Southern California

PSYCHIATRIST

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President's Column

Burnout

Curley Bonds, M.D.

Now that the endless propaganda campaign of the election is behind us, we can now look forward to the constant bombardment of holiday marketing messages. Meanwhile the steady rhythms of work will continue to beat on for most of us. With all of the expectations placed on us by our patients, the institutions that we serve, and the regulatory agencies that govern our lives it is not surprising that many US physicians will at some point experience the signs and symptoms of burnout. This month's column will be devoted to helping you identify burnout and provide some helpful hints about preventing it.

The Maslalach Burnout Inventory identifies three different domains of the burnout phenomenon: emotional exhaustion, depersonalization and reduced personal achievement. Physicians experiencing burnout often feel depleted from being overworked. They may also be cynical and feel detachment from their patients. Despite feelings of working very hard, they may also feel that they are less productive and achieving little. They may at times even question their competence. The literature on this topic is growing and it is now known to be a real, measurable concept, not just a vague idea. It affects 55-67% of those in private practice and 37-47% of academic faculty. While it was once thought to be a late career phenomenon, it is now found increasingly among younger physicians. In fact, a recent study published by the Canadian Medical Association found that 50% of resident physicians suffered from burnout.

The effects of burnout are wide reaching and can include anxiety, depression, substance abuse leading to addiction and even suicide in extreme cases. Exhaustion can lead to increased errors in clinical work and the majority of burnt-out physicians feel that their family and personal lives suffer. According to the American Medical Association, psychiatrists have moderate rates of burnout compared to other specialists hovering a little over 40%. This is compared to rates of 70% for Emergency Room docs and about 60% for general internists. The lowest rates are found among preventative medicine, occupational and environmental medicine docs at less than 30%.

Several factors contribute to higher rates of burnout. It is important to examine your own work-life balance to see how many of these might apply to you. Organizational factors top the list and can include excessive workload, workplace politics, loss of control (perceived or real), increased computerization and litigation or liability concerns. I have seen first hand how these issues can sap the enthusiasm of community and academic psychiatrists as more and more expectations are piled higher and deeper. If you've never confronted the frustration of having to learn a new electronic health

(Continued on page 2)

In This Issue...

record system, count yourself among the fortunate! Personal and patient factors also play a role. If you find your job unfulfilling and if you are vulnerable to stress you are at higher risk. As our patient population ages, they face declining health and often have unrealistic expectations for what we can provide for them. Some of our members who work with aggressive patients (e.g. correctional or forensic settings) are also at increased risk for burnout.

Fortunately, the increasing awareness of burnout has been accompanied by more information about the effectiveness of interventions. Structured individual and institutional strategies can decrease the incidence of burnout. Topping the list are things like self-care and stress reduction programs. Strive for balance in your life. Dr. Christine Sinsky from the AMA recommends that one avoid the impulse to take work home. She also suggests that when you leave the workplace and enter your home, take a moment to shift gears mentally. Consider adding date nights to your social calendar so that you'll have protected time to relax. We all have to take personal responsibility for self-care. Make time to pursue activities that you enjoy. Schedule and take vacation time. Maintain healthy diet and exercise habits and don't fall into the trap of delaying gratification. For some of us, the answer may be to create more flexible work schedules and to ask peers for help.

I cannot think of a better holiday message than to encourage all of our SCPS members to commit themselves to a culture of wellness. As you face the unrelenting demands of the season, stop and think about the reasons why you went into our field. There are boundless rewards that can come from improving the lives of others but only if we take the time to make sure that we are managing our own needs too. Have a healthy and happy holiday.

Advertisement

Letter from the Editor

Why the Holidays Are the Right Time for Our Patients to Engage in Treatment

Matthew Goldenberg, D.O.

The Holiday Season is a happy and festive time, surrounded by friends, family and happy memories. However, for many of our patients, especially those suffering from severe mental illness and/or addiction, the holidays are anything but happy. As Psychiatrists, we know that this time of year can be triggering, isolating and filled with anxiety and negative emotions.

When our patients get control of their mental health and/or addictions, it can improve the quality of life of their entire family. However, putting off treatment can be especially appealing during the holidays. No one wants to be away from family and friends during the time of year that is all about togetherness. There is also the appeal of waiting to "turn over a new leaf" in the New Year. And, really, what do a few more days of suffering matter?

The problem of course is that each day does matter with addiction and mental health. It is one more day in which a patient continues to potentially put themselves and others at risk. One more day for their symptoms to worsen, and one more day for feelings like hopelessness, guilt and despair to creep in.

However, we can educate our patients that delaying getting help during the holidays also means missing out on what can actually be one of the most advantageous times of year to get treatment, including inpatient or residential treatment, for a variety of reasons. When discussing the pros and cons of seeking treatment during this holidays consider these advantages:

> Residential rehab facilities and IOP programs tend to have more availability this time of year because everyone is doing the same thing — holding off and making New Year's resolutions. If your patient takes action now, they are more likely to get into their preferred program right away, rather than facing waiting lists or having to compromise on a second or third choice.
>
> From a purely practical standpoint, the pace slows in many professions over the holidays, and for some it can be easier to schedule time away from the job. Therefore, taking time off of work over the holidays can be an aid to confidentiality. As the holidays are a peak vacation time, being gone for a block of time will attract less attention from friends and colleagues and spark less curiosity than other times of the year.
>
> Quality residential and IOP treatment programs encourage celebration of the holiday season and provide the means to do so. There will be opportunities to connect with family, special events and programing, emotionally satisfying service projects, decorations — all of which help build even greater bonds in the treatment community than would happen at other times of the year.
>
> There is an emotional depth, potentially triggering events and strong family of origin themes to the holiday season. This time of year can lead to serious reflection which can be a powerful aid to patients' understanding and dealing with the issues underlying their addiction and/or mental health conditions.

There is rarely a good time to enter into intensive treatment like residential or IOP treatment programs. The holiday season provides additional excuses to put off treatment. Notably, our patients may feel that not being around their loved ones during the holidays is one more way they are letting everyone down.

However, I encourage you to facilitate your patients' in considering of their ability to transform their lives for the better by taking the time to get treatment. It is the best gift they can give themselves and their loved ones. Their family and friends get a break from worrying, as well as the comfort of knowing that their loved one is in a safe environment and improving their life and, by extension, the lives of those who care about them. Your patients get the gift of improved control over their mental health and/or addiction, improved quality of life and the ability to start off the New Year truly happy and healthy.

Continuing Education
The Southern California Psychiatric Society is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. The Southern California Psychiatric Society takes responsibility for the content, quality and scientific integrity of this CME activity.

The Southern California Psychiatric Society designates this educational activity for a maximum of 5 *AMA PRA Category 1 Credit(s)™*. Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

The Paranoid Patient - Perils and Pitfalls
Phillip J. Resnick, M.D., Professor of Psychiatry, Case Western Reserve University, School of Medicine.

Evidence-Based Guidelines for the Treatment of Depression
David L. Fogelson M.D., Clinical Professor of Psychiatry at the David Geffen School of Medicine and the Resnick Neuropsychiatric Institute at UCLA

Choosing Wisely in Mental Health: What Should You Do in Treatment?
Gray Norquist, M.D., M.S.P.H., Professor and Vice-Chair Emory Dept. of Psychiatry and Behavioral Sciences; Chair, APA Council on Quality Care

Treating Anxiety Disorders and OCD: An Update
Lorrin M. Koran, M.D., Professor (Clinical) of Psychiatry, Emeritus, Stanford University Medical Center

5 Hours Category 1 CME

For full details and to register, please go to:
http://www.socalpsych.org/events.html

Please note that each talk will be 1.25 hours. Two of the lectures, ***Evidence-Based Guidelines for the Treatment of Depression, and Choosing Wisely in Mental Health: What Should You Do in Treatment?*** will be taught with the opportunity to prepare in advance by reading pre-circulated materials. Using this innovative model (the flipped-classroom model) the learner does knowledge-learning up-front allowing more time at the meeting for application. The slide presentation for both of these lectures will be emailed to you in advance. You are nearly guaranteed to get more out of the day if you do this Pre-Work!

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Smoking Cessation Should Be a Core Component of Psychiatric Practice

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

Psychiatrists often overlook tobacco smoking in our patients, and leave opportunities to intervene with smoking cessation strategies unaddressed. These are monumental missed opportunities, given that over half of patients with serious mental illness report regularly smoking tobacco cigarettes compared with a fifth of those with no such illness. The high prevalence of smoking in our patients has led to repeated calls by some psychiatrists to incorporate smoking cessation interventions into our practices.

People with severe mental illnesses have poorer physical health and earlier death than those without. Previous research suggests that tobacco-related conditions comprise approximately half of the deaths of patients with serious mental illness. People with severe mental illnesses are less likely than those without to receive preventive medical care and primary care, so it is incumbent upon psychiatrists to act and protect the health of our patients through delivery of smoking cessation treatments.

In a review of nine community mental health sites, less than half of the clinicians reported asking their patients about smoking tobacco. Psychiatrists often conclude that patients with mental illness are not motivated to quit smoking, yet the data suggest these patients are just as motivated to quit smoking as other smokers. Contrary to common expectation, quitting smoking helps improve distress tolerance and emotional regulation, as former smokers no longer crave the use of tobacco products to manage nicotine tolerance and withdrawal. Smoking cessation helps protect good mental health.

The United States Preventive Services Task Force recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Psychiatrists, in particular, are in an ideal position to provide smoking cessation treatments to our patients. We generally have longer and more frequent appointments than our primary care colleagues and have specialized training in psychotherapy and psychopharmacology.

The pharmacotherapy of smoking cessation is straightforward and well described in the literature. In brief, nicotine replacement therapy (NRT), bupropion, and varenicline are all frontline pharmacotherapies for smoking cessation, with effect ratio compared with placebo reported to be, respectively, 1.6, 1.7, and 2.3.

Nicotine Replacement Therapy should be prescribed at the equivalent dose of the amount of nicotine the patient consumes through smoke. There is approximately 1 mg of nicotine per cigarette smoked to calculate the NRT dosage. While NRT has a strong safety profile, it is associated with nightmares and insomnia if taken overnight and can cause site irritation at the point of contact with the body.

Bupropion is recommended for smoking cessation at 150 mg sustained release once daily for one week and then increased to twice daily thereafter, although some clinicians uptitrate bupropion to 300 mg extended release once daily for smoking cessation. Bupropion is associated with insomnia, headaches, dry mouth, nausea, and anxiety. Bupropion is contraindicated for patients with current or previous seizure disorders, bulimia, and anorexia nervosa and those taking monoamine oxidase inhibitors.

Varenicline is a high-affinity nicotinic receptor partial agonist, and therefore it is not prescribed in conjunction with NRT. Varenicline is typically initiated at 0.5 mg daily for three days, then 0.5 mg twice daily for four days, and then 1 mg twice daily thereafter.

Lastly, smoking increases hepatic clearance of many psychiatric medications via CYP P450 1A2 and 2E1, and therefore it is recommended that psychiatrists monitor serum levels and consider dosing adjustments of psychiatric medications at transition points where patients start or stop smoking tobacco.

SAMHSA has published an excellent resource describing psychosocial approaches to smoking cessation for people with mental illness, including treatment components for successful individual and group therapy. Addi-

tionally, there is a California Smokers Helpline (available via 800-NO-BUTTS (1-800-662-8887) and https://www.nobutts.org) that offers counseling, self-help, text-message-based, and online services to help smokers and other tobacco users quit. Offering our smokers a referral to this California Smokers Helpline is an easy and low-threshold step to take.

Psychiatrists are well served to use a combination of psychotherapy with motivational follow-up sessions to assess ongoing motivation for smoking cessation and engage cessation planning. Given the rates of smoking and smoking-related health consequences in our patients, psychiatrists should be leading the delivery of smoking cessation interventions to our patients. Our patients are as motivated to quit as smokers in the general population, treatment is effective, and we have the skills to deliver high-quality smoking cessation care.

Brian Hurley, M.D., M.B.A., D.F.A.S.A.M., is an addiction psychiatrist and Robert Wood Johnson Foundation Clinical Scholar at the David Geffen School of Medicine at the University of California, Los Angeles. He is the Treasurer of the American Society of Addiction Medicine and previously served on the American Psychiatric Association Board of Trustees. His career focus is to promote the adoption of evidence-based substance use disorder treatment in general medical, mental health, and specialty substance use disorder treatment settings.

Editors note: This article should not be considered medical advice or substitute for a formal evaluation with your doctor. The SCPS believes that every patient should be evaluated with an appropriate face to face examination, taking into account his or her unique situation, before any treatment recommendations can be made.

Dr. Matthew Goldenberg, our Editor, has had the following article published in the Huffington Post. This was published on 11/26/2016 in the US Edition.

Paging Dr. Goldenberg: Part 1, The First Four Steps to Get Control of your Mental Illness and/or Addiction
By Matthew Goldenberg D.O.

For those struggling with mental illness and/or substance use disorders, one of the most challenging aspects is recognizing and accepting that you need help. I am a Psychiatrist and I specialize in the treatment of adults with addiction and/or mental illness. My patients are primarily motivated professionals, many of whom are physicians, lawyers, pilots and executives. However, an adult professional also includes teachers, actors, sales and marking specialists and everyone else in between.

The common thread in the professional population is being high achieving, highly motivated and ambitious. Many of my patients are thriving in some areas of their lives, or at least it may appear so from the outside. However, on closer inspection and beneath the happy face they maintain in public, their struggle with addiction and/or mental illness is often systematically tearing their lives apart.

When a new patient comes to my office for help, they are already on their way to recovery and to improving their quality of life. There are four essential steps you can take to get your life back on track as well. Click here, to continuing reading...

The 9-1-1 Response to Mental Health and Substance Abuse Emergencies

By Erick H. Cheung M.D.

This is a synopsis of the LA County Emergency Medical Services Commission report on the pre-hospital care of mental health and substance abuse emergencies (approved by the EMS Commission on November 2016).

The "Ad Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse (MH/SA) Emergencies" was created by a motion of the Los Angeles County Emergency Medical Services Commission (EMSC) on November 18, 2015 to address two broad goals:

To evaluate the current manner in which MH/SA emergencies are handled by the 9-1-1 system, and

To propose a short and long term vision to improve the quality of care and safety for the patients, families, neighbors and first responders.

The Committee posed a fundamental question: What happens when a person in LA County calls 9-1-1 with a MH/SA emergency?

The Answer: Unlike the response for medical emergencies, which could be generally characterized as predictably delivered and uniformly regulated, the response to MH/SA emergencies is comparatively varied and lacks the same coordinated delivery and regulation. The main source of variation lies in the fact that two very different entities, Law Enforcement (LE) or Emergency Medical Services (EMS) agencies, may be dispatched as a result of a 9-1-1 call.

A number of questions naturally follow: When does LE respond, when does EMS respond, and how is this decided? What are the differences or similarities in the LE, EMS and DMH response? Is one response better than the other in terms of patient care, or patient preference? Do LE and EMS responses lead to different standards of care or outcomes for patients?

Through a several months long process involving extensive stakeholders, The Committee identified four major themes that ultimately serve as fundamental guiding principles in evaluating both the current system and proposed changes:

MH/SA emergencies are medical emergencies, and, as such, are best treated from the point of first contact by medical/clinical personnel trained, equipped, and experienced to evaluate and manage the patient.

A proportion of MH/SA emergencies involve acute behavioral agitation, violence, threats of harm to self or others, or criminal activity, in which case they most likely require the combined response of EMS and LE.

MH/SA emergencies in adults and children are best treated in emergency facilities (transport destinations) that are appropriately designed and resourced to address MH/SA needs.

The system of prehospital care for MH/SA emergency patients should be based on established best practices, which are consistently applied throughout the County regardless of which agencies respond.

The Committee underscored the fact that prehospital care response to MH/SA emergencies is intimately related to, and impacted by, the lack of ready access to acute care services (e.g. inpatient psychiatric beds). In addition, it is impacted by patients' access (or lack thereof) to timely resources and treatment for non-emergent MH/SA problems, where case management and wrap-around care are needed to reduce the incidence of

MH/SA emergencies.

Committee Observations: The Committee made a number of consensus observations about the current MH/SA emergency response system. Several of the key observations are included below (see full report for all Committee Observations and detailed process maps):

The current MH/SA emergency field response is variable, and lacks uniformity and a source of central oversight. The dispatch of EMS or LE is based on local customs, and, in many circumstances, may be defaulted to LE as the first responder. LE officers are, therefore, often in a position of conducting clinical evaluations of MH/SA patients with a goal of determining whether the patient needs treatment, and to determine the best destination option, despite the lack of medical training.

The LE response, and more specifically the transport of patients in squad cars in handcuffs, has the undesirable effect of "criminalizing" persons with MH/SA emergencies.

LE agencies have made, and are continuing to make, valiant efforts to improve officers' training and interactions with MH/SA patients. Likewise, several agencies have developed MH/SA emergency response teams, staffed with specifically trained law or clinical personnel, to attempt to address the demand and risks of LE's response.

The current EMS field treatment protocols for management of the acutely agitated person with a MH/SA emergency are limited to identification of patients with "agitated delirium" and treatment of these patients is limited to using chemical restraint (e.g. midazolam). The use of such agents for chemical restraint in MH/SA emergencies have not been well studied and often lack efficacy.

The current system provides several destination options to LE that increase the access to appropriate mental health care for patients with MH/SA emergencies (such as options to transport to Mental Health Urgent Care Centers (MHUCCs) or directly to freestanding Psychiatric Hospitals. Conversely, the current EMS destination is limited to emergency departments only.

Many EDs that currently receive patients from EMS providers lack both sufficient resources and expertise to optimally manage MH/SA patients.

Substance use disorder services are largely unavailable or lack integration into the emergency and acute care system.

Committee Recommendations: A few of the key recommendations of the Committee for change to the current MH/SA field response are listed below (See full report for all Committee Recommendations):

Modify and standardize the MH/SA emergency 9-1-1 triage criteria to match the field response (LE vs. EMS) to the type of emergency situation. Specifically: triage LE to patients who may be combative, violent, or exhibiting potential criminal behaviors, and triage EMS to all other MH/SA emergencies.

Investigate the pros/cons of establishing MH/SA emergency specialized care centers, akin to the system for STEMI, trauma, stroke, etc., to improve the care for MH/SA emergencies.

Determine the feasibility (including regulatory and financial/economic or practical barriers) of alternate destinations to directly transport EMS patients to specialty EDs that demonstrate the capacity and expertise to care for MH/SA patients, to MHUCCs, or to other destinations that can provide the appropriate evaluation and treatment. Investigate and pursue the integration for substance abuse detoxification and rehabilitation services as destination options for EMS, LE and EDs.

Support regulatory changes to ensure parity for all populations, including the following key issues. Medi-Cal currently does not reimburse free standing mental health facilities for care to adult recipients. Further, the Drug Medi-Cal Organized Delivery System benefit program being implemented by DPH focuses on outpatient SA treatment and does not provide reimbursement for inpatient services.

Develop additional treatment protocols (non-pharmacologic and pharmacologic) to address combative, agitated or potentially violent behavior (as the result of acute psychosis, substance intoxication or withdrawal, delirium, and undetermined etiologies) in MH/SA adult and pediatric patients.

Concluding Remarks: MH/SA problems are prevalent, disabling, at times dangerous, and increasingly the cause for calls to the 9-1-1 system. In LA County, the field response to MH/SA emergencies is highly varied, with either a LE and/or EMS response based on non-uniformly standardized or regulated triage protocols. As a result, a person cannot reliably predict who will respond and how his or her MH/SA emergency will be evaluated and managed in the field, and, furthermore, how or where he or she will be transported to in the event that additional care is needed.

The current system has placed LE personnel frequently in the position of performing clinical evaluations for, and attempting to manage, MH/SA issues in the field. The Committee firmly asserts that MH/SA emergencies are medical emergencies, and as such are best addressed by trained healthcare personnel, whenever possible. Finally, the Committee fully recognizes that MH/SA emergencies are unique in their potential for first responders to encounter adult and pediatric patients who may be acutely agitated or potentially harmful to themselves or others. New protocols and training are necessary to tailor and equip the EMS and LE response to these situations, including training in verbal de-escalation as well as pharmacologic treatment protocols, in order to provide the highest quality of care and to minimize the use of force and potentially disastrous outcomes.

What's New at the APA

APA announced their new Mental Health Registry PsychPRO. PsychPRO will help psychiatrists deliver high quality care and meet new MACRA quality reporting requirements by the Centers for Medicare and Medicaid Services, (CMS). It will also serve to spur future medical research and the development of better treatment and prevention methods for mental illness. You can read more about PsychPRO here.

APA applauded a report from Surgeon General Vivek Murthy about the public health crisis of drug and alcohol abuse and calls for collected coordinated action to address the problems. APA is an active participant in TurnTheTideRX, the Surgeon General's campaign to address the prescription opioid epidemic, and pledged to continue collaborative efforts to combat the crisis. You can read more about the Surgeon General's report here.

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Get to Know Your 2016-2017 SCPS Board Members: A Brief Q+A with SCPS Secretary, Mary Read M.D.

This is the second in a series of conversations with 2016-2017 board members. We hope you enjoy getting to know a little more about Secretary, Mary Read M.D.. We thank our Board Members for their time and participation!

Q1: What initially sparked your interest in the field of Psychiatry?
A1: My mother worked at a children's hospital when I was growing up and I began volunteering with special needs children when I was still young. I was initially drawn to psychology but decided I wanted to be able to have more tools to help people so I applied to medical school.

Q2: How has field changed or been different than you initially imagined?
A2: There have been some very positive changes: Decrease in stigma and resultant increase in visibility of people with serious mental illnesses, parity, and increased early detection and treatment. On the negative side, we have seen a decrease in resources for inpatient services for all age groups but especially for children and adolescents. Trying to decrease the barriers between substance abuse, mental health, and primary care will change things even more in the near future.

Q3: Tell us about the area of psychiatry in which you practice or your practice setting?
A3: I work in outpatient psychiatry at Harbor-UCLA, a public academic setting with a residency program as well as other training programs and medical students from UCLA.

Q4: What motivated you to become more active with SCPS?
A4: I had been active with CPA for many years and was asked to become involved as the South Bay representative

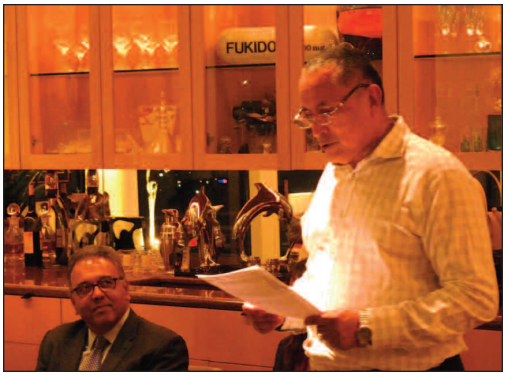
Q5: Where do you hope to see the field of Psychiatry go in the next 20 years?
A5: I hope that we develop more effective treatments both pharmacological and psychological. I would like to see more resilience work done for children in high risk settings.

Q6: If you could go back in time, with what you know now, what advice would you give yourself related to your career as a Psychiatrist?
A6: I think I have been very fortunate to have found public psychiatry in general and Harbor-UCLA in particular. I would probably tell myself not to worry so much about how things will turn out professionally but that is more easily said when it has worked out well.

Stay tuned for future Q+A's with SCPS President Curley Bonds, M.D., and Treasurer Arsalan Malik, M.D.

Photo Gallery from Recent SCPS Events

Career Fair for Psychiatrists
Meeting on Pregnancy and Postpartum with SCSCAP
Women's Lunch - TED Talk by Brene' Brown on Vulnerability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Council Highlights
November 10, 2016

David Fogelson, M.D., Acting *Secretary*

Joe Simpson, M.D., called the meeting to order

Minutes of the prior meeting were approved

President's report:
Dr. Fogelson, Schaepper, and Lawrence gave an Assembly report:

Action Paper recommended smart guns
Action Paper Mental Health Parity and the Intellectually Disabled
Action Papers on Access to Care; continuity of care to facilitate communication between outpatient psychiatrist and inpatient treatment team
JRC (Joint Reference Committee) resolution on assisted suicide, no physician shall aid a patient in dying who is not suffering from a terminal illness
Position paper on substance abuse; education of psychiatrists about this; any substance abuse adversely affects adolescent development
APA Foundation: programs for middle schoolers; typical or troubled; help teachers to identify students at risk; contribute to the foundation and the PAC; suggested a $20 contribution to each
Assembly Liaison Committee to the Steering Committee on Practice Guidelines, attended by Dr. Fogelson, minutes of that meeting follow:

Institute of Medicine standards, were adopted by the APA in 2011 to be used in the creation of Practice Guidelines, core authors must not have a COI, in part accounts for delay in guideline development process.

As new guidelines are created should they be subject to assembly approval before publication?
This is a somewhat pressing question as two new guidelines created based on the Institute of Medicine Standards, are near completion.

Concern was voiced as to whether the Assembly can move quickly enough to approve newly created guidelines; sentiment is that the Assembly should be involved in part to share real world experience that can meaningfully inform guidelines

What will the process be for updating guidelines? How do we keep them current? APA is committing resources to lit reviews and summaries to guide the process. Will it take the form of publishing and updating a Guideline watch in a timely fashion? May there be a way to "crowd source" APA membership expertise in creating the guidelines?

What should the guidelines include? Pharmacotherapy and psychotherapy and comparative studies if available, including comparisons of same modality to same modalities as well as across modalities.

The recommendations for practice should be "measurable." Utilizing the AHRQ standards as the sole standard for creating reviews is itself under review.

In accordance with national standards, including those of the Agency for Healthcare Research and Quality's National Guideline Clearinghouse

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MOC Assembly committee; ABPN; why are they as expensive as they are? Why are candidates expected to pay an annual dues when recertification is only once every ten years.

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Executive Director's report from APA meeting of Executive Directors; Mindi attended a workshop on ethics violations and procedures to follow, laid down by the APA.

The DB Execs meeting discussed, changing life members to 99 from 95 years which is combination of age and years of membership to begin reduction of dues. Discussion that new leadership at APA does not explain why state and national membership are recommended; Saul Levin says that they do support belonging to both; a new membership program will be online; once paying your dues you will receive notice that you are a member; but district branch can reevaluate; and there is a new MACRA tool kit and webinar.

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Newsletter update by Matt Goldenberg, November edition went out; had Q and A with President-elect; member spotlight; thanks to people who signed up to write articles; Scott Hunter will talk about Prop 64 and adolescents

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Consider by law change: combine Santa Barbara and Ventura they would only have one rep; combine LA South and South Bay they would have two; Santa Clarita and Antelope Valley are currently part of San Fernando Valley but they only have six members; consider them as a new district? Consider as an action item for the next meeting.

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The future of Public Psychiatry postponed to next meeting.

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Treasurers Report

October Financials were approved. Draft 2017 Budget was approved and adopted.

Membership Report; two new applicants were approved; both residents.

Program Committee Report by Mike Gales; Psychopharmacology meeting end of January, flipped class room; Philip Resnick, M.D., the difficult patient; Grayson Norquist, M.D., choosing wisely; Lorin Koran, M.D., Rx of OCD; David Fogelson, M.D., the Role of Antidepressants in Bipolar Depression. Spring meeting: need to gather ideas: C & L program; Internal Medicine for Psychiatry; Difficult Cases the suicidal patient; the treatment refractory patient. A program for EHR selection.

Career Day 45 attendees; RFMs and ECPs, wide variety of sectors represented; Attendees were enthusiastic. Fall Women's lunch at Jackie Green; TED talk on vulnerability; 11/1.

Old Business

Coordinate nominating committee with Larry Lawrence, Anita Red, Joe Simpson.

Maryanne Schaepper advised that PPOs may not honor scripts by out of network physicians; MediCare may not honor scripts by physicians who have opted out.

Maria Oquendo, President of the APA, on the national election; ensure access to mental health care; Tim Murphy of PA, working with legislators across the aisle to continue to promote the mental health of all Americans.

Adjournment

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Positions Available

Child Psychiatrist – Vista Del Mar, a 100 year old agency, is immediately seeking a 20 hrs/ wk; Board Certified, Licensed Child Psychiatrist for Wraparound / Outpatient programs. Position will work with an interdisciplinary team / medication management & consultation. jobs@vistadelmar.org

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