



DEI Task Force
Member Spotlight
APA District Branch Report
OKCAPMAP
Annual CME Meeting ... and more

OFFICERS

PRESIDENT

Britta K. Ostermeyer, MD

PRESIDENT-ELECT

Tessa Manning, MD

VICE PRESIDENT

Robyn Cowperthwaite, MD

SECRETARY

Rachel Dalthorp, MD

TREASURER

Jed Perdue, MD

PARLIAMENTARIAN

Shree Vinekar, MD

APA ASSEMBLY DELEGATES

Harold Ginzburg, MD

Shree Vinekar, MD

1ST COUNCILOR

Shannon Thomas, DO

2ND COUNCILOR

Jason Beaman, DO

3RD COUNCILOR

Harold Ginzburg, MD

COUNCILORS

Melanie Barrett, MD

Tiffany Bartel, DO

Jenny Boyer, MD

Masooda Burki, MD

J. Bryan Cates, DO

Gabriel Cuka, MD

Hashib Faruque, MD

Heather Geis, MD

Jay Lensgraf, MD

Joseph Michie, MD

Haiwang Tang, MD

Ashley Walker, MD

Diversity, Equity, and Inclusion Task Force

Update on OPPA's DEI Task Force

In the fall of 2021, the OPPA Executive Council began discussions on the APA's ongoing work to address concerns of racism and inequity within the organization and how these efforts could also benefit our district branch.

The OPPA DEI Task Force was formed in the fall of 2021 to study and implement strategies to improve organizational policies, promote awareness, and provide a forum to openly address concerns that may arise from our members or community regarding issues of diversity, equity, or inclusion.

Mission Statement:

- Develop programs and resources to bring awareness to and support the needs of evolving, diverse, and underserved patient populations in Oklahoma.
- Implement strategies to enrich a diverse representation of psychiatrists in Oklahoma and within the OPPA, to reflect the unique, cultural richness of our state.
- Provide an open forum to address issues related to diversity, equity, or inclusion that may arise from OPPA members or the community.
- Encourage the OPPA to foster connections across multiple medical sectors to end mental health inequities.

The DEI Task force is an open forum and continues to seek involvement from all OPPA members, including residents and medical students. For more information, click [here](#) to email OPPA.

In the fall of 2021, members of the OPPA Executive Council began to discuss the APA's ongoing work to address concerns of racism and inequity within the organization and how these efforts could also benefit our district branch. This discussion prompted the creation of the OPPA DEI Task Force to study and implement strategies to improve organizational policies, promote awareness, and provide a forum to openly address concerns that may arise from our members or community regarding issues of diversity, equity, or inclusion.



The Task Force immediately began their work by looking at OPPA's organizational mission, bylaws, and policies through a DEI lens. Since then, the task force members have met regularly and made several recommendations for organizational improvement to the Executive Council. One of the first tasks the DEI committee accomplished was to create a mission statement that represents the OPPA's vision to bring awareness to and support the needs of diverse, underrepresented, and underserved patient populations in Oklahoma.

Continued on page 2 >>>

UPCOMING EVENTS

APRIL 29: OPPA Annual CME
Webinar – [REGISTER HERE!](#)

MAY 13: 10:00-12:00
All Members Meeting and Awards

DEI Task Force

continued from page 1 >>>

Oklahoma Psychiatric Physicians Association Mission Statement (Previous). The Oklahoma Psychiatric Physicians Association, a district branch of the American Psychiatric Association, is a medical specialty society recognized world-wide. Our member physicians specialize in the diagnosis and treatment of mental and emotional illnesses and substance abuse disorders.

Oklahoma Psychiatric Physicians Association Mission Statement (New). The Oklahoma Psychiatric Physicians Association (OPPA), a district branch of the American Psychiatric Association, is dedicated to meeting the professional needs of its members and promoting quality treatment and prevention of mental illness and substance use disorders. In performing these functions, members of the OPPA are mindful of the unique history and cultural diversity of Oklahoma, and the influence of social determinants on health and outcomes. We aspire to model and support: sensitivity and compassion for patients and their families; advocacy for mental health access and equity; promotion of diversity and inclusion; advancement and representation of the profession of psychiatry; lifelong professional learning; and the highest standards of professional conduct.

Other implemented recommendations include changing the OPPA logo, updating the annual medical student award requirements and title, encouraging leadership participation from members of marginalized and underrepresented groups, updating district branch bylaws with inclusive language, partnering with organizations monitoring legislation that affects the mental health and delivery of care to groups facing discrimination, introducing DEI topics in CME meetings, and encouraging the invitation of CME speakers from diverse backgrounds. Most recently, the Task Force has authored a position statement against legislation that seeks to ban gender affirming care and criminalize physicians that provide and refer patients for this care. Current and future projects include improving equity of CME speaker honoraria payments, improving inclusion of general membership in forming positions on Oklahoma legislative topics, and developing a DEI framework for evaluating our organizational policies and programs.

Current DEI Task Force members: Tessa Manning, MD (Chair); Susan Daily, MD; Rachel Dalthorp, MD; Cree Clay, MD; Joseph Michie, MD; Britta Ostermeyer, MD; Ashley Walker, MD; Nicole Washington, DO.

The DEI Task Force is an open forum and continues to seek involvement from the OPPA membership, including residents, fellows, and medical students. Please email OPPA if you are interested in participating. ♦



Nearly Three In Five Teenage Girls Felt Persistent Sadness In 2021, Double The Rate Of Boys, CDC Report Finds

The [New York Times](#) (2/13, Ghorayshi, Rabin) reports, “Nearly three in five teenage girls felt persistent sadness in 2021, double the rate of boys, and one in three girls seriously considered attempting suicide, according to [data](#)” (PDF) released Feb. 13 by the CDC. These “findings, based on surveys given to teenagers across the country, also showed high levels of violence, depression and suicidal thoughts among lesbian, gay and bisexual youth.” The CDC report found that “more than one in five of these students reported attempting suicide in the year before the survey.”

The [Washington Post](#) (2/13, A1, St. George) reports, “In 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry and the Children’s Hospital Association together declared ‘a national state of emergency’ in children’s mental health,” and “a year later, the organizations sounded the alarm again.” According to [Healio](#) (2/13, Weldon), the survey data also revealed that “in all categories...girls fared worse than their male peers in 2021, with...14% reporting ever being forced to have sex – a statistic that Kathleen Ethier, PhD, director of the CDC’s Division of Adolescent and School Health, called ‘truly alarming.’” Also covering the story are [USA Today](#) (2/13, Rodriguez), [Reuters](#) (2/13, Srinivasan), and [NBC News](#) (2/13, Edwards). ♦



LEARNING CENTER
For Every Stage of Your Career

Emerging Topics In Psychiatry

Updates on Ketamine Use (Webinar)

April 10 | 3:00-4:30 pm ET

The City and Mental Health: A Social Psychiatrist’s

Perspective (Webinar) June 14 | 1:00-2:30 pm ET

Nonpharmacological Management of ADHD (Webinar)

August 16 | 3:00-4:30 pm ET



**More Free/Low Cost CME Courses for
APA/OPPA Members Here!**



Your participation is needed!

OPPA Disaster Task Force



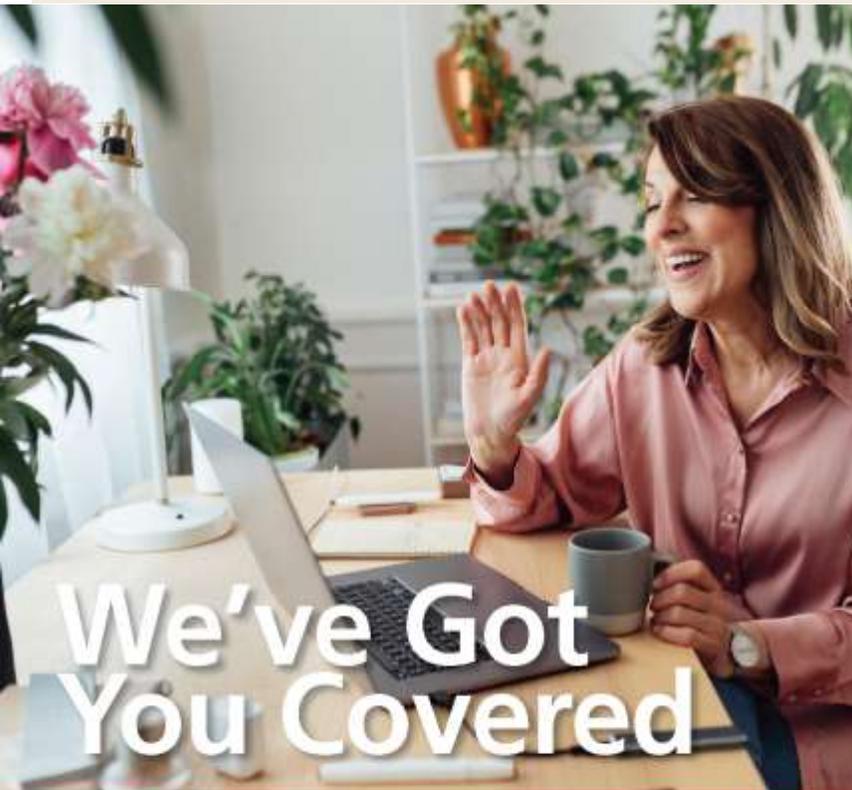
Disasters can happen anytime, anywhere. Psychiatrists provide valuable medical experience and expertise for preparing and responding to disasters and mass traumas.

It is important to understand how psychiatric care can be integrated into disaster response systems in order to effectively provide medical assessment, treatment, and consultation. Proper education and training is critical for responding to disasters and is crucial to ensuring successful interventions. The OPPA Disaster Task Force is continuing to become familiar with local and regional disaster preparedness and response systems and coordinate appropriately in the event of natural or man-made disasters.

Current Members:

Britta Ostermeyer, MD, MBA (Co-Chair); Jed Perdue, MD, MPH (Co-Chair); Robyn Cowperthwaite, MD; Rachel Dalthorp, MD; Tessa Manning, MD (OPPA President-Elect)

If you are interested in participating or would like more information, please [Email](#) OPPA.



We've Got You Covered

APA Endorsed Professional Liability Insurance Program

Comprehensive coverage that includes:

- Up to \$50,000 of **defense reimbursement**, even for board complaints (with the option to increase this limit to \$150,000)
- **Telepsychiatry**, subject to the terms and conditions of the policy
- **Cyber Protection endorsement** available for new and existing policies upon renewal (where allowable by law)

Visit us at ApaMalpractice.com or call **877.740.1777** to learn more.



American Professional Agency

LEADERS IN PSYCHIATRIC MEDICAL LIABILITY INSURANCE

ENDORSED BY THE

AMERICAN
PSYCHIATRIC
ASSOCIATION



coming soon >>>



ANNUAL VIRTUAL
CME CONFERENCE

APRIL 29, 2023

ON THE CUTTING EDGE OF MODERN
PSYCHIATRY 2023

NOT! Topics of Nationwide Interest
New Challenges for Psychiatrists

JOINTLY PROVIDED BY THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE
OKLAHOMA PSYCHIATRIC PHYSICIANS ASSOCIATION (OPPA)

Program Agenda >>>

The practice of modern psychiatry has been directly impacted by post-pandemic developments with many cutting-edge themes emerging in the wake of the pandemic. Topics discussed in this program include promising mental health treatments in the area of psychedelics, long-range mental health effects of the COVID pandemic resulting in millions of deaths, traumatic bereavement, diversity and cultural competence in addiction treatment, physician burnout, and the mental health effects of the epidemic of mass shootings and opioid use and abuse in the United States.

The pandemic exposed the devastating disparity in access to care and the resulting poor outcomes in culturally diverse patient populations. Many COVID-19 long-haulers manifesting psychiatric symptoms came to light. In addition, physicians and other healthcare providers experienced and continue to experience severe stress and trauma as a result of the pandemic.

- 8:15 am** **Welcome:** Britta Ostermeyer, MD, MBA, OPPA President
- 8:30-9:30** **Mental Health Effects of Mass Shootings** Tessa Manning, MD, University of Oklahoma School of Community Medicine
- 9:30-10:30** **The Future of Psychedelics: Problems and Promises** Charles B. Nemeroff, MD, PhD, University of Texas at Austin
- 10:45-11:45** **Intersections of Addiction, Mental Health, and Culture** Joseph Lee, MD, Hazelden Betty Ford Foundation
- 11:45-12:45** **Update on the Opioid Epidemic and Proper Prescribing*** Jason Beaman, DO, MPH, Oklahoma State University Center for Health Sciences
**This presentation fulfills the requirement of Oklahoma Senate Bill 1446 mandating physicians to annually complete one (1) hour of CME in pain management.*
- 1:00-2:00** **Diversity and Cultural Competence: The Impact Dual Pandemics on Women's Mental Health** Danielle J. Johnson, MD, Lindner Center of HOPE and the University of Cincinnati
- 2:00-3:00** **The COVID Pandemic and Long-Term Consequences** Dale Bratzler, DO, MPH, University of Oklahoma Health Sciences Center and OU Health
- 3:15-4:15** **Resident/Fellow/Medical Student Presentations**
- 4:15-5:15** **Do As I Say, Not As I Do: Burnout and Depression In Physicians** Nicole B. Washington, DO, Elocin Psychiatric Services, Broken Arrow, Oklahoma

CME Committee Chair and Coordinator:
Shree S. Vinekar, MD, DLFAPA, DLFAACAP, MACPsych
ABPN Board Certified, Psychiatry & Child/Adolescent Psychiatry

CME Committee:

Irina Baranskaya, MD	Jay Lensgraf, MD
Jason Beaman, DO	Britta Ostermeyer, MD
Sara Coffey, DO	Jed Perdue, MD
Rachel Dalthorp, MD	Phebe Tucker, MD
Heather Geis, MD	

The APA designates this live virtual activity for a maximum of 8 hours of AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



APA/OPPA Members: \$160
Non-Member Physicians: \$170
Non-Physicians: \$75
Residents/Medical Students: No charge*
**Registration required to receive link and CME Credit.*

QUESTIONS?  **OPPA WEBSITE**



Melanie Barrett, MD

Dr. Barrett received her medical degree from the University of Oklahoma College of Medicine following undergraduate studies in Psychology at Texas A&M University in College Station, Texas. She completed her psychiatry residency at the University of North Carolina Hospitals, Chapel Hill, where she served as a Chief Resident. Dr. Barrett specializes in the treatment of women's mental health disorders using an integrated approach, has obtained board certification from the American Board of Psychiatry & Neurology, is a Fellow of the APA, and has been nominated to join the 2023 OPBA Executive Council.

Dr. Barrett is the lead physician at LifeStance Health in Edmond, Oklahoma. She oversees interventional services in Edmond, providing ketamine infusion and esketamine intranasal therapy. She also provides treatment with a 60-hour continuous IV infusion with brexanolone for women struggling with postpartum depression at the LifeStance Maternal Mental Health Center in Moore, Oklahoma. In hopes of a future conference presentation and journal publication, Dr. Barrett submitted an abstract describing her treatment experience and patient response up to 12 months following administration of brexanolone.

Dr. Barrett is the most frequently requested attending physician for the OU College of Medicine outpatient psychiatry clerkship. In 2018, she and like-minded colleagues founded the International Society for Reproductive Psychiatry (ISRP) (reproductivepsychiatry.com), a non-profit organization created to increase awareness of and advocate for women with mental health illnesses. As the current president of ISRP, she leads the planning and development of a women's mental health lecture track, provided annually in partnership with Psych Congress.

Dr. Barrett has expertise and specific training in women's sexual health, perinatal mood and anxiety disorders, and the use of ketamine and esketamine for treatment resistant depression. She has provided educational opportunities to psychiatry residents, presentations and consultation with peers in the areas of interventional psychiatry, maternal mental health, eating disorders, and attention deficit disorders in women. Dr. Barrett can be contacted via [email](mailto:melanie.barrett@lifestance.com). ♦



Founded in 2017, LifeStance is reimagining mental health. LifeStance Health is one of the nation's largest providers of virtual and in-person outpatient mental healthcare for children, adolescents, and adults experiencing a variety of mental health conditions. Our mission is to help people lead healthier, more fulfilling lives by improving access to trusted, affordable, and personalized mental healthcare. LifeStance employs approximately 5,400 psychiatrists, advanced practice nurses, psychologists, and therapists and operates across 32 states and approximately 600 centers.

Interventional Psychiatry Services: LifeStance psychiatric clinicians in Oklahoma have a great deal of experience providing IV ketamine infusion, Spravato (esketamine) intranasal therapy, and IV Zulresso (brexanolone) infusion. With over 15,000 successful treatments provided to date, services are offered in office and under medical supervision in four (4) locations within Moore, Edmond, Oklahoma City, and Tulsa. Overall, all Oklahoma offices are full-service mental health care clinics. Psychiatrists, therapists, and psychologists offer in-person and remote appointments. All therapy, counseling, psychiatry, and mental health services professionals are licensed by the state of Oklahoma.

CONTACT:

Phone: (405) 676-8470

Fax: (405) 676-5802

[EMAIL](mailto:melanie.barrett@lifestance.com)

WEBSITES:

To learn about LifeStance Health, visit: <https://lifestance.com/>

To learn about Ketamine, visit: <https://lifestance.com/services/ketamine-therapy/>

To submit a referral, visit: <https://lifestance.com/referrals/>

LOCATIONS:

Moore, OK
1109 SW 30th Court
Suite B
Moore, OK 73160

Edmond, OK
2908 Astoria Way
Suite 150
Edmond, OK 73034

Oklahoma City, OK
4013 NW Expressway
Suite 105
Oklahoma City, OK 73116

Tulsa, OK
9228 S Mingo Road
Suites 101 & 103
Tulsa, OK 74133

March 2023

APA District Branch Report

Harold Ginzburg, MD and Shree Vinekar, MD
APA Assembly Delegates

MEMBERSHIP

The Oklahoma district branch currently reports 208 members, comprised of 18 Life Fellows, 22 Life Members, 2 Distinguished Fellows, 18 Distinguished Life Fellows, 20 Fellows, 85 General Members, 11 inactive Fellows, 1 retired Distinguished Life Fellow, and 31 Resident-Fellow Members. Dropped members from the last cycle include 2 Resident-Fellow members who transferred membership to other district branches. A new slate of officers and councilors will assume office during the May 13, 2023, General Membership Meeting.

APA recently began reporting medical student contact information to district branches. OPPA has so far added 22 Oklahoma medical students who opted-in for marketing, mailing lists, and CME activities.

LEGISLATIVE ISSUES

The OPPA Legislative Committee has met three times during the reporting period with various stakeholders in Oklahoma including the Oklahoma State Medical Association (OSMA), the National Alliance on Mental Illness, and the Healthy Minds Policy Initiative, to discuss the background and scope of the national and state 988 suicide prevention hotline. In addition, the OPPA Legislative Committee has joined with the Oklahoma State Medical Association to participate in 2023 Medicine Day, which is an opportunity to meet one-on-one or in groups with legislators to let their medical voices be heard on various bills impacting the practice of psychiatry and medicine in Oklahoma. More liaison and advocacy activities are planned for the upcoming year, including formal position statements on bills of particular interest to psychiatric physicians in Oklahoma.

Scope Of Practice Bills

SB 438 Montgomery, John OPPA/OSMA Oppose
Prohibits insurers from discriminating against a particular class of health practitioner with respect to copays or reimbursements.

SB 403 Pemberton, Dewayne OPPA/OSMA Oppose
Permits licensed psychologists to acquire conditional prescription certificates and prescribe psychotropic medication under the supervision of a physician.

SB 458 Stanley, Brenda OPPA/OSMA Oppose
Allows qualified certified nurse practitioners to apply to the Board of Nursing for independent prescribing authority.

SB 459 Stanley, Brenda OPPA/OSMA Oppose
Permits Certified Nurse Midwives, Advanced Practice Registered Nurses and Clinical Nurse Specialists to apply for and receive prescribing authority from the Board of Pharmacy.

Psychiatric Collaborative Care

SB 444 Montgomery, John OPPA/OSMA Support
Directs the Insurance Commissioner to keep a current list of billing codes included in the Psychiatric Collaborative Care Model and directs plans to provide related reimbursement.

Health Care Worker Assault Protections

HB 2154 Roe, Cynthia OPPA/OSMA Support

Extends certain protections against assault and battery against health care professionals to all health care facility personnel and directs health providers to share related data with the Dept. of Health.

Psychiatric Medication Prescribing

SB 217 Hamilton, Warren OPPA/OSMA Oppose
Requires physicians to offer to administer a pharmacogenomic test to any patient in order to determine possible side effects prior to the prescription of any psychotropic drug.

Bills Against Gender Affirming Care (OPPA/OSMA Oppose)

HB1011 Olsen, Jim	SB250 Dahm, Nathan
HB1377 Gann, Tom	SB613 Daniels, Julie
HB1466 Sneed, Chris	SB614 Daniels, Julie
HB2177 West, Kevin	SB878 Jett, Shane
SB252 Dahm, Nathan	SB129 Bullard, David
SB345 Hamilton, Warren	

SCIENTIFIC PROGRAMS

Oklahoma Psychiatric Physicians Association (OPPA):

2023 OPPA CME Scientific Conference: “*On the Cutting Edge of Modern Psychiatry 2023 (USA)*,” will be held via Virtual Webinar on April 29, 2023. This event is jointly provided by the APA and open to APA and OPPA members and non-member physicians, as well as non-physicians. Resident-Fellows and medical students can attend free of charge.

The practice of modern psychiatry has been directly impacted by post-pandemic developments with many cutting-edge themes emerging in the wake of the pandemic. Topics discussed in this program include promising mental health treatments in the area of psychedelics, long-range mental health effects of the COVID pandemic resulting in millions of deaths, traumatic bereavement, diversity and cultural competence in addiction treatment, physician burnout, and the mental health effects of the epidemic of mass shootings and opioid use and abuse in the United States.

Central Oklahoma Psychiatric Society/Tulsa Psychiatric Association:

Two joint events occurred on September 29, 2022 and on March 9, 2023. These events are planned and jointly sponsored by OPPA chapters, the Central Oklahoma Psychiatric Society and the Tulsa Psychiatric Association. These programs are presented in a virtual Zoom webinar format as part of the “Diversity, Culture, and Current Treatment in Psychiatry: An Educational Forum,” sponsored by the University of Oklahoma Health Sciences Center Department of Psychiatry and Behavioral Sciences (Course No. 22D10).

September 29, 2022: Trauma- and Stressor-Related Disorders,” and “Do As I Say, Not as I Do: Burnout and Depression in Physicians.”

March 9, 2023: “Strategies for Increasing Motivation and Self Efficacy in the Treatment of Patients with Substance Use Disorders,” and “Investigative Reporter Mike Gorman and Post-WW II Reform of Oklahoma State Mental Hospitals.” ♦



LET US BE YOUR VOICE OF PSYCHIATRY IN OKLAHOMA

<https://www.psychiatry.org/membership>



WHO WE ARE

The Oklahoma Psychiatric Physicians Association (OPPA), a district branch of the American Psychiatric Association, is dedicated to meeting the professional needs of its members and promoting quality treatment and prevention of mental illness and substance use disorders. In performing these functions, members of the OPPA are mindful of the unique history and cultural diversity of Oklahoma, and the influence of social determinants on health and outcomes.

THROUGH YOUR MEMBERSHIP

Members enjoy discounts on APA and local OPPA branch and chapter CME programs, legislative advocacy on behalf of all psychiatrists in Oklahoma, print and electronic newsletters, and alerts about information you need on all laws, regulations, federal and state healthcare reforms, and more!



LEGISLATIVE ADVOCACY

OPPA, in conjunction with the Oklahoma State Medical Association, is very engaged in legislative monitoring and advocacy in all matters of interest to the practice of psychiatry in Oklahoma.



CONTINUING MEDICAL EDUCATION

APA and OPPA serve as the integrated home for all your CME education needs. Attend CME events to network with colleagues, complete educational activities to earn CME credit, meet MOC requirements, learn new skills, and more!



DIVERSITY, EQUITY AND INCLUSION

OPPA is committed to developing programs and resources to bring awareness to and support the needs of evolving, diverse, and underserved patient populations in Oklahoma, implement strategies to enrich a diverse representation of psychiatrists in Oklahoma and within the OPPA, to reflect the unique, cultural richness of our state, provide an open forum to address issues related to diversity, equity, or inclusion, and foster connections across multiple medical sectors to end mental health inequities.

OKLAHOMA PSYCHIATRIC PHYSICIANS ASSOCIATION



A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION



oklapsychiatry@gmail.com



<https://www.oklapsychiatry.org>

Pendulum in Psychiatry: What Happened? What's Next?

Shree S. Vinekar, MD

In my experience in psychiatry from 1964 until now, there has been a lack of progress in caring for the "mentally ill."

When I started exploring residencies, most of the State Hospitals were in rural areas and many were understaffed housing nearly 10,000 psychiatric patients. Senior psychiatrists told me that the situation was much worse in the 1940s, when there were no effective treatments for patients except for some of those who had syphilis-induced insanities. Many of the beds in those days were occupied by tertiary syphilitic patients suffering from "general paresis of the insane" (GPI). Rest of them were suffering from chronic schizophrenia and "manic-depressive psychoses," dementias and irreversible sequelae of traumatic brain injuries or alcoholism. These illnesses were all considered "chronic" or non-treatable, just to be "managed." "Lock them up and throw away the keys" was the general societal attitude of extrusion of the mentally ill.

The first antipsychotic medication in Western Medicine was Reserpine, introduced as an anti-hypertensive by Dr. Rustom Jal Vakil of Bombay, India, and as an antipsychotic by Dr. Siddiqui, an Indian psychiatrist, in the early 1940's. The next was Thorazine in England and France, nearly 12 to 13 years later.

Both original discoverers were Indian doctors, "British subjects" who published their findings in British journals. Reserpine was considered to have been "discovered," though in reality, it was already used for the very same indications in the ancient Indian medical science of Ayurveda for many centuries. The drug was derived from the plant "Sarpagandha," later given the English name "Sarpina." This history is reminiscent of the "discovery" of digitalis. When I was a medical student and intern in India in the mid-sixties, "Sarpasil" was still used as an effective antihypertensive and antipsychotic. Reserpine depleted the dopamine in the limbic system and could lead to severe depression. The role of biogenic amines in mental illness was not very clear until the mid or late 1960's.

Continued on next page >>

PRACTICING TELEPSYCHIATRY?

As psychiatry evolves in the virtual world, you can count on PRMS® to protect you. In addition to including telepsychiatry coverage at no extra cost with our psychiatric professional liability policy, you'll also benefit from:

National Program



Comprehensive coverage that can cover patients treated anywhere in the U.S.

Risk Management Consultation Service



One-on-one risk management support via our helpline, plus access to hundreds of relevant resources from our in-house experts

In-House Claims Expertise



With a nationwide defense network comprised of attorneys experienced in psychiatric litigation

**CONTACT
US TODAY!**

(800) 245-3333
PRMS.com/Telepsychiatry
TheProgram@prms.com



Continued from page 9 >>>

One of my senior colleagues had resigned from the state hospital because there were only six psychiatrists to care for 6000 patients and there were nearly six successful suicides monthly there. A few years after completing my residency in a University Hospital I worked in a State Hospital that housed 1500 patients. One-fifth of these were under my care and I was only officially working 60% of a work week. This was much better than caring for 6,000 patients with six psychiatrists. My job was to move them out into the community setting, including nursing homes. Many ended up homeless. There were thousands of psychologists and counselors who meant well, but they were not of much use to the hundreds of thousands confined in the state hospitals.

Many of these state hospital-trained psychiatrists had very little experience in understanding neuroses, and they started diagnosing serious mental illnesses when they started treating community-based patients. They gave the diagnoses of bipolar disorder, and Schizophrenia in larger numbers than can be imagined in the so called healthy “neurotic” population outside of the state hospitals, possibly because they had no interest or training in exploring psychodynamic factors leading to their patients’ distress. Of course, their strong medications helped their neurotic symptoms, like cannons working better than BB guns to hit a two-centimeter bullseye. The role of trauma, adverse childhood experiences, abuse and neglect, maternal and affectional deprivation, social and sensory isolation, social/racial discrimination, cultural/educational deprivation, inner conflicts, and neurosis went unrecognized, unremediated, and untreated for decades in these patients for understandable and practical reasons. That is true for most patients even now.

Not much was known about the etiology of psychosis at that time. One local analyst started talking about how he was like Jesus Christ, and he had 12 disciples. His analysts took this analyst by the arm to a psychiatric hospital to be treated for psychosis. The criteria for admission were quite loose and fast in those days. A judge could simply say a potential inpatient is “mentally deranged,” and that was enough! The psychoanalysis of the 12 analysts was abruptly interrupted and the late Dr. Karl Menninger had to send some of his analysts from Topeka, Kansas to do effective crisis intervention for the abandoned analysts.

The disillusioned chairman of the department of psychiatry, who had concluded that dynamic theories could not help the seriously mentally ill wrote a book titled “The Freudian Delusion,” and in a few years was replaced by Dr. Jolly West. Around that time, the perceived voice of authority shifted from the state hospital superintendents to the psychoanalytically oriented academic psychiatrists. Some people insisted that the mentally ill needed to be liberated from their “confinement.” This carried more weight for their rescuers than meeting their basic needs for housing, food, and a comfortable social environment, which they would lose overnight when they were discharged literally to the streets. This happened in the latter half of the 1970’s.

For many, the state hospitals were their homes for 40 or more years. Many of these people became literally homeless as they could not adjust to the nursing home environments. They lived under bridges and on the street. Some received care (medications) from the community mental health clinics.

One of the psychiatrist members of the steering committee at the helm responsible for the national policy for the care of the chronically

mentally ill personally expressed to me that he had deep regrets for the decisions they made then. He recognized that the alternative community care for the seriously mentally ill had not been well planned and provided for prior to dismantling the state hospitals to primarily please the judiciary that gave enormous importance to the “liberty interest” alone. This was a one-sided approach of de-institutionalization driven by brass tacks rather than clinical considerations.



Shree Vinekar, MD

Gradually, power again shifted in academia from Psychoanalysts to Biological Psychiatrists. “Neurosis” was removed from the “DSM” in the 1970s. People began to believe that there was a medication for every psychiatric illness and the cause of every psychiatric problem was a chemical imbalance or some misbehaving molecules in the brain. Every kinky “abnormal” thought, feeling or action must have a corresponding “abnormal” or misbehaving molecule. More and more balancing and curative molecules were discovered and introduced in the care of the mentally ill. “Mind” was dismissed from Psychiatry. Mental anguish of humans became brain disorders.

Many analysts started gravitating into Child and Adolescent psychiatry, where medications played a less dominant role and there was more room for psychosocial treatment modalities with deeper understanding of mind, emotions, feelings of loss, rejection, abandonment, effects of trauma, mentation, and psychological and social interactional dynamic relational factors including normal and deviating development with due respect to helpful medications.

Most trainees graduated to become practicing biological psychiatrists. Visits of 10 to 15 minutes did little for the emotional pain and discomforts emerging from loss of love, toxic interactions, loneliness or other psychological or social conflicts. The NIMH gave prominence to biological determinants. Only recently has attention been drawn again to psychosocial determinants of mental illness. However, there is such a great shortage of psychiatrists with psychodynamic therapeutic skills and similarly sensitive therapists or care givers that there is more and more acceptance of mid-level practitioners lacking advanced psychiatric training.

The effects of these shifts can be seen, for example, in the recently “innovative” idea of providing a medical home to the chronic mentally ill which is in an experimental stage. It is an “integrated care” or “collaborative model” under the guidance of a competent PCP, with access to a psychiatrist for consultation. Over time, the psychiatric services will be diluted, yet the patients may receive over-all better comprehensive healthcare, hopefully with some rational psychiatric medication management.

Mental illnesses were not eradicated like smallpox, polio, or malaria. The mentally ill were simply redistributed in society and when they are hospitalized, they are confined in short-term, smaller institutions with revolving doors. Despite all the biotechnological advances, most patients do not have access to good treatment. Social disparities are perpetuated by the governmental policies and those of the third-party payers, who resist paying on an equal basis for treatment of mental illnesses,

Continued from previous page >>

including substance abuse, granting only lip service to the concept of “parity” for mental illness with general medical and surgical illnesses.

Therefore, it is time to recognize a key problem with the current system, that there is a large population who would be better cared-for in long term hospitals. The 1500 bed state hospital where I personally had 300 patients under my care has only 120 beds today. What happened to the rest? Moreover, what happens to all the patients who need these beds to be treated adequately, to recover and to be rehabilitated fully if they have that potential? Likely they are languishing scattered on the streets as “homeless” or as nonviolent criminals incarcerated in the prison system in the United States, one of the richest countries in the world.

Most of the mentally ill who get any care at all in the public sector psychiatry are receiving it from Nurse Practitioners, PAs, or PCPs. None of these professionals are Board-Certified in Psychiatry. And, more importantly, there is not enough systematic planning for increasing the number of trained psychiatrists.

Even 130 years after Kraepelin, the classification in descriptive psychiatry is still based on phenomenology alone, rather than solid evidence of neurobiological or psychodynamic etiology, neural circuitry, etc. Needless to state that these are antiquated paradigms though currently difficult to replace with any models that have empirical and pragmatic value despite the phenomenal growth in the fields of neuroscience.

Therefore, we ask ourselves: What is the solution to resolve these highly important issues in healthcare, mental health, and society? Below are some potentially viable thoughts to ponder upon:

While there is a need for more funding being set aside these days for improving mental health care, these funds need to be utilized strategically, and to not only attract candidates in large numbers who wish to be truly trained fully in psychiatry to the level of Board Certification but to help also maintain a sustainable work force of such Psychiatrists. There needs to be a central body with effective power to set clear goals and meet them over the next two decades. The psychiatric manpower is crucial and mass education of mid-level clinicians needs to be viewed as a transient band-aid to solve the needs of the mentally ill.

Pressure needs to be placed on health insurance industry and third-party payers to not only cover the true costs of care but require that the psychiatric care be given by skilled and competent certified psychiatrists. Mid-level clinician care givers need to be under the strict supervision of fully trained psychiatrists and their patients need such explicit reassurance that they are in good hands when their treatment decisions call for a higher level of expertise.

Fees, reimbursement, and remuneration need to be commensurate with the educational qualifications, training, and experience. Patients must be clearly informed about their options to select either psychiatric “primary care” from a PCP or mid-level non-specialist clinicians or “specialist care” from trained psychiatrists and be made aware if the corresponding cost differences so that they can make informed choices appropriate to the level of care they need but also based on what they can afford. A two-tiered care option is realistic while it gives patients the choice of and access to more specialized care when it is practical or necessary and the option for lower-cost psychiatric primary care when that is adequate. The midlevel

clinicians must be clearly defined as physician extenders and the patients must have clear concept of their status, so they have a choice to select them at a lower cost as their caregivers. There is nothing wrong with the diluted “watered down” care so long as the patients have a choice and access to more competent care if they so desire when it is practical or necessary.

Funding needs to be allocated, and perhaps even subsidized by the government for current care and again for training of experts for future high-quality care. Indeed, this is a socio-economic problem that not only affects those who are ill and their families, but the entire communities and economies in which they live.

One encouraging example of this would be to open more facilities like the one being built currently in the Houston, TX Medical Center – The UT Health Behavioral Sciences Center. This model incorporates a high-tech teaching facility and a 264-bed inpatient educational long-term hospital (not revolving door) where future physicians and specialists will be trained. As funding increases to build larger state-run facilities to accommodate the mentally ill, this sort of training hospital will enable a greater quality of care to address the huge and increasing mental health challenges we face in the United States today.

A true revolution in the care and treatment of the mentally ill, emotionally disturbed population is the crucial necessity of our time to save our future generation and societies from a disaster. Such disaster will weaken the entire country to stand up in geopolitical competition. Entire population of the country needs to be educated regarding the importance of Mental Health and the need for proper timely treatment of mental-emotional disorders. Radical changes in environmental, social and governmental attitudes towards mental health are what we need to demand from all stakeholders. ♦

Psychiatry and Public Health

People Diagnosed With Sleep Apnea May Have Increased Risk Of Dying By Suicide, Data Suggest



[Psychiatric News](#) (3/24) reported, “People who are diagnosed with sleep apnea have an increased risk of dying

by suicide,” researchers concluded in a study that “examined data from the Taiwan National Health Insurance Research Database.” The study team “selected 7,095 adults aged 20 years or older who had been diagnosed with sleep apnea between 1998 and 2010 and 28,380 adults without sleep apnea who were matched based on their age, sex, and comorbidities,” then “examined suicide attempts that took place during the follow-up period, which ended December 31, 2011 (all participants were followed up to at least one year after receiving a diagnosis).” The [findings](#) were published online March 20 in the *Journal of Psychiatric Research*.



The Oklahoma Child and Adolescent Psychiatry and Mental Health Access Program (OKCAPMAP) supports the primary care provider's provision of pediatric mental health care in the primary care setting. OKCAPMAP provides Oklahoma's primary care providers with child and adolescent psychiatry and mental health consultation, enhanced mental health education, and referral assistance to local and statewide mental health services.

OKCAPMAP is a pediatric mental health care access program (i.e., PMHCA). The first PMHCA was created in Massachusetts in 2004 (i.e., MCPAP) and this type of program was originally called a child psychiatry access program (i.e., CPAP). At this time, all fifty states and several tribal territories have created or are creating a PMHCA to address the child psychiatry workforce shortage across the US and attenuate the gap in access to pediatric mental health care. The Oklahoma Department of Mental Health, Healthy Minds Policy Initiative, and OSU Psychiatry and Behavioral Sciences partnered together and with others to bring this important program to Oklahoma.

OKCAPMAP aims to maximize the number of primary care providers in Oklahoma receiving support for their care of infants, children, and adolescents with psychiatric and mental health needs by providing real time pediatric psychiatry and mental health consultations; offering enhanced psychiatry and mental health education and training; creating and maintaining a statewide infant, child, and adolescent mental health services and supports referral network; and assisting to minimize barriers in accessing mental health care for pediatric patients.

OKCAPMAP is available free of charge to all pediatric-serving PCPs practicing in Oklahoma.. Registered PCPs receive access to all aspects of consultation, education, and referral assistance. From time to time, registered PCPs will receive requests to participate in data collection to measure outcomes, outputs, and program evaluation.

Registered PCPs receive referral assistance to help their patients find a "best fit" therapeutic alliance and create a supportive mental health network. Comprehensive local and statewide services and resources will be included, as well as details for determining best options for the patient and the family. PCPs will also be supported in follow up on referrals, family advocacy, and continuum of care.

This program is supported by funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). OKCAPMAP partners include: Oklahoma Department of Mental Health and Substance Abuse Services; Oklahoma State Board of Osteopathic Examiners; Oklahoma Medical Board; Oklahoma Health Professionals Program; American Academy of Child & Adolescent Psychiatry (Oklahoma Chapter); Oklahoma Osteopathic Association; Healthy Minds Policy Initiative; American Academy of Pediatrics (Oklahoma Chapter); and the Oklahoma Academy of Family Physicians.

5310 E. 31st St., Suite 903, Tulsa, OK 74135

Email: OKCAPMAP

Telephone: (918) 710-3600 | Website: OKCAPMAP



Program Director: Rebecca Hubbard, PhD | Medical Director: Tessa Chesher, DO, IMH-E®
Clinical Consultant and Coordinator: Christina Brent, LPC-S

Oklahoma Psychiatry

Oklahoma Psychiatric Physicians Association
P.O. Box 6887
Moore, OK 73153-6887
Telephone: 405.360.5066
Email: OPPA
Website: <https://www.oklappsiatry.org>

Harold Ginzburg, MD, JD, MPH, Editor
M. Lynn Montgomery, Director

Oklahoma Psychiatry is a publication of the Oklahoma Psychiatric Physicians Association (OPPA). OPPA, a district branch of the American Psychiatric Association, is a medical specialty society specializing in the diagnosis and treatment of mental and emotional illnesses and substance abuse disorders.

Innovate, Collaborate, Motivate: Charting the Future of Mental Health

May 20-24, 2023
San Francisco, CA

With 600+ educational sessions, 50+ topics and 20+ paid courses, APA's 2023 Annual Meeting is the best place to connect with colleagues, learn the latest in effective clinical practice and research advancements, and earn up to 43 AMA PRA Category 1 Credits™. For more information, click [HERE](#).

Can't travel? Join virtually from the comfort of your home or office to take part in select sessions from our exceptional scientific program—more details on the simultaneous virtual event coming soon. ♦



THE MENTAL HEALTH SERVICES CONFERENCE

- 📍 Capital Hilton in Washington, D.C.
- 📅 Thursday, Oct. 12 - Saturday, Oct. 14
- 🕒 8:00 a.m. - 6:00 p.m. ET

The Mental Health Services Conference began in 1949 as the Hospital & Community Psychiatry Institute to provide an intimate, interdisciplinary forum for all mental health service providers to network, collaborate, learn from each other, and take away practical solutions to real-world issues. More details and information on how to submit oral and poster sessions can be found [HERE](#).

The Mental Health Services Conference is designed for anyone delivering mental health services - particularly those serving on a multidisciplinary mental health team: psychiatrists, primary care and other physicians, medical students and residents, nurses, physician assistants, psychologists, addiction counselors, social workers, medical educators, administrators and policymakers, public health researchers, consumers, and family members. The Mental Health Services Conference brings together the whole team caring for those with mental illness, including psychiatrists, nurse practitioners, primary care physicians, social workers, and more, to collaborate on practical advice to influence systems-level change for their patients. This multidisciplinary event will empower all mental health service providers with practical tools and innovations to shape the future of community collaboration. ♦

