# Southern California Society of Child and Adolescent Psychiatry

## 2013-2014 Newsletter

## President's Letter

### by Nora Papasian, M.D.

As my time on Council draws to a close, I have been reflecting on my experiences over the past few years. One of the most memorable was a Cal-ACAP Advocacy Day Conference a couple years ago. The most engaging part of the conference was the advocacy skills training. Breaking up into small groups, we were asked to generate an idea for advocating for patients, formulate an argument for presenting that idea to a representative, and conclude with a mock presentation of that idea to the group. The entire exercise was educational and illuminating. Of the ideas presented however, one stood out that still intrigues me. Authored by Dr. William Arroyo, Past-President of SCSCAP and current President of CMA, the proposal called for required annual mental health screenings for minors.

The argument was logical and elegant: minors are required to have medical screenings annually, mental health is an important part of a person's overall health, and therefore a mental health screening should also be a required annual examination.

A plethora of evidence supports the validity of an annual mental health screening exam, and the CDC helps us quantitate the pressing reality of mental health disorders in children and adolescents.

The CDC's 2013 report on the Mental Health Surveillance Among Children – US 2005 – 2011 identifies mental disorders among children as "an important public health issue because of their prevalence, early onset, and impact in the child, family, and community." A total of 13% to 20% of children living in the Unites States experience a mental disorder in a given year. Suicide was the leading cause of death among children aged 12-17 years in 2010. In the United States, the cost (including health care, use of services such as special education and juvenile justice and decreased productivity) of mental disorders among persons aged <24 years was estimated at $247 billion annually. *(continued on page 2)*

# President's Letter

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Moreover, public perception may be more receptive, as numerous media reports have highlighted the increased occurrence of public violence, with aggressors frequently if not universally suffering from untreated or undertreated mental illness.

If such a program were implemented, clearly the primary goals would include early detection, intervention, and treatment, all aimed at ameliorating symptoms, improving coping and functioning, slowing the progression of an illness (if possible), and bolstering supports in times of crisis. Additional benefits might include increased public awareness and decreased stigma towards mental illness. Moreover, data show that early childhood mental health treatment results in decreased financial costs in special education, criminal justice and welfare assistance. We might consequently also see decreased numbers of violent crimes due to untreated or undertreated mental illness.

The main arguments against an annual mental health screening might be financial cost and logistics. Questions of who would perform the "mental health screening exam" and how or whether it would be reimbursed are two major considerations. Requiring that an annual mental health screening exam be a covered expense under insurance may be the most difficult part of making this a reality. However, In light of legislative developments in recent years, this may not be insurmountable, particularly in California. The Affordable Care Act now requires that every person has health insurance.

Federal and state parity laws seek to equalize coverage for mental and physical health coverage. Moreover, the Mental Health Services Act of California (Prop 63), passed in 2004, intended to transform the state's public mental health system, including expanded efforts toward prevention and early intervention. It also specified that funds would be appropriated for innovative new programs in mental health care, and that this could include services not covered by other insurance programs.


It appears that support for the idea of a Universal Mental Health Screening Exam is growing, and there may be a movement for this to become a political reality. As part of our goals to advocate for our patients and our members, we support the activities of our parent organization, Cal-ACAP. This includes working with our Cap-ACAP lobbying firm to support and even develop legislation that protects and advocates for our patients as well as our members. Let us know what you think on this and other issues at scscap@gmail.com.

# 2013 SCSCAP Annual Meeting and Brunch

*by Alexis Link, M.D.*

*SCSCAP Treasurer*

The SCSCAP Annual Meeting and Brunch was held on Sunday, August 18th of 2013 at the beautiful California Yacht Club in Marina del Rey. Members from far and wide gathered to meet and mingle, despite the anticipated "Orange County Carmageddon" which was predicted to occur due to a stretch of closed 405 freeway. We were delighted to see both trainees and longstanding members from the Inland Empire, Orange County, the San Fernando Valley and greater Los Angeles who braved the threat of traffic (which, thankfully, turned out to be fairly anticlimactic).

The Annual Meeting traditionally includes the yearly induction of SCSCAP Executive Council officers. Our outgoing Council President, Matthew Koury, M.D., M.P.H, graciously opened the meeting by welcoming all in attendance, and gave a special and well-deserved thanks to our tireless executive assistant, Alicja Martins, who has been invaluable to the Council's work. He was followed by our incoming Council President, Nora Papasian, M.D., who honored Dr. Koury with a plaque of appreciation for his leadership efforts over the last year. Dr. Koury's mission has been to reach a larger proportion of our membership through the use of social media, a new website, and other key technologies. Under Dr. Koury's leadership, the Executive Council conducted meetings via Skype and conference calling in an attempt to conveniently include more members who might find driving to monthly meetings prohibitive to participation. Our Council is very appreciative of Dr. Koury's dedication and service to SCSCAP.

The new Executive Council was introduced to the membership as follows: President, Nora Papasian, M.D.; President-Elect, Michael Enenbach, M.D.; Vice President, Brooke Hansen Spanos, M.D.; Treasurer, Alexis Adams Link, M.D.; and Secretary, Shivani Chopra, M.D. *(continued on page 4)*

# SCSCAP Annual Meeting and Brunch

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Former SCSCAP President and current California Academy of Child and Adolescent Psychiatry (Cal-ACAP) President, Marcy Forgey, M.D., announced an exciting event planned for November 16th, 2013. Cal-ACAP, National Alliance on Mental Illness (NAMI), United Advocates for Children and Families (UACF), and Let's Erase the Stigma (LETS) will hold the Annual Advocacy and Collaboration Conference, also at the California Yacht Club in Marina del Rey. Cal-ACAP's collaborations with these outstanding community organizations have infinitely multiplied the amount of energy and enthusiasm for advocacy events, including the first annual Cal-ACAP Advocacy Day on April 29th, coordinated by Cal-ACAP and co-sponsored by NAMI California. Members of both organizations met with legislators in Sacramento to share their unique and important perspectives on the array of mental health issues facing Californians. Dr. Forgey also celebrated a recent special event dedicated to CAL-ACAP Members-in-Training, developed and planned by

SCSCAP Council representatives Roya Ijadi-Maghsoodi, M.D. and Jessica Jeffrey, M.D., M.B.A., M.P.H., which provided residents and fellows a foundation for understanding and participating in mental health advocacy. Coordinated by two busy yet energetic UCLA child and adolescent psychiatry fellows, this was an extraordinary meeting which served as a launching pad for trainees from all over California interested in honing their advocacy skills.

Dr. Forgey also welcomed CAL-ACAP's legislative advocate, Paul Yoder, who leads CAL-ACAP's strong presence in Sacramento, and is invariably a wealth of information about the governmental policies and decisions affecting California's youth. He updated the group on the exciting passing of Senate Bill 61, introduced by California State Senator Leland Yee, which limits solitary confinement for juveniles in the prison system and highlights the needs of incarcerated mentally ill adolescents. Mr. Yoder also alluded to a number of bills facing legislators which are relevant to our work. *(continued on page 5)*

# SCSCAP Annual Meeting and Brunch

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For example, Senate Bill 491 would remove the requirement that nurse practitioners provide health care in consultation with a physician, and would authorize nurse practitioners to diagnose, treat and prescribe independently. With relevance to education and stigma reduction, Senate Bill 330 would require that the Instructional Quality Commission, the body which recommends curriculum frameworks to the State Board of Education, consider developing a distinct category on mental health instruction to educate pupils about all aspects of mental health.

Mr. Yoder also described Senate President Pro Tempore Darrell Steinberg's proposal to increase funding for innovative, cost-effective crisis mental health services throughout California, including 2,000 additional beds in unlocked crisis residential treatment programs, plus increased mobile triage personnel and mobile crisis support teams across the state. Sacramento has been abuzz with ways to prioritize and improve mental health for Californians, thanks in large part to the work of legislative advocacy.

Mr. Yoder's overview provided a vibrant forum for questions and discussion, as members pondered the impact of each issue on their work and their patients. As Mr. Yoder opined in conclusion, "there is never a dull moment in politics – especially in California!"

Dr. Papasian closed the event with an invitation to all members to reach out to the SCSCAP Executive Council (scscap@gmail.com) with feedback and suggestions. We look forward to the exciting year ahead and welcome your input. We are in your service, and strive to represent the outstanding quality of SCSCAP's broad, sophisticated and insightful membership.

**2013-2014**
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# Mental Health Advocacy Training Day - September 2013

*by Jessica Jeffrey, M.D., M.P.H., M.B.A.*
*Cal-ACAP Executive Committee Representative*
*and Roya Ijadi-Maghsoodi, M.D.*
*Cal-ACAP Government Affairs Committee representative*

Mental health advocacy is alive and thriving among Cal-ACAP members in training. On Saturday, August 17th an enthusiastic cohort of psychiatric trainees met for the first annual Member-in-Training Advocacy Training Day. The conference was held at the UCLA Semel Institute for Neuroscience and Human Behavior and featured Cal-ACAP President Marcy Forgey, MD, MPH and legislative expert Paul Yoder, Cal-ACAP lobbyist, and partner at Shaw, Yoder, Antwith, Inc.

This conference was developed in response to growing enthusiasm among trainees to be involved in advocacy work, with the goals of creating a community of early career psychiatrists passionate about mental health advocacy and equipped with the tools to promote change. The conference was generously supported by Cal-ACAP. Attendees consisted of medical students, general psychiatry residents, and child and adolescent psychiatry fellows from programs throughout California.

The conference started off with a bang with attendees learning about the "Nuts and Bolts of Effective Advocacy" from Dr. Marcy Forgey. Dr. Forgey rallied the trainees with highlights of Cal-ACAP legislative successes from the past several years. Drawing upon her vast experience advocating for child and


effective legislative advocacy techniques. Her emphasis on the essentials of a legislative visit helped to prepare attendees for afternoon workshops consisting of mock visits with legislators.

Mr. Paul Yoder complemented Dr. Forgey's presentation as he provided an overview of California's state legislative process and current child mental health issues. Mr. Yoder contributed valuable insight into useful strategies to increase the chances of favorably impacting legislation. He deftly discussed two timely and relevant bills: SB 22, the Mental Health and Substance Use Parity Enforcement bill, introduced by Senator Jim Beall, and SB 330, focused on K-12 Mental Health Education, introduced by Senator Alex Padilla. *(continued on page 7)*

# Mental Health Advocacy Training Day

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During the afternoon workshops, attendees had the invaluable opportunity to split into groups and practice advocating on behalf of a bill. Although the discussions were serious at times, trainees appeared to have fun and many felt it was helpful to rehearse the techniques discussed earlier that morning.

The passion for mental health advocacy among the members-in-training was truly inspiring and reverberated after the conference. Elizabeth McGuire, MD, an enthusiastic conference attendee stated, "One of the best things I learned from the advocacy training day is that anyone can do it. You don't have to be a political science major to get involved! Yes, it can be time-consuming, challenging, and frustrating, but we all have the skills to engage in advocacy for those we serve.

I'm definitely excited to think about how I can get involved in advocacy from here on!" Given the drive to continue to build capacity, a new Cal-ACAP Committee has been created. This Early Career Psychiatrist Advocacy Committee (ECPAC), will be chaired by Roya Ijadi-Maghsoodi and Jessica Jeffrey and will aim to provide a platform for early career psychiatrists and trainees to have an active role in advocacy. For anyone interested in joining this committee or learning more about advocacy work, please email Jessica Jeffrey at jjeffrey@mednet.ucla.edu or Roya Ijadi-Maghsoodi at rijadimaghsoodi@mednet.uclaIn this time of healthcare reform, it is wonderful to see so many medical students and trainees committed to improving mental health.

# Latest Major Threat to the Medical Field in California

*by William Arroyo, M.D.*
*Cal-ACAP Delegate*

The trial lawyers association has successfully collected enough signatures for a ballot initiative to be considered by the electorate on November 4 later this year. It is **Proposition 46**, and entitled, *Increase in Cap on Medical Malpractice Lawsuits Initiative;* it is also referred to as the *Troy and Alana Pack Patient Safety Act of 2014*. If passed, this will force virtually all child and adolescent psychiatrists to change their practice.

**It would: (1) Increase the State cap on damages that can be assessed in medical negligence lawsuits to more than $1 million.** The Medical Injury Compensation Reform Act (MICRA) capped compensation for "pain and suffering", as a result of malpractice, in 1975 at $250,000. The new level, which would be adjusted for inflation on an annual basis, would make it much more lucrative for trial attorneys to pursue such lawsuits and in all likelihood would increase medical malpractice insurance premiums. At this time there is no cap on economic damages, which may include such things as loss of a job, reduction in hours of gainful employment, etc. At least one estimate indicates that annual healthcare costs would increase by $9.9 billion statewide. The California State Legislative Office, which serves as the nonpartisan advisory body to the governor and legislature, has indicated that the proposition, if passed, will result in "State and local government costs associated with higher net medical malpractice costs, likely at least in the low tens of millions of dollars annually, potentially ranging to over one hundred million dollars annually. Potential net state and local government costs associated with changes in the amount and types of health care services that, while highly uncertain, potentially range from minor to hundreds of millions of dollars annually." The increased costs will affect virtually all types of practices including state, county and municipal health systems.

**(2) Require hospitals to administer random alcohol and drug testing of doctors in addition to those doctors "upon occurrence of an adverse event" and to report positive results and those physicians who fail to submit to testing or willfully refuse to such to the CA Medical Board (CMB).** *(continued on page 9)*

## Latest Major Threat to the Medical Field in California

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These procedures will routinely apply to physicians with inpatient admission privileges; outpatient settings will also be subject to such. Failure to submit to such tests within twelve hours of notice to the physician "may be cause" for suspension of licensure.

**(3) Require the CMB to suspend doctors who test positive pending an investigation and take other disciplinary action of the doctor was found impaired while on duty.** In addition patients who had an adverse event will be notified directly by the CMB of such decisions related to disciplinary actions imposed on their treating physician.

**(4) Require health practitioners and "any other person" to report any doctor suspected of drug or alcohol impairment or medical negligence**. "Any other person" is not well defined and so the pool of potential reporters, including dissatisfied patients among many others, is enormous.

**(5) Require health care practitioners to consult state prescription drug history database before prescribing certain controlled substances;** these substances include psychostimulants. More specifically, this refers to any Schedule II or III drug. Physicians would only proceed to prescribe these classes of drugs if there was a medically legitimate reason for doing so, especially in the case of those who have current prescriptions for such.

Failure to use the Controlled Substance Utilization Review and Evaluation System (CURES), the California Prescription Drug Monitoring Program (PDMP) or (CURES/PDMP) would be cause for disciplinary action. Pharmacists would also be required to use CURES. SB 809, which became law on January 1, allows for the California Medical Board to impose an annual $6 fee for all prescribes to upgrade what has been described heretofore as a "clunky" system with very limited staffing.

This ballot initiative clearly has many drawbacks for physicians and patients. Although there are many statewide organizations, which are opposing this ballot initiative, there is a very formidable group of organizations which support Proposition 46. For additional information, see Californians Allied for Patient Protection http://www.micra.org. If you want to may a contribution, notify rhagar@calpsych.org who is collecting donations for the opposition to Proposition 46.

# SCSCAP Annual Speaker Meeting

*by Brooke Spanos, M.D.*

*SCSCAP Vice-President*

On Jan 26, 2014, SCSCAP held the Annual Speaker meeting at the California Yacht Club in Marina del Rey. The topic was "Dialectical Behavioral Therapy (DBT): Overview and Application to Adolescents and Families." We had the pleasure of welcoming our very own SCSCAP member, Dr. Michael Enenbach, and his colleague, Jennifer Hughes, PhD, as the speakers to educate us about this increasingly used evidence-based therapy.

Although DBT programs were originally developed as a treatment for patients with borderline personality disorder, many of the concepts and skills are applicable to a wide variety of mental health settings and diagnoses. As Dr. Enenbach emphasized, even though most of us will never work in a classic DBT program, many of our colleagues now practice as a "DBT-informed" psychiatrist. I found some of the DBT concepts to be extremely helpful, and I picked up a number of pearls that I will continue to try to implement in my own practice with adolescents.

When practicing as a DBT-informed psychiatrist, one idea that struck me was the technique of fluctuating back and forth between using "heavy validation" and "moving the patient to change." When using heavy validation, they clarified that it does not mean we should merely agree with everything the adolescent may say. Rather, the purpose is to find the "kernel of truth" in an attempt to understand his/her internal world. Having a patient feel understood can go a long way considering the chronic feelings of invalidation many of them experience on a regular basis.

For some of my more stable outpatient adolescents, sometimes feeling understood and validated is enough for them to find their emotional footing and move forward on their own. However, many, especially those who lack a "secure base" to begin with, will continue to feel stuck and hopeless, despite extensive support. Patients, for whom DBT was originally designed, tend to have some of the more destructive ways of coping with intolerable feelings (i.e. cutting, suicide attempts, and other dangerous/impulsive behaviors). Looking at it from their perspective, however, these coping styles are usually viewed as "effective," especially in the short term. (For example, cutting often immediately relieves the acute emotional distress they were feeling in the first place.) It sometimes feels useless to ask a patient to stop using the only coping mechanisms that they have ever known that finds them relief. So how can we break the cycle? (*continued on page 11)*

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According to DBT, it would be through the introduction of skill building. A foundation of DBT involves actively teaching coping skills as a healthier means of dealing with intense feelings. DBT assumes that these patients are "doing the best they can," but they often lack the skills needed to function in a more emotionally constructive manner. The 4 skills groups include:

(1) Emotion Regulation
(2) Distress Tolerance
(3) Mindfulness
(4) Interpersonal Effectiveness

Briefly, **Emotion Regulation** includes first teaching an adolescent to appropriately identify and label their emotions. It also encourages healthy habits (sleep, exercise, nutrition, etc) to try to minimize precipitating factors for emotional liability. **Distress tolerance** teaches the adolescent how to observe, accept, and tolerate feelings by using relaxation and other techniques.

**Mindfulness** uses exercises derived from Buddhist philosophy and teaches them about being "present" in the moment. The goal is to learn how to non-judgmentally observe feelings and experiences in order to let them pass before acting impulsively. **Interpersonal Effectiveness** teaches assertiveness and other interpersonal problem-solving techniques. Many of these skills are used in a variety of therapies, and as you can imagine, would be helpful for adolescents (or adults) in any kind of setting.

In my experience, even when provided with skills and more healthy alternatives, adolescents don't necessarily follow through. What happens when the adolescent has poor motivation to use their new skill set? This is when I think of going back to the idea that Drs. Enenbach and Hughes discussed about fluctuating between "heavy validation" and "moving to change." *(continued on page 12)*

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But moving an adolescent to change can certainly be difficult. How can we help guide them towards that path?

One of the approaches that resonated for me was the DBT use of "sustained curiosity", which refers to describing what you see with a curious and non-judgmental stance. DBT also encourages being "radically genuine" with the patient. Adolescents are known for being very perceptive to "B.S.," so it is probably refreshing when they don't feel that you are either pandering to them or lecturing them – you are just being open and honest. Moreover, the patient and psychiatrist are in *collaboration* with each other (as opposed to in a set hierarchy) with the goal of "building a life worth living." This can often help encourage the adolescent to take on some of the responsibility for change, instead of looking to the psychiatrist to "fix it" for


What I have discussed thus far is merely a drop in the bucket when it comes to practicing as a DBT-informed psychiatrist. I wanted to thank Dr. Enenbach and Dr. Hughes for their extremely comprehensive lecture, and I know I still have a lot to learn. I appreciate the depth they went into, and I hope to continue to use some of the DBT "tools for healing" in my practice in the future.

**Have you renewed your**

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**SCSCAP Membership?**

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