Southern California

PSYCHIATRIST

Volume 72, Number 6 February 2024 Newsletter of the Southern California Psychiatric Society

President's Column

Black History Month (and Election) Edition of the SCPS Newsletter

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Happy February! In honor of February being Black History Month, SCPS continues the tradition of dedicating the February edition of the SCPS Newsletter to articles and topics related to Black History and the intersection with psychiatry and mental health.

Please join me in thanking Manal Khan MD, the Chair of the SCPS Diversity of Culture Committee and SCPS's Minority and Underrepresented Groups Representative (MUR) to the SCPS Council and Ruqayyah Malik, M.D., Deputy Minority and Underrepresented Groups Representative for their efforts in helping to organize and publish this month's newsletter.

I also want to thank all of the authors who submitted timely articles on topics that relate to this important topic and how it relates to our profession.

SCPS has a keen interest and has taken an active role in making sure diversity and underserved individuals are well represented within and by the organization. One such example is that after George Floyd's death, the Diversity and Culture Committee was founded.

From the mission statement of the Diversity and Culture Committee we recall that its founding is:
" a call for social justice in psychiatry, equity for the disenfranchised, a look at our collective history, and an attempt to move our organization in the direction of enlightened and culturally sensitive practice and professionalism".

One of the first actions of the committee, in September 2020, was the recommendation of an anti-racism resolution, which was passed by the SCPS Council. The resolution continues to serve as a platform for the work of the committee and SCPS as an organization. The resolution focuses on actions that SCPS can take that affect psychiatric practice, our patients and the vulnerable populations we all serve.

One such action from the Diversity and Culture Committee is an action paper, titled "Dismantling Racist Policies in Black Mental Health…APA to Repudiate the Moynihan Report."

You may not know the following, which was outlined in the Action Paper:
The 1965 Moynihan report "The Negro Family: The Case For National Action," created as the theoret-

ical framework to guide Federal strategies for the "War on Poverty," left largely unaddressed the role of harsh and pervasive racial discrimination and gross inequalities of educational and occupational opportunities in causing higher rates of poverty among Blacks relative to the general US population, and instead concluded that Black poverty was primarily caused by a "tangle of pathology" in Black family structure "capable of perpetuating itself without assistance from the white world;"

The Moynihan Report by pointing to cultural deficiencies among Blacks explains without recourse to now-discredited notions of biological inferiority how racial inequality persists even if race supposedly no longer matters. Its call to go "beyond civil rights," intended to highlight economic inequality, misleadingly implied that full legal and political equality had already been achieved

The continued presence of unresolved sociopolitical and economic issues mentioned in the Moynihan Report continue to promote racism via racist policies that result in health care disparities for the Black community

Structural racism negatively impacts Black individuals including psychiatric patients, psychiatric staff, families, and communities

The APA has remained silent regarding the fallacious content of the Moynihan Report which upholds that the core problems of the Black community and roots of Black poverty stem from dysfunctional family structure and culture;

A public repudiation by the APA of the methodologies and conclusions of the Moynihan Report would have an immediate, powerful, and beneficial impact on psychiatric training and practice and the perceptions of psychiatric leadership, and mental health treatment by the Black community;

The above includes relevant excerpts.

The SCPS Council unanimously voted to support and endorse the action paper and its resolutions.

The resolution was that:
The Board of Trustees of the American Psychiatric Association will issue a position statement on the APA website as well as publications in the editorials of the American Journal of Psychiatry and Psychiatric News that:
1. acknowledges the fallacies of the Moynihan report and its multigenerational negative impact upon Black mental health

2. repudiates all misguided psychotherapeutic theory and practices based upon it, primarily the fallacy of "tangle of pathologies" as being direct consequences of dysfunctional family structure

The Action Paper then went to the Assembly of the American Psychiatric Association. The end result was that the action paper passed and was adopted by the APA Assembly!
The APA Assembly review process added an additional resolution to the original Action Paper. Going a step farther, the APA Assembly voted to recommended that the APA Board of Trustees adopt a position statement, in addition to making a public statement repudiating the report.

What an amazing achievement for all of the SCPS members who were involved in this process! A single committee (Diversity and Culture), of a single district branch (SCPS) has positively influenced the APA and psychiatrists, patients and members of our communities from across the country and this is

extremely empowering.

Our colleagues from across the country, in the APA Assembly, recognized the Action Paper was not asking for superficial changes for cursory reasons. The APA Assembly's decision to add a 3rd resolution, recommending that APA produce a position statement, speaks directly to the Action Paper's recommendations being directly able to positively influence social determinants of health.

A public statement to recognize past misstatements and errors of the Moynihan report (1965) is one thing. However, a position statement will pave the way to a future where the recommendations of the action paper serve to potentially improve the economic stability, education access and quality, health care access and quality and social and community context of many members of our communities.

This is true progress. Our efforts have given APA the ability to be at the forefront of positively influencing social determinants of health.

So what is next?

After the APA Assembly passed the Action Paper, and added a third resolution, it went to the APA's Joint Reference Committee (JRC). The JRC then determined the Action Paper should be reviewed by the APA's Council on Minority Affairs.

Walter Wilson, Jr., M.D, the Council on Minority Affairs Chair, has been speaking directly to SCPS's authors of the Action Paper. This is a welcomed collaboration between our local District Branch and our national organization. I thank Dr. Wilson and the committee for their time and attention to this cause, which has the potential to have a widespread and positive impact on multiple areas of social determinates of health in long neglected communities and underserved populations across the United States.

In the near future, the Council on Minority Affairs will provide the APA Board of Trustees (BOT) with specific reasoning and suggestions for changes or improvements, if any, to the Action Paper, which has already passed the APA Assembly. We do not yet know with certainty how those recommendations will influence the subsequent BOT vote to take or reject the actions requested by the APA Assembly. Whatever the decision, I hope they will make this information public so we can all learn and improve from the feedback.

It will come to the APA Board of Trustees for a vote. The APA Board of Trustees will decide if they will accept the Action Paper recommendations, vote to accept some but not all of the recommendations (or some version of them) or to reject them all together.

Regardless of this outcome, I am extremely proud and heartened by the inclusive and diverse group of psychiatrists that are leading SCPS. I am additionally grateful to and humbled by the colleagues that contributed to this important action paper that reached and was accepted by leaders of our national organization in the APA Assembly.

The leadership at SCPS continues to be focused on improving the healthcare of every member of our profession and every member of our communities. The SCPS Diversity and Culture Committee provides an essential perspective and additional accountability for our organization. Working collaboratively, SCPS is committed to serving everyone, including those that have been historically underserved and underrepresented. This action paper is just one example of how being a member of SCPS can improve and strengthen the field of psychiatry not only at the state but also at the national level.

I said “regardless of this outcome” because SCPS is committed to diversity. The APA Assembly has taken action and given their full support. Therefore, our collective commitment to the recommendations of this action paper will not live or die by a single vote of the APA Board of Trustees. If the Board of Trustees votes to accept the recommendations, we will be taking steps into a better future together.

If the APA Board of Trustees reject the recommendations, I hope they will provide clear rationale in a clear and timely fashion. The APA Assembly and SCPS Council will work together, with like-minded colleagues from across the country to bring this across the finish line. After speaking with the authors of the action paper in preparation for preparing this article, I know SCPS is in this for the long haul and for however long it takes to right this wrong.

In addition to this Action Paper, the articles that follow are just a glimpse at the topics and focus of SCPS’s ongoing efforts. The Diversity and Culture Committee is the hub of this activity and SCPS Council is both a supporter and a beneficiary of the committee’s work.

In honor of Black History month, I am hopeful this article and the ones that follow continues SCPS’s conversation with APA leaders and our work together leads to meaningful and lasting change.

In This Issue...

Decolonizing Psychiatry and Psychopharmacology

By: Manal Khan, M.D., Guest Editor, SCPS MURR

Colonialism is defined as “a practice of domination, which involves the subjugation of one people to another.” The history of United States (US) is not unfamiliar with the concept and practice of colonialism. Built through the dispossession and displacement of indigenous populations and through the enslavement and oppression of Africans and their descendants in the US, the reverberations of colonialism, that put the interests of one group over the other, are felt even today. Along with this, inequality exists between the Global North and Global South through invasions, wars, and extraction of resources which is also a product of the colonial mindset. As psychiatrists, we can conceptualize and understand the intra-psychic and interpersonal losses in addition to the material losses that colonized communities have endured. Loss of agency, loss of initiative, loss of traditions, loss of culture, loss of identity. Lost elders and lost generations. Loss of history, loss of stories, loss of belonging, loss of language. Lost meaning. Amidst all these losses, is also the loss of fondness that accompanies nostalgia – memories forever tainted by atrocities which followed. Similarly, there is another loss – loss of “what could have been”, a loss of future free from its manufactured horrors.

Inspired by the work of Franz Fanon, decolonial and liberatory practices have entered the discourse about mental health, highlighting the limitations of our concepts of illness, functionality, and healing, the artificial separation of the personal and collective and social contexts in which individuals and communities exist, and the recognition of the harms perpetuated by psychiatry and healthcare industrial complex. Psychiatry’s past and present include harms inflicted upon minority and marginalized groups spanning across time and ranging from introducing constructs such as drapetomania to over-diagnosing of disorders such as oppositional defiant disorder among Black children [1-3]. Therefore, our clinical constructs and practice, and our professional identity require constant self-reflection. In spirit of self-reflection, we should examine how colonialism, psychiatry, and psychopharmacology might intersect.

Psychiatry has been accused of over-diagnosing, over-medicalizing, and over-pathologizing and hence colonizing areas of life and ways of being in which it does not belong. Therefore, in our clinical practice, as we diagnose and treat patients, we should stay attuned to ways in which we might be imposing our constructs of illness, functionality, healing, and recovery onto the patient and our treatments with all of their side effects and cost-related concerns onto the bodies of our patients. A collaborative approach built on partnership which is antithetical to the hierarchical physician-patient relationship is foundational to decolonizing our clinical practices. We have our expertise to offer, and the patient has their lived experience, and together, we can co-create an understanding and a narrative for their suffering which aligns and resonates with them. It is also important to recognize that the treatment is not in service of mere symptom reduction but should also serve larger developmental goals. Symptoms are not just problems - they can be indicative of ways in which patients might be coping with deeper conflicts. Medications have side-effects and our clinical trials are often limited in their demographic scope and reach. We have not fully understood the complex interplay of various factors such as genetics, environment, neurotransmitters and neural circuitry, structural alterations, neuroendocrinology, inflammation, etc. that go on to contribute to the causation and shape psychiatric disorders. Humility, curiosity, and recognition of our implicit and explicit biases, the historical and ongoing ways in which our profession has inflicted harm, and the limitations of our Euro-centric constructs of illness and health is a step towards decolonizing psychiatry and psychopharmacology. Instead of contributing to the losses, our practice should facilitate restoration of agency, discovery of meaning, and creating a sense of connectedness and belonging.

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Social Determinants of Major Depressive Disorder in Black Women

By: Ruqayyah Malik, M.D., DMURR, PGY 4

"It is not our differences that divide us. It is our inability to recognize, accept, and celebrate those differences"
-Audre Lorde

Major depressive disorder (MDD) is one of the most common psychiatric diagnoses in the United States affecting over 13 million adults or about 16% of the US adult population. MDD rates in women are nearly double those found in men (17% and 9% respectively). MDD exists on a spectrum and often impacts multiple life domains including emotional, social, and physical functioning. Studies have shown that Black populations may experience more chronic and severe forms of depression in comparison to other populations due to various social determinants of health. Indeed, "Black women are disproportionately at risk for depression owing to an overrepresentation of established factors for the illness, including gender, low socioeconomic status (which increases the likelihood of homelessness, incarceration, exposure to violence, and persistent psychosocial stressors like poverty), being never married, and having no health insurance coverage" (1). Diagnosis and treatment of MDD in Black women is limited by various factors including: stigma against mental illness in BIPOC communities, increased likelihood of somatic clinical presentations (e.g. chief complaints of insomnia or fatigue) rather than endorsement of mood symptoms, poor physician-patient treatment alliance, and insurance coverage issues (1). Stigma against having a psychiatric diagnosis and shame surrounding taking prescription medications for mental illness in BIPOC communities are a barrier to care as people are less likely to disclose their struggles and symptoms. This stigma may also be correlated with the higher presentation of somatic symptoms as opposed to mood complaints which may be subconscious. Shrinking appointment times make it challenging for a strong doctor-patient treatment alliance to develop and patients are less likely to disclose vulnerable details about their mental health in this type of setting. Finally, the shortage of mental health providers and limited insurance coverage for mental health care services are also significant barriers to care.

The L.R. McKnight-Eily et al. 2009 paper on prevalence and correlates of MDD in Black women used data from the 2006 Behavioral Risk Factor Surveillance System (BRFSS) which surveyed 8,412 Black women from 38 US states, U.S. Virgin Islands, Puerto Rico, and District of Columbia. The study found a prevalence rate of 13.8% for depression in Black women and added to the limited academic literature

on the nuanced presentation of MDD in this population. An inverse relationship between education level and depressive symptoms was found. This may be due to decreased medical literacy in Black women with a less than a highschool diploma who are less likely to recognize and seek care for depressive symptoms. Married Black women were found to be significantly less likely to report a lifetime diagnosis of MDD or current depressive symptoms in comparison to their unmarried counterparts. This protective effect of marriage is eliminated in cases of separation, divorce or death of a spouse however. Interestingly, the presence or absence of children in the household had no effect on the reported rates of depression. Pertinent modifying factors like income level, access to childcare and social support systems were outside the scope of the study however and would likely impact the relationship between parenthood and depression. Comorbid chronic medical issues and somatization were found to be highly associated with depressive symptoms in Black women. Self-reported life dissatisfaction was the most significant correlate of depression found in the study. Factors such as structural racism and sexism are major contributors to life dissatisfaction in Black women as they experience intersectional pressures to conform to dominant societal norms in order to survive. Indeed, recognizing depression in Black women who can present as over-achieving and highly productive can be challenging if one does not probe further regarding feelings of anhedonia, guilt, or poor self-fulfillment.

While addressing the risk factors and nuanced presentation of MDD in Black women is important for timely detection and diagnosis, culturally specific prevention and treatment interventions are also important. Mediating protective factors like community social support (e.g. via religious affiliations) are important in the holistic treatment of MDD in this patient population. “For example, studies have found that African Americans are more likely to cite religion as an important component of depression treatment and a belief that prayer can be helpful in their healing. Thus, prevention efforts that incorporate religious beliefs and prayer as protective mechanisms should be considered in approaches to increase social/emotional support in Black women…” (1). Patient-centered care that prioritizes preferences and needs of the patient (assuming that there are no urgent safety concerns) is also important in order to build a strong treatment alliance which can contribute to better treatment outcomes.

Citation:
McKnight-Eily, L. R., Presley-Cantrell, L., Elam-Evans, L. D., Chapman, D. P., Kaslow, N. J., & Perry, G. S. (2009). Prevalence and correlates of current depressive symptomatology and lifetime diagnosis of depression in Black women. *Women’s Health Issues*, *19*(4), 243-252.

We Can Do Better Than That:

Addressing Perinatal Depression in Black Women

By: Galya Rees, M.D., President-elect

GR (a hypothetical patient, GR are the initials of this writer) was referred to see me by her OBGYN for peripartum depression based on maternal mental health screening. Her Electronic Medical Record (EMR) tells me that she is in her early 30's, Black, married + 2 young children, and 6 weeks postpartum. She had moderate to severe postpartum depression in a prior pregnancy. Zoloft was prescribed previously by her OBGYN but was not filled. Talk therapy, postpartum depression group, and seeing a psychiatrist were recommended but never took place. A doctor's note was issued, extending her maternity leave by 1 month. Armed with this EMR knowledge, what factors should I consider before seeing GR to increase the likelihood that she will get the care that she needs? Should I change something in my approach to this patient as an individual psychiatrist? Can improvements be made within my own healthcare system or practice? And are there steps that we should consider as a psychiatric organization?*

Perinatal depression poses a significant public health concern, with adverse effects on both maternal and child outcomes. A recent report from the CDC on causes for maternal death indicated maternal mental health and substance use disorders (SUDs) as the most frequent underlying cause of mortality (22.7%). Significant shortfalls in clinical recognition, initiation of treatment, adequacy of treatment, and treatment response have been shown for peripartum depression, with more than half of the women "falling through the cracks" in each step of the treatment cascade, resulting in only 6-9% of women with perinatal depression receiving adequate treatment and as little as 3-5% achieving remission[1].

As if these numbers are not dismal enough, the literature highlights the disproportionate burden of perinatal depression in disadvantaged populations, and the lower likelihood that disadvantaged women will access evidence-based peripartum depression care. Black women, like GR, are twice as likely to experience peripartum depression. Factors contributing to this disparity include limited financial resources, transportation challenges, limited access to mental health care, systemic inequalities, lack of affordable childcare, stigma, and cultural factors that influence the reporting, diagnosis, and efficacy of treatment[2].

Screening for perinatal depression is vital, and as of 2019, CA Assembly Bill 2193 requires all licensed health care practitioners who provide prenatal or postpartum care for a patient to screen (or at least offer to screen) mothers for maternal mental health conditions. AB 2193 also requires health plans and health insurers to develop a maternal mental health program.

Improving timely, effortless access to quality mental health care is key for addressing perinatal depression in disadvantaged women. A 'next available' that takes the patient's insurance in 4-6 months is clearly not an option. Neither is expecting the peripartum patient to do her own online search and phone-calls for appointments. We should not expect this from any mental health patient, but especially not from depressed, sleep deprived, overwhelmed pregnant or postpartum moms. There are opportunities to improve timely access to care for peripartum depression at the individual psychiatrist level, at the healthcare system level, and at the policy and implementation level. In my experience, not all psychiatrists feel comfortable providing care to a pregnant or breastfeeding patients. Reasons for this may include lack of training, high liability risks, and insufficient studies and guidelines. This is something that

we may be able to improve at all levels through liaison with training programs, research, and policy. Understanding current access limitations to perinatal mental health care and the reasons for it would be a good place to start.

There are also opportunities to address some of the other factors contributing to peripartum depression treatment disparities. Culturally sensitive collaborative care models have been shown to be effective in treating perinatal depression in disadvantaged populations. Utilizing midwives and case managers to help with diagnosis and linkage to treatment is vital to decrease the number of patients that fall through each step of the peripartum depression treatment cascade. Community support programs, especially ones involving churches, would likely be helpful[3]. Transportation can often be arranged when in person visits are necessary and help with identifying affordable childcare options can also be provided. The California's Paid Family Leave is currently underutilized by California workers with very low wages who cannot afford the income cut under this program. This group is disproportionally represented by BIPOC women. Full replacement of wages, especially for low earning postpartum women would be helpful[4]. *Finally, we should consider practicing anti-racist strategies in our documentation, such as allowing patients to self-identify, avoiding the mention of race in the identifier, and not making assumptions about social needs based on racial stereotypes[5.]

Back to GR. Thankfully, she was initially seen by the midwife at our new OBGYN peripartum depression program following a positive depression screening at GR's postpartum visit. The midwife, a trusted figure that the patient knew before, started the discussion about depression with her and addressed some of the stigma associated with the diagnosis and treatment. She helped her schedule a therapy appointment and a postpartum group appointment and made sure that she received an appointment with me.

I see GR on Zoom. She appreciates the fact that she did not need to come to see me at the clinic since she has neither transportation nor childcare arrangements. She expressed worry about her copay because finances are tight. She is breastfeeding and has been with her baby 24/7. She wants me to know that she is strong. She is constantly anxious that something bad will happen to the baby. She provides all his needs but does not enjoy him. She hasn't had a streak of sleep that lasted more than 2 hours for 6 weeks. She has little support at home and no one to watch the baby while she takes a long nap. It has been impossible to keep up with household chores. She only leaves the house to go to the store or to church. She is supposed to return to her non accommodating job next week but can hardly function. She experienced racial and gender discrimination in the past and is very concerned about work. She cannot afford to take bonding time due to earning cut under Paid Family Leave. On exam, she presents as tough. She is irritable and sarcastic at times. If you look closely (another advantage of zoom) you can see tears at the back of her eyes, but she won't let them out. There is no space or confidence for that, at least not yet. I am concerned that she will continue to suffer in silence. She is not interested in medications but open to considering them. She plans to start talk therapy and group therapy. She agrees to see me again for follow-up.

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Antiracist Documentation Practices - Shaping Clinical Encounters and Decision Making

Disclaimer: The case report presented here is based on a hypothetical patient.

Honoring the Negritude Movement…

By: Ijeoma Ijeaku, M.D.

In 1926, Black American historian Carter Woodson and members of Association for the Study of Negro Life and History (current day Association for the Study of African American Life and History) announced the celebration of African American history and achievements when they launched Negro History Week. The Negro History Week was the second week of February to coincide with the birthdays of Abraham Lincoln and Frederick Douglass. For the next 50 years, various communities embraced the practice and in 1976, President Ford declared a month long celebration of Black history and achievements. Over the years, various Black leaders have pondered the implications of a Black History month. The arguments have been that Black history is American history and ought to be recognized and celebrated as such on a daily basis (as against just one week or one month in the year) by all Americans. As truly inspirational as that might sound, the reality is that the Black community continues to be marginalized along with its history and achievements of its people.

In the 1930s, the Negritude Movement was founded in response to French colonial rule and the policy of assimilation. The term, "Négritude" was coined by Aimé Césaire in his 1939 poem "Cahier d'un retour au pays natal" ("Notebook of a Return to My Native Land"). The Negritude Movement, influenced by the Harlem Renaissance (a literary and artistic flowering that emerged among a group of Black thinkers and artists in the United States during the 1920s), addressed important political issues including institutionalized racism. The Negritude Movement is a literary and cultural movement that emerged among French-speaking African and Caribbean writers living in Paris. The leaders of the movement began to examine Western values critically and to reassess African culture. The Negritude Movement aimed to raise and cultivate "Black consciousness" across Africa and its diaspora. The Negritude Movement was an important milestone in the history of African and Caribbean literature and culture, and it continues to inspire writers and artists today. The cultivation of Black consciousness has at its core, the awakening of self-worth in the Black individual. It is a call to embrace one's Blackness -one's Black skin, Black hair, Black culture and any and everything that makes one Black. It is the celebration of one's Blackness.

The issues of assimilation, belonging and fitting in within the societal context are ongoing discussions. Should we be ourselves or should we try to fit in? Will we lose ourselves if we get assimilated into the dominant culture? Should we pick and choose whether to be ourselves or be assimilated based on the space or what goals we are trying to accomplish? These are questions that members of marginalized communities constantly grapple with even from a young age especially when they are minoritized? As Psychiatrists (doctors of the soul), we constantly have to help our patients with issues related to their

identity including issues of validation and belonging. It is important therefore that we consider the possible identity dilemma in our patients who are not members of the dominant and mainstream culture even as we expertly help them navigate their psychopathology.

In honor of the Negritude Movement and what it stands for -Black consciousness and the idea that a Black individual can just be themselves in all their glory and deficits! (in all their humanness!!!), without a need to fit in or an assimilation into a dominant culture, here is a poem written in the mid-20th century by David Diop who was part of the Negritude Movement in Paris and wrote of a place he had never been, yet longed for, the birthplace of humanity…Africa

Africa, My Africa

Africa my Africa

Africa of proud warriors in ancestral savannahs

Africa of whom my grandmother sings

On the banks of the distant river I have never known you

But your blood flows in my veins

Your beautiful black blood that irrigates the fields

The blood of your sweat

The sweat of your work

The work of your slavery

Africa, tell me Africa

Is this your back that is unbent?

This back that never breaks under the weight of humiliation

This back trembling with red scars

And saying no to the whip under the midday sun

But a grave voice answers me

Impetuous child that tree, young and strong

That tree over there

Splendidly alone amidst white and faded flowers

That is your Africa springing up anew springing up patiently, obstinately

Whose fruit bit by bit acquires

The bitter taste of liberty.

The Threads of Intersectionality: Female Pioneers of Black Thought and Social Change

By: Urenna Egu

According to the dictionary, a physician is someone qualified to practice medicine. The practice of medicine has at its core the promotion, maintenance and restoration of health. The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It further argues that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. By the mere nature of mental health as a field hugely affected by the social environment, it is imperative that psychiatrists who are the physicians of the soul have a good understanding of the mental health of the individuals and communities that they treat. This is quite important as society begins to understudy the social determinants of mental health and its impact on the health of individuals and communities especially those who are part of marginalized groups.

In celebration of Black History Month, below is a paper that sheds light on the intersectionality of various social constructs and their effects on oppressed communities specifically Blacks. It is the hope of the author that this piece encourages more reading by psychiatrists, who are mental health leaders, in understanding the various ways their patients are affected by the social constructs and how these might influence their mental health.

The tapestry of American history is intricately woven with various movements and protests that have propelled social change. From the mid-1900s Civil Rights Movement to the recent Black Lives Matter uprising in the 2020s, the United States has witnessed a succession of social movements combating systemic and social discrimination against oppressed communities, particularly African Americans. While figures like Martin Luther King Jr., Malcolm X, and others have garnered recognition as significant figures within these movements, shaping current perspectives on past struggles and influencing future movements, many other activists remain overlooked. While acknowledging the significance of male figures, it is essential to shed light on three extraordinary women who have profoundly highlighted the intersectionality of race with gender, sexuality, and socio-economic status. Audre Lorde, Angela Davis, and Michelle Alexander have not only played pivotal roles in understanding intersectionality but have also contributed to the amplification of Black feminist thought. Through literature, oratory skills, and various activist work, this trinity of activists addresses critical issues within the Black community, exploring how race intersects with gender, class, and socio-economic challenges. As Black queer women, Davis and Lorde bring forth their personal experiences to enrich their advocacy within these interconnected communities, while Alexander's analysis of mass incarceration and socioeconomic status provides crucial insights into the historical and present-day connections.

Intersectionality

Coined in 1989 by American critical legal race scholar Kimberlé Crenshaw, the term 'intersectionality' is at the forefront of conversations regarding racial justice, and identity politics. Crenshaw described it as 'a lens through which you can see where power comes and collides, where it interlocks and intersects' (Columbia Law 2017). It is important to understand how race, sexuality, gender, and other forms of identity intertwine. Intersectionality is a powerful tool that helps in the understanding of any person who is experiencing oppression through two intersecting parts of their identity, specifically Black women in America. This term is crucial in understanding the impact of Audre Lorde, Angela Davis, and Michelle Alexander as each of these women uses their work to connect the shared oppressed experiences of various communities and amplify their personal experiences as Black women.

Background

Audre Lorde, born in February 1934, was an American writer, radical feminist, and civil rights activist. Her artistic prowess served as a powerful medium to address pressing issues within the Black community, as well as sexism, classism, and homophobia (Poetry Foundation). Lorde's significant contributions spanned feminist theory, critical race studies, and queer theory, all intricately interwoven with her personal experiences. Notably, her poem titled "The Master's Tools Will Not Dismantle the Master's House" offers profound insights into the intersection-

ality of race, class, and gender.

Angela Davis, born in January 1944, emerges as an American political activist, professor, and author. She played an active role in the Black Panther Party and gained recognition as a prominent leader within the Communist Party USA during the 1960s. Davis gravitated towards the Communist Party due to its more inclusive stance towards women and its opposition to capitalist ideologies. Davis has consistently shattered barriers for Black individuals, particularly Black women. In 1997, she publicly revealed her sexual orientation in an interview with Out Magazine (*Exeposé* 2020). Her fight expanded beyond the realm of Black experiences, encompassing a quest for justice within both the Black and queer communities.

Michelle Alexander, born in October 1967, pursued her undergraduate studies at Vanderbilt University before obtaining a law degree from Stanford in 1992. Presently, she is a highly esteemed civil rights lawyer and activist for the American Civil Liberties Union (ACLU). Alexander rose to prominence through her seminal work, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*, published in 2010. This influential book shed light on the pervasive issue of mass incarceration, garnering widespread acclaim for its examination of systemic racism in the criminal justice system.

Their Impact Today

Although Audre Lorde passed in 1992, her impact on intersectionality can still be felt today. Lorde's piece, *Sister Outsider*, confronts the intersectionality between race, gender, sexuality, and economic status. In "The Master's Tools Will Never Dismantle the Master's House," Lorde speaks to the shared struggles of people within these three groups while highlighting how their struggles will never allow them to beat the system. *Sister Outsider* creates a universal understanding of how each of the intersecting components still stands on its own. As a lesbian mother in an interracial relationship, Lorde uses her personal experiences to not only explain the intersection between these factors but to express the issues that come with being part of these various communities. She writes that "for in order to survive, those of us whom oppression is as American as apple pie have always had to become familiar with the language and manners of the oppressor" (Lorde 107). The oppressed having to educate the oppressors is familiar in today's society. As the current fight for Black, women, and LGBTQ+ rights continues, Lorde's piece speaks to the challenge these communities face when it comes to amplifying their voices. The importance of solidarity is stressed within her work and as time goes on, it is easy to see how oppressed communities are beginning to stand alongside one another more. For instance, in the Black Lives Matter movement of 2020 and the Stop Asian Hate movement of 2020, many of the protestors for both of these movements joined together to conquer one great evil: the American justice system. Overall, Lorde's work educates young Americans today on the complexity of identity and specifically that of Black women.

In 1970, Angela Davis was put on the FBI's most wanted list as a result of her alleged involvement in a case where her guns were linked to the murder of a judge and two others. Following her arrest and subsequent imprisonment for over a year, Davis emerged from this experience with a renewed dedication to prison reform. It was during her time behind bars that she witnessed firsthand the dehumanizing conditions and systemic injustices within the prison system, which sparked her commitment to effecting change. Nearly two decades after her release, Davis established Critical Resistance in 1997 as an organization dedicated to challenging and dismantling the prison-industrial complex. Critical Resistance operates with the goal of addressing the interconnected systems of incarceration, policing, and surveillance, which perpetuate inequality and perpetuate the cycle of mass incarceration. Today, the organization has expanded its reach, with four chapters located in Los Angeles, New York, Oakland, and Portland. Davis's work through Critical Resistance extends beyond a mere critique of the existing system. She emphasizes the importance of comprehensive social and economic reforms as integral components of dismantling the prison-industrial complex and achieving genuine social justice. Davis believes that true transformation requires addressing the root causes of crime and focusing on building strong communities. This includes prioritizing accessible education, creating job opportunities, establishing affordable housing initiatives, and ensuring accessible healthcare for all. By advocating for these vital elements of social and economic well-being, Davis and Critical Resistance strive to create a society that is more just, equitable, and free from the structural inequalities that perpetuate mass incarceration. Through their efforts, they seek to redefine the concept of justice and promote alternative approaches that prioritize rehabilitation, support, and prevention, ultimately challenging the status quo and envisioning a future where prisons are no longer the default solution to societal

problems. Today, Davis has used her platform to advocate for prison abolition and draw more attention to the mass incarceration of Black bodies.

Michelle Alexander's *New Jim Crow: Age of Colorblindness* has provided an intensive framework for understanding the fight for Black rights today, specifically as to how the system has been designed to work. Mass incarceration is extremely prevalent today and it has been for the past three decades. In her book, Alexander highlights how denial and ignorance play a key role in society's understanding of how severe this issue is. She states how when Black and brown men are locked up, "we tell ourselves they "deserve" their fate, even though we know- and don't know- that whites are just as likely to commit many crimes'' (Alexander 226). The media has conditioned society to believe that the system is not corrupt, but Alexander addresses the many ways in which citizens are blind to these issues today. Thus, the "age of colorblindness" serves as a metaphor for the current progress we see in American movements today. After seeing political progress, such as electing the first Black president, citizens assume that everything is "fine." However, Alexander's *The New Jim Crow* highlights the challenges that Black people face in society in the present day. It allows for organizations such as Black Lives Matter to be aware of certain systemic challenges they may face in their fight for equal rights. Alexander's work paints the reality of modern-day America which in turn educates society on the reality of mass incarceration and makes it easier to advocate for efficient progress.

Conclusion

Intersectionality plays a pivotal role in comprehending the intricate dynamics of social environments and the multifaceted challenges faced by oppressed communities. Esteemed scholars and activists like Audre Lorde, Angela Davis, and Michelle Alexander illuminate the significance of intersectionality through their diverse experiences.

For Psychiatrists to grasp the true milieu of their patients, they must understand the importance of social constructs and their intersectionality implications when they treat or manage the mental health of their patients. It is almost impossible to understand Black mental health (or mental health of any marginalized community) without fully grasping this context, which lays the foundation for a comprehensive evaluation of the patient's social determinants of mental health.

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The Dialectic of Nature and Nurture

Emily T. Wood, MD, PhD

"Social determinants of health" is the phrase du jour of academic medicine to describe the way that the health of individuals in our society is differentially impacted based on an individual's intersection of power and privilege. While he did not use this language, W.E.B. Du Bois was pioneering the field of social determinants of health research over 125 years ago. In 1899, he published his seminal work, *The Philadelphia Negro*, which provided a meticulous account of the special and social inequities that were contributing to the immense disparities in health and living standards between the Black and White populations of Philadelphia. Despite "emancipation," he described how chattel slavery and structural racism were organizing forces in America and the primary drivers of socioeconomic inequality.[1]

Psychiatrists have a unique vantage point to view and understand the interplay of biology, psychology, and sociology. While the pendulum has swung back and forth between the emphasis of biological versus psychological underpinnings of psychopathology in our field, for the most part, we recognize that mental and behavioral health disorders arise from a combination of intrinsic and extrinsic causes. Organized psychiatry even gave a nod to the way that our culture can cause unhappiness when it finally removed homosexuality from the DSM. More than any other medical specialty, we have the most experience in research and clinical practice with assessing, analyzing, and integrating an individual's biological, psychological, and social histories to understand their medical and psychiatric conditions. And, yet we continue to shy away from the discussion of social determinants of health for fear that our work will continue to be viewed as "less scientifically grounded."[2]

Right now, we have an opportunity as psychiatrists to uplift the voices of Black, Indigenous, and People of Color (BIPOC) and our field of mental and behavioral health. To do so, we must stop talking about social determinants of health as if they are something to regress out of our analyses so that we can get to the "real" processes.[3] The study of the toxic physiological effects of discrimination and structural racism is not new[4,5] and, as they have been disproportionately burdened, BIPOC have been at the leading edge of understanding how our culture causes biological illness. For the rest of us, the COVID pandemic clearly demonstrated that our environment and culture can make us feel sick even without direct viral infection and there is widespread agreement that our children are facing a crisis in mental health. Psychiatrists must be at the forefront of explaining the nature/nurture dialectic to our society. The mind and all of our mental and behavioral processes are created by an organ called the brain. Thoughts, emotions, sensations, learning, memory, behavior, interactions, and personality traits are all reflections of or arise out of physical and chemical variations in that slab of tissue. And, race is a product of our mind. Put succinctly by the American Association of Biological/Physical Anthropologists:

> *Like human genetic variation, phenotypic variation in our species does not follow racial lines. Race constitutes an arbitrary and artificial division of continuous variation, and thus does not provide an accurate representation of human phenotypic variation or population similarities and differences.*

Race is a critical issue for us to discuss because it is both a construct of our human minds that does not have a biological underpinning and it is one of the most profound impactors of the human mind and body. The discrimination and structural inequities experienced by BIPOC causes toxic stress at the biological and psychological levels.

Civil commitment and the passage of SB 43 provides an excellent example of how we need to be speak-

ing openly about the interplay of racism, psychiatric illness, and psychiatry. In many U.S. locales, it has been demonstrated that Black individuals are more likely than White individuals to be subjected to coercive practices in the name of mental health, including acute (initial, short-term) civil commit.[6] As it should be, this fact was a common reason cited by civil rights organizations such as Disability Rights California for opposing SB 43 and expanding the definition of grave disability. In the literature on this topic reasons are given for why Black people are civilly committed more than White people including interpersonal racism and implicit bias and structural issues such as disparity between racial groups with respect to illness severity, access to and engagement with mental health care, and distribution of upstream social determinants of health. These terms are easy to read and hard to fully conceptualize. For instance, illness severity refers to the fact that racism (not race) interacts with all of the other mechanisms contributing to psychiatric disorders such that BIPOC have more severe symptoms and courses of illness. In other words, poverty, environmental conditions, decreased access to all social services including to less restrictive levels of mental health care, and exposure to the extremely toxic and detrimental impacts of discrimination and structural racism interact with the other pathophysiological processes to cause more severe presentations for some people. This does not mean it is acceptable in any way that we are restricting the civil rights of more BIPOC than White people using civil commitment. It does mean that, in addition to doing everything we can within the mental health care system, we must be explaining to others the process and the way our society will have to heal at all levels in order right this wrong.

In 1898, referring to the impacts of racism all around him, WEB Du Bois wrote:

> *It is not one problem but rather a plexus of social problems, some new, some old, some simple, some complex; and these problems have their one bond of unity in the act that they group themselves above those Africans whom two centuries of slave-trading brought into the land.*

WEB Du Bois was an outstanding intellectual of his time. And, he was one among many Black Americans who kept moving forward with grassroots community building, education, and labor development, despite the failure of Reconstruction and ever-evolving methods of discrimination and structural barriers. This month we specifically honor these individuals and communities. This does not let us off the hook from doing the real work every single day.

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Black Patients and Schizophrenia: Overdiagnosis and Care Inequity

Chantel Fletcher, M.D.

On March 25, 1966, Martin Luther King Jr. spoke at a press conference before his speech at the second convention of the Medical Committee for Human Rights. He is often quoted as saying “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” However, he actually said, “Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death (Galarneau, 2018).” Despite the differences in these two quotes, the message was clear: inequitable quality and access to the resources needed to live healthfully has dire consequences. Unfortunately, these disparities still exist in medicine today and psychiatry is no exception. The disparate overdiagnosis of schizophrenia in Black patients is an example of this. Given that inaccurate diagnosis leads to inappropriate treatment and worsened prognosis, it is essential that this issue be addressed.

Since the 1960s, Black patients have persistently been diagnosed with the disorder far more than White patients. In fact, they are diagnosed 2.4 times more often than their White counterparts (Olbert, et al., 2018). In addition to being diagnosed with schizophrenia more frequently, Black patients are also more frequently labeled as having the paranoid subtype of schizophrenia (Whaley, 2001). While there is some uncertainty regarding why this disparity exists and explanations can vary depending on the case, the impact of medical racism can’t be denied. That is not to say that any clinician who misdiagnoses a Black patient with schizophrenia is intentionally engaging in racism. It is making the case, however, that unconscious biases and residual effects from the long history of medical racism do have a negative impact on diagnosis and treatment of these patients.

Mischaracterizing the mental health of Black patients with inaccurate diagnoses began long before the 1960s and can be traced back to slavery in this country. Dr. Samuel Cartwright, an American physician attempted to pathologize the desire of enslaved Black Americans to be free. Two examples of his effort include “drapetomania” and “dysaethesia aethiopica.” He described drapetomania as a disease causing slaves to want to run away. Dysaethesia aethiopica was a supposed mental illness that applied to both enslaved and free black people consisting of laziness and insensitivity to pain when whipped (Cartwright, 1851).” This egregious and obviously racially motivated pseudoscience was later wiped from the mainstream consciousness of psychiatry. However, a more modern version of this emerged in 1968 when psychiatrists Walter Bromberg and Franck Simon developed the idea of “protest psychosis,” which proposed that “Black Power” views led to insanity in Black men (Hazin, 2011). This was again pathologizing the desire to end racial oppression.

Though the influence of the above examples serve as a stern warning of just how far medical racism can go, the everyday occurrences in psychiatry are clearly not this extreme. So how can the disparity between diagnosis of schizophrenia in Black patients versus White patients be explained? Many explanations have been proposed. It is possible that bias, whether implicit or explicit, leads to misinterpreting of psychiatric symptoms in Black patients. The underemphasis of affective symptoms is

an important point of concern (Gara, et al., 2019). Black patients with schizophrenia are more likely than White patients to screen positive for major depression (Gara, et al., 2019). Failing to adequately recognize affective/mood symptoms in patients may lead to inadequate consideration of diagnoses such as major depression with psychotic features or bipolar disorder (Gara, et al., 2019).

Lack of awareness about cultural differences is another possible contributor. Reasonable suspicion or cultural mistrust in response to experienced discrimination and racism can be mistakenly interpreted as delusional paranoia. Patients with high levels of distrust, and social desirability appear to be more likely to receive a diagnosis of schizophrenia (Whaley, 2001). Differences in use of language is another factor to consider. Commonly used slang terms among many Black patients may be unfamiliar to the treating clinician and easily misunderstood. Although some misunderstandings may be harmless, others may be treatment altering if they lead to an inappropriate diagnosis.

Effectively combating this issue is not a simple fix. It will take time and intentional effort to correct this long-standing trend. Still, there are several approaches. Practicing humility, cultivating empathy, tolerating the possibility of being wrong and being open to new information are important gateways to change. It will also be important to accept the reality of enduring effects of racism in medicine. Evaluate and document patients as objectively as possible while fostering awareness of any bias. Consider any mood symptoms or other clues that might have been overlooked. Clarify the meaning of terms and statements patients make rather than assuming the meaning. Consider the reason behind indignance or suspicion that patients may harbor; it may not be delusional or unreasonable. It may also be appropriate to directly ask patients if and how they feel racism has impacted their mental health and treatment. Be sure to advocate for your patients and provide them with information that helps them navigate the healthcare system and learn about mental health.

As psychiatrists, we often discuss deeply personal and uncomfortable topics. We are tasked with exploring the corridors of our patients' minds in an effort to offer healing and comfort. We must be no different when it comes to the topic of racism and how it impacts patient care. As clinicians, we must be able to do the same for our field and for ourselves. Progress depends on it and so do our patients.

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“Black is Beautiful”

A poem by Dr. Wilfred Njemanze

Author’s Statement: As minorities when we experience the emotional toll that systemic oppression can take it is important that we ultimately take care of ourselves. As mentioned in my poem with the son, it is never a shame to show emotion but it should never a responsibility that we must bear on our own. Sometimes in discussion with others we find healing whether that be with family or a trained professional. Mental health is important in the process of healing and ultimately in continuing to fight for justice.

My Black boy, My Black boy, it's okay to cry
There is no need to wipe those tears from your eye
"Father", you say, "You told me that to be Black is Beautiful"
Yet in my human eyes, why do some see a justification to de-human-ize?
When I dream of running with strides of glory,
Will the color of my skin lead me to the depths of the grave,
where my blood cries out in silence in this Home of the Brave?
Tell me my father
Why do the knees of oppression cut off the breath to my lungs
for is the color of my skin a reason to negate the sanctity of life?
"Father", you say, "You told me that to be Black is Beautiful"
How long will my coffin be etched with the tears of my people?
When the bullets of injustice and hatred pierce my side
Will the justice system see when I bleed,
that a White man's blood is the same color as mine?
Tell me my father

My son I want you to look in the minor and hold your head high
To be a man means to not be ashamed when you cry
To be Black is Beautiful, Bold, and Brilliant, will you say it with me?
"To be Black is Beautiful, Bold, and Brilliant"
Be proud of your ancestry and your identity
The tears we cry are not in vain, for the Lord in Heaven sees and feels our pain.
Though anger may fill our hearts, and violence asks to dine with us tonight,
we must tell him his seat is taken by love.
My son, God's justice has and never will lose a fight
and in darkness he will give us strength to show his light.

mourning my inner [blackgirl] child

by reelaviolette botts-ward
Nomadic Press
2021
141 pages
$16.00 Paperback
ISBN: 978-1-73639-635-3

Book reviewed by Amy Woods, MD

Mourning my inner [blackgirl] child is a book of poetry that invites the reader into an intimate space with the author, reelaviolette botts-ward to explore the intersection of trauma, race, and gender. The reader is met with a gracious invitation to engage your senses, slow down, and create a safe space to allow for healing. Allowing the reader to feel the words in their spirit.

Her poems give a voice to so many Black womxn who were not afforded a voice as a child. The voices of womxn who were silenced, harmed, and whom society deemed were not innocent enough to be protected. The naming of the violence inflicted on the bodies and souls of Black girls, begins the journey of reclaiming their innocence and the joy, care, and peace they deserve. This journey opens a pathway to connect with ancestral wounds and heal intergenerational trauma.

For psychiatrists working with Black women, this book provides a nuanced lens to understand the intersection of race, gender, and trauma that shape the experiences of so many Black women. Hopefully, allowing the psychiatrist the opportunity to understand, empathize, and feel the pain described in each of the poems.

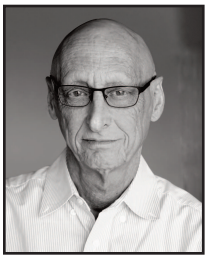
Offering this book to a patient, maybe the one offering they need to finally feel like they can name their wounds and unload the weight of the scars that they have been burdened with for so long. Allowing them the opportunity to see the blackgirl child as worthy of laughter, joy, peace, hope, warmth, protection, pleasure, care, and most importantly, LOVE.

Resources

https://www.blackwomxnhealing.com/

Widening Our Lane:
How Inclusion Strengthens Psychiatric Advocacy

Rod Shaner, M.D., Co-chair SCPS Government Affairs Committee



Leadership through the SCPS Diversity and Culture Committee turbocharges our SCPS bread-and-butter psychiatric advocacy efforts. Addressing relevant issues of diversity and culture head on has effectively transformed our strategy. Let's take a moment to explore this underrecognized connection.

Not so long ago, psychiatrist advocates were often cautioned to "stay in our own lane" when it came to developing or supporting legislative initiatives. What was in "our own lane"? Well, here is the list that I remember:

Strengthening educational standards and licensure requirements needed to practice medicine.
Supporting efforts to stop perpetuation of stigma that undermines parity of insurance benefits for psychiatric services.
Increasing access to psychiatric services for all patients.
Opposing managed care intrusions into clinical decision making and economically driven formulary policies with no clinical justification.
Opposing California Medical Board actions that ride roughshod over patient privacy or bully physicians into complying with overreaching Board demands.
Supporting legislation to prevent corporate poohbahs and government bureaucrats from exercising de facto power to make clinical decisions.
Ensuring that public mental health funding is exclusively for evidence-based interventions.

You might be thinking that this is still a darn good list of key items for SCPS to champion. And you'd be right. The difference today is that we are more successful than ever in achieving advocacy successes in each. It's critical to recognize why: Diversity, equity and inclusion make a high-octane blend.

It's not because our opponents have backed off or given up. Instead, it's because we now realize that there's a lot more in our lane than we'd admitted to in the past.

Some psychiatrist advocates once believed that recognizing social issues would be divisive and distracting. They made sure that there was a double yellow line between those things and "our lane." Perhaps this was because the impact of social determinants of health status was not yet understood. And perhaps unexamined prejudices played some role as well. Whatever the reason, critical social issues involving health disparities were routinely decreed "outside our lane."

We now understand that progress on every item in the "in our lane" list above is directly stymied by perpetuation of health disparities, political and economic disenfranchisement, and cultural prejudices. This new understanding is thanks to the current breadth and diversity of SCPS membership and the leadership from the SCPS Diversity and Culture Committee. Recognizing the social dimensions of Psychiatry and allying with other groups who are struggling to remove these barriers increases the potency of psychiatric advocacy. It brings us new and stronger support to pass legislation that ensure access to high quality psychiatric care to all those who need it.

The direct result of widening our advocacy lane has been the creation and expansion of new programs and funding for high quality psychiatric services. MHSA reform, CARE Court regulations, insurance parity regulations, grants for psychiatric residency training, modernization of conservatorship laws, Medi-Cal expansion, and publicly regulated managed care systems are some of the fruits. More is on the way. Now that we've claimed the whole freeway to high quality mental health care, we have a much better road trip ahead.

And, perhaps, each of us personally now has a broader and more satisfying sense of our own roles. We always knew that our specialty is a critical component of Medicine. We might also now credibly say that Psychiatry is the specialty best equipped to advocate for diversity, equity, and inclusion in health care systems.

Council Highlights
December 14, 2023

Laura Halpin, M.D., *Secretary*

PRESIDENT'S REPORT Dr. Goldenberg

Unhoused Work Group: The work group met November 27th. Dr Koldobskaya and Dr Chang are serving as co-chairs. Dr Rab from the LA County HOME team was present at a guest. They are planning to meet with Dr Shaner from GAC to develop advocacy priorities. Additional experts from field are going to be interviewed by committee members to continue the work of the committee.

A6A Guidelines Work Group: The work group met November 30th. Dr Shaner is chairing the group and provided an update. There are assembly representatives, the bylaws committee and representatives on from CSAP. A key goal of the group is to develop guidelines consistent with our bylaws and all governance documents from involved parties to support all groups involved (SCPS, Area 6 Assembly and CSAP) working together effectively.

Regional Councilor Messages: Dr Fast and Dr Friedman have reaching out to their regions to interface with Inland Region Members. Mindi Thelen offered to facilitate this. Those regional councilors who are interested should reach out Ms Thelen.

PRESIDENT-ELECT'S REPORT Dr. Rees

Newsletter Updates were provided. Dr Rees recognized recent contributors and reviewed next month's contributors.

NAMI Meeting Agenda was reviewed. The meeting will be Jan 11 from 6:30-8 PM. In addition to our agenda items we look forward to listening and supporting NAMI.

Motion Approved: Agenda for meeting was approved

Election Slate: the nominating committee provided the slate for next year's elections. The election slate for 2024 elections is as follows:

President-Elect: Patrick Kelly MD
Treasurer-Elect: Laura Halpin MD
Secretary: Gillian Friedman MD
WLA Councilor (3 positions): Lloyd Lee MD, Haig Goenjian MD, Tatjiana Josic DO
Inland Region Councilor (2 positions): Daniel Fast MD, Kayla Fisher MD
Santa Barbara Councilor: Anu Bodla MD
South Bay Councilor Steve Allen MD
ECP Deputy Representative Manal Khan MD
RFM Representative: Somin Lin MD, Justin Ngyuen MD, Zach Liang MD
MURR Deputy: Rubi Luna MD, Margaret Lau MD
Assembly Representative: Anita Red MD

Motion Approved: Election slate was approved

GAC ACTION ITEMS Drs.Shaner and Wood

Report from monthly meeting was provided. Two motions were presented

Motion Approved: That SCPS Council request that CSAP support the 2023/2034 FASD Respect

Act. Noted would plan for collaboration with CalACAP
Motion Approved: That SCPS shall proactively seek input from key psychiatrists from each SCPS region county for purposes of crafting advocacy to promote successful implementation of SB43 and prudent implementation of Proposition 1 if it passes in March 2024

VI. TREASURER'S REPORT Dr. Kelly
November Financials and Cash on Hand Report
Dr. Kelly reviewed various financial metrics, year-to-date. Overall, SCPS is in good fiscal health. Update was provided that Career Day provided some income.
Motion Approved: Treasurer's report approved

VII. ASSEMBLY REPORT Assembly Reps
Dr Silverman shared highlights from the recent Assembly meeting. She shared notes from the assembly meeting with APA updates, assembly election updates, and the titles of action papers which were passed at the meeting. The next in person meeting will be in NYC May 3-5 at APA Annual Meeting. The deadline for action papers is March 7th

MEMBERSHIP REPORT Dr. Ijeaku
A. Membership Report
Current Active Membership –870/983
The membership report was approved by unanimous vote. The recruitment video is almost completed. Final product expected early 2024. There was also discussion about ensuring members meet criteria for District Branch membership when joining APA as per bylaws.

COMMITTEE REPORTS Chairs
Alternatives to Incarceration – Dr. Wood The committee developed a resolution internal to the committee to advocate for stronger support of psychiatric determination of LPS detention criteria solely on clinical basis, without consideration of inpatient bed resource availability. This motion was tabled.
B. Access to Care – Ms Thelen provided an update. Members are reaching to local members of pharmacy professional organization to collaborate on stimulant shortages and other issues. This continues to be a challenge.
C. Disaster MH Relief – Committee did not meet
D. Diversity and Culture – Dr. Khan. Dr Castillo attending meeting to discuss applying JEDI principles to ACGME competencies and functions. They are considering an Action Paper. The repudiation Moynihan Report Action Paper is being considered by Council on Minority Mental Health and Disparities.
E. GAC—Drs Wood and Shaner, motions above. CSAP is reviewing the legislative proposals from all DBs within the state. There are additional upcoming meetings to review and prioritize these. With the large state budget deficit this year, we anticipate the need for significant ongoing advocacy for recently/already passed state legislation regarding infrastructure, reimbursement, workforce and other aspects of psychiatric care. There was also discussion about APA DGR Layoffs and restructuring. GAC has significant concerns on how this will affect state and federal advocacy. Other councilors expressed concern.
F. Program – Dr. Gales, annual psychopharmacology program will not occur in January. We are planning to focus on smaller programs with more narrow focus including an upcoming possible session on psychedelics. The program committee will likely be recruiting.

* * CANDIDATE STATEMENTS * *

Deadlines for Nominations by Petition February 21, 2024

In this special section, the candidates nominated for your representation discuss their views.
Please read the statements carefully before voting.
Ballots will be mailed on or around March 5, 2024.

Patrick Kelly, M.D.
President-elect

I am both delighted and honored to be nominated for the position of SCPS President-Elect. Since my induction into SCPS, it has been my privilege to serve as the Treasurer, the chair of the Child Committee, and as a member of the GA Committee, the LGBTQ+ Committee, the Programming Committee, as well as various ad-hoc committees. Each role has deepened my understanding of the issues and challenges SCPS faces and has equally prepared me for the additional responsibilities inherent in this new role.

In my past tenure as President of the Southern California regional organization of the American Academy of Child and Adolescent Psychiatry (SCSCAP), I garnered experience that I believe uniquely positions me to enhance the well-being of SCPS and to aid in deepening its connections to additional affiliated organizations.

Clinically, my experience is twofold: I work both in the Harbor UCLA Psychiatric Emergency Room and within private practice. This broad engagement with patients from diverse backgrounds affords me a unique and comprehensive perspective on the needs of our extensive community. It ensures I am equipped to navigate various viewpoints on efficiently allocating SCPS resources toward diverse advocacy and legislative initiatives.

I look forward to helping to guide and support SCPS in its mission to aid both patients and practitioners. This organization holds particular significance during this era of significant change in the structure of both the APA and the California legislation. I eagerly look forward to contributing to the vitality of our organization now and for the foreseeable future.

Thank you for your consideration and for your steadfast commitment to the psychiatric community.

Laura Halpin, M.D.
Treasurer-elect

I am honored to have been nominated to serve as the Treasurer-Elect of your SCPS Council. I am currently serving on Council as the Secretary and as a member of the both the SCPS and CSAP Government Affairs Committees. I also had the opportunity to serve as a member of the Bylaws Committee this year to work with others to update our Bylaws and other governance documents. I have previously also served as the Early Career Representative. I currently work for Kaiser Permanente, SCPMG in the Downey Service Area as an outpatient and Consult-Liaison Child and Adolescent Psychiatrist. Prior to work there, I completed Child and Adolescent Fellowship and Adult Residency at UCLA. I have previously been involved with the APA as a Leadership Fellow and member of the Council on Healthcare Systems and Financing. I have also held numerous positions in the AMA including currently serving on the Section Council of Psychiatry as the one of the APA's Delegates to the AMA House of Delegates and on the AMA Council on Science and Public Health. This past year I also served as an delegate from District IV to the CMA House of Delegates. I have previously been a Resident and Fellow Delegate to the CMA House of Delegates and served as the Chair of the CMA Resident and Fellow Section. I have a strong interest in advocacy as relates to protecting our vulnerable patients and supporting physician autonomy.

If elected as your Treasurer I will work to keep you informed about what is happening with the finances of SCPS, hear your perspective on what SCPS can do that would be helpful for you, and make sure that perspective is well-represented to SCPS Council.

Gillian Friedman, M.D.
Secretary

I am honored to be nominated for the position of Secretary for SCPS. For the past 3 years I have served as Inland Region Councillor, and for the past year have served on the Government Affairs Committee, as well as Co-Chair of the Access to Care Committee. In these positions, I have witnessed the real day-to-day implications that our Council's advocacy can have for SCPS psychiatrists and for the care we are able to give our patients.

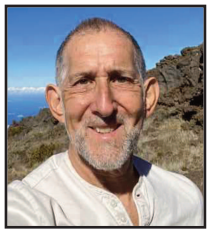
I have been a member of APA for roughly 25 years (since the beginning of residency), and for years I organized informal gatherings of SCPS members in the Inland Region. It has been so rewarding over the past 3 years to join in SCPS leadership, with the opportunity to translate Southern California psychiatrists' concerns into action.

I have spent most of my career in public psychiatry (inpatient and outpatient), but have also run a part-time private practice and have been Medical Director at a for-profit psychiatric hospital. Currently I am Medical Director at Patton State Hospital, a completely forensic setting. I have worked in virtually every psychiatric environment, so if you reach out to me, I'll understand the challenges you're facing.

There are many critical factors facing our profession currently: the shortage of psychiatrists (expected to worsen as our most experienced members retire), scope of practice issues, persistent difficulty with mental health parity despite federal and state parity legislation, ethical dilemmas when payors decline the treatments a patient needs, and many more. I am committed to hearing from you about the

issues affecting you in your practice, and to pursuing opportunities for advocacy. The decreasing access of our patients to care by psychiatrists, and the problems psychiatrists who work with insurance have in getting fair reimbursement, remain particular areas of concern for me.

Daniel Fast, M.D.
Inland Region Councillor



I have been in private practice of psychiatry since completing my residency, in Santa Monica, Beverly Hills and now Palm Springs. I hope to represent the needs of the average psychiatrist balancing personal and professional obligations, coping with an increasingly regulated and fragmented mental health system, facilitating interaction with medical and other mental health practitioners (not "providers"). Those of us far from the urban core can feel dis-enfranchised from regulatory and organizational decisions - I hope to represent and communicate both vertically between decision-makers and horizontally among us in the community.

Kayla Fisher, M.D.
Inland Region Councillor

Thank you for the nomination to serve as Inland Region Councillor for SCPS. My career activities reflect a commitment to organized psychiatry. As a Distinguished Fellow of the APA, I serve on the Executive Committee for the Religion, Spirituality, and Psychiatry Caucus, and presented at seven of the last eight annual meetings. As a forensic psychiatrist, I serve on the AAPL Program Committee and Resident Training Committee, chair the Forensic Hospital Services Committee, and provide ad hoc reviews for JAAPL. In my role as a child psychiatrist, I serve on the AACAP Ethics Committee. Elected to the American College of Psychiatrists in 2010, I hold positions on the Editorial Board for the Psychiatrists in Practice Examination and the Continuing Medical Education Committee. My career has included leadership roles in hospitals and health corporations, in addition to VA and private practice experience. Holding university appointments throughout my career, I am currently a Clinical Professor of Psychiatry at UCR where I teach residents and provide mentorship. SCPS holds a vital role in advocating for our profession. If elected, I will endeavor to support the Inland Region and work with other SCPS leadership to advocate for psychiatrists in the greater SCPS area.

Anu Bodla, M.D.
Santa Barbara Region Councillor

I am honored to be nominated for a second term as Santa Barbara Councillor. As a psychiatry resident at Community Memorial Healthcare in Ventura, part of my training involves working in Santa Barbara, giving me a unique perspective on the mental health challenges faced by our community.

My path to a career in medicine was nontraditional. I attended medical school in India after high school in the U.S. This experience taught me the critical need for increased mental health advocacy, especially in areas where mental health is heavily stigmatized. In the past few years, I have witnessed the impact of advocacy in community settings, for instance, the adoption of Welfare and Institutions Code - § 5270 in Ventura County that came about as a direct result of such advocacy efforts.

If re-elected, I am committed to advocating for broader access to mental healthcare, drawing upon my experiences to effect positive change. By fostering stronger collaborations between healthcare providers, local organizations, and governmental entities, I aim to use my position to help cultivate a community that is committed to managing mental health crises and addressing mental illness with the seriousness it deserves.

Steven Allen, M.D.
South Bay Region Councillor

It is a distinct honor to be nominated for the SCPS South Bay Region Councillor position. For the last six months, I have had the privilege of serving in this position and my appreciation for organized psychiatry has never been higher.

Currently, I work full-time in a Los Angeles County DMH clinic, serving a diverse patient population that is often marginalized and underrepresented. Additionally, I serve as the co-chair of addiction psychiatry training in the Olive View – UCLA psychiatry residency training program. Finally, I work one day a week in private practice. It is these work experiences, in addition to residency and fellowship training in the VA healthcare system, that have shaped my understanding of the many difficulties facing psychiatrists and psychiatric patients in the current healthcare system.

If afforded the opportunity to continue to serve as the SCPS South Bay Region Councillor, I pledge to support all efforts aimed at reducing mental health stigma, expediting equitable access to quality mental health care, encouraging resident physician involvement in organized psychiatry, and processes that promote physician autonomy.

Thank you for your consideration.

Haig Goenjian, M.D.
West LA Region Councillor

It continues to be an honor to be nominated to serve the SCPS council. I have had the privilege of being a councilor since finishing residency at Harbor UCLA in 2016. Since then my perspective has been refined by the robust experience SCPS has provided. In 2021 I also served as Executive Secretary. The time spent in organized psychiatry continues to motivate me to work harder to advocate for the medical science of psychiatry. This is a dual enterprise, both advocating for our patients as well as our professional standing in a world which is continually challenged by dividing forces. We face challenges from competing clinicians, payers, lawyers, and politicians. Please consider me for your vote, as I pledge my unrelenting support for our profession.

Tanya Josic, D.O.
West LA Region Councillor

I am honored to be considered for the position of West LA councilor.

I completed a child and adolescent fellowship at LAC+USC in 2019. My clinical work at the LA County Department of Mental Health and UCLA Health Behavioral Health Associates focuses on the assessment and treatment of patients from diverse backgrounds. I am also a member of the AACAP's SUD committee and started the AACAP's SUD Journal Club subcommittee.

It was a privilege to serve as a West LA councilor over the last three years. Being involved in SCPS allowed me to dig deeper into and to better understand the ways to translate the needs of our patients and our professional community into precursors for advocacy. For me, it is important to be part of an organization that supports equal access to compassionate and equitable mental health care and to continually search for solutions to issues that minority populations and individuals affected by addiction face every day.

I am grateful for the opportunity to chair the Substance Use Committee with SCPS. I will seek to increase public awareness of addiction as well as to collaborate with other organizations working toward the same goal.

Thank you for your consideration.

Lloyd Lee, D.O.
West LA Region Councillor

I am honored to be nominated as one of the West LA Councillor Candidates.

I am looking forward to starting my career in organizational psychiatry. Since my Intern Year of Residency, I have seen how government and insurance policies limit access to services and medications for patients and narrows the scope of what psychiatrists are able to do.

I became very familiar with community psychiatry during my 7 years previously working for LAC-DMH. I am currently a full-time Consult & Liaison Psychiatrist at Kaiser West LA Medical Center, where I deal with the advantages and limitations of the LPS Act on a daily basis. With the ambitious passing of SB43 & AB2275, they provide optimistic promises of increasing funding for psychiatric beds, services and patients' rights advocacy, but also pose significant challenges in executing these actions. I look forward to contributing to making sure that the promises of these bills are executed to the benefit of our patients & providers. As someone who grew up in Los Angeles County, I have sincere interest to make sure that all those struggling with mental illness can have their needs met in order to enjoy life in our beautiful community.

Manal Khan, M.D.
Early Career Psychiatrist Representative

Thank you for considering me as a representative for Early Career Psychiatrists. Currently, I serve as the Assistant Professor of Psychiatry and Associate Program Director for Child and Adolescent Psychiatry Fellowship at University of California, Los Angeles (UCLA). I work in both the inpatient and outpatient settings, and I am involved in the teaching, supervising, and training of the residents and fellows. I completed my general psychiatry residency training at University of Washington, and then my child and adolescent psychiatry fellowship training at UCLA. Some of my leadership roles include serving as the Resident-Fellow Member for Washington State Psychiatric Association and APA's Diversity Leadership Fellowship. I also worked as the Chief Resident of Wellness and Recruitment during my residency training and then as the inaugural Justice, Equity, Diversity, and Inclusion Chief Fellow at UCLA. At SCPS, I have served as the Representative of Minority and Underrepresented Groups and chaired the Diversity and Culture Committee. I also co-chair the IMG caucus for AACAP.

If elected, I will work to bring the ECP perspective (along with their hopes, aspirations, and concerns) to the SCPS executive council and ensure that our voice is represented in the conversations about our profession's future.

So Min Lim, D.O.
Resident/Fellow Member Representative

I am humbled and honored to be nominated as the Resident Fellow Member Representative. Growing up in Southern California as a 1.5 generation immigrant, I have been deeply inspired by the diverse communities around me and vowed to support and enrich the community.

I am passionate about serving the underserved, uninsured, and unhoused. My rotation at Kedren Community Health in Los Angeles allows me to primarily serve the uninsured and unhoused, and providing psychotherapy at Augustus Hawkins in Compton fosters a deeper understanding of the marginalized community.

Additionally, I have been privileged to be a part of SCPS Diversity & Culture Committee and Unhoused Work Group where I strengthen my understanding of issues we face in our profession, with focus on progressing the needs of our communities through our profession.

My interests are child & adolescent psychiatry, cross-cultural psychiatry, LGBTIQ health, understanding and advancing mental health legislation, and utilizing creative modalities of art and music in psychiatric space. I volunteer by creating wellness for patients and staff through violin and guitar in multiple inpatient psychiatric hospitals.

As I continue to learn from my experiences, I hope to foster the evolving needs of Southern California psychiatrists. Thank you for your consideration.

Justin Nguyen, M.D.
Resident/Fellow Member Representative

I am honored to be nominated for the position of resident member representative of SCPS!

Throughout medical school and residency, I have made it a priority to familiarize myself with important issues in organized medicine and psychiatry. In the AMA Medical Student Section, I co-authored a resolution that supported the use of affirmative action in medical school and undergraduate admissions decisions and spearheaded a resolution calling on the AMA to publicly oppose the 2019 public charge rule which deterred immigrants from seeking health care. As a resident member of the APA Assembly, I contributed to action papers that addressed ways that APA can support unmatched psychiatry residency applicants, the unique impacts of gambling disorder on Asian American patients, and the role of collective bargaining in improving resident wages. I am also involved in efforts to move California towards unified financing of our healthcare system.

As I approach the last year of my training, I am excited by the opportunity to bring my perspective to the SCPS Council and further the organization’s efforts to advocate for high quality patient care in Southern California!

Rubi Luna, M.D.
Deputy Minority and Under Represented Representative

It is an honor to be nominated for the SCPS position of Deputy Minority and Underrepresented Representative (DMURR). I completed my Adult Psychiatry Residency at UCSF with an area of distinction in Cultural Psychiatry and I am currently a first-year Child and Adolescent Psychiatry fellow at the UCLA Semel Institute. Throughout my residency, I mentored medical students from underrepresented groups to support the recruitment of diverse trainees into psychiatry and developed residency curriculum to promote the safety and inclusion of minority trainees. I remain passionate to address mental health disparities in immigrant and underserved communities through leadership and education. If elected to serve as the DMURR, I would work to advance the society's mission to increase the representation of minority and underrepresented trainees from programs across Southern California who share a passion for social justice. I would work with the SCPS Diversity and Culture Committee to identify strategies to address structural racism in psychiatry education and training and prioritize initiatives to improve the psychiatric treatment of minority populations. Thank you sincerely for your consideration.

Margaret Yau, M.D.
Deputy Minority and Under Represented Representative

I am honored to be nominated for the Minority and Underrepresented Groups Deputy Representative position of the SCPS. I am passionate about working with diverse communities and underserved populations, and I have pursued this passion during my medical training, research, as well as teaching.

As a psychiatry resident at the University of California, Riverside, I currently co-chair the Psychiatry Diversity Advisory Committee, which is committed to advancing diversity, equity, inclusion. I am the resident coordinator of the Riverside Free Clinic Psychiatry, which provides free psychiatric services to patients. I also volunteered with the free clinic throughout medical school. Through research, I have studied factors associated with mental health disparities and am exploring ways to promote ADHD awareness in diverse communities. In my previous career as a community college educator, I worked with and supported the success of students from all backgrounds.

If given the opportunity to serve as the DMURR, I hope to work with members to address issues affecting the mental health of minority and underrepresented groups, such as social determinants, structural barriers, and building a diverse mental health workforce.

Anita Red, M.D.
APA Assembly Representative

It is an honor to be nominated for an American Psychiatric Association Assembly Representative of the Southern California Psychiatric Society.

As one of your assembly representatives these last 4 years and over a decade and a half of continuous service on the SCPS council, it is a privilege to have the exciting opportunity to be re-elected to serve as an APA Assembly Representative.

The APA is our national psychiatric voice, and now more than ever that voice needs to be a strong one. When psychiatrists work together throughout the country, our collective voice is the loudest and most heard. The APA uses policies, legislation influences,and programs to communicate our interests, and the Assembly Representatives help bring these to fruition.

Most of my professional life as a psychiatrist has been with SPS positions on council including President and President-Elect, Treasurer and Treasurer-Elect, Secretary, San Gabriel Valley/ East LA Councilor, Early Career Psychiatrist, Early Career Psychiatrist Deputy Representative, Resident/ Fellow Member Representative for two years, and multiple committee involvement.

Thank you for the nomination of an APA Assembly Representative.

Election Timeline

Cut off to run by petition February 21, 2024
Ballots emailed March 5, 2024
Ballots are due March 28, 2024
Tellers Committee March 31, 2024
Installation April 13, 2024

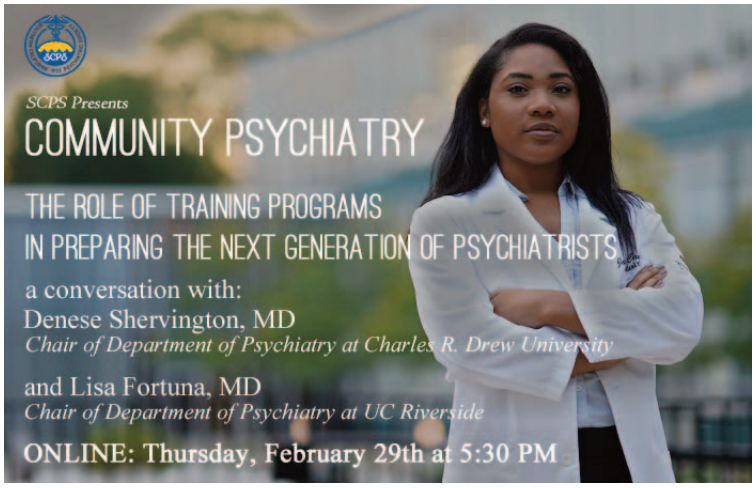
Have you been a General or Fellow member for at least eight years? If so, you may be eligible to apply for Distinguished Fellowship.

Distinguished Fellowship is awarded to outstanding psychiatrists who have made significant contributions to the psychiatric profession in at least five of the following areas: administration, teaching, scientific and scholarly publications, volunteering in mental health and medical activities of social significance, community involvement, as well as for clinical excellence. Distinguished Fellow is the highest membership honor the APA bestows upon members.

The application process takes almost a year and the 2024 cycle is about to begin. For more information please go to https://www.psychiatry.org/membership/honorary-fellowship/dfapa

If you are interested in becoming a DFAPA and believe you might be eligible, please contact Mindi at socalpsychiatric@gmail.com

She will provide you with the form required for the first step in the process.



https://www.socalpsych.org/event/community-psychiatry/

SCPS Members, please note that your 2024 dues have been billed and are due.
Thank you to those of you who have made your membership payment and continue to be a strong supporter of SCPS and organized psychiatry here at home and nationally. SCPS members are automatically provided representation at the California State Association of Psychiatrists (CSAP), the only APA affiliated and supported statewide psychiatry organization in California. If you missed the most recent town hall, please plan to join SCPS leadership at the next member event to learn more about how your membership dollars are making a difference.

If you have not already paid your dues,
please contact Mindi if you have not received your statements.
Unpaid dues on March 31, 2024, will cause your membership in
SCPS and APA to be terminated.
You may click here to make payment.
You will need to navigate to your membership category and dues amount.

(Please note, the 25% of your 2024 dues, which will be used for direct advocacy services, cannot be deducted as a business expense. Resident/Fellows do not pay advocacy dues.
We recommend that you consult with your accountant regarding dues deductibility.)

CLASSIFIED ADS

BRENTWOOD: Large office in Psychotherapy Suite /w all amenities. Half bath for staff & storage/kitchen room. By day or half time. Beautiful view & very nice professional building on San Vicente. Call 310-820-6300, please leave message.

ALL EDITORIAL MATERIALS TO BE CONSIDERED FOR PUBLICATION IN THE NEWSLETTER MUST BE RECEIVED BY SCPS NO LATER THAN THE 1ST OF THE MONTH. NO AUGUST PUBLICATION. ALL PAID ADVERTISEMENTS AND PRESS RELEASES MUST BE RECEIVED NO LATER THAN THE 1ST OF THE MONTH.

Southern California PSYCHIATRIST, is published monthly, except August by the Southern California Psychiatric Society, 2999 Overland Ave., Suite 208, Los Angeles, CA 90064, (310) 815-3650, FAX (310) 815-3650.

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