THE SOCIETY PAGE

Central California Psychiatric Society Newsletter

Issue No. 29 October 2009

The President's Report

By, Donald M. Hilty, MD
CCPS President

Recent Events

This year continues to be baffling, with juxtaposed events that seem ironic. Here are some of the good and bad highlights so far.

No successful psychologist prescribing bills occurred, fortunately, for our patients, but 2009 more bills are on the way?

The Department of Corrections has psychologists supervising psychiatrists' clinical work, due to not hiring psychiatric chiefs, even though the former's scope of practice is narrower?

County systems are in panic with services slashed and the MHSA funds are plugging 'new' gaps, that is, some new gaps due to slashing and some old gaps where services are needed?

New Members

Supriya Bhatia, MD
Jason Chapman, MD
Shivani Chopra, MD
Michael Dickerson, MD
Jonathan Fellers, MD
Jantje Groot, MD
Mark Harashevsky, DO
Tam Nguyen, MD
Michelle Park, MD
Sheela Reddy, MD
Reina Rohatgi, MD

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The President-Elect Update

By, Robert McCarron, DO
CCPS President-Elect

On the tails of historic mental health parity federal legislation, we are now in the process of developing a plan for health care reform. 47 million Americans are uninsured and at least 20 million are seriously underinsured. From a psychiatric perspective, many Americans do not have insurance coverage for mental health or substance abuse related illness. The following is an overview of principles for psychiatric health care reform, which was approved by the American Psychiatric Association Board of Trustees in December 2008.

1. Every American with psychiatric symptoms has the right to a comprehensive evaluation and an accurate diagnosis, which leads to an appropriate, individualized plan of treatment.
2. Psychiatric treatment should be based on continuous healing relationships and engagement with the whole person rather than the narrow symptom-focused perspective.

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INSIDE:

CENTRAL CALIFORNIA PSYCHIATRIC SOCIETY

Post Office Box 1071, Fresno, CA 93714-0517
Toll-Free (888) 234-1613
FAX (559) 227-1463

President
Donald M. Hilty, MD 916-734-8110
President-Elect
Robert McCarron, DO 916-762-5699
Past-President
Joseph I. Sison, MD 916-875-3373
Secretary
Glenn Xiong, MD 916-875-1167
Treasurer
Shannon Suo, MD 530-753-3962
Assembly Representative
Ravi Goklaney, MD 661-868-1800
Deputy Assembly Representative
Robert McCarron, DO 916-762-5699
Federal Legislative Representative
Captane Thomson, MD 530-753-7223
MIT Representative to CCPS
Kern— Brenda Robertson, MD ..... Not Listed
Kern—Franco Song, MD ..... Not Listed
Sacramento— Margaret Leung, MD ..... Not Listed
Sacramento —April Crofut, MD ..... Not Listed
Editor
Sam Castro, MD 559-221-6864

CHAPTER PRESIDENTS

Kern – Rajit Padhy, MD 661-868-1800
Sacramento – John Onate, MD 916-762-5699
San Joaquin - Hilary Silver, MD 209-468-8720
Sierra – ..... Position Open
Yosemite - John Jacisin, MD 209-524-9401

COMMITTEE CHAIRS

Child, Adolescent & Family
Robert Horst, MD 916-734-5070
CME
David Gellerman, MD, PhD 530-753-3962
Community Psychiatry
Andrea Bates, MD 916-525-3434
Culture & Diversity
Shannon Suo, MD 530-753-3962
Early Career Psychiatry
Rossano L. Bangasan, MD 661-868-7156
Ethics Committee
..... Position Open
Fellowship
Captane Thomson, MD 530-753-7223
Government Relations
Robert McCarron, DO 916-762-5699
Medicine & Psychiatry
Glen Xiong, MD 916-875-1167
Membership
H.T. Mohankumar, MD 661-868-8089
Public Affairs
John Onate, MD 916-874-9670
Spirituality & Religion
David Gellerman, MD, PhD 916-874-9670
Women's Health & Career
Jessica Ferranti, MD 916-762-9562

STAFF
Executive Director
Chris Stockton 888-234-1613

President Report
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Demetra Stamm, MD
Ani Tokat, MD
Tiffany Tsai, MD
Eileen Yap - Lacap, MD
Erik Youngdale, MD
Prathap Vaadyala, MD

CCPS Annual Meeting, March 19-21, 2010, Santa Cruz, at Chaminade (http://chaminade.com).
The Program Committee led by Dr. Gellerman and with the help of PESC staff, is at it again. The site is a nice, peaceful place to go and the weather is stunning. We found it friendly for spouses/SOs and the kids! Speakers will include Laura Roberts, Editor of *Academic Psychiatry*, on ethics and career issues, as well as many fine faculty, residents and students! Terry Ketter will return for an encore with regard to bipolar disorder, hopefully with some lecture and cases to discuss.

President-Elect Update
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3. Timely access to psychiatric care and continuity of care are the cornerstones for quality.
4. There must be full parity of psychiatric treatment with the rest of medicine and utilization management must be the same for people with mental illness as well as for other medical illnesses. Payment and utilization should be on the basis of treatment and services and not on diagnosis.
5. Psychiatric care should be patient and family centered, community based, culturally sensitive, readily available for patients of all ages, with particular attention to the specialized needs of children, adolescents, and the elderly.
6. Psychiatric care should be fully integrated with the rest of medicine in primary care settings and in hospitals.
7. Patients deserve to be treated with dignity and respect. When they are clinically able, they are entitled to choose their physician and other providers and make other decisions regarding their care. When they are incapable of doing so, they should receive the treatment they need and when able, they should choose future care.
8. As medical information enters the electronic age, leading to increased efficiency and ease of access to health data on all individuals, the confidentiality of these data must have the highest priority.
9 Patients should receive care in the least restrictive setting possible that encourages maximum independence and access to a continuum of clinical services.
10. Psychiatric care should be fully integrated with the treatment of substance use disorders.
11. Psychiatric care should have an emphasis on early recognition and treatment as well as prevention. Research into the etiology and prevention of mental illness and into the ongoing development of safe and effective treatment interventions must be supported.
12. Efforts must be intensified to combat and overcome the stigma historically associated with mental illness and its treatments through enhanced public understanding and awareness of mental disorders and the effectiveness of psychiatric treatment.
13. More resources should be devoted to the training for an adequate supply of psychiatrists, especially child psychiatrists, to meet the current and future needs of the population.

As a profession, we have recently made significant progress with improving care for our patients. We have a long way to go. If you get a chance, please visit http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations.aspx to get information on how the APA government relations department is representing you and your patients. If you would like to get involved with statewide or national APA government affairs, please email me at robert.mccarron@ucdmc.ucdavis.edu.

Happy Fall!

Building Bridges for our Psychiatrists in the Central Valley

Submitted By, Andrea Bates, MD, MBA, Community Psychiatry Committee Chair

Let me introduce the new CCPS Community Psychiatry Committee! Creating this Committee helps address issues specific to Community and Public Psychiatry, both locally and in coordination with the California Psychiatry Association and the American Psychiatry Association.

As Chair of the Community Psychiatry Committee, I want to improve things for our member psychiatrists and would like to find the best way to help. I was thinking, we have a complex system here in our area. I'd like to develop better unity and understanding amongst the networks of people and services.

Psychiatrists, what are your ideas to develop the bridges between psychiatrists and our Community? In our clinics, hospitals, office practices, jails, education systems – what specific real activity should the Community Psychiatry Committee do to enhance psychiatrists' practices on behalf of patients and their families?

Come join with us! If you find this Committee intriguing, come be part of the Committee personally. Or if you have an idea, email me and let the Committee know. It will help us move forward in the direction our members' desires and to know what may be a good way to go. Thanks a lot!

Yosemite Chapter Report

Submitted By, John H. Jacisin, MD, Chapter President

The Yosemite Chapter met on August 26, 2009 at Galleto's Ristorante in Modesto following a Pfizer sponsored presentation with an excellent lecture by David Smith, MD, on Clinical Challenges in the Treatment of Bipola Mania and Mixed States. Only four members attended. We have added 3 members from our Chapter catchment area, two of whom still need to finalize their membership transfer. Officially transferred is Nelly Manganas, MD, from Michigan. We await official transfers from Anton Manganas, MD, from Michigan, and Jafar Bozorgmehr, MD, from Pennsylvania. All three seem highly motivated to participate in Chapter and Society activities. All three have joined Dr. Jacisin's practice, the Psychiatric Medical Group of Modesto, but will be mostly doing inpatient work at Doctors Behavioral Health Center in Modesto. Anton Manganas, MD is the new Medical Director of Doctors Behavioral Health Center.

Spirituality and Psychiatry: A Survey of CCPS Membership

Submitted By, David M. Gellerman, , MD, Ph.D.
Chair, CME Committee

In addition to my role as the CME Chair for the CME and Annual Meeting Committee, I was also the Chair for the Religion and Spirituality Committee, which was recently merged with the Culture and Diversity Committee chaired by Dr. Shannon Suo, my… um… "Domestic supervisor." Since religious and spiritual beliefs and behaviors are such a primary aspect of culture, we felt that having two committees was extraneous, and fortunately Dr. Suo agreed to work with me yet again. For those of you fearing nepotism, be assured, we have little political ambitions!

At any rate, for the past 3-4 years we have asked our membership to complete a survey of perceptions, attitudes, and self-efficacy surrounding spiritual issues in psychiatric care. As much of my attention had been toward regaining our CME accreditation, these surveys have collected over time, and I would now like to share some of the data we collected.

The survey included the following statements, to which members were asked to rate the degree of disagreement or agreement on a 7-point Likert scale, with 1 being "strongly disagree" and 7 being "strongly agree." A score of 4 was interpreted as indifference to the topic of the statement. While the individual scores are kept within the committee (okay, that's me), I wanted to share some of the collected results.

Full Question	Short Version on Chart
1. I feel very comfortable performing spiritual assessments of my patients.	Comfort with assessment
2. I almost always include a spiritual assessment in evaluating my patients.	Usually assess
3. I feel very comfortable addressing the spiritual needs of my patients.	Comfort with addressing needs
4. Religion and/or spirituality are important components of psychiatric assessment.	Import to assess
5. Religion and/or spirituality are important components of psychiatric treatment.	Import for treatment
6. Religion and/or spirituality are frequently cited by patients as related to a cause of their psychological distress.	Cause of distress
7. Religion and/or spirituality are frequently cited by patients as related to their ability to cope with psychological distress.	Cope with distress
8. Religious and/or spiritual issues frequently present themselves in the course of the treatment of my patients.	Issues arise

Spirituality and Psychiatry: A Survey of CCPS Membership Continued

Full Question	Short Version on Chart
9. I have at least once advised or referred a patient to see a chaplain or spiritual minister (e.g. priest, pastor, spiritual leader, et al.).	Advised or referred
10. I consider myself to have some expertise in the area of religious and spiritual aspects of psychiatric assessment and care.	Expertise
11. I often teach other healthcare professionals (e.g. medical students, psychiatric residents, non-psychiatric healthcare providers, etc.) about religious and spiritual aspects of psychiatric assessment and care.	Teach
12. I would be willing to teach other healthcare professionals about religious and spiritual aspects of psychiatric assessment and care.	Will teach
13. I am comfortable integrating religious or spiritual components into my patients' psychiatric care, if they so desire.	Integrate with care
14. I would like to learn more about religious and spiritual aspects of psychiatric assessment and care.	Want to learn more

One consideration to remember is selection bias: chances are, those members who have some passing interest in spiritual and religious issues in psychiatric care would be more likely to complete the survey (or perhaps strong feeling against, which I did not pick up in looking at the individual scores). So, while 56 out of 300+ members is not bad, it certainly would be a mistake to assume this accurate reflects all of CCPS membership. During the time of the survey, 56 members responded; I excluded three that I identified as having taken the survey twice, removing the older responses. I then calculated the mean and standard deviation of the responses for each of the questions. However, there was quite a range of responses for some questions, resulting in large standard deviations. Responses to some questions seemed to be easily interpreted, such as question #6 regarding religious or spiritual issues frequently being cited as a source of distress for patients: the average score was 3.5 suggesting that our members at the very least were not aware or could recall this being a frequent issue. Compared this to question #7 regarding religion or spirituality as a source of coping; our members average rating was 4.7, suggesting that if the topic comes up, it's usual in the context of a coping strategy. Statistically significant? Nope – when you look at the standard deviation, there's little pattern.

So instead, I compared the total number of endorsement on either side of the scale, from 1-2 on the "disagree" side, and 6-7 on the "agreed side," in an effort to weed out the lukewarm 3-5 scores. This was much more interesting:

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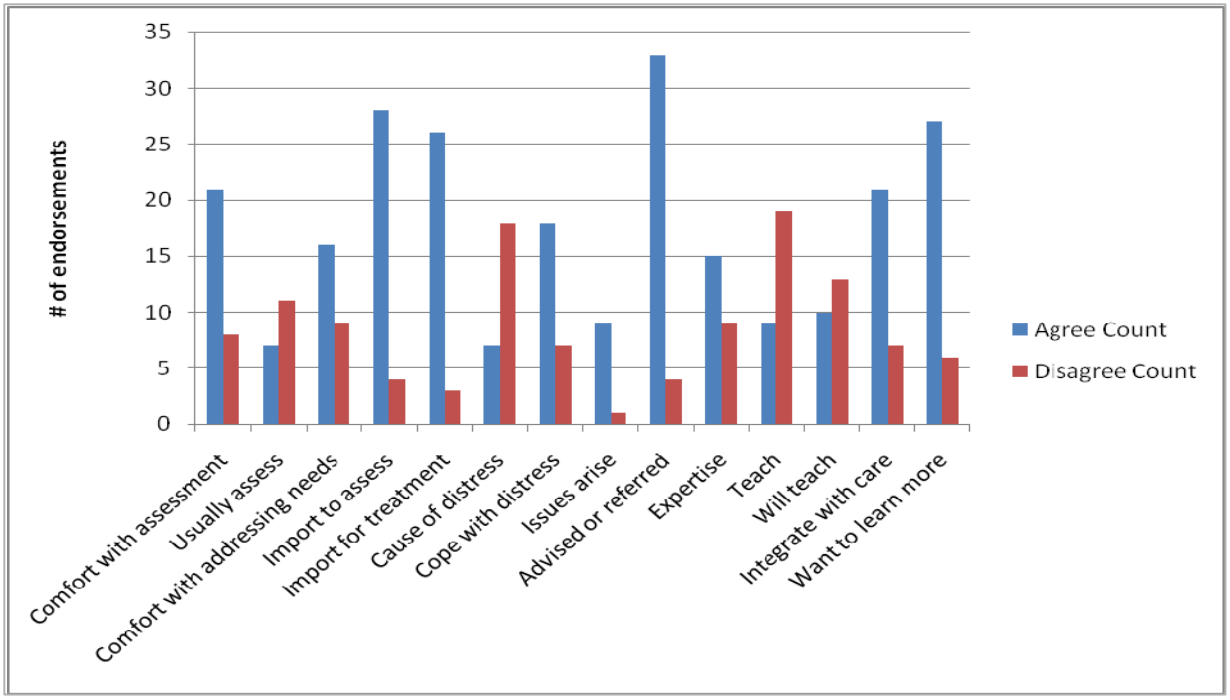
Spirituality and Psychiatry: A Survey of CCPS Membership Continued



More members endorsed "agree" or "strongly agree" to the statements regarding comfort with performing spiritual assessments, that spirituality was an important component of both assessment and treatment, was cited by patients as a coping strategy, had at least once referred or advised a patient to see a spiritual minister, and were comfortable integrating spiritual components into patient's psychiatric care and would like to learn more about this topic. Members did not endorse the statement that patients frequently cited religion or spirituality as a source of distress. Despite endorsing spirituality as a potentially important area of assessment and treatment, not many members endorsed strong agreement or disagreement with the statement regarding "almost always" including a spiritual assessment, suggesting that members who replied to the survey only included such an assessment under some circumstances. In addition, this data suggests that our members tend not to feel comfortable teaching other healthcare professionals what they do know about spiritual and religious issues in psychiatric care.

For those members who agreed with the statement about wanting to learn more, you're in luck! At the 2010 Annual Meeting in beautiful Santa Cruz, one of our CME presentations will be a panel of experts in the area of incorporating spiritual issues in the care of patients, including how to do spiritual assessments and what interventions may be appropriate, and learning about the utility of mindfulness meditation as a treatment modality.

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POST OFFICE BOX 1071 FRESNO, CA 93714

SAM A. CASTRO, MD, EDITOR