Southern California

PSYCHIATRIST

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President's Column

Too Many Meds?

Joseph Simpson, M.D.

That is the cover headline of the September 2017 issue of the magazine *Consumer Reports*. The subheading reads "Follow our doctor-approved plan to take fewer drugs, avoid dangerous side effects, *and* feel better." The cover photo depicts a man reaching up out of a full pill bottle like someone being pulled under by quicksand. The editors definitely deserve kudos for creating an attention-grabbing cover.

The article inside could not be described as completely shocking, but the statistics that are quoted are eye-opening. The Consumer Reports organization conducted a survey and conclude that a majority of Americans take at least one prescription medication – 55%. The average number of medications they take is four. The Centers for Disease Control and FDA reported 1.3 million emergency room visits for adverse drug reactions in 2014, and 124,000 deaths. This is a substantial number – comparable to the yearly total of deaths from cerebrovascular disease. Between 1997 and 2016, the number of prescriptions filled by Americans increased 85%, while the population increased only 21%. The *Consumer Reports* article asserts that Americans take "far more" prescriptions than people in any other country. Although no numbers are provided for this statement, it does seem plausible, based on what we encounter in our professional lives and perhaps also just from talking to family members and friends.

Especially dismaying about the article are the profiles of patients who ended up on a cocktail of psychotropic medications and experienced adverse effects. One man reported being treated with escalating doses of stimulants for ADHD beginning at age 13. To counter side effects including insomnia and anxiety he was given "a series of antidepressants", four in all. A woman working in her first job as a physician's assistant was put on Xanax for stress by a doctor colleague, reportedly without any discussion of the risks and benefits. She became depressed, and says she ended up seeing doctors who gave her Adderall, followed by medications to counter the side effects of the Adderall, and so on in a downward spiral. She is quoted as saying that she ultimately saw a variety of specialists for physical complaints including chronic diarrhea, joint pain and rashes, but none of them questioned her list of medications.

While these anecdotal accounts don't amount to scientific evidence, I suspect that most of us have encountered similar scenarios in our practices. How many times have you seen a new patient who comes to you already taking four or five psychotropics? I recently treated a patient who when we first met was taking two mood stabilizers, an antipsychotic, an antidepressant, a stimulant, a benzodiazepine and a "Z" drug (i.e. zolpidem, zaleplon, ezopiclone). And this was not someone disabled by severe and persistent mental illness– this was a spouse and parent with a white-collar job,

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In This Issue...

who until a couple of years previously had been on no medication. Though still having symptoms, the patient was very concerned about trying to change the regimen, fearful of experiencing destabilization. Over the course of many months, I tried weaning off medications, but found that the patient would ask to try something else to replace whatever had been stopped. In the end I was only able to eliminate the antipsychotic–the patient moved away for a job transfer still taking six psychotropics.

As physicians we have a good grasp of the fundamental principles and mechanisms of biology. But as the *Consumer Reports* article states, "intense marketing by drug companies and an increasingly harried healthcare system" contribute to conditions that could potentially lead to overprescribing, or to the prescription of medication combinations that fail to serve our patients' best interests. One could probably also add the "quick-fix" mentality that is something of an American foible to the list of factors that could lead to overprescribing.

Prudence dictates that when possible we should follow the rule of substituting rather than adding medications, especially with medications with a greater potential for side effects, like mood stabilizers and antipsychotics, and medications with potential for dependence like benzodiazepines. We should especially pause and take stock if we are contemplating adding a new medication primarily to counter the side effects of a current medication.

Our patients rely on us to develop their treatment plans, and most do not question our decisions. We owe it to them to use our training and experience to employ the tools in our pharmaceutical armamentarium rationally and judiciously. We need to guard against falling into the trap of adding something new at almost every visit – and potentially creating additional problems as bad or worse than those that brought the patient to us in the first place.

We Have Work to Do

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

I write this article having just attended the 2017 California Society of Addiction Medicine Conference. While always a high quality and extremely educational conference, this year a special treat was a keynote address by former Drug Czar Michael Botticelli. He spoke at length about the gains we have made in the fields of mental health and addiction over the past decade, including increased access to care, the Affordable Care Act (ACA) and a return to science based policy.

However, unless you have been living under a rock for the past 7 months, and even if you are living under a rock, you likely may have heard things are a lot different now under the new Presidential Administration. There are fears we could lose the ACA, funding for State Medicaid programs, the gains in parity between mental health and physical health treatments and a return to the stigmatizing criminalization of individuals with alcoholism and addiction.

The CSAM conference then proceeded to provide the most up to date data on the evaluation and treatment of addiction and co-occurring mental health conditions. As Psychiatrists, we pride ourselves in providing evidence-based care. However, as the debate on climate change and immunizations of children have shown, sometimes emotional arguments and a loud minority can overpower the best evidence and data available.

As mental health and addiction experts, our work is cut out for us. SCPS is in the perfect position to highlight evidence-based treatments for the benefit of our patients, our practices and our field. By coming together with our colleges on a local level we can influence our local spheres of influence. By working with the California Psychiatric Society (CPA) and American Psychiatric Associations (APA), we can influence and drive change on a national level.

I truly believe, like politics, all change in the field of medicine starts on the local, grass roots level. The SCPS Newsletter is an excellent opportunity for you to share the challenges you face and/or the work you are doing in your local sphere of influence to advance the field of psychiatry and improve the care for our patients. By coming together and sharing our stories, we can build coalitions of likeminded colleagues from across the State and across the country to sustain the progress we have enjoyed and continue to advance the field in meaningful and lasting ways.

So, if you have a story of the challenges you are facing or the steps you are taking to overcome them, please send us an article! Book reviews, psychopharmacology updates and other types of articles are also welcome!

You can send your articles to SCPS Executive Director Mindi Thelen. Email: mindi@socalpsych.org

SCPS LGBT Issues Committee invites you to welcome residents at our Fall Brunch Reception, hosted in Beverly Hills by Bernard Bierman, MD.

SUNDAY, September 10, 10:30 to Noon

Please forward this invitation to training programs and invite interested residents!
After brunch, we will meet briefly to create an agenda for our Committee. Please bring ideas!
To attend, please reply to this email, and I'll send you Bernie's address and phone.
Our new Chair, Patrick Wiita, MD and I look forward to seeing you!

Stanley E. Harris MD DLFAPA
CoChair, LGBT Issues Committee

inbox

Dear Dr. Goldenberg,

Thank you for your article on Physician Suicide (April, 2017) and the illustration of this tragic reality and trend. The elevated rates i.e 250% higher in female physicians and 70% higher in male physicians (compared to the general population), was alarming. The necessity for increased awareness and encouragement for psychiatrists to take initiative to speak out and reach out was much appreciated.

Indeed, why wait for such heart breaking outcomes?

After all the hard work, sacrifice, and endless energy spent in trying to help our patients lives? How can we heal the wounds of others, if we do not tend to our own?

I believe that wellbeing education & access should start from medical school onwards, given the lifetime of heavy responsibilities that lie in wait. Wellbeing committees should be a core component for staff in every medical institution, be it residencies, fellowships, universities, hospitals, clinics or correctional facilities. All deserve the benefit of access.

And in the meantime, we can look, listen and reach out...not just to our patients, but to each other and ourselves.

A kind word or a sympathetic ear can go a long way.

Best wishes,
K. Khajuria, MD

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Sacred Souls: Spiritual Applications in Clinical Practice

By: Kavita Khajuria, M.D.

"When I feel despair, prayer helps me find peace, strength and comfort."
-49 year old woman diagnosed with Schizophrenia (1)

How do religious or spiritual practices provide comfort or solace?
The precise link is unclear, but research reveals that they may help one cope with dismal life circumstances or medical illness (2). Furthermore, a majority of the population would like their physician to address spirituality during their visits (3). This compels us to enquire about this topic and work with patients to construct meanings of their experiences.

Religion and spirituality are not mutually exclusive concepts, and literature often uses them interchangeably. Spirituality refers to the connection of oneself to a higher power. It also refers to those deeply held beliefs that give meaning to a person's life (4).

80% of Americans describe themselves as religious, and over 70% of mental health consumers in California want their MH care providers to discuss spiritual concerns with them upon request (5). Studies demonstrate the importance of religion in terms of instilling hope, comfort, love, compassion, self- respect, self- confidence and increasing an appreciation of the meaning of life (1). Spiritual support also makes explanations possible and can bring a sense of control through the sacred. For some, it provides precious social support.

Interestingly, the first established psychiatric care in the U.S originally related to spirituality, and was widely practiced from 1815 to 1875. This originated in Europe and involved compassionate psychological and spiritual treatment, based on the idea that insanity was a disruption of both mind and spirit (6). Religious services were held on local hospital grounds, and patients were encouraged to attend. By the end of the 19th century however, Charcot and Freud linked religion with hysteria and neurosis, and a divide was created between religion and mental health care. This impacted the next 100 years. Eventually, 'Religious or spiritual problems' was introduced in DSM IV as a new diagnostic category which invited professionals to respect patient's beliefs and rituals (2). Over 850 studies have examined the relationship between religious involvement and various aspects of MH; the majority found that religiously inclined people experience better mental health and adapt more successfully (7).

Physicians tend to have differing approaches. Given the historical tension between psychiatry and religion or spirituality, empirical studies demonstrate that psychiatrists are measurably less religious than the general population, but developments suggest this antagonism is waning (8). Psychiatrists are more likely than other doctors to address this topic in clinical settings and believe it appropriate to enquire.

Amongst psychiatric disorders, substance use seems to be most commonly associated with spiritual interventions. The thirst for 'wholeness' is described as a quest for belonging, self -worth, having the capacity to love and be loved, to be free from self- doubt and regret, and to feel comfortable in one's own skin (9). AA is a well known example of a fellowship based on spirituality (4), and addiction is seen as a spiritual problem. Those who report having a spiritual awakening are over three times more likely to be abstinent later (4). These patients are unlikely to actually avail themselves of professional care, so inquiry into their spiritual lives better facilitates therapeutic alliance and demonstrates respect for their values (10).

Research has also demonstrated the association between the personal importance of R/S with a lowered risk of major depression in adults and their offspring (11). Individual engagement with clergy may offer prevention against future episodes of depression (11). Research on the association between religiosity and remission of depression in medically ill older adults reveals a shorter recovery time with more rapid remissions (12). Depressed inpatients with religious affiliation are also less likely to have a history of suicide attempts, demon-

strate less suicidal behavior, and express greater moral objections to suicide (13). Reports on suicide itself are sparse, however. Addressing R/S with patients diagnosed with schizophrenia can be challenging, as religious or spiritual themes can be manifestations of psychosis, as well as a coping behavior (1). Transient psychotic episodes may also be linked to the religious experience of meditation (6). Other areas of caution include misinterpretation of spiritual beliefs in a cultural context. The complexity of the relationship between religion and illness thus requires sensitivity to each unique story.

How can all this be applied in clinical practice or to a correctional setting?
Inquiry into spiritual or religious beliefs in the initial screening assessment (or Inmate Reception Center) offers the first opportunity for acknowledgement and to initiate documentation. Follow up evaluations allow demonstration of interest and sensitivity. Group therapy is another opportunity for counsellors to share their skills. Given the potentially short incarceration period in Jails, a single evaluation may be the only chance of clinical contact, which could be used in a manner which best connects to the inmate. This sometimes calls for the most impromptu mind search. It can vary from routine questions into spiritual beliefs, to supportive silence during moments of discomfort or agony. Respectful silence during their verbalization of prayer may be helpful.

General recommendations in literature include the simple acknowledgment and respect of the spiritual lives of patients, keeping interventions patient centered, consultation with experts in various faiths (Chaplain and religious services), and referral to AA when appropriate. The Consensus Panel of the American College of Physicians suggests posing four questions: Is faith importance to you? Has faith been important to you at other times in your life? Do you have someone to talk to about religious matters? Would you like to explore religious matters with someone? (13). Practices to avoid include 'prescribing' preferred beliefs or activities, or imposition of one's beliefs without knowledge of the patient's background (14).

In sum, religion and spirituality are important in the lives of many patients, and given it's largely beneficial effect on health, inquiry is appropriate and encouraged. Furthermore, patients want to be seen as *whole* persons, who have multifaceted dimensions i.e physical, emotional *and* spiritual. Religious/spiritual acknowledgments and discussion can be an invaluable adjunct to patient care.

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Process Open for Submitting Proposals to Update DSM

The publicly accessible portal on the APA website for submitting proposed revisions to the text of DSM-5 will turn a year old soon, and past APA President Paul Appelbaum, M.D., chair of the DSM Steering Committee, wants to be sure clinicians, researchers, and members of the public know they have a role to play in making DSM a “living document.”

The portal, which was launched in December 2016, was the first step in a process meant to allow incremental updates to the text as new research evidence accumulates. Instead of engaging in an extremely expensive and time-consuming process that characterized the development of past editions of the diagnostic manual, the DSM Task Force wanted to seize on the opportunity afforded by digital communication by creating a process for changes to be made incrementally, as they become warranted by the weight of new evidence. Since the portal opened late last year, however, proposed revisions have been very few and relatively minor—for example, an editorial correction to the criteria for acute stress disorder and the addition of ICD-10-CM codes for substance use disorder in remission.

Appelbaum said he believes it is most likely that clinicians and researchers are not sufficiently aware that the process exists. "We want to make an effort to spread the word and publicize the existence of this process before we conclude that the criteria are too strict,” he said.

Visitors to the portal are guided through steps to submit proposals for the following specific kinds of revisions:

Changes to an existing diagnostic criteria set that would markedly improve its validity.

Changes to an existing diagnostic criteria set that would markedly improve reliability without an undue reduction in validity.

Changes to an existing diagnostic criteria set that would markedly improve clinical utility without an undue reduction in validity or reliability.

Changes to an existing diagnostic criteria set that would substantially reduce deleterious consequences associated with the criteria set without a reduction in validity.

Addition of a new diagnostic category or specifier.

Deletion of an existing diagnostic category or specifier/subtype.

Corrections and clarifications, including changes aimed at improving the understanding and application of an ambiguous diagnostic criterion, specifier, or text.

For more information, see the Psychiatric News article “Process for Updating DSM-5 Is Up and Running.”
For previous news alerts, click here.

SCPS Career Day

Sunday, October 22, 2017 - 10:00 a.m. - 3:00 p.m.

Didi Hirsch Mental Health Services
4760 South Sepulveda Blvd. Culver City, CA 90230

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 - Shayan Rab, M.D.
Group Practice - Victoria Huang, M.D.
Clinical Trials - Haig Goenjian, M.D.
Panel Discussion on Practice Sectors

Sub-Specialties - 10:45 a.m.
Consultation and Liaison Psychiatry - Monika Choudry, M.D.
Child and Adolescent Psychiatry - Anita Red, M.D.
Forensic Psychiatry - Marc Cohen, 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, Inc., APA Inc., California Correctional Healthcare Services
California Department of State Hospitals, Community Psychiatry, Didi Hirsch Mental Health Services
Happier Living by The Genen Group, Socal Permanente Medical Group - Kaiser Permanente
Los Angeles Department of Mental Health, MHM Services Inc. Pacific Coast Psychiatric Associates
PRMS, Inc., San Bernardino County Behavioral Health, San Fernando Valley Community Mental Health Center
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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 16th.

Non-SCPS Members - $15.00
http://www.socalpsych.org/events.html

Committed

Johns Hopkins University Press, 2016 - By Dinah Miller, M.D. and Annette Hanson, M.D.
Book Reviewed by: Joseph Simpson, M.D.

Drs. Miller and Hanson are experienced psychiatrists who, along with Dr. Steven Roy Daviss, write the blog "Shrink Rap" (the three also produced the 2011 book *Shrink Rap*: *Three Psychiatrists Explain their Work*.) In this new offering, Drs. Miller and Hanson examine the pivotal and highly contentious subject of involuntary psychiatric treatment.

I first heard about the book on the last day of the 2017 APA meeting in San Diego, at a symposium on involuntary commitment organized by Drs. Miller and Hanson. Dr. Roger Peele, an eminent psychiatrist who has served APA in many capacities for over four decades, and who also spoke at the symposium, referred to *Committed* as a "must-read." I concur with that assessment, and encourage every SCPS member, and anyone else interested in mental health care, to read it.

The authors became interested in delving deeply into the topic of involuntary treatment in the aftermath of recent high-profile mass shootings. Following the tragedy at Sandy Hook Elementary School in Newtown, Connecticut in December 2012, there were proposals to reform mental health care systems in order to prevent future terrible events of this type. Without much in the way of data or evidence, calls were made to change laws to lower the threshold for mandating people into involuntary psychiatric treatment. In their initial explorations of this topic, the authors discovered, to their surprise, that many people "who had previously been committed would not want to be committed again, even if they were imminently dangerous to themselves or others." Intrigued and perplexed by this, Drs. Miller and Hanson felt compelled to investigate further.

The result of their collaboration is a work rare in the mental health literature, in that it strives to present as balanced and unbiased a view as possible. (Given that both authors are practicing psychiatrists, there are undoubtedly some who would claim that they are incapable of producing a truly unbiased discussion of these questions. But we will leave that aside.) The book is built on a foundation of interviews and correspondence with patients, family members, clinicians and researchers, including some who fit in more than one of those categories.

Unlike many books in this area, Drs. Miller and Hanson consciously attempted to approach their subject with their minds open and without prejudgment. They allow current and former patients to tell their stories in their own words, and also provide an opportunity for opponents of involuntary psychiatric treatment to present their views. These include representatives from MindFreedom International, the National Empowerment Center, the Bazelon Center for Mental Health Law, and even the Citizens Commission on Human Rights, a Scientology-affiliated organization cofounded by Dr. Thomas Szasz almost half a century ago.

Reading the book felt a lot like participating in an extended "shop talk" discussion with a group of seasoned colleagues. I found it very easy to relate to the dilemmas that are presented, as they are similar to conundrums we have all faced in our practice. It may be more common for those who work in the public sector or an inpatient setting, but even those who do exclusively outpatient work with a relatively healthy clientele are likely to encounter a suicidal patient from time to time, and face a decision: Do I risk harming the therapeutic alliance with my patient by insisting on hospitalization, working to secure admission on an involuntary basis if he refuses to go voluntarily, or do I risk a suicide by accepting the patient's assurance that she is not going to end her life and doesn't need to be confined in a hospital in order to be safe? The book highlights these types of difficult conflicts – the tension between safety and autonomy, between protecting the public and avoiding unnecessary stigmatization – which are inherent to the practice of psychiatry. Such challenges are clearly presented and examined in a balanced and thoughtful way.

Woven throughout their exploration is the authors' distinct hope that their emphasis on bringing forth the patient perspective will remind those of us who do clinical work or research of the imperative to keep the patient in mind at all times. Of all the key lessons to be found here, it is this exhortation to consider the patient's perspective that may be the most valuable take-home message of *Committed*.

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Retiring psychiatrist looking for a bright, compassionate psychiatrist to take over well-established private practice in the South Bay area of Los Angeles starting between March 1 and July 1, 2018. Please send resume to: Psychiatrist, 10573 West Pico Blvd., #413, Los Angeles, CA, 90064.

Dear Members,

It's almost that time again...Dues bills will be emailed at the end of September. Please note that CPA dues appear in your APA statement; SCPS bills separately.

We know that membership in SCPS, CPA, and the American Psychiatric Association is a choice and we thank you for your continued support. Please do not hesitate to contact the SCPS Office (or 310-815-3650) if you have any professional questions that we might be able to assist you with, or if you would like to participate on any of SCPS' committees.

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.

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