SCSCAP Newsletter 2018

The Southern California Society of Child & Adolescent Psychiatry

PRESIDENT'S LETTER

by Jessica Jeffrey, M.D.

Approximately 20% of children and adolescents within the United States have a behavioral health disorder, but only 20% of those who need help receive treatment. To make matters worse, the average delay between onset of symptoms and treatment is 8–10 years, a tragic time lapse since untreated symptoms may interfere with normal development and decrease quality of life. It is no wonder, then, that improving access to behavioral health services for children and adolescents is a principal objective for the American Academy of Child and Adolescent Psychiatry [AACAP} and the Southern California Society of Child and Adolescent Psychiatry [SCSCAP].

Nationwide, first-line primary care and pediatric providers provide approximately 75% of the behavioral health treatment received by children and adolescents. Young patients with behavioral health symptoms most often present to these settings: behavioral health symptoms account for 15% of chief complaints and inform 50% of presentations. However, pediatric primary care providers may be poorly positioned to provide a high-quality response. Primary care practices are structured to have short appointment times and there is often inadequate reimbursement for behavioral healthcare within primary care settings. In addition, primary care and pediatric providers may have limited specialized training in behavioral health. They report that challenges to accessing child and adolescent psychiatrists for consultation further limits their ability to treat patients.

As child and adolescent psychiatrists, we are able to evaluate and treat only a small proportion of the youth needing our help. In many places there are only a few of us; we face reimbursement challenges relating to insurance and parity issues. In addition, stigma is frequently associated with seeking treatment from a behavioral health provider. With so many children and adolescents in need of our services, how do we extend our reach? One way is to incorporate new models of care delivery, such as integrated behavioral health programs, into our specialty.

In This Issue:

Over the past four years, I've had the privilege and pleasure of working within a pediatric integrated care setting at UCLA Behavioral Health Associates. Such programs have demonstrated a reduction in the negative impact of childhood behavioral health conditions and an improvement in developmentally appropriate functioning. At Behavioral Health Associates, child and adolescent psychiatrists collaborate closely, on-site, with pediatric primary care clinicians, care managers, and other behavioral health clinicians, such as master's level therapists. Our reach is further extended by providing indirect assessment and treatment recommendations to primary care and pediatric providers who consult us. Although pediatric integrated care programs across the country differ in operational details, key features of these programs commonly include providing patient-centered and evidence-based care, the tracking of population health metrics, and the utilization of treatment-to-target principles. Population health metrics, such as the Patient Health Questionnaire-9, given during evaluation and follow-up appointments, are systematically tracked through a registry system. Through the use of psychometrically validated rating scales for multiple symptom domains, behavioral healthcare is delivered in a way that is measurement-based and the treatment plan is adjusted to achieve symptom remission.

The role of the child and adolescent psychiatrist within an integrated behavioral health team can be challenging. It represents a paradigm shift from traditional outpatient psychiatric clinical practice. To work effectively within such a setting, we must learn how to collaborate comfortably with an interdisciplinary team and provide indirect consultation. We need to develop familiarity with measurement-based treatment to target principles. I believe that If we cultivate and perfect these skills, we have the opportunity to better serve the populations of children and adolescents that would benefit from our care.

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DACA, DREAMers & Mental Health

by Brandon Ito, M.D.

What is DACA?

The Deferred Action for Childhood Arrivals (DACA) program was established by the Department of Homeland Security on June 15th, 2012, providing undocumented individuals brought to the United States as children, the opportunity to legally remain and work in the U.S. Under DACA, undocumented individuals could apply for "deferred action" status and temporary work authorization if they: 1) were under the age of 31 as of June 15, 2012; 2) came to the U.S. under the age of 16; 3) continuously resided in the U.S. for at least 5 years; 4) enrolled in or graduated from high school or military service; 5) had not been convicted of a felony or significant misdemeanor; and 6) did not pose a threat to national security or public safety. Individuals granted deferred action were required to apply for renewal every two years in order to maintain their active status.

Who are the DREAMERS?

The term "DREAMers" (or Dreamers) loosely refers to individuals brought to the U.S. as undocumented children and relates to a Federal bill known as the Development, Relief, and Education for Alien Minors (DREAM) Act. The DREAM Act was first introduced into Congress in 2001, and numerous iterations have been subsequently reintroduced over the years, but never passed. The eligibility criteria of the DREAM Act were later used in the creation of DACA under the Obama Administration, however, they differ in that unlike the DREAM Act, DACA does not provide DREAMers with a pathway to citizenship.

While the vast majority of DREAMers come from Mexico and other Latin American countries, a smaller number also come from several Asian and African countries. Among DACA recipients, the median age of arrival into the U.S. is 6 years old , and over a quarter of the approximate 800,000 DACA recipients reside within California, with the highest percentage (14 percent) living in the Los Angeles metro area [1, 2].

On September 5th, 2017, the Trump administration rescinded the DACA program and discontinued processing of both new and renewal applications. In the months following the rescission, it is estimated that hundreds of individuals a day lost their protections and work permits due to expiration, leaving individuals and families uncertain about their future and at sudden risk for deportation. In response, the American Academy of Child & Adolescent Psychiatry released a statement urging Congress to "take immediate action to clarify the right of these individuals who were brought to the United States as children," and to "consider and quickly pass a compassionate legislative response" [3].

In January 2018, a California judge issued an injunction and reinstated the processing of DACA renewal applications, however, new applications are currently still not being accepted. Over the past several months, DACA has become an emotionally charged bargaining tool in political debate, resulting in high levels of uncertainty and stress for in-

dividuals and family members who depend on the program for their employment and education. Additionally, undocumented children and teens at the time of DACA rescission, will continue to be unable to apply for drivers licenses, work permits, or entrance into colleges and higher education until the issue is ultimately resolved.

Stressors inherent to migration have been shown to be individual risk factors for both depressive and anxiety disorders [4]. Children of immigrant families also often experience a number of negative health effects including high rates of poverty, decreased insurance coverage, limited access to mental health services, as well as poorer physical health overall [5].

Studies assessing the impact of DACA have demonstrated a positive effect on mental health for both children and their families. In a retrospective, quasi-experimental study using a nationally representative sample, DACA-eligible individuals were less likely to meet screening criteria for moderate psychological distress and had reductions in psychological distress compared to matched non-eligible individuals following the passage of DACA [6]. Significant decreases in both adjustment and anxiety disorder diagnoses were also seen in the children of DACA recipients, suggesting the potential intergenerational mental health benefits of the program [7]. Protections under DACA were also shown to provide undocumented individuals greater economic stability, increased educational opportunities, improved access to social and economic benefits, and better access medical and mental health services [8].

Since the rescission of DACA, many children and parents are experiencing a heightened degree of stress and anxiety about the security of their families, and facing an uncertain future. It is important for us as mental health providers to consider and assess how state- and Federal-level policies are impacting the health of our patients and families. We must, likewise, also continually work to uphold and promote the ethic of justice, through the ongoing advocacy of fairness, respect, and equity for all.

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A Brand New Adolescent Psychiatric Emergency Room at Harbor–UCLA Medical Center

By Patrick Kelly, M.D. and Marcy Forgey Borlik, M.D.

Child and adolescent psychiatry is facing a crisis. There is a strong national trend toward increased recognition of mental illness in youth, and they and their families are responding by asking for help. Unfortunately, the outpatient psychiatric world is swamped by referrals, and waiting lists are getting longer and longer. Even for the most severely ill youth, inpatient units are failing to keep up with the increased need. The "safety net" for patients in crisis has become the emergency department and national surveys show that emergency physicians feel unprepared to meet the needs of this population.

This growing awareness and increased demand is demonstrated by statistics. In California, although nearly 7 percent of youngsters struggle with a mental disorder severe enough to disrupt daily living, California has fewer than 1,050 child and adolescent psychiatrists to serve more than 9 million youth. Suicide rates in 15–19–year–olds have been climbing since 2007, with suicide now the second leading cause of death in this age group.

In response to this growing need, Harbor–UCLA Medical Center will soon open a new Adolescent Psychiatric Emergency room, one of the few units of its kind in the country and around the world. We hope this new space will substantially improve the patient experience for youth with behavioral and psychiatric emergencies. Beyond the entrance, a sally port, waiting room and evaluation room display a local artist's paintings of downtown Los Angeles, the Vincent Thomas Bridge in San Pedro, and the Manhattan Beach Pier. Adolescents are initially evaluated by psychiatric staff in a large, private interview space with muted lighting and comfortable furniture. After the evaluation, patients will move to colorful rooms with faux skylights, individual recliner chair/beds, and televisions wired centrally to the nursing station which will show both entertaining and educational programming. Soft music will fill the hallways with sounds specifically chosen to provide a feeling of calm and tranquility. For self–expression, the room walls are covered with chalkboard paint, and patients may participate in both recreational and therapeutic groups. A central nursing station enables direct views into the patient rooms, and closed–circuit camera monitoring provides extra security.

Over and above the new space, a priority goal for the new adolescent psychiatric emergency room is to provide higher quality, patient–centered care to adolescents. We plan to implement an evidence–based screening battery for psychiatric symptoms to enhance both the efficiency and comprehensiveness of the diagnostic evaluation. Using the evaluation results, we will employ targeted psychotherapeutic interventions,

including an evidence–based suicide prevention intervention, to enable the teen and family to return home to continue with outpatient care when possible and, for those who will ultimately require transfer to a psychiatric hospital, to begin the therapeutic process. This relatively novel approach to using an emergency visit for therapeutic intervention, as opposed to simply acute stabilization and triage, aims to empower patients and families to maintain stability in the community when possible, avoiding unnecessary hospitalizations. In addition, we aspire to implement a psychotherapeutic milieu approach to better support staff in their provision of care for these children and adolescents with a goal of improving safety for patients and staff as well as fostering well–being for those working with this high–acuity population.

Harbor–UCLA is excited to establish itself as a leader in the emergency psychiatric care of adolescents with the opening of our new adolescent psychiatric emergency facility. In addition to the provision of high quality patient–centered care and the enhancements to patient/staff safety and wellbeing described above, we plan to elevate the educational experience of students, residents, and fellows and to continuously innovate through research and quality improvement endeavors. As co–directors of the new adolescent psychiatric emergency room, we are hopeful that our program at Harbor–UCLA will ultimately serve as a model of emergency psychiatric care locally, regionally, and nationally.

AACAP
65th Annual Meeting
October 22-27, 2018
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Be sure to register early to attend all of your preferred events.

AACAP.ORG

SCSCAP ANNUAL SPEAKER MEETING

By Ara Anspikian, M.D.

The SCSCAP Speaker meeting was held this year at The Olympic Collection located in West Los Angeles on Saturday March 11th. Continuing Medical Education credits were provided by the Los Angeles County Department of Mental Health. The California State Advocacy Update on Child and Adolescent Mental Health was prepared and presented by Melissa Immel, the Legislative Advocate for CALACAP. Some of the highlights of her presentation included comments about the 2018 California gubernatorial election, which will be held in November. The incumbent Democratic Governor Jerry Brown will be ineligible to run. The key declared candidates include Gavin Newsom (Lieutenant Governor of California), Antonio Villaraigosa (Former Mayor of Los Angeles), and John Chiang (California State Treasurer). A total of 2319 bills were introduced for 2018 with some additional carry over bills from the previous year. Some of the priority issues include tackling homelessness, managing the opioid crisis, oversight of Proposition 63's Mental Health Services Act funds and the possible allocation of these funds to childhood trauma, early onset psychosis and early intervention services. A cannabis related bill proposes support for afterschool programs by using proposition 64 funds intended for prevention of youth substance use. Another cannabis bill seeks to prohibit online and app-based advertising and marketing of cannabis and cannabis related products targeting children and youth under the age of 18. The state budget for 2019 sits at 190 billion dollars in proposed spending with a tentative surplus of 6 billion dollars.

Cal-ACAP delegate, William Arroyo, M.D.; Cal-ACAP lobbyist, Melissa Immel; and Cal-ACAP president, Hanu Damerla, M.D. address the attendees at the SCSCAP Annual Speaker Meeting on March 11th, 2018.

Doctors Bill Arroyo and Hanu Dermerla along with Melissa Immel led a riveting discussion about the possibility of establishing a Political Action Committee (PAC) for CALACAP and about the current issues confronting child and adolescent psychiatrists. In regards to the consideration of establishing a PAC for CALACAP the ROCAPS (Northern, Southern, Central, and San Diego) are discussing the merits of establishing a political action committee and are seeking feedback from the membership.

The headline speaker for the meeting was Praveen Kambam, M.D., a clinical and forensic psychiatrist who is a board certified in forensic psychiatry, general psychiatry, child and adolescent psychiatry and addiction medicine. He is an Assistant Clinical Professor at UCLA and has given numerous presentations at regional and national medical and pop culture conferences. His talk

was titled "From Pitfalls to Possibilities: Professional Considerations in Social Media and Child/Adolescent Psychiatry." Dr. Kambam was an engaging speaker who adeptly led the attendees to a better understanding of social media and the different social media platforms, the potential positive and negative effects of social media on the mental health of children and adolescents, and social media's professional considerations including ethical and legal implications. Dr. Kamban reviewed a survey of social media use, which indicated that 92% of teenagers were daily users of some form of social media. Potential negatives include damage to romantic relationships, self-esteem, mood and body image, along with the risk for contagion effects for risky behaviors (self-harm, suicide, etc.).

Potential positives include increased peer support, socialization and normalization/acceptance. He expanded about the psychological and legal aspects of sexting and cyberbullying. Dr. Kambam provided resources for families regarding social media use of their children and professional guidelines for social media use. The challenges clinicians experience in regards to availability of information about patients' online, social media boundaries with patients and the issue of clinician self-disclosure online were discussed. Finally, Dr. Kambam outlined the potential interventions for mental illness that can be implemented on social media. The topic of the meeting was timely, practical and informative. It stimulated a critical assessment of a clinician's knowledge and personal use of social media along with increasing awareness regarding the potential negative and positive aspects of the multiple avenues of available social media.

Our speaker, Praveen Kambam, M.D. at the SCSCAP Speaker Meeting - ***'From Pitfalls to Possibilities: Professional Considerations in Social Media and Child/Adolescent Psychiatry'*** *- March 11th, 2018*

Attachment Vitamins: Bolstering Secure Attachment Between Infants and Mothers Who Suffer from Perinatal Depression in the Newly Established UCLA Perinatal Partial Hospitalization Program

by Misty Richards, M.D.

It is estimated that one in seven new mothers suffer from postpartum depression in the United States. In California, approximately 20% of women giving birth in 2013 experienced either prenatal or postpartum depression. Zooming in even more, a survey of Los Angeles Public Health Maternal, Child & Adolescent Health Programs in 2014 found that 10% of mothers reported symptoms of depression before pregnancy, 26.1% during pregnancy, and, surprisingly, 47% after pregnancy. The fact that close to half of new mothers in Los Angeles County are battling depressive symptoms during this critical window for infant–mother attachment is concerning on multiple levels. If a mother is struggling to take care of herself, how is she to embrace this new role where she is tasked with caring for another human being?

The UCLA Perinatal Partial Hospitalization Program opened its doors in February 2017 to address this need. This program is multi–disciplinary in that child and adult psychiatrists, nursing staff, social workers, obstetricians and therapists work closely together to serve the perinatal mental health needs of the community. While women present with a variety of psychiatric diagnoses, the most common diagnosis – as reflected in the aforementioned Los Angeles survey – is severe postpartum depression. Interestingly, the greatest predictor of postpartum depression is depression during pregnancy, stressing the need for catching and treating symptoms early.

New mothers suffering from untreated depression experience life through a warped, cloudy, dark lens. Neurovegetative features of depression are exacerbated by profound hormonal shifts, new anxiety from the steep learning curve of becoming a parent, and a plethora of opportunities to feel inadequate and incapable in this new role. The UCLA Perinatal Partial Hospitalization Program appreciates the complexity of this struggle through creating biopsychosocial formulations for each patient designed to meet them where they are. Through this comprehensive approach, the goal is to truly understand the biological and environmental contributors to symptom manifestation.

As child and adolescent psychiatrists, we care deeply about prevention of mental illness and early intervention. As such, intervening and treating maternal depression represents one of the earliest opportunities to facilitate healthy development of infants and young children. Through bolstering the attachment relationship, optimal development occurs. Evidence shows that children whose parents have depression are at higher risk of depression themselves, with symptoms often occurring earlier and presenting as more severe. Maternal depression can also affect the quality of interaction between mother and infant, leading to more maladaptive attachment styles. In the UCLA Perinatal Partial Hospitalization Program, multiple groups are conducted each day

that focus on infant development, the complex role of becoming a mother, the different types of attachment and how to work towards secure attachment, and mentalization techniques tailored to the perinatal population. In addition to diagnosing and treating psychiatric illness in mothers, the Program prides itself in providing "attachment vitamins" to the mother-infant dyad through psychoeducation and creating a circle of security. It is the ultimate goal of the Program to aggressively treat maternal mental illness while helping to build a solid foundation for healthy family development.

If interested in referring patients, please contact Misty Richards, M.D., M.S. at mcrichards@mednet.ucla.edu. Thank you.

Dr. Jeffrey presents award of appreciation to past president, Shivani Chopra, M.D. at the SCSCAP Annual Brunch - August 2017

Putting a Spring Back in Your Step: Renewing Physician Engagement

Cassidy Zanko, M.D.

As early as I can remember, my father made clear his greatest wishes for my life: good health, happiness and to always have a spring in my step. A spring in my step? Why would that make his list? This was unclear to me until experiencing first hand the heavy steps of exhaustion that affect 50% of medical students, 40–70% of medical residents and greater than 54% of U.S. physicians.1,2,3,4 This emotional exhaustion, along with symptoms of depersonalization and cynicism, characterize the state of burnout that has reached crisis levels within the medical profession.1,2,3,4

Many physicians enter medical school with spring-step energy and meaningful intentions propelling them forward. In fact, medical students matriculate with better well-being than their age-group peers.5 But a shift in balance early on causes this to reverse, and this reversal persists into residency and practice.1,5 The state of burnout that results appears due to both intrinsic factors (e.g. personality characteristics) and extrinsic factors (e.g. EHR requirements), with consequences spanning personal and professional lines, including depression, broken relationships, substance abuse and reduced quality of care, with more medical errors and increased physician turnover.4 Tragically, an estimated 300–400 physicians die from suicide each year – approximately the size of an entire medical school.6

Knowing these negative effects, how do we rediscover purpose and engagement as physicians? From a system wide perspective,

current research and well–being coalitions are identifying extrinsic factor changes that, unfortunately, take time to implement. However, from an individual perspective, there are changes we can implement right now. Throughout my last 10 years of training, I have personally benefitted from resiliency strategies, and shared them through wellness curricula to fellow trainees as a Chief Resident. My recent experience running a 10K encapsulates many of these strategies and demonstrates what Dr. Mamta Gautam has called the Five C's of Physician Resilience:7

1. Commitment – Admittedly, I was ill prepared for three miles of the 10K going straight up hill. I found myself agonizing, "Why am I here? Why did I sign up for this!?" Thankfully, I found motivation in remembering: I was there to challenge my body and mind; I was there for the pleasure of exercise; I was there for FUN! I re–committed to the trail and gained a second wind. Having self–awareness to pause and answer these same questions about what drew you to medicine and what gives your work meaning may be the most important of the 5 C's.8 A 10k is not necessary; journaling or narrative medicine will suffice.

2. Connection – External motivators were imperative for completing my race. While my partner was supportive, he was ahead of me and out of sight. So strangers became friends along the path through exchanged smiles and supportive words of encouragement. In medicine, developing a community with caring, positive, respectful relationships, especially mentors, is essential to coping with experiences we endure (both the joys and the sorrows). And as above, partners are important, but establishing trust and support in the workplace are vital for prevention of burnout.

3. Control – I noticed during mile two that I was not performing as well as I had in my previous half marathon. I blamed poor training and doubted I would finish the race, allowing multiple "should haves" to flood my mind. Hold on! Those thoughts were utterly unhelpful mid–race. Many physicians suffer from this triad of compulsiveness9 (what I call the "nervous superhero"): exaggerated sense of responsibility, guilt and doubt. This compulsive complex gets in our way and we often misjudge what we can control. Instead, defining our values (e.g. health) and priorities (e.g. fitness) allows us to intentionally set appropriate boundaries personally and professionally – now THAT is control.

4. Calmness – My favorite aspects of running are the mind–clearing rhythm, power in breathing, and awareness of surroundings. The moment I feel anxious running, my body falls out of sync until I re–focus my rhythmic breath awareness. This is also true when feeling anxious, rushed or losing focus in medicine – our actions fall out of sync with our intentions. Recognizing when you are not calm and honing skills to reduce stress and reclaim your rhythm, allows you to control the pace of your life. Find your path to calm and practice it daily.

5. Care for self – Finally, 10K complete! And immediately I feel discomfort in my hamstring. In the past, injuries have infuriated me since exercise is supposed to be good for the body. But over years of being active,

I have developed a system my body requires using balance, moderation and time for healing. Self–care in medicine requires respect for your limits as well as awareness of what brings you joy. Notice bad habits – these are not just behaviors we start, they are also routines we stop. Always take that vacation and set aside time for you – whether it's a week in Hawaii or 20 minutes of music. And, challenge yourself to plan your next self–care before you leave the one you are in – balance requires scheduling on both ends.

Well, there you have it – how to prevent burnout and maintain wellness! We wish! Clearly, there is significant work required to impact change in our medical system – organizationally and nationally. However, as physicians, we cannot afford to wait. So with my father's words ringing in my mind, my wish is that the strategies above ignite a spring back in your steps, propelling you in the direction of good health, happiness and renewed engagement.

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Parkland's Warning: A Reminder of the Professional Duty to Protect

By Caroline Wiita and Patrick G. Wiita, M.D.

Nikolas Cruz's red flags started waving in 2013, when he averaged three disciplinary incidents per month while in middle school. The next few years would be punctuated by more flags such as when his mother reported his violence to the sheriff's department, when he declared in a YouTube comment his intention to become a "professional school shooter," and when the FBI received a tip from a caller worried about Cruz "getting into a school and just shooting the place up." Ultimately, Cruz would walk into Marjory Stoneman Douglas High School and murder 17 students and faculty with an AR-15.

Patrick Wiita, M.D. at the SCSCAP Annual Brunch - August 2017

Well-publicized tragic incidents like this can effectively turn up the volume on fears that normally live as whispers in the mind of a child psychiatrist who may wonder whether or not his/her own patient might end up being a school shooter.

Having had this thought, a psychiatrist is ethically obligated to assess the risk for future violence. This is where many of us, despite the better angels of our nature, desperately hope that our patients don't disclose anything that might warrant a legally-mandated response, such as fulfilling a Tarasoff duty to protect and/or warn.

However, we hope psychiatrists feel empowered to perform a risk assessment on appropriate patients despite such risk. Fulfilling one's duties under Tarasoff is intended to protect both clinicians and patients from future potential harm. On the one hand, a clinician who complies with state law and competent medical care by proactively assessing risk in vulnerable patients diminishes potential future liability; on the other, a clinician can potentially protect a client from more grievous outcomes, such as the ramifications of violent behavior at school or in the community.

It is important to remember that the current state of the law with respect to Tarasoff is that, in California there is no longer a duty to warn, only a duty to protect foreseeable victims. A protective action under Tarasoff can be manifested as modification of the patient's treatment plan, perhaps including inpatient hospitalization. That being said, both warning potential victims and notifying, for example, law enforcement, provides immunity from liability. While an academic argument may be made that it is not necessary to obtain immunity in order to avoid liability, it is in general the most prudent course of action to warn potential

victims and police, obtaining both immunity for the therapist and, hopefully, protection for the potential victim (http://jaapl.org/content/42/1/101.long). Therefore, if you have a patient who exhibits a non–zero chance of becoming violent, performing an evidence–based risk assessment on such a patient is advisable.

Moreover, taking action under the Tarasoff construct early and in a proactive fashion affords a measure of control over the therapeutic conditions of the protective actions. This could mean the difference between hospitalization and incarceration. If you backburner your concerns, you risk not only jeopardizing safety of society at large, you also lose the opportunity to stage a therapeutic intervention for your patient, possibly leading to more strictly punitive consequences in the case of a completed violent act.

Bearing in mind the benefits both to clinician and patient, it is imperative to not shy away from assessing risk in those vulnerable. This can include screening for significant risk factors, such as those outlined in this Facts for Families Guide on Violent Behavior in Children and Adolescents published by the American Academy of Child and Adolescent Psychiatry. Ultimately, it is within the clinician's purview to determine whether a patient communicates a "serious threat of physical violence against a reasonably identifiable victim or victims" (Cal. Civ. Code § 43.92 [2013]). Asking these hard questions may not be enough to prevent a school shooting, but not asking the questions abdicates clinical responsibility and abandons our patients.

New Center for Psychoanalysis (NCP) Child and Adolescent Clinic Low Fee Child Psychoanalytic Treatment in Los Angeles

By Susan Donner, M.D.

Los Angeles has had a long history of low fee psychotherapy for children and families through child psychoanalytic clinics, including Reiss–Davis Child Study Center, the Graduate Center for Psychotherapy and Child Development, Thalians Mental Health Center and Los Angeles Child Development Center (LACDC), which provided treatment through the support of Los Angeles area psychoanalysts, psychoanalytic institutes, and philanthropic donors and organizations. Many child psychoanalytic candidates were able to gain unmatched clinical experience under the guidance of prominent child and adolescent psychiatrists who were also psychoanalytic supervisors such as Saul Brown, Rudolf Ekstein, Hanna Fenichel, Seymour Friedman, Howard Hansen, Stan Leiken, Rocco Motto, Morton Shane, Heiman Van Dam, Frank Williams and Miriam Williams, among others.

The need for well–informed, developmentally thoughtful, effective treatment for young patients and their families has never been greater and yet the treatment options have narrowed. The Lucille Packard Foundation for Children's Health recently reported that 21% of California youth ages 12– 17 reported needing help for emotional or mental health problems but only 35% of those reported receiving counseling. With more than 12 million people today, Los Angeles is multi–cultural, multi–lingual and growing rapidly beyond the capabilities of its social services and sup–

port resources. Lower income families tend to receive a patchwork of health care services, specifically in mental health, through publicly funded sources that are often insufficiently coordinated to address the complex clinical, developmental, educational and familial stresses, traumas and conditions of these children and their caregivers. Cases that need more sustained intervention often have multigenerational histories of attachment difficulties, traumatic histories and/or complex medical and psychiatric conditions. Furthermore, less affluent families, often recent immigrants, lack a network of referrals beyond their schools to be able to access more comprehensive treatment modalities at affordable fees. Psychoanalytically informed clinic settings, like Valley Community Clinic, Maple Center and Reiss-Davis, struggle to keep up with the demand of patients who need to be seen multiple times per week.

In the fall of 2017, the New Center for Psychoanalysis (NCP) opened the Child and Adolescent Clinic for psychoanalytically informed interventions for infants, children and adolescents and their families, spanning ages 0–21. It is a "clinic without walls," built on the model of Miriam Williams' LACDC where NCP's child and adolescent clinical associates, all with terminal degrees and pursuing postgraduate psychoanalytic training, see patients and families in their own offices and receive supervision from experienced child analytic supervisors. Our students and faculty include several bilingual, bicultural mental health practitioners that speak Spanish, Russian, Farsi and French. The geographic spread at this time spans the San Fernando Valley to Newport Beach, Santa Monica to Pasadena with particular concentration in West Los Angeles. Outreach efforts have begun with NCP child faculty and candidates reaching out to school psychologists and staff at public, private and parochial schools in their particular regions to offer consultative services to the staff and parents as well as families identified by the staff.

The NCP child clinic begins to fill the gap for patients with complex clinical situations who need more frequent and more intensive intervention to "restore them to a path of progressive development," the goal of treatment as described by Anna Freud. Integrating contemporary theoretical and technical advances in psychoanalysis is a component of the innovative strategies of this clinic. For instance, newly published psychoanalytic approaches, such as dyadic psychoanalytic treatment for autism spectrum disorder (Sherkow & Harrison, 2013) and infant-parent and child-parent relational psychoanalysis (Salomonsson, 2014), (Clausen, et. al., 2012) (Lieberman, et. al. 2007), which are at the cutting edge of early intervention and prevention in mental health treatment, will be under the guidance of expert supervisors, both inside and outside NCP (we have geographic supervisors who are able to provide long distance supervision). Focus on the experience of immigration and acculturation is emphasized through the incorporation of the work of Salman Akhtar (Akhtar, 2010). Attention to emerging theory and clinical techniques with regard to gender and sexual development and identity is another important component of the clinic. Furthermore, integration of developmental psychoanalysis, that is, the weaving together of evolving neurobiological findings to inform psychological and other interventions is another novel element (Nolte, et. al., 2010). Children with a wide variety of diagnoses and conditions, including posttraumatic stress disorder, anxiety and depressive states,

psychosomatic disorders, eating disorders, developmental delays as well as attentional, learning and disruptive disorders are addressed with individualized attention to their and their families' particular history and circumstances.

Literature in this field is increasingly demonstrating evidence that psychoanalytic interventions are effective, although prospective studies in children are lagging. Anecdotal case reports describe dramatic changes beyond symptom relief and different developmental trajectories for the child and family than would otherwise be possible. As a result, one of the objectives of the clinic is to collect data and measure outcomes with the intention to investigate the results and efficacy of child and adolescent psychoanalytic treatment, including questions of therapeutic action and clinician effectiveness. The clinical and research efforts are being supported through grants, donations and NCP support since public funding and insurance reimbursement in the current political environment is not reliably available.

For more information, please see the link to the clinic on the NCP website, https://www.n-c-p.org/therapy-for-children-and-adolescents.html. For questions about referrals, the clinic or child analytic training, please contact Susan Donner, M.D. at childclinic@n-c-p.org or (310) 478-6541, Ext. 13.

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The SCSCAP Annual Brunch will be held in late August / early September.
Stay Tuned for Details

SCPS / SCSCAP JOINT MEETING

Presentation by Derek Ott, M.D.
Complimentary and Alternative Medicine

By Andrea Carter, M.D.

On November 2, 2017, Dr. William Arroyo generously opened his home to host the SCPS & SCSCAP joint meeting. Approximately 40 people attended the dinner talk on Complementary and Alternative Medicine (CAM) in Psychiatry, by Dr. Derek Ott, Assistant Clinical Professor and Director of the Pediatric Neuropsychiatry Clinic at UCLA.

Dr. Ott provided an excellent overview of various treatments in psychiatry that are not considered mainstream, reminding us that while many patients use supplements, a smaller proportion have discussed this with their physician. Attendees were encouraged to ask patients about CAMs given related safety issues, to enhance the therapeutic alliance, and as a way to potentially reduce use / side effects of other psychotropics. There is now a large body of information regarding various available products (see http://www.consumerlab.com), and the acronym SECS (safe, easy, cheap and sensible) can be helpful in identifying useful CAMs.

Dr. Ott summarized the research on omega 3s / fish oil use in psychiatry. Studies vary widely in their use of EPA vs. DHA or a combination of these, as well as dose / duration studied. DHA is thought perhaps to offer more benefit for memory, and EPA for mood/behavior. Most evidence supports doses of 1–2 grams daily. In summary, there is some evidence to support omega 3s as an adjunctive therapy for depression but limited support for monotherapy, mixed results for post–partum / prenatal depression, limited studies but some support for depression in children, and support as an adjunctive treatment in ADHD. Lavazza and Vayarin are FDA approved formulations.

Selected additional supplements discussed included: evening primrose oil (for PMS / arthritis, allergic dermatitis, diabetic neuropathy), GABA (for anxiety), L theanine (for calming, perhaps learning and memory), tryptophan / 5–HTP (for depression and insomnia), melatonin (for insomnia, jet lag, work–shift sleep disorder), N–acetyl–cysteine (NAC, for repetitive behaviors), inositol (for OCD), and St. John's Wort (for depression).

Many thanks to Dr. Arroyo for hosting, and to Dr. Ott for an engaging, practical talk and lively discussion!

UCLA Hosts 2018 Annual Klingenstein Third Generation Foundation (KTGF) National Conference

By Michael Enenbach, M.D.

In February, UCLA hosted approximately 100 medical students and mentors for the annual KTGF conference February 9th–11th, 2018. KTGF is an organization that encourages medical students to enter the field of child and adolescent psychiatry. AACAP supports the organization in coordination of activities and assisting host sites with their individual programs. Medical schools from across the country, from UCLA, UCD and Stanford in California to programs in the Midwest and northeast participated.

The event kicked off with a welcome reception and dinner at the W hotel in Westwood on Friday night. The conference took place on Saturday and involved student presentations of research activities, various team building games, and two keynote speakers, including Dr. Scott Hunter, a current addiction fellow at UCLA. He spoke on his own path through the KTGF mentorship program and how instrumental it was in his career decision and development.

Overall, the conference went off without a hitch, and a fantastic time was had by everyone who descended on Westwood for the weekend. Medical students interested in child and adolescent psychiatry can contact me at menenbach@mednet.ucla.edu to learn more about the program. Stanford will host the 2019 Conference February 8th–10th in Palo Alto, California.

GOVERNMENT AFFAIRS UPDATE

By William Arroyo, M.D.

While the rhetoric of "repeal and replace" the Affordable Care Act (ACA) has diminished considerably in 2018 after the failure of multiple attempts to do so, there remains a low grade effort as demonstrated by two issues: (1) the availability of short term health plans which although is very inexpensive, the "essential healthcare benefits" are not included and mental health and substance use disorder benefits can vary considerably and (2) the federal subsidies provided to the new health plans which are part of the states' insurance exchanges were not included in the recent two year $1.3 billion Omnibus bill thereby potentially destabilizing the individual health plan insurance industry. In December of 2017, the federal tax bill eliminated the individual mandate to have insurance thereby undermining the intent of the ACA.

Another major area of concern among many child and adolescent psychiatrists is the plight of those who are directly impacted by the Deferred Action for Childhood Arrivals (DACA). Members of the DACA population are at increased risk for severe stress. President Trump appears to be disinclined at this time to not reach a reasonable approach to this population with Congress.

On the state level, there have been several new developments. We are in an election year. Governor Brown is in the last year of his term. Four legislators have resigned and one is on leave. The governor's race is just beginning to heat up. The California Academy of Child and Adolescent Psychiatry (CALACAP) is planning to meet with the winners of the primary during early summer to identify the current interests and concerns of child and adolescent psychiatrists (CAP's).

The deadline for the introduction of new bills was February 16. A slew of new bills have been introduced; they total just over 2300 from both houses of the state legislature, many of which relate to mental health. A proposed budget by the Governor was released in January with a total just above $190 billion which includes $13.5 for a Rainy Day fund; the Governor's revised budget will be released in May after which the state legislature will deliberate and finalize it.

Proposition 64 , Adult Use Marijuana Act (AUMA), is beginning to generate revenue and not unlike with Proposition 63, Mental Health Services Act (MHSA), there is an emerging interest on the part of various organizations, state legislature, and a myriad of stakeholders to divert this new source of revenue and which is reflected in multiple bills introduced this year. In addition to the revenue, there is an emerging interest on the part of children's health advocates, including mental health, about the safeguards in AUMA relevant to children. Some were included in AUMA and the newly established state Bureau of Cannabis Control in addition to the Department of Public Health are developing several new safeguards relevant to children.

CALACAP has identified several priorities for this year which include homelessness, SUD treatment and opioid crisis, cannabis, mental health workforce issues, "grave disability"

as defined in the Lanterman–Petris–Short (LPS) Act, and county contracting (for mental health services). Some of the bills that CALACAP is closely following include SB 918 (Weiner) which would establish a state level Office of Youth Homelessness; AB 2328 (Nazarian) which would mandate the establishment of an entire continuum of care for treatment of SUD in youth; SB 1004 (Weiner) which would mandate that counties use their MHSA funds to support early detection of psychosis and mood disorders, college mental health services, and childhood trauma; AB 2018 (Maienshein) which would encourage trainees to work in public sector with loan forgiveness strategies being implemented immediately; AB 2143 (Caballero) would expand access to mental health services through loan forgiveness specifically for physicians assistants and nurse practitioners who are pursuing a career in mental health; AB 1971 (Santiago and Friedman) which would amend the definition of "grave disability" in LPS law so that psychiatrists would have to consider the need for medical services when considering involuntary care; AB 1744 (McCarty) which would expand substance use disorder prevention services and improve school attendance targeting high school students; AB 3067 (Chau) which would improve safeguards related to the marketing and sale of cannabis to youth; SB 1125 (Atkins) which would allow for additional billing for mental services under the Medicaid program; among others. AB 3087 (Kalra) is a very clumsy attempt to rein in medical costs and expand access by establishing a commission which would set all healthcare costs; it would exclude physicians from membership on commission. AB 3087 does not raise Medi–Cal rates which are abysmally low despite the proponents claim that it would expand access to care.

And, finally, but not least of all, is the consideration by CALACAP to assist in the launching of a political action committee (PAC) to enhance the efforts of organized child and adolescent psychiatry in Sacramento. The PAC, if formed, would provide campaign contributions to those legislators who support the policy agenda of CALACAP. Each of the Regional Organization of Child and Adolescent Psychiatry (ROCAP) Councils (Southern California, Northern California, San Diego and Central California) have been asked to discuss their interests in supporting the formation of ad PAC. Such an effort would require voluntary contributions by child and adolescent psychiatrists in order to sustain a PAC; such contributions would be distinct from membership dues (AACAP, SCSCAP and CALACAP) and, by law, these monies cannot be co–mingled with those of membership dues. At a recent SCSCAP CME meeting on March 11 where this possibility was discussed, there appeared to be a lot of support for this among the attendees. CALACAP will continue to encourage discussions among the other three ROCAP's throughout the next year and then embark on making a decision. If you have any thoughts on this, please send comments to CALACAP at Melissa@shawyoderantwih.com.

CALACAP is very indebted to the policy advocacy group of Shaw, Yoder and Antwih and, especially, Melissa Immel, from the group for their assistance in providing a voice for child and adolescent psychiatry in the state capitol.