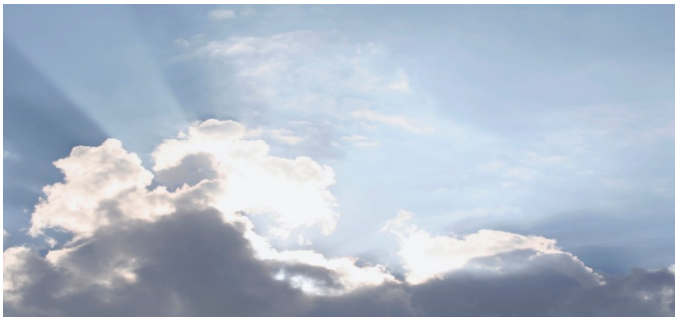
2014 Fall Newsletter

The President's Message

By Howard Friedman, Ph.D., ABPP



IN THIS ISSUE

I guess we are all back from our summer and fall vacations; I know it took me a while to get my head back into all the professional responsibilities, but here we are!

Many of you attended our summer reception in early September. We had a good time, and I'd like to express my appreciation to the CCPA Board and Association, as well as to Susan and David O'Grady for hosting the event this year. It was a perfect setting on a perfect day. As many of you know, we decided to largely cater it this year rather than having burgers on the grill, which I think people appreciated. It was great to hear from our special guest, State Senator Mark DeSaulnier, who is in the middle of a campaign for U.S. Congress. He spoke about health policy issues, in addition to other key topics.

Along those lines, in collaboration with CPA, we are coordinating other political activities, such as contacting other candidates running for office to meet with us, including Dublin Mayor Tim Sbranti, who is running for California State Assembly. He is pursuing the seat being vacated by Joan Buchanan.

We have other events planned for the rest of 2014 and into 2015. You've already received an announcement regarding our meeting on October 23 focusing on "Psychologists, Ethics, and the World Wide Web." Mark Dombeck, PhD, will present this talk on ethical and technical issues regarding considerations in offering an internet practice, and marketing on the internet. Certain electronic issues in these areas have been much more prevalent recently, and this program is a great

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starting point for us in terms of thinking about whether a virtual space is a feasible place for us to operate. Dr. Dombeck was the Director of Mental Help Net from 1999 to 2011.

Another program in the planning stages for January 2015 will be presented by Carol Goodheart, EdD. Dr. Goodheart is a former APA president and author of *A Primer for ICD-10-CM Users: Psychological and Behavioral Conditions* (available through APA Publications). She will lecture on ICD10 and the anticipated switchover to using it as a replacement for the DSM. The change date is planned for October 1, 2015. She'll also give us advance information about the next version, ICD11. We anticipate presenting this event in conjunction with one or two other local chapters and with The Wright Institute, so we might have a larger audience than usual. The Wright Institute is providing some of the funding for this event. Also, given the amount of information Dr. Goodheart needs to discuss, it's a four-hour meeting instead of the usual three hours. For this workshop we will be at the Renaissance Hotel across from Pleasant Hill BART to allow for "green" transportation.

And lastly, good news: a grassroots lobbying effort paid off in response to our letters, as Governor Brown vetoed a bill that would have required all of us to obtain mandatory CE credits on suicide assessment.

So we are continuing to roll along. I hope to see you at one of the upcoming events. ◊

CCPA Fall BBQ

CCPA Fall BBQ with Special Guest, Senator Mark DeSaulnier Aug 14th

CONTRA COSTA PSYCHOLOGICAL ASSOCIATION

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How Can Psychologists Prevent Adolescent Suicide: A Summary and Comments on Research on Reducing Recurrent Adolescent Suicide

By Bruce H. Feingold, Ph.D.

During adolescence, the individual undergoes profound change and is vulnerable to a wide range of mental health and developmental problems and challenges. An individual is more likely to die from suicide during adolescence than any other period in his or her lifetime with a lifetime rate of 4% for suicidal ideation with a plan and actual attempt; suicide is the third leading cause of death for persons ages 15 to 24 (Brent, McMakin, Kennard, Goldstein, Mayes, and Douaihy, 2013).

For psychotherapists who treat adolescents, working with a teen patient immediately after a suicide attempt or having an adolescent patient attempt suicide during treatment, is formidable and demanding. Research has found that 30 to 50% of suicidal adolescents do not adhere to treatment recommendations (Brent et al. 2013). As a psychologist who has treated hundreds of a suicidal adolescents, staying current and refining my craft is of utmost importance. I continually ask myself, “What are the best treatment interventions for suicidal youth?”

Brent et al. (2013) aim to describe the active ingredients for effective interventions for high-risk youth after initial suicidal ideation and attempts by reviewing and synthesizing the research from a wide range of theoretical orientations on preventing recurrent suicidal ideation, self-harm and suicide attempts. The authors include self-harm because research demonstrates that self-harm is a strong predictor of suicide attempts and completed suicide. Brent et al. (2103) also report that previous research estimates that between 15 to 30% of suicidal adolescents will attempt suicide after an initial attempt within a year, that the highest risk for a recurrent suicidal behavior in recently hospitalized attempters is within 1 to 4 weeks and that with depressed suicidal adolescents there is a critical 3 to 5 week window pane of risk for another suicide attempt.

The conclusion by Brent et al. (2013) on the status of current research on preventing recurrent suicide attempts might surprise many psychotherapists, “Despite more than 2 decades of research and several large clinical trials, there are still no empirically validated treatments that prevent the repetition of adolescent suicidal behavior.” (p. 1260). This is a forceful conclusion from the authors led by David A. Brent, MD, who has been one of the most prominent researchers in adolescent suicide and depression for over thirty years. However, the authors offer important suggestions that may inform our work with suicidal adolescents.

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Interventions with the Family and Non-familial Support

Brent et al. (2013) reviewed studies that increased familial and non-familial support compared with TAU (treatment as usual). These studies include an in home based program, treatment programs that provided education on communication and problem solving for the family and/or wider social network, multi-systemic therapy and several other models. The authors summarized that these programs did not reduce recurrent suicidal behavior compared to TAU.

Brent et al. (2013) reported more promising results on several interventions which included a stronger family component, including attachment-based family therapy (ABFT), a therapeutic model which focuses on adolescent-parent attachment, an integrated cognitive therapy model (iCBT), which includes specific focus on substance abuse issues, motivational interviewing and a strong family intervention, and a manual based mentalization based therapy (MBT) focused on the adolescent and family. These approaches showed some positive results in reducing suicidal ideation, depression or suicide attempts compared to TAU. Interestingly, positive results were found from three major schools of psychotherapy, family therapy (ABFT), an integrative form of CBT (iCBT) and a contemporary psychodynamic based treatment (MBT).

Summarizing the first part of the review, the authors concluded that mobilizing familial and non-familial support plus a high frequency of individual sessions might explain the positive results. For example, in the ABFT study, the experimental group averaged ten sessions and the control group received an average of three sessions; in the iCBT study the intervention group averaged 34.5 sessions versus less than 20 sessions for the control group.

Interventions Directed Toward Individual Adolescent Skills

In the second part of the review, Brent et al. (2013) looked at programs which emphasize individual skills and behaviors. Skills-based therapy (SBT), developmental group treatment (DGT), a group model focusing on problem solving, emotional regulation and social skills training, and cognitive analytic therapy (CAT) did not show significant declines in recurrent suicidal behavior in comparison with TAU. The authors conclude that, “Most individually focused interventions have not been successful in reducing suicidal risk although these conclusions could be qualified because of the relatively low number of sessions in many of the individual treatments, and the relative strength at least in term of the number of sessions of TAU” (p. 1266-67).

Brent et al. (2013) also examined studies which focused specifically on depression since depression and suicidal issues are highly correlated. Meta-analysis studies of adolescents with primary depression demonstrated that the combination of CBT and anti-depressants does *not* show a reduction in suicidal ideation and attempts compared to anti-depressants alone. Furthermore, while meta-analysis studies demonstrate that in adult depression there is a strong correlation between reduced depression and suicidality and the use of flouxetine or venlafixine, for youth aged 24 or less, anti-depressant medication reduced depression but *not* suicidality. The authors note that this is congruent with our understanding of adolescent suicide, “...depression, albeit, a highly significant contributor to suicide risk in youth, is less

central to suicidal risk in adolescents and young adults than it is in mid-life and older adults." (p. 1266). In other words, while depression correlates to adolescent suicidal risk, there are other mediators that significantly affect adolescent suicidal risk.

Five Key Factors Proposed for Further Research

The authors recommend five key factors which they propose should be part of clinical interventions and further research to reduce recurrent adolescent suicidal behavior.

1) **Increase motivation and commitment to change**: Due to poor adherence to treatment by at-risk adolescents the authors advocate Motivational Interviewing (MI) to promote motivation and adherence to treatment.

2) **Address substance abuse issues**: Research has shown a high correlation between adolescent suicide attempts and substances or alcohol abuse; therefore, directly addressing substance use with suicidal adolescents and their families should be a core ingredient of treatment, regardless of theoretical orientation.

3) **Include a strong family component**: Research demonstrates that family adaptability and cohesion are protective against suicidal risk while family conflict predicts recurrent suicidality. The interventions that had the most positive effects in reducing recurrent suicidality had a strong family component, from traditional relational family therapy to parent-child communication training. Interventions that increased family attachment, parental support for the adolescent and positive relationships appear to be the most beneficial. The authors also underscore that the increase in healthy connection might be more beneficial than reducing family conflict.

4) **Emphasize positive affect**: Negative affect highly correlates with depression and suicidal behaviors, but there is a growing understanding that positive affect may be a protective factor. Brent et al. (2013) note there has been little research on the role of encouraging positive affect and suggest that interventions which increase positive affect and positive experience is a promising area of research for preventing adolescent suicide.

5) **Address insomnia**: Insomnia has been shown to place adolescents at 5-fold increase for suicidal issues and increases negative affect, impulsivity and mood lability. However, most of the reviewed studies did not have specific treatment protocols for promoting healthy sleep. Brent et al. (2013) recommends examining ways to increase healthy sleep and its effect on depression and suicide risk.

Methodological Problems

Brent et al. (2013) note that research on preventing adolescent suicide has methodological problems, including inconsistent definitions of suicidal behavior, problems with reporting of outcomes of suicidal behavior, inadequate

dosing of treatment and not identifying the specific ingredients of therapy related to outcome. Most studies do not adequately describe the TAU comparison group so one does not know to whom the control group is being compared. Methodological issues noted by Brent et al. (2013) plague outcome psychotherapy research in general (Duncan, Miller, Wampold and Hubble (2010). As Duncan et al. (2010) point out, adolescent psychotherapy has been shown to be relatively effective across different theoretical orientations and empirically based treatment have not been shown to be more effective than TAU. Duncan et al. (2010) and Brent et al. (2013) arrive at the same conclusion that examining specific ingredients which mediate treatment outcomes, rather than comparing models, will identify specific effective interventions and be more useful for clinicians to incorporate into their therapy practices.

Clinical Implications and Comments

The five factors proposed by Brent et al. (2013) emphasize the therapist's role (motivational interviewing) and focuses treatment on *both* the adolescent's individual functioning (decrease substance abuse, thereby reducing maladaptive defenses and behaviors, increase positive affect and improve sleep) *and* the relationship with her family.

Due to poor adherence to treatment by suicidal adolescents Brent et al. (2013) encourage the use of motivational interviewing to reduce recurrent suicide attempts with adolescents. For those unfamiliar with MI, it is an empirically based intervention to enhance motivation for treatment which is collaborative and person-centered (www.motivationalinterview.org).

In my academic training and clinical supervision motivational interviewing skills were taught as "clinical skills" which were the foundation of forming a therapeutic alliance and were heavily influenced by psychodynamic and Rogerian principles. In other words, in the first session with defiant, angry, withdrawn, non-communicative, substance abusing or depressed adolescents, the psychotherapist must summon his or her best clinical skills to form an alliance with the adolescent. Psychotherapy outcome research demonstrates that a strong therapeutic alliance is the best predictor of successful adolescent therapy (Duncan et al. 2010). I believe that a strong relationship with an adolescent in crisis is the *basis* for motivation to change. Finally, in my experience a strong connection in the first session acts as a protective element to keep the teenager initially safe so treatment may unfold.

As Brent et al. (2013) found the first several weeks after a suicidal attempt are crucial, and at the onset they highly recommend intensive treatment. If feasible, I recommend at least twice a week therapy. Furthermore, the patient and family need to know how to contact the therapist in an emergency and be aware of alternative emergency services. Using standard suicidal protocol, the therapist must thoroughly assess suicidal potential (see, for example, Boesky, 2011).

The findings by Brent et al. (2013) that interventions which increase attachment to the family and support for the adolescent were more successful are bolstered by Thomas Joiner's innovative contributions to assessing and preventing suicide (Joiner, 2005; Joiner, 2009 -see http://www.apa.org/science/about/psa/2009/06/sci-brief.aspx). Joiner proposes the combination of three psychological states as the best predictors of suicide: 1) the feeling of being alone, 2) the

feeling of being a burden and 3) the acquired ability to hurt oneself, including habituation to suicidal behavior and pain in general. I recommend specially asking whether the adolescent feels alone, especially an experience of being alienated from her family, and whether the adolescent feels that she is a burden. (The frequency of attempts, lethality, exposure to violence and becoming habituated to suicidal behavior and pain should be part of one's standard protocol - see Boesky, 2011). If the adolescent feels alone, has multiple attempts and habituates to suicidal experiences and feels that she is a burden, then the level of threat is higher, and these feelings and thoughts must immediately be the focus of the treatment.

Following the recommendations by Brent et al. (2013) I suggest that the psychotherapist evaluate and address substance abuse issues in the first session. The goal is to understand the causes and purpose of the substance use, such as genetic vulnerability, the wish to escape from pain, impulsivity and need to belong to a peer group. Ultimately, the adolescent needs to reduce her maladaptive behavior to be safe and healthy and discover more successful coping mechanisms.

Finally, in the first session, I believe the psychotherapist needs to lay the groundwork for a healthier sense of self, including promoting a sense of hope that she can survive the suicidal crisis and experience positive affect. It is important for the adolescent to begin to become aware of the positive parts of herself, including her strengths, and discover potential satisfying relationships. Exploring ways to improve sleep helps the adolescent care better for herself, and improved sleep often reduces depression and impulsivity. Finally, at the end of the first session, the suicidal adolescent needs to have an initial understanding of what led to the suicidal crisis, how she might resolve it and a wish to live rather than die.

I agree strongly with the recommendation by Brent et al. (2013) to include a family component. The therapist needs to both quickly assess the role of the family in the suicidal behavior and how to involve them in treatment. If the adolescent *and* the family are both unstable with a high degree of family conflict, the therapist potentially faces a more dangerous situation. At end of the first session the outpatient therapist needs to trust the suicidal patient and her family that she may return home and be safe from harm. Additionally, in these crisis periods a therapist might need to connect with other therapists, psychiatrists, an inpatient unit or the adolescent's school to provide maximum integration of services and support for the teenager and family. All of these demands tax the therapist's stamina, energy and skill.

Like Brent et al. (2013) I suggest that family therapy and collateral treatment centering on attachment, including empathy, connection, respect and openness, are the pivotal family tasks. When I see a suicidal adolescent, I work with the parent or parents to be healing and protective. The parent or parents need to understand the meaning of the suicidal behavior and be supportive, understanding and compassionate, rather than angry, blaming or detached. Parents need to understand that suicidal problems are frequently related to the adolescent feeling overwhelmed, isolated, impulsive or wishing to escape her pain and suffering. The family needs to support the adolescent so she can resolve the issues related to the suicidal crisis.

Brent et al. (2013) do not directly address non-depressed adolescents with suicidal risk but note that there is less association between depression and suicide than in adults. I suggest that developmental issues, family dynamics, substance abuse, and personality all play a crucial role in non-depressed suicidal youth.

In her pioneering book on adolescence, Anna Freud (1936) describes the stage of adolescence as a time when " ...a relatively strong id confronts a relatively weak ego." (p.147) Contemporary neuroscience confirms Freud's original insight that during adolescence there is a significant imbalance between cognitive controls and reward systems (Reyna, Chapman, Doughtery, and Confrey, 2012). At puberty there is an increase in the emotional arousal limbic system; moreover, the prefrontal cortex matures more slowly, reducing cognitive controls, hence the risk for poor judgement and impulsivity. Secondly, adolescents depend on their families for stability, and when there is family stress or dysfunction, the adolescent is at greater risk, regardless of diagnosis. Finally, substance abuse issues, impulse problems, personality disorders, and psychotic disorders often emerge during adolescence which makes youth at greater risk for suicidal impulsive behavior. Hence, interventions which recognize and treat the unique challenges of adolescents will increase the effectiveness of preventing recurrent adolescent suicide.

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CPA Progress Notes

Anthem Blue Cross Begins Medical Chart Reviews for Exchange Patients

News from APA's Center for Workforce Studies
August 20, 2014, Vol XIII, No. XVI

In July, Anthem Blue Cross began chart reviews on enrollees who purchased an individual exchange or mirror product. Similar to the Medicare Risk Adjustment Audit process, and as required by the Affordable Care Act (ACA), the audit is designed to identify the health status and demographic characteristics of exchange/ mirror product enrollees.

Blue Cross will review diagnosis code data obtained from the medical records of exchange patients. This is not a typical audit on the practice; rather, Blue Cross is looking to identify conditions/illnesses that demonstrate patients who are at risk for being sicker or patients who are predicted to be healthier. This information will be utilized to report to the Centers for Medicare and Medicaid Services the health status of exchange plan enrollees. Blue Cross reports it will also utilize the data to better manage patient health conditions.

Blue Cross has contracted with Inovalon, Inc., a secure clinical documentation service, to conduct the medical chart reviews for exchange/mirror product enrollees. Blue Cross previously utilized Inovalon for its Medicare Advantage risk adjustment audits and the recently requested patient health assessments.

Inovalon will utilize several methods of collecting medical record information from physician practices, including:

- Scanned or faxed medical records that providers' offices send to Inovalon
- Onsite medical record reviews by clinical personnel
- Automated medical record retrieval from the provider's electronic health record (EHR) system

In cases where fewer than six medical records are being requested for review, Inovalon will contact each provider's office and request the information via fax or mailing of medical chart information.

In cases where Inovalon is requesting more than six medical records to review, the company will contact the provider's office and arrange a time convenient to visit the office to collect the appropriate information or to discuss accessibility of the information from the provider's EHR system.

Questions about the letter or the enclosures can be directed to Inovolan at (877) 448-8125 between 8 a.m. and 11 p.m., EST. Questions about the initiative can be directed to Anthem Provider Services at (855) 854-1438.

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Anthem Blue Cross Sued Again Over Narrow-Network Health Plans

Plaintiffs Say Anthem Gave Misleading or Incorrect Information, Both Last Fall and This Year, About the Medical Providers Participating in Its New Obamacare Plans.
By Chad Terhune

Suit accuses Anthem of misrepresenting the size of networks and the benefits provided in its Obamacare plans.

Anthem is sued over the narrow physician networks in its Covered California plans.

Health insurance giant Anthem Blue Cross faces another lawsuit over switching consumers to narrow network health plans — with limited selections of doctors — during the rollout of Obamacare.

These types of complaints have already sparked an ongoing investigation by California regulators and other lawsuits seeking class-action status against Anthem and rival Blue Shield of California.

A group of 33 Anthem customers filed suit Tuesday in Los Angeles County Superior Court against the health insurer, which is a unit of WellPoint Inc. Anthem is California's largest for-profit health insurer and had the biggest enrollment this year in individual policies in the Covered California exchange.

In the latest suit, Anthem members accuse the company of misrepresenting the size of its physician networks and the insurance benefits provided in new plans offered under the Affordable Care Act.

In many cases, consumers say, Anthem canceled their more generous PPO, or preferred-provider organization, plan and moved them to a more limited EPO, or exclusive-provider-organization, policy.

Compounding the problem, the plaintiffs say, the company gave misleading or incorrect information, both last fall and this year, about the medical providers participating in these new plans.

As a result, some consumers incurred unforeseen medical bills when they were treated by out-of-network doctors, according to the suit. EPO health plans usually have little or no coverage outside the network.

"Anthem profits from the premiums while these members cannot see their doctors," said Scott Glovsky, a Pasadena attorney representing the Anthem customers.

Anthem said it hadn't seen the lawsuit filed Tuesday. The company has previously defended its conduct and said consumers were properly notified about these changes.

The health insurer has said "materials at the time of enrollment and in members' explanation of benefits have clearly stated that the plan was an EPO plan which may not have out-of-network benefits."

The California Department of Managed Health Care said its investigation into network-related complaints at Anthem and Blue Shield is still ongoing.

Many health insurers offered smaller lists of providers at lower reimbursement rates to help hold down premiums for individual policies this year. Anthem and other insurers largely stuck with that narrow network strategy for 2015 plans in Covered California and outside the exchange.

To address some of these concerns, state lawmakers and consumer advocates are pushing for additional legislation.

State Sen. Ed Hernandez (D-West Covina) is backing a Senate bill (SB 964) that seeks to increase state monitoring and enforcement of existing rules on network adequacy and timely access to care.

"We have to make sure those individuals that signed up actually have access to healthcare," Hernandez said.

Health insurers say they have added thousands of doctors to their networks this year to improve coverage, and they oppose SB 964 because it's redundant to current rules.

Chad Terhune chad.terhune@latimes.com

DMHC Increasingly Fining Health Plans for Untimely Payments

California's Department of Managed Health Care This Year Has Issued Fines at More Than Twice the Tate of Recent Years Against Health Plans That Did Not Pay Providers in a Timely Manner, Payers & Providers Reports.

Background

California health plans have long been required to pay providers in a timely manner, which is usually defined as within:

- Five days of determining a payment dispute; or
- Within 45 days of receiving a claim.

Since the late 1990s, DMHC has issued an average of six penalties per year related to timely payments.

In 2011, the agency issued 10 penalties related to timely payouts -- the most ever issued in a 12-month period year. However, DMHC only issued three fines related to timely payments in 2013 and two fines over the matter in 2012.

Details of 2014 Fines

So far this year, DMHC has issued seven fines related to timely payments -- more than the annual average for the agency.

The fines total about $172,500 and were levied on:

- Alameda Alliance for Health
- Anthem Blue Cross;
- Cigna's behavioral health unit;
- Contra Costa County Medical Services;

- Sharp Health Plan;
- Simnsa Health Care; and
- United Concordia Dental Plan.

Medicare Opt Out Information From Noridian

Section 1802 of the Social Security Act (SSA), as amended by section 4507 of the Balanced Budget Act of 1997 (BBA97) permits a physician or practitioner to "opt out" of Medicare if specific requirements (discussed below) are met. Prior to enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Section 1802 (B)(5)(B) of the Social Security Act limited the types of physicians who may choose to opt out of Medicare to doctors of medicine and doctors of osteopathy.

Section 603 from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added dentists, podiatrists, and optometrists to the definition/list of physicians who may opt out of Medicare. These newly added physicians could opt out of Medicare effective December 8, 2003.

Send the completed affidavit to the attention of "Provider Enrollment" using the appropriate mailing address provided on the "Provider Enrollment Contacts" page.

- Overview
- Opt Out Listing by State
- Affidavit [PDF]
- Sample Contract [PDF]
- Opting Out of Medicare and/or Electing to Order and Refer Services – SE1311 [PDF]

Physician Quality Reporting System or PQRS

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

The program provides an incentive payment to practices with EPs (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]). EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to **Medicare Part B Fee-for-Service (FFS) beneficiaries** (including Railroad Retirement Board and Medicare Secondary Payer).

Beginning in 2015, the program also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. The website reached by this link serves as the primary and authoritative source for all publicly available information and CMS-supported educational and implementation support materials for PQRS.

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/
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Letter from the Editor

The CCPA Newsletter is a forum for sharing information. I invite submission about 1) groups that you offer, 2) reviews of workshops you have attended or book that you have found useful or 3) a variety of other topics relevant to the community. Occasionally, I include an interview with a CCPA member, so if you would like to respond to a list of questions about yourself and your practice, please contact me. It is a great way to be better known within the organization. Please consider contributing to future newsletters. The following dates are deadlines by which I must have your submission. Thank you in advance!

January 15, 2015 – Winter edition
April 15, 2015 – Spring edition
July 15, 2015 – Summer edition

The following prices are in effect for advertisements:
¼ Page Ad $30 ½ Page Ad $60 ¾ Page Ad $100

Note: Advertisements for office space are free to CCPA members.
All professional advertisements are free on the listserv for CPPA members.

Email submissions by the deadline to sarahewoodphd@hush.com ◊

San Ramon Psychotherapy Office Sublet

Small, quiet psychotherapy space for sublet in San Ramon Regional Medical Center complex. Approx. 80 sq. ft. Light, bright office. Large waiting room. Suitable for seeing adult patients. Contact Dr. Jerome Hanowsky. 925-820-8613.

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Calendar of Events

Mark Your Calendars!

Psychologists, Ethics, and the Web: How to Ethically Get Noticed Online and Win New Clients

Date: October 23, 2014
Time: 6:45 – 6:45 pm Social Hour
6:45 – 8:45 pm Presentation
Where Lafayette Park Hotel
Presenter: Dr. Mark Dombeck

CCPA Holiday Party

Date: December 5, 2014
Time: 6:00 – 9:00 pm
Where TBA

Annual CCPA Meeting
What You Need to Know About the ICD (Required by October 1, 2015)

Date: January 24, 2015
Time: 12:00 – 1:00 pm Annual Business Meeting and Lunch
1:00 – 4:00 pm Presentation
Where TBA
Presenter: Carol Goodheart, Ed.D.

RSVP to: Dr. Alissa Scanlin 3468 Mt Diablo Blvd, Ste. B203, Lafayette, CA 94549 PHONE: (925) 283-3902
EMAIL: mailto:drscanlin@pacbell.net Include your Name, Address, License#, Phone and Email
(All event locations are wheelchair accessible. Please let me know if you need any special accommodations.)

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List of Groups

"Women's Group" for Women in their 20's and 30's with emphasis on Mental Health Challenges, Intimacy, Profession Identity and Moving Forward in their Lives

Meeting Day: Alternate Tuesday's
Meeting Time: 5:40 – 7:15 pm
Meeting Location: Rockridge, Oakland
Group Leader: Fran Krieger-Lowitz, Ph.D.
Contact Number: (510) 841-2007

Breakthrough Weight Loss and Maintenance Group

Meeting Day: Thursday's
Meeting Time: 6:00 - 7:30 pm
Group Leader: Candia Smith, DMH
Contact Number: (925) 254-7823
Email: candia.smith@comcast.net

Introduction to Meditation for Stress Reduction Group

Meeting Day: 1st and 3rd Tuesday of each month
Meeting Time: 6:00 -7:00 pm
Cost: Free, small donation asked for rent
Group Leader: Candia Smith, DMH
Contact Number: (925) 254-7823
Email: candia.smith@comcast.net

Men's Group

Meeting Day: Monday's
Meeting Time: 7:30 -9:00 pm
Group Leader: Bruce H. Feingold, Ph.D.
Contact Number: (925) 945-1315

Men's Group

Meeting Day: Wednesday's
Meeting Time: 6:00-7:30 pm
Group Leader: Bruce H. Feingold, Ph.D.
Contact Number: (925) 945-1315

Mindfulness-Based Stress Reduction Class

Group Leader: Susan O'Grady, Ph.D.
Group meets for 8 weeks, 5:00 – 7:00 pm
Contact Number: 925-938-6786
Website: www.ogradywellbeing.com
Email: susanogradyphd@gmail.com

Dialectical Behavior Therapy Group (ages 19+)

Meeting Day & Time: Tuesday's 5:30 – 7:00 pm
And
Meeting Day & Time: Wednesday's 9:30 – 11 am
Group Leaders: Elizabeth Rauch Leftik, Psy.D.
(925) 314-6354
Sarah E. Wood, Ph.D.
(925) 680-1844
Website: www.mtdiablopsychologicalservices.com

Interpersonal Psychotherapy Group: Co-ed

Meeting Day: Wednesday's
Meeting Time: 5:00-6:30 pm
Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060
Website: www.DrSteiner.com

Chronic Medical Illness Group

Meeting Day: Wednesday's
Meeting Time: 12:30 - 2:00 pm
Group Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060
Website: www.DrSteiner.com

Psychotherapy Group for Psychotherapists

Meeting Day: Thursday's
Meeting Time: 12:30 - 2:00 pm
Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060
Website: www.DrSteiner.com

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List of Groups (cont'd)

Psychotherapy Group for Pre-Licensed and Early Career Therapists

Meeting Day: Thursday's
Meeting Time: 9:00 - 10:30 am
Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060
Website: www.DrSteiner.com
Website: www.PsychotherapyTools.com

DBT Skills Group for Adults in Orinda

Meeting Day: Friday's
Meeting Time: 3:00 – 4:30 pm
Location: Orinda
Group Leader: Amanda Gale, Ph.D. and Katherine Schulz, LCSW
Contact Number: Dr. Gale at (415) 295-1549 or Katherine at (925) 465-7474
Email: AmandaGaleSF@gmail.com or therapy@katherineschulz.com

DBT Group for Adolescents and Parents

Meeting Day: Saturday's
Meeting Time: 10:30 am – 12:00 pm
Contact Number: 925-956-4636
Website: www.eastbaybehaviortherapycenter.com

DBT Group for Adults

Meeting Day: Monday's
Meeting Time: 6:30 - 8:00 pm
Contact Number: 925-956-4636
Website: www.eastbaybehaviortherapycenter.com

Mother's Group with Emphasis on Parenting, Relationships, and Balancing Work and Family Life

Meeting Day: Alternate Thursday's
Meeting Time: 12:10 - 1:40 pm
Location: Walnut Creek
Group Leader: Fran Krieger-Lowitz, Ph.D.
Contact Number: 510-841-2007

2014 Fall Newsletter

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