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President's Column

CSAP and Other News

J. Zeb Little, M.D., Ph.D.

First, we would like to extend an invitation to all our members. The Annual SCPS Membership Townhall is scheduled for 7pm on December 1st and will again be held on Zoom. This meeting is an opportunity for our members to learn more about what SCPS has been doing to promote the well-being of our patients and profession. We will have reports from our Committee Chairs, including a review of the activities of our SCPS and CSAP Government Affairs Committees. We also would like to hear about the issues that matter most to you and what actions you'd like us to consider in the year ahead.

As you know, last year SCPS joined California's four other APA District Branches in forming The California State Association of Psychiatrists (CSAP). I'd like to highlight the leadership of SCPS's own Emily Wood MD, PhD who currently serves as the Chair of CSAP's Government Affairs Committee and has spearheaded the development of the organization's Policy Platform. This document brings together the values and perspectives of psychiatrists across the state and serves to codify our advocacy positions as we engage legislators and other stakeholders in the development of legislation. Once the final draft of the policy platform is approved by all California District Branches it will be posted to the CSAP website — www.calpsychiatrists.org. I encourage you to check it out.

During the last weeks of the 2022 California legislative session three CSAP co-sponsored bills were signed into law. Because these bills represent some of the most significant changes to LPS law we've seen in decades, I want to highlight them here.

SB 929(Eggman) — This bill addresses a lack of information about involuntary detentions and requires governmental agencies to collect and publish an analysis of patient assessments, detentions, treatment, and the supportive services provided during detention. Importantly, it also requires state and county agencies to make recommendations for improving these areas and assessing the effect of the different approaches used between counties.

SB 1035(Eggman) — Under current LPS law Assisted Outpatient Treatment (AOT) can be a less restrictive treatment alternative to conservatorship. This law adds to the AOT process by allowing courts to conduct periodic status hearings and review treatment adherence. This should have the effect of encouraging medication compliance and improving outcomes.

SB 1227(Eggman) — This bill adds to current LPS law the capacity for a treatment facility to initiate a second hold lasting up to 30 days for patients who are thought to have a chance to benefit from the increased time for treatment to work. This is intended to increase the number of patients benefiting from legally-mandated intensive treatment and reduce the number of patients being referred for conserva-

torship.

Hats off to Senator Eggman (D-5th District) and CSAP for fighting to reform these important areas of LPS law.

In other news, SCPS has received several reports of members having difficulty filling prescriptions for controlled substances. These reports are in addition to the increasingly common problem of shortages of stimulant medications. SCPS has received member complaints about each of the following experiences:

1. The pharmacy declines to accept new patients with CII prescriptions because they are at their "allocated limit" of patients taking CII prescriptions.
2. The pharmacy refuses to fill a stimulant prescription because the patient is also taking a benzodiazepine, or vice versa.
3. The pharmacy requests documentation from the physician to support the need for a CII prescription.
4. The pharmacy refuses to fill stimulant prescriptions above a certain dose, which may be below the FDA approved maximum, or simply refuses to fill the prescription with no justi fication.

And, in a related concern, SCPS was informed that some California physicians are being investigated and prosecuted by the CA Medical Board for prescriptions of benzodiazepines longer than three months. The Board is allegedly pursuing these actions because prescriptions of benzodiazepines for more than three months may fall below the standard of care. It would be helpful to hear from our SCPS members about how you use benzodiazepines in your practice to clarify and support the standard of care in our area.

SCPS takes these complaints very seriously. If you have experienced any of these issues or others, please let us know. You can submit information directly to Mrs. Mindi Thelen at socalpsychiatric@gmail.com. We will also be discussing these issues at the Member's Townhall on December 1st and invite you to share your thoughts and experiences then. You may RSVP to attend the Townhall by contacting Mrs. Thelen here socalpsychiatric@gmail.com.

In This Issue...

Behavioral health along the school-to-prison pipeline: how psychiatric diagnosis contributes to racial disparities in juvenile incarceration

By: Emily Wood, M.D., Ph.D.

As psychiatrists, we are aware of how imperfect the DSM is for clinical use. While it provides some common terminology to communicate with our colleagues across the field, it does not suggest an etiology nor instruct us in biopsychosocial formulation or treatment strategy. The promise of this classification scheme is that it will yield more reproducible and reliable research studies to inform our clinical treatment choices. But in our daily work, the DSM can feel more like an apparatus for billing than a useful tool for alleviating our patients' suffering. If we practice solely with this tool, we may fail to consider how societal structures and individual biases shape diagnosis and how our choice of diagnosis from the DSM may perpetuate systematic oppression of minoritized groups.

A poignant example of this process is the dramatic racial differences in rates of diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) and Conduct Disorder (CD). ADHD is a neurodevelopmental disorder with a high rate of heritability and hallmark behaviors of inattention or inflexible focus, hyperactivity, impulsivity, and emotional dysregulation. CD is associated with irritability, argumentativeness, and defiance toward authority, and is diagnosed when behaviors are felt to violate the rights of others and/or major societal norms (of note, these rights and norms have been established by the privileged majority). ADHD and CD share many risk factors including in utero exposures, child abuse and neglect, history of foster placements, low socioeconomic status, and environmental toxins. And, many similar behaviors are exhibited in both ADHD and CD. For instance, a youth who disrupts the classroom and refuses to do some assignments may have difficulty maintaining attention during group instruction and becomes emotionally dysregulated when faced with overwhelming tasks.

As early as Kindergarten and continuing through adolescence, youth who are Black, Indigenous, or people of color (BIPOC) are less likely to be diagnosed with ADHD and more likely to be diagnosed with disruptive behavior disorders such as CD. Black and Latinx children are 69% and 50% less likely than White children, respectively to be diagnosed with ADHD.[1] In carceral and non-carceral populations, Black youth are 41% and 60% more likely than White youth to be diagnosed with CD.[2,3] Importantly, these differences exist when controlling for many confounders and, evidence suggests, are based on under-diagnosis of ADHD and over-diagnosis of CD in BIPOC youth rather than over/under-diagnosis in White youth.[4]

At the very least, these racialized differences in diagnosis can limit access to appropriate treatment. The gold standard therapeutic approach for youth with ADHD includes psychotropic medications, behavioral interventions, and educational accommodations and services. While youth with CD can benefit from behavioral interventions and educational services, they are much less likely than youth diagnosed with ADHD to receive these treatments and more likely to be seen by parents and teachers as willfully defiant and oppositional. Evidence suggests that the way disruptive behaviors are interpreted and managed at school is racially biased and is the basis for the vast discrepancies seen in the school-to-prison pipeline.[5] Exclusionary discipline is the backbone of the school-to-prison pipeline as just one suspension or expulsion can triple the likelihood that a youth will become involved with the juvenile carceral system in the subsequent year.[6] This inequitable discretionary discipline is disproportionately applied to the most vulnerable youth, including racially minoritized students, students with disabilities, and stu-

dents identified as LGBTQ. In California, 28% of Black K-12 students with disabilities have been suspended at least once.[7] Racial disparities in mental health diagnoses can compound these discrepancies.

For youth in the juvenile carceral system, the prevalence of having at least one mental health disorder is as high as 92% for boys and 97% for girls.[8] The prevalence of ADHD in this system is estimated at 40% which is 5 times that of the general population.[9] Due to the high rates of comorbidity of ADHD with other mental health disorders, it is difficult to establish a causal relationship between ADHD and delinquency. For instance, high rates of adverse childhood experiences (ACEs) are associated with both ADHD and delinquency. Nonetheless, we expect that impulsivity, risk-taking, substance use, and lower educational attainment, each of which is associated with ADHD, are contributing factors. Importantly, early identification of ADHD and both psychopharmacological and behavioral therapies and supports have been shown to improve outcomes for impulsive risk-taking behaviors, substance use, and educational success.

The Sequential Intercept Model (SIM) was developed to detail five "points of interception" whereby individuals with carceral system contact may be diverted from standard prosecution and incarceration into rehabilitation-oriented alternatives for adults. The five SIM intercepts are: (1) contact with law enforcement or emergency services; (2) initial post-arrest hearings and detention; (3) jails and courts; (4) re-entry from jails, prisons, and forensic hospitals; and (5) community supports, including probation and parole. From the mental health lens, the SIM highlights opportunities for applying evidence-based treatments in the community for individuals with behavioral and mental health disorders as a means of reducing carceral involvement.[10] Even before the first intercept, early childhood family supports with screening for ACEs and developmental differences could result in vastly different trajectories. When applied down the line to juvenile detention systems, some of the most effective interventions have involved appropriate provision of mental health assessment and services at key points. For instance, in a Philadelphia school-based initiative that replaced suspension/expulsion with youth and family needs assessments for delinquent behavior, the rate of school-based arrests dropped by 54% thereby dramatically curtailing entrance into the school-to-prison pipeline or SIM intercept 1. Most importantly, of the youth who were diverted only a fraction went on to be arrested in the community in the subsequent 2-year follow-up compared to local and national rates following exclusionary discipline.[11]

Your diagnoses matter and your biases can have dramatic effects on the lives of your patients. Studies have demonstrated that physicians hold similar levels of racial, gender, and other unconscious bias as the general population and are similarly prone to fall prey to the societal stigmatization of mental health disorders. Studies have also shown that unconscious bias is not mitigated by simply learning about it. You must put in place systems and structures that take race out of decision-making processes as much as possible. While it is enticing, we must not let billing woes and DSM apathy distract us from the important task at hand.

For psychiatrists interested in a detailed account of a racialized diagnosis in adults, consider reading *The Protest Psychosis* by Jonathan Metzl.

APA recently released a free 1-hour lecture with CME credits by Dr. Matthews Edwards on *Racial Inequity and Discrimination in Mental Health*.[12]

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APA Releases New Model Legislation to Target Prior Authorization

By: Laura Halpin, M.D.

Many of us are deeply aware of the impact unnecessary prior authorizations (PAs) have on patient access to care. The recent passage of federal legislation HR 3173: Improving Seniors Access to Care (addressing Medicare Advantage PAs) as well as numerous bills in the most recent legislative session in California, signal that legislators are recognizing this and ready to work on solutions. As most of regulations of commercial insurance and Medicaid happen at the state-level, and the American Psychiatric Association recently developed new model legislation for support this process within State legislative bodies. You can read the full model legislation and access more resources at https://www.psychiatry.org/psychiatrists/advocacy

The new model legislation addresses aspects of PAs including 1) identifying categories of treatment which should never be prior authorized 2) 'Gold Card' language supporting a process by which physicians that should not receive unnecessary prior authorizations for a set time period if they meet criteria, 3) that physicians involved in process from insurance companies should have appropriate scope to make these decisions, as well other important aspects including that responses should be timely and there should be no retrospective denials. Below are more details on some of these aspects.

The APA model legislation identifies multiple categories that should NEVER be prior authorized. This type of language likely has the most potential for significant impact on number of PAs. These proposed categories include:

*generic prescription drugs that are not controlled substances
*any noncontrolled prescription drugs that have been prescribed without interruption for six months
*on the grounds of therapeutic duplication if the patient has already been previously approved for the same dose
*any prescription drug solely because the dosage has been adjusted
*on any long-acting injectable
*any drug FDA approved for the treatment of opioid use disorders

Within in California, coverage for previously covered prescription treatments are already protected under California Health and Safety Code Section 1367.22, however codifying some of these other categories would be advantageous. Some discussion related to these proposed categories has focused on the proposed exclusion of controlled substances, which in California we know are becoming increasingly contentious in recent months. Feedback from legislators about the PA model legislation has been that if there is not an exclusion of controlled substances when it comes to restricting PAs for generic treatments, then this legislation is not viable. This is due to significant public concerns about controlled substance access in the era of the opioid crisis. This is of course, a complex issue and PAs were never designed to be a process to limit unsafe access to controlled substances, however nonetheless, that is the rationale and current political environment.

Another major concept proposed in the model legislation is the idea of the a "gold card.". This name comes from the "Texas Gold Card" which is the phrase used when this type of legislation was first passed in Texas. The model legislation here proposes that a "gold card" or exemption from all prior authorizations be given to a physician for whom has been approved for at least 90 percent of the prior authorization requests in the past 6 mos. The model legislation also details all of the specific types of authorizations that would be exempted and that this is something that insurance companies must pro-

vide to all physicians versus just those who would apply, attempting to place more of the administrative burden on insurers.

Within California, this type of legislation was proposed in the 2022 session as part of Senator Pan's SB 250, however it did not make it past suspense file day. As this policy worked its way through the California Senate and Assembly, amendments were made to length of time a single "gold card" would last (one to two years), that review of prior auths must be done by physicians acting within their scope, a timeline for inclusion of brand name substances and how many prior authorizations should be audited for gold card awarding purposes. Proponents of this type of policy recognize it could significantly reduce the number of prior authorizations, opponents remain concerned this will not limit them as strongly as developing legislation prohibiting specific categories, and express concern about the administrative burden of this new process, even if that burden is proposed to fall on insurers. It remains to be seen if this legislation will be re-introduced in upcoming sessions in our state.

And just like that, I was Tarasoffed

Anonymous Submission

Death threats to physicians are very distressing, underreported, and, sadly, not rare. In a survey of psychiatrists, 34% reported that they have received at least one death threat from a patient[1]. Most of us expect to experience this “occupational hazard” at some point in our career. Yet, there are no clear guidelines on how to deal with death threats by patients or how to balance the duty to the patient with the need to protect our own safety, the safety of our family, colleagues, and workplace. Furthermore, there is insufficient literature on the emotional reaction of psychiatrists when faced with such threats. I decided to share my recent experience with a death threat in hopes that it would help others prepare for and deal with similar threats. I have asked to remain anonymous to protect the privacy of everyone involved.

I was in the car with my family on the way back from a family event. We were discussing the day and future plans when I got the call from a police officer. And just like that, on speaker, the officer informed me that a patient threatened to murder me. Wow.

For reasons that I won’t go into, this threat was considered a serious one. “Credible” - as I later learned to refer to it when talking with law enforcement or the court. I was petrified, and the emotions and thoughts that followed were all over the place. I felt scared, ashamed, morally conflicted, confused, frustrated, angry, hopeless, and sad. All I really wanted was for this threat to disappear.

In the following days, my biggest fear was the possibility that my family would be harmed. That the patient would google my name and find my home address. This was too easy, as I soon I found out when I googled my own name. It didn’t seem possible that I would ever feel safe in my home or my job again. I considered quitting my job and relocating my family and felt awful to put them through this.

The shame about the fact that this was happening to me and the guilty thinking that I brought this on myself were so profound, that it took a lot of effort to contact those who could help me. I knew that I was falling into the most typical thought distortions, but I just couldn’t help going down that rabbit hole of blaming myself for the fact that I was the only psychiatrist that I knew that faced a serious threat. A terrible unprofessional psychiatrist that deserves to be threatened.

Estimating the risk of the threat was not simple. I often wondered if I was overly fragile or histrionic. I felt conflicted, trying to balance my family’s and colleagues’ safety with my duty to protect the patient’s privacy and my oath to do no harm. Dealing with law enforcement was confusing and frustrating. After being transferred between numerous different departments and needing to be more assertive than I usually am on topics that I know little about, I was asked if I wanted to file for restraining orders, or if I wanted to press charges. Wanted? I didn’t want any of this. I definitely did not want to put a patient behind bars, and I was terrified that any legal step might further escalate the situation.

Overall, I am grateful. Once I overcame some of the shame and asked for help, it was there. The biggest help was the help from past and current colleagues. Neighbors and friends were helpful as well and connected me to services that removed most of my personal information from the web. I can’t imagine going through this experience without the support of the organization that I work in. The risk management team and leaders of my organization helped me with every step, from dealing with law enforcement and the court, to coming up with safety plans, and even placing security in front of my house when it was deemed necessary. I even called our organization’s confidential employee support. It was helpful.

I was lucky. I feel safer today, though I am still far from feeling safe. I know that some psychiatrists have not been as lucky as I am. Some were harmed. Others had to relocate their family and switch jobs. As a profession, we know too little about this rather common occupational hazard. We could do more to understand it and support each other when facing such threats.

I recommend that anyone reading this consider how you might handle a credible threat. Google your name. Think about a safety plan. Familiarize yourself with your risk management team, if you have one, or the police department you fall under. If buying or refinancing a house, try not to list your professional name. If you are involved in leadership or education, consider trainings that go beyond de-escalation and the location of the crisis button. I hope that none of you ever have to deal with a serious threat. But if you do, please be kind to yourself. Expect the emotional reaction, and don't keep this to yourself, because you are definitely not alone. I hope this is helpful.

Please be safe.

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Meet your 2023 APA Elections Candidates

The slate of candidates for election to APA's Board of Trustees is now live on Psychiatry.org. You can view the full list of candidates for office, read their biographical data and view the APA Election schedule here. Stay tuned for more information on a Meet-the-Candidates Virtual Town Hall, scheduled for December 5th. Town halls for candidates elected by members in areas 2 and 5 are scheduled for December 6th & 7th respectively. The RFM trustee town hall is scheduled for December 8th. For any questions to the process, refer to the APA Elections Guidelines or send an email to election@psych.org

Climate Change: A Resident's Perspective

By: Chan Park, M.D.

"I don't think California will be livable in the next 20 years," said one of my coresidents as we were catching up during lunch. We were talking about our future after residency, and as an individual who grew up in Southern CA, I shared that I will most likely stay in Los Angeles after residency. My friend also hoped to stay around, but she wasn't sure if it was wise to stay in California anymore, as CA broke a record heat in early September. Her words struck a chord within me. Extreme heat, wildfires and drought seemed to be lurking around us, closing in on us, as I sat with her statement and simply nodded while finishing our lunch.

My interest in climate change and its impact on mental health began when I was a medical student at University of California, San Francisco. As I marched alongside other healthcare professionals and Sunrise youth leaders at downtown San Francisco, I listened to the teenage girl describing what it felt like to see her childhood home in ashes after Santa Rosa wildfire. As a 4th year medical student, I treated a woman in her 40's who lost her family home and was admitted to the hospital for worsening depression and anxiety, unable to find consolations in medical treatment and her support system of loving family. In every story I encountered, an inner voice continued to resonate that these stories are not unique to these individuals, and climate disasters impact all of us in one way or the other.

Specific to Southern CA, wildfires, extreme heat and drought are the major topics of the daily news. Of those, wildfires directly and actively endanger lives and terrorize the community, while also contributing to air pollution and homelessness. According to wildfire.ca.gov, in the recent histories of California, acres burned stayed below 1 million acres until 2020. From nearly 260,000 acres burned in 2019, the number jumped to over 4 million in 2020, followed by over 2 million acres burned in 2021. Wildfire season is starting earlier and lasting longer. In addition to the lives and structures it has taken, the impact on the air pollution concern psychiatrists. Air pollution has neurotoxic mechanisms of air particulates, which includes systemic inflammation and brain oxidative stress. (Hahad et al 2020). As for social inequities, wildfire adds additional pressure on homeless populations as more people are displaced from their homes with limited housing resources in CA.

Extreme heat was recently experienced in September and impacts the most vulnerable populations of the society the most. According to the LA Times article by Sammy Roth in 2021, extreme heat does not impact everyone equally: elderly individuals who live alone and cannot afford resources for cooling are most vulnerable to death. According to Eric Klinenberg, a sociology professor in NYU, "heat-wave mortality [is] consistent with the city's geography of segregation and inequality". His observation of the two neighborhoods, Englewood and Auburn Gresham, in Chicago of 1995 demonstrates this clearly. While both communities were composed of ninety-nine percent of African American residents, a formerly redlined neighborhood, Englewood, fared worse death tolls than Auburn Gresham due to continued less funding and access to green spaces for cooling. Again, history of systemic and intentional redlining policies in our city and throughout cities across the USA has exacerbated the social isolation of the elderly and the disparate impacts on low-income communities worsening outcomes from death due to extreme heat.

Such stories above are the key instances demonstrating how climate change intersects with racism and other existing social inequities of our society. As psychiatrists advocating for climate change and the impacts on mental health we must simultaneously speak out and address social inequities.

Elections are one of such examples for advocacy, and November election is here. Voting for candidates that will lead on solutions to the climate crisis and for those ballot propositions addressing climate change is not only good for the environment, but also good for physical and mental health.

Prop 30 is the multi-modal climate action ballot initiative that will help expand funding for fire fighters, forest resilience programs, contribute to clean air by initiating rebates, grants, and financial assistance for clean vehicles by taxing only those who make more than 2 million dollars a year. November election is here and voting yes on Prop 30 is one simple way we can contribute to cleaner California air quality. Criticisms against Prop 30 argue that California already has one of the highest income tax rates and that this will add to taxes, and that this is a special interest serving proposition especially for ride share companies such as Lyft and Uber.

I challenge these opposing arguments: First, Prop 30 will only increase tax on individuals whose income is greater than or equal to 2 million dollars. Second, according to the Clean Miles Standard passed in 2021 by California Air Resources Board, 90% of the miles logged by rideshare fleets such as Uber and Lyft are required to be by EVs by 2030. Prop 30 will make purchasing clean air vehicle more affordable for many Californians including, but not solely ride share companies and their contractors. This will help gig workers keep their jobs; another issue of significance for protecting low-income workers and in line with a just transition to clean jobs.

We can be part of the solutions for mitigation and adaptation by joining with others for solutions to the climate crisis. We can increase awareness and advocate for equitable resource allocations such as peer program for elderly who live alone during extreme heat and funding for air conditioning for those who cannot afford it in the peak summer months. Other ways to advocate for impacts of climate related changes include joining the existing organizations such as Climate Psychiatry Alliance, Climate Health Now, among others, which are started by physicians who are concerned about its impact on our society. We can educate ourselves by implementing journal club articles around climate change and creating teaching curriculums for medical students and residents that focus on topics of climate change and how this can impact our vulnerable patient populations. As an individual, educator, physician, voter or as members of the organizations, we can look forward to the greener future that overcame the wildfires and extreme heat and be that resilient society, which learned to protect our patient populations through adverse environment. Rather than fear, we can let our hope guide our actions.

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How to save a planet episode of “Presenting: The Carbon Copy- Why Heat Waves Become Deadly”

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Message from the CSAP Board Chair

By: Takeo Toyoshima, M.D.

I author this article as the current board chair of the California State Association of Psychiatrists (CSAP), the state's premier psychiatric advocacy organization that represents over 3,000 psychiatrists. After the dissolution of the California Psychiatric Association (CPA), CSAP was founded through the cooperative efforts of American Psychiatric Association's California District Branches. At the time of writing, all five District Branches have now joined forces: in alphabetical order, Central California Psychiatric Society, Northern California Psychiatric Society, Orange County Psychiatric Society, San Diego Psychiatric Society, and Southern California Psychiatric Society. Through this article, I hope to explain what CSAP is, how CSAP operates, and how one interested in advocacy may get more involved.

How is CSAP organized? CSAP is composed of the board and committees, the primary committee being the Government Affairs (GA) Committee. With approval of the District Branches, CSAP has decided to retain Mr. Paul Yoder and his firm Shaw Yoder Antwih Schmelzer & Lange for their lobbying expertise. The board is the decision-making body of CSAP. The board has voting rights on matters relating to CSAP's operations and the legislative agenda. Each District Branch nominates two board members per term, for a total of ten members who each serve a one-year term. The chair and vice chair positions are rotated between the District Branches in an egalitarian manner.

The GA committee is where bills and other advocacy-related issues are discussed in depth. The committee is led by a chair and vice-chair (presently, Dr. Emily Wood (SCPS) and Dr. Alexis Seegan (OCPS), respectively). Each District Branch may nominate GA Committee representatives, with additional room for attendance from District Branch members who are interested and passionate about advocacy. In the end, the GA Committee votes on positions for pertinent bills and sends these as recommendations to the board for final approval. Both Board and GA Committee meetings are generally held on a monthly basis, though they may occur more frequently when the legislative session is busy.

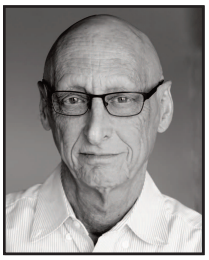
What separates CSAP from other psychiatric advocacy organizations is its focus on transparency, fairness, and accountability. As outlined above, the structure of CSAP is clearly defined, consistent with the membership-driven nature of the District Branches, and in alignment with the bylaws of the American Psychiatric Association. The board and GA Committee represent all five California District Branches and allow for each District Branch's voice to be heard. Each board member and committee member serve as representatives of their home District Branch rather than as individual psychiatrists. Terms are limited, with positions of leadership equally rotated amongst the District Branches. Financially, CSAP is funded through contributions from the District Branches, with no ulterior funding streams such as from industry and non-physician organizations. Finances are specifically allocated to advocacy and advocacy-related issues. Additionally, all five District Branches must approve any structural, financial, and other large-scale changes. The above are in place to make sure that CSAP and the District Branches can work together and effectively advocate for our patients and their families.

In 2022, CSAP co-sponsored three successful pieces of legislation. For 2023, CSAP is in the process of sponsoring or co-sponsoring several new bills (this will be decided during meetings in later in November and December). CSAP will try to improve the issues affecting the practice of psychiatry for physicians in both public mental health systems as well as private practice in California. CSAP is open to every idea suggested by its members.

How can one get involved? Of course, participating in advocacy efforts at the local District Branch level is heavily encouraged. At the same time, collective forces may effect greater change. If there is an area of medicine and psychiatry that you are passionate about, you will quickly find many like-minded colleagues who are equally passionate about advocating for effective and equitable psychiatric care. Should anyone reading this wish to get more involved, please don't hesitate to contact Mr. Yoder, or your respective District Branch board members.

The latest triumphs and defeats of some California legislative bills that matter most to psychiatrists and our patients

By: Roderick Shaner, M.D., Co-chair, SCPS Government Affairs Committee



California legislative bills run a gauntlet of Assembly and Senate committees during each two-year session of the California legislature. The track is littered with the lifeless remains of bills that don't survive. On August 31st of this second year, the legislature's work was done. Everyone—legislators, bill sponsors, advocacy groups, and media—is exhausted. Then the Governor had until September 30th to sign or at least let surviving bills get into law without his signature, or to veto them. It's enough to discourage even the most avid supporters of various bills.

So, for those of us who have eagerly watched the process for the critical bills concerning LPS reform and a couple of other issues of importance for our patients and profession, here is a quick and informal list of those that survived and those that bit the dust during these fateful dates, along with very brief (and—okay—maybe opinionated) descriptions.

Signed/Approved:

AB 2275 (Wood) Requires certification review within 7 days for back-to-back 5150s, even for patients not admitted to inpatient care

SB 528 (Jones) Juveniles' medication court orders must now include JV 220s

SB 858 (Wiener) Increases DMHC penalties for MCOs (managed care organizations) that engage in foot dragging before providing medically necessary services

SB 929 (Eggman) Requires better data collection for community mental health services, including demographic and performance data

SB 988 (Bauer-Kahan) Provides 988 Suicide and Crisis Lifeline funding infrastructure

SB 1035 (Eggman) Permits AOT medication adherence testimony to be placed in court record

SB 1227 Eggman) Permits a new second WIC 5270 ("30-day hold") for intensive inpatient treatment, potentially avoiding unnecessary petitions for conservatorship

SB 1338 (Umberg) Enacts the radically new CARE program, starting in 2023

SB 1394, (Eggman) Permits Temporary Conservatorship ("T-Con") time extension to date of court disposition

Vetoed:

SB 964 (Wiener) Would have requested report from the University of California on behavioral health job descriptions, including scope of practice for relevant licensures

SB 1143 (Roth) Would have provided a "loan" fund for building inpatient psychiatric beds, with a sketchy repayment scheme

SB 1446 (Stern) Would have created new entitlements for mental health services and "Housing the Heals"

It's a mixed bag. But, taken with other bills that passed or died earlier in the session, we can be proud of the successful efforts of organized psychiatry in the process, led by the California State Association of Psychiatrists (CSAP), the APA statewide organization of all APA California District Branches, including, of course, SCPS. Our profession and our patients are better served by the beneficial changes

in mental health law.

And, there will be more bills for us to sponsor and support—and undoubtedly some that we will have to oppose—in the coming 2023-2024 legislative session, so please stay tuned!

Disaster Committee Report

By: Danielle Chang, M.D.

The charge of the Disaster Relief Committee is:
To develop and implement plans for SCPS' response to disasters
To provide assistance to members and the public in response to disasters
To share disaster relief resources and develop relationships with other local medical and professional associations engaged in disaster relief mental health work

The SCPS Disaster Relief Committee meets on a monthly basis and welcomes any SCPS members who are interested in joining. The committee has sponsored several events and trainings over the past year. The committee organized a panel discussion on Questions and Answers: Disaster Relief and Psychiatry with panel speakers Leslie Gise, MD, Randy Mervis, MD, Mary Ann Schaepper, MD in January 2022. During the event, panelists shared about their inspiring work providing disaster mental health services. Leslie Gise discussed her work providing services after Hurricane Katrina in 2005, her service as the Mental Health Lead for the Maui Red Cross, and her experiences as part of the Maui Medical Reserve Corps. Randy Mervis discussed his work as a volunteer for the Los Angeles Chapter of the American Red Cross for over 25 years. Mary Ann Schaepper talked about her work with Syrian refugees abroad and locally, and her involvement in the Peace of Heart Project which provides mental health services to refugees and frontline workers via online telecommunication platforms.

In February 2022, the Disaster Relief Committee organized a panel discussion on Psychiatric Evaluation for Asylum Seekers: An Opportunity to Serve and Teach with Student-Run Human Rights Clinics in Southern California with panelists Nina Rabin, J.D., Director of Immigrant Family Legal Clinic at UCLA School of Law, Kristen Zaleski, Ph.D, LCSW, USC-Keck Human Rights Clinic, Tinh Luong, M.D., Ph.D., Olive View-UCLA Human Rights Clinic, *and* Medical Student Directors from Medical Students for Immigrant Justice at UC Riverside, USC-Keck Human Rights Clinic, and Los Angeles Human Rights Initiative at UCLA. The panel was an opportunity to discuss the work of psychiatrists conducting evaluations for asylum seekers and opportunities to volunteer at human rights clinics in southern California.

In March 2022 we partnered with the American Red Cross in order to provide Psychological First Aid Training presented by Lynda Harbert, LMFT, Disaster Mental Health Supervisor and Trainer American Red Cross Los Angeles Territory.

Most recently, we had a panel discussion on The Mental Health Needs of Firefighters with Steven F. Froehlich, Ph.D., Director of Behavioral Health & Lead Clinician, Los Angeles County Fire Fighters Local 1014, and several Los Angeles County Fire Fighters. The panel speakers shared about the significant stressors that fire fighters and other first responders are faced with and their impact on the mental health of first responders, as well as cultural competency issues around providing mental healthcare to firefighters.

We have been discussing plans for a panel discussion about the effects of war on mental health. In addition, the committee continues to discuss ways to help better prepare psychiatrists and patients for times of disaster and is engaged in strengthening relationships with partnering organizations. If you are interested in joining the committee, please contact Mindi Thelen for more information at socalpsychiatric@gmail.com.

Council Highlights
September 8, 2022

Ara Darakjian M.D., *Secretary*

PRESIDENT'S REPORT Dr. Little

Stimulants/BDZ Caps

Dr. Little informed council of reports from SCPS members that pharmacies were limiting the number of patients to whom they can dispense stimulants. In addition, some attorneys have reported that the medical board is closely monitoring prescription of benzodiazepenes and prosecuting physicians who prescribe more than 3 month's worth of medication. Dr. Little looks to involve state and national level advocacy organizations to protect autonomy of physician practice.

Town Hall

Dr. Little spoke regarding a town hall to be held in November or December, to keep membership informed of advocacy efforts and other SCPS activities.

Barbara Weissman, M.D. October

Dr. Weissman, Area 6 Trustee on the APA Board, will be attending the council meeting next month.

PRESIDENT-ELECT'S REPORT Dr. Goldenberg

Newsletter Articles Sign-up

Dr. Goldenberg presented monthly assignments for council members to contribute to the newsletter.

Private Practice Committee

Dr. Goldenberg welcomed additional involvement in the private practice committee.

TREASURER'S REPORT Dr. Bindra

A. August Financials and Cash on Hand Report

Dr. Bindra reviewed various financial metrics, year-to-date, as of August. Overall, SCPS is in good financial health.

Motion was made to approve the Treasurer's Report and it was accepted by unanimous vote.

GAC REPORT Dr. Shaner

Dr. Shaner reported on a busy summer. Eight days ago, the legislature's two-year cycle came to a close. A large number of bills were reviewed, and CSAP advocated for and against many mental health bills. Some bills passed and are awaiting the governor's signature, and others failed. The bills that passed, listed below, still require the governor's signature to become law.

Also, Dr. Emily Wood was elected to be the chair of the CSAP GAC committee.

LPS Matrix bills that passed:

SB 929 (Eggman) - Counties must provide standardized data concerning community mental

health service availability, quality, and access.
SB 970 (Eggman) – Requires better data collection related to MHSA
SB 1035 (Eggman) – Permits court to evaluate evidence concerning medication adherence during AOT hearings.
SB 1227 (Eggman) – Permits an additional 30 days of involuntary hospitalization in cases in which patient might improve and not need conservatorship.
SB 1238 (Eggman) – Sets up machinery to produce regional government projections ofbehavioral health service available and project future needs.
LPS Matrix bills that failed:
SB 965 (Eggman) – Required that the court accept medical record as evidence in conservatorship hearings (currently regarded as hearsay).
SB 1154 (Eggman) – Would have set up a real time database for statewide psychiatric bed availability.
SB 1416 (Eggman) – Would have added serious medical conditions to grave disability.
Other bills that passed
AB 852 (Wood D) – Requires pharmacy systems to accept standardized prescription software.
AB 988 (Bauer-Kahan) – Requires state to set up machinery for 988 hotline.
SB 225 (Weiner) – requires HMOs to provide follow up appointments within 10 business days (with exceptions)
SB 1338 (Umberg and Eggman) – Sets up machinery for a heavily funded ($20+million) new court process for hearings concerning treatment recommendations forseverely mentally ill individuals which will direct pilot counties (Orange, Riverside,San Diego, San Francisco, and Stanislaus) to provide specified resources and subjects of hearings to comply to avoid potential consequences.
SB 2242 (Santiago D) - Among other components, the bill, if signed, will require the model care coordination plan to require that an individual exiting a temporary hold or a conservatorship be provided with a detailed plan that includes a scheduled first appointment with the health plan, the mental health plan, a primary care provider, or another appropriate provider to whom the person has been referred.
Other bills that failed
SB 57 (Wiener) – Would have set up safe injection sites in model counties. It passed but was vetoed by the Governor.
Dr. Shaner presented areas of future focus for the new legislative cycle, including telehealth, prior authorization issues, treatment for neurodevelopmental disorders, nonmedical documentation demands placed on psychiatrists, and stimulant medication/ADHD quality of care issues.
Dr. Shaner made a motion that the SCPS council notify CSAP that it would be satisfied with an interim High Level Policy Platform, to be used to communicate with legislators and other stakeholders for the 2023-2024 legislative session. The document, which is already prepared, is not binding, and will be open to revision moving forward.
With some discussion, an amendment to the policy platform was passed unanimously to highlight the role of psychiatric physicians to provide leadership in behavioral health care.
The motion was unanimously approved.
APA sent a pointed letter to CMA (California Medical Association) stating that it is the only statewide organization representing all APA members in California, and that all five California

district branches have joined CSAP.

MEMBERSHIP REPORT Dr. Ijeaku

Membership Report

21 new applicants were found to be in good standing; Membership was approved by council.

COMMITTEE REPORTS

Access to Care – Dr. Friedman reported regarding a meeting with the Department of Managed Care, with a focus on issues related to Independent Medical Reviews (IMRs).
AB 988/ACR – Dr. Wood reported that stakeholder groups are being formed, and that SCPS representatives will be present to provide viewpoints of psychiatrists.
By Laws – Dr. Shaner reported that the APA updated requirements for DB bylaws. The committee has drafted new bylaws and is in the process of editing and finalizing for approval by Council, at which point it will undergo a vote by the membership.
Disaster MH Relief Committee – Dr. Chang reported on a couple of events that are coming up.
Diversity and Culture – Dr. Ijeaku presented an idea for an event, which was supported by the majority of the council
LGBTQ+ - Mindi reported that, although this committee is currently chair-less, the committee plans to organize two events that are open to all psychiatrists. There was feedback that the committee should appoint interim chair(s) prior to holding events.
Program – Dr. Gales reported regarding an upcoming APA event.

NEW BUSINESS - None Dr. Little
XI. OLD BUSINESS - None Dr. Little
ADJOURNMENT at 9:13 pm Dr. Little

CLASSIFIED ADVERTISEMENTS

Santa Monica Office for Lease

Unique unfurnished office in a two-office cottage. The cottage is part of an all-therapist complex comprised of 13 offices. The available office has a separate egress, individual AC, fireplace, furnished waiting room, call-light system, therapist parking space, and full amenities including security. Tenants have 24/7 access. The office measures approximately 11' x 10' and rents for $1085 per month.

Contact Ed: docdreyfus@gmail; (310) 994-7318

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