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Annual Meeting Recap 2016

By Janet Bryan,
SPA Executive Director

Though the weather was rainy, we had a successful Annual Meeting with the Maryland Psychiatric Society at the end of September in Baltimore. A total of 90 attendees enjoyed a powerful scientific program, including presentations about the changing healthcare environment, physician-assisted suicide of non-terminal psychiatric patients, the use of cannabis in mental illness, opioid use and addiction in psychiatry, and guns and mental illness. Other topics included transcranial magnetic stimulation, psychopathology and phenomenology, mindfulness and OCD, U.S. behavioral healthcare in the 20th century, management of mood disorders in pregnancy, and integrating spirituality with evidence-based medicine. This year’s Resident Award Winner, Dr. Scott Johnson, spoke about Predictors of Incarceration of Veterans in U.S. Veteran's Courts. A new feature this year was the panel presentation and discussion; we had three of them. Everyone enjoyed the networking opportunities, receptions, and social events, which included a reception and tour at the Visionary Arts Museum and trips by bus and boat around Baltimore and its Inner Harbor.

We were pleased to have 14 wonderful exhibitors: Allergen Pharmaceutical, Alpha Genomix Labs, American Professional Agency, Bon Secours, Greenbrook, Janssen Pharmaceuticals, TMS Neurohealth Centers, Neurostar TMS Therapy, Professional Risk Management Services, Sheppard Pratt Health System, Psychiatric Institute of Washington, Sunovion, Tranquility Woods, Tulane University, & Vanderbilt University.

Susan Proctor was recognized at the Annual Meeting for her 11 years of service to the SPA as she retired. I enjoyed meeting all of you who attended the recent meeting. I’m looking forward to working with you in the years to come.

Please mark your calendar for next year’s meeting, to be held jointly with the Georgia Psychiatric Physician’s Association at the Ritz Carlton in Amelia Island, Florida, from August 2 through 5, 2017. Please encourage business representatives to exhibit at the event.

Southern Hospitality

By Lauren M. Pengrin D.O.

I am a third year psychiatry resident at Saint Elizabeths Hospital in Washington, DC, and a new member of the SPA. I had the opportunity to attend my first Southern annual meeting this past October in Baltimore and wanted to share my impressions with others.

I saw a group of dear friends coming together to reconnect and discuss new events and knowledge in the field of psychiatry. I was immediately welcomed with open arms and encouraged to be an active participant in the organization. Though I am at the very start of my career in psychiatry, I was treated as a colleague by more senior members, who shared invaluable advice and encouragement.

Attending lectures with prominent leaders in the field was both humbling and invigorating. I learned about many different topics that I can incorporate into my own education as a resident. Because many of these subjects do not focus explicitly on meeting Accreditation Council for Graduate Medical Education guidelines, it was an opportunity for me to explore areas such as gun control, physician assisted suicide, and spirituality in psychiatry.

I also greatly enjoyed the group events planned in the Inner Harbor. The tour of the Visionary Arts Museum and the harbor cruise were wonderful; I enjoyed touring the city while getting to know fellow Southern members on a more personal level. I was very taken by the collegiality of the association. I could easily see myself coming back year after year to meet with friends and to get a taste of the latest issues facing psychiatrists.

I had a fantastic time at the annual meeting and was deeply appreciative of the “Southern” hospitality I was shown.
Letter from the Editor
What Would It Be Like to Actually “Integrate Care”?  

By Bruce Hershfield, MD 

“He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all.” (Sir William Osler) 

I’ve known for years that “integrated care” would be coming into my life—at least as far back as 2013, when I heard the APA President-elect say that the older psychiatrists could practice for a few more years in the way they have, but that in a little while no psychiatrists will actually be directly treating patients. I understood that the APA was adapting to the Affordable Care Act. On December 3rd, I attended the 4-hr class the APA made available to us to tell us how to get ready for the new way we will be practicing. 

The psychiatrist who taught us, from Cambridge, MA, was excellent, devoting a lot of the time to answering our questions and addressing our concerns. Nevertheless, I still have a few. 

The gist of the new system is that psychiatrists will interact with care managers—of different disciplines like social work, nursing, and psychology—instead of directly with patients, and will be “responsible” for thousands of people receiving care within the network. It is not clear exactly what that responsibility will be, since a psychiatrist will only be making “recommendations” to the care manager, who is then to transmit them to the primary care practitioner, etc. It is not clear to me if care managers of different disciplines will understand me the same way. Furthermore, I don’t know, in terms of legal liability, what it means to “recommend” a medication instead of to prescribe it. It’s unclear how I can learn from the feedback if I do not actually treat the patient afterwards or even how the primary care practitioner would hear my recommendations through the filter of the care manager. Whom will the patient call when there is a problem—for example, a rare side effect? How valid will the diagnoses be? As one of my colleagues at the class said, he is not really “making” the diagnosis if he has never seen the patient. This reminded me of the “Goldwater” rule that prohibits us from doing that with people who are in the public eye. 

“Here is a model “disclaimer” designed to protect us from the obvious legal pitfalls: “The above treatment considerations and suggestions are based on consultations with the patient’s care manager in a review of information available in the mental health integrated tracking system (MHITS). I have not personally examined the patient. All recommendations should be implemented with consideration of the patient’s relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.” 

No medical organization has ever invited me to take on this role, and I am not at all sure about how to go about asking one to employ me to do it. 

The APA has arranged for codes so that we will be paid for this kind of work if we choose to do it. Three new codes—G0502 (initial—70 minutes), G0503 (60 minutes follow-up) and G0504 (30 minutes) are intended to pay $143, $126, and $66. The money will go to the primary care practitioner, who is to contract with the psychiatrist on a monthly basis. 

This is a radical departure from the way most of us were trained. It’s radically different from the way we are training residents now. I know that the APA Board recently voted to spend several million dollars of a grant from the government teaching us how to do it. It never came up in a general vote of the membership, nor do I recall it being debated in the Assembly, or it being a feature of anyone’s campaign for office. 

The problem with this kind of decision is that it is top-down rather than bottom-up, with few, if any, clinical psychiatrists clamoring for the opportunity to give up seeing patients. The opportunity to get to know patients and to help them with their troubles, is, after all, why many of us went into the field in the first place. When I was asked during one of the exercises, which consisted of checking off various signs and symptoms, what else I would inquire about, I said I’d I ask the patient what is bothering him or her. It seems to me to be the missing ingredient—the shared humanity that can save our patients and us from all those check marks. I continue to believe that being a psychiatrist means more than simply “recommending” medications to “clients”. 

It’s not clear to me if this “integrated care model” will go away when the Affordable Care Act is repealed or decimated. I’d like to see some open discussion in the Assembly about this issue, since it is so important, and I would hope that our SPA Assembly Representative, Dr. Mark Komrad, will bring it up if no one else does. We can best prepare for the future by talking with each
other, respecting that we can have different opinions, and finding new models of care that can benefit our patients, communities, and ourselves. The current proposal to exclude us from directly treating patients—even backed by millions of dollars—falls far short of the best we can do.

INTERVIEW: John Looney, MD, President, SPA
October 1, 2016

By Bruce Hershfield, MD

Q.: “I’m delighted that you’re becoming our President. Would you tell us about your history of involvement with the Southern?”

Dr. L.: “My wife and I joined in the ’70s. We were at Timberlawn Hospital in the great days of that organization and, after several years there, we were given the opportunity to go to the Southern as provisional guests. We liked the people and they did invite us to join. Those were really, really fun times in the Southern—lots of people we met in good places and very good programs. It was one of our favorite meetings of the year. Then I went to Duke in 1986 and the rigors of academic life caused me to drop out of the Southern for a number of years. I was just too consumed with building some new programs at Duke.

We came back in the last 10 years. I knew people well who’d continued in the Southern at that time and I liked them so much. We decided we had a little more flexibility in our lives and wanted to go back.”

Q.: “What have you enjoyed about the organization since you returned?”

Dr. L.: “The people. People take time and talk about the relationships and experiences and things other than professional advancement. That’s what we liked before, and that’s what we like now.”

Q.: “Please tell us about your activities.”

Dr. L.: “I’m still pretty busy at Duke and expect to be working on the consortium for the study of the college student for the next three or four years. I have cut back my patient care load. We have another house, in Franklin, Tennessee, near our sons and grandchildren, and we farm near there. We have an apartment in Durham, and a home in Franklin.

Franklin was a very small town when one of the most horrible battles of the Civil War took place. John Bell Hood unadvisedly advanced upon fortified federal positions and suffered a horrible defeat. Local people still talk about it, although there are times when I think that commerce and industry and tourism cause people to forget what happened there.”

Q.: “Would you tell us a little bit about your farming activities?”

Dr. L.: “When I went to Duke in 1986 I bought a farm in Crossville, Tennessee. I expected to buy a small place and to build a cabin so I could look at the mountains, but my cousin—an attorney and farmer—said he would buy me a piece of property in the right situation and send me a bill for it. I’ve always trusted him, so I said that would be fine. He called me and said he had found a place and the bill was in the mail. It was many times bigger than I expected, and it has been a bigger commitment than I had intended to make. We raise beef cattle there and also develop wildlife. It’s good to get out and work on a tractor and plow the fields.”

Q.: “How did you get involved with Psychiatry in the first place?”

Dr. L.: “I was at Southwestern medical school and, in order to help with expenses, I heard about a job as an extern at Timberlawn hospital. In those days, Timberlawn always hired four carefully selected medical students to live on the property and to take turns rounding through the hospital at night—the last people making rounds. In the summer, we participated in the residency program at Timberlawn. I was thinking of becoming an internist, but I was so impressed with the people there. They were well-read, thoughtful, people. At dinner, we could actually have an illuminating conversation about something way outside of medicine. I decided that’s the kind of doctor I wanted to be.”

Q.: “What have you enjoyed most about being a psychiatrist?”

Dr. L.: “I really like doing evaluations and meeting people for the first time, even if they are in significant distress. I enjoy the process of getting to know them and I think that process in fact helps them feel better. That kind of connection in the beginning—you’ve just got to take the time to do it, and if you don’t get it done
the first time, you can see them again the next day and stay late and get it done then. I think that process of really getting to know them the first time and getting to feel a non-possessive interest in them is important. It makes it easier to follow them. I do a mixed psychotherapy and psychopharmacology practice—more on the psychotherapy side. I like young people. I like helping them find direction in their lives.”

Q.: “What would you do differently in your career, if you had a chance to do it again?”

Dr. L.: “I probably would try to avoid getting caught in too much administrative work. But it’s hard to avoid. When I went to Duke, the main project was to build up child psychiatry. I don’t think there had ever been any externally-funded research in child psychiatry. I recruited some really good people and developed some people who were already there. Over the years, we have accumulated, in aggregate, more than $150 million in research funding. So it’s a big enterprise in research now.”

Q.: “What are you looking forward to, during your presidency?”

Dr. L.: “I’d like to see the Southern get bigger and better—known. I’d like to see it more prestigious, as it was in the past. I’d like to see it financially solvent and secure. The two words that keep coming to my mind are “membership” and “mission”. We need more members. The relationships we have among the existing members is marvelous. In terms of mission, we need to define what is unique about our organization. This is difficult to do when people probably don’t have the economic resources they had in the ’70s to travel to meetings. It can be harder to come up with the travel money. Certainly, some of the departments and private hospitals don’t support this as much as they did in the past. I think that if we are careful in our outreach efforts, we can bring in some more good members so they can experience what characterizes this uniquely southern society.”

Q.: “How can we help you be successful?”

Dr. L.: “I think working together with me to define the mission is important. Perhaps because the economic situation is more difficult now, people look for grant organizations that help them make more money. But to go to a meeting that has an excellent eclectic program, like at this meeting in Baltimore, is different. We have help people to understand that there is a need in their lives for the kinds of affiliation and closeness that we have.”

My Professional Journey: What I’ve Learned About Addiction

By John Looney, MD

At Duke, we have recently established a program, the Consortium for the Study of the American College Student. It proposes to make our nation’s college students more competitive by reducing their abuse of alcohol and other substances. When I look back on my four decades of helping young people, I find it hard to imagine how much I have had to learn about addictive diseases, I’ll review some of what I’ve learned and about the opportunities we now have to help young people, their families, and their schools with alcohol and other substances.

At the beginning of my career, I worked at a private psychiatric center in Dallas, on the adolescent and young adult units. Treatment often involved long inpatient stays. There was no intensive family treatment. Outcome studies revealed that one group of patients we predicted would stay healthy after discharge did not. We determined that we had not sufficiently appreciated this group’s prior use of alcohol and other drugs. I learned two important lessons: 1) it is more the norm than the exception for young people to abuse substances if they have a serious psychiatric condition, and 2) addictive disease in young people is a family disorder. Little progress can be made without actively involving the families; we need to appreciate their strengths.

In 1986 I was asked to become Director of Child and Adolescent Psychiatry at Duke, where the Chair, Bernard Carroll, wanted to expand that program and to develop research within it. Based on what I learned in Dallas, I asked that the assessment and treatment of substance abuse be added. Dr. Carroll wanted Duke to be a pioneer, which we became. We developed the first substance abuse assessment and treatment center in an academic division of Child and Adolescent Psychiatry in America. We incorporated both of the original lessons I’d learned in Dallas: 1) young people with drug problems usually have other psychiatric problems, and 2) drug and alcohol problems in young people must be treated within the context of the family.
College deans and student health services began to send students, who were often in horrible crises, to the program. Through their eyes, we saw the very unhealthy drinking environments that had played a role in the development of their dangerous behavior patterns. Some private donors funded a unique initiative, so that consultation teams conducted hundreds of hours of interviews with janitors, police, students, faculty, and officials at eight universities. These were Davidson, Duke, Johnson C Smith, North Carolina Central, Southern Methodist, University of North Carolina at both Charlotte and Greensboro, and Washington and Lee. We then presented our recommendations to the Presidents of the institutions.

At Duke, the Initiative developed a set of 45 specific, implementable recommendations in multiple areas like policy development, assessment and treatment, education and training of faculty, undergraduate culture, and alternatives to alcohol, along with the collection of data about alcohol use in athletics. Two important lessons also emerged: 1) preparing students to master college life must begin long before they matriculate (freshman year is too late) and university officials need to “get out in front” by changing the alcohol culture.

I want to address some important questions. Are things on campus really that bad? Do we really need university presidents to burn significant political capital to improve things? Have not college students always been drinking too much—going back to the Middle Ages? Yes, things are very bad now. We can show that drinking has dangerously escalated. When I was in college, we had parties and party weekends when drinking was expected. Sometimes, we drank too much. But now the procedure is to get drunk and then to see what there is to do in that state. College students now spend $5.6B on alcohol annually. Almost half of today’s male college students average five or more drinks at one sitting every two weeks; females have the same rate, with four more drinks at one sitting.

We can now have a major impact on the health of college students. This came about because I mentored Brandon Busteed; as a Duke senior, he became passionate about doing something to reduce the consequences of alcohol. He served two terms as President of student government and was elected as a young trustee. He persuaded some powerful friends to start a company, “Outside the Classroom”, to try to teach students how to live healthier lives. He developed an Internet educational module, using Duke professors. Dr. Scott Schwatzwelder, who does research on the effect of alcohol in developing brains, and who is now part of our team, had a key role. Brandon proved to be a passionate and effective salesman. Over 35% of American colleges and universities now require their freshman to use the module, “AlcoholEdu”, and there’s a very high completion rate. The education led to a decrease in drinking during the freshman year. We learned from this experience that 1) students give accurate information on well–designed surveys and 2) internet education is well–accepted by young people when it is properly presented without using scare tactics or moralistic overtones.

A few years ago, Brandon asked that I find a way to bring the database—a treasure trove—back to Duke from Harvard and Boston University, so that we could mine it here. We used it to investigate some topics that touch many aspects of college life. We recently analyzed the interrelationship of eating disorders and excessive drinking and realized that we must improve both of these programs. Students with eating disorders tend to engage in binge drinking.

The Consortium’s most exciting development has been the result of a substantial competitive award from the North Carolina GlaxoSmithKline Foundation for a five–year study of how to reduce drug and alcohol problems in North Carolina high school students who then go to college. Each year, over 800,000 students take a survey about this and several associated ones. For example, some surveys are used for students who are later identified as high risk drinkers. Some modules are specific for “Greeks” and some are designed to reduce sexual abuse. This has helped us to form the Consortium for the Study of the American College Student. I believe it is possible for Duke to develop a nationally distinguished center that would actually improve the lives of college students. We need to do so now, when we are facing an increasingly competitive world.

We need to develop a national model of a comprehensive youth addiction research and treatment program, ranging from lab research (like the studies of alcohol on young animal brains to real–life treatment interventions).

A patient I had treated on the adolescent unit at the University of Michigan many years ago somehow found my unpublished work about my professional journey.
He wrote, “Recently, I was reading your Professional Journal article out of some interest about how things have transpired in your life, since I knew you near the dawn of your career. I can’t tell you how gratified I was to read about how you understand how many of us had long problems for which we were not treated in what was somewhat a psychoanalytic approach.” He then went on to tell me about the other kids who were on the unit with him. I’m amazed how well he has kept up with their lives. It was clear that several had recurring problems with alcohol and drugs. The patient was charitable: “Your Professional Journey article demonstrates that you really have come a long way and you’ve done some real good in this world.”

OBITUARY: Roy J. Ellison, Jr., MD
By Jack W. Bonner, III, MD

Roy J. Ellison, Jr., MD, died September 30, 2016, in Greenville, SC, at the age of 91 after practicing as a psychiatrist for over fifty years. He enjoyed many different activities, including his family (24 grandchildren and 9 great grandchildren), gardening, traveling with his wife, Diane, and the Children’s Residential Program he founded at the Marshall I. Pickens psychiatric hospital in Greenville.

A South Carolina native, Roy graduated from the Medical University of South Carolina, interned at Greenville General Hospital, and completed his residency in Psychiatry at Duke. He was proud of being the “second” psychiatrist to come to work in Greenville. Roy was active in several psychiatric and medical organizations in the state and served as President of the Southern Psychiatric Association. He was the first psychiatrist to serve on the SC Board of Medical Examiners. Perhaps he was most proud of starting a residential treatment program (and serving as its Medical Director) for children at a time when such facilities were even more scarce than they are today. It has successfully operated for many years—a testament to his vision and tenacity. He loved to sit with the children and listen to their stories, and he was touched when they expressed affection for him. Self-employed for most of his career, he later added some clinical/administrative roles within the Greenville Health System—though always maintaining an extensive patient practice.

He had a number of hobbies, including reading extensively, and had an encyclopedic knowledge of South Carolina’s history and environs. He lived in the country, made wine from grapes he grew himself, and had a real love for the earth. He tilled a large garden every year. Roy delighted in giving away an abundant bounty of fresh produce to family, friends and co-workers.

Those of us who knew Roy are fortunate indeed to have benefited from all the bounty he had to offer—his friendship, wisdom, and guidance.

ACT Now
By Jessica Merkel-Keller, MD

My new office is my car; last summer, I joined an Assertive Community Treatment Team (ACT) at People Encouraging People.

The ACT model coordinates wraparound services—including mental health, housing stabilization, psychological rehab, vocational training, substance abuse treatment, case management, and crisis intervention—for people with psychiatric disorders who have not responded in a traditional setting. Our team—a psychiatrist, two psychiatric nurses, two housing specialists, a vocational specialist, two substance abuse specialists, a peer advocate, a team assistant, and a program manager—meet daily. Our parent organization has an in-house primary care practitioner for the majority of our clients. We use a pharmacy that delivers medications directly to us twice a day, or stocks the clients’ personal Pyxis machines in their homes.
Pyxis machines are essentially preprogrammed secure vending machines for medications.

We aim to provide highly individualized care to reduce the use of hospitalizations and crisis services and nonessential ED visits, eliminate homelessness, and change the ways that people interact with the criminal justice system.

Since becoming a member of the ACT team, I’ve come to appreciate it. First, ACT is not “mobile treatment” because we can provide wrap-around services, we are bigger, and we have a more diverse mix of specialists. Two, we are not a medical team, so we refer to “client” or “consumer,” not “patient”. We do provide medical interventions, but we also do many other things to empower our clients. Third, we use “cyclofill”, which is a way of packaging medications so that they are in a labeled tear-off roll in chronological order, with date and time of administration printed on each packet. Fourth, we often intervene in very public places—a departure from the traditional settings found in the hospital or office.

I’m finding that my personality, idiosyncrasies, and personal life are more likely to become known than in a more traditional care setting. Previously, I tried to screen out personal information. Now, it is harder to keep this information to myself.

Being in a client’s home can challenge professional boundaries. I take one woman with me to the YMCA aquarobic class as part of “behavioral activation”. I was not prepared to chat with her in my car, much less while changing into a swimsuit in the locker room. I realized that I had never previously spent three hours and fifteen minutes talking with a client without an interruption. I am not sure how they perceive me during these sessions.

In navigating everyday situations—such as helping to cook a meal or addressing unsanitary conditions, I have come to see that our clients’ homes (if they have housing) are not always appropriate or even safe. Some have bed bugs, so it is not possible to sit there or transport the clients in our cars. Because of weapons precautions, sometimes we can only meet in public places. For example, I have given long-acting antipsychotic injections in parks, in the bathrooms of fast food restaurants, and on front porches. I have tried to provide care as privately as possible. I was very surprised when one of my clients stood up in a Dunkin’ Donuts and said, “She’s my psych doctor, and she visits me here and gives me medications.” The manager came over and gave my client a donut and offered me a cup of coffee. There was “space” for us. My client was not shunned. I was relieved.

Other encounters were not received as well by the community. I was seeing a young man with psychotic illness who often uses synthetic marijuana. He frequently takes in people less fortunate than himself, which makes his already unstable and sometimes unsanitary housing even more chaotic. One day, he was disorganized; he was drinking lotion out of a cup and was vomiting. He fell, had a possible seizure, and was refusing to go to the hospital. I called 911 and prepared the EP paperwork. The police, who were already familiar with the address, decided to take him in their car and not by ambulance. This meant handcuffing him behind his back even though he was polite. After they left, his friends began throwing rocks at my car (with me in it!) and then laid on it so that I could not safely drive off. Then, one tried to get in my car. Thankfully, the door was locked! The situation quickly calmed down.

ACT teams address the nitty-gritty details of life—helping clients file for food stamps, obtain legal identification, manage money, and plan a first trip home after years in a state hospital. We meet the clients where they are.

HIGHLIGHTS of the APA Fall Assembly Meeting
By Mark Komrad, MD
SPA Rep to the APA Assembly

As usual, the APA Assembly meetings in November were lively and groundbreaking. No Assembly position statements or action papers are final until approved by the Board of Trustees (BOT). Not everything is eventually approved by the leadership. The Assembly however at least voices the sense of the membership’s concerns, as its representative body.

Here are several Action papers that passed that would be of particular interest to SPA members:

- Both inpatient physicians and outpatient physicians should be responsible to communicate with each other regarding a patient admitted to hospital within 48 hours as
the default expectation, unless the patient specifically forbids it. This is consistent with HIPAA regulations.

- The APA will study the diverse array of Prescription Drug Monitoring Programs (PDMP) to ensure that access to the data by law enforcement agencies is as restrictive as possible, consistent with current federal regulations that secure the confidentiality of patient records.
- The APA will address the need for screening and subsequent treatment for mood and anxiety disorders during pregnancy and the postpartum period and especially the higher rates of these disorders in low-income women from minority groups.
- The APA will support “smart gun” technology as one piece of a solution to gun violence.
- A particularly ambitious resolution: the APA will partner with other organizations to advance relevant issues and/or legislation designed to reduce and eliminate childhood poverty in America.
- Another ambitious resolution was to explore models, along with the AMA, for single payer and universal healthcare access and delivery. The Assembly is asking the Board of Trustees (BOT) to quickly appoint a Task Force on Fighting Mental Health-Injurious Discrimination, arising from emerging legislations that can effect vulnerable subgroups like the LGBTQ, immigrants, etc.
- A Position Statement was approved and was sent to the BOT, providing guidelines assuring the appropriate care of pregnant and postpartum women with substance use disorders. In particular, this is in opposition to the use of the legal system to address perinatal alcohol, tobacco and other substance use, charging post-partum women with child abuse based on use of substances during pregnancy.
- A Position Statement was approved and sent to the BOT, opposing the denial of payment for prescriptions of medically necessary drugs or services covered by a third party payer solely on the basis of the network participation of the physician ordering it.

There were a number of other action papers. More details can be accessed at: https://app.box.com/s/g7q4ozhvum7mhavnx48bbz5t3t3545ie

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Should DSM Help us Rule Out Rare Conditions?

By Lauren Pengrin, DO & Roger Peele, MD

In “Brain on Fire”, the NY Post’s Susanna Calahan describes what led to her hospitalization on a psychiatric ward with “schizoaffective disorder” and other diagnoses. Eventually, she was found to be suffering from anti-N-methylD-aspartate receptor encephalitis, which can cause psychosis and severe mood symptoms.

DSM purposely has fewer disorders than DSM-IV did. Adding conditions like anti-N-methylD-aspartate receptor encephalitis is not encouraged. Should the DSM help clinicians identify rare conditions in order to avoid tragic misdiagnoses? DSM–5 only brings the following possible conditions “to the reader’s attention”: Alzheimer’s disease, frontotemporal neurocognitive disorder, Lewy body dementia, vascular neurocognitive disorder, HIV infection neurocognitive disorder, prion disease, Parkinson’s disorder, and Huntington’s disease.

Two NIMH directors and others have claimed that psychiatry is “stuck” and that the DSM’s may be the reason. Would adding such rare disorders help get us “unstuck”? If so, we would need to vastly expand its list of conditions.

A “review of systems” might include: autoimmune conditions like multiple sclerosis and lupus, cancer, cardiovascular conditions like arrhythmias & CVAs, dehydration, dermatological conditions, endocrine conditions like Cushing’s disease & thyrotoxicosis, epilepsy, hematological conditions like anemia, infections like HIV & syphilis & Lyme disease, medication side effects, normal pressure hydrocephalus, nutritional problems like vitamin deficiency, pulmonary conditions like embolisms, sensory deficits, toxins such as lead, and sequelae of trauma like TBI’s and subdural hematomas.
Future DSM’s might recommend how to exclude such “organic” disorders. A thorough physical examination—including vital signs, neurological testing, and mental status exam—is imperative. Laboratory tests should be routinely recommended. Studies like EEGs and EKGs and glucose may also be helpful in excluding organic disorders in patients who present psychiatrically. Each “system” listed in the DSM might contain further specific recommendations for testing when abnormalities are noted.

Though it may seem impractical to ask every psychiatrist to rule out every possible condition, future DSM’s should offer some strategies—helping us find “zebras, not just horses”.

Susannah Calahan wrote that identifying and treating her condition cost about $1 million. Future DSM developers should try to propose strategies to identify rare conditions like the one she had. Long-term hospitalization and nursing home care would have cost both Ms. Callahan and our healthcare system much more.

Notes From The Bureaucracy

DSM 5: Organizations, Power, and Control?

By Harold I. Eist, DLFAPA, FRCPC

Recently, waiting for a patient, I noticed my hardback copy of the DSM 5. Unthinkingly, I opened it at the beginning and started paging through it. My mind jumped to an APA Board of Trustees meeting when Dr. Jerry Weiner, an APA past president, was forcefully making a point about a person with a Ph.D. who was on a DSM IV work group in a position that could have been and he felt should have been filled by a psychiatrist.

The Board supported his perspective and voted to put a psychiatrist on the work group. (They did not however replace the non-psychiatrist.) Much to my surprise, I recently learned the current DSM 5 has 95--yes, 95!--non-psychiatrists on work groups. There are many first rate psychiatrists who could have filled some or all of those positions. I know many gifted colleagues who would have loved to participate in the development of the DSM 5.

To include almost 100 more APA members in DSM 5 work groups would have been a large “plus” for our flagging member morale, particularly since the recent destruction of the components. The December, 2016 issue of AJP published “an appreciation” for its reviewers; 387 of them have Ph.D.’s or are candidates for that degree. (This number is about 1/3 of the reviewers). Are these Ph.D.’s APA members?

Experience has taught me that members serving on organizational committees tend to read journals and stay current. Further, such members learn from others and contribute to the learning of others. They attend local and national scientific meetings. Certainly, those who participate in society activities reveal a devotion to life-long learning.

Isn’t it odd that important learning opportunities are quashed while we are simultaneously pushing expensive and intrusive MOC bureaucratic requirement that APA members abhor?

SPA MEMBER RAHN K. BAILEY, MD

Candidate for APA President-Elect
By Rahn K. Bailey

I’m pleased to ask those of you I’ve known for years and those I met when I spoke in Chattanooga—and those I’ve not yet had a chance to meet—to vote for me to be President-Elect of the APA.

I’m originally from Texas, where I graduated from the University of Texas – Galveston and did my residency at the University of Texas in Houston. I then did a fellowship in forensics at Yale and was certified in general and forensic psychiatry. From 2008-14 I was Chair of Psychiatry at Meharry and Executive Director of the Lloyd C Elam Mental Health Center, which is the largest in Tennessee. Since January, 2015, I’ve been Chair at Wake Forest.

I’m currently Chair of the Membership Committee for the APA and I’ve also served in the Assembly. I’ve been President of the Tennessee Psychiatric Association and I have been on the Executive Council of the American Association of Chairs of Departments of Psychiatry. I’ve published many articles and one book—“A Doctor’s Prescription for Healthcare Reform”.

I’m pleased to ask those of you I’ve known for years and those I met when I spoke in Chattanooga—and those I’ve not yet had a chance to meet—to vote for me to be President-Elect of the APA.
I would very much appreciate the support of my fellow SPA members as I move forward in my efforts to represent all of us who are committed to promoting excellence in psychiatric education, research, and clinical care.

SPA MEMBER R. SCOTT BENSON, MD
Candidate for APA Area 5 Trustee

By R. Scott Benson, MD.

I trained in pediatrics in Minnesota, then in psychiatry at Duke. I came to Pensacola for their pediatric training program to combine my interests. I have Boards in Pediatrics, Psychiatry, Child and Adolescent, and Forensic Psychiatry and did recertify in forensics.

I have been able to find variety in my work. Adolescent inpatient, consult-liaison, consult to children's programs, and recently evaluation of military transitioning from active duty. We had a state contract for treatment of children who were victims of sexual abuse. Our staff trained on an evidence-based model of treatment that proved successful. I presented this work at the SPA meeting in Destin and again at Sheppard Pratt.

I was busy in politics, where I learned the value of a strong district branch, then represented Florida in the APA Assembly. I was Speaker in 2012-13 for the adoption of DSM-5.

On the Board I have pushed for fiscal responsibility and strategic expenditures. We will have new headquarters in DC in 2017. We have set up regional coordinators to enhance our state legislative efforts. Our legal team has had success on parity enforcement.

But there is more to do.

And our recent national election presents the APA with a new set of challenges. We need clear lines of communication among our members monitoring barriers to care. Like you, I need quality education to keep up with advances in our field, but let's get rid of annoying tests and reporting requirements that detract from time with my patients.

I don't have all the answers. I am not even sure about the questions. But, as Trustee, I have been available to you, connecting your problems to another member, a District Branch, or an APA office.

I would appreciate your support of my campaign and your vote in January.

SPA MEMBER JENNY BOYER
Candidate for APA Area 5 Trustee

By Jenny Boyer, MD

Besides being a psychiatrist, I'm also a psychologist and attorney. I'm currently Deputy Chief of Behavioral Medicine at the Eastern Oklahoma VA. I have a small private practice and am on the faculty at the University of Oklahoma in Tulsa and Oklahoma City. I'm Vice President of the Tulsa Medical Association, on the Board of the Oklahoma Medical Association, an Alternate Delegate to the AMA, and a Past Speaker of the APA Assembly. I'm also on the APA's VA Caucus and its Council on Advocacy & Government Relations.

Medicine will be watching every action Psychiatry takes. The APA must set the proper agenda and deliver policy aimed at the forgotten men and women—the mentally ill. As Area 5 Trustee, I'll bring a fresh viewpoint and an understanding of how the Board of Trustees, Assembly, DB's, Components, & Caucuses, combined with state and national partners like the SPA, can achieve change together. I've formed countless relationships with members across the country, which is vital in moving the APA forward. I understand credentialing and have concerns about "scope of practice" issues and MOC and 10-year Board exams. My perspective as a lawyer helps me stand up for minority viewpoints. As Speaker, I served on the Board for 2 years, representing every Area and Component, including Area 5.

I helped to guide an Action Paper through the Assembly. It was brought up by the VA caucus and became the first piece of legislation introduced by the APA in quite a few years. It was a good example of how we can influence APA policy.

It's time to move forward with innovations that will improve our ability to provide patients with quality care.
We need to communicate better with our members about BOT actions, both before and after they are taken. I’ve shown I can lead and that I can coordinate with others to bring about change. With your vote, I’ll represent all voices as your Area 5 Trustee.

**SPA MEMBER BRIAN CROWLEY**  
A Candidate for APA Secretary  
By Brian Crowley, MD

The Baltimore meeting was wonderful, and so was the support so many of you gave my petition to run for Secretary of APA in next month’s election. SPA feels like an old club where new members are welcome. I’m delighted that John Looney has put me on the New Member Task Force, so I can spread the word about the SPA to still more folks.

In October, Natalie and I went to the American Association of Psychiatry & the Law meeting in Oregon, and there saw a very robust debate over MOC in Psychiatry: “Keep, Polish, or Abolish.” I came away strongly believing in the “Abolish” option, as do most of my fellow members of the Private Practice Committee of AAPL. This is a major reason I decided to run for APA Secretary: ABOLISH MOC (Maintenance of Certification) in Psychiatry. It is wasteful of our time, money, and energy, and is not evidence-based. Return to Lifelong Learning and CMEs!

After 6 years on the Board of Trustees—I completed two terms as Area 3 Trustee in May—I am experienced in getting things done.

My very broad background in Psychiatry helps me understand the concerns of many members. I have worked in:

- Private solo office practice, half-time for decades
- Hospital settings of many types
- General Hospital Psychiatric Unit (twice chaired Department of Psychiatry, Suburban Hospital, Bethesda, MD)
- State Forensic Hospitals (St. Elizabeths and Clifton T. Perkins in MD, where I coordinated release hearings)

**SPA MEMBER ROBERT ROCA, MD**  
Candidate for APA Secretary  
By Robert Roca, MD

This is a very important moment in American Psychiatry. Opportunities to have impact on the evolution of health care are greater than ever. I would love to play a role in guiding the APA’s effort as its Secretary.

- We are experts in the conditions that contribute most to disability and population health. The APA must play a major part in designing the future of health care in America and must drive the implementation of collaborative care to ensure that psychiatrists have the proper roles.
- As “value” enters the marketplace as a factor in reimbursement, we need to be leaders in determining how to define and measure it.
- As registries and other “big data” formats emerge, we need to figure out how to use these tools to advance knowledge, while focusing on the importance of the unique stories and circumstances of the individuals who come to us for care.
• All Americans should have access to high quality mental health services. We know that they don’t. Universal access to mental health care should be a major plank in the APA’s advocacy platform.

• Our advocacy efforts have greater impact if Psychiatry speaks with one voice. The APA must work with our subspecialties to ensure that we are aligned and mutually supportive.

• Our future is in the hands of our younger members. Our vitality is proportional to the active engagement of our Resident-Fellow and Early Career colleagues. We need to create new vehicles of engagement.

I have a broad clinical background (board certification in internal medicine, psychiatry, and geriatric psychiatry), many years of experience in mental health services management and performance improvement (as VP and Medical Director of Sheppard Pratt Health System), and many years of service as a leader in professional medical societies. I am Past President and Board Chair of both the Maryland Psychiatric Society (MPS) and the Baltimore County Medical Association. I represent Maryland’s state medical society on its Board of Physicians. I am MPS Representative to the APA Assembly and for several years chaired Assembly Reference Committee 2. I have served in APA Components for 12 years and am currently Chair of the Council on Geriatric Psychiatry. I have represented the APA in quality measure related activities with the NCQA, the Joint Commission, and the National Quality Forum. I also currently Chair the Committee on Aging of the Group for the Advancement of Psychiatry and was recently elected to its Board.

I am very enthusiastic about this opportunity to bring my experience and energy to the APA Board as Secretary, and I ask for your support!

EDITOR’S NOTE ABOUT SPA MEMBERS RUNNING FOR APA OFFICE

The SPA can be justifiably proud that so many of our members have been nominated to run for offices in the APA. This year, Rahn Bailey is running against Altha Stewart for President-elect, Brian Crowley and Bob Roca are in a 4-way race against Gail Robinson and Philip Mushkin for Secretary, Scott Benson and Jenny Boyer are competing against each other for Area 5 Trustee, and Steve Daviss and Paul O’Leary are trying to become the Recorder of the Assembly.

This needs to be made as clear as possible: the SPA and Southlands are not endorsing any of the candidates. SPA members have simply been invited to tell you about themselves and to ask for your vote. There are many reasons to trust that all of the candidates, whether they are in the SPA or not, are qualified. Our members can take advantage of any of multiple ways of learning about all those who are running and to decide who would best serve their interests.

SPA MEMBER HARSH K. TRIVEDI, MD, M.B.A.
Sheppard Pratt’s New President & CEO

By Thomas Franklin, MD

Harsh K. Trivedi, M.D., M.B.A., the new President and CEO of Sheppard Pratt Health System, brings to the position a passion to improve mental health care, a philosophy of deep patient respect and consistent caregiving, and an impressive resume.

Previously, he led Vanderbilt Psychiatric Hospital in Nashville, one of three main hospitals on the Vanderbilt University Medical Center campus, where he was described as one of the most promising physician administrators in the country. He was a child and adolescent psychiatry fellow at Boston Children’s Hospital and then Director of Adolescent Services at Bradley Hospital in Providence before moving to Vanderbilt in 2010.

“As I reflect on my first few months as President and CEO of the nation’s largest non-profit mental health, substance use, and special education system, I am amazed and inspired by the work that we do. From providing care to more than 84,000 patients annually, to running a domestic violence shelter, to training the Baltimore City School Police Force in de-escalation techniques, what we do is life-changing,” said Trivedi.
“We are a model for what world-class mental health care truly is.” His goal is to improve the health system while being careful to leave in place all the things that have already worked so well. “This health system has such an incredible legacy and vibrant mission; I’m interested in meaningful change,” he explained. He has maintained a clinical practice throughout his career and continues to do so at Sheppard Pratt. “Success as a hospital CEO demands retaining a clinical perspective in the midst of administrative duties,” he said.

A believer in the importance of impacting the local community while also shaping the national conversation regarding mental health issues, Trivedi stresses the importance of treating all people with the respect and dignity they deserve. “Whether we discuss lack of access to health care, incarceration of the mentally ill, the surge in opioid dependence, or all-too-frequent news reports of another school shooting — we must acknowledge how intertwined mental health issues are in these important societal issues and that more needs to be done to ensure the health and wellness of every member of our community,” he said.

He earned his MD at Mount Sinai and his M.B.A. at the University of Tennessee. He is a consulting editor of Child and Adolescent Psychiatric Clinics of North America and Chair of the APA Council on Healthcare Systems and Financing. He also holds a leadership position on the American Hospital Association Governing Council for Psychiatric and Substance Abuse Services and represents the field of psychiatry in the AMA House of Delegates. He is also active in the American Academy of Child and Adolescent Psychiatry and has received multiple awards.

The APA’s New Position on Euthanasia
A Shot Heard ‘Round the World

By Mark Komrad, MD
SPA Rep to the APA Assembly

Those who attended the SPA annual meeting in September may remember my lecture entitled: “Physician Assisted Suicide and Euthanasia of Non-Terminal Psychiatric Patients: An Approaching Ethics Tsunami.” There, I mentioned the Action Paper that I crafted as the SPA Rep to the APA Assembly, together with Annette Hanson, a Rep from Maryland. That Action Paper was converted into a “position statement”, which was approved by the APA Board of Trustees after a long and complex process in early December. The APA now has a new official policy:

POSITION:
The American Psychiatric Association, in concert with the American Medical Association’s position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death.

[“Policy documents are approved by the APA Assembly and Board of Trustees. . . These are . . . position statements that define APA official policy on specific subjects. . .” – APA Operations Manual]

The term “should not,” in the position statement, implies that it is not ethical for a psychiatrist to help a non-terminally ill person commit suicide, either by providing the means (e.g. prescriptions, helium tanks, etc.), or by direct lethal injection, as is being currently practiced in The Netherlands and Belgium. The APA is still considering its position on physician-assisted suicide for the terminally ill.

Any members of the APA engaging in these activities is now on notice that this is not acceptable. Also, because the APA has much influence internationally over both the practice and ethics of psychiatry, this new position has already been a “shot heard ‘round the world.” I am being contacted by scholars, colleagues and media from around the U.S., Canada and Europe, because they have heard news about this major new position of the APA.

I, along with several colleagues, will now be exploring the possibility that the APA will protest the activities in Belgium, the Netherlands, and elsewhere where patients with non-terminal psychiatric disorders are being helped to suicide, or literally killed by lethal injection—often by their own treating psychiatrists. Also, it is an important signal to Canada, which may soon be headed in this same direction. We remain concerned about current laws in the U.S. permitting physician assisted suicide for the terminally ill (now legal in 6 states and DC). These laws can slip down the slope towards applying to the non-terminally ill, particularly psychiatric patients (many of whom are already being helped to commit suicide by organizations such as Final Exit, as documented by PBS Frontline).
far, no other country that has implemented physician-assisted suicide has been able to constrain its application solely to the terminally ill. Eventually, they include non-terminal patients as legally eligible as well.

As a psychiatric ethicist, I continue to regard this as one of the most significant issues. I would welcome any opportunities to come to your institution to give a Ground Rounds/lecture on it. Many are unaware and shocked to learn just how far it’s gone overseas, about how close it is to happening in Canada, and about the forces that are building to bring it to the US. It’s so important that the APA has planted an “advanced flag” on this. It is likely there is more to come.

Dr. Anita Everett, a new SPA member who spoke at our Annual Meeting in Baltimore, was chosen as the APA President-Elect in February and became the Chief Medical Officer at the Substance Abuse & Mental Health Services Administration in September.

The Office of the Chief Medical Officer is a new position, and Dr. Everett has had to hire a policy analyst, a nurse practitioner, and a second physician to help her. It’s expected that in her new role she will play an important part in representing SAMSHA’s clinical perspectives to other parts of the Dept. of Health & Human Services and to other governmental agencies. She is also expected to work to improve funding that would lead to better prevention and treatment for mental disorders, including substance use.

From 1999-2003 she was the Inspector General to the Office of the Governor of Virginia in that commonwealth’s Dept. of Mental Health. More recently, she was the Division Director at the Johns Hopkins Community & General Psychiatry Program at its Bayview campus in east Baltimore. While there, she conducted research concerning people who suffer from long-term mental disorders who live in urban and underserved areas. She has also consulted concerning mental health services in Iraq and Afghanistan.
PRMS & SPA Joint Reception at the May 2017 APA Meeting

If you are planning to attend the APA Meeting in May, mark your calendar for the Reception with PRMS

Sunday, May 21, 2017, from 6 to 9 p.m.
Altitude Lounge at the San Diego Marriott Gaslamp Quarter (660 K Street, San Diego 92101)

MARK YOUR CALENDAR
2017 Southern Psychiatric Association and the Georgia Psychiatric Physicians Association Joint Annual Meeting

August 2 through August 5, 2017
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