Southern California
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President's Column

9-1-1, What's Your Emergency?

Erick Cheung, M.D.

Colleagues: Dues season is here… I once again thank you for supporting your tripartite organizations the Southern California Psychiatric Society (SCPS), California Psychiatric Association (CPA), and the American Psychiatric Association (APA).

Your support enables our professional guild to accomplish things on many levels. A case in point for your dues in action: for many years the SCPS has appointed a commissioner to the Los Angeles County Emergency Medical Services Commissions (EMSC) to represent psychiatrists and individuals with who need emergency care for mental health issues. The EMSC is an advisory body to the LA County Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical care services.

4 years ago, the SCPS, through their appointed commissioner, was instrumental in establishing an "Ad Hoc Committee on the Pre-Hospital Care of Mental Health and Substance Abuse (MH/SA) Emergencies." This committee dug deep to answer a fundamental question: What happens when a person in LA County calls 9-1-1 with a mental health emergency?

Unlike the response for medical emergencies, which could be generally characterized as predictably delivered and uniformly regulated, the response to MH/SA emergencies is comparatively varied and lacks the same coordinated delivery and regulation. The main source of variation lies in the fact that two very different entities, law enforcement or emergency medical services, may be dispatched as a result of a 9-1-1 call.

As it turns out (and as you probably already know), the system is largely defaulted towards a law enforcement response to MH/SA emergencies. And yet, mental health emergencies *are* medical emergencies. Our law enforcement colleagues have been placed in a very difficult position, serving as the first responders in most cases, and conducting "clinical" evaluations of MH/SA patients with a goal of determining whether the patient needs treatment, and to determine the best destination option, despite the lack of medical training. The law enforcement response, and more specifically the transport of patients in squad cars in handcuffs, has the undesirable effect of "criminalizing" persons with MH/SA emergencies.

The committee's final report[1] highlighted nine recommendations for change to the mental health / substance abuse field response, processes of care, and disposition by emergency medical services (EMS) and law enforcement.

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An important area of focus relates to 9-1-1 dispatch and triage of mental health and substance abuse (MH/SA) calls. The EMSC in coordination with the Los Angeles Area Police Chiefs Association conducted a survey in early 2018 to develop a more thorough understanding of the challenges that LA County's law enforcement agencies encounter in dispatching 9-1-1 mental health calls, and responding to these calls in the field.

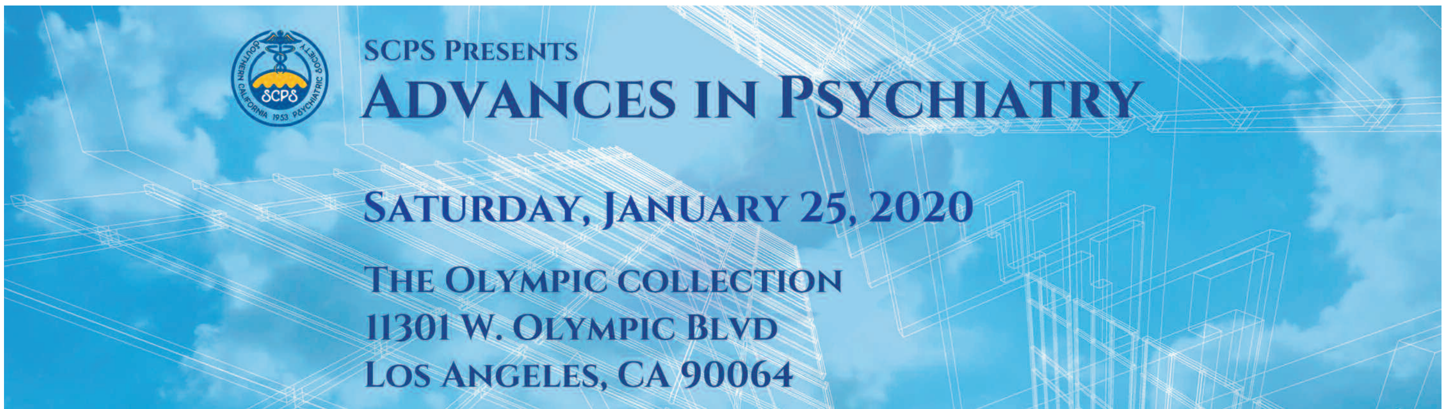
Among the many findings, it was discovered that roughly 28% of mental health 9-1-1 calls were related to suicidal ideation without an attempt.

Correspondingly, the EMSC recommended a pilot project to evaluate whether diversion or co-triage of calls related to suicidal ideation (without attempt, or risk of imminent harm) to the Suicide Prevention Lifeline is feasible. Furthermore, important outcomes should be assessed including whether it reduces the cost and risk associated with over-utilization of law enforcement, and reduces mental health holds and emergency department utilization. Connecting individuals with suicidal ideation to suicide hotline counselors would likely offer better de-escalation of an acute emotional crisis, safety planning, and better linkage to appropriate follow up care. Clearly, an important part of this pilot project will involve the creation of safe and appropriate 9-1-1 triage protocols. If successful, this program could have significant impact on a large proportion of 9-1-1 behavioral health emergencies.

Driven by the committee report and recommendations, the Los Angeles Police Department and Didi Hirsch Suicide Prevention Lifeline are now teaming up to develop a pilot project. Houston and Portland have initiated programs already, but Los Angeles would far and away represent the largest endeavor of this kind.

Your membership dues support SCPS's engagement in novel community treatment endeavors such as this, and much more. Go to the SCPS website at (https://www.socalpsych.org) to see other events, committees, and advocacy.

1. The EMS commission report can be found online : (http://file.lacounty.gov/SDSInter/dhs/1006550_EMSCAdHocCommitteeReportNovember2016.pdf



Risks and Benefits of Benzodiazepines
Richard Balon, M.D

Update on Bipolar Disorder and Treatments
Mark Frye, M.D.

The Use of Mind Altering Drugs in Therapeutic Settings
Brian Anderson, M.D.

Sleep and Neuroimmunology: Alternative Interventions for Improvement of Mental Health
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REGISTRATION OPENS SOON- SAVE THE DATE!

Impeachment is consuming the media, but let's not forget about guns.

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

This month we have two very thought-provoking articles on guns that I am pleased to share. However, before getting to those articles, I want to again thank Dr. Curley Bonds, our former SCPS President, who took up my request to expand the conversation around race and psychiatry. His very personal and very timely article is included in last month's newsletter. If you have not already, I encourage you to read it and take some time to reflect how race impacts your work and our field as a whole.

Moving to this month, I am again so appreciative of another past SCPS President, Dr. Joseph Simpson, who took up my challenge to write about guns and the impact and implications on mental health. As you will find in his two articles that follow, he discusses the current implications that mental health and the field of psychiatry have with the epidemic of gun violence and mass shootings that are occurring. He takes a very close look at how the American Psychiatric Association's public statements line up with the data that we have on gun violence and mental illness. In the second article, he discusses "Red Flag" laws and who may have the right in California to take away someone's right to own a gun.

If you have a different perspective, additional thoughts or a clinical scenario of how race or guns have impacted your patients, practice of psychiatry or the field as a whole… please send me your response via email for consideration of publication. My hope is that these articles get us thinking about these heavy topics and that reflection helps us to press forward as individuals, psychiatrists and the field as a whole.

If writing an article is not your cup of tea, but you are interested in getting more engaged with SCPS, Dr. Danielle Chang discusses two opportunities to do so with the SCPS Disaster Relief Committee and the SCPS Finance Interest Committee. See more below.

Finally, I want to thank SCPS President, Dr. Erick Cheung, for his work on improving 911 response for those with mental health emergencies. His article reminds us that more work still remains to be done and that the SCPS is instrumental in helping to push forward important initiatives like the Ad Hoc Committee on the Pre-Hospital Care of Mental Health and Substance Abuse (MH/SA). This led to the Los Angeles Police Department and Didi Hirsch Suicide Prevention Lifeline teaming up to develop a pilot project, to decrease suicides across Los Angeles County. You can read more about the work and research in Dr. Cheung's article (above).

Best,

Matthew Goldenberg D.O.
SCPS Newsletter Editor
Secretary (2019 – 2020)
Email: docgoldenberg@gmail.com

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FEATURED ARTICLE

Mental Illness, Firearms, and Mass Homicide: No Easy Answers*

By: Joe Simpson, M.D., Ph.D.

In recent years, tragedies in which a number of people are murdered by a man using firearms (the perpetrators of these horrifying crimes are almost always male) have become virtually a weekly occurrence somewhere in the United States. Although statistically speaking such awful incidents remain extremely rare in a country with a population of one-third of a billion people, the intense media focus on the perpetrators and the grieving families of the victims after each tragic event, as well as the randomness and senselessness of the acts, has created an atmosphere where many are fearful that they too might become a victim. Among the media and political leaders, there has also been an increasing focus on the availability of firearms in the U.S. and on the possible connections between mental illness and this form of multiple murder. It is perhaps unnecessary to point out that opinions, and emotions, on the topic of gun control are very intense; it likely ranks close to the debates over abortion and immigration in terms of level of division, conflict and impassioned argument.

After a particularly terrible period this summer which saw three incidents of multiple homicide by firearm within one week, in Gilroy, California, El Paso, and Dayton, the American Psychiatric Association responded to politicians and others who seek to draw a connection between mass shootings and mental illness. In an August 6th email sent to APA members, the APA quoted from news articles reporting on research that questions the evidence for a link between mass shootings and mental illness. In a press release the previous day, the APA pointed out that "the overwhelming majority of people with mental illness are not violent and far more likely to be victims of violent crime than perpetrators of violence." (1)

In my opinion, the APA is in a difficult position. I believe that in the mind of the average layperson, anyone who chooses to murder random strangers whom they have never met, and who, in most cases, expects to die during the commission of the murders (often killing themselves at the conclusion of their attacks) is, by definition, mentally ill. No one who is not "mentally ill" ("crazy" or "insane," as many in the lay public still say) would do such a thing, or so the thinking goes. (The APA and other mental health organizations have said for many years that approximately 90% of suicides are the result of mental illness. Are many perpetrators of this type of mass violence therefore in the 10% who are not mentally ill?) If those who are clearly acting from political or politico-religious motivations, as in the 2014 San Bernardino tragedy, are excluded, it would seem that no amount of scientific discussion may ever convince the general public that a significant proportion of the people who carry out mass homicides of the type that receives such pervasive media coverage are not mentally ill. Furthermore, the statement about the vast majority of people with mental illness not being violent, while true, is not relevant to the question of the mental condition of those extremely rare individuals who carry out attacks against random people with no obvious motive, often with no plan or intention to survive the attack.

On top of these complexities, there is evidence that a substantial number of the perpetrators of the most highly publicized mass homicides did, in fact, have some type of mental illness. The perpetrator of the 2008 Virginia Tech attack had been involuntarily committed to outpatient treatment. The man who severely wounded Congressman Giffords and killed six others was found incompetent to stand trial after his arrest and had to be restored to competency via administration of involuntary antipsychotic medication. The perpetrator at Sandy Hook Elementary School (who was 20 years old at the time) had not been able to attend regular school for years prior due to his mental condition. The man who carried out the attack at the movie theater in Aurora, Colorado was being treated by a psychiatrist on an outpatient basis in the months preceding that tragedy. A number of other examples could be cited.

Psychiatrist E. Fuller Torrey, founder of the Treatment Advocacy Center, wrote an op-ed article published in the *Wall Street Journal* on August 4th, 2019 (2) in which he stated, "[m]ultiple studies done between 2000 and 2015 suggest that about a third of mass killers have an untreated severe mental illness. If mental illness is defined more broadly, the percentage is higher." He quoted a 2019 Secret Service report finding that two-thirds of 27 perpetrators of mass attacks "displayed symptoms of mental illness or emotional disturbance." Dr. Torrey also cited a

2018 FBI study that, he wrote, concluded that "40% of the shooters had received a psychiatric diagnosis, and 70% had 'mental health stressors' or 'mental health concerning behaviors' before the attack." Of note, in the email sent by APA to its members mentioned above, an August 5th, 2019 *Washington Post* article is quoted as stating that "[i]n a 2018 report of active shooters, the FBI 'found that 25 percent of active shooters had been diagnosed with a mental illness…'"

None of this is to say that the APA, or anyone advocating for people experiencing mental illness or for the mental health profession, should stop putting out the message that the vast majority of people with mental health conditions are not more likely to commit violent acts than the general public, or to suggest that organized psychiatry has nothing to contribute to the debate about firearms laws and policies in this country. My goal is only to point out the complexities involved in the type of crime of the pattern commonly known as a "mass shooting."

Even without doing any research or investigation, most people would agree that these crimes are increasing. A policy prescription that will dramatically reduce them has thus far proven elusive. There is one factor, perhaps less controversial than many others, that may offer some potential for impact. This is the idea that social "contagion" is worsening the problem. Many of the individuals who have carried out these attacks, as well as many who were arrested and prevented from doing so, had studied and researched previous tragedies. A desire for notoriety, or to – as gruesome as it sounds – "win" by murdering a higher number of people than a prior perpetrator, seems to be a significant motivating factor for many of these men, in addition to more obvious characteristics such as extreme rage or nihilism. Recently, more attention has been focused on the possible role of the media in making these perpetrators seem in some way glamourous or "cool;" or in other words, turning them into "anti-heroes." In an August 12th, 2019 article in the *Los Angeles Times* (3), columnist Frank Shyong examined the role that the intense media focus on mass shootings may play in "fuel[ing] the fantasies of the next mass shooter." He wrote, "We [journalists] rank the shootings in order of magnitude to give readers a sense of their historical significance and scale. But research says those rankings, by number of dead and wounded, are treated like video game scoreboards by potential shooters, who then kill more so they can rank more highly." The article discusses an organization called No Notoriety, started by the parents of one of the victims of the 2012 Aurora shooting, which seeks to "persuade media organizations not to publish the names of the shooters or photos that would make them look impressive or intimidating."

Perhaps the APA could consider adding its expertise and *gravitas* to the call to media outlets to stop, in essence, glorifying "mass shooters" by showing the most appealing or intimidating pictures of them they can locate, publishing and analyzing their "manifestoes," and repeatedly airing the scenes of terror captured on security cameras and the like as people run for their lives. On a more basic level, if the media realize that they are not drawing an audience with this approach, it will decrease and perhaps eventually stop. Each of us should ask ourselves: Should we be clicking on news stories that discuss the latest perpetrator's upbringing and theorized "motivations?" If we all tell our family and friends about the perniciousness of the social contagion phenomenon, and enough people reduce their consumption of sensationalized news coverage, ultimately a financial signal will be sent to the various media companies, and perhaps the pervasiveness of the coverage will shrink. This in turn could lead some potential perpetrators to realize that the media-generated fame they are seeking (whether in prison or after death) is not going to be forthcoming.

* *No Easy Answers*, by Brooks Brown, is one of many books examining the 1999 Columbine tragedy. The opinions expressed in this article are the author's and do not necessarily reflect the views of the Southern California Psychiatric Society, California Psychiatric Association, American Psychiatric Association, or any other organization with which he is affiliated.

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California's "Red-Flag Law:" The Gun Violence Restraining Order

By: Joe Simpson, M.D., Ph.D.

In 2019, the debate over how to reduce mass shootings and firearm violence more generally has produced calls for so-called "Red-Flag Laws," also known by other names such as "Extreme Risk Protection Orders." Broadly speaking, such laws provide for the temporary seizure of legally-owned firearms from individuals who are determined by a judge to pose a heightened risk to themselves or others. California is one of a growing number of states which already has such a law.

The California law providing for a Gun Violence Restraining Order (GVRO) was passed in 2014 and became effective January 1st, 2016. (1) It established a procedure for immediate family members or law enforcement officers to petition a judge for a GVRO based on concern about a person's increased risk of dangerous behavior. The judge hearing the petition considers such factors as threats or acts of violence (toward self or others), violations of other types of restraining orders, history of reckless use or brandishing of firearms, prior arrests for felony offenses, criminal convictions related to alcohol or other substance abuse, and evidence of current ("on-going") alcohol or other substance abuse. If the judge finds that there is a substantial risk of dangerous behavior to self or others, a 21-day restraining order can be granted; the individual's firearms (if any) are seized, and the person is added to the state's list of prohibited purchasers. Subsequently, if the danger is determined to be continuing, a one-year, renewable GVRO can be issued by the judge. California's GVRO law does not include any requirement or recommendation that the restrained person undergo mental health evaluation or treatment.

Although the average mental health professional, not to mention the average Californian, may not have heard anything about this law, it is being used, to varying degrees. For example, due to the approach of their City Attorney, the city of San Diego has requested an especially high number of GVRO's, relative to other jurisdictions. (2)

Currently, there is no direct mechanism for mental health professionals to initiate a petition for a GVRO. Not long after the law went into effect, the state legislature passed a bill that would have expanded the pool of people who could petition to include coworkers and employers, school officials, and mental health professionals who had seen the person as a patient within the past six months. The bill was vetoed by then-Governor Brown on July 1st, 2016, on the grounds that the law had been in effect for too short a time to assess whether it was appropriate to make the proposed changes.

Perhaps in keeping with the reasoning behind Governor Brown's veto, in September 2019 the legislature approved AB 61, which adds the coworkers, employers and school officials but not mental health professionals. At the time of this writing it has not yet been signed or vetoed by Governor Newsom, though signing seems very likely. We must wonder whether an effort to make the GVRO process available to psychiatrists and other mental health professionals may come up again in the future. The ramifications for psychiatrists of such an addition could be quite complicated. If the proposal arises, the California Psychiatric Association and the District Branches will need to decide what our stance toward it will be.

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Skelton R. San Diego's city attorney is taking away hundreds of guns from those who shouldn't have them. *Los Angeles Times*, August 12th, 2019.

An Introduction to the SCPS Finance Interest Committee

By: Danielle Chang, M.D.

Financial investing can be daunting, and it can be especially difficult to know where to begin as a graduating resident or fellow. Along with making the transition from being paid as a trainee to receiving an attending salary comes both new responsibility and opportunity, but finding good mentorship in regards to this aspect of career development is often challenging.

During the most recent SCPS Career Day, Dr. George Fouras and Dr. Zeb Little shared an introduction to financial and investment strategies. Their talk was a great success and generated a significant amount of continued interest from residents and early career psychiatrists. The SCPS Finance Interest Group was subsequently developed as a space for members to meet, learn, and dialogue about matters related to financial investment.

The group held its first meeting, led by Dr. Fouras and Dr. Little, in March 2019 and drew SCPS members from residency programs throughout the southern California area. It was a highly informative evening during which basic principles of investing were explored with an unintimidating approach. The meeting was an opportunity to ask both practical and theoretical questions about topics ranging from selecting a broker and navigating online trades to dollar cost averaging, types of investment products, equities, and cognitive biases related to investment. The evening was also a chance for members to connect over a common interest and to receive mentorship from two experienced investors who are passionate about sharing their knowledge.

Financial savvy may not be widely recognized as a trait that is primary to the development of a career in psychiatry, but it is a valuable tool and a key that may open doors to professional endeavors. The SCPS Finance Interest Group welcomes new members who are interested in joining the conversation about investing.

For more information or if you would like to join the SCPS Finance Interest Group, please contact Danielle Chang, MD, MSW at daniellechang@ucla.edu, George Fouras, MD, DFAACAP, DFAPA at gfouras@dmh.lacounty.gov, or Zeb Little MD, PhD, FAPA at jzeb@drzeblittle.com.

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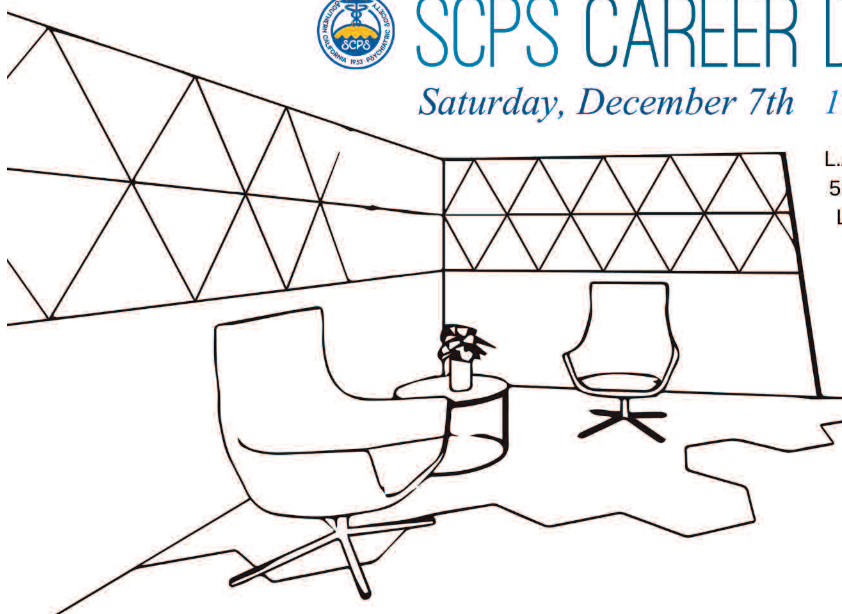

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Language matters. The use of the word "provider" may seem innocuous, but it is significant both for patients and physicians.

by: Torie Sepah, M.D.
previously published on Kevin MD

For patients, it has been perhaps the most pronounced step — if not leap — away from transparency. (Who is who? Nurse, doctor, chiropractor, podiatrist, psychologist? Doesn't matter — everyone is a "provider.")

For physicians, the ramifications have been two-fold. On one hand, the use of the word is a demotion by proxy. It dismisses and devalues the unique and difficult path that physicians must take to become physicians and to sustain the career of one.

A "provider" doesn't necessarily sacrifice a decade of their life, while becoming financially destitute, prolonging marriage and children, growing distant from friends and family, falling behind on financial milestones for their age — such as purchasing a home and investing in retirement. In reality, a "provider" may have attended a 9-12 month, 100% online NP program while working as an RN full-time.

It is difficult to reconcile the two realities as one path, yet "providers" are "providers."

The other manifestation is likely born of the first one — the effect on transparency. The long white coat and ubiquitous title of "provider," has allowed for the extrapolation that we must all indeed be equal in our ability to practice medicine. There are now 24 states that allow NPs to practice medicine independently without a medical license or any supervision of a physician — in almost any specialty that they choose (and they can switch at any time). Think this is only in rural states? California is slated to be the 25th as there are both NP and PA independent practice bills currently introduced and have passed the first round of committee hearings. The Governor supports them. More "providers," he has said, increases access to care for the poor.

And let's not forget the other providers. Five states allow talk therapists to practice medicine in the specialty of psychiatry and child and adolescent psychiatry (CAP). This despite psychiatry being at least a four-year specialty — CAP a six-year post-grad curriculum, just one year less than neurosurgery. And all "providers" can "prescribe" even if most psychiatric medications have a black box warning. Many psychiatric patients have a questionable ability to provide informed consent, the assessment of capacity is nuanced even for other physicians, and this is one of the most vulnerable populations in the U.S. Those with psychiatric diagnosis have a life expectancy that is seven years lower than the general population — even when excluding suicide as a cause of death. But a "provider" is a "provider," and if the goal is myopic — to simply increase access — then one can easily see how the use of this term has allowed for the practice of medicine to be carved up and parceled out to the highest bidder by legislators, state by state.

And why should this matter to all physicians — regardless of their position on MLPs? Because this is a fundamental shift in how our profession is practiced (and very different from the rigorous, near uniform standards we are still held to). Several other physicians and I recently completed a study on physician burnout in the context of non-physician providers (NPP), finding that close to 70% of physicians fear losing their job to an NPP. A mere 5% reported that the use of NPPs could increase their time to teach residents medical students or have more F2F time with patients. Only 30% thought they were economically advantageous.

And the elephant in the room hasn't gone anywhere — we still have 730K practicing, licensed physicians in the U.S. In the last decade, residency positions have increased by 3% annually in the NRMP, while medical school positions have increased at 22%. So when over a thousand U.S. medical school graduates don't match into a residency position year after year — isn't a no brainer as to why?

Apparently not. The frenzy that is occurring in response to the dire physician shortage is the rapid-fire scope expansion taking place in state senates across the country. This myopic strategy seems to be based on the fundamental notion that Americans don't want more physicians; they just need more "providers."

By my count, if we would've matched even 75% of those unmatched U.S. medical school grads over the last decade by Congress adopting the AAMCs GME Expansion Legislation and adjusting the number of residency positions to correlate with the demand and supply, we would have had a small army of physicians (10,000). And those would have been physicians, not "providers."

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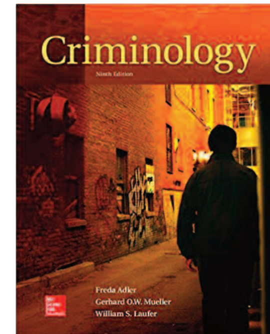

Book reviewed by Kavita Khajuria, MD

Criminology is an important social and behavioral science - criminal behavior affects everyone - either personally, professionally, or as a community.

Following a discussion of the basic concepts and historical schools, authors review techniques to measure characteristics of crime and criminal behavior. Prominent 20th century crime causation theories include biological, psychological, neurocriminological, sociological and integrated perspectives. Crime typologies are discussed - ranging from street crimes to the technology-dependent variety. The last section describes the ingredients and functioning of the criminal justice system, including operations, decision-making processes, and integration of the component parts. This last section is available to purchasers online.

The book is broad and extensive, yet easy to read and well illustrated. Referencing comprehensive research results, readers are informed of practical 'theory informs policy' programs in the United States. Despite a notable strength in the sociological sciences, biological and psychological perspectives are incorporated fairly well, considering the magnitude of the material. Readers are cautioned not to mistake correlation with causation, and authors pose ethical questions, including the utility of brain imaging results in crime prevention. The material evolves with an impressive review of the history, research, scholars, and programs and reflects the investment of national efforts. Intended for the undergraduate level, this book may also be of interest to those motivated to understand criminal behavior.

This revised edition is authored by experts in the social sciences: Dr. Adler is a Distinguished Professor of Criminal Justice and has served as a criminal justice advisor to the United Nations, federal, state, and foreign governments. Gerhard Mueller is the late Distinguished Professor of Criminal Justice at Rutgers University of Criminal Justice. William Laufer is the Julian Aresty Professor at the Wharton School of the University of Pennsylvania.

Council Highlights June 14, 2019

Matthew Goldenberg, D.O., *Secretary*

Outline of Notable Meeting Events and Discussion

1) The meeting was called to order by Dr. Cheung at 7:07PM.

2) Introductions: All council members in attendance introduced themselves, their current position, affiliations and work-setting.

3) Orientation: All members were given an orientation about board member and council responsibilities by Dr. Cheung.

4) Resident Liaisons: Mindi discussed the need to have resident liaisons from each residency training program. Council members were asked to help increase representation from all programs.

5) Fellowship Recommendations: Mindi put forward nominations from membership committee to the council. The following nominations were unanimously approved (Dr. Cheung abstained):
Erick H. Cheung, M.D.
Todd Hutton, M.D.
Zeb Little, M.D.
Karen Miotto, M.D.
Larissa Mooney, M.D.
Kristen Ochoa, M.D.
Alexander Young, M.D.

6) CPA Access to Care Committee: Dr. Cheung discussed CPA's request to have a representative/liaison to serve on this new CPA committee. A discussion took place regarding ideas and policies related to increased access to mental healthcare. Dr. Woods expressed interest in joining this committee.

7) CPA Committee/Healthcare Systems and Financing: Dr. Cheung discussed CPA's request to have a representative/liaison to serve on this new CPA committee. Dr. Schaepper discuss the purpose and mission of this committee. Dr. Camfield expressed interest in joining this committee.

8) Membership/APA Issues: Dr. Cheung summarized the series of events related to membership and communication with the APA. The Executive Committee recently composed and sent a letter to APA leadership outlining a series of mutual goals and expectations. APA rejected a plan the was discussed and proposed to approve district branch members. A discussion took place regarding the best steps forward. There is concern that our articles of incorporation may be in conflict with APA bylaws. A discussion will be had with SCPS counsel Dan Willick about legal issues pertaining to membership approval.

9) Newsletter: Dr. Goldenberg encouraged council members to sign up at least one time for the coming council term. Each committee will have an opportunity to share an update throughout the year, with the newsletter highlighting one committee per month. Mindi mentioned that the newsletter is a major source of income for the council and thanked Dr. Goldenberg for his work with the newsletter.

10) Minutes from the previous meeting were unanimously approved.

11) President-Elect Report: Dr. Fouras discussed the need for funding to continue PAC work. Dr. Fouras suggested that SCPS institute a mandatory annual contribution to CPPAC of $25 that members could opt out of.

12) Treasurer's Report: Ms. Thelen provided a financial update on behalf of Dr. Furuta who was unable to at-

tend. We are significantly under cash on hand compared to last year. The financial report was unanimously approved.

13) Legislative Report: Dr. Shaner discussed the legislative and bill submission/voting process and provided an overview of several bills related to the practice of psychiatry.

14) Assembly Report: Dr. Soldinger presented action papers that were recently approved at the APA annual meeting.

15) Membership Report: Ms. Thelen presented recommendations from the membership committee. The new members were unanimously approved.

16) Program Report: Dr. Gales discussed the first program committee meeting of the year will be Tuesday night.

17) New Business: Dr. Soldinger brought to council that future of PER still needs to be addressed. Ms. Thelen reminded council that it was decided that the Executive Council and the current members of PER would meet to discuss. Dr. Ford introduced herself as the new public affairs representative and discussed her goals and objectives for the Public Affairs Committee. Dr. Fouras discussed his attendance at the recent AMA meeting.

18) Old Business: There was no old business.

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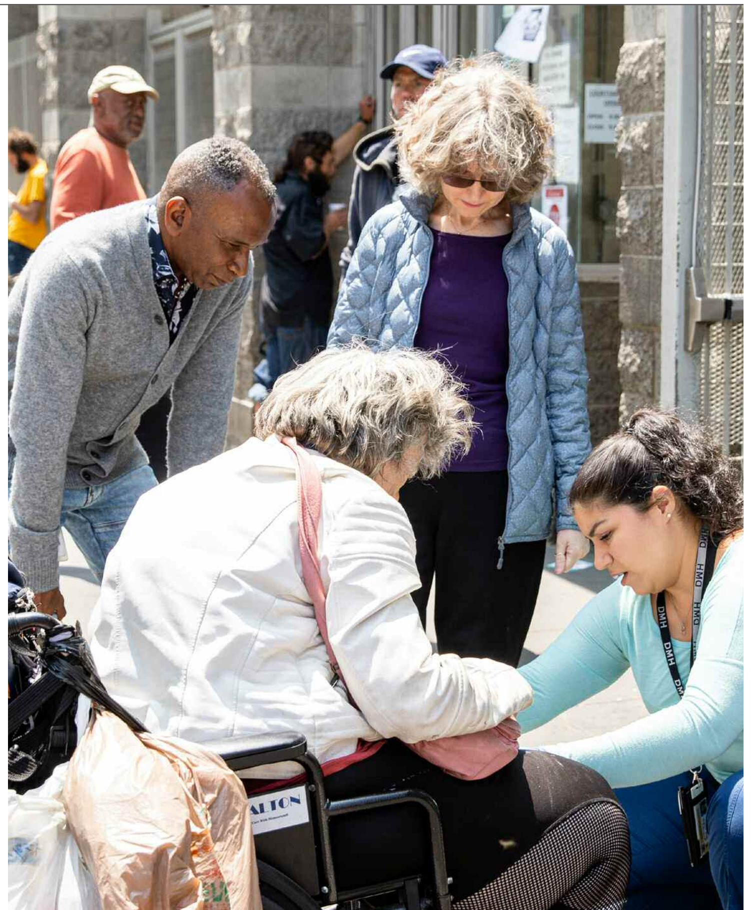
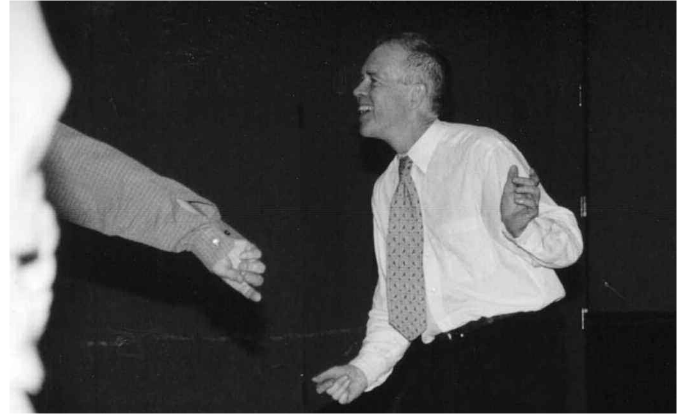


Flashback Photos

Marcia Goin, M.D., with residents

Ira Lesser, M.D, Installation and Awards

MIndi Thelen and George Fouras, M.D.



Michael Gales, M.D., dances at Spring Meeting

SCPS staff, circa 1991

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