Southern California

PSYCHIATRIST

Volume 69, Number 2 October 2020 Newsletter of the Southern California Psychiatric Society

President's Column

SCPS Selects Psychiatric Physician Alliance of California (PPAC)

George A. Fouras, M.D.

As you probably know by now, the California Psychiatric Association is closing operations due to the withdrawal of support by three of the five District Branches in California. Unfortunately, this leaves California psychiatry without a strong statewide voice to protect our patients and our profession at a time when patient care is threatened by proposed laws to give unqualified providers medical privileges presently only held by physicians. For example, there have been repeated unsuccessful efforts to grant prescribing privileges to psychologists. The immediate challenge is a law, AB 890, authorizing nurse practitioners to practice medicine, including psychiatry, without physician supervision. This was recently signed into law by the Governor despite fierce opposition advocacy by the CPA, CMA and other medical specialty societies. These kind of incidents must not be allowed to happen again. Strong, effective advocacy is essential. Your SCPS Council is aware of these dangers and has decided to work with the new Psychiatric Physicians Alliance of California (PPAC), whose sole function is focused on legislative advocacy for psychiatrists and their patients, in order to fulfill our members' need and expectations for advocacy in California.

Even as the CPA dissolved at the end of September, it is important to sing the praises of Mr. Randall Hagar who advocated for mental health and helped us achieve four major successes in this legislative session:

AB 1976 (Eggman) CPA sponsored. AB 1976 requires counties statewide to adopt Laura's Law programs of Assisted Outpatient Treatment.

SB 855 (Weiner), strong CPA support/ input. Adds substance use disorders on an equal footing with mental health disorders in California's Mental Health Insurance Parity Act.

AB 3242 (Irwin) CPA strong support. Clarifies existing law, concerning telehealth technology to be utilized in assessments and evaluations of an individual's risk of danger to self or others or their grave disability.

AB 2112 (Ramos) Establishes an Office of Suicide Prevention in the State Department of Public Health.

The decision to support PPAC was taken after review of two proposals for statewide advocacy. The proposals were reviewed extensively in weekly meetings by an ad hoc group convened by the SCPS Council for that purpose, then vetted in a due diligence process, yet again, before finally coming to full discussion and vote by SCPS Council September 10th. SCPS Council will be supporting PPAC for 2021 on behalf of you and all SCPS

In This Issue...

members. It provides SCPS with skin in the game in Sacramento.

PPAC is an advocacy-only, non-profit corporation, designed to supplement other psychiatric organizations which lack a robust lobbying capacity. It is capable of immediately stepping in to fill the void created by the dissolution of the CPA. Mr. Randall Hagar and Mr. Jim Gross, who for decades successfully lobbied for organized psychiatry, are committed to PPAC along with psychiatrists from all regions of California with extensive experience in government affairs. This team provides mental health institutional memory, continuity, expertise and continuing credibility and connections in Sacramento.

A competing proposal was also reviewed. It was in an embryonic stage and had not yet established a governance structure, retained a lobbyist, did not have a political action committee, and had notretained a lobbyist.

There are about 6,500 psychiatrists in California and a bit less than half are APA members. This means in the past nearly the full cost of advocacy was borne by DBs, that were tempted to reduce advocacy in order to reduce dues to keep members. PPAC invites all California psychiatrists—APA members and non-APA members alike to join. As a result of the decision by the SCPS Council, SCPS members are already contributing to 2021 statewide advocacy for psychiatry and its patients through PPAC. PPAC provides an option for non APA members to belong with monthly contributions. PPAC will work with all psychiatric organizations, including DBs, in furtherance of advocacy—with the same values and mission as articulated by APA and other leading psychiatric organizations.

PPAC provides stability and the opportunity to enhance both resources and diversity. And PPAC already has advocacy boots on the ground. Advocacy can't wait.

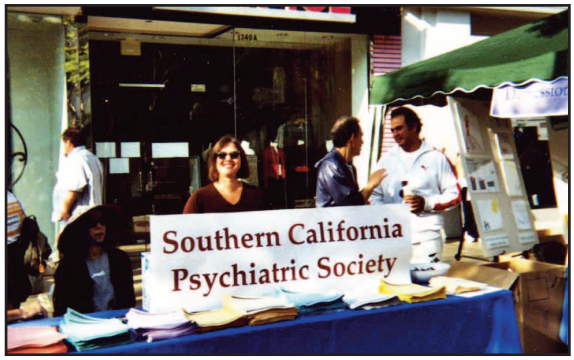
Thank you to Mindi for 29 Years of Service to SCPS!

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

This month I would like to take some time to both celebrate and thank our SCPS Executive Director for 29 years of service with SCPS! For those of you who are new to the organization, welcome! The person of whom I speak is the one and only Mindi Thelen. For everyone else, you already knew I was talking about Mindi.

Mindi started working at SCPS in September of 1991. That is long before I joined the organization, so I took the opportunity to interview Mindi and do a little digging and research in order to properly share the scope and history of her service to our organization...

As many of you know, Mindi can often be heard calling SCPS her second family, and it shows. She says that working with SCPS is a really strong fit for her and for what drives her. She enjoys working with psychiatrists and finds it rewarding that she is helping the healers to help others. Mindi has found one of the most special parts of her job is receiving the personal thank-you notes members have sent her over the years.



Mindi has seen a lot of changes in her 29 years with SCPS. She has worked in three different office locations and has had a staff of various size and scope over the years. Mindi was originally hired by her predecessor, Lisa Graziano, who subsequently left to become an MFT. At the time SCPS was housed in a very large suite at what used to be known as Colorado Place in Santa Monica.

In 1994 the Northridge earthquake hit, and the Colorado Place complex was yellow tagged making the office inaccessible. Without skipping a beat, the SCPS staff, which numbered four employees at that time, worked temporarily out of a small meeting room at a hotel in Redondo Beach. SCPS next moved to the building next to the 10 and 405 on/offramp in December of 1994 and has been in two different suites at that location. In 2004 in an effort to reduce expenses, SCPS downsized to its smaller office in the same building.

From 1992-2004 SCPS implemented additional cost saving measures and the total staff has whittled down from four, to one and a half employees. As SCPS reduced the rent and other expenses, Mindi has been instrumental in helping SCPS to continue to thrive and offer valuable services to our membership. Many of the SCPS cost saving measures occurred as more and more of the SCPS dues were allocated to CPA for advocacy and management.

It may surprise you to hear that SCPS functioned on less dues per member in 2020 ($321), and for the past 25 years ($405 in 1991). With the budget being balanced in 2021, the SCPS dues and expenses will finally be commensurate to inflation.

In addition to the staff and office reductions, other cuts included discontinuing the contract with the SCPS public relations consultant (who had helped SCPS write public service announcements. Mindi reminded me that while working with SCPS during the 1990s, the PR consultant participated in various community mental health coalitions and increased SCPS' involvement in local county and city-level advocacy).

Throughout all of the SCPS cost saving measures, Mindi has picked up the slack and always found ways to do more with less. With the advent of digital technology, Mindi taught herself desktop publishing so that she could design the newsletter and bring that function completely in-house. Later when the paper newsletter was no longer printed, Mindi led the transition to a digital version.

When I spoke with fellow SCPS members, the first thing everyone says is that Mindi is “the heart and soul of SCPS.” Honestly, it is true. Mindi has personally staffed and helped to facilitate the activities of every SCPS Committee during her tenure at SCPS, including all of the CME programming, the non-CME committee events, recruitment/retention campaigns, the Distinguished Fellowship process, and the annual NAMI-Walks events. She has coordinated special SCPS projects and in 2016, executive produced the documentary “Art of Storytelling: The Human Experience of Being a Psychiatrist.” She also traveled and represented SCPS on the discussion panels when the film was screened at the APA annual meeting in Atlanta, WPA Berlin, and at the 2018 World Mental Health Day Psychiatric Conference in Beirut, Lebanon.

Beyond representing SCPS and the film around the world, in the late 90s/early 2000s Mindi travelled a few times each year between L.A. and Washington D.C. to serve on APA components which included district branch executives. Since then, she has travelled to two APA meetings per year to meet with her district branch executive colleagues.

Enough about us... a little about Mindi outside of SCPS. She is most proud of how fiercely close she is with her family. They mean everything to her (so, her calling SCPS her second family really means a lot!). She loves reading and watching movies (her favorite genre of movie is the psychological drama about women in trouble — a rather narrow and specific, but emotionally rewarding genre!). She likes to cook but hates baking because everything needs to be measured and she feels it is less creative. Mindi loves music and going to concerts. Her favorite bands are Radiohead and the Grateful Dead, but she has very eclectic tastes. Her favorite “ritual” prior to Covid was going to her weekly farmer’s market. She power-walked 40 miles a week for ten years until she broke her foot in two places. She gets riled up by politics (but at this point, who doesn’t).

I want to thank Mindi for taking her time to let me interview her for this article. Mindi is more accustomed to being behind the scenes and letting the SCPS members shine. So, I know this was not what she thought I had in mind when I started asking so many questions.

Writing this article about Mindi made one thing very clear to me: She feels lucky to be at SCPS and we’re lucky to have her. Hopefully for many more years to come.

Please join me in celebrating Mindi’s 29th year with SCPS and if you can, thank her for her service to SCPS!

You can write directly to Mindi (scps2999@earthlink.net) or to myself (docgoldenberg@gmail.com)

Stay safe,

Matthew Goldenberg D.O.

SCPS Newsletter Editor; Treasurer (2020 - 2022)

Email: docgoldenberg@gmail.com

Climate Crises and Global Mental Health

by Kavita Khajuria, MD
SCPS Disaster Relief Committee

Wildfires recently ignited parts of California, Oregan and Washington with bewildering ferocity. Fires are nothing new to California, but the frequency and intensity seems to be escalating, along with strange weather changes. Projections for 2100 A.D. suggest the average global temperatures will rise by 2.4–5.8°C (Padhy et al, 2015).

Extreme heat events and humidity have been noted to increase hospital admissions for mood and behavioral disorders, including schizophrenia, mania and neurotic disorders (Hayes et al, 2018). Scholars note heat-related mental health morbidity to occur more often in those with impaired thermoregulation and in those taking prescription medications - specifically lithium, neuroleptics and anticholinergics. Those with substance use problems are also at risk. Wildfires also impact mental health directly- as evidenced by psychological distress, PTSD and depression in communities that were affected by the Blackfire Saturday bushfires in Victoria, Austrailia. Approximately 30% of hurricane Katrina survivors were estimated to have experienced some form of mental distress, and nearly half of the marginalized population in New Orleans demonstrated probable signs of PTSD.

There's also been increasing reports of suicide and suicidal ideations following extreme weather events. Aggressive behaviors and increased rates of criminality have been known to be associated with increased temperatures: homicide-suicide risks doubled in 1992 after Hurricane Andrew in Miami Dade County, Florida. As public awareness of the health implications of climate changes continues to grow, it's known that mental health effects can amplify other determinants of health.

One of the most well documented climate hazards that indirectly influences mental health is drought - via economic effects and the heavier impact on those living in rural remote communities. Many south Asian countries are particularly vulnerable as a result of their dependence on agriculture, poverty and reliance on livestock. A relationship has been found between the occurrence of drought and farmer suicides in India, and a study in New South Wales revealed that ~75% of farmers reported stress related to persistent drought. India has experienced devastating consequences from climate change, but hasn't been able to take effective measures to tackle these problems – it requires technology and finances of an estimated one trillion dollars - insufficient resources has been cited as the deterrant. India hasn't taken an adequately co-ordinated, collaborative and cross sectional approach to address the existing and growing potential risks as yet.

Action on mental or physical health consequences of climate change requires actions from multiple levels - globally and locally - by reduction of gas emissions, adaptation of individual and collective agencies, surveillance and monitoring, capacity building, and pragmatic preparedness, to name a few. Coordinated collaborative efforts to address the mental health implications of climate change require not only policy assessment, but additional concrete actions of practitioners with engagement in adaptation measures and preparation. Although national and global commitments are necessary, public education including patient education can be an opportunity to address the mental health effects of climate change.

References:

Padhy SK, Sarkar S, Panigrahi M, Paul S. Mental Health effects of Climate Change. Indian J Occup Environ Med. 2015;19 (1):3–7.
ncbi.nlm.nih.gov/pmc/articles/PMC4446935

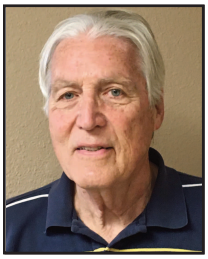
Hayes, K., Blashki, G., Wiseman, J. et al. Climate change and Mental Health: Risks, Impacts and Priority Actions. Int J Ment Health Syst 12, 28 (2018).
ijmhs.biomedcentral.com/articles/10.1186/s13033-018-0210-6

Culture Clash

by: Walter T. Haessler, M.D.

Nobody outside of a baby carriage, or a judge's chamber, believes in an unprejudiced point of view. Lillian Hellman

He (the devil) always sends errors into the world in pairs — pairs of opposites. And he always encourages us to spend a lot of time thinking which is the worse. You see why, of course? He relies on our extra dislike of the one to draw us gradually into the other. C.S. Lewis



When I told Ellaine's daughter that I'm writing an article on the contribution of a culture clash to the problem of violent confrontations between law enforcement and Black American men, she asked what I would be saying about it. I told her that I didn't know yet.

I still don't know what I'll be saying about it, but am taking the advice of Louis L'Amour: "In any case, start writing. The water does not flow until the faucet is turned on.".

There's no doubt that culture is important. It's much easier to succeed if you grow up in a culture that fosters success. We want the Marine Corps and our favorite football team to have cultures of unquestioning domination.

We wouldn't have made it as a species if we hadn't been tribal. Pre-humans and early humans could not have survived as lone hunters. They were organized into tribes; pro-tribal behaviors conveyed a selective advantage; and those behaviors are in us today as surely as are our canine teeth. It is, as they say, in our DNA.

Moral psychologist Jonathan Haidt goes into detail on this in his remarkable book The Righteous Mind. (1) In fact, loyalty to the group (often, in opposition to another group) is shown to be one of the five established foundations of human moral behavior. Space limitations don't permit further discussion of this.

Culture can be defined differently. For the purposes of this discussion I'm viewing it as a distinctive pattern of behavior, communication, attitudes and values within a tribal structure. The tribal structure may be as small as an extended family, or as large as a profession or a whole race of people.

There are books on the influence of culture, but I have read none of them. I haven't researched this subject either, beyond referring to three sources, cited below. And I've included four anecdotes that I still recall vividly, and believe to be informative.

The first of these occurred around 1985. A Black woman psychiatrist was being interviewed on TV (C-SPAN ?). She made the point that standard psychotherapy (at that time) — with goals of taking personal responsibility, gaining insight, and resolving dependency needs — was neither relevant nor useful in treating American Blacks.

She was saying, in her way, that Black American culture is in ways different — an idea that echoed loudly this summer when public pressure forced the Smithsonian National Museum of African American History and Culture to remove the "Aspects and Assumptions of Whiteness in the United States" poster from its "Talking About Race" series. (2)

Apparently intended as a criticism of "white culture", it wound up being slammed as condescending and unfair to Black people for ascribing a multitude of positive traits to "whiteness". What traits? How about hard work, self-reliance, delayed gratifiction, being on time, politeness, and an emphasis on the nuclear family.

One Black detractor is quoted as saying, "(Why not) simply allude to the fact that every great quality you ever could imagine is only (found in) white people", and referred to "...the bigotry of low expectations for Black people."

I think most Americans would agree with him on that, and I see why he finds it offensive. But if white Americans actually do see Blacks that way, I wonder if it may be useful to face that fact and deal with it.

The next was around 1995, when I was working under contract at an outpatient clinic. After a discussion with staff about a Black patient, a friendly and highly-respected Black psychiatrist took me aside and talked with me about how white psychiatrists may tend to overdiagnose paranoia in Black patients — and gave me an article on Black cultural paranoia.

As the reader can see online, there is quite a bit of literature on that subject, but I don't hear us talking about it. The police video of the George Floyd arrest reveals that before things went bad he said, "Please don't shoot me." Why aren't we talking about this? Perhaps we should be.

As we know, feelings of fear, anger, and resentment can engender a sense of victimhood. What we don't always recognize and acknowledge is that a feeling of victimhood is a reliable predictor of violence. I discussed this situation in a Psychiatric News article (3)

I'll close with two more anecdotes, both from my last ten years of employment as a psychiatrist — at one of California's maximum security prisons. I showed courage in one of them, and a lack of it in the other. Let's get that one out of the way first.

There was a monthly teleconference, involving the mental health staffs at all California's prisons and Sacramento headquarters. One day (in 2005?) the issue at hand was the suicide of a Korean inmate. The psychologist chairing the discussion seemed to me to be subtly critical of the staff at the inmate's institution, for not having been sufficiently aware of Korean cultural issues — which may have contributed to the man's death.

I was hot under the collar, and was rehearsing how I was going to jump in and say something like, "You realize, don't you, that the prison mental health staff is almost entirely white and Asian while the inmates are a third white, a third Black, and a third Hispanic? Despite this fact, we have had no trainings on Black or Hispanic culture, and here you are being critical of staff for perhaps missing nuances of Korean culture. How many Koreans are in our prisons? Ten? Twenty? Thirty?"

Sounds good, doesn't it? Anger can get one right to the point sometimes. But I chickened out. I still regret that.

And then there's this one. Around that same time, a correctional officer at Chino was murdered by an inmate. It had been 25 years since that had happened in California. Around that time I happened to look through a newsletter published by the California Correctional Peace Officers Association (CCPOA) containing a poem written by a (female) correctional officer.

The author was angry about the killing, of course, and then she really laid it on about feelings of disgust and contempt she had for prison inmates. I remember the phrase "scum of the earth." I couldn't believe what I was reading. I couldn't believe that CCPOA would publish it.

Shortly thereafter there was a mandatory all-day training on "The Green Wall" — referring to a widely-recognized code of silence among the officers (whose uniforms are green) regarding officer misconduct. After the presentations, everyone was invited to get up and speak. This time I didn't chicken out.

I read the poem to the group of about thirty — mostly correctional officers — and then kind of winged it for several minutes. I said, among other things, that the officer who wrote that should find another way to earn a living. There was visible and audible unrest in the room. I was dyin' up there.

And then a (Black) correctional captain, the highest-ranking officer in the room, got up to speak — and bailed me out. He cited an experience early in his career, when notorious inmate (look him up online, but not right before dinner) Larry Singleton was in his custody.

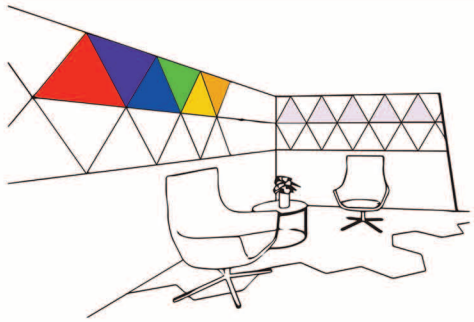
Other officers had been (illegally but openly) withholding Singleton's property, which is a way to harass inmates. The young officer defied them, and delivered Singleton's property. He reminded the group that the punishment is being in prison; that the officers are not to be instruments of punishment; that he always starts out with a fresh mind when getting to know an inmate; and that this approach has worked well for him over the years.

His words ring true. Each officer is unique. Each Black American is unique. Let's keep that in mind. I think things will go better in the long run if we can — at least by degrees — resist our innate tendency to join one tribe or another. Perhaps we can, if we want to.

(1) Haidt, J. 2012. The Righteous Mind. New York: Random House

(2) Richardson, V. The Washington Times. July 17, 2020.

(3) Haessler, W. "Another Origin of Violence". Psychiatric News. June 3, 2016.



SCPS CAREER DAY 2020

Online: Saturday, December 5th

Speakers | Exhibitors | Strategies

SAVE THE DATE!

Career Day Speakers – 9:00 a.m. – 11:45 a.m.
Managed Care/Kaiser – Galya Rees, M.D. – 9:00 a.m.
Private Practice – Katherine Unverferth, M.D. – 9:15 a.m.
Public Psychiatry – Kelly Jones, M.D. – 9:30 a.m.
Group Practice – Victoria Huang, M.D. – 9:45 a.m.
Academic Psychiatry – Charles Manchee, M.D. – 10:00 a.m.
Clinical Trials – Haig Goenjian, M.D. – 10:15 a.m.

5-Minute Break – 10:30 a.m.

Financial & Investment Strategies – George Fouras, M.D., Zeb Little, M.D. – 10:35 a.m. – 11:45 a.m.

15-Minute Break – 11:45 a.m.

Employer Exhibits – 12:00 Noon – Exhibitors include:

Community Psychiatry
Kaiser/Permanente
PRMS - the psychiatrists' program
Sites Professionals
Telecare Corp.
Traditions Behavioral Health

This will be an online event. More details and exhibitors to be announced soon! Save the Date!

How MOC is Contributing to the Demise of Physicians

By: Torie Sepah, M.D.

Let me start by saying that I am a Diplomate (i.e. "Board Certified") by the American Board of Psychiatry & Neurology. I was completely in agreement that to display competence in my specialty after four years of residency, I should pass the oral and written exams required by the ABPN, further to prove I have maintained my skills, I have always found it reasonable that I be administered the exam every ten years. I was willing to pay the thousands of dollars required for the initial exam and the expected fee for the ten year exam. That is par for the course in medicine—if there is one thing we are used to, it is standardization and expensive exams.

Here are the reasons why I now question the premise of 'board certification', in particular given its pairing with the arduous, confusing, and expensive program called "MOC" or the Maintenance of Certification Program. For one, there is a select group—Lifetime Members— who are magically bestowed with the ability to display competence in a specialty based on an arbitrary graduation date, some without having ever taken an exam ("Grandfathered" in) or others do not have to re-take an exam every ten years and participate in MOC as the rest of us do although their knowledge base is fundamentally older. Seems like an institution that promotes *"..... the heart of board certification is an ongoing assessment process," is undermining its own values by giving a whole a group a pass on re-assessment. Fundamentally, it is unethical as it promotes inequity among physicians. One group must now carry a greater burden of administrative tasks which take time and cost, and we are also charged annually for MOC. The "Lifetime Members" get to save time and money but still have the same end result, "board certification". How is that justifiable? Did they receive the Nobel prize? Publish over a 100 articles? The standard should surely be extremely high given the mission of the ABMS. Otherwise, the whole institution's integrity is compromised by this alone.*

Beyond this glaring inconsistency, maintaining certification is no longer about showing competence via an exam every ten years. Not at all. Now, I must pay an annual fee around $500 to 'maintain' the certification that I already earned fair and square. If I don't pay this fee, my status on the ABPN's website turns from 'participating in MOC" to "not participating in MOC". Really? If I don't pay the arbitrary $500, I'm now not staying up to date? Says who? I earned my certification and paid for that exam already. There's only one way to put this, it feels like a shake down. I have to pay it even though I already earned that certification.

Now, one could argue, what's $500 a year to a physician? Well, it adds up to $5k in ten years at which time I'll shell out another several grand to take the re-cert exam. Contrary to popular belief, physicians aren't exactly rolling in the dough. In fact, 8 out of 10 physicians under 40 carry over $150k in medical school debt. It all adds up—the medical license fee, the DEA fee, the specialty association fee. Is this extra $5k really necessary and if so what it is for?

Here's what it is not being used for, to protect what our 'board certification' stands for.

My 'board certification' in psychiatry means didley these days because NPs and PA's are also "board certified" in Psychiatry without attending a medical school, completing an ACGME residency program, passing the three part oral exam in order to become eligible for the written exam in psychiatry, and of course not participating in MOC or taking our rigorous written exam every ten years.

To make sure that the world knows they are 'board certified', they often embroider it on their white coats. And now in 24 states, they can practice medicine 'independantly' with 'board certification' in a specialty like psychiatry.

If the ABMS wants us to value what 'board certification' means, and pay a premium for it with out time and pocket books, I would recommend that they first show to us why the term has significance in the new world of 'providers' who are all seemingly equal in their long white coats and now 'board certified'.

All of the above is important, but not as much as physician lives which are at risk day to day. We lose enough physicians to suicide every year so that over one million patient contacts are lost. We are twice as likely to take

our lives than the general public. While there are no direct studies linking physician suicide to our consistently escalating burnout rate, now at 50%, we can safely conclude that we are in crisis.

There are some characteristics about physicians that we already know—we are self-starters. We rarely need prodding. We don't like to be micro-managed. Most of us won't be where we are if we didn't have these qualities. MOC seems to miss these key characteristics that are our strengths. Instead, the ABMS seems to be contributing to two of the key identified etiologies of our burnout syndrome: added administrative burdens and lack of autonomy.

Let's consider some facts: the average work week for physicians (after residency) is 55 hours and 25% work more than 60 hrs. We are literally drowning in charting. For every one hour of face to face to time with a patient, a physician spends two hours on the EMR. Many of us are charting during 'pajama time' after our kids go to sleep just to catch up.

I sincerely ask the ABMS if they have considered how their added MOC costs and micro-managing burdens add to the burden that frontline physicians already face? Do you they know that paying for self-assessment tests are of low utility when most of us are evaluated constantly through "'patient satisfaction scores', peer review of charts, and not to mention myriad online review platforms? If I have ten minutes to spend with my kids, I can promise you that I will not spend it doing it a (paid) self-assessment.

As someone who sincerely believes in maintaining the highest standards in my profession and specialty, I hope that the ABMS will be able to realize that in order to protect the integrity of medicine, they must first be in line with those who practice medicine.

This article previously appeared on KevinMD
https://www.kevinmd.com/blog/2020/06/how-moc-is-contributing-to-the-demise-of-physicians.html

---

Course Title: American Red Cross Disaster Cycle Services Overview and Disaster Mental Health Introduction.

Do you want to learn more about becoming a Disaster Mental Health Volunteer with the American Red Cross? This session will offer two of the four required pre-requisite courses to become a Service Associate Disaster Mental Health Volunteer with the American Red Cross. The courses are taught back-to-back in this session. Participants will receive a certificate for both courses that you can take back to your local chapter for credit when you sign up to volunteer.

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

SCPS designates this educational activity for a maximum of 3 AMA PRA Category 1 Credit(s)TM. Physicians should only claim creditcommensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

Psychiatric Residency at Charles R. Drew University

by: Rahn Bailey, M.D.

Charles R. Drew University (CDU) is a "private university with a public mission," located in South Los Angeles. Beginning in August of 1966, CDU prides itself with creating well rounded health care professional leaders who are dedicated to their community. South Los Angeles is a unique location for residency, as it allows for an opportunity to serve underserved minorities. Every year six resident physicians are selected to participate in the competitive psychiatric residency program which successfully began three years ago. Charles R. Drew University residency program is divided into 13 four-week blocks, which begins on approximately June 18th of each year. During the training experience residents are challenged with researching, problem solving, working on topics of innovation, and creating solutions for the community.

The residents can broaden their knowledge in medicine while rotating at different hospitals in Southern California. Rotation sites include: Long Beach VA Health Care System, UCLA Resnick Neuropsychiatric Hospital, Rancho Los Amigos Hospital, UCLA Harbor General Hospital, Kedren Community Health Clinic, and Kedren Primary Care Clinic.

The rotation at Rancho Los Amigos gives the residents the opportunity to partake in a quality rehabilitation and reintegration clinic. This unique medical center specializes in neurology, orthopedic, pediatric, spine surgery, and stroke rehabilitation. The patient population at Rancho Los Amigos is comprised of all socioeconomic levels, all ages, and presenting with acute/chronic neurological conditions.

At the urban UCLA Harbor Hospital, residents get to experience firsthand emergency Psychiatric care. They also get to experience working in an active 72-acre facility and gain expertise on the "six core competencies." Relating to assessment, treatment, and disposition of patients who are going through psychiatric emergencies.

Kedren Community Health Center-one of CDU's main clinical partner-allows its residents to experience and address the underserved population. This including the wellness, education, and prevention of high-level clinical care. Kedren consists of both inpatient/outpatient psychiatric and primary care services, which is family and community focused. It serves about 10,000 young children, teenagers, and adults annually in its mental health facility alone.

Charles R. Drew University is granted accreditation by the University of California Los Angeles, the Liaison Committee of Medical Education of the Association of American Medical Colleges, and the American Medical Association. Gul Ebrahim MD is the Psychiatric program director at Charles R. Drew University. Dr Ebrahim is a board-certified physician in Addiction Psychiatry & Addiction Medicine who completed his training at King Drew Medical Center in Los Angeles, CA. Denese Shervington MD is the chair of Psychiatry and Behavioral Medicine, who graduated from NYU and finished her residency at University of California, San Francisco. Rahn Kennedy Bailey MD is a neuropsychiatrist who did his fellowship in forensic psychiatry at Yale University. He is also the Assistant Dean of clinical education at CDU. Residents are confident that a program led by these professionals will strongly prepare them to work at top medical hospitals around the country. Moreover, create a blueprint to help deal with health disparities that minorities face. At the completion of the program, residents will be well prepared to use evidence- based data to further and continuously learn medicine as competent physicians at the highest level.

Annual State of the Union Address

by: Mindi Thelen

Dear SCPS Members. It is time once again for my annual 'State of the Union' article for the newsletter. This year, that concept, 'state of the union,' has layers and double entendre. I missed last year because the thrust of what SCPS was working on revolved around the crumbling of the California Psychiatric Association (CPA) as it was still very much a situation in flux.

As you now know, the CPA has now dissolved. For those of you reading this who are not intimately involved with the organization and for the newer RFM members a brief explanation of what CPA was might be helpful. CPA was the coming together of the five APA district branches (DBs) in California to perform a unified advocacy function in California. CPA was separately incorporated and had its own officers. Each of the five California DBs sent representatives who voted on CPA issues along with the CPA officers. CPA was incorporated to act as the same body as Area 6 of the APA—since Area 6 of the APA is only the five district branches in California—as opposed to Areas which encompass more than one state. Related to that function, in addition to the CPA board discussing state advocacy matters, they also handled Area 6 issues and received the block grants the APA bestows on each of their areas.

At the August 2019 CPA Council meeting, three district branches began to express that they were fundamentally dissatisfied with several crucial aspects of CPA and actions taken by the board. After months of trying to bridge the differences, in July of 2020, it finally became obvious that CPA could not continue because the third district branch, the Northern California Psychiatric Society, 'resigned' from CPA. (This was after San Diego Psychiatric Society and Orange County Psychiatric Society quit earlier in the year.)

Unfortunately, the chaos and crisis at CPA projected onto SCPS - in terms of needing to figure out how SCPS could still provide effective state and local advocacy for you, your patients, and your profession. In July an SCPS Ad Hoc Committee was formed to look at two proposals for ongoing advocacy. One named PPAC (Psychiatric Physician Alliance of CA), which was already incorporated and founded by existing and past CPA officers and Randall Hagar, CPA's lobbyist. The second proposal is in the formative stages and is being organized by the three district branches who left CPA. It has the support of APA's Department of Government Affairs. It was an arduous task to review these proposals and your elected officials spent many hours this summer reviewing all of the pros and cons of each. In the end, the SCPS Council voted to support the PPAC for 2021. PPAC is not APA-affiliated and no longer also serves as the Area 6 Council—so your Area 6 representatives, your representatives to the APA Assembly, will be meeting outside of the advocacy arena. This is a work-in-progress as many of your elected councillors and officers see the beauty of continuing with the current lobbying team inherent with PPAC, and also the benefit of a unified voice in Sacramento with your other district branch colleagues. What that might look like in the future is still unclear. We promise to keep you up-to-date as things unfold.

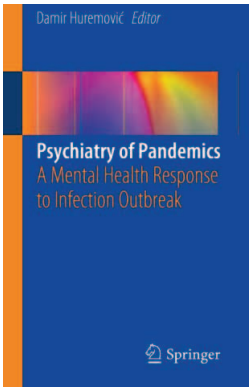
Now, that this exceedingly important decision has been made, your SCPS officers and councillors look forward to providing quality services for you during the remainder of the pandemic (and beyond). Clearly, meetings will need to be held virtually for an indefinite period of time and face-to-face networking events will not be able to be held, but our committees are hard at work designing virtual programs and events. We have two new committees: the Diversity and Culture Committee which is quickly forging ahead with resolution papers, and the Disaster Relief Committee which is planning a Red Cross disaster relief training in October. The Newsletter committee is committed to providing 11 high quality newsletters per year, and the Program Committee is committed to continuing to provide premier CME. The changes in advocacy may give us an opportunity to reinvigorate our local GA Committee. Our Distinguished Fellowship and Awards Committee is focused on its effort. The Women's Committee has organized an event for November 8th. And as always, I am here to facilitate the work of your board and committees and to provide whatever service necessary.

Dues bills have recently been mailed. If any of you have questions about your dues bill or how to make payment, please feel free to contact me at SCPS2999@earthlink.net, or 310-815-3650. Please note that there is a sec-

ond button on each payment page that can be used to make pro-rated payments, or installment payments at whatever amount and frequency you choose.

In closing, I hope you are all staying safe and well. This too shall pass.

Psychiatry of Pandemics: A Mental Health Response to Infection Outbreak
Edited by Damir Huremovic
Springer Publications
2019
185 pages
$99.99; Amazon list price $47. Paperback
ISBN 987-3-030-15346-5



Book reviewed by Kavita Khajuria, MD

This book was published shortly before the outbreak of COVID19, but it ominously predicted Disease 'X': 'a speculated source with devastating effects on humanity'. The book starts off with a brief history of pandemics - from the Athenian plague of which Hippocrates was thought to be a contemporary, to the Justinian plague with victims experiencing hallucinations prior to the outbreak and subsequently 'seized with madness' - to the bubonic plague wherein many turned to religion with an interpretation of the divine punishment of sins and the singling out of minorities and women with persecution of select targets. Interestingly, Venice was amongst the first city-states to establish dedicated practitioners to deal with the issues of the plague, from which much was learnt about human anatomy. The Spanish Flu was the first true global pandemic where the long term effects could be observed and quantified but authors note the HIV epidemic to have resulted in a better understanding of some of the challenges associated with infectious disease, including the association with substance use, stigma, guilt and shame. The SARS pandemic was another whose studies yielded valuable data including the mental health issues facing healthcare providers and offered valuable insights into the mental health of survivors, patients in isolation, and demonstrated the psychological sequelae of working with such patients. The H1N1 pandemic further highlighted the creation of panic and peddling of unproven vaccines, and the Ebola outbreak led to a significant public health awareness. The ZIKA outbreak was the first time that social researchers studied public sentiment, also known as emotional epidemiology.

Authors discuss the psychology of a pandemic - they point out the mental health aspect of pandemics to contain parallel processes - including mirroring and symbolic contagion. They analyze the concept of dread and fascination with zombies, and note the dissemination of racist propaganda and pro-violence to serve aggressive desires. Separation of community from its order and well-being led to a changed way of storing and metabolizing memories and experiences, and authors note the deep, existential meaning an outbreak may have for the individual and collective psyche - also illustrated with Sigmund Freuds comments after the death of his fifth child So-

phie Freud-Halberstadt (who died of complications associated with the Spanish flu), with his reflections and critical thinking in 'Beyond the Pleasure Principle' (1920). They also note pop culture in regards to the psychology of a pandemic.

The chapter on societal, public and emotional aspects of a pandemic outline how mass behavior affects the uncontrollable and unconscious aspects of the recipient individual. They discuss contagion psychology with respect to both emotional and behavioral contagions - and cite the real agent in many cases of mass hysteria to be anxiety, often propagated by social media and stress the importance of the internet to create an efficient public surveillance, given that fake news in social media is the phenomena that may hold a key to preparedness and the execution of public health plans. They encourage mental health professionals to familiarize themselves with basic epidemiological concepts in order to understand the emotional aspects of outbreaks and in order to provide useful recommendations. A glossary of terms is included.

The importance of culture in managing mental health responses to pandemics is emphasized - as community response and the willingness to embrace interventions devised greatly influence the outcome. Along with a brief literature review, they note cultural beliefs to be important contributory factor to general lack of awareness (and poor state facilities) and to sometimes represent a significant challenge to healthcare practitioners especially international aid workers when certain groups believe that the disease is a punishment from God. Given that burial practices for the diseased has been one of the most important modes of disease transmission, they encourage a holistic approach to meaningfully influence the outcome, as past studies demonstrate cultural preservation may also constitute a protective factor in both mental and physical health. Given how local and religious frameworks affect the outcome of international containment, they stress the need for adaptation and respect for prevalent cultural norms.

Preparation for an outbreak is discussed - while acknowledging the dilemmas and burdens of dual stressors and the possibility of contracting the infection. They note the risks for mental health patients - with worsening of mood disorders, neurosis and somatoform disorders, and aggravation or development of anxiety. They note issues of compliance and relapse in those with the more serious mental health disorders, including schizophrenia, schizoaffective disorder and bipolar disorder, as well as reckless and risk taking behaviors in the context of an outbreak, the impact of disruption of access to mental health care, and the need for balance in dispatching medications, given the risks for abuse or overdose. The consideration of switching meds that require strict monitoring is suggested, considering the potential for lack of access and blood level monitoring. They stress the importance of telecommunication to ensure continuity of care, which may now sound obvious, given the current pseudo-norm with zoom and tele psychiatry. They note the problem for those with substance use problems to include stockpiling with its own risks and complications, and suggest the consideration of alternate approaches, including automatic dispensaries and drones.

At the time of this publication, little evidence existed on how to prepare at the residential level, but they cite a New Zealand study to have revealed the need for disaster planning, understanding the community, and the importance of the support of individuals throughout - including staff. Half of the residential facilities at the time of this publication had a plan in place for the influenza pandemic. Results from other international studies include those treated in the ICU and survivors of severe H1N1 influenza. Recognition of emotional complications at a policy level was reportedly done for the first time by the National Biodefense Science Board, which included programming integration of behavioral health and scientific expertise in a comprehensive public health response. The results of the mental health sequelae of the Ebola outbreak recognized the rates of anxiety-depression and probable PTSD, while significantly acknowledging the influence of other socio-politico-cultural factors. The potential for other complications for returning providers is also pointed out: stigma and isolation. A sixteen point list outlines the levels wherein mental health experts and providers can be instrumental on several levels.

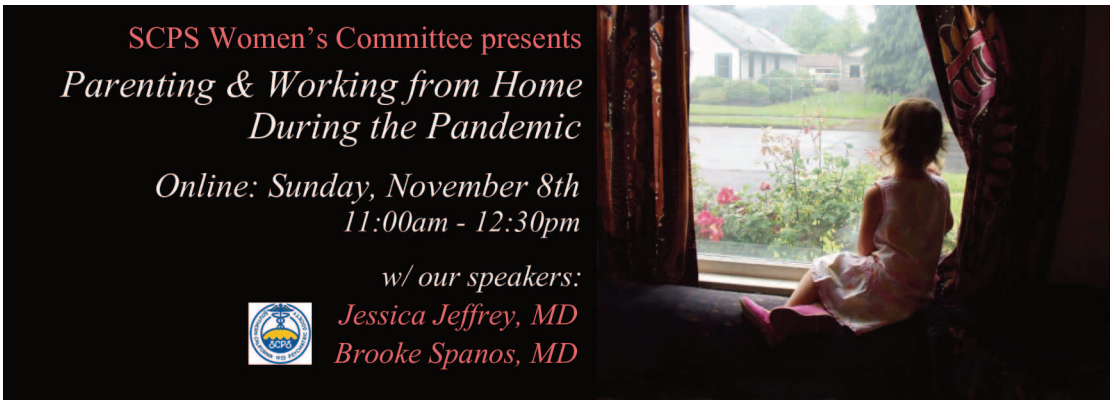
Neuropsychiatric complications of infectious outbreaks are briefly reviewed - they note them as benign thus far, except for HIV and in those on antiretroviral treatment, and a general predilection for depression and anxiety for those with recurrent antibiotic exposure. They point out the risk for the development of schizophrenia for those born to mothers seropositive for bacterial and viral agents, and the role of cytokines as an area for research interest. Social distancing, quarantine and isolation are discussed - in historical contexts from global perspectives,

including in reference to the U.S Public Service Act and the Federal Executive Order of the U.S President. Specific communicable diseases are noted with mention of 'shelter-in-place', 'cordon sanitaire' and the alternative approach: 'protective sequestration'.

The chapter on mental health care for survivors and healthcare workers in the aftermath of an outbreak seemed more striking and relevant at this juncture, wherein neurological, psychiatric and emotional complications and disorders are discussed in association with pandemics. Therapeutic considerations and recommendations are discussed - including medications, dosages, side effects and potential challenges - while noting the importance of leadership and structure. Mental health assistance to families and communities include a discussion of grief reactions, survivor guilt, stigma, and other trauma related symptoms of human loss and suffering. Other practical challenges include emotional closure in the face of areas devastated by pandemics that may outlaw traditional and religious burial rites, which is where they note community and spiritual leaders to play important roles. Rather than a single source, reliable and consistent communications from multiple sources are stressed as fundamental to contain public anxiety, including protection measures with detailed information on precautions and preparedness. They note at-risk populations including children and the elderly and encourage the use of virtual contact via technology to decrease isolation and frustration. The book concludes with a chapter on immunization and vaccination - including the history of vaccines; international programs, collaborative global efforts, complications in the making and production of pandemic vaccines, and a thorough review of vaccine 'hesitancy'.

Despite the title, the book shares more than general psychiatry in relation to pandemics, it provides a multifaceted review including but not limited to history and epidemiology. Considering the title and current timing - I would have liked to have known more about specific mental illnesses in regards to a global pandemic. Regardless - the history, global perspectives and research studies are educational and informative. The human and emotional costs translate as intuitively important, and the practical guidelines as necessarily pragmatic. The material was sometimes extensively referenced. The chapters on mental health care for survivors, healthcare workers, families and communities seem most relevant - given the timing.

As a psychiatrist, there has been much to observe from the COVID pandemic including my patients. Upon the initial outbreak, there was initial shock and an uneasy quiet, followed by a brewing storm. Apart from anxiety and uncertainty, some incorporated COVID19 into delusional belief systems, while some others denied its existence and refused to wear masks. It's been a time of challenge for everyone – a test of ones fear, strength and adaptability. Needless to say, research on the current pandemic is hastily underway, and given its global reach, it will be interesting to consider the research and lessons learned a year from now.



Council Highlights
September 10, 2020

Eric Wagreich, M.D., *Secretary*

Outline of Notable Meeting Events and Discussion

The meeting was called to order by Dr. Fouras at 7:03PM.

Introduction to the meeting
Dr. Fouras welcomed councilmembers to the meeting and set ground rules for the forthcoming discussions. Members were asked to provide COI disclosure information pursuant to the meeting's discussion:

Dr. Cheung reported: In my capacity as SCPS president I worked closely with CPA and all DB presidents over 8 months, as well as legal moderators (Jim Gross), attempting to negotiate a plan to stabilize CPA. Several of the DB presidents are authors of the CAPP proposal. I participated in additional CPA committees with the same individuals, with a goal of recommending improvements to CPA governance. I am a supporter and participant in discussions about PACC with Randall Hagar and others. I am not an officer, director, member, lender, or donor to PACC.

Dr. Fouras reported: I am a founding member and contributor of PPAC.
Dr. Goldenberg reported: I have no conflicts of interest, as I am not an officer, member, donor or lender of either proposal and I have not pledged any funds to either proposal. However, I was asked by Dr. Cheung to disclose the following:

I have met with various members of the APA from other district branches in CA to discuss lobbying options over the past few months and several of them are from the district branches that have shared the CAPP proposal with SCPS. During these communications, I have never represented myself as speaking for SCPS. I was asked by the Ad Hoc committee to serve as a liaison, along with Haig, and we met with members of all 4 other district branches (including Chris Stockton the Executive Director of CCPS) to hear their ideas and share 3 vague areas of concern that the ad hoc committee raised. After that meeting Mr. Stockton, informed me that CCPS leadership was inviting that same group to speak with them and he invited me to attend. As the ad hoc committee had not authorized any further meetings, I declined the invitation and stated it would be inappropriate for me to attend as SCPS was actively reviewing its lobbying options and had not made a decision on either proposal and I let our Ad hoc chairs know of the meeting and my declining of the invitation.

Ms. Thelen reported that she participated on a Next Steps group for several months while it was attempting to stabilize CPA and participated once on a call with representatives from the 3/4/5 DB proposal.

Other members made disclosures that were not recorded or submitted in writing.

Meeting Minutes
Minutes from the previous meeting were unanimously approved.

President's Report
Dr. Naser Ahmadi was unanimously approved to be appointed to SFV Councilor position
CPA Status.
Dr. Fouras provided an introduction and background to the events leading up to the impending possible dissolution of CPA.
Legal Counsel to SCPS, Dan Willick provided some perspective on pending legal issues.

Dr. Schaepper, current CPA President, provided perspective from CPA and noted that all attempts are being made to lower any existing CPA debts.
Questions were fielded.
One question involved what the primary debts remaining are, including CPA's rent.

Membership Report:
11 new members were approved, and report was accepted

Finance Committee Report
Dr. Goldenberg shared the finance committee's report, which included a projected $72,000 budget deficit for 2021 if no actions were taken due primarily to loss of membership and programming income. The report included that no new programming income is expected for 2021 but some virtual meetings have been discussed by the programing committee and that no other new forms of revenue expected, Dr. Goldenberg also shared the finance committee's unanimous recommendations, including that $40,000 of SCPS's operating expenses were recommended to be cut for 2021 which can be done without negatively affecting membership value. Dr. Goldenberg made the following motion based on recommendations from the Finance Committee:
The SCPS Finance Committee recommend that the 2021 budget be drafted, by the SCPS treasurer, to Hold the SCPS 2021 annual bill to members at top rate of $719, to preserve current SCPS core functions (which requires $245k after all reasonable cost saving measures, exclusive of California advocacy expenses) and to budget $87k for California advocacy expenses to balance the 2021 budget. This would allow SCPS to potentially contract for more than $87k of California advocacy services by realizing additional SCPS dues income in 2021.
The motion was initially tabled until after the Ad Hoc Committee report, and then revisited, at which time the motion was passed to accept the recommendation

Ad Hoc Committee Report
Disclosures regarding possible conflicts of interest were shared by the voting members of council
Dr. Ijeaku shared the committee's recommendations, and the committee's agreed upon benefits and drawbacks of aligning with any of the three proposed avenues for psychiatric advocacy in California
Dr. Red provided additional insight into the committee's work and recommendations
A discussion was held regarding the various options for advocacy
A motion was made by Dr. Cheung that "Contingent on due diligence that PPAC is properly organized as a lobbying organization, SCPS should consider directing funding to PPAC."
The motion passed

New Business:
There was no new business

Old Business:
There was no old business

The meeting was adjourned by Dr. Fouras at 9:58pm.

Prepared for consideration of the SCPS Council by SCPS Eric Wagreich, M.D.

Dues statements were mailed in mid-September. Please conntact Mindi at scps2999@earthlink.net, or (310) 815-3650 if you have any questions.

Please note that if you wish to pay in installments you may do so by using the second button on the payment page. That button will allow you to make payments in any increments that you wish and at what ever schedule you wish.

In the meantime, we hope you are staying safe and well!

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, 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.