California Psychiatrist

The Newsletter of the California Psychiatric Association

Volume 31, Number 2 Summer 2016

The President's Message

Community Disaster Response: *Inspiration, Education and Ethical Obligation*

William Arroyo, M.D.

By William Arroyo, M.D., CPA
President

As I begin my first term as your President, I am humbled by your confidence in electing me and determined to prove my worthiness in what is a much more important role than I had fully appreciated until I began to get "my feet wet". I owe much to my predecessors who have modeled such humility, leadership and achievement. My assurance in being able to fulfill this role is buttressed by the ongoing commitment, energy, compassion and intelligence evident in all of our CPA Council members, Committees and staff without whom the CPA could not accomplish all that it does. Additionally, my confidence is buoyed by the work done at the District Branch (DB) level, where scores of members are dedicated to the mission and ethics of our profession.

This column is inspired by the convergence of three events: my recent visit to the Council of Southern California Psychiatric Society (SCPS), my DB; the death of the quintessential humanitarian, Elie Weisel, a Nobel Laureate, author, and Holocaust survivor and the "spirit" of remembrance and pride engendered by the celebration of our country's Independence Day.

My SCPS Council meeting visit

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President-Elect/Education Committee Report

Please join us in Rancho Mirage on September 23-25, 2016!

Robert McCarron, D.O.

By Robert McCarron, D.O., CPA Chair Education Committee and President-Elect
and
Shawn Hersevoort, M.D., M.P.H., Vice-Chair CPA Education Committee

I am honored to write my first column as your President-elect. It is a privilege to represent the CPA in this capacity and I look forward to meeting with members at future regional events throughout the State. Please allow me to put on my other CPA "hat" as the Education Committee Chair and encourage you to attend our upcoming CPA CME Conferences. On behalf of the CPA Education Committee, Shawn Hersevoort, MD, MPH., Vice-Chair CPA Education Committee, and I are excited to share a preview of our upcoming **29th Annual California Psychiatric Association Premier Conference**, which will be held at the **Omni Rancho Las Palmas in beautiful Rancho Mirage, on September 23-25, 2016**. Please mark your calendars and lock in your room reservation today!

This year we are excited to announce the addition of the inaugural **CPA Clinical Updates in Psychopharmacology Pre-Conference** on Friday, **September 23rd**, which is Co-chaired by Ira Glick, MD. The Pre-Conference will feature four international psychopharmacology experts. The day will begin with Terence Ketter, MD, Professor of Psychiatry & Behavioral Science;

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Inside This Issue

Editor's Note "It's Gonna Be a Long Hot Summer"


Yvonne Ferguson, M.D.

I don't mean global warming, or the wildfire season, not even political heat, but rather cultural eruptions that tear at the seams of civility. I mean the haves vs the have-nots, Black Lives Matter, the LGBT trajectory towards equal rights, pro-life vs pro-choice, terrorist eruptions and settling of disputes with violence, or the numbing tensions with substances, all of which result in a societal heightened state of alertness that forecasts predict will become the new norm. This heightened state of alertness can lead to stress and the exacerbation of extant anxiety conditions in our current patients but there will be patients incubating under these conditions. Whether it be assisting those who are injured or have lost loved ones in assaults by or against police, treating those suffering from opioid overdoses in emergency rooms, responding to the need for community healing after mass hate/terrorist crimes, or random acts of gun/bombing/or knife violence, we are the principal agents of psychological trauma recovery. We should heed the recommendations in the President's article.

– Yvonne B. Ferguson, M.D., MPH, Editor

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California Psychiatric Association

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Capitol Insight

Check our WebSite at www.calpsych.org
APA WebSite: www.psych.org

Legal Update

A Victory For The Psychotherapist-Patient Privilege in The Face Of Medical Board Demands For Psychiatric Records Without Patient Authorization

Daniel H. Willick, Esq.

By Daniel H. Willick, J.D., Ph.D.

Introduction

CPA has won a significant victory in protecting a patient's psychiatric records from disclosure to the Medical Board without patient authorization. A recent California Court of Appeal decision adopts the position taken by CPA and CMA in a friend of the Court brief (*Gerner v. Superior Court*, www.ca.gov/opinions/documents/B268621.pdf) and rules that the psychotherapist-patient privilege prohibits enforcement of an investigatory subpoena for production to the Medical Board of patient records when the patient refuses to authorize such disclosure. Hopefully, this precedent setting decision will end the Medical Board's aggressive pursuit of psychiatric records during investigations of psychiatrists treating patients who refuse to authorize disclosure of their treatment records.

Medical Board Investigations

Typical Medical Board investigative practice is to seek patient records when a physician is accused of unprofessional conduct. This is illustrated by the case of *Lewis v. Superior Court* (Case No. S219811), which is pending before the California Supreme Court and in which CPA has joined in a CMA amicus brief. In *Lewis*, a patient complained to the Medical Board that Dr. Lewis, a physician who is not a psychiatrist, was disrespectful by suggesting she was fat and needed to follow a particular weight loss regimen. Although the patient's complaint did not concern the prescribing practices of Dr. Lewis, the Medical Board used the CURES database to obtain the three-year complete prescribing history of all patients treated by Dr. Lewis, including for patients who did not authorize disclosure of their records to the Medical Board. It is disturbing to know that the Medical Board has long asserted it has the same authority to obtain psychiatric records, notwithstanding the

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CARA to POTUS; Opioid Addiction Gets Public Health Treatment

By Ronald C. Thurston, MD, Vice Chair Government Affairs

Congress just passed CARA, with atypical bipartisan enthusiasm and POTUS is expected to sign it–despite typical Congressional underfunding.

CARA is the Comprehensive Addiction and Recovery Act and POTUS is the President Of The United States.

CARA is an urgent response to our national opioid epidemic. Nearly 30 thousand people died of opioid overdose in 2014—18,893 from prescription opioids and 10,574 from heroin. This follows a near quadrupling of opioid prescriptions—and opioid prescription deaths–since 1999.

Heroin deaths have tripled since 2010, in large part due to the volume of prescription abusers switching to less expensive heroin. Four out of five new heroin users began their addiction with prescription opioids.

"Opioid Epidemic?" Why not "National Opioid Crime Wave?" When did we switch from a crime to a public health paradigm, from criminal intent to acquired disease? Some say it's twenty-first century enlightenment. Some say it's because the numbers just got too big to be crime. Some say it's because more white people are dying. It's a little bit of all that.

The American Society of Addiction Medicine defines addiction as "a primary, chronic and relapsing brain disease characterized by an individual pathologically pursuing reward and/or relief by substance use and other behaviors," a genetically conditioned "hijack" of the brain's reward system.

CARA moves federal policy squarely into the disease and

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APA Board of Trustees Highlights

Melinda L. Young, M.D.

(from the first meeting of the APA's Board of Trustees [BOT] under the Presidency of María Oquendo, MD, on July 9, 2016)

By Melinda L. Young, M.D., D.F.A.P.A., APA Area 6 Trustee

By the Numbers

Membership numbers remain essentially stable at this time. From a financial standpoint on May 31, 2016, net income was somewhat below last year, attributable to lower attendance at the Atlanta Annual Meeting, slightly lower investment returns, and higher spending on state advocacy.

Two New APA Senior Staff Members

Chief of Government Affairs – Ariel Gonzalez, JD: Mr. Gonzalez has advocated on behalf of patient groups, physicians, hospitals and the laboratory industry for close to two decades. He has served as Government Affairs Director of federal health and family for AARP, in federal and state affairs for Quest Diagnostics, and as director of state and congressional relations for the American College of Radiology.

Executive Director of the APA Foundation – Daniel Gillison: Mr. Gillison has a long history of leading corporate and philanthropic fundraising efforts, most recently for the National Association of Counties.

Membership

The APA has begun a group membership pilot, which has brought in 4 new groups, at reduced rates depending on the number of new members in each group, adding 66 new members to the APA. Seven applications for group membership remain in the works. For interested groups, contact Jon Fanning, Chief of Membership and RFM-ECP Officer (jfanning@psych.org).

42 of 74 District Branches applied for an APA expedited grant, including CA's CCPS and NCPS District Branches. Each received $3,571 in grant funding.

Federal Advocacy

Collaborative Care – CMS announced on July 7, 2016, that Medicare plans to begin coverage and reimbursement for "Psychiatric Collaborative Care Management Services"

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A Peach of a Meeting

Joseph Mawhinney, M.D.

By Joseph Mawhinney, MD, Area 6 Assembly Representative and Barbara Weissman, MD, Area 6 Deputy Representative

The Assembly of the American Psychiatric Association held its May meeting in Atlanta, prior to the APA Annual Meeting. It was busier than usual with 20 Position Statements and 30 Action Papers to review as well as numerous presentations by officers, guests and other APA Components. The APA Treasurer assured us that the APA is in good fiscal health.

The APA is developing a national registry to parallel the rest of medicine in data collection and evaluation to continue our science based efforts and to strengthen the evidence base for the value of our work. Also the APA is actively engaged in MACRA (the replacement for the RBRVS in our interface with CMS). We are assured that even if we do not see Medicare or Medicaid patients, Tricare and the commercial carriers will be influenced by the MACRA product.

A wide range of topics were addressed in the Assembly deliberations. A more complete report may be found in Adam Nelson's Assembly Notes link which you may share with your constituents.

Barbara Weissman, M.D.

Action Papers and Position Statements included:

- The Psychiatrist's Role in Assessing Driving Ability
- The Appropriate Access of Patients to their Electronic Medical Records
- APA's Position Statement on Integrated Care
- The appropriate placement and access to care for juveniles in the criminal justice system
- Mental health care for college and university students

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Prop 64, "Initiative to Legalize Marijuana", to be on November Ballot


Timothy Murphy, M.D.

On November 8, California voters will be asked to approve the legalization of marijuana under terms drafted in part by CMA, which is giving the measure its full support. Key elements of the initiative include:

- Strict control of the cultivation, processing, manufacture, distribution, testing and sale of nonmedical marijuana through a system of state licensing, regulation, and enforcement.
- A 15% sales tax for the sale of nonmedical marijuana, in addition to a separate tax on its production.
- Allowance for local regulation and taxation. Municipalities may ban nonmedical marijuana businesses.
- The medical marijuana dispensary system will also be preserved, with exemption from some taxation.
- Prohibition of the sale, marketing or advertising to minors under the age of 21
- Prohibition of the sale of nonmedical marijuana by businesses that also sell alcohol or tobacco.
- Prevention of corporate or large-scale production for the first five years.
- Provisions addressing rights of employers.
- Provisions addressing driving under the influence of marijuana.
- Authorizations of resentencing and destruction of records for prior marijuana convictions
- Expenditure of most of the tax funds collected on designated purchases, which are to include the cost of administration and regulation of the new industry, as well as substance use disorder education, prevention and treatment.

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CPA "Neutral" on Marijuana? Room for Debate

By Timothy Murphy, MD and Ronald Thurston, MD


Ronald Thurston, M.D.

CPA Past Presidents Tim Murphy, MD and Ron Thurston, MD, have both chaired CPA's Government Affairs Committee. Dr. Murphy chaired CPA's 2013 Marijuana Policy Task Force. Dr. Thurston serves as a Trustee for the California Medical Association, which voted in 2011 to endorse the legalization and regulation of marijuana and, this year, voted to support a specific initiative--the Control, Regulate and Tax Adult Use of Marijuana Act—coming to your ballot in November. Recently, they debated CPA's "neutral" position on the upcoming initiative.

Tim: Ron, as you know, CPA is currently taking a "neutral" position on the marijuana initiative. I'm worried that such a position may send the wrong message, failing to communicate psychiatrists' serious concerns about the potential hazards of marijuana for youth, and for individuals with mental disorders.

More importantly, I worry that passage of the bill will lead to increased use, and as a consequence, more individuals being addicted or in other ways harmed by use. A 2010 Rand Report predicted that full legalization of marijuana would result in a 58% increase in consumption. At known addiction rates, that could mean over 300,000 more addicted Californians. Isn't that even worse than what we have now? Why is that something we should be neutral about? Shouldn't we *oppose* the initiative?

Ron: Let me begin by saying that my first choice is to eliminate marijuana from the planet. My second choice is for people to obey the law. But now I'm down to my third choice: regulating growing and processing and taxing the product, which requires legalization.

The acceptance and use of marijuana has increased over the years and will continue. More than 50% of public now favors legalization. Somebody will come up with some sort of legalization/regulation plan. I don't think

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Quick-Look Conference Time Schedule

We encourage you to visit the Exhibit Room to meet with the exhibitors who sponsor your conference. Please show them how much you appreciate their support by spending time with them to learn about their products and services.

FRIDAY SCHEDULE

The California Psychiatric Association Clinical Updates in Psychopharmacology

7:30 AM	Registration and Breakfast opens for Pre-conference
8:00 AM	**Welcome and Opening Remarks by the Co-Chairs of the Pre-Conference** Ira Glick, MD and Robert McCarron, DO
8:15-9:45 AM	**Personalized, Quantitative Evidence-Based Treatment of Bipolar Disorders** Terence Ketter, MD
9:45-10:00 AM	Break
10:00-11:30 AM	**Novel Agents in the Treatment of Resistant Depression** Charles DeBattista, MD
11:30-12:30	Lunch
12:30-2:00 PM	**Treating Anxiety Disorders and OCD: An Update** Lorrin Koran, MD
2:00-2:30 PM	Break
3:00-4:30 PM	**Mid and Long-term Efficacy and Effectiveness of Antipsychotic Medications for Schizophrenia: A Data-driven, Personalized Clinical Approach** Ira D. Glick, MD
4:30 PM	Concluding remarks

Registrants only attending the pre-conference are welcome to join the CPA for the President's Reception as listed below. To attend the rest of the Friday schedule you must be registered for the CPA's 29th Annual Premier Conference.

The California Psychiatric Association 29th Annual Premier Conference

2:00 PM	Registration Opens
4:00 PM	Exhibits Open
5:00-6:30 PM	**President's Reception in Exhibit Area** Hosted beer, wine and soft drinks "Meet/Greet" your colleagues
6:30-7:30 PM	**Friday Night Buffet Dinner** (please purchase tickets in advance)
7:30-9:30 PM	The Art of Storytelling: The Human Experience of Being a Psychiatrist.
(2 CME)	Discussants: Michelle Furuta, MD, Simon (Steve) Soldinger, MD, Tim Thelen, Mindi Thelen

SATURDAY SCHEDULE

7:00 AM	"Fun Run" (Participants meet at CPA registration table)
7:00-8:00 AM	Breakfast in Exhibit Area (registrants only)
7:00-8:00 AM	Women in Psychiatry Caucus
7:00-8:00 AM	Senior Psychiatrists Caucus
8:00-8:15 AM	**Welcome and Opening Remarks** William Arroyo, MD, CPA President Robert M. McCarron, DO, CPA CME Chair
8:15–9:15 AM	**Neuropsychiatric Aspects of Chronic Fatigue Syndrome**
(1 CME)	Jose Maldonado, MD

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REGISTRATION

California Psychiatric Association
Pre-Conference -Clinical Updates in Psychopharmacology & 29th Annual Premier Conference – 2016
The Omni Rancho Las Palmas, Rancho Mirage, CA
September 23-25, 2016

Full Name_____

Degree_____ Mailing Address_____

City/State/Zip_____

Phone_____ Specialty_____ Email_____
(Email address required. Confirmation of registration will be sent via email.)

How did you hear about us? _____

_____

Friday Pre-Conference Only
Non-members $215
CPA/APA Members $180

Annual Conference Only
Non-members $445
CPA/APA Members $355
Residents and Medical Students* $100 *Will be refunded upon completion.

Attendance at both Pre-Conference & Annual Conference
CPA/APA Members $485
Non-members $595

Yes_____ No_____ Attending the Early Career Mentorship and Career Planning Symposium

Tickets for the Legislative Luncheon are included in your registration fee. However, all other tickets for yourself and family or friends must be ordered below and included with your payment.
Please include the number of tickets needed in the space provided.
_____# of Tickets for Friday Night Buffet $45.00 each
_____ # of Guest tickets for Legislative Luncheon $45.00 each
_____ Late Registration Charge of $25 after September 14, 2016
_____ Cancellation Fee of $75 after September 14, 2016
_____ PAC Donor Reception. Any contribution level is welcome.
Or contribute online at http://www.calpsych.org/#!cppac-fund/ccrl
_____ # of Guest tickets for PAC reception $30
_____ Charge for Printed Syllabus $30.00, PDF included with registration fee.
_____ SPONSOR A RESIDENT/MEDICAL STUDENT

Register and pay online at www.calpsych.org under "Conferences" Or
Please make checks payable to California Psychiatric Association or charge your VISA or MasterCard by calling CPA at 800-772-4271 or by filling in the information needed below and return this form to:
California Psychiatric Association, 921 11th Street, Suite 502, Sacramento, CA 95814
916-442-5196 1-800-772-4271 FAX: 916-442-6525

Check Enclosed for Total Amount of $ _____
Please Charge My: (circle one) VISA/MasterCard

Credit Card # _____

Expiration Date: _____

HOTEL RESERVATIONS

The hotel has a reserved number of rooms for the California Psychiatric Association's Annual Meeting, September 23-25. After these rooms are filled, reservations are accepted only if additional rooms are available and may be at a higher cost.

Omni Rancho Las Palmas
41000 Bob Hope Drive
Rancho Mirage, CA 92270

Reservations made be made by calling:
- 760-568-2727 directly to the resort
- 866-423-1195 Omni Hotels & Resorts Reservations

$149 Single or Double Occupancy. Hotel room rates are subject to applicable state and local taxes in effect at the time of check in.

The conference rate applies 3 days prior and 3 days after the conference, based on availability. Please specify that you are with the California Psychiatric Association to get this special rate.

RESERVATIONS MUST BE MADE BY 5:00 PM, local time, SEPTEMBER 6, 2016.

Reservation requests are subject to availability.

To book your room directly with the hotel via their website please log onto: http://www.omnihotels.com/hotels/palm-springs-rancho-las-palmas/meetings/california-psychiatric-association-2016-annual-meeting

CHECK-IN AFTER 4:00 P.M.
CHECK-OUT TIME IS 12:00 P.M.
Reservations must be guaranteed with a credit card.
You may cancel reservations 72 hours prior to arrival.

Quick-Look Conference Time Schedule *(continued from page 6)*

9:15 -10:15 AM	**Legal and Legislative Updates in Psychiatry**
(1 CME)	Randall Hagar
9:15-3:15 PM	**Early Career Mentorship and Career Planning Symposium** (pre-registration required)
(3 CME)	William Arroyo, MD CPA President and
	Robert McCarron, DO, CPA President-elect, Chair Education Committee (Opening remarks)
	Charles D. Cash, JD
	Steve Koh, MD, MPH, MBA
	Larry Malak, MD
	David Safani, MD
	Shannon Suo, MD, DFAPA
10:15-10:45 AM	Refreshment Break in Exhibit Area
10:45-12:15 PM	**Wait, Weight Don't Tell Me! Practical Med-Psych Pearls**
(1.5 CME)	Y. Pritham Raj, MD
12:15–1:45 PM	**LEGISLATIVE LUNCHEON**
1:45-3:15 PM	**Cultural Sensitivity Nuggets for Working with Young African Americans**
(1.5 CME)	Yvonne B. Ferguson, MD, MPH
3:15- 4:00 PM	Refreshment Break in Exhibit Area (registrants only)
4:00-5:30 PM	**Physician Aid in Dying: Law and Ethics in California**
(1.5CME)	Rebecca Weintraub Brendel MD, JD
5: 45-7:00 PM	**PAC Reception** (any contribution level welcome)
	Larry Malak MD, Chair CPPAC
7:00 PM	**RFM/ECP Reception**

SUNDAY SCHEDULE

7:00-8:00 AM	Breakfast in Foyer (registrants only)
7:00-8:00 AM	Resident Fellow Member Caucus
	Psychotherapy Caucus
8:00-9:00 AM	**Anatomy of Malice: Psychiatry's Struggles with "Diagnosing Evil"**
(1 CME)	Joel Dimsdale, MD
9:00-10:00 AM	**Assessment & Management of Suicide**
(1 CME)	Jose Maldonado, MD
10:00-10:15 AM	Break in Foyer (registrants only)
10:15-12:15 PM	**Violence Risk Assessment in Youth**
(2 CME)	Matthew Soulier, MD
12:15–12:45 PM	Wrap Up and Closing Remarks

Your CPA Political Action Committee wants to thank you for all your support with a reception on Saturday Night of the CPA Premier Annual Meeting. As someone who not only cares about mental health but backs it up with support, we want to show our appreciation for all the work you.

Join your fellow CPA members and Leadership for drinks and appetizers along with many of our speakers and awardees from the conference.

A minimal $20 contribution to the CPA PAC is your ticket to informative and entertaining reception with colleagues and leaders in psychiatry.

Your continued support also helps our organization in our ongoing efforts to educate and engage with legislators that share our passion for good mental health legislation here in our beautiful state of California. Don't miss out!

Larry Malak, MD
CPA PAC Chair

Letters to the Editor

By Rimal B. Bera, MD
Clinical Professor of Psychiatry
University of California, Irvine

Welcome to the second column of the proposed addition to our quarterly newsletter titled, "Thinking Outside the Box." The first column appeared in this year's spring newsletter and focused on a new strategy to approach mental health care on college campuses and I encourage you to take a look at it if you haven't. Today I would like to share another "Outside the Box" idea. Over the last 10 years, I have often pondered the question, "What does society want/expect from the field of psychiatry?" I have asked this question of my peers, my patients families, lawmakers, law enforcement, our medical colleagues in other fields, family, friends, people in education, and many more. There is no universal answer that comes back, but there are some common themes I hear. These revolve around difficulty accessing a psychiatrist, homelessness, families burdened with caring for someone with chronic mental illness and incarceration- the common denominator being these are often people with chronic conditions. Adding my personal experience of the last twenty-five years I feel that we can provide better care and outcomes, if as an entire collective field, we all have a role in caring for the chronically mentally ill. So my idea is "Should we have a loose mandate that everyone who chooses psychiatry, as their specialty of practice, devote at least ½ day per week to the care of this population." The way I see it we spend much of our training working on inpatient units, working in medication clinics seeing people with chronic conditions and community mental health settings, but following graduation, often gravitate to areas of practice that do not care for schizophrenia, bipolar disorder and refractory depression. Rather settings that do not involve Medi-cal/Medicare, but more lucrative places of re-imbursement. In last month's Journal of Clinical Psychiatry, June 2016, a wonderful article titled "The Economic Burden of Schizophrenia in the United States" suggested that this condition is today one of our costliest diseases when you consider both direct and indirect costs. It focused greatly on unemployment, productivity loss due to caregiving, law enforcement costs and homelessness as being the biggest costs. So what do you think if every psychiatrist devoted ½ day per week to working in a com-

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I Am a Physician Too

By Sanford Weimer, M.D.

I am a physician. My specialty is psychiatry. People come to me suffering in pain or loss of function centered in the brain, sometimes due to disease elsewhere. As in all branches of medicine, there are science and laboratory results to explain the patient's complaints. Sometimes we know from experience what the patient's history and complaints mean about what is wrong and how to treat it. Like the classical French doctors, I cure rarely, improve frequently, and always give comfort. In medicine generally, history is crucial as Sir William Osler, father of modern American medicine, emphasized.

Let me be clear, I treat the patient's subjective complaints, sometimes, but not always guided by objective evidence. And most often, we both rejoice when the condition gets better and suffering is banished. I keep records as an aid to memory, to be able to discern patterns over time, and yes because my malpractice and state regulators require me to do so. Let me be further clear... when I treat patients, I do not evaluate parenting skills for lawyers nor workability for insurance companies. In extreme cases, where child abuse, elder abuse or intended murder is suspected, I am required by law to report to the proper authorities.

However, my practice is increasingly overwhelmed by attempted intrusions into sanctified confidential records. Lawyers want to use my records to lend support in adversary proceedings, often to the disadvantage of people with whom I have an intimate professional relationship (self admittedly to win a case, not to establish "truth"). Disability and health insurance companies also functionally work as adversaries trying to use records to deny paying disabled beneficiaries or their doctors. The process is intrusive, often arbitrary, especially in public programs like Social Security and leads to the destruction of the basic confidentiality that allows the patient to be candid. Once out of the sanctity of the doctor's office, the record and all its intimate details are public, losing all protection.

The most venal examples in legal situations have to do with custody and spousal support cases. Lawyers have a legal tool called the duces tecum subpoena. Without review or accountability by any authority such as a judge, the lawyer attempts to compel the doctor to supply copies of the patient's record, essentially without cost to the law-

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President's Message *(Continued from page 1)*

was an agenda item related to community disaster responses and the opportunities afforded to psychiatrists from SCPS. (I have chaired the SCPS Disaster Response Committee for some time and was a member of the APA Assembly Disaster Response Committee.) This Council meeting followed a prior meeting of the SCPS Disaster Response Committee with SCPS member, Teresa Frausto, M.D., who provided some of the leadership in the local disaster response in the wake of the San Bernardino terrorist attack December 2nd, 2015, in which fourteen people were killed and twenty-two injured. The SCPS Council had invited staff from the Los Angeles County Emergency Medical Services Agency to speak about how members of SCPS could assist in community disasters. There are two options for volunteer work with the disaster response unit which coordinates disaster responses in Los Angeles County. One option is to work in a hospital based emergency room where a psychiatrist would likely function by providing brief emergency interventions. No additional training is required for this option. In the second option, a psychiatrist would work closely with organizations such as The American Red Cross that is often summoned to provide disaster response on a temporary basis in many communities. (I chose the latter in both the Northridge and Loma Prieta earthquakes.) A brief training course is required to participate in such work which can be characterized as the provision of a lot of education to various community sectors about normal and abnormal responses to disasters and some triage work. At the conclusion of the presentation by the Los Angeles County representatives, forms for volunteers were distributed. To my surprise, approximately three quarters of SCPS Council completed them. It is this degree of enthusiasm that inspires and energizes me.

As I reflect on this commitment by SCPS Council members, I realize that all psychiatrists in California are similarly skilled to participate in community disaster responses and, as physicians, have the moral obligation to engage in such work. Psychiatrists, more than any other medical specialty, understand and are trained to intervene with people who are suffering from psychological distress. I challenge the other DB's to explore volunteer opportunities for their members' participation in such important work and to share that information with their membership. SAMHSA provides a number of useful documents to guide responders http://www.samhsa.gov/dtac/dbhis-collections. The APA provides additional information https://www.psychiatry.org/psychiatrists/practice/professional-interests/disaster-and-trauma?_ga=1.30535039.1747666255.1445107557. Kudos to those members of the Florida Psychiatric Society who responded to the recent Orlando massacre http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.7a23. I invite the DB's to inform our members statewide of their great work in community disaster preparedness and response by submitting a newsletter article.

The link of community disaster response to Elie Weisel relates to the trauma he survived and the moral obligation he inspired on an international level through publications and his work on behalf of all communities subjected to extreme trauma as did those who survived the Holocaust and many other groups, including Native Americans, who were subjected to cruel methods of extermination at the hands of oppressive and imperialist regimes. Mr. Weisel's plea extended beyond our usual role as psychiatric physicians; it is a humanitarian role which he advocated for all people. On a more personal note, I studied psychological trauma in children and their families directly related to community violence and war related violence in the early part of my career. I sat on a panel of experts discussing trauma on NPR that included Rachel Yehuda, Ph.D., who discussed the effects of severe trauma on descendants of Holocaust survivors http://www.scientificamerican.com/article/descendants-of-holocaust-survivors-have-altered-stress-hormones/. Frankly, I found her discussion incredible until I began co-habitating ten years later with my life partner, Mark, whose parents were Holocaust survivors. I then began to observe the behaviors in Mark which Dr. Yehuda studied.

As we celebrate our independence as a country, we should celebrate our values and contemplate our future as a nation. Without capable and healthy citizens, we do not move forward as a society. As physicians, we are entrusted with the task of maintaining the health of our nation's members. Familiarize yourself with the AMA's discussion of our obligation as it relates to participating in disaster response http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9067.page in order to preserve the health of those adversely impacted by community disasters in order to be prepared to respond. Together we can work to improve our communities, heal our patients and promote our profession.

CPA President Elect *(Continued from page 1)*

Chief Bipolar Disorder Clinic; Stanford University School of Medicine who will present "Personalized, Quantitative Evidence-Based Treatment of Bipolar Disorders." Following will be: "Novel Agents in the Treatment of Resistant Depression," by Charles DeBattista, MD, Professor of Psychiatry and Behavioral Sciences, Stanford University School of Medicine. After a break for lunch we will hear from Lorrin Koran, MD, Professor of Psychiatry, Emeritus, Stanford University Medical Center. Dr. Koran will present "Treating Anxiety Disorders and OCD: An Update." The final presentation will be "Mid and Long-term Efficacy and Effectiveness of Antipsychotic Medications for Schizophrenia: A Data-driven, Personalized Clinical Approach," by Ira D. Glick, MD, Professor Emeritus, Stanford University School of Medicine. The Pre-Conference conclusion will coincide with the opening of the CPA 29th Annual Premier Conference.

The annual conference this year will continue to build on the excellent content from last year with world class speakers, workshops, and events. Friday will begin with registration opening at 2 PM and exhibits at 4 PM, followed by our President's Reception in the exhibit area with hosted beer, wine and soft drinks. A buffet dinner follows before the night concludes with the film and discussion "The Art of Storytelling: The Human Experience of Being a Psychiatrist." Saturday opens with a fun run and breakfast as well as the start of our second year of professional caucuses: Psychiatry Residency Training Directors, Women in Psychiatry, and Senior Psychiatrists. The rest of the day features diverse and fascinating topics from a wide array of experts: talks on managing agitation by Jose Maldonado, MD (Stanford), legal updates by Randall Hagar (CPA Director of Legislative Affairs), med-psych pearls by Y. Pritham Raj, MD; Oregon Health & Science University (OHSU), cultural sensitivity with Yvonne B. Ferguson, MD (CPA past president), and closing with "Physician Aid in Dying: Law and Ethics in California" presented by Rebecca Weintraub Brendel (Director, Bioethics, Harvard). Saturday will also feature our second annual Early Career Mentorship and Career Planning Symposium and will close with the Political Action Committee (PAC) Reception lead by CPPAC Chair Larry Malak. Sunday opens with the Resident Fellow Member and Psychotherapy caucuses. Followed by Jose Maldonado, MD once again, as well as two talks on the more challenging side of our work: "Anatomy of Malice: Psychiatry's Struggles with Diagnosing Evil" by Joel Dimsdale, MD (UC San Diego) and "Violence Risk Assessment in Youth" by Matthew Soulier, MD (Program Director, UC Davis Child and Adolescent Psychiatry).

If you are a resident or fellow and plan to attend the CPA conference, please contact Lila Schmall, CPA Executive Director, at: lila-schmall@calpsych.org to get information on CPA travel stipends for trainees. I would love to hear any suggestions for this and future conferences, as the Education Committee makes it a point to select topics and speakers which have been recommended by CPA members and meeting attendees. Please email me at rmmccarron@ucdavis.edu with any questions about the conference and I very much look forward to talking with you in beautiful Rancho Mirage on September 23-25! Please see page 7 for registration.

Legal Update *(Continued from page 3)*

added protection of the psychotherapist-patient privilege and even if the patient refuses to authorize disclosure of the records. On behalf of CPA, I have been battling against these aggressive policies for over 15 years. In the *Gerner* decision, CPA has achieved a precedent setting decision which should rein in the Medical Board.

The Gerner Case

In the *Gerner* case, a patient suffering from ADHD became upset with his psychiatrist, Dr. Gerner, because the psychiatrist was attempting to reduce the high dosages of Ritalin and associated stimulants which the patient had been prescribed when he was being treated abroad. The patient even met with a Medical Board investigator and signed a revocable authorization for Dr. Gerner to produce his treatment records. However, the patient revoked the authorization before the Medical Board issued an investigatory subpoena for the psychiatric records.

The Court of Appeal decision overturned a Superior Court ruling enforcing the subpoena. The Court of Appeal ruled that the psychotherapist-patient privilege prohibited enforcement of the subpoena and that the patient had not waived his right to the protection of the privilege. In reaching its decision, the Court of Appeal quoted from a California Supreme Court case in which the CPA had filed a successful amicus brief (*Menendez v. Superior Court*) nearly 25 years ago and which affirmed the power of the psychotherapist-patient privilege to protect the confiden-

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Legal Update (Continued from page 11)

tiality of therapy and limited claims that the privilege had been waived by the patient.

Conclusion

I am privileged to participate in this long and grinding battle to protect your ability to practice your profession and to protect your patients. The victory in the *Gerner* case is one example of a longstanding and sustained CPA strategy to achieve this goal. The next time a colleague questions the value of CPA, suggest that he or she read the *Gerner* decision, which is the result of a decades-long battle fought by CPA.

The sustained decades-long efforts of your professional society, CPA, have resulted in victories for you and your patients in protecting confidentiality[1], in obtaining and protecting mental health parity[2], and in defeating efforts to allow non-physician psychotherapists to practice medicine[3].

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[1] .See, e.g., *Gerner v. Superior Court* (2016); *Menendez v. Superior Court* (1992); and Civil Code Section 43.92.

[2] See, e.g., Insurance Code Section 10144.5 and Health and Safety Code Section 1374.72 [California's Mental Health Parity Act, sponsored by CPA] and *Rea v. Blue Shield* (2014) [a precedent setting decision in which the Court adopted CPA's broad interpretation of parity].

[3] CPA has successfully lobbied to defeat no less than eight bills and one attempt to qualify a ballot measure to allow psychologists to prescribe. CPA also intervened in and defeated a federal civil rights lawsuit (*Walker v. State of California*) which sought prescribing privileges for psychologists.

CARA to POTUS (Continued from page 3)

public health model, emphasizing prevention, treatment and rehabilitation over criminalization and incarceration.

Among its many provisions, CARA supports wider use of buprenorphine and naloxone.

Buprenorphine provides a modest opioid effect but hogs the opioid receptors, i.e., it has a strong affinity for the mu-receptor that may last several days, pretty much precluding other opioids from acting on that receptor. Buprenorphine is an excellent treatment for opioid addiction because it satisfies, more or less, the opioid addiction, deters use of other opioids, and pretty much prevents overdose disasters.

Buprenorphine had been around for several decades before it was approved in 2002 as the first office-based opioid treatment for addicts. And that wasn't easy. The law-and-order community, in the person of the DEA, was quite reluctant, and included strict controls and extra scrutiny, and a special DEA number, for prescribers. Until 2002, it had been illegal for physicians to prescribe opioids to addicts, unless indicated for pain.

Methadone was—and still is—only prescribed to addicts in federally-licensed methadone clinics. In other words, buprenorphine--the drug--was not the biggest breakthrough. The biggest breakthrough was permission for physicians to prescribe it as part of their office practice!

Naloxone is a very safe, generic and, until lately, inexpensive, short-acting opioid antagonist that immediately reverses opioid overdose. It can even be delivered as a nasal spray. Why not hand it out to first responders, to family members, to opioid-dependent patients and to addicts? No good reason why not but plenty of what we psychiatrists call "resistance." Wouldn't that be encouraging bad (criminal) behavior? We met the same resistance with needle exchange programs which, for the record, proved to reduce blood-borne infection and property crime without increasing drug use. Naxolone saves lives.

In related news, the Los Angeles Times reports July 17—in its business section--that several manufacturers of naloxone have just raised their prices, by as much as 1,000%. Now, is that a criminal or a public health problem, or just business as usual? thurstonrc@gmail.com.

APA BOT Highlights (Continued from page 4)

beginning in 2017. Members can learn more about this model of care through the CMS Transforming Clinical Practice Initiative (TCPI) grant.

The Medicare Access and CHIP Reauthorization Act (MACRA) is set to replace the old sustainable growth rate formula for reimbursing Medicare Part B physician services by replacing the SGR with a more stable, updated system. The final rule for MACRA is expected to be released in November 2016, and go into effect January 2017. APA is working with other physician and health organizations in advocating for a 6-month extension for the effective date in order to further advocate within the system for physicians and to educate physicians on the new requirements for documentation and reimbursement. An educational webpage is available at: https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/about.

Mental Health Reform legislation: The "Helping Families in Mental Health Crisis Act" of 2016", H.R. 2646, passed the House on a vote of 422-2. The focus has now moved to the Senate to pass a similar bill, S. 2680.

The Comprehensive Addiction and Recovery Act (CARA), S. 524, was passed by the Senate on a vote of 92-2 on July 13, following the previous House adoption by a vote of 407-5.

APA Mental Health Patient Registry: As reported in my last Trustee's Report, the APA Board of Trustees voted to proceed with the development of a patient registry (a clinical data base of mental health disorders, treatments and interventions, and outcome measures that will combine data generated by clinicians as well as patient-generated data) based on recommendations from the APA Registries Work Group, working with the Councils on Quality Care, Research, and Healthcare Systems and Financing. The Board of Trustees voted in July to ask the APA Finance and Budget Committee to review options to identify revenue and expense reductions to support funding for the registry, requesting a report back to the Board in October 2016. A Registry Oversight Workgroup, with representatives from various components, including the Assembly, was formed and will closely follow its development. The American Board of Psychiatry and Neurology (ABPN) has opened discussions with the APA to provide financial support to build the registry; the Board has directed the APA Administration to work with the ABPN on the terms of that agreement.

Psychiatry Subspecialty Training: The American Board of Psychiatry and Neurology requested comments from the APA regarding using the PGY-4 year of training to also fulfill the requirements of ACGME-accredited subspecialty training. After consultation with all appropriate APA components, the APA's Board of Trustees did not approve this proposal.

If you have any questions or comments on this report, or on your representation on the APA's Board of Trustees, please don't hesitate to contact me at m.l.youngmd@gmail.com.

A Peach of a Meeting *(Continued from page 4)*

- Advocacy against legislation and policies which have authorized pharmacists to substitute medication within a class or proposed mechanism of action. Continued vigilance is strongly recommended relating to expansion of scope of practice by pharmacists.
- Emergency action was taken to support a Position Statement by the Association of Gay and Lesbian Psychiatrists regarding discrimination against LGBTQ citizens in some states under the guise of religious liberty.

Access to Care and issues related to Managed Care were major concerns for Assembly members resulting in the following: revision of the APA Position Statement relating to persons with serious mental disorders; advocacy for mental health needs of refugees and victims of sex trafficking; updating a Position Statement regarding children and adolescents requiring acute hospitalization and the need to reinvest in an appropriate continuum of care; an Action Paper to develop a Practice Guideline on acute hospital care; a Position Statement regarding Emergency Department boarding of patients with mental disorders and the multidimensional nature of that problem and its solution; advocacy for quality medical care for persons with substance use disorders; and access to appropriate care for patients with erectile dysfunction (restricted by Medicare).

With regard to Managed Care, there was a reassertion of policies and advocacy to correct provider network inadequacy; reaffirmation of any willing provider, Point of Service alternatives; support for use of off-label medication and continuity of medication; addressing out of pocket costs as a barrier to psychiatric and other medical care for seriously ill patients; development of a resource document to address the ethical tension of psychiatrist employees of Managed Care Organizations in the context of Parity Legislation and APA policy; advocacy to eliminate the Federal Parity Opt Out.

All of the above and more. As you are probably aware, actions of the Assembly are advisory and do not become policy until approved by the Board of Trustees. However, many of the initiatives and policies of the APA originate from the Assembly, often stimulated by members at the DB and/grassroots level. If you have any concerns or ideas for positions or initiatives of the APA, please contact your District Branch Assembly Representative or Joe Mawhinney, MD and Barbara Weissman, MD (your APA Assembly Representatives).

Letter to the Editor *(Continued from page 9)*

munity mental health center, board and care, consult in an ER, homeless shelter, provide education to NAMI and law enforcement, possibly open their practice to Medical/Medicare patients? Wouldn't this solve many of the perceptions of concerns that many have of our field and help society with what it expects of the field of psychiatry? Would we not have an ever better mental health of our country and most important bring health care costs down? I do not see this as a ½ day of just voluntary ser-

(Continued on page 14)

Letter to the Editor (Continued from page 13)

vice, rather one would get compensated for this work, understanding it would most likely be at a lower amount than the rest of the week. We have so much to give with our expertise and compassion: let's devote some of this to the place where we can have a huge impact on patients, families and society. Please share your thoughts on above at rbera@uci.edu and I'd love to hear your "Outside the Box" ideas for future columns.

I am a Physician Too (Continued from page 9)

yer for time spent processing the demand. Thus there is no disincentive to gather information, whether germane, appropriate or privileged.

In summary the laws and customary behavior by lawyers and insurance companies result in a loss of privacy, most often unnecessarily, damages the doctor patient relationship, and may seriously injure the patient irreversibly, Among the possible remedies, two stand out. Doctors' offices need to push back and watch requesting entities modify or retract unreasonable demands. Appropriate challenge sends a message of caution to attorneys and insurance companies. The situation would certainly be improved for doctors and their patients if requesters had to pay reasonable fees, not the pittance currently enshrined in old statute, which encourages fishing. Moreover, the law needs to change to protect records and force adequate compensation for time spent in negotiating and preparing appropriate responses, e.g. summaries, interpretations, and exceptionally record transcripts. Moreover, if it isn't already illegal, certainly private disability companies could be prohibited from holding back payment and required to engage their own vocational expert when delivery of records is deemed inappropriate.

Note from CPA Attorney Dan Willick: a psychiatrist, with the advice of an attorney, should seriously consider objecting to any subpoena for psychiatric records if the patient refuses to authorize disclosure. (See Evidence Code section 1015.) Your malpractice insurer should provide you with legal advice. (See Mr. Willick's article elsewhere in this newsletter)

Prop 64 on Ballot (Continued from page 5)

- Provision for Legislative amendments of provisions in the initiative, so long as the amendments do not conflict with initiative's purposes and intent.

If passed, the State Legislative Analyst projects net reduced costs ranging from tens of millions of dollars to potentially exceeding $100 million annually to state and local governments related to enforcing certain marijuana-related offenses, handling the related criminal cases in the court system, and incarcerating and supervising certain marijuana offenders. Net additional state and local tax revenues potentially ranging from the high hundreds of millions of dollars to over $1 billion annually related to the production and sale of marijuana.

CPA, by vote of its Council and at the recommendation of the Government Affairs Committee, has adopted a "Neutral" position on the initiative. Members recognize the important benefits of bringing order to the current unregulated marijuana industry. But many are worried that it could appear that psychiatrists are endorsing marijuana as harmless, when in fact there is great concern about risks to children and young adults, as well as those with psychiatric disorders.

CPA "Neutral" Debate (Continued from page 5)

that should be left to just any somebody.

CMA and likeminded stakeholders devised a reasonable plan for the November ballot. Given the options, I think that's good idea.

Tim: I'm not convinced we should refrain from opposing a bill that harms people (through increased use, increased users, increased addiction, and increased impairment in habitual users), to thwart passage of a potentially worse initiative.

Shouldn't we oppose all initiatives that make things worse?

Ron: Use will continue to rise, with or without regulation. But without regulation, the drug is not grown safely and potency is uncertain, the Sinaloa cartel keeps the money, more young people--predominantly minority youth--get arrested, and the much abused "medical marijuana" program puts doctors in the middle, lending credibility to marijuana as a safe and effective panacea. All this continues until somebody writes the initiative that the public is waiting to vote for. That's an ugly default scenario. It's not the CMA-supported initiative that's opening this Pandora's box, it's public opinion. What can I say?

But I don't think that CPA should support the initiative, just stay neutral. Our members are divided, it's not really our mission and we carry little weight in the outcome.

Tim: If no regulation, use still goes up, you say. Although it doesn't show it now, what if evidence from Colorado ultimately suggests that with full legalization, use goes up much more? Might that not be worse than "drug is not safe, cartel keeps the money and youth get arrested"? Not that kids are getting arrested for possession.

And, by the way, the bill still keeps doctors in the dispensary business. Taxes will be lower on marijuana purchased through the dispensaries. So we'll still have patients getting marijuana for their ADHD and so-on, perpetuating dangerous myths about marijuana as medicine for psychiatric conditions.

Ron: The use of marijuana will continue to rise due to public's tolerance of the drug and disrespect for the law. The drug is less and less illegal but not yet regulated. I expect that use will jump with actual legalization but at this point more problems are solved than created. The main point is that use is being pushed by public opinion, will continue to rise, and we are at a point where somebody's legalize-and regulate-plan will be endorsed. If you have a plan for reversing this trend, let me know. If not, the choice is good regulation or not-so-good or even bad regulation.

There are instructive parallels in our national experiment with Prohibition. During Prohibition: Less drinking, more crime. After repeal of Prohibition: More drinking, less crime. Alcohol is still a problem, just managed in a different way.

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