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Welcome to *JAACAP Connect*!

What is *JAACAP Connect*?

All are invited! *JAACAP Connect* is an online companion to the *Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP)*, the leading journal focused exclusively on psychiatric research and treatment of children and adolescents. A core mission of *JAACAP Connect* is to engage trainees and practitioners in the process of lifelong learning via readership, authorship, and publication experiences that emphasize translation of research findings into the clinical practice of child and adolescent psychiatry.

Why do we need *JAACAP Connect*?

The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. *JAACAP Connect* engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences.

Who reads *JAACAP Connect*?

All students, trainees, and clinicians who are interested in child and adolescent mental health will benefit from reading *JAACAP Connect*, available online at **www.jaacap.com/content/connect**. AACAP members will receive emails announcing new quarterly issues.

Who writes *JAACAP Connect*?

You do! We seek highly motivated students, trainees, early career, and seasoned clinicians and researchers from all disciplines with compelling observations about child and adolescent psychiatry. We pair authors with mentors when necessary, and work as a team to create the final manuscripts.

What are the content requirements for *JAACAP Connect* articles?

JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our first edition, the topic and format can vary widely, from neuroscience to teen music choices.

How can *JAACAP Connect* help with my educational requirements?

Motivated by the ACGME/ABPN Psychiatry Milestone Project©, *JAACAP Connect* aims to promote the development of the skillset necessary for translating scientific research into clinical practice. The process of science-based publication creates a vital set of skills that is rarely acquired elsewhere, and models the real-life thought process of translating scientific findings into clinical care. To bring this experience to more trainees and providers, *JAACAP Connect* aims to enhance mastery of translating scientific findings into clinical reality by encouraging publishing as education.

JAACAP Connect combines education and skill acquisition with mentorship and guidance to offer new experiences in science-based publication. We will work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles. Opportunities for increasing knowledge and skills through publishing as education will be available through continued contributions and direct involvement with the *JAACAP Connect* editorial team, using an apprenticeship model.

Start Thinking About Authorship With *JAACAP Connect*

What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate. All are welcome, and *you* are invited.

A Pandemic-sized Effect on Writing and Editing

At the beginning of my time as Editor of *JAACAP Connect* in 2019, I was excited for the opportunity to expand the tent of writers to *Connect* by involving those who may have never thought of an academic journal as a forum for their interests, such as those participating in advocacy. The ability to collaborate with the American Academy of Child and Adolescent Psychiatry's Advocacy Committee to bring in new writers to *Connect* was the exciting first step in this mission. As Editor of *Connect*, I learned that there are situations you will never be able to anticipate when trying to plan out your time as an editor. 2020 became a very clear example of the unpredictability of life and quickly showed our editorial board that we need to be equipped and ready to develop content pertinent to current situations. COVID-19 and the associated pandemic has become the primary thought on everyone's mind. Though we might not be caring for patients in ICUs with COVID-19 or worrying as much about the physical impact of COVID-19 on the children we see, it is still impacting every part of our professional and personal lives. We went from seeing kids in person to seeing them through a Zoom or FaceTime. We have listened to the impact of being removed from the classroom, all while worrying about ourselves and our families' safety every time we stepped foot into the office or the hospital. It became clear to us how much the pandemic affected our readers and writers through the article content that arrived in the *JAACAP Connect* inbox. We saw a significant uptick in papers with a focus on the impact of COVID-19. As an Editorial Board we recognized the responsibility to provide content that focused on the impact of COVID-19 in child psychiatry. Anne McBride, the incoming *Connect* editor, *connect*ed the changes we were seeing with COVID-19 to the larger systemic difficulties we face daily as child psychiatrists, and opportunities to use this pandemic for greater systemic change, spearheading this theme issue to raise these questions. While I would have never expected the final issue I would work on as editor would be focused on a virus, it also further fulfills the mission that as writers and editors we need to be ready to expand the tent to include what is clinically relevant, which may include advocacy, a global pandemic, or the significant impact of systemic racism on the mental health of children.

Justin Schreiber, DO, MPH
Outgoing *JAACAP Connect* Editor

I love the name *JAACAP Connect*. *Connect*ing with others has always been important to me, and this year, amidst isolation and division, forging and maintaining *Connect*ions is one of the most critical things we can do. Now is the time to come together. In this spirit, I was delighted when Justin and I made the decision to co-write the introduction for our special issue on the COVID-19 pandemic. It has been an absolute pleasure to work with Justin over the past 18 months as he has prepared me for the transition to *Connect* Editor. He has made me feel so welcomed and included, and has modeled so beautifully the role of a true team leader. Thank you, Justin. You, and the growing list of former *Connect* editors (Michelle Horner and Oliver Stroeh), are handing off an extremely well cared for and impressive publication. As we move forward with *Connect*, I can't help but think about how we move forward as a field, a nation, a world. Earlier on, perhaps a few months into the COVID-19 pandemic, when my own sadness, fear, and anxiety diminished to a more manageable level, I reflected on how the devastating effects of the pandemic would undoubtedly lead to profound change. I also now reflect on how tragically, as I write this introduction, the number of lives lost in this country due to COVID-19 has doubled when compared with the number of lives lost at the time that many of these articles were written. But even early on, I realized that our country has an opportunity to create systemic changes. I have to believe that something good will come out of tragedy—that we can build better ways of doing things. As child psychia-

trists with unique perspectives and broad knowledge, we can all have a voice in envisioning great change. When I shared the idea with my fellow *Connect* editorial board members, the response was overwhelming with enthusiasm and interest. The majority of these articles were thus written with collaboration between our board members and trainees, promoting the *Connect*ivity, education, and mentorship that form the core mission of *Connect*.

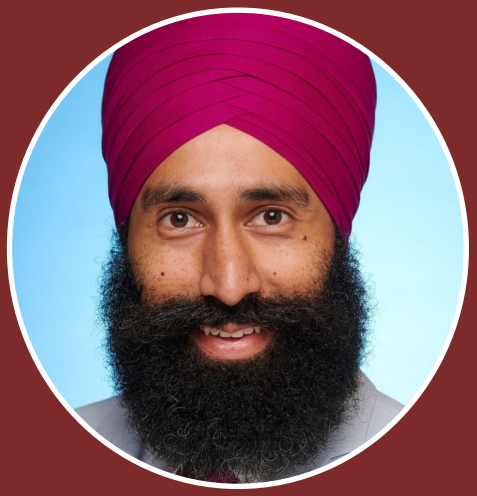
The issue begins with a wonderful piece by Drs. Hoq and Henderson, who introduce a thoughtful and critical discussion about children's rights in general, and specifically within the context of a global pandemic. From there, I had the privilege of working with 2 outstanding medical students and future child psychiatrists, Steven Lam and Jacqueline Williams, along with my colleague, Michael Kelly, in a collaborative article examining child care in the United States, a system uprooted by the pandemic, further exposing systemic flaws and disparities. Similar to Hoq and Henderson's thesis, prioritizing children and child development in the child care system can lead to positive systemic change. Next, Drs. Jeffrey, Szeftel, and Herman suggest that supporting employee wellbeing in our Head Start (early childhood education) programs can have profound beneficial effects on the provision of educational services to children. Moving on to elementary, middle, and high school, Dr. Schreiber *et al.* provide a relevant update on how virtual schooling has affected our students, particularly when it comes to mental health needs, and present opportunities for collaboration between teachers, schools, families, and child psychiatrists. We then continue on to medical education and graduate medical education (child and adolescent psychiatry) during a pandemic (respectively Ms. Thaler and Dr. Shankar; Ms. Ojha and Dr. Richards) before highlighting teaching opportunities from the perspective of an educator during the pandemic (Dr. Calhoun and Dr. Martin). Finally, I could not be prouder of the child psychiatry fellows from my own program who wrote an inspiring piece about their creative experience in their program's attempt to stave off isolation and burnout while providing patient care during a pandemic. As I read through this collection, I am left feeling hopeful as I consider all the creativity, knowledge, experience, talent, and grit that is clearly present and necessary when considering our part, as child psychiatrists, in building better systems of care. I hope you are left with similar hope and inspiration.

Anne McBride, MD
Incoming *JAACAP Connect* Editor

AACAP SPOTLIGHT
Shawn Sidhu, MD, FAPA, DFAACAP

COMPONENT WORK

Engaging in so many aspects of our organization has been an absolute privilege, honor, and blessing. This is a true testament to AACAP's mentorship, collegiality, inclusiveness, and willingness to develop young members. While certainly a sizable organization, AACAP quickly felt like home. Mentors and colleagues have supported and inspired me, and I'm continuously in awe of the incredible human beings I meet. Our talented, hardworking, and dedicated trainees show us that the future of child psychiatry is indeed very bright! All of this has been made possible by the hardest working staff in the business to whom we owe an immeasurable debt of gratitude. They work tirelessly and often in multiple roles, to insure that our members are well-served, and more importantly, that we are provided resources to deliver the best possible care to our patients. They also continue to advocate for our members and our patients on Capitol Hill, and help to shape the national discourse around child and family mental health. Thank you AACAP!



2018 AACAP ADVOCACY AND COLLABORATION GRANT

Project: *All Families Matter: An Asylum Evaluation Training Symposium for Mental Health Providers as a First Step in Creating A State-Wide Infrastructure and Coalition for Families Fleeing Persecution*

Through the AACAP Advocacy and Collaboration Grant, we built a coalition of 19 local organizations to provide training on conducting mental health evaluations for asylum-seeking individuals. Over 200 individuals have received asylum (including undocumented children of deported parents) through the efforts of the mental health providers who attended the training.

One of the worst feelings is powerlessness. This feeling not only affects us emotionally but contributes to feelings of burnout and professional inefficacy. An antidote is advocacy. This project demonstrated to our team that a small group of passionate individuals serving as a voice for children and families who remain disempowered can create real grassroots momentum that can then translate into real and meaningful change in the lives of our patients.

2019 AACAP CATCHER IN THE RYE AWARD FOR A REGIONAL ORGANIZATION (NEW MEXICO)

Project: *All Families Matter: An Asylum Evaluation Training Symposium for Mental Health Providers as a First Step in Creating A State-Wide Infrastructure and Coalition for Families Fleeing Persecution*

The Catcher in the Rye Award was given in recognition for the model developed in the aforementioned Advocacy and Collaboration Grant. After hosting our training in Albuquerque, we replicated trainings across the Southwest in several cities. In collaboration with local and national politicians and officials, we have trained over 500 mental health providers in how to assist asylum-seeking families. In an effort to create a culture change in our communities, we have written op-ed pieces and appeared on the local news and radio. We have now tapped into a Southwestern network of like-minded providers and advocates, and together have inspired one another to continue fighting for this disadvantaged group without any rights.

ABOUT DR. SIDHU

JOINED AACAP
JANUARY 2006

WORKS AT
UNIVERSITY OF CALIFORNIA SAN DIEGO MEDICAL CENTER; RADY CHILDREN'S HOSPITAL

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WORKFORCE IMPACT

One of the most enjoyable Annual Meeting experiences has been serving in the Mentorship Progam for over 5 years concurrently. Every year we get to meet the best and brightest students, who without a doubt will be our future leaders! Often I learn as much if not more than I share, and it is a way to keep me young at heart and tuned into issues that are currently relevant for our junior members. I was also honored to speak at the 2019 Medical Student and Resident Breakfast, and for several years I have been engaged in an annual meeting presentation on physician wellness.

*Visit **www.aacap.org/awards** to discover available award opportunities!*

Children's Rights in the COVID-19 Pandemic

Rakin Hoq, MD, and Schuyler W. Henderson, MD, MPH

The SARS-CoV-2 pandemic has affected populations across the globe. While COVID-19, the disease caused by infection with the SARS-CoV-2 virus, has appeared to be less harmful to youth relative to older populations (though still causing significant morbidity and mortality[1,2]) the psychosocial effects of the pandemic on youth have been extraordinarily widespread, both those shared with adults and those unique to youth.

The psychosocial effects of the pandemic on youth include, but are not limited to, increased symptoms of depression and anxiety,[3] increased exposure to bereavement,[4] and have resulted in mass school closures and extended isolation at home. Data from previous epidemics has shown that extended school closure and home confinement increases risk for exposure to abuse and domestic violence,[5] exposure to gender-based violence,[6] as well as having loss of free school meals, loss of access to support services for children with special needs, and loss of access to peers.[7] Social isolation from peers alone has been shown to have immense negative impact on the mental health and wellbeing of children.[3,8] So the social isolation coupled with lack of social and mental health support caused by the pandemic has already and will likely continue to have detrimental consequences to children worldwide.

These factors are magnified even further in marginalized and vulnerable populations, including racial minorities, children from low socioeconomic backgrounds, and youth with disabilities.[8] For example, it is already well established that there is racial disparity in the direct effects of COVID-19. Ethnic minorities, particularly Black and Latinx populations, have been shown to be at higher risk for COVID-19 infection and have more severe outcomes of the illness.[9] Furthermore, it is well established that children among marginalized populations, particularly those of lower socioeconomic status, have significantly less access to digital technology like computers and internet, which are currently being relied on to provide crucial developmental and health supports like schooling and mental health treatment.[10]

Many of the challenges for youth stem at least in part from public health interventions designed to mitigate the risk of spreading the SARS-CoV-2 virus, not as a direct result of infection. The imposition of public health mandates across the world has been met with impressive, though imperfect, compliance around mask-wearing and social distancing, including school closure, but has also engendered debates, some of which are better informed than others, about the efficacy and legality of these impositions. One important consideration is how public health mandates can conflict with established human rights: human rights are designed to protect autonomy and respect dignity across individuals and populations, largely in the face of collective and governmental impositions, restrictions, and violence. Public Health impositions can conflict with human rights, from privacy and confidentiality rights (as when there is mandatory disclosure of infection and contact tracing) to the freedom to wear, or not wear, what you want (masks, motorcycle helmets, seatbelts), to rights to congregate freely, to walk the streets, or to manage your business as you see fit, free from arbitrary interference.

Identifying the potential conflicts between public health mandates and human rights is not just an abstract exercise. When public health comes into conflict with rights, public health officials (both those designated as such, and also those in government instituting public health rules such as presidents, governors and mayors) must transparently and clearly explain why the rights need to be curbed, how the benefits should be greater than the risk, how these impositions are, to borrow a familiar psychiatric term, 'least restrictive' and how the imposition or restrictions are not discriminatory or arbi-

trary. Making this case is by no means a guarantee of the efficacy or ethical validity of the intervention, and a great deal of violence has been enacted under the guise of 'public health' (just look at the term 'ethnic cleansing' to see notions of health and hygiene imported into the concept of genocide). Nevertheless, a rights discourse can ideally compel public health officials to offer justifications, identify structural concerns that can make widespread acts discriminatory, limit the proposed infringements and even consider other options.

Unfortunately, children's rights historically have been poorly written and ill-thought-out, when they are even considered. Hillary Rodham Clinton (then Hillary Rodham) began a 1973 Harvard Educational Review article with, "The phrase 'children's rights' is a slogan in search of a definition."[11] Little has changed since then. The most significant effort to establish children's rights, the Convention on the Rights of the Child (CRC, available at: **https://www.ohchr.org/en/professionalinterest/pages/crc.aspx**) leaves much to be desired.

In one regard, many written articles of children's rights are designed to respond to 'public health.' As an example, consider Article 15 of the CRC:

Article 15

1. *States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.*
2. *No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (ordre public), the protection of public health or morals or the protection of the rights and freedoms of others.*

Compare this to Article 20 of the Universal Declaration (available at: **https://www.un.org/en/universal-declaration-human-rights/**):

Article 20

1. *Everyone has the right to freedom of peaceful assembly and association.*
2. *No one may be compelled to belong to an association.*

Article 20 (the adult right) is far shorter, more straightforward and is presented as absolute and unconditional as long as it is 'peaceful' (a term that we will admit gives a fair amount of leeway for abusive interpretation). Article 15 initially voices a sentiment to protect freedom but is followed by a lengthy imposition of restrictions, heavily worried that freedom to assembly/association for children may pose a threat to public health and safety, and the list of caveats—national security, public safety, public order, public health, morals, or the rights of others—are so comprehensive that just about any authority figure can determine the right is non-existent.

If rights truly are inalienable and children are supposed to be afforded equitable rights, then why is it that children's rights are written with such ambiguity and conditionality, and can be stripped away by pretty much any adult authority? Why is there no serious consideration of what autonomy and dignity and non-discrimination means for children? And why is it so clearly stated that public health must be considered for children but not for adults?

One answer to these questions is that children's rights are actually not considered inalienable or real. In a case like this, they are quasi-idealistic suggestions, at best.

While this has a tremendous number of consequences for how we think about children, the one we want to point out here is that the existing construct of children's rights severely limits our ability to consider and address the consequences of the pandemic for children.

For example, the rise in child abuse during the pandemic is not conceived of as population-wide human rights violations that need to be assessed and addressed with

absolute urgency, but is instead simply acknowledged as a sad thing happening behind closed doors.

The fact that children's rights are at most, adult rights-"lite", fails to give us the imagination and structure to address what is happening to children when public health infringes on children's lives. So as another example, the most prominent answer to the collapse of education appears to be re-opening schools—while schools provide education and socialization (along with, in some cases, necessary meals, and other social and developmental benefits to children), given the paucity of media attention on the experience and inherent rights of children in the midst of such frenzy for school reopening, it could be surmised that the true primary agenda is to facilitate the rights of the adults to work (that is, children are going to school so their parents can attend to work responsibilities—a far cry from the happier ideal that parents work so their children can go to school). This not to downplay the importance of schools in any regard, and is written as we watch schools and teachers struggle with immense political pressure to open up while being aware that it is unsafe, that teachers and schools are fundamentally required to engage in practices that are unusual for them, complicated, and expensive, and with the knowledge that this opening will result in the death of some teachers. Rather it is to point out that foregrounding and supporting alternative structures—even ones involving the same teachers—to provide education, rather than forcing people into a school building and calling it done, has been at the bottom of the agenda.

Another prime example of our societal oversight, and a failure to afford children their real autonomy and dignity, is that there is no 'right to play' for children, which should surely be a central right if we were to consider rights that specifically belong to children, instead of watered-down versions of adult rights. This neglect of children's right to play is visible everywhere: during the pandemic, streets remain open to car traffic but not closed to give children the space to play safely near their home—drivers, and the adult economy, have rights, while children are not considered. The closure of playgrounds and schoolyards did not result in a comprehensive public effort to ensure that children can safely enjoy this most of rights.

The arguments at the crossroads of public health and rights of adults is front and center of our sociopolitical stage, while children's rights appear to have no considerable footing. Stripping children of their rights by simply naming 'public health,' rather than making an argument as with their adult counterparts, and moreover failing to even articulate meaningful children's rights means that we lack clear a foundation from which to base advocacy efforts for children, especially during a worldwide crisis.

Take Home Summary

The COVID-19 pandemic has highlighted several existing disparities in current declarations of children's rights in comparison to those of adults, and raises question of how children's rights should be re-considered and re-conceptualized.

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This article was edited by Anne McBride, MD.

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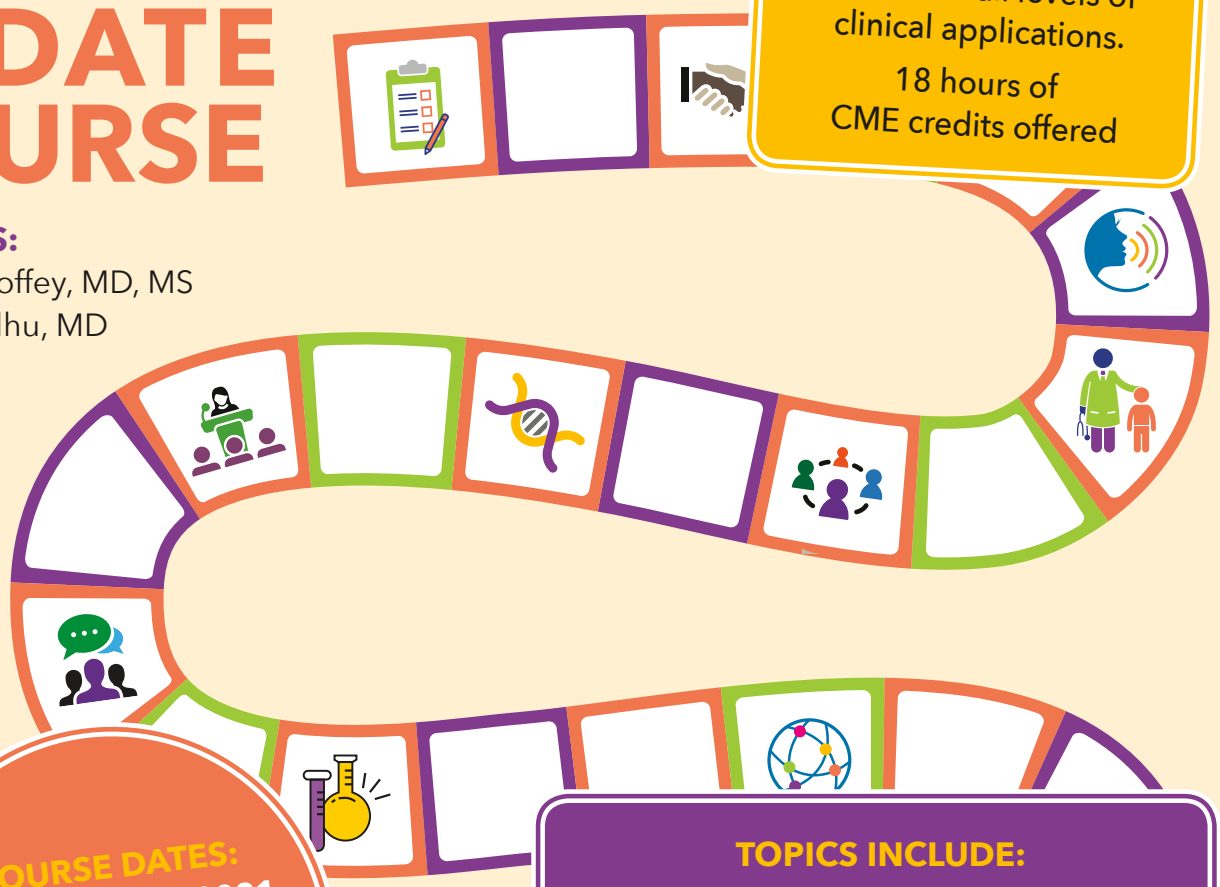

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Putting Our Kids First: The Need for Systemic Changes in American Child Care

Steven Lam, Medical Student, Jacqueline Williams, Medical Student, Anne McBride, MD, Michael Kelly, MD

The COVID-19 pandemic has magnified issues with the American child care system, chiefly that children are not our central focus. This is evident by the vast disparities in child care cost, access, and quality, leading to systemic inequities with detrimental consequences for child development and beyond. While we have an abundance of research to support evidence-based interventions that promote children's development, these interventions have not been a national priority. However, child care became a clear national priority when schools across the nation transitioned to distance learning in early 2020. Caregivers who continued to work on-site or on the front lines were suddenly confronted with urgent child care needs, often at substantial unbudgeted expense. Caregivers who transitioned to work exclusively from home had to manage their own employment while caring for their children. But was the loss of child care exclusively at the detriment of caregivers and their employment? No, and more critically, it became increasingly apparent that the lack of child care and on-site schooling was a significant loss for many children who depended on these systems for reasons outside of basic supervision needs. The pandemic upheaval presents an opportunity to prioritize child development and well-being as the foundation of our child care system and rebuild a correspondingly supportive infrastructure. This article explores the historical roots of the US child care system, including the disparities engrained within it, demonstrates the importance of child care in development, and imagines a new child care system that prioritizes children.

History of Current Child Care

Historically, the US approach to child care focused on parents and the workforce, but left marginalized groups behind. The system initially relied upon women remaining home, outside of the traditional workforce, to raise children. For example, the widows' pensions of the 1930s incentivized widowed mothers to stay home with children instead of looking for work, but pensions were typically not available to women who were not White and/or were of low socioeconomic status.[1] Eventually, such incentives for child care took the form of tax credits that have historically disproportionately benefitted upper and middle class households. Child care centers were formed during World War II as a means of accommodating a rapidly growing female workforce; however, the end of the war reduced the female workforce, resulting in vast closures of child care facilities. The decades following WWII included social and economic changes that led to more women working outside of the home without a commensurate increase in federally sponsored child care programs.

In the present, issues of cost, quality, and accessibility are major obstacles to child care for many American families. Child care is expensive, with some forms costing more in one year than a year of tuition at a 4-year public college, and an estimated total of $28.9 billion in wages is put towards child care annually.[2] Due to sheer need, working families are often pushed to the limits of their financial means when paying for care. For instance, the Department of Health and Human Services recommends that 7% of a family's income should go towards child care; however, 1 in 4 families spend over 10% on child care.[3] In addition to the significant financial costs of child care, availability is a major concern. For example, before the pandemic, 42% of children aged 5 or under lived in areas without adequate child care supply to meet the demand.[4] Further complicating matters, child care industry workers are often underpaid, averaging $22,000 a year in income, thereby contributing to high turnover, limited access, and diminished quality.[1,5] In short, even without the pandemic, American families are

left to compete for a limited number of available child care spots, and lower income families are disproportionally left with few feasible options. Despite our nation's prosperity, only 0.5% of the total GDP is spent on early childhood education, about half the average spent by other industrialized countries.[6] These data suggests that child care has been greatly underprioritized.

The Role of Child Care in Development

High quality child care programs offer child development opportunities well beyond addressing supervision needs, ranging from improvements in academic performance, psychosocial behavior, and positive health outcomes. While there are numerous permutations of child care, we will focus our review on two: early child care (infant to school-aged) and afterschool programs.

Early childhood encompasses a critical developmental period. Early child care programs have the potential to have profound impact during this developmental period, particularly in fostering optimal growth and preventing poor outcomes. For example, a meta-analysis of 22 early child education (ECE) programs (which typically target cognitive and socio-emotional development) found that participation in ECE led to a significant decrease in special education placement and grade retention as well as increased rates of high school graduation.[7] Investing in ECE programs, particularly those targeting disadvantaged children, has the potential to optimize early childhood development and reduce (or even eliminate) multiple disparities, leading to impressive economic return and substantial societal growth.[8] The most effective early education programs include elements related to the quality of the provider, sufficient learning time, evidence-based curricula, individualized child assessment, and meaningful family engagement.[9]

In the United States, Head Start programs, established in 1965, are free, federally funded programs for early childhood educational intervention that integrate educational and supportive services (eg, healthcare access, service access for children with disabilities, housing stability, parental job training and education) into care for low-income families. In the 2018-2019 program year, Head Start programs served 1,047,000 children (birth to age 5) and pregnant women,[10] yet about ten-times as many children ages 5 and under are considered low income in a given year.[11] Moreover, given our now expansive understanding of the relationship between adverse childhood experiences and later detrimental outcomes,[12] involvement in a child care program can be viewed as an intervention point to mitigate the effects of prior adverse experiences and to prevent future adversity, particularly given that adverse experiences have been heightened by the pandemic.

Afterschool and other child care programs for older children can also be viewed as important opportunities for growth and the prevention of poor outcomes. Programs that incorporate active play foster physical and social development by providing children the opportunity to feel a sense of control and self-efficacy.[13,14] Afterschool programs have been shown to improve qualities of grit, self-control, growth mindset, positive social behaviors and even motivation, traits often tied to success in adulthood. Similar to early childhood programs, success of afterschool programs appears related to quality and level of participation as programming with little engagement by children garners no tangible benefits.[14,15] Engaging youth in prosocial activities that are appropriately supervised, such as afterschool programs, can also prevent poor outcomes (eg, mental health, substance use, delinquency, victimization). In one striking example, consider the following statistic: violent crimes perpetrated by juveniles most frequently occur on school days in the hours immediately following the close of school.[16] And in fact, implementation of an afterschool park-based youth mental health promotion program in Florida was associated with a significant reduction in youth arrests.[17] Such an example illustrates how access to afterschool programs can meaningfully impact an individual's trajectory as well as the community and our greater society.

Moving Forward

From financial hardship to child care center closures to balancing workload and child care at home, the pandemic has magnified the barriers to high quality child

care while centers and providers struggle with safety and service in uncharted territory. Additionally, families already facing racial and economic disparities in care are most severely impacted.[18,19] Overall, this threatens child well-being, slows development, and increases educational and health disparities. Alternatively, child care reform that prioritizes child development and well-being by including healthy parent/family involvement in child care, reducing prohibitive costs to families, and investing in quality improvement could reverse this course. Child and adolescent psychiatrists are well-positioned to provide expertise and psychoeducation about child development and evidence-based interventions. For example, child psychiatry fellowship programs can partner with child care centers to provide consultation and identify children in need of further intervention while simultaneously providing substantial experience for trainees. Such potential collaborations additionally highlight the need to adequately train child psychiatrists to effectively provide appropriate psychoeducation.

If we are to have a system that prioritizes child development, we must start from birth. Notably, the United States is the only Organisation for Economic Co-operation and Development country without paid parental leave. Currently, the United States' Family and Medical Leave Act allows for 12 weeks of unpaid parental leave, which functionally covers only 56% of American workers, many of whom do not have the financial means to take an unpaid leave.[20] Unpaid parental leave has not shown clear benefits to child health outcomes, but in studies where benefits were found, they were isolated to socioeconomically advantaged groups,[21] thus increasing the health disparities between children of differing economic backgrounds. In addition to benefits associated with early bonding and attachment, paid parental leave has clear benefits to infant mortality across several studies, with reductions in mortality of around 3%, possibly due to increased breastfeeding, safer parenting behaviors, and greater utilization of healthcare, including immunizations.[21] Thus, any significant reform with the intent to improve the health and well-being of children will make paid parental leave a priority. This is an area where child and adolescent psychiatrists can serve as adovocates such as at the legislative level or in counseling a family facing child care choices.

Fiscal recovery from this pandemic will take the work of all industries and employees, pushing many families to utilize external child care. For some, increased access to high quality child care that is attached or in close proximity to (and even subsidized by) the parent's place of employment can strengthen bonding and attachment, decrease wasted and environmentally harmful commute time, and potentially impact parent and child well-being.

For all families, high quality child care must be affordable. One step to achieve this goal is implementing a sliding scale for child care costs that amounts to a maximum of 7% of the family budget. This would serve to decrease inequities in child care access as existing subsidies currently reach only a minority of eligible children.[4,22] Although financial barriers are often cited as an obstacle to quality improvement, investing in and prioritizing high quality, affordable, and accessible child care has profound developmental and economic implications that outweigh the initial financial investment.[8]

Finally, we know that high quality care includes education as well as the supportive services outlined earlier; however, further steps are necessary to enable universal implementation of evidence-based interventions. Such steps include ensuring providers are supported, well trained, and compensated at rates that reflect their critical role in supporting child development and well-being. There is likely to be pressure during the pandemic to cut corners on quality as providers face unprecedented circumstances in providing care, but is important to be deliberate and thoughtful in providing child care that is safe while fostering child development. Child and adolescent psychiatrists can provide psychoeducation to families and guidance at a systems-level to promote the most effective and impactful interventions for children.

Conclusion

As the pandemic progresses, child care programs are opportunities to address systemic inequity, provide

screening and evidence-based interventions when warranted, and add infrastructure and support at the community level. Focusing on child development and well-being will guide our use of resources to build a better child care system. Child and adolescent psychiatrists can play a critical role in building a child care system that truly prioritizes children.

Take Home Summary

The pandemic highlights issues of quality, cost, and access in child care. Ideally, child care optimizes child development and reduces socioeconomic disparities. Child and adolescent psychiatrists should serve as advocates and experts in the opportunity to build a better system.

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Supporting Head Start Employee Well-Being During the COVID-19 Pandemic

Jessica Jeffrey, MD, MPH, MBA, Zara Szeftel, MD, Ariella Herman, PhD

The coronavirus disease 2019 (COVID-19) pandemic is impacting many aspects of individual, family and community life. This is especially true for vulnerable children and families, such as those served by Head Start. Added emotional and socioeconomic pressure on families during the pandemic has put disadvantaged children at higher risk for adverse home events, mental health symptoms and long-term developmental consequences.[1,2] Head Start programs, which began in 1965, were developed to mitigate the effects of economic disadvantage by supporting the cognitive, social, psychological and educational development of vulnerable children.[3,4] Early childhood intervention programs involve a comprehensive array of educational and psychosocial supports which depend on the work of the early childhood workforce.[4] The recent implementation of COVID-19 social distancing guidelines has created numerous personal and work-place challenges, resulting in significant stress on the essential workers at Head Start.

There is a growing understanding of the connection between early educator well-being and quality of early childhood education.[5,6] While there are broad considerations in this area, recent focus has been on the impact of the work environment, work-related stress, psychological and emotional well-being.[6] In a sample of Head Start teachers, greater workplace stress (more demands, less control, low support) was associated with more conflict in teacher–child relationships.[7] Additionally, teacher-perceived suboptimal working conditions, especially chaotic child care environments, have been associated with higher teacher 'psychological load' (depression, stress, and emotional exhaustion) which can interfere with effective social-emotional teaching.[8] Furthermore, teachers with higher psychological load have been shown to have more negative reactions to children, while teachers' coping abilities (reappraisal emotion regulation and problem-focused coping strategies) correlate with more supportive reactions to children.[9] Given the impact of early educator well-being on children's social-emotional development, there has been research into which workplace supports and interventions can promote early educator well-being.[6,10]

The UCLA Health Care Institute (HCI) at the UCLA Anderson School of Management has been dedicated to the implementation of health promotion interventions in Head Start for nearly 20 years.[11] Working at the program level, HCI provides tools, trainings and other supports for early childhood employees to optimize the health and well-being of the Head Start families they serve. In this paper, we describe the results of a large, nationwide survey conducted in May 2020 that assessed stressors impacting Head Start employees and suggest systemic approaches to supporting early childhood educator well-being in the face of unprecedented stressors brought on by the COVID-19 pandemic.

Pandemic Impact Survey

In May 2020, the Health Care Institute at the UCLA Anderson School of Management, surveyed Head Start employees to learn how their lives have changed since the COVID-19 pandemic began in March 2020. The Head Start Coronavirus Pandemic Survey consisted of 15 questions (check boxes and free response options) querying personal and work-related stresses, as well as feelings about reopening Head Start Centers during the pandemic. The survey also elicited strengths of Head Start employees. The survey was sent to past participants of the UCLA Head Start Management Fellows Program and the UCLA Health Care Institute. There were 4,443 individuals from 332 Head Start Agencies who responded within one week. Almost half of the

respondents (48%) identified as "teachers/educators/teacher's aide." The survey was written by the Health Care Institute and incorporated select questions from the Epidemic-Pandemic Impact Inventory.[12]

Results of the Survey

Distance Learning and Other Professional Challenges. Head Start employees face a number of professional challenges during the COVID-19 pandemic. A large percentage of employees reported a transition to distance learning and support for children and families (83%). Staff reported engaging in distance communication with staff (82% of respondents), distance support for families and children (71%) and distance learning for young children (59%). Many described challenges with the transition to remote work, most significantly, difficulty communicating with parents (48%), maintaining parent and child motivation (46%) and monitoring learner progress (40%). Technological issues were also reported, such as families having limited access to reliable internet or devices (35%), employees lacking experience in virtual teaching (36%) and access to flexible teaching materials (25%). Additionally, employees expressed concerns about virtual interactions not meeting the social needs of very young children, especially in trying to help children cope during this crisis.

Personal, Family, and Professional Stressors

Survey results revealed an increase in personal and professional stressors for Head Start employees due to COVID-19. See Table 1. Personal stressors included an increase in mental health symptoms (64% of respondents), such as mood symptoms, anxiety symptoms, sleep disturbance (62%), and difficulty managing the uncertainty of the current situation. Home dynamics also changed due to the pandemic. Employees reported having to manage their own children's schooling (41%) and emotional/behavioral problems (27%). Some also had more conflict in the home (18%). Employees described a decrease in activities that promoted well-being such as seeing close family and friends (88%), doing enjoyable activities/hobbies (79%), engaging in physical exercise (66%), healthy eating (64%) and religious activities (63%). Some also reported financial uncertainty about the future. Professionally, many employees reported a difficult time transitioning to working remotely (50%) and an increase in workload/responsibilities (42%). A large number reported anxiety about returning to work, specifically citing worries about

Table 1. Most Common Stressors Reported by Head Start Employees

Stressor	Respondents (%)
Personal	
Decrease in well-being—promoting activities:	88
Seeing close friends and family	79
Enjoyable activities/hobbies	66
Physical exercise	64
Healthy eating	63
Religious activities	64
Increase in mental health symptoms	62
Increase in sleep problems/poor sleep quality	41
Managing own children's schooling	
Professional	
Anxiety about returning to work:	57 = yes, 20 = not sure
Being able to do job well	65
Being able to social distance at work	62
Contracting COVID-19	58
Lacking PPE	55
Difficulty transitioning to remote work	50
Increase in workload/responsibilities	42

Note: *PPE = personal protective equipment.*

not being able to do their job well (65%), not being able to social distance (62%), contracting COVID-19 (58%) and lacking access to testing and PPE (55%). They also had concerns about workplace adherence to CDC guidelines, having to leave home and put family at risk as well as worry about the financial and overall well-being of Head Start children and families.

Strengths and Innovation

In addition to describing personal and professional challenges and stressors, the survey highlighted employee strengths and ways they have extended themselves or innovated for Head Start families during the COVID-19 pandemic. The majority (91%) of employees reported being more appreciative of things they usually took for granted. They also reported having more quality time with friends and family, even from a distance (76%). In addition to working as distance educators, some employees described delivering classroom materials, meals and other essential items directly to families or by curbside pickup. They showed creativity in the ways they tried to connect with families virtually and through drive-by or letters. Some employees also found ways of supporting each other, offering relevant online trainings, webinars and mental health support.

Supporting Head Start Employee Well-Being During the COVID-19 Pandemic

The results of the pandemic survey illustrate how COVID-19 has generated unprecedented personal and professional stressors on Head Start employees, especially early childhood educators who are the virtual front-line workers. Similar to reports of other early childhood teachers during the pandemic, the survey revealed that distance learning has brought new challenges which contribute to increased workload and responsibilities for Head Start early childhood educators.[13] Worries about a safe transition back to work were also a notable source of stress and may reflect changing public health guidelines and fluctuating infection risk.[14] An increase in personal stressors was reported including mental health symptoms, changes in home dynamics, and a decrease in activities that promote well-being, which is consistent with growing public health awareness of the pandemic's impact on mental health.[15] It is important to highlight that despite the many challenges, Head Start employees showed resilience, finding creative ways to utilize their strengths in supporting Head Start families and colleagues.

As Head Start programs navigate the COVID-19 pandemic and plan to re-open, there is an opportunity to tailor systemic changes to support employees. Addressing the burden of personal and professional stressors brought on by COVID-19 and providing opportunities for employees to enhance strengths with targeted support may contribute to improved well-being, leading to more effective teaching. Systemic changes designed to target areas of workplace and personal stress could involve: (1) professional development (2) workplace safety and (3) COVID-19 educational resources. See Table 2. Professional development opportunities oriented towards learning how to engage children and families in online learning, trauma-informed educational practices and supporting professional well-being during this challenging time could reduce teacher stress and workload. Promoting workplace safety with a comprehensive return-to-work plan, including safety protocols and available PPE which adheres to CDC guidelines could address employee anxiety about returning to work. Finally, providing low literacy COVID-19 pandemic educational materials for families and Head Start employees could help increase awareness, enhance resilience, and promote emotional well-being. This may include information about coronavirus safety, psychoeducation about the impact of stress and uncertainty on mental health, recommendations for connecting with loved ones virtually, parenting while working at home and doing activities that promote well-being.

Table 2. Recommendations for Systemic Interventions to Support Head Start Employee Well-Being During the COVID-19 Pandemic

Professional development
■ Provide training on how to engage young children in online learning, including resources for virtual teaching and monitoring learner progress
■ Provide workshops and/or webinars on trauma-informed care practices
■ Provide workshops and/or webinars on professional well-being
Workplace safety
■ Create a comprehensive return-to-work plan that adheres to CDC guidelines (including specific guidelines for social distancing and sanitation safety protocols that would affect workflow)
■ Provide adequate PPE
■ Address issues relating to job security
Low literacy COVID-19 resources for families and Head Start employees
■ Education on COVID-19 and current public health guidelines
■ Psychoeducation about the impact of stress and uncertainty on mental and physical health
■ Recommendations for connecting with loved ones virtually
■ Recommendations for parenting while working at home
■ Recommendations for doing activities that promote well-being

Note: *PPE = personal protective equipment.*

Take Home Summary

Research shows that early educator workplace stress and emotional well-being are intimately connected to development of social-emotional competence in children. The COVID-19 pandemic has generated new challenges for early educators, increasing workplace stress and impacting emotional well-being. Implementing systemic changes in Head Start and other early education programs to promote early educator well-being may have positive downstream effects on vulnerable children in need.

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Using COVID-19 as an Opportunity to Build Collaborations With Schools

Justin Schreiber, DO, MPH, Ajjya Acharya, MD, Christopher Mock, MAT, Daniel Mejia-Garcia, MA Special Education

I've lived in 3 foster homes, one group home, and 2 homeless shelters. I got taken out of my mom's custody because she was on parole and she was caught up under the influence of a controlled substance and in possession of drug paraphernalia. In addition, she was charged with child endangerment because my appendix had burst and I was not taken to a hospital for over 24 hours; I was dying. There were no family members or anyone who could take me and my 3 siblings so the system became my life.

— 17-year-old high school student

Within this context, this student developed symptoms of aggression, school absenteeism, suicidal ideation, cutting, and depression. What is more, now with the addition of the COVID-19 pandemic, her once stable institution, school, is removed and she works from home without the typical check-in from teachers and school behavioral health.

Students often express anxiety due to the pressure of deadlines, tests, attendance, and school performance, but COVID-19 has brought new challenges. Sitting in front of a camera, some students experience raw emotions around self-image or shame about their home environments. They may be expected to juggle studying while caring for their younger siblings, or at times even teaching their younger siblings who are also doing distance learning. Students and parents are forced to address new technology expectations, some with a lack of appropriate internet or computer resources. For students who relied on school for behavioral health services, adult support and guidance, and food access, the impacts of not physically being in school are surfacing. For example, the Teen Line, based in Los Angeles, is reporting a 140% increase in calls reporting child abuse, 17% increase in anxiety, 24% increase in self injury, and 29% increase in loneliness and family struggles.[1] What can students and families do? What can teachers do? What can we as child psychiatrists do? To address the underlying behavioral health needs at schools unmasked by the consequences of COVID-19, we require a coordinated effort by teachers, behavioral health professionals, and families.

Lack of School Resources and Mental Health Cuts

The financial impact of the pandemic on schools and districts has been often overlooked when state and federal governments have been providing pandemic relief funding. Many districts overnight saw their budget projections plummet in response to the pandemic's effects on local economies. Because most districts and schools are funded by local or state property taxes, the level of impact varies wildly from school to school. Estimates on cuts to K-12 education vary from 10-25% in different states.[2] To balance their budgets, districts have necessarily proposed cuts, which for some have included termination of the school's mental health service providers.[3]

Districts and schools around the country are faced with similar situations. The 2015-2016 National Teacher and Principal Survey (NTPS) conducted by the US Department of Education found that two-thirds of schools have a psychologist on staff, either full or part-time, while approximately 40% have a social worker.[4] The report indicates that 94% of schools have at least some type of mental health staff member, although this includes academic counselors who are often given little, if any, training to support students struggling with mental health issues. Removing the few mental health resources on campus during a global pandemic which

brings unprecedented stress and anxiety to students is particularly troubling.

The continued budget difficulties might not allow for the solution to be to hire more mental health workers. Instead this is an opportunity for child psychiatrists to develop collaborations with schools to meet these needs. As child psychiatrists we could provide consultation to schools or work to build bridges between schools and community mental health services. This is an opportunity to develop a collaboration that addresses previous and current needs.

Teachers Are Not Able to Check In With Students

Teachers serve as incredibly important gatekeepers who identify student mental health needs. They spend a lot of time building relationships with students and monitoring daily changes. In person, a teacher can frequently observe when a student isn't quite themself and seems particularly anxious, stressed, or depressed. A teacher can reach out to get a sense of what is happening and try to provide the resources they need. While school closures, online learning models, and socially distanced in-person classrooms have been necessary public health precautions, they have real impacts on a teacher's ability to serve as a screener of mental health concerns. The unfortunate reality is that when classes are online, or when students are masked, it is much more difficult, if not impossible, to identify these subtleties, leaving it largely up to the student to disclose if they are in distress. As child psychiatrists, we will often get this information in session from the student or a parent, which represents another opportunity to communicate with teachers regarding what to look out for, if the family allows.

Changes in Education Impact on Internalizing Disorders

We know that at-risk youth who report more positive connection to their schools endorse less severe symptoms of depression, social anxiety, and suicidal ideation,[5-7] but the online platform strains a student's relationship with school. The loss of connectedness and perceived loss of school support surrenders an important protective factor for vulnerable teens. Similarly, as the opportunities to develop social skills with peers and educators transitions online, children with underlying vulnerabilities like social anxiety are especially at risk for worsening symptoms and severity. Correlational data suggests children who substitute virtual interaction for in-person interaction "intensify their social impairments."[8]

School attendance is linked to longitudinal outcomes including opportunities for higher education, enhanced lifetime earning potential, improved risk aversion, and reduced death rates. Further, school attendance is a protective factor against negative mental and physical health outcomes.[9,10] However, online school poses new challenges to supporting school attendance. For example, families may not have reliable computer or internet access. When access is available, homes may be strained by the number of children requiring access. Of those who don't have internet access, 34% report this is due to it being too expensive, and this was before the financial strain of the pandemic.[11] However, even when a child can find themselves screen-to-screen with their educators, the ability to keep a child present in a distance learning classroom proves to be an obstacle. As child psychiatrists this presents an opportunity to advocate to schools when a child should go into school when the option is available, especially in school age children where data so far shows less transmission.[12] It is also important to be aware of resources, such as hubs, to provide to families, offering a more structured environment to participate in class.

Impact on Children With Attention-Deficit/Hyperactivity Disorder and Learning Disabilities

Currently 9.4% of all children are diagnosed with ADHD and about 20% of all children have a learning disability.[13,14] Many of these students require extra support in school evidenced by the 14% of all students who have an Individualized Education Program (IEP).[15] With the pandemic, these students are now forced to sit in front of a screen, dealing with multiple distractions

at home, and not always able to get the same supports from their IEP. In a typical school environment, students struggling with executive function difficulties would at least have a structured day and a teacher present to provide assistance and redirection. In a virtual learning environment, students might have a mix of live learning and pre-posted videos or assignments, and are often asked to navigate multiple platforms and platform locations to find assignments. Students with ADHD already struggle with acquiring skills such as reading at level with peers; these new obstacles lead to missed assignments, worsening grades, and rising concern for how far behind these students will fall during this time of virtual learning.[16] Typically, these students would be supported with an IEP—more time for tests, a quiet space, more individualized education—but these educational supports might look different virtually then they did in person.[17]

As families are presenting to their health care providers expressing concern for new or worsening ADHD symptoms, there are increased difficulties in assessments. Teachers are no longer able to see their students in-person which, as we have seen, limits the teachers ability to fill out Vanderbilt assessments. Without the teacher assessment the specificity of the Vanderbilt forms decrease, leading to increased risk of over-diagnosis of ADHD.[18] Meanwhile, we have seen schools delay or be unable to perform much of the testing required to write new IEPs or reassess current IEPs without students physically in school. This is an opportunity for child psychiatrist to collaborate with the school to enhance supports while working virtually.

Disparities in Care

Pre-pandemic, challenges to school access were particularly prevalent in low income areas and frequently communities of color[19] and school absence rates were higher amongst students of color, students from economically disadvantaged families, and students with IEPs.[20,21] Major cities like Los Angeles identify similar populations as being "disproportionately negatively impacted" during the transit to distance learning.[22] Those who can have a parent sit with them to help redirect during online learning or can afford individualized support from supplementary educational programs may not be as negatively affected. Families who have the resources to advocate for their student's IEP to be modified to match the needs of online learning will have an increased chance of success. Meanwhile, the disproportionately higher number of students of color and in poverty that don't have these resources continue to fall behind.

Of further concern, students of color, students from lower income households, students with disabilities, and English language learners are disproportionately likely to need mental health services but lack access outside of school. For instance, the suicide rate amongst Black adolescents is increasing while access to services outside of school is decreasing.[23] A school is tasked with addressing the opportunity gap between the different populations it serves; to do so requires at least maintenance, and more likely expansion, of school-based mental health services.

Child Psychiatrists and Teachers Working Together in Response to COVID-19

The impact of the COVID-19 pandemic on education cannot be understated. As teachers, pediatricians, and a child psychiatrist, the authors of this article are seeing an opportunity for collaboration and system change to address these concerns. Technology and virtual communication offer an opportunity to collaborate and access data that was never available before.

Often, behavioral health providers have not been able to participate in IEP or 504 meetings due to challenges getting on-site or coordinating schedules, raising concerns that IEP recommendations may not reflect evidence-based practices to address a child's needs.[24] With virtual meetings, there is increased opportunity for participation by child psychiatrists to collaborate with educators. This might include discussions around the need for organization of all assignments into one place, reviewing signs of depression when a student is not participating, and much more. Even outside of IEP/504 meetings, there are opportunities to communi-

cate through email updates or teacher questionnaires. This increases the involvement of teachers in the diagnosis and treatment process for the students they know extremely well, and allows providers to share important red-flag signs and symptoms for teachers to monitor.

There are additional opportunities to get data quickly if students bring their computer in to an in person visit or screen share a virtual visit. A provider can review missed assignments, difficulties with individual assignments, and how the assignments are organized. This information provides specific data on why a student might be struggling.

As more visits occur virtually, there may even be opportunities to invite teachers or other school supports to participate in virtual mental health appointments with children and families, perhaps providing the most direct feedback to determine the impact of medication changes, need for different levels of service, and concerns that may be present in school but not home.

Conclusion

The pandemic has exposed disparities that exist in educational supports for children with mental health needs. School-based mental health supports have decreased, opportunities for teachers to be present with their students have diminished, risk of isolation and depression have increased, and children with ADHD and learning disabilities may have additional challenges. Even with these difficulties, through the use of previously unavailable or underutilized technology, we as child psychiatrists are presented with the opportunity to collaborate with schools in new ways to learn more from teachers about the needs of our patients. This is a chance to significantly impact the way that mental health interfaces at schools, and as child psychiatrists we need to work with teachers to cement these changes while the opportunity is here.

Take Home Summary

COVID-19 has lead to many changes in the way that school is conducted, especially for kids with psychiatric conditions. Due to the struggles teachers and child psychiatrists are facing in addressing the comorbidities of worsening mental health and school performance, there is an opportunity to partner together. Identifying ways to increase communication and collaboration will be essential in ensuring good care for these kids and will hopefully continue after the pandemic.

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The Rise of Telehealth in Medical Education and Healthcare in the Era of COVID-19 and Beyond: Can Psychiatry Take the Lead?

Nicolin Thaler, MD Candidate, and Ravi Shankar, MD

Telemedicine has been a trendy topic in the medical field in recent years. The possibility of increasing access to healthcare for remote or limited-mobility populations, improving provider efficiency, and possibly reducing costs to providers (including reduced physician travel time and personnel costs) has made the idea of implementing telehealth more enticing to many physicians.[1] However, most still hesitated on its widespread adoption in their field, especially among seasoned practitioners, due to fears of reduced patient satisfaction, issues with reimbursement and licensure, breaches in privacy or safety, and difficulties with technologic operability.[2] For example, in the field of psychiatry, though overall telemedicine use had been increasing, its use was not evenly distributed as only a select few physicians accounted for most visits: 100 physicians in 2014 accounted for over half the tele-mental health visits that year in psychiatry.[3] The COVID-19 pandemic has presented a new urgency for the utilization of telemedicine tools for patient care and medical education, forcing rapid acceptance of a previously possibly controversial health care tool into the daily lives of many providers and medical students nationwide. Despite the difficulties and uncertainty of telemedicine tools, this pandemic presents the medical community with an opportunity to both improve our ability to respond to future crises and usher in an era of healthcare that allows increased access to care and medical education.

Kannarkat *et al.*[4] remark on this phenomenon in psychiatry noting how policymakers have taken action to remove restrictions on licensing as social distancing guidelines have limited patient contact with healthcare. The use of telepsychiatry and telemedicine in general is now being more readily accepted by once-hesitant practices and providers as previous legal, reimbursement, and technological barriers are being resolved quickly in order to increase access during the pandemic.[5] Adjacent to patient care by providers is medical education for our future physicians, which has similarly been impacted by social distancing restrictions. While this technology is being adopted as a possible staple in the future of healthcare, we believe that it too may play an important role in the future of medical education. In light of the increasing transmission of COVID-19, in March of this year the AAMC guidelines strongly supported pausing clinical rotations, leading to the removal of medical students from in-person clerkships in medical schools nationwide.[6] During this time, faculty members had to work quickly to adjust their curriculum to be based remotely using online platforms such as Zoom not only for lectures, but also for inpatient rounds, standardized patient encounters, and direct patient care. Some have previously called for standardized telehealth education guidelines for students to provide basic knowledge of its use and include skill competencies pre-COVID-19.[7] However, as with telemedicine use for patient care, the COVID-19 pandemic has quickly pushed the utilization of telehealth in education to the forefront. This shift in education delivery towards remote learning has also illuminated the potential for teleteaching technologies to substitute in-person learning not only during the pandemic, but beyond.[8] At the University of Missouri School of Medicine in Columbia we are interested in how the utilization of telemedicine and remote learning tools has affected the quality of medical student education and if this technology may indeed play a role in future curricula. We are in the process of gathering data from students and educators based on their experiences transitioning into using remote learning tools

in both educational and clinical settings when first affected by the pandemic in various settings across the medical school.

This widespread adoption of remote-learning tools for telemedicine and tele-education in medical schools presents both beneficial opportunities and possible shortcomings. Benefits of online platforms tools such as Zoom include the ability to incorporate multiple learners into telehealth visits without much disruption to patient care. Students are able to partake in the patient interview process and turn their camera off to avoid pulling focus from the provider when the student is observing, allowing the encounter to continue naturally. Additionally, tele-education represents an opportunity to improve medical student mental health by offering an improved work-life balance—remote sessions allow students to be in their home environment and to increase productivity between sessions which is more difficult to achieve during down-time in a clinical setting. The incorporation of telehealth within the medical school curricula is also exposing students to this platform for patient care, an experience which some believe is necessary for more widespread adoption of telehealth in students' future practice as providers.[2,3,9] Conversely, a potential downside of tele-education is the issue of anonymity for students during large group sessions with the option to forego displaying their video, which may disincentivize students from actively participating in lectures, problem-based learning groups, or team rounds. Also, relying solely on telemedicine for clinical education may not be ideal for specialties that largely depend on in-person contact such as surgery, likely resulting in lower quality of educational experience for students on these clerkships. Lastly, medical students this year face the uncertainty of virtual residency interviews which invite a great degree of anxiety about having only limited contact with potential future employers and co-residents as well as remote school examinations which conjure worries about dishonesty and academic integrity that are relying on little more than faith in a school's honor code. Regardless of such uncertainty, medical schools around the nation are relying on remote learning and telehealth during this crisis to continue educating our future physicians and awareness of both pros and cons of such a change is needed to achieve the best quality training for our current students (See Table 1).

One arena of medicine and education that adapted smoothly to such transitions was psychiatry. At our institution we noticed that the Department of Psychiatry was one of the first to offer direct patient care learning opportunities to students after the policy for remote learning for students was implemented. This was done utilizing Zoom for multidisciplinary team rounds, patient rounds, standardized patients, and student lectures. This graceful transition is likely due to the department having had prior experience using telepsychiatry to deliver patient care. In addition to there being an increasing body of literature that reports effectiveness and outcomes equivalent to in-person care across a broad range of mental health disorders and patient populations, telepsychiatry seems to be preferable to in-person care in specific child and adolescent populations, including children with depression and adolescents.[3,10,11] In addition, embracing this technology grants the ability to gain access and awareness of a patient's

Table 1. Pros and Cons to the Use of Remote Learning Tools and Telehealth in Medical Education

Pros	Cons
Involve learners in telehealth visits without disruption	Increased anonymity, decreased participation during group learning sessions
Improve student mental health	Telehealth not compatible with well-rounded learning in all specialties
Early exposure to telehealth platforms	Limited contact with residency programs before The Match
Reduced travel costs with virtual residency interviews	Concerns over academic integrity with remote examinations

home and personal life as clinical interviews via Zoom often occur from a patient's own living room. This significantly aids in the biopsychosocial approach to the patient formulation that psychiatrists strive to achieve and may even bring up socioeconomic barriers faced by some patients and their families such as discovering a mother is unable to afford toys for her child when asked to find a toy for a parent-child interaction coaching session.[12] Lastly, widespread access and use of telepsychiatry has the potential to reduce no-shows and increase compliance among patients as the barriers of transportation, access to care, and higher healthcare costs may be avoided.[1,13] On the other hand, possible downsides to widespread adaptation of telepsychiatry may include difficulty establishing trust with patients experiencing paranoia and maintaining adequate patient privacy given the option to record sessions on some platforms.[2,3,14] As the COVID-19 pandemic has accelerated the rise of telepsychiatry, it is important to be aware of both the opportunities to improve psychiatric care and the potential pitfalls that we must work to prevent.

Overall, it has become impossible to ignore the growing role and utility of telemedicine and remote learning tools in healthcare today. The rapidity with which this technology has become a necessity for medical practice and education has shed light on the many opportunities these platforms provide and the possible complications they may cause. While many will phase out telehealth once this pandemic eventually subsides, we believe there are advantages to permanently incorporating this technology into the future of both medical education and the field of psychiatry, the latter of which appears to be leading the medical community in its adoption and application of telemedicine and remote-learning tools in both the clinic and the classroom.

Take Home Summary

The widespread employment of telemedicine during the COVID-19 pandemic offers a unique opportunity to better understand and embrace this technology to improve the future of healthcare and medical education.

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ACADEMY & ASSOCIATION 101

What is the American **Association** of Child and Adolescent Psychiatry, and how does it differ from the **Academy**?

The American **Association** of Child and Adolescent Psychiatry was formed in 2013 **as an affiliated organization of the Academy** as a way for CAPs to increase their advocacy activities. Activities such as AACAP's Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the **Association** affect me as a dues paying Academy Member?

Your **dues remain the same** whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. **Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.**

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American Association of Child & Adolescent Psychiatry

Child Psychiatry Training During COVID-19: Impact on Clinical Care, Education, and Fellow Well-Being

Rashi Ojha, BA, and Misty Richards, MD, MS

The COVID-19 pandemic has altered all aspects of personal and professional life, including how we practice psychiatry and teach trainees. This article presents and explores the challenges faced by child and adolescent psychiatry program directors in addressing the educational needs of fellows amidst this international crisis. The challenges presented by the pandemic to program directors include prioritizing fellow safety and education while ensuring quality treatment for our vulnerable patients and families. Amidst these difficulties, and remaining mindful of fellow well-being, program directors work to preserve communication and connection through transitioning in-person clinical care to telepsychiatry and live teaching onto remote platforms. This article addresses these current issues while reflecting on the future of child psychiatry training as programs prepare for subsequent stages of the COVID-19 pandemic.

The COVID-19 pandemic has transformed the fabric of our society. In some ways, the world's response to the pandemic has been inspiring, with healthcare professionals, frontline workers, and public health leaders joining forces to fight a deadly global disease. As we continue adjusting to a new way of living, we are left to consider multiple systems that must accommodate and continue operating under the new restrictions. Notably, the mental health field has been in the spotlight as individuals struggle to tolerate the lasting effects of this virus and its impact on society. From the perspective of child psychiatry program directors, initial challenges due to the pandemic included massive workflow adjustments across clinical settings while protecting the mental and physical health of fellows. In facing these challenges, we strongly believe that child psychiatry program directors must model resiliency and provide steadfast leadership through approaching problems systematically, communicating updates and policy changes clearly, and incorporating well-being into every opportunity.

Consolidating COVID-19—Related Information for Fellows

Training future child psychiatrists involves translating and implementing the policies of multiple governing bodies, including the Accreditation Council for Graduate Medical Education (ACGME) and institutional graduate medical education (GME) programs. In the context of the COVID-19 pandemic, governing bodies have needed to modify standard requirements for child psychiatry fellows without compromising educational priorities, with the understanding that trainee, patient, and educator safety comes first. As policies and procedures change by the minute, it is paramount that we, as program directors, ultimately deliver a clear message to fellows reflecting a bottom line. Specifically, program directors must filter through countless daily e-mails in order to consolidate information into a uniform message for trainees frequently enough to establish a sense of direction.[1,2] This has been helpful in discussions around surge planning, personal protective equipment (PPE) guidelines, COVID-19 testing, and workflow adjustments. The combination of effective communication from program leadership, involvement of trainees in decision-making, and the flexibility of the ACGME and GME policies, has allowed for training of future child psychiatrists to progress at a steady and thoughtful pace.

Telepsychiatry in Child Psychiatry Training

COVID-19 has catalyzed the integration of telemedicine in healthcare.[3,4] Telepsychiatry, a subset of telemedicine, involves providing services to patients via a virtual platform including psychiatric evaluation, follow-up care involving therapy and medication management, and

psychoeducation.[5] To decrease community transmission of COVID-19, many institutions across the country have moved to telepsychiatry for outpatient appointments. While this is manageable on an outpatient level, it can be challenging to transition more acute settings to telepsychiatry such as inpatient units, partial hospitalization programs (PHP), intensive outpatient programs (IOP) and Consultation-Liaison services. Specifically, for child and adolescent psychiatry fellows, transitioning to the use of virtual conferencing services can pose challenges given the intrinsic group-focused nature of the specialty. Patients are often connected to a cohesive network of individuals, from family members to educational providers and counselors. Coordinating family visits and obtaining information from educational professionals in a timely and comprehensive manner can pose challenges given the changes the pandemic has posed with daily schedules and education. Additionally, virtually assessing a young child with a limited attention span and severe behavioral issues offers a compromised ability to observe and intervene, two essential components of an evaluation. As such, in more acute settings, training programs throughout the country have opted for a hybrid version of in-person contact with young patients together with virtual communication with family members and community partners to preserve quality care while limiting COVID exposures.

There are unique challenges for child psychiatrists, including managing issues resulting from schools transitioning exclusively to remote learning. Children have needed to adjust to a new virtual curriculum which can be difficult for students, parents, and teachers. With increased screen time for children, less overall structure, limited peer contact, and working parents who are unable to monitor online learning, the opportunities for distress tolerance are abundant. With respect to the child, there can be difficulties learning from solely one platform, as access to visuospatial and tactile inputs is compromised. Additionally, having limited to no contact with peers and limited physical play can be difficult for a child in terms of nurturing social-emotional development during this critical developmental time. These problems are relevant to child and adolescent psychiatrists who often need to address the needs of their patients within the context of the family unit. Supervisors can model experiences such as creating a holding environment for these families, validating their struggles, and supporting trainees as they find their new system. Some of the most valuable teaching can come from opportunities to join with families in this way, demonstrating to the trainee that, despite imperfect circumstances, a powerful intervention can be simply listening and truly caring.

This rapid transformation to telepsychiatry involves extensive training and innovation. Outpatient visits, with direct supervision, are conducted completely differently in the era of COVID. Faculty members with varying degrees of technological comfort have been asked to join virtual patient encounters, staff cases with trainees, and create treatment plans, all while trying to preserve high quality patient care. Despite the adjustment, there are clearly many benefits to telepsychiatry. Expanded use of videoconferencing increases access to mental health care, reduces delays in care, diminishes emergency room burden, improves continuity of care, and further reduces the barrier of stigma.[6] Still, many providers and patients miss the human connection involved with in-person contact. In feeling the weight of this loss, we encourage our trainees to temper this with gratitude for being part of a specialty that values the connection between patient and provider.

Remote Teaching

The majority of child psychiatry training programs have transitioned to remote teaching to minimize viral spread. Ensuring that trainees obtain high quality education is essential for ACGME milestone requirements, but also for developing the rich knowledge base necessary to practice child psychiatry.[7] To streamline the process, a major investment was made to educate core teaching faculty on how to utilize common videoconferencing platforms to establish competency and troubleshoot in a less pressurized setting. Individuals have different levels of comfort with virtual teaching. To address this issue, program directors can supplement with vetted,

online modules to ensure that there is minimal disruption to trainee education, such as the well-received "Quarantine Curriculum" from the National Neuroscience Curriculum Initiative (NNCI).[8] In addition to didactics, videoconferencing has been successfully utilized for supervision for psychotherapy and medication management. Faculty and trainees are encouraged to approach this rapid change with a growth mindset—the belief that success is dependent on persistence, effort and embracing challenges—which has been instrumental for its success.

Well-Being

The focus of well-being shifted from the early stages of the pandemic to its current state. Initially, programs focused on creating new workflows for hospital and clinic settings to minimize in-person exposure while preserving access and high-quality treatment for patients. However, trainees and faculty were understandably worried about their own safety and their families' health. Many trainees also experienced anxiety about the potential necessity for psychiatrists to serve in medical services outside their core specialty. Initially, trainees' basic needs and safety were prioritized before addressing higher-level needs,[9] including education about good hygiene habits, access to PPE, accurate and clear information regarding the frequently changing workflows, health system-wide surge planning, child care, and housing in case of sickness or quarantine.[10] Regarding fears of redeployment, the most helpful interventions included specific data, such as sharing institutional dashboards of occupied ICU beds, number of COVID + admissions, and detailed contingency plans, which helped assuage trainees' fears through detailed information. Moving up Maslow's hierarchy, additional well-being activities were also introduced, including mindfulness exercises, remote process groups, and other community-oriented activities. As we settle into our new training environment (six months into the pandemic), we are reminded of the value of human connection more than ever to decrease emotional burnout and preserve morale, including recognition in departmental communications of individual trainees for their resiliency, flexibility, and dedication.

The Future

Looking forward, we must consider the consequences on trainee well-being, professional identity, and clinical experience while making timely modifications to the educational curriculum in preparation for the challenges ahead. This crisis affords an opportunity to provide emergent learning around relevant topics such as psychological first aid, high-quality telepsychiatry visits, and treatment of illness-related anxiety. There is also the hidden curriculum of role modeling the ability to cope and make difficult decisions amidst uncertainty which will undoubtedly shape trainees' leadership styles. Similarly, supporting one another directly showcases how to maintain solidarity during a crisis and prevent burnout. Moving ahead, we face additional uncertainty. Which patients benefit most from in-person appointments? How do we decide between which learning can occur in-person or remote? How do we translate what this crisis has taught us about the human condition to become better child psychiatrists? While we may not have the answers just yet, for now, posing these questions is important in addition to remaining hopeful as we continue to rise to the needs of our patients and communities.

Take Home Summary

Although the COVID-19 pandemic has posed many challenges for educating and training future child psychiatrists, there have been noteworthy developments related to improving communication strategies, rapid telepsychiatry expansion into clinical practice, curricular adjustments, and increased prioritization of well-being.

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Don't Let a Good Educational Crisis (or Three) Go to Waste

Amanda Calhoun, MD, MPH, and Andrés Martin, MD, MPH

What if 2020 isn't cancelled?
What if 2020 is the year we've been waiting for?
A year so uncomfortable, so painful, so scary,
so raw —
that it finally forces us to grow.

— Leslie Dwight

The Zoom Where It Happens (Or Not)

With over 400,000 COVID-related deaths in the United States alone at the time of this writing, it may come across as insensitive to consider the *positive* sides of the pandemic. And yet, an appraisal of the educational opportunities unleashed by the coronavirus reveals objective opportunities we would not have seized otherwise.

Two sets of examples are indicative: the first taken from our own research. "*Sex Ed 201:* Sexual Health for Child and Adolescent Psychiatrists" was initially developed as a session for trainees at Yale University. The pandemic forced our group to rethink our delivery approach, and in so doing, led us to increase our sample size ten-fold (from one site to 16, and from 12 trainees to 125). We were able to share hard-to-come-by knowledge well beyond the physical confines of New Haven, Connecticut. Through synchronized videoconferencing we were able to recruit from as far afield as California and Brazil.[1] Using a similar method of information dissemination and real-time, face-to-face exchange, we have completed studies about the role of shared living experience with medical students in Israel,[2,3] and with physician assistant students across the United States.[4] We have been able to test the efficacy of a didactic module on electroconvulsive therapy that incorporates videos using standardized patient depictions.[5] None of this could have been possible (let alone in a four-month interval) were it not for communication platforms like Zoom, which have become ubiquitous as a result of the pandemic.

The second set of examples will be easier to relate to, as they affected so many of us: large in-person professional meetings. The 24th World Congress of the International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP), and AACAP's 67th Annual Meeting had been respectively scheduled to take place in Singapore in July, and in San Francisco in October. Both were moved to virtual platforms. This was not exactly good news, and certainly not for those of us who look forward to the deep social immersion that these gatherings provide. Still, one cannot but think of the positive effect such changes had on carbon footprints—and on reaching those who would have otherwise not attended due to prohibitive costs or competing professional or personal responsibilities. I remain optimistic that one of the upsides of such virtual e-meetings will be their ability to reach many more participants. The pilot experience from this fall has certainly been promising.

Time will tell more about the opportunities and shortcomings of practicing virtually. When it comes to clinical practice, we are by now rather fatigued of virtual visits. We miss the immediacy of clinical contact. We miss our patients and their families, with screens and pixels able to communicate only so much of their humanity. We celebrate the shot-in-the arm that the pandemic has given to telepsychiatry; we revel in our new set of skills; we even feel proud of our doctorly screen-side manner. And yet, despite our learning curve and fully booked e-schedules, we cannot but think of those we are *not* seeing, the many we are unable to see. For one thing that the pandemic has revealed all too painfully is the digital divide across this vast land of ours: so let's please not *aZoom*.

An Older Virus

The pandemic has also shed light on an even older divide in the US, one that existed long before the digital age: the racial divide. We are in the midst of a syndemic, the double pandemic of COVID-19 and racism, the former just an infant, the latter well over 400 years old. The disproportionate number of deaths in the Black community only serves to highlight the racial inequities in the US when it comes to underlying health conditions, socioeconomics, and access to healthcare. But this is not the entire story. Experts have encouraged us to look deeper, beyond and separate from socioeconomics, and to begin treating racism as the social determinant of health that it is. The American Academy of Pediatrics released a policy statement in 2019 naming racism a major driver of health inequities in children,[6] and a growing evidence base documents the effects of chronic stress due to racism on the mental and physical health of Black Americans.

And then came COVID-19. Then came the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and countless other Black Americans. The protests that ensued are reminiscent of the Civil Rights movement and make one wonder: was this really 2020? Why must Black Americans and their allies protest to protect the dignity and humanity of Black lives? And what can we, as psychiatrists, and academic physicians do to push an antiracist agenda in our country?

For starters, one thing we can do is re-define the language we use to discuss racism. As academics, we are guilty, like so much of society, of using euphemisms to make hard truths more palatable. But is it right to sugarcoat the experience and trauma of Black Americans for the comfort of others? And even beyond that, is it effective at truly promoting change? As psychiatrists, we believe in the power of language and its ability to convey meaning – to heal and to soothe, or to be wielded like a weapon. To this end, we must be sure that the vocabulary we use around race is targeted, direct, and clear.

The language we use to discuss racism should focus on identifying it and on protecting those targeted by it. In essence: we should call a spade a spade and normalize the R word. If we cannot even name racism, how can we expect to promote an antiracist agenda? Let us use this pandemic as a time to learn, adapt, and move forward. Let us move beyond implicit bias, beyond colorblindness, beyond microaggressions, and beyond race relations. Let us instead confront and stand up to structural racism, coded racism, everyday racism, and White supremacy. Let us embrace antiracism and remember that the opposite of 'racist' is not 'not racist': it is antiracist. Let us move from the assumed 'implicit' or unconscious intentions of the aggressor and instead start focusing on the impact that racist behavior has on those on its receiving end. We have brought this ambitious and overdue set of priorities to our everyday clinical practice, to our teaching and supervising interactions, and to our university-wide policies. Moreover, we have started to explore empirically the impact of race, racism, and the development of antiracist attitudes and behaviors. We are actively doing so through a range of research efforts that, at their core, rely on the *quality* of meaningful conversations, in a way that checklists or close-ended interviews would not be able to capture.

Hearing Voices

For all of our professional experience in disentangling what hearing voices signifies clinically, we would argue that as a discipline we could do better at listening to our patients' voices. This is neither a cheap shot nor professional self-loathing; instead, it is an invitation to enrich and broaden our research efforts.

A few introductory definitions and reminder are in order. Epistemology, that five-dollar word, refers to the branch of philosophy concerned with the nature of knowledge. Simplified to its core, it posits that there is an objective or positivist approach to knowledge: one in which reality is 'out there' in the world, and our task as researchers is to go find, describe, and measure it. By contrast, there is the alternative approach of interpretivism or constructivism, in which we recognize that as social actors we are part of the reality we seek to describe. Rather than considering our own views as noise or bias, we incorporate them fully as part of an exercise in reflexivism.

Let us translate these arcane concepts into the realities of child and adolescent psychiatry today. They can be summarized into a bumper sticker of sorts: 'Keep the baby's bathwater: embrace qualitative methods.'

The realist approach to science is readily recognizable to all in the quantitative approach that dominates our field: numbers, statistics, sample sizes, error measures, power, objectivity, controls, *p* values. Sadly, patients' voices are often lost in this quantitative shuffle. On those few occasions when we recognize a legitimate voice come across the written page, it often is under the case vignette or the psychoanalytic literature. But these two approaches don't take full advantage of the qualitative and mixed methods approach that our colleagues in sociology, anthropology and psychology have been fruitfully using for decades. Methods in which voices, recorded verbatim, become the data themselves. Voices that can include those of patients, families, care providers, and other stakeholders. Voices of those who are often silenced or unheard.

We hope that the pandemic will encourage new research efforts that move from numbers alone, to ones in which voices (through qualitative methods), or voices and numbers (through mixed methods) can further enrich our work. Let's complement our large-n quantitative science with the opportunities and unique vantage points of the small sample, of the lived experience of unique individuals. We hope that more investigators in our field will come to appreciate this approach and join us in using the pandemic crisis as an opportunity to embrace qualitative methods.[7]

The qualitative approach incorporates human stories and personal narrative. As such, it can feel particularly familiar in the field of psychiatry. Many of us were first drawn to the field as a way of making sense of behaviors and emotions, of disentangling people's complexity, of sounding the depths of interpersonal experience. In this way, the qualitative approach offers more than machinery toward the publication of empirical research: it is a means to enrich our everyday clinical, supervisory, and teaching experiences.

Words attributed to Einstein come to mind: "Not everything that can be counted counts, and not everything that counts can be counted." More painfully relevant to these days of pandemic heartache are words from a poem[8] by Pádraig Ó Tuama: "When I was a child,/ I learnt to count to five/ one, two, three, four, five./ But these days, I've been counting lives, so I count // one life/ one life/ one life/ one life/ one life// because each time/ is the first time/ that that life/ has been taken./"

Embracing 2020: Overcoming Hegemonies

What a year of reckoning this was. If we ever had, we can no longer claim ignorance: we cannot sit by the sidelines, blissfully unaware.

By embracing virtual possibilities, we are committed to moving away from a hegemony of place. But by realizing the inherent limitations of our e-reach and the stark reality of a digital divide, we will not capitulate to a hegemony of the virtual. We will meet patients and families where they are, even it means leaving the comfort of our own spaces.

By embracing antiracist policies in all that we stand for and do, and by opening our eyes (and those of our colleagues and field more generally) to the toxic effects of racism on health, we will fight the hegemony of race. And by realizing that numbers can say only so much, and that we can do better at listening and sharing the voices of those under our care, especially of those who have been unheard or disenfranchised for far too long, we can brave the tide against a hegemony of the numerical.

We are recommitting our professional lives, our clinical and our research endeavors to move away from hegemonies that have at best led us astray, at worst limited our reach from where it is most needed. Will the field of child and adolescent psychiatry follow us? Will you?

Take Home Summary

The COVID-19 pandemic has brought a reckoning to the health professions. We explore 3 ways in which this has played out in the case of child and adolescent psychiatry: 1) the ascendance of virtual clinical care; 2) by confronting the realities of racism; and 3) by incorporating patients' and clinicians' voices into teaching and research.

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AACAP AWARD SPOTLIGHT
Naser Ahmadi, MD, PhD

2016 AACAP BEATRIX A. HAMBURG, MD, AWARD FOR THE BEST NEW RESEARCH POSTER BY A CHILD AND ADOLESCENT PSYCHIATRY RESIDENT

Poster Title: *Adverse Childhood Experience Is Associated With Impaired Coronary Distensibility Index and Predicts Major Adverse Cardiovascular Events*

This unique research opportunity facilitated an in-depth understanding of neurobiology of youth traumatic stress disorder, and led to the subsequent development of a pilot intervention grant based on the findings of the study.

Findings of our research revealed that impaired coronary distensibility index (CDI) is strongly associated with the severity of adverse childhood experiences' (ACE) symptoms and predicts an increased risk of major adverse cardiovascular events (MACE) in subjects with ACE. Findings highlight the important role of early intervention and preserving CDI in identifying individuals with ACE at risk for MACE.

2016 AACAP PILOT RESEARCH AWARD FOR ATTENTION DISORDERS

SUPPORTED BY AACAP'S ELAINE SCHLOSSER LEWIS FUND

Project: *Trial of Positive Psychiatry in Comorbid Attention-Deficit/ Hyperactivity Disorder With Posttraumatic Stress Disorder*

The Pilot Research Award study investigated the impact of reminder-focused positive psychiatry (RFPP) on vascular function, inflammation, wellbeing and attention deficit/ hyperactivity disorder (ADHD) and PTSD symptoms in adolescents with comorbid ADHD and PTSD. There were several novel findings, and the study results were published in a recent paper in the September 2020 issue of *The Primary Care Companion for CNS Disorders*.

The AACAP Research Committee's valuable support, mentorship, and funding of this pilot research consolidated my academic career as an assistant professor of psychiatry at UCLA, with strong commitment to AACAP and its stellar mission. The Pilot Research Award played a pivotal role in the successful completion of my training in positive psychiatry, as well as completion of this translational study. I have been continuing my academic CAP clinical and research practice, with active contributions to the field, children and their families, as well as supporting the AACAP community and initiatives.

ABOUT DR. AHMADI

JOINED AACAP
AUGUST 2015

WORKS AT
UNIVERSITY OF CALIFORNIA LOS ANGELES

POSITION
HEALTH SCIENCE ASSISTANT PROFESSOR OF PSYCHIATRY; DIRECTOR OF UCLA OLIVE VIEW FAMILY TRAUMATIC STRESS CLINIC

INTERESTS

- AUTISM SPECTRUM DISORDER
- ADVERSE CHILDHOOD EXPERIENCE
- POSTTRAUMATIC STRESS DISORDER
- ATTENTION DEFICIT/ HYPERACTIVITY DISORDER
- ARTIFICIAL INTELLIGENCE AND AUGMENTED REALITY

WORKFORCE IMPACT

I am a firm believer in active contributions to AACAP and improving children's mental wellbeing. I am extremely grateful to have received these rewarding opportunities, which allowed me to serve as mentor for eight medical student and ten resident AACAP members during the research period.

*Visit **www.aacap.org/awards** to discover available award opportunities!*

Connect Corner: The Power of Play Among Us

Shreesh Prasad, MD, Ozra Nobari, MD, Melinda Armstead, MD, Naren Clark, DO, Kevin Nowrangi, MD

The first few months of my child and adolescent psychiatry fellowship have occurred amidst a raging global pandemic, large-scale civil unrest, and increasingly polarizing political discourse. Given our Northern California locale, a literal flaming countryside and ashen sky have completed the apocalyptic tableau. It should come as no surprise that staving off burnout has been on my mind lately, but when Drs. McBride and Wadell announced we would be playing Among Us,[1] an online multiplayer social deduction game, in place of one of our regularly scheduled didactic sessions, I was skeptical. From the plethora of memes I had seen on Reddit, I knew the game had exploded in popularity among teenagers, but I wondered whether a group of doctors awkwardly stumbling through it would be better for our mental health than simply having an extra hour off to decompress after a stressful morning.

The premise of Among Us is that you and your crewmates on a spaceship are accompanied by a sinister stowaway who kills off the crew while sabotaging key systems on the ship. The crew's win condition, on the other hand, is to either complete a set of maintenance tasks or, more commonly, detect the imposter and summarily eject them from the nearest airlock. The twist: nobody can speak outside of meetings, which are called when a body is found or on an emergency basis when a crew member believes they have discovered the imposter. From the moment my little astronaut avatar dropped onto the ship, it was clear my skepticism had been unfounded. I felt a sense of kinship with my co-fellows and attendings that had been quite sorely missing from my fellowship thus far. The experience was a simple reminder that the true antidote to burnout is connection. It was as if we were all truly on that ship, striving toward a common goal—despite the fact that one of us was actively trying to murder the crew and subvert our mission. Or was that me?

- Shreesh Prasad

As a team, we have talked, learned, healed, presented, and advocated for the same cause. But have we ever played? Nope. At the encouragement of our thoughtful program leaders, UCD child psychiatry fellows and supervisors started to play the online game Among Us. None of us had played before, but after a brief practice run the crewmates began completing tasks as the imposters killed off the crew in secret. Our inner children played, relaxed, and laughed. I realized that just as water puts out the fire, play and interconnectedness hold back the real evil sneaky 'imposter' killer among us, burnout.

– Ozra Nobari

First year of child psychiatry fellowship has been much different than I thought it would be. The world is evolving into an unfamiliar scary place for patients and providers alike. COVID-19 continues with no end in sight and telehealth has become common place leaving us with limited human interactions. In California, the wildfires rage, making a difficult situation even worse overnight. After one particularly difficult week, I was surprised to learn at Zoom didactics that I wasn't alone in this sentiment. What was really 'among us' was feelings of isolation, fatigue, and burnout. It was at that point our program directors encouraged us to engage in what child psychiatrists have been incorporating into practice for years, the power of play.

The next week we started off our typical Zoom didactics as a cohort by playing the game Among Us. I admit I was hesitant. I am not an avid gamer; even as a child I was terrible at video games and I hate playing anything where I know I will lose. More importantly I felt there was no way this would be a good use of our time but at this point figured it couldn't make things worse. After just 10 minutes I found myself genuinely laughing and bonding with my co-fellows and supervisors. The feelings of isolation faded away and the burdens of

the day seemed less heavy. What I thought would be a waste of my time was actually the highlight of my day and I finished the game refreshed, ready to engage in didactics with renewed mindset.

– Mindy Armstead

During a recent clinical interview on an adolescent inpatient unit, my attending asked our patient to explain the idiom grasping at straws. She quickly answered, "the man who is drowning is desperate and will grab anything to try and survive." I didn't know it at the time, but this would end up perfectly describing my state of mind as I pleaded with my co-fellows and our program directors not to eject me into the cold abyss of space. I was desperate, and I was innocent.

When I heard we would be playing the game Among Us in place of our usual didactics, I dismissed it without much thought. These past few months have been an extraordinary challenge; there have been more than a few moments of grasping at straws. As the majority of our encounters have become virtual, the biggest detriment to my own mental health has been the associated feeling of disconnection. This disconnectedness created a desire to hibernate until we can crawl out from our caves, shake hands, and embrace again. I was skeptical that a game about murderous cartoon astronauts could wake me from my slumber. But as my little blue astronaut wandered aimlessly about the spaceship, I found myself smiling and laughing, until I was promptly murdered by the real imposter. Aside from being fun, it demonstrated the power of play and its ability to create connections. It made me realize that we can still use creativity and ingenuity to reach through the virtual void and connect.

– Naren Clark

I warily observed my colleagues, hearing their qualms and rebuttals as each were accused of being the saboteur on our spaceward voyage. Among the mixture of mentors and colleagues with whom I have worked closely and believed I knew well, there was a malicious culprit. Shreesh exclaimed, "It had to be Kevin. I was near Ozra and Mindy!" Erik, Mindy, and Naren somberly gazed as I pleaded my innocence, exclaiming, "I am not the imposter!" Paula had rallied the cohort to cast their votes and I was quickly banished from our ship into the void of outer space. The miscreant eventually succeeded in halting the journey as our vessel sailed forward, haunted only by the ghosts of the innocent. It was discovered that the deceptions of Anne, the true imposter, had led to our demise! In spite of my early ejection, I found that this captivating adventure had lifted some of the burdens I had been experiencing over my difficult clinical cases. The bonding, cheer, and laughter amongst my colleagues was an uplifting end to a difficult week, and I am already looking forward to our rematch next week.

– Kevin Nowrangi

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