SCSCAP Newsletter 2026

The Southern California Society of Child & Adolescent Psychiatry

Presiding Over An Organization Dedicated to the Mental Well-Being of Future Generations in Some Extraordinary Times

By Anish R. Dube, MD MPH MLS;
President of SCSCAP

Nominally, there is cause for optimism, celebration even. Rapid advances in the sciences and technology should point to a future in which the current generation of young people benefit from more effective medical treatments, fulfilling lives with ample time for leisure and a greater societal allowance for self-discovery. These are the years following the great pandemic, when they may have gone months without sharing the same physical space as their friends, but now return to communal gatherings of all sorts. Surely, we are due for a grand flourishing of the arts as history tells us follows such periods of global catastrophe. Then why does the present time not feel more hopeful for me as a child and adolescent psychiatrist and for the young people that we treat?

Tellingly, while there were periods in the past when young people expressed cynicism about their present, they nevertheless looked to the future with hope. Today, young people not only describe a contested present, but they also see futures that are neither certain nor entirely hopeful. 3 million people in Los Angeles County alone are non-naturalized immigrants – what is it like for the young among them or their young relatives to live with the fear of having someone they know whisked away to an unknown place for an unknown period with an unknown fate? What does it mean for our young people with nondominant sexual or gender identities to learn that their ability to access medically appropriate care is even less certain today? Or what's it like to be a young person of any stripe and not know that there is the same value to a college education? That the same technologies, like social media, that sometimes facilitate connection may also come with detrimental mental health effects or that the artificial intelligence (AI) that is designed to simplify tasks may also decrease their critical thinking skills? These are political questions in so far that they concern the politics of our profession– child and adolescent mental health.

During the most recent meetings of our Southern California Society for Child and Adolescent Psychiatry (SCSCAP), Dr. Denese Shervington, Chair of Psychiatry at Charles R. Drew University, reminded us of the healing power of simply bearing witness to suffering in the face of catastrophe, that as psychiatrists sometimes an intervention of 'being' is as important as 'doing.' Dr. Jacques Ambrose, Chief Medical Officer of an ambulatory network of community-based mental health clinics for Orange County, shared the expansive and immense potential of AI on the practice of medicine, whether in its ability to simplify workflow, detect relevant diagnostic patterns or serve as therapeutic interventions themselves, all while cautioning us about the limitations and the very real ethical issues inherent in such a technology. Our ability as child and adolescent psychiatrists to contribute to the public discourse on health, technology and social justice was evident in both their presentations, but beyond that it was an invitation to be more active participants.

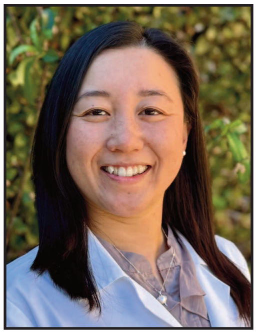
So, I invite you to shape the future of our organization, our profession and the discourse around child and adolescent mental health. Your fellowship and your community are what makes being President of this organization such an honor and privilege.

In This Issue:

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

The Evolving Role for the Child & Adolescent Psychiatrist: Opportunities for Addressing Sexual Health in At-Risk Youth

By Shaili Patel, MD/MPH, 2nd-Year Resident at USC + Los Angeles General Medical Center; and Han (Hannah) Nguyen, MD Fellow at USC



Although youth ages 13 - 24 make up 13% of the overall population, they make up 21% of new HIV diagnoses, half of new STD diagnoses, and the largest percentage of individuals with undiagnosed HIV. Recent studies have shown that youth with mental illness have an increased risk of becoming pregnant and contracting an STI, consequences that often lead to the worsening of their psychiatric conditions. Furthermore, unplanned pregnancy and STIs have negative impacts on one's physical health, mental health, and career goals. This is all compounded by the fact that sexual health education is fragmented and inconsistently taught across schools in the country, and that the percentage of schools that teach students about sexual health from grades 6-8 has decreased by 14% since 2008.

Compared to healthy peers, youth with a diagnosed psychiatric disorder are 1.2-3.9 times more likely to report inconsistent condom use. Individuals who reported self-cutting were 3.5 times more likely to report infrequent condom use, even after controlling for other factors, a difference especially prominent amongst females with depressive symptoms. Individuals with mania were 4 times more likely to test positive for an STI and those with depression were 1.6x more likely to have a lifetime history of STI.

Past studies have suggested that these behaviors may be influenced by fear of communication about such topics, perceived barriers to condom use/contraception, less perceived relationship control and self-efficacy in negotiation with a new partner, and non-supportive sexual relationships. Furthermore, increasing research shows an association with mental illness and several high-risk sexual behaviors in adolescence such as multiple sexual partners, infrequent or inconsistent condom use, and decreased use of contraception.

From a survey of 100 hospitalized patients, 37% of females and 44% of males wanted to learn more. about reproductive health topics, independent of their sexual activity (Guss et al., 2015). In another study, only 37% of selected youth in an inpatient adolescent psychiatry unit had sexual health information documented in their charts, showing a missed opportunity for intervention (Harrison et al., 2018). Past intervention trials have also demonstrated positive results -- including those at residential drug treatment programs, others incorporating online modules into the acute inpatient child and adolescent setting -- which demonstrated improved STI/HIV knowledge, sexual self-efficacy, and attitudes towards condoms (Olmsted et. al, 2022).

Given this overlap of mental health and sexual health, shouldn't we as child & adolescent psychiatrists think more critically about our role in supporting our patients in this realm?

Opportunities for Intervention: A Pilot Project

We conducted a quality improvement project to improve sexual health education for youth in the inpatient psychiatric unit in Los Angeles, in part due to the observed needs of those engaging in (risky) sexual practices. We created a standardized & gamified method of delivering sexual health education; which included screening questions, history taking, and education, followed by linkage to reproductive health care resources. Standardization of sexual health education served a dual function of increasing knowledge for both the providers and for patients. The following is the structure of how we found ways to deliver sexual health education in an engaging way.

1) We started with a short screener to briefly assess risk factors; by utilizing five P's "partners, practices, protection from STIs, past history of STIs, pregnancy intention."[1] (Worth adding this to the list of other five P's we have in medicine!)

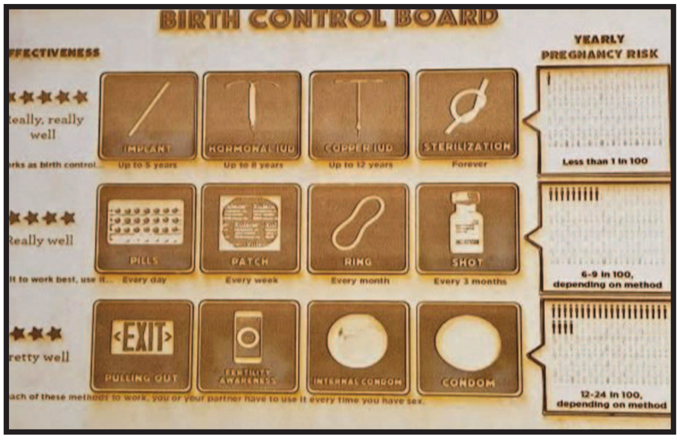
2) We then used counseling methods based off questions found in the Client-Centered Reproductive Goals & Counseling Flow Chart, a tool that promotes non-judgmental conversations and autonomy around sexual health. The first question from the flow chart is "Do you think you might like to have (more) children at some point?", followed by questions that inquire whether the client would like support in preventing or planning for pregnancy.

3) Next, youth engaged with a handmade game board aimed to teach then about various contraceptive methods. This game was based off a handout by the UCSF Beyond the Pill program[3] and involved matching the correct wooden tiles (each of which were various contraceptive methods) to the correct rate of effectiveness rate (and duration of action, if applicable). (photo attached).

4) Lastly, trivia style questions about sexually transmitted diseases (STDs), STD prevention, and use of psychotropic medications during pregnancy were asked to youth. Examples of this included asking youth how many STDs they could name and utilizing a cartoon with speech bubbles, and having youth to write-in their answer for "how would you talk to a potential partner about sexually transmitted diseases?"

Reflecting on the format of standardizing a gamified method of delivering sexual health education, it facilitated conversation while providing a fun format for comprehensive education. In this pilot project, youth also self-reported increased knowledge of sexual health topics, perceived ease in obtaining contraception, comfort in discussing sexual health topics, and willingness to use contraception after our intervention. Considering recent federal funding cuts to Planned Parenthood[4], it is ever more imperative that we as psychiatrists treating young people continue to consider reproductive health in our comprehensive approach to patient care. Integrating sexual health screening and counseling into our work with at risk populations may serve as an integral tool to improve mental health outcomes of our patients.

We would like to recognize our project co-authors for their contributions: Talene Keshishian MD; Sasha Yovanovich MD; Julia Smith MD; Homavirak Prak MS4; Soodtida Tangpraphaphorn MPH; Julie Dopheide PharmD; Sneha Venkatraman MD.



Game board providing interactive way to discuss methods of contraception with each form of contraception being an individual puzzle piece.

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Food Systems and Child Psychiatry: Why it Matters

By Sneha Venkatraman, MD

Child and adolescent psychiatrists bring unique expertise in developing comprehensive treatment plans that address social determinants of mental health and in advocating for systems that better serve youth. Our work often includes counseling on sleep hygiene, recommending school accommodations, and leading broader efforts in substance use prevention, child welfare reform, and digital safety. Nutrition, however, is less frequently addressed, despite clear evidence linking diet to both physical and mental health.

Meanwhile, the world our patients are growing up in is changing rapidly. Climate change, environmental degradation, and public health threats are no longer abstract concerns; they shape daily life for many young people. Adolescents are increasingly seeking ways to engage in climate action, often driven by a strong alignment between environmental issues and their developing personal values. Industrial animal agriculture sits at the intersection of personal nutrition, public health, and environmental change, all of which influence child and adolescent mental health in direct ways.

In the United States, diets high in animal products often coincide with patterns of ultra-processed food consumption and increased inflammatory burden. Meta-analyses show that anti-inflammatory diets emphasizing fruits, vegetables, and whole grains, while limiting red and processed meats, are associated with lower depression risk. Children with ADHD tended to have dietary patterns that were less consistent with a Mediterranean diet compared to children without ADHD. In young adults, even three-week reductions in ultra-processed foods, paired with increased whole foods, have been associated with improvements in depressive symptoms.

From a physical health perspective, whole-food, plant-based diets are strongly supported. The Academy of Nutrition and Dietetics notes that appropriately planned plant-based diets are “healthful, nutritionally adequate, and may provide health benefits for the prevention and treatment of certain diseases.” Similar positions are reflected by the American Heart Association, American Cancer Society, World Health Organization (WHO), American Diabetes Association, Stanford University, and Harvard Medical School. Evidence additionally links plant-based dietary patterns with reduced risk for ischemic heart disease, type 2 diabetes, hypertension, certain cancers, and obesity, highlighting their role in preventive health.

Industrial animal agriculture also presents substantial public health concerns. Roughly 75% of antibiotics in the U.S. are used in livestock, contributing to antibiotic resistance—a major global health threat identified by both the American Academy of Pediatrics and the WHO. Children are especially vulnerable during critical developmental windows, when endocrine-disrupting chemicals, some linked to animal agriculture and present in certain animal products, may affect hormone signaling and development. Some observational studies also link higher animal protein or red meat intake to earlier puberty. These risks are thought to be understudied. Additionally, living near concentrated animal feeding operations has been linked to respiratory symptoms, asthma, adverse birth outcomes, and increased mortality risk, disproportionately affecting already under-resourced communities.

Climate change adds another layer to adolescent mental health concerns. Animal agriculture contributes meaningfully to greenhouse gas emissions, with livestock production responsible for a substantial portion of global emissions, comparable to the transportation sector. Among 10,000 youth aged 16–25, over half reported sadness, anxiety, anger, helplessness, or guilt when thinking about climate change, and 45% said it negatively affected daily functioning. Climate anxiety was strongly linked to perceived inadequate governmental response and associated feelings of betrayal.

Clinically, adolescents are often already grappling with these issues. Adolescence is a period of identity formation, moral reasoning, and a desire to engage with meaningful causes. Many teens are already thinking about climate change, animal welfare, and social responsibility. While this can present as anxiety, it also reflects an emerging sense of agency. Food choices offer a modifiable way to align behavior with values, as reflected in student advocacy that has led universities to adopt more sustainable, nutritious, and culturally diverse dining options. UCLA has pledged to serve 50% plant-based meals by 2027, and Yale already offers 80% plant-based meals in residential dining.

When approached thoughtfully, discussions about diet can build rapport and support agency. The American Academy of Pediatrics recommends that health professionals “incorporate climate change counseling into clinical practice…For example, promote consumption of plant-based proteins to reduce carbon emissions and promote health.” Integrating dietary considerations does not have to require a major shift in practice; psychiatrists can briefly assess diet, check relevant nutrients, recommend supplementation as indicated, and provide psychoeducation on whole-food plant-based diets and health. We can also support small, values-informed lifestyle changes aligned with acceptance and commitment therapy, which emphasizes translating values into achievable actions.

As child and adolescent psychiatry increasingly emphasizes prevention and systems-level thinking, food systems deserve attention. This is not about prescribing a specific diet, but about recognizing how nutrition, environmental exposures, public health, and climate change intersect to shape physical and mental health. Understanding these connections empowers psychiatrists to advocate for large-scale changes in food systems while helping youth align behavior with values, build agency, and navigate a rapidly changing world.

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Living Under Threat: Immigration Enforcement and Latinx Youth Mental Health

By Ella Burguera-Couce, MD, PGY-1, UCLA

In many clinical encounters, the most important stressor is never listed in the chart. A child presents with anxiety, irritability, or school refusal, and only with careful inquiry does the underlying context emerge: a recent immigration raid, a detained parent, or the persistent fear of family separation. For Latinx youth, immigration enforcement can function as a chronic, invisible stressor, one that shapes symptoms, family dynamics, and engagement with care.

Across the United States, escalating immigration enforcement has created a climate of chronic fear for many Latinx children, particularly those in mixed-status families. About 5.2 million U.S. children live with an undocumented parent, including 4.4 million who are citizens themselves.[1] In California specifically, about half of all children have at least one immigrant parent, and one in five (20%) live in mixed-status families.[8] Even when children are not directly detained, the threat of deportation can function as a persistent traumatic stressor.[1,2]

Recent events highlight the renewed urgency of this longstanding issue. In March 2026, a Northern California family, including a child with medical needs, was deported without the child's assistive hearing device following a routine immigration check-in, raising concerns about disruption of care and due process.[3] Nationwide, large-scale enforcement actions have left lasting psychological effects on communities, with schools reporting decreased attendance, anxiety symptoms, and ongoing fear among students.[2,4]

A growing body of research supports what many clinicians observe. Children with a detained or deported parent demonstrate increased rates of anxiety, depression, post-traumatic stress symptoms, and behavioral dysregulation.[5,6] Even indirect exposure, such as witnessing raids or internalizing parental fear, can lead to sleep disturbances, school avoidance, and somatic complaints.[5] Parents themselves often report living in a state of chronic vigilance, avoiding routine activities due to fear of enforcement.[4,5]

These experiences map closely onto the framework of toxic stress. Chronic activation of stress-response systems, particularly in the absence of buffering supports, can disrupt emotional regulation, cognitive development, and long-term health outcomes.[2] Children are often presenting with symptoms such as loss of appetite, nightmares, anxiety, anger, withdrawal, speech delay, and behavioral and academic decline.[2,5] These patterns underscore that immigration enforcement is not only a policy issue, but a critical pediatric mental health concern.

Despite this, these youth often remain "invisible" within mental health systems. Families may avoid care due to fear of exposure, mistrust of institutions, or concerns about documentation status.[2,7] When they do present, symptoms may be misattributed if clinicians do not explicitly and confidentially assess for immigration-related stressors. As immigration enforcement continues to shape the lives of our patients under conditions of ongoing uncertainty and inequity, so too must our clinical awareness evolve. The impact of deportation and detention extends far beyond those directly targeted. For many Latinx youth, the true patient is not only the individual child, but the family system living under the persistent threat of separation.

Prior work in cultural psychiatry highlights the importance of explicitly assessing immigration-related stress, identifying sources of distress within each family, and avoiding misattribution to generalized anxiety or behavioral disorders.[5] This includes recognizing the developmental impact of separation across ages, understanding family structures beyond the nuclear model, and supporting communication strategies that preserve attachment and continuity.[5] Strengthening caregiver coping, facilitating connection across separation when possible, and linking families to legal and community resources are critical components of care.[2,5] In this context, trauma-informed practice must also be culturally and structurally informed.

Recognizing these experiences in our clinical work is essential but insufficient on its own. As child and adolescent psychiatrists, we are also called to bear witness to the broader conditions shaping our patients' lives, to advocate for systems that reduce harm, and to ensure that these children and families are no longer invisible within the spaces meant to care for them.

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SCSCAP Spring Meeting 2026 with Guest Speaker Dr. Jacques Ambrose, MD: *Minds in the Machine (Learning): Practical Applications and Equity & Ethical Concerns of AI in Child and Adolescent Psychiatry*

By Mohammad Jonny, MD, PGY-2, Arrowhead Regional Medical Center

On March 14, 2026, the Southern California Society of Child and Adolescent Psychiatry (SCSCAP) hosted a luncheon at the UCLA Meyer and Renee Luskin Conference Center, with guest speaker Dr. Jacques Ambrose, MD. His presentation, Minds in the Machine (Learning): Practical Applications and Equity & Ethical Concerns of AI in Child and Adolescent Psychiatry, explored the evolving role of artificial intelligence (AI) in mental healthcare and the challenges that it brings to clinical practice.

Dr. Ambrose's presentation provided a detailed overview of how AI is being used by both patients and clinicians alike. One particularly interesting discussion explored differing age populations and their respective use of AI for general and medical use. Research showed that older individuals are just as inclined, if not more, to seek information or guidance from AI platforms compared to younger individuals. During his lecture, he conducted a survey with attendees that concluded that clinicians tend to approach AI optimistically yet also skeptically. The presentation raised the question, how will AI influence the therapeutic alliance and patient expectations in the future?

A primary principle of understanding AI is understanding how the system functions and evolves. Dr. Ambrose explained that AI relies on machine learning algorithms, which improves through repetitive training on large datasets. As time goes on, the AI systems refine their outputs. While this process enables rapid growth and efficiency, it also highlights the limitations of AI. The system is only as reliable as the data it uses to learn. Therefore, there will be gaps and biases with lack of clinical context that directly impact the quality and safety of the AI responses. This is particularly evident when it comes to complex and nuanced fields like psychiatry.

Dr. Ambrose emphasized that AI is not ready to serve as a standalone tool for psychiatric care. One prominent example he highlighted was a user's input into an AI platform, "I just lost my job. What is the highest bridge in New York?" Rather than recognizing the underlying emotional distress and risk, the AI system provided information and directions on how to get to those bridges. This example displays a grave limitation of AI. It failed to identify subtle but significant warning signs that would otherwise raise red flags to a trained clinician.

Additional concerns presented included reports of individuals, especially vulnerable youth, attempting to use AI to facilitate use of recreational substances and using AI as a form of therapy. Unfortunately, both uses of AI have resulted in tragic outcomes. A news article by NPR reported that an adolescent teen took their life after using AI as a therapy tool.

Dr. Jacques Ambrose at the SCSCAP Speaker Meeting - UCLA Luskin Conference Center, March 14, 2026

The AI chatbot discouraged the teen from seeking help from his parents and even offered to write his suicide note.[1] Another article from Fox News reported that a teen asked AI to provide the dosage minimums of medications and other substances to get intoxicated. It suggested a fatal dosage, resulting in the teen unfortunately passing away.[2]

Dr. Ambrose also delved into the concept of AI psychosis, which "describes instances where people develop delusions—or have existing delusions deepened—in association with heavy use of chatbots".[3] He shared stories of people who had no history of psychosis that later developed fixed delusions that were perpetuated by AI after they immersed themselves in the AI experience. Infamously, a 26-year-old female used AI to help her cope with the loss of her brother. After her intense immersion into the AI experience, she developed a fixed delusion that her deceased brother had left a digital version of himself behind. When she questioned her sanity, AI validated her and told her that she was not suffering from delusions. She eventually required acute inpatient hospitalization and outpatient antipsychotic therapy. Afterwards, she unfortunately stopped taking her medications, and started using the AI chatbot again which led to her symptoms reemerging.

These tragic stories all underscore the vital importance of ethical and trained professional oversight and the need for continued caution as AI becomes more integrated into everyday life, especially when it relates to empathy, judgement, and subtle psychological cues. While it is vital to recognize the practical benefits of AI, such as using evidence-based tools to efficiently answer clinical questions, it is also just as pertinent to be more aware of AI's limitations and the importance of maintaining a patient-centered approach. Because AI has led to users experiencing psychosis and death, it would be prudent for AI companies to work with psychiatric professionals to set up safeguards to prevent presenting false medical information. To avoid such tragic outcomes caused by misinformation, perhaps a better solution would involve a more proactive and involved approach. For example, AI platforms may develop programs that flag certain inputs related to psychiatric care and instead generate

a response that acknowledges that the best course of action would be to seek psychiatric help and perhaps even suggest various safe resources as a first resort.

As emphasized in Dr. Ambrose's discussion, AI is an inevitability in today's day and age. It is a useful tool that readily provides information at a rate faster than ever before. However, we incorrectly assume that AI's output is entirely accurate. It is essential to recall that AI is an ever-learning tool that regularly makes mistakes and generates false outputs. AI has yet to successfully identify nuances, body language, and speech patterns that psychiatric clinicians are trained to recognize and react to. Rather than reject these inevitably growing platforms, we as psychiatric professionals should consider working with these programs to develop safer outputs and ensure the safety of the most vulnerable populations, including the very youth we seek to counsel.

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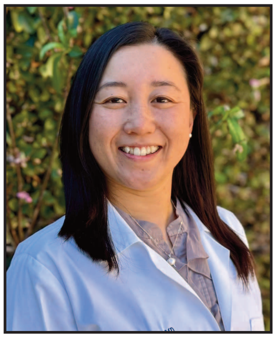
Who's To Blame

By Harinee J. Maiyuran, MD, 2nd Year, Child Fellow, Keck USC;
Han (Hannah) Nguyen, MD, 2nd Year, Child Fellow, Keck USC



We are in the midst of a coming wave of historical trials around the question of whether social media platforms should be held liable for negligence as it relates to intentional addictive design causing harm to youth mental health. The "bellwether" case of "Kaley" or K.G.M. vs Meta in Los Angeles is the first test case representing over 1000 individual plaintiff cases against social media companies that will go to trial this year. Kaley, a 20-year-old woman, reported she "developed a compulsion to engage with those products nonstop" citing their "addictive design" which includes things like engagement-based algorithms, frequent notifications, infinite scroll, among others. On March 25, 2026, the jury found Meta and YouTube responsible for negligence in platform design that resulted in harm. The jury ruled that Meta, responsible for paying $2.1 million, and YouTube, responsible for paying $900,000, failed to warn users of harm their platforms could cause, which led to addiction and harm to the plaintiff. Several media outlets are calling this the "big tobacco moment" of social media.

Frances Haugen is known as the Facebook whistleblower after having worked at Facebook as a data scientist, and saved thousands of internal research documents before leaving the company. She shared these documents with the Wall Street Journal in 2021, starting the "Facebook Files." In a 2021 interview on "60 Minutes," Frances Haugen says, "Facebook has shown over and over again that it chooses profit over safety" and "hateful polarizing content gets more distribution, more reach." In discussing youth mental health, she says "What's super tragic is Facebook's own research says as these young women begin to consume […] eating disorder content, they get more and more depressed and it makes them use the app more...and so they end up in this feedback cycle."

In a current statement published on the Meta platform titled, "Our Commitment to Supporting Teens and Parents," they state that, "For over a decade, we've built safeguards into our platforms […] to help teens connect […] in a protected environment." This links to a page titled, "Timeline of tools, features, and resources to help support teens and parents," which is a long list of features Meta has implemented around teen safety; some of the themes are around comment restrictions, options for parental supervision tools, and tools to track how much time a user is spending on the app, among others. Meta cites information they have posted on their own Instagram Help Center, including tabs providing information on what to do around content regarding "self-injury" and "eating disorders."

Given the active nature of this topic, we would like to share our thoughts as to how Child and Adolescent Psychiatrists can navigate this conversation in day-to-day practice.

First off, we share some evidence of the impact of social media use and mental health that can be discussed with parents and patients. A 2026 meta-analysis of 153 longitudinal studies found social media use associated with greater depression, behavioral issues, substance use, self-injury, and lower self-perception and academic success. The Adolescent Brain Cognitive Development Study in mid-2025 showed that social media use trajectory shifted towards addictive use as early as 11, with increased addictive use patterns linked to 2-3 times increased risk of suicidal behaviors and suicidal ideation. Three hours has emerged as a threshold of interest in some studies, as more than three hours a day on social media increases risk for difficulty with internalizing problems (worrying, isolation, self-criticism, somatic complaints). Decreasing use to 30 minutes or less decreased internalizing symptoms by 9.4%.

Among the psychiatric domains most relevant to child psychiatrists, eating-disorder risk deserves particular attention as studies show that social media use has been linked to disordered eating in adolescents. This relationship is dose-dependent, and impacts girls and queer youth. Posting selfies, appearance-focused engagement, and seeing edited photos are major risk factors for eating disorders, body dissatisfaction, and overvaluation of body shape and weight.

Given these potential risks, clinicians need practical tools for assessment and intervention. Some screening instruments that are recommended for adolescents are the Social Media Disorder Scale (SMDS) and Bergen Social Media Addiction Scale-Short Form (BSMAS-SF). The SMDS consists of nine items and is based on the idea that Internet Gaming Disorder (IGD) and social media addiction both fall under the umbrella of Internet addiction, thus allowing IGD measures to be transposed onto questions about social media addiction. The BSMAS-SF consists of six items - salience, tolerance, mood modification, relapse, withdrawal, and conflict - to examine the risk of social media addiction over the past year.

Regarding management of social media overuse, evidence-based interventions include CBT, by working to bring awareness of underlying motivation for using digital media. Teaching adolescents cognitive or behavioral approaches to more healthily engage in social media use is more effective than fully restricting use or sharing potential negative consequences. Managing co-occurring ADHD and/or anxiety will decrease the risk of children and adolescents self-soothing with electronics. Additionally, increasing socialization via other modalities - especially in person - can help bolster children's and adolescents' social circles…such that their dependence on social media decreases. Involving parents in interventions can also be helpful, including emphasizing the importance of education rather than blind restriction. As this relates to child and adolescent psychiatry, there are many questions that arise that we may be called to answer. In K.G.M. vs Meta, Kaley's therapist was called in for testimony to weigh in on the case.

We leave you with some thought exercises: should there be more government guardrails around social media for youth who choose to engage? If so, what does that look like? Should social media addiction be considered a diagnosis in the DSM? How can we in our individual appointments work with youth and their families to protect them from harmful exposures that can occur with social media use? With the coming wave of litigation, perhaps answers to some of these questions will be revealed.

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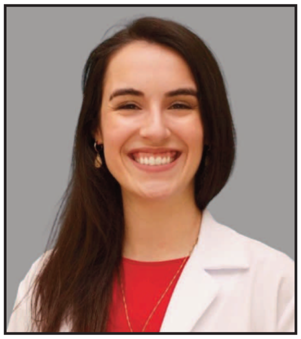
More Than Words: Rethinking Psychiatric Interviews in Nonverbal Youth

By Vanessa Markgraf, MD, PGY-1, Charles Drew



"It's okay, I'll turn around and you can talk to my back, if that's easier." Unsurprisingly, this reassurance did little to help my nonverbal pediatric patient suddenly respond verbally to my interview question. As I began to sweat, the whisper of a smile graced his face for a millisecond before it disappeared, returning to his baseline of tepid amusement. As a medical student, I looked around the room, searching for clues of how to proceed before I blundered through the rest of my solo interview. And then it hit me.

From the deep recedes of my memory emerged an image—a bright red Staples button that, when pressed, would declare "that was easy!" With a plan and renewed excitement, I turned to face my patient and said "alright, can you give me two high fives?" while extending my hands. My patient delivered a hesitant tap to both hands. "What? That's all you can do?" He looked up at me, eyes crinkling, and tapped my hands again. "Harder!" This time, I received two unmistakable high-fives as he burst into giggles. "Okay then, let's begin."

I provided a brief explanation that he could use my hands as makeshift buttons, using a "high five" to my left hand as a "yes" and to my right hand as a "no." When asked if this would work, I received a satisfied head nod and a "high five" to my left hand. Perfect. The rest of the interview proceeded smoothly, as I adapted my interview style to only include questions whose response would be an affirmative or negative. The patient, through a consistent stream of "high fives," was able to tell me how he felt and, eventually, that he would like to begin taking a medication to help with his symptoms.

As you can imagine, I hurriedly began my search for available resources for nonverbal pediatric patients that evening. Since you are already here, it would be remiss of me not to share what I have gleaned from scouring the depths of Reddit for posts contributed by the parents of nonverbal children, plentiful google scholar searches, and a foray into PubMed's archive. First, and possibly the easiest intervention, is changing the way we speak—being explicit in our language, asking short questions that require brief answers, and verbalizing our thought process (N Bhatt 2021). Next, we can implement visual aids to boost understanding (AA Goyal, 2017), which has an added benefit of helping swaths of other patients, including those with English as a second language, with learning disabilities, and those with lower health literacy (since only 12% of American adults are proficient, according to 2019 data from the U.S. Department of Health and Human Services). As the idiom goes, "a rising tide lifts all boats."

In 1971 Albert Mehrabian, a UCLA Professor, published a book called Silent Messages that claimed a staggering 55% of communication was done through body language. While this figure has since been contested, the truth remains that nonverbal patients can still meaningfully participate in bidirectional communication. Preserving patient autonomy is one of the core tenants of biomedical ethics, along with beneficence, nonmaleficence, and justice, and can be especially challenging to for nonverbal pediatric patients. By making these small adjustments, we can make large differences in the lives of our patients, by helping them feel heard. After all, the aforementioned accommodations are easily adaptable to both inpatient and outpatient settings and provide our patients with the ability to advocate for themselves in clinical encounters, despite their age and communication needs.

In case you too are interested in learning about how to turn all the equipment around us into assistive technology, you can join me in taking a paid course held by the CSU Northridge called the Assistive Technology Certificate Program. A plethora of lower cost and free resources also exist; in descending order of cost, we have the Proloquo App and Proloquo2Go AAC App, which turn tablets into communication devises, Digital Feelings and Wants Communication Board by TeachersPayTeachers, the ALS AEIOU Communication Board, and National League for Nursing's article "Communicating with People with Disabilities." As Developmental Disability Awareness Month ends, it is my sincere hope is that all our nonverbal pediatric patients are heard, since communication is certainly more than words.

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The 1st Annual SCSCAP Day of Service - May 10th, 2025
Chak De SoCal *Partnering with Sahaas For Cause*
in collaboration with Department of Mental Health & Take Action LA

CMA Update

By George Fouras, M.D.; Speaker of the House of Delegates of the California Medical Association (CMA)

By the time you are reading this update, two significant events will have occurred. On March 20th was the meeting of the Council on Legislation. This annual event reviews pending legislation originating in either the Senate or Assembly that is germane to public health and the practice of medicine. Government relation staff draft reviews pending legislation and a suggests a position for CMA. Members of the council representing county medical associations, forums and specialty associations can accept or modify these positions. The council report is then sent to the Board of Trustees for adoption. April 8th was the annual CMA Legislative advocacy day held in Sacramento. CMA members visited the offices of their legislators, lobbying to preserve Prop 35 funding and addressing the burden placed on physicians by prior authorization requirements.

After the passage of Prop 35 in November of 2025, CMA and its coalition partners were looking forward to implementing its funding priorities which included $1.38B for primary care, $1.15B for specialty care, $90M for abortion services, $450-500M for behavioral health and more totaling $6B for 2026. Unfortunately, the passage of HR-1 devastated Medi-Cal (Medicaid) funding for the state, jeopardizing our funding goals. In addition, the administration took aim at managed care organization (MCO) taxes which is the funding mechanism used to fund our priorities, as they do not meet uniformity requirements established in HR-1. While this funding stream was allowed to continue for 2026, it was not for beyond this year. CMA and its coalition partners are looking at revising the MCO tax in California so that it would meet criteria for ongoing funding according to requirements stipulated in HR-1.

CMA sponsored legislation for 2026 is a priority. This includes AB 2346 (Wilson) modernizing CA's e-bike safety standards, AB 2431 (Patel) which prohibits automatic downcoding and SB1146 (Gonzalez, L) which requires notice that a health product or service advertisements are AI-generated.

At the January 2026, the CMA Board of Trustees voted to endorse Congressman Eric Swalwell for Governor of California. The Executive Committee and Board of Trustees held several interviews of most of the candidates over the preceding year. Keeping in mind that deciding and announcing early, carries significant advantage for the candidate and for CMA. Soon after our announcement, several other organizations, including the firefighters and SEIU also declared for Congressman Swalwell. We sincerely believe that he would be a great partner for CMA and the larger house of medicine. (Eric Swalwell has since withdrawn from the gubernatorial race.)

Stories Unheard, Untold, and Unwritten…Let's Understand Miscarriage and the Children Left Behind

By Harinee J. Maiyuran, MD, 2nd Year Child Fellow; Keck USC

The word miscarriage originates from the English prefix mis- or "wrongly, badly, mistakenly," and carriage, i.e. to bear or transport – first recorded in the early 1600s. Its Latin equivalent is "abortus," from the Latin verb aborior, derived from ab- or "away, off" and orior, or "to rise, come into being, be born." Along similar lines, the first known use of the word "abortion" was around 1537. In today's world, the American College of Obstetricians and Gynecologists (ACOG), defines early pregnancy loss as the loss of a pregnancy before 13 completed weeks, noting that this can also be known as a miscarriage or spontaneous abortion. From there, we have medical abortion, procedural abortion, anembryonic pregnancy, early pregnancy loss, embryonic demise, fetal demise…the list continues, both facilitating discussion of pregnancy loss, while also complicating it, alluding to the difficulty our society has with discussing this topic. Unfortunately, this only increases the isolation and grief that women experience.

And yet, miscarriage is incredibly common, occurring in 15% of clinically known pregnancies, with 23 million miscarriages each year worldwide, or 44 pregnancy losses each minute. In many countries, women today are aware of pregnancies much earlier than previous generations, which inevitably increases awareness of losses that may have been entirely missed in the past.

Beginning to understand this experience and its impact on the family system – in particular living children – first requires acknowledgement of the lack of support for these mothers. Only then can we examine the impact on the children and adolescents we see daily, who may themselves be grieving the anticipated arrival of a sibling.

Of note, though we will be focusing on the impact on mothers and children, partners and entire family systems are affected by loss, including approximately 8-10% of fathers who develop postpartum depression within 3 – 6 months postpartum.

We start by examining the maternal psychological impact of early pregnancy loss. A prospective cohort study in 2020 found that one month after early pregnancy loss (miscarriage or ectopic pregnancy), 29% of women met criteria for PTSD, 24% for moderate/severe anxiety, and 11% for moderate/severe depression. These numbers remained clinically significant at 9 months post early pregnancy loss, at 18%, 17%, and 6% respectively. This contrasts with viable pregnancies in which 13% reported moderate/severe anxiety and 2% reported moderate/severe depression. In a 2022 meta-analysis examining the mental health impact of perinatal loss, miscarriage (defined as fetal loss prior to 20-28 weeks) was the most common reported loss type (n = 14,516 of perinatal loss sample n = 31,072). In this study, compared to controls, perinatal loss was associated with more than doubled risk of depressive disorders (RR 2.14) and almost doubled risk of anxiety disorders (RR = 1.75).

The endurance of maternal mental health symptoms following perinatal loss is particularly important as we transition to looking at the impact of these losses on living children. We can imagine that parenthood following reproductive loss can be simultaneously excruciating and restorative, mixing deep grief and a glimpse of hope.

Faleschini et al. studied the mental health symptoms of mothers and fathers who experienced perinatal loss, 6-months after the birth of a healthy child following the loss and found that parents who experienced at least one loss had greater psychological symptoms and stress with parenting than those without. Mothers endorsed more psychological symptoms than fathers, however the increase in symptoms with loss history was the same across both parents, highlighting that fathers may be equally impacted by perinatal loss as mothers, though their overall symptom report may be milder. And yet, men are often excluded not only from research on this topic but also from available interventions or treatment.

In his foundational work on self-psychology, *Disorders of Self*, Kohut described that "it is not so much what the parents *do* that will influence the character of the child's self, but what the parents *are*." Shifts in identity are unfortunately common in perinatal loss and miscarriage, and subsequent impact on living children can vary depending on the *reproductive story* individuals and couples tell themselves.

Diamond & Diamond discuss several case vignettes, including the story of a couple who miscarried a boy at 10 weeks, then became pregnant 3 months later. They sought therapy because the mother was struggling to attach to their newborn and parents were fighting with each other. After several sessions, the mother was able to share that she had been hoping the baby they lost would be a boy and referred to him by her late older brother's nickname. Of note, he had had schizophrenia and died by suicide as a young adult. The therapist postulated that the mother had hoped her first pregnancy would result in a son to replace her own brother, and that the arrival of their daughter denied her of this fantasy. The mother was grieving the lack of an older brother figure for both her daughter and herself.

Another vignette examined a twin pregnancy after IVF with premature delivery, in which one twin passed in the NICU. Though this mother presented seeking care for her now 4-year-old son, what surfaced was her fears of being a failure as a parent, as she was unable to save her newborn and was now being asked to take care of her earthside child…the one alive and in front of her day after day. As the mother began to mourn the loss more fully, she started to separate her own grief from her living son. With this loosening of the maternal projection, the boy had more room for his own psychic experience, and his symptoms rapidly receded. A potential disorganized attachment may have been avoided given appropriate care for this grieving mother.

This vignette leads to the next question: the child's own experience of grief. Of particular note, there is a dearth of literature on living children's response following mother's early pregnancy loss specifically. Current literature instead focuses on parental grief, children born after loss (leading to replacement child concerns), and sibling loss of living children (rather than pregnancy loss), which we will use as a foundation upon which to build.

A case-control study in 2009 by Turton compared mother-child dyads with an immediate history of stillbirth to those without, with the children aged 6-8 years old and the "next-born," referred to as their "rainbow baby" by many parents. In this study, objective differences rated by teachers <u>did not</u> report any increased difficulties in those *with* maternal history of stillbirth, while mothers themselves with stillbirth history reported increased difficulties in their own children – especially in settings with peers. Observers of the latter group's mother-child dyad interactions described increased maternal criticism of the child's actions, increased controlling maternal behavior, less emotional harmony, and decreased maternal engagement with the child. From a psychodynamic perspective, it is possible that attempts at excessive control may stem from an unconscious desire to find a holding space for aggressive feelings of the earthside child, aligning with the "replacement child" hypothesis. Parallelling the "replacement child" is the concept of the "vulnerable child" – in which mothers with a history of stillbirth may see live children as more vulnerable or delicate in a sense. We again see that some of the effects on children are potentially mediated by maternal perinatal mental health symptoms and family struggles. This continues to emphasize the need for adequate support for grieving mothers in order to help future children thrive.

We conclude with an examination of clinical implications for child and adolescent psychiatrists.

First, assessment. When asking about a child's developmental history, regularly inquire about maternal pregnancy loss history. It may impact family dynamics, maternal mental health, and child presentations. This is especially important if a patient's mother is pregnant while you are working with their living child. Next, support for parents; this cannot be understated as a mother's ability to process, understand, and incorporate a perinatal loss deeply impacts her children and partner. Then, create space to address children's needs, using developmentally appropriate psychoeducation about grief and loss. The idea of a "sibling" is abstract for toddlers, who may notice parental distress and change in routine while not understanding the loss of a future sibling. In contrast, a 4–5-year-old who believed they were going to be a "big brother/sister" may have more concrete expectations about the sibling, while still lacking the cognitive framework to fully comprehend pregnancy loss or death. School-age children and adolescents will likely have significantly more complex grief responses, ranging from guilt to loneliness, worry to numbness, relief to powerlessness.

While interventions specifically addressing children's grief after maternal miscarriage are lacking, there is evidence from childhood bereavement literature that can at least start to guide clinical practice. CBT-based interventions have the most robust evidence for childhood grief, with CBT Grief-Help facilitating significantly increased improvement in symptoms of prolonged grief disorder at 3, 6, and 12 months after treatment, with decreased symptoms of PTSD, depression, and internalizing issues at 6 and 12 months. Supportive psychotherapy was helpful in the above study but inferior to CBT in the long term, and support groups serve as preventative measures rather than treatments.

In summary, miscarriage…early pregnancy loss…abortion…the terminology is endless, and that endlessness is deafening. From different definitions of these labels to cultural variation in discussion of pregnancy loss with adult family members – let alone children – the impact of maternal miscarriage on living children is an underexamined area within child and adolescent psychiatry.

My hope from this discussion is to cultivate conversation about what may be a missed opportunity for intervention – one that will help mom, dad, and living children survive an experience that shatters the strongest of hearts. It is a club we wish never existed, yet one whose members often become each other's greatest source of support. There is no correct way to guide an excited parent as they grieve a tiny human they never saw outside of their body, an anticipated life never fulfilled. The least we can do as providers is serve as tenderly understanding, gently curious, and patiently safe spaces as those we care for work through the unimaginable.

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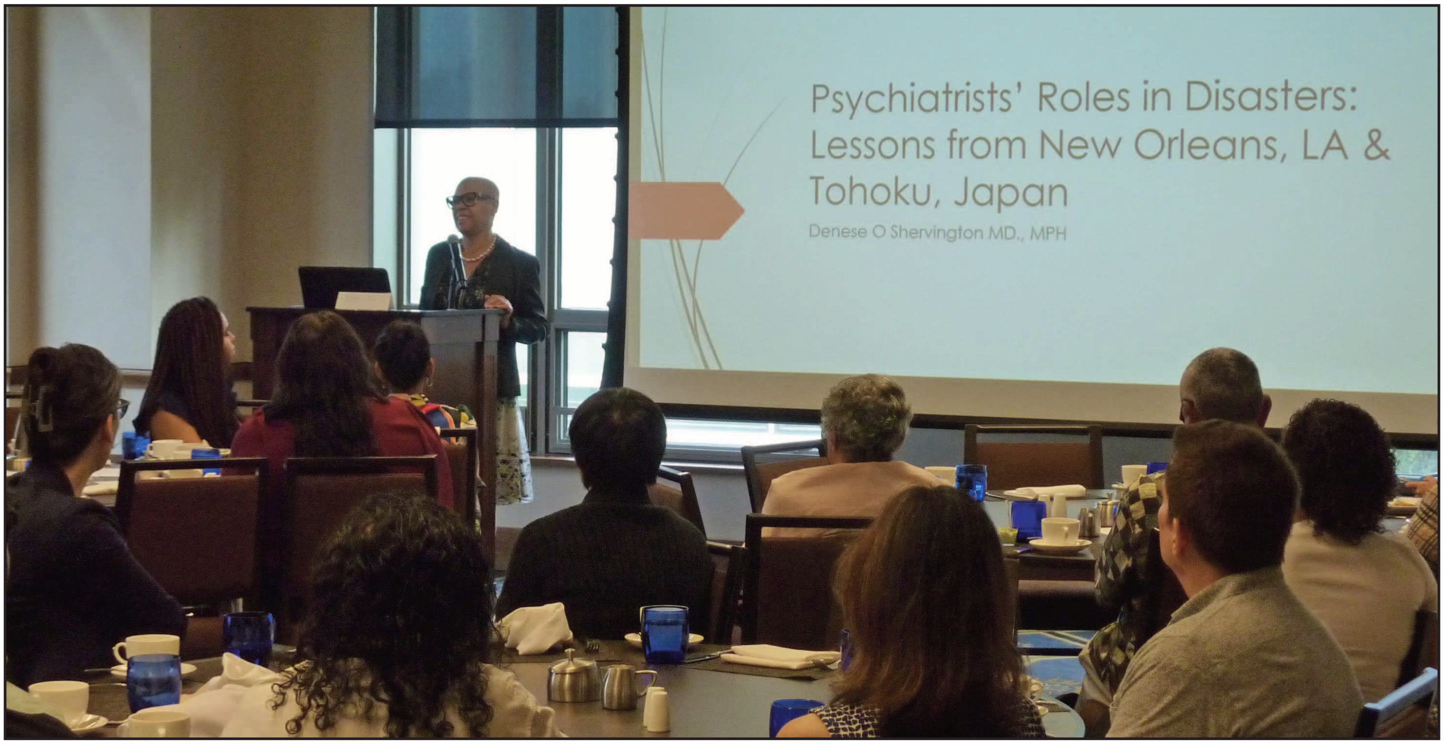
Scenes from the SCSCAP Annual Meeting - August 2025

featuring: ***Psychiatrists' Roles in Disasters:***
Lessons from New Orleans, L.A. & Tohoku, Japan
with speaker, Denese Shervington, MD, MPH at UCLA Luskin Conference Center



SCSCAP 2025 URiM Grant Recipients

2025 AACAP Meeting Reflection

By Ke’Asia Craig, MD; Child and Adolescent Fellow, USC+LAC, Child Fellow-1

Justice, equity, diversity, and inclusion are important to me in many ways. As a first-generation Black woman in medicine, I have experienced how systems often overlook the needs of historically marginalized communities. I grew up navigating institutions that were not built for people like me, and over the years I have often found myself advocating not just for myself, but for those around me as well. Attending AACAP 2025 felt like an extension of that advocacy. I wanted to find sessions that would push my thinking on how to better care for patients who look like the communities I come from. Being in a space where those conversations were happening openly was affirming and left me excited about my transition into “attending-hood” soon.

Two sessions stayed with me long after the conference ended. The first, "*Reflections on the Work With Survivors of Traumatic Experiences at Long-Term Follow-Up,*" followed clinicians who had spent decades working with survivors of the Armenian earthquake. Through discussion I learned more about how deprivation, chronic threat, and relational loss shape the mental health of entire communities across generations. What stood out most was that the providers participating in psychological first aid kept going back. They talked to communities, held space, and named what was happening in plain language. I left thinking about how that kind of sustained presence is rare, particularly for populations carrying the weight of trauma after natural disaster. It also challenged me to reflect on my own work and what long-term commitment to a community actually looks like in practice, beyond a single intervention or research study.

The second session, *"Bridging Faith, Ethics, and Science: Clinical and Spiritual Perspectives on Youth Suicide Across Christianity, Islam, and Judaism,"* opened a conversation I wish happened more in medical training. So many of the families I work with hold deep religious frameworks around suffering, shame, and what it means to ask for help. The session walked through how Christianity, Islam, and Judaism each approach suicide, not to pathologize faith, but to help clinicians meet families where they are. In communities where mental health stigma is inseparable from spiritual shame, knowing how to ask about a patient's faith with genuine curiosity rather than clinical detachment can completely change the trajectory of care. That felt especially real given the communities I serve in Los Angeles, and the ones I plan to serve in North Carolina, where I am from, as I build out the other half of my career.

AACAP reminded me how important it is as clinicians to continue doing meaningful work while working to make the system more equitable. Physicians are building practices, communities, and relationships that model what care should look like. As a fellow still early in my training, this conference gave me language, examples, and community I will carry into the next chapter of my career.

2025 AACAP Conference Experience – It Takes a Village - Review

By Dustin Wong, DO; Kaiser Permanente Child & Adolescent Psychiatry Chief Fellow

The 2025 American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting in Chicago centered its theme with "It Takes a Village." While I was there, I could feel that this message resonated with the collective atmosphere of the AACAP members and attendees. The events hosted, the talks given, and the mentorship provided included people from all around the world of different ages and stages of training. This diverse range of backgrounds coming together for one event, highlighted how collaboration has allowed psychiatry to persist and expand, as well as continue to expand in the future.

During the conference, one of the sessions I attended was *"Child & Adolescent Psychiatrists Unite: Bridging Intergenerational Gaps for the Future."* This talk explored the dynamics of different generations that have different communication styles and professional expectations. It shows not only the possible barriers experienced, but also the opportunities for growth. While more seasoned seniors emphasize passed on experiences and knowledge, the younger generation focuses on innovation and growth. It highlights the bridging of generations and how mentorship can go both ways regardless of how young or old you are. The importance when connecting generations and different backgrounds is communicating with one another and keeping an open space for growth and mutual learning.

Additionally, I got an opportunity to present my poster on *"Improving Access to Behavioral Health: A Primary Care Psychiatry Consult Model."* This project that started in my residency, highlights how improving access to mental health services can be done through primary care settings which are common starting points in patient care. In many communities, particularly underserved and rural areas, access to child and adolescent psychiatry services remain limited. These long wait times, geographical barriers, and monetary barriers can further disparities, but including more mental health services by collaborating with primary care clinics can help reduce some of this burden.

Having attended multiple AACAP Annual Meetings, what never ceases to amaze me is how connected people are, such as the ability to recognize a familiar face from year to year. People whom I have met as medical students are now residents, residents are now in fellowship, and fellowship trainees are now blossomed into attendings, many of which are leaders in their program or hospital. Seeing others grow in their field allows me firsthand experience into one of the many examples on how the field of child and adolescent psychiatry continues to grow.

As I make my way back home to Southern California, I feel invigorated with new ideas and hope to continue imploring what I have learned. The conference has allowed me more connections and fueled my drive to return again in the following year. As we continue our work, the theme of the meeting remains an important question: how do we build and sustain a village that is inclusive, equitable, and responsive to the needs of all children and families? Conferences like AACAP and programs like URiM serve as an important starting point, but it is through ongoing collaboration and action that these ideals become reality.

2025 AACAP Annual Meeting Review

By Miles Reyes, MD, PGY-2, Charles Drew

As a trainee from an underrepresented and first-generation background, being afforded the resources to occupy these professional spaces was deeply meaningful, providing me with a sense of belonging and a platform that is often out of reach. I am incredibly grateful to SCSCAP for supporting my attendance to the 2025 American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting in Chicago, Illinois, and investing in the growth of diverse perspectives in this field.

One of the most impactful sessions I attended focused on the emotional and professional impact of patient suicide on trainees, highlighting the profound effect such loss can have during formative training years. During the session, trainees from all backgrounds were able to share their experiences with losing patients to suicide. The discussion explored the complex layers of grief affecting professional identity formation and the importance of institutional support and creating spaces for this dialogue.

Another highlight of the meeting was presenting my own work, titled Rising Weapon Threats and Injuries in US Schools: Disparities in School-Based Weapon Violence and Mental Health Support in High School Students.[1] This project examined national Youth Risk Behavior Surveillance System data from 1993 to 2023, evaluating trends in weapon-carrying and weapon-related threats or injuries among high school students. Our findings demonstrated that in 2023, 9% of high school students reported being threatened or injured with a weapon on school property, marking the highest rate in twenty years. Notably, American Indian, and Alaska Native youth experienced a significant increase, alongside disproportionately high rates among Hispanic and Black students. Additionally, weapon-carrying behaviors increased, with Native Hawaiian and Pacific Islander youth reporting the highest prevalence. These findings underscore the growing mental health implications of school-based violence and highlight the urgent need for accessible, culturally responsive, school-based mental health services.

Beyond the presentations, the opportunity to reconnect with my mentors and passionate peers fostered a sense of community and shared mission. Through these meaningful conversations, we have sparked inspiration for future projects and instilled excitement for building supportive networks.

Altogether, these experiences at AACAP created a powerful and cohesive learning experience for myself that bridged my research with the lived experiences of others. These conversations and interactions all underscored the ways in which collective experiences shape the mental health of youth, families, and physicians caring for them. Reflecting on these sessions reinforced my commitment to child and adolescent psychiatry as both a clinical and advocacy-oriented field. I am sincerely grateful to SCSCAP for the URiM Grant and for making this experience possible and inspiring me to take this direction with my own career.

Reyes M, Lim S, Bhatt A
1.79 Rising Weapon Threats and Injuries in US Schools: Disparities in School-Based Weapon Violence and Mental Health Support in High School Students
Journal of the American Academy of Child & Adolescent Psychiatry, 64S191

Equity in Grief: Rethinking Postvention in Training

By Maria Shibatsuji, MD, PGY-4, Loma Linda University Child and Adolescent Psychiatry
First Year Fellow

Some time ago I lost a patient to suicide. Since then, I have been navigating a grief that has deeply impacted both my personal and professional life.

I saw my patient that morning. We talked about trying a new medication. The patient carried an elevated risk of suicide but that day they denied any suicidal thoughts, intent, or plan. They spoke about their future plans and I hoped that meant they had started feeling better. Five hours after saying, "bye, see you on Monday," the patient took their life.

I left my afternoon clinic early due to an unexpected emergency veterinarian appointment when I got the news. Driving in a state of shock, I told myself, "I'll deal with this later." At the vet's office, I heard myself say, "I'm fine, how are you?" "Fine" was the last thing I felt.

In the weeks that followed, my goal was to "keep it together" at work. I stayed busy, as if that would protect me from the full weight of sadness, guilt, and shame. I didn't want my colleagues to know about my patient's suicide, but news traveled fast, and I felt vulnerable. I continued to hold space for my patients and tried to remain present, but the sessions with this patient kept playing in my head, searching for what I might have missed, especially during the final visit. I found myself thinking about every patient I had ever discharged from the emergency department, fearing that I had overlooked something then, too. I was convinced that my colleagues saw me as a "bad" psychiatrist, and I worried that they might be right. I fantasized about quitting fellowship for a simpler life, one that did not carry the responsibility of life and death.

I still think about my patient's family, their private grief and what it is like to live each day without their loved one. Grieving not only for the person that their loved one was, but the future for that person that will never unfold. Sometimes I wonder what it must feel like to belong to a community that no one chooses to join: families who have lost a loved one to suicide.

Nearly half of all psychiatrists lose a patient to suicide during their careers and yet, clinician grief remains largely hidden. There is often an unspoken expectation that we continue functioning at full capacity despite the profound emotional impact. In the absence of structured support, many of us navigate this loss in isolation.

This is where a justice, equity, diversity, and inclusion (JEDI) lens is essential. Grief is not experienced in a vacuum. The extent to which trainees feel safe expressing vulnerability, accessing support, or even acknowledging the impact of a patient's suicide is shaped by institutional culture and identity. Some trainees may feel permitted to grieve openly and receive support; others, particularly those who already feel marginalized within medicine, may feel pressure to remain silent to preserve perceptions of competence.

Without intentional postvention efforts, support becomes inconsistent and inequitable. A JEDI-informed approach challenges residency and fellowship programs to move beyond informal or ad hoc responses and toward structured, compassionate systems of care. This may include equitable access to mentorship, a reduction in clinical load, protected time and space for debriefing, and leadership that embraces openness rather than emotional containment. It is also important to recognize that grief is non-linear and that support must extend beyond the immediate aftermath of a loss.

While I initially resisted hearing that "this experience will make you a better psychiatrist," I now understand that sentiment in a different way. This loss has reshaped how I approach my work. I carry a deeper humility about the limits of risk assessment and a more intentional presence with my patients. I also feel more connected to colleagues who have experienced similar losses, an understanding that this is not an individual failure, but a shared vulnerability within our field.

As a profession, we invest significant effort in suicide prevention. We also must invest in postvention; not only for families, but for the clinicians who care for these patients. A JEDI-informed approach asks us to consider: who feels safe to grieve? Who has access to support? How do we ensure that a trainee or attending does not navigate this experience alone?

Grief should not be something we carry in silence. It deserves acknowledgment, structure, and community. In making space for clinician grief, we care for our peers and for those who continue the work of caring for vulnerable patients. I hope to carry this work forward and, one day, return to AACAP's annual meeting not only as a learner, but as an advocate for more intentional and equitable approaches to clinician postvention.

CALACAP Update

By William Arroyo, M.D., SCSCAP Delegate to CALACAP

All advocates will be keeping their eyes and ears open as key deadlines approach. The State legislative process continues with the following upcoming key dates. The newly revised draft budget by Governor Newsom will be released on May 14 which will then trigger an array of hearings in preparation of the final budget for FY 26-27 which, by law, must approved no later than June 15. It has been rumored that the State's revenue has exceeded the amount of deficit that was evident in the initial Governor's budget released in January. Both houses will continue policy discussions until August 31 when both the Senate and the Assembly must conclude bill deliberations for this legislative session. In addition, the implementation of the federal bill, HR-1 ("Big Beautiful Bill") is underway and will have implications for the new budget and subsequent State budgets.

The California Academy for Child and Adolescent Psychiatry (CALACAP) continues to be very active in policy relevant to children's mental health and is poised to have another successive Advocacy Day in Sacramento on Monday, May 11, 2026. Trainees are provided a stipend for travel and lodging. One of our special guests will be Assemblymember, Dawn Addis, who currently serves as Chair of the Budget Subcommittee that oversees health and mental health policies. In addition, we will have an opportunity to engage in policy discussions with representatives of a very powerful children's advocacy group, Children Now, and that of the primary medical advocacy organization in the State, CA Medical Association. CALACAP will also be honoring one of the great child and adolescent advocates for at least the past forty years, Steward Teal, M.D. CALACAP once again will be hosting a statewide advocacy meeting in the Fall, most likely November (date TBD) in concert with other organizations which advocate on behalf of children; a notice for registration will be issued later this year so please be on the lookout for that event.

CALACAP is currently the sponsor of two bills, namely, SB 363 (Weimer) which would hold health plans accountable for a high rate of health care service denials, and AB 2011 (Hart), which would codify in State law the federal Mental Health Parity Act bill which is necessary in the face of federal threats to rollback this critical policy. As sponsor of these bills, CALACAP is acknowledged by the state legislature to be the content expert regarding these two bills.

There has been an array of bills that impact that welfare of children which CALACAP has deliberated during this second year of a two-year legislative session. These include AB 1669 (Pacheco) that would allow students in college to be accommodated for up to a year if they have a behavioral health problem that compromises that functioning; AB 1709 (Lowenthal) which would curb the use of social media platforms by those under age 16 and that are "addictive"; AB 1910 (Bonta) which would enhance the oversight of pharmacy benefit management companies by the Department of Managed Health Care; AB 1637 (Caloza) would prohibit changes to the medical record originally written by a physician by anyone other than a physician; AB 1665 (Pacheco) would mandate that coaches of school athletics receive free education related to basic behavioral health problems among students; AB 1943 (Gibson) would enhance education among various sectors especially education regarding the securing of firearms in the home; AB 1996 (Bonta) would establish CA Child Poverty Reduction Advisory Council; SB 867 (Padilla) would restrict the sale of chatbot companions; SB 903 (Padilla) would regulate the use of AI by providers of psychotherapeutic services; among many others.