

PRESIDENT'S COLUMN

By Patrick Kelly, M.D., SCSCAP President



It has been one of the greatest joys of my professional life to have served as the President of SCSCAP during this past year. Understandably, this joy has been tempered with struggle, as it has for all of us. Our newsletter contains articles detailing

both sides of this coin, reviewing the triumphs of our organization over the past year, as well as presenting areas of our field still in need of review. We also discuss how we can (and must) take better care of ourselves as clinicians.

SCSCAP has had a productive year, supporting and educating our membership. In November, our organization, together with the Southern California Psychiatric Society, hosted Dr. Rupinder Legha for a (virtual) forum on Antiracism, Abolition and Psychiatry. An article by Dr. Borlik reviews this presentation and its greater impact on our field. It has never been more important for our discipline to no longer settle for attempts at neutrality, but to take up the mantle of actively fighting against racist ideas, everywhere from our clinical practice, to our research questions, to our daily lives.

We also present an article by Dr. Wyman reviewing the impact of COVID-19 on child abuse reporting. While reports of and visits for suspected child abuse initially decreased, this was likely driven more by decreased ER visits overall, decreased surveillance in a child's life (through social and educational isolation), and a fear of involvement with law enforcement due to worsening economic insecurity. In actuality the rates of abuse may have gone up – particularly psychological or emotional maltreatment.

An article by Dr. Khan reviews the importance of contextualizing a patient's story, not only for a deeper understanding of the events of their life for our own diagnostic acumen, but as a therapeutic technique. Dr. Khan reviews the many uses of contextualization across various psychotherapeutic modalities (frequently known by different names), and the common thread through which it can validate and deepen a patient's understanding of their own experience.

This issue also discusses the recent rise in the utilization of the emergency room by children and adolescents in psychiatric crisis. Although, as always, the etiology of this trend is multifactorial, it seems particularly exacerbated by the confluence of an increase in need during the COVID crisis and a reduction in available resources to meet this need. At our own facility, we have had more than a few visits by frustrated parents simply due to the fact that the ER was the only location available where they could procure a face-to-face evaluation for their struggling child.

Finally, I review some elements of provider wellness, using my own story as a call to action to all of us to recognize our own need to take better care of ourselves during this trying time. Wellness can be a dirty word in the medical profession, denoting anything from a sort of dual message from administrators of

In This Issue:

President's Column
Antiracism, Abolition and Psychiatry
Child Abuse During the Covid-19 Pandemic
Psychiatric ER Visits During Covid
Contextualization -
More Than Just History Taking
Advocacy and Children's Mental Health
Practitioner's Wellness: A Cautionary Tale

“take care of yourself so you can work harder,” to a non-sense concept full of unproven and trivial methods with no real efficacy, to a code-word for unproductiveness or even laziness (“they’re taking off a wellness day”). I review some of the evidence summarizing the actual crisis a lack of wellness presents, discuss how inattention to wellness landed me in the cardiac care unit, and open the discussion as to how we must change our focus as a field to prioritize our own care so that we can continue to be useful to our patients and our communities.

I hope you enjoy our newsletter, and remain happy and healthy in the coming year. Remember to take the advice you give patients each and every day – slow down, reflect, and prioritize those activities which are good for you and which improve your well-being. Have a happy and healthy year, and thank you, as always, for the work you do supporting our organization and our community.

Antiracism, Abolition, and Psychiatry

By Marcy Forgey Borlik, MD, MPH, DFAACAP, DFAPA; Delegate to CALACAP

The Southern California Society of Child and Adolescent Psychiatry and the Southern California Psychiatric Society welcomed Dr. Rupinder Legha, MD, Assistant Clinical Professor of Psychiatry at UCLA, to our annual joint “virtual” meeting November 22, 2020. Her talk, “Antiracism, Abolition, and Psychiatry,” was very well attended.

Dr. Legha described the legacy of white supremacy in the United States and its relationship to police brutality, social inequity, and structural racism on Black, Indigenous People of Color (BIPOC). She also illuminated the impacts of this legacy on the medical field and the burdens and traumas faced by both Black and indigenous students and patients, leading to activism among students and residents to demand antiracism in medical education to combat systemic racism in America.

Dr. Legha recommended the following books to help us begin our journey toward antiracist education: *Me and White Supremacy* by Layla F. Saad, *The Racial Healing Handbook* by Dr. Annaliese A. Singh, and *How to be an Antiracist* by Ibram X. Kendi.

Antiracist Clinical Care

Dr. Legha identified the following steps toward the provision of antiracist clinical care: 1) learn about America’s legacy of racism to avoid perpetuating it; 2) admit to our personal racism as a prerequisite for antiracist care; 3) pause to heighten racial awareness and prepare to challenge racism; 4) identify and oppose racism at the individual, institutional, and policy level; and 5) assure reporting and accountability.

She described the history of scientific racism through polygenism, eugenics, sterilization, holocaust, and IQ testing. She highlighted the overdiagnosis of schizophrenia, conduct disorder, borderline personality disorder and underdiagnosis of mood disorders and Post Traumatic Stress Disorder among black individuals. She also called attention to their higher rates of hospitalization, restraint, reporting to child protective services and their disproportionate accusation of “malingering” or “secondary gain.”

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Dr. Legha followed with strategies for the provision of antiracist clinical care. Some examples include: eliminating coercive measures like seclusion, restraint, and intramuscular injections; ceasing to report families to child protective

services; eliminating denials and refusals of care; acknowledging patients' perceptions of discrimination and mistreatment as valid; and listening carefully to the subjective complaints of our patients, with sensitivity to their trauma and suffering.

She also explained the importance of language and stated that we commonly use pejorative phrases to describe minoritized patients. She provided some examples. "That child is oppositional." "This family is difficult." "That's a frequent flier." "She's just like that." "The patient no-showed." "Patient is at baseline." "They're not a good fit for this clinic." "He's a malingerer." She recommended that we eliminate such language in our discussions and documentation.

Antiracist Supervision

Dr. Legha implored supervisors to recognize racism as the public health crisis of our time and confront their own racism, heightening their own racial consciousness. In addition, she insisted that for antiracist supervision, they must master foundational knowledge pertaining to racism, challenging historical arcs in health care. She provided some examples of such history, including physical exploitation and human rights abuses toward blacks, narrative of racial difference (black inferiority and white superiority), denial and segregation of medical services, white male predominance, and silence on injustice/failure to atone. She further stated that supervisors must eliminate racial discrimination while promoting anti-racist clinical approaches in supervision. She also stressed the importance of language, zero tolerance for abuse/mistreatment, and to recognize that "silence is violence," "to defend is defensive," and "inaction is action" regarding racism.

Moving Toward Antiracist Language in Supervision*	
FROM:	TO:
Death	Lynching
Police violence	Police Brutality
Inclusion	Desegregation
URM	Historically excluded
Minority	Minoritized
Diversity	Antiracism
Inappropriate	Racist
Reform	Abolition
"I'm sorry."	"I'll do something."

*adapted from Dr. Legha's slides

Examples of books for supervisors from the presentation include: *Killing the Black Body* and *Fatal Invention* by Dorothy Roberts, *Medical Apartheid* by Harriet A. Washington, *An American Health Dilemma* by W. Michael Byrd and Linda A. Clayton, and *Medical Bondage* by Deidre Cooper Owens.

Abolition

Dr. Legha also highlighted the importance of abolition, which "seeks to undo the way of thinking and doing things that sees prison and punishment as solutions for an array of social, economic, political, behavioral, and personal problems." She emphasized the critical need to abolish the carceral and family regulation systems. She highlighted the necessity for abolition of the coercive "carceral" aspects of mental health previously mentioned, additionally stressing the necessity of police removal from hospital and school settings, reparations for our role in the legacy of slavery, elimination of diagnostic and assessment measures rooted in eugenics/whiteness, and the reimagination of organizational priorities and public health initiatives.

Dr. Legha's presentation simultaneously challenged the history and practice of medicine and psychiatry and inspired us to embrace critical change toward a future in which antiracist principles dominate evaluation, treatment, supervision, and education.

On a side note, SCSCAP is grateful to Dr. Legha's leadership in advocacy to openly expose and confront the horrors of the past and present and to motivate us with this important antiracist roadmap to guide our path for the future.

Child Abuse During the COVID-19 Pandemic

By J. Helen Wyman M.D., Child and Adolescent Psychiatry Fellow, LAC + USC Medical Center



Around the world, the number of child abuse reports suddenly dropped in mid-March of 2020, when strict social distancing measures were enforced to prevent the spreading of COVID-19.¹⁻⁴ But this was not good news. It is well known that natural disasters and economic

difficulty are frequently associated with an increase in the incidence of child abuse.^{3,5} Despite a decrease in emergency department visits related to suspected child abuse and fewer cases at child advocacy centers, the proportion of cases involving head trauma or requiring hospitalization increased.⁵⁻⁷

The lower number of child reports in this context is actually cause for concern. It likely means that more children are suffering from hidden maltreatment, their existence and pain going unseen. School closures meant that educators, typically responsible for almost one-quarter of child abuse referrals,⁸ were no longer able to engage with their students other than through a screen. And for many schools, those online classes lasted for only a few hours a day. While children being bullied at school may have been relieved, some children in abusive homes find school to feel more like a safe haven than home. But they no longer had that period of reprieve built into their schedule. Headlines and hashtags read “Safer at Home,” but these children were not safer at home.

Studies of recent data are showing that a particular type of child maltreatment seems to have increased during the COVID-19 pandemic - psychological maltreatment, also referred to as emotional maltreatment.⁹⁻¹⁰ Yet recognition of psychological maltreatment is highly variable, often under-identified, even when it occurs alongside other forms of abuse.¹¹ Educators may not recognize this type of abuse, even if patterns of increased maltreatment continue after schools resume in-person instruction. Would we as mental health care providers recognize it? We certainly

recognize that mental health needs have increased during the pandemic. But at what point do we as psychiatrists consider psychiatric symptoms in children to be signs and consequences of serious psychological abuse or neglect, especially if we see no signs of physical or sexual abuse?

Despite the limited attention given to psychological maltreatment, studies have shown that childhood psychological abuse is just as if not more predictive of negative outcomes than other forms of maltreatment such as physical or sexual abuse.¹² Yet too often, cases of severe emotional or psychological maltreatment are reduced to pathologizing the child. This is particularly the case when the parents or caregivers seem to be pleasant and cooperative individuals during interactions with providers. In a review of fatal child abuse cases, Sim identifies that “dysfunctional parental representations... mask the context of the abuse and injuries, which are reframed by the perpetrators as the failings of the victims.” Parents’ cooperation with clinicians, child welfare workers, or even law enforcement officers may further lead to dismissing of any concerns for child safety, leaving children in extreme danger.¹³

As child psychiatrists, we are frequently presented with immediate symptoms or problems - cuts on an arm, a suicide attempt, or a violent outburst. And medical training has taught us to think diagnostically even before we begin speaking with a patient. But we need to see beyond what is immediately visible to us, and we cannot do this alone. We desperately need better integrated, interdisciplinary and interagency collaboration to protect these children effectively.¹⁴ And we need to educate our colleagues and members of the community about the signs of child abuse, including psychological or emotional abuse, as this is often the core of all forms of child abuse.^{12,15}

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Psychiatric ER Visits During COVID

By Patrick Kelly, M.D.

For many years, ER visits by children for mental health concerns has been on the rise. The COVID crisis caused a spike in this trend. This past year has seen the terrible impact of increased mental health stresses on children, combined with reduced services available to meet these needs. The COVID pandemic has led to social isolation, parental stress, economic insecurity, and increased reliance on individual coping and educational skills with distance learning. At the same time, children were isolated from teachers, counselors, doctors, and other individuals who are typically watching for signs of worsening mental health. For those already in treatment or seeking treatment, outpatient clinics had reduced capacity and, when open, had a more difficult time providing the same level of care, often having to rely on video or phone visits. One of the few locations still able to provide face-to-face evaluations was, unfortunately, the emergency department.

Between April and October 2020, the proportion of child emergency room visits for a primary mental health concern increased 30 percent.¹ Consider that this is against the backdrop of parents wishing to avoid the emergency department at all costs, for fear of COVID exposure, and the picture is even bleaker than it initial appears. During this same time period, children on Medicaid or CHIP received 44% fewer outpatient mental health visits.² Not fewer face to face visits, fewer visits *total*, including telepsychiatry. This, of course, does not count mental health visits typically provided in the school setting, which dropped to near-zero as schools adjusted to closure. This is a substantial percentage of our children – 35% of children and adolescents receive their primary mental health support in the school setting.³

All of these factors have led to an increase in children and adolescents seeking care in the emergency room for psychiatric concerns. Sometimes, this has taken the form of patients with mild to moderate symptoms, who simply couldn't access care any other way. At other times this has appeared as high-risk individuals who

have lost access to their typical care systems or other services which had previously kept them safe. We have seen children with developmental disabilities who cannot tolerate the stress of their families or their reduced ability to manage their symptoms, and children with substance abuse who substantially worsen with the reduced responsibilities of having to go to school, or even get out of bed.

Unfortunately, all of these presentations are occurring at precisely the time that intensive follow-up services, which would have previously helped to avoid unnecessary hospitalizations and shorten length of stay, were less and less available, and wait lists grew longer.

Given that these needs are not likely to decrease any time soon, it may be time for institutions to take another look at how they manage children and adolescents presenting to the emergency room for psychiatric reasons. The old model of "Admit, Discharge, Transfer" as the limit of the emergency care is simply no longer sufficient to meet the needs of this population.

At Harbor UCLA, we are incredibly fortunate to have a dedicated emergency unit for adolescents. It allows us to provide a more flexible level of care that can meet the needs of the patient in front of us, as opposed to remaining fixed at a stabilize-and-triage level. We can dedicate the time and resources to de-escalate suicidal patients, connect children and their families to secure outpatient resources, advocate and collaborate with school systems, and even initiate medication treatment. However, this represents a rare and precious resource for the 2.2 million children and adolescents living in Los Angeles county.

Being able to evaluate and intervene in possibly the highest point of crisis in a family's experience is a privilege. We can make a tremendous amount of difference in a very short period of time, and can sometimes change the direction of a young person's life. The ER

can serve as a family's first foray into the mental health system, and can set a template for all future experiences. Or it can serve as the last chance to catch a young person before a terrible outcome. I believe it is time for the health care system to recognize the role of the emergency department as a vital care provision venue for mental health assessment and treatment, and to expand the capabilities of these vital resources. Much like trauma centers are divided (and resourced) to serve the population of a larger region, so should psychiatric ER resources be more strictly organized at the state or county level to meet the needs of our population. The COVID crisis has exposed a large gap in our supply and demand of child mental health resources, and perhaps now is an opportune time to encourage recognition and support of this de facto care source for so many children under our care.

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Contextualization – More Than Just History Taking

By Manal Khan, M.D.



Contextualization is defined as “to place in context”. It is frequently employed to gather information about patients presenting concerns. In psychiatry, we try to weave together a narrative that explains how patients’ symptoms and suffering developed, how they impact their current life, and what are some of the resources

that we can provide patients given their unique bio-psycho-social situations. We then put this narrative in the context of larger cultural, social, financial, political, and historical themes. We create a living and breathing story that interacts with its environment. This technique allows us to reach a more comprehensive understanding of our patients’ clinical presentation.

Contextualization is a very well-established technique for history taking. However, in my clinical practice I have also come to appreciate its role in patients’ healing. Here, I make a case for using contextualization to deepen patients understanding of their own story (contextualization for self) and that of others (contextualization for the other). I have sat across many patients who carry tremendous shame, guilt, and regret about their choices. I have also heard stories of injustices, betrayal, and resentment. In these situations, facilitating discovery and development of a narrative around patients own actions and those of others can bring about healing.

Contextualization for self is perhaps an integral part of all psychotherapies. In cognitive behavioral therapy, behaviors are understood in tandem with feelings and thoughts. In dialectal behavioral therapy, the biosocial model facilitates patients understanding of their personality organization. In psychodynamic psychotherapy, the patient begins to peel away and discover various layers of their story. Understanding and sharing the development of your own narrative can be validating and hence therapeutic. It allows for a shift in how patients approach themselves; there is movement from judgment to curiosity, and then to compassion. A therapist who can simultaneously serve as a collaborator, com-

panion and witness to this process often results in exposure to emotion and corrective experience. Exposure occurs through patient’s acknowledgment and sharing of their story and corrective experience is brought about by therapist’s reception, understanding, and containment of their narrative.

Contextualization for the other is also shared as a technique among different psychotherapies. In integrative behavioral couples’ therapy, partners gain an understanding of each other’s narrative through DEEP (differences, emotional sensitivities, external stressors, and patterns of interaction) formulation. In behavioral therapies, the concept of fundamental attribution of error facilitates an understanding of others’ circumstances instead of defaulting to characterological blame. In mentalization, patients attempt to understand the mental state of others. Building a narrative for the other humanizes them. It introduces the other as a story with a developmental arc and an environmental influence. It allows the patient to approach the other with diminishing suspicion and anger and an enhanced understanding and empathy. Here the therapist models and coaches the patient through the process.

Special attention needs to be paid to the sequence, messaging, and the role of the therapist when employing contextualization. It makes most sense for contextualization for self to precede contextualization for the other. If the reverse order is attempted, especially when prompted by the therapist, there is risk for perceived invalidation and therapeutic misalignment. Finally, using contextualization does not intend to diminish autonomy. On the contrary, it highlights the reciprocal relationship and dynamism of choice and context which leads to enhanced insight and agency. As a relatively new therapist with a growing toolkit, I have come to appreciate contextualization as more than just history taking. Psychotherapy is as much an art form as it is science and often the artistic endeavor is not to create something new but to create a new way of looking at the same old thing.

Advocacy and Children's Mental Health

By William Arroyo, M.D.; Delegate (Alternate) to CALACAP

The main mental health policy issues challenging children and families this year, to no one's surprise, are: Covid, school re-openings, racism, and violence. And not far behind is the increasing number of children, especially unaccompanied ones, who are detained at the U.S.- Mexican border.

The California Academy of Child and Adolescent Psychiatry (CalACAP) is sponsoring a bill, SB 528 (Jones) during the current legislative session which would create a health portal wherein all health providers would have access to the health information, including the JV 220 forms, whenever they are providing a service to a child who is a dependent (and in some cases ward) of the State, namely, children in the foster care system in addition to some of those youth who are in the probation system.

The CALACAP Spring Advocacy Day will be a virtual one this year and take place on Monday, May 17. Registration link will be issued soon. It will be held in conjunction with at least two other statewide children's advocacy partners.

CALACAP launched its inaugural Wasserman Education Fund in honor of Saul Wasserman, M.D., who was a career long children's mental health advocate. Each Regional Organization of AACAP (ROCAP) was allocated \$500 for distribution to its winner(s); each of the ROCAP's selected at least one winner of this year's award. Candidates competed for award based on their history of involvement in advocacy and an essay on a current children's mental health policy issue. The winners included Jiwon Helen Wyman from LAC-USC Child and Adolescent Fellowship program; her current policy issue was related to child abuse reporting during the Covid pandemic

The Committee on Anti-Racism and Equity (Care) was launched this year with leadership provided by Huey Merchant, M.D. This Committee is guiding CALACAP on issues of racism and health equities through the review of bills in the state legislature that pertain to these general areas.

CALACAP has been reviewing and developing positions on various bills which are going through the legislative process. In addition to SB 528 (Jones), some of the bills which have been considered by CALACAP include: AB 27 (Luz) which would mandate that each district routinely identify which students are experiencing homelessness, that each school district administer a questionnaire to parents and students to determine homelessness, that a staff member is assigned the responsibility to address and coordinate the special needs of students experiencing homelessness; AB 10 (Ting) which addresses various aspects of in person learning in those counties where such is allowed; AB 58 (Salas) which would require that all school districts revise and update their student suicide prevention policies; AB 226 (Ramos) which would create a new type of children's inpatient services which are not hospital-based; SB 17 (Pan) which would establish an Office of Health Equity; S 100 (Hurtado) which would extend some benefits for children in foster care system; SB 106 (Umberg) which would expand the use of MHSA funds for youth mental health programs; among many others.

For any policy issues or additional information on these or other bills, please write me at: wmarroyo@pacbell.net.



Practitioner Wellness – A Cautionary Tale

By Patrick Kelly, M.D., SCSCAP President



The past year has taught all of us many things about healthcare and wellbeing. As psychiatrists, it is typically our role to diagnose and treat mental illness. Although our field is continually expanding its focus on the more positive aspects of mental health, including aspects of prevention, wellness, and resilience, never have these aspects of our practice been more critical than this year.

Along these lines, it is time we begin applying these principles to ourselves as well as our patients. Physician and practitioner burnout is rampant, and likely to become even more acute as the demands for mental health care continue to increase. As physicians and allied practitioners, we are frequently called upon to reach for our deeper empathy to care for more and more individuals, sometimes at our own expense. Health care providers have been hailed as the heroes of the COVID-19 crisis for our selfless acts and dedication, but this has at times led to catastrophic consequences for us as individuals and as humans. We often forget how to care for ourselves, while telling others how to care for themselves.

I am, unfortunately, a cardinal example of this trend. I work both in a high acuity LA County hospital performing and overseeing emergency evaluations, as well as maintaining a small private practice. During the onset of COVID, I considered myself lucky to be able to maintain my employment and provide such a critical service to the community. On the other hand, my private practice demand, if anything, increased, somewhat contrary to my expectations. I expanded my hours at both the hospital and in my practice to try to meet these demands. For five months the stress continued to mount, but in my mind it was reflective of a time-limited sacrifice, one I was willing, even happy, to make in order to support those in more need than myself. Then, one Saturday morning, after a full week of ER

shifts and while getting ready to see my first outpatient, I began experiencing chest pain and a difficult-to-define feeling that something was wrong. I felt suddenly exhausted, heavy, and like it was difficult to move.

I was having a heart attack.

I still finished my outpatient appointment before calling 911.

Our dedication to our field and our patients is our greatest strength as a profession, yet possibly our greatest weakness as individuals. We need to begin to find a way to follow the advice and the direction that we give our patients. We have CPT codes for overwork and for excessive stress which by definition make them conditions worthy of attention, yet the prevalence of these in our practitioners are so high that they are considered the new normal.

Physician burnout is a phenomenon recognized for some time. Yet, despite this long-standing recognition, it seems that organizations have only recently begun to take responsibility for the problem and to start to more thoroughly understand and ameliorate it. In 2017, the APA appointed a Workgroup on Psychiatrist Well-Being and Burnout.¹ In one recent study, 78% of APA members were identified as having high levels of burnout on the OLBI self-report index, and 16% had clinically significant depression on the PHQ-9.² These data were collected in 2017 and 2018, before the time of COVID, and the rates have only increased since then.^{3,4}

I actually consider myself to be quite lucky. Because of the excellent care I received I am now the proud owner of a brand new stent and, despite my MI, seem to have little to no residual damage. To be clear, I can take no responsibility for this beneficial outcome. It was only through the insistence and generosity of the caring individuals in my life who, without batting an eyelash, absorbed my work shifts and patient load,

and advised (and by advised I mean forced) me to take some much-needed time to recuperate. I am supremely and eternally grateful to those who slowed me down when I was unwilling to slow myself down, and hope that I can pass this spirit forward so that others do not have to take quite so long to recognize a need to improve their own self-care. Our field needs to take a hard look at the way medicine as a whole is practiced, and how we can create a plan to support our own well-being as we support the well-being of others. The resources for recognizing and addressing burnout are expanding. Various organizations have sites dedicated to addressing these concerns.^{5,6,7} Although there is certainly more work to be done, all of us can start taking our own advice and find a more suitable balance which will allow us to continue our dedicated service to our patients.

Here is to a healthy, happy, and more balanced next year!

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