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President's Column

Better Than We Found It

Matthew Goldenberg, D.O.



Writing to you as SCPS President, I want to begin my first article by thanking Dr. Zeb Little for completing a fantastic year as SCPS President. On behalf of the SCPS Council and the full SCPS membership, join me in acknowledging Dr. Little's contributions and service to SCPS during this past year leading SCPS. Those on the SCPS council will share my observation that Dr. Little was a wise and stabilizing leader for SCPS. His approach to solving difficult problems was thoughtful and his leadership style was welcoming, encouraging and motivating. Let me share just a few of his achievements as

SCPS President.

Over this past year, Dr. Little oversaw SCPS's integration into the [California State Association of Psychiatrists \(CSAP\)](#) and faithfully served as one of SCPS's first board members to CSAP.

This is a huge milestone for SCPS and its membership because CSAP is the only statewide advocacy partnership between all five district branches of the American Psychiatrist Association (APA).

CSAP is the only California advocacy organization for psychiatrists in California where psychiatrists have direct voting representation for the advocacy efforts being made in Sacramento.

Be assured, your SCPS membership entitles you to have representation at CSAP. The SCPS Council has elected representatives on the CSAP Board and on all of CSAP's committees. When you come to SCPS townhalls, send emails with your concerns, or share your experiences with SCPS committees, your participation guides the SCPS Council on how to vote on the most important advocacy issues facing psychiatry. Every voting member at CSAP has been elected in an election by their local American Psychiatric Association (APA) district branch (DB). That is how CSAP ensures that each vote taken represents SCPS's (and the other DBs of California) preferences.

In addition to its power through direct and elected representation, CSAP works directly with APA on statewide and national advocacy efforts. CSAP is the only Psychiatry advocacy organization in California that is associated with the APA. This collaboration and affiliation with APA makes CSAP extremely effective and connected, not only in California, but also on the national level.

By strengthening SCPS's connection to CSAP and APA, Dr. Little's leadership brought SCPS, and its members, into a closer collaboration with our colleagues at APA and our colleagues at the four other district branches across California. We are stronger when we work together. We are now working together to solve the biggest issues facing our patients, our practices and our profession.

My goal as SCPS President is to pick up where Dr. Little left off. “Leaving things better than we found them,” is my main goal for this coming year. My hope is to strengthen and grow the many diverse activities and services that SCPS offers to its members and our community. I hope to also work with SCPS Council to grow our membership and empower more of our colleagues to get engaged with organized psychiatry.

My journey to getting engaged with SCPS, and to becoming this year’s SCPS President, began in Arizona during my psychiatry residency at Banner Good Samaritan Medical Center. I initially served as a Resident/Fellow Member to the Arizona Psychiatric Society (APS). I was asked to fill in for a classmate who was unable to attend a council meeting. I had no idea what I was signing up for. After my first meeting, I was hooked. I had accidentally stumbled into the hub of our profession in the state of Arizona. I had no idea there was a world of organized psychiatry outside of residency training. At APS, I witnessed advocacy and grass roots efforts that were being made to serve the community and our patients. I engaged with psychiatrists coming together to advance our profession.

When I moved back to California for my addiction psychiatry fellowship training, the Executive Director of APS (Teri Harnisch) put me in touch with Mindi Thelen (our SCPS Executive Director). My fellowship was partially at the Sepulveda VA (as well as UCLA and Cedars Sinai). Accordingly, Mindi mentioned that there was an open San Fernando Valley Council position. She recommended that I come to an SCPS event and meet the current SCPS president (Heather Silverman MD). Dr. Silverman ended up appointing me to serve in that spot and I have been on council ever since.

Over the years I have served as a counselor, secretary, treasurer-elect, treasurer, president-elect and now president. I also served as the newsletter editor over the past 6 years. I have learned so much from the past SCPS Presidents with whom I have had the privilege of serving with. I have enjoyed meeting and getting to know and collaborating with colleagues from all over southern California.

Mindi, our SCPS Executive Director, is the heart and soul of SCPS. She puts the Midas touch on everything that SCPS offers. I want to acknowledge and thank her for 31 years of service to SCPS! She is constantly going above and beyond for our organization and SCPS is so lucky to have her. I am personally grateful to have her support and guidance for this coming year!

While Mindi is the glue that holds it all together, none of the work done at SCPS would be possible without the contributions from the dedicated colleagues who serve on the [SCPS Council](#) and [SCPS Committees](#). I want to thank those members, and their families, for the time and dedication that they have given to SCPS and continue to give to SCPS, the field of psychiatry and our patients. This is a volunteer driven organization, and it humbles me to be part of an organization with such dedicated and selfless leaders.

This coming year I hope we can continue to showcase the substantial work of SCPS and its leaders at townhalls, programing and other events for our members. I encourage all SCPS members to participate and engage in these events!

If you are interested in learning more about what SCPS has to offer, please keep an eye out for this year’s townhall meeting announcement.

If you are interested in getting involved with SCPS, reach out to Mindi (socalpsychiatric@gmail.com) to learn more about what [SCPS committees](#) might be a good fit for your interests and passions.

I highly encourage you to consider getting involved. Whether you are interested in advocacy, access to

care issues, diversity and inclusion issues, women's issues, LGBTIQ+ issues or any other aspect of psychiatry, SCPS likely has other likeminded members whom you will enjoy engaging with. Any contribution, whether large or small, makes a huge difference.

SCPS provides a wonderful opportunity to engage with colleagues outside of our daily clinical setting and in areas of medicine you may not have thought much about since going into medicine and psychiatry.

If you are already engaged with SCPS, I am eager to continue our work together. If you are ready to join us, I will welcome you and support your efforts and contributions. Please reach out to me or Mindi and we will help you to find a home at SCPS.

Let's work together to leave things better than we found them!

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Guilty of a Mental Illness: The Incompetent to Stand Trial System

By: Reba K. Bindra, M.D.



The intersection of mental health and the law in California is a storied one. From the history of the state hospitals to LPS laws to involuntary treatment, there's never a dull moment. One of these pieces is the "incompetent to stand trial" system. It's a complicated and cumbersome approach to managing severely mentally ill patients caught up in the legal system. It is a well-intentioned system that purports to treat mental illness but really designed to treat the legal system. More and more patients are languishing in jails without court-ordered treatment (or court orders that are not enforced), not convicted of any crime and unable to stand trial.

I have been deep in the weeds with the incompetent to stand trial (**IST**) population since 2016 and will talk about it to anyone who will listen. I realized however, that my passion falls flat if no one knows what I am talking about. I have tried to provide an overview of the IST system here and ask for the indulgence of the forensic psychiatrists who may see this as an oversimplification—it is for the greater good. Here, I am mostly referring to LA County. Each county in California is an island unto itself and there will be variations on these themes.

The process starts with getting arrested. Mentally ill, unhoused, substance-using folks are easy targets for the legal system. Starting a fire in a metal canister in winter to stay warm can be "arson". Urinating in an alleyway and someone accidentally seeing you can be "indecent exposure". Stealing a bag of chips is a misdemeanor but if you don't give them up immediately, it is now a felony. I could go on, but you get the picture.

Let's follow JD (Jane Doe—very clever, I know). 57y/o female, arrested for a felony. JD has an extensive psychiatric history including >20 acute inpatient hospitalizations and 5 previous state hospital admissions all related to competency. At JD's initial court hearing in criminal court, someone (often the defense attorney concerned for the patient's health) raises "doubt" about JD's ability to participate in her own defense. She is evaluated by a court-appointed forensic psychiatrist to determine if her symptoms are the result of a mental illness and the evaluator then makes a recommendation to the court regarding competency. If the judge accepts the recommendation, JD will be designated felony IST (**FIST**) and will be court-ordered to take medications (this order is almost automatic in LA County but varies in other counties). *In the LA County jail setting, this is the most common path to involuntarily administer medications when patients refuse treatment.*

* The process from "doubt" to being declared IST can take *weeks to months*. If JD refuses medications while waiting in jail during this process, there is no recourse other than to wait for a court order for involuntary medications associated with competency status or admission to an acute inpatient setting if she meets 5150 LPS criteria.

Let's review some terms:

INCOMPETENT TO STAND TRIAL (IST): A *legal* designation given by the court after evaluation by a court-appointed forensic evaluator (a psychiatrist in LA county). The evaluation finds the patient's mental illness is interfering in their ability to appreciate/understand their charges or their ability to participate in their own defense. *It is essentially a patient being found guilty of a mental illness.*

* There are two IST categories: Misdemeanor Incompetent to Stand Trial (**MIST**) and Felony Incompetent to Stand Trial (**FIST**). This article will focus on FIST patients, the MIST patients have

a slightly different path.

* FIST designations have a 2-year maximum commitment which means that the state has up to 2 years across all settings to either restore someone to competency or determine they are **not restorable**. The options for patients who cannot be restored will not be covered here in detail.

* *Competency should not be confused with Capacity.* The former is a legal designation, and the latter a clinical one. Capacity concerns arise for example when a patient lacks a full understanding of the risks and benefits of a specific treatment, specific medication, or specific medical procedure. Did I mention it has to be specific?

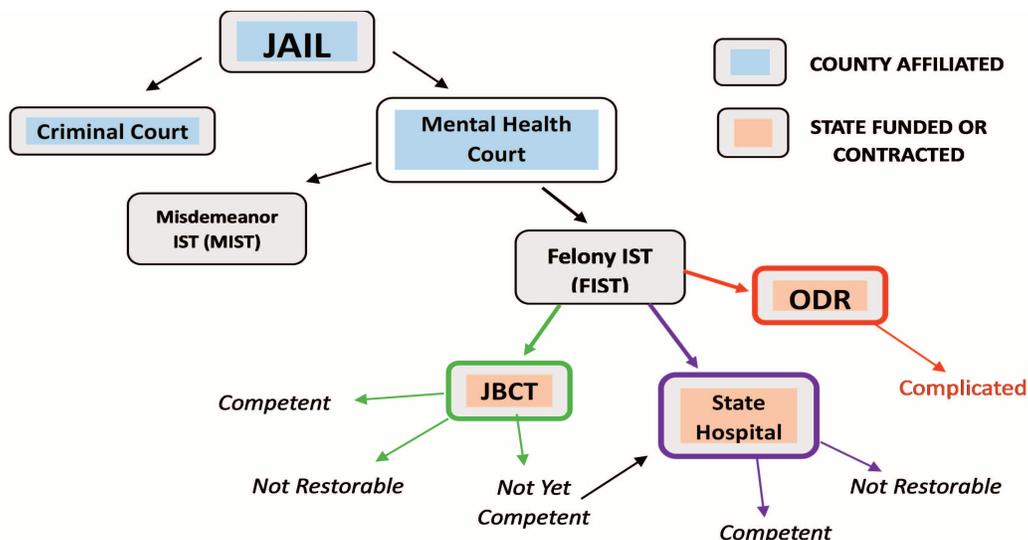
JAILS: This is where it all starts. A person gets arrested and is taken to a **county-operated** facility to await adjudication. *This is the innocent-until-proven-guilty crowd.* (Prisons are for those that have been convicted and are operated by the state).

CA STATE HOSPITALS: State-operated forensic facilities operated by the Department of State Hospitals (DSH). There are 5 facilities in California (Patton, Metropolitan, Atascadero, Coalinga, Napa) that house different classifications of mentally ill patients *all related to the legal system one way or another.* These are not like other hospitals where acute care is delivered.

JAIL BASED COMMUNITY TREATMENT (JBCT): An intermediary for IST patients between the jails and state hospitals. These programs are embedded in the jails and are intended to restore competency and prevent state hospital admission. It is usually limited to 90 days* and if the patient has not regained competency in that time, they are then referred to the state hospital. *Can exceed 90 days for various reasons—no beds at the state hospital or patient is close to competence, etc.

OFFICE OF DIVERSION AND REENTRY (ODR): Housed within the Department of Health Services for LA County, this program diverts patients with serious mental illness away from the incarcerated settings and into community-based care. ODR is partnered with DSH for IST patients. ODR really needs its own illustration to do it justice. What I will say is that on paper it is a great idea but it has some unrealistic expectations paralyzing the good intents.

Once JD is declared FIST, there are several potential outcomes as illustrated in the diagram below. Let's reconvene after you have had a chance to look at it.



Welcome back! I got a little dizzy making this so I am assuming you may be a bit cross eyed. This is the “simple” version, believe it or not. Let’s get back to JD and assume she ends up competent in one of those 3 pathways (JBCT, ODR, State Hospital). *Once patients are restored to competency, there are no more court orders for medications or mandated treatment in the community.* The legal system has been satisfied so JD’s treatment is no longer on the radar. She pleads guilty in her case and is given time served. She is released into the community with a paper list of clinics and shelters (and a 30-day supply of medication in hand which will likely get thrown in the trash can outside the jail). I will remind you that JD has 5 previous state hospital admissions where she went through the exact same cycle. How much longer until the 7th hospitalization? *Lather. Rinse. Repeat.*

Involuntary medication orders attached to competency are simply a means to an end and should not be confused with treating mental illness. *Medicating to competence is not truly treatment* and I say this as someone who has worked in a state hospital, a JBCT and in multiple jails. Somewhere along the way, the legal side of this (lawyers, judges, legislators) bought in to the idea that all of this is justified because the patient is receiving “treatment”. We rarely talk about the lengthy waiting lists to get into a state hospital (over 1200 patients waiting last time I checked) and patients who are languishing in jails in sometimes deplorable conditions while waiting to “get competent”. We also don’t talk about how a patient’s criminal case is on pause while they are held in the competency system—there is no right to a speedy trial here. There are cases where patients are waiting behind bars longer than their maximum sentence would be. *Punishment for having a mental illness* In cases where the charges get dropped or maximum time served has been reached, patients are simply released with no further requirements for treatment or follow up. A patient that was too ill to stand trial is still ill if the charges are dropped so treatment is not important anymore? *Treating the legal system.*

If you made it this far and are not completely overwhelmed, I applaud you. Imagine what patients must feel trying to understand all of this. Delusional, hallucinating, cognitively impaired, paranoid, frightened, and confused—how do they take it all in? For a system designed to protect them, it certainly has a strange way of showing it. I did not even touch on the organic process of how patients are restored to competency. This brings a whole different set of ethical dilemmas and moral obligations that are directly tied to a patient’s civil rights. Consider it a preview of coming attractions. Stay tuned.

Disclaimer: All identifying factors have been changed to protect Jane Doe’s confidentiality.

DEA, SAMHSA Extend COVID-19 Telemedicine Flexibilities for Prescribing Controlled Medications for Six Months While Considering Comments from the Public | SAMHSA

<https://www.samhsa.gov/newsroom/press-announcements/20230509/dea-extend-covid19-telemedicine-flexibilities-prescribing-controlled-medications>

Supporting Parent Trainees

By: Manal Khan, M.D.



The Accreditation Council for Graduate Medical Education (ACGME) set forth a policy in July 2022 which mandates all sponsoring institutions to provide trainees with a minimum of six weeks of paid parental, caregiver, and medical leave. This policy is a welcome step because it at least begins to acknowledge the need for parental leave for trainees. A survey conducted in 2013 revealed that 40% of the trainees consider parenthood during their Graduate Medical Education (GME) training. Most of the literature about parenting challenges during residency and fellowship training stems from surveys. 40% represents a significant number and establishes that parenthood during training should be expected. Parenting during training poses several challenges for trainees and has important consequences for them. It impacts specialty choice, graduation timeline, practice intentions after graduation, and attrition following training. Although paid and protected parental leave is an important first step, it does not address all the challenges faced by trainees, some of which require a shift in systemic and institutional policies and cultural practices. The United States is unique amongst its neighboring and peer countries in that it does not have a federal law that provides a right to paid parental leave.

Donald Winnicott (a British pediatrician and psychoanalyst) said there is no such thing as a baby. This statement highlights the importance of the dyadic relationship between the parent/caregiver and the baby. The baby's survival and wellbeing are contingent on this dyadic relationship. Winnicott also introduced the concept of "primary maternal preoccupation", a period following childbirth during which the mother becomes preoccupied with the infant which allows for a heightened sensitivity to the infant's needs. These concepts underscore the importance of protecting the early parent-child relationship. A survey done at University of Washington revealed that trainees who had more than 8 weeks of parental leave were more likely to breastfeed their babies and have negative postpartum depression screens. They were also more likely to report higher satisfaction about their decision of becoming parents during training. Another survey done at the same institute showed that financial and professional factors played an important role in determining the length of the maternity leave for trainees. Family's finances, and ability to graduate on time, take board examinations, and start fellowship or job were cited as the most important determinants.

In addition to paid parental leave, trainees who are parents or considering parenthood face several other challenges. Residency and fellowship training coincide with the time during which most people consider parenthood. The average age of completion of medical training in the US is 31.6 years for all trainees. Female physicians are twice at risk for infertility compared to general population. Therefore, treatments such as oocyte cryopreservation are being pursued by medical students and trainees. However, these treatments are costly. On average, each cycle costs \$10,000 and often multiple cycles are needed. Additionally, the cost of medications to assist these treatments range from \$3,000 - \$4,000 and the storage costs are about \$500 per year. Hence as we envision policies to support medical students and trainees, it is important that we demand insurance coverage for these treatments.

Training also impacts the health of the birthing parent and the baby. Together they are at risk for low birth weight, intra-uterine growth restriction, growth retardation, hypertensive disorders of pregnancy, miscarriage, and placental abruption. The cost and accessibility of childcare facilities is another important challenge for parent trainees. Trainees often match at programs away from their families and relational support systems. The following quote from an Internal Medicine Resident (IM) at Penn Medicine for NPR encapsulates the importance of having free-of-cost or heavily subsidized childcare options. Leah Rethy (the IM resident) said, "The cost of daycare ... in a month is about half of my salary in total, and

the cost of a nanny is essentially the entirety of my salary".

Easy access to clean lactation facilities is another important facet of parenthood that needs to be taken into consideration by training programs. Trainees often have short parental leave and long work hours. Data shows that most trainees plan on breastfeeding their babies. Therefore, ensuring easy access to lactation facilities while also allowing time during the workday for lactation-related activities is crucial.

Lastly, there is a significant stigma attached with parenthood. Trainees are socialized into believing that taking any time off is equivalent to falling short. Parent trainees often feel guilty about burdening their colleagues with additional responsibilities when they take parental leave. A survey revealed that program directors have negative perceptions about the clinical and scholarly productivity of female trainees who become parents. These perceptions are not supported by the data and are indicative of a bias against mothers.

It is important to recognize the vast scope of the challenges faced by parent trainees. The ACGME paid parental leave policy is a step forward in the right direction, but it should not be mistaken as the destination. Children represent our future, and it is imperative that we do everything as a society to ensure their wellbeing.

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The Consequences of School Closures: Examining the Impact on Adolescent Mental Health

By: Patrick Kelly, M.D.

(A version of this article appeared in the 2023 newsletter of the
Southern California Society of Child and Adolescent Psychiatry)



The COVID-19 pandemic has generated unprecedented challenges, leaving a lasting impact on numerous aspects of life. Adolescence, already a critical developmental period characterized by substantial physical, emotional, and social changes, has been further complicated by the pandemic. As psychiatrists, our understanding of the unique challenges faced by adolescents is crucial. The pandemic has not only exacerbated pre-existing mental health issues but also given rise to new ones.

The Centers for Disease Control and Prevention (CDC) reported that in August 2020, 25.5% of young adults aged 18-24 years had seriously considered suicide in the previous 30 days. This percentage was significantly higher than those reported by other age groups: 16.0% for adults aged 25-44 years, 3.6% for adults aged 45-64 years, and 2.0% for adults aged 65 years and older.¹

Notably, there were significant differences in the experiences of various demographic subgroups during the crisis. Research conducted by the Kaiser Family Foundation found that 56% of parents with an annual income below \$25,000 reported that their children had experienced at least one adverse mental health symptom due to the pandemic, compared to 35% of parents with an annual income of \$100,000 or more.² The supportive school environment's loss, which provided socialization and essential resources for some groups, partially explained this discrepancy.

LGBTQ+ youth were among the most impacted subpopulations, with The Trevor Project's National Survey on LGBTQ+ Youth Mental Health 2021 reporting that 42% of LGBTQ+ youth seriously considered attempting suicide in the past year, including over half of transgender and nonbinary youth. The survey also found that the pandemic had negatively impacted the mental health of 94% of LGBTQ+ youth respondents.³ School closures and disrupted social networks resulted in many LGBTQ+ youth losing access to supportive environments and resources, exacerbating feelings of isolation and marginalization.

One significant shift during the pandemic was seen in adolescent mental health emergency room (ER) visits. Mental health-related ER visits for adolescents increased by 31% in 2020 compared to the same period in 2019. Younger adolescents (12-14 years) demonstrated a greater increase in the proportion of mental health-related ER visits than older adolescents (15-17 years).⁴

This disparity may be attributed to the more significant impact of school closures, social isolation, and family stressors on younger adolescents.

The consensus among these publications is that school closures were a significant risk factor, particularly for the mentioned population groups. A recent article by Bonnie Zima and colleagues⁵ aimed to specifically examine the impact of school closures on acute care visits. Their study, published in *Psychiatric Services*, analyzed data from 44 US children's hospitals to investigate changes in acute mental health care encounters among children and adolescents during the COVID-19 pandemic (from March 1 to November 7, 2020). The study provided valuable insights into the trends and patterns of acute mental health care encounters:

1. During the study period, overall emergency department (ED) visits declined significantly. However, mental health (MH) ED discharges declined by only 16.5% compared to the 45.2% decline in general medical (GM) discharges.
2. Seasonal trends in acute mental health care encounters varied by type, with MH ED discharges declining by 25.6% during spring 2020, increasing by 3.3% during summer 2020, and decreasing by 6.7% during fall 2020. These patterns deviate from pre-COVID-19 trends, suggesting that the summer 2020 increase was driven by heightened clinical needs that overcame hospital avoidance.
3. Suicide attempts or self-injury and depressive disorders accounted for approximately half of MH ED discharges and 60% of MH hospitalizations. Acute care encounters for suicide or self-injury increased by about 5 percentage points following school closures, while those for depression remained relatively stable.

When evaluating subgroups of adolescents presenting to the ER, adolescent girls were found to be particularly vulnerable following statewide school closures. Hospitalizations for suicide or self-injury in fall 2020 increased by over 40% for children aged 12-17 years and by almost 50% for girls. This is consistent with trends identified in public health surveillance data – a CDC study found that from March to October 2020, emergency department visits for mental health issues increased by 26% among boys aged 12-17 compared to the same period in 2019. However, this increase was even more substantial among girls, rising by 37%.⁶

Dr. Zima and colleagues discuss several factors that could help explain the relationship between school closures and increased acute care visits:

1. **Disruption of Routines:** The pandemic upended adolescents' daily lives, with school closures, online learning, and the cancellation of extracurricular activities. This lack of structure and routine can exacerbate feelings of anxiety and depression.
2. **Social Isolation:** Adolescence is a crucial time for developing social connections and identity. However, social distancing measures have limited opportunities for peer interaction, leading to loneliness and a sense of isolation.
3. **Increased Screen Time:** The shift to remote learning and increased reliance on technology for social interaction has led to more screen time, which may contribute to sleep disturbances, heightened anxiety, and depression.
4. **Family Stressors:** The pandemic introduced new stressors within families, such as financial strain, job loss, and illness. Consequently, adolescents may absorb the emotional burden of their family's stress, negatively impacting their mental health.
5. **Grief and Loss:** Many adolescents have experienced the loss of a loved one due to COVID-19. Dealing with grief during such an uncertain time can be overwhelming and may lead to increased anxiety, depression, and even PTSD.
6. **Limited Access to Mental Health Services:** The pandemic has made it challenging for adolescents to access mental health services, as many facilities were forced to limit in-person appointments. While telepsychiatry has helped bridge the gap, it may not be as effective or accessible for all patients.

The study's findings underscore the critical role of acute mental health care encounters in addressing the mental health needs of children and adolescents during the COVID-19 pandemic and possibly during school closures in general. The trends identified in the study, particularly the disproportionate impact on adolescent girls, emphasize the importance of understanding the various factors driving these acute care encounters. As we transition to pandemic recovery, further research is needed to identify ongoing

risk indicators and develop targeted interventions for the most vulnerable subgroups. By staying informed and engaging in discussions about these demographic changes, we can continue to serve our adolescent patients in the most effective way possible.

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The Emerging Field of “Emergency Psychiatry?”

By: Neal Christopher, D.O.



The field of medical specialty training is continuously advancing to keep current providers up to date with challenges and produce new providers who can immediately put evidence-based medicine into practice. Recently, there has been increasing talk of emergency psychiatry as a possible new sub-specialty. Many questions arise when discussing this topic, including: What exactly is emergency psychiatry? Whether psychiatry needs a new sub-specialty? and Whether all psychiatrists are already sufficiently trained in this area?

Emergency psychiatry has been around in many forms for as long as people have been providing mental health treatment during acute events. Any psychiatrist who has evaluated a patient since the first emergency rooms opened in the 1960s has, in one sense, practiced “emergency psychiatry.” Psychiatrists, and many other providers, are trained to notice the classic emergencies of mania, agitation, suicidality, medication-induced dystonia, Serotonin syndrome, Neuromuscular Malignant syndrome, behavioral disturbances from delirium, substance intoxication, substance-induced psychosis, and even medical complications from problems such as autoimmune encephalitis. Emergency psychiatry would certainly include training in recognizing and treating these conditions, but it is not limited to them.

As a sub-field, emergency psychiatry has the distinguishing features of expanded evaluation of acute mental health crises and early intervention and treatment of these conditions. These providers undertake special training in the reasons why people seek emergency psychiatric evaluations, symptoms and exacerbations that precipitate crises, systems of care available beyond hospitals and emergency departments, and the best practices for increasing the speed of delivering evidence-based care at the lowest level possible. No matter how often the ED location is the primary setting, emergency psychiatry is not limited this location.

Emergency psychiatrists are trained to connect patients to other levels of care, such as crisis residential units, where patients can stay for a much longer period of time than they typically could in an acute hospitalization. These units allow time not only for medication response but also appropriate case management solutions for family reintegration, legal documentation, housing and substance disorder connections, and time to practice psychotherapeutic skills in controlled group settings, all before being released to the stressors and triggers of the “real world.”

Emergency psychiatry must distinguish itself with a more intense focus on risk assessment, especially in dealing with the chronically suicidal patient and others who re-present to acute emergency environments often. These providers include training in dealing with the many substance use complications seen daily from methamphetamines, fentanyl, alcohol, and cannabis, such as psychoses, intoxications, withdrawals, and other comorbidities and consequences of use disorders. They are familiar with rapid inductions for MAT services and Motivational Interviewing. They can readily identify change talk, and use OARS to enhance the patient’s internal motivations for change. The emergency psychiatrist understands the crises of personality disorders, particularly those from borderline, antisocial, and narcissistic PDs. They can readily use at least one of the evidence-based approaches for treating BPD crises, such as Good Psychiatric Management for BPD, Dialectical Behavioral Therapy skills, Mentalization-Based Therapy, or Transference Focused Psychotherapy. Personally, this author has seen many emergency suicidal crises triggered by relational instability be diverted away from the inpatient psychiatric hospital using these techniques. Providers working in these environments should be up-to-date on the current options for treating agitation. While having a place, using haldol, ativan, and benadryl is no

longer the standard of practice for agitation and that there are so many other options available such as inhaled loxapine and sub-lingual dexmedetomidine.

Emergency psychiatrists must be cognizant of an ever-widening range of presentations. On any given shift they could see a patient with acute homicidality with a target and means, acute alcohol withdrawal with seizure history, fentanyl overdose, fentanyl withdrawal, methamphetamine induced psychotic agitation, behavioral disturbance from Autism, behavioral disturbance from dementia, Cannabis induced psychosis, a 10 year old child transported in handcuffs from school with no history or records, a discharge from the jail for “smearing feces on wall,” a county agency request for competence to stand trial, a county agency request for LPS conservatorship, a discharge from the state psychiatric hospital after 12 years of treatment with nowhere to go, and undomiciled individuals suffering from complications from weather extremes or lack of food, and a patient presenting from a local clinic in crisis with adverse reactions to medication and treatment resistance who are actively suicidal. Of course, several of these cases will not assist in their own evaluations or allow treatment.

Currently, there are at least three recent textbooks related to emergency psychiatry, and five emergency psychiatry fellowship training programs. The University of Buffalo, Columbia University, Denver Health, ECS in Grand Rapids, and Arrowhead Regional Medical Center offer such programs. There is a special interest group in emergency psychiatry in the Academy of Consultation-Liaison Psychiatry and the American Association for Emergency Psychiatry, which hosts an annual National Update on Behavioral Emergencies conference. The EMPsych podcast (hosted by this author) aims to produce 12-16 episodes focused on the field.

Emergency psychiatry may or may not become an accredited sub-specialty with more of its own accredited fellowships, but all those working in these environments could benefit from additional training in current medications for agitation, evidence-based psychotherapeutic approaches to patients in crisis, induction for MAT, and best practices for non-hospital levels of care that can address patients in crisis.

Links and References:

<https://www.psychiatrictimes.com/view/promise-potential-emergency-psychiatry>

<https://www.emergencypsychiatry.org>

[The Jacobs School of Medicine Emergency Psychiatry Fellowship](#)

[Columbia - Columbia Emergency Psychiatry Fellowship](#)

[Denver - Denver Health Emergency Psychiatry Fellowship](#)

[Grand Rapids - Emergency Care Specialists Emergency Medicine \(EM\) Behavioral Health Fellowship](#)

[Vituity \(Arrowhead, CA\) - Vituity Emergency Psychiatry Fellowship](#)

<https://www.igalmihcp.com>

<https://www.adasuve.com>

<https://empsych.captivate.fm/>

<https://www.vituity.com/healthcare-services/psychiatry/empath-units/>

Paranoid is Marie: Love and Misery

By Candice Ballinger

Independently published.

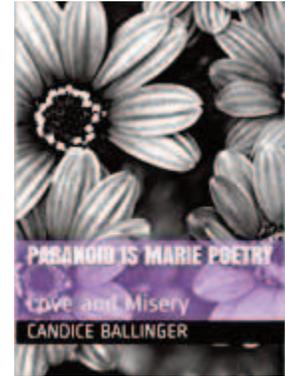
2021

60 pages

\$9.99 Amazon Kindle

Book reviewed by Kavita Khajuria, MD

Trigger Warnings: self-harm, suicidality



This chapbook contains themes of suffering, entrapment, and existentialism, with references to hallucinations, obsessions, and addiction. It speaks to feeling alone, enchained, and with a questioning of life and living. Differing emotional states convey self-harm, yet a wish to break free from internal pain. Romantic enamor opens the door to sensual yearning and gratitude with a quest to feel whole - followed by conflict, loss, and self-confessed sarcasm - yet a craving for connection and to be heard - an intense read with the use of occasionally complex words.

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It was so wonderful to hold SCPS' Installation and Awards Ceremony live again for the first time since Covid-19. (Last year was Installation only for a smaller group.) The ceremony was held on Saturday, May 6th, at the UCLA Faculty Club. We hope that next year even more members will join us! In the meantime, here are photos from this year's celebration.



Outgoing President, J Zeb Little, M.D., and Incoming President, Matthew Goldenberg, D.O.



Anita Red, M.D., personalized her presentation of the Distinguished Service Award to her friend, Ijeoma Ijeaku, M.D.



Ijeoma Ijeaku, M.D., accepts her award.



While her family cheers her on! (Her A team!)



Lawrence Gross, M.D. presents a Special Award to Mark Gale, a longtime NAMI leader dedicated to improving the lives of patients.



Dr. Ijeaku presents Outstanding Achievement Award to Deborah Deas, M.D., Dean of UCR Medical School.



Emily Wood, M.D., who does so much for SCPS and CSAP, accepts her Appreciation Award.



SCPS member, Anum Baig, M.D., and resident at Charles Drew, accepts PER Award



Our second Outstanding Achievement Award went to Alex Kopelowicz, M.D.



West LA Councillor, Alex Lin, M.D.



Ventura Region Councillor, Joseph Vlaskovits, M.D.



Outgoing Secretary, Ara Darakjian, M.D., and Incoming President-elect and Acting Editor, Galya Rees, M.D.

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SCPS Members Go to APA Annual Meeting!

SCPS' Docuseries, "Champions of Social Justice: Psychiatry in Marginalized Communities," <https://www.socalpsych.org/docuseries/> was presented at the APA annual meeting in San Francisco. Here are some photos from the presentation as well as various shots of SCPS members at APA!



Docuseries presenters, joined by Tim and Mindi Thelen.



Docuseries breakout group.



Your SCPS APA Assembly Representatives!



Don't they make the annual meeting look fun!?!
(Drs. Shaner, Red, Freeman, Gales, and Silverman.)



Our own Maria Lymberis, M.D., was bestowed a well-deserved award from the Senior Psychiatrists of APA.



Drs. Schaepper, Ijeaku, Red, and Lymberis.

Council Highlights

April 13, 2023

Ara Darakjian, M.D., *Secretary*



PRESIDENT'S REPORT

Dr. Little

NAMI Walk – Dr. Little encouraged councilmembers to possibly join him to raise awareness of mental illness.

Installation – Ceremony is coming up in May, at the UCLA faculty center.

Election Results – Dr. Little reviewed the results. The slate was approved by membership. President-elect – Galya Rees, Treasurer – Emily Wood, Secretary – Laura Halpin, ECP – Yelena Koldobskaya, RFMs – Drs Adler and Navid, MURRDR – Ruqayyah Malik, Councillors – Drs. Woods, Pylko, Lin, Assembly rep – Ijeoma Ijeaku.

PRESIDENT-ELECT'S REPORT

Dr. Goldenberg

Private Practice Town Hall – Dr. Goldenberg commented on town hall that took place earlier in the month. Dr. Emily Wood, Paul Yoder, Dr. Gillian Freedman, Dr. Shaner and Dr. Robert Burchuk served on a panel to discuss advocacy concerns relating to private practice. Dr. Goldenberg also thanked Mindi for her efforts in organizing the event.

Newsletter Updates – Dr. Goldenberg reviewed the contributing authors for the upcoming month. He expressed appreciation for all of the contributors in the past year. Dr. Galya Rees will be taking over as newsletter, and he reviewed the process for signing up for the upcoming year.

TREASURER'S REPORT

Dr. Bindra

Admin Bank Change – Mindi recounted her shock when the news broke of Silicon Valley Bank's demise, since SCPS had an account with them. Thankfully, she was able to recover the money and switch to City National Bank, and open accounts with them. Dr. Little thanked Mindi for her efforts in quickly handling this issue.

March 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. Silverman reported on the Area 6 meeting at the Hotel Marina Del Rey. Dr. Little did an outstanding job reporting on SCPS's activities. Interestingly, NCPS reported that their GAC may be winding down, so there were thoughts about how to revitalize the NCPS GAC.

There was a long discussion regarding how the Area 6 Council and CSAP could work together. After much discussion, it was decided that Trustee Dr. Barbara Weissman and Area 6 Representative Dr. Lawrence Malak would be invited to the CSAP Board Meetings.

Dr. Red mentioned two action papers coming out of SCPS and praised Dr. Ijeaku and Dr. Wang for their contributions.

MEMBERSHIP REPORT

Dr. Ijeaku

A. Membership Report

Current Active Membership – 832/411

Dr. Ijeaku reported there were 18 new applicants (15 RFM, 3 General) in the past month. One of the new members is a UCLA faculty member, which is a positive step for building a presence in academic centers. The new members were approved by unanimous vote.

COMMITTEE REPORTS

Chairs

Alternative Crisis Response – Dr. Wood reported that the committee is connecting regularly with DMH regarding Care Court issues. Dr. Shaner mentioned a prominently positioned article in the LA times today regarding 988 and challenges in implementing crisis response.

Access to Care – Dr. Rees opted to let the GAC report update the council on Access to Care issues (centering around psychostimulant shortage).

Disaster MH Relief – Dr. Chang reported there are plans to do a training at some point this year. The committee will meet later this month.

PER Awards – Dr. Gross reported on this award, which is for residents in General Psychiatry Programs. There are 13 General Psychiatry programs, so 13 awards will be given. 11/13 programs submitted residents for the awards. The council approved a motion to invite the residents to the ceremony in June.

Diversity and Culture – Dr. Ijeaku reported that the Social Justice award will be given to Dr. Derick Sherrington (sp?). She also reported that they will be doing a presentation at the APA Annual Meeting in San Francisco about the Champions of Social Justice Docuseries.

Dr. Ijeaku also has written an action paper regarding the Moynihan report which will be reviewed by the APA assembly.

Dr. Ijeaku reported that the committee did not receive the Assembly Best Practice Award, which they had applied for.

Program – There was no report from this committee.

GAC REPORT

Dr. Shaner

The Committee met on April 11th.

CSAP was invited to the Area 6 Council meeting in Marina Del Rey. Dr. Shaner attended and gave a legislative update. The Council was enthusiastic about inviting Paul Yoder to confer regarding advocacy issues. Attendees expressed optimism about growing partnerships to strengthen the membership-directed statewide voice of advocacy by APA psychiatrists in California.

Federal and APA Issues – APA has been focusing on private practice issues, partly due to Area 6 advocacy work that is influencing the national APA agenda.

California Budget – Governor Newsom has proposed a ballot initiative to improve treatment of mental illness, substance abuse, and homelessness. The initiative includes amendment of MHSA, putting \$1 billion dollars a year in housing and residential services, increased community behavioral health beds, and \$3-5 billion for unlocked facilities.

Eggman bills – Dr. Shaner reviewed bills written by Senator Eggman, which hope to expand the definition of grave disability, create an internet database for identifying available beds, and to make it a crime to transfer a firearm to someone on the “California Do Not Sell list.”

Other LPS related bills – Dr. Shaner briefly reviewed SB 65, AB 1001, AB 1316, and AB 1451, and CSAP/CMA positions for these issues.

Private Practice focused bills – Dr. Shaner reviewed SB 282, AB 616, AB 1241, and SB 582, and CSAP positions for each.

Parity and scope-related bills – Dr. Shaner reviewed SB 238, SB 70, AB 317, AB 874, AB 236, AB 1437, SB 598, and Witt vs. UBH.

Health Systems and Other Legislation – Dr. Shaner reviewed SB 372 and SB 373.

Youth Mental Health Crisis – Dr. Shaner reviewed SB 11, AB 665, SB 599, and other bills related to youth mental health.

CSAB Board met on 3/16/23. They resolved to approach the California State Board of Pharmacy on behalf of psychiatric patients and families, who are having difficulty filling prescriptions.

Local Advocacy Issues – Dr. Rees presented a motion to address the stimulant shortage: That SCPS and CSAP would both publish positions statements.

Second, SCPS would ask CSAP to collaborate with Area 6 Representatives and APA to work with the DEA, FDA, and state agencies to hold pharmaceutical companies/pharmacies accountable to ameliorate the shortage, and to discuss prevention and management of future shortages of psychiatric medications. CSAP would also revise APA clinical guidelines to allow concurrent use of benzodiazepenes and psychostimulants in patients who have comorbid anxiety disorders or those who cannot tolerate stimulants alone due to anxiety-related side effects.

Third, CSAP will urge relevant state agencies to address the current shortage.

Fourth, CSAP will ask SYASL to approach California legislators to ensure adequate supplies of psychiatric medications. (of note - Rep. Eric Swalwell (D-Calif) reportedly approached the DEA to discuss the issue).

There was much discussion regarding the portion relating to revising APA clinical guidelines to allow concurrent use of benzodiazepines and psychostimulants. There was a motion to move that portion, which passed with 14 votes.

The amended motion was passed.

Dr. Shaner presented letters drafted by the GAC to go to Los Angeles County DMH and the Mental Health Commission regarding CARE Court Implementation with the following points:

to provide transparency in DMH development of the CARE Court Procedures, 2) include specific operational components that would facilitate clinical psychiatric practice within the framework of the plan, and 3) provide ongoing feedback on the inclusion status or those specific operational components as DMH plan development proceeds.

Of note, Harold Turner, Executive Director of NAMI Urban LA and a former Mental Health Commissioner, was invited to review the letter. He felt that the content and effect of the letters seemed appropriate and likely would engender support from NAMI affiliates, possibly including signing on to the MHC letter.

There was a motion to send the letters, which was approved unanimously. Dr. Vlaskovits asked to have a discussion regarding SB43, which would expand the definition of grave disability. He opined that the proposed law is well-intentioned, but he voiced concerns about the pressure this would put on acute psychiatric hospitals, which are already struggling to deal with the number of patients they care for.

Dr. Wood commented that Governor Newsom's ballot initiative would have given funding to increase psychiatric beds. Dr. Shaner commented that the bill would lead to many lives saved, and also shared the sentiment that the Governor's Ballot Initiative would address the need for money and hospital beds. The GAC report was accepted by unanimous vote.

CLASSIFIED ADVERTISEMENTS

Office for Sub-lease

The SCPS office space in west Los Angeles is available for sub-let. This is a great office for face-to-face patient visits. Three separate rooms; two with beautiful mountain views, plus a general common area. Conveniently located at the intersection of the 10 and the 405. Owners will make improvements to space if sublessor is interested in a longer lease. If interested contact Mindi at socalpsychiatric@gmail.com

Have a safe and happy summer. We'll be back next month with the July issue, but remember, no August issue

The office is open and staffed all summer, so if you have any questions, concerns, or needs, please contact Mindi at socalpsychiatric@gmail.com

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Editor Galya Rees, M.D.
Writer Kavita Khajuria, M.D.

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