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# PSYCHIATRIST

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Newsletter of the Southern California Psychiatric Society

## *President's Column*

# Prioritizing Women's Mental Health

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



In writing last month's article on the ongoing oppression and discrimination against Black people in America, I felt it was important to maintain the centrality of the experiences and needs of this diverse group in my message. But, clearly there are many others in our society disadvantaged by injustice and inequality. With March being Women's History Month, I'd like to reflect on the inequities suffered by women generally while recognizing the complex interactions of a person's sex with other social and political identities such as race, age, ethnicity, socioeconomics, and gender identity that influence the forms and degree of injustice and discrimination experienced by individual women.

Women in the United States face unique challenges that directly affect their physical and mental health. Across all racial and ethnic groups, women are more likely to live in poverty than men. They also experience unequal pay and fewer opportunities for career advancement. Cultural expectations about caregiving along with inequitable policies related to childbirth and childcare further disadvantage women. Throughout their lives, women suffer much higher rates of physical and sexual violence which contributes to a lifetime prevalence of PTSD more than twice that of men.<sup>1</sup> Women also experience disproportionate challenges related to their reproductive health. These factors contribute to increased rates of mental illness like depression and anxiety as well as producing barriers to treatment.

The problems experienced by young women in America are especially dire as highlighted by the most recent Centers for Disease Control and Prevention Youth Risk Behavior Survey.<sup>2</sup> This biennial nationwide survey collects data from high school students on a range of health behaviors including mental health. The most recent report reveals that high school-aged women are experiencing record levels of violence, sadness and suicide risk. Nearly 60% of the young women surveyed reported feeling persistently sad or hopeless. And, one in five respondents reported experiencing some form of sexual violence in the last year. Girls are almost twice as likely as boys to experience electronic bullying. And, one third of young women report seriously contemplating suicide at some time in their life while 10% reported an attempted suicide in the past 12 months! When the student identified as LGBTQ+, the reported incidence of attempted suicide rose to 20%. To quote Dr. Debra Houry, CDC's Chief Medical Officer, "These data show a distressing picture. America's teen girls are engulfed in a growing wave of sadness, violence and trauma."<sup>2</sup>

Addressing the problems faced by women in our society requires a multifaceted approach that involves individuals, communities, grassroots organizations, and government working together. These efforts

must address the biased and objectifying ways we portray and value women in our society. They must include policies that support women's equal access to employment and equal pay as well as equitable workplace protections and remuneration for the essential but unpaid work of family caretaking performed predominantly by women. We must support equitable access to housing, transportation, and childcare. Most families who are experiencing homelessness are headed by single women, and these women experience posttraumatic stress disorder at a rate higher than the national average.<sup>3</sup> Thus, in order to develop effective policies, we must also improve our understanding of the relationship between an individual's history of trauma and homelessness. Perhaps most importantly, women must be provided equitable opportunities to hold positions of power and influence in our society. And, their experiences and perspectives need to be prioritized in discussions of how best to address the problems they face.

At SCPS, we have a long tradition of including and elevating women's perspectives. Our organization has benefited from women in leadership positions throughout its history including as Committee Chairs, Presidents, Treasurers, Secretaries, and for the last three decades our Executive Director. The SCPS Women's Committee, formed in 2010, has held regular meetings to promote the needs of women in our profession, learn from experts, and provide support to one another. Several of our other committees are focused on issues central to the inequalities and disadvantages affecting women including our Access to Care, Diversity and Culture, and Disaster Relief Committees. In our organization's legislative policy platform, we have emphasized advocacy that reduces stigma, supports community housing, improves perinatal care and postpartum mental health screening, and increased access to school-based mental health programs.

As Psychiatrists, we also have a unique opportunity to have conversations and provide interventions that take into account the specific ways injustice and oppression have affected the women we treat. Awareness and sensitivity to factors such as violence, barriers to healthcare, and cultural differences in the understanding and experience of mental illness can help us better meet the needs of our patients. Screening for common conditions and impactful life events like trauma and substance abuse, providing education about effective coping strategies, and validating the importance of self-care are also important interventions. Lastly, in our offices, homes, and schools, we can participate in and encourage conversations that raise awareness about women's experiences. By sharing in these opportunities to understand the prejudices and injustices experienced by women in America, we can increase our empathy for the challenges they face, highlight the resilience they manifest in rising to meet them, and move us all closer to a society that is fully inclusive and just.

1. Kimerling, R., Weitlauf, J. C., Iverson, K. M., Karpenko, J. A., & Jain, S. (2013). Gender issues in PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and Practice*. New York: Guilford Press

2. Centers for Disease Control and Prevention Youth Risk Behavior Surveillance System (YRBSS), Youth Risk Behavior Survey Data Summary and Trends Report 2011-2021 (2023). [www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS\\_Data-Summary-Trends\\_Report2023\\_508.pdf](https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf)

3. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

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# A Potential Legal Alternative to Some LPS Conservatorships - “Treatment Guardianship.”

By: Joseph Vlaskovits, M.D.



One of the aspects I find remarkable about the longstanding crisis surrounding the provision of mental health services is the continued unwillingness by our state government to provide new legal avenues for involuntary (e.g., long-acting antipsychotic depot) medications for our most vulnerable patients.

Despite the addition of Assisted Outpatient Treatment (mandated for all counties in 2021) and more recently the Governor’s CARE Courts (which as of this writing are tangled up in litigation challenging their constitutionality), neither effectively enforces psychotropic adherence, which is often the critical missing piece for a person suffering from severe and persistent mental illness.

Therefore, presently, in the civil treatment setting, there are only two legal ways to enforce involuntary psychotropic medication orders. Either, under a Riese petition in an acute inpatient environment or through LPS Conservatorship, if the county of conservatorship permits it.

Although it is often considered a panacea by grass roots advocates for treatment, LPS Conservatorship is inherently burdened by its nature, and is simultaneously cumbersome and expensive to implement.

First, LPS Conservatorship has an extremely restrictive nature, which essentially strips a person of their civil liberties, or as one jurist pithily remarked, “it is like going to prison.” Among other aspects, basic rights to one’s money, and choice as to one’s living situation are taken away.

Understandably, given these high-stakes, the law mandates that grave disability must be proven beyond reasonable doubt – at the same level as a criminal offense. Further, the process accords a panoply of rights to the proposed conservatee, making the legal proceeding complex<sup>1</sup>, and includes the right to a jury trial.

Apart from these barriers, the process is not only expensive, but due to its draconian nature also risks alienating the person from future voluntary care.

There are clearly cases in which LPS Conservatorship is the most appropriate support despite its restrictive nature. In the extreme, the severity of the illness, the lack of insight by the patient, and no other way in which they can effectively be assisted, may need to culminate in LPS Conservatorship as the only realistic option to protect them.

However, in my experience, in many cases the aforementioned barriers cause LPS Conservatorship to be either too draconian, or simply out of reach because the legal bar cannot be met.

Fortunately, as of the beginning of the year, Welfare and Institutions Code §5270 was expanded from one to two thirty-day periods to provide more time to treat the symptoms causing grave disability in an acute inpatient environment while not necessarily having to resort to LPS Conservatorship.<sup>2</sup>

I would like to advocate for an additional option, that while not a panacea, would provide another avenue to assist those most in need. New Mexico adopted its civil commitment statutes several years after

California, and has an alternative worthwhile exploring, namely Treatment Guardianship<sup>3</sup>.

Unlike LPS Conservatorship, under Treatment Guardianship the right to refuse psychotropic medications is the sole civil right taken away for those suffering a major mental illness who lack the capacity for informed consent.

Treatment Guardianships provide for court appointed substitute decision makers (e.g., trained volunteers that receive a modest stipend for their time) that only approve or deny the psychiatrist's request for psychotropic informed consent. Other rights, including the person's estate or choice of where and how to live are wholly unaffected. The burden of proof is also significantly lower, by clear and convincing evidence, and the petition must prove that this is the least drastic means of treatment. Trials are by judge, not jury, and the substitute decision maker (i.e., Treatment Guardian) is appointed for the least amount of time necessary, but no more than a year initially, with the possibility of renewal. Should the patient regain the capacity for informed consent, the Guardianship should be terminated. The petition is usually brought during acute hospitalization, with the aim of preventing harm to the patient but also future hospitalizations.

The addition of such a legal mechanism, I believe would be far more effective and accessible in helping many of those suffering from major mental illness who have lost their capacity for informed consent, while otherwise safeguarding their rights than our present legal options.

<sup>1</sup> Notably, recent efforts to expand the definition of grave disability to include physical health criteria have faltered in the Legislature repeatedly.

Further, a change this year in the law codified that a jury trial must be held within 10 days of the demand and could only be continued at the request of the conservatee.

<sup>2</sup> Notably, 5270 also needs to be adopted by individual counties, and while extremely widespread is not universal in the state.

<sup>3</sup> Treatment Guardian | New Mexico Developmental Disabilities Planning Council ([nmddpc.com](http://nmddpc.com))



The graphic features a purple and blue background with a stylized blue building icon on the right. The text is arranged in horizontal bands: a purple band with the SCPS logo and event title, a lighter purple band with the date and time, and a dark blue band with the speaker list.

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## *Lather. Rinse. Repeat.*

By: Reba Bindra, M.D.



As I'm sure you have heard by now, Governor Newsom has a fancy, larger-than-life, \$14 billion (that's billion with a B) proposal known as Community, Assistance, Recovery, and Empowerment (CARE) Court (SB 1338). It is focused on the unhoused as well as mental health services with the target population being those with severe mental health and substance use disorders. Admittedly, I have not read the whole thing and I'm guessing most haven't since it is rumored to be several hundred pages, double-sided, single-spaced, and in 8-point font (or was it 6-point?). It may be digestible in pieces but even then, it sometimes reverse-travels up the esophagus like a bad case of acid reflux. Let's just say that it is not without controversy or several loose threads flailing about. Utilization of psychiatric inpatient hospitals and emergency rooms are square in the cross hairs of this proposal since this is where we generally find our severely mentally ill. The plan rightfully references these settings but there are actually a few other places these patients tend to hang out in, namely jails and state hospitals. So far, there has not been a whole lot of chatter about these entities in the CARE Court plan.

I worked in county psychiatric inpatient settings almost exclusively for over a decade and have an enduring passion for treating patients with Schizophrenia. Inpatient work always made sense to me in a visceral way. However, 3 states and 7 counties later, I was ready for a change. By happenstance, I ended up working at a state hospital. I knew very little about forensics but imagined the state hospital work would be inpatient with a twist. It was a twist that ended up changing the trajectory of my career and challenged me both as a psychiatrist and a human being. My education into the world of forensics, specifically corrections, over the last 7 years has been a sobering lesson about the interface of the legal system and mental health in California.

While working in hospitals all those years, some patients would come in and out of the hospital so often I didn't even need to review their charts to know what medications they had been on. They would get admitted and we would then do the medication dance—capacity to refuse or not? Let's have a hearing! I would get the court order, administer the medications involuntarily and promptly discharge them on Day 17 (5150+5250, thank you LPS laws). 99.9% of the time, I knew that patient would not take another single dose of medication. Not unexpectedly, they would decompensate and then run head on into another 5150 which would start the cycle all over again. *Lather. Rinse. Repeat.* I am a believer in involuntary medications because I have seen the dramatic shifts in patients who receive treatment, but it does not come without some angst. Evidence has emerged that giving on-again, off-again treatment with antipsychotic medications can potentially have long term negative effects on the brain and could possibly alter response to medications in the future. And what of the side effects? If they are drooling, sedated, and have a tremor so bad they can't hold a fork to feed themselves, do I stop the medications? Do I lower the dose? Oh wait, it's Day 17 and they have to go. I still dutifully give them a 30-day supply of medications in hand as they walk out the door (which would end up in the trash can outside) and calculate in my mind when they would be back. Spoiler alert, it's sooner than you think.

I find myself in familiar territory now working at 2 different county jails. As a reminder, jails are for those who have been arrested but *not convicted* and prison is for those who have been found guilty and are serving time. The patients I work with are *innocent until proven guilty*. Not surprisingly though, they are often deemed "guilty until proven innocent" by almost all facets of society just by virtue of being in jail. I could spend the rest of this article pointing out all the reasons we all need to reflect and ask ourselves if we believe that every single person who gets arrested really committed the crimes they are accused

of. Or maybe it's easier to believe that someone who is homeless, using drugs and mentally ill is automatically guilty because that's what they do, right? It makes us uncomfortable to think maybe the wrong person got arrested or evidence was tainted or there simply wasn't any. What about erroneous police reports? False identifications? Our patients are vulnerable to all of this and have everything stacked against them so perhaps we start by not convicting them in the court of our own minds. Some of the charges our severely mentally ill patients get arrested for is a fascinating study into how charges are erected and applied. The discrimination is more than skin deep.

The jails parallel the inpatient settings in so many ways (except for the less-than-useful treatment plans and 5250 hearings) where patients present in the throes of psychosis with substance use complicating their cases. Consider this: a patient with Schizophrenia gets arrested and is booked into jail just as gravely disabled as the one in the hospital but the one in the hospital gets an evaluation by a psychiatrist within 24 hours. Medication decisions are made instantaneously, and a court order can be had within 5 days of hospitalization. Unlike the hospital, the process to get an involuntary medication order (IMO) in jail is not quite that simple. There are a few ways to get an IMO in jail settings but only one way is utilized in the jails I work in. When a patient gets classified as "incompetent to stand trial" (IST) by the court, it usually comes with an IMO. To make a very (very) long story short, once in the IST system, it's like one of those eye puzzles (Autostereograms—I had to Google it) where there is a vague picture that never completely come into focus (then again, I can't read an autostereogram to save my life so maybe it's just me). What takes 5 days in the hospital takes several months in the jail setting. Psychotic patients languish and wait while in extremely disturbing conditions and they have no voice to advocate for themselves. Sometimes just getting a blanket becomes an insurmountable task. They wait for the wheels of the legal system to turn which runs on 3 flat tires. The IST system in California is a complicated, cumbersome, illogical and fascinating foray into the mentally ill trapped in the molasses that is our legal system. It's just *lather, rinse, repeat* disguised as good intentions. As much as I would love to go off on an IST tangent here (one of my favorite things to do), I could not do it justice in just a few lines so consider it a preview of coming attractions.

We openly talk about patients who repeatedly cycle through ERs and psychiatric hospitals but we skip over the conversations about the severely mentally ill who circulate through the jail system. These patients are deemed guilty before they are convicted of anything and thus are classified in the criminal system instead of the healthcare one. The patients in the ERs and hospitals are in the healthcare system and thus there is a different standard of care. That is not to say that we don't need to raise the standard of care in our psychiatric hospitals because, well, have you ever been in a county inpatient hospital? Consider this: at any given time, the same patient can either be arrested/taken to jail or put on a 5150 and taken to a hospital—the mental illness is the same in both scenarios but only one is treated with compassion. I find it mind boggling that somehow being arrested means their psychiatric symptoms are less of an emergency. There is no magic metal detector that patients go through in the jail that somehow decreases the intensity of their symptoms. As someone who has worked in both settings, I am starting to believe the ones in the jail may be a little worse off.

We need to question why we as a society have settled in to *lather* (inpatient/jail), *rinse* (treatment/state hospital) and *repeat* (discharge/readmit) as the standard of care. These patients need more than a bandage for a hemorrhaging wound. Doesn't CARE Court address this though, you ask? Not all of it apparently. I am really hoping someone will correct me and tell me there is some plan addressing the jails and state hospitals. Or maybe Governor Newsom will read this and give me a call (Governor, have your people call my people). I should also mention that much of my skepticism of this plan comes from the fact that it is based on "voluntary" participation of the patient. Perhaps the authors of the plan know something I don't since the patients that are the supposed beneficiaries are the ones who are *involuntarily* being brought to hospitals and *involuntarily* medicated. If they can get these patients to participate

voluntarily then the last 20 years signing 5250 holds, applying for conservatorships, getting into the weeds with competency and filling out (extensive) paperwork for involuntary medication orders seems like overkill. I did not do all those things without understanding the impact of taking away a patient's rights under the justification of beneficence. I would love nothing more than for there to be treatment that preserves a patient's dignity and minimally curtails their rights. I just hope those plans include all mentally ill patients no matter what setting they are in.

If you have made it this far, thank you. Bringing compassion to severely mentally ill patients is my life's work, and my more recent mission is to break some of the stereotypes about patients who are tangled up in the legal system. I will be waiting anxiously for the Governor's call and in the meantime am going to start working on a piece about the incompetent to stand trial system. It will be full of intrigue, mystery, secrets, and drama. You aren't going to want to miss it!

\*Special shout out to my fellow psychiatrists at the jail who patiently listen to my repeated rants about this stuff on a regular basis.

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# What is going to happen with the Ryan Haight Act?

By: Laura Halpin M.D., Ph.D.



Throughout the course of the COVID-19 public health emergency (PHE), telehealth has changed the practice of psychiatry immensely. With the passage of the Omnibus bill at the end of 2022 (HR2617), many of the pandemic-related telehealth exemptions to support telehealth were codified, or at least extended through the end of 2024. One area that we have all been questioning, was what would happen with the Ryan Height Online Pharmacy Consumer Protection Act (RHA), and more specifically, the prescription of controlled substances using telehealth. The DEA recently issued a proposed rule for this on Feb 24, 2023. Here, we will review some background on the RHA and describe some of the recently proposed changes. Of note, these changes are not final and will have a 30-day public commenting period. The current iteration of proposed changes suggests a 6-month transition period from the end of the public health emergency until the new rules take place. This 6-month transition period will not be set in stone until the final rule comes out, likely closer to when the PHE ends on May 11, 2023.

The RHA was passed in 2008. It regulates online prescriptions for controlled substances and is enforced by the DEA. More broadly, the DEA is charged with enforcement of the entire Controlled Substances Act and that, along with the RHA, gives them much of the authority that is relevant for the new proposed rule. Outside of controlled substances, the DEA does not have authority relating to telehealth. When written, the RHA already included provisions for exemptions, one of which was the presence of a public health emergency, hence this act has been suspended during the PHE. There are other exemptions listed that involve working in different federal health systems (such as Indian Health Service or Veterans' Health Administration) and variabilities based on location of patient being treated (such as in a hospital setting), however most do not apply to patients being treated with telehealth during the pandemic.

This existing RHA includes requirements relating to prescribing controlled substances via telehealth. Most notable is the require for an in-person medical exam in the physical presence of the practitioner, prior to dispensing controlled substances over telehealth. Importantly, frequency of in-person visits after this initial visit is not mandated in the act. The act also requires separate DEA registration when a practitioner prescribes in different states.

The pre-existing RHA also provides provisions for a "special registration for telemedicine", and while the law provides for this registration, the DEA has never issued a rule or developed specific regulations that creates it in practice. It was highly anticipated that this would be the mechanism by which the DEA would address future prescribing via telehealth. However, the DEA did not do this, stating they believed this process would be too burdensome. Instead, they proposed the some of the below changes. The full proposed rule can be found on the DEA website and is over 60 pages long, of note these changes are only relevant when 1) no in-person evaluation has happened, 2) controlled substances are prescribed. The information below is provided only to support further debate and feedback among our membership. Some of the most salient proposed changes are:

-For non-narcotic Schedule III, IV and V medications and buprenorphine (benzodiazepines): can be prescribed by telehealth alone for 30 days without in-person evaluation or when referred for evaluation by another DEA practitioner who provided in-person evaluation. After 30 days, in-person evaluation is needed for further prescribing or there is a provision for a joint-synchronous video evaluation with another in-person practitioner.

-For Schedule II (including stimulants) and narcotic medications: must seen for in-person evaluation

OR referred for evaluation by another DEA practitioner who provided in-person evaluation before being prescribed by telehealth.

-New documentation requirements for the use of telemedicine in prescribing controlled substances including the date of the prescription, the name and address of patient, all details about the prescribed medication, the address where the practitioner is located during encounter, the city and state where the patient is located during the encounter, the NPI of the referring practitioner (if this is to be used as the in-person evaluation), and a copy of this referral. Please note it is proposed that these documentation requirements may be effective immediately at the end of the PHE (and not subject to the 6-month transition period)

-that it was must clearly be noted on a prescription if that prescription was issued in a telehealth encounter

-that audio-only option is possible when a patient is “unable to use, does not wish to use or does not have access to two-way AV technology”. It would be expected that the remote practitioner would have these capabilities.

In the coming weeks, we suspect these new regulations will be intensely debated as organized medicine prepares comments during the 30-day public comment period. Please note once this is open, anyone can provide comments (see [www.regulations.gov](http://www.regulations.gov) once open). It is anticipated that some of the most highly debated topics will include the new documentation requirements, the process for the in-person evaluation by referring practitioner and the high level of regulation proposed for Schedule II non-narcotic medications (stimulants).

Beyond these new regulations, please also keep in mind that it is also important to be aware of all the other state and federal regulations related to telemedicine, controlled substances, PDMP review and documentation, and state licensure requirements.

*You may wish to review this helpful DEA infographic*

<https://www.dea.gov/sites/default/files/2023-02/Controlled%20Substance%20Guidance.pdf>

The SCPS election is open. Ballots were transmitted to members on Monday, March 6th, 2023. If you did not receive your ballot by email, please let us know. If you wish to vote by paper, please contact Mindi to request a paper ballot.

[socalpsychiatric@gmail.com](mailto:socalpsychiatric@gmail.com)

*Please note, there is a Bylaw ammendment on this year's ballot.*

**Please be sure to vote!**

# The Current State of Behavioral Health Crisis Response

By: Emily Wood, M.D.



Alternative Crisis Response (ACR) is a movement toward developing adequate inclusive, timely, trauma-informed behavioral and mental crisis response for all communities that relies as little as possible on law enforcement. Please see the [January 2022 SCPS Newsletter](#) for a general overview of ACR.

## National Progress

On July 16, 2022, the 988 Suicide and Crisis Lifeline went live and phone companies nationwide started routing calls dialed to 988 to local mental health resources. 988 is a hotline that provides free, 24/7 call, text, and chat support and resources to people experiencing or affected by mental and behavioral health crises.

## State Progress

On September 29, 2022, Governor Newsom signed AB 988, The Miles Hall Lifeline & Suicide Prevention Act. This law established a 5-year long phase-in for establishing a comprehensive behavioral health crisis prevention, response, and care system in California. This bill was named for Miles Hall, a young man with serious mental illness, who was shot and killed by the Walnut Creek Police in 2019 after his family sought help through 911 when Miles was in crisis. The most important part of this bill is that it provides a dedicated revenue source to fund the 988 system in California. The California Health and Human Services Agency has been tasked with assessing needs and developing a plan for moving forward. As part of this, we expect to see “clean-up” language to the 2022 bill in the next legislative cycle that will specify how the funds can be used and what behavioral health crisis response services counties must provide.

## Los Angeles County Progress

In 2020, the Alternative Crisis Response initiative was created by Board of Supervisors (BOS) as a partnership between LA County’s Department of Mental Health (LACDMH) and the Alternatives to Incarceration (ATI) Initiative of LA County’s Chief Executive Office. This initiative was in response to the “Care First, Jails Last” report by the ATI Work Group earlier in the year. The ATI report cited findings from a 2020 RAND Corporation report that developed and utilized a set of structured legal and clinical criteria and estimated that around two-thirds of the LA County jail mental health population could be appropriately diverted from the jails to community programs.<sup>1</sup> A key diversion strategy is to utilize behavioral health responses for individuals experiencing mental health and/or substance use disorders while avoiding and minimizing law enforcement responses.”<sup>2</sup> In June 2022, LACDMH established a new ACR Unit dedicated to ensuring crisis response services and systems are coordinated and comprehensive throughout Los Angeles County, and in November LACDMH officially assumed responsibility for ACR implementation.

LA County is implementing comprehensive crisis care focused on the three core areas put forth by SAMHSA<sup>3</sup>:

### **Regional crisis call centers** (someone to call)

Are expected to operate 24/7/365 by clinically trained team members who will be able to triage and connect individuals with the appropriate services through warm hand-offs utilizing an “air traffic control” approach such that contact is kept with individuals in crisis until they are safely in the hands of another provider. These call centers should have modern technology that in-

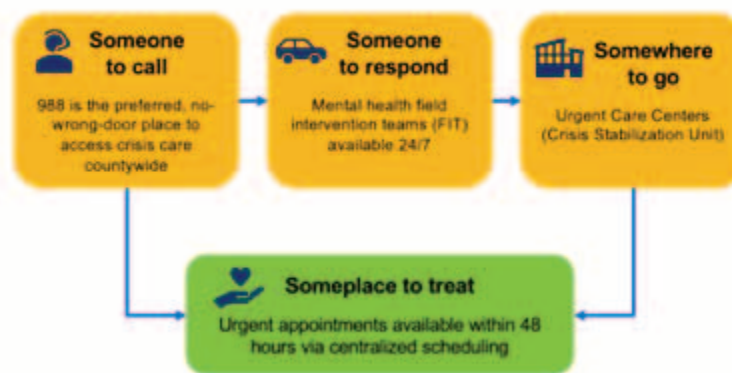
terfaces with other emergency services in a bidirectional format as well as with crisis bed registries and outpatient scheduling databases.

### **Crisis mobile team response** (someone to respond)

Should include properly licensed/credentialed clinicians who can respond to locations across the community in a timely manner and transport or coordinate transport with warm hand-offs to nearby stabilization facilities when individuals cannot be adequately stabilized in the community. These services should include peer support and should be focused on providing therapeutic support from first contact, de-escalation, and resolving situations to avoid higher levels of care when possible.

### **Crisis receiving and stabilization facilities** (somewhere to go)

Should offer “no-wrong-door” access to acute (<24 hours) mental health and substance use care that is staffed with a multidisciplinary team able to assess and manage care for the full range of crises and provide appropriate dispositions to higher and lower levels of care as needed with warm hand-offs.



### **Someone to call**

Since June, LACDMH has been working closely with Didi Hirsch Mental Health Services, to rollout 988 services in LA County. Didi Hirsch Mental Health Services is the service provider that was contracted to manage the 988 hotline for LA County. Since July 2022, they have been receiving over 5,000 calls per month – this is a 26% increase in calls over pre-988 levels. Calls are answered by a trained crisis counselors who can provide emotional support, risk assessment, and safety planning. Didi Hirsch has hired 76 additional crisis counselors since July 2022. On average, calls are answered within 13 seconds and last around 13 minutes.

Of calls to 988 over the last 8 months, 95% of the situations have been de-escalated safely by phone without in-person response. Previously, the other 5% was dealt by 911 or the caller getting help for themselves by calling for a mental health field team or resorting to taking themselves (or those experiencing a crisis) to the hospital/ER. With ACR, we’re trying to build out that connection into the rest of the crisis continuum to help make 988 a true alternative to 911. We have already built a connection between 988 and the LACDMH ACCESS Help Line to warm transfer callers needing a mental health field team.

### **Someone to respond**

LACDMH is expanding Field Intervention Team availability across LA County. Field Intervention Teams, or FIT, are made up of a team of mental health professionals (typically a clinician and peer support staff) and provide crisis intervention services in the location where the individual is most comfortable (e.g., home or other field location). The goal of FIT is to stabilize the individual and allow them to remain in the community. DMH has both directly operated FIT known as Psychiatric Mobile Response Teams

(PMRT) and contracted FIT known as Mobile Crisis Outreach Teams (MCOT). There are 33 PMRT teams for LA County spread over eight service areas that operate from 8:00 am to 2:00 am daily. FIT are typically dispatched by contacting the DMH Help Line ACCESS Center. Whereas 988 calls in our area are still predominantly made by individuals in distress and the issues can be handled over the phone, 90% of calls to the LACDMH ACCESS helpline are from third parties and 27.5% result in dispatch of a FIT.

### ***Somewhere to go***

Los Angeles County established 2 more crisis stabilization centers in the last year bringing the total number of centers to 9.

### **Priorities for the coming year**

In 2023, the LACDMH ACR unit is prioritizing:

- \* Continued expansion of Field Intervention Teams to reduce FIT response time and operate 24/7
- \* Development of a standardized screening tool to appropriately triage mental health crises. The goal is for the LACDMH ACCESS line to merge with 988 and to work seamlessly with 911.
- \* Partnership with Law Enforcement to develop best practices in co-response and expand 911 diversion. LACDMH is working with the LA Countywide Criminal Justice Coordination Committee (<https://ccjcc.lacounty.gov/>) to develop best practices, protocols, and training with all of the LA county law enforcement agencies (45 agencies)

The SCPS Alternative Crisis Response Committee is involved in both the development of the standardized triage tool and in providing real-world experience and research regarding law enforcement and mental health co-response. Our focus has been to highlight the importance of gathering stakeholder feedback from the diverse communities that make up Los Angeles County regarding their experiences with crisis response and how they would like to be supported through crises in their community. Toward this aim, we are collecting real-life behavioral health crisis experiences to gather community stakeholder input on how Mental Health and Law Enforcement may partner to best care for and keep safe individuals with mental illness. Please help us share this survey across your network.

### **ACR Stakeholder Experiences Questionnaire**

If you are interested in learning more about the movement to make crisis response more equitable, the Kennedy-Satcher Center at the Morehouse School of Medicine has some excellent resources.<sup>4,5</sup>

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Transformed by Trauma: Stories of Posttraumatic Growth

By RG Tedeschi and BA Moore

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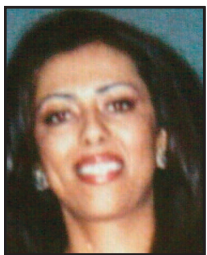
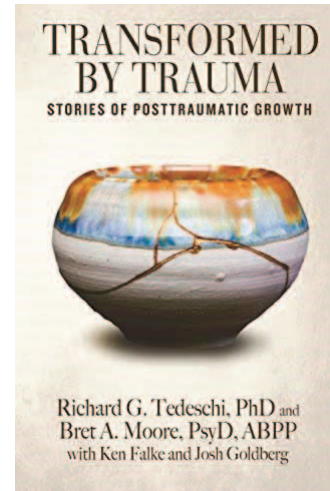
ISBN: 9798600226357

290 Pages

\$ 15.99 Paperback

Book review by Kavita Khajuria, MD

“from struggle comes strength”



Trauma can leave a trail of destruction, but this book describes the opposite - experience of transformative psychological changes in the aftermath of trauma that can compel posttraumatic growth. Authored by psychologists, posttraumatic growth is explained as a process and an outcome, as well as a pathway to resilience – while differentiating the two. Traumatic effects are compared to the beauty of Kintsugi, where a broken and repaired piece of pottery is simply a piece of pottery in a different form - where flaws are highlighted and embraced. Mental disorders are referred to as labels with consequent treatments that don't always work.

The importance of finding meaning and purpose in suffering to allow for the development of strength and wisdom is stressed. Five domains of growth are discussed; they note many to experience growth in more than one. With the roots of posttraumatic growth stemming from philosophical traditions, the impact of religion is noted to have considerable impact. PTSD is also discussed – what it is and isn't - explained as a complex condition requiring a comprehensive approach to wellness. Authors discuss the paradox of PTSD and posttraumatic growth for some, with gain from traumatic loss. They stress the importance of normalization of trauma - with an emphasis of people as different with the potential to experience PTSD differently and not necessarily fulfilling the symptoms in DSM. Other topics include risk factors, protective factors, maintenance factors and the strongest predictors for growth. They note PTSD to not be all bad: citing the more the struggle, the more the opportunity for growth and strength.

Reliance on others for support is noted as crucial, compounded by trust, illustrated by stories of combat veterans in the latter part of the book - purpose and a sense of mission noted to offset despair and compel an appreciation for life. Authors explain 'expert companions' - those who understand the process and know how to support those afflicted by trauma. The book concludes with discussion of disclosures including safe avenues and final elements of the PTG process - including understanding the value of what is learnt from a tragedy, a new identity, and the sharing of knowledge and wisdom with others.

The combat veteran stories were sobering yet inspirational and the argument against prolonged exposure therapy compelled some thought. Despite what appears to be a book for the public, parts of the book that can be appreciated are reminders to avoid pathologizing all traumas, the need for a trustworthy or reliable therapist, and simple points for patient education: an overreactive sympathetic nervous system, techniques to calm the nervous system, expected reactions to trauma, and practical information with preventive maintenance.

SCPS held a screening of its recent mini-documentary project, “Champions of Social Justice: Psychiatry in Marginalized Communities,” on Saturday, February 11, 2023 in celebration of Black History Month. The docuseries will also be presented at this year’s APA annual meeting in San Francisco.



The audience assembled.



The panel including interviewees and community experts.



SCPS President, J. Zeb Little, M.D., addresses the crowd.



Ijeoma Ijeaku, M.D., the director of the project.



Interactive panel discussion.



Panelists PK Fonsworth, M.D., and Helena Hansen, M.D.

# Council Highlights

## January 12, 2023

Ara Darakjian, M.D., *Secretary*



### PRESIDENT'S REPORT

Dr. Little

Santa Barbara Ventura Region – Dr. Little reported that he sent a letter to the Santa Barbara membership regarding merging their representation with Ventura County, since they struggle to have a member to volunteer as a councilor. Options were discussed. Dr. Little asked Dr. Shaner and the Bylaws committee to review if changes to the Bylaws would be required.

### PRESIDENT-ELECT'S REPORT

Dr. Goldenberg

Dr. Goldenberg thanked the council for continued contributions to the Newsletter.

The private practice committee also continues to be active in meeting and planning events. There will be a panel discussion about Substance Use Trends and Treatments online, on January 18.

Dr. Bindra thanked Dr. Goldenberg in his role for a productive meeting with NAMI.

### TREASURER'S REPORT

Dr. Bindra

December Financials and

Cash on Hand Report - Dr. Bindra reviewed various financial metrics, year-to-date, as of November. Overall, SCPS is in good financial health. A motion was made to approve the Treasurer's Report and it was accepted by unanimous vote.

Advocacy overage – There is money left over in the advocacy account related to switching from PPAC to CSAP. Various options were discussed to spend or save these funds. A motion was made to table the discussion to the next meeting. There was 1 no vote, 5 abstentions, and 16 yes votes.

### MEMBERSHIP REPORT

Dr. Ijeaku

Membership Report

5 RFM's and 4 GM's that submitted applications. Dr. Ijeaku recommended accepting the new members, which was accepted unanimously.

**Current Active Membership –1000/884**

### COMMITTEE REPORTS

Chairs

Diversity and Culture – There is a black history month event played on Saturday February 11 from 6-8 pm, where they will show their docuseries at the NPI. The committee made a request for the council to approve a \$300 budget for the event.

Dr. Ijeaku also reported that she shared her draft of an action paper with some assembly representatives for feedback. The action paper wishes to address the continued impact of the Moynihan report, and calls the APA to commit to supporting anti-racist policies in the field of psychiatry.

Dr. Silverman stated her intention to share the paper at the Area 6 meeting next week. A motion was made to share the paper with Area 6 council in order to get additional feedback, and it was approved unanimously.

GAC REPORT

Dr. Shaner

SCPS and CSAP have sent out surveys regarding challenges with pharmacy filling of prescriptions. The results were reviewed at the last GAC meeting and will be agendized for further action. There is a consensus that greater APA focus on development and advocacy of specific solutions would be useful.

Use of CURES data to sanction physicians was discussed. A motion was made to address the lack of clarity by the CA DOJ and Medical Board concerning the use of CURES data to investigate and sanction certain physicians. Specifically, the motion directs SCPS CSAP representatives to recommend that CSAP work with CSAM, CMA, and other stakeholder groups to seek clarity and voice concerns regarding patient confidentiality and physician harassment.

There were two abstentions, and one in opposition. The motion passed.

Dr. Shaner reported that the High Level Policy Platform was agreed upon by the 5 district branches. A motion was made that the SCPS Council adopt the CSAP High Level Policy Platform for use by SCPS. The motion passed unanimously.

ADJOURNMENT – 9:13 pm

Dr. Little

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