SCSCAP Newsletter 2025

The Southern California Society of Child & Adolescent Psychiatry

PRESIDENT'S COLUMN: ***“Communication is merely an exchange of information, but connection is an exchange of our humanity.”***

By Sabrina Reed, MD, MACM
SCSCAP President

This quote by Sean Stephenson expresses the essence of our ambitions as an organization this year. Despite the devastating fires, we have seen remarkable resilience and hope persist through this time of uncertainty. I've learned so much from many of you as colleagues and it is essential for our well-being that we stay engaged and committed to supporting our patients and one another. It has been a privilege to serve as president of the Southern California Society of Child and Adolescent Psychiatry this year. I am honored to work alongside a remarkable executive team and executive assistant who has fostered the creativity to advance our organization.

The council has been committed this year to expanding our efforts in mentorship. We initiated our first mentorship program pairing over 20 medical students, residents, and fellows with like-minded child psychiatrists, and pairs have already started connecting in person and virtually. In February, we hosted a mentorship mixer for those involved to help encourage these meetings and continue our focus on in-person connection. We sincerely thank the significant number of you who have volunteered your time and expertise to help inspire and guide those committed to being future child psychiatrists. Our organization also continues to support 4 trainees underrepresented in medicine to attend the annual AACAP meeting and we look forward to hearing about their experiences in this newsletter.

Our year started with our annual meeting in August where Dr. Bridget Callaghan, a UCLA psychologist who studies interactions between mental and physical health across development, educated the crowd on the role of microbes on emotional development. During the subsequent joint SCSCAP/SCPS meeting, Drs. Emily Wood who serves as the medical director for spectrum psych and Sid Puri who serves as the medical director for the county of San Luis Obispo, presented a virtual talk on the stimulant shortage which reminded us of the importance of ADHD assessments, particularly when co-morbid substance-use disorders exist. Finally, our spring speaker meeting welcomed Dr. Shawn Sidhu, professor of psychiatry at UCSD and faculty member at the asylum medicine training initiative, who gave an advocacy talk titled, “Silenced Voices: The Untold Story of Psychosocial Adversity in Migrant Youth and Families.” An article by Dr. Asilnejad highlights the mental health challenges faced by immigrant children and their families while sharing her own experience working in an asylum clinic.

This newsletter will follow the theme of amplifying the lived experiences of youth populations often overlooked, with a robust number of submissions this year written by future child psychiatrists. Drs. Nguyen and Girdler shed light on the gaps in care that exist for youth with developmental disabilities and young children with ADHD respectively. Both highlight the need for increasing awareness among practitioners and improved comfort levels of early intervention. You also will read about different perspectives of grief. Dr. Maiyuran reminds us of how the mental health of youth may be affected in the aftermath of the wildfires. She discusses the risk factors that lead to an increased likelihood of long-term mental health problems as well as protective measures such as peer & family support and community efforts. MS4 student, Ms. Lum, discusses the coined phrase “doom scrolling" and how youth have connected with like-minded people about issues related to grief on social media, allowing for affirming identity through storytelling and fostering a sense of community. Drs. Chamanadijan and Imbrie present us with the friendly reminder that though AI is likely to become a predominant force of healthcare delivery in the next decade, there are ethical challenges we need to consider: the likely exacerbation of healthcare disparities given algorithmic bias and lack of underrepresented populations being represented in healthcare research data. Among those underrepresented, Drs. Nguyen and Patel discuss the importance of integrating cultural considerations into psychiatric diagnosis and treatment—particularly for children in the Asian American and Pacific Islander communities, who remain among the least likely to access mental health services despite a rising suicide rate over the past two decades.

As always, you will also read updates about advocacy efforts related to our region and the state of California.

Thank you for the support you have offered SCSCAP through the years. I hope you enjoy our newsletter and take a moment to reflect and learn something new. As we go about our busy lives and strive to uplift youth and their families, I invite you to join us on this meaningful journey of learning, growing, and making a lasting impact in our communities.

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

In This Issue:

Evidence-Based Intervention for Young Kids (ages 4-6) with ADHD: Strengthening Self-Concept for Lifelong Success

By Julia Girdler, MD, and Misty Richards, MD

Attention Deficit Hyperactivity Disorder (ADHD) impacts an estimated 7 million (11.4%) children ages 3 to 17 in the United States.[1] The severity of ADHD often determines when it is first diagnosed, with more severe cases typically presenting earlier. ADHD is usually diagnosed around age 4 in severe cases, age 6 for moderate cases, and age 7 for mild cases.[2] For kids, we know that medication can be used safely and effectively to treat symptoms of impulsivity, inattention and hyperactivity.[2] Specifically, stimulants are the most effective medications for treating ADHD (with 80% of children showing response). Despite this, less than a quarter of kids with ADHD under age six receive medication.[1] This article will explore the importance and challenges associated with treating ADHD in young children within the community (ages 4-6).

Young children who are hyperactive, impulsive, and inattentive suffer. They suffer in school settings, where they often require frequent correction, redirection, and intervention. They struggle socially, where they often invade personal space, interrupt, and find conflict even unintentionally. They struggle in the community, where they cannot meet the social expectations to sit still or slow down. And they struggle at home, where they often appear oppositional or defiant due to the frequent need for re-prompting and more involved parenting. In almost all spaces they inhabit they struggle. And so often, by the time a young child presents to the doctor to receive a diagnosis of ADHD they have already been labeled, explicitly or implicitly, a “bad kid.”

Children, even as young as four, can begin to internalize this “bad kid” identity. And when they do, the results can be devastating. For example, take a four-year-old, with intense hyperactivity. At the beginning of the year, he moves through his class like a joyful tornado; but as he does, he constantly bumps into other kids (which they don’t like) and knocks things over (which they see as problematic). Eventually, his classmates come to reject him. They don’t want him to build blocks with them, because they fear he is going to knock them over. They don’t want to play soccer with him, because they fear he is going to run into them. They are not being mean to him, per say, but they don’t want him to be involved in their play. Eventually, after being rejected from play enough times, he does get mad and he starts knocking over their tower on purpose, further fulfilling their expectations of him and solidifying his identity as a bad kid or bully. This happens not just with other kids, but with parents and teachers. And suddenly the carefree hyperactive, impulsive, inattentive kid truly begins acting in defiant and oppositional ways because that is how their world responds to them. Kids with ADHD find themselves on a negative spiral. As clinicians, our job is to get kids off this negative spiral and onto a positive one.

However, when it comes to treating young kids with ADHD, at the community level, we don’t do a great job. As mentioned, the cases of ADHD that present to our offices before the age of 7 are more likely to be severe. And when it comes to treating kids under 7, we have a paucity of data. The most famous trial we have looking at the treatment of ADHD in kids is the Multimodal Treatment of Attention Deficit Hyperactivity Disorder (MTA) Study.[3] It looked at children ages 7 to 9 and assigned them to one of four treatment groups: medication alone, behavioral treatment alone, combination of medication and therapy, or routine community care. What they found was that medication alone and combination treatment were far more effective in reducing ADHD symptoms (inattention, hyperactivity, impulsivity) than therapy alone or routine care. However, in other areas of functioning (academics, social skills, parent child relationships) combination care was better than routine care, where as medication alone or therapy alone were not. Interestingly, kids in the combination treatment group also required lower overall doses of medication than kids in the medication alone group. This data is from 7- to 9-year-olds though; so, what do we do with the little kids?

The American Academy of Pediatrics recommends behavioral therapy before the initiation of medication for children six and under. The behavioral therapies recommended include classroom interventions and parent management training (through programs like Parent Child Interaction Therapy, Triple P- Positive Parenting Program, or the Incredible Years Program). Classroom interventions might include specific seating, fidgets, scheduled breaks, extra time or support, behavioral reinforcement programs, and in some cases, an aide. The reason for this recommendation is that kids under six can be more sensitive to medications and side effects, but quite frankly it is also because we don't have robust literature on medication use in this population.

Behavioral treatment is first line treatment for the youngest kids we treat, and yet only 50% of kids with ADHD between ages 3-5 receive such services.[1] Beyond that, we need to be practical and transparent with parents and pediatricians about what to expect from these interventions. Therapy does not directly target the core symptoms of ADHD, rather it more directly impacts other areas of functioning. It can enhance positive rapport between parent and child. It can help caregivers understand how to better parent their child with ADHD. It can help a child get through a school day by motivating and shaping behavioral changes. And these things are important, because nearly half of all children with ADHD also have behavior or conduct challenges (they are on a negative spiral).[1] Therapy can absolutely make life with a young kid with ADHD more manageable by addressing behavior driven symptomatology, however it will not directly alter the core symptoms of ADHD, which are often most severe in kids diagnosed by age 5. Behavioral therapy for young kids is not a treatment for the ADHD itself, but an intervention targeted at the downstream challenges ADHD creates. And sometimes, behavioral therapy is enough to make life manageable until the child gets a little bit older, and parents or providers feel more comfortable starting medication. But other times, it is not.

When it comes to medication management of ADHD, stimulants are first line care. In the Preschool ADHD Treatment Study (PATS), they looked at the safety and efficacy of immediate release methylphenidate in preschool-aged kids with moderate to severe ADHD and found improvements in the core symptoms of ADHD with some side effects of decreased appetite, sleep disturbance and irritability.[5] The response rate to stimulants in ages 3-5 is around 82%.[4] Despite this, in practice, we see many providers start alpha-agonists (guanfacine or clonidine) in children under the age of 6 because they perceive it to be safer or a more conservative intervention. We don't have great safety data for alpha-agonists in young kids. We do know that alpha-agonists have a lower response rate than stimulants in preschool age kids, and the side effect profile includes daytime sedation.[5] In sum, there is not good evidence to start an alpha agonist before a stimulant for young kids with ADHD.

When starting stimulants in young kids, we should advise our pediatrician colleagues that there is a choice between amphetamines and methylphenidates. Methylphenidates are generally better tolerated, and therefore a good first choice for young kids.[6] Within this class, there are many formulations of methylphenidate (both immediate release and long acting). We notice in young kids, many pediatricians will start with an immediate release formulation. There can be good reason to use immediate release in this age group (for example, if they still need a nap or to allow for midday appetite). However, there are also downsides including a need to re-dose midday. The alternative is long acting, and in practice we see pediatricians nervous about using the long-acting agents they typically use with older kids for fear of insomnia and appetite suppression (Concerta or Focalin XR). That concern is reasonable because those agents can work for 8-12 hours. But there are other good options for long-acting methylphenidates. We see less community familiarity with long-acting methylphenidates that have shorter durations of action (for example Metadate CD which lasts 6-8 hours, Ritalin LA which acts for 8-10 hours, or the Daytrana patch where action depends on wear time) which can serve as better options for our youngest patients. In sum, when advising pediatricians starting a stimulant for a young child with ADHD, we typically start with methylphenidates and should consider long-acting options that work with the needs of the child's life.

It is imperative that we hone our skills when it comes to treating ADHD in young kids. When ADHD presents early, it is usually more severe.[2] And contrary to what parents hope for, most (89%) of kids will not outgrow the diagnoses in the next six years.[7] Concerningly, when we leave ADHD untreated in this population, we put kids in situations where they continue to receive negative feedback in all domains in life, they get on a negative spiral, and eventually, they begin to internalize that feedback. It is no surprise that as kids age, anxiety becomes increasingly comorbid with ADHD.[1] It is our job to get these young kids on the positive spiral. We can achieve this by educating their families, engaging them in behavioral management, and not hesitating to prescribe medication when necessary. It is crucial that we empower our colleagues in pediatrics to do the same. Expanding their understanding of available stimulant formulations will make this process more accessible. Treating ADHD in young kids is not just about making life easier for teachers and parents, it is about shaping the way these children will perceive and understand themselves moving forward.

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Mind the Gap - In Caring for Youth with Co-occurring Neurodevelopmental Disability and Serious Mental Illness

By Han (Hannah) Nguyen, MD, First Year Child & Adolescent Fellow, Keck USC Department of Psychiatry & Behavioral Sciences

Youth with co-occurring neurodevelopmental disabilities and serious mental illness face significant barriers in accessing appropriate levels of care. This article summarizes two (modified and de-identified) adolescents facing seemingly insurmountable odds including intellectual disability, serious mental illness, being wards of the state, medical comorbidities, and sexual trauma history who have poor prognoses due to several gaps in the continuum of care.

“Angela” is an adolescent female with a history of post-traumatic stress disorder, victim of sexual exploitation, major depressive disorder, methamphetamine abuse, intellectual disability (Regional Center connected), with medical history of extensive sexually transmitted infections including human immunodeficiency virus 1 (HIV) with medication non-compliance, syphilis, gonorrhea and chlamydia initially brought in to a medical hospital by emergency transport after she was found down in the street. She is a ward of the state. In the emergency department (ED), she was identified as a missing person previously reported by the Department of Children and Family Services (DCFS). She was admitted to the medical hospital for workup of shortness of breath. Psychiatry was consulted in the hospital for recommendations regarding agitation requiring multiple behavioral codes in the ED. Her relevant history includes one previous 5585 hold for danger to others after she eloped from placement, used methamphetamines, and destroyed property at an establishment. Notably, Angela has a repeating pattern of eloping from DCFS placements; in the past few years, Angela reportedly stayed at a placement for only one week. From a psychiatric standpoint, Angela’s agitation resolved when she was moved from the noisy ED to a room in the pediatrics unit. However, psychiatry remained involved due to concerns about Angela’s mild agitation and disposition plan. Once the patient was medically cleared, doctors, DCFS and social work were all advocating for higher level placement due to Angela’s tendency to elope, become noncompliant with her HIV treatment, and engage in risky behaviors. However, efforts to secure appropriate placement were unsuccessful as there were simply no alternative options. She did not meet criteria for a psychiatric hold, and DCFS was unsuccessful in securing an accepting facility or home. She was discharged, and once again eloped from placement soon after.

“Jasmine” is an adolescent female with a history of autism spectrum disorder, intellectual disability (Regional Center connected), attention deficit hyperactivity disorder, post traumatic stress disorder and seizures; she was brought in on a 5585-hold due to eloping from placement, assaulting officers, and having suicidal ideation with plan. Also, she is a ward of the state. Relevant history includes Jasmine’s recent admission to a psychiatric inpatient unit one month ago after she had eloped from her foster family, engaged in prostitution, and was hospitalized for self-harm; she was stabilized then discharged to a new foster family. On the inpatient unit, Jasmine had behavioral codes almost daily for destroying property, punching herself, banging her head on the wall, or barricading herself when she became frustrated. Exhaustive measures were taken by the treatment team and DCFS to explore all potential options for appropriate higher level of care placement, especially considering her tendency to impulsively elope. Ultimately, no alternative options were available, and Jasmine was placed with yet another new foster family.

In these two cases, several systems of care intersected (DCFS, the Regional Center, community Behavioral Health services, hospitals), yet still seemed to leave a significant gap in the continuum of care. One can argue that these two specific patients could benefit from locked placement due to failing less restrictive environments with wraparound services, not meeting acuity criteria for further prolonged psychiatric hospitalization, and a tendency to engage in high risk behaviors. There are few options for locked placements for youth with comorbid neurodevelopmental disability and serious mental illness. One pathway is via the Welfare and Institution Code 6500 which states "a person with a developmental disability may be committed to the State Department of Developmental Services for residential placement." However, the 6500 order is not easily accessible as it currently requires the District attorney to file a petition, typically after obtaining approval from the Regional Center. Another factor contributing to few options for locked placement include tighter regulations for children. For example, facilities with secured perimeters are limited to a maximum of six children as opposed to 15 adults. Furthermore, the State Medi-Cal (or Medicaid) Manual Section 4930D excludes "mental retardation, senility, and organic brain syndrome" for consideration of Institution for Mental Disease (IMD) placement because "these diagnoses represent the behavioral expression of underlying neurological disorders." Despite several systems of care heavily involved with the goal to place these high risk youth in an appropriate environment, the current infrastructure makes it difficult to close this gap.

Practically speaking, a discussion about gaps in care would not be complete without mention of funding. The Regional Center receives most of its funding from the state's Department of Developmental Services and federal funding through Medic-Cal, which can vary based on policies of the federal administration. The Los Angeles County Department of Mental Health receives most of its funding from Medi-Cal (state and federal) and the state sponsored Behavioral Health Services Act (formerly Mental Health Services Act). Varying funding sources can potentially complicate care coordination due to differences in budget priorities, as well as possible disagreements in which system is financially responsible for the youth at that time (DCFS, Behavioral Health, or the Regional Center). Medical necessity criteria for psychiatric hospitalization, Medi-Cal and many private insurers require a billable primary psychiatric diagnosis thereby excluding neurodevelopmental disorders (except for autism spectrum disorder). However, oftentimes an individual with a neurodevelopmental disorder in crisis may have impulsive behaviors qualifying as danger to others or grave disability, and poor emotional regulation skills sometimes qualifying for danger to self. The current funding in place does not appear to reflect the need that we are seeing in practice.

There are prominent gaps in the continuum of care for individuals with comorbid serious psychiatric illness and neurodevelopmental disorders, and several places to intervene. AACAP's policy statement on co-occurring psychiatric conditions in autism spectrum and intellectual developmental disorders recommends "policymakers and health facilities invest in making clinical services more inclusive for individuals with ASD/IDD to reduce healthcare disparities." The American Psychiatric Association (APA) assembly is currently considering an action paper that would create a work group of several APA Councils to address barriers to a robust continuum of care for individuals with neurodevelopmental disorders. Youth with co-occurring neurodevelopmental disability and serious mental illness are some of our most vulnerable youths, and they are facing a grim future. Perhaps by increasing awareness of need, availability of hospital beds with special accommodations, placement options for those who fail community-based mental health services, funding or infrastructure, we can begin to close this gap.

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The January 2025 Fires

By Harinee Maiyuran, MD, First Year Child & Adolescent Fellow, Keck USC Department of Psychiatry & Behavioral Sciences

Fire season in Southern California has typically been in May/June, through October, heavily driven by the arid Santa Ana Winds. This year, unprecedented wildfires broke out on January 7 in the affluent neighborhood of the Palisades, taking 24 days to be contained. It burned 23,448 acres and killed 12 people, destroying 6,837 structures. Almost simultaneously, the Eaton Fire began the evening of January 7 as well, burning 14,021 acres, killing 18 people, and destroying 9,418 structures.

Within those structures were 11 schools across Southern California, including Palisades Charter High School, Palisades Elementary, Pasadena Rosebud Academy, and Eliot Arts Magnet Middle School. To learn more about the potential impact of these losses, we look back at studies concerning the Camp Fire that ravaged Paradise, CA back in 2018. There were significant impacts on education, with student performance and engagement impacted for years to come. Unstable living conditions and the trauma of displacement were powerful in derailing even the most resilient, while the trauma itself had deleterious impacts on concentration and memory. These consequences aligned with known patterns in disaster psychology. As one can see, even if a child's school remains standing after a wildfire, academic performance can suffer immensely.

In addition to academic struggles, mental health certainly suffers in the setting of a natural disaster such as wildfires. Perhaps most notable is Post-Traumatic Stress Disorder (PTSD) and Mood Disorders as a whole. One analysis of North American wildfire impacts found that children exposed to wildfires have increased rates of PTSD starting in the acute phase and lasting for years. In a study of the 2016 Fort McMurray wildfire in Alberta, Canada, 37% of surveyed adolescents met criteria for PTSD 18 months after the fire. By the third year after the wildfire, more youth reported intrusive memories, nightmares, and distress than at prior follow-ups, in contrast to expectations. This suggests that without adequate support, the trauma burden in wildfire-exposed children may remain high or even worsen as initial shock diminishes and chronic stressors are ongoing, such as displacement or rebuilding challenges.

In the realm of Mood Disorders, several studies in California and elsewhere point to significant levels of anxiety and depression among youth survivors even 5+ years after wildfire disasters. Among adolescents who experienced wildfires, rates of depression around 1–2 years post-disaster have ranged from 30% to 40% in some samples. In the Fort McMurray study mentioned above, approximately 31% of students screened positive for depression and 27% for anxiety disorders at 18 months post-fire. Perhaps most concerningly, these mental health indicators did not necessarily improve with time; depression and anxiety scores worsened in the 1.5-3.5 years post-wildfire, with simultaneous declines in self-esteem and quality of life. At the three-year mark after the fire, many teens reported persistent worry, mood disturbances, and in some cases, emerging suicidal thoughts – underscoring that the psychological toll can be enduring and severe.

In order to support children experiencing wildfires, parents, families, and educators can start with open and honest, age-appropriate conversations, whether that is a concrete statement of “the fire is gone, we are safe,” or a shared fear of the future, which may sound like, “I don't know what will happen to our home” as a parent evacuates their home with teenagers in tow. Routines play a unique role as they provide some semblance of normalcy despite all odds. If a school is standing, and it is safe to return, allowing children to re-engage in the academic and social fabric of school is invaluable, in addition to consistent mealtime and bedtimes. Virtual classrooms or temporary classrooms can also provide vital socialization and learning during this difficult time. Emotional expression – often in the form of play for younger children, creative outlets for school aged children, and conversations for teens and adolescents – is crucial in processing trauma, making kids feel less alone and more understood by those around them. Finally, providing some responsibilities such as younger children helping arrange items in a living space or teens setting up a donation space for a neighborhood drive will help them feel more in-control and self-sufficient, rather than powerless and dependent.

Despite these timelier interventions, given the devastation of the Palisades and Eaton Fires, ongoing interventions and resources are crucial in the days, weeks, months, and even years to come. This includes Child Psychiatry and Psychology Services, empowering counselors and teachers to support kids at school, and community programs such as religious institutions or sports – especially if physically attending school is no longer an option. A crisis tends to shed light on what we need to survive; when options are limited, those remaining are that much more crucial.

Risk factors that increase the likelihood of long-term mental health problems include severity of exposure, extent of personal loss, and demographics. Gender and age are significant, with girls more likely to develop anxiety or PTSD than boys. Re-exposure and re-traumatization are linked to worse outcomes, which is particularly noteworthy in the dry, hot climate of Southern California as fire season is exactly that – a seasonal occurrence. Developmental stage at the time of the disaster will influence processing tendencies; younger children will potentially lack an understanding of the experience while taking in loved ones' emotions and responses unconsciously, leaving them with unprocessed trauma that they may not be able to describe for years to come. Older adolescents may understand the losses and impact more, while still lacking control and influence within their family to have that understanding manifest in a productive, fulfilling way.

Protective factors include social support from friends, peers, and family, as family cohesion and positive communication will provide a buffer from more severe consequences of wildfires. Coping strategies that are more adaptive will similarly make a difference, versus avoidant coping such as suppression and disengagement. Community efforts – including that which helps rebuild the community following the fires – will provide purpose that can counteract powerlessness, as the very fire that hurt the community can facilitate the cohesion necessary to heal. Long term support for mental health is a new but growing concept; given the enduring nature of struggles after wildfires, many are turning to more sustained intervention plans that involve longer access to therapy, long term/regular mental health check-ins with a mental health provider or pediatrician, and programs to build coping skills and facilitate processing. Trauma-focused CBT can help address the PTSD and depression symptoms in children and adolescents, though more targeted research is needed.

As climate change increases the risk of wildfires in Southern California, there is undoubtedly a need for further research, with future generations being more likely to experience wildfire consequences than those who came prior. Studies should be ongoing, especially in the years following recent fires including the 2018 Camp Fire, 2018 Woolsey Fire , or 2017 Thomas Fire, and now the 2025 Palisades and Eaton Fires. This will facilitate a better understanding of conversation surrounding wildfires – from the risk factors for mental health consequences to the developmental impact...from potential interventions at schools to management of persistent PTSD and Mood Disorders. There are numerous opportunities for the adults in these youths' lives to foster resilience and recovery rather than reexperiencing and regression, with outcomes dependent perhaps most heavily on family and community cohesion in the face of indescribable loss and devastation.

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The Southern California Society of Child and Adolescent Psychiatrists (SCSCAP) Diversity and Culture Committee is proud to announce the SCSCAP Annual Day of Service on May 10th

We are going to partner with Sahaas for Cause, a non-profit organization founded by South Asian Americans to advocate on behalf of their community. They are having a mental health awareness day called **Chak De SoCal** in collaboration with Department of Mental Health and Take Action LA as well as Southern California Youth Cricket Academy. This special day of service brings together dedicated child psychiatrists and community advocates to support mental well-being, promote awareness, and provide valuable resources to families and youth. Through games, sports, music and dance, educational discussions, and community engagement, we aim to break the stigma surrounding mental health in the South Asian community and learn about the Indian/South Asian culture. Learn more about this event here: https://www.takeactionla.com/events/chak-de-socal-3-0

We are looking for volunteers to take shifts stationed at an informational table offering psycho-education on common diagnoses/medications (think AACAP Facts for Families). Other responsibilities could include helping with registration for the event, assisting with games, help distributing food at lunch, and wrap up. You can enjoy some delicious Indian food, watch a cricket game, play traditional Indian games, and learn some dance moves. Join us in making a difference and connecting with others from SCSCAP!

Please fill out this form if you’re interested:
https://forms.office.com/r/DuqHcQGntx

We expect a 4 hour commitment for the day. Thanks!

Sincerely,
Nithya Ravindran, DO
Chair, SCSCAP Diversity & Culture Committee

SCSCAP Spring Meeting with Guest Speaker Dr. Shawn Singh Sidhu, MD Silenced Voices: The Untold Story of Psychosocial Adversity in Migrant Youth and Families

By Brenda Asilnejad, MD

On March 8th, 2025, SCSCAP members gathered for an insightful presentation by Dr. Shawn Singh Sidhu, Professor and CAP Program Director at UCSD, Co-Director of the Society of Asylum Medicine, and a trainer for Physicians for Human Rights and the Asylum Medicine Training Initiative. His lecture, Silenced Voices: The Untold Story of Psychosocial Adversity in Migrant Youth and Families, shed light on the hidden struggles faced by immigrant children and their families, emphasizing the urgent need for clinical intervention, advocacy and systemic change.

Dr. Sidhu began by outlining the magnitude of forced migration, noting that over 47 million children worldwide are displaced (UNHCR Global Trends Report). Their trauma often begins long before they leave their home countries. Many are unaccompanied, fleeing violence, human rights violations, political instability, and extreme poverty. In Central America, 77% of child migrants cite violence as their primary reason for fleeing, with 30% enduring sexual or gender-based violence. In countries including El Salvador and Honduras, gangs and cartel members outnumber law enforcement officers, creating an environment escape becomes a matter of survival. Growing up in these conditions significantly heightens the risk for lifelong mental health challenges, including PTSD, anxiety disorders, depression, and intergenerational trauma.

Migration itself compounds these hardships, with many children experiencing dehydration, human trafficking, and violence along their journey. Dr. Sidhu shared alarming statistics: 30-60% of Latin American women and children are sexually assaulted during migration (Amnesty International 2010). Migrant children are also twice as likely to develop depression, PTSD, and psychotic symptoms compared to their non-migrant peers (WHO 2023).

Once in the U.S., many migrant children face additional hardships, including family separation, detention, and constant fear of deportation. Dr. Sidhu highlighted the severe emotional impact of policies like the U.S. government's Zero Tolerance policy, which resulted in the separation of over 5,000 families. Studies indicate that even short-term separations can lead to attachment disorders, developmental regression, and emotional and behavioral difficulties (Shadid 2021).

The impact of parental detention or deportation is particularly severe. Dr. Sidhu noted that 30% of children of detained or deported parents meet the criteria for depression, and many experience emotional and behavioral disturbances (Gulbas 2014). The detention process itself is linked to long-term

Dr. Shawn Sidhu at the SCSCAP Speaker Meeting - UCLA Luskin Conference Center, March 8, 2025

PTSD, with detained individuals reporting higher rates of suicide and severe depressive symptoms. Detained children experience higher rates of PTSD, depression, hyperactivity, conduct disorders, and anxiety compared to children in community care settings. Deportation represents a major life trauma, linked to/correlated with increased risk of substance abuse, unemployment, and interpersonal difficulties (Zuniga & Hamann 2006, Brabeck 2014). Children who experience multiple immigration-related stressors, such as immigration raids, are at even greater risk for depression, anxiety, and PTSD.

Dr. Sidhu also addressed the challenges faced by Dreamers. He explained that undocumented immigrants use healthcare, education, and social services at lower rates than their U.S.-born peers. Despite their profound need for support, undocumented families often avoid seeking medical care, workers' rights, and other social services due to fear of deportation or potential legal repercussions under the Public Charge rule, which could disqualify migrants from receiving legal status if they use public services. Undocumented immigrants are often paid below minimum wage and are ineligible for most public assistance programs. Their families also face higher rates of food insecurity, and limited access to education and healthcare, exacerbating poverty and perpetuating cycles of health disparities in their children (Bernhardt 2009).

Most Importantly, Dr. Sidhu emphasized the vital role of mental health professionals in supporting migrant youth. Clinicians can create safe spaces, provide culturally responsive trauma-informed care, and advocate for policy changes to protect migrant families. He urged support for expanding access to mental health services and opposing harmful policies like family separation. Dr. Sidhu also highlighted organizations such as Physicians for Human Rights, the Mount Sinai Human Rights Program, Humanitarian Outreach for Migrant Emotional Health, and grassroots organizations which offer opportunities for clinical care, asylum evaluations, and advocacy. He encouraged clinicians to engage in forensic evaluations for asylum seekers, noting that these evaluations significantly increase the chances of garnering asylum status.

My experience as a volunteer with Physicians for Human Rights at Georgetown University's Asylum Clinic, where I facilitated forensic evaluations for asylum seekers, is consistent with Dr. Sidhu's findings. This work was particularly meaningful to me as the daughter of an asylum seeker from Iran who fled religious persecution. From the HIV-positive Colombian national who endured years of abuse, including sexual assault, police violence, and threats from gangs due to his sexual orientation, to the Guatemalan teenage girl who fled repeated sexual and physical violence from her father and death threats from an abusive employer whose advances she rejected, it was gratifying to see asylum seekers find safety and stability in the U.S.. These–and many other cases–underscored for me the importance of advocating for vulnerable populations and using psychiatry as a tool for justice.

Dr. Sidhu's presentation reinforced the need for a compassionate approach to migrant youth mental health care. As clinicians and advocates, we must amplify the voices of vulnerable populations, ensuring they receive the support they need to heal and thrive. The moral and ethical obligation to support these children is clear—our response must be equally resolute.

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Considering the Cultural Nuances that Shape the Mental Health of AAPI Youth & Families

By Diem-Khanh Nguyen, MD, and Shaili Patel, MD

Given the increasingly diverse makeup of the United States, it is essential to consider the unique nuances that influence youth's mental health and their interaction with the treatment landscape. Recent studies have pointed to an increase in mental health service usage among youth, a phenomenon attributed not only to rising rates of mental illness, but also to decreasing stigma around treatment over the past decade. Despite this general trend, certain populations disproportionately underutilize mental health resources. One of these often-overlooked populations is the Asian American and Pacific Islander (AAPI) community, comprising 7.3% of the U.S population.[1] Research indicates that this group, despite demonstrating similar rates of mental illness when compared to non-Hispanic white youth, are among the least likely to utilize mental health services despite the increasing suicide rates in the population over the last two decades.[2]

While often conceptualized as the “model minority,” the AAPI community is a diverse group of 50+ ethnic groups,100 languages, and a range of socioeconomic backgrounds and language fluency rates. Of all racial/ethnic groups, they have the lowest help-seeking rate with under a quarter of those with mental illness receiving treatment in 2019. Additionally, AAPI youth when compared to white and other ethnic-minority peers are more likely to report internalizing symptoms, victimization, and lower self-esteem. This is further compounded by the increase in racially motivated bullying since the COVID-19 pandemic, with 33% of Asian undergraduate students having experienced such an encounter.[2]

Culture is a major contributor to the underutilization of resources among AAPI youth. Many AAPI communities come from traditionally collectivist cultures that contrast with the United States’ primarily individualistic society. Value is placed on the family unit, interpersonal relationships, and focusing on the collective good. For youth who often occupy “lower” gender or age-based positions in their family hierarchy, this expectation can inadvertently invalidate feelings around mental health – especially if these feelings contradict their elders’ more stern and traditional beliefs about mental illness. And notably, the “stigma of mental disorders is much more severe among Asians and ethnic minorities than among white Europeans or Americans.”[3]

Additionally, while close-knit communities can be protective for mental health, studies have shown that the stigma toward mental health leads to underreporting, underdiagnosis, and undertreatment in current mental healthcare systems. Firstly, youth may have difficulty self-disclosing due to pressure to “save face” within their communities. Secondly, individuals from collectivist cultures tend to somatize mental health symptoms into gastrointestinal distress, body pains, and headaches; thus, they may be missed by screening questionnaires that assess for more apparent, “obvious” mental health symptoms.[4] In the same vein, youth with high-functioning depression may go underdiagnosed because they do not fit the traditional picture of depression (e.g. poor performance in school, social withdrawal, etc.). In the same vein, youth with high-functioning depression may go underdiagnosed because they do not fit the traditional picture of depression (e.g. poor performance in school, social withdrawal, etc.).

It is thus crucial for both diagnostic and treatment approaches in the mental health field to consider the aforementioned cultural considerations. Sue et al. 2012, for example, urges for future efforts to "modify assessment procedures to account for cultural variations in symptom expression and to determine how to account for culture-bound disorders."[2] Furthermore, in outpatient settings, integrating standardized tools within family therapy to assess acculturation and the impacts of racism on family dynamics might be helpful establishing understanding and rapport with families. The Asian American Parental Racial–Ethnic Socialization Scale, for example, is one scale that measures the stressors of assimilating into a new country while remaining connected to one's ethnic roots. "The multidimensional scale includes seven subscales: maintenance of heritage culture, becoming American, awareness of discrimination, avoidance of other groups, minimization of race, promotion of equality, and cultural pluralism."[5]

Another method of mitigating unmet care needs of Asian American and other minority families is to methodically involve family members in treatment in an effort toward destigmatization. Li et al. proposes using "strategic structural system engagement," a model that prioritizes family engagement in treatment even prior to the first patient encounter. Healthcare workers are encouraged to clarify expectations and needs for services ahead of time, maximize parents' investment, identify attitudes toward services, build alliance, and invite various family members to intake sessions. By doing so, and by encouraging family members to share their own experiences with bullying/racism/stressors, providers can help promote modeling of open disclosure in informal contexts. In addition, framing medications and therapy as progress towards a tangible goal (such as decreased anxiety, improved mood, etc.) may improve adherence to care, by tapping into the cultural emphasis placed on measurable outcomes. Such efforts may empower caregivers to participate more actively and constructively in their children's treatment long term.[6]

Additionally, despite the barriers that culture may raise in accessing treatment, a strong sense of ethnic identity can be a protective factor in the face of mental illness. Accordingly, once caregivers and parents are invested in their youth's care, it is essential to draw from the many strengths of the AAPI community to deepen the therapeutic and alliance within family units. For example, bilingualism is a strong protective factor and essential to incorporate in family therapy; 32% of AAPI Americans are not fluent in English, and clear parent-child communication is essential in ensuring post-discharge stability plans. In addition, acknowledging and understanding the role that diverse traditional healers like acupuncturists and herbalists can play in mental health can be beneficial in building trust. In many AAPI cultures, mental diseases may be conceptualized as spiritual illnesses, and a strong sense of spirituality/religion has been shown to be a protective factor against developing psychological stress in this population.

Lastly, therapy that frames ethnicity and culture as a strength can lead to increased resilience among patients, with studies showing that the strength of someone's ethnic identification is directly associated with fewer depressive episodes and lower suicide rates.[7] Bath et al. expands more on this concept, stating that "race-conscious interventions, particularly those that focus on racial/ethnic connectedness and... pride, can not only be protective and health promoting in their ability to mitigate the emotional harms of experiencing racism, but can also foster social-emotional functioning and successful academic outcomes among ethno-racially minoritized individuals."[8] [9] In this way, fostering parenting styles that promote ethnic pride and integration within the majority culture can be useful in promoting social connections and a sense of "equality or cultural pluralism" that reduces cognitive dissonance in youth.

In sum, while mental health challenges among youth in the United States are on the rise, certain groups, such as the AAPI community, remain significantly underserved in terms of mental health resources. This underutilization can be attributed to cultural factors, including stigma, collectivist values, and a tendency to somaticize mental health symptoms. Despite these barriers, understanding and integrating cultural considerations into diagnostic and treatment processes, as well as strategically involving families in the care process, can improve mental health outcomes for AAPI youth. Leveraging strengths such as a strong sense of ethnic identity, bilingualism, and traditionally accepted coping methods can also enhance the therapeutic process. Ultimately, by acknowledging and addressing the unique needs of the AAPI community, mental health care systems can foster more inclusive, effective, and culturally competent care for all youth.

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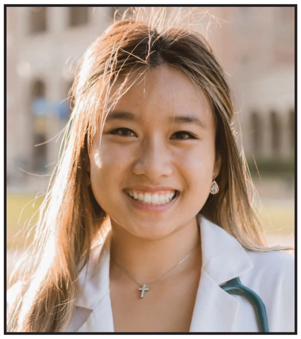
Gloom-Scrolling: Using Social Media to Navigate Grief

By Meachelle Lum, Third Year Medical Student, UCLA



"Doom-scrolling." I learned about this Gen Z term while volunteering as a mental health advocate at minoritized high schools. Doom-scrolling was how the students described spending countless hours on social media consuming news, even though they were aware of its negative impacts on their mental health.

Despite this, students were reluctant to give up social media for good. This came as no surprise, given that 95% of youth ages 13–17 report using a social media platform.[1] Rather than repeatedly focusing on the harms of social media, it was more effective to discuss how it could be used to support their mental health. Considering that mental health was one of the most frequently searched health topics among adolescents, social media could be used to inform them of proper mental health literacy. [2]

One of the mental health topics we explored with the students was grief. They identified the most common causes of grief in their school as the death of a loved one, breakups in relationships or friendships, and stress related to finances or academics.

This aligns with national trends, with the death of a caregiver, sibling, or loved one being the most reported and most distressing form of grief among adolescents.[3] Youth bereavement is associated with a range of mental and behavioral health problems, including depression, post-traumatic stress, substance use, and decreased academic performance.[3]

Adolescents also process bereavement differently from adults, as they may find it more challenging to express their emotions, often struggling to articulate how they feel.[4] In a national survey among adolescents, many reported the difficulty of finding emotional support about the topic, with 52% reporting that talking to their friends about death was hard.[5]

Interestingly, what resonated with me was how the students defined and processed their grief in unique ways. Despite grief being a universal experience, it was felt and understood differently by each of them. Some students described their grief in terms of sadness and anxiety, while others said it made them feel confused.

Therefore, social media offers an invaluable platform for adolescents to express these complex emotions. It provides a space to connect with others enduring similar experiences. These digital communities allow adolescents to share their feelings openly, seek support, and even offer comfort to others, all without the barriers of cost or location.

This is especially important to consider in marginalized communities, as social media can be seen as a haven for people of underrepresented backgrounds. These communities prioritize storytelling and personal narratives as powerful tools for affirming identity and fostering a sense of community.[2]

Although there are valid concerns about the safety and accuracy of social media posts, its widespread use makes it crucial to consider. Evaluating social media usage should be a standard part of assessing an adolescent's wellbeing, and it can serve as a powerful tool for providing grief support.

*Mental Health Workshops were conducted monthly by medical students, Psychiatry residents, and fellows. The team developed and presented an evidence-based mental health literacy curriculum.
*The students were from various schools across the Riverside and Los Angeles districts, with the majority identifying as Black or Latinx.

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The 1st Annual SCSCAP Mentorship Mixer in Beverly Hills, CA - February 16th, 2025

Letter To the Editor

from Chris Chamanadjian, MD, and John Imbrie, MD

AI holds the potential to streamline healthcare delivery, enhance diagnostic accuracy, facilitate patient management, and increase access to care. A new AI referral system, Limbic Access, well exemplified these potentials in large observational study for patients of the UK's National Health Service. The AI-driven system demonstrated reduced wait times, reduced dropout rates, improved allocation to appropriate treatment pathways, and improved recovery rates (Rollwage et al., 2023). Importantly, AI can maintain focus solely on patient inputs without distractions more typically encountered by human practitioners, such as note documentation during an encounter. This standardized documentation can be swiftly and precisely generated for human review. Moreover, AI-enabled wearables have shown promise in predicting serious medical conditions such as cancer and heart disease, suggesting a future where they might preemptively identify to surgical complications (Li et al., 2022). The technologies herald a transformative era in healthcare, poised to become an integral component within the next decade.

With significant technological advancements, AI will likely become a predominant force in healthcare delivery within the next decade. However, the integration of AI is not without challenges. The issue of algorithmic bias is of particular concern. If not carefully monitored, AI could exacerbate healthcare disparities among underrepresented populations. Already poorly represented historically in healthcare research data, minority populations may be impacted by algorithmic bias potentially worsening healthcare outcomes. Algorithms can only be as strong and representative as the datasets they are trained on. Disadvantaged groups are less likely to be part of research trials. This may lead to algorithms improving the care of advantaged groups, who are also more likely to receive care in the first place, but worsening the care of disadvantaged groups. If those groups are less likely to come into the hospital, the AI may statistically improve overall care while compounding inequities. To mitigate these risks, it is essential for physicians to critically evaluate the datasets used for training AI systems and advocate for ongoing improvements based on expansive and inclusive data. (Ratwani et al., 2024).

Of course, the human doctor will be the final safeguard against AI's dangers. When advice derived from machine learning algorithms conflicts with years of clinical experience, doctors should be open minded to learn yet be cautious of possible inaccuracies. Parallelling autopilot systems in cars, medical AI aims to revolutionize safety in the next ten years. However, we are much further from a world where removing steering wheels or doctors' expert judgment is appropriate.

In conclusion, while AI like ChatGPT-4o offers remarkable capabilities that could revolutionize surgical practice and patient care, it is imperative to approach its integration with a balanced perspective, emphasizing both the potential enhancements and the ethical considerations it raises. The evolution of AI in healthcare promises significant advancements, but it must be harnessed responsibly, ensuring it complements rather than supplants the critical judgement of medical professionals.

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SCSCAP Council Retreat - Summer 2024

Vegan Pizza Making at the home of Anish Dube, MD

Theme: Youth in Revolt

Leading and Managing Change through Disciplined Messaging

By Vivien Chan, MD, DFAPA, DFAACAP, CPE, AACAP Councilor-at-Large

Over 2500 years ago, Greek philosopher Heraclitus emphasized the importance of people living together in social harmony and wrote that logic and reason have underlying connection between opposites (e.g. hot/cold;disease/health /good/evil).[1] He is commonly recognized to have described the process of constant flux and change through a flowing river metaphor.[2] While his philosophies were unpopular during his time, they seem timely and prescient now, particularly in light of a barrage of change and polarized dialogue.

Finding community and common ground helps us endure and grow through change. As we are united by our profession and are more effective with cohesive advocacy and message discipline, I want to re-share three groupings of resources with you. I hope you will find these helpful. The AACAP website regularly posts refreshed updates at its bottom banner: (image for illustrative purposes only[3]

Grouping 1: some words from our current AACAP President, Dr. Tami D. Benton, and a recent summary sent to AACAP Council from Rob Grant, Communications Director.

"AACAP remains focused on our mission—advocating for children's mental health, supporting our workforce, and ensuring our policies are grounded in science and clinical expertise. Our priority is always to contribute where our expertise adds the most value, particularly in areas directly impacting child and adolescent psychiatry."

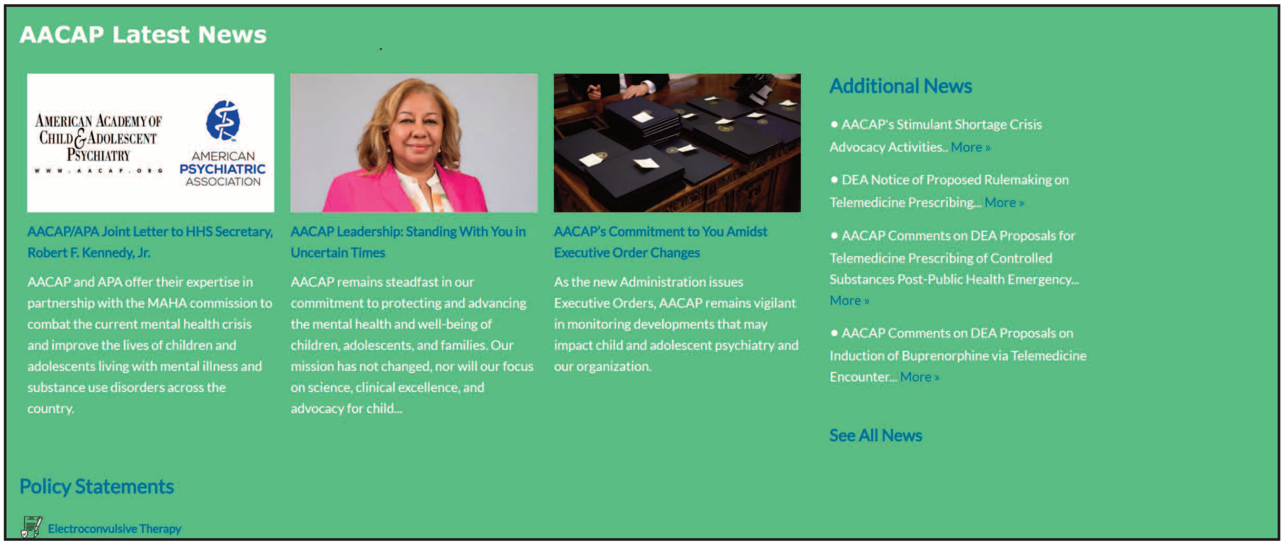
- **Our commitment to children's mental health during shifting policy landscapes:** AACAP Commitment Amidst Executive Orders
- **Standing with children, families, and our field in uncertain times:** Standing With You in Uncertain Times

Grouping 2: addressing federal health intended/announced priorities

Responsive to this February 13, 2025 Presidential Action from the White House[4] which specifically calls out concerns about the diagnosis of and prevalence of ADHD and stimulant medication, as well as psychotropic medications,

- **Our joint efforts with APA on key advocacy issues:** AACAP & APA Letter to Secretary Kennedy

and the following, reviewed and approved 2/24/2025



AACAP Latest News

AACAP/APA Joint Letter to HHS Secretary, Robert F. Kennedy, Jr.

AACAP and APA offer their expertise in partnership with the MAHA commission to combat the current mental health crisis and improve the lives of children and adolescents living with mental illness and substance use disorders across the country.

AACAP Leadership: Standing With You in Uncertain Times

AACAP remains steadfast in our commitment to protecting and advancing the mental health and well-being of children, adolescents, and families. Our mission has not changed, nor will our focus on science, clinical excellence, and advocacy for child...

AACAP's Commitment to You Amidst Executive Order Changes

As the new Administration issues Executive Orders, AACAP remains vigilant in monitoring developments that may impact child and adolescent psychiatry and our organization.

Additional News

- AACAP's Stimulant Shortage Crisis Advocacy Activities.. More »
- DEA Notice of Proposed Rulemaking on Telemedicine Prescribing... More »
- AACAP Comments on DEA Proposals for Telemedicine Prescribing of Controlled Substances Post-Public Health Emergency... More »
- AACAP Comments on DEA Proposals on Induction of Buprenorphine via Telemedicine Encounter... More »

See All News

Policy Statements

Electroconvulsive Therapy

by our committees on Psychopharmacology, Governmental Affairs, Communications, Executive Staff, and President

Talking Points on Psychopharmacology and Children's Mental Health:

- **AACAP’s Role as the Trusted Authority:** AACAP is the leading professional medical organization dedicated to advancing the mental health of children, adolescents, and families through research, education, and advocacy. Our members are board-certified experts in diagnosing and treating psychiatric conditions in youth.

- **SSRIs as a Treatment Option:** When clinically appropriate, SSRIs can be a valuable tool in the treatment of depression, obsessive-compulsive disorders, and anxiety disorders in children and adolescents. Decisions about prescribing these medications are made carefully, based on a comprehensive evaluation by a trained medical professional.

- **Other Evidence-Based Medication Options**: In addition to SSRIs, there is strong evidence for other medication classes for treating psychiatric conditions in youth. For example, stimulants for the treatment of ADHD; atypical antipsychotics for bipolar disorder, schizophrenia, and irritability associated with autism spectrum disorder; and mood stabilizers, including lithium, for bipolar disorder.

- **Emphasizing Safety:** Like any medical treatment, psychotropic medications require monitoring. Physicians work closely with families to assess the risks and benefits of psychopharmacology, as well as to monitor for potential side effects, altogether ensuring each child receives individualized care.

- **The Importance of a Comprehensive Approach:** Medication is often part of a broader treatment plan that may include talk therapy, lifestyle and school changes, and family support. AACAP strongly advocates for a personalized approach considering each child's unique needs.

- **Commitment to Evidence-Based Care:** Treatment of childhood mental health conditions, including the use of psychopharmacology, is based on decades of research and real-world outcomes showing consistent improvement and excellent tolerability in both the short and long term. AACAP supports the responsible use of evidence-based treatments to improve the well-being of children and adolescents.

<u>Grouping 3: Advocacy Resources/Events</u>

1st Monday of the Month, 8:00 p.m EST/5:00 p.m. PST: AACAP Government Affairs Advocacy Liaison Network Calls (staffed by AACAP’s State Advocacy Manager Emily Rohlffs, open to join, the “eyes and ears” of ROCAP legislative and regulatory affairs). Often includes policy conversations on a relevant topic to child and adolescent psychiatrists. Members at any point in their careers, or with various levels of advocacy experience are welcome. No limit on # of members who attend each call. Email govaffairs@aacap.org to get added to the AL Network email list. For <u>additional AL Network information</u>[5]

Join via Zoom:

<u>https://zoom.us/j/545858442?pwd=cWtIN05DRSt4VnpkeUg0ZitrcUthQT09</u>

Meeting ID: 545 858 442 Passcode: 242055 Registration[6] is Open for AACAP’s 2025 Legislative Conference (“LegCon”) May 5-6, 2025 Washington, DC. Meeting registration will close 4/10/2025 and no registration is available onsite.

It is my privilege to represent you as a Councilor-at-Large in my 2nd of a 3-year-term. Let’s continue to engage in dialogue together.

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Scenes from the SCSCAP Annual Meeting - August 2024

featuring: 'Brains and Bugs - What Role Do Microbes Play in our Emotional Development?'
with speaker, Bridget Callaghan, Ph.D at UCLA Luskin Conference Center

SCSCAP 2024 URiM Grant Recipients

Embracing Justice, Equity, Diversity, and Inclusion (JEDI) in Child & Adolescent Psychiatry: Navigating Microaggressions, Imposter Syndrome, and Finding Strength in My Identity

By Amira Collison, MD, PGY1, UCLA Neuropsychiatric Institute

As a 29-year-old African-American first-year Child & Adolescent Psychiatry fellow at UCLA, I've encountered many challenges—both personal and professional - that have shaped my path in this field. One of the most powerful lessons I've learned thus far is the importance of integrating Justice, Equity, Diversity, and Inclusion (JEDI) principles into my work and my life. These principles are not only essential for improving patient care but also for navigating the unique struggles I've faced as an African-American woman in a predominantly White medical field.

Throughout my journey, I've often experienced feelings of imposter syndrome, subtle discrimination, and microaggressions—experiences that many underrepresented minority (URM) professionals know all too well. While pursuing my training in psychiatry, I've encountered moments where my identity felt at odds with the expectations of the environment I was in. Whether it was being one of the few Black women in the room or facing the question of "How did you get here?" in ways that didn't feel celebratory but rather condescending, these experiences have made me question my place in this field.

Yet, in facing these challenges, I have found ways to combat these feelings and remain grounded in my mission. My personal experiences have helped me better understand the emotional struggles of many of the youth I serve, particularly those from marginalized communities. These patients, many of whom come from minority backgrounds, often face not just the typical adolescent challenges but also the added weight of navigating a world that doesn't always see or validate their identity.

One of the most poignant experiences I've had as a fellow working with a young patient who was struggling with severe anxiety and depression, compounded by feelings of racial isolation in their predominantly white school. The patient, much like I have at times, struggled with the feeling of being "othered." They felt invisible, misunderstood, and disconnected from their peers. In our work together, I learned that their distress was exacerbated by a lack of cultural representation and a consistent experience of microaggressions.

As I listened to their experiences, I couldn't help but feel an emotional connection. I saw so many parallels between their struggles and my own challenges of finding belonging in an environment where my identity was often questioned or dismissed. This experience reinforced the importance of providing culturally competent, inclusive care—care that not only addresses the mental health needs of a child but also validates their identity and experiences.

In my own life, I combat the effects of imposter syndrome, discrimination, and microaggressions by staying rooted in my sense of purpose. I remind myself that my presence in this field is not an accident—it is the culmination of years of hard work, perseverance, and dedication. I lean into my identity as an African-American woman and find strength in knowing that I bring a unique perspective to my work. I also seek mentorship from other women of color in medicine who have navigated similar struggles, as their support and wisdom help me stay resilient.

Attending the 2024 AACAP Child & Adolescent Psychiatry Conference, thanks to the Southern California Society of Child and Adolescent Psychiatry (SCSCAP) Underrepresented Minority (URM) scholarship, was a pivotal moment in my journey. It allowed me to connect with other professionals who share my commitment to JEDI and gave me the space to reflect on how my personal experiences as a minority in this field can help shape my approach to patient care.

I now approach each clinical encounter with a deeper understanding of the intersectionality of race and mental health. Just as I have worked to overcome the microaggressions and biases I've faced, I am committed to addressing these same issues in my patients' lives. Through my work, I aim to create a space where all children, especially those from underrepresented communities, feel seen, validated, and empowered to heal.

As I continue my journey, I am more committed than ever to advocating for marginalized communities, ensuring that mental health care is not only accessible but also inclusive, compassionate, and culturally responsive for all children and families. Through my work, I hope to create spaces where youth from all backgrounds can thrive, knowing that their identity and experiences are not just acknowledged, but celebrated.

First AACAP Experience

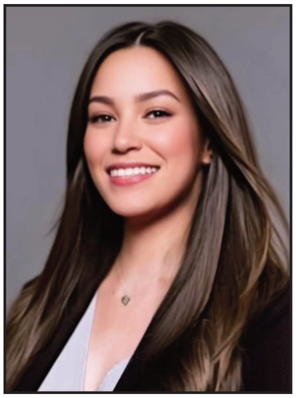
Frederick Burton III, MD
PGY3, UCLA Neuropsychiatry
Institute of Psychiatry

From the moment that I landed in Seattle and entered the conference hall I knew that I had found my community. Not only were people engaging in thought-provoking discussions about the future of mental health care, but they were also warm, welcoming, and genuinely passionate about advancing the field. Surrounded by like-minded professionals dedicated to patient care, research, and advocacy, I felt an immediate sense of belonging. Through keynote presentations, panel discussions, and interactive workshops, I gained valuable insights into the complexities of caring for young patients while networking with professionals who share a common goal of improving mental health outcomes for children and teenagers.

One of the most impactful sessions explored the career trajectories of three seasoned child and adolescent psychiatrists and the work they were doing by changing policy to increase access to mental health resources for their cities. This was particularly impactful to me because I have had a strong interest in quality improvement and changing systems, particularly our healthcare system, for the better. It was good to learn about their trajectory and learn what steps they took to get to where they are now.

Another session explored the rising prevalence of anxiety and depression among adolescents, particularly in the context of social media. There was compelling data on how excessive screen time, cyberbullying, and online validation-seeking behaviors contribute to emotional distress. This helped to emphasize the importance of integrating digital literacy into therapy ranging from understanding gaming to knowing the latest TikTok trends. This discussion was particularly relevant given the increasing number of young patients I encounter who struggle with self-esteem issues linked to their online presence. Better understanding technology and mental health is imperative for helping children develop a healthier perspective of technology and managing the challenges of this new landscape.

Beyond the sessions, the conference provided opportunities to connect with like-minded peers. I networked with other current, and future child fellowship applicants as well as current Child and Adolescent Psychiatry Fellows. There were even moments to slow down and discuss deep topics during dinner such as the impact of artificial intelligence on the field. Engaging in discussions about innovative treatment modalities, policy advocacy, and interdisciplinary collaboration highlighted the collective effort required to improve youth mental health care. The experience left me feeling energized and motivated to implement new knowledge into my clinical practice and to consider future areas of research.



Advancing Equity in Child and Adolescent Psychiatry: A Personal Commitment to JEDI Principles

By Johana Pena, MD,
UCLA/VA PGY3

My interest in psychiatry stems from growing up in an underserved community where access to healthcare was limited. As a Latina from Oakland, California, I witnessed firsthand how social, racial, and economic disparities create significant barriers to mental health care, especially for marginalized populations. These early experiences shaped my dedication to addressing these disparities and advocating for vulnerable communities in the field of child and adolescent psychiatry.

The challenges faced by underserved populations are compounded by a lack of access to mental health resources, resulting in poor health outcomes. Growing up, my family’s struggles with healthcare were compounded by cultural stigma, financial limitations, and immigration status. These experiences gave me a unique perspective on how inequity in healthcare can directly impact the mental well-being of individuals and families. It was through these experiences that I realized the importance of mental health care that is both accessible and culturally competent.

At the 2024 AACAP Annual Meeting in Seattle, I had the privilege of connecting with colleagues and mentors who share a commitment to the principles of Justice, Equity, Diversity, and Inclusion (JEDI). The conference provided a platform for learning about the latest advances in child and adolescent psychiatry, but it was the discussions on integrating JEDI principles into clinical practice that truly resonated with me.

A key takeaway was the importance of cultural competence in addressing mental health needs. By acknowledging and respecting cultural differences, we can create more inclusive environments that foster trust and improve patient outcomes. Early intervention is critical in child and adolescent psychiatry, and by applying JEDI principles, we can ensure that all children, regardless of their background, receive the specialized care they need.

The sessions at AACAP also emphasized the need for collaboration across disciplines to eliminate barriers to care and develop policies that make mental health services more accessible to underserved communities. Engaging in these discussions reinforced my commitment to dismantling the structural inequities that perpetuate disparities in mental health access.

As I continue my journey in psychiatry, I am determined to integrate JEDI principles into my practice. I am passionate about serving vulnerable populations and ensuring that children and adolescents from all backgrounds receive the care and support they deserve. The knowledge and connections I gained at AACAP will be instrumental in my efforts to improve mental health care for underserved communities and advance equity in the field of child and adolescent psychiatry.

Guardians of Innocence: Protecting Children from Online Exploitation

By Alfonso Vera Jr, MD, Child and Adolescent Psychiatry Fellow Year 1, UC Irvine; and
Lauren Schooner, MD, Child and Adolescent Psychiatry Fellow Year 2, UC Irvine

As current child and adolescent psychiatry fellows at UC Irvine (UCI), we are granted the wonderful opportunity to work with a diverse patient population. UCI has a strong partnership at the Children's Hospital of Orange County (CHOC) where we complete inpatient and consultation rotations. During these rotations, we encountered several cases of children who were unfortunately exploited through online social media. These injustices took place through various forms, such as: grooming, coercion through blackmail, and exploitation using social media. Social media is utilized to obtain substances which are known as "plug" connections. The term "plug" is a person that deals drugs, but coined is this nuanced term to potentially avoid detection from parents and law enforcement. We have heard many stories about child and adolescent patients who were forced into sexual favors to obtain drugs, which was initiated from the older perpetrator initiating the conversation through social media to meet in person. In other instances, patients were befriended in social chatrooms where older individuals were identifying as minors to eventually obtain revealing photos. Once the perpetrators obtain photos, they would demand more photos or videos which is known as "sextortion." The presentations of all the patients have similar themes of shame, isolation, and depressive symptoms. In all these cases, children who have been manipulated by online child exploitation (OCE) may manifest depressive symptomatology and undergo unnecessary treatment and interventions, when the root cause of the issue is that someone behind the scenes is causing mental anguish through coercion and manipulation. These presentations highlight the importance of protecting vulnerable youth from the dangers of OCE and the importance for heightened awareness and protective measures to safeguard young individuals from harm in the online world.

Importance of screening for Online Child Exploitation. OCE is an umbrella term that includes various subtypes including grooming, trafficking, and sextortion, and each subtype requires its own method for intervention. With social media rapidly evolving, the risk of exploitation rises significantly. The toll on victims' mental health is profound, with depression, anxiety, and suicidality prevalent among those subjected to online exploitation [1]. The increases in documented cases, evidenced by an 82 percent increase in online enticement cases reported by the National Center of Missing & Exploited Children (NCMEC) [2], stresses the urgent need for proactive measures to mitigate this pervasive threat. More importantly, there is dire need for psychiatrists to learn how to understand the intricacies of online victimization to accurately diagnose, report, and support those being victimized by OCE.

Recent research emphasizes the prevalence of online child sexual abuse, with many cases going unreported or overlooked [5]. The mental and emotional trauma inflicted on victims stresses the importance of comprehensive support and intervention strategies. Additionally, the correlation between childhood maltreatment and later suicidality is alarming, with victims of abuse being at least two to three times more likely to attempt suicide in later life [4].

Reporting Methods. What happens if you encounter a presentation as above; how do you report it? The response is to contact Child Protective Services (CPS). According to the California Department of Social Services, "If you suspect that a child's health or safety is jeopardized due to abuse or neglect by a parent or caretaker, contact your county's child protective services agency." [3] However, how do you report if the abuse is from unknown perpetrators? If the abuse involves online exploitation, it is recommended to file a report with NCMEC at their CyberTipline at https://report.cybertip.org/. [2] NCMEC reviews these cases and forwards verifiable incidents to agencies such as Internet Crimes Against Children Tasks Forces (ICACTF), federal, state, and local law enforcements. The agencies vary particularly when the abuser is located across state lines or in another country. Such cases often qualify as sextortion, grooming, or trafficking across state lines which require federal investigation. From a psychiatric context, understanding the reporting process is critically important to navigating victim's treatment and implementing future safeguards.

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The Unraveling of Policies and Politics

By William Arroyo, MD, (Alternate) Delegate to CA Academy of Child and Adolescent Psychiatry

While I was tempted to entitle this article, Make America Sane Again, the notion of unraveling may be more to the point here. We are witnessing one of the most extensive dismantling of federal institutions that have served to guide states in many policy and service areas, including health and public health. A recent opinion piece in JAMA refers to the dismantling of the U.S. Department of Health and Human Services as "guaranteed pandemonium".[1] In the Executive Order, *Make America Healthy Again*, an agency to be led by Robert F. Kennedy, Jr., is established which will issue a *Make Our Children Healthy Again Assessment* in 100 days in which the new agency will review "the prevalence and threat posed" by the prescription of all major classes of psychotropic agents.[2.] A joint statement [3] has been issued by the AACAP, APA, among other national organizations in response to the federal government's plans. Perhaps the greatest threat to the financing of behavioral health services in CA is the final federal budget which must be determined by the end of September; many proposals for this budget include massive cuts to the Medicaid (Medi-Cal) program which is the largest funding source for behavioral health services in the U.S. It is evident that more changes at the federal level are underway.

Currently there is minimal, if any, similar process at the state level in CA. However, much of CA's healthcare financing is dependent on federal funding, much of which is still at stake at the time of publication of this newsletter. CA was anticipating an additional $1 billion of Covid-19 pandemic related funding until the federal administration announced in March that this relief program would be brought to a halt; this funding stream has been supporting mental health and substance use services. A lawsuit against the Trump administration's attempt to eliminate this funding stream was filed and blocked by a U.S. Judge for now. While greater tax revenue has been realized in CA than had been projected in January, there is still a projected budget shortfall of $2-4 billion; this projection does not take into consideration any new cutbacks imposed by the federal administration. The governor's revised budget is not released until early May which will still not reflect new federal cuts. Clearly, the CA state budget will be influx for several months with a major deficit projected.

Despite this landscape of turmoil and financial unpredictability, advocacy by the CA Academy of Child and Adolescent Psychiatry (CALACAP) continues at the state level. We are in the first year of a two-year legislative cycle wherein a bill, that may not move through the legislative process the first year may still be considered the following year. CALACAP, once again, is the co-sponsor of two bills, SB 363 (Weiner) and SB 531 (Rubio). The former bill would require a health plan to publicly report various data. Such reporting would occur when a prescribed service is denied, delayed, or modified after an independent medical review is requested and not resolved within thirty days; reporting includes annual number of denials or modifications, number of reviews which result in overturning the health plans initial decision. An administrative penalty would be imposed on health plan if more than forty percent of independent reviews are overturned. SB 531 (Rubio) would require the inclusion of "mental health education" as a component of any health course offered in grades 1-12. Other bills that CALACAP will be discussing are AB 408 (Berman) which would establish a Physician Health and Wellness program with a non-profit entity to assist those physicians with physical or mental health conditions that may impair their ability to practice medicine. Another is AB 1034 (Farias) which would mandate that beginning teachers have basic training in youth mental health. Others include: AB 319 (Jackson) would mandate that counties develop a plan with other key local agencies on how to ensure that children in the foster care system are provided trauma-informed care; AB 951 (Ta) prohibits a health plan from requiring a child, who has been referred with a diagnosis of autism, to undergo another mental health evaluation for the purpose of establishing a diagnosis. AB 1135 (Macedo) would require the CA Department of Education to post statewide resources on website of assistance for victims of dating violence. AB 1230 (Bonta) would mandate that school districts develop a rehabilitation plan for students who have been expelled from school for committing specified acts. Many other bills will be reviewed and positions on these bills will be determined by the Council of CALACAP.

CALACAP is sponsoring its annual advocacy day on May 12, 2025, in Sacramento. CALACAP will provide reimbursement for travel expenses of current trainees in CA (general residents and CAP fellows). In addition to visits to state legislators' offices, presentations by one or two legislators are arranged. Registration is required; the link for registration is:

https://www.surveymonkey.com/r/X68TZ3Z

CALACAP will be instituting a quarterly newsletter shortly in which it will report on state advocacy activities and activities by the four regional organizations of CALACAP.

I can be reached for any comments or questions related to CALACAP advocacy at wmarroyo@pacbell.net

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