths. Patients with psychiatric disorders are overrepresented in those who have overdosed. Suicide rates are elevated among patients maintained on chronic opioid treatment.

Neurophysiological Patterns of Pain and Addiction

Evidence supports the co-occurrence of frequent CNCP and addiction. Most chronic pain involves abnormal neural processing at various levels of the peripheral or central nervous systems. Similarly, addiction results when normal neural processes, primarily in memory, reward and stress systems, are al-

tered in ways that are similar to individuals with persistent use of illicit addictive drugs. Both also have significant behavioral components, are mediated by genetics and environment, and have harmful consequences if not addressed.

Neither chronic pain nor addiction are static, both fluctuate in intensity over time and, under different circumstances, require management as chronic illnesses with expected frequent exacerbations. Treatment for one can aid or interfere with treatment for the other. Individuals with addiction display neuroplastic alterations that may interfere with pain transduction and overlap with symptoms of depression.

Ongoing pain can trigger emotional responses including sleeplessness, anxiety, depressive symptoms, and increasing perception of pain. Many patients may self-medicate with substances in response. Emotional status can predetermine the outcome of pain management. Effective pain management in those with or recovering from SUD should address both conditions simultaneously.

Co-existence of significant depression is common among patients with chronic pain. Treatment of the depression cannot only alleviate distress related to depression, but alleviation of such symptoms may reduce the need for analgesic agents.

Cross Addiction

The term "cross addiction" denotes addiction to a substance as a result of switching or tapering from another. It can also indicate simultaneous addiction to two or more substances. Effects from each substance on the brain are similar in effect. Of those hospitalized for opioid use disorder, 75% have previously dealt with a non-opioid use disorder. Individuals with chronic pain and SUD are at higher risk for cross addiction when placed on opioid therapy. Chronic pain management facilitates both positive (euphotic effect) and negative (pain reduction) reinforcement of substance use.

Guidelines for Managing Pain in Those with SUD

For individuals with active addiction and CNCP, it is recommended to start addiction treatment and defer opioid analgesia when possible. New FDA guidelines suggest reliance on non-opioid drugs initially. In the case of individuals already on opioid therapy, clinicians should attempt weaning but may continue if the patient is amenable to immediately start SUD treatment.

Individuals with chronic pain and SUD are at higher risk for cross addiction when placed on opioid therapy

Choice of analgesic should be determined based on underlying pain physiology with non-pharmacological modalities. CBT, physical therapy, complementary medicine such acupuncture, massage and chiropractic care are frequently helpful.

If in recovery, a non-opioid analgesic is preferred guided by an understanding of the underlying etiology of the painful stimulus. If on agonist therapy, it is recommended to continue the agonist and increase the dose as required for analgesia. Implementation of concurrent non-pharmacological treatments is often helpful.

Identification and treatment of co-occurring psychiatric or sleep co-morbidities is critical. If adequate benefit is not achieved, an opioid trial should be instituted with frequent assessments for functional improvement, change in quality of life and rigid adherence to the prescribed regimen.

The doctor-patient relationship is critical for those with co-morbid pain and SUD. Some patients may believe the clinician is discounting pain while criticizing substance use. Consequently, it is important to maintain a level of respect and concern while reassuring both conditions are addressed.

Opioid Selection

An important concept in treating patients with SUD is to minimize exposure to euphoric effects. Use of opioids with minimal rewarding properties (tramadol, codeine) and avoiding supra-therapeutic dosages is preferred. If high-potency agents are required, use of opioids with prolonged duration is advised.

Administration routes influence addiction risk. It is best to avoid those that can be injected or that can be converted to forms that can be injected, smoked or snorted. Some prescribers favor transdermal patches with the agreement to return used patches, thereby minimizing risk of tampering.

In patients with SUD, especially opioid use disorders, there is a significant risk of rapidly developing tolerance. Using titration schedules designed for the non-SUD patient can place the SUD patient at risk for inadequate pain management.

Although there is no universal schedule for titration, if low doses of opioids other than methadone are initiated for severe pain, they should be titrated to avoid subjecting patients to a prolonged period of dose finding. If relatively high doses are initiated, titration should be slower and determined by the half-life.

For those who have relapses and quickly regain stability while on opioids, provision of counseling may suffice. Opioids should be closely monitored with short dispensing

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Department of Psychiatry

The patient's best interests always come first. This commitment is our top priority. Even though we are an academic center with serious commitments to education and research, we never lose sight of the fact that all our activities serve one person — the patient. We are well known for the high quality services provided in the Neuropsychiatric and Electroconvulsive Therapy (ECT) programs.

Our mission: Improve the health and well being of the people of this region by means of Patient Care, Education, and Research. It is the full and thoughtful integration of these three elements that makes academic medical centers different; it is the dedication to placing patient care first that identifies the best of these centers.

Inpatient Services: Adult inpatient services (24 bed unit) emphasize evaluation and treatment of depression, bipolar disorder, anxiety disorders and schizophrenia offering inpatient ECT when needed.

Child and adolescent inpatient services (14 bed unit) include evaluations and treatment for depressive disorders, anxiety disorders, oppositional defiant disorder, and conduct disorder.

Outpatient Programs: Our outpatient programs encompass services for adults - including a separate geriatric program - adolescents and children. A faculty member participates with a resident physician in the evaluation of every patient at every visit. The full-time faculty is available for specialty consultations.

Adult outpatient services include evaluation and treatment for the full range of psychiatric disorders including depressive disorders, neuopsychiatric disorders, anxiety disorders, schizophrenia, alcoholism and substance abuse. Intensive outpatient group therapy, individual evaluations and therapy form the core of our alcohol and substance abuse services. We are known for the quality of our ECT program offered on an outpatient basis.

The child and adolescent outpatient services perform evaluation and treatment of all childhood psychiatric disorders including depressive disorders, schizophrenia, bipolar disorder, anxiety disorders, conduct disorders, and attention deficit disorders.

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What Psychiatrists Need to Know About... Opioid Prescribing Monitoring

A Letter from the NC Medical Board

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The state of North Carolina is in the midst of a public health crisis related to deaths from prescription opioid overdose. It is generally recognized that most opioid medications implicated in unintentional overdose deaths were originally prescribed by a licensed medical professional. In an effort to address this crisis, the North Carolina General Assembly amended state law to authorize the Department of Health and Human Services (DHHS) to release certain opioid prescribing information to the North Carolina Medical Board (NCMB) and other medical regulatory boards.*

NCMB began receiving prescribing information in late 2015 and is now in the process of implementing a new investigative program based on DHHS data. We are writing to provide you with general information on this initiative, which might impact physicians and physician assistants employed with, insured by or otherwise involved with your organization. Please share this information with those who may be impacted by this new program. We are a resource to answer questions on the programs and initiatives put in place to address this public health crisis.

The Board will contact prescribers who meet one or more of the following criteria:

- The prescriber falls within the top one percent of those prescribing 100 milligrams of morphine equivalents (MME) per patient per day.
- The prescriber falls within the top one percent of those prescribing 100 MMEs per patient per day in combination with any benzodiazepine and is within the top one percent of all controlled substance prescribers by volume.
- The prescriber has had two or more patient deaths in the preceding twelve months due to opioid poisoning.

The Board will determine the appropriateness of prescribing through standard methods, including review of patient records, independent expert medical reviews and written responses from the prescriber.

We recognize that prescribers identified through the criteria stated above may be practicing and prescribing in accordance with accepted standards of care. However, given the known risks of opioids and the rising incidence of unintentional overdose deaths, the Board has an obligation to verify the appropriateness of care and prescribing.

Thank you,

Pascal O. Udekwu
President, North Carolina Medical Board

*See, N.C. Gen. Stat. § 90-113.74 and related administrative rule, 21 NCAC 32Y .0101

NOTE: The North Carolina Medical Board has set up a comprehensive web page with multiple resources for physicians and other medical professionals. The page includes links to clinical guidance document from NCMB as well as CDC guidelines for the treatment of pain. There are links to enforcement documents and FAQs for the board's Safe Opioid Prescribing Initiative. Of particular interested is information about registering for access to the NC Controlled Substances Reporting System and various CME offerings. You can reach this page at: http://www.ncmedboard.org/landing-page/safeopioids

NCPA's Addiction Committee is actively engaging on this issue, working to develop resources and materials for psychiatrists.

...President's Column continued from page 3

our members to encourage thoughtful and clinically sound supervision for the behavioral health team.

• The Preferred Drug List/Prior Authorization Task Force was chaired by ***Ted Zarzar.*** Thanks to his persistent and patient efforts, NCPA has been able to influence policies relating to prior authorizations for care. More about the work of that task force is found in this newsletter.

NCPA members can be proud of our leadership involvement on many issues relating to parity, expansion of Medicaid and response to a myriad of requests for opinions and action. These and other accomplishments led to our Honorable Mention award for outstanding District Branch of the APA at this year's APA meeting. Our Assembly Representatives, ***Steve Buie, Debra Bolick and Samina Aziz***, along with NCPA staff Katy Kranze, accepted the award on behalf of NCPA this year.

Looking forward, NCPA will soon hold a leadership retreat for the purpose of evaluating how we may best focus our resources on priorities considered most important to our members and most effectively improve access to quality psychiatric care in our state.

We are faced with strong, but poorly defined, pressures to change the way in which physicians are reimbursed. Evidence is growing for the effectiveness of integrated models of delivery of mental health care, and NCPA has its fingers on the pulse of developments in this area. These pressures can be an enormous opportunity for psychiatry to display our expertise to the public as well as to our colleagues in the other medical specialties.

Several sources suggest that we are in the midst of historical changes adversely affecting the wellbeing of the US population. For the first time in our history, some population groups are experiencing a decline in life expectancy. Rates of completed suicide are increasing. North Carolina has not been spared of these trends and the causes can be largely traced to psychiatric disorders. I believe that this is an exciting and challenging time to be a psychiatric physician in North Carolina.

As your new President of NCPA, I am committed to building on the many successes our organization has had over its 81-year life. I know that our physician leadership and staff, under the very able executive direction of Robin Huffman, will continue to provide the critical representation supporting its members in offering the finest psychiatric care possible.

Input, suggestions and comments from members are of critical importance as we move forward in our efforts to define how we allocate resources in the future. I invite and encourage each of our members to contact staff, those serving on Executive Committee, or me with observations, concerns or advice. Standing together as the North Carolina Psychiatric Association, I am confident that the practice of medicine in the interest of those with mental health and addictive disorders will thrive in our state.

To reach NCPA staff or Executive Council members, it's easiest to send an email to info@ncpsychiatry.org. Emails sent to this address are quickly routed to the appropriate staff member, Executive Council member, and/or Committee Chair. You may also call our office in Raleigh, 919-859- 3370.

...Prescribing for Substance Use Disorders continued from page 9

intervals and frequent urine screening. For those who suffer severe relapse, referral to treatment programs for methadone or buprenorphine maintenance therapy is ideal.

Risk Mitigation

Monitoring for CNS depression or sedation in patients with SUD on opioids is critical. Concurrent alcohol use may cause "dose dumping" (rapid release of the opioid). Introduction of abuse deterrent formulations (ADF) have curbed the ability of patients to alter the route of administration. Attention to use of these formulations can reduce risk of overdose or diversion.

While it is unusual for psychiatric clinicians to prescribe opioids in the course of their practice, many of their patients will either be prescribed these agents or might be considering use of opioids for long term pain management. An awareness of safe prescribing practices can be helpful in avoiding the many adverse individual and public health consequences of their use.

APA Announces 2016 Honorees

Congratulations to the following NCPA members who have achieved Distinguished Fellowship, Fellowship, Life Member, and/or 50-Year member status! New honorees were formally recognized at the APA Annual Meeting in Atlanta in May. Please note, honorees listed below may hold additional distinctions other than those most recently awarded.

Distinguished Fellow
Jane Gagliardi, M.D.
James Kimball, M.D.
Michael Lang, M.D.
Mary Mandell, M.D.
Kim Masters, M.D.
Christopher Myers, M.D.
Christopher Britt Peterson, M.D.
Michael Smith, M.D.
Nicole Wolfe, M.D.

Fellow
Erica Arrington, M.D.
Hasan Baloch, M.D.
John Barkenbus, M.D.
Durga Bestha, M.D.
Lee Bourgeois, M.D.
Iverson Carter, M.D.
Manuel Castro, M.D.
Mary Christenbury, M.D.
Karla deBeck, M.D.
James Disney, M.D.
Ira Doneson, M.D.
Linda Francis, M.D.
Lance Fuller, M.D.
Tesfa-Alem Gebremeskel, M.D.
Logan Graddy, M.D.
Nicola Gray, M.D.
Jessica Hairston, M.D.
Obinna Ikwechegh, D.O.
Tia Konzer, M.D.
Philip Lartey, M.D.
Bahman Malekpour, M.D.
Andrew Newberg, D.O.
Joshua Pagano, M.D.
Marcus Pelucio, M.D.
Rommel Ramos, M.D.
Jennifer Segura, M.D.
Warren Steinmuller, M.D.
Qionna Tinney Raleigh, M.D.
Rodney Villanueva, M.D.
R. Lance Waycaster, M.D.
Jason Webb, M.D., Ph.D.
Robert Weinstein, M.D.
April Welborn, M.D.
Nicholas Zarzar, M.D.

Life Member
William Bowens, M.D.
Paul Buongiorno, M.D.
Christopher Colenda, M.D.
John Diamond, M.D.
Jill Hendra, D.O., M.B.A
Valerie Holmes, M.D.
Susan Levy, M.D.
Pamela Pittman, M.D.
Samuel Thielman, M.D.
Barbara Thomas, M.D.
Peter van Dyck, M.D.

50 Year Member
Myron Liptzin, M.D.

Classified Advertisement

Carolina Behavioral Care, a mental health and substance abuse provider located in the Piedmont and Sandhills of North Carolina has openings for either a full time or part time adult psychiatrist providing hospital emergency department consulting services. This is a tele-psychiatry position which can be configured to provide clinic face to face services as well if candidate commits to full time effort. This position can be based at any of our locations; Durham, Hillsborough and Pinehurst with full time compensation of $240,000.00 annually. This position will work with a cadre of other staff members which will include nurse/therapist who will provide the initial interview with the ED patient. This position will work with the ED attending physicians at the various hospitals to determine therapy recommendations and disposition. There are no continuing care expectations with these encounters beyond re-evaluation in the ED if commitment had not been facilitated due to lack of available beds. Duty will be segmented into half day (5hr) clinics each weekday resulting in ten clinics totaling 50 clinical duty hours each week with an expectation of ten consultations for each half day clinic.

Send CV and contact info to kwise@carolinabehavioralcare.com.

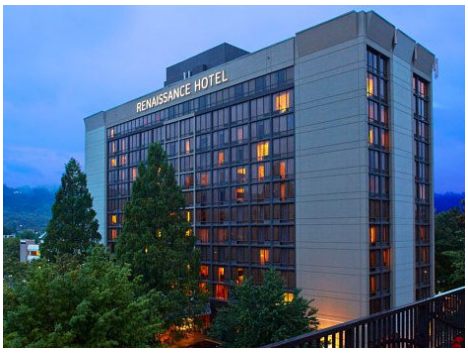
Annual Meeting continued from cover...

While earning credits, cruising the exhibit hall and networking with psychiatrists and other mental health professionals, you'll be able to take advantage of all beautiful Asheville, North Carolina has to offer. The city is consistently named a top travel destination for its local arts community, outdoor adventures, cuisine, craft brewery culture, and much more!

The Renaissance Asheville Hotel is now taking reservations for the 2016 Annual Meeting. Reserve your room early before the discounted room block is full!

Renaissance Asheville Hotel
31 Woodfin Street
Asheville, NC 28801
Phone: 1-800-468-3571
For online reservations visit http://tiny.cc/ncpa-hotel

Reservations must be made by August 10, 2016 to receive our group rate.



Tentative Scientific Schedule: This schedule is subject to change at any time leading up to the conference. Please check www.ncpsychiatry.org/annual-meeting for the most updated conference information.

Thursday, September 8

2:00 – 6:00	NCPA Registration
2:00 – 5:00	NCPA Executive Council, Top of the Plaza
6:00 – 7:30	Welcome Reception, Patio

Friday, September 9

7:00	Registration, Exhibits Open & Continental Breakfast
7:45 - 8:00	Welcome; Thomas Penders, MD, NCPA President
8:00 – 9:00	*An Introduction to Collaborative Care*; Anna Ratzliff, MD and Lori Raney, MD
9:00 – 10:00	*Subjective Evidence and Measurement in Depression*; Philip Ninan, MD
10:00 – 10:30	Break with Exhibitors
10:30 – 11:30	*Update on Neurochemistry: Decision-Making for Clinicians*; Pierre Blier, MD, PhD
11:30 – 12:30	*Post-Partum Depression and Apple HealthKit Study*; Samantha Meltzer-Brody, MD
12:45 – 1:45	NCPA Business Meeting and Lunch (NCPA Members Only)
2:00 – 4:30	*Collaborative Care Workshop*; Anna Ratzliff, MD and Lori Raney, MD
5:00 – 7:00	NCCCAP Social, Battery Park Book Exchange

Saturday, September 10

7:00	Registration, Exhibits Open & Continental Breakfast
7:00 - 8:00	NCCCAP Executive Council Breakfast

General Psychiatry Track

8:00 - 9:00	*Contemporary Issues in the Psychotherapeutic and Pharmacological Management of MDD*; Michael Thase, MD
9:00 – 10:00	*Beyond the Antidepressant Label: Neuroscience Based Nomenclature*; Pierre Blier, MD, PhD
10:00 – 10:30	Break with Exhibitors
10:30 – 11:30	*Future MDD Treatments: Ketamine and Beyond*; Larry Park, MD
11:30 - 12:30	*Point-Counterpoint: Use of Benzodiazepines*; Stephen Wyatt, DO and Eric Morse, MD

Child & Adolescent Psychiatry Track

8:00-12:30	*Today's 'Genderation' of Youth: A Developmental Approach to Treating Transgender and Gender Diverse Children and Adolescents*; Scott Leibowitz, MD *Panel Discussion*; Scott Leibowitz, MD, Deanna Adkins, MD, Echo Meyer, PhD, Kristen Russell, LCSW
12:45 – 1:45	NCCCAP Business Lunch (NCCCAP Members Only)
2:00 – 4:30	*Collaborative Care Workshop*; Anna Ratzliff, MD and Lori Raney, MD
6:00 – 9:00	Resident Poster Session, Reception & Awards Dinner

Sunday, September 11

7:00 – 8:00	Continental Breakfast & NCPA Committee Meetings
8:00 – 9:00	Sethi Award Lecture: *Rethinking Depression and its Treatment: Insights from Studies of Deep Brain Stimulation*; Helen Mayberg, MD
9:00 – 10:00	*Treatment Resistant Depression*; Michael Thase, MD
10:00 – 10:30	Break to Check Out of Hotel
10:30 – 11:30	*Gender and Sexuality Competence in Psychiatric Practice: An Field in Evolution and Relevance to Modern Day Clinical Practice*; Scott Leibowitz, MD
11:30 – 1:00	*Top 10 Research Findings of 2015-16*; Sy Saeed, MD, MS, FACPsych

REGISTRATION FORM
2016 Annual Meeting & Scientific Session:

Mail registration form with your check to: NCPA, 4917 Waters Edge Drive, Suite 250, Raleigh, NC 27606

For Credit Card Payment – Register and Pay Online: www.ncpsychiatry.org/annual-meeting

Primary Attendee Name: _____ Degree(s): _____ First Annual Meeting? ____

Email:_____ First Name for Name Badge:_____

Address: _____ City: _____ State: _____ Zip: _____

Guest Full Name(s) for Name Badges (not for CME):_____

Meeting Registration Fees:

Please indicate # attending for CME:	"Early Bird" Before 7/8	General After 7/8
_____ NCPA/NCCCAP/APA Member	$450	$550
_____ Psychiatry Resident	*Registration paid by the NC Psychiatric Foundation*	
_____ Non-member	$550	$650
_____ Nurse Practitioner/Phys. Asst.	$400	$500
_____ Single Day Registration (indicate day)	$250	$250

Please indicate # of guests attending:	Before 7/8	After 7/8
_____ Spouse/Guest (Non-CME)	$100	$100
_____ Children 6-17	$25	$25
_____ Children 5 and under	Free	Free

Registration fees include:
Continental breakfasts (Friday, Saturday, Sunday), Thursday evening receptions and Saturday night reception and dinner for all ***registered*** members, guests, and children. Other receptions may be added. **If you are bringing a non-registered guest to the Saturday evening dinner only, there is a $50 per guest charge.*

Please indicate the number of people attending (Registered Guests Only):
___ Thursday Evening Welcome Reception
___ Friday NCPA Business Lunch (NCPA Members ONLY)
___ Friday Evening NCCCAP Social (NCCCAP Members and Residents ONLY)
___ Saturday NCCCAP Business Lunch (NCCCAP Members ONLY)
___ Saturday Evening Reception & Awards Dinner

Please Include any Dietary Restrictions: _____

ELECTRONIC Handouts: NCPA will provide electronic handouts via web & USB to all registered attendants. *Paper handouts are available for advance purchase for $25*.
Do you want to purchase paper handouts? *Yes ($25)* _____ ***No*** _____

TOTAL FOR NCPA MEETING: $ _____

To pay by CHECK, mail this registration form with payment to: NCPA, 4917 Waters Edge Dr., Suite 250, Raleigh, NC 27606. (Check payable to NCPA)

To pay by CREDIT CARD, Register Online: www.ncpsychiatry.org/annual-meeting or call 919-859-3370.

Registration and Payment Confirmation Will Be Emailed Upon Receipt.

Early Bird Registration Deadline: Registration must be received by **July 8**.

General Registration Deadline: Registrations must be received by **September 1**. Walk-in registration rates apply after this date.

Cancellation Policy: Cancellations on or before ***September 1*** will receive a full refund, less $50.00 for administrative fees. Refunds are not granted for no-shows.

Hotel Reservations:

The discounted room block expires August 10, 2016.

Mention the NC Psychiatric Association Annual Meeting to receive the discounted room rates.

Renaissance Asheville Hotel
Phone: 1-800-468-3571
Single/Double: $185.00 per night

Additional conference information is available on the NCPA website:
www.ncpsychiatry.org/annual-meeting

Please Support the Psychiatric Foundation of NC

You can sponsor the registration fee for a psychiatric resident attending the Annual Meeting with a tax-deductible contribution to the Psychiatric Foundation of North Carolina. The Foundation also accepts general donations.

Please indicate your tax-deductible donation amount: $_____
(Mail check payable to Psychiatric Foundation of North Carolina to above address)

Donations also may be made online at www.ncpsychiatry.org/foundation

Please Note*: Only donations made to the Foundation are Tax-Deductible as Charitable Contributions. You will receive your donation information at the end of the year.*

NORTH CAROLINA
Psychiatric
Association

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

4917 Waters Edge Drive, Suite 250
Raleigh, NC 27606
P 919.859.3370
www.ncpsychiatry.org

Calendar of Events

June 25, 2016
NCPA Executive Council Meeting & Retreat
NCPA Office Building
Raleigh, NC

September 8-11, 2016
Annual Meeting & Scientific Session
Renaissance Asheville Hotel
www.ncpsychiatry.org/annual-meeting