THE
MARYLAND PSYCHIATRIST
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Patrick T. Triplett, MD: New MPS President

By: Jessica Merkel-Keller, MD

Patrick T. Triplett, MD

Patrick Triplett, MD, the new President of the MPS, attended Amherst College, then the University of Kentucky School of Medicine, before training at Johns Hopkins. He served as Chief Resident and did a fellowship in Geriatric Psychiatry while there, and is board-certified in both Psychiatry and Geriatric Psychiatry.

He has been a member of the MPS since 2000. He was Co-Chair of the Residents & Fellows Committee from 2001-04 and our Early Career Psychiatry Rep from 2005-07. He has served on the Editorial Advisory Board of "The Maryland Psychiatrist" and also on the Legislative and the Disaster Relief Committees. He was elected to the Council in 2012 and became Secretary-Treasurer in 2016.

Dr. Triplett is an Assistant Professor at Johns Hopkins, and serves as the Clinical Director for the Dept. of Psychiatry & Behavioral Sciences, where he runs a proactive consultation service.

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MPS HOLDS ANNUAL DINNER
An Evening of Thanks

By: Bruce Hershfield, MD

On April 26, 2018, 97 MPS members and guests attended the MPS annual meeting at the Hopkins club. It was an evening of taking time to acknowledge those who have done so much for our society and our community.

It began with the 2018 Maryland Foundation for Psychiatry "stigma advocacy award", which went to W. Daniel Hale, PhD, for his Op– Ed piece about depression in the Baltimore "Sun". It was delivered on what would have been his daughter's 21st birthday, three years after her suicide. He talked about the hunger that is "out there" for information about depression and its treatment.

MPS Poster Contest Finalists (L-R) Drs. Robert Roca, Raina Aggarwal, Paul Nestadt & Idris Leppla

Dr. Paul Nestadt then received two awards – – for the MPS Best Paper Award and as Co-Winner, with Traci Speed, MD, PhD-- for the MPS Poster Competition. Dr. Nestadt won for "Urban-Rural Differences in Suicide in the State of Maryland: The Role of Firearms, and Dr. Speed for "Survey of Pain Therapies in Marfan Syndrome".

This was followed by Dr. Neil Warres, who received the 2018 Lifetime of Service Award. He has served as the Chair of the Distinguished Fellows Committee and has had multiple roles on the committees that do much of the work of the MPS and related organizations---– including the MPS PAC and the Maryland Foundation for Psychiatry. He has also been President of the MPS. He described how he first got involved in the MPS, in what he described as the "dark days of managed care". He said he was heartened at that time by the support of the MPS, when he was threatened with a suit by one of the companies he had exposed. He referred to the pressure that many psychiatrists are under now, doing only diagnostic evaluations and brief medication checks, which robs psychiatrists of what is truly the best part of what we do. He thanked those who have taught him and supported him through the years.

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Jennifer Palmer, MD, then talked about what it has been like for her during her presidency. She spoke about the seamless transition that the staff had recently undergone, replacing its Executive Director, and about the multiple successes of this year. Dr. Palmer plans to continue serving the MPS as its Council Chair next year, and also plans to stay on the legislative committee, where she has done so much good for so many years.

Dr. Patrick Triplett, our incoming President, who is the Clinical Director of the Department of Psychiatry and Behavioral Sciences at Johns Hopkins and who has served on the Resident and Fellows Committee and also on our Legislative Committee, thanked all those who have helped in his transition. He spoke about upcoming reimbursement issues. He is clearly optimistic about his upcoming year.

As a special treat, we had the pleasure of hearing the APA President and MPS member, Dr. Anita Everett, talk about her two presidential initiatives. She pointed out that the APA now has its highest number of members in a long time, and the average age of our members has declined from 57 to 53. The APA recently opened its new headquarters in DC's Wharf Area. One of her initiatives concerns physician burnout. She pointed out that Psychiatry is among the better specialties in that regard. Another innovation concerns how to partner with the changes in technology. She has also been considering about whether we need to create a Women's Council as part of the APA governance. The MPS has been fortunate indeed to have Dr. Everett serve as APA President.

We have had a history of extremely effective leadership and we are all indebted to those who have sacrificed so much time and effort on our behalf and on behalf of our patients.

Jennifer Palmer, MD &
Patrick Triplett, MD

Neil Warres, MD &
W. Daniel Hale, PhD

(L-R)
Mansoor Malik, MD (WPS President), Jennifer Palmer, MD, Patrick Triplett, MD, Marilou Tablang-Jimenez, MD &
Anita Everett, MD

Courts vs Hospitals:

Who Holds the Key to the Admission Delay Problem?

By: Annette L. Hanson, MD

Annette Hanson, MD

An opinion piece in the August 24th issue of "The Baltimore Sun" criticized Maryland for failing to do enough to hospitalize mentally ill criminal defendants held in the state's jail system. The author, a member of an advocacy group for parents of mentally ill children, stated that current "wait times" for hospital transfers were "akin to torture" and that the detainees would represent a danger to public safety if not hospitalized because they would be "more dangerous" after being locked up in jail.

The facts are that most mentally ill people are not detained for violent crimes and that many only get treatment while incarcerated. The op-ed piece presented an incomplete and narrow description of the problem, a description in which the Maryland Department of Health is the only villain.

Clearly, a reduction in public inpatient beds has created a virtual treatment logjam. Patients committed through *civil* procedures rather than through the order of a *criminal* court judge often wait days to weeks in the emergency department waiting to be admitted to a psychiatric inpatient unit. Patients in the ER who are seeking *voluntary* admission face even greater delays, and also the risk that an insurance company may not approve payment for treatment if he or she turns out not to be a danger.

This year's general assembly considered two bills that attempted to fix the jail transfer problem. The first, introduced and sponsored by the judiciary, would have given criminal court judges the authority to order immediate, same-day admission to a state hospital even if no beds were available. Failure to comply with the court order would have been automatic grounds for holding the facility—and its clinical leadership—in contempt of court. A companion bill, sponsored by the health department, would have allowed 21 days to admit an incompetent defendant, and would have given the department the discretion to decline admission to detainees who were too dangerous to be treated in a hospital setting.

The final compromise bill, which will take effect this October, requires incompetent criminal defendants to be admitted within *ten* days, but otherwise gives little leeway or discretion for clinical judgement about hospital admissions. An admission cannot be declined, even if the hospital has inadequate security to manage the patient's dangerousness. While the compromise bill did not make automatically make failure to comply with the order an issue of contempt of court, the committing judge could still consider it. The Department of Health may also be required to reimburse the jail for the daily cost of care for every day that the detainee is held beyond the court-mandated deadline.

The MPS opposed both versions of the jail transfer bill. In written and oral testimony, we warned that similar laws in Minnesota and Colorado led to increased patient-on-staff assaults, which placed hospital accreditation at risk. We agreed with the opinion of the Maryland Court of Appeals in last year's Powell v DHMH case, which said that jail transfer times should be based upon clinical necessity rather than an arbitrary time limit. We recommended amendments which would have required judges to consider clinical information when setting a transfer deadline. None of this feedback was incorporated into the final law.

Ironically, no consideration was given to the role that the Maryland judiciary plays in the jail transfer problem. A 2011 report by the Justice Policy Institute found that Maryland defendants were being held in regional hospitals longer than should have been necessary for competency restoration. The report identified several barriers to discharge created by judges, defense attorneys, and prosecutors. Current law requires hospitals to provide a community discharge plan for every criminal defendant who has been restored to competence and is ready for release. Courts will not release a detainee if the judge disagrees with the treatment plan. Defense attorneys may challenge the hospital's competency assessment and delay discharge because they know that their clients will be transferred back to jail when they are found competent. Prosecutors are unlikely to drop charges or allow release of a defendant who cannot be restored to competence if the crime is particularly heinous or notorious. All these responses cause hospitals to hold people who don't clinically need to be there. A state workgroup convened in 2016 to study the forensic service system concluded that the lack of available beds was due not only to the actual numbers of

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beds but was also the result of a complicated and inefficient system.

There's more than enough guilt to go around. Everyone can own a piece of the problem. It's always easier to point fingers than to find a solution.

We should look beyond the stop-gap response of creating more inpatient beds. This approach will eventually cost the state $92 million, according to the fiscal note on the jail transfer bill. In 2011 the National Judicial College, an organization dedicated to educating judges and attorneys, recommended "best practices" in competency restoration procedures. These recommendations included: 1) the use of least restrictive environments for competency restoration that also protect public safety--such as outpatient programs and jail-based restoration programs, 2) limitations on the length of time that a defendant can be considered "restorable" before charges are dropped, 3) enhanced community services for forensic patients ready for discharge, and 4) prompt scheduling of hearings to expedite resolution of criminal charges.

As a forensic psychiatrist who works in correctional facilities, I feel obliged to point out what no wants to mention. If the problem is inadequate mental health care in Maryland's jails, we need to fix *the jails*. The MPS and my colleagues who work in corrections are doing our part to solve this complicated and distressing problem.

Celebration and Seminar 10th Anniversary of the Parity Law

The landmark 2008 Mental Health Parity and Addiction Equity Act reaches a major milestone in October. During the decade since the passage of this federal non-discrimination law, we also witnessed the enactment of the Affordable Care Act, which expanded but also complicated parity enforcement.

The MPS Payer Relations Committee will host a gathering on October 16th from 7-9PM so members can get the facts in person, ask questions and even get help with current treatment coverage issues. Henry Harbin, M.D. will be the featured speaker for this event, which will be held at the MPS office in Baltimore.

For more information, including the agenda, or to register please CLICK HERE.

Prepare for Maryland All Payer 2.0

Collaborative Care: Improving Access to Mental Health Care Services

8 AM - 2 PM Saturday, October 13

APA Office Building
800 Maine Ave, SW, Suite 900
Washington, DC 20024

The **Collaborative Care Model** integrates effective psychiatric care into primary care practices. The care team consists of a care manager, psychiatric consultant, and a primary care provider (PCP). The course describes the delivery of mental health care in primary care settings with a focus on the evidence-base, guiding principles, and an introduction to implementation strategies.

In addition, you will hear from experts on:

Using Collaborative Care to Reduce Physician Burnout
and
The Virtual Consult: Current Trends and the Future of Telepsychiatry/Telemedicine Best Practices.

The Registration fee for the conference is $30, covering the cost of attendees' continental breakfast and lunch provided during the event. The Collaborative Care training is provided as a result of APA's participation in the Transforming Clinical Practice Initiative (TCPi) supported by CMS.

REGISTER HERE

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians.

The APA designates this live activity for a maximum of 6 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Assessing Risk in Psychiatric Practice

Classes on How to Avoid Problems in Practicing and How to Work with CRISP

By Bruce Hershfield, MD

Bruce Hershfield, MD

On May 24, the MPS sponsored two talks at Med-Chi's Osler Hall.

First, Charles D. Cash, Esq., representing the PRMS insurance company, presented a series of vignettes entitled, "What Would You Do If..?" Members of the audience used clickers to select which of four answers was the best, then the correct one was described. Topics included "confidentiality", "the treatment of minors", "treatment relationships", and "remote treatment". He advised that practitioners avoid making statements about patients that are unsupported by records, and also to follow the maxim that, " If it's not in the record, it didn't happen." He talked about how to handle bad reviews on the Internet and in social media and advised to avoid "astroturfing" the Internet to make up fake positive reviews in order to balance negative ones. He also admonished us to resist "googling" patients unless there is a valid clinical purpose. Mr. Cash said that is not true that "some care" is always better than "no care", since partial treatment can clearly fall below the standard. He finished with remarks about patients who take sedatives and then get in car accidents. It was a sobering session, designed to keep us out of trouble.

Sheena Patel, MD, CMPE then talked about "CRISP: Best Practice and Clinical Usage". The program is administered by the Behavioral Health Administration section of the Department of Health. CRISP includes the collection of clinical data; the PDMP we are mandated to cite, before prescribing benzodiazepines or opioids initially and no less than every 90 days, is a part of it. We need to document that we queried the PDMP in the patient's clinical record.

There are some exceptions to the need to cite the program before prescribing. It is not required if the prescription will cover three days or less or when delaying prescribing it would negatively impact the patient' s medical condition. Furthermore, when there is no electronic access, for example if the doctor is not near a computer when receiving a phone call; in that case, it should be documented as an exception. The state does keep a record of who is checking in with the CRISP system. It collects information about fatal and non-fatal overdoses. Patients can opt out of the data collection part of CRISP, but not out of having their records checked in PDMP. It is hoped that e-prescribing systems can eventually be successfully integrated with CRISP, so as to save the practitioner's time.

The state is looking for patterns of use and also for overdoses in each of the counties and ZIP Codes so as to figure out where to place its resources better.

Questions about CRISP can be called into Kate Jackson at the Behavioral Health Administration at 410-402-8609. It is hoped that this program, consistent with those in each of the other 49 states, will cut down on opioid and benzodiazepine abuse throughout the state.

Louis J. Kolodner Memorial Lecture: The Opioid Crisis: What Can Physicians Do About It?

September 20 @ 5:35 pm - 8:00 pm

In honor of Recovery Month, we invite you to a **FREE** dinner lecture, jointly provided by the Kolmac Outpatient Recovery Centers, Med-Chi, Maryland State Medical Society; and co-sponsored by the Maryland Psychiatric Society. Richard S. Schottenfeld, M.D. will present, "The Opioid Crisis: What Can Physicians Do About It?"

AGENDA:
5:30PM – 6:30PM: Dinner
6:30PM – 8:00PM: Lecture

To Register **PLEASE CLICK HERE**

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society, and the Kolmac Outpatient Recovery Center. MedChi is accredited by the ACCME to provide continuing medical education for physicians.

MedChi designates this live educational activity for a maximum of 1.5 AMA PRA Category 1 Credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Questions? Contact Brandy Littlejohn at blittlejohn@kolmac.com or call 301-589-0255

REMEMBRANCE:
David Cowie, MD

By Bruce Hershfield, MD

David Cowie, MD

Dr. David Cowie, who had practiced in the Baltimore area for many years, died on February 11 at age 83. Born in Cardiff, Wales, he attended King's College Medical School in London, then came to Canada, where he served as a Captain in the Canadian Air Force Medical Corps. He trained at Johns Hopkins, then was on the staff at Sheppard Pratt—where he also counseled students at Towson University--and had a private practice that he expanded to a full-time basis. He taught at Johns Hopkins, Towson, and Loyola University. He did clinical research and was a senior supervisor on the Davenloo's Faculty of Intensive Short-term Dynamic Psychotherapy.

Dr. Chester Schmidt, who met Dr. Cowie in 1966 when he was a first- year resident at Phipps, commented about his contributions to case discussions. He described them as always intellectually insightful and pointed out that he would sometimes challenge conventional thinking about them. He remembered Dr. Cowie would bring a light touch to his work, while still being a dedicated professional.

Dr. Laurie Orgel said of him: "David Cowie was a thoughtful, sensitive, and outspoken man, which he showed through his clinical work with patients, his mentoring of residents, and his relationships with colleagues. As a teacher, he urged his residents to consider different ways of seeing patients, even if they differed from his own. He challenged us and he helped us. He talked about how to do the job – – how to set up an office, how to bill. Once residents graduated and began in private practice, he made a habit of calling them with referrals. He valued his work and that of his colleagues. He felt the responsibility for relieving psychiatric suffering was rewarding and had a great respect for those who chose to do it. Many of us experienced his intense devotion to his patients and his love of learning about how to treat them. He was not shy about introducing novel concepts. He was very funny, with a dry wit. I remember listening to him good – naturedly discussing whether the Welsh needed Britain or Britain needed Wales. That almost always ended with David leading in the singing of the Welsh national anthem – – in Welsh! He felt a genuine respect for the integrity of the people he treated and he really wanted to understand their circumstances. He taught us all well."

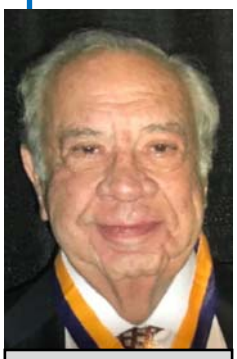
David was my friend, starting from the 1970s, when I first worked with him. He had a generous heart and was always willing to stand up for what he considered to be right, despite the cost. His judgment was good, too. He had a genuine feeling for what patients go through and was constantly trying to find out how best to help them.

I will always remember one time, in 1980, when I saw him get up and tell the entire group that they were wrong about something. (He was right, too.) It required understanding, which he had, and courage, which he had, and good sense. (Which he also had.)

He was a lovely man.

REMEMBRANCE:
Basri Sila, MD

By Bruce Hershfield, MD



Basri Sila, MD

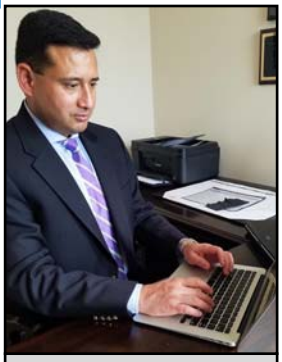
Dr. Basri Sila, who practiced child and adolescent psychiatry in the Baltimore area for many years, died on June 2 at age 87.

Originally from Turkey, he trained in St. Louis, returned to his homeland to serve in the Air Force for two years, then came back to United States in 1964, settling in Baltimore.

He had a private practice in Baltimore and in Lutherville until he retired in 2017. For 30 years, he was a child psychiatry consultant for the Baltimore Head Start program. He was on the faculty at the University of Maryland and also at Johns Hopkins. An early member of the Maryland Society for Adolescent Psychiatry, he served as its president and was named a Life Fellow by the American Society for Adolescent Psychiatry. The MPS awarded him a certificate of appreciation.

Generation X and iGeneration
A Tug of War

By Shobhit Negi, MD



Shobit Negi, MD

About 6 months ago I evaluated a teen who was about to turn 17. His pediatrician had referred him because he had been expressing passive suicidal ideation to his parents and friends. Until about a month before that, he had been a stellar student and captain of his lacrosse team. He had engaged in sexting; in this age of digital media this seems to have become a normative component of teen behavior. Apparently, one in nine teenagers becomes a victim of forwarding sexts without consent, as had happened to him. Although rates of sexual activity among high school students appear to be declining, digital sexual activity is probably becoming more common. Within a day of him sharing images depicting his personal body parts with a female classmate, he became a laughingstock in school and his Snapchat group, leading to his existential depression.

> *"What awaits is not oblivion but rather a future which, from our present vantage point, is best described by the words "post biological" or even "supernatural." It is a world in which the human race has been swept away by a tide of cultural change, usurped by its own artificial progeny."*
>
> *Hans Moravec, 'Mind Children'*

According to a recent study published in the *Journal of Developmental and Behavioral Pediatrics*, based on parental reports, the rate of anxiety or depression among children aged 6 to 17 years increased from 5.4% in 2003 to 8.4% in 2011-2012. Research also indicates that self-injurious behavior is on the upswing.

What is causing these surges? Prior to the 1980's, many mental health professionals thought that the teenage brain could not be afflicted by emotional disorders affecting adults, as it was not developed enough. However, a growing body of neuroimaging research and a better understanding of psychopathology across the developmental lifespan have challenged longstanding assumptions. Research shows that half of all lifetime cases of mental illness begin by age 14 No-one knows exactly why emotional disorders are on the rise in adolescents. It is clear they are spending substantial amounts of time in front of screens. The extended family structure has eroded. They may be more comfortable now sharing their emotional problems and seeking help. Children are entering puberty earlier.

We are social animals who have always relied on communication to strengthen our relationships. Since the inception of the first recognizable social media site, *Six Degrees*, in 1997, we have seen an astronomical increase in social networking sites. They have had a positive impact on a very small fraction of patients. Although some of my adolescent patients struggling with social anxiety have desensitized themselves by initiating interactions on social media, for the majority it has proven to be detrimental to their emotional health.

Unrestrained and unmonitored use of social media often can cause an adolescent's emotional malady or significantly exacerbate it. Patients tell me that they use social media to connect with others in order to find social support. However, I find that the more time they spend on their devices, the more they are emotionally distressed. Instead of bolstering their sense of self, it starts acting as a measurement of their achievements and failures. Adolescents go through multiple changes. Coupling that with peer pressure and the modern hyperconnectivity of modern – day teenagers means that day-to – day school dramas play out in "real time." They are often unable to restrain themselves from posting embarrassing images or comments on social media, or from getting addicted to the practice. I have seen patients with no premorbid illnesses contemplating suicide because they have shared posts revealing personal details, either anatomical or emotional, with someone they unilaterally have confided in. Later, they are mortified because the post is no longer kept private. What adolescents may not realize is that posting such images or videos can have consequences, such as felony child pornography charges and school suspensions.

Cyberbullying, implicated in numerous cases of adolescent suicide in recent years, takes place in various forms, including flaming, harassment, outing, exclusion, impersonation, and stalking. Digital self-harm, another form of self – hatred, occurs when an individual creates an anonymous online account and uses it to publicly send hurtful messages or threats to one's self. This can cause a lot of self-harm.

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TUG OF WAR

(Continued from page 8)

When we engage in face-to-face communication, social information is conveyed by verbal and non-verbal cues. Non-verbal communication includes facial expression, eye contact, and tone of voice as well as posture, space between individuals, etc. Understanding the non-verbal aspects of communication is crucial in modifying our behavior in response to the reactions of others. Children and adolescents who understand emotional cues in social settings can develop superior social skills and more positive peer relationships. When children and adolescents use digital communication extensively, it can curtail the face-to-face experiences necessary for them to develop and master important social skills.

As part of evolving, we have developed additional layers of the brain, upright posture, and other physical attributes. Artificial intelligence is knowingly or unknowingly permeating our everyday lives. A time will come when intelligent machines will be able to duplicate individual minds. Technology is changing the way we communicate with each other; this will become a saga that our children and grandchildren will share with their progeny. Maybe the iGeneration is just following the natural course of what the future holds!

Maryland Psychiatric Society Psychopharmacology Symposium

Saturday November 17, 2018
The Conference Center at Sheppard Pratt

Agenda

Hypnotics
David Neubauer, M.D.

Medical Cannabis and Cannabis Use Disorders
George Kolodner, M.D. & Sunil Khushalani, M.D.

Optimizing Safe and Evidence-based Medication Treatment of Children & Adolescents
Gloria Reeves, M.D.

Update on the Psychopharmacology of Opioid Use Disorders George Kolodner, M.D. & Sunil Khushalani, M.D.

Pharmacogenomic Testing for Psychiatrists: An Introduction Francis Mondimore, M.D.

Update on the Psychopharmacology of Alcohol Use Disorders George Kolodner, M.D. & Sunil Khushalani, M.D.

Don't miss this highly anticipated event.
More information or register available here.

Narrow to Be Associate Medical Director at Hopkins Bayview's CPP

Some Thoughts on DSM-5

By: Jimmy Potash, MD, MPH

Jimmy Potash, MD, MPH

Editor's Note: This is a version of Dr. Jimmy Potash's "Cheers from the Chair" of 5/18/18
He is the Director of Psychiatry & Behavioral Sciences at Johns Hopkins

The Hopkins Bayview Community Psychiatry Program (CPP) is overwhelmingly the largest chunk of our department's outpatient efforts, with a huge and thriving program that includes 20 specialty clinics and about 102,000 visits a year. It is housed in a beautiful new building on Lombard Street that opened last summer.

The newest face on Lombard Street will soon be Associate Professor William "Bill" Narrow, MD, MPH, who is coming to us from the University of New Mexico. He has spent the bulk of his career at the National Insitute of Mental Health (NIMH) and the American Psychiatric Association (APA). In his role as Associate Director of Research at the APA from 2001-15, Dr. Narrow played a major role in creating the DSM-5. He has edited three books and written dozens of papers, reviews, and book chapters about its conceptual framework, and about the empirical studies that drove some of the creation of what is sometimes called the "Bible of Psychiatry". Congratulations to Dr. Kostas Lyketsos, the Chair at Hopkins Bayview, for successfully recruiting Dr. Narrow!

I came to have a healthy respect for the DSM during my tenure as Chair at the University of Iowa. Faculty there had played a large role in bringing about the sea change that occurred in 1980 with the "revolutionary" DSM-III, which marked the dawn of the "era of empiricism". Iowa's Nancy Andreasen, a schizophrenia research powerhouse and a former Editor of the *American Journal of Psychiatry*, was on the committee that engineered that transformation. More recently, Iowa's Susan Schultz was the text editor of the DSM-5. The department had a healthy respect for data and a deep mistrust of theory. That stance is consistent with a key strength of the DSM. Others include maximizing reliability of diagnoses,

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creating more uniformity to treatment and research, and emphasizing clear boundaries between normal and abnormal.

The DSM has at times been disparaged within our department, and it undoubtedly has its weaknesses. Our former faculty member Dr. Francis McMahon once gave a talk here where he referred to the DSM as a "roach motel, where diseases check in but they don't check out." He was referring to the increase in the number of disorders from the original DSM, which had 106 of them, to the DSM-IV, which listed 297. While the DSM-5 did add some new disorders, it also consolidated others. Professor Paul McHugh and Emeritus Professor Phillip Slavney have derided the DSM for promoting a checklist approach to Psychiatry that fails to promote thorough knowledge of patients and avoids discussing the causation and mechanisms that are critical to a deeper knowledge of disease.

William "Bill" Narrow, MD, MPH

The faculty at Hopkins played a substantial role in making the DSM-5. Former Bayview CPP Director Anita Everett, MD, served on the clinical public health review committee. Dr. John Walkup from Child Psychiatry (now at the University of Minnesota) served on an anxiety disorders workgroup, Professor Roland Griffiths served on the substance-related disorders workgroup, and Associate Professor Cynthia Munro lent her expertise to the neurocognitive disorders workgroup. Dr. Ben Lee (now Chair at the University of Rochester) was a part of the sleep-wake disorders group and Professor Ray DePaulo served as a reviewer. Clinical Vice Chair Bernadette Cullen and Associate Professor Holly Wilcox led the DSM-5 Field Trials Pilot Study at the Hopkins Hospital CPP. This pilot study led to a 2014 paper in the *International Journal of Methods in Psychiatric Research* -- whose senior author was Bill Narrow.

The DSM has also been criticized outside our four walls. In 2013, when the DSM-5 came out, a front-page story in the *New York Times* focused on criticism from NIMH Director Dr. Tom Insel, who said that, with regard to understanding psychiatric diseases, "we cannot succeed if we use DSM categories as the 'gold standard.' " He said that for decades we have been rejecting biomarkers because they do not detect a DSM category. He proposed collecting data of all kinds-- including genetic, brain imaging, physiologic, and cognitive -- to see how all of it, rather than simply clinical signs and symptoms, cluster together, and how these clusters relate to biomarkers and treatment responses. "That is why NIMH will be re-orienting its research away from DSM categories. Going forward, we will be supporting research projects that look across current categories, or sub-divide current categories, to begin to develop a better system." This caused quite a stir! The NIMH has since walked this back a bit and clarified that they do still support research based on DSM categories, though they continue to look at ways of refining their research-focused framework they call RDoC or "Research Domain Criteria."

I can't imagine that Dr. Narrow or anyone else involved in the DSM-5 believed they had created the *final* version of the classification of mental disorders. They all understood that this is a work in progress, and that improvements will come as our knowledge base, fueled by research, grows. What Dr. Narrow also understands is that there

2018-2019 MPS Membership Directory

Thanks to all members who have updated their practice information! The MPS directory is now in print and we expect copies to arrive in members' mailboxes this month.

The annual directory consistently ranks as one of the most valued member benefits.

Enjoy!

Interview: Drs. Anne Hanson & Dinah Miller

By: Bruce Hershfield, MD

Bruce Hershfield, MD

*At the Annual Meeting in May the APA Ethics Committee gave **Drs. Dinah Miller and Anne Hanson** the APA's Carol Davis Ethics Award for their book, Committed: The Battle Over Involuntary Psychiatric Care. The book addresses one of the thorniest ethical issues in psychiatry, and indeed, in society at large – the question of involuntary commitment to psychiatric hospitals and to mandated outpatient treatment. Our ethical principles, as APA members, require us to adhere to ideals that may at times seem to come into conflict: respecting the rights of patients, other health professionals, colleagues, safeguarding patient confidences, privacy, and dignity, while providing competent care, and respecting the law. Their book is a valuable companion for thinking through some of the most complex medical – and human – dilemmas.*

Q.: "Congratulations on getting the award!"

Dr. Hanson: "Thank you! We were very excited to get it. Our work was three years in the making. We decided that we wanted to talk about a topic that wasn't generally discussed among psychiatrists. We had heard many stories from patients who wrote to our blog and talked about their experience with involuntary care and what it was like to be placed in seclusion, placed in restraints, and to be given involuntary medication. We thought it would be good for our colleagues to hear about this."

The Carol Davis Ethics Award Ceremony
(L-R)
MPS Executive Director, Heidi Bunes, Annette Hanson, MD,
MPS Ethics Committee Chair Joanna Brandt, MD &
Dinah Miller, MD

Q.: "How has the book—'Committed'-- worked out?

Dr. Miller:" It has been good! We have gotten a lot of positive feedback on the book, though the topic of involuntary treatment can be very polarized and there have been people who don't agree with our viewpoints, but that's to be expected.

Q: "How did the two of you split up the work?"

Dr. H: "We divided up the tasks, so Dinah did the interviews and the initial drafts, and I did background research and summarized the legal and ethical issues. It was useful in our last General Assembly because a lot of the bills that the MPS legislative committee reviewed have involved gun violence and mental illness, particularly following the shooting in the St. Mary's High School. There were times when we went to Annapolis when I really wished I had a copy of the book, that I could have just handed. Over to the bill sponsors so they could have had a context for these laws that they were writing."

Q: "Dr. Hanson, you have done a lot of this work in the past, on behalf of the MPS, haven't you?"

Dr. H: "Yes, I have been the Chair of the legislative committee. I worked on a lot of issues related to civil commitment and involuntary medication. I'm very grateful that our General Assembly only meets for three months, because I don't know how people do it places where the legislature meets year – round. The fun part has been getting our students involved. I'm on the faculty at Maryland and I bring my Residents and my Fellows with me and we sit around reviewing bills and we suggest amendments and try to shape the laws. Sometimes we oppose them, when we really don't want them to pass. Sometimes it's successful; sometimes, it's not."

Q.: "How did the two of you start working together?"

Dr. M.: "We've been friends since residency. Anne is very interested in computers and technology. For a while, she was working one day a week as a programmer. In 2006, I said to my husband, ' I want a blog. What's a blog?' I didn't really figure out what a blog actually was, but I knew I wanted one! I set it up at blogger.com, and when it asked for a name, I wrote in 'Shrink Rap'. I called Anne and Steve Daviss because they were the two 'techie' people I knew and asked if they wanted to help me with it. So, we started 'Shrink Rap'. Eventually, Steve said that we needed a podcast, so we started meeting in person in order to do that. At some point, I suggested we make it into a book, so that is how we got our first book, *'Shrink Rap:*

(Continued on p. 12)

Three Psychiatrists Explain Their Work'.

Q: "Would you tell us a little about that?"

Dr. M.: "The title tells you a lot about it. We talk about what it is that psychiatrists do, who goes to a psychiatrist, what is the difference between a psychiatrist and a psychologist and a psychiatrist and a therapist, how do we assess people for medicine, what are we targeting with medicines, and what is psychotherapy. There are several chapters about forensic issues. Neither of us had much experience with inpatient or consult – liaison work so Steve did those chapters and he did some on health information systems and genetics.

We noticed on the blog that whenever the topic of involuntary treatment came up, the conversations among our readers in the 'comments' section would get very heated. It's tempting to read these and say things like, 'Oh, you don't remember how sick you were, that people probably had no choice but to involuntarily treat you.' There was a pediatrician who for three years wrote after every blog post that psychiatry is not a believable specialty because we involuntarily treat people. People talked about how traumatized and upset they were. When the drumbeat goes on for years and years, eventually, you wear down and you must start thinking, 'Maybe patients have a point.' We weren't hearing anybody fight back, saying, ' You were treated badly, but I was treated really well; this really helped me'.

So, we started getting the sense that people are really traumatized by this. But, believe it or not, the topic of involuntary psychiatric treatment can be dry, so I decided that this book should be filled with stories that held your attention. In the chapter on civil rights, we took a story from the newspapers -- it was the one instance when I did not interview the person. She was a woman who was involuntarily committed to the hospital and did not have a hearing for six weeks. The reason she was involuntarily committed was because she got very upset upon finding out that her ex-husband had murdered their son and then killed himself. It was a compelling story."

Q.: Dr. Hanson, what did you learn when doing the background work for this book?"

Dr. H.: "The thing that impressed me was that a lot of this information is just not getting out to the general public. So, when we brought up the topic of involuntary treatment, it was in the context of the Sandy Hook shooting. Immediately after that, there was a lot of public outcry about the dangerousness of the mentally ill. Congress was debating bills to liberalize civil commitment statutes. Editorials were being written about how we need to create bed space, bring back the asylums. People were thinking that if it wasn't for a few pills, everybody with a mental illness would be a criminal. The point that I wanted to get out in writing this book was that if you follow that line of thinking, you will be going backwards in history. When we wrote the history chapters, we started with the bad old days, when there were lots of beds, when a man could sign his wife into the hospital and leave her there for decades. That is the piece the general public doesn't know. When you talk about expanding involuntary treatment, what you're really doing is going backwards in time, when people just didn't have the protections we take for granted today."

Dr. M.: "That's just not a conversation from 2012 or after a mass shooting. In the last week, the *New York Times* had an article about whether we should go back to having asylums. I think we all agree we should have more beds. But people who *want* to occupy them have trouble getting into them. We should ask why it is we care about the mentally ill *homeless*; shouldn't we also care about the addicted homeless or the indigent homeless. If you're going to have an asylum so bad that people don't want to be there, that they would rather be on the street, then we are going to go backwards. It's a common thought-- that we need to go back to the days of the asylum. I think it's a provocative word, associated with insane asylum. I think they need to be voluntary facilities."

Dr. H.: "I think we need to attack two myths, and they are that by expanding involuntary treatment the public will be safer, and that if you expand involuntary treatment we will have fewer mentally ill people in prison. The majority of people in prison, even if they have mental illnesses, are not there because of mental illness, but because of the same reasons that the non – mentally ill are."

Q.: "What are the two of you planning to work on in the future?"

Dr. M.: "I'm starting to think about a book with a tentative title of 'I Just Want to Be Happy: Misery in the Land of Plenty'. Look at the problem with physicians. I am talking about people who are generally very fortunate, who have chosen a career, who are intelligent, who have been able to figure out the finances to make this career happen. It's a career that's always been held in very high esteem. We have rewarding relationships with people. And yet we have such a high suicide rate, we have physician burnout, people retiring early. Why are so many people using opioids? You don't do that if you're happy with your life."

Q.: "Dr. Hanson, do you have any plans that you'd like to tell us about"

Dr. H.: "We have talked about a third book, but that's like asking someone who has had triplets when they want their next child. A huge time commitment. I need to write a book chapter that I promised someone about involuntary treatment and public safety. It should be easy to do, when I finally get time to do it!"

REMEMBRANCE:
Walter Weintraub MD

By Mark Ehrenreich, MD

Walter Weintraub, MD

Dr. Walter Weintraub, a long-time faculty member at the University of Maryland, died at the age of 92 on March 12, 2018.

Walter was a pivotal figure in my life and in the lives of many other psychiatrists. I would be hard-pressed to name another person who impacted the practice of Psychiatry in Maryland as much or who influenced as many psychiatrists.

In 1970, he established the Combined Accelerated Program in Psychiatry (CAPP), an innovative program in which a select group of University of MD students received additional training in Psychiatry from their first year of medical school. This program continues to provide exceptional training to approximately 600 students who have gone on to careers in Psychiatry as well as in other areas of Medicine. For me, a graduate of a small liberal arts university, the CAPP program's seminars and early training in psychotherapy provided a necessary respite from the rote learning and large lectures typical of medical education at that time.

In 1971, Walter was appointed the Director of Residency Training, a post that he held for 20 years. In that role, he helped train many of the psychiatrists practicing in the state of Maryland. In 1976, he established the Maryland Plan, which merged the state hospital psychiatric training program with the University of Maryland's. This collaboration still exists today. The plan brought academically-trained psychiatrists to the state hospitals and the community clinics and ultimately improved the quality of care. It became a model for other states. The large number of Maryland-trained psychiatrists working in the public sector is one of his enduring legacies. In recognition of his groundbreaking work, he was given the 1978 Vestermark Psychiatry Educator Award from the APA-- the highest such honor it can hand out.

In addition to his work as a psychiatric educator, he published articles and books on the relationship between verbal behavior and personality styles. As a result of this research, he analyzed the speech patterns of foreign leaders and suspected terrorists for the FBI and the CIA.

Walter's professional accomplishments were impressive, but I believe his personal qualities were what led so many psychiatrists to attend his funeral on March 27th. He was a kind, gentle, and wise man. He took a genuine interest in his trainees and the department's junior faculty. He led by example. Brian Hepburn, MD, the Director of the National Association of State Mental Health Programs and his longtime friend, commented: "What made Walter a good mentor? What made Walter such a good leader? He believed in treating everyone fairly. He treated everyone with respect. He had a calming presence. He was positive and hopeful. He respected differences of opinion, and he respected and recruited for diversity. He made you want to be on his team."

As his son, Daniel, said in a tribute at the 60th anniversary of the founding of the Department of Psychiatry, "I think because he was so comfortable in his own skin, not worried about impressing others or seeking adulation, it was hard not to feel good about yourself when you spent time with Dad."

Walter was a pivotal figure in my life. It would not be too strong a statement to say that I am where I am now because of him. The CAPP program helped me get through medical school and solidified my desire to be a psychiatrist. In large part, he was the reason I stayed at Maryland to do my residency. He served as one of my most valued psychotherapy supervisors-- so much so, that I continued to see him as a junior faculty member. I still quote him to the residents I currently supervise. As the current Training Director of the University of Maryland/Sheppard Pratt Psychiatry Residency Program, I do my best to nurture the program that he led for many years. I had an excellent role model.

Walter is survived by his four children-- Phillippe, Eric, Daniel and Michele-- all of whom became psychiatrists. Just as he was a role model as a psychiatrist and as a person for many of us, he was for his children.

We will miss him greatly, but his legacy will live on through his children and all of us he so profoundly influenced during his lifetime.

LETTER FROM THE EDITORS
Lawyers Defining Psychiatry

By: *Bruce Hershfield, MD*

"Will you walk into my parlor?,
said the spider to the fly."

I have attended several lectures recently, by lawyers who represent companies that protect us in the event we get into legal trouble. I attend these lectures voluntarily and always find them useful, but *scary*.

Here are a few pointers I've heard recently. I've been told we need to document independently in the record that patients who sign "consent" forms understand what they are signing, and I need to get written permission to talk with anybody who accompanies the patient into the office, and I also need to get signed authorization to talk with the pharmacist about a prescription I've written. These are sometimes presented as "standards", presumably based on case law, though of course they can't be *standards* because almost nobody is doing them.

This leaves me almost no time to actually interact with my patients-- to find out what is actually *troubling* them. I'm expected to check all sorts of boxes to show that I have asked what the government, insurance companies, and lawyers believe I should. We are warned that every patient or potential patient can turn into a plaintiff--in a system of interaction between patient and psychiatrist that has to be built on mutual trust. One frequent bit of advice is to consult an attorney or a risk management consultant before doing anything.

The legal profession has been affecting the practice of Psychiatry for a long time, but lawyers have no real understanding of what we *do* in our offices. They insist that we practice in ways *they*—or even judges and juries--imagine we should.
This is taking away our own right to define the standards of *our* profession.

I know that these people and companies are trying to keep me up- to- date on the latest legal developments, so that I can stay out of trouble. I appreciate what they are doing; that's why I go to hear them. However, if one accepts everything that they are saying, it could become impossible to practice at all. As Voltaire pointed out, "The perfect is the enemy of the good." Lawyers and companies and governmental agencies can state their points of view, but how psychiatrists should practice needs to be ultimately set by our professional organizations, especially the MPS and the APA. In recent years, the APA's has set up "practice *guidelines*"—not standards—and they have been useful. We need more of them and they should be more widely disseminated in our CME meetings.

The number of psychiatrists is going to be decreasing soon, and our places will not be taken so much by other psychiatrists as by people from other professions. Some will be pleased when clinicians check long lists of boxes. It is, after all, an easy system to teach to non-psychiatrists, who can then claim they are doing "behavioral health" work at the same level as we are. We may completely lose our ability to interact empathically with our patients. Then, something valuable-- the heart of it all-- will be lost, and, when the heart dies, the brain and the rest of it soon follow.

By not defining ourselves sufficiently and by trying to avoid getting trapped on any of a myriad of sticky filaments, we may lose sight of the web itself and serve as an example of *one* profession being swallowed by *another*.

Come Join Us
for an
OPEN HOUSE

The MPS is not just some abstract organization! Join us for an informal gathering of colleagues to socialize and take a look "behind the curtain" where a lot of the work gets done.

Tuesday October 9th 5:30–7 PM Meet
MPS leadership and staff,
including the MPS lobbyist team,
tour the MPS office,
learn interesting MPS history and
network with other MPS members.

Drinks and appetizers will be served.

Register today!