Southern California

PSYCHIATRIST

Volume 65 Number 2 October 2016 Newsletter of the Southern California Psychiatric Society

President's Column

The Epicenter of Change

Curley Bonds, M.D.

Recently Southern Californians were warned that we should be on heighted alert for the possibility of a major earthquake. The uncertainty and fear generated by rumblings under the Salton Sea mirror the unrest surrounding recent political activity and the rapidly approaching elections. Faulty legislation can have a dramatic impact on medical care in our country so it is essential that we remain vigilant in our fight against laws that could cause a tectonic shift in how we practice. While the terrain under our feet may be shaky, one thing that has remained steadfast is the commitment of our professional organization to protecting the welfare of our patients and our colleagues. Last month Governor Jerry Brown signed two pieces of legislation supported by CPA. *AB 38, Mental Health: Early Diagnosis and Preventative Treatment Program*, (Eggman-D), establishes support for psychosis treatments for privately insured families. He also signed SB1177, the *Physician and Surgeon Health and Wellness Program,* (Galgiani-D) which authorizes the Medical Board of California to establish a program that provides early identification and treatment of physicians experiencing substance abuse problems. These are only two examples of bills that were priorities of CPA.

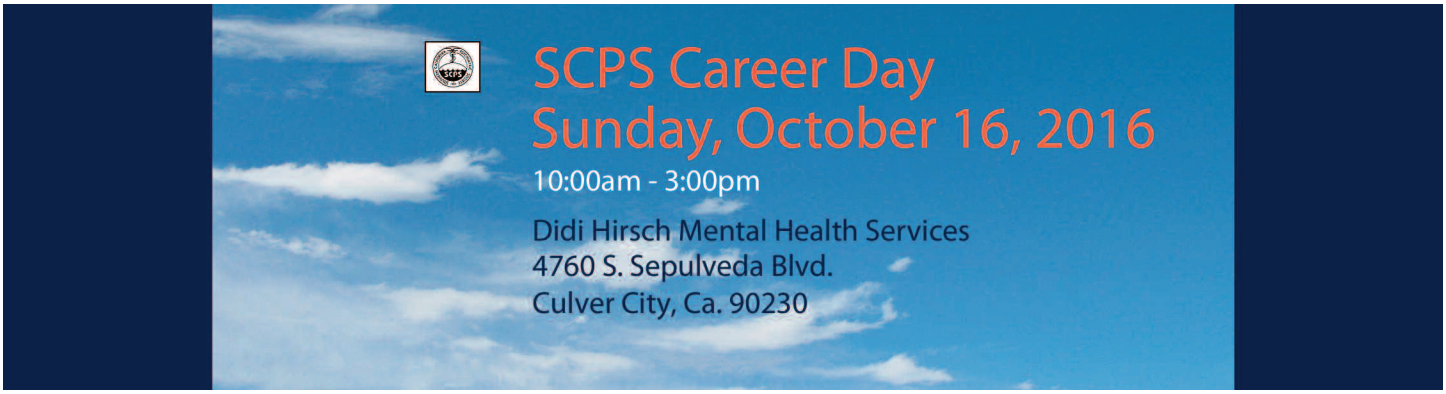
Child psychiatrists who treat minors in the foster care system watched carefully as SB253 *Juveniles: Psychotropic Medication* (Monning-D) worked its way through both houses and eventually landed on the Governor's desk. This bill was intended to place many onerous restrictions and requirements for preauthorization on those who prescribe and administer psychotropic medications to dependent or delinquent children. Advocates who recognized the dangers of allowing a judge or the courts to practice medicine prevailed and the bill was vetoed by the Governor. However, SB1174 *Medi-Cal: Children: prescribing patterns: psychotropic medications* (Mike McGuire-D) will require annual monitoring of high-prescribing doctors and allow the CA Medical Board to discipline "violators". While proponents of this bill feel that it will protect children from reckless doctors intent on poisoning them with drugs, they fail to appreciate the fact that it might unfairly target providers who are courageous enough to treat severely mentally ill children. Over time, the aftershocks may include a reluctance of child psychiatrists to take on complex cases in a system where access to alternatives to medications is limited.

In addition to the ongoing statewide legislative rumblings, the national stage was also active over the summer. In July legislators passed HR2646, *Helping Families in Mental Health Crisis Act* of 2015 by an overwhelming majority of 422-2. This bill, also known as the Murphy Bill, underwent significant revisions along the way but it promises to

(Continued on page 2)

In This Issue...

bring some important changes including codification of Medicaid coverage for inpatient mental health care, HIPPA education programs, reports and transparency on parity, and grant programs. With ongoing initiatives ranging from psychologist prescribing to the legalization of marijuana there will be no shortage of issues that we will need to educate ourselves about so that we can make informed decisions in the voting booth come November. This year's California ballot will contain 17 statewide initiatives including a handful that could have a significant impact on patient's access to care. This is the largest number since 2000 when 20 measures qualified. By now you should have received your state voter guide which is a pithy 224 pages of reading weighing in a whopping 10 ounces! Other resources will emerge over time outlining the basic points of proposed legislation, pros and cons including the financial impact on patients and tax paying citizens. California will likely be at the epicenter of many changes given our state's history of innovation. In addition to stocking your emergency supply kit in preparation for The Big One, do your research early and be prepared to make your voice heard come November 8.



Schedule
Practice Sectors - 10:00 a.m.
Managed Care/Kaiser Permanente - **Galya Rees, M.D.**, *Private Practice* - **Anita Red, M.D.**, *Academic Psychiatry* - **Yvonne Yang, M.D.**, *Public Psychiatry* - **Roderick Shaner, M.D.**, *Group Practice* - **Victoria Huang, M.D.**
Panel Discussion on Practice Sectors

Sub-Specialties - 10:45 a.m.
Consultation and Liaison Psychiatry - **Yara Salman, M.D.**, *Child and Adolescent Psychiatry* - **Anita Red, M.D.**, *Forensic Psychiatry* - **Kristen Ochoa, M.D.**, *Addiction Psychiatry* - **Matthew Goldenberg, D.O.**, *Geriatric Psychiatry* - **Pauline Wu, M.D.**
Panel Discussion on Sub-Specialties

Employer Exhibits open at 12 Noon - Exhibitors include:
Adelpha Psychiatric Group
CA Department of State Hospitals
Didi Hirsch Mental Health Services
Kaiser Permanente
Los Angeles Department of Mental Health
MHM Services, Inc.
Mind Health Institute
Professional Risk Management Services
Psychiatric Centers at San Diego
San Fernando Community Mental Health Center
Sovereign Health Group
TLC/Telecare Corporation

Box lunch will be served. (Lunch and Booth Exhibits until 3:00 p.m.)

SCPS Members - Free

Please RSVP to scps2999@earthlink.net by OCTOBER 10th.

Non-SCPS Members - $15.00 - CLICK HERE TO REGISTER -

Letter from the Editor

Bullying in the Digital Age (Bullies No Longer Have the Courtesy to Stop at the Front Door)

Matthew Goldenberg, D.O.

October is national bullying prevention month. Bullying is a serious mental health problem that impacts at least 1 in 4 students. Additionally, it is thought that nearly two-thirds of students who are bullied do not report it. The most common reasons for being bullied include looks, body shape and race.

The reason that bullying is a mental health issue is that it leads to increased risk of adjustment problems, trouble sleeping, anxiety and depression. These problems are known to persist into adulthood. In many cases, students are both a bully and a target of bullying and these cases seem to have highest risk of mental health and behavioral problems. In other cases, the impact of bullying leads to significant physical symptoms including headaches and stomachaches which may lead the cause to go unrecognized.

You might ask yourself why you should care? Or you might say, “everyone gets bullied”. “It is a rite of passage”. You might have been bullied growing up and feel kids today need to “grow a thicker skin”. The problem today is that the bullying is not just confined to school or summer camp or the school bus.

Kids who were bullied before the rise of the internet could come home and find it a safe-haven, free of the pressures and bullying of school. Today, almost as many kids report being bullied online as they do at school. In some sense, bullies have followed their victims home and there is no longer a safe haven. There are countless examples in the media of school age suicides that are at least in part due to cyber bullying.

Whether you are a parent or a clinician there are steps you can take to help victims of bullying:

Report Bullying. Open a dialog with your kids and your patients so they feel comfortable talking with you about their experiences at school and online.

Intervene. Stop bullying when you see it. Model and teach appropriate interpersonal skills.

Encourage healthy behaviors. When kids are left out of a group they should be encouraged to find other peers, groups, clubs and activities to build a connection with.

It’s not your fault. Victims of bullying need to hear it is not their fault and that they do not deserve to be bullied.

Find a peer mentoring group. Many schools now have peer based anti-bullying and mediation groups to help improve the conditions at their school.

I encourage you to speak with your kids and your patients regarding issues surrounding bullying. As the negative impact of bullying often persists into adulthood, as adult psychiatrists we should also be mindful of these traumas and stressors, as they related to and impact our patients. Bullying is grossly underreported, if you do not ask about it and provide a safe environment for processing and addressing it in your psychiatric practice, it only serves to perpetuate the secrecy,

shame and isolating nature of being a victim of bullying.

References

http://www.pacer.org/bullying/resources/stats.asp

http://www.stompoutbullying.org/index.php/information-and-resources/parents-page/

http://www.stompoutbullying.org/index.php/information-and-resources/parents-page/tip-sheet-bullying-and-what-you-can-do-about-it/

Photos from the 2016 LA NAMIWalk at Grand park on Saturday, October 1, 2016.

EMERGING RISKS REQUIRE ENHANCED COVERAGE

AS THE PRACTICE OF PSYCHIATRY EVOLVES, SO SHOULD YOUR MALPRACTICE COVERAGE.

The dedicated experts at PRMS® are pleased to bring you an enhanced insurance policy that protects you from the emerging risks in psychiatry.

MEDICAL LICENSE PROCEEDINGS

Psychiatrists are more likely to face an administrative action than a lawsuit.

Separate limits up to $150,000

HIPAA VIOLATIONS

HIPAA enforcement continues to increase at the federal and state levels.

Separate limits up to $50,000

DATA BREACH

The use of electronic media in psychiatric practice has increased.

Separate limits up to $30,000

ASSAULT BY A PATIENT

Violence by patients against psychiatrists is more common than against other physicians.

Separate limits up to $30,000

These are just a few of our enhanced coverages included at no additional cost. Visit us online or call to learn more and receive a free personalized quote.

More than an insurance policy

(800) 245-3333 | PsychProgram.com/**EnhancedPolicy** | TheProgram@prms.com

PRMS® the psychiatrists' program®

Thank You, Dr. Copelan. Thank You, Dr. Goldenberg

by: Walter T. Haessler, M.D.

In college, I made a point of avoiding courses that required much writing. For one thing, I was a terrible procrastinator, leaving too much to do in the frenzied last day or two before the deadline. But besides that, I just didn't like writing.

I didn't like the writing required in psychiatric practice. And, while seeing the usefulness of electronic records, I imagine I would like that even less.

On recently re-reading Kenneth Colby's *A Primer for Psychotherapists* (1951), I was reminded that he reviewed there the pros and cons of keeping ANY records. Those were the days, eh?

Well, all that changed for me in 2012. At that time, I was more than a little annoyed at *Psychiatric News* for editorializing in a front-page "news" article ("Psychiatrists Occupy Place in Protest Movement," January 20, 2012). I wrote a response, which they received on March 1.

My mood did not improve over the next three months when, after a number of exchanged messages and two telephone conversations, I was told that the Editor in Chief had not yet said whether or not he would print my letter; and that I should feel free to submit it for publication elsewhere.

That's what I did, and the "elsewhere" was *Southern California Psychiatrist.* I wrote a cover article explaining the situation, and that article, along with my rejected letter to *Psychiatric News*, were published ("Counterpunching," July, 2012). Thank you, Dr. Copelan.

Not a word was changed. And not a word had been changed in all the articles I have since submitted. And all my articles had been accepted for publication until this July, when one was rejected. It was a little long, and more than a little political; on reflection, I agree that *Southern California Psychiatrist* is not the right place for it.

Anyway, I now enjoy writing, and devote some time to it. I have also written for *California Psychiatrist, Psychiatric News* (on the third try), and *The* (Riverside) *Press-Enterprise.* And it started with that July, 2012 article.

Those who have read my articles know that I write on many different topics, with at least some relevance to our profession. I like throwing in some personal anecdotes, some philosophizing, and some efforts at humor. That makes it more fun for me, and, it is hoped, for the reader.

But it remains a hope, because the only feedback I have received on a dozen or so articles was on "Counterpunching." One reader called, and we talked for an hour and a half. He was embarrassingly laudatory about my "courage" in taking on the big boys and saying what others dared not say. I didn't tell him this, because I didn't think of it at the time, but the courage award goes to the editor. The letter and cover article that ran in her publication were hard-hitting, and were critical of our parent organization. Thank you again, Dr. Copelan.

My topics are varied. In 2015, for example, I wrote on: lies in high places, medical economics, and the status of women ("Pixie Dust," January); mindfulness, the writing process, and some changes in medical practice ("Horseback Writing," April);
career choice and some concerns about the direction of psychiatric practice ("Maybe Surgery Would Have Been Easier," July).

So I read with interest our new editor's introductory "Letter from the Editor" in the September issue. It ended with a plea for articles from members, "...from research abstracts, to original articles on a topic of your choosing, to book reviews, to psychopharm or therapy updates to anything else you want to share...".

Amen to that, Dr. Goldenberg, and thank you for taking on this responsibility. With a thousand or so members, we can only imagine how much material there is to share — to inform, stimulate, and entertain us.

If a reader is thinking about writing, and needs a nudge to actually put pen to paper, try to come up with something that makes you mad. It worked for me.

Save the Date!
SCPS' Psychopharmacology Update 28
Saturday, January 28, 2017
The Olympic Collection in West LA.
Watch for brochure soon!

Why Marijuana Is Still a "High" Risk for Physicians

LinkedIn Post 9/8/16
Donna Vanderpool, MBA JD
Vice President of Risk Management, PRMS

As more and more states are legalizing recreational and/or medical marijuana, physicians need to understand the risk associated with promoting the use of marijuana.

Here's the problem…marijuana is a Schedule I controlled substance, which is defined by the federal government as having "no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse." Other substances in Schedule I include heroin, LSD, and Ecstasy. It is illegal to prescribe Schedule I controlled substances. Just last month, the Drug Enforcement Agency (DEA) considered but rejected two petitions to reschedule marijuana, "because it does not meet the criteria for currently accepted medical use in treatment in the United States, there is a lack of accepted safety for its use under medical supervision, and it has a high potential for abuse." The denial letter points out that the government supports and encourages research and outlines the ways it is promoting medical marijuana research.

Bottom line – Under federal law, it is illegal to prescribe marijuana as it is a Schedule I controlled substance.

But what about state law? Knowing of the federal prohibition on prescribing, state laws do not use that term, but rather terms such as a physician's "referral" or "recommendation" or "certification" or "order." Regardless of what the document written by the physician is technically called, the federal government may see it as illegal. There are serious consequences if a physician is found to have committed a criminal act or civil violation, including, but not limited to, loss of license to practice and loss of liability insurance coverage.

You may have heard that there are specific conditions, which if all are met by the state, will preclude the federal government from going after activities related to marijuana. The Department of Justice (DOJ) has put out several memos on marijuana enforcement. The memo from 2013, referred to as the "Cole Memo", was from the Deputy Attorney General James Cole to all US Attorneys within the DOJ and the subject was "Guidance Regarding Marijuana Enforcement." The memo listed the following eight priorities for federal enforcement:

> Preventing the distribution of marijuana to minors;
>
> Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
>
> Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
>
> Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
>
> Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
>
> Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
>
> Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
>
> Preventing marijuana possession or use on federal property.

Some believed after reading this memo, that the federal government would leave states and citizens of those states

alone if the state had enacted sufficient protections consistent with the federal government's eight priorities. However, this is only "guidance" and it contains the language that nothing in the memo, including the absence of the listed factors, precludes investigation or prosecution.

You may also have heard that a recent court decision protects doctors from federal prosecution when they recommend medical marijuana consistent with state law. First, let's be clear on the facts. This case involved ten combined criminal prosecutions, almost all dealing with growing marijuana, but none dealing with physicians recommending marijuana. The case revolved around Congress' prohibition on spending funds to prosecute those who complied with state marijuana law. This federal appeals court opined that the appropriations law (prohibition) would mean the federal government could not prosecute if state law was followed. The appellate court remanded the cases back down to the trial courts to determine if state law was followed. But keep in mind that this is just one appellate court's thoughts; other federal appellate courts could decide the same issue differently. Also, as noted by the court:

> Congress could appropriate funds for such prosecutions tomorrow; in fact, the appropriations measure expires September 30, 2016
>
> The spending prohibition does **not provide immunity** from prosecution for federal marijuana offenses
>
> The Controlled Substances Act prohibits the manufacture, distribution, and possession of marijuana.
>
> Anyone in any state who possesses, distributes, or manufactures marijuana for medical or recreational purposes (or attempts or conspires to do so) is committing a federal crime
>
> The federal government can prosecute such offenses for up to five years after they occur
>
> Congress could restore funding tomorrow, a year from now, or four years from now, and the government could then prosecute individuals who committed offenses while the government lacked funding

The risk management advice is to understand the risks. There could be a criminal investigation or prosecution by the federal government. As stated in an interesting article by Bruce Reinhart, Esq. in the Florida Bar Journal, "Doctors or pharmacies helping a patient obtain marijuana risk losing their DEA license, being excluded from the Medicare program, losing their assets, and going to prison." And, medical malpractice insurance policies typically exclude coverage for illegal acts.

And we cannot forget the clinical risks. As noted by the American Academy of Child and Adolescent Psychiatry (AACAP) in its 2012 Medical Marijuana Policy Statement:

"…adolescent marijuana users are more likely than adult users to develop marijuana dependence, and their heavy use is associated with increased incidence and worsened course of psychotic, mood, and anxiety disorders. Furthermore, marijuana's deleterious effects on cognition and brain development during adolescence may have lasting implications."

AACAP spells out the reasons it opposes legalization of marijuana in its 2014 Marijuana Legalization Policy Statement.

Similarly, the American Psychiatric Association (APA), in its Position Statement on Marijuana as Medicine starts by noting "There is no current scientific evidence that marijuana is in any way beneficial for the treatment of any psychiatric disorder." The Position Statement concludes with this statement: "Physicians who recommend use of smoked marijuana for 'medical' purposes should be fully aware of the risks and liabilities inherent in doing so."

The APA has two other relevant resource documents – Resource Document on Marijuana as Medicine and Resource Document on the Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Marijuana.

Editor's Note: This article contains opinions from a malpractice insurer who provides insurance to a substantial number of psychiatrists. The article alerts all psychiatrists to a possible legal problem which could impact the psychiatrist's malpractice coverage. The opinions expressed should in no way serve as an endorsement by SCPS or its members.

Upcoming Events!

Career Fair, Sunday, October 16, 2016

NAMIWalk Inland Empire (Hemet), Saturday, October 29, 2016

SCPS/SCSCAP Joint Meeting, Monday, November 7, 2016

Women's Lunch, Saturday, November 12, 2016

Psychopharmacology Update 28, Saturday, Januray 28, 2017

Dues statements were emailed on Friday, September 30th. Please let us know if you did not receive that email.

Thank you for renewing your membership. Your membership is important to us!

Council Highlights
September 8, 2016
Galya Rees, M.D., Acting *Secretary*

The annual joint SCPS Council/NAMI meeting was held on September 8, 2016. The meeting was opened by SCPS President-Elect Dr. Joseph Simpson and Mark Gale of NAMI San Fernando Valley. After all the participants introduced themselves, the floor was opened to NAMI members. Highlights included:

Overview of the NAMI Southern California organization and work: Provided by NAMI Representative Brittany Weissman. Presented the 12 NAMI affiliates / branches in Los Angeles, and highlighted aspects from their annual report. NAMI also provided an update on mental health training to over 1400 Sheriff's deputies and 300 police officers in an ongoing training program. HR 2646 (Helping Families in Mental Health Crisis Act of 2015): NAMI representatives discussed and expressed their overall support for the bill.

Diversion: Mark Gale (NAMI) reported that there are efforts to enhance diversion (away from the criminal justice system and towards mental health treatment) through a proposed "sequential intercept model", increase in supportive housing units for persons exiting jail, and additional measures.

Parity: We discussed parity and the need to provide data to Dave Jones Insurance Commissioner of State of CA regarding violations of mental health parity. There may be opportunity for cooperation between NAMI and SCPS in developing a reporting system to provide data on violations of parity, including inpatient/outpatient services that are not authorized at the same level as equivalent medical services, as well as the ferreting out of "ghost" insurance panels. A simple reporting tool is needed, or perhaps a smart phone application.
Shortage of Psychiatrists, Especially those who accept insurance: Discussion was held regarding the bottlenecks and shortages of all level services and inability to move people up and down in level of services. Dr. Krankl provided the perspective of rural psychiatrists and the severe lack of services and access to care for patients, and ancillary services for providers. Possible ways to draw psychiatrists to rural areas were discussed, as well as pros and cons of alternatives, such as Telepsychiatry and the increasing pressure to use general practitioners and nurse practitioners in rural areas.

NAMIwalks: NAMI representatives thanked SCPS for stepping up and becoming silver sponsors at the upcoming NAMIwalks.

SCPS Items for the joint meeting included:

Stakeholder input on performance measures for full service partnership. Dr. Shaner and Mark Gale discussed the need to develop reliable performance measures for full service partnership programs. They provided an update on a plan to develop performance measurement tools for Assisted Outpatient Treatment (AOT) programs, which provides an avenue to court mandated treatment under Laura's Law.

Ensuring that individuals with co-occuring mental health and substance use disorders have access to integrated drug treatment with the new drug medical waiver. Participants discussed why accessing integrated treatment is challenging under current medical rules, and what needs to be done in the future.

Meeting with mental health courts about views on finding grave disability for purposes of LPS conservatorship.

SCPS and NAMI representatives expressed concern about how difficult it has become to get LPS conservatorship for severely mentally ill individuals in the past year. Obstacles include finding a hospital bed for a patient on a grave disability hold, keeping him at the hospital for long enough, and finally, possibly a rising number of denials of LPS conservatorship cases by Department 95 of the LA Superior Court. SCPS provided an update on a letter sent to the court in which SCPS offered assistance. A live discussion was held on ways to better educate society and the courts about mental health needs. One idea was to have summit of psychiatrists, NAMI, and court representatives.

Fostering family engagement in inpatient and outpatient settings through improved understanding of privacy laws. Misconceptions about current privacy laws were discussed. Dr. Shaner reported that DMH is working on a handout for families. He will send a copy of the handout to SCPS and NAMI representatives.

EMS commission – pre-hospital care for mental illness. Dr. Cheung provided an update on recent EMS commission efforts, including the comprehensive mapping of events from the moment a patient or family dial 911 to arrival in hospital, identifying key times of decision points, and potential areas of improvement. The current default by triage is to send law enforcement for any 911 call, rather than EMS or mental health teams. NAMI and SCPS representatives expressed concern that placing mentally ill patients in cuffs criminalizes mental illness. A discussion was held about pros and cons of the current system vs. alternatives and need for law enforcement mental health teams who are able to handle acute medical needs in potentially agitated patients. NAMI currently provide families with an LAPD checklist – a handout that families can use to increase the probability that their mentally ill loved one will be taken to an ER rather than arrested following a 911 call. SCPS representatives requested a copy of the handout so that they can provide it to patients and families as well.

The joint session was adjourned at 9:25 PM.

The Council held a brief business meeting immediately following the joint session. The meeting was called to order by President Dr. Bonds, at 9:30.

The previous meeting's minutes were approved unanimously.

New Members: Ten new members-in-training and four general members were unanimously approved for membership.

Financial report: A motion was made to accept the Treasurer's report. All voted in favor, none opposed.
A motion was made to approve an education grant request made by the UCLA Child and Adolescent Psychiatry program. Approved.

A request was made by APA for district branches to share the travel cost of sending two representatives attending to the annual APA meeting, a cost covered by APA in the past. A motion was made to approve the request. Approved.

APA nominations: The deadline for nominations is October 1 2016.
SCPS booth at NAMIWalks, 10/1/16

Dr. Bonds adjourned the meeting at 9:50 PM.

ALL EDITORIAL MATERIALS TO BE CONSIDERED FOR PUBLICATION IN THE NEWSLETTER MUST BE RECEIVED BY SCPS NO LATER THAN THE 1ST OF THE MONTH. NO AUGUST PUBLICATION. ALL PAID ADVERTISEMENTS AND PRESS RELEASES MUST BE RECEIVED NO LATER THAN THE 1ST OF THE MONTH.

SCPS website address: www.socalpsych.org

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

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