2023

The Southern California Society of Child & Adolescent Psychiatry

PRESIDENT'S COLUMN

By Brandon Ito, MD, MPH, SCSCAP President



It has been an absolute honor to serve as the Southern California Society of Child & Adolescent Psychiatry President this year. Due to the remarkable advancement of science and availability of effective vaccines, we continued to move towards the new normal of remote as well as in-person meetings

and events. These events reminded me of the importance of face-to-face fellowship and community that has been severely impacted over the last several years.

We kicked off our year in August with the SCSCAP Annual Meeting with Dr. Melissa Brotman, leader of the Neuroscience and Novel Therapeutics Unit in the Emotion and Development Branch at the National Institute of Mental Health Intramural Research Program, delivering an extraordinary talk on the diagnostic and treatment challenges of irritability in youth.

And in March, nearly 3 years to the day from the start of the COVID-19 pandemic, we held our first in-person Speaker Meeting at The Westin in Long Beach since 2020. Our esteemed presenter Dr. Ara Anspikian, Chair of the Department of Psychiatry at Loma Linda University and past SCSCAP President, highlighted the ongoing opiate epidemic and its devastating effects on families and communities. A summary of the event is covered in this newsletter by Dr. Sabrina Reed.

This year, the Executive Council continued to uphold the principles of justice, equity, diversity and inclusion (JEDI), establishing financial support for two child and adolescent psychiatry fellows from underrepresented groups in medicine to attend next year's AACAP Annual Meeting and join the Assembly meeting as a SC- SCAP representative. Additional initiatives included supporting regional committees to promote recruitment and provide events for local members, advocating for juvenile justice reform in a letter to the LA County Board of Supervisors, and expanding representation and voices within our Executive Council.

The Council's commitment to JEDI is evidenced throughout the incredible articles in this newsletter. In her article on California's youth carceral system, Dr. Elizabeth Dohrmann speaks on the recent changes and ongoing challenges for justice-involved youth, many of whom arrive from minoritized and underserved backgrounds. In addition, Dr. Han Nguyen describes her experience visiting a remote village in Tanzania, and Dr. Chris Chamanadjian takes us through the potential uses of artificial intelligence to bridge the gap in mental health care services in rural and under-resourced areas.

With the return of children and adolescents back to school post-COVID, we are continuing to observe, as well as discover, the tremendous toll of the pandemic on child mental health. Dr. Patrick Kelly discusses the mental health effects of school closures and impact on emergency department visits during the pandemic. Later, Dr. Misty Richards and Theo Stoddard-Bennett, a rising medical student star, detail CDC data on mental health in female and LGBTQ teens, and how crises such as COVID-19 exacerbate disparities within already vulnerable populations. Lastly, I describe the physical and mental health effects of the escalating political rhetoric in our country, and in particular its' contributions to violence targeting racial minority and LGBTQ youth.

Finally, Dr. Vivien Chan reminds us in her article that we are not immune from the emotional burden of our work along with the daily stressors we all face. As we mourn the loss of several colleagues to suicide this past year, it is vitally important that we check in with

ourselves as well as one another. I hope we can collectively acknowledge the value of the care we bring to so many children and their families, lives that need our expertise more than ever.

In This Issue:

President's Column

- The Consequences of School Closures: Examining the Impact on Adoelscent Mental Health
- Exploring Mental Health Disparities among Girls and Queer Adolescents in 2021 CDC Data
- Forging a Way Forward: The Changing Landscape of California's Youth Carceral System
- Taking Care of Others (and You), [and Me]
- Childhood Stunting and Mental Health: My Experience in Rural Tanzania with Global Volunteers
- The Benefits of Digital Technologies in Child and Adolescent Psychiatry
- What Are The Kiddos Thinking About?
- SCSCAP Spring Meeting with Guest Speaker, Ara Anspikian, M.D. - Substance Abuse with a Focus on Fentanyl
- The "Un" Intentional Effects of Political Rhetoric
- California Academy of Child and Adolescent Psychiatry (CALACAP) – Update

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

SCSCAP EXECUTIVE COUNCIL 2022-2023

Brandon Ito M.D. President

Misty Richards, M.D. President-elect

Sabrina Reed, M.D. Vice President

Elizabeth Dohrmann M.D. Treasurer

> Anish Dube, M.D. Secretary

Rishi Parikh, M.D. ECP Representative

Helen Wyman, M.D. MIT Representative

Benjamin Schneider, M.D. Past President

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

> Ara Anspikian, M.D. Past President

Preetpal Sandhu, M.D. Membership Coordinator

Amy Woods, M.D. Chair, Diversity Committee

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

> Marcy Borlik, M.D. CALACAP Delegate

William Arroyo, M.D. CALACAP Alternate Delegate

The Consequences of School Closures: Examining the Impact on Adolescent Mental Health

By Patrick Kelly, MD



The COVID-19 pandemic has generated unprecedented challenges, leaving a lasting impact on numerous aspects of life. Adolescence, already a critical developmental period characterized by substantial physical, emotional, and social changes, has been further complicated by the pan-

demic. As psychiatrists, our understanding of the unique challenges faced by adolescents is crucial. The pandemic has not only exacerbated pre-existing mental health issues but also given rise to new ones.

The Centers for Disease Control and Prevention (CDC) reported that in August 2020, 25.5% of young adults aged 18-24 years had seriously considered suicide in the previous 30 days. This percentage was significantly higher than those reported by other age groups: 16.0% for adults aged 25-44 years, 3.6% for adults aged 45-64 years, and 2.0% for adults aged 65 years and older.¹

Notably, there were significant differences in the experiences of various demographic subgroups during the crisis. Research conducted by the Kaiser Family Foundation found that 56% of parents with an annual income below \$25,000 reported that their children had experienced at least one adverse mental health symptom due to the pandemic, compared to 35% of parents with an annual income of \$100,000 or more.² The supportive school environment's loss, which provided socialization and essential resources for some groups, partially explained this discrepancy.

LGBTQ+ youth were among the most impacted subpopulations, with The Trevor Project's National Survey on LGBTQ+ Youth Mental Health 2021 reporting that 42% of LGBTQ+ youth seriously considered attempting suicide in the past year, including over half of transgender and nonbinary youth. The survey also found that the pandemic had negatively impacted the mental health of 94% of LGBTQ+ youth respondents.³ School closures and disrupted social networks resulted in many LGBTQ+ youth losing access to supportive environments and resources, exacerbating feelings of isolation and marginalization.

One significant shift during the pandemic was seen in adolescent mental health emergency room (ER) visits. Mental health-related ER visits for adolescents increased by 31% in 2020 compared to the same period in 2019. Younger adolescents (12-14 years) demonstrated a greater increase in the proportion of mental health-related ER visits than older adolescents (15-17 years).⁴ This disparity may be attributed to the more significant impact of school closures, social isolation, and family stressors on younger adolescents.

The consensus among these publications is that school closures were a significant risk factor, particularly for the mentioned population groups. A recent article by Bonnie Zima and colleagues⁵ aimed to specifically examine the impact of school closures on acute care visits. Their study, published in Psychiatric Services, analyzed data from 44 US children's hospitals to investigate changes in acute mental health care encounters among children and adolescents during the COVID-19 pandemic (from March 1 to November 7, 2020). The study provided valuable insights into the trends and patterns of acute mental health care encounters:

- During the study period, overall emergency department (ED) visits declined significantly. However, mental health (MH) ED discharges declined by only 16.5% compared to the 45.2% decline in general medical (GM) discharges.
- Seasonal trends in acute mental health care encounters varied by type, with MH ED discharges declining by 25.6% during spring 2020, increasing by 3.3% during summer 2020, and decreasing by 6.7%

during fall 2020. These patterns deviate from pre-COVID-19 trends, suggesting that the summer 2020 increase was driven by heightened clinical needs that overcame hospital avoidance.

 Suicide attempts or self-injury and depressive disorders accounted for approximately half of MH ED discharges and 60% of MH hospitalizations. Acute care encounters for suicide or self-injury increased by about 5 percentage points following school closures, while those for depression remained relatively stable.

When evaluating subgroups of adolescents presenting to the ER, adolescent girls were found to be particularly vulnerable following statewide school closures. Hospitalizations for suicide or self-injury in fall 2020 increased by over 40% for children aged 12-17 years and by almost 50% for girls. This is consistent with trends identified in public health surveillance data – a CDC study found that from March to October 2020, emergency department visits for mental health issues increased by 26% among boys aged 12-17 compared to the same period in 2019. However, this increase was even more substantial among girls, rising by 37%.⁶

Dr. Zima and colleagues discuss several factors that could help explain the relationship between school closures and increased acute care visits:

- 1. Disruption of Routines: The pandemic upended adolescents' daily lives, with school closures, online learning, and the cancellation of extracurricular activities. This lack of structure and routine can exacerbate feelings of anxiety and depression.
- 2. Social Isolation: Adolescence is a crucial time for developing social connections and identity. However, social distancing measures have limited opportunities for peer interaction, leading to loneliness and a sense of isolation.

3. Increased Screen Time: The shift to remote learning and increased reliance on technology for social interaction has led to more screen time, which may contribute to sleep disturbances, heightened anxiety, and depression.

4. Family Stressors: The pandemic introduced new stressors within families, such as financial strain, job loss, and illness. Consequently, adolescents may absorb the emotional burden of their family's stress, negatively impacting their mental health.

5. Grief and Loss: Many adolescents have experienced the loss of a loved one due to COVID-19. Dealing with grief during such an uncertain time can be overwhelming and may lead to increased anxiety, depression, and even PTSD.

6. Limited Access to Mental Health Services: The pandemic has made it challenging for adolescents to access mental health services, as many facilities were forced to limit inperson appointments. While telepsychiatry has helped bridge the gap, it may not be as effective or accessible for all patients.

The study's findings underscore the critical role of acute mental health care encounters in addressing the mental health needs of children and adolescents during the COVID-19 pandemic and possibly during school closures in general. The trends identified in the study, particularly the disproportionate impact on adolescent girls, emphasize the importance of understanding the various factors driving these acute care encounters. As we transition to pandemic recovery, further research is needed to identify ongoing risk indicators and develop targeted interventions for the most vulnerable subgroups. By staying informed and engaging in discussions about these demographic changes, we can continue to serve our adolescent patients in the most effective way possible.

¹ Centers for Disease Control and Prevention. (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. Morbidity and Mortality Weekly Report, 69(32), 1049-1057. ² Hamel, L., Kearney, A., Kirzinger, A., Lopes, L., Muñana, C., & Brodie, M. (2020). KFF Health Tracking Poll – July 2020: The Impact of Coronavirus on Life in America. Kaiser Family Foundation.

https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/

³ The Trevor Project. (2021). The Trevor Project's 2021 National Survey on LGBTQ+ Youth Mental Health. https://www.thetrevorproject.org/survey-2021/

⁴ Leeb, R.T., Bitsko, R.H., Radhakrishnan, L., Martinez, P., Njai, R., & Holland, K.M. (2020). Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1– October 17, 2020. Morbidity and Mortality Weekly Report, 69(45), 1675-1680.

⁵ Zima, B. T., Edgcomb, J. B., Rodean, J., Cochran, S. D., Harle, C. A., Pathak, J., Chi-hong, T. & Bussing, R. (2022). Use of acute mental health care in US children's hospitals before and after statewide COVID-19 school closure orders. Psychiatric Services, 73(11), 1202-1209.

⁶ Hill RM, Rufino K, Kurian S, Saxena J, Saxena K, Williams L (2020). Suicide Ideation and Attempts in a Pediatric Emergency Department Before and During COVID-19. Pediatrics 147(3)

Exploring Mental Health Disparities among Girls and Queer Adolescents in 2021 CDC Data

By Theo Stoddard-Bennett, BS and Misty Richards, MD, MS





As "America's teen girls are engulfed in a growing wave of sadness, violence, and trauma," the 2021 CDC mental health data on teenagers, especially the data on girls and LGBTQ+ teens, urges us to act with greater compassion and prioritize at-risk populations to tackle this persistent crisis.

Rates of sadness, suicidal ideation, suicide attempts, and mental health crisis emergency room visits among girls and LGBTQ+ youth are the highest reported in a decade. Nearly 60% of girls and 70% of LGBTQ+ youth felt persistent sadness or hopelessness during the past year, double the rate of boys. More than 25% of girls made a suicide plan; this percentage increased 60% over the past ten years. Alarmingly, emergency department visits for suicide attempts for girls increased more than 50% in the past two years alone. For those who identify as LGBTQ+, the data are even more staggering and heartbreaking. When compared to heterosexual peers, they reported three times the likelihood of suicidal ideation (45% vs 15%), plans for suicide (37% vs 12%), and suicide attempts (22% vs 6%). Of note, the 2021 survey did not collect gender identity data, excluding transgender students who also face increased mental health challenges.

Establishing a personal identity is a difficult task of selfdiscovery for all teens. But teenage girls and queer youth face uniquely difficult realities in our current society. Teenage girls and LGBTQ+ youth are expected to conform their behaviors to fit societal expectations that often clash with their desires and self-conceptualization. This conflict is further complicated by heightened beauty standards, online hate, academic pressure, and self-doubt. CDC data show that female and queer teens experience sexual harassment and cyberbullying at roughly twice the rate of their male counterparts. Girls and queer youth also fear for their physical safety and experience increased levels of sexual violence and bullying. 14 percent of girls and 20% of LGBTQ+ students reported being forced to have sex at some point in their lives. Rates of forced sex have been increasing in girls and, unacceptably, queer teens experience this sexual violence at 4x higher rates.

What can we do about these alarming statistics as child psychiatrists? It's easy to become numb or overwhelmed by data at the national scale. But regardless of our current clinical practice situation, we cannot lose sight of the humanity behind these numbers. As individuals, we have all been given a voice and an ability to empathize with those who are struggling. As child psychiatrists, formally screening for discrimination, bullying, and other social stressors is crucial, though we must also truly listen and understand what our pediatric patients are telling us. At the same time, it is important to note the larger context. This national tragedy has been long-standing and further accelerated by the social isolation and stress of the pandemic. Madigan et al. recently showed that this lack of social outlet caused an increase in screen time among all children. As a result, many teen girls turned to social media to recreate these social connections online. This dependance on social media for validation has only intensified unrealistic body standards, comparisons, and competition and contributed to increased levels of depression. However, recent pediatrician partnership programs have improved mental health access, reduced emergency department visits, and increased primary care physician's comfort in managing mental health concerns. These models hold promise to tackling this problem at scale in a sustainable way. As a community, we must provide inclusive, collaborative care and work with our pediatrician colleagues to identify patients in need of urgent psychiatric care. We must also advocate for policy changes on a local, regional, and national level to address this worsening crisis.

As students return to in-person learning, connectedness at school is a powerful protective factor against depression and anxiety. We must infuse resources and support into our schools and teachers, as they are on the front lines for our children. Specifically, bolstering schools with school counselors and appropriate mental health support staff will help rescue teachers from the burnout they are feeling while also explicitly identifying mental health care as a priority. Finally, modeling positive behavior for families and identifying safe adults at school can help at-risk youth feel more connected. To achieve meaningful improvement in children's mental health, it is crucial to collaboratively remodel broken systems to ensure that all children are supported early, effectively, and equitably. 1. YRBSS Data Summary & Trends | DASH | CDC. Accessed March 25, 2023. https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_ data_summary_and_trends.htm

 Godoy L, Hamburger S, Druskin LR, et al. DC Mental Health Access in Pediatrics: Evaluating a Child Psychiatry Access Program in Washington, DC. J Pediatr Heal Care. 2022;0(0). doi:10.1016/j.pedhc.2022.11.009

3. Madigan S, Eirich R, Pador P, McArthur BA, Neville RD. Assessment of Changes in Child and Adolescent Screen Time During the COVID-19 Pandemic: A Systematic Review and Meta-analysis. JAMA Pediatr. 2022;176(12):1188-1198. doi:10.1001/JAMAPEDIATRICS.2022.4116

4. Teens, Social Media and Technology 2022 | Pew Research Center. Accessed March 25, 2023. https://www.pewresearch.org/internet/2022/08/10 /teens-social-media-and-technology-2022/

 Hunt MG, Marx R, Lipson C, Young J. No More FOMO: Limiting Social Media Decreases Loneliness and Depression. https://doi.org/101521/jscp20183710751.
2018;37(10):751-768.
doi:10.1521/JSCP.2018.37.10.751

Forging a Way Forward: The Changing Landscape of California's Youth Carceral System

By Elizabeth Dohrmann, MD



When I open my patient list at the juvenile hall and see a name unbolded, I know that youth has been released. A smile crosses my face thinking of their return to the community, and often a sadness follows from knowing that in the best of circumstances where they do not return to jail,

I may not see them again. My favorite moments are when the stars align to allow me to follow released youth through LA County's specialized transitional outpatient clinic. These reunions with our brave and resilient teens outside of jail are among the most joyful parts of my job. And my fervent hope is that the role of such specialized clinics will grow, so that I can meet more of these youth at risk for detainment before they ever get locked away – not just afterwards.

For decades now, incarcerated youth populations across the country have been in decline. Long the most prolific incarcerator in the United States, Los Angeles County is currently detaining approximately 500 youth, down from thousands in the peak years of the 1990s. Other counties, such as San Francisco, are averaging fewer than 20 detainees.¹ This downward trend is a result of shifting policies driven by multiple factors, including increased awareness that incarceration is predicated on extreme racial basis; that it worsens recidivism, educational achievement, employment, and life expectancy; that it increases the risk of gang entrenchment and sex trafficking; and that the system itself is rife with abuse and neglect.² As a result, more youth are being diverted by law enforcement or by the courts, instead of proceeding to juvenile halls (the youth equivalent of jail). This results in a downstream effect of fewer youth proceeding to juvenile camps (the equivalent of short-term prison) or longer-term sentencing programs (equivalent to prison).

With fewer youth in the halls, camps and longer-term facilities, costs go up. In San Francisco, for example, the annual cost for detaining a youth was \$135k in 2011, but this increased to \$374k in 2020 with a lower census. This is one reason why probation department budgets have not decreased over time – we are paying exorbitant prices to fund carceral campuses that are fundamentally problematic. In recognition of this system's role in worsening youth outcomes at a high cost, Governor Newsom signed SB 823 in 2020 with the purpose of shuttering the state youth prison (known as the Division of Juvenile Justice, or DJJ) and sending all sentenced youth back to their 58 counties by July 1, 2023, with accompanying redistribution of the estimated \$300k annually per youth to the counties in block grants.³ These grants are overseen by the new Office of Youth and Community Restoration (OYCR) and are intended to be invested in local communities to provide transitional and ongoing care.

With the closing of the state youth prison and the return of youth to their home communities, counties are now responsible for the housing and programming for youth offenders with longer-term sentences. The majority have developed programs known as secure youth treatment facilities (SYTF). Prior to SB 823, Los Angeles County spent \$53 million dollars to construct Campus Kilpatrick in Malibu, a state-of-the-art facility designed to provide progressive rehabilitative programming to youth sentenced to camp, or now SYTF. However, for various reasons the facility has seen limited use with insufficient programming and allegations of abuse, reflective of the wider chaos in the juvenile facilities. All eight youth detainment campuses are reeling from understaffing, which worsens the already limited access to appropriate education, medical and mental-health care. Suicidality, substance use, violence, and disturbing incidents of abuse are all significant problems. The resulting ongoing investigations by the Department of Justice and the State Board of State and Community Corrections are both necessary but frankly insufficient to fully address these issues.

So, what are we to do, as citizens and child psychiatrists? The writing is on the wall - the age of traditional juvenile incarceration is coming to a close, and Los Angeles County has committed to being at the vanguard. In November 2020, the LA County Board of Supervisors unanimously approved a plan to shift programming and facility management from corrections into a new Department of Youth Development, which received its first infusion of funding last year. This shift reflects steps made by other states and signals a commitment to the principle of "Care First, Jails Last" by investing in community health care, housing, and programming and reducing the use of incarceration. The result will be an increase in the already desperate need for integrated outpatient systems with varying levels of care, as only the minority of youth will stay in incarceration settings.

Like any transition of this magnitude, it is both painful and political - many dedicated custodial staff feel alienated and left behind, stuck in a system that has not been able to evolve, and many LA communities don't want at-risk youth in treatment settings nearby. However, as child psychiatrists, we know that growing pains are inevitable, and that this shift has the potential to improve youth development and reduce harm. We know that our carceral system serves as a makeshift safety net for the most vulnerable youth, most of whom have suffered extensive childhood trauma fueling school failure and delinguency. We know that most youth offenders are detained for low-level offenses and are much better managed through diversion to specialized interventions. We know these community alternatives cost our society less and help youth more. And we know that wonderful feeling that comes when seeing the older, wiser faces of these youth in our offices - outside the barbed wire, outside the courtroom, and full of hope.

The future of caring for these youth depends on our ability to strengthen our outpatient networks. Our task involves identifying high-risk and dual-system (DCFS/court-involved) youth through pediatric practices and schools and actively engaging them in care to support their full developmental potential. Stripped of all the politics and confusion and fear, our roles are clear: we are child psychiatrists empowered by evidence to provide the best possible care for these patients. And in the years ahead, by making our voices heard in LA County and beyond, we will have an incredible opportunity to do just that.

Editor's note: Three former juvenile offenders, now in their early twenties, from Los Angeles County were observed in the State capitol advocating with state legislators on behalf of current incarcerated juvenile offenders.

Further reading:

https://file.lacounty.gov/SDSInter/bos/supdocs/150 726.pdf https://www.chhs.ca.gov/oycr/ https://www.bscc.ca.gov/s_djjrealignment/ https://dyd.lacounty.gov/

¹ https://www.sfchronicle.com/sf/article/San-Francisco-juvenile-hall-17182867.php

² https://www.sentencingproject.org/reports/whyyouth-incarceration-fails-an-updated-review-of-theevidence/

³ https://ebudget.ca.gov/2019-20/pdf/Enacted/GovernorsBudget/5210.pdf

Taking Care of Others (and You), [and Me]

By Vivien Chan, MD, DFAPA, DFAACAP



As child and adolescent psychiatrists, we provide expert guidance to complex dynamic and systems-of-care issues, all with an individualized lens to each patient and family. Our experience and training ideally buffer us to provide emotional safety and to lead others through murky, dark,

and confusing inner states. We know that part of this includes adopting resiliency skills, selecting self-help skills and later refining them. One intervention I often recommend for the young (and not-so-young) is creating a "five senses coping toolbox:" a literal container with personally customized items for touch (sensory toys, bubble wrap); scent ('scratch and sniff stickers,' lotions); taste (very small packages of nonperishable treats); hearing (podcast; playlist by mood) and seeing (photos, gif's/memes). When is the last time I put together my own coping toolbox for home or office? (Hint: the last time I had to teach coping skills or present on physician wellness, performatively.) Using the framework of development, we regularly apply developmental milestones to our patients. The medical literature^{2,3} also describes a professional developmental model for physicians' careers: student/trainee; early career; mid-middle; senior; and retired. (Figure 1) And, may I say, it was a momentary reality check for me to learn that I am categorized as a "late career" doctor.

For many of us, our daily clinical practice includes dealing with rising distress in children and adolescents, exacerbated by the recent COVID-19 pandemic and ensuing educational vicissitudes. Our mental health care system, already functioning with cracks in its foundation, must withstand more pressure. In adult culture, civility and solutions are polarized; in youth culture, debates abound on authenticity and social media use. We continue to reckon with our understanding of systemic injustice, bias, racism, and improving inequities. Paradoxically, our work requires that we simultaneously set these aside and bring them into the treatment space as necessary, one by one, person by person.



We are human, just like our patients. We hold many personal roles, with our professional selves being just one of many identities. In our profession, there is controversy about psychiatrists and "the cost of caring," described as secondary trauma, sometimes also called vicarious trauma, or compassion fatigue.¹

This is different than clinician burnout, defined by the Agency for Healthcare Research and Quality (AHRQ) as a long-term stress reaction marked by emotional exhaustion, depersonalization, and a lack of sense of personal accomplishment.² [I don't know about you, but there are times where I'd like to go on a tirade about the bureaucracy of medical practice, and sometimes, I reflect and wonder what impact I'm making in the field of medicine and with my chronically-struggling patients and families. I also personally do not find it congruent to describe my frustrations as physician burnout. Am I grappling with denial, and stigma?]

According to the Agency for Healthcare Research and Quality (AHRQ), up to 50% of us are experiencing burnout, with the midcareer group being the most vulnerable. Research shows that to aid the midcareer cohort, explicitly teaching medical leadership skills can help.³ Did you also know there is a dedicated peer physician support line for medical students through attendings in the U.S. (free, confidential staffed by volunteer psychiatrists M-F 8a-1a E.S.T., 1(888)409-0141)⁴?

We have successes, and we also make mistakes. Recently, I had a series of conversations about a mutual colleague's death, by suicide. I am also certified to teach Mental Health First Aid (MHFA). (This may seem like a tangent, but kindly read on.) In this training, we teach laypersons to assess for safety before delivering MHFA and continually assess for crisis. One crisis is suicide, and an explicit teaching exercise includes leading the class to ask about suicide, together, out loud. For some, it may be the first-time learners have used phrases like "suicide" or asked, "Do you want to kill yourself?" Some learners bravely express how uncomfortable even this group practice, with facilitated verbalizing among many, can feel. Now I will return to my conversations with psychiatrists about the unknown suffering of one of our colleagues and the colleague's death by suicide. It gradually became an apparent that, while we frequently discuss such topics as suicide in our daily work, we were ironically addressing the death of our colleague in oblique, indirect terms. What a mirror to hold up to ourselves! We finally concluded that we could do better and that we should model this for ourselves in the present and for the future.

In addition to prioritizing a good night's sleep, setting up boundaries between work and play, engaging in physical exercise, and spending quality time with those I love for the purpose of sustaining and enhancing my own resiliency, connecting with you, my peer child and adolescent psychiatrists, is critical. Crawling through difficult conversations, consultations, (and venting), our collegial learning and informal peer support is something that has been personally very valuable. This includes one-on-one conversations, locally in my area, or as a group through SCSCAP, and nationally, at AACAP. I hope that whatever your professional needs are, you will consider seeking support and refuge with colleagues.

References

1. Boscarino JA, Adams RE, Figley CR. Secondary Trauma Issues for Psychiatrists. Psychiatric Times. 2010 November 25; 27(11);24-26.

2. https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html, accessed March 17, 2023.

2. Hilty DM, Yager J, Seritan AL et al. A Historical Review of Key Events and Components of Faculty and Professional Development in Psychiatry. Psychiatr Clin N Am 42(2019) 357-373.

3. Teshima J, McKean AJS, Myint MT et al. Developmental Approaches to Faculty Development. Psychiatr Clin N Am 42(2019) 375-387.

4. https://www.physiciansupportline.com/faq, accessed March 17, 2023

Childhood Stunting and Mental Health: My Experience in Rural Tanzania with Global Volunteers

By Han (Hannah) Nguyen, MD, PGY2

Childhood stunting is estimated to affect around 22% of children under the age of 5 years old worldwide¹. Stunting is defined as low height for age, two standard deviations below the World Health Organization Child Growth Standards mean. Causes of such poor growth can include poor nutrition, poor psychosocial stimulation, and repeated infection². Globally, stunted growth is often associated with poor educational performance, increased risk of chronic diseases, long term effects at the societal level, and mental health consequences³. A prospective cohort study followed stunted children from poor neighborhoods in Kingston, Jamaica and conducted follow up surveys at 17-18 years old. The results demonstrated children who were stunted during infancy reported more anxiety, symptoms of depression, and lower self-esteem at 17-18 years old than those who were not stunted. Additionally, the study found that parents of stunted children tended to report more oppositional behaviors than parents of non-stunted children⁴. Many organizations, including the United Nations International Children's Emergency Fund (UNICEF), focus on nutritional intervention during the first 1000 days of life, a critical stage of neural, cognitive, and social development, to reduce the risk of stunting⁵. One example of poor nutrition that has been shown to be particularly critical in neurodevelopment is iron deficiency. Iron deficiency during the first 1000 days of life has been associated with poor cognition, poor behaviors, and lower intelligence⁶.

In February 2023, during my current PGY-2 year, I had the opportunity to volunteer for the organization Global Volunteers in Ipalamwa, Tanzania, a small rural village with one of the worst rates of stunting in the country. The organization launched a program called "Reaching Children's Potential." This program focuses on the first 1000 days of a child's life to reduce stunting via a multifaceted plan of attack including providing nutritious meals, conducting parent workshops, making regular home visits to provide stimulation and support for the infants, providing primary health care,



Dr. Nguyen (second from right) in rural Tanzania

and more. An internal study demonstrated a significant reduction (up to 57%) in stunting from the years 2017-2021 since the program's inception⁷.

Global Volunteers is also at the cusp of launching a mental health campaign in the Ukwega ward. They are tasked with providing mental health services to underserved, rural communities. They are training their caretakers (the staff that conduct regular home visits) some basics of recognizing mental health problems. Additionally, the caretakers are provided a binder of printed educational slides on quick facts about depression, anxiety, and how to seek help. There was a focus on alcohol abuse, as I learned it plagued many families and was even commonly abused by children. 19.8% of young students reported ever drinking alcohol according to a study from Dodoma, the recently appointed capital of Tanzania, located approximately 320 km or 200 miles away from Ipalamwa⁸. The locals educated me on ways alcohol was made with readily available bamboo shoots called ulanzui or local beer. Locals simply cut young bamboo shoots, wait for sap to collect, and allow for fermentation for 12 hours for an easy, cheap source of alcohol. Other sources of alcohol were produced from various crops that were all readily available including cashew seeds and coconut leaves.

I was privileged with an invitation to speak at the community level in a village called Mkalanga on the topic of mental health. Global Volunteers cleverly paired the day of the community meeting with dispensing meals and taking their routine baby weights, thereby increasing participation to both events. It was a great utilization of partnership and leveraging the space to provide education to this village. This particular community suffered two suicide attempts (one completed) within the last year so mental health was of great interest. I was asked to address the topics of depression, suicide, effects of alcohol use during pregnancy or childhood, and the importance of supportive parents on the overall development and wellness of the child.

I was able to learn much about this remote Tanzanian village, but by far, the most memorable parts were the people I met while volunteering. I met a 16-year-old female who was caring for an 18-month-old infant. For anonymity, I'll call her Naima. They lived in a modest home made of cow dung and dirt walls. Daily meals consisted of farmed avocado and bananas. The main source of protein were eggs from the freely roaming chickens that also joined our interview. Naima moved to this village hundreds of miles away from her own family to live with her husband. The baby had some kind of eye infection that required referral from the local primary doctor to the next higher level of care in town. The problem was, Naima could not afford the 4hour travel to town to see a provider. In addition, her husband suffered long term complications from Typhoid fever within the last year and had not been able to return to farming. This was taking a huge toll on Naima financially, physically, and mentally. She spoke in a soft voice, making very little eye contact with mostly constricted affect and downcast gaze. We had a long discussion about her future goals of wanting to start a business selling dresses, putting her own mental and physical health first, and encouraging her to participate in therapy or even visiting the clinic.

Another very memorable story for me was about a 3year-old stunted child, whose family was plagued by what seemed like never ending trauma stemming from alcohol abuse and domestic violence of which dad was the aggressor. I'll call the child Merius. Merius' mother died just 3 months ago from malaria complications. Since the mother's death, his father had disappeared into town, and the child is now cared for by grandmother. Merius now lives with 5 other cousins who are all small children. The oldest cousin, at 6 years old, is unable to attend school because he helps care for the smaller children while the adults tend to the daily labors of farm work. Merius has visible folliculitis on his head and an audible wheezing cough. We were informed that he was not meeting milestones. He was throwing frequent tantrums, unlike the other children in the home. His grandmother said Merius was throwing food and things around constantly, and she found it hard to understand why his behaviors were so different from that of his cousins. Merius mostly shied away from us, hiding behind the long skirt of his grandmother or crying when we tried to engage him. His grandmother obviously cared for him, but her resources were already running so thin. Reflecting on his behavioral disturbances and the grave stressors which he has already experienced, I could not help but think that this child must be experiencing toxic stress from poor nutrition, sequential loss of both parents, and his current medical conditions, to now having behavioral disturbances. I kept thinking about the shaky foundation this child has had and about the questions about his life trajectory. Could he get better nutrition and recover from his stunted growth? What kind of deficits will he have, if any? Will he develop good coping skills for life, or would he develop oppositional behaviors? Would he follow his father in the cycle of alcohol abuse and leaving the family unit?

I will be taking away some valuable lessons from this trip. I have more of an appreciation of the critical period of a child's social and cognitive development that lays the foundation for the rest of their life. In all, I was pleasantly surprised that mental health awareness is reaching remote villages in Africa. It was a reminder that child adolescent mental health is not only a priority in the U.S., but its relevance is greatly appreciated abroad. There is a realization that these critical periods of development through childhood have long lasting effects, and the work of a child and

adolescent psychiatrist is needed here and there, more than ever.

References

1. World Health Organization. (n.d.). Joint child malnutrition estimates. World Health Organization. Retrieved March 28, 2023, from

https://www.who.int/data/gho/data/themes/topics/joi nt-child-malnutrition-estimates-unicef-whowb#:~:text=In%202020%2C%20149.2%20million%20chi Idren,for%20their%20height%20(overweight).

2. World Health Organization. (n.d.). Stunting in a Nutshell. World Health Organization. Retrieved March 28, 2023, from https://www.who.int/news/item/19-11-2015-stunting-in-a-nutshell

3. De Sanctis V, Soliman A, Alaaraj N, Ahmed S, Alyafei F, Hamed N. Early and Long-term Consequences of Nutritional Stunting: From Childhood to Adulthood. Acta Biomed. 2021 Feb 16;92(1):e2021168. doi: 10.23750/abm.v92i1.11346. PMID: 33682846; PMCID: PMC7975963.

4. Walker, S. P., Chang, S. M., Powell, C. A., Simonoff, E., & Grantham-McGregor, S. M. (2007). Early childhood stunting is associated with poor psychological functioning in late adolescence and effects are reduced by psychosocial stimulation . The Journal of Nutrition, 137(11), 2464–2469. https://doi.org/10.1093/jn/137.11.2464 5. UNICEFInnocenti. (n.d.). The first 1,000 Days of Life: The brain's window of opportunity. UNICEF. Retrieved March 28, 2023, from https://www.unicefirc.org/article/958-the-first-1000-days-of-life-thebrains-window-of-opportunity.html

6. McCarthy, E. K., Murray, D. M., & Kiely, M. E. (2021). Iron deficiency during the first 1000 Days of Life: Are we doing enough to protect the developing brain? Proceedings of the Nutrition Society, 81(1), 108–118.

https://doi.org/10.1017/s0029665121002858

7. RCP impact report - 2022. docs.globalvolunteers.org. (n.d.). Retrieved March 28, 2023, from https://report.rcpimpact.org/#page=3

8. Dwyer, T., Kulasingam, S., Kamm, K. M., Chinunje, D., Malamsha, R., Mawji, S., Kapinga, R., & Majinge, C. (2019). Risk-taking behaviors and sexual violence among secondary school students in Tanzania. Journal of Community Health, 44(4), 749–755. https://doi.org/10.1007/s10900-019-00673-2



The Benefits of Digital Technologies in Child and Adolescent Psychiatry By Christopher Chamanadjian, MD, PGY-2



Introduction

Artificial intelligence (AI) can potentially revolutionize the field of child and adolescent psychiatry. Mental health disorders in children are on the rise. According to the Centers for Disease Control and Prevention (CDC), 17 million

children and adolescents in the United States have been diagnosed with at least one mental health disorder. This statistic underscores the increasing need for pediatric mental health specialists. These technologies can help overcome access barriers for children living with socio-economic or geographic limitations in obtaining mental health care resources. With the increasing prevalence of mental health disorders in children, Al can offer valuable opportunities to increase access to pediatric mental health specialists.

Furthermore, using AI-powered diagnostic tools in mental health can offer diagnostic assistance to medical professionals and parents alike, allowing for earlier identification of mental health diagnoses. Artificial intelligence (AI) can address some of the most pressing needs within the field, such as improving mental health service access disparities, providing diagnostic aid, allowing early detection, facilitating early intervention, and enhancing quality of care. With these potential advantages at hand, now is an ideal time for child and adolescent psychiatrists to understand how the significance of integrating AI technologies may benefit the field.

Early Detection

Artificial intelligence (AI) can be a diagnostic aid for screening for complex pediatric mental health conditions such as autism spectrum disorder and Attention-Deficit/Hyperactivity Disorder. Artificial intelligence is increasingly important in providing early intervention for children with mental health conditions, enabling more accurate and timely diagnoses and faster access to tailored treatments.

Early diagnosis and intervention are essential for the diagnosis of autism spectrum disorder (ASD). AI-powered technologies such as Cognoa allow earlier detection of autism spectrum disorder (ASD) with a 90% accuracy rate. The average age of ASD diagnosis is four years old, but with artificial intelligence technologies such as Cognoa, children can be diagnosed as early as 18 months. Cognoa is a pediatric behavioral health company developing digital diagnostics and therapeutics to enable earlier and more equitable diagnosis and treatment of behavioral health conditions. In 2017, Cognoa's AI platform detected ASD with a 90% accuracy rate after a 20-minute assessment session significantly higher than the average diagnostic accuracy of 66%. The accuracy of the results provided by Cognoa has been verified through extensive testing against the gold standard for diagnosis, the Autism Diagnostic Observation Schedule (ADOS) test. Using a combination of computer vision and machine learning algorithms to analyze patient behavior, Cognoa matched ADOS results with 88-90% accuracy in clinical studies. Early intervention for children with ASD is crucial for their long-term outcomes and cognitive development. Studies suggest early intervention with Applied Behavior Analysis therapies can improve vital developmental skills, including language, communication, and social skills. With AI-powered technologies as diagnostic aids for general pediatricians, earlier detection provides the ability to obtain earlier intervention, ultimately improving lifelong outcomes for children with autism. Healthcare providers can then expedite their patients with timely treatments and coordinate collaborative care early on, bringing early intervention for the child, who could dramatically improve their quality of life.

Al algorithms are not only helping in the detection of autism, a condition that is renowned for its hard-todetect nature but are also proving to be an invaluable diagnostic aid for other conditions, such as depression and anxiety. Utilizing Al programs for the early detection of mental health conditions enables swift medical help and tailored therapeutic support, providing beneficial overall health outcomes. As our understanding of AI grows, sophisticated AI-based programs could become increasingly important in providing early intervention services across various pediatric mental health diagnoses.

Improving Access Barriers

Digital technology advances provide new and powerful ways for underserved communities to access quality care. Notably, healthcare innovation can be implemented to improve the mental healthcare access barriers of the underserved population with economic or geographic limitations. For example, Project ECHO (Extension for Community Healthcare Outcomes) is a program that uses video conferencing technology to connect specialists from larger medical centers with primary care providers, particularly in rural settings. Child and adolescent psychiatrists can extend their reach and provide appropriate care for families facing access barriers due to location or socio-economic constraints. Project ECHO focuses on improving access to guality healthcare for underserved populations by providing virtual case-based learning, education, and support to primary care providers. Primary care providers can submit questions about their patients' cases which are then discussed during weekly virtual meetings with the specialist team. Through this collaborative process, primary care providers receive guidance and training on evidence-based practices related to the diagnosis and management of autism in rural settings.

The program was applied to mental health care and used successfully in the United States to provide autism-specific services to rural communities. In this way, digital technologies can be used to bridge distances and break down socio-economic barriers to enable more children and families affected by mental health to get the quality care they need. Overall, Project ECHO has succeeded in increasing access to quality mental health care for autistic individuals living in rural settings by providing real-time consultation from specialists and up-to-date educational resources to primary care providers. Through its innovative approach of applying telemedicine technology and collaboration between specialists and primary healthcare professionals, Project ECHO has helped decrease the disparity gap in mental healthcare access for families limited by the lack of availability of mental health specialists, geographic constraints, or socio-economic burdens.

Efficiency

AI-based programs also provide scalability and efficiency in diagnosis, allowing Child & Adolescent Psychiatrists to detect mental health conditions quickly, providing swift medical help and tailored therapeutic aid that could lead to beneficial overall health outcomes. AI-powered tools can be used to accurately assess a patient's condition more quickly than they would through traditional methods. Artificial intelligence algorithms for mental healthcare have successfully detected symptoms of depression, PTSD, and other disorders by analyzing behavioral signals. Other studies have shown that algorithms can spot behavioral signs indicative of anxiety. For example, a randomized controlled trial conducted by AI chatbot Woebot researchers has revealed that participants experienced a substantial decrease in depression and anxiety after just two weeks of using the app.

Al systems can scan many patient records effectively and identify patterns between diagnoses, environmental factors, and treatments. By considering the data from multiple sources within a fraction of the time it would take a human provider, AI can assist in identifying potentially effective treatments more quickly. Additionally, AI can monitor patients outside traditional clinical settings by analyzing biomarkers such as heart rate and sleep activity. Through early implementation and use of AI-powered technologies in child and adolescent psychiatry, clinicians will be well-positioned to respond swiftly to changes in symptoms and better long-term outcomes for their patients.

Limitations

Overall, while the use of AI in pediatric mental health has the potential to revolutionize care and improve outcomes, it is essential to consider the ethical impli-

cations, potential risks, and need for further research in this area. The emergence of artificial intelligence (AI) technology has presented several opportunities to advance pediatric mental health care, yet ethical considerations and potential risks must be considered. There is the potential for issues around privacy and autonomy, as well as bias due to data availability or limited representation. Further research and evaluation are needed to ensure accurate, effective, and safe interventions by AI-assisted models. Research initiatives must consider important questions on preferences around risk assessment and treatment decision-making, the usability of user interfaces for clinicians and patients, safety considerations to prevent misuse of data stored on AI frameworks, and the effect of AI systems in terms of unbiased judgment from healthcare providers. Ultimately, through rigorous testing and further research in this area, we can strive to develop AI technologies that support both patient well-being and responsible clinical practice.

Conclusion

AI has the potential to revolutionize mental health care for children and adolescents. We can use it to provide efficient, personalized care to a larger population of underserved youth. AI can enable us to accurately diagnose mental illness, track the progression of disorders over time, and develop preventative programs that detect diagnoses early and promote early intervention and healthy development. Of course, these potential benefits must be weighed against potential ethical implications, and further research is needed to determine how best to integrate AI into existing systems. As child and adolescent psychiatrists, we should understand the impact of AI within our field and its potential application possibilities when considering treatments or preventative strategies in high-risk or underserved populations. By taking proactive steps towards incorporating this technology appropriately, we can improve the lives of children throughout our community.



Brandon Ito, MD presents President's Plaque to SCSCAP Past-President, Benjamin Schneider, MD

Please Renew your AACAP Dues Online www.aacap.org

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

What Are the Kiddos Thinking About? By Zhijia Liang, MD, PGY-2



Ecological momentary assessment (EMA) is a research methodology that employs realtime data collection, often with smart or wearable sensors, to sample naturalistic behaviors and their determinants of participant subjects; it is, also, viewed as the modern iteration of experience sampling method-

ology¹⁻³. EMA in children was recently reviewed by Russell and Gajos in the Journal of Child Psychology and Psychiatry². Select statistics of health outcomes for adolescents offer insights into their representative experiences.

Children, like most, begin and end their day with sleep. At the minimum, 8-10 hours is recommended for ages 13-18⁴. Adolescent sleep disorder estimates range 20-40%, and 72% use cellphones prior to sleep⁵⁻⁷. Poor sleep has been linked to obesity, with national prevalence of 22%, higher in Hispanic and Black adolescents⁸. Body dysmorphic disorder and eating disorders estimates are 1-2%, higher in females⁹⁻¹¹. Gender dysphoria estimates 1-4%, with challenges in methodology, and has been increasing¹²⁻¹³. Learning disorder estimates 5-15%, with evolving conceptualization of "disorder"¹⁴⁻¹⁵. Estimates of bullying vary widely, victimization 20%, involvement 9-98%, and increasingly by cyberbullying¹⁶⁻¹⁷. Gun violence exposure has reportedly been as high as 13% and has been the leading cause of death for children in the U.S. since 2020¹⁸⁻²². Suicidal ideation and non-suicidal self-injury (NSSI) are increasing in frequency, and suicide deaths nearly match gun deaths among those of ages 15-24²³⁻²⁴. Twothirds of youths experience adverse childhood experiences (ACEs)²⁵⁻²⁶. One in six youths are diagnosed with a mental health condition, and more are beginning to diagnose themselves and others²⁷⁻²⁹. 19% of age 16-19-year-olds work, and child labor laws are changing³⁰. Leisure is divided among social media, socializing, visual media, gaming, and physical recreation³¹⁻³². Over half have had sexual intercourse by age 18, and pregnancy rates were 17% in 2019³³⁻³⁴. 47% of youth have tried substances by grade 12, with vape, alcohol, marijuana among the most common³⁵.

A representative profile for an adolescent who is receiving mental health services may be as follows. They awake to less than fully restorative sleep to scan social media and to socialize with peers. Their academic performance may be compromised by an undiagnosed learning disability or another health condition. They are a victim of bullying and, ironically, may be a participant in bullying, associated with trauma, abuse, or other ACEs. They engage in NSSI, have contemplated or attempted suicide, and have been exposed to gun violence in their communities. As they engage in leisure at home, themes of isolation, anger, devaluation, revocation of power, nihilism may predominate in certain contexts of social media, gaming, or other platforms. They take extended time falling asleep while using electronic devices. Their foundational and higher hierarchy of needs—economic, social, psychological—may be wanting in safety, security, surplus, and upward mobility. And throughout their experiences they consider their role or identity, popularity or relation to peers, close relationship vs isolation, their future and role in society, normative and prescriptive judgments, as well as praxes, specializations, and values, in accordance with the psychosocial, cognitive, and moral development theories of Erikson, Piaget, Kohlberg.

Such global representation is enhanced by EMA via data that elucidates idiographic, naturalistic, causaldirectionality level assessments within individuals and population-level variations across individuals. Questions such as "do some kiddos inclined to aggressiveness seek forums or if such forums increase aggressiveness?" and "what environmental, individual, and mutable factors influence substance craving or use?" may be determined. The potential for improved understanding and intervention of health outcomes is impressive, as is the potential room for misuse or abuse of such privileged information.

References

- Shiffman, S., Stone, A.A., & Hufford, M.R. (2008). Ecological momentary assessment. Annual Review of Clinical Psychology, 4, 1– 32.
- Russell, M.A., & Gajos, J.M. (2020). Annual Research Review: Ecological momentary assessment studies in child psychology and psychiatry. J Child Psychol Psychiatr, 61: 376-394.
- Shim, Y., Scotney, V.S., & Tay, L. (2022). Conducting mobile-enabled ecological momentary intervention research in positive psychology: key considerations and recommended practices. The Journal of Positive Psychology, 17:5, 708-717.
- Paruthi, S., Brooks, L. J., D'Ambrosio, C., Hall, W.A., Kotagal, S., Lloyd, R.M., Malow, B.A., Maski, K., Nichols, C., Quan, S.F., Rosen, C.L., Troester, M.M., & Wise, M.S. (2016). Recommended Amount of Sleep for Pediatric Populations: A Consensus Statement of the American Academy of Sleep Medicine. Journal of clinical sleep medicine : JCSM : official publication of the American Academy of Sleep Medicine, 12(6), 785–786.
- Trosman, I., & Ivanenko, A. (2020). Classification and Epidemiology of Sleep Disorders in Children and Adolescents. Child and Adolescent Psychiatric Clinics of North America.
- Gradisar, M., Wolfson, A.R., Harvey, A.G., Hale, L., Rosenberg, R., & Czeisler, C.A. (2013). The sleep and technology use of Americans: findings from the National Sleep Foundation's 2011 Sleep in America poll. Journal of clinical sleep medicine : JCSM : official publication of the American Academy of Sleep Medicine, 9(12), 1291–1299.
- Dube, N., Khan, K., Loehr, S. et al. (2017). The use of entertainment and communication technologies before sleep could affect sleep and weight status: a population-based study among children. Int J Behav Nutr Phys Act 14, 97.
- Morrissey, B., Taveras, E., Allender, S., & Strugnell, C. (2020). Sleep and obesity among children: A systematic review of multiple sleep dimensions. Pediatric Obesity; 15:e12619.
- Enander, J., Ivanov, V. Z., Mataix-Cols, D., Kuja-Halkola, R., Ljótsson, B., Lundström, S., Pérez-Vigil, A., Monzani, B., Lichtenstein, P., & Rück, C. (2018). Prevalence and heritability of body dysmorphic symptoms in adolescents and young adults: a populationbased nationwide twin study. Psychological medicine, 48(16), 2740–2747.
- US Preventive Services Task Force. Screening for Eating Disorders in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2022;327(11):1061–1067. doi:10.1001/jama.2022.1806
- National Health and Nutrition Examination Survey 2017–March 2020 Prepandemic Data Files Development of Files and Prevalence Estimates for Selected Health Outcomes. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention,
- 12. Zucker, K.J. (2017). Epidemiology of gender dysphoria and transgender identity. Sexual health, 14(5), 404–411.
- Bonifacio, J.H., Maser, C., Stadelman, K., & Palmert, M. (2019). Management of gender dysphoria in adolescents in primary care. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne, 191(3), E69–E75.
- 14. What Is Specific Learning Disorder? Psychiatry.org What Is Specific Learning Disorder?,
- 15. National Center for Education Statistics.
- 16. Armitage, R. (2021). Bullying in children: impact on child health. BMJ paediatrics open, 5(1), e000939.
- Beckman, L., Hellström, L. & von Kobyletzki, L. (2020). Cyber bullying among children with neurodevelopmental disorders: A systematic review. Scandinavian Journal of Psychology, 61, 54–67.

- Turner, H.A., Mitchell, K.J., Jones, L.M., Hamby, S., Wade, R., Jr. & Beseler, C.L. (2019). Gun Violence Exposure and Posttraumatic Symptoms Among Children and Youth. Journal of Traumatic Stress, 32: 881-889.
- Bancalari, P., Sommer, M. & Rajan, S. (2022). Youth Exposure to Endemic Community Gun Violence: A Systematic Review. Adolescent Res Rev 7, 383–417 (2022).
- 20. Gun Violence: Prediction, Prevention, and Policy. American Psychological Association, American Psychological Association,
- Cunningham, R. M., Walton, M. A., & Carter, P. M. (2018). The Major Causes of Death in Children and Adolescents in the United States. The New England journal of medicine, 379(25), 2468–2475.
- Rajan, S., Branas, C.C., Myers, D. et al. Youth exposure to violence involving a gun: evidence for adverse childhood experience classification. J Behav Med 42, 646–657 (2019).
- Kennebeck, S., & Bonin, L. (2021). Suicidal behavior in children and adolescents: Epidemiology and risk factors. In D. Brent, & D. Solomon (Eds.), UptoDate. Available from
- Glenn, C., & Nock, M.K. (2021). Nonsuicidal self-injury in children and adolescents: Epidemiology and risk factors. In D. Brent, & D. Solomon (Eds.), UptoDate. Available from
- Crouch, E., Probst, J.C., Radcliff, E., Bennett, K.J., & McKinney, S.H. (2019). Prevalence of adverse childhood experiences (ACEs) among US children. Child abuse & neglect, 92, 209–218.
- Carlson, J.S., Yohannan, J., Darr, C.L., Turley, M.R., Larez, N.A., & Perfect, M.M. (2020). Prevalence of adverse childhood experiences in school-aged youth: A systematic review (1990–2015), International Journal of School & Educational Psychology, 8:sup1, 2-23.
- Whitney, D.G., & Peterson, M.D. (2019). US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr, 173(4):389– 391.
- Data and Statistics on Children's Mental Health. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 8 Mar. 2023,
- A Challenge with Social Media: Self-Diagnosing Mental Health. Department of Psychiatry and Behavioral Sciences, McGovern Medical School, 26 Mar. 2021,
- 30. U.S. Teens (16-19) Enrolled in School and Working 1985-2021. Statista, 19 Jan. 2023,
- 31. The Way U.S. Teens Spend Their Time Is Changing, but Differences between Boys and Girls Persist. Pew Research Center, Pew Research Center, 30 May 2020,
- 32. What Teens Do with Their Downtime (and Why They Should Have Hobbies). Evolve Treatment Centers, 4 Jan. 2021,
- Over Half of U.S. Teens Have Had Sexual Intercourse by Age 18, New Report Shows. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 22 June 2018,
- 34. About Teen Pregnancy. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 15 Nov. 2021,
- 35. Teenage Drug Use Statistics [2023]: Data & Trends on Abuse. NCDAS, 1 Jan. 2023,

SCSCAP Spring Meeting with Guest Speaker, Ara Anspikian, MD Substance Abuse with a Focus on Fentanyl

By Sabrina Reed, MD

SCSCAP members gathered on March 19, 2023, for the SCSCAP Spring meeting at the Westin Long Beach which was the first in person meeting since 2019. This educational event was about substance abuse with a focus on fentanyl led by past president of SCSCAP; Dr Anspikian currently serves as Chair of the Department of Psychiatry at Loma Linda University. The gravity of this presentation was clear: *"Fentanyl is the single deadliest drug threat our nation has ever encountered... We must take every opportunity to spread the word to prevent fentanyl-related overdose death and poisonings from claiming scores of American lives every day"* (DEA 2022).

Dr. Anspikian began by illustrating how the faces of fentanyl have changed and the growing impact of fentanyl on child and adolescent populations. In an increasingly digital world, an estimated 75% of synthetic opioids are procured through social media channels and adolescents have used various emoji combinations to describe which drugs they are using or what they are interested in buying. Moreso, fentanyl can be purchased very cheaply with one dose costing as little as \$2. Dr. Anspikian emphasized multiple times that 2mg, the equivalent size of a few grains of salt, can lead to death. For these reasons, adolescents are increasingly at risk of unintentional exposure to lethal fentanyl doses.





Dr. Anspikian continued onto the history of opioids and data related to its use. The earliest reference to opium dates to 3400 BC and the more recent opioid crisis in America has progressed through three waves: prescription opioid use, followed by heroin use, and in 2013 the rise of synthetic opioids which has disproportionately impacted communities of color. More recently, data suggests we are entering a new fourth wave characterized by mixed stimulant and fentanylbased products (Jenkins 2021). This has led to a change in clinical presentations as people may not present with the traditional signs and symptoms associated with opioid intoxication (e.g., pinpoint pupils, decreased respiratory rate) when the drugs are mixed. Since the 1970s, with the exceptions of nicotine vaping and marijuana use, adolescent illicit drug use has surprisingly remained stable or decreased. Despite stability in overall opioid use, overdose deaths increased by over 100% for adolescents aged 10-19 years old from 2019-2021 (Tanz 2022). Moreover, these deaths have been more severe on the West Coast, and the highest increases have been seen in American Indian and Latinx populations.

Dr. Anspikian concluded his discussion by advocating for harm reduction, prevention, and treatment, with a focus on developmental approaches and linking individuals to appropriate levels of care. Suggested

harm reduction strategies include increased access to fentanyl test strips and naloxone kits. Notably, fentanyl test strips have high sensitivity and specificity to detect fentanyl and its analogs in different kinds of drugs and drug forms. They are low cost and can be purchased for about \$1 per strip or obtained for free from many needle exchange settings. Though they do not measure the potency or quantity of fentanyl, positive results may lead people to alter their use behaviors, including discarding their drug supply, using with someone else, and keeping naloxone nearby (Goldman 2019). Access to the emergency response Naloxone is also essential. Naloxone is only effective for up to 90 minutes and because opioids have various half-lives and strengths, having access to multiple Naloxone doses is recommended. Effective treatments, including medications and counseling, remain available but underused. Adolescents are particularly undertreated with medications for opioid use disorders. Currently, adolescents can provide consent for non-medication addiction treatment, but parental consent is required for prescribed medications. Methadone use in adolescents is limited to individuals who have consent from a guardian and can prove 2 failed withdrawal or non-medication attempts. Buprenorphine is approved for people 16 years old and older. Though naltrexone doesn't have a pediatric FDA approval, it may be used off label for addiction or self-harm. Since the elimination of the x-waiver in December of 2022, any prescriber with a standard DEA can prescribe buprenorphine without federal patient caps; this is a hopeful step to improve access to care in adolescents.

<u>References</u>

DEA. 29 April, 2022. Fentanyl Awareness. Retrieved from: https://www.dea.gov/fentanylawareness on 1 April, 2023

Goldman JE, Waye KM, Periera KA, Krieger MS, Yedinak JL, Marshall BDL. Perspectives on rapid fentanyl test strips as a harm reduction practice among young adults who use drugs: a qualitative study. Harm Reduct J. 2019 Jan 8;16(1):3. doi: 10.1186/s12954-018-0276-0. PMID: 30621699; PMCID: PMC6325714.



Q&A at the SCSCAP Annual Speaker Meeting, March 19th, 2023 at the Westin Long Beach. Our first inperson meeting in over 3 years!

Jenkins RA. The fourth wave of the US opioid epidemic and its implications for the rural US: A federal perspective. Prev Med. 2021 Nov;152(Pt 2):106541. doi: 10.1016/j.ypmed.2021.106541. Epub 2021 Aug 28. PMID: 34482994.

Tanz, L. J., Dinwiddie, A. T., Mattson, C. L., O'Donnell, J., & Davis, N. L. (2022). Drug overdose deaths among persons aged 10–19 years — United States, July 2019–December 2021. *MMWR. Morbidity and Mortality Weekly Report*, 71(50), 1576–1582. https://doi.org/10.15585/mmwr.mm7150a2



SCSCAP President, Brandon Ito, MD welcomes attendees and introduces Dr. Anspikian.

The "Un" Intentional Effects of Political Rhetoric

By Brandon Ito, MD, MPH



Over the past several years, there has been a shift in the use of political rhetoric and, in particular, a violent political rhetoric targeting marginalized and minoritized groups. *Rhetoric* is broadly defined as "the art of using language as to persuade or influence others" through expressions of opinion or thought (Oxford dictionary,

1989). In its original form, rhetoric operates and influences others through the processes of *logos* (use of data), *ethos* (use of authority or standing), and *pathos* (use of emotion). As medical providers, we utilize rhetoric to promote individual and public health; for example, we use data to provide recommendations for evidence-based treatments and interventions. Additionally, as mental health providers we understand the use of words and language as both a means of validation and healing, or alternatively, a means of injury and trauma.

Political rhetoric has direct negative effects on mental health. Increased political polarization is associated with increased depressive, anxiety, and sleep disorders. Furthermore, political rhetoric targeting specific racial or sexual and gender minority groups not only affects mental health but threatens physical safety as well. Over the course of the COVID-19 pandemic, the frequent use of anti-Asian rhetoric political discourse accompanied a significant increase in anti-Asian violence and discrimination across the country. In addition, a growing amount of literature demonstrates a direct link between exposure to political rhetoric and discriminatory policy with poorer mental health in racial minority youth, LGBQ and transgender youth, and immigrant families among others.

On March 27th, news of yet another school shooting took the lives of 3 children and 3 staff members in Green Hills, Tennessee, becoming the 14th school shooting in 2023 and 158th since 2018 (Education

Week, 2023). Following the event, a number of political figures vehemently denied the role of violent political rhetoric or firearms as contributors to the mass shootings that have now become commonplace, while simultaneously escalating hateful rhetoric by attacking and blaming the shooter's gender identity . Data, however, suggests that violent political rhetoric is, in fact, directly related to increases in mass shootings . ("Un")intentionally lost in the noise is the deleterious effect of continued school shootings on child mental health and safety, and the unacceptable fact that firearm-related deaths are now the number one cause of death for children aged 1-19 years.

As child psychiatrists, we understand the immense power of words and language. Using scientific data, our standing as experts, and the ability to utilize and harness emotion, we are uniquely positioned and ethically bound to combat the pervasive political rhetoric harming our most affected and vulnerable patients.

Ahn, L. H., Yang, N., & An, M. (2022). COVID-19 Racism, Internalized Racism, and Psychological Outcomes Among East Asians/East Asian Americans. The Counseling Psychologist, 50(3), 359-383. https://doi.org/10.1177/00110000211070597

Alfonseca, K. (2023). Anti-trans sentiment follows Nashville shooting as some conservatives focus on shooter's identity. Retrieved April 26 from https://abc7ny.com/nashville-shooting-covenantschool-transgender-shooter/13037124/

Chavez, L. R., Campos, B., Corona, K., Sanchez, D., & Ruiz, C. B. (2019). Words hurt: Political rhetoric, emotions/affect, and psychological well-being among Mexican-origin youth. Soc Sci Med, 228, 240-251.

https://doi.org/10.1016/j.socscimed.2019.03.008 Flores, A. R., Hatzenbuehler, M. L., & Gates, G. J. (2018). Identifying psychological responses of stigmatized groups to referendums. Proceedings of the National Academy of Sciences, 115(15), 3816-3821. https://doi.org/10.1073/pnas.1712897115

Goldstick, J. E., Cunningham, R. M., & Carter, P. M. (2022). Current Causes of Death in Children and Adolescents in the United States. New England Journal of Medicine, 386(20), 1955-1956. https://doi.org/10.1056/NEJMc2201761

Gover, A. R., Harper, S. B., & Langton, L. (2020). Anti-Asian Hate Crime During the COVID-19 Pandemic: Exploring the Reproduction of Inequality. American Journal of Criminal Justice, 45(4), 647-667. https://doi.org/10.1007/s12103-020-09545-1

Nayak, S. S., Fraser, T., Panagopoulos, C., Aldrich, D. P., & Kim, D. (2021). Is divisive politics making Americans sick? Associations of perceived partisan polarization with physical and mental health outcomes among adults in the United States. Soc Sci Med, 284, 113976.

https://doi.org/10.1016/j.socscimed.2021.113976

Nugent, W. R., Abrams, T. E., & Joseph, A. A. (2022). The Relationship between Violent Political Rhetoric and Mass Shootings. Journal of Social Service Research, 48(2), 246-258. https://doi.org/10.1080/01488376.2021.2018089

Paceley, M. S., Dikitsas, Z. A., Greenwood, E., McInroy, L. B., Fish, J. N., Williams, N., Riquino, M. R., Lin, M., Birnel Henderson, S., & Levine, D. S. (2023). The Perceived Health Implications of Policies and Rheto-

ric Targeting Transgender and Gender Diverse Youth: A Community-Based Qualitative Study. Transgend Health, 8(1), 100-103.

https://doi.org/10.1089/trgh.2021.0125

Valentín-Cortés, M., Benavides, Q., Bryce, R., Rabinowitz, E., Rion, R., Lopez, W. D., & Fleming, P. J. (2020). Application of the Minority Stress Theory: Understanding the Mental Health of Undocumented Latinx Immigrants. American Journal of Community Psychology, 66(3-4), 325-336. https://doi.org/10.1002/ajcp.12455



CALACAP which represents SC-SCAP, a regional organization of the American Academy of Child and Adolescent Psychiatry, in statewide advocacy, along with three other regional organizations from California has had a busy year. In November of 2022,

it sponsored a strategic planning effort on statewide advocacy along with two other statewide organizations, namely, Children Now and the CA district of the American Academy of Pediatrics. The goal of this meeting was to establish a policy agenda that could be supported by the three organizations. In addition, it held a discussion the lead state representative, Melissa Jones of the CA Department of Healthcare Services, of the <u>Child and Youth Behavioral Health Initiative</u> which is funded to the level of \$4.8 billion dollars for five years. This is the largest children's mental health initiative ever launched in California and one identified by the U.S. Surgeon General as a model for other states.

CALACAP, once again, will have a legislative day on May 15 when child and adolescent psychiatrists can meet with their elected representatives in the state legislature to discuss bills on children's mental health which are pending before the legislature. Anyone who is interested in attending can register at https://www.calacap.org/civicrm/event/info?reset=1&id=22. Travel costs for trainees are reimbursed by CALACAP.

CALACAP is the co-sponsor of two bills pending. AB 599 (Ward) will remove a provision of current state law that allows for students who have been smoking tobacco or possess tobacco to be considered for suspension or expulsion from school if passed and signed into law. SB 598 (Skinner) will prohibit a health plan from requiring a physician to submit a prior authorization for a benefit covered by the health if that physician has maintained at least a 90% approval rate of all prior authorizations submitted to the health plan during the previous one year if similarly succeeds through the legislative process. Any organization which sponsors a bill is deemed to be the content expert of that bill, a status not given to an organization if it merely "supports" a bill. Sponsorship of a bill in the state legislature is very rare for any regional organization of the AACAP.

CALACAP is following at least twenty-five other bills currently being reviewed by the state legislature. CALACAP supports the following bills. SB 350 (Menjivar) would allow for a child who has an immediate family member who is recently deceased to be excused from school for up to five days and would excuse a child from school if the child is obtaining victim related services. SB 363 (Eggman) would establish a real time web based statewide bed registry related to inpatient and residential care for mental and substance use disorders; physicians would know bed availability instantly. SB 238 (Wiener) would automatically require a health plan which modifies, delays, or denies a covered health plan benefit to an external independent reviewer; currently the patient or guardian must request this referral. Other bills being monitored by CALACAP include: AB 921 (Bonta) on workforce in mental health; AB 1120 mental health screenings of students; AB 589 (Boener Horvath) transitional housing for homeless you.

The governor has formulated a proposal to restructure the Mental Health Services Act, Prop 63, in order to prioritize funding for services for individuals who have serious mental illness and are at risk of experiencing homelessness. While this proposal is still being formulated, there was a preliminary open forum with the state administration during which it was implied that some of the funding may be shifted from children and youth. CALACAP and other organizations are closely monitoring this aspect of the proposal in light of the fact that funding for children's mental health services remains desperately needed.

Page 24

SCSCAP.ORG