

# THE PSYCHIATRIC SOCIETY OF VIRGINIA VIRGINIA NEWS



A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SPRING 2010

## A MESSAGE FROM THE INCOMING PRESIDENT

By Cheryl Jones, MD, DFAPA

I send greetings to all. I am honored and excited to be the President of the Psychiatric Society of Virginia for the 2010-2011 year. This is a huge challenge and I am looking forward to working with many members to make our upcoming year a success. My vision for the year is to foster and populate the goals of the PSV as listed on our website. They are as follows:

### GOAL I: To be truly relevant to our members

1. Increase membership
  - a. Increase member numbers in all categories
  - b. Communicate regularly with member and non-member psychiatrists to determine whether the PSV is meeting their professional needs
2. Increase accuracy of member email list
3. Continue and expand office support services for individual members through Psychiatric Office Personnel meetings
4. Continue referral service for patients through PSV Executive Director and Membership Directory

### GOAL II: To promote advocacy and ethical care for the mentally ill

1. Increase the number of members joining the MHA or VAMI or an advocacy group
2. Support VAMHE with PSV donations and encourage psychiatrists to join as Board members
3. Develop and advance yearly legislative priorities (e.g. parity, ethical prescribing, confidentiality, public mental health financing, etc.)
4. Increase psychiatry's participation and influence in all significant state-wide mental health initiatives

5. Annual membership presentation on ethics

### GOAL III: To foster science and the progress of psychiatry

1. Establish meaningful relationships with Psychiatry Training Programs
  - a. Support training through teaching and supervising residents and medical students
  - b. Help raise endowments for training or research
2. Provide members with CME, network with members across the state and communicate with APA about important issues in other states which could impact our members (e.g. parity, prescribing privileges)
3. Support psychiatry's role as the best qualified team and most cost effective leader with a unique role as evaluator, diagnostician, psychotherapist and psychopharmacologist

### GOAL IV: To make a positive contribution to our communities

1. Volunteer on Community Service Boards and at medical schools, free clinics
2. Offer service to the Red Cross in case of disasters
3. Offer public education presentations
4. Encourage members to provide at least one hour a week for community service

These are excellent goals set forth by the organization. It is my belief that they cannot be addressed by me alone. In fact, they cannot be addressed by the Psychiatric Society of Virginia in isolation. The PSV must reach out of its comfort zone as an organization to actively engage with its membership, allied health professionals, and the community at large. It is true that there

exist differences in ideology of the many allied health professionals that we engage with on a day-to-day basis concerning the way mental health care should be delivered. However, I assert that there is more common ground than difference. Mental illness is a disease process that takes no consideration of any boundary. It touches the lives of the young, old, all social-economic classes, all races and ethnicities. We all know someone that has grappled with a mental health concern. If we admit it, we, ourselves, have had concerns in our lives as well.

We are not alone in this journey and, therefore, we should not act as if we are. It is important to engage all health professionals, our friends at the Medical



Cheryl Jones, MD, DFAPA  
President

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**Psychiatric Society  
of Virginia**

2209 Dickens Road  
 Richmond, VA 23230-2005

Phone: (804) 754-1200

Fax: (804) 282-0090

Email: psva@psva.org

[www.psva.org](http://www.psva.org)

Letters to the editor and editorial contributions are welcome. Submissions may be sent to Jose Edwin Nieves, MD, FAPA, or to Kathleen Stack, MD, FAPA, via email at jose.nieves@med.va.gov or to kathleen.stack@med.va.gov. Paid advertising is accepted on a first come, first served basis. To place your advertisement or to request a rate sheet, contact Beverly Bernard at PSV Headquarters via email at beverly@societyhq.com or by phone at (804) 565-6321.

## A MESSAGE FROM THE EDITOR

### WHERE IS THE BOUNDARY BETWEEN A PSYCHIATRIST AND THE INTERNET?

By Kathleen M. Stack, MD, DFAPA



Kathleen Stack, MD, DFAPA

I am not in the habit of using a search engine to look up information on my patients. I had not even considered it until recently. A colleague of mine told me with dismay that a patient discussed her personal information, obtained from the internet, in a session. It was clear that the patient considered this not an invasion of privacy but routine and acceptable behavior. My first thought was of the dynamics of the situation and how this would change the therapy. I also asked about the person's diagnosis, assuming the behavior was a reflection of this. There was no obvious connection. I considered this an oddity and gave it no further thought.

At a social gathering, an acquaintance told me about a disgruntled person who posted grossly inaccurate and vindictive information about him on a website. He found out about this when he was queried about them in a job interview! He then tried, but was not able to respond to the inaccurate information on the "web."

In another setting, a patient told me one of his peers was "faking" and that he "knew" this from information found on the internet. I did not want this information to affect my treatment of the alleged fake, and I worked hard to keep it out of our interactions. I still wonder if I was successful. I did not go online and check, but I was tempted. I was also aware that if he was checking up on one of his peers, he was very likely to have done the same or a more detailed type of check on me.

I was discussing the use of such search engines with another physician, who uses them often to look for information on patients and peers. As you may suspect, this person is younger than me. To them, this was also routine and to be expected. That evening I went home and looked up my name online. To my relief, there was nothing, that I found, which was worrisome. I was also acutely aware that my search capabilities were very simplistic.

On a more serious note, I began to wonder if I was missing out on a resource for knowing more about my patients. I considered this an invasion of privacy, but maybe it was more like obtaining "collateral information" from available acquaintances of dubious reputation.

A search brought up an article I had read, but forgotten, by Lois Wingerson "Internet social media present new quandaries for psychiatrists," published in the *Psychiatric Times* May 15, 2009. I suspect I did not remember this article because, at the time, I did not see how it applied to my practice. Now with Wi-Fi at the hospital, and patients with internet phones, I see my own naiveté (or worse).

I am going to include some excerpt from this article, as it raises interesting points for consideration. Damir Huremovic, MD, read the printout of a suicide note in email form while at the bedside of a patient in the ICU. There was a link to a blog which he was unsure about opening.

"My dilemma was whether or not to open it," said Huremovic. "I finally did, considering that his blog may yield critical information about his attempt." The information, and the e-mail, may have saved his life.

"As I skimmed over his personal musings in chronological order," Huremovic recalled, "I could get an almost instant insight into the course of his drama, his aspirations and hopes, and his big disappointment which culminated with the suicide attempt. I found this way of learning about the patient so easy and almost seductive." At the same time, he was uneasy about trespassing in a realm of intimacy and privacy—even though the patient had willingly posted the information in the most

*Continued on page 15*

## A MESSAGE FROM THE OUTGOING PRESIDENT

### GUIDELINES NEEDED FOR THE USE OF ELECTRONIC COMMUNICATION AND OTHER ELECTRONIC SOCIAL MEDIA IN PSYCHIATRY

The push to move care closer and closer to the patient, making the patient the “point of service” (also called “patient centered care”) has continued to promote the use of electronic communication devices and technologies in the last few years. On the other hand, the legal, ethical and clinical consequences of this practice have lagged behind, leaving individual practitioners wondering what is or is not appropriate use of some of these devices or medias. In her column, Dr. Stack raised the issue of the ethical dilemmas that plague the use of the Internet by both patients and clinicians, while at the same time, she gave a few examples of boundary crossing dilemmas for clinicians.

From a legal point of view, one of the greatest risks in the use of electronic mail (email) clinically is the potential for privacy (or confidentiality) violations. Most emails between clinicians and patients are related to administrative purposes such as appointment scheduling, reminders, limited sharing of clinical data such as laboratory results, etc. Patient education materials, refill reminders or treatment adherence notifications are other applications on the rise. However, in psychiatry, the use of emails to exchange therapeutic material, even briefly, may have a profound impact in the therapeutic alliance. What if some patient-specific information would wind up being divulged? Who would be liable? The clinician? The Internet server?

In addition to liability concerns, the use of email to share information lacks much context. Psychiatry is a context-rich field, where the nuances of communication, like the tips of the head, body language and periods of silence, often complete the message being conveyed by the patient. How many times, after a long therapeutic relationship with a patient, have one of you been able to assess the patient before the first word is uttered by just looking at your patient’s demeanor and body language? This would not be possible with the use of electronic communication. How would this method of information sharing impact the cultivation of empathy so necessary in our field?

Electronic mail is asynchronous, and may raise patient expectations about his/her clinician’s availability and ability to return electronic messages. What would be an appropriate response lag time between a patient and his clinician? Would it be necessary to post a heading such as “Dr. Nieves will return emails only during normal business hours” as if it were a telephone call? There is no official guidance on how to address these issues.

What about the patients that do not have access to an electronic mail account? Would the expectation be that all patients are connected to the Internet? And if not, are those patients receiving a lower standard of care because they do not enjoy the same level of access to their clinician as those who do?

These questions will probably be answered over time. As Dr. Stack points out, the new generation professionals and

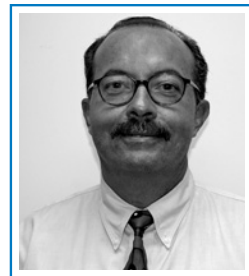
patients are increasingly familiar and adept at these technologies and are ready to use them. They may be the ones that establish the new “electronic clinical era” practice guidelines. In the meantime, it is important to remind clinicians that maintaining ethical boundaries and optimal clinical care remain our responsibility.

Below, I am including several references that I read in preparing this short piece for those of you who may be interested.

#### References:

“E-mail and psychiatry: some psychotherapeutic and psychoanalytic perspectives”. Bhuvaneswar CG, Gutheil TG. *Am J Psychother.* 2008;62(3):241-61.

“E-mail and the psychiatrist-patient relationship.” Recupero PR. *J Am Acad Psychiatry Law.* 2005;33(4):465-75.



J. Edwin Nieves, MD, DFAPA

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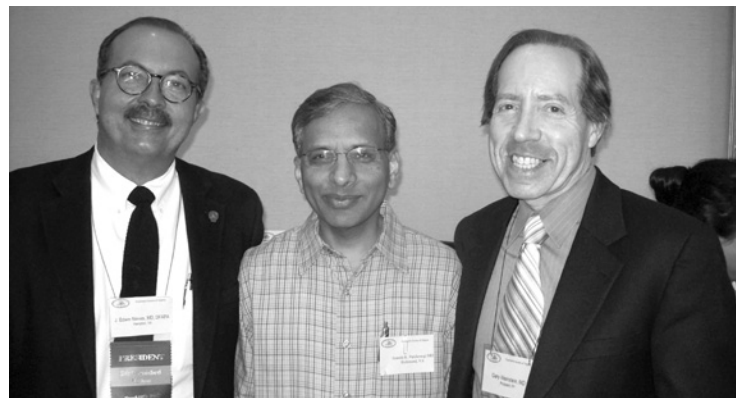
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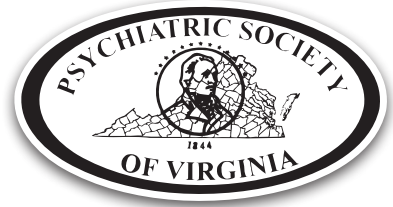
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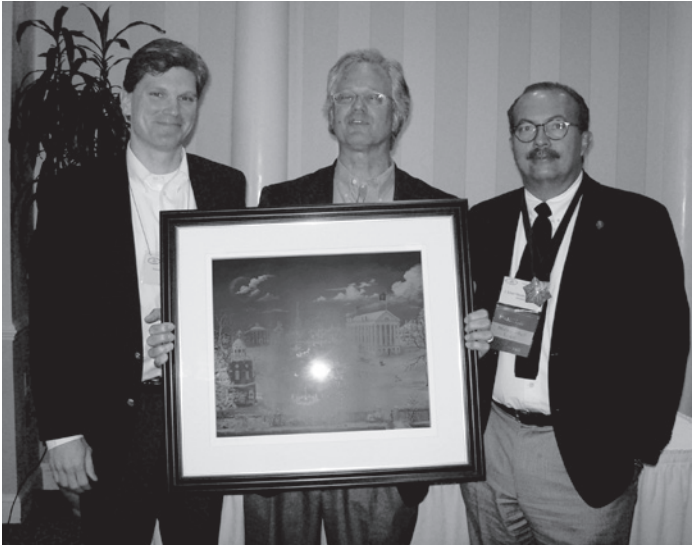




# IN THE NEWS

## JAMES REINHARD HONORED AT THE PSV 2010 SPRING MEETING

By James Krag, MD



*Pictured from left to right: James S. Reinhard, MD, DFAPA; James Krag, MD and J. Edwin Nueves, MD, DFAPA, outgoing President. Dr. Reinhard was presented with a limited edition print by Parks Duffey as a token of appreciation.*

At the Spring meeting, the PSV honored James S. Reinhard, MD, DFAPA, for his service and leadership in public sector psychiatry.

Directly out of his residency at Dartmouth in 1988, Dr. Reinhard entered work in the public sector as Director of the Forensic Psychiatry Services for New Hampshire. After his Fellowship at Harvard's Program in Psychiatry and Law, he was simultaneously Director of a Forensic Evaluation program in New Hampshire and Director of inpatient psychiatry for the Department of Veterans Affairs in Vermont.

In 1994, he was recruited by Virginia to be the Medical Director of Catawba State Hospital and then in 1998, he simultaneously served as Catawba's Executive Director. In August 2001, he was appointed Assistant Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services under Governor Gilmore. Governor Warner promoted him to Commissioner and, because he was so successful and respected in that position, Governor Kaine reappointed him as Commissioner until January 2010.

During his tenure of over eight years, Dr. Reinhard led a department of over 9,000 employees and an annual budget of approximately 1 billion dollars. With increasingly limited resources, he attempted to keep the focus of his department on the long-range needs of people with mental illness and

has been an advocate for a variety of enhanced community services and for mental health recovery.

Prior to Dr. Reinhard's appointment as Commissioner, it had been many years since a psychiatrist had led the Department. Mental health advocates throughout the state developed great respect for Dr. Reinhard's leadership, approachability, humility, strength of character, calmness and compassion. During his tenure, he very positively enhanced the image and role of psychiatrists. Our leadership has been enhanced both in the state hospitals and the forty community services boards, as well.

During these years of service in the public sector of psychiatry, Dr. Reinhard actively participated with his wife of 30 years in raising five children. One has graduated from college, three are currently in college and one is still at home.

The PSV wanted to honor Dr. Reinhard and thank him for his leadership in the field of public psychiatry and for his advocacy for our fellow citizens with mental illnesses.

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# WELCOME TO OUR NEW MEMBERS

## DISTINGUISHED FELLOW

Anthony J. Thornton, MD .....Hardy, VA

## FELLOW

Madhu Bhatia, MD .....Sterling, VA

## GENERAL MEMBERS

Jessica Addison, MD .....McLean, VA

Tuesday E. Burns, MD ..... Norfolk, VA

Eve S. Fields, MD ..... Vienna, VA

Stephanie M. Gabathuler, MD ..... Richmond, VA

Charlotte Hagan, MD .....Fincastle, VA

Neema Hardeman, MD ..... Vienna, VA

Willis Leavitt, MD .....Arlington, VA

Bruce M. Lovelace IV, MD .....Portsmouth, VA

Robert G. Marietta, MD .....Chesapeake, VA

Benjamin G. Pumphrey, MD ..... Lexington, VA

Anuradha Reddy, MD, MPH.....Roanoke, VA

Cynthia M. Shappell, MD ..... Lorton, VA

Snezana Sonje, MD .....Henrico, VA

Devi Vasu, MD.....Madison, MS

Lyndy Wilcox, MD ..... Norfolk, VA

## MEMBERS IN TRAINING

Christine P. Baker, MD ..... Richmond, VA

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Sanjeev Kumar, MD .....Roanoke, VA

Abigail J. Mansfield, MD ..... Norfolk, VA

Jessica Mees-Campbell, MD .....Poquoson, VA

Anjela Rahimova, MD, MPH.....Roanoke, VA

Taral Sharma, MD, MBA .....Roanoke, VA

Jennifer Sokol, DO, MPH ..... Richmond, VA

Reena Thomas, MD.....Roanoke, VA

Amanda J. Winters, MD.....Charlottesville, VA

## STUDENTS

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Jordan B. Schooler..... Richmond, VA

Alpana Senapati ..... Blacksburg, VA

Jerome H. Taylor, Jr. .... Decatur, GA

Kasia Trebska-McGowan..... Fredericksburg, VA

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# HEALTH REFORM SPECIAL REPORT

## HEALTH REFORM'S IMPACT ON PSYCHIATRISTS AND PATIENTS

On March 23, President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) into law as Public Law 111-148. Congress also passed separate "reconciliation" legislation -- the Health Care Education Affordability Reconciliation Act (H.R. 4872) -- on March 25, which changes some provisions of PL 111-148. Enactment of the two bills completes more than a yearlong debate on comprehensive health reform, and will have far-reaching effects on both patients and psychiatrists and other physicians.

No legislation is perfect and PL 111-148 is no exception. APA is committed to seeking changes in the law where needed (such as repealing the establishment of an appointed payment advisory board that could require mandatory Medicare cuts). On balance, however, the law includes numerous positive features for psychiatrists and particularly for patients. Above all else, the law will ensure that virtually all Americans will have comprehensive health insurance coverage that includes coverage for treatment of mental illness including substance use disorders (SUD), and that individuals may not be excluded due to pre-existing conditions or dropped because of their health status.

Here is how the new law may affect APA members and their patients:

# = APA supported/lobbied for  
@ = APA opposed/lobbied against

### KEY MENTAL HEALTH PROVISIONS IN REFORM

- Five percent temporary increase in payment for mental health services: For 2010, Medicare will increase payment for psychotherapy services by five percent. This is an extension of the same "bump" for part of 2008 and all of 2009 that expired on January 1, 2010. #
- Essential Benefits Package: Includes mental health and SUD treatment in the required essential benefits package offered in the state exchanges. #
- Parity for Mental Health and SUD Treatment: Requires mental health and SUD benefits to be offered at "parity" with other medical and surgical benefits for all insurance plans sold within the health insurance exchanges that are created under the new law. The exchanges are designed to be a competitive marketplace for individuals and small employers to shop for health insurance. #
- Support, education, and research for postpartum depression: Provides support services like screening to women suffering from postpartum depression and psychosis and also helps educate mothers and their families about these conditions. Provides support for research into the causes, diagnoses, and treatments of postpartum depression and psychosis. #
- Co-locating primary and specialty care in community-based mental health settings: Authorizes \$50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings. #
- Centers of Excellence for Depression: Directs the Administrator of the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders starting in fiscal year 2011. #
- Medicaid Emergency Psychiatric Demonstration Project: Requires the Secretary of Health and Human Services to establish a three-year Medicaid demonstration project in up to eight states. Participating states would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition under the hospital anti-dumping law known as EMTALA. #
- Community Mental Health Centers: Increases funding for community mental health centers. #

## IMPACT ON PSYCHIATRISTS AND OTHER PHYSICIANS

### MEDICARE

- Geographic payment differentials: Re-establishes in 2010, the now-expired national average "floor" on Medicare's geographic payment adjustment (commonly known as the GPCI) for physician work. In 2010 and 2011, Medicare will make a separate adjustment for the practice expense portion of physician payments that will benefit physicians including psychiatrists in rural and low cost areas. Physicians in 51 localities in 42 states, Puerto Rico and the Virgin Islands will benefit from the two practice expense adjustments.
- Medicare shared savings program: Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient cohorts over time. ACOs can include groups of health care professionals and providers (such as physician groups, hospitals, nurse practitioners, physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.
- Physician Quality Reporting Initiative: Requires all physicians participating in Medicare to report performance measures. Starting in 2015, physicians who fail to report successfully will be penalized 1.5 percent. APA opposes the penalty and successfully lobbied to have it pushed from 2013 to 2015. @
- Independent Payment Advisory Board: Establishes an "IPAB" to recommend changes in Medicare payment policy. If spending exceeds target, IPAB would recommend reductions to achieve the target; Congress would have to intervene to stop such reductions. APA opposes the IPAB. @



## MEDICAID

- Health Home: This state option to provide health homes for enrollees with chronic conditions now includes an APA-lobbied coverage of individuals with a persistent and serious mental illness. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination. #
- Demonstration project to evaluate integrated care around a hospitalization: Establishes a demonstration project, in up to eight states, to study the use of bundled payments for hospital and physicians services under Medicaid.

## HEALTH INFORMATION TECHNOLOGY

- Health Information Technology: Beginning in 2013, health insurance plans must implement uniform standards for electronic exchange of health information to reduce paperwork and administrative costs.

## WORKFORCE

- Federally supported student loan funds: Eases current criteria for schools and students to qualify for loans, shortens payback periods, and decreases the non-compliance provision to make the primary care student loan program more attractive to medical students.
- Health care workforce loan repayment programs: Establishes a loan repayment program for pediatric subspecialists and also includes APA-supported language covering providers of mental and behavioral health services to children and adolescents who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population. #
- Funding for National Health Service Corps: Increases and extends the authorization of appropriations for the National Health Service Corps scholarship and loan repayment program for FY10-15. #
- Mental and behavioral health education and training grants: Awards grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health (including APA-supported coverage of child and adolescent psychiatrists), and pre-service or in-service training to paraprofessionals in child and adolescent mental health. #

## IMPACT ON PATIENTS

### PRIVATE INSURANCE REFORMS

- State-based exchanges: Beginning in 2014, health insurance exchanges will open in each state for individuals and small employers to shop for standardized health packages.
- High-risk pools: Establishes high-risk pools in 2010 to cover adults with pre-existing conditions. This will end when the health care exchanges are in place.
- Individual coverage mandate: Requires virtually all Americans to have health insurance, with significant subsidies for those with lower incomes.

- Employer coverage mandate: Beginning in 2014, companies with 50 or more employees must offer coverage to employees or pay a penalty after their first 50 employees.
- No lifetime or annual limits: Prohibits plans from establishing lifetime limits, and annual limits beginning in 2014, on the dollar value of benefits. Prior to 2014, plans may only establish restricted annual limits as defined by the Secretary of HHS, ensuring access to needed services with minimal impact on premiums.
- Prohibition of pre-existing condition exclusions or other discrimination based on health status: No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past. #
- Extension of dependent coverage: Requires all plans offering dependent coverage to allow unmarried individuals until age 26 to remain on their parents' health insurance.
- Immediate access to insurance for people with a pre-existing condition: Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. #
- Preventive Care: All plans must provide preventive care without deductibles and co-payments by 2018.

## MEDICAID CHANGES

- Expanded Medicaid: Medicaid eligibility increases to 133% of poverty, with 100% federal funding to all states for newly eligible Medicaid recipients for three years. Provides additional federal matching funds to states that already cover childless adults in their Medicaid programs. Eligible individuals include all non-elderly, non-pregnant individuals who are not entitled to Medicare. #
- Medicaid coverage for former foster care children: Beginning in 2014, causes the state option to cover former foster children in Medicaid to become mandatory. Limits such coverage to children who have "aged out" of the foster care system as of the date of enactment.
- Primary Care Payments: Requires states to pay for primary care services at the Medicare rate. APA is seeking inclusion of psychiatrists. #

## CHANGES IN PRESCRIPTION DRUG COVERAGE UNDER MEDICARE AND MEDICAID

- Closing the Medicare doughnut hole: Medicare patients whose prescription expenses reach the so-called Medicare Part D coverage "doughnut hole" (\$2,700 to \$6,150) in 2010 will receive a \$250 rebate. During the next 10 years, the beneficiary co-insurance rate for this coverage gap will be narrowed in phases from the current 100 percent to 25 percent in 2020.
- Elimination of exclusion of coverage of certain drugs under Medicaid: Beginning with drugs dispensed on January 1, 2014, smoking cessation drugs, barbiturates, and benzodiazepines would be removed from Medicaid's excludable drug list. #

# APA AREA V COUNCIL MEETING

## ATLANTA, GA MARCH 20-21, 2010

The Area V Council of the APA met in Atlanta, GA on March 20-21, 2010. It was chaired by John Gaston, MD. The discussion was very intense and the council covered many issues:

1. Scope of Practice. The discussion centered around the fact that Nurse Practitioners are trying to, and have succeeded in some states, in getting permission to use medications without supervision from physicians and are also allowed to use narcotics for treatment of pain. The latest attempt is by LCPs who are asking for capacity to diagnose and treat mental illness and suggest treatment for developmental disabilities 'without the use of medications.' It is axiomatic that the prescription will be the next step (My comment).
2. The discussion of the 'Applebaum Report' which originally, was supposed to be a guideline as to the relationship between psychiatrists and the pharmaceutical industry...was long and prolonged. It is going to be discussed in detail in the next Assembly session in New Orleans, LA.
3. The Work Group Report on the reorganization of APA structure was delivered by Helen Davis, MD, Area V Board member and by Anne Sullivan, MD, recorder of the Assembly. Many suggestions were made as to make APA more effective and to have a closer relationship with the rank and file of the psychiatric physicians.
4. Area V is considering a mentoring program for all newcomers to the Assembly and has recommended mentoring of new Residents and has recommended that the DBs extend mentoring to new practitioners, too.
5. Finances are more stable and 2009 saw a surplus of about \$3 million in savings after cutting staff numbers and benefits and reducing the length of APA meetings.

### A Message from the Editor

*Continued from page 2*

public of places.

Huremovic suggested talking to the patient about it at the onset of treatment and suggests it may be an interesting point in therapy.

Geoffrey Neimark, another psychiatrist referred to in the article, asked, "What about other potentially useful, although perhaps more controversial, sources of information on the Internet? Many states now have websites that list parole absconders and wanted fugitives and offer online registries of sex offenders. In addition, elements of patients' financial, criminal, and civil histories can be obtained on the Internet. What, if any, role could and should this sort of information have in clinical evaluations, and what are the ethics of this?"

I can readily imagine a time when we will be held medically-legally accountable for information we did not know, but

could have found on the internet. The nightmare hypothetical of "you discharged a known pedophile to a boarding home right next to a middle school. Dr Stack, why did you put those children at risk?"

This week the *Psychiatric Times* Resident's Corner had an article by Gonzalo J. Perez-Garcia, MD, who wrote about another perspective. April 2010, vol. XXVII, no. 4, p. 8. He had a blog in Medical School and was contacted by a person getting psychiatric care from someone else. This person began to post comments on his blog. Dr. Perez-Garcia began to censor the posts and was met with anger, then pleading. His blog was commented on when he went to a residency interview. He addressed his use of Facebook and how it is transforming communication and social interaction. He gave the example of a remembrance wall for those grieving a loss. The idea of processing major life events in this way is foreign to me, but will be part of the normal life experience of some of my patients and peers. I have received emails from other psychiatrists I know only professionally inviting me to "check them out on Facebook." I assume this is not an isolated situation.

I wonder if there will be a time that the Internet will replace the phone book. No wait, I think that may have already happened!

The process of preparing this article has helped me to realize that I will have to become more familiar with new social networking systems. I am nowhere near having a Facebook page, but I have tried out a new technology. I used Skype to communicate with a family member who was out of the country. I marveled at the ability to see and talk to someone who could see and talk to me while they were in Europe. The most amazing part was I did not have to buy anything or pay a fee. (If you are not familiar with this program, think of the Jettsons cartoon from our youth where you could see the person you were talking to on the phone. Yes it is real. I am now hoping for Rosie the Robot to clean up my house.)

As soon as I tried it, I began to think of possible clinical applications of this technology. I can imagine a time when a patient will sign on to the free live image and voice system during their scheduled appointment from anywhere in the world or just from their home. This would solve transportation problems and make keeping appointments easier for those who cannot travel due to health concerns or preferences. I also recognize the limits of confidentiality up to and including seeing the session posted on YouTube later that day. The most unsettling part for me is that it could also happen intentionally. They just wanted others' opinions on the session.

In the particular area of technology, things seem to change at a rate so rapid that I cannot even determine if I am asking the correct questions. The degrees of use and self disclosure vary wildly for professionals and patients. I have yet to fully formulate a rationale for my actions. I would welcome the thoughts of other PSV members to include in a future issue of the newsletter.

# 2010 GENERAL ASSEMBLY UPDATE

Contact PSV Advocacy Coordinator Cal Whitehead for additional information on any of the items in this update at [cwhitehead@whiteheadconsulting.net](mailto:cwhitehead@whiteheadconsulting.net) or (804) 389-2825.

## BUDGET

- Only needing one extra day, the General Assembly approved and sent a \$70 billion biennial budget to Governor Bob McDonnell. The budget closes a \$4 billion deficit.
- Includes a three percent Medicaid provider cut in fiscal year (FY) 2011 and four percent in FY 2012. The proposed cuts would apply to physicians, hospitals, nursing homes, dentists and other providers.
- These cuts will be avoided if federal Medicaid funding is approved by Congress as expected.
- Does not include cuts to managed care organizations that serve Medicaid enrollees – those cuts would have certainly been passed on to physicians and other providers.
- Restored funding for the Commonwealth Center for Children & Adolescents, a state operated acute mental health facility in Staunton.
- Maintained an open access exemption for psychiatric medications from Medicaid “preferred drug list.”
- Restored some “safety net” funding for community health centers, free clinics, and the Virginia Health Care Foundation.
- Found \$4 million of savings from administrative cuts.
- Governor McDonnell may amend the budget before the General Assembly returns on April 21 for “Veto Session.”

## MENTAL HEALTH SYSTEM REFORM LEGISLATION

- HB 248 - Kilgore - SB 65 – Lucas Psychiatric treatment; revises Psychiatric Inpatient Treatment of Minors Act.
- HB 729 - Albo – Involuntary admission; allows court to enter an order for mandatory outpatient treatment following.
- SB 63 - Lucas – Reduces from 30 to 10 days the length of time for a person to appeal to circuit court an order for involuntarily commitment, mandatory outpatient treatment, or certification for admission to a training center. The bill also provides that an appeal does not operate to suspend any such order unless so ordered by a judge or special justice and provides that an order of the circuit court shall not extend the duration of involuntary admission or mandatory outpatient treatment set forth in the order appealed from.

## BILLS IMPACTING PHYSICIANS AND HEALTHCARE DELIVERY

- HB 11 - Marshall, R.G. – Peer Review. Intended to expedite the appeal process for peer utilization reviews on reconsideration of an adverse decision by a health insurer.
- HB 150 - O'Bannon – Authorizes community services boards, behavioral health authorities, and clinics established by the Virginia Department of Health or local health departments to receive, store, retain, and repack-age prescription drug orders dispensed to a patient for the purpose of assisting a client with self-administration of the drug.
- HB 153 - O'Bannon – Advertising of “physical therapy” is prohibited if not provided by a licensed physical therapist or assistant.
- HB 174 - Cox, M.K. – Veterans Services; eliminates requirement that Wounded Warrior Program cover only combat injuries.
- SB 675 - Wampler – Mandated coverage for telemedicine services.
- SB 538 - Newman – DBHDS to require presence of a physician in any state training center.

## FAILED OR CARRIED OVER BILLS

- SB 263 - Whipple - Nurse Practitioners; moves responsibility for licensure and regulation to the Board of Nursing and would have ended the supervisory role of physicians.
- Several bills to mandate insurance coverage for autism and related disorders.
- A study to establish temporary licensure for naturopaths to provider health counseling on preventive methods.

## 2010 ISSUES AND OPPORTUNITIES TO REPRESENT PSV

- DBHDS planning process for children’s mental health services
  - o Need volunteers to provide input
  - o Report to General Assembly in October and final report November 2011
- Voices “Campaign for Children’s Mental Health.” [www.1in5kids.org](http://www.1in5kids.org)
  - o Bela Sood and Wesley Carter
- Medical Society of Virginia (MSV) Legislative Summit on May 12.



# PSYCHOTROPIC MEDICATIONS, INSOMNIA AND ADDICTION

by Kathleen P. Decker, MD

Brace yourself - this is going to be a discussion of a controversial subject! I have been musing about the difficulty of obtaining good research data on one of the most common medical complaints in history – non-habit forming agents to treat insomnia. There is a plethora of studies utilizing benzodiazepines, partial benzodiazepine agonists, and expensive new sedative-hypnotics to deal with both short-term and prolonged insomnia. Studies have been conducted on normal volunteers, medical patients, psychiatric patients and just about anyone that complains of insomnia. In fact, there are now studies completed on the Internet on insomnia where the investigator never even meets the patient!<sup>1</sup> So, what's missing from the research literature and why do people still suffer from insomnia? For one thing, it is a symptom of anxiety disorders, mood disorders, psychosis, as well as multiple medical problems. In fact, a recent study out of the Netherlands suggests that insomnia persists in patients with depression or anxiety even after the affective or anxiety condition remits.<sup>2</sup>

What's missing is simple. Well-designed, randomized controlled trials of non-habit-forming medications to deal with insomnia are rare. I don't pretend that I caught them all, but there are fewer than 20 total studies on the use of Trazodone for insomnia that I can find in *PubMed* over a 25-year period, two of which were reviews. Meanwhile, it has been used off-label for insomnia for more than 20 years. It is not habit-forming and, because of that, many psychiatrists like me would far prefer to prescribe it than Benzodiazepines or even the partial Benzodiazepine agonists like Zolpidem, which clearly has addiction potential. In fact, a recent study in West Virginia shows it is the second most popular prescription sleep remedy (after benzodiazepines).<sup>3</sup> Yet if I were to use literature to justify this use, there is precious little and it's an off-label use, even after all these years. Before it, Amitriptyline was used for insomnia (and still is by some physicians) which has utility in chronic pain and insomnia but has much more serious side effects, including overdose, so psychiatrists use Trazodone, also a sedating antidepressant, but more tolerable in overdose and less cardiotoxic.

Off-label use is ok, but some physicians worry about malpractice exposure, so they will use an FDA-approved medication such as a Benzodiazepine (which might be habit-forming), instead of a well-known medication for which there is no FDA indication. YIKES! Think about that...who would prescribe a drug with known abuse potential rather than one without? And why do we have more habit-forming medications for insomnia approved by the FDA than non-habit-forming ones? As a psychiatrist who spends most of her time getting people OFF addicting substances, I really get annoyed with physicians who put patients ON them.

Why, then, is it so difficult to find controlled studies on the use of Trazodone or other antidepressant in insomnia? I

think it's the elephant in the room. I dislike putting it in print, but I have to suggest that in large part it is due to economics...pharmaceutical companies make far more money off habit-forming drugs for insomnia such as Benzodiazepines or newly designed hypnotics, (e.g. partial benzo agonists) than Trazodone or other non-habit-forming approaches. Trazodone is already generic and already FDA-approved for depression, so what pharmaceutical company wants to put in the money to do randomized, controlled trials of Trazodone for insomnia when physicians can just use it off-label? And if there's no funding, no speaking engagements and lots of work, why should academic psychiatrists do drug trials on an old medicine rather than doing trials on a sexy new Benzodiazepine or partial Benzo agonist for which they will get successful funding and support from pharmaceutical companies? Another study topic I found almost (ALMOST) humorous – a synthetic Cannabinoid was tested versus Amitriptyline for insomnia, because patients have reported that marijuana helps with sleep. What's wrong with people? Why should we develop synthetic Cannabinoids for insomnia treatment? Don't we have enough trouble with addiction to the natural Cannabinoids? Perhaps I'll eat my hat one day, but I think they're really on the wrong track with that one.

I only hope that Gabapentin, which some psychiatrists (including me) use as a new non-habit-forming approach to insomnia,<sup>4</sup> does not suffer the same fate as Trazodone, research-wise. Medications like Gabapentin which might treat both chronic pain and insomnia and which, to date, have shown no addiction potential, are not metabolized in the liver and have very few side effects and may become very useful in treating insomnia. Pregabalin has even better press for use in chronic pain, but I haven't tried it for insomnia treatment and was able to find only one literature report on its use for treatment of insomnia. That one was for patients with Generalized Anxiety Disorder and insomnia and it improved both anxiety and insomnia symptoms.<sup>6</sup> That's where I think we should really push research forward.

So, let's get some more hard-core, well-designed research to put Benzodiazepines, Cannabinoids and ANY OTHER habit-forming alternative OUT of the insomnia business. Insomnia is too prevalent, addiction is too prevalent, and the cost of both insomnia and addiction is enormous. For physicians in pure academic research jobs or for pharmaceutical researchers, here are some (FREE) specific research questions. First, let's get some more randomized, controlled trials of Trazodone vs. Gabapentin or Pregabalin in acute and chronic insomnia. There's only one trial of Trazodone vs. Gabapentin and it was open-label, but it's intriguing and caused me to rethink my practice. They found less morning grogginess with Gabapentin than Trazodone and both were effective at sleep induction<sup>4</sup> (600-1200 mg qhs of gabapentin). I began to switch people to Gabapentin and have been delighted with it. It also treats some chronic pain and one can then wonder if reducing the chronic pain was part of the insomnia problem (chicken or egg?), but both get better (in my clinical experience).

Let's get some MORE trials with EEG recordings and sleep efficiency, etc! Let's not just ask people if they sleep

better, but carefully obtain objective effects on sleep induction, maintenance and architecture. This makes the study more expensive and certainly much more difficult to conduct than a sleep survey, but people are notoriously unreliable in their sleep perceptions, so objective (and including subjective) data is critical to the analysis. Sleep surveys should only be adjuncts to studies of sleep architecture, not the major criterion of insomnia treatment. And I can think of many problems with self-report of insomnia in internet-based trials. Other trials badly needed are randomized, controlled trials of Gabapentin and Pregabalin vs. Benzodiazepines<sup>6</sup> or partial Benzodiazepine agonists in the treatment of acute insomnia and chronic insomnia. If patients need long-term (greater than 2-4 weeks) treatment of insomnia, there really should be no argument for Benzodiazepines or partial Benzo agonists. There are cogent arguments against their use, including the relative lack of education of primary care doctors in the US and several other countries in which there is supposed to be a 2-4 week insomnia treatment window.<sup>6-8</sup> Remember, NO Benzodiazepine is FDA-approved for long-term treatment of insomnia. Stick to the 2-4 week window (if you can) and if you can't, you're part of the problem and you're also using it off-label so you have even less justification than if you use Trazodone, which is off-label but with no known abuse potential in long-term use! Hopefully, medications like Gabapentin or Pregabalin will provide similar low addiction potential solutions. Let's prove it!

So let's use our collective intellectual, medical and political weight to encourage pharmaceutical companies and academic physicians to do research on the RIGHT kind of solutions for insomnia, rather than continuing to support research on medications that have high addiction potential but may be easy choices from the 20th century. For pharmaceutical companies, research is great and you have the power, money and even financial incentives to do it, especially since federal funding for research continues to decrease. Let's work together to step up development of NON-habit-forming sleep remedies. Your company will still make a mint in the long run and who knows what other uses such drugs will have. But JABs (Just Another Benzodiazepine) really don't deserve to be developed or pushed now that we understand how damaging they are. There is too much substance abuse already. The socially responsible thing for both pharmaceutical companies and physicians to do is to recognize that patients very rarely adhere to 2-4 week use of habit-forming medications, so we need to encourage them to get treatment for the underlying medical or psychiatric disorder immediately and/or start them on non-habit-forming medications when they first present to the physician, instead of starting them on potentially habit-forming medications while it's being sorted out.

**DISCLAIMER:** Neither the author nor the above column was sponsored by any pharmaceutical companies nor is she on any speaker's bureau lists at the current time. The column represents the author's opinion, based on clinical practice, literature review and research interests.

*References on page 15*

## A Message from the Incoming President

*Continued from page 1*

Society of Virginia, our Legislators and, most importantly, the community at large. When we give our time to teach and mentor students and residents and participate in support programs such as the annual Resident Scientific Program, we are fostering the science and progress of psychiatry. When we join organizations such as NAMI, give our time in community events, serve on the Board of community organizations involved in mental health concerns, volunteer at free clinics, give presentations at schools or community events, or participate on media events, we are making a positive contribution to our communities. We can promote advocacy and ethical care for the mentally ill by making monetary donations to our Political Action Committee or joining other organizations such as the Virginia Health Alliance. Lastly, to be truly relevant to our members, we must network and promote membership as a powerful tool to reach our goals.

As President-Elect, I hit the ground running with the help of the PSV Planning Committee. Our Spring Meeting entitled, *Get off the Couch: Integration of Mental Health Services in Non-Traditional Settings*, was a success.

The meeting opened with our Board meeting on Friday afternoon. The meeting was well attended and various pertinent topics were discussed. The Board is strongly encouraging all Chapter Presidents or their designees to attend Board Meetings since all Chapter Presidents are voting members.

Directly following the Board meeting, we moved to our Reception with exhibitors and area legislators. The informal, but warm, atmosphere lent itself to the heartfelt recognition of legislators and individuals who have impacted and shaped the delivery of mental health care in the state of Virginia. We recognized Dr. James Stewart, Interim Commissioner of Mental Health and the former Commissioner of Mental Health, Dr. James Reinhardt and Mira Signer, Executive Director of the Virginia Chapter of the National Alliance for the Mentally Ill. The highlight of the evening was a surprise award given to Cal Whitehead for his dedication and outstanding guidance as our lobbyist. He was recognized with emphasis on his successful efforts in squashing Psychologist prescribing at the level of the Joint Commission for Health Care. Ms. Kim Snead from the Committee was at the reception. Cal was clearly surprised and humbled by the award. He proceeded to introduce Dr. Ram Shenoy, who presented Representative Roselyn Dance with The Legislator of the Year Award. Ms. Dance, a former RN at Central State Hospital, has a keen understanding of mental health issues. Her clinical expertise and wisdom have been a guiding force in the legislature when grappling with mental health concerns. She was thankful and moved by the recognition. Representative Joe Morrissey was also present and spoke favorably of mental health practitioners and the needs of the Commonwealth in regard to mental health. The evening was capped off by networking with exhibitors and friends. A workshop on financial planning and a dinner by Eli Lilly were offered

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## A Message from the Incoming President

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to interested guests.

The morning session was opened by our President, J. Edwin Nieves, MD, DFAPA. We were then offered snapshots of the integration of psychiatric services in the Pediatric, Veterans' Administration and Palliative Care Settings. A. Bella Sood, MHSA, FAACAP, outlined her vision of the integration of pediatric and psychiatric services. Her thorough presentation entitled, *Integration of Psychiatric Services in the Pediatric Setting*, delineated both the benefits and challenges of such a model. Dr. Robert K. Schneider, Chief of Psychiatry at McGuire Veteran's Medical Center, followed with a talk entitled, *Integration of Mental Services for Veterans in the Primary Care Setting*. Boarded in both Internal Medicine and Psychiatry, he has been a champion of an integrated model. He defined the models of delivery in an integrated system and offered a view of the Veteran's Administration's vision. Another Veteran Administration integrated system of care was presented by Jorge Cortina, MD, DFAPA. *Integration of Psychiatric Services in the Palliative Care Setting* which was both moving and informative. A video clip of a veteran grappling with end of life issues illustrated the value of psychiatric services to this population. All three talks led to a lively and thought provoking panel discussion.

The afternoon speakers illustrated my theme of integration of disciplines into the Society. Nurse Practitioners, Steven Carter and James Poindexter and Psychologist, Jennifer Cameron, all from McGuire Veteran's Administration Medical Center presented. The audience was engaged in the talks by James Poindexter, entitled *Medication and Psychosocial Modalities for the Treatment of Opioid Dependence in Veterans with Substance Use Disorder* and by Steven Carter, NP and Jennifer Cameron, PhD, entitled, *Pain Management and Substance Abuse*. Participants stayed past the allotted time to glean information and engage in Q&A.

This meeting was packed with opportunities to gain information and learn new skills. The PSV offered media training to participants with emphasis on training individuals from the various regions in the Commonwealth. Integration of psychiatry into the mainstream media is a topical challenge given the advances in media technology of this century. Megan Rowe and Alben Foreman-Trice, MMA, offered *Media Training for Medical Professionals*. This unique opportunity gave participants a didactic, as well as a rare, opportunity to step in front of a camera to participate in a mock television interview. Participants were presented a scenario and then joined in a mock television interview. Immediate feedback revealed that this was quite challenging, but the workshop left participants feeling better prepared if their services were needed. The PSV Planning Committee endorsed the workshop, since our expertise is often requested by the public and the media seeks us out to comment on areas of interest such as the Virginia Tech tragedy. The PSV wants to be prepared for these occasions with "trained" clinicians whenever possible.

The upcoming Fall Meeting and Resident Scientific Program entitled: *Get the Word Out: Challenges and Innovations of a New Decade in Mental Health Care* promises to be even more stimulating. The meeting will be held on Saturday, September

11, 2010, from 8:00 am to 3:45 pm. The focuses will be areas in which the Society has identified as key to the psychiatric community in the upcoming years. These areas include:

- Responding to global disasters that affect various cultures and ethnicities outside of the US, such as the earthquakes in Haiti and in Chile. Knowing that minority populations are disproportionately negatively affected, have we learned anything from Hurricane Katrina?
- Understanding our responsibility and goals for recruitment, teaching and retention of trainees and provision of continuing education for practicing psychiatrists. This is topical for rural areas where there is a shortage of psychiatrists. Scope of practice issues are on the horizon for many states as to whether other allied health professionals could better meet this need.
- Understand the Resident, Residency Training Director's and early career psychiatrists' viewpoints on education. A panel of discussants will be formed to give participants an understanding of the current experience of these professionals.
- Innovations in technology, such as telemedicine, are becoming more relevant across many sectors of practice. Could this technological innovation be the answer to rural communities and help with shortages of psychiatrists? Would scope of practice discussions be impacted? The Membership would like to review advances and challenges of telemedicine with a keynote speaker and a panel.
- Innovation in pharmacology and neurosciences are spawning not only new medications and medication delivery systems, but also new devices such as transcranial magnetic stimulation. The membership would like an overview of the direction we might be going in the new decade.

The Planning Committee is already hard at work recruiting the following presenters for the topics. They include Dr. Annette Primm, Director of the Office of Minority Affairs of the APA, Dr. James Scully, Executive Director of the APA, Dr. Tony Graham, MD and Dr. Varun Choudhary as experts in telemedicine; a Resident Panel, consisting of an Early Career Psychiatrist and Residents in various levels of training, and Dr. Anand Pandurangi, MD, DFAPA, as an expert in neuroscience.

In addition, we are encouraging all members to begin preparation for our Resident Scientific Program. This event has been a huge success. Residents have given positive feedback for the unique opportunity and learning experience in presenting a poster presentation while still in Residency. Their efforts are financially supported by the Psychiatric Foundation. All providers are encouraged to assist a resident in a small Research project. There have been approximately 20 entries since inception of the program.

Again, I look forward to working with the membership. We cannot afford to work in isolation on the myriad issues surrounding the delivery of mental health care. We all need to integrate ourselves with our peers, colleagues, other disciplines and the community as we go forward on this journey to reach the goals of the PSV.

The world is dynamic and changing. The field of psychiatry is as well. To keep up with the changing times and the multitude of issues, we need each other. *Let's Get off the Couch* and take action! Let's *Get the Word Out* about who we are and what we are about!



# PLAN NOW!



## 2010 PSV Fall Meeting GET THE WORD OUT!

Innovations & Challenges of a New Decade in Mental Health Care

**September 10-11, 2010**

Colonial Williamsburg Woodlands Hotel & Suites • Williamsburg, VA



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## PSYCHOTROPIC MEDICATIONS, INSOMNIA AND ADDICTION

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# 2010 PSV Fall Meeting **GET THE WORD OUT!**

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**ABSTRACT DEADLINE: AUGUST 20, 2010**

Submit your abstracts to [psv@psva.org](mailto:psv@psva.org)

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