THE
MARYLAND PSYCHIATRIST
NOVEMBER 2023 VOLUME: 46 NO: 2

President's Column

Unsettling Times

By Carol Vidal, MD

Carol Vidal, MD PhD

There is no denying that these are unsettling times.

I write this column exactly a month after the attacks of the terrorist group Hamas on Israeli civilians. The weeks after that horrific weekend have been draining for everyone, especially for those with personal connections to the area. They have been too turbulent to want to recollect all the way, from people blaming victims in two already highly traumatized populations, to denial and discrimination. There have even been physical assaults and at least two deaths of Americans of both "sides."

Horrible events happen in the world every day. The difference this time is that the perpetrators of the crimes sent videos of their cruelty for everyone to see. Some videos were later taken off social media, but if you were one of the unlucky ones browsing the web on that Saturday morning, you are likely to have been haunted by the images. These images were followed by those of the subsequent devastation of Gaza and the deaths of more innocent civilians, the knowledge that children and older-age people continue to be held hostage, and the uncertainty about when the conflict will end, if it does in our lifetime.

A student who had worked with me as an undergraduate and is currently in medical school emailed me to tell me that she would have to postpone working on a project because she was overwhelmed "by the events happening in the world." She was not stressed about school, or family complications, but about the horrors she has seen in countries she may have never visited. This is how far-reaching the consequences of these events can be these days, when we are all so connected.

The MPS made a statement after the weekend of the October 7 attack - that we were appalled by the violent and deadly attack by Hamas on Israel and the thousands of civilian deaths resulting from the war, many of them children. We endorsed the statement issued by the American Psychological Association that warned about the psychological impacts of violence in the Middle East. It condemned without uncertainty the violent attack by Hamas on Israel, and expressed feeling "disturbed by the crisis of human suffering and loss of life and liberty for civilians who are caught in this escalating conflict." The statement expressed concerns for the physical safety and mental health of the millions of Israelis and Palestinians affected by the surge in violence, and the rise of associated anti-Jewish and anti-Arab rhetoric. It also acknowledged that these impacts are also being felt by people around the world with families and friends in the region, as well as those concerned about war in general. The statement ends with "prevention of violent conflict is imperative for a world in which mental health and well-being are the norm, and to achieve peaceful, sustainable societies."

This statement was likely not enough for anyone who feels they are on one side of the conflict or the other. When emotions are intense, you need friends who will be with you entirely and unconditionally. Institutions, as we have seen happening on college campuses, often walk a fine line between censoring free speech and allowing hate speech. The people representing those organizations are often not able to expose personal opinions that may go against the beliefs or values of some of their members, students, and staff. Complex organizations are built by people of such diverse backgrounds and life experiences that we are often surprised when we actually agree with someone on all the nuances of this and other conflicts. I believe this reality has made some of us feel very lonely these days, and others not knowing how to best respond.

As psychiatrists, we do have the luxury to sit with our patients, one-to-one, and make the world just about *them*, their feelings and emotions for that particular space and time. We can tell them with words or actions that we are entirely *with them* when we are, or just remain quiet and still support their well-being when we are not. Our patients may project their hopes on us, they may see us as friends, or family, and at

(Continued on p. 2)

In This Issue

President's Column

Continued

times, as the only person who can understand them, even when we don't really completely understand. While many people will find this type of relationship in their personal lives, for many patients, we may be the only ones who provide that support. Most importantly, we have the opportunity to find the humanity in every patient - to understand their hopes, dreams, and fears, so strikingly similar to ours, even when we insist in differentiating ourselves from others so often. This humanity can get lost in media wars and on social media. It is nice that our jobs allow us to share that space with other human beings.

During these times, it can be hard to give ourselves a break from the news. The option to shut down phones and delete social media applications, or watch Netflix instead of the News, is not for everyone. It is natural to draw our attention to a world that sometimes seems to be burning down. Some are able to take action to feel better, like attending a meeting and engaging with others who think alike. Some may choose to volunteer in the distance with organizations like Chai Lifeline (www.chailifeline.org/crisis) and Project Hope (https://www.projecthope.org/volunteer/), which offer crisis services in times of conflict.

For others, doing something means actually taking a plane and going to 'ground zero.' That would be people like Dr. Desmond Kaplan, one of our MPS members, who travelled to the area right after the conflict started. He is a child and adolescent psychiatrist who has dedicated much of his career to treat children with developmental disabilities. He is also a great person divided between two countries he loves.

We are all waiting for good news. In the meantime, I hope we can all take care of ourselves as we continue to take care of others. We are needed. After all, we are experts at promoting empathy, dialogue and conflict resolution, all of which are much needed these days.

New MPS Employee Introduction: Jora Hritz

Jora Hritz, MPS Membership, Meetings & Publications Coordinator

On November 1st, Jora Hritz became the first Membership, Meetings, and Publications Coordinator for the MPS.

Originally from Pittsburgh, she recently graduated from the University there with a BS degree in business administration for marketing and also got a certificate in Digital Media. She spent time in high school volunteering at hospitals (UPMC Mercy and UPMC Children's Hospital of Pittsburgh). While at the U of Pittsburgh, she worked as a patient transporter at UPMC Magee-Women's Hospital. During her time in college, she interned with the National Kidney Foundation as their marketing intern. She worked closely with their Development Managers to coordinate events, manage members and volunteers, and communicate with sponsors and donors. She enjoyed receiving first-hand experience on the patient-care side as well as seeing nurses, doctors, and other healthcare professionals navigate the field.

She commented, "I am excited to bring my healthcare perspective, along with my marketing degree, to help organize events and promote the MPS. I look forward to meeting, assisting, and working with the many members of the Maryland Psychiatric Society. I know there is a lot for me to learn but am confident that with Heidi Bunes and Meagan Floyd's help, I will fit right in with the MPS."

We are thrilled to have Jora join the MPS staff! I have no doubt our members will appreciate her positive energy, hard work and fresh ideas. She has been a great addition to the MPS and we look forward to working with her for years to come.

Meagan Floyd
MPS Executive Director

A Sonnet for Boots

Jesse Hellman, MD

Our Boots had just the softest fur
Upon our laps she'd sit and purr --
She'd scare the rats and mice away
So that we lived in peace each day.
Nine lives for cats would give them powers
(As then their lives might equal ours).
If humans truly love their pets
They'll get them all the finest vets,
The softest pillows, rugs, and toys,
And not complain if they make noise.
So Boots lives on in Heaven now
(I think that's so), and make this vow:
If pets do not in Heaven dwell,
St. Peter, send me, then, to Hell!

December 20, 2021

I wrote this after my nephew's cat, Boots, died. On Facebook a very short time ago Annelise Morani, the director of the Italian Cultural Society in Bethesda (I took Italian lessons from her when she lived in Homeland), posted that her beloved cat had just died, so I sent her this sonnet. She wrote back that her cat had also been named Boots, so the sonnet had that much more meaning!

Enhance Your MPS Membership!

Join the MPS Listserv

Join the online MPS community to quickly and easily share information with other MPS psychiatrists who participate. To join, click here. You will need to wait for membership approval and will be notified by email. If you have any problems, please email mps@mdpsych.org.

Member Spotlight Opportunity

Have you recently worked on an exciting research project? Reached a milestone in your career and want to share it with other MPS members? Have some good advice for younger psychiatrists who are just starting their careers? Submit a short article and photo through this Google Form to showcase your experiences with the MPS community.

Dr. Joe Bienvenu is First in a New Professorship in Anxiety Studies

Takes on the Judy Yin, Shih, PhD Professorship at Hopkins

By Elizabeth Wise, MD

Elizabeth Wise, MD

O. Joseph (Joe) Bienvenu, MD, PhD, has become the inaugural recipient of the Judy Yin Shih, PhD, Professorship in Anxiety Disorders at Johns Hopkins. On September 19th, some 70 of his colleagues, friends, and family members gathered there to commend him, Dr. Shih, and their commitment to the treatment of anxiety disorders.

"This professorship [is] a wonderful investment in making life a little easier for the many of us who have anxiety disorders," Dr. Bienvenu said at the ceremony, as both he and Dr. Shih spoke of their respective families' experiences of anxiety. Described as one of his heroes and a true Renaissance woman, she is a mental health clinician, public policy analyst, artist and musician, and generous advocate, whose professorship will allow Dr. Bienvenu to continue to devote "the time and cachet to teach about and thus advocate effectively for people with anxiety disorders."

Dr. Bienvenu directs the John and Mary McGlasson Anxiety Disorders Clinic, as well as the residents' outpatient continuity clinic at Hopkins, and he attends on the consultation-liaison service at Hopkins. He did a research fellowship with Dr. Gerry Nestadt (whom he referred to as his "Baltimore Dad" in his speech) and then impressively took on and accomplished the ambitious goal of getting a PhD in clinical investigation while continuing to work as an MD.

His research has focused on the relationship of personality to anxiety and depressive disorders and of obsessive-compulsive disorder to other anxiety disorders, as well as the risk of PTSD after being in an intensive care unit.

He has mentored many psychiatrists and other mental health professionals. One of them, Dr. Elizabeth (Liz) Prince, described Dr. Bienvenu as a "trusted mentor for clinical issues, career decisions, musical choices, and over-all life direction." Dr. Prince completed her residency at Hopkins and then a consultation-liaison psychiatry fellowship at the University of Maryland. When she returned to Hopkins to join the faculty, she insisted she have an office in the same hallway as Dr. Bienvenu's.

Dr. Jimmy Potash—Chair of the Department of Psychiatry & Behavioral Sciences—has spoken of (and written about in his *Cheers from the Chair*) Dr. Bienvenu's warmth and his spirit of inquiry. He summed him up astutely in his *Cheers* column: "Joe is a gem."

Dr. Bienvenu is a steady and kind clinician; he is a humble and compassionate clinician and teacher; he is a talented drummer; and he and his wife Holly Tominack know how to throw a brilliant bash.

Joe Bienvenu, MD

Eloise and the Three Graces

Jesse Hellman, MD

A daughter, newborn, brings her parents great joy
Yet led the Three Graces to pause and to fret:
Which of their virtues would she most employ
To traverse the world, both to give and to get?
Aglaia was certain (or so she maintained)
That beauty and glory would be her acclaim:
Days having sunshine despite when it rained,
Her virtues thus bringing both succor and fame.
"Merriment truly will be her first grace,"
Euphrosyne countered, "I know that will be."
But Thalia differed, "Her singing, you'll see,
Will be outstanding and gain her first place."
Then Athena decided (as a goddess true):
"Eloise will have wisdom and all graces, too."

Feb 19, 2023

I recently wrote this for two friends you had a daughter a few months before. The mother is a soprano who is truly excellent..

Behind the Bar

By: John Buckley, MD

John Buckley, MD

The term BAR in the legal world refers to the practicing attorneys in a given jurisdiction. It is derived from the courthouse railing which separates the spectators from the area reserved for lawyers and other court officials.

From 2002 until 2022, I was a "public" (non-lawyer) member of the Maryland Attorney Grievance Commission. Like other professions, (educators, health care licencees, police et. al.) lawyers have long included lay members on their review committees. This was to make internal workings more transparent and include some public opinion in closed networks. I have never seen an outcome study of this practice.

My adventure began when a politician asked MedChi to submit three names to the Bar Association. The other two may have thought better of spending volunteer hours surrounded by lawyers, but I said yes to the invite.
I received my official letter of appointment. A week later, I opened my mail to find a packet of details- homework from the Bar Association. This included a hefty spiral bound compendium: The Rules of Professional Conduct. This proved to be a detailed and useful list of lawyer rules for all occasions. The medical licensing board could help us all with something similar, though medical decisions have more variables and more judgment calls than legal ones.

The legal peer review process starts with the appointment of a panel of 4 or 5 lawyers and a public member to review a breach of rules sent from the Maryland Bar, often the result of a complaint. I might get a notice (1-3 times a year) of availability for a panel date 60-90 days in advance. If I agreed, a screening would assure that the panelists had no connection to the complainer or to the " respondent ".

The lawyers on the panel were always a cordial group. There was a wide age range. Everyone dressed in business attire, as if appearing in court. They seldom were pals, and might include different practice specialties: personal injury, family finances, immigration, corporate taxes etc. All panelists did the homework which could take hours to digest. The data sent ahead would include the charges (rule infractions), any complaints, all correspondence between the respondent and the Bar counsel, financial records, investigator reports, the total package covering many months. If a doctor isn't sure, the next step can be More Tests. A lawyers mantra might be " When in doubt, call Time Out". Delays and repeated postponements were a common part of information exchange.
The panel would meet (usually promptly at 10 a.m.) around a conference table in a law firm suite....that of the designated panel chair. Physician offices are lower on the sumptuous scale. The respondent could have his own attorney by his side. Those questioned could include the Bar counsel, the complainer, the respondent, an investigator, anyone with useful information. The questions could come from anyone in the room; informal, no minutes, no recordings, no rules of evidence, any notes shredded, strict rules for panel confidentiality. The lawyer questions tended to be about details of the data (" Tell us about that escrow deposit "), but they might learn more about the case with open ended personal questions ("How are Marge and the kids?"). It seemed the lawyers were expert at determining the What with less concern about the Why. Panels in my experience lasted two to six hours.

After private discussion, the panel would vote on a recommendation to be sent to the Bar Association, ranging from dismissal of charges, to reprimand, to probation with rehab, to loss of license. The Maryland Bar and the AG office make the final decision. As in medical peer review, the main charge is to protect the public. Any case in which a client was injured (e.g. the widow loses her pension due to a late filing) or a case which exemplifies an unacceptable pattern of practice resulted in a stern recommendation from the panel.

I found it rewarding to see a group of conscientious attorneys at work with no resemblance to the TV dramas or omnipresent ads trolling for victims.

A psychiatrist on the panel is not likely to have a decision-altering impact, but could help the focus of interviews. Substance abuse was a common issue.. For the 54 year old attorney with blunted affect and little to say, who cannot explain his failure to follow through on all his cases, an evaluation for mood disorder is indicated. For the 33 year old attorney who looks hastily dressed, talks rapidly, and interrupts questions, maybe treatment for ADHD would be helpful.

When the reappointment letter every two years) arrived last in 2022, my wife asked "Why in the name of Freud are you still donating your time to this group?"

It was time to move on.

Leadership on the Ballot

Annette Hanson, MD

The September meeting of Area 3, composed of Maryland, Virginia, Pennsylvania, New Jersey, and Delaware, was fairly routine, with one exception.

The Board of Trustees reported that they have embraced directions from the Assembly with regard to expanding diversity and seeking input from all interested parties. The organization is doing well financially, with the exception of a drop in revenue from lower annual meeting attendance. The APA has hired a marketing firm to publicize its efforts. It also has officially approved the formation of a Council on Women's Mental Health.

Our Area has a new regional director, Robin Levy. The Maryland prior authorization bill has spurred similar efforts in New Jersey and DC. Part of a similar bill was signed into law in Montana. Non-compete clauses are a new focus of legislation, in addition to legislation to expand the number of GME training slots. "Scope of practice" has been addressed with regard to psychologist prescribing bills in 12 states, although none passed. Funding for collaborative care is being addressed at both the federal and state level.

The APA's structural racism committee has suggested 18 action items to identify under-represented members for office, to create mentors, and to track organizational demographics.

An important issue concerns recruitment for the new APA Medical Director, in light of Dr. Saul Levin's impending retirement. The posted job description did not specifically require that the new CEO/medical director be a physician--much less, a psychiatrist. A letter to the search committee and the CEO expressed concern about this and was co-signed by multiple past presidents, past Board of Trustee and Assembly Speakers, and dozens of Distinguished Fellows. Dr. Petros Levounis, APA president, responded to confirm that in fact the search committee was considering the applications of non-physicians.

An action paper directing the APA to require that the new CEO/medical director be a board-certified psychiatrist is to be discussed at the November Assembly meeting (in Baltimore, for the first time). All APA members are entitled to attend.

The APA is supposed to uphold the stances it has already taken-- in particular the 2020 position statement on Leadership of Academic Departments of Psychiatry and the 2019 one on Leadership of State Behavioral Health Services. Both of these statements emphasize the importance of strong physician leadership.

MPS Best Paper Contest

The MPS established annual "best paper" awards to recognize outstanding scholarship by young psychiatrists in Maryland. Previous winners are listed here. The Academic Psychiatry Committee is currently soliciting nominations for the 2023 Paper of the Year Award in three categories:

Best Paper by an Early Career Psychiatrist Member (ECP):

Eligible psychiatrists are ECP members who are first authors of papers published or in press in 2023. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2024.

Best Paper by a Resident-Fellow Member (RFM):

Eligible psychiatrists are Resident-Fellow members who are first authors of papers that were written, in press, and/or published in 2023. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2024.

Best Paper by a Medical Student Member (MSM):

Eligible students are Medical Student Members who are first authors of papers that were written, in press, and/or published in 2023. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2024.

Scholarly work of all kinds (e.g., scientific reports, reviews, case reports) will be considered. If you would like to nominate a paper and author, including your own, please email the paper to either of the co-chairs below by **January 31**. Please include a brief explanation of why you believe the work is worthy of special recognition.

Matthew Peters, M.D. mpeter42@jhmi.edu
Traci Speed, M.D., Ph.D. speed@jhmi.edu
Academic Psychiatry Committee Co-Chairs

Sleuthing the Stimulant Shortage

by: Robin Weiss, MD

Robin Weiss, MD

A shortage of Adderall—announced by the FDA in October 2022—heralded what has come to be known as The Stimulant Shortage. A year later, I thought, let's see where we stand, and I'll share the information with my fellow MPS members. Little did I know that my quest to understand this would lead me down a rabbit hole, branching into a warren of tunnels, lined with initialisms (NASEM, APSARD, CHADD, and more!). Some paths led me to more questions than answers.

In the fall of 2022, Bloomberg News reported that Teva had experienced a workforce scarcity, which caused the original manufacturing shortfall of Adderall. A domino effect led to shortages of other stimulants, including Concerta, Ritalin, Focalin, and Vyvanse.

Demand grew, too. According to the FDA and the CDC, data from 2012 to 2021 show that dispensing of stimulants increased by 45.5%. From 2020 to 2021, during the pandemic Public Health Emergency—when virtual prescribing was permitted—the percentages in certain age groups, and also in women, grew by more than 10%.

Was this increase alarming? Not necessarily, says Craig Surman, MD, Director of the Clinical and Research Programs in Adult ADHD at Massachusetts General Hospital. He and others postulated in an editorial in the Journal of Attention Disorders that the increases may be "medically appropriate," stemming from more self-diagnoses during the pandemic because of a relatable online neurodiversity movement (e.g., on TikTok), lack of structure because people were working at home, more access in rural areas, and other factors.

Non-traditional prescribers contributed to the mix. Cerebral is a startup online mental health provider, where employees claimed they felt pressured to prescribe stimulants. By May, 2022, Cerebral and Truepill—their online pharmacy of choice—halted prescribing of Adderall and other drugs to treat ADHD, as they came under scrutiny by the DEA for questionable prescribing practices.

By May of 2023, the APA and The American Academy of Child and Adolescent Psychiatry had heard stories of mounting exacerbation and exhaustion from members all over the country. They composed a joint letter to the FDA documenting our travails, and the heavy toll the shortage had been extracting on patients and their families. The case stories appended to the letter illuminated our patients' dire situations, and for that reason are the most compelling portion. Each case would be achingly familiar to you. One doctor recounted the story of a 10- year-old boy with impulsivity, who in the past had accidently set his clothes on fire reaching for a candle on a countertop, sustaining 2nd and 3rd degree burns and requiring skin grafts. The family embarked on a wild goose chase from Walmart to CVS to Rite Aid, pleading with their insurance company, withstanding prior authorization denials, and enduring pharmacy supply scarcities. The child missed school and stayed with his grandparents. The parents ultimately paid out of pocket for his stimulant (which they could not afford). The doctor spent untold time on the phone. As we all know, adult patients with ADHD suffer as well; when deprived of their medication, they risk accidents, addiction relapse, depression, broken relationships, legal jeopardy, work trouble, and more.

In response to the letter, APA staff, various other professional organizations, and FDA staff—and eventually the FDA Commissioner—held meetings. According to APA staff, some were fruitful, and some were fraught with finger-pointing between organizations treating patients and the federal agency.

In August, the Commissioner of the FDA and the Administrator of the DEA authored a joint letter to the country about the stimulant shortage. You might guess that such a letter would ooze the usual pablum; on the contrary, its content is eye-popping. We learn that, though the DEA sets quotas on how much amphetamine medication manufacturers can produce, in 2022, manufacturers sold only approximately 70 % of their allotted quota for the year. That translates into approximately one billion more doses that manufacturers could have produced, but did not make or ship. Data for 2023 show a similar trend.

The letter begins, "Dear Americans," and continues, "We (DEA and FDA) have called on manufacturers to confirm they are working to meet their allotted quota amount. If any individual manufacturer does not wish to increase production, we have asked the manufacturer to relinquish their remaining 2023 quota allotment. This would allow DEA to redistribute that allotment to manufacturers that will increase production."

The 107 individual companies that produce stimulant medications have

(Continued on p. 8)

no obligation to report to the DEA about their stock of raw material and production. It can only politely ask them to relinquish their unused allotment so that the DEA can reassign it to other companies that have the capacity to produce more drugs. In short, the system isn't working for us, dear Americans. (Of note, DEA Administrator Anne Milgram announced some further changes in the production process—probably in response to consumer pressure— on November 1st, immediately before TMP went to press. Among the improvements: Manufacturers will be required to submit production timelines in advance of receiving their quota allotments; they will apply for allotments quarterly instead of yearly; and DEA will require monthly, digital reporting on the amount of drug being produced and shipped.)

The FDA, meanwhile, is concerned about the recent increase in stimulant prescriptions. The federal agencies, understandably, fear a replay of the opioid crisis, and they are turning the spotlight on prescribers to fine-tune our diagnoses of ADHD and take more care when prescribing stimulants.

However, the specter of overdose deaths from the stimulants that we prescribe may be overblown. Stimulant deaths have risen dramatically, but the causes of that upturn are methamphetamine and cocaine, most often mixed with the synthetic opioid, fentanyl. Counterfeit Adderall laced with fentanyl does exist on the street, and we should always warn our patients about its dangers, but it is not a major cause of overdose deaths. SAMSHSA has published an excellent advisory "Prescription Stimulant Misuse and Prevention Among Youth and Young Adults," available on-line.

Because the FDA is concerned about prescribing habits, it will fund a workshop at the National Academy of Science, Engineering, and Medicine, in December. The conveners hope to build consensus among public, private, and academic stakeholders on the diagnosis and treatment of ADHD, including drug development and non-drug therapy, and risks and benefits of ADHD medicine in adult populations. To a similar end—that of clarifying diagnostic precision—The American Professional Society of ADHD and Related Disorders (APSARD), in collaboration with Children and Adults with ADHD (CHADD) plan to release the first U.S. evidence-based guidelines for the diagnosis and treatment of ADHD in adults later this year.

A new DEA rule does not yet benefit us in Maryland. The DEA published a Final Rule in the Federal Register in August, 2023, concerning the Transfer of Electronic Prescriptions for Schedule II to V Controlled Substances, which allows the transfer of electronic prescriptions between pharmacies, for initial filling, upon request from the patient, on a one-time basis. This change would bring a modicum of relief to patients and doctors' offices when the first pharmacy patients try does not have the stimulant prescribed by their doctors.

I called three pharmacies in Baltimore: A Harris Teeter, a CVS, and a small independent one. None of the three pharmacists had heard of the new rule. I followed up with Lisa Guy, Chief of the Enforcement Division for the Office of Maryland's Controlled Substance Administration (OCSA). She was enthusiastically supportive, and after our conversation, she planned to bring up the new rule at the joint monthly OCSA/ Board of Pharmacies meeting, which was to take place the day I spoke with her. She was hoping that the Board of Pharmacies would post a notice about the Federal Rule on their website. Without advocacy from us and OCSA—and, possibly, legislative action—pharmacists have the right to stick with the more restrictive state regulation. We shall see if our state will comply.

Public health crises—the HIV/AIDS epidemic, and, now, the COVID pandemic—expose underlying flaws in our public health infrastructure. The DEA and FDA know that manufacturers have unused stockpiles of stimulant raw material in the face of an ongoing shortage, but these agencies don't have the authority to query them individually, nor the regulatory muscle to redistribute the allotments. Perhaps the drugmakers are sitting on the unused material because they still have workforce problems and are waiting for the time when they are able to use it; we just don't know. A functional Congress perhaps could push executive agencies to be more aggressive; however, we have learned that the "Big Pharma" lobby would most likely prevent it from interfering.

We need more epidemiologic data about the true extent of ADHD, especially in adults, before we can fully write a level-headed assessment of this perplexing situation. However, the "sleuth' in me believes that—when it comes to the cause of the stimulant shortage—one billion unmanufactured doses of stimulant, languishing somewhere in the hands of the drug companies, will more than likely have played a major role.

Interview: John Campo, MD

by: Bruce Hershfield, MD

John Campo, MD

Q: "Please tell us about your work."

Dr. C: "I've been at Hopkins about 3 years now. Besides being the Vice-Chair, I am the Director of Mental Health at the Children's Center here and the VP of Psychiatric Services at Kennedy Krieger. So, the question for me is, 'How does one come into a place with such incredible tradition, whose first Director was Leo Kanner?' I think the Division is really quite good, but because it's Hopkins, you always want to be better. The goal is to be the best."

Q: "How has it been going?"

Dr. C: "I've loved being in Baltimore and I've loved lots of things about the organizations. The biggest challenge has been a bit of fragmentation. It's one Division of Child & Adolescent Psychiatry, but there is one at Johns Hopkins Children's & Adolescent Center, there is a Division at Bayview, we have the children's mental health center in East Baltimore. We also have a huge presence at Kennedy Krieger. So probably half our faculty and maybe a little more of our staff are employed by Kennedy Krieger, the other half directly by Hopkins. My first challenge had to do with figuring out how to move beyond people having this idea that 'I'm a Bayview child psychiatrist' or 'I'm a Hopkins child psychiatrist' or' I'm a Kennedy Krieger one'. The other is taking an incredible amount of talent and finding a way to begin to put together a comprehensive system of pediatric health care."

Q: "What about your background enables you to do this job?"

Dr. C: "I was a first-generation college kid. I grew up in Scranton, went to a small college and got into the med school at Penn. I thought I was going to do hematology oncology, but ended up training in pediatrics at Children's Hospital of Philadelphia. I had always been interested in Psychiatry, but it took me a while to give myself permission to do it. I suppose I had my own prejudices about being a 'real doctor'. Just seeing what pediatric Medicine was like and the incredible impact of emotional life on physical health—and *vice versa*. The other thing was seeing some of my friends as we hit young adulthood. One or two of them had some pretty significant problems, which woke me up to the reality that mental disorders can impact anybody and that this was an important and valuable way to live my life."

Q: "What prepared you to take on all these administrative responsibilities?"

Dr. C: "The first part of my career was at that interface between Pediatric Medicine and Psychiatry. I trained in Psychiatry and Child Psychiatry at Pittsburgh. I stayed on as faculty, but I was a clinical guy. We developed and I ran a Med Psych unit, then I did a lot of Consultation/ Liaison. Academically, I wrote a chapter or two, but my core identity was as a clinician. With the encouragement of David Brent, who was the Division Chief and a suicide researcher, I wrote my first grant application and got lucky.

I didn't think I had any interest in getting involved on the administrative side. One night when I came home, while David (my boss and mentor) was in an argument with the Chair, I was talking with my wife about why anyone would want to be a Division Chief. My wife, who is very perceptive said, 'I know you don't like the administrative stuff, but you have problems with authority and you won't be able to help yourself.' She was right.

After I turned down one or two administrative jobs, I then moved to Ohio State, where I became the Chief of Child Psychiatry, then was Medical Director at Nationwide Children's for about 5 or 6 years, then they asked me to be the Chair of the Department, which I did for 7 or 8 years."

Q: "So your wife recognized your ability to say 'No', which is essential for a leader."

Dr. C: " I think she recognized I could be a troublemaker. I married well!"

I've had a couple of different careers. That I was a Division Chief and a Chair and that I'm now the Division Director at Hopkins ...how did that

(Continued on next page)

happen?"

Q: "Do you see patients yourself now?"

Dr. C: "I do—not enough. My calling is still as a clinician. A lot of my research was service-focused, like 'How do you integrate mental health services into primary care?' We built an integrated network in primary care in western PA and then turned that into a practice-based research network. I was really interested in kids who had unexplained physical symptoms and their relationship with emotional disorders. Then, as I moved on. I have gotten more interested in suicide prevention. That is my primary research preoccupation these days."

Q: "What have you discovered about suicide prevention that has surprised you?"

Dr. C: "Just how little we think about suicide and the impact of the problem. A number of years ago I went to the CDC and just looked at the numbers. Between ages 10 and 24, suicide is the 2nd leading cause of death. A number of years back, I gave a talk at Children's Hospital of Philadelphia and made a 'pie chart' of causes of pediatric death. Accidents, suicide and violence are essentially 75% of the deaths! We all know it, but we don't behave like we know it. I tell them, "See that slice, that ¼--*that's* what we learned to take care of when we were Residents., *This* is what kills the majority of kids.' When you walk into the emergency room you see we have all these algorithms for asthma, this and that. When you come there for a mental health crisis, the first mindset often is 'How do we get him out of here so we can go back to doing real Medicine?'

Q: "What would you like to accomplish here?"

Dr. C: "I want to have pediatric services that focus on mental health issues in proportion to their public health impact. How do we make that happen—if nothing else, become the thought leaders to get the word out to do that? How do we even 'walk the walk'? How can we be able to provide the comprehensive services that are necessary? How do we build a comprehensive system of care? If you look at most departments of Psychiatry in academic medical centers you think about the public health pyramid--primary care, ambulatory care, intermediate care, then inpatient care. But most academic medical centers are not built like this. We have the acute level of care, but we don't construct the necessary access to all the levels people need. A lot of it is driven by reimbursement. If you and I were in the ER 'business' and somebody called us and said, 'We will give you the space, you can bill for everything, when can you start?' We would say, 'Never' because there is no way we would be able to bill, ourselves, to cover the cost. If you want to talk about a contract, that's a different story.'"

Q: You have taken on a huge task! Who is helping you?"

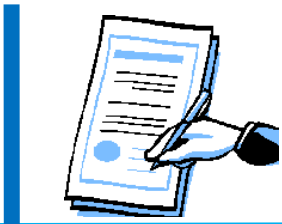
Dr. C: "I think there has been tremendous support here. Certainly, at the departmental level, I think Jimmy Potash is really invested in how can we make Child Psychiatry not just very good, but great. I also think that Maggie Moon and David Hakem, in leadership at the Children's Center, are very committed to this at the School of Public Health. Holly Wilcox has been a great collaborator. We have a new Chair of Mental Health there whom I am looking forward to working with more closely. The leadership at Kennedy Krieger has been very focused and very serious about the impact of mental disorders on the developmental lives of kids."

Q: "How can the membership of the MPS help?"

Dr. C: "At the academic medical center, we always talk about the tripartite mission—clinical service delivery, education, research. We often leave out advocacy. We are doing better in terms of stigma and in getting the word out concerning the importance of mental health issues, but I think the biggest area is advocacy. How do we find a way to change the way people think about this? When we think about suicide many people say that it has something to do with some sort of sin or moral failing. How do we take these problems seriously and how do we improve what we do?"

Dr. Campo is the Vice-Chair of the Johns Hopkins Dept. of Psychiatry & Behavioral Services and the Director of Division of Child & Adolescent Psychiatry.

Interview Date:
September 20, 2023



Prior Authorization

An Update on Legislation

by: Robert Herman, MD

Robert Herman, MD

Over the last several years, our legislative committee has been involved in efforts to pass legislation aimed at reforming "prior authorization". This is the process where pharmacy benefit managers approve, or re-authorize, or deny medications. Those of us in outpatient practice are spending Increasing amounts of time filling out forms or arguing on the phone to get our patients the medications they need.

The MPS legislative committee drafted a bill two years ago concerning this. That was a unique occurrence—normally, it just reviews bills that others write. We were able to get a sponsor in the State Senate (but not the House). That bill had a hearing, but it was killed in committee.

In the summer of 2022, Med Chi expanded our bill and proposed it for the 2023 legislative session. It received widespread support from multiple provider groups--Including physicians—and specialty organizations. It had several sponsors in the House as well as in the Senate, which is required for a bill to become law. Many physicians and others took time to testify in favor of it. Some of the testimony was quite dramatic, with physicians telling stories of patients suffering and even dying because of denial or delay in receiving appropriate medication. The bill was again killed in committee during "backroom" discussions. The vice chair of the committee promised that we would have informal meetings after the legislative session ended to try to reach a compromise.

Starting in July, group of representative physicians--Including two of us from MPS--accompanied by our lobbyist-- began a series of meetings, chaired by an attorney for Med Chi. We again detailed the various problems that we were having. Many of our colleagues told frustrating stories of Illogical denials. For example, they told of faxing multiple pages of patient records and then getting denial notices that made it clear that nobody had read the records. One of the main topics discussed was re-authorization of a patients' existing medication when they have already been stabilized on it and it has proven effective. This is because of formulary changes that make a patient's medication no longer "preferred", or even no longer on the formulary. These formulary changes are usually based on profits, not on clinical considerations.

After several meetings, we then met via Zoom with representatives of the insurers and their pharmacy benefit managers. For the most part, they remained silent. Most of them kept their cameras off as well, so we could not even see if they were actually listening We saw this as disrespectful and an indication of their lack of interest in working with us on this issue. The few times they spoke, they claimed that many denials are caused by errors that physicians make in not checking the right boxes.

We countered that the forms we are asked to complete are burdensome and unnecessary. If patients are stable and doing well on a medication, the form should simply ask if they are being monitored appropriately.

In the last two meetings, members of the Health and Government Operations Committee attended as well. The representatives of the insurers and the PBMS turned on their cameras at these meetings and seemed to be more conciliatory. The legislators voiced our concerns and told them we have a bill coming up in the next session. This was a most hopeful sign.

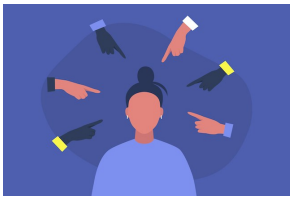
As of this writing, we hope to see a draft of this bill that attorneys and legislators are working on. The session begins in January, and we expect it will be introduced at the beginning of it. We are expecting another fight, but we hope to see a different outcome this year.

We hope our members will be contacting their Senators and Delegates to push for passage of this bill.

Poster Contest for Residents & Fellows!

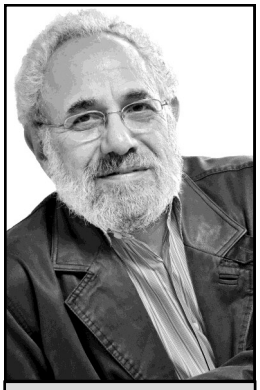
The MPS poster competition for our Resident-Fellow Members will be held again this year, with all entries displayed at our annual meeting in April 2024! Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the meeting. Two finalists will also be selected and will receive **$100 each** in addition to complimentary tickets.

Winners in past years are listed here. Please click here for complete details about the process and requirements. **The deadline to enter is January 31.** For more information, or to apply click here.



"Decriminalization" is Misconceived

By Michael B. Friedman, LMSW
Public Policy Analyst and Mental Health Advocate
This is a version of an article printed in *"Behavioral Health News," Fall 2023*



Michael B. Friedman, LMSW

Reports about the problems that have emerged with Oregon's experiment in the decriminalization of drugs have rekindled debate about this approach. I feel great sympathy for young people who have been arrested for using or sharing illegal drugs with friends and then subjected to very severe penalties. Drug use of the kind that is an ordinary part of being a young person in America should not land someone in jail.

I am, therefore, very sympathetic to the idea that the use of all illegal drugs should be "decriminalized", i.e., that there should not be criminal penalties for ordinary drug possession and use. I am also sympathetic to the idea that this should be combined with a vast increase in the prevention and treatment of addiction.

But it seems to me that **the current policy of "decriminalization" is misconceived**. It protects illegal drug *users* from criminal prosecution, but does nothing about illegal drug *producers* and *dealers*. For them, the failed policies of the "War on Drugs" continue. Decriminalization does nothing to disrupt the illegal drug business, which is the source of drug-related violence and of overdose deaths.

We need a broader conceptual approach, but most discussions of drug policy focus exclusively on the so-called "illicit" drugs—cannabis, cocaine, heroin, methamphetamine, etc. This is a very limited view of the dangers of substance misuse. There are nearly 500,000 tobacco-related deaths, plus about 150,000 alcohol-related deaths, in the USA every year. Many medicines are also dangerous if used incorrectly.

But the production, distribution, sale, and use of tobacco, alcohol, and medications are not criminalized; they are *regulated*. This approach is generally regarded as striking a reasonable balance between the government's obligations to protect people from harm and also to protect individual freedom.

The criminalization of "illicit" drugs has been an abysmal failure. It has resulted in the overpopulation of jails and prisons (disproportionately with people of color), has ruined lives, has broken families, and has led to widespread corruption and violence. Despite the "war on drugs", overdose deaths have been increasing at an alarming rate.

Once, we had a war on alcohol in the United States, which was also an abysmal failure. The remarkably successful end of prohibition was not the decriminalization of drinking, but a thoroughgoing system of regulating the production, distribution, and sale, of alcohol.

Similarly, the USA did not get control of the "snake oil" salesmen of the 19th century by criminalizing the use of phony medications, but by a system that made medications that are safe and effective available via prescriptions. The FDA studies and approves medications. Manufacturers are subject to safety protocols. Drug distributors and drug stores are required to control their sales. Patients get instructions on how to use them.

Tobacco is also subject to regulatory controls and its use has declined dramatically because of effective public education campaigns.

These regulatory approaches -- not decriminalization of drug use-- should be models for reforming drug policy.

Substance regulation is sometimes referred to as the "legalization" of drugs, but that is very misleading. The term suggests unlimited access to substances that may or may not be safe. No one supports unlimited access. Governmental oversight of dangerous substances is essential. But that can be accomplished via a comprehensive, regulated system.

Decriminalization? Yes, no one should be subject to criminal penalties for the ordinary use of what are currently illegal drugs. And yes, there should be a vast increase in prevention and treatment. But we also need to disrupt the illegal drug industry, which is largely the cause of overdose deaths and of the violence associated with drugs. The "war on drugs" has not and will not work. We need a new approach to controlling the supply of currently illegal drugs by making them available safely. As with other dangerous substances—alcohol, tobacco, and medications—that can be accomplished by regulating manufacture, distribution, and sale; and by criminalizing only those who go outside the regulated system.

Tribute to Dr. Larry Alessi

by Jimmy Potash, MD
Chair, Johns Hopkins Dept. of Psychiatry & Behavioral Sciences
Previously Printed in *Cheers from the Chair*

Jimmy Potash, MD

Cheers from the Chair

Out of life's school of war—
What does not kill me makes me stronger.

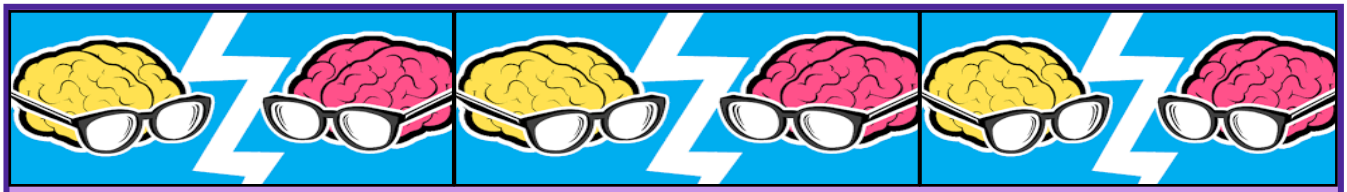
--from Twilight of the Idols,
Frederick Nietzsche, 1889

Larry Alessi started his life at Hopkins as an undergraduate in 1960, finishing up four years later as a fellow class officer with Michael Bloomberg. He moved on to the Hopkins School of Medicine, and then residency at our Phipps Clinic. But residency was interrupted by a year as a psychiatrist in the US Army in Vietnam, where he served as Captain Alessi (photo). He would return to Hopkins and take a position on our faculty, attending on the inpatient service, where his first resident was Dr. Fred Berlin, now director of the Sex and Gender Clinic. In 1976 he supervised his first chief resident on the inpatient unit, Dr. Bob Robinson, who would go on to be the Department Chair at the University of Iowa. In 1998, Dr. Alessi was my attending for my six-month chief resident stint as sub-attending on the General Psychiatry Service, rounding with me each morning from 7:30-8:30 and providing valuable guidance, before heading off to his day job running the Harford Belair Community Mental Health Center. Now 47 years after kicking off this role, Dr. Alessi is still going strong as the attending on the chief resident-driven General Psychiatry Service, as dependable as ever. His remarkable steadiness and devotion to patients and duty were on display last week as he rounded on one of his own outpatients, a young man whom he had hospitalized on Meyer 5 for psychotic symptoms and disorganization. With no warning of any kind, the man leapt up and punched Dr. Alessi in the face, splitting his lip. After the fact, I said to Larry, "that must have been very upsetting." He replied, "No. I spent a year in Vietnam. It takes a lot more than that to upset me. It's like the opposite of PTSD. Very little fazes me. The residents were more upset than I was." I told him how impressive he was and how grateful I was for his long and stellar record of service to patients and to the department. He said "Thank you. People keep asking me when I am going to retire, and I tell them, 'As soon as I find something I like doing more.' I haven't found anything else yet. I enjoy this work. I like taking care of patients and the residents are wonderful to work with." Let us salute the Captain! Thanks to Larry for all he has done and continues to do for us!

Larry Alessi, MD
Alessi in the Army 1970-71

Managing agitated patients was the focus of a recent review paper published in the *Journal of the Academy of Consultation-Liaison Psychiatry* by senior author Durga Roy and co-first authors Idris Leppla and Will Tobolowsky. They focused on the question of what educational resources are available to the consultation-liaison psychiatrist who wants to teach other medical professionals about how to work effectively with agitated patients. We know that important principles in this regard include talking the patient down to a calmer state, knowing what elements in the environment can trigger greater agitation and adjusting or managing those appropriately, and being attuned to when emergency medications may be appropriate. Sophistication about these issues comes with experience, and also with training. The authors screened 3,250 papers and settled on 51 that reported on studies of relevant curricula. Ten focused on agitated psychiatric patients, 32 on those in long-term care facilities, and just six on patients in general hospital settings. Some examined results for learners, like improved confidence, morale, and communication skills, and others looked at outcomes for patients, such as decreased restraint use and lower scores on the Cohen-Mansfield Agitation Inventory. A major conclusion is that "there are a lot of curricula for patient care technicians and nurses, but relatively few for physicians and advanced practice practitioners, especially in a general hospital setting." Dr. Roy is working now to change that with a project aimed at applying an online curriculum to teach non-psychiatric providers how to manage agitation in patients on medical services who have neuropsychiatric conditions. Congratulations to Drs. Roy, Leppla, and Tobolowsky on this valuable work!

Australian singer-songwriter Kasey Chambers' debut album *The Captain* came out in 1999 and was a family favorite of ours for several years. Here's the title cut: https://bit.ly/3KLd9tT



Free Happy Hour & Trivia Night for Residents and Fellows

Join the MPS on February 6th @ 6PM at HomeSlyce Pizza Bar (336 N Charles St. Baltimore, MD 21201) for dinner, open bar, trivia & cash prizes!

Teams of residents and fellows will vie for cash prizes. For fun, we will even throw in a team from the MPS leadership to see who *really* comes out on top! Trivia will be run by Charm City Trivia.

This event is open to members, non-members, and their guests. Attendees can reserve up to 2 tickets per person. Click here to register or for more information.

What it Was Like to Testify to Ireland's Parliament About Assisted Suicide

by: Mark Komrad M.D.

Mark Komrad M.D.

I wanted to share my recent experience of testifying before the Irish Parliament Committee on Assisted Dying. They are inviting experts from countries where these practices have been legalized, and I was asked to be an expert witness on the experience in the US.

There were three of us. Tom Jeanne MD, is the chief of the Oregon Health Authority. He was invited to speak about the Oregon experience ("the Oregon Model") . He is not a practicing clinician, but an administrative epidemiologist. The second was Margaret Battin. a philosopher who argues in favor of assisted suicide and euthanasia. Many consider some of her ideas to be fairly extreme (eg her infamous thought experiment philosophically supporting the idea of implanting smart bombs in peoples' brains that could be programmed by them to kill themselves under certain physiological, brain parameters —a suicide advanced directive).

I was the third--the only one who is a physician seeing patients. I was clearly there to make the arguments objecting to these laws and practices and pointing out their flaws. As one parliamentarian said, "Dr. Komrad has clearly made up his mind on this." I was trying to argue that the negative ethical and policy consequences outweigh the understandable "good reasons."

The discussion was primarily around Oregon and the Oregon experience, though I tried to keep it more centered on the US experience in general. The parliamentarians were clearly of divided opinions. Unfortunately, one of them, who's very pro-euthanasia (and it turns out is the author of assisted suicide legislation in Ireland) launched a pointed, *ad hominem* attack on me, deriding some of the ways that I made statements that he called "dramatic, provocative, and not appropriate academic discourse." (For example, he objected to my use of the term "doctor shopping".). Margaret Battin then piled on and said she agreed. Later, two other parliamentarians objected to this attack and were critical of both the MP who had derided me and of Ms. Battin for piling on. They defended me and my approach. I pointed out in response that my approach comes from me being in the position of the only one on the panel who deals with suicidal people and who sees the profound effect that these laws and practices are having. I also spoke of the ways these arguments influence public health messages about suicide prevention. I referred to the deleterious impact on the actual practice of Medicine by those who are carving out a zone of acceptable, doctor-facilitated suicide. I made no apologies for my display of concern--even a touch of outrage in some of the ways I express my points.

Dr. Jeanne from the Oregon Health Authority said he was not permitted to give opinions about the rightness or wrongness of these practices. He kept asserting how the Oregon data demonstrate that there have been no problems, no slippery slopes, no concerns about compliance with the law, etc. All of which is incorrect:

- Review of Oregon's assisted dying law finds significant data gaps
- Some Oregon and Washington State Assisted Suicide Abuses and Complications

Margaret Battin, and I were in a "debate mode", with each of us bringing up points to try and undercut the arguments the other made. I kept returning to the viewpoint of a clinician.

The politicians used their allotted time for questions to make their own statements that revealed their viewpoints-- in the same way they had framed the questions.

I don't expect that my participation in this (exhausting) two-hour discussion is going to change the course of Ireland. If I had to guess, I think these practices will eventually be legalized. If they are, I hope Ireland can learn from our mistakes and build a tighter system, so it can avoid taking the road I believe is towards ethical perdition.

Who knows? Perhaps I might have said enough to change one legislator's mind when it comes to the final vote.

LETTER FROM THE EDITOR
Getting Together

by: *Bruce Hershfield, MD*

Bruce Hershfield, MD

I started attending MPS meetings shortly after I joined in 1976. There were about 6 per year and I enjoyed meeting members who worked in different settings. I heard stories that there had been an annual social event (with dancing) not long before that. When I attended three of the Texas Psychiatric Physicians Society meetings about 10 years ago, I really enjoyed the dancing and singing. ("The Eyes of Texas Are Upon You"—with everyone standing and looking very serious.)

For any *association* to prosper, its members have to *associate* with each other. They usually have to do this in person, more than once or twice per year. I understand that only about 10% of our members attend the annual meetings and no more than that attend the annual educational seminars. It's not enough. The times are changing too rapidly.

I am not criticizing the people who donate their time to plan these events. They do a great job and I enjoy attending the meetings.

We need to meet more often—even if we can't get CME credits each time. I think we should ask any one of our members who is good at interviewing to have a one-on-one conversation with any of our many members who have something interesting to say. We all know who some of them are. I haven't checked with any, but Glenn Treisman, John Campo, Ray DePaulo, Harsh Trivedi, and Will Carpenter come immediately to mind. (We have lots of others, including folks in private practice.) We could even group a few into panels to address issues that impact all of us, like where Psychiatry is going and how we can arrive there safely. Viewing movies together –like we did with "Silver Linings Playbook"—or listening to a member talk about the psychiatric history of an artist or writer—like Richard Kogan did for George Gershwin---would also be good opportunities. I am suggesting that the Council ask one of our committees to try scheduling a few of these as a pilot project.

I'd gladly pay to attend and it would be a good chance to see old friends and to make new ones. When I look at the list of members in our directory, I realize I don't know most of them—particularly the newer ones.

It's a refrain we hear a lot when we are leaving family events and class reunions—"We should get together more often."

THE MARYLAND PSYCHIATRIST IS PUBLISHED BY THE MARYLAND PSYCHIATRIC SOCIETY. MATERIALS FOR PUBLICATION SHOULD BE FORWARDED TO THE EDITOR. THE VIEWS EXPRESSED IN ***THE MARYLAND PSYCHIATRIST*** REFLECT THOSE OF THE AUTHOR AND NOT THOSE OF THE MPS, APA OR EDITORIAL BOARD.

SUBSCRIPTION RATES: $25 PER YEAR PAYABLE TO THE MARYLAND PSYCHIATRIC SOCIETY.

SEND ALL CORRESPONDENCE TO:
MARYLAND PSYCHIATRIC SOCIETY, INC.
1101 ST. PAUL STREET, SUITE 305
BALTIMORE, MD 21202
PHONE: (410) 625-0232; FAX: (410) 625-0277
EMAIL: MPS@MDPSYCH.ORG