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President's Column

SCPS Program Committee Redux

Matthew Goldenberg, D.O.



Happy March! I hope everyone has stayed safe and dry with all of this rain!

This month I want to share an opportunity for you to engage in something truly historic. The SCPS Program Committee is looking for SCPS members who are interested in medical education and/or academic psychiatry to help us bring the SCPS Program Committee into a new phase.

Before we get to the opportunity, let's talk a little about the history of the committee. For 30 years, the SCPS Program Committee organized and presented an annual Psychopharmacology Update. In more recent years, the annual program transitioned into "Advances in Psychiatry".

Here are some quick facts about the SCPS Program Committee:

The first annual Psychopharmacology Update was held in 1989 under the Chairmanship of Michael Gitlin, M.D.

The next chairs were Dr. Behnaz and then, Deborah Nadel, M.D.

Our current and longstanding Chair, Michael Gales, M.D. has been in the position for two decades! Over the years some longstanding committee members included: William Arroyo, M.D., Jackie Green, M.D., Samuel Miles, M.D., Ronald Onkin, M.D., Heather Silverman, M.D. and Harvey Sternbach, M.D.

More recently, Patrick Kelly, M.D., joined the committee as a liaison between SCPS and the So CA Society of C&A Psychiatry.

A real treat of the psychopharmacology meetings was the longstanding tradition of having one or two speakers who were not local, so that attendees could get a chance to learn from someone whom they otherwise might not be able to. These meetings were often attended by 100 or more SCPS members and served as a valuable opportunity for local psychiatrists to socialize and liaison. In addition, the meetings served as an important source of income for SCPS, and the funds have been utilized for member benefits and to help keep membership dues as low as possible.

Not unlike many professional organizations, Covid really changed the equation for the SCPS Program Committee. Members are preferring virtual meetings, and the Program Committee is preparing to set the groundwork for the rest of this decade.

And here is the opportunity. The SCPS Program Committee is looking for interested SCPS members who are involved in medical education, academic psychiatry, have an interest in the most up to date and cutting-edge trends in psychiatry and/or want to contribute to one of SCPS's most historically active and vibrant committees. The committee is transitioning into the post-covid world and virtual meetings open up an op-

portunity to reach more members and to bring in more geographically diverse speakers and audience members/participants. The possibilities and opportunities for the committee are unlimited.

If you or a colleague are interested, please reach out to Mindi.

The committee is rich with history and tradition and is seeking an infusion of ideas, passion and a continued commitment to evidence-based psychiatry. If this sounds like something a colleague would be interested in, please share this opportunity with them and encourage them to reach out to Mindi! Whether you are an RFM/ECP or have been a SCPS member long enough to remember the Psychopharm meetings, please consider participating. The first step would be to join an upcoming SCPS Program Committee meeting as a guest.

If the future of the SCPS Program Committee is anything like the past, you will be a part of something not only historic but also essential to SCPS and the future of psychiatry in the Los Angeles area.

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Shining A Light in a Dark Place

By: Reba K Bindra, M.D.

Note: I use the terms women/female and men/male here because this is how the jails are divided. This is not meant to exclude anyone who identifies outside of these constructs.



I work in a jail, specifically a women’s jail. Century Regional Detention Center (CRDF) is 8 miles south of Downtown LA and is part of the largest jail system in the country (see December 2023 SCPS newsletter for a full breakdown of the LA County jail system). According to the LASD Correctional Services Daily Briefing (2/16/24) there are 1,351 inmates at CRDF.

“But isn’t it dangerous?” is usually the first question I get asked when I say I work in a jail. Answer: not really. For many years I worked in psychiatric inpatient units as well as the state hospital where patients walked freely with no handcuffs, and I spoke to them face to face with little space between us. At any point you could be the subject of intended or unintended violence. In jail, for basically the same patient, I have to yell loudly through 3 small holes on a locked, heavy metal, maximum security-designed door. (No, the women’s jail is not a maximum-security facility, but it operates like one. Different story for a different day). Hospital vs jail safety? Jail wins, hands down. But that’s about the only thing that the jail will win.

Good time to remind you that although the terms “jail” and “prison” are often used interchangeably, jails are county-run facilities that primarily hold people who are awaiting resolution of their charges (innocent until proven guilty crowd), while prisons are state or federal institutions where people who have been convicted of crimes are sent to serve their sentences.

I’m not risking much by saying that jails are dark, tough places—unforgivably inefficient, chronically understaffed, and routinely lack basic humanity. Access to showers, thermals, blankets, toothbrushes and even water are sometimes challenging. What does a psychiatrist have to do with any of this? The 2020 Rand Corporation report on mental health diversion in the LA County jail system estimated that 76% of those held at the county’s women’s jail have mental health needs. In recent decades, the incarceration of women has grown at twice the pace of that of American males though men still far outpace women in terms of incarceration. While incidents of trauma and victimization are not unique to any gender, women are disproportionately victims of domestic violence and sexual assault which often have lasting effects on their mental health and quality of life. Pregnancy and experiencing separation from their children as the primary caretaker are just a few of the other hurdles women face.

According to the LA Sheriff’s department (LASD) website, inmates are reportedly offered several programs during their period of incarceration. It’s an impressive read until you run into the reports and surveys about how often these programs are actually offered to inmates. Many programs have not been maintained because of funding or languished due to inattention. The Sybil Brand Commission published a report in 2023 titled “Los Angeles County Education Based Incarceration Survey” which specifically breaks down who is and is not receiving services. Spoiler alert: it’s kind of a downer. However, CRDF fared slightly better than the other facilities.

I was curious about what programs were available at CRDF. I spent some time with the people running some of these programs in order to better understand them. What I found was complex programs with dedicated teams of people that involved deputies, custody assistants and civilians.



E.B.I.
Education Based Incarceration



Education Based Incarceration (EBI): Created in 2012 by the then-sheriff, this offers both high school level and college courses. Alumni of EBI programs have an increased chance of finding employment, increased potential for a higher income, and are less likely to return to incarceration (“Incarceration, Recidivism and Employment,” Bhuller M, Dahl GB, Løken KV, Mogstad M. NBER Working Paper 22648, September 2016). Certified teachers and a college certified instructor teach classes that inmates get credit for which translates after their release. There are specialized programs that focus on life skills, domestic violence, vocational training, parenting, and a program called “ABC” which stands for Adults Bonding with Children. This addresses the challenges associated with parenting while incarcerated. It helps parents to rebuild/maintain bonds with their children during the incarceration period and includes video visits with their children to apply the techniques in real time.

Currently there are approximately 100 women enrolled in EBI at CRDF but the goal is much higher. The limitations of space in the jail and funding are the main hurdles to expansion. There are other factors that may limit participation: some inmates may be discouraged from participating because of a lingering bias that certain people in custody are irredeemable and not deserving of the services or that it is reserved for certain demographics. A program such as this should be prioritized considering the established connection of education/vocational skills and re-incarceration. Reviewing the LASD website, you would think that access, space and participation are not issues at all. This is far from the truth.

Thank you to Officer Veal, Officer Haley-Graham and Deputy Quinones whose dedication was clearly evident as they guided me through the program.



M.A.T.
Medication Assisted Treatment



Medication Assisted Treatment (MAT): As its name suggests, this uses evidence-based medical model for treatment of opiate and alcohol use disorders. I spoke with 2 of the physicians, Dr. Charles Cardenas (Senior Physician) and Dr. Heidi Mock (Family Practice) who help run the MAT program at CRDF. This is overseen by Correctional Health Services (CHS) and the CRDF program is part of the larger program run by a physician who is addiction specialist at Twin Towers Correctional Facility (TTCF). Inmates with opiate use disorders are considered for daily Suboxone (buprenorphine/naloxone) or monthly Sublocade (buprenorphine). Both have been shown to lower potential for misuse, diminish effects of physical dependency and reduce cravings. (*Centers for Disease Control and Prevention. Prescription Opioids Overview. <https://www.cdc.gov/drugoverdose/data/prescribing/overview.html> Published March 17, 2021.* Any in-

mate can request MAT services and there are approximately 85-100 inmates currently enrolled. The biggest barrier of the program Dr. Cardenas and Dr. Mock identified was access to the program. Sometimes inmates are not aware of the availability of services, or they do not get referred in a timely fashion. Ideally, this should be offered on admission to every inmate to better capture those with the highest need.



S.T.A.R.T.
Substance Treatment And
Re-entry Transition



Substance Treatment and Re-entry Transition (START): This is funded by the Correctional Health Services (CHS). This is a recent program and attempts to substance use, mental health and re-entry services. It is an 8-week program within the jail which offers group therapy, substance use counseling and case management. It is an evidence-based curriculum which includes courses such as relapse prevention, anger management and life skills, to name a few. Inmates can repeat the program multiple times if desired. There is a coordinated effort to link people who have been in the program to services in the community once they are released. There are approximately 75 women in the program and there is an extensive waiting list. As with almost every county funded program on planet Earth, funding and space are limited.

Thank you to Officer Lopez, program manager Yvonne Vollaire and Sandry Esquivel, clinical supervisor for taking the time to speak with me. Their enthusiasm and dedication was hard to miss.

There are numerous studies that support the idea that governments can effectively address crime by investing in education, vocational training, substance use treatment and counseling. I have purposely left out psychiatric treatment here because it deserves a discussion of its own. I wanted to try to keep this article somewhat positive so giving my perspective on treating mental health in the incarcerated population would not likely add much positivity to the discussion. The programs at CRDF appear to do something tangibly good for many individuals who have not had the opportunity to access these services in the community. (It's a sad situation when jail is where people are offered the most opportunity to advance their lives in a practical way). There should be proactive and aggressive expansion of these services to be able to serve more people, however I think we have a long way to go before incarcerated individuals are considered, well, individuals. This project was a great experience thanks to all the people who donated their time to educate me. There is so much more to explore and hopefully I can continue to shine a small light in an otherwise dark place.

*Special shout out to Lieutenant Magdalik who oversees the Access to Care team at CRDF. As the name implies, they address barriers to patient's access to basic needs and services. He serves as my encyclopedia of all things CRDF and graciously responds to my persistent emails about patient's access to blankets and thermals (to name a few). He deserves a public thank you not just for putting up with me but for running a team that is responsive and invested with an open door anyone can step into when needed.

Alternatives to Incarceration:

Detainment cannot promote mental and physical health

By: Emily Wood, M.D., Chair Atl Committee



There is a misconception that jail can promote health. Over the last 50 years, we have defunded mental and behavioral health programs and built out a massive incarceration system that serves to perpetuate the marginalization of minoritized communities. This has resulted in the trans-institutionalization of individuals with serious mental illness (SMI) from state hospitals to the carceral system. We, as a society, have established that jail is the de facto social safety net for the least privileged and most exploited members of our communities.

Many of us feel powerless to provide the care and support that we know our patients need and deserve. We sit with their family members and nod in validation when they express relief that, “At least we know they are alive and where they are.” We understand the desire to believe that jail must be better than living on the street, fighting for survival, and not receiving adequate food, clothing, or medical care.

The reality is that jail is no better for our patients. The only difference is that when people are incarcerated, the rest of us feel like their well-being is no longer our responsibility. Medical care in jail is inconsistent at best and at worst is dehumanizing due to biases about the worth of incarcerated individuals. These biases exist even though 50% of the individuals in the LA County jails are in pretrial detention, meaning they have not been found guilty of any crime. Both advocates and jail staff have branded the jails as a human rights catastrophe. The deplorable conditions within the jails, such as inadequate mental health services, numerous complaints about excessive force, and suicides, led to the United States Department of Justice placing the jail system under [compulsory federal oversight](#) in 2015.¹

Trauma-informed

Every person in jail has experienced trauma and hardship. For the few who are lucky enough to have Adverse Childhood Experience (ACE) scores under 6, the process of being arrested and booked into jail is likely to be one of the most traumatic experiences of their lives.

Trauma-informed care is a framework that involves understanding, recognizing, and responding to the effects of all types of traumas. It is an approach that emphasizes physical, psychological, and emotional safety for both patients and providers is essential for healing. When the amygdalae and hypothalamic-pituitary-adrenal axis are in control and disproportionately activating fight/flight/freeze responses, healing is put on hold. The rest of the brain, especially the frontal cortices, cannot do the work necessary to achieve psychological recovery. Applying a trauma-informed care approach is recommended in all health professions and environments, irrespective of whether a patient has disclosed or experienced trauma. Adopting universal precautions for trauma establishes safety for trauma survivors, aligns with patient-centered care, and is particularly pertinent for individuals from marginalized communities.²

Jail is by its nature not safe. Therefore, healing cannot happen there.

Alternatives to Incarceration across SCPS

This year, I requested that the ad hoc committee I chaired on Alternative Crisis Response (ACR) be renamed as the committee on **Alternatives to Incarceration (ATI)**. When the ACR committee first began, the national [988 Suicide and Crisis Lifeline](#) was just hitting the news cycle and the California legislature was drafting and debating the bill, AB 988, to move forward with developing and implementing a full continuum of mental health crisis response in our state. AB 988, also known as the Miles Hall Lifeline Act, was passed and signed by the governor in Fall 2022 and implementation is in early stages. The Act rec-

ognizes the need for a multi-tiered system for crisis response, focusing on mental health professionals as first responders rather than law enforcement. The state has set up new training programs for these responders, intending to ensure that they are equipped to handle mental health crises. The new 988 hotline has also been launched and is available statewide, providing immediate access to mental health support for those in crisis.

All of the counties in the SCPS catchment have implemented various programs and initiatives as alternatives to incarceration, with a particular focus on addressing mental health issues. In **Los Angeles County**, the Justice Care and Opportunities Department (JCOD) and Office of Diversion and Reentry (ODR) are two prominent initiatives addressing mental health crises and incarceration alternatives. **JCOD** is a newly established central agency in LA County that consolidates the county's non-clinical initiatives aimed at aiding individuals and communities affected by the justice system. The department is committed to advancing the Board of Supervisors' vision of *Care First, Jails Last*.³ The **ODR** is a division of the Los Angeles County Department of Health Services that focuses on diverting individuals with mental health disorders away from the criminal justice system and into community-based treatment programs. They work closely with the court system, legal partners, and service providers to develop individualized treatment plans for eligible participants. Their goal is to reduce the number of individuals with mental health disorders in the criminal justice system and to improve the health and social outcomes for these individuals.

In **Ventura County**, the **Stepping Up Initiative** is a key program. It works to reduce the number of people with mental illnesses in jail by connecting them with community-based treatment and supportive services. The initiative also employs a specialized mental health court that works to divert individuals with mental health disorders from the criminal justice system to appropriate support systems. **San Bernardino County** has implemented the **Homeless Outreach and Proactive Enforcement (HOPE) Team**, a program that focuses on connecting homeless individuals, many of whom have mental health issues, with necessary resources and support, thereby diverting them from the justice system. In **Riverside County**, the **Mental Health Court** works with individuals charged with non-violent offenses who have significant mental health issues, aiming to reduce recidivism by connecting these individuals with treatment and support, rather than sentencing them to jail time. **Santa Barbara County** Sheriff's Office has a **Behavioral Sciences Unit Co-Response Team** that pairs law enforcement officers with mental health professionals to respond to crises. This partnership ensures a more compassionate response to individuals in crisis, focusing on treatment and support over incarceration.

These programs demonstrate the recent efforts within each of the SCPS counties toward building a more humane, effective, and just response to mental illness and to the challenges faced by individuals with mental health disorders who become involved with the justice system. With the help of our members who are involved in this work, SCPS and its ATI committee will highlight progress and encourage follow-through. After all, ***the number and portion of individuals suffering from serious mental illness in our jails has only risen in recent years.*** (For Los Angeles County, current data are updated regularly by the [Vera Institute of Justice](#).)

What can we do?

To start with, as individual clinicians, each of us can continue to educate ourselves on the state of the full continuum of mental and behavioral health care in our communities, including in the carceral system. A high-yield series on the mental health crisis in Los Angeles County jails was written by The Appeal in collaboration with the USC Annenberg Center for Health Journalism in **March 2023**.^{1,4,5} This information is critical to incorporate into our decision-making to properly assess the potential risks associated with our treatment decisions.

At SCPS, the ATI committee is partnering with local NAMIs to better understand the forces influencing the treatment and care options of psychiatrists who work at the intersection of mental health care and

carceral institutions. In particular, we invite our emergency psychiatry colleagues to share their experiences so that we may better support you in upholding *your* values in clinical care.

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Reimagining a Physician Health Program in California: Balancing Care with Regulation in the Treatment of Physicians with Substance Use Disorders

By: Anu Bodla, M.D.



In December, I attended the American Academy of Addiction Psychiatry conference in San Diego. A compelling case presentation highlighted the intricate challenges faced by medical professionals grappling with substance use disorders (SUDs). The discussion underscored the critical absence of a Physician Health Program (PHP) in California, and I was surprised to learn that California is one of the few states without such a program. This revelation prompted me to delve into the history of the California PHP and potential future of a PHP in California and its role in supporting physicians in need.

The inception of PHPs traces back to the American Medical Association's 1973 report, titled "The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence", which underscored the necessity for the medical profession to address mental health concerns including substance use disorders (SUDs) amongst its members (1). This led to the establishment of PHPs by state medical boards, which were organizations that closely collaborated with state licensing boards to provide confidential, rehabilitative support. California was at the forefront of this movement, with the establishment of the California Diversion Program in 1980. In its initial years the program demonstrated notable success rates in helping physicians resume their practice. Of the 117 physicians who participated in the program in the first two and a half years, 109 were able to return to practice (2).

However, a 2004 audit revealed significant shortcomings in the program's operation, leading to its discontinuation. The audit identified that the program's drug monitoring mechanisms were poorly enforced, with only ten staff members overseeing 275 physicians. This led to predictable drug testing dates, allowing some physicians to evade detection. Furthermore, the program suffered from a lack of enforceable regulations, including no clear standards for termination from the program or consequences for relapse. These findings, along with the continued issues highlighted in a 2007 re-audit, ultimately led to the Medical Board of California's decision to end the program (2).

Today, as California stands among three states without a PHP, the discussion for its reinstatement is timely, given the high stakes for physician well-being and patient safety. Despite the absence of a PHP in California for many years, the state legislature took a significant step forward in 2016 with the passage of SB1177. This law authorized the Medical Board of California to establish a new Physician and Surgeon Health and Wellness Program aimed at early identification and intervention for physicians struggling with substance use disorders. The legislation required the development of regulations for the program's operation, the selection of an administering agency, and the establishment of a fee structure for participants (3).

As of the February 2024 issue of the California Public Protection & Physician Health (CPPPH) newsletter, the proposed regulations for the new PHP are slated for discussion at the Medical Board of California's quarterly meeting which was scheduled for March 1, 2024. Should the board adopt any

changes to these regulations, the modified text will be made available for public comment for 15 days, offering a vital opportunity for our community to contribute their perspectives. I strongly encourage readers to review the forthcoming regulations on the CPPPH website once they are available. If you have concerns or suggestions, this period of public comment is a critical time to voice them. Engaging in this process is essential for ensuring that the new PHP effectively balances regulatory oversight with compassionate support for physicians in need.

The criticism of PHPs often centers on their perceived alignment with regulatory boards over the physicians' welfare, creating a barrier for those in need of help. The fear of punitive consequences, such as license revocation, has deterred many from seeking assistance. Yet, models in other states show promise by prioritizing confidentiality and voluntary participation. For instance, in the state of Maryland doctors advocated for a separate voluntary and confidential program not run by the medical board, this voluntary program is bound by strict confidentiality and as a result most of the doctors with SUDs in Maryland are in the voluntary program, this is in contrast to other states such as North Carolina where only 5% of physicians enter the PHP voluntarily (4). However, at the time of writing this article no data is available regarding the outcomes of the voluntary program in Maryland. Despite the lack of outcome data for Maryland's program, its emphasis on confidentiality and voluntary participation could offer valuable insights for California's efforts to create a more supportive and less punitive environment for physicians seeking help and highlights an alternative approach to supporting physicians with substance use disorders.

As we look to the future, California's Medical Board is on the brink of adopting new regulations that could revive the PHP. Drawing lessons from other states and addressing past challenges, California's new PHP must prioritize confidentiality, evidence-based treatment, regular monitoring, and peer support. These elements are critical for a program that aims to rehabilitate physicians and ensure they can continue to provide high-quality care to their patients. The Medical Board of California's meeting today represents a pivotal moment for the medical community to influence the direction and effectiveness of the new PHP.

The revival of PHPs in California marks a critical step toward acknowledging and addressing the mental health and substance use challenges within our profession. In moving forward, it is essential for us to engage with the proposed changes, offering feedback and advocating for a PHP that truly serves the best interests of physicians and their patients alike. Engagement from the medical community and other stakeholders in reviewing and commenting on the proposed regulations is essential for shaping a PHP that truly serves the best interests of California's physicians and their patients. A well-structured PHP can provide a lifeline for physicians, fostering an environment where seeking help is a sign of strength, not a weakness. By ensuring the program is built on the principles of respect, rehabilitation, and retention, we can enhance the health of our healthcare providers and, by extension, the safety and quality of care for our patients.

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A Psychodynamic Perspective on Addiction

By: Ruqayyah Malik, M.D.



Addiction is an important subspecialty in the field of psychiatry as it affects hundreds of millions of people worldwide and has significant morbidity and mortality rates. About 5% of the adult world population struggles with alcohol use disorder (1). About 22% of the adult world population struggles with tobacco use disorder (1). Cannabis is the most widely used psychoactive substance at 3.5% of the global population endorsing use of it (1). The neurobiological basis of addiction (i.e. drug addiction being the result of hypersensitive reward centers in the brain) has been the focus of much research in recent times. Indeed, many drugs of abuse increase the concentration of dopamine in the nucleus accumbens. Cravings and relapses are thought to be due to alterations in this complex reward system: "...addiction is a 'chronic brain disease' in which the brain is hyperresponsive to cues in the environment, setting off an uncontrollable urge to repeat use of a drug" (2). Long-term drug abuse is associated with decreased dopamine function and reduced frontal lobe executive functioning (2). While the neurobiological understanding of addiction has contributed to potential advancements in pharmacological treatment options, there is also a significant psychological basis to addiction that should be considered.

The psychodynamic perspective on addiction proposes that it is a form of self-medication. Addiction offers a reprieve from overwhelming anxiety and intolerably painful emotions. It can also be a defense against overwhelming helplessness or powerlessness (2). Addiction is a displacement of an action that is prohibited or not feasible for the patient. We name addictions by their displacements: "If the drive to reverse a sense of helplessness is displaced to drinking, we say the addiction is alcoholism. If it is displaced to gambling, it is 'pathological gambling' and so forth" (2). Indeed, alcohol and drugs are an easy way to regulate or numb one's emotional state. Those seeking oblivion may gravitate towards narcotics, those seeking to ward off the heavy clouds of sadness and anhedonia may gravitate towards stimulants and those seeking to calm feelings of anxiety and fear may overuse alcohol. It is important to investigate the emotional triggers and drives for the often compulsive behaviors seen in addiction. This understanding of the individualized psychological basis of addiction restores some measure of power back to the patient and decreases the central driver of feelings of helplessness. "It helps to clarify that their seemingly irrational behavior, along with its apparent disregard of its harmful effects on themselves and others, is not a sign of moral turpitude or other weakness. It is a compulsion whose nature and basis can be understood..." (2). In addition to medications that can help manage cravings and mitigate withdrawal, psychodynamic psychotherapy offers patients an opportunity to investigate the drives behind their behavior and work towards establishing healthier "displacements". "Too often, treatment efforts stress motivational issues which presume that compulsive behavior is repeated because of a lack of motivation to stop it; or taking valuable time focusing on the consequences, rather than the causes, of addictive behavior..."(2).

For example, helping a patient gain insight that they tend to drink more when they are in conflict with family or friends can help them anticipate and manage their negative emotions more effectively. This gives them an opportunity to feel more in control of their situation, increase their sense of self-efficacy and likelihood of successful treatment.

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ASAM American Society of
Addiction Medicine

ASAM Weekly Guest Editorial

History Repeats Itself: Psychedelics Are Promoted Today the Way Opioids Were Promoted in the Early 2000s
by Anna Lembke, MD, FASAM

Anna Lembke, MD, FASM is a professor of psychiatry at Stanford University School of Medicine, program director of the Stanford Addiction Medicine Fellowship, and author of *Dopamine Nation: Finding Balance in the Age of Indulgence*.

January 22, 2024

After more than two decades as a practicing psychiatrist, I'll be the first to admit that we need new and innovative treatments to treat depression, anxiety, and other psychiatric disorders. Psychedelics like LSD, psilocybin, and MDMA (Ecstasy) are being researched and promoted as ground-breaking advances for combatting mental illness. [Multiple jurisdictions](#) have already relaxed laws or policies related to these substances, often with an eye toward therapeutic use.

But the evidence to support the therapeutic use of psychedelics is not yet robust enough to justify liberalized access, especially for unsupervised use. Even more concerning, I see eerie similarities between the promotion of medicinal psychedelics today and medicinal opioids beginning in the 1990s, based on unsubstantiated claims of high benefit and low risk. Full disclosure, I have been retained as a medical expert witness in opioid litigation against Purdue Pharma and others.

The unsubstantiated claims about opioids are the following: (1) Opioids are the safest and best treatment for chronic pain; (2) opioids are the answer to our epidemic of pain; (3) opioids are 'rarely' addictive when prescribed by a doctor for a patient with pain.

In fact, the evidence shows that [opioids are no better than Tylenol](#) in the treatment of chronic pain and incur more medication-related adverse events. The increase in opioid prescribing did not decrease the population pain burden and was instead a major contributor to today's opioid epidemic of addiction and overdose death. Far from being 'rare,' getting addicted to opioids through a doctor's prescription is [tragically common](#).

Almost identical false claims used to promote opioids are now being used to promote psychedelics.

The first unsubstantiated claim about psychedelics is that they are safe and effective treatment for a variety of mental health disorders. Bottom line, we do not yet have sufficient evidence that psychedelics are safe and effective treatment for any mental health condition. Limitations in the studies of medicinal psychedelics to date — many studies are funded by the psy-

chedelic industry and/or authored by individuals with close ties to the industry, studies are too short to assess efficacy for chronic mental health conditions, studies lack robust control groups, and studies are plagued by systematic underreporting of [adverse events](#) — mean they're not yet ready for prime time. The absence of reliable data on psychedelics highlights the need to loosen restrictions on Schedule I drugs so that it is easier to conduct this much needed, unbiased research.

Just to highlight the egregious lack of data on harms, and the way that spurious datapoints are used to promote a false sense of safety, note that this [oft-cited paper](#) which gives the “lowest overall harm scores” to “mushrooms” as compared with 19 other drugs, is based not on data but on ‘expert consensus,’ with some of those experts having a vested interest in the psychedelic industry. This so-called study further fails to take into account the prevalence of drug use in the population. When access to psychedelics was low, evidence of harm was correspondingly less. We [just published data](#) showing that with increased access to psychedelics in the state of California between 2016 and 2022, observed hallucinogen-associated ED visits increased by 54% between 2016 and 2022, (from 2,260 visits to 3,476 visits), compared to a 20% decrease in alcohol-associated ED visits and a 15% increase in cannabis-associated ED visits. The observed hallucinogen-associated hospitalizations increased by 55% over the same period, (from 2,556 to 3,965 hospitalizations), compared to a 1% increase in alcohol-associated hospitalizations and a 1% increase in cannabis-associated hospitalizations. This rise in hallucinogenic ED visits was significantly different from the trend in cannabis-associated ($p < 0.001$) and alcohol-associated ($p = 0.005$) ED visits. The hallucinogen associated hospitalizations trend also significantly differed when compared to cannabis ($p < 0.001$) and alcohol ($p < 0.001$) associated hospitalizations.

The second unsubstantiated claim about psychedelics is that they are the answer to our current mental health crisis. As for whether psychedelics can ameliorate our current mental health crisis, to date the evidence does not show a decrease in mental health burden as psychedelics becomes more prevalent in the community. Of course, it may be too soon to tell, but as above, data are already showing increased harms.

The third unsubstantiated claim about psychedelics is that they are rarely addictive when administered by a doctor for a patient with a mental illness. As with any mind-altering drug, [psychedelics have the potential to be addictive](#). They are often falsely touted as non-addictive because of their rapid tolerance and limited physical withdrawal. But it is not tolerance or withdrawal that defines addiction. The hallmark of addiction is mental preoccupation with the drug and repeated use despite harms. Further, some psychedelics, like MDMA, have a clear withdrawal or comedown ([see 'blue Mondays'](#)).

To prevent history repeating itself, let's press the pause button on loosening access to unproven drugs until we have more information about the risks, benefits, and alternatives, not just at the individual level, but also at the level of public health.

Acknowledgement:

Reprinted with permission from ASAM Weekly, American Society of Addiction Medicine 1/24/2024.

Rising Popularity of Kratom: Therapeutic Potential, Risks, and Clinical Implications

By: Dyanna Soto, M.D.



As many as 30% of adults in the US endorse current or past use of herbal-based supplements to help treat their medical conditions¹, and of these herbs, kratom is rapidly growing in popularity for its potential therapeutic benefits. Kratom is a substance derived from the leaves of a tree native to Southeast Asia that contain Mitragynine², which at lower doses (<5g) produces stimulant effects similar to coffee, and at higher doses (>5g) produces opioid-like effects such as analgesia and sedation³. Kratom is typically consumed as a powder with a beverage, though use of capsules, pills, or self-prepared teas are also common. As the use of kratom continues to rise, so too do concerns and debates surrounding its safety and efficacy, as well as questions about how clinicians should be approaching kratom use with their patients.

An estimated 10–16 million people in the United States use kratom³, with reports of use increasing every year. From 2021 to 2022, past year use of kratom among young adults aged 18 to 25 increased from 2.1% to 2.6% (or 313,000 to 371,000 people), and among adults aged 26 or older increased from 1.7% to 1.8% (or 1,394,000 to 1,455,000 people)⁴. Prior research also suggests that current prevalence ranges of 1.3%–6.1% from national representative surveys may underestimate the number of regular kratom users⁵. Despite its increasing popularity, the US Food and Drug Administration (FDA) does not recognize kratom as a dietary supplement and has not issued guidance or regulatory standards on the use of kratom in regards to product contents, alkaloid concentrations, and/or dosage guidelines². In fact, most data about kratom use has been gathered from self-report research and case reports, which in turn, severely limits the generalizability of the data. Even so, multiple reports suggests that people in the US are using kratom for its various stimulant, analgesic, and/or anxiolytic properties, and perhaps most importantly, for the reduction/substitution of opioids and/or attenuation of opioid withdrawal⁶.

More than 20 alkaloids in kratom have been identified, however its two most active alkaloids, mitragynine (comprising 60%) and 7-hydroxymitragynine (comprising 2%)⁷, are primarily responsible for the plant's psychoactive properties³. Both alkaloids act as partial agonists at the mu-opioid receptor and have preferential activation of G protein coupled receptors relative to beta arrestin activation. It is thought that the lack of beta-arrestin activation at the mu-opioid receptor is the mechanism which allows for kratom's opioid-like effects with milder respiratory depression¹. Such properties are likely why kratom users often report successfully substituting or supplementing prescriptions opioids/benzodiazepines with kratom, report assistance with opioid withdrawal, and endorse self-treatment of dependence/addiction to opioids with kratom use⁶. However, it has also been established that those who use kratom regularly and/or at high doses can become dependent and experience withdrawals, as well as develop cravings and tolerance which may require additional treatment⁸. Additionally, there is little to no guidance in terms of what is considered a "normal" versus "high" dose of kratom. While doses from 1-5g result in stimulant effects, and 5-15g result in opioid-like effects, in one study looking at buprenorphine treatment for kratom use disorder, patients reported past average daily dose of kratom between 0.06g/d to more than 850g/d, with an average daily dose of 92g⁸. Case reports have also identified kratom as contributing to overdose deaths, however in such cases polysubstance use was also reported therefore the relationship is still unclear⁹. Although limited self-report data suggests kratom may serve a role in harm-reduction for opioid use disorder, it must also be questioned if kratom may increase the risk of developing a substance use disorder in the future, especially in adolescents and young adults who may have otherwise not been exposed or "desensitized" after using kratom. Data from various surveys and case reports indicate an overlap in those who use kratom and alcohol, opioids, and/or stimulants, though

due to limited research, no causal or explanatory relationship has been made at this time⁶.

When screening for kratom use, it is important to keep in mind the demographics and characteristics of those most likely to be using kratom. Survey research reflects that people who use kratom tend to be males, middle-aged (31-50 years), Caucasian, employed, have private insurance, a household income of \$35,000 or more, and possess at least some college education^{3,9}. Most popular reasons for regular kratom consumption include increased energy, improved focus, reduction in depression and anxiety, better sleep, and pain management especially. The most common conditions where kratom use was identified were back/spine pain, acute pain from injury, fibromyalgia, migraine/headache, and rheumatoid arthritis³. When discussing kratom use with patients, it is important to advise them of potential adverse side effects including cardiovascular (tachycardia, palpitations, hypertension) gastrointestinal (nausea, constipation, diarrhea, vomiting), neurologic (headache, seizure), and psychiatric (anxiety, depression, irritation) adverse effects⁹. Chronic use of kratom has also been associated with rare instances of cholestatic injury and acute liver failure¹⁰. Onset of injury is usually within 1 to 8 weeks and associated with symptoms of fatigue, nausea, pruritis, and/or jaundice which typically resolve with treatment¹¹, though there have also been cases where the long-term use of kratom lead to jaundice and end-stage liver disease requiring transplant¹². Of note, the metabolization of kratom is primarily hepatic and via cytochrome p450 (CYP450) enzymes¹³. Clinicians should keep in mind that kratom's major alkaloids are CYP inhibitors, with potent CYP2D6 enzyme inhibition and moderate CYP3A4 enzyme inhibition as well¹⁴. As such, it is extremely important to consider potential drug-drug interactions when initiating psychotropic medications and be mindful of potential complications such as serotonin syndrome and/or QTc prolongation.

Those who use kratom regularly may experience opioid-like withdrawals after discontinuation including mood changes, irritability, restlessness, loss of appetite, yawning, itching, insomnia, runny nose, vomiting, diarrhea, myalgias, and tremors⁸. Indeed, one should consider possible kratom use if withdrawal symptoms occur after the initiation of naltrexone in a patient with a urine drug test negative for opioids. There is also evidence of neonatal abstinence syndrome among children born to mothers who use kratom. Commonly reported symptoms include undisturbed tremors, increased muscle tone, and high-pitched cry⁹. As stated above, there are no guidelines for suggested or safe doses of kratom, therefore clinicians should keep in mind what dose a patient has achieved stability/response on, establish goals, and manage recommendations accordingly.

In terms of access, legality of Kratom in the US varies by state and is legal for use in California except for in the city of San Diego. Even so, among a subsample of 26 vape shops located in the city of San Diego, kratom was available in 46.2% (N=12) of stores². As such, town, city, or state of one's practice should be of less concern when assessing for potential kratom use in patients. Lack of surveillance and regulation on kratom products in the US also raises concern for an increase in the adulteration and contamination of kratom products, which could lead to more severe adverse effects or an increase in the number of deaths related to kratom use. Currently, no medications carry an FDA-approved indication for kratom use disorder in the US. National Poison Data System data from 2011 to 2017 revealed that approximately half of people exposed to kratom were given intravenous fluids, and nearly a third received benzodiazepines⁹. Additional interventions included naloxone, methadone, oxygen, and in severe cases intubation. In a promising study, Broyan et al⁸ show that treatment with buprenorphine/naloxone (4mg to 20mg) significantly decreased kratom use as treatment progressed, and that patients who restarted kratom use during treatment also reported less kratom than they initially used before starting treatment. As both buprenorphine and methadone are mainly metabolized by the CYP3A4 isoform, one must also keep in mind the risks of toxicity when choosing this treatment given the pharmacokinetics of kratom's alkaloids as mentioned above.

As the prevalence of kratom is likely to continue growing, clinicians are encouraged to approach kratom use in patients with an open mind, staying informed about the latest research and individual patient experiences to provide optimal care and guidance. Research beyond surveys and case reports are needed, and until controlled human lab studies are conducted to establish therapeutic efficacy, clinicians must remain cautious of kratom use in all patient populations.

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Council Highlights

January 11, 2024

Patrick Kelly, M.D. and Emily Wood, M.D., *Acting Co-Secretary*



NAMI meeting occurred during the first half of this Council meeting. Dr Galya Rees organized and presided over the meeting. Members from local NAMI chapters were invited to this section of the meeting.

Statewide Advocacy Activity

California State Association of Psychiatrists (CSAP) – Paul

Yoder

SB 43 update – The BOS of some counties that delayed implementation are requesting that their department of mental health move earlier

Governor's budget was introduced yesterday and differs from that of the legislative analyst

CARE Act Implementation – no budget changes

Behavior Health Continuum Infrastructure Program – spending may be delayed

\$1.2 billion of \$2.2 billion already awarded and there are 2 rounds of funding remaining

This is the primary funding for MH infrastructure, including crisis response

Healthcare Workforce – spending may be delayed

Managed Care Organization Tax – recommended increase to help pay Medi-Cal and physician reimbursements (including psychiatrists)

Looking for Legislative partners

Riese Hearings – Working with Senator Eggman to introduce legislation to minimize redundant hearings

Detention of medically ill patients who lack capacity to understand the risks of leaving the hospital and are at significant risk for harm

Possible Co-Sponsored Leg

Parity – expand the penalty scheme for health plans

Eliminate sunset date for court-ordered medication for people incarcerated county jail who are not serving sentence yet

ECT for Youth – working with CAL ACAP

Bills of interest that were introduced last year

SB 402 (Wahab) – allow counties to designate non-peace officers who can take someone into custody

SB 294 (Weiner) – would establish an automatic grievance process for insurance refusals for age < 26yo

Proposition 1

Polling well with 2 separate polls in the high 60%^s

Slogan = “Treatment not tents”

“By right” language – allows facilities to be built in all non-residential zones

NAMI California State Advocacy Review- Traute Winters and Paul Stansbury

Supporting Prop 1

Involved with CARE Act implementation including information dissemination (at self-help centers, etc.) and meetings with DMH. Lack of staffing for CARE implementation is a major concern.

SB 43 – they would like to implement earlier than 2026

They are reviewing the Gov's budget

Comments

Mr. Stansbury – asked Paul Yoder to expand on SB 855 parity regulations. Paul reports that the final regulations from the Dept of Manage Health Care (DMHC) have been slow to come out.

Policy Platforms and key legislative advocacy priorities

Access to quality Care and Mental Health Insurance: Parity steps, Stimulants – Dr. Robert Burchuk from our access to care committee led discussion regarding the following:

Key NAMI Member Concerns:

Psychiatric responsiveness to patients

Shortage of psychiatrists, especially of those willing to treat SMI and Clozapine

Psychiatrists not taking insurance and reimbursement rates for psychiatrists

Access to telehealth vs. in-person psychiatric care,

Clozapine restrictions: Clozapine has also been difficult to locate in pharmacies due to pharmacies not enrolling or managing REMS

LPS reform II: Next steps with Prop 1 - Dr. Emily Wood

With the delay of implementation, we have time to push counties to build the infrastructure they feel is needed and, we can maximize the current criteria

Comments

MH courts seem to be overwhelmed and court dates are being extended.

Riese hearing legislation. – Dr. Erick Cheung shared plans to develop legislation to address the need for multiple Riese hearings as patient continues on subsequent LPS holds

Other local/state issues: e.g., County Mental Health Programs, Jail and court reforms, local care, psychiatric education

Homelessness Initiative – Dr. Yelena Koldobskaya

CARE Court Rollout in LA County – Dr. Rod Shaner

Reiterated the importance of upholding current LPS criteria while building the infrastructure for SB 43

Mark Gale raised concerns about loopholes that the counties will use to delay

Brenda Scott reported that Mt. San Jacinto is pushing to move up SB 43 implementation

Clarify how the counties will communicate with the court about non-adherence so that patients do not fall through the cracks so that CARE Court does not follow the path of AOT.

Prop 1 establishes oversight and accountability

Alternatives to incarceration – Dr. Emily Wood

Council Meeting

PRESIDENT'S REPORT

Dr. Goldenberg

A6A RFM/ECP: Accepting nominations through 1/19/24

A6A & CSAP Guidelines Workgroup met 1/10/24 to establish best practices for optimizing communication and advocacy between these two organizations.

Resident Recruitment Project: a video has been created and will be reviewed by the recruitment committee and council. Tim was thanked for editing, and Mindy for hosting interviews. All participants were acknowledged.

APA Department of Government Relations Petition to the APA BOT to request due diligence regarding the budget.

Motion Approved: Approve SCPS sign-on to letter

PRESIDENT-ELECT'S REPORT

Dr. Rees

Newsletter Updates were provided. Dr Rees recognized recent contributors and reviewed next month's contributors for the Black History Month Edition that focuses on EDI. Dr. Khan is collecting contributions from the D&C Committee members.

Newsletter contributors were also reminded timely submission of articles is important

GAC ACTION ITEMS

Drs. Shaner and Wood

APA DGR Restructuring: Since the last Council meeting the Executive Committee made the decision to sign on to a petition authored by Francis Lu (Central California) and others regarding APA's Department of Government Relations changes. The petition calls for pausing implementation until proper review.

Motion approved: The council approved the EC's decision to sign this petition

APA DGR Restructuring: SCPS GAC Motion: The SCPS GAC also developed a motion for the SCPS CSAP representatives to request a web-based meeting with the new advocacy policy and practice advancement section of the APA. The purpose of the meeting is to understand the new organizational structure, operational model, and ensure coordination with Area 6 advocacy efforts.

Motion approved: Be it resolved that Area 6 Council and CSAP request a web-based meeting with staff from the new APA Advocacy Policy and Practice Advancement section, including the Managing Director of Government Relations, to discuss the new structure and processes in place for coordinating state advocacy efforts. After this meeting, CSAP representatives will update the CSAP Board for dissemination of information to all Area 6 district branches

TREASURER'S REPORT

Dr. Kelly

December Financials and Cash on Hand Report

Dr. Kelly reviewed various financial metrics, year-to-date. Overall, SCPS is in good fiscal health. The income is slightly under budget for the year by about \$2000. Expenses however are also under budget by over \$10,000, and total assets are \$11,000 over compared to this time last year. This report was accepted by unanimous consent with no opposition

Motion Approved: Treasurer's report approved

MEMBERSHIP REPORT

Dr. Ijeaku

A. Membership Report

The membership report was approved by unanimous vote.

COMMITTEE REPORTS

A. Diversity and Culture Committee: Dr Khan- Plans for a Black History Month event featuring Dr. Fortuna and Dr. Shervington were mentioned. The committee is collecting write-ups for the February newsletter issue

Community Psychiatry: The Role of Training Programs in Preparing the Next Generation of Psychiatrist Zoom Meeting, February 29, 2024



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