SCSCAP Newsletter 2024

The Southern California Society of Child & Adolescent Psychiatry

PRESIDENT'S COLUMN: *"Create the things you wish existed."*

By Misty Richards, MD, MS, SCSCAP President

This quote hangs in the center of my home, as a reminder that life is full of hope, possibility, and wonder. I find myself reflecting on this quote more often these days, as deep societal fault lines have been unearthed in the post-pandemic era. Many of these fractures impact children and their families in profound ways, contributing to the rising rates of childhood suicide and depression in this country. During difficult times like these, I feel tremendous gratitude and appreciation for the Southern California Society of Child and Adolescent Psychiatry (SCSCAP). Together, we grapple with the challenges of practicing child and adolescent psychiatry while dreaming of ways to remodel broken systems and practices to benefit our littlest patients. It has been an absolute honor to work closely with the talented SCSCAP Executive Council and the ever-helpful SCSCAP Executive Administrator, Tim Thelen, this year in my role as SCSCAP President. Our collective goal is to keep our finger on the pulse of issues impacting child and adolescent psychiatry (CAP) and to present opportunities to learn more about these issues to advocate for change.

The essence of this SCSCAP year can be distilled into one word: *connection*. Connection to our community, connection to our patients and families, and connection to ourselves. We continue to host three meetings every year for members, starting off with the SCSCAP Annual Meeting and Luncheon in the fall. We were delighted to welcome Dr. Lisa Fortuna, Chair of the Department of Psychiatry and Neuroscience at UC Riverside, who presented a thought-provoking talk titled, *"The Landscape of School-Based Mental Health Services: Cultivating Health Equity with Students, Families & Communities."* Following this, for our joint SCSCAP/SCPS meeting, Dr. John Torous who serves as Director of the Division of Digital Psychiatry at Beth Israel Deaconess Medical Center, presented an innovative virtual talk on *"Developments in AI Technology and its Impact on Psychiatry."* Finally, for our 2024 Speaker Meeting, the dynamic Dr. Susan Swick who is the Executive Director of Ohana (a center for child and adolescent behavioral health at the Community Hospital of the Monterey Peninsula) gave a public-health informed talk called *"Stone Soup: Engaging the Community in Youth Mental Health."* From school-based mental health services, to artificial intelligence, to building a center for child and adolescent mental health services from the ground up, all three of these presentations focus on the power and momentum that come with connection. If we have learned one valuable lesson from the COVID pandemic, it centers on the idea that we are better together and stronger in community.

This newsletter will dive deeper into some of the talks while also highlighting important and current issues in CAP. Articles will feature topics ranging from re-examining ACES through the lens of displaced children to a 4-year proposal for combined general and CAP training to addiction in modern times, focusing on the increasing potency of substances and risk to youth. Two articles from superstar general psychiatry residents (and future child psychiatrists!) are also included, with one discussing the importance of paid parental leave and its impact on mental health outcomes of children and families and the other describing a high school intervention to address mental health literacy in BIPOC youth. Importantly, readers will learn more about our four Underrepresented in Medicine (URiM) Grant recipients (all CAP fellows), who share a bit about their personal journey and how

they utilized SCSCAP-sponsored funds to support their travel and participation at the 2023 AACAP Annual Meeting in NYC. We are particularly grateful for the perspectives of our trainee authors, who are often in the trenches and managing some of the most complex pediatric mental health cases. We appreciate their unwavering dedication to not only learn child and adolescent psychiatry, but to make our practice even better. One way to show appreciation for our beloved CAP fellows is to gift an annual membership to AACAP/SCSCAP to help connect them to mentors and a like-minded community. Several CAP training programs are already engaged in this practice, including UCLA and Loma Linda University, which has helped recruit the next generation of local child psychiatry leaders. **If you are involved in CAP training program leadership and would like to learn more about this gifting opportunity, please reach out to us at scscap@gmail.com.**

In concluding these remarks and thinking about the collective passion of our SCSCAP community, I am hopeful about the future of children's mental health. May you all reconnect to yourselves, others, and humanity and create the things you wish existed in this world. (And have a little fun along the way too!)

These articles are solely the opinions of the authors. SCSCAP does not endorse them.

In This Issue:

President's Column

A Proposed 4-Year Combined Training Program of General Psychiatry and Child and Adolescent Psychiatry: Opportunities and Cautions

Addiction in Modern Times: How the Increasing Potency of Substances and Social Media Compound Adolescent Risks

Re-Examining ACE's Through the Lens of Displaced Children

Addressing Mental Health Literacy in BIPOC Youth Living in Under-Resourced Communities: A Pilot Peer Health Leader High School Intervention

SCSCAP Annual Meeting and Interview with Dr. Lisa Fortuna

Support at the Tap of a Finger: California's New Virtual Mental Health Services

Artificial Intelligence in Psychiatry: An Interview with Dr. John Torous

Designing A Cognitive Behavioral Intervention for Anti-hate Training in Psychiatry Using Web-based Technology

Paid Parental Leave: A Policy to Improve the Mental Health Outcomes of Children and Families

SCSCAP 2023 URiM Grant Recipients at AACAP Annual Meeting NYC

California Academy of Child and Adolescent Psychiatry (CALACAP) – Update

A Proposed 4-Year Combined Training Program of General Psychiatry and Child and Adolescent Psychiatry: Opportunities and Cautions

By Patrick Kelly, MD

The mental health crisis among children and adolescents in the United States has reached epidemic proportions, further exacerbated by the COVID-19 pandemic. In October 2021, the American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Pediatrics, and Children's Hospital Association declared a national emergency in child and adolescent mental health [1]. Despite the growing need for specialized care, there is a severe shortage of child and adolescent psychiatrists (CAPs) in the country. 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].

To address this workforce crisis, multiple organizations including AACAP and AADPRT have joined forces in proposing a potential solution: a 4-year combined training program in both general and child and adolescent psychiatry. The proposed program would allow medical students to match directly into a combined program, completing their training in 4 years instead of the current 5 or 6 years.

Dr. Erica Shoemaker, Chief of Clinical Services at the LAC and USC Department of Child and Adolescent Psychiatry and Associate Program Director for the Child and Adolescent Psychiatry Fellowship, was a foundational member in creating such a proposal. She believes that the 4-year track could attract more medical students to the field by making training more appealing. "For some people, one more year is a point at which they drop off," Dr. Shoemaker explained. "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."

By allowing residents to focus on child and adolescent psychiatry from the start, the program aims to maintain their interest throughout their training and foster a strong professional identity as CAPs. "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 their professional identification really is as people whose focus is working with children and adolescents," Dr. Shoemaker noted.

The current 4-year proposal's curriculum is modeled after existing successful combined residencies, such as Med-Peds and Triple Board programs, which have demonstrated excellent outcomes in terms of board passage rates and quality indicators. Dr. Jeffrey Hunt, Chair of the AACAP Task Force on the Crisis in Recruitment and Professor and Program Director for the Child and Adolescent Psychiatry Fellowship and the Triple Board Program at the Alpert Medical School of Brown University, is working closely with the Accreditation Council for Graduate Medical Education (ACGME) to develop and implement the program. The proposed curriculum would include a mix of primary care, neurology, general psychiatry, and child and adolescent psychiatry rotations, with a focus on competency-based assessments. Innovative features, such as remote didactics provided by a pool of experts across institutions, could help to streamline resources and provide high-quality, standardized education. "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.

However, some experts in the field have raised concerns and cautions about the potential impact of a condensed training program. Dr. Paramjit Joshi, a

leader in child and adolescent psychiatry and the Interim Chair of the Department of Psychiatry and Human Behavior at the University of California, Irvine, expressed mixed feelings about the proposal, which came to her attention in part during her time as Chair of the Board at the American Board of Psychiatry and Neurology. "My question is which part of training you're cutting short to 4 years. Something has to give. And what does give?"

One major concern is the depth and breadth of training in both general and child and adolescent psychiatry. Dr. Joshi argues that even with the current 5-year "fast-track" model, residents already face a significant amount of material to master in both fields. "There is so much crammed in, and there's so much new knowledge to acquire," Dr. Joshi noted. "There are so many new psychotherapies that need to be mastered." Shortening the program further may compromise the residents' ability to master the necessary knowledge and skills to practice independently, particularly in areas such as psychotherapy and family-based interventions.

Another concern is the potential for creating a two-tiered system of CAPs, with those who completed the 4-year program being potentially viewed as less qualified than those who completed the traditional 5 or 6-year programs. "It could create a system of second-class citizens," Dr. Joshi said. "And then what impact does it have, if I'm recruiting a faculty member and I see someone who's had the full training and then someone who hasn't? What might they be lacking?"

The financial and logistical implications of implementing a 4-year combined training program also warrant consideration. Creating a new curriculum and the associated infrastructure would require significant resources. Dr. Joshi raised questions about the impact on institutional funding and buy-in. "If there are now 3 programs [in psychiatry, including a General Residency, a Child and Adolescent Fellowship, and a 4-year track], do we need to now fund 3 separate pools of faculty? Why do they need so many resources?" she asked.

Concerns have also been raised about the potential impact on resident well-being and the ability to accommodate life events, such as starting a family, during the condensed training period. Both Dr. Shoemaker and Dr. Joshi acknowledged the challenges of balancing the intensive training with personal life events. "It can be hard to imagine how someone takes an extended family leave and finishes in 4 years," Dr. Shoemaker said. "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."

Despite these concerns, the increasing popularity of psychiatry among medical students in recent years may offer an alternative solution to the CAP shortage. Dr. Joshi highlighted this positive trend, stating, "Psychiatry has become one of the leading attractive fields for medical students. Here at UCI, psychiatry is either the first or the second best-rated clerkship. Our match results just came out—out of a class of 99, 20 went into family medicine, 15 went into psychiatry."

With a full cohort of applicants and very few unfilled spots in general psychiatry residency programs, this trend could naturally lead to more residents choosing to subspecialize in child and adolescent psychiatry. "The pipeline is full," Dr. Joshi said. "There were only 10 unfilled spots in psychiatry this year in the country. Last year there were, I want to say, 17." The growing interest in child psychiatry among residents has already led to changes in programming, with an increase in the number of programs offering formal "child tracks" in their general training.

As the field of psychiatry continues to evolve and attract more medical students, it is crucial to explore a range of strategies for increasing the number of CAPs and ensuring they receive comprehensive training and support. The proposed 4-year combined training program is one exciting solution, but it is not without its challenges and concerns.

Currently, the 4-year combined training program is in the pilot phase, with a goal of launching in July 2026.

AACAP, led by Dr. Jeffrey Hunt, is working closely with the ACGME through its Advancing Innovation in Residency Education (AIRE) program to develop and implement the program. As the pilot progresses, it will be essential to carefully monitor and evaluate its outcomes, addressing any challenges that arise and making necessary adjustments to ensure the program's success.

The proposed 4-year combined training program in general and child and adolescent psychiatry represents a promising step towards addressing the critical shortage of CAPs in the United States. However, it is important to consider both the potential benefits and the concerns raised by experts in the field, such as Dr. Erica Shoemaker and Dr. Paramjit Joshi. The development of such a program through the AIRE mechanism will provide the necessary oversight to ensure that such an endeavor is thoroughly vetted before generalizing further, if indeed such a next step is indicated. Overall, it is this author's belief that evaluating such innovative approaches to training is the best way to ensure that we are meeting the needs not only of our patients, but our practitioners, our medical students and trainees, and our field.

[1] American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, Children's Hospital Association. A declaration from the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, and Children's Hospital Association. October 2021. Available from: https://www.aacap.org/App_Themes/AACAP/Docs/press/Declaration_ National_Crisis_Oct-2021.pdf

[2] Substance Abuse and Mental Health Services Administration. Behavioral Health Workforce Report. December 28, 2020. Available from: https://www.mamh.org/library/behavioral-health-workforce-report.

SCSCAP EXECUTIVE COUNCIL 2023-2024

Misty Richards, M.D.
President

Sabrina Reed, M.D.
President-elect

Elizabeth Dohrmann, M.D.
Vice President

Anish Dube M.D.
Treasurer

Rishi Parikh, M.D.
Secretary

Mahta Baghoolizadeh, M.D.
ECP Representative

Ed Castelo, M.D.
ECP Representative

Christopher Chamanadjian, M.D.
MIT Representative

Zhijia Liang, M.D.
MIT Representative

Brandon Ito, M.D.
Past President

Patrick Kelly, M.D.
Past President/SCPS Liaison

Preetpal Sandhu, M.D.
Membership Coordinator

Nithya Ravindran, M.D.
Chair, Diversity Committee

Vivien Chan, M.D.
Chair, Orange County Committee

Marcy Borlik, M.D.
CALACAP Delegate

William Arroyo, M.D.
CALACAP Alternate Delegate

Addiction in Modern Times: How the Increasing Potency of Substances and Social Media Compound Adolescent Risks

By Jose Flores, MD, PhD, Child and Adolescent Psychiatry Research Fellow and
Sivabalaji Kaliamurthy, MD

The potency, purity, and concentration of most drugs encountered by US adolescents have increased over the past two decades. In addition, the integration of electronics and social media into the daily lives of adolescents facilitates streamlined access to substances previously out of reach. Thus, the modern drug landscape is more addictive, harmful, lethal, and accessible than ever. Four stark examples are: 1) counterfeit pills containing fentanyl, 2) high-purity methamphetamine, also known as crystal methamphetamine, 3) cannabis with THC concentrations that were unheard of in the past, and 4) e-cigarettes with nicotine salts, resulting in nicotine levels higher than those found in adolescents who regularly smoke conventional cigarettes.

Counterfeit pills with fentanyl: The increasing potency and lethality of opioids among adolescents is now well established after the drug overdose death rate quadrupled from 2019 to 2021.[1] Fentanyl is cheaper to produce and easier to conceal and transport which has led to the widespread prevalence of counterfeit pills. Each pill ranges in price from $2 to $10 dollars, less costly than other substances such as cannabis, making it more accessible to adolescents who find themselves in an environment filled with deception and risking death. In addition, the diversion of controlled substances among adolescents has always been a concern. Medications for common conditions like anxiety, ADHD and pain are readily exchanged among youth. However, the increase in counterfeit drugs means that someone seeking a psychostimulant might be given methamphetamine or those seeking prescription pain medications might unknowingly get fentanyl. Most concerning is the scenario where an adolescent with anxiety but without opioid tolerance might seek out anxiolytics only to encounter a fatal overdose of fentanyl.

Crystal methamphetamine: Methamphetamine has also seen a significant increase in purity and potency. Until around 2005, meth labs used ephedrine, pseudoephedrine, and phenylpropanolamine as precursors. However, the Combat Methamphetamine Epidemic Act of 2005 made these precursors heavily regulated and scarce. Since 2012, methamphetamine producers have reverted to using phenyl-2-propanone (P2P), an older method of synthesis.[2] By 2019, the resulting crystal meth reached a staggering purity of 97.2% and a potency of 97.5%.[3] The high levels of potency significantly increase the risk of addiction for adolescents who encounter this substance.

Cannabis: Due to recent advances in cannabis extraction techniques, and selective breeding of marijuana plants to increase the percentage concentration of delta 9 THC, the average THC percentage available in the market has increased.[4] Some estimates suggest that from the 1960s to 2017, the THC content in marijuana flowers increased from 2% to as much as 28%.[5] Adolescents also prefer using easily concealable cannabis vapes which often contain alternatives to delta 9 THC such as delta 8 THC or delta 10 THC. These products also contain higher concentrations of THC than that found in the marijuana plant. This increases all the risks associated with cannabis use including addiction, mental health concerns, and bodily harm.

Nicotine: Cigarette smoking in youth has declined while e-cigarette use has simultaneously increased. Though federal law prohibits selling tobacco products to people younger than 21, the rate of e-cigarette use continues to be high; in 2021, about 4.5% of adults used e-cigarettes,[6] compared to 11.3% of middle school students and 34% of high school students.[7] These devices are commonly used with e-liquids that have 5% salt nicotine. Policy changes around the sale of e-cigarettes have changed the landscape of devices. Most adolescents now use devices that produce nicotine levels approximately equal to 19 packs of cigarettes per device. Their daily exposure varies depending on how long each device lasts. While e-cigarettes contain fewer toxicants compared to conventional cigarettes, they also result in higher nicotine levels. Nicotine is known to affect critical periods of adolescent brain development through aberrant activation of nicotinic acetylcholine receptors (nACHRs). In addition, nACHRs are key regulators of the mesolimbic dopamine system and multiple brain areas associated with reward processing. As a result, nicotine increases sensitivity and susceptibility to other drugs of abuse.[8] Therefore, even if exclusive use of e-cigarettes in adults reduces exposure to toxicants compared to combustible cigarettes, no safe levels of e-cigarette use exist for adolescents and young adults since their use can impair normal brain development.[9]

Conclusion and recommendations: Given these trends toward more potent substances, a multi-level strategy is essential. At the individual level, child and adolescent psychiatrists and pediatricians should actively educate young patients about the trends in increasing potency as a pressing reality. Such discussions can become brief interventions to promote abstinence or harm reduction. Adolescents who are informed about the varying levels of potency and associated risks will be better equipped to make safer choices. Most adolescents will abstain from substances but for those who do use, they can be empowered to minimize harm by choosing lower potencies and concentrations, a decision more likely to take place when they understand that health risks exist on a continuum. Careful clinical consideration must be given when obtaining substance use history since adolescents might not have complete awareness of all the different substances they are using. We strongly recommend the prescription of Medications for Opioid Use Disorder for adolescents who use opioids, whether exclusively or in conjunction with other substances like methamphetamine, as part of their treatment. Nicotine replacement therapy should be adjusted to account for higher nicotine content. At the family level, providers should educate parents not only about potency trends but also encourage developmentally appropriate supervision of social media use. At societal levels, strict enforcement of regulatory policies is necessary to prevent underage access to these substances, including tightening control on marketing and sales to youth and enhancing the regulation of social media platforms frequented by adolescents. In addition, although multiple pharmacological interventions for substance use disorders have been FDA-approved for adults, only buprenorphine is approved for adolescents aged 16 or older and varenicline for adolescents 17 and older. Thus, it is critical to fund research to discover and approve more interventions for adolescents who use substances. As drugs become more potent, concentrated, harmful, addictive, and deadly, youth direly need their healthcare providers to be well-informed about the current drug landscape and equipped with information and interventions to minimize short-term and long-term harm. As valuable resources, the Drug Enforcement Administration's "One Pill Can Kill" awareness campaign (https://www.dea.gov/onepill) and the Substance Abuse and Mental Health Services Administration's "Talk. TheyHearYou" campaign: (https://www.samhsa.gov/talk-they-hear-you) offers crucial guidance to help families understand these dangers and empower parents and caregivers to talk with children early about alcohol and other drug use.

Note: Other concerning trends that providers should be aware of but were not covered in this essay include the evolving landscape of youth alcohol use between genders, the increasing prevalence of other synthetic drugs (e.g. synthetic cannabinoids), and the adulteration of existing drugs to increase their potency (i.e. the addition of xylazine to the fentanyl

supply).

Works Cited:

1. Friedman J, Godvin M, Shover CL, Gone JP, Hansen H, Schriger DL. Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021. JAMA. 2022;327(14):1398. doi:10.1001/jama.2022.2847

2. Courtney KE, Ray LA. Methamphetamine: An update on epidemiology, pharmacology, clinical phenomenology, and treatment literature. Drug and Alcohol Dependence. 2014;143:11-21. doi:10.1016/j.drugalcdep.2014.08.003

3. Drug Enforcement Administration. 2020 National Drug Threat Assessment (NDTA). https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment_WEB.pdf

4. Freeman TP, Craft S, Wilson J, et al. Changes in delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) concentrations in cannabis over time: systematic review and meta-analysis. Addiction. 2021;116(5):1000-1010. doi:10.1111/add.15253

5. Stuyt E. The Problem with the Current High Potency THC Marijuana from the Perspective of an Addiction Psychiatrist. Mo Med. 2018;115(6):482-486.

6. Cornelius ME, Loretan CG, Jamal A, et al. Tobacco Product Use Among Adults – United States, 2021. MMWR Morb Mortal Wkly Rep. 2023;72(18):475-483. doi:10.15585/mmwr.mm7218a1

7. Gentzke AS, Wang TW, Cornelius M, et al. Tobacco Product Use and Associated Factors Among Middle and High School Students — National Youth Tobacco Survey, United States, 2021. MMWR Surveill Summ. 2022;71(5):1-29. doi:10.15585/mmwr.ss7105a1

8. Yuan M, Cross SJ, Loughlin SE, Leslie FM. N icotine and the adolescent brain. The Journal of Physiology. 2015;593(16):3397-3412. doi:10.1113/JP270492

9. Toll B, Smith T, King B. Nicotine e-cigarettes: considerations for healthcare providers | Nature Medicine. Accessed April 16, 2024. https://www.nature.com/articles/s41591-024-02926-7

Re-Examining ACE's Through the Lens of Displaced Children

By Rubi Luna, M.D., Child and Adolescent Psychiatry Fellow Year 1

It is an era of global crisis migration. Over forty million children have been forcibly displaced from their homes due to civil unrest, violence, and climate disasters around the world.[1] Since 2014, the number of children fleeing violence in Central America and arriving at our southern border has grown significantly. California is the second state in the nation welcoming a growing number of unaccompanied migrant children, and thousands of children released from federal immigration custody have been placed throughout Southern California.[2] Furthermore, new waves of migrants continue to arrive from other world crises, as exemplified by the gradual influx of Ukrainian and Russian students in local school districts like LAUSD.[3]

Unaccompanied youth arriving in the United States are crisis migrants who escaped their home country's large-scale emergencies without their parents.[4] Because of their journey and the circumstances forcing their migration, unaccompanied minors are at high risk of Adverse Childhood Experiences (ACEs). ACEs are associated with stress reactions in children interrupting normal physical and mental development and predisposing youth to chronic health conditions later in life.[5] Substantial evidence suggests that the number, severity, and chronicity of ACEs during childhood are associated with mental health issues including depression, anxiety, substance use disorders, and an array of chronic health conditions in adulthood.[6] However, little is known about how ACEs differ in vulnerable populations, including unaccompanied migrant children.

The original ACE study (1998) examined experiences in a primarily white, middle-class, highly educated sample[7], and largely focused on ACEs that reflected a lack of safety and nurturing care within the family. These measurements, encompassing physical and psychological abuse, neglect, domestic violence, parental mental illness, or incarceration, failed to capture numerous adverse experiences unique to migrant children, including exposure to war, violence, natural disasters, and forced displacement.[8-9] One significant ACE specific to this population is the separation of children from their parents prior to perilous journeys across the border.

As child psychiatrists serving diverse communities in Southern California, it is important to appreciate the unique adversities of displaced children to understand their vulnerability to ACEs before, during and after migration. Evidence suggests that traumatic events like forced parent-child separations may contribute to post-traumatic stress, anxiety, depression, and suicidal ideation among youth. Unaccompanied minors are more likely to witness or experience life-threatening medical problems, physical or sexual assault in their journey to the border.[6] Once in US government custody, where unaccompanied minors remain detained until they are released to sponsors, these children often face uncertain and unsafe living conditions that restrict them from an age-appropriate environment in a critical period of development.[10]

Given ongoing humanitarian crises that will continue to displace children into our communities, we must expand our conceptualization of ACEs through the lived experiences of migrant youth to better understand the impact of their unique ACEs on mental health outcomes. As current and future child psychiatrists, it is critical to call on leaders to support policies to expand mental health services that are welcoming and inclusive of a rising number of displaced children.

References:

1. United Nations Children's Fund, Uprooted. The Growing Crisis for Refugee and Migrant Children, UNICEF, New York, September 2016.

2. U.S. Department of Health & Human Services. (2024, April 1). Unaccompanied Children Released to Sponsors by State. Office of Refugee Resettlement (ORR). https://www.acf.hhs.gov/orr/grant-funding/unaccompanied-children-released-sponsors-state

3. Johnson, H. (2022, March 10). Ukrainian Immigrants in California. Retrieved April 14, 2024, from Public Policy Institute of California website: https://www.ppic.org/blog/ukrainian-immigrants-in-california/.

4. Menjívar, C., & Perreira, K. M. (2019). Undocumented and unaccompanied: children of migration in the European Union and the United States. Journal of Ethnic and Migration Studies, 45(2), 197–217. https://doi.org/10.1080/1369183X.2017.1404255

5. Chapman DP, Dube SR, Anda RF. Adverse childhood events as risk factors for negative mental health outcomes. Pediatric Annals. 2007; 37:359–364.

6. Ertanir, B., Cobb, C.L., Unger, J.B. et al. Crisis Migration Adverse Childhood Events: A New Category of Youth Adversity for Crisis Migrant Children and Adolescents. Res Child Adolesc Psychopathol 51, 1871–1882 (2023). https://doi.org/10.1007/s10802-022-01016-x

7. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. Am J Prev Med. 1998;14(4):245-258. doi: 10.1016/S0749-3797(98)00017-8

8. Flores, G., & Salazar, J. C. (2017). Immigrant Latino children and the limits of questionnaires in capturing adverse childhood events. Pediatrics, 140(5), 10.1542/peds.2017-2842. Article e20172842.

9. Bürgin, D., Anagnostopoulos, D., the Board and Policy Division of ESCAP. et al. Impact of war and forced displacement on children's mental health—multilevel, needs-oriented, and trauma-informed approaches. Eur Child Adolesc Psychiatry 31, 845–853 (2022). https://doi.org/10.1007/s00787-022-01974-z

10. Corona Maioli S, Bhabha J, Wickramage K, Wood LCN, Erragne L, Ortega García O, Burgess R, Digidiki V, Aldridge RW, Devakumar D. International migration of unaccompanied minors: trends, health risks, and legal protection. Lancet Child Adolesc Health. 2021 Dec;5(12):882-895. doi: 10.1016/S2352-4642(21)00194-2

Addressing Mental Health Literacy in BIPOC Youth Living in Under-Resourced Communities: A Pilot Peer Health Leader High School Intervention

By Amira Collison, M.D., (soon-to-be) Child and Adolescent Psychiatry Fellow Year 1

In the United States, 1 in 6 youth aged 6-17 experience a mental disorder each year, however, almost half of these children with a mental health need do not receive treatment[1]. The consequences of unmet mental health needs in youth can be dire, leading to increased risk for chronic absenteeism and academic failure, substance use disorders, juvenile delinquency, suicide, and unemployment in adulthood.[2-4] Now, more than ever, there exists a need to improve access to mental health care, particularly for BIPOC youth who are less likely to receive mental health care services compared to their White counterparts.[5]

A major barrier to timely and equitable mental health care in children and adolescents, particularly from under-resourced communities, is mental health literacy. Schools provide a great opportunity to promote mental health awareness and education given the substantial daytime hours that adolescents spend in this setting. Peer-led mental health initiatives are emerging as an increasingly important mode of delivering health information to youth compared to more traditional adult-led models, given that there is some evidence to suggest that adolescents are more likely to modify their behaviors and attitudes if they receive health messages from similarly aged peers who face similar concerns and pressures.[6] The availability of peers from shared identities and ethnic backgrounds offering mental health information may enhance its acceptability among BIPOC students. Thus, our team developed an academic-community mental health partnership to provide free mental health education to BIPOC peer health leaders across ten high schools in a large, public school district.

The members of our partnership are composed of trainees and faculty in the Psychiatry Department at the University of California Los Angeles (UCLA) and a partnering community-based organization, the Los Angeles Trust for Children's Health (LA Trust) in a large public school district. The LA Trust has developed a peer-to-peer health education program within the school district, called the Student Advisory Boards (SABs). SABs participate in extensive health education trainings and serve as health ambassadors on campus. In recent years, SABs reported wanting to learn additional information on ways to maintain student wellbeing and the mental health challenges impacting their peers.

Our team adapted an existing evidence-based high school mental health literacy curriculum, the Mental Health & High School Curriculum Guide, for use with the SAB peer leaders. As a large, urban school district, with 84% of students identifying as Black or Latinx and over 70% qualifying for free/reduced lunch, we adapted the curriculum guide to be culturally responsive and relevant to this setting. Adaptions of the Guide were primarily manifested through case discussions that reflected the racial, ethnic, and gender diversity of our students, and included topics that SABs voiced as prevalent in their peer communities.

In the pilot year, our team implemented the adapted mental health curriculum with 78 high school peer health leaders across ten high schools in the school district. Students received one hour of mental health training per month during 1 academic school year. The curriculum was delivered by medical students, Psychiatry residents and fellows.

All participating peer leaders at the ten sites were asked to complete an anonymous survey at the beginning and end of the school year. On the post-survey, 93.9% of respondents reported the adapted mental health literacy intervention improved their understanding of mental health and various mental disorders and 96.9% of post-survey respondents indicated they were able to utilize information they learned from the adapted curriculum to talk to their peers about mental health, as indicated by a

strongly agree or agree response.

Our adapted mental health literacy intervention showed promise and highlighted the potential of academic-community partnerships to prepare and mobilize BIPOC peer mental health leaders. Other academic medical institutions should consider this approach for building community partnerships to train peer mental health leaders in their respective communities.

References

1. Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389–391. doi:10.1001/jamapediatrics.2018.5399.

2. Janiri D, Doucet GE, Pompili M, Sani G, Luna B, Brent DA, Frangou S. Risk and protective factors for childhood suicidality: a US population-based study. Lancet Psychiatry. 2020 Apr;7(4):317-326. doi: 10.1016/S2215-0366(20)30049-3. Epub 2020 Mar 12. PMID: 32171431; PMCID: PMC7456815.

3. Hauenstein EJ. Depression in adolescence. J Obstet Gynecol Neonatal Nurs. 2003 Mar-Apr;32(2):239-48. doi: 10.1177/0884217503252133. PMID: 12685676.

4. Yampolskaya, S., & Chuang, E. (2012). Effects of mental health disorders on the risk of juvenile justice system involvement and recidivism among children placed in out-of-home care. American Journal of Orthopsychiatry, 82(4), 585–593.

5. White A, Liburd LC, Coronado F. Addressing Racial and Ethnic Disparities in COVID-19 Among School-Aged Children: Are We Doing Enough? Prev Chronic Dis. 2021 Jun 3;18:E55. doi: 10.5888/pcd18.210084. PMID: 34081577; PMCID: PMC8220967.

6. Dodd, S., Widnall, E., Russell, A.E. et al. School-based peer education interventions to improve health: a global systematic review of effectiveness. BMC Public Health 22, 2247 (2022). https://doi.org/10.1186/s12889-022-14688-3.

Journal of the American Academy of Child & Adolescent Psychiatry

Call for Book Forum Submissions

Authors are invited to submit proposals for consideration in the Book Forum to the editorial office. A proposal should include an initial outline, along with the full list of proposed authors so that early feedback and guidance can be provided prior to the development of a full manuscript. An invitation to submit does not guarantee acceptance of the manuscript. All papers should conform to the guidelines for book reviews (see Guide for Authors). As a matter of Journal policy, we cannot guarantee acceptance of reviews. However, we will do everything we can to work with authors to help them produce high-quality, publishable reviews.

A book review should be 900 – 1,200-words in length and should include a synopsis of the text, some context for the book, an outline of why it is important to JAACAP readership in general (and perhaps also a nod to the specific audience that might find this book most compelling), and finally that details the merits and shortcomings of the text. Visit the Guide for Authors for more details.

Please direct inquiries and proposals to support@jaacap.org

SCSCAP Annual Meeting and Interview with Dr. Lisa Fortuna

By Sabrina Reed, MD

In August 2023, SCSCAP had the pleasure of welcoming Lisa Fortuna, MD, Chair of the Department of Psychiatry at University of California-Riverside and co-designer of the connected for wellness app, a digital mental health intervention (DMHI) for youth and caregivers.

The designers saw an opportunity to supplement evidence-based services by integrating digital mental health technologies to help overcome the challenges faced by youth particularly since the pandemic. According to the CDC, since 2019, the proportion of mental health-related visits for children aged 5-11 and 12-17 years increased approximately 24% and 31% respectively. One in four young adults between the ages of 18 and 24 say they've considered suicide because of the pandemic. The statistics are even more alarming for children of color where the suicide rate for black children, ages 5-12, is 2x that of their white peers. Moreso, youth of color are dramatically overrepresented in the juvenile justice system and are more likely to have unmet behavioral health needs.

Dr. Fortuna discussed the use of DMHI to bridge the gap among socioeconomic and digitally marginalized youth. The brand new Connected for Wellness app aims to combine mobile technology with mental health prevention tools, peer support, and navigation with resources shared by trained professionals. It is designed for school communities and primary care to connect youth ages 14-18 to mental health care and supports. The app provides wellbeing tools for students, staff, and parents (English and Spanish) with topics that include grief and loss, managing emotions, building social connections, and getting better sleep. I had the opportunity to sit down with Dr. Fortuna to ask her the following questions about the piloting of this app:

The connected for wellness app is meant for targeted intervention. Who is the best candidate for this app?

Dr. Fortuna: We were looking to target high school aged students with a focus on first tier prevention. There are a lot of skills related to emotion regulation, communication, identifying and managing emotions and information about what mental health is. There are daily affirmations and youth are encouraged to use the daily check-in feature to assess how connected they feel to guide what interventions to use if it is a difficult day. There are also monthly check-ins that go into a deeper dive about mood. The WHO 5 is offered to assess well-being and those with lower scores may be urged to use some of the wellness activities, pick among practicing skills, or are encouraged to connect with a provider when appropriate. There is also easy access to a suicide prevention line if needed.

How does this app differ from other mental health or wellness apps that exist?

Dr. Fortuna: The premise was meant to address mental health disparities in terms of access to information and encourage the use of mental health resources that may be underutilized especially by an underserved population of kids. It includes a separate parent section with parallel information from their perspective in addressing mental health needs.

Dr. Lisa Fortuna at the SCSCAP Annual Meeting - UCLA Luskin Conference Center, August 2023

They can access screeners on social determinants of health and link up with resources that can help their families based on where they are.

There are parent co-developers with videos of brief testimonials and informational pieces from their own experience. There are youth co-developers who have helped to create videos so there is a refreshing of material on the app, and you can highlight new material to keep people engaged. There are reinforcers for checking in to keep youth interested (e.g. badges). We wanted to make it engaging enough to compete with other sources of technology they may be using.

What are some important lessons learned about working collaboratively with youth, community stakeholders, and families?

Dr. Fortuna: People come up with ideas you would have never thought about or ideas you thought about but didn't prioritize as much. I learned youth really wanted to talk about school stress, managing feeling overwhelmed, different learning needs they had and feelings around it, how connected they feel to their school, navigating tensions of identity, and being first generation and wanting to go to college. So, we added more information regarding these topics.

How do you ensure the safety and privacy of families using the app particularly considering the sensitive nature of mental health?

Dr. Fortuna: Youth use the app anonymously and it is HIPAA compatible and encrypted. There is no free text to be able to write things that are self-disclosing. It is a closed system so youth need to have a school code to access it and it doesn't interact with open social media. The app asks about ethnic background to see if it links to certain preferences in using the app but does not collect or store direct identifiers such as name, phone, or email.

How are you measuring outcomes of improvement in mental health issues on the app?

Dr. Fortuna: Our main objective is to see how youth are using it and does it make a difference in people accessing care. The WHO-5 collects information on how they are doing with mood in their daily check ins, and we are interested in seeing how this correlates with how youth are using the app. We can tell if people accessed the suicide prevention resources and request for more services. For those who opt to engage in professional care, we will look to see if using the app impacted them wanting to seek help and will screen for mental health issues at that point.

How has the team worked to make the app more accessible to children from diverse backgrounds and marginalized communities?

Dr. Fortuna: Most schools involved are within LAUSD and we reached out to schools that represent predominantly minoritized communities. We are also in the primary care setting in Riverside and working with an organization that serves many Latinx communities in low service areas. Tools on the app are available in both English and Spanish.

What changes have been made to the app based on initial feedback from users?

Dr. Fortuna: The anonymous piece was a big issue as youth were clear that it needed to be anonymous and without surveillance. This created an understanding of how important of a need this was and how information embedded needed to be secure (i.e., not having free text options to prevent them from disclosing information about themselves or suicidality). Schools and primary care settings are co-developers and have contributed to what they think is feasible within their community based on their own policies and what safety measures need to be place.

Can you share any success stories of children and families who have benefited from using the app?

Dr. Fortuna: The pilot has been done and we are moving on to trials in the next school year. So far, we have heard that caregivers find the information to be compassionate and understanding of what parents go through. They like the approach of it.

How can child psychiatrists get involved with supporting usage of the app?

Dr. Fortuna: As it starts to scale, promoting the app would be fantastic. It is also important for child psychiatrists and psychologist to be involved in the development of apps. We have a specific expertise to contribute to the tech world. We also can be involved in giving feedback on how this app and other apps can be improved so we can promote things that are created by us and our field that are of high quality.

SCSCAP President, Dr. Misty Richards welcomes attendees to the Annual Meeting at UCLA Luskin Conference Center, August 2023 and presents the president's plaque to outgoing SCSCAP President, Brandon Ito, MD.

Support at the Tap of a Finger: California's New Virtual Mental Health Services

By Christopher Chamanadjian, MD, PGY-3
(soon-to-be Child and Adolescent Psychiatry Fellow 1)

The prevalence of youth mental health disorders in the United States is increasing. According to the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey, US high school students reporting persistent feelings of sadness or hopelessness increased from 28% in 2011 to 42% in 2021.[1] In California, approximately 1 in 3 adolescents experienced serious psychological distress, with an alarming 20% increase in adolescent suicide between 2019 and 2021.[2] Furthermore, the "State of Mental Health in America" report from Mental Health in America (MHA) reports over 287,000 California youth with major depression do not receive treatment.[3] Exacerbated by the shortage of mental healthcare providers, California's barriers to mental healthcare access become particularly damaging to the uninsured, lower income, people of color, and people with disabilities.

Understanding the need for more mental health support, the California state legislature and Governor Gavin Newsom collaborated in establishing the Children and Youth Behavioral Health Initiative (CYBHI). The initiative is a five-year, $4.7 billion project within his Master Plan for Kids' Mental Health aiming to improve access and conditions for youth mental health in California. As part of the state CalHOPE program, with funding from the CYBHI, the California Department of Health Care Services (DHCS) recently launched the Behavioral Health Virtual Services Platform. The platform features two free mental health apps: BrightLife Kids (by Brightline) and Soluna (by Kooth).

After evaluating over 450 potential collaborators, Kooth and Brightline were ultimately selected to lead the initiative of providing free digital mental health services for all children in California. The selection process involved thorough research with a strong emphasis on user-centered and culturally sensitive priorities. The DHCS conducted over 300 interviews with young individuals as well as focus groups and think tank sessions. To optimize access and ease for all youth in California, the DHCS released two mobile health applications for two different age groups.

These two Behavioral Health Virtual Services Platforms are offered free of charge and do not require insurance for registration. Both web-based and app versions of these platforms provide access to educational materials, one-on-one coaching, assessment tools, and care navigation services. The platforms are deemed to provide personalized interventions that are both confidential and evidence-based.

BrightLife Kids, by Brightline, offers services for children ages 0-12, as well as parents and caregivers. Services provided include bilingual coaches, digital resources, and peer support communities. The digital resources aim for parents and caregivers with articles and videos to assist with everyday challenges in the age group such as insomnia, behavioral issues, and self-esteem. Bilingual coaches are available via phone, video, or chat for one-on-one cognitive behavioral therapy (CBT) coaching sessions. A BrightLife Kids parent's testimonial on the BrightLife Kids website reflects a promising outlook stating, "I often feel like a failure as a parent, but BrightLife Kids has been giving me hope that it can get better." The focus of BrightLife Kids is on prevention and early intervention in the hope of addressing issues at a young age and avoiding detrimental mental and physical health outcomes later in life.

Soluna, by Kooth, is tailored to adolescents and young adults ages 13-25. Features include in-app coaching, journaling, mood tracking, podcasts, educational content, self-assessments, and 24/7 peer support communities clinically moderated by certified behavioral health professionals. The primary focus of Soluna is reaching young individuals who may not typically seek mental health support, resources, or wellness tools. Soluna seeks to provide early intervention via support with messaging and ongoing coaching to improve

mindfulness and improve coping skills with stress, anxiety, and bullying. Coaching is available in up to 19 languages. At the time of this writing, the ratings on the Apple App Store are an astounding 4.9 out of 5 stars.

California's pioneering launch of the BrightLife Kids and Soluna apps is a significant step toward addressing the mental health needs of contemporary youth. As child and adolescent psychiatrists, we should familiarize ourselves with these platforms and encourage patients and families to explore these innovative apps. Integrating innovative solutions into our burdened mental health landscape could offer a lifeline to our patients with new avenues to navigate life's challenges outside of the clinic.

References:

1. Youth Risk Behavior Survey Data Summary & Trends Report: 2011-2021.

2. Wright B, Padilla-Frausto DI, Tse HW, Crawford-Roberts A, Kabir F, Salem S. Nearly 1 in 3 Adolescents in California Reports Serious Psychological Distress.

3. Reinert, M, Fritze, D. & Nguyen, T. (October 2022). "The State of Mental Health in America 2023" Mental Health America, Alexandria VA.

Artificial Intelligence in Psychiatry: An Interview with Dr. John Torous

By Christopher Chamandjian, M.D.
PGY-3 (soon-to-be Child and Adolescent Psychiatry Fellow 1)

On December 3, 2023, the Southern California Psychiatric Society (SCPS) and SCSCAP community virtually gathered to explore the exhilarating frontier of artificial intelligence (AI) in psychiatry. Dr. John Torous, Chair of the American Psychiatric Association's (APA) Smartphone App Evaluation Task Force, discussed the intersection of AI and psychiatry and guided members through the emerging landscape.

Raised in Southern California, Dr. Torous expanded his California branches to northern California, where he obtained a degree in engineering and computer science from UC Berkeley. Returning to his Southern California roots, he attended medical school at UC San Diego. He then switched coasts to Harvard University, receiving a master's degree in biomedical informatics and fellowship training in clinical informatics. Dr. Torous has published over 250 peer-reviewed articles and 5 book chapters about technology and psychiatry. Currently, he serves as the director of the digital psychiatry division in the Department of Psychiatry at Harvard-affiliated Beth Israel Deaconess Medical Center (BIDMC). With a background in electrical engineering and computer science, Dr. John Torous continues implementing innovative ways to deliver wholesome patient care at his digital psychiatry clinic.

Dr. Torous toured the chronology of AI's history. Three periods were covered: (1) first, he introduced ELIZA, the first chatbot therapist established in 1964; (2) the three-decade AI Winter period halted research and funding; and (3) the contemporary AI boom burst out of the dormant "deep freeze" like a Big Bang explosion from an Ice Age.

Since the COVID-19 pandemic, the profound advancements in AI, the increasing prevalence of mental health conditions, and limited access to mental healthcare have led to a growing enthusiasm for using AI within psychiatry.

Several questions were posed to Dr. Torous:

What most excites you about AI in Psychiatry?
Dr. Torous shared "How to leverage technological advancements within the field of Psychiatry." Artificial intelligence technologies potentially allow psychiatrists to gain a more comprehensive understanding of our patients beyond the traditional clinic walls. He is intrigued with where the future of AI in psychiatry can go. However, with excitement comes caution.

What are the challenges of AI in psychiatry?
One of the challenges of artificial intelligence technologies in mental health is the quality of training data. During his presentation, Dr. Torous introduced the audience to the fundamentals of machine learning (ML). He illustrated complex computer algorithms into digestible concepts for the audience, comparing chatbot's decision-making paths to children's "choose-your-adventure" books. Dr. Torous emphasized the importance of data—high-quality data! Emerging chatbots, like ChatGPT, use large language models (LLMs), which require ample data to train the responses. LLMs are confined to the data they receive. The quality of input data determines the quality of output responses. This becomes difficult within the mental health field. Establishing a consensus on mental health diagnoses is a challenge, even among a small 'n' of two board-certified psychiatrists. The indistinct boundaries of DSM diagnoses, overlapping diagnostic criteria, and subjective differences between practitioners create a murky dataset for machine learning.

What do you fear about AI use in Psychiatry?
Dr. Torous prioritizes approaching the emerging frontier through the lens of our Hippocratic Oath—do no harm. AI technologies carry significant unresolved risks and potential harms to individuals. Unbeknownst to the public, countless well-documented risks, and instances of direct harm to patients have occurred within the past year. For example, Koko, an emotional support chat platform, ran an experiment using AI-written mental health counseling responses to 4,000 individuals without informed consent. Similarly, Woebot, a widely popular chatbot, revealed

John Torous, MD - Chair of the American Psychiatric Association's (APA) Smartphone App Evaluation Task Force

that many users were unaware they were speaking to a chatbot. Without proper vetting, chatbots may also pose elements of harm to the population. For instance, the National Eating Disorders Association's (NEDA) chatbot Tessa (eventually removed) provided inaccurate and harmful dieting information directly to users with eating disorders. The deployment of artificial intelligence in mental healthcare necessitates careful examination of the lack of transparency, safety issues, and ethical concerns.

The American Psychiatric Association (APA) advises physicians to approach AI tools cautiously. The APA refers to AI as "augmented intelligence" and emphasizes that it should "coexist with human intelligence, not supplant it." Psychiatrists should educate patients that chatbots are not clinical devices but augment their care—treatment adjunct, not treatment displacement. Private companies and nonprofit organizations do not fall under the legal requirements of experimenting on human subjects, established by Congress from the 1974 Tuskegee Syphilis study. The seriousness of mental health, evidenced by the increasing prevalence of diagnoses and suicide rates in the U.S., should not be taken lightly. Quickly allowing such technologies directly into the sensitive space of a human being's mental health warrants extreme caution. With no apparent oversight, regulations, or protocols in the current landscape, there is an urgent

need to establish appropriate guardrails to prioritize patient safety.

What would you like other Psychiatrists to know?
In this rapidly evolving industry, Dr. Torous hopes external regulations outcompete the marketing force. Dr. Torous states, "We are not near the stage of generative AI in clinical practice, nor near it." Gaining an understanding of AI tools and their capabilities allows physicians the opportunity to guide future implementations of AI within psychiatry patient care safely and ethically. The risks of nonregulated technology applications warrant the importance of establishing regulatory oversight by mental health professionals. He advocates for a collaborative effort among clinicians, stakeholders, and policymakers to develop safe guidelines, ethical standards, and evidence-based protocols for implementing AI technologies within psychiatry.

AACAP Assembly Delegate, Anita Red, MD
at the AACAP Legislative Conference April 2024

Please Renew your AACAP Dues Online
www.aacap.org

or by contacting the
AACAP Membership Department
202.966.7300
membership-mail@aacap.org

Designing A Cognitive Behavioral Intervention for Anti-hate Training in Psychiatry Using Web-based Technology

By Tashalee Brown MD, PhD
Child and Adolescent Psychiatry Fellow Year 2

Systemic racism and provider implicit bias in medicine are crucial drivers of poor healthcare outcomes among racially and ethnically minoritized populations [1]. In child and adolescent psychiatry, this is evident in the disproportionate rates of delayed diagnosis and lack of access to treatment for autism spectrum disorder and the overdiagnosis of conduct disorder and underdiagnosis of attention-deficit/hyperactivity disorder among Black youth [2].

Antiracism is opposing racism and promoting racial tolerance and cultural sensitivity [3]. There is a strong need for antiracism interventions, including those targeting implicit racial bias among clinicians. However, putting antiracism into practice is a challenging task due to cognitive processes, such as cognitive dissonance, which often prevent clinicians from acting according to their core antiracist values. Cognitive-behavioral frameworks have been used successfully to address prejudiced thoughts, feelings, and behaviors [4] but have yet to be applied to mental health clinicians. Mental health clinicians are aptly positioned as a target population, as they are familiar with cognitive-behavioral therapy (CBT) interventions.

We adapted existing evidence-based cognitive-behavioral frameworks into a demo module for a web-based antiracism educational intervention targeting mental health clinicians [5]. We then conducted semi-structured interviews with 12 mental health clinicians at a single academic center regarding the acceptability of the web-based antiracism intervention. The semi-structured interview featured a presentation of a digital demo module of the CBT-based intervention, which discussed core beliefs that may be harmful in the treatment of patients in mental health care. The module features real-world examples, presents examples of self-monitoring, and provides a visual representation of the engagement and reward components of the intervention. The semi-structured interviews were recorded, transcribed, and analyzed using thematic and content analysis.

Our results showed that fifty-eight percent (n=7/12) of respondents desired more antiracism training, and sixty-seven percent (n=8/12) enjoyed the web-based demo module and the CBT-based components. Respondents desired more robust antiracism training and found the digitally delivered demo module acceptable. We plan to develop the intervention further and begin pilot testing of the web-based antiracist curriculum targeting mental health clinicians soon. Please read the full article for further details on the findings of this study [5].

[1] Li H, Eack SM, Montrose DM, Miewald JM, Keshavan M. Longitudinal Treatment Outcome of African American and Caucasian Patients with First Episode Psychosis. Asian J Psychiatr 2011 Dec;4(4):266–271. PMID:23051160

[2] Jansen MO, Brown TR, Xu KY, Glowinski AL. Using Digital Technology to Overcome Racial Disparities in Child and Adolescent Psychiatry. Journal of the American Academy of Child & Adolescent Psychiatry 2022 Oct 1;61(10):1211–1217. doi: 10.1016/j.jaac.2022.03.013

[3] Kendi IX. How to Be an Antiracist. New York: One World; 2019.

[4] Brown TR, Xu KY, Glowinski AL. Cognitive Behavioral Therapy, and the Implementation of Antiracism. JAMA Psychiatry 2021 Aug 1;78(8):819–820. doi: 10.1001/jamapsychiatry.2021.0487

[5] Brown TR, Amir H, Hirsch D, Jansen MO Designing a novel digitally delivered antiracism intervention for mental health clinicians: an exploratory analysis of acceptability. JMIR Human Factors. 06/02/2024:52561 (forthcoming/in press) DOI: 10.2196/52561 URL: https://preprints.jmir.org/preprint/52561

Paid Parental Leave: A Policy to Improve the Mental Health Outcomes of Children and Families

By Chelsea L. Shannon, MD (PGY-2), Misty C. Richards, MD, MS

Paid parental leave has been shown to have a significant positive impact on maternal mental health outcomes. In child psychiatry, we see that the mental health of parents often directly affects the health of the child as well. With rates of mental illness on the rise, it is imperative that we advocate for policies that have been shown to improve the mental health of both parent and child.

Postpartum depression has increased in prevalence since the start of the pandemic, affecting an estimated 1 in 5 women.[1] Infants of mothers with postpartum depression may experience challenges with weight gain, decreased breastfeeding, sleep disruptions, and decreased maternal infant bonding.[2,3,4] As children get older, they are more likely to experience delays reaching developmental milestones, challenges with cognitive development such as language and IQ, and increased risk of behavioral disturbances.[5,6,7] Unsurprisingly, these effects can have a lasting impact on the mental health outcomes of our patients.

In addition to improving access to postpartum mental health care, it is essential to consider how structural changes can decrease the risk of postpartum depression. In a recent meta-analysis published in The Lancet Public Health, paid parental leave consistently improves maternal mental health outcomes.[8] Among those with access to parental leave, paid leave of at least 2-3 months is the most protective. Longer parental leave is associated with decreased depressive symptoms, decreased stress, decreased use of mental health services, and decreased hospital admissions. The positive effects of paid parental leave can extend beyond the postpartum period, improving long-term health outcomes of both mother and child.[8]

The United States is currently the only high-income country that does not guarantee access to paid parental leave. The Family Medical Leave Act requires some employers to provide unpaid leave to eligible employees, but it excludes many low-wage workers and LGBTQ+ families. In 2023, fewer than one third of workers in the United States had access to paid parental leave.[9] This disproportionally affects families from lower income backgrounds, further exacerbating socioeconomic, racial, and gender inequities.[10]

Paid parental leave has consistently had strong public support across party lines.[11] Despite this, the United States has not enacted legislation on this issue in over 30 years. Recently, both the House and Senate have announced bipartisan efforts to expand access to paid parental leave, but legislative frameworks are in early stages. This presents an opportunity for psychiatrists to use our expertise to advocate for a more just and equitable system. By advocating for a federal paid parental leave policy, we can improve the mental health of children, parents, and families.

Citations:

1. Wang, Z., Liu, J., Shuai, H., et al. (2021). Mapping global prevalence of depression among postpartum women. Translational psychiatry, 11(1), 543.

2. Saharoy, R., Potdukhe, A., Wanjari, M., & Taksande, A. B. (2023). Postpartum depression and maternal care: exploring the complex effects on mothers and infants. Cureus, 15(7).

3. Gress-Smith, J. L., Luecken, L. J., Lemery-Chalfant, K., & Howe, R. (2012). Postpartum depression prevalence and impact on infant health, weight, and sleep in low-income and ethnic minority women and infants. Maternal and child health journal, 16, 887-893.

4. Kim, S., Park, M., & Ahn, S. (2022). The impact of antepartum depression and postpartum depression on exclusive breastfeeding: a systematic review and meta-analysis. Clinical Nursing Research, 31(5), 866-880.

5. Lubotzky-Gete, S., Ornoy, A., Grotto, I., & Calderon-Margalit, R. (2021). Postpartum depression and infant development up to 24 months: A nationwide population-based study. Journal of affective disorders, 285, 136-143.

6. Mirhosseini, H., Moosavipoor, S. A., Nazari, M. A., Dehghan, A., Mirhosseini, S., Bidaki, R., & Yazdian-Anari, P. (2015). Cognitive behavioral development in children following maternal postpartum depression: a review article. Electronic physician, 7(8), 1673.

7. Grace, S. L., Evindar, A., & Stewart, D. E. (2003). The effect of postpartum depression on child cognitive development and behavior: a review and critical analysis of the literature. Archives of women's mental health, 6, 263-274.

8. Heshmati, A., Honkaniemi, H., & Juárez, S. P. (2023). The effect of parental leave on parents' mental health: a systematic review. The Lancet Public Health, 8(1), e57-e75.

9. "What Data Does the BLS Publish on Family Leave?" U.S. Bureau of Labor Statistics, U.S. Bureau of Labor Statistics, 21 Sept. 2023, www.bls.gov/ebs/factsheets/family-leave-benefits-factsheet.htm.

10. Shuffrey, L. C., Thomason, M. E., & Brito, N. H. (2022). Improving perinatal maternal mental health starts with addressing structural inequities. JAMA psychiatry, 79(5), 387-388.

Horowitz, Juliana Menasce. "Americans Widely Support Paid Family and Medical Leave, but Differ over Specific Policies." Pew Research Center's Social & Demographic Trends Project, Pew Research Center, 23 Mar. 2017, www.pewresearch.org/social-trends/2017/03/23/americans-widely-support-paid-family-and-medical-leave-but-differ-over-specific-policies/.

A few scenes from the SCSCAP Speaker Meeting - April 21, 2024

Stone Soup: 'Engaging the Community in Youth Mental Health' with speaker, Susan Swick, MD at UCLA Luskin Conference Center

SCSCAP 2023 URiM Grant Recipients at AACAP Annual Meeting NYC

My Unforgettable Experience at the 2023 AACAP Annual Conference

By Felicia Boakye-Dankwah, MD

Child and Adolescent Psychiatry Fellow Year 1

Attending my inaugural American Academy of Child and Adolescent Psychiatry annual meeting was an unforgettable experience.

Seated in the grand auditorium, I casually awaited the commencement of the Lawrence A. Stone MD Plenary session. The speaker, Russell J. Ledet, MD, PhD, MBA, delivered an emphatic address entitled "The 15 White Coats Legacy: We Ain't Following The Rules." Dr. Ledet, a triple board resident physician at Indiana University with roots tracing back to Louisiana, captivated the audience with his impassioned narrative. He openly shared his journey as a descendant of enslaved individuals from Lake Charles, Louisiana, to his remarkable achievements, notably his founding of the 15 White Coats organization. This initiative is devoted to fostering mentorship, providing financial assistance, and promoting positive imagery to inspire the next generation of diverse healthcare leaders. Dr. Ledet commenced his talk by playing a heartfelt voice message from his ailing mother, who, unable to attend the event in person, offered her unwavering support in a fervent prayer played over the microphone. This poignant moment set the tone for the profound discussion that followed. It was a testament to the deeply personal motivations driving Dr. Ledet's work and the profound impact of familial support on one's journey.

As an African American psychiatrist navigating the landscape of healthcare in America, I too, am acutely aware of the glaring disparities that persist. Yet, amidst a climate of disillusionment, Dr. Ledet's narrative of resilience offered a beacon of hope. His founding of 15 White Coats exemplified the transformative power of converting an idea into action and rallying a community behind a shared vision. Central to Dr. Ledet's message was the powerful imagery cultivated by the 15 White Coats organization. He showcased a photograph depicting 15 black medical students from Tulane University School of Medicine standing before the historic slave quarters of the Whitney Plantation in Edgard, Louisiana. This poignant image symbolized a profound shift in narrative—an affirmation of identity, resilience, and the enduring legacy of triumph over adversity.

For me, this moment held particular significance. As a first-generation American born to Ghanaian immigrant parents, I vividly recalled visiting the Whitney Plantation during the 2022 American Psychiatric Association annual meeting in New Orleans. The experience was a stark reminder of the painful legacy of slavery and the resilience of generations of those who endured it.

Dr. Ledet's presentation brought this full circle, underscoring the importance of acknowledging our history while striving to create a more equitable future. Dr. Ledet's impassioned address served as a powerful reminder of the transformative potential of individual resilience and collective action. As I reflect on his words and the impactful work of the 15 White Coats organization, I am inspired to continue striving for positive change within my own community and beyond.

My First Psychiatric Conference: AACAP in New York City

By Michael Garcia, M.D.
General Psychiatry Resident, PGY 4

As I stepped into the grand halls of the American Academy Child and Adolescent Psychiatry (AACAP) Annual Conference in the heart of New York City as a first-year CAP fellow, a surge of excitement coursed through me. It was my first psychiatric conference. The air was electric with the promise of discovery and enlightenment, as clinicians, researchers, and educators from every corner of the globe gathered to share their insights and innovations for the same passion.

Amidst the whirlwind of presentations and discussions, I found myself immersed in a tapestry of diversity. From the kaleidoscope of voices and perspectives to the mosaic of faces and backgrounds, the conference celebrated the rich tapestry of humanity that defines our profession. As I exchanged ideas with fellow attendees from every corner of the globe, I was reminded of the boundless potential of collaboration and shared learning that delved into the intricate web of diversity, culture, and community in child development.

As I navigated the labyrinthine corridors of the conference venue (and frantically searched for the entrance to Rhinelander South), I found myself drawn to sessions that promised to push the boundaries of conventional wisdom. One session, titled "Beyond Being a Good Enough Mother: The Role of Extended Maternal Figures in Clinical Practice Through a Cultural-Sensitive Lens," resonated deeply with me. It underscored the importance of understanding the diverse array of parenting styles and the vital role that extended family members play in shaping a child's development. By recognizing the cultural nuances inherent in caregiving practices, clinicians can better tailor interventions to meet the unique needs of each family.

Equally enlightening was the workshop on parent management training (PMT) interventions. As I absorbed the strategies and techniques outlined in the session, I gained a newfound appreciation for the profound impact early PMT skills interventions by caregivers can have on the emotional development and behavior of a child, particularly in children with externalizing behaviors such as ADHD and ODD. By equipping caregivers with the tools and support they need to manage challenging behaviors, clinicians can foster healthier family dynamics and promote positive outcomes for children to carry over into adolescence in conjunction with or independent of medication management.

The importance of sleep emerged as a recurring theme throughout the conference, with multiple sessions highlighting its critical role in child development and mental health. From exploring the link between sleep disturbances and psychiatric disorders to discussing evidence-based interventions for sleep-related issues, the conference underscored the importance of prioritizing sleep hygiene in clinical practice. Another session, steeped in the mystique of ASD, illuminated the complex interplay between genetics, culture, and mental health, challenging attendees to rethink traditional diagnostic paradigms.

Moreover, I was inspired by the myriad of community health initiatives showcased at the conference, each designed to address the complex interplay of social determinants of health that impact family wellness. As I absorbed the strategies and techniques outlined in this session, I gained a newfound appreciation for the profound impact that a caregiver's mental and physical health can have on the well-being of a child. From innovative programs aimed at bridging gaps in mental health care access to grassroots initiatives focused on promoting holistic well-being, these initiatives served as powerful reminders of the transformative potential of community-driven solutions challenging the confines of our current, at times segmented, medical health system while still pursuing adequate insurance reimbursement for services rendered by providers.

As I bid farewell to the bustling streets of New York City and the enlightening sessions of the 2023 AACAP Annual Conference, I feel emboldened to chart a path forward where every child and adolescent has access to the compassionate and culturally sensitive care they deserve. I carry with me the echoes of voices and ideas, each one a beacon lighting the path forward in the noble pursuit of healing and hope for the future committed more than ever to fostering environments where every child and family can thrive. I cannot help but express my deepest appreciation to all the presenters, volunteers, support staff, guests, and especially the Southern California Society of Child and Adolescent Psychiatry for making this experience possible. As we all move forward with our careers, I leave you with one of my favorite quotes which encompasses my indebtedness to all the contributions to the field of child and adolescent psychiatry: *If I have seen further, it is by standing on the shoulders of giants (by Sir Isaac Newton).*

My 2023 AACAP Conference Experience

Ashley Hite, MD
UCLA Child & Adolescent Psychiatry Chief Fellow

The gathering of the minds at the 70th Annual AACAP meeting held in New York City was one of the most impactful conferences for me as a budding child and adolescent psychiatrist. This conference covered a large breath of themes which allowed me the opportunity to delve deeper into the emerging topic of parent-infant mental health, a growing sector within the field.

As part of my C&A fellowship at UCLA, I enhanced my training by declaring an area of distinction in parent-infant mental health. I've been devoting much of my time in training mastering the skills to diagnose and treat women during the peri-partum period. I was so enthused to see the heavy attendance at these lectures. This fueled my passion to continue furthering my knowledge as I plan to continue work in this area post-fellowship. There were symposiums, clinical perspective talks, and institutes covering topics such as looking at the role of extended maternal figures in clinical practice through a culturally sensitive lens and exploring infants' neurodevelopment in contexts of high adversity. Additionally, I wanted to highlight an excellent talk given by the President of SCSCAP, Misty Richards, who I am blessed to be trained by, which was on the expansion of our role as child & adolescent psychiatrists within reproductive health care.

I also had the pleasure of attending an institute talk entitled, "Is This Student Safe to Return to School? Critical Strategies for Threat Assessment and Management in K-12 Schools." Unfortunately, this is an issue within our field that we have all become acquainted with as our young patients are describing increased fear and anxiety of going to school. The concern of being harmed while at school continues to be of growing relevance heightened by the post COVID-19 pandemic shift. It was an in-depth discus-

sion and provided listeners with strategies and techniques to assess children with severe mood symptoms and those that exhibit behaviors that have been deemed dangerous to those around them. The takeaways included proper communication with defensive parents, utilization of cultural brokers to gain trust amongst parents and providers and evaluation of patient's daily activities (i.e. social media, doodles, online groups joined) for indications of violence. The talk reviewed useful scales for assessment including the structured assessment of violence risk in youth (SAVRY) and the modified overt aggression scale (MOAS).

From engaging lectures to an invaluable networking opportunity with fellow psychiatrists and psychologists, as well as enjoyable social festivities, it was truly an amazing experience. I am so grateful to have been selected as a recipient for this scholarship which subsidized my conference expenses and provided me with an opportunity to present my research alongside my co-researchers and our mentor, Dr. Robert Suddath. At our symposium entitled "Impacts of the COVID-19 Pandemic on Children Hospitalized With Mental Illness: Depression, Anxiety, Family Functioning, Virtual School, and Impacts on Disadvantaged Populations," I led the discussion of the COVID-19 impacts based on race. Amongst minority populations, some studies have suggested higher population prevalence of psychiatric disorders such as depression, anxiety disorders, eating disorders and substance abuse. Social contextual factors that reflect exposure to chronic and acute stressors linked to the living and working conditions of these populations play a role in shaping their mental health risk. We used a retrospective chart review utilizing two COVID-19 specific questionnaires (PHQ-9 and GAD-7). Racial categorization was based off self-reported demographic data. There was a total of 230 subjects. The study concluded that depression and anxiety worsened for all participants in the study during the pandemic but for Latino and Asian youth depression scores increased the most relative to peers in other racial groups. Given that the pandemic was also marked with many social injustices affecting each community that were featured prominently in the news and social media, these findings are worth further investigation.

The learning and connections were never ending at this past years AACAP conference. I am so grateful I was afforded the opportunity to attend. I look forward to the next annual conference and hope to see fellow members of SCSCAP there as well!

References:

https://www.ncbi.nlm.nih.gov/books/NBK24685/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6532404/

California Academy of Child and Adolescent Psychiatry (CALACAP) – Update

By William Arroyo, MD

As a reminder, the California Academy of Child and Adolescent Psychiatry (CALACAP) is the advocacy arm in Sacramento of the four regional organizations in CA of the American Academy of Child and Adolescent Psychiatry (AACAP). CALACAP has been very busy during the past several months.

CALACAP sponsored the Winter Advocacy and Collaboration Conference on December 9, 2023, in Beverly Hills. The partner organizations for this conference were Children Now, the California Alliance for Children and Families, and the National Alliance on Mental Illness (California); each provide their policy updates. In addition, two legislators spoke at the conference. Assemblywoman Jacqui Irwin (D-44) addressed the bond component (AB 531) authored by her of Proposition 1 which was recently passed in the March election; it will provide supportive housing for veterans, supportive housing for people experiencing or at risk of homelessness and who have behavioral health needs, and for IMD's, hospital beds and other highly intensive treatment services. Assemblyman Rick Chavez Zbur (D-51) discussed challenges of people experiencing homelessness and marginalized populations such as LGBTQ+. In addition, CALACAP honored the recipients of the Wasserman Education Fund.

CALACAP sponsored two bills, namely, and . CALACAP had never sponsored bills in consecutive years; last year it sponsored two bills. AB 2711 (Ramos) would impose new protocols, and thus making it more difficult for schools, to suspend or expel a student, who, for example, had tobacco products on his person. SB 516 (Skinner) is an attempt decrease the burden of the prior authorization process. Being a sponsor of a bill requires a lot of work on behalf of CALACAP as the sponsor is expected to provide testimony at key legislative hearings and as a content expert resource to the author's office as the bills make their way through the legislative process. CALACAP considered many bills during this legislative period. These include AB 2110 (Arambula) which would mandate additional trauma screenings; SB 1353 (Wahab) which would mandate schools to implement a suicide crisis intervention policy; SB 1012 (Weiner) which would allow for "facilitators" to prescribe psilocybin and other psychedelics; and SB 1184 (Eggman) which would decrease burden of hearings related to involuntary medication during an episode of involuntary treatment.

CALACAP will be sponsoring a legislative advocacy day on May 20 in Sacramento during which time child and adolescent psychiatrists will make visits to various legislator's offices to address specific bills and other relevant policies. All are welcome to participate; please register and send inquiries to info@calacap.org. Travel stipends are available for trainees.