NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

DECEMBER 2014

Top photo: U.S. Representatives Tim Murphy and Renee Ellmers hold a Town Hall Meeting in Fayetteville; Middle photo: Rep. Murphy talks with Marvin Swartz, M.D., D.L.F.A.P.A.; Bottom photo: Rep. Ellmers talks with John Kraus, M.D., D.F.A.P.A.

IN THIS ISSUE

NCPA Weighs In on Federal Mental Health Reform Bill

In early August, NCPA got an urgent call from the APA — U.S. Congressman and Oversight and Investigations Subcommittee Chairman Tim Murphy (R - PA) and Congresswoman Renee Ellmers (R-NC) were scheduling a round table discussion about mental healthcare reform and wanted psychiatrists there. Executive Director Robin Huffman sprang into action — collaborating with the APA to brainstorm strategies and talking points to make the most impact and identify members able to attend. After all, it's not every day Congress comes calling, and time was of the essence.

Then with three days to spare another call came — Rep. Murphy wanted a more intimate pre-meeting for a more policy-driven conversation with university researchers and advocates, and could NCPA host? After a second round of whirlwind preparations, Duke and UNC researchers, representatives from NCPA, and a few other advocacy groups met on August 26 at the NCPA office with Rep. Murphy for a discussion about his bill, The Helping Families in Mental Health Crisis Act (HR 3717). Later that day, another group joined both Rep. Murphy and Rep. Ellmers in Fayetteville for a town hall community discussion of the bill and the overarching need for federal mental healthcare reform. NCPA members present at the meetings include: ***George Corvin, M.D., D.F.A.P.A., Burt Johnson, M.D., D.L.F.A.P.A., John Kraus, M.D., D.F.A.P.A., Keith McCoy, M.D., F.A.P.A., Philip Ninan, M.D., D.L.F.A.P.A., John Santopietro, M.D., F.A.P.A., Linmarie Sikich, M.D., D.F.A.P.A., Marvin Swartz, M.D., D.L.F.A.P.A., and John Wagnitz, M.D., D.L.F.A.P.A.***

Rep. Murphy, a clinical psychologist who was spurred into action following the Sandy Hook tragedy, wants mental health clinicians to lead reform efforts and believes this approach will lead to smarter policy, better outcomes, and increased savings.

Rep. Murphy's bill has gained both praise and criticism nationally; the APA and NCPA support many —not all— provisions of the bill. Specifically, the positive efforts include creating an Assistant Secretary for Mental Health and Substance Use Disorder within HHS who is either a psychiatrist or clinical psychologist; creating several new federal agencies and committees aimed at increasing research and data related to serious mental illness, developing grant programs to support telepsychiatry, primary care, and Assisted Outpatient Treatment, developing a path to stronger community behavioral health, and several more initiatives that aim to reform and improve HIPAA, law enforcement/emergency response training and other criminal system diversion programs, and more.

For more, visit www.ncpsychiatry.org/murphy-bill to see resources related to the bill and the APA's response. As the legislation evolves and moves through the Congressional process, NCPA will keep members apprised.

Don't Forget to Deduct Your APA and NCPA Dues!

As you prepare your tax documents in the New Year, remember that a portion of your APA and NCPA dues are tax-deductible as a business expense. Likewise, if your employer covers the cost of your membership, the company is entitled to the tax-deduction.

According to the APA, all but 9 percent of your national 2014 dues are tax-deductible (in other words, you may deduct 91 percent of your 2014 APA dues).

For your 2014 NCPA dues, all but 17 percent are tax-deductible — so, 83 percent of your 2014 dues may be deducted as a business expense.

The non-deductible amount represents the portion of dues that is used to pay for direct lobbying efforts, such as NCPA's paid lobbyist and the time that NCPA staff spends on lobbying efforts. Both of these figures are found on your APA dues statement.

If you need assistance determining the amount you paid in 2014 for your APA and NCPA membership, please call the NCPA office at 919-859-3370 or email info@ncpsychiatry.org.

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North Carolina's "ED Boarding" Crisis

Burt P. Johnson, M.D., D.L.F.A.P.A., President

North Carolina has a crisis on its hands: the relative lack of psychiatric inpatients beds compared to the volume of patients assessed in emergency departments (EDs) as needing admission to those beds. The result is a backup in the EDs of psychiatric patients, referred to as "boarders," who are waiting until a bed can be found. A literature survey conducted by the U.S. Department of Health and Human Services concluded that this boarding can lead to severe consequences, both for the psychiatric patients and staff as well as to the care of other patients in the ED.

These unfortunate psychiatric boarders, who are mostly on involuntary legal commitments and being held as virtual prisoners, have been known to languish in an ED for as long as six weeks. If the hospital is large enough, there may be mental health professionals in the ED to provide some treatment other than tranquilizing medications, but that is not the case in most North Carolina hospitals where suboptimal care is the norm. The staff in the EDs who care for the boarders regard the process as inhumane and unconscionable.

By way of contrast, consider how patients with other —that is, non-psychiatric— illness are treated in an ED. Once designated as requiring admission, they are promptly admitted to inpatient status or quickly transported by ambulance or even helicopter to another facility.

North Carolina has seen a progressive loss of psychiatric beds over the last 15 years. Some general hospitals have closed their psychiatric units because inadequate insurance reimbursements led to consistent deficits. As part of the dramatic "Reform" of its mental health system at the start of the last decade, North Carolina set out to downsize its State Hospital bed capacity, but notoriously diverted the savings, which were intended to expand community resources, to other non-healthcare areas of need.

North Carolina ranks 44th in the nation in availability of state psychiatric inpatient beds...

As a result, North Carolina ranks 44th in the nation in availability of state psychiatric inpatient beds, having about 8.5 beds per hundred thousand residents compared to a national average of about 14. According to the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS), operating State Hospital beds in North Carolina decreased by 52 percent from 2001 to 2012, while the population of NC grew by 18 percent.

A surging demand for acute behavioral health services since the middle of the last decade has overwhelmed the state's capacity to provide appropriate care for its acutely ill psychiatric patients. Mission Hospital in Asheville provides a good example; there, recently half of its 100-plus ED beds were filled with behavioral health patients, about half of whom were awaiting transfer to inpatient care. That the majority of these individuals boarding in EDs are uninsured or covered by Medicaid has been a factor in this unfortunate situation being essentially invisible to the larger community, but it entraps patients of all economic strata.

This deficit of psychiatric beds, both State and community, exists against the backdrop of virtually no coordination of the placement process of patients out of EDs. The result is a chaos of inefficiency with every ED investing significant resources in each patient, calling and faxing information packets to multiple facilities around the state. It is every ED for itself in a daily scramble. A patient manifesting aggressiveness is likely to have a longer wait since most units outside of State facilities are reluctant to take aggressive patients.

North Carolina is not the only state in the nation to face these problems. In August of this year, the State Supreme Court of Washington State ruled that "psychiatric boarding" was unlawful and should be eliminated. They ruled that psychiatric ED patients have a right to adequate care and individualized treatment, and that state law required they be placed in certified treatment facilities (not EDs). Washington State has added 150 newly staffed state psychiatric beds by the end of November 2014.

The status of psychiatric boarding in EDs has become a major focus of concern in the Mental Health and Emergency Department communities, and NCPA has developed the following initial ideas.

It is long past time for the Governor and the General Assembly to face up to this crisis in our Emergency Departments and commit the sub-

continued on page 13...

What Psychiatrists Need to Know About... Telepsychiatry

In North Carolina, telepsychiatry is defined as "the delivery of acute mental health or substance abuse care, including diagnosis ttvor treatment, by means of two-way real-time interactive audio and video by a consulting provider at a consultant site to an individual patient at a referring site."[1] A key driver behind the growth of telepsychiatry is the national shortage of psychiatrists, particularly in specialty areas and in rural and underserviced geographical areas.

Most states require that the telepsychiatrist be licensed in both the jurisdiction where the patient is located at the time care is provided, and in the telepsychiatrist's own state (if different from the patient's location). A physician who practices telemedicine in North Carolina must be licensed in the state. Physicians using telemedicine technology must provide an appropriate examination prior to diagnosing and/or treating the patient; however, the examination does not need to be in-person if the technology is sufficient to provide the same information to the physician as if the examination had been performed face-to-face.[2]

State laws often vary on issues such as prescribing, reporting child endangerment, participation in the civil commitment process, supervision/collaboration with other providers, etc.[3] As such, it is important to be aware of the state variations if you intend to engage in telepsychiatry both inside and outside of North Carolina. Additionally, psychiatrists who provide care or prescribe through online services are also considered practicing medicine and must also be appropriately licensed in all jurisdictions where patients receive care.[4] The North Carolina Medical Board indicates that it would be inappropriate and unprofessional to prescribe medications to individuals the physician has never met based solely on answers to a set of questions, as is common in internet or toll-free prescribing.[5]

Risk Management Considerations

When contemplating practicing telepsychiatry, psychiatrists should be aware of their potential liability and risk management exposures. Some of these risk management considerations include:[6]

- Understand when a psychiatrist-patient relationship is established
- Ensure compliance with state licensure requirements
- Understand applicable state laws regarding supervision of other healthcare providers
- Protect the confidentiality of patient information/data
- Adhere to established standards of care when evaluating and treating the patient
- Regulations concerning prescribing and dispensing of certain medications
- Use HIPAA compliant technology. Please note that Skype is not considered to be HIPAA compliant.
- Psychiatrists should provide a formal, written emergency plan to the patient for their use should they need emergency assistance.
- Informed consent for the use of telepsychiatry should be obtained prior to the initiating the first session.
- The patient record created during the telepsychiatry treatment must adhere to all state/federal laws governing medical records and should be maintained in a similar manner to conventional psychiatric encounters. Additional documentation of a telepsychiatry session should include:
  - Location of psychiatrist and patient
  - Type of equipment used, including any malfunctions that may have occurred
  - Who was present during the session, and their role
  - An entry indicating that the service was provided via telepsychiatry and the time the service was started and the time it ended.
- Written policies and procedures should be maintained to the same standards as required in face-face office encounters.
- Office staff should be trained in the use of the telepsychiatry equipment and be competent in its use.
- If using a mobile device, note that you may not be reimbursed

for the session if using applications that are not considered to be HIPAA compliant such as Face Time, Skype or other similar applications.

- Establish with malpractice carrier whether coverage extends to providing telepsychiatry services.

Conclusion

Telepsychiatry is changing the manner in which psychiatry is practiced. North Carolina has a number of resources if considering practicing telepsychiatry including the State of North Carolina's Guidelines for the Use of Telepsychiatry.[7] Since laws vary from state to state, it is important that you are familiar with your jurisdiction's laws as well as the principles of medical ethics. Finally, should you have questions, consider consulting an attorney or your risk management professional.

Kristen Lambert, J.D., M.S.W., L.I.C.S.W., F.A.S.H.R.M. is Vice President of Risk Management for AWAC Services Company, a member of Allied World Assurance Company Holdings, AG ("Allied World"). Mariea Urubek, R.N., M.S.N., J.D. is an Assistant Vice President of Healthcare Risk Management at AWAC Services Company.

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PSYCHIATRIC MEDICINE – FACULTY POSITIONS
(Position Numbers 966055 and 000672)

The Department of Psychiatric Medicine at the Brody School of Medicine at East Carolina University is accepting applications for two Adult Psychiatrists to serve as a full-time Assistant or Associate Professor. These positions offer an excellent blend of clinical care, teaching, and scholarly activities in a growing, multidisciplinary, and collegial Department. The successful candidates will provide direct clinical care in both community-based and academic settings; Assist in the teaching and clinical supervision of medical students, residents, and other health professional trainees; Collaborate with other faculty members in conducting clinical research, with the opportunity to initiate projects; and function as University faculty members, performing such duties as appropriate to academic rank and position. The clinical responsibilities may be in inpatient and/or outpatient settings, including services via telepsychiatry.

East Carolina University is the 3rd largest public university in North Carolina, with approximately 27,400 students and over 5,000 faculty and staff. ECU combines the rich tradition of college life with the energy and innovation of a doctoral research university. This combination allows students and faculty to enjoy the benefits and resources of a large research university in an atmosphere more typical of a smaller college. The University is located approximately 85 miles east of Raleigh, the capital city of North Carolina, and approximately 87 miles west of the Atlantic Ocean. The teaching hospital affiliated with ECU Brody School of Medicine is Vidant Medical Center (formerly Pitt County Memorial Hospital), a 900+ bed tertiary care academic medical center serving Eastern and coastal North Carolina. The hospital provides acute, intermediate, rehabilitation, and outpatient health services to more than 1.4 million people in 29 counties. The hospital also has a 52 bed psychiatric service that houses acute beds, combine MI-ID beds, and combined Med-Psych beds.

Fixed Term or Tenure Track positions available at the title/rank of Assistant Professor or Associate Professor. Salary and academic rank/title (tenure track or fixed term) commensurate with experience and academic background. Qualifications: Requirements include MD or equivalent degree from an appropriately accredited institution, completion of accredited psychiatric residency training program, and board certification or eligibility for board certification.

East Carolina University requires applicants to submit a candidate profile online in order to be considered for this position. In addition to submitting a candidate profile online, please submit online the required applicants documents; Curriculum Vitae, Letter of Interest, List of Three References (noting contact information). Equal Opportunity/Affirmative Action Employer.

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Member Notes

Debra Bolick, M.D., D.F.A.P.A.

Debra Bolick, M.D., D.F.A.P.A., Past President of NCPA and current APA Assembly Representative, has been named as the Area 5 Representative on the APA Assembly Rules Committee. The Rules Committee considers all new business and action papers to be presented to the Assembly, prepares such items for presentation, rules on their appropriateness, and reports them to the Assembly.

Don Buckner M.D., D.F.A.P.A.

Don Buckner, M.D., D.F.A.P.A., received the APA's William W. Richards Rural Psychiatry Award for Area 5. The award is presented to one psychiatrist in each of the APA's areas who practices in a rural and under-served location and who shows exemplary contributions to both the medical community and local community agencies. Dr. Buckner received the award during NCPA's Annual Meeting.

Stephen Buie, M.D., D.F.A.P.A.

Stephen Buie, M.D., D.F.A.P.A., APA Assembly Representative, has been named to the Access to Care Work Group Committee within the APA Assembly representing Area 5. The group will focus on grass roots experience of patients and psychiatrists identifying problems of access, including: denials, delays, disruptions of care, access to psychiatrists or delivery of treatment in a timely and effective manner.

Palmer Edwards, M.D., D.F.A.P.A.

Palmer Edwards, M.D., D.F.A.P.A., has been elected the Speaker for the North Carolina Medical Society House of Delegates for 2015-2016. Dr. Edwards has served on the NCMS board since 2009 and led the Forsyth-Stokes-Davie Medical Society as president in 2010.

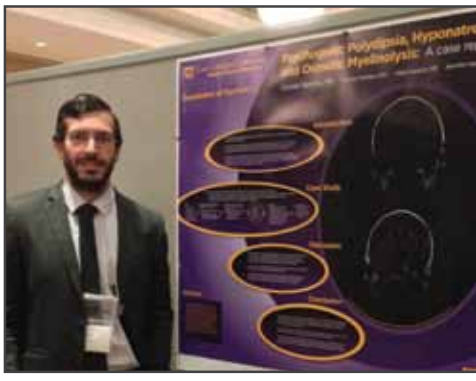
Harold Kudler, M.D., D.F.A.P.A.

Harold Kudler, M.D., D.F.A.P.A., became the Chief Consultant for Mental Health Services for the Veterans Health Administration Central Office in Washington, DC effective July 27, 2014. Before assuming this position, he was the Associate Director of the VA's Mid-Atlantic Mental Illness Research, Education, and Clinical Center (MIRECC) for Deployment Mental Health, and from 2010 to 2013, Dr. Kudler served as Medical Lead for the VISN 6 Rural Health Initiative.

Keith McCoy, M.D., F.A.P.A.

Keith McCoy, M.D., F.A.P.A., will represent NCPA in the 13th class of the North Carolina Medical Society Foundation's Leadership College. The elite program allows physicians and physician assistants to excel as leaders within organized medicine, hospitals, health care systems, medical staffs, group practices, and in the public policy arena.

Cornel Stanciu, M.D., presented a poster during the Scientific Poster Session at the North Carolina Medical Society's 160th Annual Meeting and House of Delegates. His research poster focused on a case of extrapontine myelinolysis presenting in a 49 year-old individual with a history of severe Schizoaffective disorder and psychogenic polydipsia with extreme hyponatremia. Dr. Stanciu is a PGY-2 resident at East Carolina University's Brody School of Medicine.



Cornel Stanciu, M.D.

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

Medical Marijuana: Evidence, Accepted Indications and Current Use

Chelsea L Neumann, M.D. is a Resident Fellow Member and PGY-IV at Duke University; Ashwin A. Patkar, M.D., D.F.A.P.A., MRCPsych is Professor of Psychiatry and Community and Family Medicine, Duke University Medical Center.

This is the fifth in a series of articles by the NCPA Addictions Committee designed to review the current status of the science that may inform opinion as each member considers his or her stance on changes in public policy and legislation relating to cannabis. Please note: due to space limitations, references cited are available online at www.ncpsychiatry.org/marijuana-series or by calling 919-859-3370.

Introduction

The use of marijuana (cannabis) for medical indications remains controversial due to limitations in scientific evidence, state and federal restrictions, and legal status of marijuana. As of November 15, 2014, 23 states and the District of Columbia have legalized marijuana for medical purposes despite DEA classification of cannabis as a Schedule I drug with no currently accepted medical use and high potential for abuse. Four states and the District have legalized recreational marijuana. Physicians are caught between growing medical research indicating medical potential for Δ(9) -tetrahydrocannabinol (THC) and cannabidiol (CBD) and federal regulations limiting legal prescribing.

In North Carolina, House Bill 1161, introduced on May 20, 2014 would have placed on the November 4, 2014 statewide election ballot, a constitutional amendment to allow the medical use of cannabis. The bill died when the legislature adjourned May 22, 2014, rendering medical marijuana currently illegal in North Carolina. However, a bill was signed and approved by Governor Pat McCrory in June 2014, legalizing the use of CBD oil, an extract from the popular strain of cannabis known as Charlotte's Web, for intractable epilepsy in North Carolina.

Position Statements of National Medical Associations

The American Medical Association (AMA) stated in June 2001: "The AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease...." In November 2013, the AMA reaffirmed its opposition to marijuana legalization, but also called the current federal approach to reducing the drug's use "ineffective" and endorsed a review of the "risks and benefits" of new legal markets in Colorado and Washington. The 2011 position statement by American Society of Addiction Medicine (ASAM) asserts that "cannabis, cannabis-based products and cannabis delivery devices should be subject to the same standards that are applicable to other prescription medications and medical devices, and that these products should not be distributed to patients unless such products or devices have received marketing approval from the Food and Drug Administration (FDA). ASAM rejects smoking as a means of drug delivery since it is not safe." In 2013, the American Psychiatric Association (APA) announced its position statement on marijuana clarifying that "there is no current scientific evidence that marijuana is in any way beneficial for the treatment of any psychiatric disorder. In contrast, current evidence supports, at minimum, a strong association of cannabis use with the onset of psychiatric disorders. Further research on the use of cannabis-derived substances as medicine should be encouraged and facilitated by the federal government. If scientific evidence supports the use of cannabis derived substances to treat specific conditions, the medication should be subject to the approval process of the FDA." A 2004 FDA testimony before the U.S. House of Representatives stated "Simply having access, without having safety, efficacy, and adequate use information does not help patients," and "FDA will continue to be receptive to sound, scientifically based research into the medicinal uses of botanical marijuana and other cannabinoids."

Synthetic Cannabinoids and Medical Uses

Preparations of the marijuana plant Cannabis sativa has been used for centuries in the treatment of rheumatism, convulsions, pain and other medical indications throughout the world. Of the approximately 60 phytocannabinoids found in cannabis, the two most medically relevant are THC and Cannabidiol (CBD), a cannabinoid extract of botanical cannabis. CBD has been

shown to have anti-convulsive, sedative, hypnotic, anti-psychotic, anti-nausea and anti-inflammatory effects.[1]

Chemotherapy induced nausea and vomiting and AIDS-relating wasting syndromes

Synthetic cannabinoids approved by the FDA since 1985 include the Cannabinoid (CB1) receptor agonists dronabinol (Marinol®) and nabilone (Cesamet®). Dronabinol, a Schedule III controlled substance, is indicated for chemotherapy induced nausea and vomiting and AIDS-related anorexia and wasting, with therapeutic effects lasting up to six hours and onset of action 30 to 60 minutes. Nabilone has therapeutic effects that last up to twelve hours and onset is 60 to 90 minutes. Though synthetic, both THC analogs cause unwanted side effects similar to botanical cannabis, which is associated with euphoria, dysphoria, cognitive slowing and paranoia. Also, the long onset of action and oral preparation is argued to be less favorable to patients as opposed to immediate onset with inhaled marijuana. A placebo-controlled randomized controlled clinical trial (RCT) found that in HIV-positive marijuana smokers, both dronabinol (at doses eight times current recommendations) and marijuana (3.9 percent THC) were well tolerated and produced substantial and comparable increases in food intake."[2]

Pain syndromes

Several molecular, biochemical and pharmacological studies support the existence of reciprocal interactions between the opioid and endocannabinoid systems, suggesting a common underlying mechanism.[3] Furthermore, these systems are thought to work synergistically to enhance analgesia. Recent reviews have indicated a likely future indication for the use of cannabinoids and opioids in tandem for pain and palliative care as a mode of minimizing adverse effects and tolerance associated with the use of opioids alone for analgesia; however no formal controlled trials support this indication at this time.[4]

The U.S. FDA has expedited a review of Sativex®, a medical marijuana spray for the treatment of pain in patients with advanced cancer that is currently in Phase III trials. Sativex®, generic name nabiximols, is composed of CBD and THC in a mucosal spray that is approved in Canada, Mexico and Europe for the treatment of muscle spasticity caused by multiple sclerosis. Canada also allows the use of Sativex® for relief of neuropathic and advanced cancer pain.

Medical marijuana is being used to treat pain associated with a multitude of medical conditions. A recent open-label study found that THC/CBD spray was effective for peripheral neuropathic pain associated with diabetes and allodynia, with half of the patients experiencing at least 30 percent improvement in pain, in addition to improvement in sleep quality.[5] A controlled trial found smoked marijuana was well tolerated and effectively relieved chronic neuropathic pain associated with HIV concluding its effects were as effective as conventional pain medications.[6] The safety evidence for medical marijuana as a treatment for HIV-associated neuropathic pain and weight loss is mixed, mainly due to concerns that inhaled marijuana may decrease immunity and contribute to opportunistic infections. There is limited evidence for cannabis as treatment for migraines.[7]

Glaucoma

Cannabinoids in smoked marijuana have been shown to reduce intraocular pressure in humans and suggested a therapeutic role in glaucoma.[8] One limitation of smoked marijuana is that it reduces intraocular pressure for only three to four hours, necessitating smoking six to eight times a day and increasing risk of adverse effects. Based on available scientific evidence, the American Academy of Ophthalmology Complementary Therapy Task Force found no scientific evidence demonstrating increased benefit and/or diminished risk of marijuana use in the treatment of glaucoma compared with the wide variety of pharmaceutical agents available.[9] The National Institute on Drug Abuse (NIDA) approved the use of botanical cannabis for glaucoma in 1976, which led to a group of patients receiving treatment until 1992 when the FDA's Compassionate Investigational New Drug Study (CIND) program was suspended.[10] The CIND currently supports the treatment of approximately four patients with federally grown medical cannabis for diagnoses including glaucoma, multiple sclerosis, nail patella syndrome and a rare bone disorder.

Neurological Disorders

Evidence supporting the use of medical cannabis for other neurological disorders is mixed. A recent systematic review concluded that oral cannabis extract, THC and nabiximols were possibly effective for Multiple Sclerosis related spasticity and central pain as well as spasms. Nabiximols was probably effective for bladder spasms, though THC and oral cannabis extract was probably not effective. THC and oral cannabis extract were probably ineffective and nabiximols was possibly ineffective for tremor, and oral cannabinoid extract was probably ineffective for levodopa-induced dyskinesias in Parkinson's disease. The review also concluded

continued on page 14...

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NCPA and NCCCAP Congratulate the Poster Session Winners from the 2014 NCPA/NCCCAP Annual Meeting & Scientific Session in Wrightsville Beach!

First Place - ***April Seay, M.D.***, Duke University; Second Place - ***Cornel Stanciu, M.D.***, East Carolina University; Third Place - ***Behrouz Namdari, M.D.***, Duke University; People's Choice Award - ***Oliver Glass, M.D.***, East Carolina University; Child and Adolescent Award - ***Goshawn Chawla, M.D.***, East Carolina University.

For more about this year's Annual Meeting, including other award winners, and to see information about the 2015 meeting, visit www.ncpsychiatry.org/annual-meeting.

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It's Always a Good Time to Support the Psychiatric Foundation of North Carolina

The Psychiatric Foundation of North Carolina, organized for charitable, educational and research purposes, is primarily focused on providing training, education and research to improve care for the psychiatric patient, among other goals.

Each year the Foundation covers the registration of Psychiatry Residents and Medical Students to attend the NCPA Annual Meeting & Scientific Session. This serves to further the Foundation's mission and enhance their learning experiences and networking opportunities.

The Foundation also recognizes researchers who make outstanding contributions to the field of mental health research through the Eugene A. Hargrove, M.D. Mental Health Research Award. Further, the V. Sagar Sethi, M.D. Mental Health Research Award brings world-class researchers to share their knowledge and findings at the NCPA Annual Meeting.

Please support the Psychiatric Foundation of North Carolina through a tax-deductible donation. Donations may be made online (credit card) at www.ncpsychiatry.org/foundation. Donations may also be mailed to the Psychiatric Foundation of North Carolina, 4917 Waters Edge Drive, Suite. 250, Raleigh, NC 27606.

Submit your nominations for the 2015 V. Sagar Sethi, M.D. Mental Health Research Award now! Nominations must be submitted before the January 15, 2015 deadline. Submission criteria and instructions are available online, www.ncpsychiatry.org/sethi-award.

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...President's Column continued from page 3

stantial resources necessary to fix the problem. Funding is needed for expanded staffing to support reopening of unused wards at State Hospitals, and to maintain full staffing on weekends so admissions and discharges can continue apace throughout the full week.

Secondly, funds are needed to expand the size of general hospital psychiatry units, and to convert some of them to high acuity facilities able to accept complicated, aggressive psychiatric patients. Most general hospital units will decline such patients, who then must wait for scarce State Hospital beds to open up.

NCPA has taken a first step to reverse this process by bringing a resolution to the North Carolina Medical Society (NCMS) opposing ED boarding and calling on the Governor and Legislature to fund the two interventions described above. At its annual meeting in October, the Medical Society's House of Delegates approved our resolution, which was co-sponsored by the N.C. College of Emergency Physicians who expressed interest in joining our effort. This approval brings with it $20,000 in lobbying funds.

Turning back the tide of ED boarding is one of this year's principal goals for NCPA, and several of our committees are tackling it. The NCMS resolution approval is only a first step in the process of influencing this issue.

...Medical Marijuana continued from page 8

Oral cannabinoids are of unknown efficacy in non-chorea-related symptoms of Huntington disease, Tourette syndrome, cervical dystonia, and epilepsy and warned of the serious adverse psychological effects with the use of these medications.[11]

A high concentration CBD: THC strain of cannabis, popularly known as Charlotte's Web, is currently approved for refractory cases of epilepsy in eleven states. This strain gained prominence due to the case study of Charlotte, a 5-year-old girl in Colorado with Dravet syndrome, a debilitating gene mutation that contributes to a form of epilepsy that caused her to have more than 50 grand mal seizures daily, refractory to conventional anti-epileptic medications. After administering CBD oil in a dose of 4mg CBD/pound per day, Charlotte's seizures decreased to three seizures per month.[12] Its popularity and touted efficacy has thousands of patients on waiting lists to obtain the oil, traveling across Colorado state lines to obtain the medicine due to its limited availability and high demand. Although there are no available randomized controlled trials of botanical cannabis in epilepsy, anecdotal and survey evidence suggests that it may benefit patients with epilepsy.[13]

Epidiolex© is a highly purified CBD containing medication containing no THC extracted from botanical cannabis. Epidiolex© has been granted Orphan Drug Designation by the FDA in the treatment of Dravet and Lennox-Gastaut syndromes since November 2013, each of which are severe childhood-onset drug-resistant epilepsy syndromes. It is manufactured by the UK's GW Pharmaceuticals, and is composed of highly purified CBD containing no THC extracted from botanical cannabis. As of October 30, 2014, a worldwide phase 2/3 clinical trial is underway testing the safety and efficacy of Epidiolex© in children and adolescents with Dravet syndrome. Epidiolex© is considered a Schedule I substance by the FDA and is closely monitored and restricted by both the FDA and U.S. Drug Enforcement Agency.[14,15]

Psychiatric disorders

There is strong evidence to suggest that frequent cannabis use is an independent risk factor for emergence of psychosis and those with established vulnerability are particularly sensitive to its effects, leading to poor outcome.[16,17] A causal relationship between cannabis and schizophrenia has not been firmly established. Given the association between cannabis use and psychosis, individuals at risk for or suffering from schizophrenia or bipolar disorder should be discouraged from marijuana use.[18] However, GW Pharmaceuticals is currently enrolling patients in the UK and Poland in a phase 2a trial to investigate possible antipsychotic properties of a high potency CBD and low potency THC compound GWP42003 in patients with schizophrenia, noting on their web site "GWP42003 has shown notable anti psychotic effects in accepted pre clinical models of schizophrenia and importantly has also demonstrated the ability to reduce the characteristic movement disorders induced by currently available anti psychotic agents."[19]

Limited evidence from small studies suggests THC may reduce tics and behavioral problems in patients with Tourette syndrome.[20] There is minimal evidence to support use of medical marijuana for symptoms of major depressive disorder, bipolar affective disorder, anxiety disorders and PTSD, with some evidence suggesting adverse effects of cannabis on these conditions in adolescents.[21,22,23,24]

While biochemically it is believed that the endocannabinoid system, specifically anandamide, may have implications in the extinction of fear, experts are hesitant to claim botanical cannabinoids in their current medicinal form may be useful as treatment for PTSD.[25] Current research indicates only temporary relief may be obtained for individuals with PTSD using currently available cannabinoids as treatment.[26]

There is insufficient evidence indicating positive effects of medical cannabis on symptoms of depression, however studies indicate significant daily use of marijuana is likely to contribute or exacerbate symptoms of depression.[27] Prospective and retrospective studies have found that marijuana use did not correlate with increased or decreased suicide.[28,29]

There is some pilot data that nabilone may reduce symptoms of marijuana withdrawal, however current evidence to support use of medical marijuana in marijuana, opioid or other substance dependence remains insufficient.[30]

Conclusions and Future Directions

Medicinal use of marijuana may benefit selected cases of refractory chemotherapy-induced nausea and vomiting and AIDS-related wasting syndromes and intractable seizures. There is emerging evidence that medical marijuana may also have a role in specific pain syndromes and neurological disorders. However, in all these conditions, there is a clear need for more efficacy and safety research. Pharmacological studies investigating synthetic cannabinoid compounds that can selectively modulate the >>

NCPA Announces 2015-2016 Slate of Officers

Voting begins in January

In early January, the NC Psychiatric Association will mail the 2015-2016 election materials, including the ballot and a return envelope, to all voting NCPA members. ***Electing leadership for the association is one of the most important duties of NCPA's membership base. Please read the election letter and ballot carefully and return your anonymous vote by the deadline indicated in the voting materials.***

Members of Executive Council serve staggered term limits to ensure a smooth transition of leadership each year. Once elected, the slate of officers will begin their new terms at the close of the APA Annual Meeting in May; NCPA's calendar runs from May 1 until April 30, annually. Please note, Arthur Kelley, M.D., L.M., the incoming President, was previously voted into office on the 2014-2015 ballot as President-Elect.

Please contact the NCPA office with any questions, 919-859-3370 or info@ncpsychiatry.org.

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...continued from previous page

endocannabinoid system in humans have increased substantially. This may permit better understanding of the effects of THC and CBD on the individual CB1 and CB2 receptors and can clarify the potential medicinal effects of these chemicals.

The health risks posed by smoking marijuana, challenges of dose administration by smoking, and the negative psychological effects associated with ingesting and smoking botanical cannabis, limit acceptability and safe prescribing by the medical profession. Clinical research in medicinal use of marijuana can improve our understanding of potential positive effects as well as the risk and safety of the product. Such research can help clinicians, patients, policy makers and the public to make informed decisions regarding the role of medical marijuana.

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Calendar of Events

December 7, 2014, 10:00 am
Executive Council Meeting
Raleigh, NC

February 26-27, 2015
2015 Clinical Update and
Psychopharmacology Review
The McKimmon Center, Raleigh, NC
Register online: http://goo.gl/v5hKCZ

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