Suicide

Anita Red, M.D.

Suicide is a focus of attention in the media, and we as mental health professionals are center stage. Suicide is preventable, and we are here to help.

The day Anthony Bourdain committed suicide, two patients cried about it in my office. Recent suicides in the media have resonated with the public.

Personal friends have asked me, “How does this happen?” They don’t understand the darkness and hopelessness that others feel. It’s hard for some to grasp how someone that seems to have everything takes his or her life.

The same week as the tragedies of Anthony Bourdain and Kate Spade, I had a 12 year old patient tell me about his depression. He said that people tell him, “You’re fine. You’re only 12. This should be the time of your life. You have nothing to be depressed about.” This patient told me that others don’t understand his dark thoughts.

We’ve all now heard the CDC report that suicide rates are up, as much as 30%. The CDC report said that “middle-aged adults had the highest number of suicides and largest rate increases.” It also said that “nearly half of people who died by suicide had a known mental health condition...But those without a known mental health condition were more likely to struggle with a significant life event.”

The American Psychiatric Association published a statement from our president, Altha Stewart, M.D. She said, “Suicide is a critical issue for all of us who work in health care. Anyone contemplating suicide should know that help is available, and that there is no shame in seeking care for your mental health.”

(Continued on page 2)
As psychiatrists, we have the tools and are equipped to assist. There are so many who are suffering that don’t have access to care or don’t ask for help. People have started a conversation, and we need to respond with compassion and attentiveness.

Anthony Bourdain photo - JStone/Shutterstock.com
Kate Spade photo - Everett Collection/Shutterstock.com

SCPS / APA Media Training
Saturday, September 29, 2018

The New Center for Psychoanalysis
2014 Sawtelle Blvd., L.A., CA 90025

to register: scps2999@earthlink.net

Save the Date and Watch for More Information

Psychodynamics and Psychopharmacology

David Mintz, MD
Saturday, August 4, 2018
9:30 AM - 12:30 PM

At New Center for Psychoanalysis
2014 Sawtelle Blvd
LA, CA 90025

This event is co-sponsored by NCP and SCPS
$55 Pre-registration, $65 at the door, $15 Student Rate

To Register and For More Information
How Can Psychiatrists (especially in those private practice) Assist Individuals Who Cannot Afford Mental Healthcare?

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

I am not in-network in my private practice. In other words, like many psychiatrists on the “Westside” of Los Angeles, I do not accept insurance. Accordingly, I am considered an “out of network provider” and will provide a superbill, so that those with a PPO insurance plan can seek reimbursement from their insurance company.

I made the conscious decision not to accept insurance because I wanted to be able to practice psychiatry and provide mental health treatment with the autonomy to make recommendations and provide treatments that I believe will best help my patients achieve their goals. Not accepting insurance allows me and my patient to have full control over the frequency and duration of office visits and also the modalities of treatment that I provide. I have heard some health insurance plans stopped covering therapy provided by psychiatrists but I could not find a reference to confirm or deny this claim. Patients find many benefits going to a psychiatrist outside of their insurance, including having sessions that are not rushed, having the time to answer questions and having a psychiatrist who is not so inundated with billing/coding and paperwork that they are able to return phone calls and emails between visits.

However, one large drawback and negative to not accepting insurance is that many individuals who need treatment cannot afford to pay “out of pocket”. In a time of growing demand for mental health treatment, I often wonder how my colleagues handle this situation?

Personally, I have found two ways to be of service to those who are not able to afford care outside of their insurance and for individuals who do not have health insurance. First, I have a couple of sliding scale spots. Meaning, I have a select number of patients that I see below my current rate. This allows me to help those in need, while being able to continue to practice psychiatry how I prefer; with full autonomy for me and my patients.

Second, I provide a free brief (5 to 10 minute) screening phone call for all prospective patients. Many patients find me through the internet, or on old lists provided by their insurance providers and call me after having failed to connect with a psychiatrist after a series of calls.

I have made it my practice to return phone calls and emails even if I am aware they are not able to afford seeking care in my office or that they desire to find an in-network provider. On these calls I do my best to help individuals find the help that they need, if I am unable to be a good fit for their needs. I provide resources, make general recommendations on where to seek assistance and do my best to refer to colleagues and clinics that may better fit their needs.

If they are looking for therapy, I will often refer to colleagues that I know work on a “sliding scale.” In other cases, I will refer to psychiatry training programs where residents, who are supervised by experienced clinical instructors provide care at lower costs. A recent NBCNews article points out that there are new and highly acceptable apps that can provide low cost alternatives as well.

My goal is to at least get the prospective patient on the right track to obtaining help or being closer to doing so after speaking with me.

I am curious what each of you do in this area?

How do you help those who are not a good fit for your practice?
Do you have specific resources you are willing to share or specific referrals that you provide that we could share in a future newsletter article to provide our colleagues with additional low-cost treatment options?

If so, please send me an email (see below).

Best,
Matthew Goldenberg D.O.
SCPS Newsletter Editor
Email: docgoldenberg@gmail.com

Psychiatrist Patrice Harris, M.D., M.A., Elected President-Elect of the AMA

APA member Patrice Harris, M.D., M.A., a former APA board member and AMA board member, was elected as president-elect of the AMA during the AMA’s House of Delegates meeting in Chicago.

Harris is the first African-American woman to hold the office.

Harris served on the AMA Board of Trustees beginning in 2011 and served as secretary for the 2014-2015 term and as chair of the board for the 2016-2017 term. As a practicing psychiatrist trained in child/adolescent and forensic psychiatry, she consults with both public and private organizations on health service delivery. She is also chair of the AMA Task Force to Reduce Opioid Abuse and is an adjunct assistant professor in the Department of Psychiatry and Behavioral Sciences at Emory University.

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www.psychiatristjobs.la
Anger—Part 2: Towards a Diagnosis

by: Stephen Read, M.D.

In the May Newsletter, I summarized my opinion that the omission of Anger in the DSM is an oversight that ignores major phenomena in mental life and that is consequential on many levels. In this follow-up, I will suggest how interested psychiatrists might proceed in fostering recognition and characterization of Anger when it is present.

As a first step, I propose that clinicians utilize the category of “Anger and Irritability,” coded as R45.4 in ICD-10 under “Symptoms and signs involving cognition, perception, emotional state and behavior.” Consistent with a first step, this simply notes the presence of “Symptoms, such as . . .

1. Angry,
2. Feeling angry,
3. Feeling irritable,
4. Irritability.”

Use of this ICD-10 code, when such features are present, would be, in my opinion, a useful and appropriate starting point for the issue of Anger and Irritability as a diagnostic construct. Coding R45.4 Anger and Irritability would support identification of potentially important treatment goals and assist clinicians and patients in identifying and “owning” the importance of these features, itself an advance in my opinion, akin, e.g. to assisting depressed patients understand the endogenous origin of their symptoms. From this first identification step, ideally, clinicians would then characterize differing features, accompanying conditions, and responses to treatments. Correlations with other clinical domains—medical/physiological, psychosocial, circumstantial, epidemiologic—would further assist definition and understanding as to how these conditions would best fit into the nosologic spectrum. My own observations would support the following hypotheses:

1. Irritability is reasonably considered a premonitory state that can lead to Anger, i.e. the usage of the term, pending more careful study, suggests recognition that we are discussing a phenomenon that has varied intensity.
2. Anger and Irritability clearly can co-occur with a large percentage of other DSM diagnoses. When present, anger or irritability can be clinically significant features of depression or mania and can become the feature that dominates a clinical situation, e.g. a call to police, a 5150, an emergency visit, a session in family therapy. Since Anger and Irritability are not expressed in all cases, its presence would reasonably be considered a subtype of the primary mood disorder (or other DSM diagnosis), similar to anxiety accompanying depression.
3. Anger and Irritability is frequently associated with alcohol use or abuse, or of other habits, again a feature that warrants recognition and considerations for treatment directly and for the alcohol use itself.
4. My reading of the accounts of mass shootings, terrorism, and politics, increasingly frequent over the past year, suggests also that Anger can become an overriding and persistent state, therefore worthy of consideration as a “mood disorder.” In my opinion, statements from psychiatrists that “Anger is not a mental disorder”—because it is not a diagnosis in the DSM—do not pass a common sense test, i.e., many of these descriptions depict disturbed persons long-recognized as being consumed by anger. I find it difficult to understand how we would not consider this a type of mental disorder. A particularly important aspect of the dynamics of such persons in my
opinion would be identifying events that evoke socially dangerous actions in such chronically angry persons.

5. An important issue is the role of oppression reinforcing a state of Anger, especially acknowledging the likelihood that chronic anger is likely to be sustained by a sense of oppression. Even when anger is "understood" or "justifiable," however, it may be subjectively problematic for the angry person. While learning to "manage" such anger can be a challenge, it may be important in terms of safety and for setting appropriate and realistic goals. One such goal, e.g., would be to limit "spill over" into family or personal relationships, i.e., potential "collateral damage," however "justifiable" the anger. More than one responder raised concerns that making Anger a diagnostic category would open its use to reducing culpability for actions claimed to result from "understandable" anger-induced actions. I note, however, that this concern has been obviated for persons diagnosed with Anti-social personality disorder. In addition, in my experience, such concerns will be adjudicated, and in my opinion, judges and juries are capable of making appropriate analyses of the role of mental disorders in a criminal action. It is also of note that such concepts continue to evolve in jurisprudence: an historic example is that killing of an unfaithful spouse and his or her lover was previously acceptable, if not applauded. A more current issue would be the killing of a young woman by family when she has been judged to have "disgraced" the family by some sexual act—even perhaps when she suffered rape—which is considered as justified in some cultures, but is judged as murder in many other societies.

My thoughts have been developed in response to feedback to my ideas over the past few weeks, both supportive and some with critiques. I especially want to thank Nick Caskey, PhD, erstwhile colleague of mine at the VA West LA, who drew my attention to ICD-10, and a brief review of what is available on this subject reveals that our psychologist colleagues have not been hindered by the lack of a formal diagnostic option in developing programs and concepts for anger problems. More surprising to me is the lack of enthusiasm for my proposal among several psychiatrists who are actively involved in anger treatment. I have come to understand that these dedicated clinicians proceed in their work without feeling the need for a diagnosis and so did not find its omission inhibiting to their work. Although skepticism about psychiatric diagnosis has come from within our profession, perhaps the most well-known critic being the late Thomas Szasz, my interpretation of these cool responses was more that there was no felt need for a diagnosis to continue with the current treatment paradigms. For myself, however, a cardinal principle of functioning as a physician and psychiatrist is to have my work informed by a diagnosis, and also that diagnoses support research and better understandings of different conditions.

So, the proposed first step awaits—using the ICD-10 code of R45.4 Anger and Irritability. Give it a try!! What will follow? Our skills of analysis and questioning, fueled by curiosity and in response to the phenomena will generate organized inquiry, to explore themes such as I have suggested above, and, undoubtedly, other and more sophisticated ideas that will arise in the field. We have large cohort of psychiatric clinicians—e.g. the SCPS Newsletter goes out to about 1000 psychiatrists. Southern California has rich opportunities for these investigations, including, inter alia, a vital and busy Department of Mental Health with Emergency Services and hospitalization together with outpatient services. VA programs certainly have their share of patients with Anger. The LA County jail, known now as the largest “mental health” facility west of the Mississippi River in our country, would be expected to have ample clinical examples of Anger issues—in persons both identified with other mental disorders and those without. Links between these and university programs, both in psychiatry and associated areas such as Public Health, offer rich resources for understanding data that will be generated. Although the future is difficult to predict, California has the resources and creativity to investigate the question as to whether Anger and Irritability, pending further refinement, warrants formal recognition as a diagnosis. I of course believe that investigations will establish that and will come to generate the data necessary for the keepers of the DSM to see the wisdom of including Anger and Irritability as a diagnostic category. Given my impression of the high frequency of Anger and Irritability, and its relationship not only to the well-being of our patients and their families, but also to
problems such as managing homelessness, I believe substantial benefits will accrue to this effort.

In conclusion, I appreciate the opportunity to share these views with SCPS colleagues, including both critiques and support I have received in return. Clearly, we are at best at the very beginning of accepting Anger and Irritability as a diagnostic category, defining criteria, and considering its place in the nosological system. SCPS is in a strong position to advance this effort.

Remember, no August Issue
But we’ll see you in September!
SCPS Council, Newsletter Committee, and Staff,
Wish you a Safe and Happy Summer!

Advertisement

THE WELLNESS COURSE: 
BRINGING JOY TO THE PRACTICE OF MEDICINE
Friday, October 19, 2018 | 7:30 a.m. – 5:15 p.m. | Cedars-Sinai—Harvey Morris Auditorium

Cedars-Sinai Department of Psychiatry invites healthcare professionals to register for this year’s CME wellness course “Bringing Joy to the Practice of Medicine”. The course will include keynote speaker Carol Bernstein, MD and will take place at Harvey Morse Auditorium on Cedars-Sinai’s main campus.

This unique course examines the importance of wellness and provides recommendations, tools and resources that healthcare professionals can utilize to develop resiliency, work/life balance and self-care. By using a skills lab approach, attendees are expected to learn and practice stress management methods and emotional intelligence techniques, with the opportunity to meet in small groups with fellow healthcare professionals to acquire and practice wellness skills.

To register, visit thewellnesscourse.org. For more information, call 310-423-5548 or email cme@cshs.org.

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Violence by patients against psychiatrists is more common than against other physicians.
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Sexual Harassment in Medical Academia: Clinical & Professional Implications

By Kavita Khajuria, M.D.

The #MeToo movement opened the door to sexual harassment awareness last year.

Sexual Harassment (hereafter referred to as SH) initially received significant attention in the mid '70s. By 1991, Supreme Court hearings and other claims opened the door to a surge of awareness, charges and lawsuits. A universally accepted definition of SH, or every behavior that may be considered to be SH does not exist (1,2,3). Most researchers contend it to be a psychological experience based on sexually unwanted, offensive, and threatening behaviors (2,4).

Perceptions, Misperceptions

The majority of those who report SH tend to be women, while the majority of alleged harassers tend to be men (2,4,6,7,8,9,10,11,12). Many types of unwanted physical, verbal and visual behaviors can constitute SH. Offensive jokes or comments tend to be the most prevalent, while the more severe behaviors (physical or sexual assault) are the least frequent (1).

SH of men by men (regardless of sexual orientation of either party) is typically based on deviation from gender stereotypes, whilst SH of women usually consists of a cumulative series of escalating experiences causing the person to experience a chronic level of stress and affective arousal (1). The most common response to SH is to ignore or avoid it. Studies reveal subtle forms of SH to be not easily recognizable as discriminatory acts, and individuals exposed to workplace SH who do not utilize strategies for detection and coping can feel vulnerable and inept, which can instill a sense of helplessness (2).

Misperceptions?

Some of those afflicted may be recipients of sexual overtures that were actually intended to be compliments (12). Differences in perception may derive in part from generational and sex differences, but a compliment about a physical attribute in the absence of malice could nevertheless leave a person feeling demeaned and intimidated (9). A relationship may also not be truly consensual despite appearances, particularly when the relationship involves power differentials i.e a supervisor and a subordinate (24). Historically, the greater the inequality in position, occupation and age, the more likely the behavior would have been labelled SH by an observer (12). Educational hierarchy combined with traditional inequality between doctors and nurses and other power-imbalanced working relationships have been cited as an explanation for the infiltration of sexist attitudes in the medical field (13). Residents and students can be more vulnerable to harassment and assault due to these inherent power differentials (14).

Professional and Academic Environments

Research has revealed SH to be a persistent phenomena in medical academia as reflected in studies, surveys and landmark cases. SH has affected faculty, clinician-researchers, residents and medical trainees (6,7,8,9,10,11,13,14,15,16,17,18). A large study of U.S medical schools revealed female faculty to perceive gender harassment more than twice than that of their male peers (18). In a 2014 study, 30% of female clinician-researchers reported having experienced SH compared to 4% of men (8). An international meta-analysis of medical trainees revealed more than two-thirds to have reported SH during their training, with consultants and senior doctors cited as the most frequent source of such behaviors (7). A study of ER medicine residents revealed 68.9% of female and 41.9% of male responders to have reported SH (17). Other large studies revealed more female students to have experienced SH or gender discrimination during medical school and training i.e internship, residency, fellowships (19), and core clerkships (6). Both males and females believed this to be more common in surgery (6, 13) and OBG (6). Male trainees were noted to be more subject to SH during residency than during medical school, and in contrast to females, the SH was primarily by nurses, rather than attending physicians (9).
Consequences

Potential consequences include distraction from studies (9), high levels of stress (7, 9), depression, isolation, guilt, anger, fear, low self-esteem (17), hostility and helplessness (20). Harassed trainees were more likely to drink alcohol for escape (7) and to be subject to alcohol and prescription use and misuse (20). Medication misuse included antidepressants and sedatives (20).

Somatic complaints have included disturbed sleep, nightmares, headaches, fatigue, GI disturbances, loss of appetite and weight loss (17). Work related consequences included absenteeism, poor work evaluations, and poor work performance (17). Psychiatric sequelae can include depressive and anxiety disorders (1), including adjustment disorder, panic disorder, generalized anxiety disorder & PTSD (17). Exposure to the more common, less severe behaviors have been found to be less likely to result in PTSD in the absence of a pre-existing vulnerability (1)

Professional Consequences.

Studies reveal an impact on choice of residency placements and specialty choices, and ultimately one’s career (13, 14, 21). The negative effects of SH on medical training can create a stressful and hostile learning environment (9), with a negative impact on patient care (9,14). In a 1996 study, approximately a third of family practice residents reported negative effects to include psychological sequelae that required therapy (22). In some cases, it caused residents to transfer programs (22). Among women reporting SH in the 2014 study, two thirds perceived negative effects on confidence in themselves as professionals, and approximately half reported these experiences to have negatively affected their career advancement (8). Reasons for not reporting most commonly included a lack of confidence that one would be helped, and a fear of retaliation (9) from attending physicians (14). Other factors included shame, guilt (9) and a concern that privacy would be breached by the treatment team (14).

Legal Standards

A study of over a hundred workplace SH cases revealed only ~3/4’s of employers to have adequately disseminated a SH policy, and the courts considered only ~ half of them to be ‘good’ (23). In 1972, Congress passed the landmark Title IX Amendment, which mandated that no person could be denied any educational benefits or be discriminated against on the basis of sex (14). The more recent 2017 decision established that any hospital that trains residents are also subject to Title IX (14). The legal standard as to whether behavior arises to an actionable level includes whether a ‘reasonable person’ would have found the behavior offensive or distressing (1). SH does not have to be repeated to be unlawful, as the standard is ‘severe or pervasive’. An afflicted individual may not be comfortable approaching the harasser and it can still be unwelcome even if the afflicted person did not confront the harasser or ask him/her to stop (24).

Conclusions/Solutions

Research confirms SH and gender discrimination to be widespread phenomena (1). The confusion of definitions may fail to provide an accurate reflection of reality (2) or the potential dilemmas (24). ‘Organizational tolerance’ of SH has been demonstrated to be a strong contributor to psychological damage to afflicted individuals over and above that attributable to the harassment itself (25). Recognition is important, as perceptions that SH is rare may increase stigmatization and discourage reporting (8). Lack of training is one factor associated with misconduct that leads to high financial and personal costs (26). Education is necessary for all parties to understand what constitutes harassing, abusive and hostile behaviors. Early education and awareness, expectations of how to deal with negative behaviors, the need to speak up, implementation of standards, and mechanisms to respond to unacceptable behaviors have been some recommendations cited by academia (13). Others include treatment interventions, (including EAPs) that recognize and appropriately label SH as such (20). An expectation of zero-tolerance and reliable reporting channels (16) are necessary for individuals to know that a responsible system is in place.
References:
5. EEOC Website. Facts about Sexual Harassment FSE/4.


Other Resources:
1. EEOC Website. Filing A Charge of Discrimination.

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**From CPA's News, Updates, and Alerts**

**Half Time.** A shout out to CPA members and CPA RFMs meeting with members and staff of the legislature at CPAs Advocacy Day in April. CPA had great results at “half-time” as surviving bills are passed to their second house. All but one CPA bill has moved over to its second house awaiting action that could start as early as next week. It’s too early to declare victory and go home, but momentum for the CPA policy agenda has been established.

**Showing up** is 90% of Advocacy. Great things can come from small acts. Visiting legislators for a short 15 minutes may not seem like it would have great impact. But, when 45 CPA members hit the halls of the Capitol in one afternoon, it’s a palpable demonstration that CPA is in the building and ready to rumble. It sends a message, it sets a tone, it makes a difference. People notice. It helps to drive the CPA policy agenda forward.

**Victory Lap.** $1 million in state funding was approved this week, capping 6 months of CPA advocacy. Here’s a well deserved shout-out for CPA president Robert McCarron, MD, and Shannon Suo, MD, directors of the Train New Trainers, Primary Care Providers program at UC Irvine and UC Davis respectively for this proposal promoting scholarships for one-year fellowships in primary care psychiatry. CPA and state officials administering the scholarship program are talking.

**Tensions. Grave Disability.** Opponents of AB 1971 have met with CPA, Los Angeles County, and Steinberg Institute representatives, co-sponsors of this measure, attempting to get medical care for gravely disabled individuals with severe mental illness living on the streets. Some objections to AB 1971 are philosophical, others are practical concerning resources and funding necessary to implement the proposal. Opponents and supporters alike are united in the broader goal of saving lives. Stay tuned.

**Out of the Ashes.** CPA youth substance use treatment continuum bill (AB 2328) died in May. CPA has been invited to co-sponsor a similar bill, SB 275 (Portantino), by its co-sponsors the California Society for Addiction Medicine and Services Employees International Union. CPA accepted. SB 275 is up for hearing in the Assembly Health Committee next week. Stay tuned.

An article of interest:

**New AMA Report Shows California’s Physicians Leading Fight Against Opioid Crisis**

http://www.physiciansnewsnetwork.com/la_county/article_ec527c14-6d92-11e8-ad5e-63cbdb1fd412.html
Meeting called to order at 7:08pm by Dr. Simpson

MINUTES Dr. Woods
Motion by Dr. Lawrence and 2nd by Dr. Folgelson to approve minutes for March 2018 meeting. Motion approved unanimously, no opposed, no abstentions.

PRESIDENT’S REPORT Dr. Simpson
Le Merigot Beach Hotel
Installation and Awards Reception Saturday April 28, 2018 3-7pm

Le Merigot Beach Hotel
1740 Ocean Ave.
Santa Monica, CA 90401

There was an email sent out that there might be a labor dispute and there is a possibility of a picket line. The dispute should not impact the meeting.

SCPS Election Results
President-elect - Erick H. Cheung, M.D.
Treasurer-elect- Michelle Furuta, M.D.
Secretary-Ijeoma Ijeaku, M.D.
ECP Deputy Rep. - Michelle Meshman, M.D.
Resident-Fellow Rep. Katherine Unverferth, M.D., Eric Wagreich, M.D.
APA Assembly Rep.- Heather Silverman, M.D.
Inland Region Councillor - David Seigler, M.D.
San Gabriel Valley/ELA Region Councillor- Zaheib Idrees, D.O.
West L.A. Region Councillor - Zeb Little, M.D.

CPA Pub Psychiatry Committee:
Seeking reps from district branches that are active either, on the council or on a committee and employed for county behavioral health departments, interested in serving on this committee as a representative for the district branch.
- Mindi will provide a list of members that are currently on committees.

CPA Election Results:
President- Mary Ann Schaepper, M.D.
Treasure elect Steve Koh, M.D.

Website Update:
Dr. Unvenverth: Quotes for website design was about $6,000 flat rate in HTML format to redesign and make mobile friendly. Particularly, needing the newsletter to be mobile responsive. Mindi will contact the company to get examples of their work for the committee/council to review. Mindi will also inquire if they have the option of maintenance for at least 1 year for technical support. Committee will meet again to look at updating content of the website before embarking on the redesign.

Logos: One quote $400- for someone to redesign or another one quote is $250 they will give you options to choose from.

Public Affairs Committee:
Dr. Haddad: Mission Statement: The goal of SCPS’s public affairs committee is to promote the profession of psychiatry to the public, especially towards the goals of humanizing those with mental illness and their providers and thus reducing stigma through the use of education, connection and humor. Our projects include 1) cultivation of engaging and humanizing speakers knowledgeable on social, medical and legal issues related to psychiatry who will speak to media and the general public about these issues 2) Development of outreach, including blogs, social media, videos and/or podcast to engage the public in this mission. We will be actively creating content, so anyone interested in comedy, acting, writing or production is very encouraged to join.
- The committee will be working on getting a grant up $10,000 to help with these projects.
- Also committee will work on updating the speakers bureau list. Members can sign up to speak on different topics as well as in what capacity they would be comfortable speaking. Members would not be speaking on behalf of SCPS.
- Will look into getting a media training workshop for SCPS members provided by APA. CMA might also be a way to get media training.
- Drs. Wiita, Do, Rees, Furuta, Woods are interested in joining the committee.

Follow up Council Venue:
Recommend trying the UCLA conference room again for next meeting, May 17th.

Newsletter:
Mindi: There is a sign up sheet for members to contribute to the newsletter. Member suggestion, to make some of the articles available to the public and/or making them available to post on social media. Another suggestion by member is making the newsletters searchable.

PROGRAM COMMITTEE REPORT Dr. Gales
Spring meeting will be held on April 21, 2018 topic will be The Opioid Epidemic. Member made suggestion to have the meeting live streamed or make CME credit available.

TREASURER’S REPORT Dr. Cheung
SCPS is financially stable for March 2018.
Motion to accept treasurers’ report by Dr. Lawrence and second by Dr. Witta. Motion passed unanimously, no opposed, no abstentions. Motion to approve tax return documents by Dr. Lawrence and second by Dr. Red. Motion passed unanimously, no opposed, no abstentions.

ASSEMBLY REPORT Dr. Fogelson
Action Paper: Access to care committee action paper has been revised. The changes from last month include the suggestion to fund a study to evaluate different models of healthcare, to see which would achieve the APA's goal to have every person have access to healthcare as a human right.
- Members suggested on specifically focusing on the delivery of mental health care in specific systems. Dr. Fogelson will bring feedback to the committee.

MEMBERSHIP REPORT Ms. Thelen
Membership Report Current Active Membership –992, Total Membership 1065
Motion by Dr. Wiita and second by Dr. Lawrence to approve 4 new members. Motion passed unanimously, no opposed, no abstentions.

LEGISLATIVE REPORT: None

NEW BUSINESS Dr. Simpson
- Committee looking at MOC reform.
APA and MOC Reform: There is currently a pilot program to test new method of MOC. Any suggestions on how to improve the MOC process? Committee is looking at various aspects of the current process and if there is any evidence showing a benefit.

- Please email Mindi to RSVP to installation awards.

- Advocacy Day is April 16, 2018 there will be 7 residents from SCPS attending.

- Dr. Lymberis: PER will have awardees at the installation awards for residents.

- Film is accepted to APA-IPS 2018 conference in Chicago in October. Film will also be screening at AACAP. Dr. Goenjian will explore having a film screening at a conference in Lebanon.

- Next month the meeting in the 3rd Thursday May 17, 2018 due to APA meeting.

- This is the last meeting of the year.

OLD BUSINESS Dr. Simpson: None
Council Highlights
May 17, 2018
Ijeoma Ijeaku, M.D., Secretary

Meeting called to order at 7:01pm by Dr. Red

Introduction of Council members
Dr Red welcomed all council members to the 2018-19 year and asked that all council members introduce themselves especially with newly elected council members on board

MINUTES Dr. Woods
Motion by Dr.Little and 2nd by Dr. Soldinger to approve minutes for April 2018 meeting. Motion approved unanimously, no opposed, no abstentions.

PRESIDENT’S REPORT Dr. Red

Orientation:
Dr Red asked the SCPS legal adviser Mr Dan Willick to do an orientation to educate new council members and remind the older ones about expectations of SCPS council membership. Mr Willick reminded council members of their role as directors of the SCPS council board. He recounted the various duties and responsibilities of council members even as they continue to play different roles in other mental health domains.

He explained the conflict of interest (COI) concept as it pertains to serving on the SCPS council. Council members who had not completed any COI document in the last year were asked to complete these during the meeting.

CPA Council Meeting/Advocacy Day:
Dr Red noted that SCPS council had inadequate representation at the recent CPA council and this affected the district’s ability to decide representation at the national level. She employed council members to take their office seriously and to use this effectively. She mentioned that so many important bills were being considered and that CPA had taken various positions on these bills.

Dr Unverfeth also gave a report thanking council for giving so many residents and fellows opportunity to be part of the event stating that it had been really important to interact with other members in training from other parts of California.

Distinguished Fellowship:
Dr Red announced that there are three potential nominees to be considered by APA for distinguished fellowship from our district for this year. These are
- Dr Marcy Borlik
- Dr Daniel Schaefer
- Dr Benjamin Woo

The Fellowship and Awards committee has reviewed these candidates and make recommendations to the council.

Public Affairs:
Ms Thelen reported that the revamping of the public affairs committee of the SCPS would involve two main things speakers’ bureau and media training of members interested in becoming part of this bureau; a potential date is 9/29/18 for about 3 hours. Council members have signed up for different topics. They were also encouraged to reach out to non-council member colleagues for topics an innovative grant.

Members discussed various aspects of what training might entail, funding and possible venues. We will continue deliberation at the next meeting.

Career Fair:
Lower than usual turnout was noted at the fall 2017 career meeting. Surveys among residents for possible reasons for this had a very poor response rate.
Council members discussed possible ways to increase attendance including bringing on interesting and diverse topics. One recurring theme among respondents was need for some financial guide about how to navigate the post medical school/training life.

**Installation:**
Ms Thelen noted that there were 24 ‘no-shows’ at the awards ceremony in April 2018. Council members deliberated on this and voted unanimously to have a registration fee of $10 required of members who RSVP to attend. This nominal fee may cover a drink at the event.

**Website Update:**
Dr Unvenverth had sent out various designs for websites prior to the meeting tonight. Members discussed various concerns about potential website. A quote to get a logo design at the cost of $150 was adopted by council members unanimously.

**Newsletter:**
Dr Goldenberg thanked council members for greater involvement in the newsletter. He encouraged members to continue to make contributions. A sign-up sheet for members to contribute to the newsletter was passed around.

**Resident Liaison:**
The council passed a unanimous vote to have no more than eleven resident fellow members join the meeting each month.

**Dinner Payment:**
Dr Red noted that council members were not paying for their meals after the meetings as expected. The council members discussed various ways to avoid this ongoing occurrence and agreed that members will have the option of paying for their meals at the meeting. Ms Thelen will look into paypal options for payments on-site.

**PRESIDENT-ELECT’S REPORT Dr Cheung**
Dr Cheung noted that there were various bills being considered. He was particularly concerned about two bills. One was related to expansion of ‘grave disability’ AB 1971 and the other was the EMS bill AB 1795. There were some discussions about these bills and their relevance to practice but due to time constraints, the discussion will be continued at the next meeting.

**PROGRAM COMMITTEE REPORT Ms Thelen**
Spring meeting was held on April 21, 2018 and the topic was The Opioid Epidemic. There was lower than expected attendance and some potential financial loss (final amount unknown at this point). However, the attendees provided feedback about high level of satisfaction about the event.

**TREASURER’S REPORT Dr Rees**
SCPS is over budget as far as expenses, over budget as far as cash on hand, under budget as far as dues, over budget as far as publications, over budget as far as psychopharm meeting and under budget as far as spring event. A unanimous vote was passed to accept the report.

**ASSEMBLY REPORT Dr Soldinger**
Dr Soldinger noted that there is a recommendation by the assembly to get rid of the MOC requirements thus allowing members to have lifetime certification. This is coming in the heels of concerns that the MOC is very financially demanding and does not appear to offer a lot of educational benefits as originally proposed by ABPN.

**MEMBERSHIP REPORT Dr Ijeaku**
Membership Report Current Active Membership – 997, Total Membership 1070
Four new GMs applied and one RFM; both have met the basic criteria for membership. During the voting, there was one abstention but all other members voted to accept the new members.

**LEGISLATIVE REPORT Dr Shaner**
Dr Shaner provided a report on the position of the CPA on several priority bills.

**NEW BUSINESS Dr. Red**
- LACMA has a historic installation coming up; first female president who is also a psychiatrist. She has reportedly been involved in SCPS events. There is a request that SCPS get involved in this event. Motion passed unanimously to donate $1000 towards this event and to have SCPS president and president-elect be at the event.
Dear CPA Colleagues,

Members have been asking me what the APA is doing about forced separations of children from their parents at the southern US border. The following is an update from Saul Levin, MD, MPA, APA CEO/Medical Director:

We have all watched in incredulity at the actions being taken by the Administration to separate families seeking asylum at the U.S. border. The forced separations have left many in shock and disbelief, wanting to take action. Dr. Stewart’s statement on May 30th made APA one of the first medical associations to publicly oppose the separation of children from their parents. To date, that statement has been quoted in NBC News, AOL News, The Washington Post, and several smaller media outlets. We have also facilitated media interviews with Self Magazine, Everyday Health, Live Science, and Medscape.

The President signed an Executive Order that appears to end the practice, but details remain unclear on how the order will be implemented, and what will happen to the thousands of children already separated from their families. We will continue to focus significant attention to this issue to prevent further trauma from being inflicted on these children and families.

Today, we led 17 other mental health organizations in sending a letter to the Department of Justice, Department of Homeland Security, and Department of Health and Human Services, urging the Administration to immediately end its policy of separating children from their parents at the U.S. border.

Below is something you can do now to make your voice heard:

Take Action Through the APA Action Center

Click on the following link if you want to send your own letter to the Department of Homeland Security or the Justice Department condemning the family separation policy and calling for families to be reunited.


Respectfully,

Mindy Young
Melinda L. Young, MD, DLFAPA
APA Trustee - Area 6/CPA
Safety Nets Shouldn’t Be “Optional”  
by: Torang Sepah, M.D.

I’ve thought a great deal about what to say, if anything, about the suicides last week of two people who were not merely celebrities in the TMZ sense, but people who represented creativity—perhaps in a way that seemed tangible to the rest of us—and seem to have become celebrities almost by happenstance.

Suicide is not an unfamiliar or difficult topic for me. After all, I am someone who has spent the better part of the last nine years addressing someone’s struggle with suicide, day in and day out. As a physician, I’ve been exposed many times to untimely death—whether intentional or due to a childhood cancer or a catastrophic accident. As one who specializes in the field of psychiatry, it seems a day doesn’t pass that doesn’t involve suicide—from the contemplation phase, to an act interrupted, and if you practice long enough and in acute, high risk environments, the aftermath of an act completed enters the scope of your work.

I am able to apply the objective, matter-of-fact, step-by-step prioritization of tasks that a physician’s brain is trained to do when addressing suicide at the first two junctions: contemplation and mid-act. I can quickly assess the risks—what was the plan, what is the access to lethal measures, what are protective factors, and decide to admit a patient for acute stabilization vs close follow-up. I can follow through on steps of resuscitation, assess the location of cut down kits, narcan administration, place pressure on an artery, provide reassurance and guidance to the nursing team when a patient is found mid-act.

Where I lose all of this objectivity, is in the aftermath. I am as stunned and heartbroken as a child who has lost a puppy. The world seems topsy turvy—no matter how intently I try to adjust my vision, everything looks upside down. I have no direction to give, no answers to provide and no reassurance or guidance for others. I feel as lost as everyone else.

This feeling springs up not only when I’ve heard about a completed suicide within a system I’ve worked in—I feel this when I hear about those who I have no connection to, like fellow physicians, family members of friends, and celebrities like Kate Spade and Anthony Bourdain. There is a knot that forms in my stomach and the same sentence runs through my head, we didn’t catch this person when they were falling.

Well, how can you “catch” someone who you don’t know? This is surely an irrational conclusion my brain reaches.

I guess this notion is based on something else I see everyday: no not just lack of access, but something more prevalent: refusing access because the stigma of psychiatric diagnoses are so feared that people would rather die than seek care.

Of course, for physicians this is complex as there is a real concern that their seeking any form of psychiatric care will result in a medical board report. This fear likely perpetuates the high suicide rate of physicians, which is 2.2 x of general Americans. The vast majority of physicians who take their lives were not receiving any treatment for a psychiatric illness, including depression.

And why does it matter? Yes, it is sad, but it now has significant ramifications on public health. There are only 770k licensed physicians in the US for a population of 345 million. On average, each physician has 3k+ patient contacts per year. Every year, due to the loss of physicians from suicide alone, we lose 1 million patient contacts.

But every life that is taken by an individual represents a net loss, whatever their profession is. We lose a person who had more to give.

For us physicians, we’re working on increasing our reliance on one another vis a vis peer support, even on a closed Facebook group—it has utility in bringing down the walls, slowly replacing the stigma with each individual story that is collectively all of ours. We also have a referral list now of psychiatrists in various states who can treat physicians, and we can make these connections, thereby reducing yet another barrier. We are trying to “catch” each other.

The deaths this week are a reminder that more people need catching. As a society, we create the safety net by normalizing psychiatric care, removing the burden that the insurance companies have imposed with the euphemistically
termed “Behavioral Health” which implies volitional control of psychiatric diagnoses. This allows for a lack of parity in coverage, a la carve outs for “Behavioral Health” which are add-ons like massage therapy or yoga. And if you can’t shake that schizophrenia off, well then you might want to get the add on coverage. This has perpetuated the difficulty in access but perhaps more importantly, it underscores the “optional” nature of treatment for illnesses such as depression.

Given that suicide is the fourth leading cause of death for those between the ages of 18-65, it’s time we question this stratification (and the resultant stigma) of psychiatric diagnoses and their treatment. In doing so, we are building the safety net to catch more people.

Brief assembly report by Dr. Steve Soldinger, SCPS Assembly Representative

I serve as one of your assembly reps to the American Psychiatric Association. In this regard, there are a number of action papers which I deem most relevant for us to know about. I will give you the language and the results of the particular action papers as follows:

First, the assembly voted to ratify the proposed language in the APA bylaws, replacing the rule of 95 with a semi and fully retired category. This was referred to the Chief of Staff, Chief of Membership, Strategy officer and to the Board of Trustees.

Second, the assembly voted to approve item 2018A1 12. C which asks:

1. That the APA will encourage and support research to determine the efficacy and safety of unsupervised mental health practices by psychiatric mental health nurse practitioners and physician assistants compared to psychiatrists.

2. That the APA will develop a position statement in support of appropriate supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry.

3. That because of the various types of doctoral degrees that are available to non-physicians, that the APA advocate that all healthcare professionals wear a designation of their license large enough for all patients to see, i.e., physician, nurse clinician, physician assistant, etc.

4. That the APA will include simplified information for public consumption on the patient and family section of the APA website, comparing the education of psychiatrists and prescribing non-physicians for awareness and educated consumer choice.

Third, Action Paper - The assembly voted to approve item 2018A1 12.J, which asks that APA lobby the ABPN to offer a minimum of four five-day examination periods throughout the year.

Fourth, the assembly voted to approve item 2018A1 12.L which asks:

1. The American Psychiatric Association will support the continuation of the public service Loan Forgiveness program, and make its defense an advocacy priority as an access to care matter.

2. The American Psychiatric Association will partner with other medical societies, when appropriate, to further this advocacy goal.

Fifth, the assembly voted to approve item 2018A1 12.M, which asks the APA advocate with the ABMS and the ABPN to return to lifetime board certification.

These are the most relevant items that I dealt with at the last assembly meeting. There were many other items that we dealt with, and I hope that other assembly reps will give you their take on what they found most important.
SANTA MONICA - Bright PT/FT office in calm, quiet suite, top floor, huge view, glass wall & door to private patio, separate exit, beautiful waiting room, pleasant, competent staff/receptionist on site for your administrative needs. Refrigerator/microwave/coffee, internet, A/C, secure building at Wilshire Blvd/22nd Street. Suite shared with compassionate specialists in other consult rooms (MD & integrative, health promotion RDNs).

Contact Felicia or Michelle at 310-829-4469.