During my installation ceremony in April 2021, I announced three overarching goals for the year: improve SCPS involvement and working relationship with APA, improve involvement, engagement, and participation of various regions within SCPS and increase focus on social justice and equity issues as related to the psychiatric field in the greater Los Angeles area. In the last year, we engaged other APA psychiatrists within the state of California in conversations that help unify us all thus bringing all psychiatrists under one umbrella again and strengthening our relationship with our parent organization, the APA. Four of the five CA district branches are now unified in one organization; California State Association of Psychiatrists (CSAP) and we continue to associate and work well with all district branches to ensure that we have a unified and strong voice for psychiatry within California. It is a known fact that California leads then others follow when it comes to advocacy. Our strength within California is really an important factor for organized psychiatry at the national level. We have cultivated a better working relationship with the APA, and it is my hope that we can maintain and perhaps surpass the current level of cordiality with our parent organization. We started some conversations with our Inland Empire members, thanks to the power of virtual space! We were also able to meet and forge new coalitions with longtime allies; the various NAMI affiliates within southern California all within one space fall 2021, again thanks to the power of the virtual connection! Our NAMI allies have now become more involved with various SCPS committees to contribute much needed input that allows us to become better-informed advocates and clinicians.

When the Southern CA Psychiatric Society (SCPS), which is the local district branch of the American Psychiatric Association serving about 1000 psychiatrists in the greater Los Angeles area, elected its Black female President, it truly opened the door for celebration of otherness within our space. In the last year, I have seized the opportunity to have the district branch take a closer look at what it means to be a psychiatrist from a marginalized community as well as what it means to be a psychiatric patient of color. While we have just barely begun to scratch the surface of otherness as it pertains to our colleagues, patients, and the communities that we serve I hope that SCPS will be brave and courageous enough to keep challenging the status quo and truly embracing inclusion, equity, and diversity in our dealings and in the way we conduct our businesses. The truth is that there are many shades of us practicing psychiatry and our experiences are important and necessary pieces of the collective. More importantly, there are many more shades of people suffering from psychiatric disorders so if we must truly be in excellence with the patients and communities that we serve then we must incorporate diversity as a tool of excellence. The pandemic brought this concept to light at the national and local levels. SCPS’ role in developing and providing the guiding light for our field is critical. For psychiatry to retain its promise to nurture the soul and bring healing and meaning to the mentally ill including those within marginalized communities, diversity must become a tool of excellence at all practice settings, at
institutions for training medical students, residents, and fellows and at all spaces where decisions are made regarding patients of color and psychiatrists of color

At the June 2021 council meeting, I shared with council a vision to showcase SCPS members who have been champions of social justice in their practice: the minority mental health docuseries project. Council members unanimously accepted it. In the last nine months, we have showcased one SCPS member (champion of social justice) each month in a short video of their work within marginalized communities. My special thanks go to the minority mental health docuseries work group; Dr Bill Arroyo, Dr Christina Ford, Dr Tatjana Josic and Dr Galya Rees for answering the call when I reached out to you in planning and executing the step one process of that work. Thank you to Tim Thelen for doing an awesome job of capturing the essence of the work that our champions of social justice do. Thank you to our long-term partner PRMS for sponsoring the project. Thank you to our champions of social justice who shared their struggles and joys in the work they do as they practice psychiatry in marginalized communities. Kimberle Crenshaw coined the term intersectionality in 1989 as an analytical framework for understanding how aspects of a person's social and political identities combine to create different modes of discrimination and privilege. This framework provides structure for looking critically at the various aspects of social marginalization and challenges faced by individuals as well as looking at the privilege experienced by others in contrast. In addressing social justice issues, one must cultivate the capacity to look at various levels and types of discriminations and how these compound the identity of the individuals and affect their mental health status. The intersectionality framework helps in the examination of the discrimination and biases that exist in various spaces in society where various types of biases combine in a synergistic way to affect certain individuals at certain intersections in a way that is worse than the combination of these apparent biases. Our champions of social justice are finding ways to make a difference in minority communities bearing in mind that intersectionality of various stigmatized identities can compound issues for their already under-resourced patients but willing to roll up their sleeves, get dirty and do the much-needed work that these communities need to begin the work of healing, recovery and move towards wholesomeness. As the minority mental health project moves to the next step of assessing common themes from our project and using these as guides to influence research, advocacy, academic and clinical work within our field, it is my hope that we can enlighten others with what we have learnt so that we make lasting change in how we practice psychiatry.

During my President-Elect year, I received feedback from some of our members alleging that SCPS was becoming too involved and preoccupied with racism and social justice issues. These complaints came in the wake of the social uprisings that followed the killing of George Floyd and the awakening of the social consciousness of the nation. Locally we had started the Diversity Committee within our organization and sent out communications to members infused with our thoughts about various topics. These members felt that SCPS was becoming too political. In the last year plus since these allegations, I am happy to see that SCPS has not backed down in its pursuit of excellence. In fact, the Government Affairs Committee of SCPS has resurfaced and reconnected with other organizations to address the issues, which affect our profession and our patients including those affect health equity and influence of racism in medical practice. It is indeed pleasing to me that we have managed to redefine ourselves as a major force to reckon with within organized psychiatry in California. Thank you to the Co-Chairs Dr Rod Shaner and Dr Steve Soldinger and every other person who serves on that committee for the work that you have done and continue to do. As a result of your hard work, we are now part of CSAP. Dr Little, our incoming president has been such a valuable right-hand person supporting me every step of the way. I am indebted to you Zeb and pledge my support in the coming year as SCPS continues to make important strides in the right direction. I am indebted to Dr Matt Goldenberg our most dedicated SCPS editor, outgoing treasurer/finance committee chair and now president-elect who has kept members informed of all the stuff going on and who has kept our account in the black in the last few years. I am
most impressed by the executive committee that has worked so well with me in the last year sometimes at the drop of a coin to make quick decisions to move our organization forward. The committee chairs specifically Dr Emily Woods, Dr Danielle Chang, Dr Gillian Feldman, Dr Madeleine Lipshie-Williams, Dr Galya Rees, Dr Erick Cheung, Dr Hanu Damerla and Dr Michael Gales have been instrumental in the progress that we have made in the last year. I have been impressed by Dr Weei LoAllen who organized trainings and educational sessions in disaster relief and asylum work for our members and Dr Kavita Khajuria for her regular and meaningful contributions to our newsletter in the last year. Thank you for working really hard to serve our membership. SCPS Council of 2021/2022 has been collegial and fun to work with and for that, I remain most grateful. Thank you for working hard and being professional even when the topics were difficult and unpopular. Thank you to every SCPS member for believing in organized psychiatry and doing your part in keeping the flag flying really high…

I close by celebrating Mindi Thelen who has been the face, heart, and soul of SCPS. She is what makes us who and what we are. She has given 30 years to build us and make us better. Please reach out to her to thank her for her meritorious service to SCPS. And I hope that she gives us another 30 years! To Mindi!!!

In This Issue...
Champions of Social Justice: Gillian Friedman, M.D. ........4
Letter from the Editor: A Call to Action .......................5
Mental Health for Asian Americans .........................13
The Color of Justice ........................................14
The Impacts of Covid on BIPOC Youth ....................16
Riverside Free Clinic -
A Collaborative Healthcare Safety Net ....................19
Charles R Drew University is Poised to
Train the Next Generation of Physician Healers
in Child and Adolescent Psychiatry .......................20
Let’s Keep the Conversation Going! ......................22
Champions of Social Justice-Bios and Links ...........25
Care Court: What Position will SCPS Take? ...........33
Book Review: Managing Oneself ..........................34
Council Highlights .........................................35
Gillian Friedman, M.D., completed her medical degree, residency in psychiatry, and fellowship in women’s mental health (reproductive psychiatry) at the University of Illinois at Chicago. She is board-certified in psychiatry and in addiction medicine. She is a board member of the International Society of Reproductive Psychiatry, and serves as Inland Region Councillor to the Southern California Psychiatric Society.

Dr. Friedman has worked in public psychiatry in Northern and Southern California since 2002, focusing on treatment and advocacy for people with severe and persistent mood and psychotic disorders. She has expertise in managing psychotic and addiction problems during pregnancy and postpartum, in the treatment of eating disorders, and in inpatient and outpatient medication therapies for alcohol and opiate use disorders.

Dr. Friedman current serves as Chief of Staff at Patton State Hospital, a fully forensic hospital in California’s Department of State Hospitals system. She previously served 2017 – 2019 as medical director for San Jose Behavioral Health Hospital (a free-standing private psychiatric hospital, partial hospital program, and intensive outpatient program). She also has extensive experience in public psychiatry 2002 – 2016 working in Assertive Community Treatment (ACT-model) programs in Los Angeles County and San Bernardino County.

You are cordially invited to attend the

**SCPS 2022 Awards Ceremony**

**Thursday, May 12th, 2022 at 6:30pm via Zoom**

Please RSVP to socalpsychiatric@gmail.com
This month I am going to skip the normal pleasantries and I want to apologize in advance, for the long article and my tone.

I spent the better part of a week deciding whether to publish this article. In the end, I felt it was important to give you this information and I believe you deserve to hear it without it being watered down.

I am very concerned, and you should be as well.

As was first brought to our collective attention in last week’s CSAP newsletter, MICRA, as we have known it for almost 50 years, is not long for this world:

Californians Allied for Patient Protection (CAPP) which includes the California Medical Association, announced an agreement on proposed legislation to modify California’s Medical Injury Compensation Reform Act of 1975 (MICRA).

CAPP noted since MICRA became law, there has been “…decades of debate about the need to ensure health care that is accessible and affordable for all…”

I want to thank Paul Yoder and the leadership at CSAP for immediately taking action. They are hosting a Townhall this week on Thursday (5/5/2022 at 6pm) to discuss what is unfolding and I encourage all SCPS members to attend. Zoom details are in the CSAP newsletter that came out via email this past Friday.

It was purely coincidental that SCPS planned to make this month’s newsletter theme “Psychiatry in Marginalized Communities”. I planned to write an upbeat article and planned to thank all of the participants in SCPS’s film project: Champions of Social Justice: Psychiatry in Marginalized Communities.

I do want to thank everyone involved in the film project. This includes Tim Thelen who provided the camera work and editing expertise to bring the idea to life.

I hope you review the wonderful and inspiring work of our colleagues and the SCPS committee that put this all together in the newsletter that follows. This film series is transformative and highlights the amazing and important work that SCPS members engage in every day.
While you review the film project, I want you to think about these patients. Think about our most disenfranchised, vulnerable, and marginalized patients.

By weakening MICRA, how much more difficult is it going to be for them to access affordable care?

How will the increased cost of malpractice insurance and the increased litigation, that will result from significantly raising the cap limits of noneconomic damages, impact all of our patients?

Unfortunately, we are all going to find out very soon, because AB 35 is on a fast track. It is currently headed to hearings in the next week and will likely be passed and signed before our kids are out of school for the summer.

Editor’s Note: I want to be clear, because this is moving so quickly, SCPS has NOT yet had an opportunity to come together to make an official determination, as an organization, as to a support, oppose or watch position for this bill.

However, because AB 35 is moving to become law in the next few weeks, I wanted to share my opinion, because so much is at stake, and this is so timely. This is strictly my personal opinion that I hope will begin a dialogue with SCPS members and may be the catalyst that is needed to move talk into action.

I welcome and will be eager to publish any and all opposing views in next month’s newsletter. If you have an opposing opinion to mine, please write into the newsletter.

Personally, and professionally, I always remain open to good ideas and look forward to any information that I have not considered in shaping my opinions. I am eager to listen and am open to changing my opinion if new and better information becomes available.

These are the 10 reasons that I (personally) strongly oppose AB 35:

**A Backroom Deal Was Reached to Gut MICRA**

Like me, you probably are just hearing about this major change to how healthcare is practiced in California. That is because the California Medical Association (CMA) and others engaged in closed door and secret backroom negotiations and just announced their “compromise”.

The first reason that I oppose AB 35 is because of a lack of transparency.

I am unclear if actual patients or physicians directly participated in these negotiations or if was the staff and executives of the professional organizations that were involved.

I am unclear how much CMA and others had to give up and why.

I am also confused by why this is moving forward so quickly without the usual public input. To my understanding, the timing of the amendments left virtually no time for organized opposition (as would be the case with a bill introduced in February that would then have to be in print at least 30 days before its first hearing). CMA announced this Tuesday (5/3/2022) that the bill passed the judiciary committee already.
It also does not appear if the time was taken to research the negative consequences of gutting MICRA, which is what happens if AB 35 becomes law.

The Public Gets No Say

The second reason that I oppose AB 35 is because I believe if we are going to fundamentally change healthcare in California, voters have a right to weigh in.

Supporters of AB 35 want us to be comforted by their gutting of MICRA because a proposed ballot initiative ("Fairness for Injured Patients Act" (FIPA)), that was planned for the fall, will now be removed from the ballot.

However, we have not seen any polling that would suggest the public supports AB 35 or FIPA.

Where is the polling and who did it?

Why have we not seen it?

My malpractice carrier, Cooperative of American Physicians (CAP), sent an email this past Sunday that noted, “CAP’s own recent polling showed that FIPA was readily defeatable, and CAP was prepared to commit up to $10 million to fight this anti-MICRA initiative”.

Personally, I am not worried about a ballot initiative. This is because, in my opinion, we should let the people of California vote on this massive transformation to their healthcare.

Why would CMA and other supporters of AB 35 announce their “compromise” at the 5-yard line and rush through hearings, unless they want to get it into law before physicians and patients realize how bad of a deal it is for them?

If Californians, if our patients, if our neighbors, want to invite lawyers into the exam room, should they not be given the chance to vote on that?

If California voters want to pay more for healthcare, so that less of their hard-earned payments go to their doctor and more of their medical payments to go to lawyers, why take away their opportunity vote on this?

The Changes to MICRA are more Substantial Than They Want You to Believe

The third reason that I oppose AB 35 is that its supporters are disingenuous about the severity of the changes that they are making to MICRA.

The authors of this AB 35 designed the roll out to be over 10 years. This was done so that they can announce what seems to be small initial changes to MICRA.

However, the bill then makes drastic changes to MICRA over the next 10 years.

Attorneys Are the Main Beneficiary

While the 10-year roll out will certainly slow the pain, the purpose of this bill and the beneficiaries of destroying the protections of MICRA are transparent.
We know that if the caps on damages can be lifted, it is much more economically feasible and motivating for attorneys to take on these cases, especially on contingency.

With attorney payments clearly on their mind, the authors of AB 35 made sure to specify how much the attorneys get paid on each case.

**AB 35 even provides attorneys a work around** for them to earn even more of the patient’s award. “the attorney representing the plaintiff or claimant… file[s] a motion… for a contingency fee in excess of the [normal] percentages” and they will receive it based on “… the court’s discretion based on evidence establishing good cause for the higher contingency fee”.

**Increased Cost of Medical Care in California**

The fifth reason that I oppose AB 35 is that it will significantly increase the cost of medicine in California. The two major sources of the increased cost will be the increased cost of malpractice insurance and the expense and time of defending increased numbers of malpractice cases.

Malpractice premiums are obviously going to go up to cover all of the additional litigation. Physicians in private practice will have to decide how much of this to pass on to patients.

Physicians who are employed will find that employers find ways to cut costs to cover the additional malpractice insurance expense. Employed physicians may see pay stagnation, other benefits decreasing, or increased patient loads or less support staff.

Or maybe patients will just be forced to pay more to cover the increased cost of medicine that will go to malpractice attorneys.

**Decreased Access to Affordable Healthcare in California**

The sixth reason I am opposed to AB 35 is that it will make access to affordable healthcare more limited in California.

First, I am worried that California physicians will have to decrease the amount of patient care they provide to increasingly take time off to defend themselves via hearings, depositions and other aspects of the litigation process. Already busy clinics will be even more understaffed.

Second, clinics that are serving our most vulnerable patients and barely scraping by, will have the most difficult decisions to make. How much of the increase in overhead cost will be directly passed onto patients who are barely scraping by?

Third, **high risk specialties** like Neurosurgery, Thoracic - Cardiovascular Surgery, General Surgery, Orthopedic Surgery, Plastic Surgery, Obstetrics and Gynecology, Urology will be especially hard hit by this cap increases. Patients may find it most difficult to access these medical and surgical specialists who may choose to leave the state of California or may retire early due to the unsustainable change to their ability to afford and obtain malpractice insurance.

Other than the attorneys that will profit from this legislation, does anyone really want to pay more for healthcare or make it harder to access a specialist?
Can underserved clinics afford the increased overhead that AB 35 will create?

**There is No Evidence AB 35 Increases Patient Safety**

The seventh reason that I oppose AB 35 is that it tries to solve a problem that does not exist.

In California, public protection and oversight of the medical professional is administered by the Department of Consumer Affairs (DCA). DCA controls the administrative and legal process related to the practice of medicine in California.

If the authors of AB 35 were worried about “bad” doctors and patient safety, there are certainly other ways to improve patient safety without increasing the cost of medicine, making healthcare less accessible and enriching malpractice attorneys.

**Judge and Juries are Replaced by Lawyers and Malpractice Carriers**

The eighth reason that I oppose AB 35 is that it creates a kangaroo court.

By gutting MICRA, AB 35 creates a system where the malpractice attorneys are the judge, bringing forward any case they want to take on contingency.

In this system, the malpractice carrier is the jury, who will decide if the physician must settle or if they will cover the costly expense of a trial.

The patient and the doctor are going to be less important than the cold hard financial calculations that will be made on their behalves.

Ask yourself this question, does your malpractice insurance allow you to determine if you settle or go to trial or do they decide?

Ask yourself another question, does it matter if you have a say?

It was pointed out to me this week that an example of the legal complexities is Business & Professions Code section 801(g), which uses ambiguous language to state a physician must consent to any settlement by an insurer BUT that if the insurer chooses to settle anyway (regardless of physician consent) the settlement is valid.

I am very concerned that California physicians will be forced to settle increasingly frivolous cases.

How are you going to feel when the first case is brought against you with these higher limits, and you know that you did nothing wrong? But to keep costs down, your malpractice insurance plan forces you to settle.

It is likely going to be much less expensive for your malpractice carrier to settle, than to pay for 2 to 3 years of litigation to prove your innocence.

**There are No Checks and Balances**

The ninth reason that I oppose AB 35 is that there are no protections to prevent abuse of the system
that is created by gutting MICRA.

Why did CMA and other authors of this bill not include language that would bar an attorney from future malpractice cases in California if it were determined that they have brought forward cases without merit?

Why is there no fund or protection to pay physicians for damages related to defending themselves against cases that are found to be brought without merit?

There does not seem to be any checks or balances to this devastation to MICRA and this windfall for malpractice attorneys.

Take a look for yourself, here is the meat of AB 35. You can read exactly how it guts MICRA “which has been in existence for over 45 years and, among other provisions, limits the amount of damages for noneconomic losses in an action for injury against a health care provider based on professional negligence to $250,000”:

The bill will remove the $250,000 limit on noneconomic damages and expand the law to include an action for injury against a health care institution. It will increase annually the amount of the limitation and eventually adjust it annually for inflation. It will allow statements related to sympathy or regret not be admitted into evidence. It will change the amounts of contingency fee limitations charged by an attorney in connection with an action for injury or damage against a health care provider based upon such person’s alleged professional negligence. The new limits would be:

25% of the dollar amount recovered if the recovery is pursuant to settlement agreement and release of all claims executed by all parties thereto prior to a civil complaint or demand for arbitration being filed.

33% percent of the dollar amount recovered if the recovery is pursuant to settlement, arbitration, or judgment after a civil complaint or demand for arbitration is filed.

In addition, when a case is tried in a civil court or arbitrated, the attorney representing the plaintiff or claimant may file a motion with the court or arbitrator for a contingency fee in excess of the above percentages and decided in the court’s discretion based on evidence establishing good cause for the higher contingency fee.

The bill would amend Civil Code Section 3333.2 to add “health care institution” to the current law allowing a civil action against a health care provider. It would delete the $250,000 limitation on damages for noneconomic losses. Instead, the law would now provide that, in any action for injury that does not involve wrongful death against one or more health care providers or health care institutions based on professional negligence, after 10 years, the limit would be $750,000 and would rise by 2% per year. For wrongful death, after 10 years, the limit would be $1,000,000, rising 2% per year. Thereafter, the applicable amounts set forth above for noneconomic damages for personal injury of $750,000, and for wrongful death of $1,000,000, would be adjusted for inflation on January 1 of each year by 2 percent beginning on January 1, 2034.

It Further Erodes the Field of Medicine

The tenth and final reason that I oppose AB 35 is that I care about the field of medicine and AB 35 further erodes our profession.

That is why it is surprising to me that CMA would support something that weakens MICRA, as much as AB 35 does.
All I see is that the attorneys got what they wanted. By gutting MICRA with AB 35, they successfully and significantly increased the money pie AND they get a much larger slice of it.

Do you really want attorneys in our exam rooms?

We already invited the insurance companies in.

We already invited the administrators and their EMRs in.

The result has been clear, the cost of healthcare has gone up exponentially and physicians are increasingly burnt out and leaving medicine.

Now imagine trying to squeeze the attorneys into the room with you and your patient.

So, as you read through the stories and enjoy the films, please think about our patients, and ask yourself, do you really think they want or can afford to pay for an attorney to be with them in the exam room?

These are my suggestions for how physicians in California should move forward with both urgency and courage:

I urge CMA to immediately withdraw their support of AB 35 and others to let the voters decide if they want to kill MICRA. I understand the fight will be expensive, but with so much at stake, if this is not worth fighting for, what is?

What is the purpose of organized medicine, if physicians continue to allow non-healthcare providers to dictate the doctor-patient relationship and what goes on in the exam room?

Psychiatrists should come together at CSAP and with Paul Yoder take every action possible to share the concerns I have raised above and to oppose AB 35.

Our Psychiatry representatives at the CMA house of delegates should bring the opposition and message directly to CMA. If Psychiatrists lead, other specialties may well follow and join us.

Every physician in California should put pressure on CMA. Unfortunately, many believe that the passage of AB 35 is likely a forgone conclusion and it likely will be if other physicians do not speak up and share their opposition.

Unless CMA fears a major loss of members or loss of other income streams, they will stick with their financial decision that backing down was more cost effective for CMA than spending the money needed to fight for the doctors and patients that will be negatively impacted by the gutting of MICRA.

If CMA continues to support AB 35, the most likely source of resources needed to fight against AB 35 and the initiative will be the medical malpractice insurers.

Physicians should join with them and any other allies who seek to keep the cost of medicine down, access to care high and attorneys out of the exam rooms.

So, my call to action is to encourage you, my colleagues, to speak up and let your voices be heard. We cannot and should not stand by and allow this to happen to our field.
This is our time, and we will have no one to blame but ourselves if we roll over and give up without fighting for our profession, for our patients and for what is right.

I know you are busy, and I know this will be hard, but I am imploring you to join this fight.

We are stronger together and I know can overcome if we all work together and strongly oppose AB 35.

Here are some ways you can let your voice be heard:

- If you are a member of CMA (or even if you are not), consider writing to them and sharing how gutting MICRA will negatively impact you and your patients.
- Come to the CSAP townhall
- Write to your representatives and tell them not to support AB 35
- Write into the newsletter to share your story and perspective. *I will share any perspective on this, even it opposes mine.*
- Consider joining a SCPS committee and getting engaged.
- Share this newsletter article with a colleague to spread the word

Let your voice be heard,
Matthew Goldenberg D.O.
SCPS Newsletter Editor
Treasurer (2020 – 2022)
When thinking of inequities in mental healthcare, Asian Americans are commonly overlooked as a group that struggles with mental health and access to mental healthcare, given the model minority myth that has been placed on these communities. Even as an Asian-American female, working in a public psychiatric hospital where majority of the patients are not Asian, I often forget about the struggles that Asian Americans face in mental health. In fact, when an Asian person does enter our inpatient facility, many of us are shocked, and we all know, “If an Asian patient is here, they must have it really bad” because this is such a rarity here. While this may or may not be true in the larger setting, there are many reasons that we may see it this way, and a lot of it likely comes down to the lack of mental health awareness in many Asian and non-Asian communities.

Growing up in a tight-knit South Asian community, mental health was always a taboo topic. People absolutely did not want to talk about their mental health problems. As part of the “model minority,” our community internalized this identity, and the goal was always to act like nothing was wrong, to brag about how perfect your children were to other parents, and to always simply be part of the best family. Then in 2018, a South Asian friend of mine died by suicide, and his death shook the community’s core. This was one of the only times I had seen the community come together to talk about mental illness so openly, and it was not easy. His family was considered bold for allowing his true cause of death be made so public, and while it was amazing to see so many community members come together to support them, there were still many people who believed his death was his fault and who did not understand why a successful, educated adult from a decent family could have committed such an atrocious act. Because of responses like this, there have been other suicides in our community, but the average person would never know. I see so many families stay quiet about their loved ones’ suicides in our community, and they only speak in hushed voices in private about the mental illness that people may have dealt with. In the community, these kinds of deaths remain mysteries, and the families work tirelessly and desperately through their own grief, to hide the truth. This is obviously not the case in other situations when a person’s heart attack or another’s cancer diagnosis spreads like wildfire across our close community.

As a Sikh American, I consider myself lucky that I grew up the daughter of a psychiatrist. I could have easily grown up in a family that ignores mental health issues, given our culture and our surrounding community. However, I was able to learn from my mother that mental health should not be ignored. Mental health was normalized in our household, and we became well-versed in the importance of mental health maintenance. So, when my mother was diagnosed with a rare form of ovarian cancer, our family sought out ways to care for our health in a holistic way, our physical as well as our mental health. In fact, one of the first things my mother did was search for a therapist to help her cope with her terminal illness, and it was amazing to watch her take control of her mental health and ask for help when needed. Her courage to embrace wholesomeness both physically and mentally was beautiful to watch. Though she passed away a year later, I remember feeling empowered by watching her during that year. I will never forget how she taught me how to acknowledge the grief and trauma that I experienced as her caregiver, to openly talk about it and to be able to sit with it and accept it.

My mother was lucky to know how to take care of herself and her family’s mental health. We were so privileged to have had a mental health advocate right in our own home, who had the knowledge and the resources to help us. Unfortunately, this is not the norm in many Asian families. Finding psychiatric re-
sources in the community is not easy for the general population, and for many Asian communities, they are taught to not even try to seek these resources. The blame for a young adult’s depression, behavioral issues, or substance use is often thought to be a result of poor choices in friends or other environmental factors that can be superficially addressed, and then shoved aside, only to be spoken further in whispers. Asking for help is often not a feasible task.

It is imperative that we break down these social barriers to mental health. As Asians, we need to stop identifying ourselves as this “model minority” group that cannot be less than perfect. It is unrealistic to place entire groups of people into this mythical group that makes superior achievements compared to the average populations. When we take on this role, we feel that we cannot seek help for our internal struggles without feeling weak, and we must keep everything bottled up inside. When this strife stays hidden inside for so long, it builds up until it can no longer stay inside, leading to serious crises involving psychiatric hospitalizations and preventable causes of death such as suicide. It is time to change this problematic narrative, get rid of this false identity that society has put on us Asians, and finally normalize mental health in our communities.

The Color of Justice

By: Kavita Khajuria, M.D.


George Floyds death was cited as a clear catalyst for a ‘vision of transformation’ of public safety practices and investments, as opposed to the trend within the criminal justice system. Leading the world in incarceration rates, the U.S contains 2.3 million individuals behind bars with 1.2 million in state prisons. The report details the disparities among Black and Latinx persons in the US prison system, with an approximate five times higher rate in Black Americans, and Latinx at a rate 1.3 times higher than that of White Americans. Incarceration is noted to be a life changing event with numerous detrimental consequences, including but not limited to employment, housing, lifetime earnings, and on children of incarcerated parents – all with compounding of greater disparities in the communities.

On another note, nine states were noted to have lowered the prison population by 30%+ in recent years, including California - accomplished by policy and practice reforms that reduced admissions and duration of stay. Nellis argues true progress towards a racially just system to require an understanding of the variation in racial and ethnic inequities in imprisonment, including an understanding of policies and the day-to-day practices that drive them.

The report documents incarceration rates for Caucasians, African Americans and Latinx populations. It contains some startling statistics: One in 81 Black adults in the U.S is serving time in state prison, and in 12 states: more than half the prison population is Black. The report displays a national view of the concentration of incarcerated persons by race and ethnicity – states with the highest rates of African American incarcerations included Wisconsin, Oklahoma, Idaho and Montana. Arizona had the highest rates of incarceration for Latinx individuals, although the report conceded an absence or unreliability of ethnicity in some states as most Latinx in those states would be counted in the white prison population, and
some states didn’t report ethnicity figures to the US Bureau of Justice Statistics in 2019. Another contention was an unknown exact reporting of Latinx population in Florida – all contributing to what the report cites as a likely inflated number for Caucasians. States with the highest rates of disparity in imprisonment were located primarily in the northeast or upper Midwest, while higher rates of incarcerations for both Black and Whites prevailed in the southern states.

Explanations for the persistence of racial disparities references a seminal research-based discussion of racial differences in arrests compared to the demographic composition of state prison populations, particularly for drug offenses. Subsequent studies replicate this, with an analysis of court records in Denver ’17-'18, with felony drug cases against White defendants statistically more likely to be moved to drug court than similarly situated cases against Black defendants. Research based evidence cites evidence of racial disparity at the point of sentencing as well, most evident for low-level crimes, where judges ‘depart from the constraints of the law’. In sum - all of this leads to a notable proportion of disparity in prison that cannot be explained by patterns in criminal offending.

What about juveniles? A study of county level differences in juvenile justice outcomes across 65 counties in a northeastern state revealed the composition of the community of the juveniles residence to make the difference, rather than individual-level characteristics. Juvenile delinquents who lived in areas with more heterogenous populations were determined to be more likely to be detained, regardless of race or ethnicity, supported by Wacquants (UC Berkley) observations on location as a driver in disparity.

Regarding long term impacts of slavery on anyone in a particular county: the report cites University of Illinois researchers findings: a higher likelihood of detention, imprisonment and length of sentence in counties that were associated with a substantial legacy of slavery – for both Blacks and Whites.

Causes of Disparity are discussed, including an enduring legacy of racial subordination, described as policies, practices and structural disadvantages that perpetuate disparities with influence on criminal justice outcomes. Incarceration is noted to be merely but one form of white supremacy and disparate treatment of Black youth by law enforcement. It alludes to intergenerational trauma and racialized assumptions to influence outcomes with resultant harsher sanctions due to perceptions of greater threats to public safety with misrepresentations from distorted media portrayals that consequently inform public opinion.

The report stresses race to play a role at multiple points within the criminal legal system, police-citizen relations to reflect bias (including disparity at initial point of contact), depending on locations and low-level offenses that allow ‘a high level of discretion’ noting the presence and impact of a prior record on the decision to incarcerate for subsequent offenses (when stopped for a police traffic stop), and the impact on thousands by the New York ‘stop, question and frisk’ policing program based on little more than suspicion. Black and Latinx drivers were reported as more likely to be ticketed, searched and arrested, with a lower bar for searching.

Pre-trial detention was another area to be more likely to be imposed on Black defendants due to income inequality, with higher likelihood of conviction and a longer term prison sentence. An analysis of 40 state sentencing processes reveal Black and Hispanic offenders, particularly the young, male and unemployed – to have been more likely to be sentenced to prison with additional factors that leaned for more punitive treatment. Other analyses revealed Blacks as approximately four times as likely to be arrested for drug offenses and 2.5 times as likely to be arrested for drug possession (than Caucasians). A prior criminal record was noted to impact heavily at sentencing (“recidivist premium”) – noting the reference to a prior criminal record as intuitively wise, but problematic. The California’s 3 strikes laws was
described as widening the disparities, given the higher likelihood of prior convictions among African Americans. Other structural disadvantages included the disproportionate share of African Americans living in poverty-stricken neighborhoods where socio-economic vulnerabilities contribute to higher rates of crime.

The impact of structural disadvantage starting early in life was noted to be related to those who go on to commit crime versus those equipped to desist - youth of color cited as more likely to experience unstable family systems, exposure to violence, elevated rates of unemployment and higher school dropout rates - all more likely to exist in communities of color - a replication of social inequity and a contribution to the decision to engage in crime. The report concedes the criminal justice reform to have become a regular component of mainstream domestic policy discussions, yet with a recognition by policy makers that mass incarceration has not been an effective remedy, thus the pursuit of reforms and legislative enactments by some. It cites New Jersey as an example of reforms and decarceration, despite its high racial disparity.

The report includes recommendations: elimination of mandatory sentences for all crimes - arguing mandatory sentencing as giving prosecutors too much authority while eliminating the discretion of 'impartial' judges. It urges the requirement of racial impact statements for all criminal statutes, and for decriminalization of low-level drug offenses given the downhill consequences of a criminal record, with accumulative convictions and deeper involvement in the criminal justice system, citing the war on drugs as ineffective and worsening racial disparity. The report emphasizes truly meaningful reforms to the criminal justice system as unable to be accomplished without acknowledgment of its racist underpinnings. Given a recent (and delayed) apology earlier this year to Indigenous populations regarding the trauma sustained from residential schools, this may propel one to consider the possibilities for others who have been wronged, and the possibilities for recognition, reparation or reclamation.

This report can be accessed at: The Color of Justice: Racial and Ethnic Disparity in State Prisons | The Sentencing Project

The Impacts of COVID on BIPOC Youth

By: Emily Wood, M.D.

Andre* is a 15-year-old, Black, cis-heterosexual male with a history of inattention, hyperactivity, many school suspensions, witnessed gang-related shootings with associated post-traumatic symptoms, and irritability who uses cannabis most days. He has a 3-month-old daughter but is not close with her mother, so he has only seen her a few times. He was brought into Juvenile Hall in January 2022 at the height of the COVID-19 delta-variant contagion. The car he was in was searched by police for unclear reasons and he was found to have a firearm. After being shot at in his neighborhood last year he began carrying a gun. Upon admittance to Juvenile Hall, his nose was swabbed, and he was isolated in a single room by himself with a toilet and a sink. He was allowed to use the unit cell phone twice weekly for 15-minute phone calls and was not connected with school services. His COVID test came back negative, so he was moved to a regular unit. Several days after he arrived, the unit was quarantined from the rest of the facility due to a unit probation officer testing positive for COVID. All youth were swabbed and, two days later, 15 of 18 were found to be COVID positive. The 15 youth were transferred to isolation rooms for 14 days. Toward the end of this period Andre’s newly assigned therapist put in a referral for psychiatry and I was able to meet with him shortly after he came out of isolation. When asked how he was doing he said, “I was locked in my room 24/7 for 14 days. I was going crazy... my depression was super high... I’ve felt down before but this was the first time I had suicidal thoughts.”
Many of us have heard and read that COVID has disproportionately impacted Black, Indigenous, and People of Color (BIPOC) compared to White Americans. This is evidenced by decreased access to health care resources, higher hospitalization rates, and higher death rates. But, the disproportionate suffering extends far beyond the direct effects of the virus upon Black and Brown bodies. In particular, BIPOC youth and youth with neurodevelopmental or emotional disorders have experienced major setbacks in their development related to lack of services and isolation.

While schools continue to be generally underfunded and underequipped in BIPOC communities, they remain a major source of mental health resources for youth, in addition to providing services that include occupational, speech, and recreation therapies. When the schools closed in March 2020, youth who depended on special education teachers and/or school counselors for critical supports had to go without. Our patients with Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Depression, and other neurodevelopmental, behavioral, and emotional disorders had the greatest difficulty adapting to the COVID landscape as evidenced by decompensation and increased psychiatric visits to the emergency department. This wave of acute mental illness on top of a system that was already struggling to meet demands led the American Academy of Child & Adolescent Psychiatry, the American Academy of Pediatrics, children’s hospitals across the country and the U.S. Surgeon General to declare a state of National Emergency in children’s mental health in October 2019.

Despite the Los Angeles population being composed of 29% White and 12% Asian individuals, White and Asian youth account for less than 5% of Los Angeles Police Department youth arrests and make up less than 1% of the juvenile detention center population. Previous studies have demonstrated that trauma exposure and mental illness are overrepresented in carceral-involved youth with as many as two thirds of boys and three quarters of girls meeting criteria for at least one mental health disorder. In the Los Angeles County Juvenile Halls, COVID decimated a wide range of services including mental health therapy groups and substance abuse support groups. As many therapists have chosen to work remotely, youth who are already experiencing strained caregiver attachment have been forced to attempt to connect with these strangers virtually at “kiosks” (a laptop in a small room). All youth who are admitted to the Juvenile Halls must have nasal swabs collected for PCR testing and then they are housed in isolation as they await results. While the youth are tested when they come into the Juvenile Halls, none of the probation, medical, mental health, or school staff are required to be tested to enter. Employees are instead expected to monitor their own symptoms and alert the facility if they test positive for the virus. With this policy, units of 15-20 kids who were previously COVID negative have been infected by staff and put in isolation units for up to 14 days at a time.

The psychological effects of isolated confinement on adolescents can be profound. Adolescence is a developmental period characterized by intense focus on peer interactions which is part of the process of social development and self-concept construction. Research in animal models of isolation during critical periods has demonstrated that adolescent isolation is associated with widespread structural and functional brain changes. One consistent finding is that dopamine release in reward regions increases while dopamine activity in executive function regions decreases following adolescent isolation. These changes are associated with behavioral changes including increased hyperactivity, impulsivity, and anxiety. Examinations of individuals who have undergone solitary confinement have shown that it leads to increased distress, depression, aggression, and self-harm. Studies of incarcerated persons have shown that the number one predictor of self-harm is solitary confinement followed closely by mental illness and age <18-years-old.

During the days following his 14-day isolation, Andre experienced cravings for social contact with his family and friends. He was involved in an incident involving several peers where they tried to lock probation staff out of a small room where they were writing music. When his unit was let out for recreation on the grassy area, he started running around and was cited by probation for “going out of bounds”. When I asked him about these incidents, he could only explain that he felt like he needed to be with peers and run. Due to the
severity of his mood symptoms, Andre was willing to start an antidepressant with the hope of getting some relief, but he got little while remaining in detention.

As of this writing, the COVID virus has resulted in 6.23 million deaths worldwide, 992,000 deaths in the United States, and 90,000 deaths in California. The actions we have taken and not taken to protect ourselves from the pandemic have had widespread negative consequences. While many people felt let down by how long it took for the LA teacher’s union to come to an agreement with the Los Angeles Unified School District (LAUSD) regarding a return to the classroom in Spring 2021, LAUSD is has since been one of the safest districts in the country in terms of taking appropriate precautions to protect students and keep them in school.(9) They mandated vaccinations for staff and students 12-years-old, required appropriate mask upgrades as new data and new variants have emerged, and continue to perform on campus PCR testing for every student and staff weekly. LAUSD is one of the few school districts (large or small) that did not experience major closures after the return from Winter break in January 2022 when the Los Angeles County Juvenile Halls were reeling. In other words, while it took them some time to get organized, LAUSD learned from the heartache of 2020 and is doing their best. This is not the case with the juvenile detention system. Despite knowing about the costs, our juvenile system has not chosen to take the necessary precautions to protect the most vulnerable youth in our society – BIPOC youth with extremely high rates of trauma exposure and mental health disorders.(10) Time and again, systemic racism plagues our society as we demonstrate to these youth that they matter less.

*Disclaimer: Andre is a fictitious patient combining traits from more than one patient.*

References
Food, clean water, clean air, education: these are some of the commonly accepted basic human rights. Things that are necessary for an individual--whether in California or Columbia--to have a chance at living an independent and fulfilled life. Healthcare is another privilege that in recent years has been called to be added to the list of basic human rights. While the Affordable Care Act passed in 2010 has helped millions of Americans secure access to affordable good quality healthcare, approximately 15% of Americans are still uninsured or underinsured. This is where free clinics come into play and provide a patchwork of support. A 2010 national survey of free clinics found that there were over 1,000 locations serving 1.8 million people and accounting for 3.5 million medical and dental visits (1). Riverside Free Clinic (RFC) is just one of many across the state that exist to help provide multidisciplinary healthcare services to vulnerable patient populations through collaborative action and volunteerism.

RFC first popped up on my radar during the latter half of my intern year. I was cleaning out my inbox when an email came in about recruiting new resident leadership. Within 2 minutes I sent off a reply that I was interested. In medical school, I spent many weekends volunteering at community health fairs, organizing healthcare career days and mentoring pre-med students. These community service activities helped break up the monotony of studying for endless exams and remind me of the reason I went into medicine in the first place: to connect with and help others. I saw RFC as a great chance to continue my history and passion for service. RFC offers a wide variety of services including medicine, psychiatry, dentistry, optometry, counseling, and social work services. As a psychiatry resident leader my main duties include coordinating clinic staffing with residents and supervising attendings. I also work with medical student leadership to ensure that patients are being triaged appropriately and all necessary documentation/referrals are being completed.

I was thoroughly impressed by the scale, organization and efficiency of the clinic when I first started. The clinic had been shuttered for several months due to the COVID-19 pandemic and had to make many adjustments to comply with social distancing protocols. Nevertheless it was humming with activity: medical students, nursing students, translators, residents, attendings, pharmacists, social workers, and therapists all seeing and providing care to patients. Most of the patients seen at RFC are experiencing food and housing insecurity. No insurance or proof of citizenship is required and service is rendered on a first come first serve basis. These were the circumstances for my first patient (Mr. X) at the clinic who was both undocumented and uninsured. When he initially presented to the clinic he was very depressed and residing in various shelters. Mr. X’s struggles with substance use also made it difficult for him to maintain stable employment and social relationships. RFC was a unique opportunity for him to come and engage with healthcare providers on his own terms. Translators were available to make sure he was able to tell his story and over time he began to trust the clinic and engage in multidisciplinary care. Antidepressant treatment was started, social services and therapy were offered. Over time Mr. X got better and he started to re-engage with the world. He was able to secure stable employment and housing and I encouraged him to connect with the more extensive county mental health services. To my surprise he declined stating that he preferred to come to RFC where all his needs were already being met. The
key for Mr. X lied in choice: he could choose when and if he engaged with RFC and this respect for his autonomy was the reason he returned.

The mission of RFC is to help reduce the healthcare disparities in the Inland Empire by removing barriers to care (e.g. legal status and financial status) while also providing a learning environment for healthcare students and leaders. Many other free clinics across the country operate under these same guiding principles and are often fueled by the generosity of their local philanthropic organizations and healthcare community. I am continually awed by the selflessness of those willing to give their time, expertise and energy to further serve their community. Research into free clinics, while limited, has shown steady growth over time (1,2) This is likely because they fulfill a niche for those who have no other options and/or prefer to engage with smaller scale healthcare infrastructures on their own terms. Healthcare is a human right. My work at RFC is a small component of a bigger movement working towards that goal and I’m proud to be a part of it.

*Mr. X is a fictional patient that is representative of many patients seen at RFC

References:

Charles R. Drew University Is Poised to Train the Next Generation of Physician Healers in Child and Adolescent Psychiatry

By: Amy Woods, M.D. and Nithya Ravindran, D.O.

Charles R. Drew University (CDU) was founded in South Los Angeles in 1966 to address the health disparities of the community highlighted after the Watts Rebellion of 1965. The uprising was primed by decades of structural racism resulting in disparities of economics, housing, and health in the Black community of South LA. As the only Historically Black Graduate Institution (HBGI) on the West Coast, as well as a charter member of the Hispanic Serving Health Professions Schools, Charles R. Drew University has been transforming medicine by training leaders that are committed to dismantling the systems of oppression that drive health disparities. To accomplish this, the training programs at CDU are guided by principles of specialized research, social justice, global service, health policy and community engagement.

The same structural inequalities that instigated the Watts Rebellion and led to the founding of CDU have continued to persist. The murder of George Floyd in 2020 propelled the social movement for racial jus-
tice to the mainstage again. The global pandemic and ongoing racial injustices have demonstrated the interconnectedness of our lives with each other, but also the aspects of an individual’s environment including families, communities, physical environment, and societal structures. Marginalized communities have faced further widening of chasms of inequality, and existing structures of oppression have been exacerbated. The effects are evident in the state and health of our children. As a country, we have failed to protect our children of color from the harms of racism, which permeate every aspect of their human experience. It’s only recently that major national physician groups, such as The American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children’s Hospital Association (CHA), have acknowledged a national state of emergency in child and adolescent mental health. However, for far too long we have been complacent in accepting children of color bearing the burdens of social injustices and structural racism, to the determent of their mental health.

Denese Shervington, MD, MPH, Department Chair of Psychiatry and Assistant Dean of Graduate Medical Education at CDU, whose career has been at the intersection of public health and psychiatry, has actively addressed health disparities, social determinants of health and strength in underserved communities, because she has recognized children of color have always borne the burden of social injustices. In New Orleans, she has had tremendous impact on the narrative around trauma in Black youth and creating post-disaster healing spaces through her work in various academic appointments and at the Institute for Women and Ethnic Studies (IWES), which she founded in 1993. She came to CDU to continue this work in South LA. With her vision of promoting the well-being of a community by centering the healing needs of children, she has guided the growth and efforts of CDU’s psychiatry department to include a CAP fellowship. In 2020, the Office of Statewide Health Planning and Development (OSHPD) awarded Dr. Shervington a five-year grant to address workforce shortages of child and adolescent psychiatrists in SPA6.

Materializing a vision requires leaders who understand the vital importance of the people who are tasked with implementation. Dr. Shervington selected this team by utilizing her experience of creating meaningful systems change. In actualizing Dr. Shervington’s vision, the team built a program that is child-centered and focused on healing. Aligning with the program’s fundamental values, clinical partners who have a deep commitment to serving under-resourced communities were chosen. These partners serve as the ground on which CDU fellows will develop into child and adolescent psychiatrists who are compassionate, social justice advocates, and excellent clinicians.

In July 2022, CDU will welcome its inaugural class of two fellows to the Child and Adolescent Psychiatry Fellowship Program. CDU fellows will be required to engage with the community within the clinical setting, and also beyond. As medical professionals, we have been naïve to think that staying within the boundaries of the clinic walls will lead to healing the wounds of injustice that have been neglected for far too long. Child psychiatrists understand the interconnectedness of children, families, community, and society as it impacts the child. In order for the child to fully heal, we must be active participants in healing all of those elements and be willing to expand our reach beyond the confines of the clinic.

CDU is poised to train the next generation of physician healers in child and adolescent psychiatry. In order to stay true to the mission described, the child and adolescent psychiatry fellowship program at CDU is guided by the question, “are we advocating for the child or the system?” At CDU, the answer will definitively be, “the child.” Doing so will create an environment for all children to heal. Within this philosophical framework, fellows will be nurtured to become champions of children and families both locally and globally and their learning of medical knowledge will be enhanced with human connections to the history and vitality of this area of Los Angeles.
As training directors, we invite others to collaborate and commune with us to center healing in our work as physicians and educators. We all have a responsibility to champion children’s rights because we can no longer be blinded to the injustices that inform the experiences of those around us. We hope that in doing so, we can collectively imagine a better world for all of us.

References


Amy Woods, MD
Program Director
Child and Adolescent Psychiatry Fellowship
Department of Psychiatry, College of Medicine

Nithya Ravindran, DO
Associate Program Director
Child and Adolescent Psychiatry Fellowship
Department of Psychiatry, College of Medicine

Let’s Keep the Conversation Going
By PK Fonsworth M.D. and Tanya Josic D.O.

When I met Dr. Fonsworth for the first time, I felt immediately at ease. It’s the wisdom beyond his age and his approachability that resonate through every conversation with him. Growing up with his adoptive Japanese-American grandmother in the Philippines taught him important cultural and benevolent lessons that are woven into his highest professional achievements. Whether it is in small talk or discussion about social and political events with profound impact, Dr. Fonsworth’s insight is deeply influential.

We started our conversation during the Psychiatry in Marginalized Communities documentary featuring Dr. Fonsworth, and we are happily sharing our follow-up interview.

You made a powerful statement about “identity through language and human connection” as a lesson learned through your incredible life journey. How did it shape your professional life?

I grew up in the Philippines where Tagalog was the main language. I spoke Tagalog everyday at school with my friends and my Filipino family. For the first ten years of my life, I was known as “the American Boy” because I was raised by my adoptive American grandmother. Yet, in the Philippines, Tagalog was the bridge that allowed me to be as Filipino as needed. Upon coming to the United States at age ten, that bridge disintegrated. Immersed in a mainstream America where only English was spoken, I could not speak to anyone in Tagalog. After only three months, Tagalog just disappeared. I can only recall a few words and phrases; I have totally forgotten how to speak the language.

I was not aware that I felt the dearth of Tagalog until sophomore year of high school when my passion for Spanish began. It was that moment when my sophomore Spanish teacher, Señor Stevens de-
declared, “Language is the most beautiful and precious artifact that any culture can leave behind.” He believed it was more precious than art or architecture, for the simple reason that underneath communication lies connection. In that Spanish class, I learned that language and culture are intricately intertwined and that one cannot exist without the other. In that instant, I realized I was passionate about Spanish. I had been longing to connect with someone through language the way I was able to when I spoke Tagalog, and I allowed Spanish to be that catalyst for connection.

In college, I was a student who had never given up a profound interest in two radically different majors, Molecular Biology and Spanish. Through medicine and patient interaction as a psychiatrist I have achieved a synthesis of my passions for Spanish and Biology. Through my formal training in Spanish language and literature, I have learned a different and complementary set of skills and can see the world through a different lens. In Spanish-speaking communities—such as the one I serve in South LA—I am able to understand patients by first understanding their culture, which gives critical information about how a disease, such as mental illness, can unfold.

From my experiences with language, I now have insight. I have seen the effects of a lost language on me. However, I have also gained a language—Spanish—and through the Spanish connections I have made, I have regained the sense of self that was missing when I lost Tagalog.

As an early career psychiatrist, how does addiction psychiatry fellowship compare to your work now?

When I was an addiction psychiatry fellow at UCLA, I treated “everyone under the LA County sun”: celebrities, family members of celebrities, UCLA college students, homeless patients. Although my fellowship training was stellar, I never saw a single Spanish-speaking patient—and part of my heart languished. Great news for me and my patients is that at MLKCH and MLKCMG I treat Spanish-speaking addicts and alcoholics nearly every day. South LA also has a population in which I see an extraordinary amount of cocaine use in patients with severe medical and psychosocial consequences, and young black women with risky, heavy use of MJ with cyclical vomiting syndrome and cannabis use disorder. All of these patients are the reason why I come to work everyday: to deliver excellent and compassionate care for those who need it the most. For me it’s an opportunity to work with the underserved. It’s an opportunity to speak Spanish every day. This work deepens and refines my vision of addiction psychiatry as an instrument for social justice.

You mentioned there is an underinvestment in low-income communities. What have you seen in your practice?

South LA has Los Angeles County’s highest rate of drug or alcohol-related overdoses. It has the second highest rate of binge drinking and misuse of prescription drugs. It has the highest marijuana-related emergency department visits for youth and young adults. It also has a dire shortage of providers compared to more affluent areas. Psychiatrists are in even shorter supply. A bilingual Spanish-speaking addiction psychiatrist? Well, they do have me!

My team and I believe that mental health, physical healing, and the patient experience as we integrate the two — in the setting of South LA and the history of South LA — makes our comprehensive approach to health care so necessary.

Our patient experiences have shown us that physical and behavioral health should be integrated. We’re overdue for this. There is so much need and until recently, so few providers and so little integration of care. People were getting treated piecemeal for different conditions but nobody was considering the whole patient.
This is important because: patients are more likely to stay in treatment if they maintain a connection with treatment providers through a continuum of care.

With Integrated Behavioral Health at MLKCMG we aim to offer more complete care from the hospital to the clinic and beyond. Behavioral health has been considered at every level of care—the emergency room, the hospital, the clinic. When someone is admitted, I will be consulted if there is a concomitant psychiatric issue. A substance abuse counselor may see someone in the emergency room or the hospital and refer them instantly to the clinic, a rehabilitation center, or other addiction services. A therapist can provide daily supportive psychotherapy to someone admitted to the hospital and make referrals and appointments in the community. It is not an afterthought. It is part of the standard treatment.

Some readers might think, “Well isn’t this what happens in all health care systems?” My answer is, it’s one thing to come into a health care system where this is already the norm. It’s another when you’re the person building that service line and nourishing it.

Message of hope?

We want to grow the synchronous treatment of physical health and mental health and substance abuse disorders because it is the future of care in South LA. What my colleagues and I do together as a bilingual integrated system of care is powerful for a community that may have never had that level of care before.

We would like to hear your stories, and your life and career lessons related to marginalized populations.

Let’s keep the conversation going!

Please send correspondence to: socalpsychiatric@gmail.com
View Docuseries: https://www.socalpsych.org/docuseries/

Below, for your quick reference, we are repeating all 9 individual links and bios. SCPS cannot express enough thanks to the following members—not only for participating in this project, but for doing the important work that they do!
Huey B. Merchant, M.D. is an African American, Spanish-speaking, child, adolescent, and adult community psychiatrist. Currently, Dr. Merchant works at two community mental health clinics in the Antelope and San Fernando Valleys of Los Angeles County attending to the needs of families in underserved and lower socioeconomic communities. The clinics serve families through various programs including School-Based services, Therapeutic Behavioral Services, Substance Use Treatment, Evidence Based Practices, and Intensive Services. Many of his patients reside in foster homes and group homes.

Dr. Merchant attended Pomona College in Claremont, CA. and studied at Keck USC School of Medicine in Los Angeles, CA. He completed his Adult Psychiatry Residency and Child and Adolescent Fellowship training at Harbor-UCLA Medical Center where he served as Chief Resident and Chief Fellow.

Dr. Merchant is a past president of the Southern California Society of Child and Adolescent Psychiatry. Recently, he served and completed his role as a member of the DEI Board Committee at an independent school in Los Angeles. Currently, he is a member of the UCLA Resnick Neuropsychiatric Hospital Board of Advisors. Also, he serves as co-chair of the Committee for Anti-Racism and Equity (CARE) in the California Academy of Child and Adolescent Psychiatry, an organization that represents interests in California's legislative process, public policy making and clinical service administration.

Dr. Merchant was born in Bronx, New York and raised in San José, California. He currently resides in Los Angeles with his husband and their two children.
Deborah Deas, M.D., M.P.H. is the Vice Chancellor for Health Sciences, the Mark and Pam Rubin Dean of the School of Medicine, and Professor of Psychiatry at the University of California, Riverside (UCR).

Her appointment as dean at UCR made her the first female African American dean of a medical school in the UC system, as well as the first African American and female African American dean of a school or college of any kind at UC Riverside.

Under her leadership, the school has seen tremendous growth in its medical education, biomedical sciences, and clinical enterprise programs, helping it fulfill its mission to improve the availability of healthcare for the people across Inland Southern California.

Since arriving in 2016, Dr. Deas has led efforts to increase the class size of our medical and biomedical sciences programs, expand clinical affiliations, develop and expand the robust UCR Health clinical enterprise, and increase National Institutes of Health (NIH) funding as well as private giving.

She has worked with UC leadership and state legislators to secure state funding for a new medical education building as well as an ongoing commitment of $25M of annual state funding to support the operational expenses for the school.

Dr. PK Fonsworth is the first addiction psychiatrist at Martin Luther King, Jr. Community Healthcare in South LA, a community with formidable social, economic, and healthcare disparities. Dr. Fonsworth speaks Spanish fluently and double-majored in Molecular Biology and Spanish Literature at UC Berkeley. He graduated from UCI Irvine’s signature Program in Medical Education for the Latino Community (PRIME-LC) that focuses on delivering compassionate, and culturally and linguistically excellent health care to the growing and underserved Latino community. Following psychiatry residency at Harbor-UCLA in which he was also a chief resident, he completed a fellowship in Addiction Psychiatry at UCLA. Dr. Fonsworth is grateful for the opportunity to help pioneer a bilingual integrated behavioral health program focusing on addiction for MLKCH.
Roderick Shaner, M.D. is a clinical psychiatrist with extensive experience in the design and operation of public health systems, mental health crisis services, addiction treatment, clinical research, health policy, and direct clinical care.

Dr. Shaner recently retired from service as Medical Director of the Los Angeles County Department of Mental Health (LAC DMH) where his major responsibility was ensuring quality mental health treatment for individuals and their families who receive services through LAC DMH programs. He oversaw development of clinical standards, operations of clinical risks management, managed care, pharmacy, LPS designation, clinician credentialing, physician recruitment, and peer review.

Dr. Shaner has previously served as Director of the Psychiatric Emergency Service at LAC+USC Medical Center, where he managed a major community mental health resource and was tasked with expanding liaisons with mobile emergency response teams and law enforcement agencies. He also served as a clinical professor of psychiatry at the Keck School of Medicine at USC and directed medical student education for that department.

Dr. Shaner’s research and policy activities center upon public mental health systems, with special focus on laws and policies related to involuntary treatment, access to acute hospital resources, integration of mental health and addiction treatment for individuals with co-occurring disorders, and managed care operations. In addition to peer reviewed articles and presentations, Dr. Shaner wrote a popular psychiatric review text for medical students and residents.

In clinical practice, Dr. Shaner treats children and adults, served as medical director of a residential clinic for people with serious psychiatric illness, and worked as medical director for behavioral health for a managed care company.

Dr. Shaner has been active in advocacy at local, state, and national levels. He works within a variety of organizations to improve mental health services, especially for those with serious mental illness. He is a past president of the Southern California Psychiatric Society (SCPS), serves as co-chair of the Psychiatric Physicians Association of California Public Psychiatry Committee and co-chair of the SCPS Government Affairs Committee, and is a recipient of a NAMI Exemplary Psychiatrist Award.

Dr. Shaner received his MD from David Geffen School of Medicine at UCLA and his residency and fellowship training in general and child psychiatry at the Keck School of Medicine at USC. He is board certified in General, Child and Adolescent, and Geriatric Psychiatry, and Addiction Medicine.

Dr. Shaner and his family enjoy being a part of the Los Angeles community. His outside interests include running, traveling, attending cultural events, and reading.
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.

BACKGROUND
Dr. Sepah graduated from UCLA with a BA in Political Science, magna cum laude, and went to work as a journalist, becoming the Assistant Editor of Ms. Magazine, where she wrote the health column sparking her interest in medicine. After completing a post-baccalaureate pre-medical program, she attended Tulane School of Medicine.

She received her Doctor of Medicine degree in 2006, with a lifetime induction in the Arnold P. Gold Humanism in Medicine Foundation. Dr. Sepah completed her internship in family medicine at Kaiser Permanente Los Angeles Medical Center and then completed a psychiatry residency at LAC+USC Medical Center, where she served as Chief Resident in her fourth year. She received the 2012 PER Foundation’s Excellence in Research Award for original research on physician burnout syndrome.
Gary Tsai, M.D. is the Director of the Substance Abuse Prevention and Control, a division of the Los Angeles County Department of Public Health. In this role, he is responsible for leading over 400 staff with a budget of approximately $400M, overseeing a full spectrum of substance use prevention, treatment, and recovery support services for the 10 million residents of Los Angeles County. Dr. Tsai is board certified in both general adult psychiatry and addiction medicine.

Having experienced the stigma and criminalization that often accompanies serious mental illness as the son of a mother with schizophrenia, Dr. Tsai is a passionate advocate for improving our behavioral health systems. He is a member of the Advisory Board of the Treatment Advocacy Center and Strong365 (a One Mind project) and a former APA / SAMHSA Minority Fellow.

In his pursuit of meaningful change, Dr. Tsai is also the founder of Forgotten Films, a film production company that focuses on social issue projects, with particular expertise in the area of behavioral health. He is the producer and co-director of Voices (http://voicesdocumentary.com/), the award-winning documentary film about psychosis that premiered on public television in May 2015 for Mental Health Awareness Month and was awarded a 2016 SAMHSA Voice Award. He also produced and co-directed a short film about the criminalization of mental illness titled Mental Illness on Trial, which premiered at the Socially Relevant Film Festival in New York and featured notable mental health advocates such as Patrick Kennedy.

https://youtu.be/WYngSYBT7Vo
Dr. Tsai completed his medical training at the University of California, Davis School of Medicine and his residency training at the San Mateo County Psychiatry Residency Training Program. His professional interests include public psychiatry, severe mental illness and early intervention, behavioral health policy, addiction, cultural psychiatry, and media/technology in behavioral health.

Danielle Chang, MD, MSW is originally from New York and received her undergraduate education at Dartmouth College. Post-college, she was awarded a Public Interest Fellowship through Princeton University’s Project 55, where she developed an arts-based after-school program for special needs children at the Association to Benefit Children. Through this experience, she fostered an appreciation for social work and went on to receive her Master of Social Work from New York University. As a social work intern, she founded the Preventing HIV/AIDS in the Next Generation Program, which gave HIV positive clients the opportunity to challenge stigma by sharing their stories with high school students and other at-risk populations in New York City.

Dr. Chang attended medical school at Michigan State University and trained as part of the Leadership in Medicine for the Underserved and Vulnerable (LMUV) program in Flint, Michigan. She received her Doctor of Medicine (MD) degree in 2015 and was inducted into the Gold Humanism Honor Society.

Dr. Chang completed her internship in psychiatry at the UCLA San Fernando Valley Greater Los Angeles VA. She completed her residency training in psychiatry at UCLA Olive View Medical Center, where she served as a chief resident during her fourth year and received the Outstanding Graduating Resident Award. Dr. Chang became involved with the Southern California Psychiatric Society (SCPS) as a Resident Liaison and received the SCPS Outstanding Resident Award, Psychiatric Education and Research Foundation Excellence in Psychiatric Education award, and an SCPS Presidential Commendation for her work as Chair of the SCPS Disaster Relief Committee. She represents SCPS on the California Disaster Mental Health Coalition and is an SCPS liaison to the American Psychiatric Association Psychiatric Dimensions of Disaster Committee. She has continued to serve as an SCPS Council Member representing the San Fernando Valley for past three years.

Dr. Chang currently works as a psychiatrist at Olive View Community Mental Health Urgent Care and teaches residents as a UCLA Health Sciences Clinical Instructor for the Olive View Medical Center Psychiatry Residency Program. She is a psychiatric consultant for the Los Angeles County Office of Diver-
sion and Re-entry, providing psychiatric services to patients enrolled in a Department of State Hospitals incarceration diversion program. Dr. Chang is passionate about providing services to patients who have limited access to care and is looking forward to being involved in developing a specialty clinic for LGBTQIA+ patients at a new outpatient mental health clinic at Olive View Medical Center.

Gillian Friedman, M.D., completed her medical degree, residency in psychiatry, and fellowship in women’s mental health (reproductive psychiatry) at the University of Illinois at Chicago. She is board-certified in psychiatry and in addiction medicine. She is a board member of the International Society of Reproductive Psychiatry, and serves as Inland Region Councillor to the Southern California Psychiatric Society.

Dr. Friedman has worked in public psychiatry in Northern and Southern California since 2002, focusing on treatment and advocacy for people with severe and persistent mood and psychotic disorders. She has expertise in managing psychotic and addiction problems during pregnancy and postpartum, in the treatment of eating disorders, and in inpatient and outpatient medication therapies for alcohol and opiate use disorders.

Dr. Friedman current serves as Chief of Staff at Patton State Hospital, a fully forensic hospital in California’s Department of State Hospitals system. She previously served 2017 – 2019 as medical director for San Jose Behavioral Health Hospital (a free-standing private psychiatric hospital, partial hospital program, and intensive outpatient program). She also has extensive experience in public psychiatry 2002 – 2016 working in Assertive Community Treatment (ACT-model) programs in Los Angeles County and San Bernardino County.
WHY PRMS?
CONSIDER THE PROGRAM THAT PUTS PSYCHIATRISTS FIRST.

OUR FOUNDATION IS SUPPORTING THE PSYCHIATRIC SPECIALTY

Since 1986, PRMS has provided professional liability insurance for individual healthcare providers and group practices across the country, delivering customized insurance products, preeminent risk management services, and unparalleled claims and litigation expertise.

Now more than ever as the field of psychiatry evolves, we’re here for our doctors with timely risk management support, updates, and the latest resources. Our psychiatry-specific expertise, paired with our long-standing ability to defend and support our clients, allows us to keep you covered — with more than an insurance policy.

Before selecting a partner to protect you and your practice, make sure your carrier offers what we can:

• Telepsychiatry coverage at no additional cost
• Up to $150,000 medical license defense at no extra charge
• A national program with comprehensive coverage that can cover patients treated anywhere in the U.S.
• State- and psychiatry-specific risk management alerts
• Network of defense attorneys skilled in psychiatric litigation throughout the country

Contact us for a quote today!

WHY PRMS?

CONSIDER THE PROGRAM THAT PUTS PSYCHIATRISTS FIRST.

OUR FOUNDATION IS SUPPORTING THE PSYCHIATRIC SPECIALTY

Since 1986, PRMS has provided professional liability insurance for individual healthcare providers and group practices across the country, delivering customized insurance products, preeminent risk management services, and unparalleled claims and litigation expertise.

Now more than ever as the field of psychiatry evolves, we’re here for our doctors with timely risk management support, updates, and the latest resources. Our psychiatry-specific expertise, paired with our long-standing ability to defend and support our clients, allows us to keep you covered — with more than an insurance policy.

Before selecting a partner to protect you and your practice, make sure your carrier offers what we can:

• Telepsychiatry coverage at no additional cost
• Up to $150,000 medical license defense at no extra charge
• A national program with comprehensive coverage that can cover patients treated anywhere in the U.S.
• State- and psychiatry-specific risk management alerts
• Network of defense attorneys skilled in psychiatric litigation throughout the country

Contact us for a quote today!

WHY PRMS?

CONSIDER THE PROGRAM THAT PUTS PSYCHIATRISTS FIRST.

OUR FOUNDATION IS SUPPORTING THE PSYCHIATRIC SPECIALTY

Since 1986, PRMS has provided professional liability insurance for individual healthcare providers and group practices across the country, delivering customized insurance products, preeminent risk management services, and unparalleled claims and litigation expertise.

Now more than ever as the field of psychiatry evolves, we’re here for our doctors with timely risk management support, updates, and the latest resources. Our psychiatry-specific expertise, paired with our long-standing ability to defend and support our clients, allows us to keep you covered — with more than an insurance policy.

Before selecting a partner to protect you and your practice, make sure your carrier offers what we can:

• Telepsychiatry coverage at no additional cost
• Up to $150,000 medical license defense at no extra charge
• A national program with comprehensive coverage that can cover patients treated anywhere in the U.S.
• State- and psychiatry-specific risk management alerts
• Network of defense attorneys skilled in psychiatric litigation throughout the country

Contact us for a quote today!

WHY PRMS?

CONSIDER THE PROGRAM THAT PUTS PSYCHIATRISTS FIRST.

OUR FOUNDATION IS SUPPORTING THE PSYCHIATRIC SPECIALTY

Since 1986, PRMS has provided professional liability insurance for individual healthcare providers and group practices across the country, delivering customized insurance products, preeminent risk management services, and unparalleled claims and litigation expertise.

Now more than ever as the field of psychiatry evolves, we’re here for our doctors with timely risk management support, updates, and the latest resources. Our psychiatry-specific expertise, paired with our long-standing ability to defend and support our clients, allows us to keep you covered — with more than an insurance policy.

Before selecting a partner to protect you and your practice, make sure your carrier offers what we can:

• Telepsychiatry coverage at no additional cost
• Up to $150,000 medical license defense at no extra charge
• A national program with comprehensive coverage that can cover patients treated anywhere in the U.S.
• State- and psychiatry-specific risk management alerts
• Network of defense attorneys skilled in psychiatric litigation throughout the country

Contact us for a quote today!

WHY PRMS?

CONSIDER THE PROGRAM THAT PUTS PSYCHIATRISTS FIRST.

OUR FOUNDATION IS SUPPORTING THE PSYCHIATRIC SPECIALTY

Since 1986, PRMS has provided professional liability insurance for individual healthcare providers and group practices across the country, delivering customized insurance products, preeminent risk management services, and unparalleled claims and litigation expertise.

Now more than ever as the field of psychiatry evolves, we’re here for our doctors with timely risk management support, updates, and the latest resources. Our psychiatry-specific expertise, paired with our long-standing ability to defend and support our clients, allows us to keep you covered — with more than an insurance policy.

Before selecting a partner to protect you and your practice, make sure your carrier offers what we can:

• Telepsychiatry coverage at no additional cost
• Up to $150,000 medical license defense at no extra charge
• A national program with comprehensive coverage that can cover patients treated anywhere in the U.S.
• State- and psychiatry-specific risk management alerts
• Network of defense attorneys skilled in psychiatric litigation throughout the country

Contact us for a quote today!

WHY PRMS?

CONSIDER THE PROGRAM THAT PUTS PSYCHIATRISTS FIRST.

OUR FOUNDATION IS SUPPORTING THE PSYCHIATRIC SPECIALTY

Since 1986, PRMS has provided professional liability insurance for individual healthcare providers and group practices across the country, delivering customized insurance products, preeminent risk management services, and unparalleled claims and litigation expertise.

Now more than ever as the field of psychiatry evolves, we’re here for our doctors with timely risk management support, updates, and the latest resources. Our psychiatry-specific expertise, paired with our long-standing ability to defend and support our clients, allows us to keep you covered — with more than an insurance policy.

Before selecting a partner to protect you and your practice, make sure your carrier offers what we can:

• Telepsychiatry coverage at no additional cost
• Up to $150,000 medical license defense at no extra charge
• A national program with comprehensive coverage that can cover patients treated anywhere in the U.S.
• State- and psychiatry-specific risk management alerts
• Network of defense attorneys skilled in psychiatric litigation throughout the country

Contact us for a quote today!
CARE Court: What Position will SCPS take?
By: Rod Shaner, Co-Chair, SCPS Government Affairs Committee

Our patients benefit when Californians focus on providing resources for better psychiatric treatment. The CARE Court proposal, currently making weekly headlines, is doing just that. Care Court promises more effective psychiatric treatment, but it also has some divisive features as well. Our voice, backed by the credibility of APA and CSAP, our statewide association of APA District Branches, will provide essential guidance. Please read further for a thumbnail sketch of the critical psychiatric issues involved, and then weigh in.

CARE Court is a Newsom Administration proposal. At its core, it appears to couple two important elements:

1) A new set of requirements for evaluation and provision of mental health and housing services to individuals with specific diagnoses of either schizophrenia spectrum disorder or other psychotic disorders, and who demonstrate a lack of capacity to manage without additional services in the community;

2) A court directed process—rather than the existing county-directed process—that identifies individuals who meet criteria for receiving services and

orders individual counties to be responsible for the provision of the services and
orders program participants who do not cooperate with treatment to be referred to either the public guardian for LPS conservatorship or remanded to the correctional system, if they were originally referred from that setting.

The Governor has indicated that the program will be publicly financed by about 14 billion dollars from various funding sources. The Administration appears to hope that this structure and funding will first play favorably with groups that have strongly supported a major expansion of a robust continuum of care that does not depend on County decisions to implement and sustain, as Counties sometimes fail to do so. They also hope that an ambiguous set of provisions to compel participation in treatment will play favorably with groups that believe that mental health funds are currently ineffectively reaching those in most need, whom they believe too often do not have the capacity to consent to treatment.

Beyond these concepts, details at this point remain unusually sketchy, which disturbs many advocates from all sides of the spectrum. A recent bill to clarify concepts, SB 1338 (Umberg and Eggman) specifies the regulatory underpinnings, but even that language is remarkably ambiguous.

Unfortunately, the ambiguity appears currently to be discouraging support from either of the two sets of advocates. Those groups that focus on a much more robust continuum of care are very concerned that linking such things to forced treatment is both repugnant and likely ineffective. They have forcefully rejected it. One of their key arguments is that forced treatment will fall disproportionately on communities of color, based on existing demographics and practices. They believe this perpetuates social injustice.

On the other hand, those who believe that involuntary treatment is essential to reach many SMI individuals who aren’t surviving on their own are convinced that the relevant language is too ambiguous. They think that the Care Court proposal and SB 1338 will not be useful in effectively compelling the promised services.
Most people believe that much more negotiation will occur before even the barebones actual framework is fleshed out and can be meaningfully evaluated.

As psychiatrists, we must evaluate the validity of these claims against our knowledge of the diagnoses involved, the structures of the systems in which we work, and the way our clinical work decreases social injustice or, although perhaps inadvertently, perpetuates that social injustice. A key question with which we must grapple is whether involuntary treatment for individuals whose mental illness contributes to their inability to manage on streets is either a benefit for them or an injustice to them.

SCPS will take a directive position of support or opposition to whatever the final shape of CARE Court becomes. We are speaking with legislators and a wide range of advocacy groups. SCPS, as well as APA psychiatrists across California, will play a decisive role in crafting our message. We aren’t simply “giving input” to others.

Your voice must be added to our SCPS Council discussion. Please share it either directly via email to the newsletter or with your Council representatives.

Managing Oneself
By Peter Drucker
Harvard Business Review Press
2017 Reprint
128 pages
$19.99 hardcover
ISBN 9781633693043

Book reviewed by Kavita Khajuria, MD

This book offers guiding principles and two classic articles: one on self-management, and the other on management of others. Drucker initially focuses on self-awareness and self-development - with a down to earth reminder on the basic principle of civil decency. The section on performance and learning differentiates between readers, writers, listeners, talkers, advisors, decision makers, big organizations and little ones.

With thought provoking questions, Drucker asks where one belongs - outlining decisions, choices, and the price of incompatibility between policies and differing values. Contributions, relationships and communications are reviewed, including styles, roles, responsibilities and expectations. Questions to consider include how to search for opportunities and challenges - and the benefit of a second job or hobby. The second section stems from a managerial perspective - addressing practices, opportunities, rules of leadership, and an approach to mindful decision making. The importance of questioning, innovation and flexibility are emphasized, in order to allow for optimal growth.

This book offers relevance for psychiatry and the mental health specialties, as those employed outside of solo practice are likely subject to organizational responsibilities that may parallel those outlined herein. The book is informative and concise. Peter Drucker was a writer, renowned consultant, and professor of social science and management.
Outline of Notable Meeting Events and Discussion

I. CALL TO ORDER  Dr. Ijeaku
   The meeting was called to order by Dr. Ijeaku at 7:02 PM.

II. MINUTES OF THE PREVIOUS MEETING  Dr. Ijeaku
   Approved unanimously

III. PRESIDENT’S REPORT  Dr. Ijeaku
   CSAP Endorsement
   Response to APA
      A letter drafted to APA’s Assembly was reviewed. This letter is in response to a letter sent by the APA on December 9, 2021 requesting clarification of SCPS’s plans for policy representation and to ensure compliance with APA Procedural Code and Bylaws. The content and wording of the letter was discussed in depth. The original letter from the APA was also reviewed to elucidate what exactly they were requesting from SCPS. A motion was made to approve the letter as written, and the council voted to approve it (12 yes, 3 No, 4 abstentions).

   CSAP interim appointments
      Council was informed that Dr. Shaner and Dr. Soldinger were appointed to serve on the CSAP board, and Dr. Bindra, Dr. Shaner, and Dr. Wood were appointed to serve on the CSAP Government Affairs Committee.

   CSAP regular appointments
      A discussion was held regarding the process for designating SCPS representatives to CSAP positions. A motion was made for the SCPS President and the State Legislative Representative (a position appointed by the president.) The regular appointments would start in June of this year. The motion was unanimously approved.

      Dr. Ijeaku and Dr. Bindra also brought up that there are positions to be filled on CSAP’s committees and CSAP’s GAC subcommittees. Dr. Goldenberg made a motion that the SCPS GAC could quickly fill such positions and for council to ratify these appointments later on. The GAC would draw from the SCPS general membership for these appointments. The motion was approved unanimously.

NAMI Walks
   SCPS has been supportive of NAMI Walk events in the past. A motion was made to continue support of NAMI Walk events, with a $1000 for each of 3
walks in different counties.
The motion was approved unanimously.

Mini Documentary Series Project (D+C)
Dr. Ijeaku reported that the last of the mini documentaries was recorded. She thanked all those involved.

IV. PRESIDENT-ELECT’S REPORT Dr. Little

Future Meeting
Dr. Little suggested consideration for an in-person or hybrid meeting, given that the coronavirus pandemic appears to be subsiding. Various options were discussed.

New Committees/Task Force (Homelessness)
Dr. Little suggested a committee be formed to examine the new proposal of “Care Courts”, and to ultimately form a statement position for SCPS. It was suggested that a workgroup could be formed including individuals from the SCPS general membership. The suggestion was met with enthusiasm by multiple members.

V. NEWSLETTER COMMITTEE REPORT Dr. Goldenberg

Dr. Goldenberg thanked April’s Guest Editor’s Kristina Eipl and Janet Martin for their work on the Woman’s Issues edition.

Dr. Goldenberg announced the coming month’s newsletter themes will include:
April: War and Veterans Health. Guest Editor: Oleksandr Trofymenko MD
May: Psychiatry in Marginalized Communities. Guest Editor: A member of the documentary film committee.
June: Ethics. Guest Editor: William Arroyo

Dr. Goldenberg requested council members submit articles or seek out colleagues who would like to submit on these topics.

TREASURER’S REPORT Dr. Goldenberg

February Financials and Cash on Hand Report
Dr. Goldenberg reported that overall, SCPS is up $107,000 cash on hand compared to last year, but funds for advocacy have not yet been paid.

GAC REPORT Dr. Shaner

Dr. Shaner informed council of the first SCPS participation in the CSAP GAC on 3/3/22. Drs. Shaner, Soldinger, Bindra, and Wood attended and were warmly welcomed.
A motion was made to adopt the CSAP positions on the “consent calendar” (a list of bills on which CSAP has adopted positions).
The motion was approved unanimously.
A number of bills were taken off the CSAP Consent Bill List:
Fairness for injured Patients Act – this is a bill that attempts to overturn MICRA. CSAP opposes this bill and CMA historically has opposed it. A motion was made to oppose this bill, and this motion was approved unanimously.
LPS Bill Matrix – Dr. Wood was voted earlier to serve on CSAP public psychiatry committee, which will be working regarding these issues.
AB 1636 (Weber) – a bill to take away medical licenses for physicians that sexually abuse their patients. A motion was made to support this bill and was unanimously approved.
AB 2551 (McCarty) – A bill concerning removal of firearms, which CSAP supports. A motion was made to support this bill and was unanimously approved.
SB 964 (Wiener) – This bill opens up scope of practice of mental health clinicians to a legislative process. A motion was made to take an oppose unless amended position, and the motion was unanimously approved.
A letter was drafted to California Medical Association (CMA), stating that SCPS has joined CSAP, and that CSAP is the only state level organization with voting privileges on the CMA council. A motion was made to send the letter as written, and it was approved unanimously.
Additional appointments to GAC: Dr. Shaner discussed proposition that if SCPS members are interested in participating in GAC, there may be a path for this to occur if they are serving actively on other committees. A motion was made that a committee could have two representatives on GAC, and it was approved unanimously.

COMMITTEE UPDATES Chairs/Thelen
Disaster
Dr. Chang reported that this Saturday there will be a seminar on “Psychological First Aid”.
Fellowship and Awards
There will be a face to face installation ceremony, and a separate awards ceremony that will be virtual, possibly during the May council meeting. A motion was made to approve the reward recipients, and was unanimously approved.
LGBTQI
This committee will need a new chair as the current chair will be moving out of state.
Alternative Crisis Response
Dr. Wood provided an update regarding the 988 bill.
Access to Care
Dr. Friedman provided an update on the activities of the access to care committee.
Program
Mindi reported that there will be upcoming meeting with Dr. Gales and executive committee members to discuss programming in what is potentially the post-COVID era.

IX. MEMBERSHIP REPORT Dr. Ijeaku
Membership Report
Current Active Membership –935
(February 923)
New members were unanimously approved.
NEW BUSINESS

Dr. Silverman reported that an action paper written by Dr. Friedman about the effects of overly narrow diagnostic criteria for postpartum depression was submitted to the Area 6 Council.

ADJOURNMENT

Meeting adjourned at 9:33 pm by Dr. Ijeaku

Prepared for consideration of the SCPS Council by Ara Darakjian, M.D.