

PSYCHIATRIST

Volume 72, Number 9 May 2024

Newsletter of the Southern California Psychiatric Society

President's Column

You Are What Makes SCPS Great: Thoughts of an Outgoing SCPS President

Matthew Goldenberg, D.O.



It has been an honor and privilege to serve as SCPS President the past 12 months. I strongly believe that SCPS is an essential professional organization for all psychiatrists in the southern California area. SCPS provides psychiatrists with an opportunity to come together to improve our field and to advance the cause of quality psychiatric care for our patients. SCPS provides an opportunity for local psychiatrists to positively influence local, statewide and national issues and challenges.

However, none of the work, the advocacy or the liaison activities would be possible without the dedicated, passionate and compassionate psychiatrist colleagues that make up the SCPS committees and the SCPS council. I would like to share with you my appreciation and thanks for the individuals who have made SCPS a success this past year. I shared these thoughts and sentiments at our recent installation and awards ceremony (more about that and some pictures, below).

I would first like to thank our esteemed Executive Director Mindi Thelen. Mindi is truly the heart and soul of SCPS. She is our historian, the connection and support for our members and she attends and participates at every committee and council meeting. She is the glue that holds it all together. I also want to thank Tim Thelen for all of his contributions to SCPS the past year. Most of these are behind the scenes and it was long overdue that he was formally presented an award at the recent installation and awards ceremony (see below).

Please join me in thanking all of the members of this year's Executive Committee:

Gayla Rees MD– President Elect
Patrick Kelly MD– Treasurer
Emily Wood MD– Treasurer-Elect
Laura Halpin MD– Secretary
Heather Silverman MD– Senior Assembly Rep
Zeb Little MD– Immediate Past President

The Executive Committee takes on the responsibility of making urgent decisions for SCPS that cannot wait for a full council meeting. It is a combination of rising SCPS leaders and more seasoned ones. I thank each of them for their availability and exceptional support and contributions to SCPS this past year.

I want to thank all of our committee chairs. SCPS committees are where ideas, projections and action items are born and developed. Much of the work of SCPS Council comes from our active committees. Committees are open to all members and are the place to get involved if you are interested in getting more involved in organized psychiatry. Please consider joining a committee as a guest and reaching out to Mindi for info!

A special thank you to the very active and busy committees and their chairs this past year:

Lawrence Gross MD – Academic Liaison and Fellowship and Awards
 Gillian Friedman MD and Robert Burchuk MD– Access to Care
 Emily Wood MD – Alternative Crisis Response
 Roderick Shaner MD – Constitution and By-Laws Committee Chair and Guidelines Working Group Chair
 Danielle Chang MD – Disaster Mental Health Relief
 Manal Khan MD – Diversity and Culture
 Roderick Shaner MD and Emily Wood MD – Government Affairs
 Ijeoma Ijeaku MD – Membership
 Galya Rees MD – Newsletter
 Michael Gales MD – Program
 Yelena Koldobskaya, M.D. and Danielle Chang, M.D. - Unhoused Work Group

I also want to thank all of the [members of council](#) this year. Your commitment to SCPS, the courage to speak up for our patients and the practice of psychiatry and willingness to make personal sacrifices to be able to be present is what makes SCPS possible. This year’s SCPS Council, like so many that I have had the opportunity to be a part of, was a group of extraordinary psychiatrists and I am proud to call each of you colleagues. Thank you for your contributions and commitment!

My first year on SCPS was in 2016, after outgoing SCPS President Heather Silverman MD appointed me to an open Counselor position on Council. Curley Bonds MD was the SCPS President, and the Art of Psychiatry Committee had just completed “The Film”. We met for dinner meetings in Beverly Hills, and no one had heard of Zoom meetings yet. A lot has changed since then. However, a lot has stayed the same. SCPS remains the professional home of caring and passionate psychiatrists, who want to improve our field and seek to help our patients and our communities have increased access to high quality mental health and psychiatric treatments. For those of us who have been lucky enough to hang around over the years, SCPS Council remains our “family”.

One year ago, I stated my goal as president was to leave SCPS better than we found it and I do believe we have achieved that goal. I again thank and give full credit to the SCPS Council for all of the hours of commitment and sacrifice that went into everything we accomplished this past year.

Some of this year’s highlights include:

- a) Completing a recruitment video to help improve our outreach to new members.
- b) Expanded advocacy efforts and results: i.e. SB 43 and Care Court reform
- c) Released the first annual Advocacy Newsletter Edition
- d) Started a work group to better understand and address the Mental Health issues related to the Unhoused Crisis.
- e) Completed a set of guidelines on SCPS council’s statewide and national representation positions
- f) An action paper addressing the Moynihan Report passed the APA Assembly
- g) Solidified a transition plan for SCPS GAC and PAC Leadership positions. Thank you to Laura

Halpin MD for serving as our first CSAP PAC representative!

Finally, I want to thank the council members who endured the difficult transition from CPA to CSAP several years ago. This was a very challenging time for SCPS, and I am so grateful that SCPS endured, CSAP emerged, and the relationships with my SCPS colleagues were able to grow stronger.

For those who served on the SCPS council then, but are no longer on the SCPS Council, please know that SCPS is now stronger, our voice is now louder, we are now working in closer collaboration with our colleagues from across the state. SCPS is also now working more closely with allies like NAMI. Most of all, all SCPS members now have true representative advocacy, that is transparent, accountable and is directly driven by SCPS and its members. While you may no longer be on SCPS council, please know your efforts and your contributions have made SCPS better and stronger.

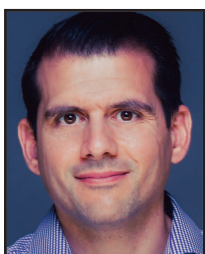
This is why I am confident that the future of SCPS, and our field of psychiatry is bright and our best days are ahead. Thank you to every SCPS member for supporting and being a part of this amazing organization.

I look forward to supporting Galya Rees MD, our incoming SCPS President, starting after this month's APA meeting!

In This Issue...	
Potential Roles of GLP-1 Agonists in Psychiatry	4
The Neurobiological Mechanism of Fear Generalization . . .	7
A Potential Solution to the Child and Adolescent Psychiatry Workforce Crisis:	
A 4-Year Combined Training Program	10
Dispelling Four of the Most Common Myths	
About EMDR	13
Holiday Parties and Trainees	15
What About the Wheel That is Not Squeaky Enough to Get the Grease	
	17
Review of the Joint SCPS/SCSCAP Presentation on AI	
	18
Installation and Awards Ceremony- in Pictures	20
Council Highlights	22
Classifieds	25

Potential Roles of GLP-1 Agonists in Psychiatry

By: Matthew Markis, D.O.



In recent years, we have seen a surge in the use of GLP-1 receptor agonists for the treatment of type 2 diabetes and weight loss. Their efficacy in treating these conditions has been well established, providing patients with results who have struggled with different weight loss strategies including lifestyle changes and medications. However, there is promising evidence pointing to a variety of other therapeutic applications in the field of psychiatry. Over half of individuals with severe mental illness are overweight or obese, and a multitude of factors may contribute including lifestyle, psychiatric conditions, medical comorbidities and medication induced weight gain. The limited options available are often poorly tolerated or produce insufficient results. The need for alternative therapies is important for both the physical and mental well-being of our patients.

Although Glucagon-like peptide-1 (GLP-1) is a hormone secreted by the intestinal ileum and colon L-cells following food intake, GLP-1 receptors are present in multiple organ systems throughout the body. Activation in the pancreas not only increases insulin secretion and decreases glucagon release, but also increases β -cell proliferation and survival. This leads to increased storage of glycogen by the liver. Gastric emptying and mobility of the GI tract are delayed, and there is increased glucose uptake by fat cells and lipolysis. However, GLP-1 receptors are also present in various parts of the brain, impacting a variety of neurologic and cognitive functions. Some potential uses for these agents in the field of psychiatry are highlighted below.

Depression

Preclinical studies have provided evidence of GLP-1 receptor agonist's antidepressant properties. They have been shown to increase neuroprotection and cognitive function and decrease neuroinflammatory processes. Studies also indicate that GLP-1 modulates the release of neurotransmitters including serotonin, dopamine, GABA, and glutamate. A meta-analysis published last year in *The American Journal of Geriatric Psychiatry* comprised of 2,071 participants included in 5 randomized controlled trials and 1 prospective cohort study. The treatment group showed a significant reduction in several depression rating scales compared to the control group. However, a separate review published in the *Journal of Psychiatric Research* produced mixed results. Although the FDA has been evaluating reports of suicidal thoughts or actions in patients treated with GLP-1 receptor agonists, preliminary results have not found evidence of this, and the FDA is continuing to investigate this issue. Further randomized controlled trials focusing on depression as the primary outcome with larger sample sizes and more consistent rating scales would be beneficial.

Binge Eating

Currently, Vyvanse is the only FDA approved medication for binge eating disorder. However, potential for adverse effects can limit its use, along with Topamax. Although SSRI's are used as well, a meta-analysis of seven randomized trials compared them with placebo for remission of symptoms and found a significant but clinically small advantage favoring SSRI's.

GLP-1 receptor activation may have a variety of mechanisms involved that can impact binge eating, including pathways mediating satiety signaling and food reward pathways. One open-label study examined the effects of semaglutide on Binge Eating Scale (BES) scores in individuals. Patients with

both moderate and severe binge eating disorder who were given semaglutide exhibited greater reductions in binge eating scores compared to those who took either Vyvanse, Topamax, or a combination of semaglutide and Vyvanse or Topamax. A systemic review showed positive results in addition to a favorable side effect profile compared to current options, although further trials were recommended to establish safety, efficacy and dosing. I have heard several patients in my practice describe profound relief on GLP-1 agonists, with thoughts of binge eating either being dramatically reduced or eliminated altogether.

Medication Induced Weight Gain

Numerous psychiatric medications can contribute to weight gain through a variety of mechanisms, potentially impacting our patient's physical health, mental health and overall quality of life. For many, the burden of weight gain is too much to bear, even if the medication is controlling their symptoms. Studies on the effects of GLP-1 agonists specifically related to iatrogenic weight gain are limited, as most have focused on individuals who are overweight or obese, with or without type 2 diabetes.

One systematic review and meta-analysis of randomized controlled trials looked at patients treated with antipsychotics on several different GLP-1 agonists. The treatment group showed a decrease in body weight (3.8 kg) and BMI (1.04 kg/m²) compared to placebo. The treatment group also demonstrated a significant improvement in glycemia and lipid profiles.

A 72 week study of tirzepatide used in patients who were overweight or obese showed substantial results. Patients receiving a 5 mg/week dose saw an overall 15% decrease in body weight, and those taking 15 mg/week saw a 20.9% weight reduction.

Only one study thus far has tested a GLP-1 agonist specifically for iatrogenic weight gain. It was a 16 week randomized trial of liraglutide used in patients with schizophrenia who experienced weight gain and prediabetes on olanzapine or clozapine. Far more subjects on liraglutide developed normal glucose tolerance compared to those on placebo (64% vs 16%) and body weight decreased by a mean of 5.3 kg.

Dementia

GLP-1 agonists have shown promise in early clinical studies as potential treatments for dementia. Although much of the research has focused on Alzheimer's disease, they may have broader applicability in treating other forms of dementia. Emerging evidence has pointed to a number of neuroprotective mechanisms including anti-inflammatory effects, reducing Ab plaque deposition and tau protein hyperphosphorylation, increasing neurogenesis and reducing neuronal apoptosis. Researchers noticed an unexpected result in studies of people receiving GLP-1 agonists for type 2 diabetes. These patients were less likely to report cognitive impairment or dementia, so researchers accessed insurance databases and found the same correlation in every database examined.

One Danish study looked at patients with type 2 diabetes who subsequently developed dementia in three randomized double-blind placebo-controlled cardiovascular outcome trials (15,820 patients) and a nationwide Danish registry-based cohort (120,054 patients). Dementia rates were lower both in patients randomized to GLP-1 RAs versus placebo (HR: 0.47), and in the nationwide cohort study (HR, 0.89).

In 2021, Novo Nordisk who manufactures semaglutide (also sold as Wegovy, Ozempic, Rybelsus) began studying semaglutide in thousands of patients with early Alzheimer's, with results expected by 2025.

Future Directions

While the potential roles of GLP-1 agonists in psychiatry are promising, further research, including large-scale clinical trials, is needed to establish their efficacy, safety, and optimal dosing regimens across different psychiatric disorders. Identifying patient subgroups most likely to benefit from GLP-1 agonist therapy and elucidating the underlying mechanisms of action will be crucial for realizing their full therapeutic potential in mental health care.

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The Neurobiological Mechanism of Fear Generalization

By: Zeb Little, M.D.



Addressing the consequences of fear-related disorders is of significant interest to psychiatrists and their patients. Conditions like Post Traumatic Stress Disorder represent chronic conditions of disabling fear triggered by otherwise innocuous stimuli. Studies have identified alterations in the physiology of brain regions such as the amygdala and hypothalamus as underlying the expression and maintenance of fear-related symptoms, but the mechanisms by which these changes occur and by which they are sustained are largely unknown. A recent article by Spitzer et al.¹ sheds new light on the neurobiological mechanisms by which mammals encoded, generalize and sustain fearful reactions to non-threatening situations.

Rodent models of fear induction and maintenance are often based on the use of Pavlovian conditioning by pairing an unconditioned stimulus such as an electrical foot shock with a conditioned stimulus such as exposure to a specific location. In experiments of this type, fear is often measured by the percentage of time an animal spends frozen versus exploring their environment. Using such a paradigm, Spitzer and colleagues investigated the mechanisms by which fear is conditioned to a specific location and generalized to other environments. In the first of their experiments, they replicated previous studies by showing a weak foot shock led to increased freezing behaviors in the environment in which it was given (conditioned fear) but did not result in increased freezing behaviors in a new, non-conditioned, environment (generalized fear). By increasing the intensity of the foot shock freezing behaviors were extended to the new, non-conditioned environment. They further tested the generalization of these fear behaviors by placing both sets of animals in a novel third environment and found increased freezing only in those animals that received a strong shock. Thus, conditioned fear was induced by both weak and strong stimuli while fear generalization occurred only with a strong stimulus.

Fear generalization requires a switch in co-expressed neurotransmitter from glutamate to GABA

Drawing on previous research they investigated whether fear generalization was associated with alterations in the neurotransmitter profile of neurons in the lateral wings of the dorsal raphe nucleus (DR^{lw}). These neurons represent an interesting target of study due to their co-expression of both serotonin and either glutamate (an excitatory neurotransmitter) or GABA (an inhibitory neurotransmitter). Additionally, their axonal projections are known to project to other brain regions associated with generalized fear such as the periaqueductal gray and amygdala. Using immunostaining, they quantified the number of neurons co-expressing serotonin and the vesicular glutamate transport molecule (VGLUT3), an analog for the presence of glutamate, or glutamate decarboxylase 67 (GAD67) which is the enzyme responsible for converting glutamate into GABA and is considered an analog of GABA. In animals exposed to a weak shock, they found no changes in the number of neurons or the ratio of neurons co-expressing serotonin and either glutamate or GABA. In animals exposed to a strong shock, they again found no change in the total number of neurons expressing serotonin but did find an increase in the number expressing GAD67 (GABA) and a reduction in the number of neurons expressing VGLUT3 (glutamate). Thus, a strong shock, but not a weak shock, was correlated with changes in neurotransmitter co-expression and the induction of generalized fear. To determine if this switch in neurotransmitter is essential for the generalization of fear, they blocked the expression of GAD67 and repeated the experiment. This resulted in a reduction in freezing to the initial conditioned location and complete abolishment of freezing in new, non-conditioned locations. Thus, a switch from glutamate co-release to GABA co-release in serotonin neurons of the DR^{lw} is necessary for the production of generalized fear behaviors.

Next, they examined the amount of time required for the change in neurotransmitters to occur and the

expression of both conditioned and generalized fear behaviors to emerge. The presence of conditioned fear to either weak or strong foot shock was evident on day 1, but no change in neurotransmitter expression or fear generalization to non-conditioned environments was observed. Evidence for changes in neurotransmitter co-expression, as well as expression of generalized fear behaviors, was not observed until day 3 post-stimulus. The degree of change in neurotransmitter ratio plateaued over 1 week which positively correlated with the degree of freezing behavior in non-conditioned environments. Additionally, these changes in neurotransmitter co-expression and generalized fear behaviors were sustained when tested again after 4 weeks, roughly equivalent to 3 years in humans, and indicative of a stable alteration in function.

To further establish that the mechanism by which generalized fear is induced in humans involves a change in neurotransmitter co-expression from glutamate to GABA, the researchers evaluated post-mortem tissue from 4 people with PTSD and 4 control subjects. All individuals in the PTSD group had active symptoms of more than 3 years duration at the time of their death. The number of neurons expressing VGLUT3 (glutamate) in the DR^l of PTSD diagnosed individuals was roughly half that of control subjects while those neurons expressing GAD67 (GABA) were nearly 3 times higher than that of controls. These changes are consistent with the researchers' findings in mice receiving a strong foot shock.

Changes in neurotransmitter co-expression within the dorsal raphe projections to the amygdala and hypothalamus are necessary for fear generalization

The serotonergic neurons of the DR^l project to several brain regions associated with fearful reactions. These include the central nucleus of the amygdala, the lateral habenula, the paraventricular nucleus of the hypothalamus and the lateral hypothalamus. To investigate which of these regions is innervated by neurons that undergo a switch in neurotransmitter following a strong stimulus, Spitzer et al. used a combination of anterograde tracers and fluorescent markers of presynaptic vesicle proteins to label serotonin neurons and their projections. Following induction of generalized fear, they evaluated which of the above brain regions received projections from serotonin neurons that had changed from expressing glutamate to GABA. They found that projections to the lateral hypothalamus and central nucleus of the amygdala had reduced numbers of glutamate containing vesicles and increased numbers of GABA containing vesicles but not those projections to the lateral habenula or paraventricular nucleus of the hypothalamus. Additionally, they established that the total number of serotonergic cells projecting to these areas was unchanged, and only the expression of glutamate and GABA was altered. A subsequent study used modified RNA to prevent the stimulus induced increase in GAD67 in these specific projections. This resulted in diminished conditioned and generalized fear responses and further established that generalized fear behaviors were mediated by the change in neurotransmitter co-expression in DR^l projections to these specific brain regions.

HPA axis activation causes the switch from glutamate to GABA and fear generalization

To better understand the mechanism by which a strong stimulus induces the change from glutamate to GABA in the DR^l, they injected corticosterone, analogous to human cortisol, into the animal's peritoneum. Injection of corticosterone alone was insufficient to induce fear or a change from glutamate to GABA, but when injection of corticosterone was followed by a mild foot shock fear generalization and the expected change in neurotransmitter expression was observed. Corticosterone is released by activation of the hypothalamic pituitary adrenal (HPA) axis. Spitzer et al. tested the necessity of HPA axis activation for inducing the switch in neurotransmitter by genetically modifying hypothalamic cells to prevent release of corticosterone releasing hormone (CRH). In these modified animals decreased release of CRH in response to a strong foot shock prevented both the neurotransmitter switch and the generalization of fear. They also found blocking the synthesis of corticosterone or blocking its receptor on DR^l neurons prevented the induction of generalized fear and changes in the expression of GABA. Thus,

activation of the HPA axis mediates the neurotransmitter switch and implicates the dorsal raphe as an important site of corticosterone action in producing generalized fear responses.

Serotonin selective reuptake inhibitors have been shown to reduce stress-induced fear conditioning. The researchers tested whether exposure to fluoxetine influenced the development of generalized fear or changes in neurotransmitter co-expression. Animals were given fluoxetine in their drinking water either 1 day or 2 weeks after a strong foot shock. Animals receiving fluoxetine on day 1 did not develop increases in GABA co-expression and did not develop generalized fear behaviors. Those receiving fluoxetine 2 weeks after foot shock did not show any effects of the drug on behavior or neurotransmitter expression. Further, by artificially increasing the presence of GABA in these neurons the researchers negated fluoxetine's effects indicating the mechanism by which fluoxetine prevented fear generalization was through preventing the switch from glutamate to GABA in projections from the DR^{lw} to the lateral hypothalamus and central nucleus of the amygdala.

In summary, the findings of Spitzer et al. represent an elegant investigation into the mechanisms by which behavioral responses to distressing stimuli are generalized to non-threatening conditions and sustained over time in the mammalian brain. It also raises many scientific and clinical questions about the underlying causes of fear-related psychiatric symptoms and their treatment. How does the alteration in neurotransmitter expression change the activity of circuits involving the amygdala and hypothalamus to manifest generalized fear behaviors? How do SSRIs prevent the switch in neurotransmitter and why are those effects limited to such a narrow window of time? What are the consequences of chronic stress on these circuits and their sensitivity to pathological alteration? What effect does the stage of brain development have on the above mechanisms and their consequences? Are there opportunities for more effective treatments that take into account the priming effects of HPA activation on fear encoding and the time course for consolidating the neurobiological changes underlying generalized fear? In successful treatment of PTSD what happens to the observed changes and how do interventions like talk therapy produce their beneficial effects? As with all good research, the current studies leave us with more questions than answers.

Additionally, the work by Spitzer et al. provides support for two other important neurobiological insights: synaptic plasticity is not the only way the mammalian brain can encode and retain new information and fully mature neurons can alter the type of neurotransmitter they release. These striking results suggest there will be many fascinating and unexpected discoveries ahead in our efforts to understand the neurobiological basis of psychiatric illness and develop effective treatments to help our patients.

1. H. Li, W. Jiang, M. Pratelli, C. Chen, V. Gupta, S.K. Godavarthi, N. Spitzer, *Science* Vol. 383, 1252-1259 (2024).

A Potential Solution to the Child and Adolescent Psychiatry Workforce Crisis: A 4-Year Combined Training Program

By: Patrick Kelly, M.D.



The mental health crisis among children and adolescents in the United States has reached epidemic proportions. Even before the COVID-19 pandemic, rates of anxiety, depression, and suicidal behavior were rising at an alarming rate. The pandemic has only exacerbated this crisis, with the American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Pediatrics, and Children's Hospital Association declaring a national emergency in child and adolescent mental health in October 2021.¹

Despite this growing need, there is a severe shortage of child and adolescent psychiatrists (CAPs) in the US. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are only 8,000-9,000 practicing CAPs, while an estimated additional 48,000-49,000 are needed to meet the mental health needs of children with serious mental illness.² AACAP itself reports that there are currently about 8,300 practicing CAPs and over 15 million children and adolescents who need their specialized expertise.³ Though this topic has been relevant and attracted numerous interest and proposals over the years,⁴ at no time has it been more important than during our current national emergency.

To address this workforce crisis, AACAP has proposed a potential solution: a 4-year combined training program in both general and child and adolescent psychiatry. One proponent and contributor to his proposal is Dr. Erica Shoemaker. Dr. Shoemaker's current and prior roles as the Chief of Clinical Services at the LAC and USC Department of Child and Adolescent Psychiatry, the Associate Program Director for the Child and Adolescent Psychiatry Fellowship, the Chair of the Child and Adolescent Psychiatry Caucus for the American Association of Directors of Psychiatric Residency Training (AADPRT), and the Co-Chair of the Training and Education Committee at AACAP make her ideally suited to understand the very real nature of the recruiting and workforce crisis in the field. I recently had the opportunity to interview Dr. Shoemaker to discuss the origins, highlights, and current state of this proposal.

Dr. Shoemaker explained that the idea for a 4-year track emerged from discussions within both AACAP's Assembly and the executive committee and the child and adolescent psychiatry caucus of AADPRT. "The job of the caucus chair in AADPRT is to represent child psych at the executive council...A lot of my effort was really to redirect the attention of that group of people from talking about how we were splitting up a small pie of child adolescent psychiatry applicants to saying we need to make the pie bigger."

One of the key arguments for a shortened combined training program is its potential to attract more medical students to the field of child and adolescent psychiatry. Dr. Shoemaker noted that many general psychiatry residents start out interested in child psychiatry but lose that passion by their PGY-3 year when it's time to apply and commit to fellowship, in part due to the additional training time required. "For some people one more year is a point at which they drop off," she said. "We really need to address how we make that training more accessible for people and one of the easiest ways to do that is to make the training shorter, which really makes it less financially burdensome for somebody who wants to do child and adolescent psychiatry training." The timing of applying to fellowship may also provide a barrier, occurring during a busy year of residency when potential applicants are already prone to burn-out and looking forward to the completion of their training.

By allowing applicants to match directly into a combined program out of medical school, the 4-year track

could help to capture more interested parties and lead to board certification in both general and child and adolescent psychiatry. "Instead of people starting out liking kids and then deciding that adults would be good enough, they are working with children and adolescents the whole way through their training so that they're professional identification really is as people whose focus is working with children and adolescents," Dr. Shoemaker explained.

To bring this new training model to fruition, AACAP, led by Jeffrey Hunt MD, Chair of the AACAP Task Force on the Crisis in Recruitment and Professor and Program Director for Child and Adolescent Psychiatry Fellowship and the Triple Board Program Alpert Medical School of Brown University, is working with the Accreditation Council for Graduate Medical Education (ACGME) through its Advancing Innovation in Residency Education (AIRE) program. AIRE allows for the piloting of novel approaches to graduate medical education, with a focus on competency-based assessments. Programs in the pilot will be required to demonstrate trainee competence in multiple domains throughout the 4 years, with close monitoring by the ACGME, as a step towards generalization and formal creation of a new combined training program.

The proposed curriculum for the 4-year program is modeled after existing Med-Peds and triple board (pediatrics, general psychiatry, and child and adolescent psychiatry) programs, which have demonstrated excellent outcomes in terms of board passage rates and quality indicators. Dr. Hunt has worked extensively with ACGME, American Board of Psychiatry and Neurology, American Association of Directors of Psychiatry Residency Training, American Psychiatric Association, The American Association of Directors of Child and Adolescent Psychiatry, and AACAP to make sure their input is reflected in the proposal. At the time of this article, the program would likely include 4 months of primary care, 2 months of neurology, 21 months of general psychiatry, and 21 months of child and adolescent psychiatry. Dr. Shoemaker emphasized that the focus will be on "recruiting people who are bright, talented and self-directed learners" and "creating people who are competent general psychiatrists but who are really committed to child and adolescent psychiatry."

One innovative aspect of the proposed program is the use of remote didactics, with all pilot programs receiving high quality interactive seminars from a pool of experts across institutions that are synchronized to the clinical experiences the pilot residents are exposed to in each of the four years. "There's a hope that you can condense your resources, which then relieves faculty to do a little bit more of in person, one to one learning and observation and competency assessment," Dr. Shoemaker said. "But also doesn't put the burden on any one institution to provide all of these didactics."

While there are valid concerns about condensing training, including the impact on resident well-being and the ability to accommodate life events like starting a family, Dr. Shoemaker believes these challenges can be addressed. "It can be hard to imagine how someone takes an extended family leave and finishes in 4 years," she acknowledged. "As someone who just really strongly believes that people should take time off to be with their families and also believes that residency is hard, and should be hard, it's difficult for me to see how we keep everybody healthy in the context of a really condensed program. So I think that's something we would need really need to work on is to figure out how to accommodate the fact that residents have real lives." Notably, we have ample data from the Triple Board programs that have been in existence for over thirty years that residents are able to thrive in the integrated and condensed pathways.

Interestingly, the desire to start a family is also one major reason that potential applicants to child and adolescent psychiatry may instead choose to complete their general psychiatry residency instead, and so thinking about starting a family may in fact drive more applicants to consider the condensed, 4-year program. In addition, as Dr. Shoemaker points out, other condensed training programs are highly suc-

cessful and seem able to allow for unexpected events during training. “You don't hear a lot about people in triple board programs not finishing on time, and the same for Med-Peds.”

Despite these challenges, the potential benefits of a 4-year child and adolescent psychiatry training track are significant. By making training more accessible and appealing to medical students, this model could help address the severe shortage of child and adolescent psychiatrists in the US.

While still in the pilot phase, with a goal of launching in July 2026, a 4-year child and adolescent psychiatry training program represents an important step forward in meeting the mental health needs of our nation's youth. As Dr. Shoemaker put it, “The real problem is that we have a lot of kids who are in trouble and who would benefit from our level of expertise. And there's not enough people training to learn how to do this work. So we need to really start thinking much more about how we recruit people into our field and make training in our field more appealing.”

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HEALTH CARE SERVICES



Dispelling Four of the Most Common Myths About EMDR

By: Christopher Chamber, LCSW



Eye-Movement Desensitization and Reprocessing, also known as EMDR, has become a leading evidence-based treatment of trauma. Awareness of this modality has only grown as more clinicians receive training and an increasing number of EMDR success stories get shared publicly. Despite all of this attention, though, significant misunderstandings of the model persist. Dispelling these myths may help providers coordinate treatment accordingly.

What exactly is EMDR?

EMDR is a specialized psychotherapy that helps clients work through networks of maladaptive memories. Firstly, a treatment plan is created targeting a specific problem area. Past memories, present triggers, and future templates connected to this memory network are then identified. Once the treatment plan is settled, the clinician goes through each target memory one-by-one, eliciting negative images, beliefs, emotions, and somatic sensations. As the client focuses on the most disturbing parts of an event, the provider initiates bilateral stimulation of the cerebral hemispheres, often through side-to-side eye movements. Over time, the client may experience significant changes in mood, imagery, beliefs, or bodily sensations surrounding this event.

Myth #1: EMDR is hypnosis.

When EMDR practitioners talk about having clients visually follow their fingers laterally, visuals of swinging pocket watches and hypnotic states may emerge. EMDR is not hypnosis, however. No thought or image insertion occurs in EMDR. The individual's brain and associated memory networks—not the practitioner's agenda-- lead this work. Follow the brain, EMDR says, because the brain knows where it needs to go.

Bilateral stimulation of the cerebral hemisphere is key for desensitization and reprocessing, and the primary way this was achieved in the early days of the model was through rapid eye movement. However, other methods, such as tapping, have also been found to generate sufficient bilateral stimulation. Despite what it looks and sounds like, EMDR actually shares very little with hypnosis.

Myth #2: EMDR only works for trauma.

Thanks in part to the APA, VA, and WHO recognizing EMDR as a preferred method of treating PTSD, an assumption could be made that EMDR is strictly a trauma treatment. In fact, EMDR specialists would agree that this model focuses on reprocessing traumatic memories. The confusion comes down to the use of the word trauma, which has come to take on many different meanings. As opposed to the traditional clinical interpretation of trauma as experiencing or witnessing a life-threatening event, EMDR clinicians take a broader view. In this model, trauma is defined as an event or circumstance that fundamentally impacts the way a person sees themselves or the world around them. So yes, EMDR focuses on reprocessing trauma, but this also translates to working well with individuals experiencing a wide array of diagnoses. Indeed, research has shown EMDR to be effective in working with depression, phobias, anxiety disorders, and more.

Myth #3: EMDR must be done in-person

For many years, EMDR professionals insisted that treatment must be done in-person to achieve positive outcomes. Because of the limited understanding researchers had about why EMDR worked, practitioners adhered closely to the known protocol. This was deemed the most ethical approach—any significant deviation from the in-person, regimented protocol could result in missing out on a hidden

benefit of EMDR.

This norm was challenged by the pandemic. With the threat of contagion looming, EMDR practitioners logged onto telehealth platforms and began adapting the model. Significant periods of time was spent focusing on ways to emulate the bilateral stimulation that is so key for EMDR. When the results began pouring in, EMDR practitioners found that telehealth was as effective as in-person treatment.

Like with so many professions, EMDR practitioners were forced to become creative during the pandemic. In order to capture the eye movement, practitioners began asking their clients to use a large enough screen and maximize their telehealth windows so that they can get enough swing in their eye movement. Other platforms began popping up as well. One platform, similar to Zoom, allows clients to follow a dot on a line left to right as the practitioner manages the speed.

It should be said that the standard contraindications and considerations for using any form of telehealth still apply to EMDR.

Myth #4: EMDR always works quickly.

EMDR providers often speak excitedly about how quickly they achieve positive outcomes with their clients. EMDR specialists may even discuss the magical experience of lifelong distress being alleviated in a handful of sessions. These outcomes are all legitimate, and EMDR can work quickly. However, it is important to maintain reasonable expectations on the timeline. C-PTSD, for example, can still take substantial time to treat. Dealing with multiple maladaptive memory networks complicates treatment, as blocking beliefs and feeder memories from one network or the other can interfere. Sometimes a substantial amount of time needs to be set aside to help teach an individual how to regulate themselves, too. Additionally, the course of each target can vary. A person can rapidly deescalate from a SUDS score of 9 to 4, over the course of one or two sessions, then spend months moving down to 0. Alternately, the opposite can be true, where a consumer hovers around a high SUDS level for a significant amount of time until something shifts and rapid reduction of distress occurs. For EMDR practitioners, a memory remains a target until the SUDS falls to zero, there is a strong belief in a positive cognition connected to the memory, and the client reports a clear body scan. The time frames vary widely.

Conclusion

EMDR is an effective, evidence-based treatment for a great range of problems that our populations face. Unfortunately, significant misunderstanding of this modality throughout the mental health community impact treatment decisions. With more dialogue about what it offers, EMDR can be better understood and called upon to help heal the wounds of this world.



Holiday Parties and Trainees

By: Manal Khan, M.D.



Holiday parties and workplace socials are a significant part of the United States (US) work culture. In medicine, residency and fellowship programs organize social events to foster a sense of community and belonging among residents. Community building is often seen through the lens of preserving meaning and mitigating risk for burn out. [1] These social events especially when tied with holidays can include participation of program leadership. Therefore, these events have the potential to not only encourage bonding between trainees but also present opportunities for trainees and the program leadership to interface and engage in a casual setting. All of this then leads to visibility and personal connection which can result in opportunities for professional development.

In recent years, efforts centered around diversity, equity, and inclusion have gained momentum and many aspects of residency and fellowship training including recruitment and education have attempted to incorporate these principles. [2] Similarly, many organizations outside medicine have also been forced to ask themselves “who are we unintentionally excluding in the after-work activities?” and how to be more inclusive towards employees of all backgrounds and group identities. These efforts have resulted in a shift from “happy hour” to “social hour” (decentering alcohol consumption) and a greater consideration towards attendees’ dietary preferences. When organizing these activities, an important group to keep in mind are parents of young children. Approximately 40% trainees plan to have children during Graduate Medical Education training. [3]

Like any other group, parents of young children are not a monolith. This group identity can also intersect with other identities such as parental status (single vs co-parent), gender, race/ethnicity, class, immigration status, etc. Based on these affiliations it’s possible to have parents in residency and fellowship training who cannot afford a sitter to watch children while they attend after-hours work social, who don’t have family nearby to watch children if they need to attend a weekend holiday party, and for whom the idea of leaving their children behind for a social gathering is unfathomable. This then limits the participation of parent trainees in social events. The impact on these parent trainees can manifest as isolation and missed opportunities for community building, personal connection, and professional growth. Another important factor to consider is the already prevailing negative perception towards the clinical performance and academic productivity of parent trainees despite the data indicating the opposite. [4] Therefore, in addition to promoting wellness and mitigating risk for burn out, it is imperative to not exclude parent trainees from opportunities for visibility and for creating a personal connection with program leadership.

In medicine, conversations regarding standardization of parental leave policies during residency and fellowship training are gaining momentum. Employers outside medicine are also actively considering ways to incorporate family friendly culture in workplace settings. Parents of young children often bring a unique skill set to work which includes time management, problem solving, conflict resolution, flexibility, systems approach, and relatability. Based on the number of trainees who plan to be parents during training, this demographic also presents itself as a significant group for future employment. Therefore, it is in the interest of the training programs to adopt family friendly policies to boost employment, retention, and participation of parent trainees and physicians.

As we continue to find ways to be more inclusive, it is important to keep this demographic in mind too. While planning work socials and holiday parties, training programs and hospitals can adopt some simple strategies to include parents. These include organizing work socials or holiday parties during work hours to limit the amount of after-hours work engagement. Program leadership can serve as role models by bringing their own children and families to these events. Programs can also be explicit in their communication and state that children are welcome. To accommodate children during these events, programs can think about either engaging with outside childcare agencies or providing on-premises childcare for formal events such as graduation and winter galas. For less formal events, programs can create a “kids corner” with activities such as bubbles, coloring books, and snacks to engage young children. There are many ways to engage young children and consequently the parents of those young children who make a significant part of physician workforce. It is also not only important for workplaces to be inclusive towards parents as future employees, but it is crucial for society to include young children in everyday activities, especially celebrations when possible.

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What about the wheel that is not squeaky enough to get the grease?

By: Nassi Navid, MD



California's homelessness crisis is multifaceted, driven by a confluence of socioeconomic, political, and healthcare-system factors (1). Although predominantly men, including veterans, unhoused persons include women, women-led families, LGBTQ+ persons, adolescents, and children. Mental illness exerts a profound toll, exacerbating vulnerabilities and perpetuating cycles of poverty and homelessness (2). More than two-thirds of these individuals grapple with severe psychiatric disorders such as schizophrenia, bipolar disorder, and major depressive disorder, often compounded by substance use disorders, history of trauma, and the stigma surrounding mental illness (3).

Mentally-ill unhoused individuals who experience more severe psychiatric symptoms often get noticed, because they cause issues in the community; e.g., by attempting to hurt themselves or others. They are more likely to end up involuntarily hospitalized; however, this is the lucky group of patients who after stabilization frequently get connected to mental health resources upon discharge; e.g., Assertive Community Treatment – “the squeaky wheel gets the grease.” As well, academic, community psychiatry, and other mental health programs with “street psychiatry” designations most often focus on detecting the same group of individuals in the community in case they have relapsed due to medication non-adherence or comorbid substance use disorder, and facilitate their hospitalization, re-starting treatment and re-connecting to resources with goal of preventing further escalation.

On the other hand, those who suffer from a serious mental illness but are not having enough behavioral issues to be hospitalized often will go undetected and unconnected to mental health services (4). They don't exist on any census to get psychiatric help. They themselves also prioritize seeking assistance for physical ailments over their mental health concerns, influenced by limited insight and/or negative prior encounters with mental health institutions. Therefore, this group is more accessible to community-based medical teams and can be referred to homeless outpatient clinics, including for psychiatric care when their mental illnesses are ultimately recognized.

After volunteering for weeks with “backpack” medicine teams going to homeless encampments, I propose including a “community Consultation-Liaison psychiatry” curriculum into psychiatry residency programs so residents can work with outreach teams during their C/L rotations. This will offer trainees additional tools to provide efficient and timely mental health care for unhoused individuals. Consultation-Liaison (C/L) psychiatry, initially developed to provide expertise in non-psychiatric medical and surgical settings, holds unique promise to bring timely and effective mental health services to unhoused individuals, facilitating a broad range of rapid consultation resources for the other physicians in the field. This collaboration will streamline the detection, triage, and provision of treatment and social services to all mentally ill persons within a homeless community, as well as educate team members about the panoply of mental illnesses in these populations. Timely and comprehensive treatment interventions for the unhoused mentally ill will lead to improved quality of life, fewer safety concerns, and more cost-effective outreach teams, benefiting society as a whole.

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Review of the Joint SCPS/SCSCAP Presentation on AI

By: Patrick Kelly, M.D.



The interest in using AI in medical and psychiatric practice continues to grow. In December 2023, at an event jointly hosted by the Southern California Psychiatric Society and the Southern California Society for Child and Adolescent Psychiatry, Dr. John Torous provided a fascinating and sobering assessment of the current state of artificial intelligence. As the Director of Digital Psychiatry at Beth Israel Deaconess Medical Center, Dr. Torous is well-positioned to separate the hype from reality when it comes to AI applications in mental health.

Dr. Torous explained that what is labeled as AI is not truly “intelligent” in the traditional sense of the word, leading to misunderstandings and errors in the system. The basic premise behind “AI” chatbots like Chat-GPT¹ is that given enough training data and examples, machine learning algorithms can learn to recognize patterns and mimic human-like responses. These are based on what are known as “large language models” or LLMs, which allow the computers to essentially predict the statistically most likely response for a given query. Many mental health apps and chatbots claim to be “AI-powered”, giving the impression of intelligent systems that can understand context and provide tailored support. However, Dr. Torous explained, most of these are actually glorified decision trees, with only the natural language processing component really using any sort of AI-like capacity.

The knowledge and reasoning capabilities of today's mental health chatbots are quite limited. Furthermore, the training data used is often low-quality and riddled with biases and misinformation (e.g. training on Reddit posts questioning if depression is even real). The result is AI systems prone to factual errors which can reinforce stigma, as exemplified by AI art generators producing disturbing images equating schizophrenia with “terrifying clowns.”²

One of the most concerning aspects of AI chatbots are their ability to sound human-like, while distributing what is actually incorrect advice. Early research applying AI to clinical use cases has revealed serious issues such as subtly incorrect cancer treatment advice that is hard for even experts to detect, as it is couched in such seemingly appropriate language³. Students using AI to write reports produced results which seemed logical and correct, though on closer inspection actually argued the opposite point than was requested.

Examples of AI gone awry are unfortunately increasingly common. The National Eating Disorders Association (NEDA), for example, began using an AI assisted chatbot to provide responses to patients contacting an eating disorders help line, only to find that the AI, without being given enough context and responding using statistical likelihood to patient questions, began giving out dieting advice.⁴

However, Dr. Torous is clear to mention that AI may have a place in health care, provided that it is not used as a thinking-replacement and is instead relegated to administrative activities. Before deploying AI tools in routine care, Dr. Torous argues they need to be rigorously evaluated for safety, effectiveness, and bias using the same standards as other medical devices and interventions. Privacy safeguards also need to be put in place, as many AI chatbots and apps are not currently HIPAA-compliant, and some even use the questions posed in their own recursive training algorithms, introducing the possibility that patient information could become unknowingly ensconced in additional computing protocols.

While major tech companies are investing heavily in building powerful language models and diagnostic algorithms, Dr. Torous notes that psychiatry experts are often not involved in their development process. Mental health AI applications will require deep engagement and oversight from our field to ensure clinical utility and mitigate potential harms. Professional societies like SCPS and SCSCAP could play a key role interfacing with technology companies to inform the responsible development of AI tools. This is becoming increasingly recognized. The American Psychiatric Association⁵ and the American Academy of Child and Adolescent Psychiatry are both launching efforts within their organizations to monitor and contribute to the development of these resources and protocols.

In short, while AI holds long-term potential to augment psychiatric practice, the current generation of mental health chatbots and algorithms is still quite limited. Bold claims and marketing hype should be evaluated with healthy skepticism. There are already dozens of products on the market promising to save hundreds of hours in generating patient notes and correspondence, with scant testing or safeguards around the information they present. It is likely only a matter of time before one of these notes shows up in some court case or other, and the physician will be hard pressed to explain the inconsistencies or inaccuracies contained therein. Strong caution should be exercised by individual providers attempting to utilize these resources. Though the potential to alleviate administrative burden is of course exciting⁶, the reality of these tools and their limitations argue against their whole-sale incorporation into clinical matters.

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⁴ Wells, K. "Eating disorder helpline takes down chatbot after it gave weight loss advice." NPR All Things Considered, June 2023. <https://www.npr.org/2023/06/08/1181131532/eating-disorder-helpline-takes-down-chatbot-after-it-gave-weight->

⁵ "AI in Psychiatry: What APA Members Need to Know" (October 20, 2023). By Psychiatric News. The webinar addressed clinical, ethical, and legal considerations for AI in psychiatry. Retrieved from psychnews.psychiatryonline.org

⁶ "AI in Psychiatry: Things Are Moving Fast" (January 12, 2024). Psychiatric Times. Retrieved from psychiatrictimes.com

SCPS Welcomed the Following New Members in April

Jaskaran Grewal, M.D.
 Eric Kazangian, M.D.
 Carolina Osorio, M.D.
 Michelle Sun, M.D.
 Scott Weigold, M.D.
 Lyndon Yu, M.D.
 Yalun Zhang, M.D.

SCPS Installation and Awards Ceremony held on Saturday, April 13, 2024



Outgoing President, Matt Goldenberg, D.O. with Incoming President, Galya Rees, M.D.



Ira Lesser, M.D. and Lawrence Gross, M.D.; member and Chair, Awards Committee



Dr. Goldenberg presents Commendation Award to Paul Yoder, CSAP Advocate



Ruqayyah Malik, M.D. presents George L Mal-lory Award to Ijeoma Ijeaku, M.D.



Thomas Strouse, M.D. receives Outstanding Achievement Award



Zeb Little, M.D. receives Distinguished Service Award



Incoming Council Members



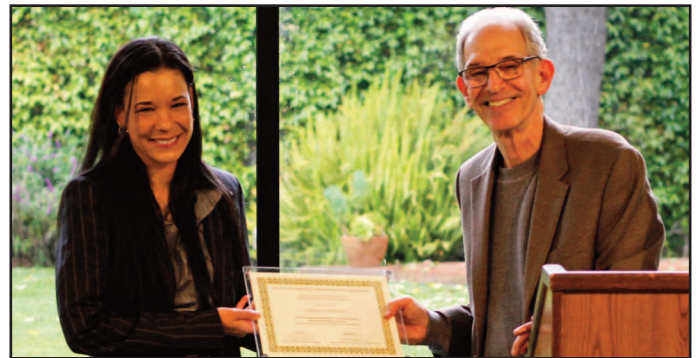
Rod Shaner, M.D. receives Distinguished Service Award



PER/SCPS Resident Awardee, Sarah Mohtadi, M.D.



PER/SCPS Resident Awardee, Saul Lincoln, M.D.



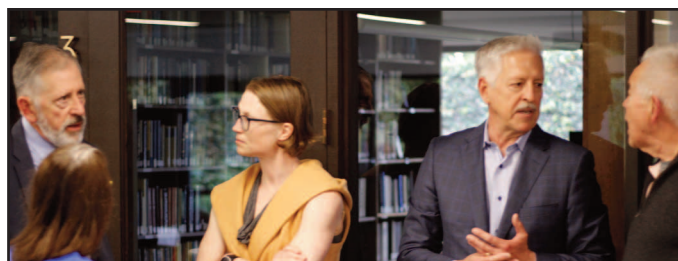
PER/SCPS Resident Awardee, Teresa Nolfi, M.D.



PER/SCPS Resident Awardee, Alyssa Tate, M.D.



So Min Lim, D.O., Incoming Resident Representative on Council



Members, Awardees, and Advocates

Council Highlights

March 14, 2023

Laura Halpin, M.D., *Secretary*



PRESIDENT'S REPORT

Dr. Goldenberg

Storage/Scanning: As lease of in person office is expiring soon, we will need to decide what to do with documents. We will continue to hold all legally required documents. A workgroup met to discuss this further. It was determined that all legally required documents, past newsletters, photographs of past presidents would be scanned. No physical storage would be maintained

Motion Approved: All past physical documents from office will be scanned

SCPS Programming: There was discussion about forming a new program committee to develop new educational programming for members. Discussion was had about need for this meet changing needs regarding format and CME as well as revenue for organization. Any interested parties should contact Dr Goldenberg and/or Mindi Thelen

Centralized Billing: There was discussion about changing from SCPS billing dues to APA billing dues. In past years, SCPS has done our own billing due to concerns about APA doing this effectively and also due to the way APA does billing results in funds being released to DB later in year and less trackable way. We discussed that when Ms Thelen retires (5-6 years), we may have to move to centralized billing, so it may be worth piloting this sooner rather than later so we can troubleshoot. Based on concerns about timing within SCPS and APA right now, it was decided to wait until the next APA contract cycle to do this, which is 2 years from now.

NAMI Walk: Scheduled to be May 4, 2024. Anyone interested in attending should reach out to Dr Goldenberg and Ms Thelen

Oregon Amicus Brief: The APA is considering participating in a *City of Grants Pass v. Johnson* Amicus brief and reached out to discuss if we have opposition. The memo regarding this was reviewed by members of the unhoused committee and there were no objection

Motion Approved: SCPS does not oppose APA joining Amicus Brief in *City of Grants Pass v. Johnson*

Dr Wood Endorsement: There is a new Board of State and Community and Corrections. Dr Wood has been endorsed by SCPS and CSAP. There are no updates yet regarding this from the governor's office.

IV. PRESIDENT ELECT REPORT

Dr Rees

Newsletter Updates: Dr Rees reviewed contributions to the February newsletter focused on Black History Month. Drs Khan and Malik co-edited the newsletter. The focus of the March newsletter will be Advocacy

APA annual reception: APA will be in Los Angeles in 2025. NCPS has held receptions for all of CA vs all of APA. There was further discussion that SCPS will plan a reception at the Annual meeting in 2025. There was discussion that planning should begin now given the need to reserve facilities early and also budget for this expense. There was discussion that cost of this reception could be \$20-25,000. A committee is forming to plan this, please reach out if interested. Dr Goenjian volunteered to join committee

V. GAC ACTION ITEMS

Drs. Shaner and Wood

Report from monthly meeting was provided and the following action items were discussed with the following motions approved:

Motion 1, Approved: That SCPS Council take an Oppose position on SB1012 (Weiner) SB-1012 The Regulated Psychedelic-assisted Therapy Act and the Regulated Psychedelic Substances Control Act. (ca.gov) and request that it's CSAP representatives transmit SCPS concerns to the CSAP GAC and Board.

Motion 2, Approved: That the SCPS Council amend the Area 6 Representation Guidelines to include duties of the SCPS representative to the CSAP PAC.

VI. TREASURER'S REPORT

Dr. Kelly

February Financials and Cash on Hand Report

Dr. Kelly reviewed various financial metrics, year-to-date. Overall, SCPS is in good fiscal health.

Motion Approved: Treasurer's report approved

VII. MEMBERSHIP REPORT

Dr. Ijeaku

A. Membership Report

Current Active Membership –880/995

Motion approved: The membership report was approved by unanimous vote.

VIII. ASSEMBLY REPORT

Assembly Reps

The next in person APA assembly meeting will be in NYC May 3-5 at APA Annual Meeting. Dr Red reviewed upcoming issues which may be addressed by the assembly including medical-aid-in-dying. There was also discuss that in recent elections, Area 6 representatives and deputy representative will be Drs Malik and Dube.

IX FELLOWSHIP AND AWARDS

The committee had additional discussion about an achievement award for services to the committee and the Academic Liaison Committee. There was discussion about awards. Installation and awards will be Saturday April 13th and New Center for Psychoanalysis. The winners of the PER awards were also approved.

COMMITTEE REPORTS

Chairs

Alternatives to Incarceration – Dr. Wood The committee is working on first stages of a project to understand how patients end up in carceral system, especially secondary to emergency room care decisions.

Access to Care – Dr Friedman gave an update that the committee continues to work to understand new DMHC parity regulations along with CSAP private practice committee. The committee is also discussing clozapine access and review of REMS process. They are also exploring partnership with NAMI on these issues. Dr Elizabeth Casalegno attending a recent meeting to give perspectives on taking insurance in private practice. They are also looking at programming with the private practice committee regarding this.

C. Diversity and Culture – Dr. Khan. There was upcoming programming from the committee and Dr Denise Shervington, Chair of Psychiatry at Charles Drew University and Dr Lisa Fortuna, Chair of Psychiatry at UC Riverside about The Role of Training Programs in Preparing the Next Generation of Psychiatrist, working with communities. It was be a virtual program and went well. The repudiation Moynihan Report Action Paper is being considered by the APA BOT. The committee also discussed

the Mallory award. They discussed they have developed a new more equitable process whereby nominees can be nominated or self nominate and then submit CV.

Motion Approved: Dr Ijeoma Ijeaku was selected for the Mallory award this year and this was approved by council

D. GAC—Drs Wood and Shaner, motions above. CSAP is currently in process of reviewing bills for the current legislative year. There was discussion about concerns with SB 402 (Wahab) Involuntary commitment. “LPS designation” expansion, AB 1316 (Irwin) Emergency services: psychiatric emergency medical conditions. We also discussed CSAP-sponsored AB 1184 (Eggman) Riese Hearings. There was also report from the CSAP Board meeting about linking CSAP with APA CAGR, considering the length of meetings and the consent calendar

CSAP PAC- Dr Halpin provided updates about the following PAC contributions, Dr Akiliah Weber (democrat, running for senate, \$5,500), Dr Jasmeet Bains MD (democrat, running for assembly re-election, \$5,500), Rozzana Verder Aliga LMFT (democrat, running for senate, \$2,000, event for Cecilia Aguiar Curry (democrat, assembly re-election, \$500 to attend event).

E. Membership committee: The recruitment video is complete and discussions are ongoing about using this as part of a recruitment tool in residency programs. We have new contacts for program directors, so this should help.

F. Unhoused Workgroup Dr Chang updated that the group has met multiple times. They are meeting with leaders in community psychiatry to understand the issue, barriers to caring for patients, especially systemic issues, and identify next steps. There was discussion about a goal to wrap up work of the committee in coming months and determine how to weave the results of their work into existing committee structure

ADJOURNMENT – 9:04 pm

Dr. Goldenberg

Incoming Officers to Serve Under President Galya Rees, M.D.

Patrick Kelly, M.D. (President-elect)

Emily Wood, M.D. (Treasurer)

Laura Halpin, M.D. (Treasurer-elect)

Gillian Friedman, M.D. (Secretary)

Election Results/Council

Daniel Fast, M.D. and Kayla Fisher, MD. (Inland Region)

Anu Bodla, M.D. (Santa Barbara Region)

Stephen Allen, M.D. (South Bay Region)

Haig Goenjjan, M.D., Tanya Josic, D.O., and Lloyd Lee, D.O. (West LA Region)

Manal Khan, M.D. (ECP Rep)

So Min Lim, D.O. and Justin Nguyen, D.O. (RFM Reps)

Rubi Luna, M.D. (DMURR)

Anita Red, M.D. (Assembly Rep)

CLASSIFIED ADS

SANTA MONICA OFFICE FOR LEASE

Residential Environment Designed Especially for Mental Health Practitioners

13 office building

Unfurnished Office Available with Separate Egress

First floor

Furnished Waiting Room - Fireplace - Sound-proofed - Call Light System - 24-hour access - Operable Windows - Individual Climate Control - Filtered Water - Security Cameras - Non-smoking Environment – Refrigerator and Microwave - Free Wi-fi - All utilities and janitorial provided. On-site personal tenant parking included. 2-5 years lease. Starting rent: \$1675 per month.

Contact: Dr. Edward Dreyfus

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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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