Southern California

PSYCHIATRIST

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President's Column

Ringing in 2022.... Happy New Year!!!

Ijeoma Ijeaku, M.D.

A new year is a time for reckoning. A time to take stock of what is and what is not. A time for a rebirth. A time to take a fresh look at what has been and what could be. A time to align or re-align with new (and sometimes old) pathways depending on outcomes from the previous path. A time to celebrate the opportunity for new possibilities. In that vein, I bid this new year welcome!

I say welcome to 2022 because I hope that this is the year that we can finally take control of the COVID-19 virus which has brought so much pain and calamity to the human race in its 2-year existence. I am hopeful that we have collected enough scientifically driven data to help us understand the nature of the virus, its capacity to mutate, its susceptibility to the available vaccines and its ability to wedge such a devastating war against humanity. I am hopeful that this data can be put to good use and that it is indeed a gift that allows us to understand what we need to do and how we need to do it so that we can finally defeat this virus and reclaim our lives.

On March 11, 2020, the WHO declared the COVID-19 a pandemic. The order to stay home gave rise to various levels of anxieties about the nature of the novel virus including its transmission pattern, associated symptoms, and fatality rates. During this pandemic era and its aftermath, unpredictability is our new reality. We have a constantly changing new normal. As the infection rages, our sense of well-being is constantly challenged. Even as we cautiously re-engage in society, the fear of a resurgence (of a mutated variant) as well as the drain (physical, mental, emotional, financial, etc) that we have suffered so far are ongoing issues we have to deal with. As providers within the field of mental health, we have encouraged ourselves and our patients to become more emotionally intelligent and to practice healthy coping skills in a bid to deal with the uncertainty of the times. However, I am wary of sustained and chronic stress on the individual's overall health status from issues related to the pandemic. Hence, I hope that we have gathered enough data to make real and lasting change that eliminates the level of uncertainty that we currently live with.

In the field of organized psychiatry, at the national, state, and local levels, this is a time to take stock of what has been, review how well things have worked (or not) and seek new avenues for doing things. From considering continuation of one's membership within the APA and the district branches, to deciding who to vote for to serve in the upcoming elections, to participation in various committees, to discussions around policies at various levels, I hope that this is the year that we take stock of the beauty of organized psychiatry and its role in a constantly changing world. As the intersection between politics and policies that affect our patients and our profession continue to clash in very challenging ways, we are saddled with deciding what policies are worth pursuing and what policies we are willing to sell our souls for. We also have other policies which have federal mandates but nothing more otherwise and so stakeholders must engage in lengthy meetings to help develop these. In this new year with the promise of opportunities for our vulnerable population of mentally ill and their families, I hope we pause to think about the implications of our actions and inactions.

As SCPS approaches its 60th year as a district branch of the APA, we need to take stock of who we are, what we represent and how we brand ourselves. This year SCPS will hopefully continue to embrace solid pathways that have worked so far and seek new pathways if necessary. From our brand-new social justice movement primarily through our Diversity and Culture Committee as well as LGBTQ Committee, to ongoing programs and continuing medical education events, to our Disaster Relief Committee working on various programs and teaming up with other agencies and coalitions at the state level, to our collaboration with NAMI and other organizations, we are definitely not backing down. From our engaging newsletters to a vibrant docuseries project, we are finding ways to communicate what is important to the Psychiatrist of the 21st century and their vulnerable patients especially those in marginalized communities. From our interest in engaging in local politics and defining how we get involved to our interest in crafting and defining policies like we are doing in the Alternative Crisis Response Committee, SCPS is rebranding itself as a stakeholder and necessary ally. Our Alternative Crisis Response Committee has worked hard in the last several months to engage marginalized communities, stakeholders, and various agencies to collaborate on the way forward for safe crisis response protocols. As our Government Affairs Committee continues to do important work of determination of policies that serve our patients and our profession, we continue to seek the best advocacy vehicle for 2022. Of utmost importance to SCPS also is finding ways to collaborate with other district branches in CA to coordinate our advocacy efforts at the state level.

Indeed, I welcome 2022 and I welcome us all to 2022! Here is hoping for SCPS' best year yet!!!

NB: Please consider joining any of the SCPS committees (check out current committees through our website socalpsych.org) by reaching out to our most devoted executive director Mindi Thelen @ socalpsychiatric@gmail.com to contribute your ideas so that SCPS continues to grow and serve all of us.

In This Issue...

Kristen Ochoa, MD, MPH is Medical Director for the L.A. County Office of Diversion and Associate Clinical Professor at the UCLA David Geffen School of Medicine. She received her MD from the USC Keck School of Medicine, completed her residency at Harbor-UCLA where she served as a chief resident, completed her forensic psychiatry fellowship at USC and her MPH at UCLA. She serves on the L.A. Superior Court Criminal Panel, and is a forensic psychiatrist at L.A.'s Mental Health Court in Hollywood.

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Alternative Crisis Response (ACR) Edition

By Newsletter Editor
Matthew Goldenberg, D.O.

Happy New Year!

I hope you and yours had a healthy, safe and happy holidays and new year. However you celebrated the winter solstice, I hope it was with those you care about and that you are refreshed and ready for 2022.

As we enter 2022, the SCPS Newsletter intends to continue the monthly themes. We encourage you to consider submitting an article for the coming months. February's theme will be *Diversity and Psychiatry* and March will be *Woman's Issues and Psychiatry*. If you are interested in contributing an article, please contact myself or Mindi Thelen.

This month, our theme is Alternative Crisis Response (ACR) and I want to thank Dr. Emily Wood, our guest editor. Dr. Wood is chairing an ad-hoc committee on this important topic and is leading SCPS's engagement and advocacy in this important and evolving area.

As you will read in the articles that follow, Dr. Wood notes that, "Alternative Crisis Response (ACR) is a movement toward developing adequate inclusive,
timely, trauma-informed behavioral and mental crisis response for all communities that relies as little as possible on law enforcement."

This is one area where the SCPS ACR ad-hoc committee and the (GAC) are actively engaged in advocacy on your behalf. Meeting monthly, and under the leadership of co-chairs Roderick Shaner, M.D. – State Legislative Rep (2021-2022) Steve Soldinger, M.D. – Federal Legislative Rep (2021-2022), the SCPS GAC actively engages and is influential local, statewide and national advocacy.

The SCPS GAC develops policy and advocacy recommendations for the SCPS Council to consider and potentially adopt. The SCPS GAC considers positions in many areas, including those related to government initiatives, legislative bills, and regulations. The SCPS's GAC also closely tracks and monitors government actions, manages SCPS's partnerships with key stakeholders and ensures that SCPS is engaged in critical forums for public policy discussions. If you are interested in learning more or getting engaged, please reach out to Mindi Thelen.

Advocacy and community engagement is an essential part of the work that is done by SCPS. There are many SCPS committees that are engaged on these topics and this month we are highlighting the work of the ACR committee.

I want to thank Dr. Wood for her leadership in this important area of our field, our communities, and our colleagues and once again for helping me to craft the newsletter this month.

In addition to articles on this important topic, you can read my interview with SCPS President, Dr. Zeb Little, in the pages that follow.

Continue to stay safe,

Matthew Goldenberg D.O.
SCPS Newsletter Editor

Treasurer (2020 – 2022)

Get to Know Your SCPS Board

By Newsletter Editor
Matthew Goldenberg, D.O.

This month I want to share part of an ongoing series of interviews with members of the SCPS Executive Council Leadership. My hope is that this will facilitate SCPS members to better get to know their SCPS leadership.

May a better understanding of the history of SCPS and how our leadership got involved, serve to inspire a new generation of future leaders to join and become active on the council.

For the January 2022 edition of our newsletter, I have the pleasure of presenting my brief interview with President-Elect, Zeb LIttle M.D. I hope you enjoy getting to know a little more about your SCPS Council. Thank you to Dr. Little for taking the time to chat with me!

President-Elect, Zeb Little, M.D.

1) What initially sparked your interest in medicine and specifically the field of Psychiatry?
During college I pursued an independent study major with courses loosely connected by the theme of understanding consciousness through the lens of various disciplines such as neurophysiology, cognitive neuroscience, and philosophy. These experiences led to an interest in clinical medicine and basic science research. During my MD/PhD program it was really a toss up between Neurosurgery and Psychiatry, that is until I realized I had two left feet for hands.

2) How has the field changed or been different than you initially imagined?
There are a lot fewer bowties.

3) Tell us about the area of psychiatry in which you practice and your practice setting?
I am trained in Adult, as well as, Child and Adolescent Psychiatry. I provide medication and psychotherapy services as a solo practitioner in West Los Angeles.

4) What motivated you to become more active with SCPS originally? How did you get introduced to the council and involved? Are you involved in other professional organizations?
The SCPS Nominating Committee, and David Fogelson MD specifically, asked me to participate because there was an empty WLA Councillor position. It was a slippery slope, made more so by the good people and causes

of SCPS, to become more involved.

In addition to SCPS, I am a member of UCLA's Department of Psychiatry Voluntary Clinical Faculty where I supervise 2-3 Residents and Child Fellows each year. I also sit on the Voluntary Clinical Faculty Appointments and Advancement Committee. I'm an Executive Director of the Psychiatric Clinical Faculty Association, their current Secretary, and Distinguished Psychiatrist Seminar Series Chair.

5) Where do you see the field of Psychiatry go in the next 10 years? What changes would you like to see for our field and our patients?
I think we will see increased use of technology in all areas of mental health. Technology will continue to help people connect with information and each other, empower self-help, provide new diagnostic techniques and treatments, and aid the development of personalized medications.

My fear is that as the field of Psychiatry increasingly relies on technology to diagnose and treat illness we will further erode the listening, formulation, and interpersonal skills that are so important to our profession's capacity to heal. I would like to see mental health care recognized as a universal human need and understood as a fundamental aspect of all health care.

6) If you could go back in time, with what you know now, what advice would you give yourself related to your medical education, training and becoming a Psychiatrist?
Buy Apple!

7) If someone is reading this and thinking about getting involved with SCPS, what advice or encouragement would you give them? What do you enjoy most about serving on the SCPS Council?
You won't find a more welcoming, supportive and inclusive group of people. I enjoy learning about the many different facets of Organized and Community Psychiatry and their role in advancing mental health in our society. Participating in the organization's efforts to address the needs of its members and our profession has been a great growth experience.

8) As incoming President, do you have any big goals or objectives for next year? How do you hope SCPS will be improved or stronger at the end of you presidency year?
SCPS must continue to work with other stakeholders to promote diversity and inclusion initiatives, resolve disunity between California's APA District Branches, and create tangible value for its membership. My goal as President is to support and empower our members in these endeavors.

9) Surprise us. What is something we didn't know about Dr. Zeb Little?
I walk to work.

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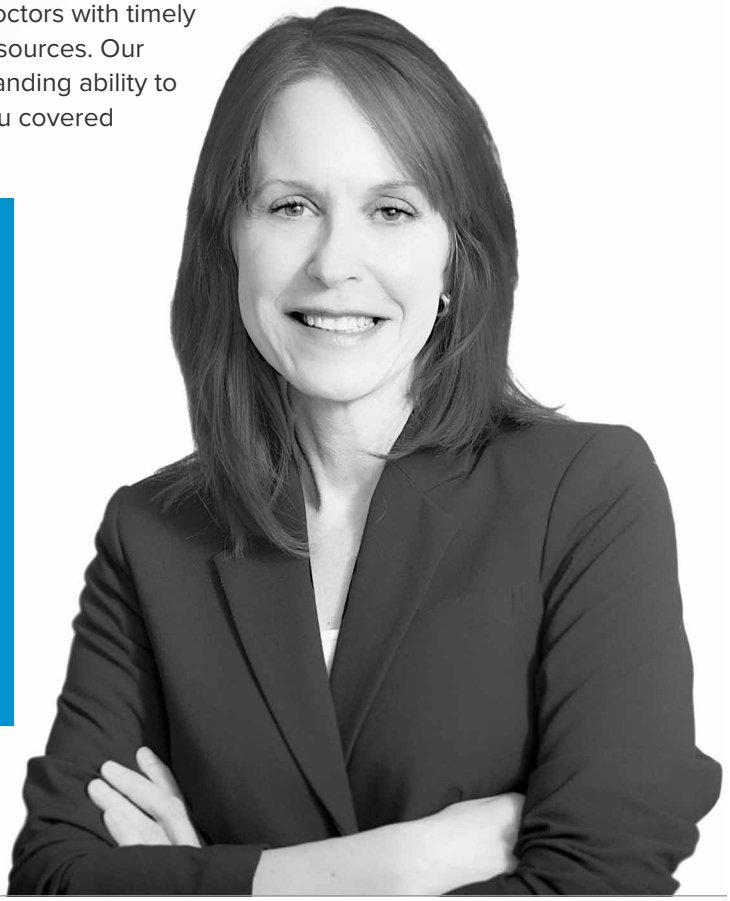

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The Movement for Alternative Mental Health Crisis Response

By: Emily T. Wood, MD, PhD

What is Alternative Crisis Response?

A mental health or behavioral crisis is a period during which a person or family experiences emotional distress that could lead to reactive, dangerous behaviors. While the presence of *danger to self or others* is often the technically qualifying crisis attribute, DTS/DTO usually occurs at the climax of a crisis episode that may have involved catastrophic life events, intense distress, and severe dysfunction. These occurrences are in and of themselves traumatic and life altering. Children and adults with serious mental illness (SMI) or emotional disorders often find themselves in a state of recurrent, significant crises. All individuals can find themselves in a mental health crisis upon experiencing a series of unfortunate but all too common events (e.g. poverty, homelessness, contact with law enforcement, discrimination) without adequate supports.

Not all crises are preventable, nor is a mental health crisis the inevitable consequence of mental illness. As psychiatrists, we are acutely aware that individuals with SMI can thrive with access to essential services including stable housing, community support, medical care, mental health care, and substance abuse care. Therefore, we know that the best way to improve outcomes and prevent further crises is to develop social services systemically. The Substance Abuse and Mental Health Services Administration (SAMHSA) pointed out in their 2009 Practice Guidelines: "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. *Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements*."[1] Therefore, a necessary but not sufficient part of this social services network is a comprehensive mental health and behavioral crisis response system.

Alternative Crisis Response (ACR) is a movement toward developing adequate inclusive, timely, trauma-informed behavioral and mental crisis response for all communities that relies as little as possible on law enforcement. SCPS recognizes that psychiatrists should be at the forefront of planning and implementation of mental and behavioral health crisis response. For this reason, SCPS President Ijeaku appointed an ad hoc committee on Alternative Crisis Response that first met in Fall 2021. The goal of the committee has been to understand the landscape of ACR generally and in our catchment area so that we may provide clinical guidance to the community and advocate for legislation that includes psychiatrists' input in the design and operation of behavioral and mental health crisis response programs.

Stigmatization and Bias in the Current System

Our patients, especially our patients who are Black, Indigenous and People of Color (BIPOC), are disproportionately negatively impacted by the dearth of adequate mental health resources at all levels of care in our society. The 1950s and 60s Civil Rights movement sparked the deinstitutionalized of state mental hospitals that was followed in the 1970s by the war on drugs, the militarization of local police forces in the 1980s, and the mass incarceration of Americans that made the US have the highest per capita incarceration rate in the world since the 2000s.[2] Individuals with mental illness identifying as BIPOC are more likely to interact with law enforcement and the carceral system. National studies estimate that 10-20% of law enforcement encounters involve an individual with SMI and at least 1 in 5 jail/prison inmates suffers from SMI. Within American prisons and jails, the BIPOC population is vastly disproportionate to the general population such that Black men were 10 times as likely as white men to be incarcerated in 2010.[3] BIPOC and individuals with SMI are being outright harmed or killed by the lack of appropriate crisis response services. *At least 25% and as much as 50% of fatal police shootings involve a victim with serious mental illness.*[4] In 2016, Black and Native American individuals were more than two and three times (respectively) as likely to be killed by law enforcement as White individuals.[5] Furthermore, non-lethal encounters with the police in Black communities has been associated with worsening mental health including depression, PTSD, anxiety, suicidal ideation and attempts, suggesting that negative police interactions may be a cause of psychological distress in this population.[6]

Over the last decade, the mental health needs of children have been on the rise without a corresponding in-

crease in community and school mental health services, leading to emergency departments and law enforcement acting as the first line of response to youth experiencing behavioral health crises.[7] Between March to October 2020 the rate of ED visits for mental health emergencies increased by 24% for children ages 5-11 years old and 31% for youth 12-17 years old and the numbers have continued to rise. The gap between BIPOC children and their White peers has continued to widen as evidenced by the suicidal death rate growing the fastest among Black youth and the disproportionate impact of COVID-19 on families of color. For children and adolescents in distress, it is especially important to have trauma-informed mental health and behavioral crisis response services that can treat individuals in the community with family support. For BIPOC youth as compared to White youth, law enforcement responses are more likely to lead to juvenile carceral involvement and trauma for families rather than connection with appropriate mental health services. Youth are at especially high risk for experiencing race-based traumatic stress from discriminatory racial encounters in the setting of personal and family mental health crises.[8]

A role for law enforcement?

According to a recent poll by the National Alliance on Mental Illness, 62% of respondents said they would be afraid that the police might hurt a loved one while responding to a mental health crisis, and almost half (46%) would not feel safe calling 911 if a loved one had a mental health crisis.[9] Individuals with a mental health condition and BIPOC are more likely to agree that they would not feel safe or may feel afraid calling current emergency services (911 or the police) if a loved one needed help during a mental health crisis. Moreover, Americans believe that people experiencing a mental health crisis should NOT be taken to jail or into police custody for help. Police are also interested in decreasing their role in mental health crisis response. Many law enforcement officers recognize the limits of their training and the immense time sink of mental health crisis response activities.[10] In 2017 an average of 10% of law enforcement agencies' total budgets and 20% of total law enforcement staff *time* was spent responding to and transporting persons with mental illness.[11]

Over the past 40 years, law enforcement agencies nationwide have started to develop programs to address their increasing interaction with individuals with mental illness as well as the lethal outcomes in mental health-related police encounters. A popular intervention is Crisis Intervention Training (CIT) which is typically taught by mental health professionals and may include information about mental illness, stories from family members of individuals with serious mental illness who have been in crisis, and training in non-violent de-escalation techniques. 2,700 CIT programs exist across the country ranging from a few to 40 hours in duration. Currently, there are minimal supporting data that demonstrate CIT's effectiveness in decreasing lethal outcomes or use of force.[12] There are some data demonstrating that CIT is associated with more referrals to mental health services and improvements in "officer-level cognitive and attitudinal outcomes."[13] The LAPD and LASD have been at the forefront of CIT and embedding mental health clinicians in law enforcement units (detailed below). And, as you may know from the regular news reports, Angelenos with mental illness continue to die in law enforcement encounters and, on any given day, 30% of individuals incarcerated in the LA county jail system are in mental health housing units or prescribed psychotropic medications.[14] For these reasons, the ACR movement is committed to minimizing the use of law enforcement in crisis response to prevent lethal uses of force and to avoid traumatic engagements with the criminal legal system.

Mental Health Crisis Response Design and Implementation

When designing an appropriate crisis response program, we must utilize the same core principles and essential elements that we value in treating patients at all levels of mental health care. Some of these elements can be more specifically defined for the crisis and urgent care setting.[1] For instance, timely access to supports and adequate time spent are key features across all settings. In the crisis setting, this calls for 24-hour/7-days-a-week availability that can accommodate individuals who require patience. Services should be provided in the least restrictive manner. This means that interventions should avoid coercion and preserve an individual's community connections and supports as much as possible. This often means meeting crisis patients where they are in the community. Treatment plans should be strength-based and cohesive such that emergency interventions consider the overall mental and medical health treatment plans for each individual. Rights must be respected. Individuals in crisis are in a vulnerable state and responders must be extra-protective of individual's rights of legal counsel, informed decision making, confidentiality, etc. In fact, as the state of crisis for many is largely defined by loss of control and autonomy, good crisis response prioritizes helping individuals regain a sense of control and empowerment. Trauma-informed care becomes even more important in the setting of crisis where current events may be trig-

gering memories of past traumatic experiences that are shaping the reactions to present situations. Mental health services must be congruent with the cultural needs of the individual in crisis including gender, race, ethnicity, age, sexual orientation, health literacy and communication needs. Many community, family, and patient-led organizations have advocated for and demonstrated that peer-support is an invaluable aspect of mental health crisis response that improves rapport building and hopefulness.[15]

Current efforts to design and implement comprehensive, contemporary, and efficacious crisis care have focused on 3 core areas and minimal operating standards were put forth by the SAMHSA for each of these areas:[16]

1) **Regional crisis call centers**
   Are expected to operate 24/7/365 by clinically trained team members who will be able to triage and connect individuals with the appropriate services through warm hand-offs utilizing an "air traffic control" approach such that contact is kept with individuals in crisis until they are safely in the hands of another provider. These call centers should have modern technology that interfaces with other emergency services in a bidirectional format as well as with crisis bed registries and outpatient scheduling databases.
2) **Crisis mobile team response**
   Should include properly licensed/credentialed clinicians who can respond to locations across the community in a timely manner and transport or coordinate transport with warm hand-offs to nearby stabilization facilities when individuals cannot be adequately stabilized in the community. These services should include peer support and should be focused on providing therapeutic support from first contact, de-escalation, and resolving situations to avoid higher levels of care when possible.
3) **Crisis receiving and stabilization facilities**
   Must offer "no-wrong-door" access to acute (<24 hours) mental health and substance use care that is staffed with a multidisciplinary team able to assess and manage care for the full range of crises and provide appropriate dispositions to higher and lower levels of care as needed with warm hand-offs.

The Role for Psychiatrists

In November 2021, SCPS passed a resolution confirming our commitment to advocating for effective and comprehensive mental health crisis response programs in our area. SCPS believes that the design, implementation, and operation of safe and effective mental health crisis response models requires input from highly skilled clinicians with an understanding of the medical, substance-related, legal, developmental, and equity dimensions of psychiatric illnesses, violence assessment, and crisis response. We know that psychiatrists are uniquely trained to assess the diagnostic, medical, legal, and substance abuse issues that are often present in mental health crises and are also equipped to effectively access medical resources and initiate care. Our first and most fundamental training is in triage and urgent/emergent care. For these reasons, psychiatrists should be clinical leaders of multidisciplinary crisis response teams and should be involved in the design and implementation of local mental health crisis response systems. A critical role for psychiatrists in Southern California will be in helping to weave together approaches that the medical and mental health establishment deems empirically driven and effective with the strength-based, trauma-informed principles that respect our patient's dignity and the diverse cultures that make up our communities.

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Reframing the Narrative: A Developmental Approach to Crisis Response

By: Elizabeth Dohrmann, M.D.

We are at another crossroads. With the surgeon general's acknowledgment of a persistent youth mental health crisis worsened by the fallout from COVID-19, and the imminent rollout of a national 988 hotline with associated state ACR initiatives, crisis response for youth is in the spotlight.[1] Although we often compartmentalize adult and youth crisis responses, recognition of the developmental linkage across the lifespan is essential to building a system that can change life trajectories. To improve mental health care and reduce its inequities from childhood, we need to not only triage in schools and pediatric offices, expand mobile crisis outreach teams and build accessible outpatient, emergency, and inpatient networks – we need to ensure that our interventions move all children equitably towards care and away from punitive and pathologizing systems that compound suffering at critical stages of development.

Take Sharon, a 14-year-old Black student with a history of sexual assault as an example. Following a conflict with a school resource officer who restrained her during an argument with her peers, Sharon's irritability crescendoed, leaving her mother, who struggled with her own history of abuse, despondent and overwhelmed. Sharon was suspended and transferred to a new school administrative team. She stopped attending school and began spending more time out of the home, with increased exposure to substance use, sexual victimization, with worsened impulsivity and irritability. Her new school team struggled to link her to outpatient mental health services.

This pathway is familiar – many children in our society face adverse childhood experiences (ACEs) stemming from structural forces which lead to downstream mental and physical health problems that follow them into adulthood.[2] Schools are ground zero for providing not only educational and social safety net needs, but mental health access. An estimated 50% of mental health problems become apparent by age 14, and 60% of affected youth leave high school before graduation, nearly half of them without receiving treatment.[3,4] Of those funneled to juvenile detainment through criminalization pathways – often from school – over 70% have an identified mental health disorder.[5] Suicide rates among youth ages 10-24 years increased 57% between 2007 and 2018 – with Black children almost twice as likely to die by self-harm.[6,7] How do we shore up the cracks in these systems to better reach these youth?

Essential strategies include mental health integration and crisis training within pediatric practices and schools. An increased workforce of mid-level mental health providers embedded in pediatric practices can efficiently facilitate early linkage of youth to outpatient services.[8] Comprehensive school mental health systems also leverage a range of mental health providers to monitor and link youth to necessary supports. As we see with Sharon, however, the results from school responses to crises vary substantially. In some cases, the effective use of mental health professionals leads to outpatient linkage and appropriate cross-collaboration. In other cases, mobile crisis teams may involuntarily detain youth in order to provide immediate mental health linkage that cannot otherwise be accessed as an outpatient. This may lead to a range of outcomes, including a) an appropriate hospitalization, b) quick release from an urgent care facility because no inpatient beds are available, c) resolution of the crisis, or d) unnecessary hospitalization that may distress the child/family and adversely impact later service utilization.

In yet other cases, particularly in situations involving minoritized youth with mental health behaviors categorized as being "disruptive," limited mental health triage occurs and children are excluded from the school setting by suspension or expulsion and/or referred to law enforcement. These responses fail to identify underlying causes of the behaviors and can lead to escalations of conflict and resulting juvenile detentions.[9] At the very least, as in the case of Sharon, such actions can delay access to care and isolate the youth from the resources and supports of the school environment. Ultimately, the path taken by schools in response to youth mental health needs remains highly stratified based on race, community setting, and funding.

Standardization of these school crisis response pathways will require money, planning, training, and commitment. In 2021, the American Rescue Plan Act (ARPA) provided $122.8 billion in grants to schools nationwide through the Elementary and Secondary School Emergency Relief Act (ESSER), with all 50 states submitting proposals. Many included plans for bolstering school mental health services through partnerships with community-based mental health programs and health agencies, increasing the school mental health workforce, and training school personnel in trauma-informed practices.[10] State and local funding opportunities can also fuel meaningful change. Largely in response to community activists, for example, the board of the Los Angeles Unified School District (LAUSD) voted in 2021 to reallocate funding from the Los Angeles School Police Department to the Black Student Achievement Plan (BSAP), which was developed in 2019 and expanded to support the hiring of school climate coaches, nurses and counselors in schools serving predominantly Black students.[11] This effort highlights an essential fact of correcting the course of our crisis response efforts: we must not only build the teams and networks and facilities that provide equitable care across the lifespan. We must examine childhood environments and specifically fund initiatives that will direct that care to those who have been most marginalized.

A few months after the suspension, with a higher level of outpatient care and a reduced use of school exclusionary discipline, Sharon began reengaging with school. She found out that she loves math and is starting to imagine her life with a high school degree. She is talking about her trauma. Our systems failed her for many years, but her resilience persists. Ours can too – in the face of seemingly insurmountable systems and dispiriting legacies, we can still provide care, make policy, and fund initiatives that will take us a few steps closer to equitable care in crises and beyond.

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The Current Landscape of Mental Health Crisis Response Across SCPS

By: Emily T. Wood, MD, PhD

The movement for alternative crisis response is not new and is occurring at all levels of our government and communities. In fact, organized psychiatry may be a late comer to the discussion. Here is a look at federal, state, and local progress influencing the SCPS catchment area.

National Progress

In July 2020, the FCC established a plan to designate 988 as the 3-digit number to take the place of the National Suicide Prevention Lifeline (NSPL) and "to aid rapid access to mental health support services."[1] By July 2022, phone companies across the country must be routing 988 calls to the appropriate mental health resources for the caller's area. It is up to state and local governments to establish the coordination and distribution of mental health resources. 988 presents a unique opportunity for the behavioral health system, law enforcement, 911 systems, and other stakeholders to strengthen crisis response capacity throughout the U.S. and to provide people experiencing a mental health crisis with appropriate support.

In 2021, the American Rescue Plan Act (ARPA) provided a provision for increased availability of Medicaid matching funds to support mobile crisis intervention services across the country, especially for child and adolescent services. The provision requires that the behavioral health crisis teams be available 24/7/365 and meet certain training requirements including trauma-informed care approaches and maintaining partnerships with community-based providers.[2]

At the federal level, bills have been introduced that would increase funding for mental health crisis response alternatives to current law enforcement methods. House Representative Napolitano, from California's 32nd congressional district, introduced HR 2611, the "Increasing Behavioral Health Treatment Act" in 2021. This bill would repeal the "IMD exclusion" that currently prohibits federal Medicaid matching funds to states for services rendered in institutions for mental diseases (IMDs) for individuals <65 years old. The legislation would also require state Medicaid programs that cover IMD services to improve patient access to expand crisis stabilization services and facilitate care coordination between providers and first responders along with other expansions of outpatient and community-based behavioral health care and cost reporting.[3] House Representative Porter from California's 45th congressional district put forward HR 1368, the "Mental Health Justice Act of 2021" that would create grant programs for state and local governments to train and dispatch more mental health professionals for crisis response, instead of law enforcement.[4]

In February 2021, NSPL 988 State Planning Grants were awarded to agencies across the country to support the developmental of clear roadmaps for "coordination, capacity, funding and communication strategies that are foundational to the launching of 988." Through this, a $20 million grant was award to Didi Hirsch Mental Health Services. Didi Hirsch is a Los Angeles-based organization that has been providing mental health, substance use, and suicide prevention services to families in Los Angeles since 1942.

State Progress

With the federally mandated 988 dialing number taking effect in July 2022, California has started to investigate ways to meet the need for mental health crisis response. Toward this aim, AB 988 or "The Miles Hall Lifeline Act" was introduced by assembly member Bauer-Kahan during the 2021 legislative term. Miles Hall, a young man with serious mental illness, was shot and killed by the Walnut Creek Police in 2019 after his family sought help through 911 when Miles was in crisis. As it currently stands (this bill has gone through multiple iterations and has a many co-authors from both houses), AB 988 would establish a 5-year-long phased-in approach for implementing comprehensive mental health crisis continuums of care including: access to a 24/7 crisis counseling line though call, text and chat; mobile crisis teams staffed by trained mental health professionals and peers that can be deployed instead of law enforcement as possible; and, access to crisis receiving and stabilization services. AB 988 would also establish a user fee of up $0.80 per phone line per month, similar to the model currently used by California's

911 fee. While this bill died during the 2021 legislative session (largely due to opposition from the telecommunications industry and distractions related to the governor recall election), it is expected to be brought up again in 2022 and is sponsored by organizations including NAMI California, the Steinberg Institute, The Kennedy Forum, and the County of Los Angeles Board of Supervisors.

In September 2021, the California Department of Health Care services appropriated $20 million to build up call centers in the state. These funds were part of Governor Newsom's "California Comeback Plan" which is utilizing the 2020 budget surplus to tackle persistent challenges for the state including homelessness and wildfire resilience.

In December 2021, the California legislature held an informational hearing about the Lanterman-Petris-Short Act (LPS law), the 1967 statutes regulating involuntary civil commitments to mental health institutions. While a variety of perspectives were presented on whether LPS law appropriately protects citizen's rights, there was widespread agreement that appropriate community and crisis mental health services are severely lacking in California and that this contributes to issues surrounding public safety and protecting the rights of individuals with mental illness. For instance, current mental health practices in California rely by default on law enforcement response to mental health emergencies both due to inadequate unarmed, non-law enforcement crisis response services and our LPS law which gives law enforcement ("peace officers" as the law is written) special privileges in transporting and transferring custody of persons requiring mental health assessment. Briefly, while current LPS law defines emergency crisis response as a clinically based activity and allows counties to designate 5150 authority, it also specifically authorizes law enforcement to transport individuals to a wide range of facilities which is not allowed to other mental health emergency responders. In this way a catch-22 has been set up where law enforcement holds are a powerful carte blanche into the hospital system even though law enforcement presence at mental health crises is fraught.
LPS law as it currently stands may be a barrier to the State and counties moving forward with developing a comprehensive response system for behavioral and mental health crises. The Southern California Psychiatric Society requested that the committee members take a closer look at LPS peace officer authority and whether it needs to be amended appropriately.

Los Angeles County Progress

Law Enforcement Embedded Teams

LA County has a relatively long history of developing specialized mental health crisis response. In 1993, the city of Los Angeles Police Department (LAPD) was one of the first law enforcement organizations to develop police/mental health co-responder teams which are called Systemwide Mental Assessment Response Teams (SMART) in partnership with the Los Angeles County Department of Mental Health (LACDMH). Today, the LAPD Mental Evaluation Unit (MEU) led by Lt. Brian Bixler includes: 1) a Triage Desk which fields calls from patrol officers to provide guidance, consults MEU and LACDMH databases for care linkage, and dispatches the SMART units; 2) SMART with approximately 12 units dispatched per day, always including an armed officer; 3) the Case Assessment Management Program which pairs officers with LCSWs and MH-RNs from LACDMH to identify, track, and develop long-term intervention strategies to decrease repeat encounters (currently ~7 teams); and, 4) a 40-hour Mental Health Intervention Training program available to all LAPD officers (completed by ~10% of officers).[5,6]

In February 2021, the LAPD contracted with Didi Hirsch Mental Health Services to start a program to divert 911 calls for suicidal ideation to counselors who could work with distressed individuals and connect them with services. The pilot started at 8 hours per day and was ramped up to 24 hours per day in July 2021.[7] As Didi Hirsch has also received federal grant funding (see *National Progress* above) to develop 988 crisis line services, this partnership has been essential in LA County planning efforts.

The Los Angeles County Sheriff's Department has similar programs including: 1) Mental Evaluation Team Triage Desk; 2) Mental health co-responder teams called Mental Evaluation Teams (MET)(~23 units); 3) the Risk Assessment and Management Program (6 investigators & 5 clinicians); and 4) a 32-hour Crisis Intervention Training (CIT) program for all officers (completed by approximately 3000 total or 25% of current officers).[8] The LASD

CIT program is currently being re-formulated as the Respond, Observe, Assess, and React (ROAR) Response Model and emphasizes evidence-based principles including trauma-informed methods, positive psychology, non-violent communication, emotional intelligence, and mindful policing (e.g. the importance of officer mental wellness in optimal job performance).[9]

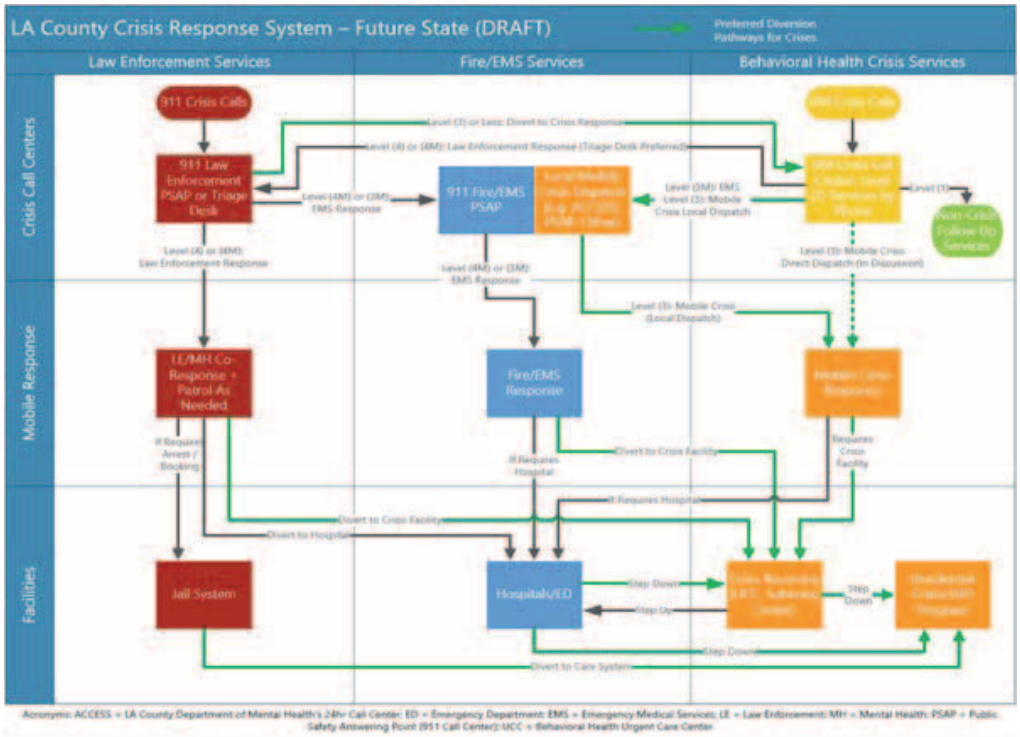
Department of Mental Health Psychiatric Mobile Response Teams (PMRT)

The LACDMH has been providing non-law enforcement-based mobile crisis response to Los Angeles community members experiencing crisis in the community. These services are dispatched through LACDMH's ACCESS Center which will also provides referrals to other supports as necessary and appropriate. There are about 30 PMRT teams for LA County spread over eight service areas eight service areas and operating from 8:00am to 2:00am daily. In FY2019-20, PMRTs responded to more than 20,000 calls with roughly 7,000 resulting in a patient being taken to a hospital. While the teams have been found to be highly effective in de-escalating mental health and behavioral crises, it is widely agreed that there are not enough teams for the area as they can take up to 24 hours to arrive if they can be sent at all.

Department of Mental Health and Alternatives to Incarceration

In 2019 the Los Angeles County Board of Supervisors commissioned the office of the CEO to create a public-private County Work Group on Alternatives to Incarceration (ATI), charged with developing a "road map, with an action-oriented framework and implementation plan, to scale alternatives to incarceration and diversion so care and services are provided first, and jail is a last resort." In March 2020, the ATI Work Group released their report called "Care First, Jails Last" which highlights five key strategies and developed 114 recommendations that were developed and approved through an intensive consensus-building process of >1,000 government and community stakeholders. A key strategy is to "Utilize behavioral health responses for individuals experiencing mental health and/or substance use disorders, homelessness, and other situations caused by unmet needs; avoid and minimize law enforcement responses."[10] The ATI Report cited findings from a 2020 RAND Corporation report that developed and utilized a set of structured legal and clinical criteria and estimated that around two-thirds of the LA County jail mental health population could be appropriately diverted from the jails to community programs.[11]

Based on the 2020 ATI report, the Board of Supervisors developed the LA County Alternative Crisis Response Initiative and in September 2020 tasked the LA County Department of Mental Health to move forward with "next steps." Dr. John Sierra who received his Ph.D. in Industrial and Systems Engineering with a focus on health systems has been working under the LACDMH Director, Jonathan Sherin and the LACDMH Deputy Director of the Intensive Care Division, Amanda Ruiz to lead the LACDMH Alternative Crisis Response project.[12] To date, the



project has made several key accomplishments:[13]

1. Developed a consensus, cohesive model/vision for ACR in LA County through substantive discussions and listening sessions with a broad mix of stakeholders, including law enforcement, fire department/EMS providers, crisis care providers, and other community members. This work has included diagramming current Crisis Response System pathways that helped illuminate current inefficiencies and missing system linkages as well as designing future pathways that include appropriate linkages and support a "Care First, Jails Last" approach (see figure). They have also proposed a Crisis Call Assessment Matrix and are working closely with the 78 primary 911 call centers (aka Public Safety Answering Points or PSAPs) in LA County and Didi Hirsch to develop efficient ways to triage and hand-off calls between the 911 and developing 988 networks.[14]
2. Established a portfolio of ~15 change projects needed to achieve this vision including capacity expansion (especially with respect to crisis center beds and the mobile crisis team workforce), quality improvement, legislative advocacy, technology and financing needs, and structural/organizational/cultural changes. Several new crisis receiving facilities (23-hour Urgent Care Centers or UCCs) and crisis residential treatment programs (CRTPs, multi-day care programs) opened this Fall or are in the pipeline for next year.
3. Contracted and onboarded RI International to consult with LA County on design and implementa tion planning; they have already solidified preliminary recommendations and are working on finance strat egy and the argument needed to drive and sustain change. RI International is a global organization with more than 50 programs located throughout the United States and abroad and is known as a worldwide leader of mental health and substance use crisis service design delivery as well peer delivered care.

Emergency Medical Services (EMS)

LA county has one of the largest and oldest EMS systems in the nation and is made up of >18,000 certified EMS personnel employed by fire departments, law enforcement, ambulance companies, hospitals and private organizations. The most recent data from Los Angeles County shows that 8% of adult EMS responses and 5% of pediatric EMS responses in 2019 were deemed Behavioral/Psychiatric Crises.[15] In 2016, the LA County EMS Commission put out a report on "The Prehospital Care of Mental Health and Substance Abuse Emergencies. They found that mental health crises called into PSAPs/911 centers are sent to law enforcement agencies over EMS at a ratio of 4:1. Per LPS law, law enforcement have several destination options for individuals experiencing mental health or substance abuse crises, including UCCs, free-standing psychiatric hospitals, and sobering centers. EMS destinations, however, are limited to Emergency Departments of which two-thirds in LA County are non-LPS designated and many lack access to a mental health treatment team. The EMS Commission also pointed out that, while there are little to no standardized treatment protocols for agitated individuals experiencing mental health crises, EMS agents have access to pharmacological agents which can help deescalate and reduce restraint use that are not available to law enforcement officers or most mental health clinicians in the field. The LA County EMS Agency is at work improving protocols and training for managing mental health crises. Similarly, the transportation of individuals to other receiving facilities is being explored, although it may require changes to LPS law (see above under *State Progress*).

In an effort to improve access to services, DMH has partnered with the LA City Fire Department to pilot a Therapeutic Transportation program. This program embeds mental health teams including experts and peer supports into fire stations to co-respond to or take the lead on incoming emergency calls related to mental health crisis. Currently this program only exists in 5 fire stations across the county and the expansion has been delayed.

<u>Other Counties in our Area</u>

As part of our mission to engage stakeholders from across our catchment area, the SCPS Alternative Crisis Response Committee (Thank you especially to Weei Lo!) has been reaching out to counties outside of Los Angeles to get information on their approach to mental health crisis response. With regard to the implementation of the 988 crisis line and AB-988, counties with smaller populations and resources than Los Angeles are waiting to get state mandates regarding deadlines and specific system requirements. They describe past experiences of attempting to predict State policy, starting programs, and then not having adequate funding to continue programming when State resources end or fall through.

An issue mentioned by County Mental Health Department leaders is the need for legislators to consider funding sources, including managed care organizations and private insurances, in any legislative mandates. While most private insurances and managed care organizations have developed systems for transferring care and funds for medical emergency services, this has not been the case for mental health. For example, when an HMO patient is taken by ambulance to the nearest hospital and medically stabilized, the HMO will transfer the patient as soon as possible to their facility and pay the EMS and hospital fees with minimal conflict as mandated by law. This is not always the case with mental health care.

The ***Ventura County Behavioral Health Administration*** currently has 1-2 mobile crisis teams of 2 clinicians each that provide 24/7 crisis intervention as possible to individuals in Ventura County. During COVID, the teams started using remote assessment and have been able to spread their teams' reach to provide more services. About 20% of the crisis calls are made by individuals engaged in county mental health services and 80% of the calls are made by individuals with private insurance.

Ventura County has been training law enforcement in crisis intervention since 2001. They utilize widespread officer crisis intervention training (CIT), liaison and collaboration work with the Behavioral Health Department, and interagency meetings to improve safety in mental health crises and divert individuals with mental illness out of the carceral system. They currently report that 88% of patrol officers and 67% of dispatchers throughout the county have undergone CIT.[16] For unhoused individuals struggling with serious mental illness in particular, they have a field-based outpatient mental health team that co-responds with police.

Ventura County is in the early phase of 988 crisis line implementation as they await State guidance. At this time, they predict that their current mobile crisis team will not have sufficient resources to respond to all of the calls. There has been discussion of utilizing EMS to respond to the 988 calls, but since EMS is under the Public Health division in Ventura County, this may not be feasible.

The ***San Bernardino County Department of Behavioral Health*** (SBC DBH)currently has Community Crisis Response Teams staffed between 3 county areas consisting of 42 responders (when fully staffed). These teams are available form 8am-10pm daily and are dispatched by the DBH ACCESS center. The SBC DBH teams are paid for by a 50/50 split between State and Federal funding. Except, federal funding is not provided for most adult services. They also partner closely with schools through contracted agencies to provide crisis support on campus.

The San Bernardino County DBH pays for and runs the mandatory law enforcement mental health crisis intervention trainings (ranging from 8-32 hours) for all law enforcement officers in the county. There are DBH embedded agents working with law enforcement and in emergency departments throughout the county (including Kaiser EDs).

While San Bernardino County is also waiting for clear mandates and funding support from the State of California regarding 988 implementation, they have applied for grant money for call centers from the State of California. In recent years, they have contracted to open several crisis stabilization units and crisis residential treatment programs in the county.

Conclusions

This overview is far from inclusive as it does not include any information from Santa Barbara and Riverside Counties. Nor does it account for the activities of individual municipalities throughout the counties, aside from Los Angeles. **The SCPS Alternative Crisis Response Committee welcomes any information about ACR activities throughout our area as well as Committee engagement and participation.**

The need for more comprehensive, high quality, and easily accessible mental health crisis response has been recognized at all levels of our government. Many locales have come to rely heavily on law enforcement as the will and funds for mental health care infrastructure have diminished and law enforcement budgets have grown. Communities will have to identify the best models to fit their needs for crisis response programs that are able to equitably serve the most individuals while minimizing further trauma and moving toward long-term social safety

net solutions that make crises less likely to occur. Going forward, psychiatrists can play an important role in advocating for sound, evidence-based crisis-response policies and implementation that considers the needs of local communities.

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Helping Youth at Risk for Mental Illness: Prevention of Prodromal States

By: Kavita Khajuria, MD

The Center for the Assessment and Prevention of Prodromal States (CAPPS) associated with UCLA Health Sciences, David Geffen School of Medicine, recently presented a webinar in December, 2021. A variety of speakers shared information, but the goal was the same: Prevention of full-blown illness in youth.

Dr. Bearden PhD, introduced the program, noting this 20-year-old free services program to have screened 1500 adolescents and helped over five hundred children and their families.

Tom Gordon, a graduate of the program, shared his experience: noting that despite the initial hesitation, he felt cared for and enjoyed resilience therapy. He appreciated the encouragement to allow his thoughts and feelings to flow and described feeling more confidant and future-oriented as a result. Reconnection with friends was the major turning point for him. He asked that the program continue to expand.

Jamie Zinberg, MA and Marc Weintraub MD discussed the goals of treatment at CAPPS to include increased knowledge and family communications, development of insight, stress reduction, enhanced coping skills and caregiver support, and reduction of family isolation. General themes of the program were noted to include Teen and Parent Skills Groups (including CBT and Mindfulness), psychoeducation, individual therapy, psychiatric consultations and other collaborations. Dr. Weintraub spoke in more detail about Group CBT for youth with symptoms of serious mental illness, including age criteria, emotional conditions and challenges, number of sessions and duration of treatment, and outcomes including decreased risk of high-risk psychosis and decreased depression rates, as well as increased global level of functioning.

Dr. Adery, Associate Clinical Director, discussed the CAPPS Resilience Group, a “multimodal evidence-based group therapy empowering members to thrive”. She stressed the importance of social networks and other elements, which results in lowered anxiety and depression and better coping skills. Other topics included psychiatric care, peer advocacy, bridging community disparities, and assessment of quality care.
Dr Gil Hoffman MD, PhD, explained his motivations for involvement, including friends and family with mental illness. He stressed the importance of providing support and rational interventions as early as possible and research including brain MRIs and genetics to help characterize risk trajectories. CAPPS Clinical Services Line with a focus on risk of psychosis was noted as important as well as the teaching and training of future community doctors and psychologists across various disciplines.

Dr. Misty Richards MD, MS, Medical Director of CAPPS, Division of Child and Adolescent Psychiatry, emphasized the importance of early intervention starting with family psychoeducation, noting “it takes a village”. Important elements included appropriate school interventions, stress management, CBT, DBT, trauma informed treatments and group therapy to bolster resilience and life skills. She stressed that Family focused therapy and medication management should “meet them where they are, not where you think they should be” and warned against treatment with antipsychotics in the absence of psychotic symptoms – to treat only after symptoms of psychosis reach a clinical threshold for a diagnosis.

Another student of the program (Cole) shared his thoughts and feedback, as well as his mother. Cole spoke about his initial fears of the program, thought distortions, and the benefit derived from mindfulness practice. His mother appreciated different group therapies as ‘together but separate’, noting the benefit and support derived from groups. She expressed appreciation of family therapy, wishing it were longer. She noted them to be ‘better communicators’ as a result of these experiences, with better understanding of each other, and was grateful to be at the webinar to give back by talking about their experiences. Coles parting advice about the program: “It’s worth it”.

To learn more about UCLA CAPPS, visit www.cappsucla.org or contact Lauren Bayans, Assistant Director, UCLA Health Sciences Department: ibayans@mednet.ucla.edu

Council Highlights
November 2, 2021

Haig Goenjian, M.D., *Secretary*

Outline of Notable Meeting Events and Discussion

Minutes from the previous April meeting were unanimously approved without addendum.

PRESIDENT'S REPORT Dr. Ijeaku

A. Report from Town Hall:

Discussion regarding recent Town Hall meeting. Topics at the Town Hall including a range from managed care to access to care. Committees all gave reports including GA, Disaster relief, Diversity and Culture committees.

B. Report from ACR-988 Committee - Presented by Dr. Wood

- Discussion circulated around the question of what iis the best role for us to play in alternative crisis response development. Supporting the efforts at the state level in terms of getting AB 988 Bill that will provide groundwork for a comprehensive crisis response, which needs to include response from psychiatrists. Also, discussion regarding

awareness of the importance of involving local communities.

Recommendation: Therefore, be it resolved that SCPS Council:

1. Advocate that legislation related to implementation of the 988 Mental Health Crisis response in California include a requirement to include in the design and operation of such systems input by psychiatric experts in:

- community mental health- substance-use addiction - forensics- children & adolescence- equity, diversity & inclusion- emergency treatment

2. Advocate that LPS law mandate means for non-law enforcement systems to transport and transfer custody to LPS designated facilities for purposes of evaluation to make more effective alternative crisis response systems

3. Advocate for local communities to be involved in the development and implementation of crisis response strategies in their areas

4. Advise PPAC to take a proactive role in the development of such legislation and related requirements.

5. Reach out to local mental health agencies (County Departments of Mental Health, etc.) and community organizations (NAMI, LA Care, etc.) in our area to engage stakeholders. Passed unanimously.

Other highlight comments from related to this discussion:

- LA County has recently launched a Therapeutic Transportation Program (PMRT with vans equipped to transport to facilities).- Each of the 5 areas in LA County will have two vans that are supposed to be operated by fire stations

C. Joint Meeting with SCSCAP Reminder - Upcoming meeting to discuss emergency responses

D. Report from Diversity and Culture Committee - Latest focus of the committee has been on book reviews that they would like to put in the newsletter. Currently they are pending review of the Monohan report. Dr. Shaner reports the work of this group coincides with interests of NAMI, which was discussed during the joint NAMI meeting. Our bylaws allow for “consultants” (non voting members) and NAMI members may attend.

E. Mini Documentary Series Project (Update) - 4 interviews have been completed; 3 are posted. Will do one/month till May 2022. Link is available on the Newsletter

F. Disaster Relief Committee Update : We are planning 3 events for general membership starting in January 2022. We plan to have a panel of psychiatrists who are doing disaster relief work and who will speak of their experiences. Per Dr. LoAllen, another event will be for medical students with the goal to introduce them to volunteer opportunities, event tentatively planned for February. Goal to have 4 speakers - 10 min each, plus 15 min discussion. The third event plans to be Psychological First Aid, an offshoot of Red Cross training.

G. Executive Director 2022 Contract - Overall praise for Mindi Thelen, and agreement to increase salary and bonus. Exact amount to be decided upon review of last year’s increases and to be finalized by Executive Committee.

H. Area 6 Trustee Forum Update - Discussion led by Dr. Shaner. SCPS has asked APA for permission from their elections committee to permit non scheduled activities regarding the Area 6 trustee campaign. This will allow us to listen to the 3 candidates and see how their candidacy relates to our DB. Area 6 is a particular “hot area” in that we do not have a state organization and our coordination of state advocacy is challenging. We received permission for 3 activities.

SPCS plans to send a series of questions to the candidates: Shannon Suo, Barbara Wiseman, Mary Ann Schaepper. SCPS plans to report verbatim their responses in the December issue of the Newsletter.

Invited candidates are to spend an hour with council for QA - e.g what their plans are to unify Area 6 for the purposes of effective Area 6 advocacy and how they see Area 6 coming together.

I. Parity/Access to Care Committee - Dr. Friedman.

The goal is to be multidimensional e.g. to look at racial disparity, economic disparity, parity of psychiatric services as compared to other medical services, and geographical access to care.

J. Managed Care Committee/Mentorship -

- This committee was born out of the town hall committee. Newer career psychs were talking about the challenges they have with managed care. This is newly formed and chaired by Dr. Burchuk We explored who could help out with this.

IV. PRESIDENT-ELECT'S REPORT Dr. Little

K. Nominating Committee To meet November 10th

V. GOVERNMENT AFFAIRS COMMITTEE Dr. Shaner

L. GAC Report -

Most recently met 11/2/21:

Legislative: Some key issues discussed with Randal Hagar from PPAC at last meeting. SB 379- Sen Weiners bill suspended, which curtails UC systems care based on non- medical criteria. The UC regents took steps to develop regulation of renewal of contracts. There are 33 separate contracts for the 33 hospitals. SCPS would then reconsider taking a support position..

- Update on AB 988 - Alternative crisis response discussed - see attached reports

. Advocacy Contract Sub Committee Report - Primary focus circulated around development for a metric of analysis of our contracted state advocacy.

- EC met on 10/20 - gave charge to GAC to look at other options as well as exploring possible improvements if staying with PPAC. GAC assessed an advocacy assessment criteria, so that we can use a standardized way of assessing our options.

- CSAP appears eager to engage in discussions

- GAC reviewed PPACs contractual obligation to review their funding sources. It was determined no disclosure was received for the 2nd Quarter, though we did receive this for the 1st and 3rd Quarters. For the 1st Quarter, we were not provided with the amount or where the funding was directed to. Although we are not contractually obligated to this information, it is usually customary to be provided. GAC has asked for the 2nd Quarter report.

- GAC approached APA for coordination of state advocacy with them. GAC will meet with APA in February or March depending on their availability.

All motions approved unanimously.

M. NEWSLETTER COMMITTEE REPORT Dr. Goldenberg

- Dr. Kelly - ACAP declared a state of emergency for children. Please refer to Newsletter

- Next month - APA Election themed newsletter.

N. TREASURER'S REPORT Dr. Goldenberg

October Financials and Cash on Hand Report:

Approved unanimously

VIII. MEMBERSHIP REPORT Dr. Ijeaku

5 new RFMs in last month, 3 new GMs, approved unanimously

O. PROGRAM REPORT Dr. Gales

- Joint meeting with SCSAP - Sunday November 7th.

- Career Fair - Dec. 4th, which will be a condensed version as compared to previous years

- Psychopharmacology Update/Advances in Psychiatry - The next session will be on psychedelics with Charles Grob and Brian Anderson. We may be able to give CME credit with assistance of APA.

P: Assembly Report - Dr. Red:

- The Assembly is set for the November 6th weekend.. We elected as our new Area 6 RFM Deputy Rep Justin Nguyen.

Q. NEW BUSINESS Dr. Ijeaku

- Dr. Ijeaku returned to a discussion earlier in the meeting and clarified that she recommended to keep the Access to Care Committee separate from the Private Practice Committee.

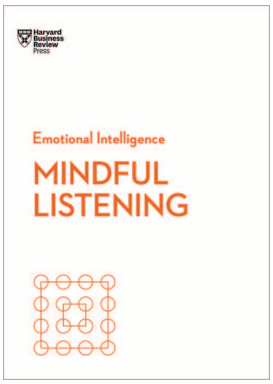
ADJOURNMENT Dr. Ijeaku

Every year we like to take the opportunity to graciously thank our dues exempt members who have made contributions during the year. Your generosity is greatly appreciated:

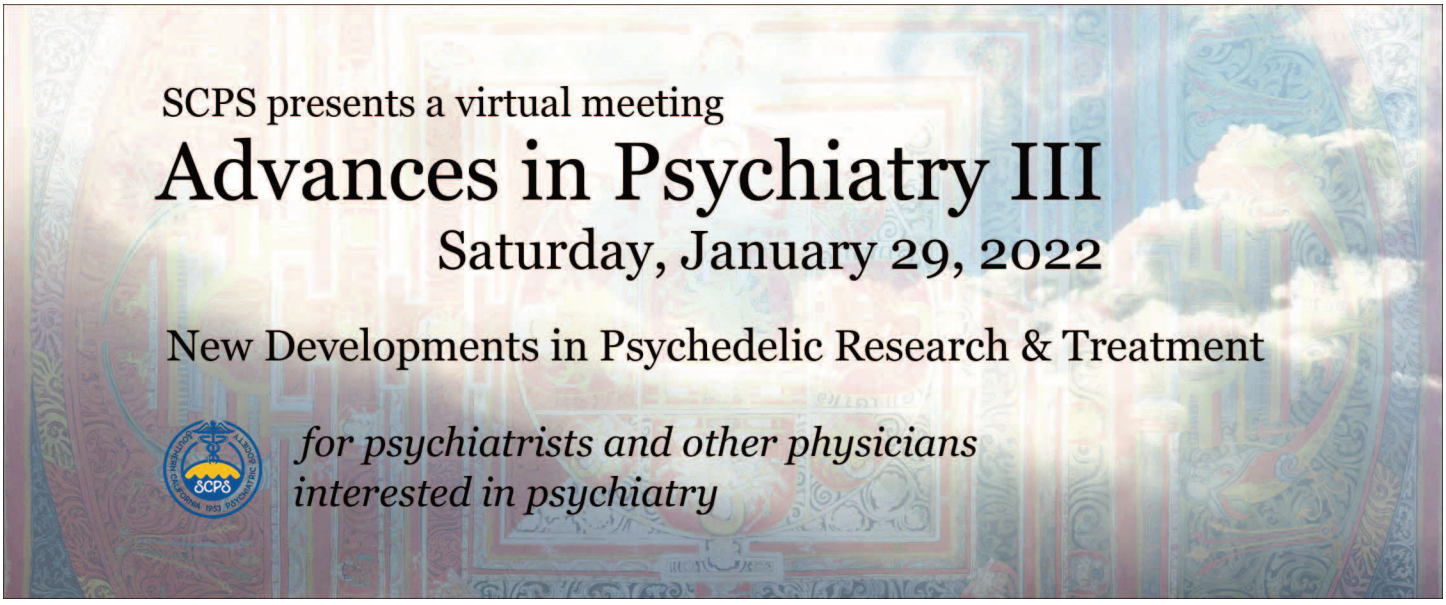
Sarkis Arevian, M.D
Daniel Auerbach, M.D.
David Bender, M.D.
Michael Blumenfield, M.D.
William Bondareff, M.D.
Thomas Brod, M.D.
Murray Brown, M.D.
Steven Charles, M.D.
Dugold Chisholm, M.D.
Thomas Ciesla, M.D.
Ned Cowan, M.D.
Richard Deamer, M.D.
Richard Dickes, M.D.
Raymond Friedman, M.D.
Bruce Gainsley, M.D.
Michael Gales, M.D.
Elizabeth Galton, M.D.
Arnold Gilberg, M.D.
Irving Godofsky, M.D.
Armen Goenjian, M.D.
Sidney Gold, M.D.
Jairo Gomez, M.D.
Roderic Gorney, M.D.
Richard Greenberg, M.D.
Michela Gunn, M.D.
Neil Haas, M.D.
Hiawatha Harris, M.D.
Kenneth House, M.D.
Sharon Jacobson, M.D.
Quinton James, M.D.
Julian Kivowitz, M.D.
Doryann Lebe, M.D.
Stuart Lerner, M.D.
John Lundgren, M.D.
Richard Mack, M.D.
Ronald Milestone, M.D.
Clinton Montgomery, M.D.
Johannes Ndlela, M.D.
Marvin Osman, M.D.
Richard Palmer, M.D.
Marta Pariewski, M.D.
Norma Pariewski, M.D.
Robert Pasnau, M.D.
James Rosenblum, M.D.
Nancy Rosser, M.D.
Alberta Samuelson, M.D.
Ernest Schreiber, M.D.
John Wells, M.D.
Samuel Wilson, M.D.

Mindful Listening
HBR Emotional Intelligence Series
By Harvard Business Review Press
2019
160 pages
$ 19.99 Paperback
ISBN-13: 978-1633696679

Book reviewed by Kavita Khajuria, MD



As part of the HBR Emotional Intelligence Series, authors share eleven essays on various aspects of listening, including an interview with psychiatrist Mark Goulston. Authors include specialists from areas of organizational behavior, management, psychology and psychiatry. The profession of psychiatry naturally requires active listening – but what makes a 'great' listener? Discussions include the characteristics and keys to successful listening, relationship building and how to help others 'feel felt'. Other topics include levels of talking and listening - and what gets in the way - including fear, the inner critic and multitasking. Experiments and field studies include guidelines on how to handle the costs of a 'toxic handler'. Tips and strategies are shared on a mindful presence and how to listen with more empathy. This is a relatively short and easy read with helpful information to further professional growth. Select parts are particularly interesting or insightful, while others may be better guidance as to how to be a better friend in addition to being a good listener.



For more information and to register:
https://www.socalpsych.org/event/advances-in-psychiatry-3/

Happy New Year!
Stay safe and well.

Next month's issue will include the
2022 SCPS election materials
and is also our Diversity and Inclusion Issue!

ALL EDITORIAL MATERIALS TO BE CONSIDERED FOR PUBLICATION IN THE NEWSLETTER MUST BE RECEIVED BY SCPS NO LATER THAN THE 1ST OF THE MONTH. NO AUGUST PUBLICATION. ALL PAID ADVERTISEMENTS AND PRESS RELEASES MUST BE RECEIVED NO LATER THAN THE 1ST OF THE MONTH.

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