Southern California

PSYCHIATRIST

Volume 66, Number 9 May 2018 Newsletter of the Southern California Psychiatric Society

President's Column

Another Great Year for SCPS

Joseph Simpson, M.D.

As I complete my year as SCPS President, what stands out most is the enthusiasm and dedication of our officers and members. The membership rolls remain strong, with around a thousand people, despite all of the competing organizations and distractions out there. Given the cost of APA membership, it is clear that a lot of Southern California psychiatrists recognize its value. Many members turned out for one or more of the events put on by SCPS this year including the Annual Psychopharmacology Conference, the conference on the opioid epidemic, the Career Fair, residents' movie night, and the Women's Committee lunch.

Just a few other highlights of the year:

This was the first year for our new resident liaison positions on Council, designed to increase access to the deliberations of the Council beyond just the Resident-Fellow Member representatives. It went very well and will continue to provide a direct channel between SCPS Council and all the training programs in our district branch area.

It was a very successful year for the SCPS movie, which is undoubtedly one of the most prominent documentaries ever to arise out of an APA district branch. *The Art of Storytelling: The Human Experience of Being a Psychiatrist* was shown at multiple venues, including the World Psychiatric Conference in Berlin and the Black Psychiatrists of America Transcultural Psychiatry Conference in Delhi. Art of Psychiatric Medicine Committee Chair Dr. Michelle Furuta (director), SCPS Executive Director Mindi Thelen (producer), Mindi's husband Tim Thelen (video editing), and the nearly two dozen psychiatrists who were interviewers or interviewees can be extremely proud of this contribution to the ongoing effort to destigmatize our patients and our profession.

Our Newsletter has been very successful thanks to the efforts of editor Dr. Matt Goldenberg and the great articles, book and movie reviews contributed by a substantial number of members of the SCPS community.

We continue to have a strong relationship with the Psychiatry Education and Research Foundation, known as PER, led by Dr. Maria Lymberis. PER has embarked on a tour of *The Art of Storytelling* at Los Angeles County Medical Association events so that our colleagues in other branches of medicine can access it. SCPS is also very grateful for PER's sponsorship of awards honoring outstanding residents from training programs throughout the SCPS region.

Reflecting back on my term, I am particularly struck by the level of participation of resident-fellow and

(Continued on page 2)

In This Issue...

early career members on committees and at Council. While it goes without saying that SCPS needs people to contribute at any and all stages of their careers, the influx of young psychiatrists interested in learning the ropes is a sure sign that the organization will remain in good hands, and that its future is bright!

New Beginnings

By: Matthew Goldenberg D.O.

SCPS Newsletter Editor

My April newsletter article, "Do You Think I am Going Crazy?," generated some nice discussion. My hope is that it was thought provoking and a patient experience you were able to relate to. I am so pleased that several members took the time to respond and share their thoughts and perspectives. Those responses can be found below.

This month, I want to do a little reflecting. As with all new beginnings, something must come to an end, before we can begin anew. As you read above, Dr. Simpson is passing the baton to Dr. Red. This also marks the end of my second year on the council. It has been an honor to have been led by such strong physician leaders including Past President Dr. Curly Bonds and this past year by President Dr. Joe Simpson.

It also marks the end of my second year of editing the SCPS Newsletter. It is now the most visited page on the SCPS website and the monthly views continue to grow steadily each month. I would be remiss if I did not thank and acknowledge Mindi and Tim Thelen for their tireless support and contributions each month. Those who have been a part of the SCPS Council know that Mindi, the SCPS Executive Director, is the cornerstone of the organization that keeps us moving forward.

I also want to thank each of the authors who have contributed, some multiple articles, to the newsletter this past year. We have had many high-quality articles on a wide range of topics. It goes without saying that this Newsletter would not be possible without those of you who have and continue to contribute topnotch articles.

This next year, which starts in May (the month of the APA annual conference), I look forward to sharing a profile on the new members of the executive council including our new treasurer-elect and secretary. Our president-elect, Dr. Erick Cheung was profiled back in January of 2017, on page 9 of that month's newsletter. Incoming President, Dr. Anita Red was profiled on page 3 of the February 2018 Newsletter.

Additionally, I hope to continue to spark conversation and dialog amongst our members. My goal is to use my articles as a forum to initiate the sharing of ideas, clinical and personal experience and to catalyze action. I encourage each of you to take the time to write an article, a letter to the editor or simply share a perspective from your neck of the woods.

This is and will continue to be your newsletter. It is a product of and belongs to our members and it remains an honor to serve as your newsletter editor.

If you are so motivated, please send your articles directly to me. I am eager to see what this year will bring us all.

Best,

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

Dear Dr. Goldenberg (Matthew, if I may—),

You bring up age-old questions about boundary issues in psychiatrists' (and other mental health clinicians') relationships with patients. In my experience, one's posture depends on context. For example, indicating to a patient who experienced the death of someone close that you are sorry for their loss may shut down expression of negative or ambivalent feelings about the deceased, but it also may be a spontaneous expression of shared humanness and bring some solace to the patient. It depends on what you, the therapist, already know about the relationship between the patient and the deceased. If not much, you can offer a neutral expression of compassion; e.g., indicating it is always a shock when we learn about the death of someone we know, and "can you tell me about this person and your relationship with him/her?"

At a more fundamental level, I believe patients almost always feel vulnerable to their psychiatrists' imagined power (consider the appellation, "headshrinker"). And, very real power. Frank Tallman, MD, one of my teachers in my residency at UCLA, stated that the psychiatrist's word can be sharper than any surgeon's scalpel. In my residency we also considered how long a patient might remember a psychiatrist's words; we agreed it might be only a few minutes or for a lifetime. So when a patient asks, do you think President Trump is mentally ill (or more directly, do you think I'm crazy), the question indicates the patient's concern about the psychiatrist's being "on the same page" as he or she is; i.e., "can I trust you to help me, not hurt me, with your sharper-than-a-scalpel words?" Depending on the amount of anxiety the patient has and the putative diagnosis, one can craft an answer that is reassuring but not dismissive; e.g., for an outpatient with some psychotic symptoms, one might reassure that the individual is not "crazy" - he or she continues to function day-to-day (one assumes), but has thoughts that seem to be troubling, may not be quite realistic, and need to be considered further.

To sum up, there are no shortcuts to a therapeutic alliance; it develops only by working together over time. I am reminded of an anecdote told by Lawrence Friedman, MD, a psychoanalyst, during my residency: He was interviewing a new patient, a young, driven, vocal businessman, who stated emphatically that he was Jewish; he used a lot of Jewish expressions in his speech; and to be fully understood he needed an analyst who also was Jewish. He then asked Dr. Friedman if he were Jewish. Dr. Friedman calmly replied, "We'll see."

With kind regards,

Bob Rubin

Robert T. Rubin, MD, PhD
Distinguished Professor Emeritus
Department of Psychiatry and Biobehavioral Sciences
David Geffen School of Medicine at UCLA

Matt,

Thank you for the invitation to share our thoughts on the Trump anxiety-related issues you raised in your April article. Maybe I'm missing something, but I find it easy enough to answer your hypothetical patient's questions, which I have condensed down to four. Here goes.

"Do you think I'm going crazy?" No, not at all -- for two very good reasons. For one thing, "crazy" is a slang term for insane, or out of touch with reality, and that certainly does not apply to you. For another thing, your thoughts and concerns are shared by many Americans; widely-shared ideas and concerns, even if they turn out to be exaggerated, are not evidence of insanity.

"Are you worried about it too?" Actually, I try not to worry. It really doesn't get you anywhere. If you pray, remember the Serenity Prayer and pray for the courage to change the things you can change (in this case, probably through some sort of political action), the serenity to accept the things you cannot change, and the wisdom to know the difference.

"I feel anxious and depressed -- triggered by watching the news and discussing politics with friends." I'm betting that, like most people, you tend to watch the cable news channel(s) that correspond with your own political position; also, that you tend to have friends who are like-minded. Thus, your opinions and fears are reinforced and strengthened, rather than challenged. This has been referred to as an "echo chamber." As far as possible avoid this situation, stay independently informed, and do your own thinking.

"What do you think is wrong with President Trump? Do you think he's crazy?" My professional organization, the American Psychiatric Association, has a clear prohibition against psychiatrists' trying to diagnose people at a distance -- without a diagnostic interview, and without informed consent. That said, if I actually believed the President was "crazy," I would probably speak up anyway, thinking it to be an emergency. But no, he's not insane. As for his integrity, values, intellect and judgement -- well, you be the judge.

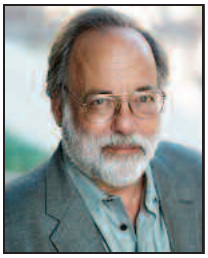
And overriding all of this is my concern about spending much time on this in our sessions. He is a polarizing figure: about a third of Americans think he is wonderful, a third think he is horrible, and a third are trying to figure out what's going on. What if you and I agree, and what if we disagree? I can see problems either way. While it is useful to get others' perspectives on things, there are other ways to do that. The psychiatric hour is too important -- and too expensive -- to use for that purpose.

I hope this answers your questions. I'm here to talk with you about anything -- including politics -- but I just don't think we should spend much time on it.

Walter T. Haessler, M.D.

OPINION: THE LACK OF ANGER DIAGNOSES IN THE DSM IS A DISSERVICE TO OUR PATIENTS AND TO SOCIETY

Stephen Read, M.D., Clinical Professor, UCLA (ret)
www.geriatricpsychiatrist.com



Las Vegas, Parkland, Yountville, the multiple shootings continue. Many responses to the problem are repetitive and formulaic, although there are grounds for hope that a more creative and energized resistance will evolve. This opinion piece originates from my dismay at the very limited, and, yes, formulaic, response from our profession. For example, Hirschritt and Blinder, in a recent Viewpoint in JAMA Psychiatry, efficiently summarize the lack of evidence that those who suffer "serious mental illness" commit more than a very small percentage of such acts, and I do not reject their premise, which is that focus on "serious mental illness" is a straw dog in this debate, with control of weaponry the major issue.

Nonetheless, in my reading of the news accounts, I am impressed with the likelihood that perpetrators of these acts are described as angry, frequently enraged, most often chronically. One reads of acts and threats that induce fear in those around them, and when assistance is sought for their distress it is unavailable or, sadly, ineffective. a state not recognized as worthy of diagnosis in the DSM, through its several revisions. Consider Mr. Nicholas Cruz, now arraigned for multiple murders in Florida, and Mr. Albert Wong, the identified killer in Yountville: Both were long identified as troubled men with a lot of anger. They inspired fear. There is no report that they were psychotic or suffering from a major mood disorder (Mr. Wong presumably was diagnosed with combat-related PTSD), as per current nosology, although for both their distress—and anger and rage—were long-standing. Therefore, while I agree with Hirschitt and Blinder's emphasis on the critical role of access to weapons, I am also impressed that "serious mental illness," as currently defined, does not include any significant nosology for anger, which in retrospect can be recognized as a central feature that led to the terrible actions they undertook.

The absence of anger as a diagnostic category has been inexplicable to me since from the beginning of my training in psychiatry. I came to Harbor-UCLA Medical Center in 1979 as a PGY-2 resident in Psychiatry, shortly after the devolution of mental health care in California from state to county responsibility. Harbor was the public referral facility of a "catchment area" of over 2,000,000 persons, so we were very busy with psychiatric emergencies, sometimes seeing more than 30 patients on a night shift. One fact evident early in my experience was that roughly a quarter of those persons evaluated were seen for an incident that involved anger, with at least the threat of aggression; this included both involuntary patients on 5150, usually brought by police, but also walk-ins, most often prompted by family. The faculty and more senior house officers at Harbor, which had previously been a psychoanalytically-oriented department, frankly had little experience with many of these issues, and there was no diagnosis specific to this in the DSM-II. DSM-III was a huge disappointment in the area of anger—my angry ER patients were only covered by the bland and uninformative category: "Adjustment reaction with mixed emotional features and behavior." Amazingly to me, anger continues not to be diagnosable in its common manifestations in subsequent versions up through DSM5.

As a result of the avoidance of anger in the spectrum of diagnoses, is that there is little investigation or description of anger, its dynamics, the likelihood of dangerous, or productive action resulting from anger, or of interpersonal or pharmacologic interventions that might produce more favorable outcomes. Psychiatry is thereby hindered from learning how to address the distress of patients and their families, friends, and also society at large. An example from my own field of Geriatric Psychiatry: As a medical director of the John Douglas French Center, a model program for patients with dementia licensed as skilled nursing, together with day care and other out-patient programs, I was quickly aware that the potential for anger and "violence" were not rare and were fears that often pre-occupied caregivers of patients with dementia. Our care responses were made particularly difficult in the late 1980's, because we were forbidden to use "agitation" as a problem in our treatment planning, even though it was a serious issue for the mental well-being of patients, staff, families, and milieu. This limitation compromised investigation, treatment paradigms, and even discussion (note: I invented an "irritability index," which helped to get around some of these management and communications problems). The fact that these and other clinical issues continue to arouse controversy cannot, in my opinion, be expected to improve unless we acknowledge the importance of anger in our patients and their lives, and to begin to learn how to engage more meaningfully with its presence.

Anger is a familiar feature of many people's lives, likely including the readers who have come this far. Anger can complicate daily interactions at times, and at other times motivate useful and creative behaviors. The ubiquity of anger is reflected in many stories—literature and opera--and in religion and mythologies. The God of the Old Testament is "wrathful," and also "jealous," an example of anger accompanying other feeling states such as guilt, or envy, or shame. Greek and Norse deities frequently act from anger, but in the current context, we might recall that Tisiphone, in Greek mythology, is the Fury of Vengeful Destruction, perhaps a holdover or incorporation of a more ancient deity, but illustrating implacable rage that cannot be assuaged; woe betide those who become the subject of her wrath. So we "understand" that anger is not always inappropriate, but the actions that result may be disproportionate or even endangering, analogous to the dichotomous features relevant to the term mental "disorder" that are found in other moods that we do dignify with diagnoses—sadness cf. depression, happiness cf. mania. There are features of anger that need studies prior to formal attempts to develop criteria for anger as a diagnosis: Anger may be more labile than other mood states. Anger commonly accompanies other mood states and other diagnoses, but, for example, while we can diagnose mixed depression and mania, or depression with anxiety, we are not offered the option of diagnosing depression associated with anger, although irritability and anger are not uncommonly present. These preliminary considerations suggest that the concepts we have developed for other disorders, especially mood syndromes, including degrees or stages of anger, associations with other disorders, and the degree of associated dysfunction caused by anger would be useful as one considered anger as a separate syndrome or as associated with other identifiable and better-defined disorders.

In conclusion, I offer this statement to my Southern California colleagues, mindful of the major contributions made by our psychiatric community to the growth and understanding of mental disorders over the past decades. I am also mindful of the interest and support in our state and especially in Los Angeles County for issues of mental health care, and the awareness of the major impact that these issues have not only for those who suffer with these conditions, but their families and, indeed, all of society, and I invite discussion regarding the substantial omission of anger as a condition worthy of being considered an important aspect of mental disorder.

How Psychiatrists Became Lesser Physicians

Torie Sepah, M.D.

Recently, a form showed up on my desk to sign, approval for something or other. Not uncommon, given my role at the time as a chief psychiatrist, I signed dozens of such letters, memos, or forms, drafted by an administrative assistant. I signed so many; I never looked at the last line — at how my name had been typed out. Just once my eyes wandered to the end and read: "Torie Sepah, PhD. Chief psychiatrist."

Well, must be an innocent mistake. The support staff who had drafted this memo was experienced, knowledgeable, and was the liaison between myself and the medical school. Of course, she knows that I'm a physician — she compiled all the credentialing documents for myself and my staff physicians in setting up the medical student rotation. If for nothing else, my name on my door has an MD next to it.

When I pointed out the error to her, to my surprise, she replied that it's wasn't a mistake at all. To her knowledge, she understood a psychiatrist as not being a physician, as they were not categorized as medical doctors, but they were called doctors like the psychologists, who had PhDs. The difference was that psychiatrists had special privileges to prescribe medications. Oh and the door sign? That was probably an error, she thought.

Although this seems out of left field, it's really not. When you consider that within the state system that we worked in, all psychiatrists were categorized as mental health providers or simply as psychiatrists annotated with a "PSY" to differentiate from "psy" which represented the other mental health providers, the psychologists. None of us wore white coats, even in one of our two licensed inpatient units. Our ID tags said "Dr. xx" without any degree or what we were licensed as (not compliant with the 2010 law codified under the California Business and Professional Code, Article 7.5, Sec. 680 (a) requiring license type ("physician") to appear on health care badges).

In fact, the other physicians were all organized into the medical department and deemed the medical doctors. Their title was "physician and surgeon" to reflect their license (same license as ours). They were universally referred to as the physicians, and we were called the psych docs. This silo may seem benign, except there were other psych docs: the psychologists. Over time, although therapists, their title became clinician and in the EMR it was primary clinician. Somehow, they became more medical as we were distanced from it. As clinicians, they began applying their right under Title 22 of the California Health Code to admit independently to inpatient psychiatric units. In some cases, nobody knew who was who. Nurses would ask the doctor who admitted a patient for diet orders, and the psychologist would comply, not knowing that those orders were actually medical orders and for the psychiatrist to enter.

The bottom line is that within this system, a silo existed separating medical and mental health and psychiatrists who truly bridge both of those worlds, were lumped into the non-medical one. This ultimately allowed for the ambiguity inherent in the common sounding titles of psychiatrists and psychologists, and the lackadaisical use of "doctor" to lower the psychiatrists to a non-physician status while elevating the therapists to a medical one: clinicians. Hence, psychiatrists can be viewed outside of the breadth of their medical training, as a special form of a mental health provider similar to psychologists, with the exception of being able to prescribe medications.

While it's easy to blame big systems for creating these silos which have made it more affordable to provide care to the mentally ill (mental health providers cost less than psychiatrists; these include advanced nurse practitioners), the rhetorical we as psychiatrists need to accept some of the blame.

Psychiatry carries the burden of being known as the specialty chosen by those who didn't want to be real physicians. Many medical schools haven't helped dissuade this notion — at least mine didn't — which is why I chose a different specialty initially, then entered psychiatry residency as a PGY-2 when I realized I could be a physician and a psychiatrist concurrently.

For many years it was an unpopular specialty that suffered from the lesser physician label. In some systems, this is quite ingrained. Physical exam upon admission to psychiatric hospital? I've heard: "Oh no, I'm a psychiatrist. I

don't touch the patient." So do you refer for cog-wheeling? Where does one draw the line? At what point will we have allowed ourselves to be seen as therapists who can prescribe?

In the current climate of rapidly changing laws and demand for care, the notion that we're not really physicians has likely helped set the stage for the nonsensical scope expansion laws enacted and currently proposed. If we're doctors-light, then surely the other psych doctors (psychologists) can be brought up to speed to fill in for us in a pinch. How else could five states pass laws allowing talk therapists to prescribe psychotropics?

Fortunately, the tide is changing, thanks in part to strong academic departments and public hospital systems that have brought some of the silos down separating psychiatry from the rest of medicine, allowing greater exposure to psychiatry for medical students, who are entering the specialty more and more (psychiatry had a 99.7 percent match rate in the 2017 NRMP, even after adding 130 new positions).

But, we need to do more. We need to reclaim our status as physicians, and not just settle for being called the psych doc (I identify myself as a physician psychiatrist, and I do wear a white coat because it has utility in my work environments).

We also need to look beyond our own specialty, and identify with other physicians as a whole. After all, the proponents and authors of these bills are simply nurse practitioners and psychologists. In kind, as formidable advocates for the practice of medicine, it makes sense for us to identify as what we are fundamentally: physicians.

This article originally appeared on kevinmd.com
https://www.kevinmd.com/blog/2018/02/psychiatrists-became-lesser-physicians.html

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The Madman: His Parables and Poems
By Kahlil Gibran
2002 reprint of the 1918 original
Dover Publications
71 pages
$4.95 (paperback)
ISBN 0-486-41911-8

Book Reviewed by Kavita Khajuria, MD

The Madman is a collection of 34 poems and parables authored by well- known Lebanese-American poet, writer and artist Kahlil Gibran (1883-1931). Gibran was a writer of the New York Pen League, and was considered a literary and a rebel in the Arab world. He became well known in the U.S in 1918 with the original publication of The Madman. The reprint is presented in an easy to read format and contains 3 illustrations authored by Gibran himself.

Themes include masks, misconceptions, perspectives, imperfections, solitude, suffering, and the self.

Gibran refers to the masks people wear. One is not necessarily as one seems. To dispose of the mask and mentally expose oneself is an invitation to laughter and fear, yet it is genuine to expose the true self, and therein lies the power of freedom. Gibran compels the reader to ask oneself - Can you really see and appreciate what lies beneath? Do we really comprehend our own hearts and minds?

Interactions of perceptions and misperceptions are portrayed - how a virtue to one could be a sin to another, depending on the lens through which one looks. Gibran muses as to not knowing whether one is being complimented or belittled, and emphasizes the ultimate relativity of perspectives. Worldly power is comically addressed, including the potential irony of justice and the power of influence. Traps of enthronement and self- absorption compel one to consider concepts of humility and understanding, both recognized as powerful elements of connection for the greater good. The eventual fading of language and prophecies with time emphasize impermanence and imperfection -nothing is set in stone, and there is no perfect person.

Gibran describes a preference to experience laughter and darkness alone. *"Here I sit between my brother the mountain and my sister the sea. We three are one in loneliness, and the love that binds us together is deep and strong and strange"*. Other verses resonate solitude, defiance, aloneness, and the feeling of being shunned and scorned. 'Night and the Madman' queries as to whether one can truly accept and embrace all aspects of the self and the challenges of this worldly life.

This book contains deep expressions of the heart and soul, which can be affirming and healing. Certain aspects speak to darker and lost periods of one's life, with a struggle to exist in a 'perfect, orderly, and measured' world. This can be helpful, yet should perhaps be used with caution depending on the current state of mind of the reader.

In the end, simplicity and complexity drive the points home. Gibran's ability and courage to explore, embrace, and express the most vulnerable aspects of himself allow for a deeper connection to all of us.

"For the first time the sun kissed my own naked face and my soul was inflamed with love for the sun, and I wanted my masks no more"

-Kahlil Gibran-

It is with great sadness that we report the passing of Marcia Kraft Goin, M.D. on Thursday, April 26th. She was an esteemed member of our professional community and a leader in American psychiatry, having served as the 130th President of the American Psychiatric Association. There will be a memorial service on Saturday, May 12, 2018, at 2pm. Little Church of the Flowers, Forest Lawn GLENDALE, 1712 S. Glendale Ave.,Glendale, CA 91205.

Dr. Goin was profiled in the June 2017 edition of the newsletter. Click here to read more about her and her long impactful career in psychiatry.

Reception immediately following hosted by Suzanne and Jessica, David and Will.

Council Highlights March 8, 2018

Amy Woods, M.D., *Secretary*

PRESIDENT'S REPORT Dr. Simpson
Awards Reminder:
Installation and Awards Reception Saturday April 28, 2018 3-7pm
Le Merigot Beach Hotel
1740 Ocean Ave.
Santa Monica, CA 90401

Follow Up Council Venue:
Members express concern about meetings being on the Westside and impact on members that liver further inland. Considered potentially using virtual meeting platform for meetings.

Motion by Dr. Soldinger and seconded by Dr. Wiita to have Mindi continue to explore meeting room options and have dinner catered either at UCLA or at Mindi's office building. Daily Grill will be back up location. Motion passes unanimously, no opposed, no abstentions.

CPA Advocacy Day:
SCPS will be sending 8 residents to CPA Advocacy Day April 16, 2018. Current residents attending Drs. Moore, Montgomery, Chang, Chung, Fonsworth, Unververth, Meshman, Woods.

May Council Meeting:
May council meeting will be held on May 17th because of APA and not May 10th per regular schedule.

Women's Lunch: Dr. Meshman
Topic was Sexual Harassment in the Psychiatric Workplace with speakers Alicia Oeser and Dr. Karen Miotto. Event was successful with great turnout.

Newsletter: Dr. Goldenberg
Provides highlights on last months SCPS newsletter. Members are encouraged to sign up and contribute to the newsletter.

PRESIDENT-ELECT'S REPORT Dr. Red

Responsive Website: Dr. Red
Tim is working on updating SCPS website and to make it more mobile compatible would require hiring an outside person to make website more responsive on mobile devices.

Motion by Dr. Goldenberg and second by Dr. Seroussi to have website committee come up with 2 proposals and

budget to present to council on potential updates to current website including making it mobile responsive, updating the logo, and the entire site. Committee Chair will be Dr. Unverferth and members will include Drs. Do and Seroussi. Motion passes unanimously, no opposed, no abstentions.

Sign On Letter – Open Dialogue
Letter from APA in response to Florida School shooting. They are encouraging district branches to sign letter and give to congressmen. Dr. Red reads sample letter which discusses issues in mental health and recommendation that more resources be allocated to mental health treatment.
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PROGRAM COMMITTEE REPORT Dr. Gales
Spring meeting will be held on April 21, 2018 topic will be The Opioid Epidemic. Will encourage invitation to non-psychiatric specialties and medical organizations. Speakers will include Larissa Mooney, MD, Matthew Goldenberg, DO, and Richard Burr.

TREASURER'S REPORT Dr. Cheung
SCPS is financially stable for February 2018.
Motion to accept treasurer's' report by Dr. Solidinger and second by Dr. Gross. Motion passed unanimously, no opposed, no abstentions.

Retention Campaign:
Currently 170 members have not paid this year dues. Requesting that council members contact members directly to help with membership retention. Deadline is March 31.

ASSEMBLY REPORT Dr. Fogelson
Action Paper: Dr. Fogelson is requesting feedback regarding action paper by the Access to Care committee regarding prior authorization for mediation and the barrier to treatment that is created. Action paper was not distributed before meeting and will be sent out to council members following meeting and members are encouraged to give feedback directly to Dr. Fogelson to bring back to committee by March 15.

MEMBERSHIP REPORT Dr. Ijeaku
Membership Report Current Active Membership –990

Motion by Dr. Soldinger and second by Dr. Wiita to approve new members.

LEGISLATIVE REPORT Drs. Agustines and Soldinger

- March 15 deadline for action papers.

- APA is partnering with states on issues related to psychology prescribing practices. Currently there are 3 states that are currently in the process of making rules for psychologist to prescribe medications.

Dr. Shaner reviews current bills in California.

- Currently EMS must bring patients to the closest ED. For patients with mental health issues that is not always an optimal situation. LA county is sponsoring a bill to look at being able to take people with mental health issues to alternative destinations that are LPS designated.

- Currently there is a bill regarding transporting patients from medical emergency rooms to psychiatric units that are not on psychiatric hold.

- Opiate prescribing bill that wouldn't allow more then a 3 day supply of opiates unless MD thinks they need more.

- Current bill that would add medical care to the definition of grave disability. The psychiatric acute care consortium has reservation to adding this because under LPS law there is no was to provide the medical care to treat

the medical condition.

- LA county board is starting a program of teams comprised of DMH and law enforcement to identify students that are at high risk.

Dr. Fouras
- CMA is having legislative advocacy day April 18, 2018. They will be having a meeting to determine which gubernatorial candidate they will support. If council members have strong feelings about candidates contact Dr. Fouras. He will also update council on CMAs position on current bills in legislature.

NEW BUSINESS Dr. Simpson
- CPA elections are open until March 20

- RFM movie night was successful event, with 2 members making it from Riverside.

- On April 15, 2018 APMC at UC Irvine, School of Medicine will be showcase the SCPS film to all medical students. SCPS members are invented to be part of the panel.

- Dr. Cheung is the new Associate Medical Director for the UCLA Resnick Neuropsychiatric Hospital.

OLD BUSINESS Dr. Simpson
None

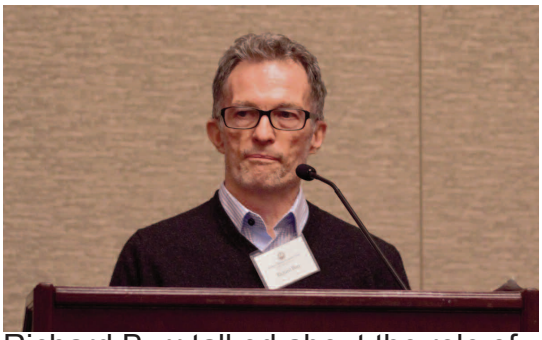
ADJOURNMENT Dr. Simpson
Meeting adjourned at 8:50pm

On Saturday, April 21st, SCPS presented its annual Spring Meeting, *The Opioid Epidemtic: Our Current Crisis*, at the Marina Del Rey Marriott. The meeting was extremely well-received. Here are some photos.

Larissa Mooney, M.D., gave an overview of the epidemic.

Matthew Goldenberg, D.O., discussed the psychopharmacological treatment for opioid addcition.

Drs. Mooney and Goldenberg's panel presentation.



Richard Burr talked about the role of mindfulness and spirituality.

A big thanks to PRMS for supporting this, and all, of our events!

Here are a couple of photos from CPA Advocacy Day, which was held on Monday, April 16th in Sacramento.

CPA members met with Senator Anthony Portantino.

SCPS member, Peolia Fonsworth, III., M.D., at Advocacy Day

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Space Available

Brentwood: San Vicente/Barrington. Great location. Beautiful, spacious 6th floor window office in quiet three-office psychotherapy suite. Large waiting room/call lights, private exit, individual temperature control, sound-proofing, refrigerator/microwave. Building impeccably maintained and secure. Full-time preferred. Contact Charlene Williams, Ph.D. at (310) 442-9286 or mindfulness777@yahoo.com.

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Southern California PSYCHIATRIST, (ISSN #10476334), is published monthly, except August by the Southern California Psychiatric Society, 2999 Overland Ave., Suite 208, Los Angeles, CA 90064, (310) 815-3650, FAX (310) 815-3650.

POSTMASTER: Send address changes to Southern California PSYCHIATRIST, Southern California Psychiatric Society, 2999 Overland Ave., Suite 208, Los Angeles, CA 90064.

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