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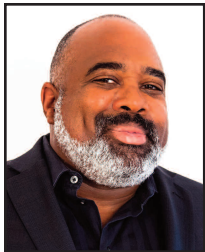
April 2017

Newsletter of the Southern California Psychiatric Society

President's Column

Adversity or Diversity?

Curley Bonds, M.D.



The field of psychiatry has a long emphasized tradition of cultural inclusiveness and diversity. The DSM 5 contains a Cultural Formulation Interview (in the often-overlooked rear section) that can help guide us towards making informed treatment plans for those with backgrounds different from our own. Our specialty boasts trainees and practitioners from all walks of life and every corner of the globe. Here in Southern California our numbers are strengthened by the International Medical Graduates (IMGs) who make their way to the Western US with the promise of sunshine and a better life. The true beneficiaries of the large number of cultures, religions, languages and ethnicities among SPCS members are the patients that we treat who also represent globalization in broader society.

This is why recent efforts from the Executive Branch of our government to restrict the freedom for people from select Muslim countries disturb me greatly. Equally concerning are recent so called "religious freedom" bills and laws that would allow for businesses to deny services, housing or even mental health treatment to individuals whose beliefs or sexual orientation conflict with their own religious values. These bills, laws and orders run counter to all of the policies and professional values of our professional organization.

Dr. Tom Nasca, CEO of the Accreditation Council for Graduate Medical Education, distributed an open letter to all members of the Graduate Medical Education Community in the wake of the first Executive Order outlining the potential harmful effects of such a ban on physicians and patients alike. More than 10,000 licensed physicians in this country graduated from one of the 7 countries listed in the original Executive Order. Many of them practice in severely underserved areas and an educated guess would be that many of them practice psychiatry. More than 1,800 residents and fellows-in-training graduated from medical school in one of the 'banned' countries. Collectively they provide care to an estimated 900,000 patients. In his letter, Dr. Nasca correctly identified these individuals as a valued and welcomed group of colleagues. If this type of xenophobic legislation is allowed to stand, the end result can only spell further shortages of psychiatrists in urban, rural and other areas where we are already in short supply.

I have learned many lessons from colleagues and trainees from war torn countries like Syria and Yemen about how to respectfully and appropriately address the special needs of refugees. Mentors from places like Iraq where years of economic sanctions have taken their toll on citizens have made me proud to live in a country that has always been a safe harbor for free expression. But the closed minded views

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of some of our nation's leaders give me pause about the dystopian society that they will create if left unchecked. As psychiatrists, we are charged with providing consolation and care to immigrants from hostile regimes where their lives may have been threatened. Sadly, now I find myself attempting to provide hope for those who feel that their new home is unwelcoming. Yet another group fears deportation to places that they may have never called home and are anxious about seeking treatment at a community mental health center because of fear that being "in the system" will reveal their whereabouts. How can a therapeutic alliance develop when I am viewed as a cog in the machine that oppresses them? Reassurance is the only tool in my treatment utility belt and recently it has felt very fragile.

Fortunately, we live in a society where we can speak out against policies and laws that run against our core values. Advocacy has been well-covered by others in our newsletter, so I will not review the details of how political activism works except to say that it starts with personal responsibility. Our donations to non-profit organizations and political action committees are more important now than ever before. I urge our members to perform a personal inventory of whether they can give time, money or service to help some of the most vulnerable members of our society – the people that we treat.

You and a Guest
are Cordially Invited

SCPS Installation and
Awards Ceremony

Saturday, April 22, 2017
Le Merigot Beach Hotel
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3 pm - 7 pm

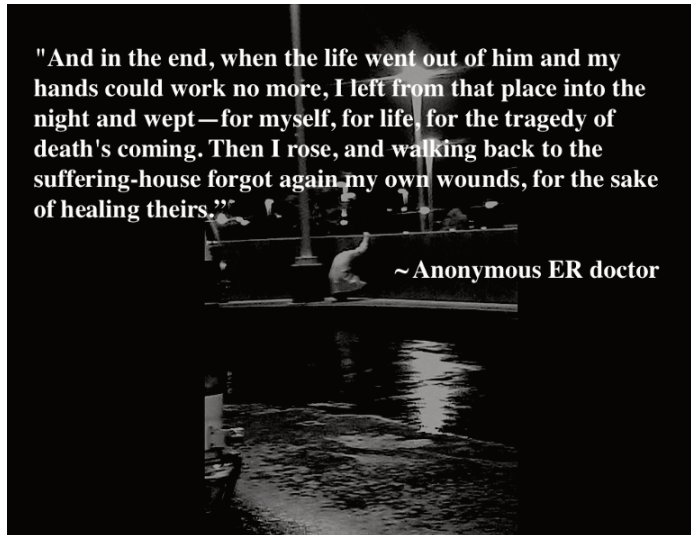
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Letter from the Editor

Do You Know the Only Cause of Death that is More Prevalent Among Physicians than the General Population?

Matthew Goldenberg, D.O.



In the March 17th, 2017 edition of [Psychiatric News there is a story](#) that I hope caught your attention. On page 14 is the story of our colleague Greg Miday M.D. who took his own life on June 22, 2012. The article quotes his suicide note,

*"My family, I love you.
To others who have been good friends, I love you too.
This is just the end of the line for my particular train."*

This young physician's tragic end is all too common. It is estimated that between 300 and 400 physicians die by suicide every year. In fact, the answer to the question posed in the title is: suicide is the only cause of death that is more prevalent among physicians than the general population. The risk is higher in female physicians (250% higher than the general population), compared to male physicians (70% higher than the general population). We also know that the increased risk begins as early as Medical School and that this is a worldwide phenomenon.

The largest risk factor, for suicide in physicians, is a history of psychiatric illness. However, we know most physicians who end their lives in suicide have relied on self-treatment and are never formally diagnosed or treated. While a history of a suicide attempt is a major risk factor for future suicide attempts in the general population, that is not the case for physicians. Because physicians' initial suicide attempts are much more lethal, few physicians have a history of a previous attempt. This is key. If you are evaluating a physician and they have a history of suicide attempt, they are likely to already be deceased.

Some of the largest barriers to obtaining treatment for physicians who are suffering seem to be stigma and fear and systemic barriers such as lack of time due to work obligations. Unfortunately, when physicians do seek help, it is often by a "curbside consult." Unfortunately, in many cases our colleagues may undermine the quality of care by seeking to avoid a formal diagnosis, documentation and hospitalization for many of the same reasons mentioned above (namely stigma, and fear that their colleague's career might be put in jeopardy).

So what can we do? Much like the general population it is important to limit access to lethal means. Beyond

firearms which we often think of, physicians have access to lethal drugs but by virtue of their ability to write prescriptions and also, in many cases, in their office or operating room as part of their practice of medicine. We need to train Psychiatrists on how to better evaluate and treat Physicians. It is vital to understand that the risks and needs of Physicians are different than members of the general population. This evaluation and treatment must be outside of the physicians medical group or health system, so that they get confidential, independent and unbiased treatment.

Maybe most critical is that medical school and residency programs need to start better screening and educating our early career physicians about depression, burnout and other challenges that are inherent to the practice of medicine. If we shift from a focus on a physician's psychological history to their current symptoms and present fitness of their professional abilities, we will see less stigma, less secrecy and decreased fear of seeking help.

Physician Health is both the academic and clinical focus of my career. I have been fortunate to have been mentored by Karen Miotto M.D. and Greg Skipper M.D., who are two of the leaders in the field of Physician Health. There are unsung heroes I have had the pleasure of meeting from Wellbeing Committees around our State and Physician Health Programs around the country. There are organizations fighting to improve physician health like [CPPPH](#), which is committed to bringing back a quality Physician Health Program to California.

If we look at our colleagues as members of our team, we should speak up and support those who are suffering from mental health conditions, substance abuse and burnout, because they all raise the risk of suicide. When one member of our team is struggling and is unwell, our whole team is not functioning at its highest capacity. Not only does the individual physician suffer, but the quality of care their patients receive and patient satisfaction is also negatively impacted.

I am always available for a confidential consultation regarding a personal concern or one regarding a colleague. Your hospital wellbeing committee is also available as a resource. Hopefully soon we will also have a fully functioning Physician Health Program in California that will be accessible, confidential and highly effective for Physicians across the State.

At APA's Annual Meeting in San Diego, APA President-elect Anita Everett, M.D., will chair a town hall discussion on the drivers of physician burnout and strategies for promoting wellness addressed at APA's 2017 Annual Meeting. Dr. Everett, M.D., will chair the session, and APA CEO and Medical Director Saul Levin, M.D., M.P.A., and Trustee-at-Large Richard Summers, M.D will participate. Join in the discussion on Sunday, May 21, at 10 a.m. in Room 30B of the San Diego Convention Center.

References are available upon request via docgoldenberg@gmail.com

Matthew Goldenberg D.O. has presented data related to Physician Suicide, and other Physician Health related topics, at local and national conferences and is available upon request to present to your medical group or organization. For more information education related to Physician Health visit: www.ProfessionalsHealthSolutions.com

Letters to the Newsletter

Dear Editor:

I read your article and appreciate your opening a dialog about the Goldwater Rule. While most cases of this rule are clear, there may be a time when the United States Constitution requires that one of our colleagues violate this Rule. Specifically, one of us may be called upon to opine about the President's health, even though we have not personally examined him. Our opinion might be required in order for the Vice President and others of the executive branch to carry out their duties. I believe this because the 25th Amendment to the United States Constitution, Section Four states:

"Whenever the Vice President and a majority of either the principal officers of the executive departments or of such other body as Congress may by law provide, transmit to the President pro tempore of the Senate and the Speaker of the House of Representatives their written declaration that the President is unable to discharge the powers and duties of his office, the Vice President shall immediately assume the powers and duties of the office as Acting President."

This would be uncharted territory. At what point does the President become unable to discharge the powers and duties of his office due to mental illness? How would the Vice President, executive branch, or Congress determine if the President is disabled by mental illness. Is there ever a case where mental illness causes such a disability? It is not difficult to imagine a President who becomes progressively impaired by dementia or Bipolar Disorder to the point that he/she is unable to perform the duties of the office of the President. Other mental illnesses might cause similar degrees of impairment. Who is supposed to advise the Vice President and Officers of Congress in this matter? If called upon to examine the President's mental health, do we abdicate that role? If the President will not allow a direct examination do we opine about his disability based upon public and third party information about the President?

We do not want to repeat mistakes of the past. For example, in the old Soviet Union, they used psychiatrists to lock away dissidents with sham diagnoses. However, we cannot stand idly by when a President impaired by mental illness is making decisions that affect all of the people of the world.

It is not out of the question, that one day, one of us may be called upon to weigh in with an opinion on the President's ability to discharge the powers and duties of his office. A forum for discussing how to respond when the call is received is much needed. I suggest a discussion in the APA Assembly would be helpful and a useful place to start.

David L. Fogelson, M.D.
Clinical Professor of Psychiatry
UCLA Department of Psychiatry and Biobehavioral Sciences

Dear Dr. Bonds,

In response to your February President's Column, *Are Psychiatrists an Endangered Species*, to more quickly provide skilled psychiatric care to underserved populations, the first thing we should try to do is to persuade all 50 states to allow reciprocity' to all MD and DO licensees with Certification in Psychiatry by the Board of Psychiatry and Neurology to treat patients in all 50 states teletherapeutically.

I know personally several highly such experienced and skilled psychiatrists in Southern California alone who would be eager to provide services to patients seeking psychiatric help in other states if they could do so legally.

Roderic Gorney, MD, PhD

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Sexual Orientation, Gender Identity, Sex Development and Substance Use Disorders

Brian Hurley, M.D., M.B.A., D.F.A.S.A.M.

An earlier version of this article appeared in the American Academy of Addiction Psychiatry Newsletter, 31(2), 2015. It has been amended and updated for this Southern California Psychiatric Society newsletter.



The prevalence of substance use disorders are not equally distributed among all populations in the United States. The National Epidemiologic Survey on Alcohol and Related Conditions survey asks respondents to identify their sexual identity, sexual attraction, and sexual behavior, and McCabe (2009) identified that lesbian, gay, and bisexual people in the United States have higher rates of substance use disorders, compared with straight people.¹ Further, lesbian and bisexual women's risk is greater for alcohol use disorders, whereas gay and bisexual men's risk is greater for illicit drug use.² Tobacco use disorder have been well demonstrated to be more prevalent among lesbian, gay and bisexual men and women than straight men and women.³ Authors have posited the minority stress model⁴ to explain that the higher prevalence of substance related conditions among lesbian, gay, and bisexual people results from the additive stress related to social stigma.

Substance use disorder treatment is generally underutilized throughout the general population, but there are differences in the utilization of substance use disorder treatment based on gender and sexual orientation.⁵ Among LGB patients who seek treatment, gay and bisexual men report more methamphetamine use, less heroin use, and were more likely to use their primary substance through smoking compared with their straight counterparts.⁶ There is evidence that treatment engagement and retention is enhanced with gender and sexual orientation issues are incorporated into addiction treatment.⁷ Additionally, LGB individuals that enter addiction treatment are more likely to have physical and mental health problems than their straight counterparts.⁸ Recognizing the importance of addiction treatment in lesbian, gay, bisexual, and transgender (LGBT) populations, the US Substance Abuse and Mental Health Services Administration published a providers guide to "improve and advance substance abuse treatment for a community of individuals whose health care needs are often ignored, denigrated, or denied."⁹

The Institute of Medicine's 2011 report, "The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding"¹⁰ noted the disparities in the rates of substance use disorders among gay, lesbian, and bisexual people. There are no national epidemiological surveys addressing transgender populations, so little is known about the substance related incidence, etiology, and treatment needs of transgender Americans. Further there are no systematic population-based studies examining substance use disorder behaviors in people who are gender nonconforming (defined as those who do not conform to prevailing gendered behaviors or roles within a specific society⁸). The Institute of Medicine identified these as an important areas where future research is needed. The substance use disorder incidence, etiology, and treatment needs of people born with differences of sex development (DSD) – where the development of chromosomal, gonadal, and/or anatomical sex is atypical¹¹ – also remain unexamined. The sexual orientations, gender identities, and sex development characteristics of participants in studies that inform the addiction research literature are rarely collected, and addiction investigators are encouraged to collect this information in future studies.¹²

One would imagine, in this context, that psychiatry training would include robust inclusion of sexual orientation, gender identity, gender expression, and sex development topics. Indeed there are no shortage of lesbian and gay psychiatrists, and the American Psychiatric Association in partnership with AGLP (formerly, the Association of Gay and Lesbian Psychiatrists) features LGBT-focused programming each year at the Annual Meeting and Institute on Psychiatric Services. The Accreditation Council for Graduate Medical Education (ACGME) includes program requirements for general Psychiatry training¹³ that include two competencies that are inclusive of sexual orientation: professionalism (residents must demonstrate sensitivity and responsiveness to diverse patients) and medical knowledge (requiring residents demonstrate knowledge of factors that significantly influence physical and psychological development throughout the life cycle). Gender is referenced in patient care and procedural skills, indicating that residents must demonstrate competence in the evaluation and treatment of patients of different genders and backgrounds. Programs are also required to expose residents to patients from different genders, although it is not clear that the ACGME's references to gender refer to a binary cisgender understanding of

male / female or are inclusive of broader gender identities. In practice, sexual orientation, gender identity, gender expression, and sex development topics are inconsistently included throughout psychiatry training programs.

To respond to the need for a common set of education competencies addressing these topics, the Association of American Medical Colleges (AAMC) convened an advisory committee on sexual orientation, gender identity, and sex development in 2012. The committee defined a set of professional competency objectives to improve health care for people who are or may be LGBT, gender nonconforming, and/or born with DSD. These are defined for all physicians and oriented to undergraduate medical educators, but are easily adapted across both various medical specialties and the medical education continuum. Just as important, the AAMC published a guide entitled “Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD: A Resource for Medical Educators.”¹⁴ The purpose of this guide is to improve the healthcare of individuals with diverse sexual orientations, gender identities, and sex anatomies. An emphasized approach in the guide is to re-work existing curriculum to integrate these topics as part of existing lessons, rather than adding additional hours of didactic instruction. These competencies and implementation guide are powerful tools for medical educators and institutional champions seeking to integrate the sexual orientation, gender identity, and sex development topics critical to the modern practice of psychiatry.

The AAMC Implementation Guide was released in 2014 and is available as a free download at: <http://www.aamc.org/lgbtdsd>. A video series, clinical vignettes, and other resources associated with the project can be found at: www.aamc.org/axis. Psychiatrists need to be well prepared to deliver effective care to these patient populations. The AAMC’s goal is that all physicians are ready to address the health needs of our patients, regardless of sexual orientation, gender identity, and sex anatomy.

Brian Hurley, M.D., M.B.A., D.F.A.S.A.M., is an addiction psychiatrist and the Medical Director of Substance Use Related Care Integration at the Los Angeles County Health Agency’s Departments of Health Services and Mental Health.

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¹¹ Originally published in Glossary A: Definition of Terms, in Hollenbach A, Eckstrand K, Dreger A (Eds). Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, and Born with DSD: A Resource for Medical Educators, Association of American Medical Colleges, page 220, 2014

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¹³ Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry, 2016. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2016.pdf. Downloaded August 3, 2016.

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Mental Health Psychiatrist



A Case for Psychological Evaluations for All Medical Students

By Allen Rodriguez, MS3 David Geffen School of Medicine at UCLA

There is a growing demand for access to mental health services, in part due, to changes in laws related to health-care parity. However, there are stagnant numbers of psychiatrists which has resulted in greater unmet needs for those seeking care. Approximately 4000 Mental Health Professional Shortage Areas were recently identified in the United States, defined as having less than 1 psychiatrist per 30,000 people. As a result, primary care physicians have been increasingly responsible for managing acute and chronic mental health issues. In addition, physicians in all specialties are often first-responders when it comes to patients approaching a crisis. This highlights that all physicians should be equipped to recognize signs of mental illness and addiction and where and to whom to refer their patients. Being that so many go without access to mental health care, it is important that all physicians have the skillset to know when friends, family, colleagues, and even themselves, need the help of a professional.

Indeed, healthcare providers appear to be at high risk for clinical depression, and the data indicates that this phenomenon may begin during medical school training. A recent meta-analysis found an overall prevalence of depression or depressive symptoms among medical students was 27.2%, and the overall prevalence of suicidal ideation was 11%. Another survey of 505 medical students showed that despite significant rates of prior diagnosis of depression (14.7%) and treatment of depression (9.5%), most students indicated that, if depressed, they would feel embarrassed if classmates knew and many believed that revealing depression could negatively affect professional advancement. These trends likely continue throughout residency and beyond, when physicians experience increasing pressures to establish one's career and often little time to visit a doctor themselves.

Untreated depression among physicians comes with deadly consequences. The combined results of 25 studies suggest that the suicide rate among male doctors is 40 percent higher than that among men in general, whereas the rate among female doctors is 130 percent higher than that among women in general. Studies on burnout among physicians at all stages of their careers also show alarming levels. The extent of the morbidity and its effects on patient care and the health care system as a whole is unknown.

Some universities have proposed requiring medical students to engage in a psychological evaluation upon entering medical school, and others have proposed the requirement of a psychotherapy experience. Is there a better way of addressing these issues than requiring that medical students, the very people who will be referring others to these services throughout their careers, get exposure via a first-person experience? When counseling and psychiatry programs are made available, a significant proportion of available faculty, residents and fellows make use of them. However, the number of trainees who end up receiving assistance may be limited by lack of time, perception of stigma or institutional bias, and personal biases against mental illness. By contrast, making a thorough psychological intake, as well as follow-up visits, a completely confidential and required aspect of training for medical students, we could not only improve their wellness, but also increase their awareness and sensitivities to the mental health needs of their future patients.

Improving the wellbeing of the healthcare workforce has been shown to improve patient satisfaction and clinical outcomes. Therefore, we need to invest more effort in optimizing the health of the healthcare providers. This should begin with meeting their mental health needs. A secondary benefit of medical students who are better trained in mental health, is that they will be better equipped to meet the vast unmet needs of the general patient population. They will be more adept at identifying those in need and educating these patients about non-medication and medication treatment options. Finally, the requirement of psychotherapy as a standard part of medical education will also serve to destigmatize the need for mental health services. This will be one less barrier for patients, medical students and physicians to get the help that they need.

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[YOU ARE INVITED! to an Orange County Psychiatric Society Event](#)

Date: Tuesday, April 11, 2017

Topic: Former NFL player Ryan Leaf sharing his personal story

Description: This lecture is the kickoff event for the Sports Psychiatry Committee. Ryan Leaf is joining us to share his story and how it relates to mental health, addiction, and resilience.

Speaker: Ryan Leaf is a graduate of Washington State University where he was also a standout quarterback leading the Cougars to the 1998 Rose Bowl. Ryan went on to play professionally in the NFL but injuries cut his career short. Now author and motivational speaker, Ryan shares his message of perseverance, gratitude, and hope. His motto of “Focused Intensity” is helping mentor young athletes on the high school and collegiate levels. Ryan serves as a guest analyst on numerous national radio shows while writing and speaking nationwide. Ryan currently serves as the Program Ambassador for Transcend Recovery Community and its Mentoring Program. Given his personal growth and road to recovery, Ryan is extremely passionate about helping young adults manage the stress and difficulty of high school, college, and the transition to adulthood. Whether he is conducting assemblies at local schools, or speaking directly to students in a classroom, Ryan Leaf is dedicated to helping young adults reach, and maintain, their potential. **(Click here for more information: <https://transcendrecoverycommunity.com/ryan-leaf-biography>).*

Time: 6:30 p.m. – Dinner (provided)

7:00 p.m. – Presentation

Location: OCMA Conference Center

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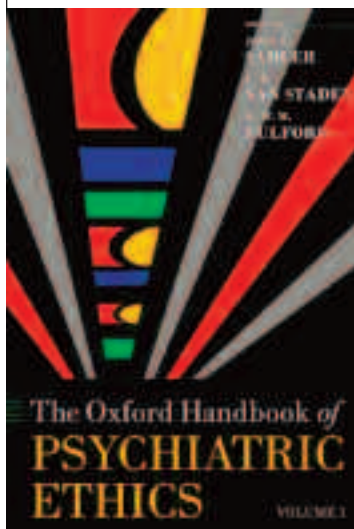
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BOOK REVIEW: Oxford Handbook of Psychiatric Ethics

By Erick H. Cheung, MD



Edited by John Z. Sadler, Werdie Van Staden, and K.W.M. Fulford; Oxford, UK: Oxford University Press; 2015 • 1417 pages • \$295.00 (hardcover, 2 volumes)

The field of psychiatry is vast in scope, setting, and purpose. The Oxford Handbook of Psychiatric Ethics (OHPE) glowingly reflects the diversity and complexity of our field, in a 2-volume, 94-chapter, 1417-page “megalodon.” The timing of such an extensive text of psychiatric ethics is clearly appropriate in the setting of accelerated scientific knowledge about the brain; evolving technologies (ie, the digital/electronic revolution); and the ever-changing societal, cultural, and political interactions with psychiatric providers, patients, and the public at large.

The authors are careful to focus on psychiatry (as opposed to “mental health” ethics, or medical ethics), with a clear intent to present novel areas of debate that expand the domain of psychiatric ethics. The result is a mixture of theoretical, philosophical, and practical-clinical ethics, organized into the following major themes: people come first; specific populations; philosophy and psychiatric ethics; religious contexts of psychiatric ethics; social contexts of psychiatric ethics; ethics in psychiatric citizenship and the law; ethics of psychiatric research; and, finally, ethics and values in psychiatric treatment.

Readers familiar with other titles in psychiatric ethics will recognize several traditional areas of ethics redux, such as therapeutic boundaries, issues unique to children and adolescents, forensics, consent and research, and a substantive review of philosophical theories as they apply to psychiatric ethics... [continue reading the full text.](#)

Dear Friends and Colleagues,

It is with great pleasure that I announce the publication of my team's article addressing the stigma of psychiatry in different minority communities, and the role of social media. The idea for this body of work came to me three years ago, and without the dedication and efforts of my colleagues who worked with me on this project, we would not have presented it, as we did, at the last two APA meetings. This year, we decided to take the project to print, and now here it is! A special thanks to my co-authors, Dr. Tiffani Bell, Dr. Racquel Reid, and Dr. Chuan-Mei Lee.

We are grateful to Medscape for taking an interest in our work and providing a platform where it can reach many viewers outside our world of psychiatry, thus helping to spread understanding, and decrease stigma.

Take a look when you have a moment, and feel free to share, as this is an important topic for all to grasp.

You will need to login to Medscape to read the article.

Here is a link: <http://www.medscape.com/viewarticle/876115>

Thank you for your time. Enjoy!

Sincerely,
Wilsa M.S. Charles Malveaux, MD, MA

Council Highlights

February 9 and March 9, 2017

Mary Read, M.D., *Secretary*



February 9, 2017 SCPS Council Minutes

The minutes of the previous meeting were approved

President's Report

Council Venue location: Dr. Bonds has investigated using the space at Didi Hirsch in Culver City for the meetings and this seems to be possible. We would have the meals catered. The facility would need to insert a caveat that if they need the space for some reason, they would have priority, but that does not seem to be a frequent issue with other users of the space. Positives: the venue is free, the parking is free, it is close to the freeway and easier to get to for many. Negatives: we would need to move if Didi Hirsch needed the space, we would need to arrange catering, security is only there until 9:00 and we would need to pay the security costs for any time we needed after 9:00.

We will see if we can try this in March to see if it works.

Inland Representation: The Inland Empire may have over 100 members after the membership renewals are done for the year and would be due another councilor. No decisions were made. Will see what the census is later in the year.

CPA RFM nomination: Discussion of USC third year resident Dr. Noorishad's nomination for the CPA RFM Deputy Representative position. Her nomination will be forwarded to CPA.

Member retention campaign: List was passed around so that all could sign up to contact 5 people about renewing their memberships

Member increase: Our membership has slightly grown (from 963 to 972)

Advocacy Day – RFM participation stipends: Dr. Arroyo has generously offered to cover airfare to and from Sacramento for one resident from each program. There was a discussion about how to choose the residents. The dilemma was whether to choose residents already involved in SCPS who know the issues or to try to get other residents involved. The eventual synthesis was to choose the three residents who currently come to the SCPS Council meeting and then open it up to those running for the SCPS Council seats for next year. We will not exceed \$5,000 in expenses.

Paypal Option: For \$20/month, we can have a quarterly payment option for members. We are not sure how popular this would be. The vote was to offer this for a year and then to review in 9 months (November 2017) to decide whether or not to continue. If it is used by <5% of the membership or there are problems with the revenue stream or workflow, it will be discontinued.

APMC Update: Still awaiting film festival decisions. Will be shown at Harbor-UCLA Grand Rounds 3/14/2017, at APA PsychSign in May as previously reported, and very likely at a co-sponsored event with PER.

Award Nominations: presented by Dr. Gross for the committee and unanimously approved

Distinguished service: Dr. Thurston and Dr. Silverman

Outstanding Achievement: Maria Lymberis, M.D.

Outstanding Resident: Drs. Wiita and Woods.

Media: we will see if Mayim Bialik (Big Bang Theory) would accept if it is given

Treasurer-Elect stepping up: Dr. Malik has had to resign as treasurer and Dr. Cheung has agreed to step in for the rest of this year and continue next year as treasurer as planned.

President-Elect's Report

Residents on Council: Dr. Simpson reports that after much discussion, the committee recommendation is that we retain two RFM voting members on the SCPS Council and in addition have one resident from each training program in the SCPS area at the meeting to act as a liaison for their program. Each program could decide how to choose the person. It could be one person or could rotate. The Council voted for this option.

Stepping Up Summit (Sacramento): This was a statewide meeting with almost all California counties represented, some at a high level. Dr. Simpson had previously emailed out a report to the Council and he read highlights from that report. There was a discussion about the concept of "criminogenic risk" and the dangers of stigmatizing people further. It is unclear if this will be an annual meeting or was a one-time occasion.

Membership Report

Presented by Mindi – there were 12 new RFM candidates and two General Member candidates. All were approved.

Legislative Report

Mr. Willick spoke about the possibility that if mandatory benefits under ACA are undone, parity may be undercut for many people. There is state law protecting parity but there still might be difficulties.

Dr. Shaner spoke about how CMS has ordered DHCS to conduct a parity survey testing if, under ACA, health, mental health, and substance abuse treatment have complied.

There have been three bills introduced by the CA Emergency Physicians Association: 1) Grants 5150 authority to ER doctors 2) Removes liability exposure for ambulance drivers/companies 3) Changes the interpretation of EMTALA so that psychiatric hospitals must accept emergency transfers even if they do not have an ED. Mr. Willick here pointed out that EMTALA is a federal law and this would be open to a quick challenge

Newsletter Report

Dr. Goldenberg thanked everyone for contributing to the last issue and passed around the sign-up sheet for future articles. Dr. Bonds suggested that people could link to their articles on social media. Dr. Goldenberg suggested sending the link to other psychiatrist and other mental health professional to widen readership.

Treasurer's Report

Dr. Cheung reviewed all spreadsheets sent out to the Council. We remain in good shape

Program Committee Report

Dr. Gales reports that the Psychopharmacology meeting generated more money this year as a result of more booths and more attendees though there was some mixed reaction to the format of some of the talks that allowed for more interactive time during the presentation. Next meeting is the Internal Medicine for Psychiatrists on April 1.

New Business

Dr. Bart Blinder from OCPS called to say that Orange County is interested in adding Long Beach and Riverside to its membership pool. It is not clear where this came from or is going.

Mr. Willick informed us that the Medical Board is getting more assertive about subpoenaing records even if the patient does not consent and that they seem to be reviewing the CURES data base for prescribers of ADHD medications as well as for prescribers of psychotropic medications for foster children.

Mr. Willick also highlighted a new billing practice in which an inpatient substance abuse facility hires a psychiatrist, pays the psychiatrist for the treatment given to patients regardless of reimbursement, then the facility bills Medicare Part B or other insurance on behalf of the psychiatrist and keeps any payments. There is a concern that this practice could be questioned.

Old Business

Mindi bought two new computers but neither worked out. They have been returned along with all of the software and a new computer will be purchased.

Dr. Bonds adjourned the meeting at 8:45pm

March 9, 2017 SCPS Council Meeting Minutes

The meeting was gaveled to order at 7:05 by our President, Dr. Curley Bonds.

The minutes of the previous meeting were approved

President's Report

Call with Dr. Levin re: APA, Inc.: This is the preferred malpractice carrier for APA . There are strings attached to some APA grants because of this. There was a discussion of the independent status of SCPS and our ability to make our own contracts.

APMC/AdHoc/PER Update: The film is fully insured and cleared. DVDs will be made. The film will be shown at Harbor-UCLA Grand Rounds on 3/14, and at several regional meetings as well as twice at the APA annual meeting, once at PsychSign for the medical students and once for older psychiatrists. The AdHoc Committee is still working on SCPS/PER collaboration with NAMI to show the film somewhere near UCLA with CME provided. Mindi will check on various issues. Dr. Lymberis said that PER is talking with the LACMA CEO about showing the film to the LACMA membership for CME. PER is looking for contributions for this venture and to have all of us act as ambassadors for the film.

Meeting Location Update: Didi Hirsch did not pan out. Billingsley's is another option but after an amusing interlude and memories, it was decided not to return there. Several options were floated. Members would be willing to pay slightly more for the meal but many West LA venues are more expensive than our current place. Council voted to fund \$500 for Mindi to explore other options and report back in two months.

Member Retention Campaign Update: Our efforts worked (or at least more people have paid)

Internal Medicine CME: 50 signed up so far, probably will not be the 100 we expected but we will be okay financially as Cedars is providing the space free of charge.

Installation Day Reminder: April 22 at Le Merigot

Advocacy Day – Resident Update: We have residents signed up to participate

Newsletter Report: Dr. Goldenberg thanked everyone who has contributed and asked that we continue to forward the information to others to increase readership. We discussed future possible topics and how many current affairs topics might be appropriate like the ACA repeal and replace, immigration policies, etc.

Assembly Report (out of order because of conversation about topics for newsletter)

Dr. Fogelson, Dr. Gross, and Dr. Schaepper led the discussion about possible action papers. Dr. Gross spoke about activism v. advocacy – what one might do as an individual v. a psychiatrist v. as a member of a larger organization. How involved should we get as an organization? Would we alienate members by taking strong stands? We discussed ACA repeal/replace, transgender rights (and other LGBT rights), immigration, Planned Parenthood and women’s health, and gun laws. The APA Federal Advocacy Day has not been scheduled though it is usually in April.

And back to the President’s Report...

Dr. Joe Schneider passed away recently. Known to many in our organization

Fellowship and Awards Follow up

It was overlooked last month that Dr. Erik Cheung has also been given an award this year. Mayim Bialik, it was noted, is Jewish and observant, so a Saturday afternoon occasion would not work but could we have her acceptance by video or should we postpone to next year?

LA Psychiatric Acute Care Collaborative

Dr. Cheung presented this idea that has sprung from the West LA VA. Is there value in developing a consortium of public and private folks who do emergency work to share solutions, advocacy issues, court issues processes and outcomes etc.? We have this for the Los Angeles County public Psychiatric EDs but not outside of them.

President Elect’s Report

Dr. Simpson clarified the Step Up concept of “criminogenic” after correspondence with some of the originators of the concept. It sounded more like a parallel diagnosis, akin to substance abuse and another mental illness as a dual diagnosis

Treasurer’s Report

All emailed reports were reviewed. We are financially stable

Membership Report

All were approved: Drs Downie, Eller, and Spinie as RFMs and Dr. Geetha Puri as a reinstatement as a GM.

We also discussed and voted in favor of granting dues amnesty for those returning members in line with current APA policy

Legislative Report

Neither Dr. Read nor Dr. Shaner had been on the previous CPA GA Committee call but will be in Sacramento all day on Saturday and will report back. We were unaware of anything beyond the chaos of the ACA repeal efforts.

New Business: none

Old Business: Mindi is working on getting internet and a new laptop that function well together

The meeting was adjourned at 8:45pm

On Saturday, April 1st, the SCPS Program Committee held its first *Internal Medicine for Psychiatrists* CME meeting. Speakers included: Michael Bush, M.D., who spoke on Endocrinology; Caroline Hwang, M.D., who spoke on Gastroenterology; and Mark Urman, M.D., who spoke on Cardiology. Here are some photos hot off the press!



Michael Gales, M.D., and Michael Bush, M.D.



Michael Bush, M.D.



Caroline Hwang, M.D.



Mark Urman, M.D.

My First Foray into “Advovism”

by: Mindi Thelen, SCPS Executive Director

Advocacy, Activism....Advovism

ad·vo·ca·cy (ăd'və-kə-sē) *n.*

The act of pleading or arguing in favor of something, such as a cause, idea, or policy; active support.

ac·tiv·ism (ăk'təvīz'əm)*n.*

The use of direct, often confrontational action, such as a demonstration or strike, in opposition to or support of a cause.



There have been a few articles in this newsletter recently about advocacy and its importance to the organization, to your profession, and to your patients. There has also been a series of Action Alerts over the last few days as President Trump and the GOP fervently tried to pass new healthcare reform that would have been to the detriment of anyone who suffers from mental illness. A lively discussion took place at last month's Council meeting about activism and whether or not there is a role for that form of advocacy in this organization and this newsletter.

I have had my first foray into.....'advovism.' Using the definitions above, what I did wasn't quite advocacy and wasn't quite activism, but it had tinges of both. In early January I read a blog post that an ex-neighbor of mine had posted on her website. It was this lovely story about an experience she and her children had at a potluck that they had been invited to at the local mosque. She talked about meeting a remarkable Muslim man from Ethiopia and about what a positive event it was for her children. I thought it was a wonderful story, but kind of forgot about it. Then, President Trump wrote his Executive Order. I'm sure you know the one I mean. I immediately remembered my friend's story and decided to go to the local mosque and see if they would be interested in hosting a community potluck if I organized one. They were touched by the offer and pleased to host. But, this article isn't about the potluck or the reason that I did it. It's about the many things I did and learned along the way.

I had to figure out how to reach the community. I went to my first Homeowners Association Meeting. I never knew I could go since I am a renter, but I was welcomed with open arms. At that meeting, the three candidates for the then-upcoming election for the City Council seat in my district had five minutes each to address the neighborhood. One of the Association officers mentioned how HOAs are really the very first level of government and explained how they are connected to neighborhood councils and the City Council. It made sense and I decided that I would start attending the bi-annual meetings.

Next, I went to a couple of free community events and passed out flyers for the potluck. That was fun, but the most interesting and important thing that I did was go to my Neighborhood Council meeting. I was familiar with them because I go to my neighborhood Farmer's Market every week and had visited with them there, but I had never gone to an official public meeting. At that meeting I realized that Neighborhood Councils are a step above HOAs and have a direct link to city and county government. They have several committees that the public can participate on and offer a real opportunity to make a difference in your neighborhood and the larger community. I am on the cusp of two neighborhood councils (Palms and Mar Vista) and plan to be an active participant of both!

If going to your legislators' offices to do advocacy is not your thing or you are unable to commit to being a 'key contact' when we send out Action Alerts, maybe joining your Neighborhood Council's Homeless Committee, or another committee, will be right for you. I am sure they would benefit from the expertise a psychiatrist could offer. Not all neighborhoods have Neighborhood Councils, but if yours does, I urge you to get involved. Most of the committees only meet for an hour or two a month and you could have a direct effect on your own neighborhood and possibly a greater effect on the city and county.

I've also joined a local Democrats Club and I'm hoping to do some effective things with them. There's no better time to get involved than now.

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