Dr. Lisa Dixon (00:07):

Welcome to our podcast, Psychiatric Services from Pages to Practice. In this podcast, we highlight new research or columns published this month in the journal Psychiatric Services. I'm Lisa Dixon, editor of Psychiatric Services, and I'm here with podcast editor and my co-host, Josh Berezin. Hi, Josh.

Dr. Josh Berezin (00:27):

Hi, Lisa.

Dr. Lisa Dixon (00:28):

Today we're going to talk with Professor/Dr. Elizabeth Bromley about an approach to helping individuals who are homeless and have serious mental illness in LA. Really special effort and my initial work when I first graduated from residency on a homeless outreach team is... This is where my heart is. So I'm really glad to have Elizabeth Bromley with us today.

Dr. Josh Berezin (00:56):

We are very happy to have Dr. Elizabeth Bromley, who is a professor in the Department of Psychiatry, Biobehavioral Sciences and Anthropology at UCLA here to talk about her and her co-author's paper, Addressing Mental Health Disability in Unsheltered Homelessness Outpatient Conservatorship in Los Angeles. So Dr. Bromley, thank you so much for joining us.

Dr. Elizabeth Bromley (01:15):

Thank you. I'm really glad to be with you to talk about this.

Dr. Josh Berezin (01:18):

Could you tell us a little bit about your career trajectory and how this topic or this particular projects kind of fits in with your work in general?

Dr. Elizabeth Bromley (01:28):

Yeah, I can try to give you a short story about that. My work engagements have always been a bit diverse and I've had a bit of an unusual trajectory, but in a way, things always come full circle and back together, don't they? I trained in psychiatry and I got a master's degree in the history of medicine. And then after my psychiatry residency, I entered a health services research fellowship and at the same time finished a PhD in medical anthropology.

Dr. Elizabeth Bromley (01:56):

And so my work has always been in the health services space and particularly partnered health services research work around implementation and community settings. And then I've had, alongside that, some engagement in medical anthropology, sometimes on topics quite different from what I do in health services work. For instance, have had an anthropological interest in physician emotional experience for a number of years. And I also have always been relatively clinically engaged. So even during my heavy years of research, I was doing probably a day or a day and a half of clinical work, and that's been since 2004 within the Mental Health Intensive Case Management program at the VA, which is really the team that we've had in the MHICM program has given me an opportunity to understand assertive community treatment and working in a multidisciplinary context.

Dr. Elizabeth Bromley (02:51):

In 2018, there was an opportunity to engage with the LA County Department of Mental Health in a much more substantive way than faculty at UCLA had had previously.

Dr. Josh Berezin (03:04):

So I'm going to step back with a giant question that hopefully you can rein in a little bit. Just to give our listeners a little bit of context before we dive into the program and the paper specifically, could you talk a little bit about homelessness in California, in LA County? What are some of the unique things about the population? And also you hear a lot just in the popular press about some of the broader government initiatives both on state and a local level. So what should readers know about California and LA County in particular to going into talking about this issue with you?

Dr. Lisa Dixon (03:44):

I want to jump in just for a second because I'm especially interested in your answer, given your anthropological background. You bring this multi-dimensional perspective, so I just wanted to remind our listeners that you're not just a physician, you're an anthropologist.

Dr. Elizabeth Bromley (03:59):

Well, I think at the most basic level, anthropology attends to context and to social context. And of course whenever we think about homelessness, structural factors are critical. And in LA County and in California, that is the case. Homelessness is a problem of housing unaffordability, housing unavailability. And in any context where that takes place, we know that individuals with the most challenges are going to have the hardest time accessing and maintaining housing. And that's true in California.

Dr. Elizabeth Bromley (04:28):

And in LA County, now there are about 75,000 individuals who are experiencing homelessness. Unlike some areas of the country, the vast majority of those individuals are unsheltered, so they're living on the streets. The shelter system in LA County has been relatively smaller than some other places such as New York City. But the problem continues to grow and increased at about 10% last year compared to the year before. For the last couple of decades, there's been a substantial challenge around homelessness in LA County, and that is related to the high cost of housing in LA.

Dr. Elizabeth Bromley (05:02):

Average rent is above $2,400 in LA. And really in particular for the population experiencing severe mental illness, we've seen a huge loss of housing capacity, of housing resources that are appropriate, easily accessible for people with severe mental illness. And I'm thinking specifically about individuals who may experience some functional challenges as a result of a severe mental illness, which is a minority of individuals who are diagnosed with a mental illness. But for those that experienced some functional challenges, executive function difficulties, challenges maintaining employment, those are things that complicate housing.

Dr. Elizabeth Bromley (05:43):

One of the things that is the case about services for people experiencing homelessness in LA County is that it wasn't really until about 2017 that there was the staffing of a substantial active homeless outreach staff. So with what was called Measure H, it passed in 2015 and was fully funded in 2017, LA

County began to make a concerted effort to reach individuals experiencing homelessness for outreach. And that did result in about almost a thousand individuals who were on the streets conducting homeless outreach to try to link people experiencing homelessness to housing and other services that they needed.

Dr. Elizabeth Bromley (06:24):

And so we did see a substantial increase in the number of individuals doing homeless outreach beginning in 2017 and linking people to resources. But the majority of that homeless outreach workforce was doing what we might call generalist outreach. They attended to be conducted by individuals who might be case managers, many, many individuals who had lived experience of homelessness, and they tended to try to serve a finite geographic location, but tended to not have as much capacity around specialized assessment or addressing special needs related to physical health difficulties or to mental health difficulties. So quite rare in fact, to have social workers, mental health social workers, physicians and psychiatrists doing homeless outreach.

Dr. Elizabeth Bromley (07:12):

In 2020, the Department of Mental Health in LA County decided to invest heavily in building their specialized mental health homeless outreach teams. And so the HOME team itself, it existed before, but in 2020 really started to coalesce around an intentional service model and importantly started to include psychiatrists on every team and also hired nurse practitioners, more nurses on their teams. So beginning in 2020, they really wanted to offer a particular service to that subset of individuals who experienced homelessness and needed treatment on the street for mental health challenges in order to access other resources. And that is the HOME program The HOME program began to grow at that time and really begin to focus on a target population with some mental health related disabilities.

Dr. Elizabeth Bromley (08:00):

I think the other thing I would add about this is that for the vast majority of people experiencing homelessness, treatment on the street is not what's needed. Even mental health treatment is not what's needed. What's needed is housing. And the housing first approach works, and it works for the vast majority of people experiencing homelessness. And when we're thinking about the need for street-based psychiatric treatment, we're really talking about a minority of individuals experiencing homelessness. There is a minority though, and we might say it's around 10%, where we see that until there is in place some effort to provide some mental health treatment, moving into housing is not possible. So that too is a barrier. We're really talking about a highly vulnerable, small segment of a much larger problem, and that small segment needs some specialized resources. So I think it took a while to really recognize we'd need to do more than generalist outreach. We'd need a population health approach. We're really trying to target needed resources, intensive resources to the subsets of the population that needed special services.

Dr. Josh Berezin (09:05):

I think that's a good segue into the paper. I think it'd be helpful to describe what you all came up with around 2020. And then just sketch out kind of the broad service that was created and which this paper is an evaluation of.

Dr. Elizabeth Bromley (09:20):

Along recognition, that there were individuals experiencing homelessness who seemed to experience grave disabilities. Grave disability is a legal definition. In most states, grave disability means that as a result of a mental illness and individuals having challenges providing for their basic needs, food, clothing, shelter, safety. And that treatment is needed to address safety in an urgent way. So sort of broad category of grave disability is something that people doing homeless outreach recognized was present.

Dr. Elizabeth Bromley (09:53):

In California, in general, in order to address grave disability, there's a strategy called Lanterman-Petris-Short conservatorship, an LPS conservatorship. It's designed for individuals with a severe mental illness. And it is a legal process, but if an LPS conservatorship is placed, there's a temporary transfer of an individual's rights, for instance, to decide where to live, those rights are transferred to a guardian. It could be a family member, it could be a public guardian. And so LPS conservatorship as a strategy to address grave disability to ensure safety in the presence of grave disability.

Dr. Elizabeth Bromley (10:30):

In California and particularly in LA County, it's typically only available as a result of a very long inpatient hospital stay. And this is simply because of the way the mental health court process has been organized to implement conservatorship. The mental health court has needed for individuals to be in a hospital for many, many months sometimes to work all the way through that legal process of accessing an LPS conservatorship.

Dr. Elizabeth Bromley (10:57):

Hospitalizations are extremely hard to access for people experiencing homelessness in particular, but we see this across the system that admission to a hospital is hard, bed availability is very, very low, and it's very, very expensive for a hospital to move all the way through conservatorship. It means that the hospital typically needs to hold onto that individual in a locked setting for many, many months for an uncertain court process. Many people doing homeless outreach would see grave disability and recognize there was no solution for it. There was no option for a hospital to offer a strategy of safety for the individual. And so many of those individuals are simply unserved.

Dr. Josh Berezin (11:39):

Is it fair to say that one of the issues with LPS conservatorship is that it requires a lengthy inpatient stay in order to access the outpatient?

Dr. Elizabeth Bromley (11:54):

Yes. And the LPS conservatorship process as it's currently implemented is exceedingly rigid and entirely reliant on inpatient settings during the process of accessing the conservatorship. So the wait for a hearing or a trial with the judge where there's a decision about whether grave disability is present or not, whether an LPS conservatorship will be placed or not, the wait can sometimes be a year. And that whole time while waiting, an individual needs to remain on an inpatient unit and for an odd reason. That's because there needs to be a psychiatrist to testify before the judge at the hearing or the trial. A psychiatrist needs to testify to how the individual is doing. And if someone were to leave that inpatient psychiatric setting, there would be no outpatient psychiatrist available to testify. So because that person doesn't have a care team attached to them, the court process has been reliant on inpatient psychiatrists.

Dr. Lisa Dixon (12:57):

Certainly, it is not person-centered.

Dr. Elizabeth Bromley (12:59):

Correct. There's no opportunity to be responsive to the clinical situation in the present moment and to indicate that an individual still needs help, for instance, accessing housing, but being on an inpatient unit right now is not necessary. We will help them transition to an adult residential facility, for instance, an unlocked housing setting. We can support them there and there will be a psychiatrist available to speak to the judge when it's needed to the decision about LPS conservatorship.

Dr. Josh Berezin (13:36):

So maybe you could talk a little bit about how that aspect fits into the rest of the program, because I'm getting a sense of the full picture as we're talking more.

Dr. Elizabeth Bromley (13:44):

The LA County board of supervisors was interested in both addressing homelessness and disrupting the cycle of homelessness, jail, inpatient psychiatric treatment for those individuals experiencing homelessness who needed special support. And what they did in a board motion was allow the HOME team, the LA County DMH, specialized mental health homeless outreach team, to petition for a conservatorship for someone outside of a hospital. What that meant was that the HOME team psychiatrists could make a determination that someone seemed to fit the criteria of grave disability would need a conservatorship. You do that from the street. They could admit that individual to a psychiatric hospital if it seemed clinically necessary for their safety, but that HOME team could also move them outside of the hospital, for instance, to a board and care, could move them down to a less intensive hospital setting while waiting for the hearing or the trial to determine whether they needed an LPS conservatorship because that HOME team psychiatrist would be available to mental health court to testify about the client's need for conservatorship.

Dr. Elizabeth Bromley (14:53):

And so it's that key step of allowing the HOME teams themselves to initiate and follow clients through that conservatorship process that made available options for decreasing the intensity of reliance on hospitals, on restrictive settings, on locked hospital placements for people who needed conservatorship.

Dr. Josh Berezin (15:12):

It seems like this is, first of all, much more person-centered. It also is better for the system in terms of inpatient psychiatric capacity. And it seems like it's focused on least restrictive settings. Was there anybody, as you were developing this, who was resistance? Or where was any resistance coming from? Like the community at large, whatever that means, or particular players was like, "It sounds like a great idea to me," but was there anybody who was raising a flag and saying, "No, no, no, no, no, no, this is not going to work, or this isn't safe"?

Dr. Elizabeth Bromley (15:54):

Yeah, there are many different reasons that there was a lot of skepticism and concern about this at the beginning. Perhaps a big one is that it's difficult to argue we should make conservatorship more available for people. That sounds like we'd be relying on restricted practices on taking patient's rights

away. On some level, trying to address homelessness through coercive care practices. That's what it sounded like could happen, that it could open the floodgates to using conservatorship in ways that none of us would like. And those of us in the care system, we recognized that that would be bad for patients, would be bad for communities, bad for our systems of care. And yet it sounded like what was being made possible by outpatient conservatorship was new uses of course of practices.

Dr. Elizabeth Bromley (16:46):

There was also a lot of concern that conservatorship meant people were in locked facilities for long periods of time because traditionally that's how conservatorship would work. Someone would go into a hospital while they wait for conservatorship, they sit there. They'd been disconnected from their entire community, from where they've been living, from the people that they know. And also their control over that process has been taken away while they're waiting for a court proceeding. So a lot of resistance about what that would mean for individuals.

Dr. Elizabeth Bromley (17:17):

One of the very interesting aspects of doing outpatient conservatorship was watching the team learn to do it, watching them understand what it would mean to serve individuals who are highly vulnerable in new ways. So many people doing homeless outreach had not worked in the hospital setting before, perhaps had had no experience working with conservatorship. And so it meant you were taking someone's rights away, did not had a first-hand experience of noticing whether that could be a person-centered process, whether that could result in some benefits for the client in terms of resources that were available to them.

Dr. Elizabeth Bromley (17:52):

The team learned how to work through some ethical dilemmas around this and worked very, very actively to understand all perspectives about whether it was time for something like a hospitalization, whether it really felt like the individual would need conservatorship in the end, what kind of treatment setting or housing setting would be best for that individual. The team tried to pull in all perspectives about those points of view.

Dr. Lisa Dixon (18:18):

The teams included peer support?

Dr. Elizabeth Bromley (18:20):

All of the teams have a good amount of peer support and individuals with lived experience of homelessness. They're multidisciplinary teams. They tend to include a nurse, a couple of peers, a couple of case managers or medical caseworkers, usually a psychiatrist as well.

Dr. Josh Berezin (18:36):

And so we've talked a lot about the conservatorship aspect, but there's two other parts to the program that you outlined in the paper, so could you go a little bit into those as well?

Dr. Elizabeth Bromley (18:48):

It took all of us a long time to understand what we were doing, like many systems of care. LA County DMH has an urgency about standing up new programs, and so they needed to get started. And it was

really... It took us a while to understand what they'd created and what its key elements were. So part of what the HOME teams began doing first of all, was to use a fairly rigorous risk stratification approach to think about all the clients they were serving and to identify those who seemed the most vulnerable, those individuals who had been on the streets for the longest, who were most difficult to engage, who seemed the most isolated, who had the most severe symptoms. And that might mean they were very difficult to talk with, very difficult to connect with or understand or maybe had very elaborate delusional ideas about their need to be in an unsafe setting on the street. They may have an idea there was a mission for them to be in a particular place on the street, and they were stuck there to an extent for long, long periods of time.

Dr. Elizabeth Bromley (19:50):

Many of them also had what looked to be very severe medical challenges or had been failed by multiple systems. They tried many different systems that had been failed by those and were nonetheless to homeless. So the HOME team began very concerted efforts to really understand who was most vulnerable among the individuals they served and ended up only referring about 2% of the unique clients that they were serving for consideration for outpatient conservatorship.

Dr. Elizabeth Bromley (20:16):

What that meant was that there was a committee that would hear the case. And that over a period of time, that committee every week would get an update on that individual. And the committee, which really implemented multi-sector care coordination for all of the clients, included representatives from many different sectors, not just mental health, but housing, hospital, health services at times. And everyone on that committee tried to problem solve to see what sorts of other resources could be made available and offered to that individual. So that was the first task, was to see if there were some resources that could be in a more timely fashion made available. That multi-sector care coordination continued throughout that client's trajectory in the program.

Dr. Elizabeth Bromley (20:57):

If it turned out that the full array of voluntary resources and services had been offered, and the committee felt over time they really had been offered in the best possible context with the best possible engagement with the client, then there would be a discussion about whether a petition for LPS conservatorship was appropriate. Really what that means is that the program itself was not an Outpatient Conservatorship Program. It was really an intensive case conferencing care coordination initiative, the outcome of which might be that for certain individuals it did seem to be that the consensus of the group was that LPS conservatorship was the right approach.

Dr. Elizabeth Bromley (21:36):

And what that meant as well was if the individual was petitioned for LPS conservatorship, the support of the HOME team, the support of all the members of the committee would stay involved with that individual while they were in a hospital if they needed that, while they were placed into housing, as they went through the court process, whether they ended up having a conservatorship or not, those resources were available to meet their needs in a responsive way.

Dr. Elizabeth Bromley (22:00):

And so the HOME team, because it had served the individual on the street, because it had gone through this process of consideration with the committee about the client's needs, because it had overseen their

admission to a hospital if that was needed, because it was following them through the court process, that HOME team was available for them if they could step down to housing, they could step into an apartment on their own, move into permanent supportive housing. The HOME team was the glue, the care coordination bridge that kept that individual connected to a clinical team throughout the process of moving off the streets and into some safe setting.

Dr. Josh Berezin (22:34):

The paper that you published is a description of all of this and also an initial evaluation. So what are some of those top line findings I guess from the initial evaluation?

Dr. Elizabeth Bromley (22:48):

We really feel like describing this approach is significant. And it doesn't feel good to need to admit it, but we, in mental health services, we really still struggle with system fragmentation, not just in mental health services, but all the other resources that our clients need. We struggle to coordinate those. And I think the appropriate word about how those systems are fragmented is something more like chaos. It's really much more of a chaotic system, and it feels often like getting someone linked to the housing, medical services, benefits, food and mental health services that they need is a matter of chance rather than clear coordination across sectors of care that are necessary for this population.

Dr. Elizabeth Bromley (23:33):

The HOME approach, the Outpatient Conservatorship program approach, the fact that they could coordinate across sectors of care to try to make resources available in a very timely way is a key part of the approach. But that actually also worked well because at the same time, the teams were focusing on risk stratification. So they were thinking about who is it that we're serving who needs this intensive level of intervention, of care coordination and intensive level of support from us so we can pull in all the resources that they need. That approach of thinking about an intensive intervention for those that can most benefit from it was very critical to the activities.

Dr. Elizabeth Bromley (24:16):

And that they were also always thinking about maximizing autonomy, using least restrictive settings as much as possible, understanding client preferences the whole way through. Those three components of the program were very, very impactful and they were interdependent. So for instance, HOME team members became much more comfortable with the outpatient conservatorship approach because they recognized that it would make available for their clients new resources. It didn't automatically mean that someone was conserved. It didn't automatically mean that someone was in the hospital. They recognized, "This would be a way for me to explore some housing options for my client." So that care coordination allowed people to identify risk, to bring people forward. And also the fact that there was always going to be an attention to maximizing autonomy made clinicians feel more comfortable thinking about with others, thinking about what degree of care would be needed. They knew there'd be substantial deliberation before they moved to something that would be coercive or that would revoke their patients' rights.

Dr. Josh Berezin (25:21):

So as we start to wrap up, I want to also mention there's another aspect of the paper besides describing the program in some depth, but you also got some initial quantitative measures about what the

program is doing. And so I'm wondering if you can talk to us a little bit about those and also what you learned from those or you take home from them.

Dr. Elizabeth Bromley (25:42):

I mean, there are a couple of findings that were really very profound to consider with the team in reflecting on what they'd achieved. The program was very successful at moving individuals who had been homeless for long periods of time into a safer context.

Dr. Elizabeth Bromley (25:59):

So almost 90% of those who had been served by the program were no longer unsheltered after a year, and that's really a substantial degree of success. That's unlike other homeless outreach services in LA County. Nonetheless, about half of those individuals were still in hospital settings at a year. So about half of the individuals still seemed to need intensive inpatient services at about a year out. And that was because there were, in this population, substantial functional deficits, really a degree of functional challenge that I had not encountered in any other service setting. And we can understand that to be very likely due to the trauma of experiencing homelessness, the challenge of untreated psychotic symptoms, the degree of isolation and abandonment that people experience when they have a psychotic experience in they're living on the streets. That might mean that there would be months before individuals were able to bathe independently. It could take many months for individuals to acknowledge that they had been living on the streets, delusional symptoms that persisted for long, long periods of time, many months even after treatment was initiated.

Dr. Elizabeth Bromley (27:16):

And so at a year, the HOME team and all of its clinical partners, inpatient psychiatric staff for instance, all agreed that that individual still needed hospital care. There was the availability of stepping out of that hospital, but all of those entities still felt like inpatient treatment was important for that individual's safety. So that's just a testament to the degree of disability, the degree of challenge that people with very severe mental illnesses have experienced as a result of homelessness.

Dr. Elizabeth Bromley (27:45):

At the same time, the program was successful in reducing the average length of hospital stays. So there was a similar group study quite recently in LA County that showed that usual length of time at a hospital for individuals experiencing homelessness who access a conservatorship, it's about two months longer than what was seen in the Outpatient Conservatorship Program. So the program seemed successful in reducing the average length of inpatient hospital stays back to around an average of three months. Some individuals didn't need to use a hospital. But for those that did, their stays were much, much shorter. But that does suggest there's untapped opportunities to reduce the amount of lock setting use, restricted practices for individuals with severe disabilities.

Dr. Josh Berezin (28:33):

One of the things that I'm struck by is how much coordination and buy-in you really need from aspects of the system that are not always rowing in the same direction. So I'm just wondering, this paper is a bit of a look back, but looking back on the whole process, are there any lessons for academic institutions or municipalities or government agencies that are developing services in what are probably similarly fragmented service settings? What would you say were some of the keys to your success or some pitfalls that you think other places might be able to avoid?

Dr. Elizabeth Bromley (29:20):

Yeah. There are two kinds of answers to that question. The first has to do with institutions and structures of care. One of the things that was very clear from the experience of this team is that hospitals are a critical partner in addressing homelessness and that structured housing settings are also a very important partner, again, for minority of individuals. But for those who need it, that the hospitals are at the table and can play a salutary role in supporting individuals experiencing homelessness is very crucial. It was facilitated in this particular program. But that array of resources sometimes forgets about the need for intensive mental health services on inpatient units, hospitals, and emergency rooms and the key role they play in facilitating solutions to homelessness. So that's the structural level.

Dr. Elizabeth Bromley (30:11):

At the ground level though, for the people doing the work, one of the things that was so critical to success here was that the HOME team includes a large number of very experienced peers who have had lived experience with mental illness or who've had lived experience of homelessness. It needed the engagement of the community in order to build some trust around a process that could address individual's needs in a responsive way. So those individuals were very critical to ensuring that this wasn't about conservatorship, "This wasn't about coercive practices, this wasn't about putting people in hospitals. This was actually about learning the needs of individuals who are highly vulnerable, who had been abandoned by multiple systems over many years. What does that individual need to succeed at this point? How can we make sure they're getting everything they might want and that we're proceeding from what they would prioritize us there first need? Can we start there? And what happens if we're able to engage intensively enough in a way that they need in a person centered manner?"

Dr. Elizabeth Bromley (31:16):

Maybe that ends in something that might entail some practices where their rights are temporarily restricted, maybe it doesn't. They really saw frequently that once they could, in an intensive way, respond to the individual's needs as they were expressing them, they were able to eliminate the need for conservatorship. Or again, as the paper shows, minimize the amount of time that they needed to spend in a lock setting in order to move to safety.

Dr. Josh Berezin (31:41):

So I think we will leave it there for today, but we're obviously looking forward to hearing how things continue to develop. And we just want to thank you so much for joining us today and also for the paper. It's really fascinating read, and I was really happy to hear you be able to explain even more about it. So I encourage everybody to check out the paper.

Dr. Lisa Dixon (32:03):

Yeah, thanks Beth. Thanks, Elizabeth.

Dr. Elizabeth Bromley (32:05):

Thank you. It's such a complicated story, a really important story. Hard to tell it in all of its detail with all the relevant partners that came to the table to do this really well. So thanks for your interest. I'm glad we could discuss that.

Dr. Lisa Dixon (32:18):

Okay, that's it for today. Thanks to Aaron van Dorn for mixing and editing and Demery Jackson for additional production support. We invite you to visit our website, ps.psychiatryonline.org to read the article we discussed in this episode as well as other great research. We also welcome your feedback. Please email us at psjournal@psych.org. I'm Lisa Dixon.

Dr. Josh Berezin (32:42):

I'm Josh Berezin.

Dr. Lisa Dixon (32:43):

Thank you for listening. We'll talk with you next time.

Speaker 4 (32:47):

The Medical Mind podcast recently featured a limited series from the APA's Women Psychiatrist Caucus, in which women's psychiatric leaders from across the country were interviewed about their experiences. One of the interviews featured Dr. Lisa Dixon, editor of Psychiatric Services and cohost of Psychiatric Services from Pages to Practice, another APA Publishing podcast. All of which you can find at psychiatryonline.org/podcasts or wherever you get podcasts.

Speaker 4 (33:10):

The views and opinions expressed in this podcast are those of the individual speakers only and do not necessarily represent those of the American Psychiatric Association. The content of this podcast is provided for general information purposes only and does not offer medical or any other type of professional advice. If you're having a medical emergency, please contact your local emergency response number.