Southern California

PSYCHIATRIST

Volume 63, Number 10 June 2015 Newsletter of the Southern California Psychiatric Society

President's Column

First Tracks

Heather Silverman, M.D.

It is with great enthusiasm that I assume the role of President of SCPS. Through personal contact with many residents and members over the years, as well as several years serving on Council, I have great confidence in our potential to accomplish many things on behalf of our patients and membership.

The strength of our national organization, the APA, was very much in evidence at the recent annual meeting in Toronto. Not only was the Toronto meeting replete with educational offerings and convincing demonstrations of support for patient wellbeing, it also consistently underscored the extent to which our national organization works to represent the best interests of our profession. This is not an easy task as our best interests are subject to seemingly endless reappraisal due to the similarly endless and shifting social, political, and economic forces in play.

Whether we like it or not, our role as physicians, our identity and our job descriptions have already been shaped by the forces defining health care in the US. As the St. Vitus dance of healthcare realignment continues, it is more important than ever that we take a proactive stance. Indeed, our newly seated APA president Renee Binder is proposing an activist role for us in relation to firmly establishing the leadership role of the psychiatrist in new models of healthcare delivery. Likewise, our state organization, the CPA, has been working tirelessly in Sacramento to represent the interests of our patients and members to legislators and policy makers.

The SCPS Council and by extension all members via their Council reps, have the opportunity to engage in a monthly dialogue on issues and goals and how best to accomplish them. This month we will continue our good works with our local NAMI groups and meet with NAMI leaders. We have a history of solid relationships we can build upon, and I hope that in the coming year we can focus on improving access to mental health care in the community. We are also forming a Psychotherapy Committee under the able leadership of Maria Lymberis, to promote interest, skill development and integration of psychotherapies as a pillar of psychiatry in professional training and practice.

In the large geographic area that SCPS covers it is easy for individual psychiatrists to lose contact with one another. What can we do to offer members the opportunity to stay connected with one an-

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other? One proven pathway is through the medium of educational activities with live speakers, live audiences and ample time for networking. We intend to bring increased activity in the educational and social realms through our programs and committees.

In closing I want to thank the many individuals who give their time on behalf of SCPS and look forward to working with you in the coming year. For those of you interested in more active involvement, please do not hesitate to contact us at SCPS.

APA/CPA/SCPS dues are due June 30, 2015 to avoid membership termination.

If you have not already paid your dues, please contact Mindi at scps2999@earthlink.net

Letter from the Editor

Aid in Dying

Colleen Copelan, M.D.

Late last year, Brittany Maynard moved to Oregon so that she could end her life with prescribed medicine. Brittany Maynard was a 29-year-old California woman with a fatal, inoperable brain tumor. She did not want the tumor to dictate the terms of her final days.

Oregon's Death With Dignity Act allows physicians to prescribe a lethal dose of medicine to terminally ill patients. Legislation, voter initiatives and court decisions have since established similar options in in three other states, one county and all of Canada.

Brittany Maynard campaigned for the expansion of Death With Dignity laws and gave impetus to California's proposed End of Life Option Act (Senate Bill 128). The bill has recently passed the Senate and now lies in the Assembly.

SB 128 was given oxygen when the California Medical Association repealed its longstanding opposition to such legislation and took a "neutral" position on SB 128 after the authors took certain amendments enhancing patient and physician protections.

The APA has no policy on this issue so is de facto neutral. The CPA recently sent all of us an email Survey Monkey asking our opinion. I got mine. I sent mine back. Did you?

Surveys are easy to do nowadays. Your opinion always counted and—now—it's accessible for counting.
cocopelan@aol.com

Letter to the Editor

SCPS Members:

I have just gotten around to reading the April 15 newsletter and the president's message and advocacy statement "Art of Dying". Politicizing this issue helps to obscure some important questions, as is typically the case in politics. For example: Does the individual have the right to choose to die whenever he or she wishes? The answer to this is generally in the US, yes, for most jurisdictions do not have laws that make suicide an illegal act, though this has only come about in the past 30 years. Dr Fogelson's opinion that it is "one of the heaviest responsibilities I have carried…preventing suicide in my patients." suggests that either he does not think it should be up to the patient to decide, or that the patient may only decide when they are not in a depressed mood! (I have yet to come across a person who seems cheerful and happy about his life and therefore is planning to end it that day. So it would amount to about the same thing.) This way of thinking confuses the Psychiatrist's assumed role of preventing suicide in patients with the individual's right to end his/her life. And it seems that American society as a whole sometimes confuses these two issues. Deciding to end one's life is defacto evidence that the person is not in their "right mind" and therefore unable to make the choice. So although there are few laws against choosing to kill oneself, it is generally difficult to be assessed capable of making that decision responsibly. This is clear in his question "Should the severity of the depression in any way mediate a patient's right to request PAS?" A similar and more vexing question might be "Should happy and apparently comfortably persons who request PAS be considered unable to assess their life choices?"

Damned if you and damned if you don't. So I must reject the issue of depression as a moderator of the right to choose to commit suicide. Either the society permits its members to choose to die without interference (after age 18?) or they don't.

But the second question is more vexing: why are physicians exempted from the consequences of aiding suicide? And when they (anyone?) aids the individual is it still suicide or is it "half suicide and half murder". Given the availability of guns, cars, and drugs in our society it seems obvious that no individual needs any assistance in killing him or herself unless a sudden loss of motor capacity makes it impossible for the person to carry out the necessary actions. (Let's leave out sudden severe strokes for the moment, and ALS although the individual could decide sooner rather than later to enable his/her demise.) And by the way, why would a physician want to aid someone in dying? (Should we make it a non reimbursable service to remove any financial motivation? Then why does a physician wish to do this?)

The heartfelt 10 Reasons of Furuta and Malik are all about why it might be "ok" to do this but no clear reason why any physician would have any motivation for doing this. "Achieving a "good death"? come on who wants to help kill someone who can kill themselves without your help and have whatever death they want, good or bad?). Oh and by the way, if lethal injection is any indication, physicians are not that good at killing people even when they are state sanctioned to do so!

For me the issues seem clear:
1) A person has the right to choose his/her death and it has nothing to do with how unhappy or depressed they are or are not. (A person who is in a treatment relationship to stop feeling suicidal should have the courtesy to end that relationship once he/she makes up his/her mind to die. If the person remains in the relationship it is presumed that he/she continues to want help in dealing with this issue.)
2) Ample means to kill oneself are readily available to all adult members of our society but a few severely behaviorally disabled persons. There is absolutely no need to enlist physicians to help this process, especially as they have no training and limited skill in this area, and should expect no compensation for performing such an act.

Sincerely,
Ron Milestone, M.D.

William Arroyo, M.D., receives an award of appreciation for his many years of service on the APA Ethics Committee. (APA Annual Meeting, Toronto)

A New Housing Option for Family Members with Serious Mental Illnesses

by: Stephen R. Marder, M.D. and Tod Lipka

The parents of adults with serious mental illnesses often struggle to find an adequate housing option for their child. We know that stable supportive housing is a key component for recovery but there simply are few housing options available for a young adult. They can live with their parents but this is rarely the best option. The young adult feels under the microscope of their parents. And what twenty- or thirty-year old wants to live with their parents? The parents know it is not the best option for their child- nor for them. While Los Angeles has focused on providing housing for people with mental illness through programs like Project 50 and United Way's Home for Good, almost all of this permanent supportive housing being developed in our community for people with a mental illness are for those that have been the most chronically homeless for years, sometimes decades. While it is noble and responsible that these resources go to those in the most extreme need, it means that an adult child with a mental illness who is still connected to their families with greater financial resources for support, are almost always eliminated from consideration for these permanent supportive housing units. But that doesn't mean their need is any less great. They are in fact being penalized for maintaining their connection to their families and for not deteriorating into a condition that leads to chronic homelessness.

For those who can afford it, some parents have purchased a condominium for their child or rented an apartment in the community. While this provides stable housing, it offers no support and a young adult can decompensate quickly in an environment with too little structure and too much freedom. There are private board and care facilities but these certainly are often not the best options for a young adult. Families are desperate for stable supportive housing solutions for their adult child yet few options exist in our community. Parents worry about their adult child's need for stable housing and support services now and they worry greatly about their child's living situation after they are no longer around to provide support.

Step Up has created a new program, called Family Centered Housing, to answer the very desperate need of families to secure long term, permanent supportive housing for their adult children. Family Centered Housing essentially takes the public financing model of permanent supportive housing and privatizes it. Step Up organizes families who have sufficient resources to "buy" access to a unit in a building that Step Up will acquire and own. Once Step Up has commitments by a minimum number of families, they go out and purchase a building with a sufficient number of vacant units for the number of families buying into the project.

It is important to clarify that Family Centered Housing is not structured as an investment opportunity for families. Families buy into the program but they are not purchasing a unit like in a condo project. They don't own the unit. Family Centered Housing is designed as a long term housing solution for families with adult children with mental illness. So what families buy into is *access* to the unit. Why is it designed this way? For more information on Family Centered Housing, contact Tod Lipka, CEO of Step Up at tod@stepuponsecond.org or call (310) 901-9142.

Step Up positions this program as very long term housing and support. Step Up intends this program to address family's needs for housing of their children as their children themselves grow old. This is based on the experience that most young adults currently in their twenties or thirties, will likely need some form of lifelong housing and support to achieve their highest level of functioning. In order to assure very long term housing and support, Step Up recognized the challenges of making such a commitment to families when there is a shared ownership of a building and the sometimes contentious relationships that develop. In order to assure housing over the long term, Step Up needed to own the building in order to insure long term quality housing.

Therefore in the Family Centered Housing model, families buy into access to a unit for their son or daughter in a Step Up-owned apartment building. In addition to the initial buy-in cost, families pay an ongoing monthly fee to cover utility and services. Step Up is then able to infuse this building with on-site life skills training, mental health care and other services to insure it is service enriched housing.

Since families will be committing to a six figure buy in cost, it could be argued that this is a limited solution largely for the families who can afford such a solution. Step Up foresees a future that might enable the project to grow with wealthy families that would create such momentum to allow less well-off families to buy in now at a much lower cost, contingent

upon some future asset, such as a life insurance policy or proceeds from a home sale, supporting the long term costs.

Family Centered Housing is intended to provide housing and support now and into the future to provide comfort to the most worrisome issue families face… Who will take care of my child after I am no longer around to help them? In fact, Step Up envisions this housing and care until near end of life issues. Family Centered Housing is intended to provide housing and support up until the individual's health care needs can no longer be met in an independent living setting.

SCPS' 62nd Annual Installation and Awards Ceremony - A Photo Perspective

Outgoing President, David Fogelson, M.D.

Attentive listening to our wonderful guest speaker, Marvin Southard, D.S.W.

Ira Lesser, MI.D. presents award to Marvin Southard, D.S.W.

David Fogelson, M.D. presents award to Galya Rees, M.D.

David Fogelson, M.D. presents award to Michelle Furuta, M.D.

Larry Gross, M.D. presents award to Steve Soldinger, M.D.

Steve Soldinger, M.D.presented an award to Sophie Duriez, M.D.

Ariel Seroussi, M.D. received a PER Resident's Award

Erick Cheung, M.D., SCPS Secretary, and other audience members.

Heather Silverman, M.D., Incoming President.

Curley Bonds, M.D., Incoming President-elect

Council Highlights
May 7, 2015
Erick Cheung, M.D., *Secretary*

Minutes from the April 2015 meeting were approved by council (unanimous approval).

President's Report (Dr. David Fogelson):

Dr. Lesser was invited to report on CPPPH and efforts to provide diversion services, as well as the aging of physicians and the assessment of "late career" physicians and questions about screening for ongoing ability to practice as it relates to safety. Core elements of such screening might include H/P, peer assessments, observations from others, assessment of cognitive function with standardized tests.

Council members remarked that it is not clear how this would potentially impact or apply to private practitioners, though it may be relevant to hospitals and similar facilities that are responsible for credentialing their staff. If screening exam demonstrated problems, there might be further investigation by a hospital well-being committee (with the advantage being non-disciplinary and non-reportable) to discuss accommodations. CPPPH is recommending adoption of hospital screening programs. Only a small percentage of hospitals (estimated by some at 5% or less) currently do screening of late career physicians.

Dr. Pakier questioned the stigma against treatment of impaired physicians. This question was identified as important but distinctly different from the one of mandatory screening of late-age physicians.

Members questioned whether the practice could be considered discriminatory. Remarks were made that there are already systems in place to evaluate physician performance, which should be sufficient to serve the purpose of screening for physician impairment in late life. Dr. Furuta and other members remarked that the practice of screening late life physicians may not be especially problematic, and is in the interest of public safety.

Dr. Thurston moved that "SCPS not endorse the CPPPH proposal". The motion was seconded by Dr. Fogelson. Vote was taken that resulted in 12 yes, and 2 no votes.

Dr. Shaner was invited to comment on the proposal by LA County Coalition in support of an office of healthcare enhancement. He summarized the current status of the county movement towards a single agency that would integrate the clinical services of DMH, DHS, and DPH. The arguments in favor include better integration of mental health and medical services; the strongest arguments against would be the potential diminished voice (and fund ing) of the mental health population and their needs. The proposal is that "an Office of Healthcare Enhancement should act to develop, coordinate, update and continually advise the Board on the implementation of a Strategic Plan to enhance the healthcare of County residents in the areas of overlapping responsibility of the involved County Departments – DHS, DMH, and DPH. Similarly, those three County Departments should maintain their current operational responsibilities and budgetary authority, and the three Department Directors should maintain their current authority over the day-to-day operations of their departments."

Members of Council emphasized that SCPS has already issued stakeholder comments communicated to the focus group including potential benefits, disadvantages, and alternative models; in addition to core principles that are important to protect the voice, funding, and support for mental health services. Concerns were articulated about the need to permit the process to continue and that supporting the "proposal" would potentially short circuit or pre-empt that process.

Dr. Thurston recommended to not support the proposal, with the rational that separate budgets lead to segregated services. Dr. Bonds also described his experiences with agency segregation and fragmentation of care related to fragmented funding. Dr. Thurston made a motion that SCPS not support the current proposal. The motion was seconded by Dr. Stroman. The motion was unanimously approved.

Dr. Fogelson requested feedback and discussion on behalf of CPA President Dr. Tim Murphy related to federal

law and a proposed bill that would:
Reschedule Cannabis from I to II
Removes cannabidiol from the definition
Allows banks to participate in commerce related to marijuana
Lowers obstacles to research
Allows VA physicians to provide opinions and recommendations regarding marijuana

Dr. Furuta made a motion that we defer discussion until the bill has been received by all members of the board for consideration. Dr. Malik seconded. In discussion, Dr. Lymberis suggested that major organizations have supported the concepts of these bills. Motion was defeated unanimously. Council expressed general interest in such a bill.

Dr. Galya Rees presented on the topic of MIT/ECP committee, with a focus on developing a career day, website improvements, and proposals to use website to facilitate notices/advertisements for moonlighting positions. Mindi Thelen discussed conflicts related to advertisement in newsletter and webpage. A motion was made to ask Dan Willick to review the document and seconded. The Council unanimously approved the motion. Dan Willick clarified that information authored by a UCLA resident that provides general guidance about moonlighting can be posted with a disclaimer.

Dr. Shaner made a motion that SCPS permit all parties interested in employing moonlighters permitted to advertise within the SCPS website with information that includes posting of hours, fees/reimbursement, and targeted advertising towards MITs and/or ECPs. The motion was seconded. The motion was unanimously approved.

Mindi Thelen discussed logistics related to joint NAMI/SCPS meeting for 6/11/15. Will need to set agenda. Dr. Bonds will chair this meeting.

Council discussed APA state advocacy day and considering to send Dr. Soldinger

Dr. Lymberis discussed the importance of the APA Psychotherapy caucus, and strongly encouraged attendance at APA. She made a suggestion that SCPS consider forming a psychotherapy committee or group.

Dr. Gross reported on the survey put forth by CPA regarding Physician Aid in Dying.
Dr. Furuta and Dr. Malik articulated that question #2 of the survey appears biased or is not worded neutrally. Extensive discussion was held regarding this item. Dr. Shaner made a motion to remove the phrase from question #2: “Recognizing that this issue may be divisive for our members and not clearly part of APA’s mission…”, it was seconded by Dr. Furuta. Dr. Fogelson made an amendment to provide the same question response choices that are in question #1.
The motion was approved, with the exception of Dr. Thurston who abstained.

Dr. Gross reported on distinguished fellow nominees made by the committee: Dr. Damerla, Dr. Casaus and Dr. Thompson. A motion was made, seconded, and unanimously approved to support these nominees.

Dr. Gross provided assembly report, noting that the most significant action paper will be related to firearms. He also noted that there will be discussion about the re-organization of the assembly.

Heather Silverman provided update on CPA, stating that 2 assembly bills that CPA sponsored: that counties would, by default, be a part of Laura’s law and would have to “opt-out”. Clarified that law enforcement officers could consider a patient’s history and collateral with more emphasis as opposed to the current standards for imminent dangerousness. ECP rep election was discussed and that Dr. Micah Hoffman will not be able to take the position due to a job in San Francisco. Motion was made by Dr. Silverman to appoint Dr. Jaime Garcia as ECP rep, seconded by Dr. Stroman, unanimously approved. A motion was made, seconded and unanimously approved to appoint Dr. Sophie Duriez to WLA councilor position vacated by Dr. Bonds as he serves as President-elect, in the upcoming term.

Treasurer’s Report (Dr. Duriez):

A review of current financial status of the organization was presented. A motion was made, seconded, and approved to accept the treasurer’s report.

Legislative Report (Dr. Read):

Reported on SGR and approval in the US House of Representatives, though stalled in the Senate. CMS has a proposed rule that would align mental health and substance abuse parity benefits.
California SB128 passed the senate judicial committee. Discussed California's efforts to enforce federal parity rules. Discussed concerns related to the current status of foster children and regulators' response, discussed the poor media portrayal of the situation.

Program Committee Report (Dr. Silverman): ADD/ADHD program was a success. The committee is commencing discussions about psychopharm meeting.

CLASSIFIED ADVERTISEMENTS

Positions Available

PSYCHIATRISTS COUNTY OF SAN BERNARDINO SOUTHERN CALIFORNIA

San Bernardino County Dept. of Behavioral Health is seeking Board Eligible/Certified adult and child psychiatrists. Openings are in several outpatient clinics, jail services and juvenile hall.

Full-time Adult Psychiatrist BE/BC staff positions range from $226,949 - $239,263/yr, with full benefit package including medical, vision/dental, vacation, sick time, deferred compensation and retirement package.

Contract positions for BE/BC Adult Psychiatrists starting at $121.29 - $131.01/hr, Child Psychiatrists BE/BC $136.71 - $138.71/hr. with and without medical/dental/deferred compensation and retirement.

Full-time and Contract Psychiatrists who are assigned to a Correctional Mental Health Services designated facility will receive a $5/hr. differential in addition to the base salary. **Bilingual (Spanish/English) candidates are highly desirable and receive additional compensation.**

Must possess either a valid Physician's & Surgeon's License or Osteopathic Physician's and Surgeon's License issued by the State of California Medical or Osteopathic Board.

Applicants must hold U.S. citizenship or a permanent resident Visa. Please send C.V. and copy of current License to: Teresa Frausto, MD, Medical Director, 303 E. Vanderbilt Way, San Bernardino, CA 92415-0026, (909) 388-0810, fax (909) 890-0281 or email jpringle@dbh.sbcounty.gov.

For more details, please review the announcement at www.sbcounty.gov/hr. Application can be made on-line – apply ASAP – open until a sufficient number of applications has been received. Human Resources: (909) 387-8304 - EEO/ADA

Psychiatrist part-time for private pre-employment and return-to-work (non-Worker's Comp) evaluations for professionals. Requires significant experience with addictive disorders.

The Aeromedical Assessment Center is expanding to OC. We provide evaluations for aviators.

Send CV to cjaffephd@aasd-aac.com or 858-793-1124. For more information visit our Jobs page at accurateassessmentsandiego.com

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CHILD and CHIEF PSYCHIATRIST Contractor: Seeking psychiatrist to provide services at LA Child Guidance Clinic. Work in a large children's mental health clinic affiliated with County + USC Medical Center's School of Child and Adolescent Psychiatry. Psychiatrists must possess and provide updated documentation of current, valid licenses or certificates. **Send current vitae and cover letter to hr@lacgc.org Human Resources Dep., or contact Jackie Garcia for further information. 3031 S. Vermont Avenue, Los Angeles, CA 90007. EOE/ADA. FAX: 323-373-1946 TEL: 323-373-2400**

Seeking a psychiatrist to join our growing practice in Arcadia. Qualified candidates will possess an MD or DO, be board certified in psychiatry and hold a California medical license in order to be eligible. A strong interest in building a private practice is needed, as well as a comprehensive approach to treating the psychiatric patient to provide excellent continuity of care. Interested applicants, please forward your CV to: wendy@soultenders.com

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Space Available

EXCEPTIONAL CENTURY CITY MEDICAL OFFICE SUB-LET RENTAL AVAILABLE!
Well-established Psychiatric Practice has sublet space available in Century City. Newly constructed office in a Class A building with 14th floor views. Complete high-tech turnkey office support services including e-billing and e-progress notes that allows clinicians to focus on patient care. Patient referrals also available. Within steps of soon-to-open cutting edge rehabilitation center. Perfect space for newly licensed clinicians and those looking to expand their practice. Please contact Dr. Allen Chroman (Fellow, APA), (310) 284-8500 for more information.

Events to watch For:

CPA Annual Meeting in Dana Point
September 25-27, 2015

LA NAMIWalk - Grand Park, Dowtown LA
October 3, 2015

SCPS Career Day
October 18, 2015

Women's Brunch
November 1, 2015

Annual Psychopharmacology Update
January 2016

DO YOU HAVE AN EXTRA $47,000 TO DEFEND YOUR REPUTATION?

You are more than likely to have an administrative action brought against you than a lawsuit. And, this can cost you.

A psychiatrist just paid over **$42,000** out of his own pocket defending a board action. This only covered defense counsel involvement and expert evaluation. He also lost **over $5,000** in income for time spent assisting the defense team - all because his medical professional liability insurance did not cover him.

If you find yourself facing an investigation from a state licensing board, the federal government over HIPAA complaints or other governmental agency related to billing or any other administrative defense issue, **are you confident you are fully covered?**

Remy Palumbo
Senior Account Manager
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SCPS website address: www.socalpsych.org

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