Southern California
PSYCHIATRIST
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President's Column

Year in Review

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

As this is my last article as SCPS President, I would like to start by thanking you, our members. Without your involvement and financial support, we wouldn't be the dynamic, effective organization we are. I am deeply grateful for the opportunity to serve SCPS's members, our patients, and our profession. The year has been, for me, one of personal and professional growth. It has provided a deeper appreciation of the mental health needs of our society and the social and professional challenges to addressing them. My greatest appreciation goes to the individuals who make up the working committees and executive council of SCPS. The knowledge, selflessness, and energy these individuals bring to the organization and its mission is inspiring. Through their expertise and commitment, they make our organization's goals a reality.

There were also challenges to the organization's efforts this year. Some are perennial concerns for Psychiatry such as addressing obstacles to parity, allied professional's scope of practice, and improving access to treatment for our patients. Other challenges more directly related to SCPS' day-to-day functioning include evaluating new sources of revenue and opportunities for cost cutting. And, given the changing landscape of mental health care, we must determine how SCPS can position itself to meet the evolving educational and professional needs of our members. We also continue our efforts to find a balance between the efficiency of online meetings and the joie de vivre of in-person gatherings.

Looking ahead, I am optimistic about SCPS' future and that of Psychiatry generally. This optimism is supported by the increasing awareness of the importance of mental health in our society. Local and national governmental agencies are currently focused on legislation and funding for mental health related concerns. And, there is an increasing appreciation that "psychosocial" elements are as important as biological ones in producing and relieving the suffering of mental illnesses. I believe SCPS can play a positive roll in the nature and outcome of these heartening developments. Our members' range of professional, personal and cultural expertise and collaborative spirit can aid productive dialogue and more effective problem solving. SCPS' close working relationships with local and national organizations provides significant opportunities to benefit one another and improve the circumstances of our patients. Whether or not it's through SCPS, I encourage you to consider the professional and social causes you are passionate about and how you can support them.

In closing, I'd like to give a special word of thanks to our Executive Director, Mindi Thelen, who provides near-daily support for the activities and demands of the organization. Our success would not be possible without her experience, skill, and genuine care for SCPS and its members. I also want to thank the Executive Council and Committee Chairs for their support, patience and humor during the course of our many meetings throughout the last twelve months. And lastly, I am excited by the prospects for

the organization in the year ahead. Our incoming Executive Council led by Dr. Matt Goldenberg brings experience, vision, and initiative that will provide a strong foundation for our continued success and will provide SCPS the leadership it needs to address the challenges and capitalize on the opportunities of the future. Thank you for your continued support of the Southern California Psychiatric Society.

In This Issue...

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On Philosophy, Boredom, Paternalism, and Pragmatism

By: Alex Lin, M.D.

When I had finished the previous article, I had originally anticipated that I would explore the philosophical underpinnings of Dr. Moncrieff's writings in this piece. The more I read about her perspective, however, the more confused I became. I think spending some time discussing the reasons for my reactions would be as useful as is analyzing Dr. Moncrieff's perspectives.

For the sake of completeness, I will summarize the recurrent themes in Dr. Moncrieff's writings.

She is apparently as skeptical of psychotherapy as she is of psychotropics. In a blog post entitled, "Talking Down the Talking Cure," she comments, "Surely all this therapy is a good thing? Surely there's nothing the matter with talking to a nice middle class professional who is paid to listen attentively and focus on you and your worries?"[1] She also makes a statement later in the same post that psychotherapy is problematic because it helps society to turn a "blind eye"[1] to conditions that made psychotherapy needed "in the first place"[1] and that organized psychiatry and defining mental issues as medical disorders facilitate the problems of capitalism.[2]

In an article[3] she wrote in 2020, she consolidates and elaborate upon all of her ideas regarding modern psychiatry and society. She believes that defining mental-health issues as medical disorders is conceptually wrong because medical disorders must have a clear pathophysiological cause; that the medicalization of certain "aspects of character"[3] is used to justify coercive treatments such as involuntary hospitalization and medication administration; that emotions are different from "biological conditions"[3] because emotions are "meaningful"[3]; and that the volitional aspect of behavior invalidates defining a pathological state as negatively-valued or unwanted because "[c]ancer and burglary are both negatively valued… but that does not make them same sort of thing!"[3]

Dr. Moncrieff's concerns about "psychiatric coercion"[3] and the over-medicalization of possibly non-pathological states are certainly laudable, but the article has some considerable leaps in logic: the exact pathophysiological cause is unknown for at least a few diseases (such as migraine) that are uncontroversially considered medical disorders[4]; it is unclear how the "meaningful-ness" of emotions somehow by definition causes them to be separate from "biological conditions" (an acquaintance of mine used the auras he had during migraines to create a second career as an artist); and Dr. Moncrieff not acknowledging the non-volitional aspects of behavior simply runs counter to my – and I imagine many other's — experience as a clinician. I do not think that most of my patients who have depression, bipolar disorder, suicidal thoughts, or substance abuse would consider their issues to be "volitional."[3]

One of the last sections of the article describes the outcome of an imaginary person ("Eric") with schizophrenia in two situations: (1.) in a society in which the symptoms are defined as a medical illness and (2.) in a society in which the behaviors are simply viewed as "an expression of his individuality" (Dr. Moncrieff's preferred conceptual perspective). She concludes that, in the first situation, Eric would be involuntarily hospitalized and medicated. In the second situation, Eric "quickly become[s] homeless and destitute, because he would not qualify for sickness or disability benefits, and his behavior is incompatible with finding or maintaining employment."

It seems that her approach may offer no practical benefit.

The article ends by concluding that defining mental illness as a medical disorder would somehow divorce "meaning" from mental illness and that separating mental illness from medical illnesses "could [somehow] potentially facilitate more transparent and personally empowering solutions for the range of problems these situations present."[3]

Her interest in re-defining mental illness apparently stems from her "intuition that mental disorder has something profound to teach us about the nature of being human."[5]

As far as I know, she never comments in any of her writings on what the "something profound" is or why that justifies withholding psychotropics outside of an acute decompensation. She also admits that she does have "not a blueprint for a fairer system"[6] but believes that developing this system "surely… is not beyond the capacity of the modern world"[6] that she repeatedly criticizes.

I believe that the boredom I felt in reading Dr. Moncrieff's work stems from the anti-climactic, circular, imprecise, overly binary, and solipsistic qualities to her stance. In preparing this article, I read some threads about physics and philosophy, and I believe that some of the opinions apply to this situation:

> For me, the "usefulness" of a physical theory is more important than "truth."[7]

and

> … the idea is not that you want theories that turn out to be wrong, it's that you want theories such that if they *were* wrong, you'd *notice.* [8]

We, as clinicians, do not treat philosophical principles. Theories about illness, even if incorrect, can be helpful in providing a framework for treatment and in generating and organizing data. And ideally theories would be test-able, allowing us to determine if the theory is accurate or not (thereby hopefully leading to more useful theories).

I am unsure how one would test philosophical principles in a psychiatric context.

I do not see any point in tearing down a paradigm without offering an alternative, especially when human suffering is involved.

I realized that another source of my frustration was the lack of patient narratives and representation in Dr. Moncrieff's writings. There is a lot of discussion about the ills of organized psychiatry and of society. There seems to be relatively little discussion *about* those with mental illness and generally no talking *to* those with mental illness. In an era where the field (and medicine, in general) is looking for ways to discuss and rectify past wrongs by amplifying minoritized voices, Dr. Moncrieff's stance seems curiously anachronistic. Her stance, even if well-intentioned, is still a form of objectification and is ultimately othering.

I began to look for patient narratives. A 2016 study[9] took a qualitative approach to exploring symptom management by interviewing high-functioning individuals who had been diagnosed with schizophrenia. The authors expressed a hope that "[s]ervice providers, consumers, caregivers, and researchers can reflect and expand on the strategies shared by our participants in order to reconceptualize and advance what is possible in mental health recovery, especially when consumer voices and lived experiences are prioritized."[9]

Elyn R. Saks (one of the study authors) wrote an opinion piece for The New York Times discussing the study, explaining that such studies are important to help reduce stigma and because conventional approaches can fail "to take into account individuals' strengths and capabilities, leading mental health professionals to underestimate what their patients can hope to achieve in the world."[10]

Dr. Saks had the following to say in one interview[11]:

> I used to say, I don't want to use a crutch [regarding her previous hesitation to use medications]. I now say, if my foot were broken, I'd use a crutch. Aren't my neurotransmitters entitled to as gentle treatment as a broken foot?
>
> […]
>
> We don't like to be strapped down to a bed and left to suffer for hours anymore [sic] than he would. In fact, until very recently, and I'm sure some people still hold it as a view that restraints help psychiatric patients feel safe. I have never met a psychiatric patient who agreed with that view.
>
> Today, I'd like to say, I'm very pro-psychiatry but very anti-force. I don't think force is effective as treatment and I think using force is a terrible thing to do to another person with a terrible illness.
>
> […]
>
> I've had excellent treatment, four to five-day a week psychoanalytic-psychotherapy for decades and continuing in excellent psychopharmacology.
>
> […]
>
> Recently, a friend posed a question. If there were a pill I could take that would instantly cure me, would I take it? The poet Rainer Maria Rilke was offered psychoanalysis. He declines it saying, don't take my devils away because my angels may flee too. My psychosis, on the other hand, is a waking nightmare in which my devils are so terrifying that all my angels have already fled. So would I take the pill? In an instant. That said, I don't wish to be seen as regretting the life I could have had if I'd not been mentally ill, nor am I asking anyone for their pity. What I rather wish to say is that the humanity we all share is more important than the mental illness we may not. What those of us who suffer with mental illness want is what everybody wants. In the words of Sigmund Freud, "to work and to love."

Dr. Saks's statements persuasively address the issues Dr. Moncrieff has with modern psychiatry and provide a power and vibrancy that is absent from Dr. Moncrieff's approach. It is possible to combine the pragmatic (such as taking medications or utilizing avoidance behaviors) with the existential (engaging spirituality and being employed or continuing one's education).

Thoughts posted by one commentator on Dr. Moncrieff's blog[12] (who states they actually agree broadly with Dr. Moncrieff and who have alluded to their own mental-health issues) eloquently address the problem with taking an overly philosophical approach to psychiatry. I believe that repeating those thoughts here would be an appropriate way to end this article:

> The point I'm making is that you don't reduce social oppression by fiddling with words….. If you

> change the words without changing the attitudes and mechanisms of oppression you have achieved nothing. And the medical model is not a mechanism of oppression, it's an expression of those mechanisms….
>
> Doctors in the southern US don't talk about drapetomania anymore. But it wasn't changes to medical textbooks that freed the slaves. It was a war. And there are still any number of institutional mechanisms for punishing black people who "step out of line".
>
> "Autonomy" is actually a huge philosophical question that hinges on the age old unresolved dialectic of "determinism vs free will". You don't need a brain disease model to be able to claim someone lacks it and treat them accordingly. We do it to children, animals, minorities, people who don't share our political or religious beliefs and many others, without recourse to medical "experts".[2]

and

> [T]o try to give it [the poster's psychosis] a specific 'meaning' (in the broader sense – not merely 'definition') is to delegitimise the experiences – and often the suffering – of many of those who have experienced it.
>
> I can think of one way of framing psychosis that might enable fairly broad consensus as to whether or not it's a disease symptom. According to Joseph Campbell[,] "The psychotic drowns in the same waters in which the mystic swims with delight." If you're drowning in your psychosis, if it's an experience you can't integrate into your notion of self (or non-self), if it's causing harm or distress that you can't use to find insight or promote personal growth, then it's a problem. It may not be a disease as such but it could well be indicative of one. In any case, it becomes a valid target for medical research and, perhaps, intervention. Whether or not current or future medical therapies are more likely to help or harm is a separate question.

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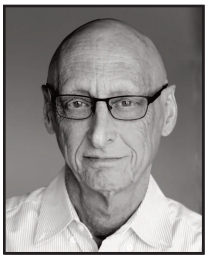
Healthy Sausage, Anyone?

Roderick Shaner, M.D.
West Los Angeles Councilor, Co-chair, Government Affairs Committee



Ventura Councilor Joe Vlaskovits and I disagreed at the last SCPS Council meeting. He proposed striking out a section of a draft SCPS position statement that called for better patient access to psychostimulant medication. That section requested APA guidelines that explicitly approve co-prescribing of stimulants and benzos for patients who need them. Joe felt that this statement underplayed the contribution of prescribing to inappropriate stimulant use.

I opposed Joe's amendment because I don't think that efforts to curb illicit prescribing should ever interfere with access to medication by patients who need it. President-elect Matt Goldenberg spoke in favor of the amendment because removing it would increase consensus for the rest of the position statement and we could examine relevant APA guidelines separately. His argument convinced me and most in Council to support Joe's motion. The amended position statement can be read in this issue, and it will be an important tool in our struggle to improve patient access to care.

Efforts behind closed doors to achieve consensus among legislators by compromises has been denigrated as "sausage making," and rightly so. Buried beneath the sausage casing may be misinformation, faulty reasoning, hidden agendas, and conflicts of interest. Opaque groups that claim to be our voice and seek our dollars and "input," but operate without our direction, can put our reputation at risk. By contrast, strong, member-directed organizations that adhere to standards for voting and transparency, like APA, SCPS and CSAP (our statewide advocacy organization of California District Branches), nourish our professionalism and forward the care of our patients. Participate as actively as you can—-contribute your views, join our committees, or run for elected positions at SCPS. It's a healthy delight.

Southern California Psychiatric Society
POSITION STATEMENT
April 14th, 2023

Stimulants are recognized as an effective and safe treatment for ADHD. The ongoing shortage in stimulants is causing irreparable harm to patients with ADHD, from children who regress behaviorally and academically, to adults who are unable to perform their daily duties without these medications. Additionally, the shortage places patients with ADHD at increased risk for substance use, car accidents, depression, anxiety, and other comorbidities.

SCPS calls upon policymakers, pharmaceutical companies and psychiatric organizations to take focused action now to prioritize the needs of patients with ADHD over attempts by law enforcement agencies to prevent illicit provision of medication when those attempts create dangerous shortages in the supply of psychiatric medications essential for the health of children and adults.

On Story and Recovery

By: Christopher Schamber, LCSW

Modern storytelling typically revolves around the arc of a character. As a story begins, the reader becomes acquainted with a dysfunctional protagonist, and throughout the story they must overcome a debilitating flaw. This is not so different from psychotherapists and psychiatrists assessing new clients for painful thought patterns or self-destructive behaviors. However, in direct contrast to mental health providers, writers endeavor to torture their protagonists. This philosophy is not born out of sadism, but rather to test the hero. As one Chinese proverb says, “Out of the hottest fire comes the strongest steel.”

Although storytellers and mental health providers typically run in very different circles, they can learn a lot from one another. Storytellers know obstacles and loss can lead to growth. Screenwriter and script consultant John Truby designed an entire storytelling system about giving characters a deep wound, and then attacking it in the most painful ways to create change. In the classic film *Good Will Hunting*, Matt Damon’s character, Will, works as a janitor sweeping the floors of MIT. Will knows his innate gift of solving complex mathematic problems, yet shouts and fights with the peoplewho try to help him. At face value, one might judge him for being irrational and mean. But Will, having grown up around substance abuse and family members constantly letting him down, fears vulnerability. It is only after he is thrust into constant emotionally and socially vulnerable positions that he gradually learns to love himself and take on a life lofty enough to risk failure. Any treating professional would proudly hold such an individual up as an icon of mental health recovery.

Will Hunting’s progression has entertained generations of viewers by this point, but its “address the wound to create change” structure can be found all over media. Does anybody think a young Luke Skywalker would have willfully chosen to become a Jedi master? It was only after he lost his aunt and uncle and got pushed out of his remote desert home that he joined the rebels’ fight for galactic freedom. Look back further and one will find this structure in classic literature across generations and cultures. Consider Wu Cheng’en’s *Journey to the West*. Or the Persian epic, *Shahnameh.* Or *Beowulf*. The list never ends.

These connections and parallels were finally explored in one of the most important literary research works, Joseph Campbell’s *The Hero’s Journey.* Campbell researched stories and myths in cultures around the world and found that they all contained some combination of the following stages. Read along and see if you see a connection to modern psychological models such as the Stages of Change.

Status Quo
Call to Adventure (IE: something happens to disrupt status quo)
Refusal of the call (notice how often a person avoids change when they can)
Meeting the mentor
Crossing the first threshold (hero leaves their comfort zone)
Tests, allies, enemies (IE: the boons and roadblocks of pursuing change)
Approach the inmost cave (getting closer to the goal)
Ordeal (The biggest test yet)
Reward/Seizing the Sword (hero got what they set out for, but other matters persist)
The road back (attempting to return to status quo)
Resurrection (the final hurdle is encountered)
Return with the Elixir (the hero returns home, different)

Campbell, a longtime admirer of Carl Jung's psychoanalytical writings, argued that the Hero's Journey story model was so universal because it reflected the human experience. "Myths are the clues to the spiritual potentialities of the human life," Campbell once said.

Mental health professionals may recognize the parallels to treatment immediately. Constantly being thrust into vulnerable situations creates an organic sort of exposure response prevention. Furthermore, stories typically begin with a character holding certain core beliefs about themselves and their place in the world that, over a sequence of events, become reframed and restructured into something healthier. The protagonist begins to see their story differently. If a provider looks close enough at a story's structure, they will likely see their favorite therapeutic modalities smiling back at them.

In the end, the world revolves around the stories we tell ourselves and others. Great films, TV shows, and books can teach incredible lessons around resiliency and growth. Yes, transitions, stressors, and trauma can inflict tremendous hardship. Yet as mental health providers, we have the opportunity to hold hope. Together, we can work with individuals to change the narrative, transforming the hardest moments in their lives to being an essential step along their story toward a happy ending.

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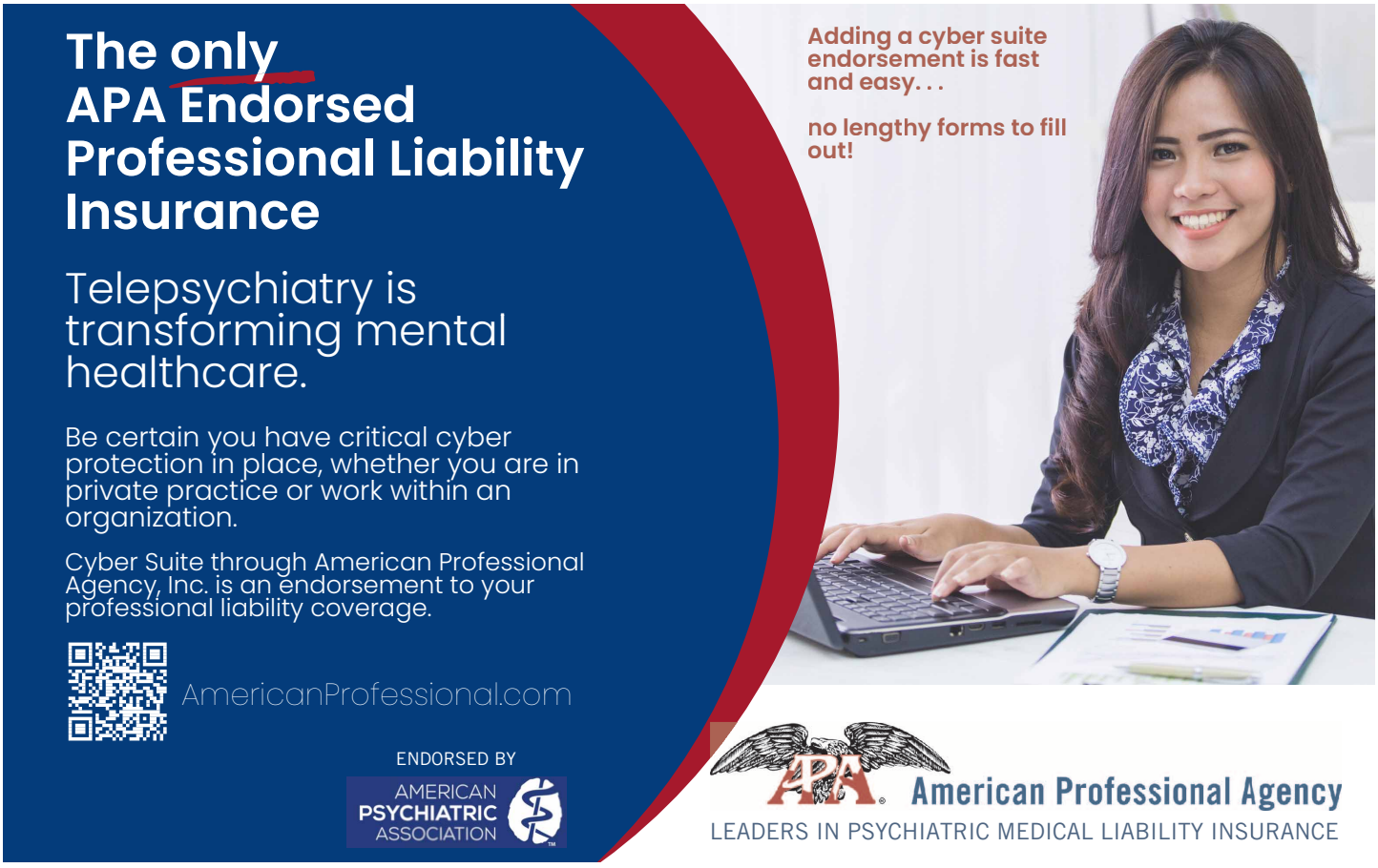

Chasing Demons
By Carissa K. Harkness
Independently Published
2021
166 pages
$10.34 Paperback
ISBN-13: 979-8542171937
Trigger warning: suicidality, domestic violence, abuse, addiction

Book reviewed by Kavita Khajuria, MD

“silence has the courage to say the things we can’t…”

Chasing Demons is a collection of poetry and prose that artfully capture emotional survival from domestic violence, abandonment, and addictions – with a key theme of self-worth. The haunting effects of childhood abuse resonate loudly with ripple effects “my fathers yelling became the soundtrack of my life..” . Mental numbness and the safeguard of psychological imprisonment conflict with a need for connection amidst perceptions of human disregard. Rage and resentment are burdened by anxiety and the capacity for self-love is questioned in the face of criticism and judgement. Emotional instability and tortured loneliness convey emotional weight and a sense of futility, but the subjection to manipulation resonates with palpable anger. The tide turns suddenly with the enamor of love - the reader can hear safety, craving and intoxication - followed by the rollercoaster of heartbreak - with pain, obsessive angst, and grief. These permeate with realizations, consolations, and affirmations, including insight - a rising occurs with confrontation of individual and global sexism. Resilience and hope emerge with the embrace of individuality and new beginnings. This is a powerful read which beautifully captures various emotional states- insightful moments include self-observations.

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Council Highlights
March 9, 2023
Ara Darakjian, M.D., *Secretary*

PRESIDENT'S REPORT Dr. Little

SB Councillor – Dr. Little reported that a candidate had emerged for the Santa Barbara council – Dr. Anu Bodla came highly recommended. It was too late to include her on the ballot, so Dr. Little will appoint her until the next election. A motion was made, and was approved unanimously.

Goss Award – Dr. Little requested nominees for this award, which is for extraordinary leadership in taking care of mentally ill individuals in the criminal justice system. Dr. Kelly made a motion to nominate Dr. Emily Wood, for her work in the 988 initiative. Judge Stephen Manley was nominated for the judge category. The motions were approved unanimously.

Area 6 RFM – Dr. Ijeaku moved to nominate Dr. Zhijia (Zach) Liang for this position. The council approved with unanimous vote.

Area 6 Inquiry regarding PPAC attendance – Dr. Little reported that Dr. Malak, Area 6 representative, had inquired if there would be any concerns inviting Randall Hagar to the Area 6 meeting in Marina Del Rey that is coming up in April.

Dr. Goldenberg made a motion to oppose Mr. Hagar's attendance. There was also discussion regarding the potential benefits of having Mr. Hagar attend and present. Dr. Shaner proposed an amendment, stressing that PPAC is an opaque organization with unclear conflicts of interest. The amendment was unanimously accepted. The motion passed with 1 opposing, and 1 abstention.

Office Lease – Mindi suggested that the office be advertised to be subleased. The motion was approved unanimously. Dr. Lin volunteered to make a post on a Facebook group for mental health office space.

IPRESIDENT-ELECT'S REPORT Dr. Goldenberg

Private Practice Town Hall – The private practice committee continues to meet to discuss and advocate issues faced by private practice psychiatrists. The next town hall meeting is on March 21.

Newsletter Updates – Dr. Goldenberg thanked the contributors who have made the newsletter lively and unique, and reviewed the council members assigned for the April newsletter.

A motion was made to approve the President-Elect's report, and passed unanimously.

TREASURER'S REPORT Dr. Bindra

February Financials and Cash on Hand Report

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

ASSEMBLY REPORT Assembly Reps

Dr. Red reported that it is the time of year when the Assembly meets. She reviewed that SCPS is supporting two action papers – one from Dr. Ijeaku and one from Dr. Key.

It is expected that the relationship between CSAP and Area 6 will be a large item for discussion. Council members from all District Branches are invited to attend the reception on Saturday night. Leadership from the District Branches are also invited to join meetings to give input regarding the interface of CSAP and Area 6.

The Assembly report was approved by unanimous vote.

MEMBERSHIP REPORT Dr. Ijeaku

Membership Report

Current Active Membership –999/898

Dr. Ijeaku reported there were 5 new applicants in the past month. The new members were approved by unanimous vote.

COMMITTEE REPORTS Chairs

Alternative Crisis Response – Dr. Wood reported that the committee has been meeting with NAMI. Dr. Wood herself has been meeting with the department of mental health as well. Her goal is to receive feedback form individuals who have been involved in crisis interventions by law enforcement or other individuals.
The report was approved by unanimous vote.
Access to Care – Dr. Friedman reported the committee's focus on spreading awareness to request independent medical reviews for denied medications.
Bylaws – Dr. Shaner reported that the Bylaws Amendment is on the ballot.
Disaster MH Relief – In Dr. Chang's absence, Mindi reported about a War and Trauma program, which was well done. Dr. Rees emphasized that it was a great program. There is ongoing work with the California Coalition of Disaster Mental Health Relief. They are invited to the next meeting.
DFAPA and Awards – Mindi Thelen reported that the committee nominated Dr. Ijeaku for the Distinguished Service Award, Dr. Dees and Dr. Kopelowicz for Achievement, Dr. Emily Wood for the Appreciation Award, and the Mallory award for Dr. Denese Shervington. They are considering special awards for Mark Gale and Connie Draxler, as well as media award for a new column in LA times called "My Therapy."
Diversity and Culture – Dr. Ijeaku reported about an event they held at UCLA, at which there was a good turnout.
Dr. Ijeaku also reported that they will be presenting at APA on May 20th, and encouraged SCPS members to attend the presentation.
Dr. Ijeaku also reported that they are nominating Dr. Denese Shervington (Chair of Psychiatry at Charles Drew) for the Mallory award.
Program - None

GAC REPORT Dr. Shaner

Dr. Shaner reported that CSAP passed SCPS motions to Area 6 (A6) nonvoting representation on the CSAP Board, identified the CSAP Board Chair as the ex officio CSAP representative to the A6 Assembly, and approved a joint working committee with A6 Assembly to develop a collaborative framework for advocacy.
There will be continued work in strengthening the relationship between A6 Assembly, CSAP, and SYASL at the A6 Assembly meeting in April.
Federal and APA Issues – NCPS will host the APA meeting in San Francisco in May. NCPS will reportedly seek sponsorship from CSAP and each of the other 4 Area 6 DBs, the latter at the level of $1000 each. The committee voted to recommend to Council that SCPS support the requested sponsorship by CSAP and SCPS. The motion passed unanimously.
CSAP GAC met twice in the past month
Eggman Bills – Dr. Woods was noted to play an extraordinary role, answering press questions at the Eggman/Weiner press conference on March 3. SB 43 expands the definition of grave disability to include inability of an individual with mental illness to provide for critical medical needs or safety.
Sacramento Legislation Day – CSAP will attend; date has not yet been set.
Dr. Shaner presented a motion that SCPS approve the GAC's drafting of more detailed policy statements, based upon member suggestions, for possible inclusion into the SCPS High-Level Policy platform and possible recommendations to CSAP to consider the same approach. The motion was approved unanimously.
Meeting with US DOJ regarding pharmacy issues – CSAP had a conference call with the US Attorney General's Office on March 6. AG representatives seemed genuinely interested in the issue and unaware of these consequences, noting that it would likely be useful for CSAP to obtain input from the State Board of Pharmacy and report the results to the AG. CSAP plans a future meeting the Pharmacy Board.
CSAP Board meeting

At its meeting of March 2, the CSAP Board voted to support, as the CMA psychiatric specialty organization, two resolutions supporting the development of "medical holds" for patients on general medical inpatient units who lack capacity to understand dangers of leaving the hospital or the need for treatment.
Dr. Shaner presented a motion that SCPS Council support the CSAP PAC sponsorship of a CMA legislative event at the $5000 level, to be taken from existing CSAP PAC funds.

The motion was approved unanimously.

SCPS advocacy issues – Dr. Shaner made a motion as follows:
SCPS Council shall have its representatives to the CSAP Government Affairs Committee (GAC) and/or CSAP Board make a motion(s) that:
CSAP formally approach the California State Board of Pharmacy and the California Pharmacists Association to develop mutual guidelines for assuring that in carrying out our corresponding responsibility we protect access to safe and appropriate care for our patients.
CSAP will discuss this issue with the California Medical Association (CMA) to seek collaboration.
The motion was approved unanimously.
Dr. Shaner made a motion as follows, regarding CARE court implementation, based on work completed by Dr. Wood:
Resolve that SCPS Council shall:

Direct the SCPS GAC to coordinate the drafting of a letter to the Director of LAC DMH for possible signature by SCPS and NAMIs that requests:

Acknowledgement and comment on specific concerns set forth by the signatory organizations regarding the structure and clinical operational components of the DMH CARE Court implementation plans,
Specific additions or modifications in the current clinical operational components of implementation plans that address the above concerns, and
Ongoing feedback on the status of the above specific operational component requests as DMH plan development proceeds.
Involvement of specified key stakeholders in Los Angeles County implementation of the CARE Act.

Partner with local NAMI organizations to engage LAC DMH regarding the structure of their CARE Act implementation committees and working group.

Other SCPS Advocacy Issues – the advocacy work regarding Adolescent ECT and Riese initiatives is ongoing.

The GAC report was approved unanimously.

We understand many members are looking for more information about DEA training requirements for DEA-regsitered practitioners on the treatment and management of patients with opioid or other substance abuse disorder. As of publication date, the DEA has not yet provided definitive information on what the requirements will be.

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