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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.
Building an Advocacy Toolkit

2020 has been a year like no other. With COVID-19, racial injustice, natural disasters, and political discord, it is expected that there will be significant impacts to the mental health of children and adolescents. It is becoming clear that the role of child psychiatrists now includes advocacy to fully be able to address the mental health of children. The recognition of this need has prompted the JAACAP Connect Editorial Board to dedicate 3 upcoming issues to themes of advocacy, system changes due to COVID-19, and racism.

This issue is focused on the child and adolescent psychiatrist as an advocate. Often times, what colleagues say limits them from participating in advocacy is being unprepared. They are not experts in health care policy, the workings of insurance companies, or health care finance. This can make talking to a legislator or insurance company intimidating. It also might deter a child and adolescent psychiatrist (CAP) from joining a board or taking on leadership due to fear of not knowing enough about these topics. What most CAPs would agree is that we know child and adolescent mental health, and we have plenty of stories to show where systems have let our patients and families down. Those who are most involved in advocacy will reinforce the importance of these stories to highlight the problem to those who haven’t had that experience. Recognizing that the lack of knowledge is often what stops a CAP from taking steps to advocate leads to the development of this issue. Think of it as a resource guide, providing the map and talking points to address significant systemic issues in child and adolescent psychiatry with a legislator, insurance company, or anyone else that needs to listen. The evidence base that exists in this issue intends to supplement the stories you know so well to prepare any reader to dive headfirst into the world of advocacy.

This advocacy themed issue starts with a Lab to Smartphone by Dr. Rettew that guides us through the balance of advocate and clinician, showing us that this is not always easy, but it is possible. Dr. Sagot investigates the advocacy training provided to CAPs as compared to other physicians through an in-depth literature search. It has always been hard for people to get coverage to see CAPs, but mental health parity laws were meant to equal the playing field between physical and mental health. As Drs. Morgan and Rogers highlight, there is still significant advocacy required to ensure true mental health parity. The topic of prior authorizations continues to be an area of frustration for CAPs and patients. Drs. Sica and Koss provide the framework to be prepared to advocate to legislators and insurers to address this systemic issue that frequently impairs care for patients and decision making of CAPs. Drs. Abidi and Arroyo identify a population that requires increased advocacy: youth who are experiencing homelessness. Drs. Wagner and Peirce finish off these articles by going through the role of a political action committee (PAC) in advocacy. Featured next is the second edition of Connect Corner with a focus on an important subject for any advocate: resilience. Finally, we end this issue with 3 CLiPPS touching on topics of keen advocacy interest.

Our patients and their families need us to step up. We must raise our voices for systemic changes to improve the care they can access and receive. If reading this issue leads to you attending your first legislative day, calling your legislator, joining a committee, or volunteering for an advocacy group, or anything else, please reach out to Connect to let us know how it went.

Justin Schreiber, DO, MPH
Editor
The Expert and the Advocate: Cousins, not Twins

David Rettew, MD

A few years back, I was asked by a state legislative committee to give testimony about a bill that would fund some netting under a bridge that had become somewhat of a suicide hotspot in our state. Like a lot of mental health professionals, I cared deeply about preventing suicide and was inclined to support initiatives that tried to help. During the testimony, however, I took pains to lay out what I thought was a very balanced perspective on what is and isn’t known about these suicide prevention efforts. The next day, I received a cordial but somewhat unusual email from the committee clerk: the committee was very grateful for the extremely useful testimony I had given but really wanted to know whether or not I actually favored the proposed legislation.

Child psychiatrists and other medical and mental health professionals are increasingly “getting out there” when it comes to engaging the public and the media about important topics. This is a very good development and one of the reasons this Lab to Smartphone column was created. Frequently, our task is to synthesize scientific information that can be technical, inconsistent and even contradictory in a way that is understandable and even entertaining. In this way, we combine our training and direct experience as clinicians, researchers, and teachers to perform the role of the wise and objective expert.

But psychiatrists, as it turns out, are also human beings with emotions, passions, beliefs and, yes, biases. Inevitably in the course of laying out the data and arguments to help others form opinions, we develop some of our own. When that happens, some of that same clinical experience and research can start getting used not only to explain what is happening but also to encourage what should be happening. As the goal shifts from one of informing to one of persuading, the role of the expert slowly gives way to the role of the advocate.

Fortunately, wearing both hats of expert and advocate is usually not a problem. Indeed, the 2 roles can be quite complementary, as even a balanced account of what is known about a particular subject requires some kind of conclusion in the end. For example, a child psychiatrist who studies the effects of exercise on the brain might conclude, as an expert, that there overall is a positive effect. That person may then quite logically advocate on behalf of some group trying to bring exercise-related programs or education into a school.

But sometimes, there can be tension between the roles of expert and advocate. Once an expert states a conclusion publicly, especially on a more controversial topic, people respond to it: some with praise and agreement, others with condemnation and even insults. The ones who agree often want to hear more by way of articles, lectures, and maybe even entire book. Soon, the expert is known not just for their knowledge on a particular topic, but their position on it.

When was the last time you read a research paper from a noted expert that provided evidence against their typical position? It doesn’t happen often. Basically, those who have staked out the scientific opinion that SSRIs are dangerous, cognitive-behavioral therapy is awesome, cannabis is medicine, or videogames are bad for developing brains (etc, etc), have tended to stay there for the rest of their career. Even more astounding is that the data they actually produce somehow always seem to support that perspective too. Does this mean that many of our prized researchers are intentionally manipulating their data? Absolutely not—but it does suggest that scientific bias can work its way in through channels other than paid talks and consultant gigs from pharmaceutical companies.
The partnership between experts and advocacy organizations can also be awkward at times. Mostly there are shared perspectives and common causes but then there’s the question of how to handle that valid point from the other side or that thorny study that contradicts the advocacy group’s central message? The expert role demands that such information be considered and weighed. The advocate, however, sees opposing information as something to be ignored and, if that isn’t possible, refuted. Start changing or even moderating your views and you risk angering and losing your colleagues. Perhaps even worse is the possibility of being seen as weak or (gasp) “wishy washy.”

Those who start with more moderate positions on debatable topics may be particularly vulnerable to the expert versus advocate pressure. Media outlets generally gravitate to conflict and drama. Feature a discussion on a controversial topic, and what you typically get are two people with opinions at the extreme ends of either side who won’t or can’t acknowledge any legitimacy to any of the arguments from the other person. The poor scientific expert in the middle who sees merits and pitfalls with both extremes often is pushed to get “off the fence” with polarizing questions designed to fit complex dimensional issues into little binary boxes.

What to do about this? The solution is certainly not to abandon our important role as advocates towards some kind of robotic broker of scientific information (even if that were possible). There are just too many important causes out there that need action. What we can do, however, is acknowledge the daylight that can exist between being an expert and being an advocate and be more fully aware of where we are at any given time. Theoretically at least, psychiatrists should be pretty decent at this, as we do spend time in training thinking about how we filter information through “our stuff.”

Being successful at this role clarification doesn’t mean that we necessarily have to lose effectiveness as an advocate, although at times it might. Using the analogy of an old-fashioned scale, we can remember that it tips just as far to one side whether there is a lopsided difference in weight between the two sides or just a tiny difference. Decisive actions are not dependent on extreme beliefs.

These reflections come not from a person who has mastered these challenges but as one who has struggled with them. Maintaining success as an advocate for issues I care about while not overly compromising the integrity of the expert will continue to be a demanding balancing act for years to come. I’ve stumbled before and undoubtedly will again. The goal here is not some kind of state of pure expert nirvana but rather a continued pursuit of positive change while maintaining a healthy dose of introspection and humility.

About the Author

David C. Rettew, MD, is an associate professor of psychiatry and pediatrics at the University of Vermont Larner College of Medicine and the Medical Director for the Child Division of the Vermont Department of Mental Health. He is author of the book *Child Psychiatry: New Thinking About the Boundary Between Traits and Illness* and the “ABCs of Child Psychiatry” blog on the Psychology Today website. You can follow him on Twitter at @PediPsych.

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To Participate in the Lab to Smartphone Column

To suggest a topic for this column or to inquire about co-writing a Lab to Smartphone column with Dr. Rettew or another child psychiatry mentor, please send an email to david.rettew@med.uvm.edu.
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.

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
Advocacy Training in Residency and Addressing Needs in Child and Adolescent Psychiatry: A Review

Adam J. Sagot, DO

The American Medical Association (AMA), in its Declaration of Professional Responsibility, states that all physicians must “advocate for the social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.” Increasingly, medical schools and graduate medical education (GME) programs are “adopting advocacy and service-learning curricula that include community resource identification and referral, screening for social determinants of health, [and] effective use of medical-legal partnerships and political engagement,” aimed to improve outcomes of physician-driven advocacy efforts.

Given the rapidly evolving political climate and health care reforms, trainings focused on medical-legal partnerships, health policy and political engagement serve to better enable the production of much needed and more well-informed and skilled physician advocates for children and adolescents. Moreover, child and adolescent patient populations have readily identifiable needs for effective physician-driven advocacy, as youth have “little political voice of their own and rely on the proxy voice of others” to affect change. This author defines the role of the physician advocate as one encompassing purposeful action to affect change through the use of both information and skill. This is accomplished by identifying social determinants of health that adversely impact individuals and/or communities, using expertise to inform those that can enact change or initiating change oneself by addressing community and system-level issues through legislation/policy.

With the notable exception of pediatric training requirements, currently there is little specific and directed mention of “advocacy” despite some recent changes in language in the common or specialty training program requirements by the Accreditation Council of Graduate Medical Education (ACGME). These requirements do not fully capture all that is expected of training programs. Additionally, each specialty has a Milestone Project through joint initiatives between the respective associated specialty board certifying organization and the ACGME. The projects provide frameworks for the assessment of the developing trainee for use in evaluations of key dimensions of physician competency in their field. These expectations and assessment criteria are specific to each required milestone. Similar to the ACGME training program requirements, pediatrics is again the sole exception containing both language for modular learning, a rotational experience, in “child advocacy” in their requirements and milestone specific to advocacy. Despite serving the same population, child and adolescent psychiatry (CAP) fellowship ACGME requirements have yet to as fully incorporate specific and more directed language for advocacy training as pediatric programs do respectively. Requirements for CAP fellowship have made some effort to include language inferring advocacy training without actually using the term “advocacy.” Instead, the language that is used describes only the level of competency in a specific learning domain in the evaluation metrics for milestone achievements including understanding of systems as a criteria for higher marks in the grading rubric. This alone is insufficient as the trainee can still achieve the higher level marks without necessary meeting this specific criterion.

To provide an informed and evidence-based representation of current practices and methodologies used to train residents around advocacy, this author performed a systematic literature review. This review included literature from across all medical specialties, with a particular focus on CAP programs, that addresses the training of residents in health policy and legislative advocacy. This
author posed the following specific questions: (1) What are the current requirements for advocacy training in resident programs with additional focus on CAP fellowship programs? (2) What are the current learning objectives, practices and competency assessments for effective advocacy training with specific attention to health policy and legislative advocacy?

Method
A fixed-length systematic review of academic literature on advocacy training during residency and a subsequent review of academic literature specific to advocacy training during psychiatry and child and adolescent psychiatry training programs was obtained through PubMed. Table 1 summarizes the inclusion criteria, and Figure 1 on the following page, summarizes the search strategy and keywords used. Manual search of resulted publications, referenced articles, ACGME Training Program Requirements/Milestone projects and “related” publications recommended by PubMed and/or GoogleScholar was performed. All relevant publications published from January 1992 to December 2017 were included in this review.

Table 1. Criteria Used to Assess Academic Literature and Related Articles for Inclusion

1. Clear focus on specific domains of advocacy training; policy education, policy change, contacting legislators, understanding health inequalities, and understanding the role of the health advocate.

2. Clear focus on training house-staff/resident physicians in advocacy efforts, and/or competency, and/or interest in health care advocacy.

3. Format was limited to letters to editors, editorials, opinion/commentaries, cohort studies, systematic reviews, prospective and retrospective appraisals of advocacy training efforts, and meta-analyses.

4. Articles were required to be published/presented in finalized draft.

5. Excluded articles were those with clear focus only in advocating for resident physicians, on patient advocacy regarding health care choices without inclusion of above noted issues pertaining to advocacy, or solely promoting citizens’ access to existing services or benefits, etc.

6. Due to the rapidity of change in the policy landscape and residency training requirements, a 25-year scope was applied to search results limiting all results to those published from January 1, 1992 to December 31, 2017.

Results
The literature search produced 281 publications, of which 49 met the inclusion criteria and were reviewed. An additional 46 publications were identified from materials referenced or related, as noted above, and reviewed. Additional items reviewed included ACGME Program Training Requirements (n = 18) and Milestone projects (n = 17). A total of 130 sources were selected and reviewed; these sources included literature reviews, meta-analyses, letters to editors, opinion editorials, cross-sectional surveys, retrospective/prospective analyses, published program requirements/milestones and textbook excerpts.

What are the current requirements for advocacy training in resident programs with additional focus on cap fellowship programs? From among the reviewed publications, ACGME program requirements and Milestone projects, only Pediatric training programs had language requiring modular learning in advocacy including the requirement that “a minimum of five educational units of ambulatory experiences, including: (Core) ambulatory experiences to include elements of community pediatrics and child advocacy.”4,5,6,7 The common program requirements and other specialty specific requirements include advocacy language that is limited and does not require a specific experience in advocacy during training. It requires programs to train residents and fellows to “advocate for the promotion of health and the prevention of disease and injury in populations.”4 Psychiatry program requirements include the addition of “advocate for the promotion of mental health and the prevention of mental disorders” and “advocate for quality care and optimal care systems,” and child and adolescent fellowships include the additional statement requiring trainees to “advocate for quality patient care and assist patients in dealing with system complexities. Including disparities in mental health for child and adolescents,” but neither require a training experience in advocacy.5,9

The child and adolescent psychiatry fellowship milestones project mention advocacy as part of understanding systems which include schools, courts, community based organizations, and governmental
agencies; looking further, advocacy is again mentioned in the grading criteria recommended to evaluate a trainee's level of expertise. The pediatric training programs have a milestone regarding systems-based practice specifically in advocacy with more advanced criteria ranging from the novice recognizing an issue in a patient evaluation relevant to public action to working on a new piece of legislation at the expert level.

What are the current learning objectives, practices, and competency assessments for effective advocacy training with specific attention to health policy and legislative advocacy? As program requirements and milestone projects provide framework and recommendations, there has not been consistent standardization of how, when or where to implement an advocacy experience. Looking specifically at the
training requirements and opportunities, of the 83 pediatric residency training programs surveyed (response rate = 43%) 30% offered a separate training track and or 6 block individualized curriculum in community pediatrics or advocacy." Schwartz et al. looked retrospectively at a 2-week elective experience where as Delago et al. compared 4-week and 2-week electives. They concluded that trainees preferred advocacy training interwoven throughout other rotations and that there is no statistically significant difference in outcome between 2- and 4-week elective experiences. Goldshore et al. looked at trainees’ experiences and concluded that >8 days of involvement in community settings (66.6%, n = 683) showed that the more involved the trainee had been during training the higher the likelihood of anticipated involvement in advocacy.

Specific activities during the advocacy rotations or learning experiences required by pediatric training programs included legislative activities, clinic-based group projects, classroom based didactic and formal poster presentations as the most frequent teaching methodology. Evaluation tools used to gauge trainee performance and recommendations for training opportunities were also studied, of which, grading by observational evaluation, portfolio review and written reflection was most frequent. One study reported that faculty and residents in one survey (n=79) described participation in either short-term or longitudinal projects was “the best way to teach and learn advocacy skills.”

Discussion
ACGME training requirements provide a framework and a set of requirements to maintain a standard outcome for trainees. Taking a step further, Milestone Initiative Projects provide rubric-styled guidance and set of evaluation criteria to determine proficiency and competence attained during that training to more clearly define what an acceptable standard outcome should be in achieving specialty competency. Training programs may be providing opportunities in advocacy, but there is no requirement to do so. Pediatric programs have requirements for modular learning that have proven to be helpful in increasing trainees willingness to participate in advocacy related events as well as anticipation of involvement. As the health care landscape evolves and system frustrations with managed care continue, understanding the principles of effective advocacy with the expectation of involvement instilled during training will be a critical step to address the gap that has already been identified and addressed in pediatric training programs. As subspecialists who provide care to children and adolescents as well, child and adolescent psychiatrists should be provided training to be more effective advocates similar to our colleagues in pediatric training programs.

Few studies were identified that evaluated general psychiatry resident or child and adolescent psychiatry fellows’ interest in advocacy education or experiential learning opportunities. It is time to consider new strategies to broaden the scope of training to include advocacy more definitively. Legislative committees of local and national organizations need to expand their role from engagement in public policy to include training. Whether through pilot initiatives in individual programs or through outside experiences, such as the American Academy of Child and Adolescent Psychiatry (AACAP) Resident Scholar Fellowship, opportunities for training need to be expanded. Changes to training program requirements is the most effective strategy to standardize a framework for training strong child and adolescent psychiatry advocates.

Take Home Summary
Children rely on the voice of others to affect political change. Pediatric residencies have required training in advocacy since the early 2000s to address this need for children, and child and adolescent psychiatry training programs need to catch up.

References


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This article was edited by Justin Schreiber, DO, MPH.
Families Pay the Price of False Hope in Parity Enforcement

Brian Morgan, DO, and Chris Rogers, MD

We all see it. The frustration. The fear. The loss of hope in a system that has let them down again and again. Words like “does not meet medical necessity” translate to “your child’s suffering is not that important.” Again. “Not taking new patients” begins to mean “you are on your own.” Again. “Not a covered benefit” becomes “the safety of your children doesn’t matter.” Again. And again.

As child psychiatrists, we all see the hollow promise of true mental health parity on a personal level all too often. Now, we have a powerful tool outlining just how big the gap is nationwide between coverage for physical and mental health. The Milliman Company, an independent actuarial firm founded in 1947, breaks down the data in painful detail in the 2019 Milliman Report. Spoiler alert: the news isn’t good. Milliman Reports completed in 2017 and 2019 evaluated insurance companies’ performance in providing affordable coverage to families following the enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. This federal law was designed to prevent insurers from imposing less favorable mental health or substance use disorder (MH/SUD) benefit limitations as compared to medical/surgical benefits. This law, also known as the Federal Parity Law, requires most insurers to cover psychiatric illness such as depression, anxiety, and substance use disorders commensurate with medical or surgical conditions. Today, 12 years later, there shouldn’t be a difference in families’ benefits for depression vs an appendectomy. Unfortunately, the law did not get fulfilled by many, and millions of Americans continue to remain without adequate mental health coverage. This during an unprecedented time of increased deaths from suicide as well as drug and alcohol abuse.

Milliman researchers analyzed three years of claims data, 2013 to 2015, from 42 million US employees and family members. In December of 2019, the researchers updated that same study to include data from 2016 and 2017. The Milliman report simplifies data into 4 categories of treatment: (1) inpatient facility services, (2) outpatient facility services, (3) primary care office visits, and (4) specialist office visits. It then compares the level of out-of-network use for behavioral health vs physical health. In 2013, a family had a 2.8 times greater likelihood of paying for care at an “out of network” behavioral health facility than for care at a medical/surgical facility. This number increased by 85% over the five-year research period. The report notes that “disparities are particularly bad for children. In 2017, a behavioral health office visit was 10.1 times more likely to take place at an ‘out of network’ provider than ‘in-network,’ more than double the adult disparity.” The Milliman research reports “insurers spent only 1% of their total health care dollars on treatment for substance use disorders and 2.4% for mental health in 5 years of 2012-2017.” Given the proportion of morbidity and mortality resulting from inadequate MH/SUD treatment this is inexcusable.

The story for the child and adolescent psychiatrist and the families they treat gets worse. The Milliman report demonstrates that insurers reimburse psychiatrists 20-30% less than they pay other doctors for treating the same illnesses, despite child and adolescent psychiatrists’ extensive, specialized training in mental health treatment (Figure 1). For example, in 2015, primary care physicians in Colorado were paid 121% of the Medicare reimbursement rate for office visits while psychiatrists were paid just 85.9% of the rate (This is for low; 99213 and moderate complexity visits; 99214). In 11 states the report reflected that reimbursement rates for PCP office visits were >50% higher than behavioral health visits and in 13 others PCP reimbursements were 30-49% higher than behavioral health. Commercial insurers often pay less than Medicare reimbursement rates for mental
Families Pay the Price of False Hope

Before anyone had ever heard of COVID-19, the US was already in the midst of a pandemic of overdoses and suicides. From 2016-2018, over 3 million (12%) adolescents ages 12 to 17, or more than one in ten, had depression and/or anxiety. Suicide was the second leading cause of death for age groups 10 to 24 (19.2% of deaths in 2017). Suicidal thoughts and suicide rates among adolescents have increased over time; the crude rate of suicide deaths among adolescents was 7.0 per 100,000 in 2018 versus 3.7 per 100,000 in 2008. Additionally, substance use is a concern among adolescents. Research shows that substance use among teens often occurs with other risky behaviors and can lead to substance use problems in adulthood.

This was the grim challenge we faced at the beginning of 2020. Now, we face the single greatest challenge to the mental health of our nation in our lives as we grapple with the COVID-19 pandemic. Theodore Roosevelt once said, “The more you know about the past, the better prepared you are for the future.” How does this apply to us today amid the COVID pandemic? For a preview of what may come, we can analyze the research available on mental health in the aftermath of the recession of 2008. “In 2008, the Great Recession ushered in a 13 percent increase in suicides attributable to unemployment with over 46,000 lives lost due to unemployment and income inequality in that year alone.”

Logic tells us if such stark numbers occurred in 2008, then the current

Figure 2. Higher Proportion of Behavioral Out-of-Network Care: Behavioral Office vs Primary Care Office Visits in 2015

Looking at the data in the Milliman Report can be daunting and even overwhelming; however, the news isn’t all bad. Some plans have recently taken steps towards substantive changes such as Blue Cross Blue Shield of Massachusetts (BC/BS of MA) which recently acknowledged, “Access to mental health services is a serious issue across the country and has become even more pronounced during the COVID-19 pandemic.”

This past July BC/BS of MA established an incentive program to increase reimbursements to child psychiatrists by 50% with hopes of expanding their network of providers, as well as committing to adding 2,000 more clinicians to their mental health network. Unfortunately, concrete efforts to address the mounting need for mental health services are rare and not likely to happen without pressure from providers and customers alike.

More likely, insurers will make changes only when they are forced to or the financial penalties of not providing parity are compelling. In the last 2 years, a few major private insurance companies have had to pay penalties and fines for noncompliance with the Federal Parity Act. Aetna was fined $190,000 in 2019 for their lack of compliance. More impressively, United Behavioral Healthcare was fined $1 million for failure to pay, or sometimes denial of care for customer’s claims relating to mental health in 2019. In the latter case, the Pennsylvania Insurance Department, whose main function is to audit insurance companies, found that United Behavioral Healthcare was using flawed medical review criteria and rejected claims on more than 50,000 people who were attempting to obtain coverage for mental health. Blue Cross Blue Shield were not fined, but were audited. During the audit, Blue Cross Blue Shield agreed to pay $5 million in 2018 to expand mental health services. These serve as templates for action that can be encouraged in states across the nation.

The time is now! Physicians and patients need to demand equality and accountability from health insurance companies. Along with our patients, psychiatrists can be the trailblazers for a more proactive process in correcting the disparities in mental health care coverage. Lawmakers and insurance companies have to be made aware of and accountable for this noncompliance. Psychiatrists have too many families seeking mental health services just to find out they are out-of-network, not covered, and ultimately, denied. After being told that they are not covered the next step is a protracted process of appealing insurance determination and filing a complaint. Given how COVID-19 has disrupted more than just mental health, consumers are less likely to follow through with such a process that can take months to complete not to mention the average consumer won’t have the legal knowledge required to complete such a parity complaint. The other option for the consumer is to contact their state insurance commissioner to ensure mental health parity. These state insurance commissioners have the ability with their position to enforce the law by ensuring plan compliance before being sold to consumers. Unfortunately, too few of the State insurance commissioners are living up to this obligation. No family should ever have to endure their child’s suffering due to red tape and lack of enforcement of the Final Rule. We must lead the way to both empower the families we serve to seek justice and to hold our own state governments accountable for this lack of parity. The costs are too high to wait any longer.

Take Home Summary
Physicians and patients need to demand equality and accountability from health insurance companies. The Federal Parity Law was supposed to close the gap between mental health or substance use disorder benefits when compared to medical/surgical benefits. The disparities continue to be a problem for psychiatrists and families.

References


About the Authors

Brian Morgan, DO, is a fourth-year psychiatry resident at The Medical Center of Aurora. Professional interests include inpatient and outpatient management of multiple demographics; youth and adolescent, geriatric, adult, and substance abuse.

Christopher Rogers, MD, is Medical Director of Child & Adolescent Services at The Medical Center of Aurora, the President of the Colorado Child & Adolescent Psychiatric Society and the Associate Training Director of the HealthOne Psychiatry Residency program. Professional interests include teaching, advocacy and psychotherapy.

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A deafening silence permeated the room. A mother visibly overwhelmed, tears filling her eyes, looked forlorn as she had brought her 14-year-old son to the psychiatric emergency room for evaluation of his behavior. The reasons for prompting the visit were evident on minute one of the encounter. The dysphoric and withdrawn appearing young man adamantly avoided eye contact as he reluctantly revealed numerous superficial and deep lacerations to his forearm. The patient did not engage much and had a prominent apathetic affect, often shrugging his shoulders responding, “who cares” and “whatever” to questions asked. This was a stark contrast from the vibrant straight A high school freshman that had recently joined his school’s marching band.

“How could this happen?” questioned the mother as she looked down, sniffling and damply pressing tissues to her eyes. “We were doing so well. He hadn’t cut or thought about suicide for over a year.”

In fact, the patient had been doing well. He was attending all medication management appointments with his outpatient psychiatrist, had active and engaging participation in individual therapy with his counselor once weekly, and had just started a new job as a cashier at a local pizzeria.

So, What Went Wrong?

COVERAGE was DENIED. The patient’s fluoxetine, one of the most commonly prescribed psychotropic medications with well-established US Food and Drug Administration (FDA) indications, was no longer approved by the patient’s insurance provider due to formulary changes. An integral part of his stabilization was thus not afforded. What resulted was an unfortunate adverse event in which the patient went days and weeks without his medications as a cumbersome administrative appeal took place via a prior authorization (PA) procedure.

Making changes to medications for pediatric patients is complex. Risks and benefits, contraindications, medication tolerability, patient preferences, and evidence-based practices are all factors that influence the individualized care from child and adolescent psychiatrists (CAPs). Recently however, CAPs and patients are having to familiarize themselves with an onerous PA process that often belabors the decision-making and treatment received. This paper addresses the issue of PAs and identifies how CAPs can best advocate for patients by ultimately improving the quality and trajectory of care with specific principles of reform and advocacy initiatives. The goal is to elevate awareness to change PA procedures through informed intent.

PAs for medications prescribed in clinical practice is commonplace. A recent 2018 American Medical Association (AMA) physician survey indicates 88% of physicians have reported increased PA burden over the last 5 years, completing on average 31 PAs per week.1 Serving the purpose of ensuring medications are medically necessary, CAPs are often resigned to justify selection, continuation, or dose adjustments of medications in comparison to lesser expensive alternatives. This justification takes time, making it an obstacle to tending directly to patient’s needs. This administrative burden reduces meaningful spent time on evaluating patient needs and requires approximately 14.9 business hours of lost clinical time per week.2 What can result are restrictions and limitations of full range of psychotropic medications utilized, minimizing the evidence-based practices of CAPs and degrading quality of care.
Care-Driven or Cost-Driven?

As stated in The Principles of Practice of Child and Adolescent Psychiatry, the primary concern of CAPs is the welfare and optimal development of the child. The informed uses of psychotropic medications, such as the careful selection and uptitration of fluoxetine in the case vignette, becomes elucidated as a fundamental component in improving the lives and outcomes of children and adolescents who suffer from psychiatric illness. Efficacy, safety, and patient satisfaction are always of primary concern in the treatment of pediatric psychiatric issues.

The particular issue of costs has taken center stage in the discussion on the impact of care received by patients. Given that the CAP is often personally completing the required documentation and follow-up for patients, PAs represent an “extra step” health plans require before deciding to pay for certain treatments. On average, the time to complete PAs range from 1 minute to 2 hours, with a mean of 13.4 minutes to complete. The estimated resultant burden of cost for completing PAs, not including psychiatrist involvement and lost patient time, is $7 to $10 per PA request, approximating 10% of the reimbursed costs for public insurance. What results is resources diverted away from patient care, negatively affecting patient health outcomes. A 2018 AMA Prior Authorization Physician Survey indicates that 91% of patients requiring PAs reported care delay, with 26% of patients waiting at least 3-5 days of no treatment received. As was tragically apparent in this case vignette, 75% of patients reported PA can lead to treatment abandonment and nonadherence, resulting in 28% of patient outcomes leading to serious adverse events (eg, death, hospitalizations, disability/permanent bodily damage, or other life-threatening event). CAPS are therefore concerned that PAs do not allow for best practice guidelines, instead preferring lesser expensive options. For example, this can manifest with patients trialing numerous older, less expensive psychotropic agents prior to initiating novel medications with less side effect profiles. It is important to note that adverse patient outcomes should be the center of discussion when advocating for PA reform.

PAs can also represent a unique barrier to equity of care by lowering resource levels at CAP practices who service patients from underserved and minority populations. Persistent racial and ethnic disparities have been found in access to pediatric mental health care and use of psychotropic drug use. PA procedures only further perpetuate treatment disparities, and policy reform should aim to focus on reducing barriers to access of non-white, black and Hispanic patients. Ensuring the strength of CAP workforce by addressing principles of PA reform is essential in optimizing patient care and targeting bias mitigation for marginalized patients.

Increased Collaboration With Insurers?

The issue of costs and care are not dichotomous amongst CAPs and insurers. Both share concomitant goals of delivering patients with psychiatric illness access to quality care. Despite perceptions of being a workplace hinderance, the US Government Accountability Office in 2012 addressed how PAs have reduced systems costs by $1.9 billion over 5 years of implementation. Similarly, states implementing PA have found utility in addressing prescribing patterns, with evidence pertaining to CAPs. For instance, many state Medicaid programs have seen prescribing reductions of antipsychotics in children ages 6 to 12 years old. These policies have better educated patients and families of long-term cardiometabolic profile changes associated with antipsychotic use, in addition to inform CAPs on best evidence-based practices negotiating risks and benefits.

PAs are here to stay, are standard operating practice in the United States, and have a powerful lobbying force behind them. Given the potential daily impact of PAs, CAPs are having to adjust accordingly by working with, not against payers, to mitigate the structural impediments of PAs. Many CAPs are staying informed and continuously familiarizing themselves with requirements for PAs by reading bulletins and newsletters offered by insurance and pharmaceutical companies. CAPs are learning to better engage with insurers by avoiding PA submissions with unmet requirements or little chance of approval, which can explain a recent June 2020 quality
assurance study with a scope of psychopharmacologic prescribing practices at Massachusetts General Hospital revealing 84% of PAs were approved, with only 16% denied requiring appeal or change to another medication.³

The AMA, AACAP, and a host of other medical organizations have also partnered to identify similar opportunities in improving the PA process with the collective goals of promoting safe, timely, and affordable access to evidence-based care for patients.⁴ Costs alone are never the sole arbiter of psychiatric decision making, and it has been well established that untreated and undertreated psychiatric disorders in children increase medical costs for children and their parents.⁵ The specific reform principles developed by the AMA to improve the PA process and patient outcomes can be found on AMA’s website, at https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf and https://www.aacap.org/AACAP/Policy_Statements/2019/PriorAuthorization_for_Psychopharmacology.aspx.

An Advocacy Call to Action

PA reform must be included among the advocacy priorities selected to improve access to care for the children we serve. Improvements must include reduction of the overall volume of PA requests; streamlined, standardized and automated procedures; increased transparency; and timely responses from payers. CAPs have specific knowledge and clinical experience that will help to advance advocacy efforts and support the unique mental health needs of children and adolescents.

The following steps provide a framework to engage in grassroots advocacy.

1. Understand the PA laws in your state.


3. Collect examples of PA policies, practices or regulations that conform to or do not conform to the principles as outlined in the above resources. Incorporate these examples in your elevator speech to illustrate the impact of PA policies on patient care, clinical outcomes and health care costs.

4. Contact AACAP’s Department of Government Affairs and the AACAP Advocacy Liaison representing your regional organization to learn about PA advocacy initiatives.

5. Join grassroots campaigns.
   a. Your AMA state medical society may be organizing advocacy efforts and likely in need of physician advocates.
   b. Share your PA experiences at FixPriorAuth.org.
   c. Identify and meet with other allies and coalition partners.

6. Meet with payers, elected officials and other decision makers who have jurisdiction over utilization management policies and regulations.

Simply put, PAs are somewhat of a necessary and inevitable evil. Therefore, an informed understanding of the cost savings, safety and patient outcomes of PA will surely benefit early-career CAPs and the patients we serve. Similarly, any further research efforts should address patient outcomes that guide advocacy efforts, as PAs have been known to affect patient satisfaction, distrust of medical professionals, and poor psychiatric service utilization.⁷

The need for PA reform is critical and the time for action is now. With knowledge and an empowered voice to stand up for patients’ rights, CAPs can have a transformative impact on the landscape of utilization management principles and health care coverage.
Take Home Summary

PA remains an integral and inevitable component in practice. It serves CAPs to have a firm understanding of PA including the benefits, drawbacks, and impact on quality patient care. AACAP encourages advocacy efforts by all members to reform the PA process through the listed means.

References


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Follow @AACAP for the latest news on your membership and in child and adolescent psychiatry.

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AACAP AWARD SPOTLIGHT
Sudhakar Kateel Shenoy, MD

2019 AACAP SYSTEMS OF CARE PROGRAM
Poster Title: The Ripple Effect: Children of the Opioid Epidemic and the need for Wraparound Services

For the AACAP Systems of Care Program, I worked on a project emphasizing the need for wraparound services that echoes a grassroots effort in community-based teamwork from both individuals and organizations. This project set off a chain reaction of learning, using all available resources at my university, fellowship program, local institutions and organizations, governmental programs, and the general community. Attending the day-long program and presenting a poster with fellow awardees was interactive, informative and fun. Now as an attending physician, I apply the concepts of systems-based care in collaborating with our colleagues from several other specialties.

2018 AACAP EDUCATIONAL OUTREACH PROGRAM (EOP) FOR CHILD AND ADOLESCENT PSYCHIATRY RESIDENTS
SUPPORTED BY THE AACAP ENDOWMENT FUND

Through AACAP’s EOP program, I was able to experience at the Annual Meeting a glimpse of the breadth and depth of opportunities AACAP can provide combined with rich mentorship. I felt inspired by various child and adolescent psychiatry leaders and got to share the table with the President of AACAP over the Young Leaders Awards Breakfast. A memory I will treasure is during the Life Members’ Dinner I was the youngest one at the table and was nervous; the Life Members endearingly addressed me as “kiddo” and had great conversations with me. With this experience, it felt like I grew a personal relationship with AACAP, despite this being my first Annual Meeting.

AACAP’S ADVOCACY COMMITTEE

I strongly believe that every physician is inherently an advocate for our patients. My first brush with the Advocacy Committee came in the form of a presentation by Drs. Deb Koss and Karen Pierce on the important role of physicians in mental health policy. This created a deep impression and ignited my interest to learn and involve myself in such efforts. I successfully applied for the Resident Scholar Fellowship opportunity, which allowed me to work closely with AACAP’s Department of Government Affairs on projects that support lawmakers’ offices in Congress, aiding in policies related to child and adolescent mental health. Living in Washington DC in July, visiting Senators’ and Representatives’ offices on the Hill, I felt like a congressional summer intern (without the coffee runs!). I also received exposure collaborating with other stakeholders with mutual goals in the “House of Medicine.” Since joining the committee in 2019, the committee members and AACAP’s support staff have become like family. I feel like I am ‘always learning’ in the midst of these esteemed committee members and the knowledge they bring to the table is awe-inspiring. I strongly urge you to join our Advocacy Liaison Network, the backbone of our grassroots effort! We would love to have you on our team.

MILESTONES

Born in India, I grew up in a household that instilled in me that knowledge and values are one’s greatest assets. At age 8, I was playing cricket with friends when our ball went onto a roof. Upon retrieving it, I was electrocuted by a high voltage power line and needed nine life-threatening surgeries to survive. Life “as a patient” motivated me to strive hard and become the first doctor in my family. Upon finishing medical school in India, I turned to the United States after experiencing inhuman discrimination in my effort to pursue further specialty training. Navigating a new country without knowing anyone was humbling, living on couches while preparing my residency applications; and the uncertainty of basic necessities like food and shelter, taught me a lot about life. I worked hard and eventually trained and did research at Harvard. I matched and pursued both residency and fellowship at SIU School of Medicine in Springfield, Illinois. Abe Lincoln’s town! My motto is “Learn to serve; serve to learn.” I am an immigrant physician, taking it one day at a time, serving the underserved population. Life’s uncertainty continues but AACAP has become my steady source of support and camaraderie through members and colleagues like you.

Visit www.aacap.org/awards to discover available award opportunities!
Why PACs Are an Essential Part of Advocacy

Elizabeth Wagner, MD, MPH, and Karen Pierce, MD

Advocacy is a broad term which encompasses a range of activities, from direct advocacy of patients, their parents and their community, to population-based federal and state legislative advocacy through statutory policy and program changes. It has been suggested “that advocacy occurs on a spectrum that includes legislative, administrative, clinical and patient-centered endeavors.” As child and adolescent psychiatrists, we are well suited to be advocates for children's mental health at all of these levels, because we are “immersed in the communities directly affected by these policies and can more quickly synthesize personal experience and scientific research to inform the debate.” The American Medical Association declaration of professional responsibility states that physicians commit ourselves to, “advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.” In order to be effective advocates for our patients and our profession there are multiple ways to get involved, for example direct lobbying from AACAP’s Government Affairs Department, grassroots lobbying by our members individually or in coordination with the Association, and AACAP-PAC contributions by our Association members. In this article we will be focusing on Political Action Committees’ (PACs) basis for advocacy and education, and more specifically the AACAP-PAC.

What PACs Do, and Don't Do

PACs, which were created through campaign finance reform laws, collect campaign contributions from their members and donate these funds to campaigns. At the Federal level, these contributions allow for direct contact with Members of Congress and candidates for national office to educate them through fundraisers and “meet and greet” gatherings that individual AACAP members would not be able to participate in as frequently otherwise. Voluntary contributions from Association members are made so that Members of Congress or worthy challengers can win campaigns. This is not a mechanism for allegedly “buying votes,” which would never be appropriate nor permissible. Instead, it is a legal, transparent, and necessary part of educating lawmakers, present and future. It is a protected first amendment right to contribute to any political cause or candidate, within established legal limits.

PACs have limited funds and must be selective in which campaigns they contribute. PACs have historically invested in campaigns of candidates who are proven effective legislators. In their paper on the topic, Box-Steffensmeier and Grant sought to determine if PAC contributions during the 103rd and 104th Congress were related to a member’s legislative effectiveness which they defined as their “hit rate,” the percentage of bills a member sponsors that becomes law. They confirmed that contributions were statistically higher for more effective members of Congress.

What AACAP-PAC Does

The mission of AACAP-PAC is to “educate, support, and elect candidates for Congress who advocate for child and adolescent psychiatry and child mental health.” By supporting Members of Congress and congressional candidates who are champions of children's mental health, it is our vision that “child and adolescent psychiatry will have strong relationships with legislators, so that Congress acts to improve child mental health.” Our AACAP-PAC helps to identify and elect candidates to Federal office who support child and adolescent psychiatry and are pro-children’s mental health.

AACAP-PAC has a board of directors made up of Child and Adolescent Psychiatrists (CAP), and a CAP Fellow board member, appointed by our AACAP President, who work to ensure compliance with the legal requirements of the PAC and discuss and decide where funds should be distributed. As volunteer members of the AACAP-PAC Board of Directors, we help to evaluate...
candidates we are considering for support and also make final approvals for all contributions. Currently, the power and presence of AACAP-PAC is opening doors as never before, as Members of Congress and other candidates reach out to talk by zoom through daily “meet and greets.” We cannot ignore the important role politics plays in Washington that affects children’s mental health policy, and it is our ethical duty to promote change that will positively impact the health of populations. In fact, through AACAP-PAC we are members of the Medical and Dental PAC group (MaDPAC), which allows our lobbyists to regularly meet with other national medical specialty lobbyists and candidates who share common goals. This literally creates more visibility in extended conversations with legislator candidates. For example, by attending a MaDPAC-organized fundraiser, our federal lobbyist was able to directly share information on children’s mental health with the Speaker of the House and her political campaign.

Who: The Importance of Fellow Members
Especially in this Presidential election year, it is important to have experience, training and competence with all aspects of advocacy and political action. For fellows and early career psychiatrists, we must consider ourselves the advocates of the future. The children’s mental health laws being created and discussed in Washington today will determine the way we practice our profession and impact the lives of our patients and families. It is our responsibility and duty to participate because unless we educate, support and elect members of Congress who advocate for child and adolescent psychiatry and children’s mental health, the problems affecting our patients and us will go unresolved.

Historically, physicians are reluctant to engage in politics, with only half of eligible healthcare professionals voting. It is imperative that we influence the policies made today, because we have the expertise and knowledge to educate policy makers. Psychiatrist Dr. Stefan Priebe offers a call to action when he asks: “What credibility and what societal relevance do we have as a profession, if we disseminate the evidence in scientific journals, but do not care about the political action required to implement it?” It has also been proposed by residents Dr. Anastasia Coutinho and Dr. Kristina Dakis in an Academic Medicine letter to the editor that “empowering trainees with skills to effect positive community or policy change may increase physicians’ sense of personal accomplishment and overall career satisfaction.”

AACAP-PAC is one mechanism that empowers us to champion our cause and help to educate our legislators on needed policy changes to relieve suffering and improve human well-being. In the coming weeks, we encourage you to reach out to us, other board members of the AACAP-PAC or our staff to hear about our most recent efforts in Washington during this important election year.

Take Home Summary
As child and adolescent psychiatrists, we have many ways to advocate for our patients. One particularly powerful way that we want to highlight, especially during this election season, is through the use of political action. Our AACAP-PAC is working in Washington, DC right now to educate, support and elect Members of Congress and candidates who advocate for child and adolescent psychiatry and child mental health.

References


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**Elizabeth Wagner, MD, MPH,** is a fourth-year resident in the Combined Program in Pediatrics, Psychiatry, and Child & Adolescent Psychiatry (Triple Board) at Alpert Medical School of Brown University. Dr. Wagner is the fellow member on the advisory board of the American Association of Child and Adolescent Psychiatry Political Action Committee (AACAP-PAC).

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Childhood Homelessness and Its Dire Implications

Neil S. Abidi, DO, and William Arroyo, MD

It is increasingly evident that the homelessness problem in America is intensifying. An important component of this crisis is the scope of child and family homelessness, and the implications on the general welfare of children and their families, including their mental health.

According to the US Department of Housing and Urban Development’s (HUD) 2019 Annual Homeless Assessment Report (AHAR), on a given night in 2019, an estimated 568,000 people were experiencing homelessness in the United States. Nearly two-thirds were staying in sheltered locations and more than one-third were in unsheltered locations deemed unsuitable for habitation. California itself has more than half of all unsheltered homeless people in the country. In fact, the number of unsheltered individuals in California rose 21% between 2018 and 2019, an increase of more than 18,000 people. Despite having the highest Gross Domestic Product (GDP) among US counties, Los Angeles has the largest census of the chronically homeless population. In order to address this problem effectively, it is important to understand the elements of homelessness relevant to children and families. The Greater Los Angeles Homeless Count of 2019, a point-in-time estimate of homelessness, demonstrated an 16% increase for Los Angeles County. Economic factors (eg, unlivable wages, rent) in many communities are driving the increase in homelessness. Excessive rental costs and insufficient affordable housing capacity is evident in some urban areas, for example as in Los Angeles, where it is a significant cause of homelessness. Of particular concern is the alarming data provided regarding homelessness among children. It is estimated that there are currently more than 17,000 homeless children in the Los Angeles Unified School District alone. A staggering 80% of children in the school district meet the guidelines for poverty, well above the national average of 25%. The National Center for Homeless Education reports that there are more than 1.5 million homeless students nationwide. Recently, the US Government and Accountability Office has conjectured that homelessness may increase during the COVID-19 pandemic in 2020 due to the related economic downturn, increasing unemployment and lifting of a moratorium on evictions.

Elements of Youth Homelessness

There are varying definitions of homelessness among youth; this varies among the different levels of government and agencies who serve said populations. The variation has significant implications for data collection. In addition, the youth are additionally classified by “typologies,” ages, and duration of being homeless. Such complexity reflects the diversity of experiences and backgrounds among youth experiencing homelessness, who cannot always be placed into a single category. Another facet is that of “couch-surfing;” children who couch-surf are counted as homeless pursuant to the federal law known as the McKinney-Vento Act but are not considered homeless in other regulatory frameworks. Such heterogeneity has made it difficult to create targeted interventions for this vulnerable group and provide linkage to relevant services. In California, the term “homeless youth” generally refers to unaccompanied minors ages 12 through 17 who are living apart from their parents or legal guardians, young adults ages 18 through 24 who are economically and emotionally detached from their families, and are experiencing homelessness or living in unstable or inadequate living situations.

Youth who are homeless, according to the McKinney-Vento Act (MVA), are those “who lack a fixed, regular, and adequate nighttime residence;” and may share housing with others due to loss of housing. Such a youth may use a private or public space not ordinarily used at night for sleeping accommodations. A youth is, also, homeless if sleeping in public places such as
parks, abandoned buildings, and transportation centers according to MVA.

Previous studies have demonstrated that the vast majority of families experiencing homelessness were comprised of single mothers with two young children, often under the age of six. These families tended to be residentially unstable, moving frequently, and often forced to live in sub-standard housing and low-opportunity neighborhoods due to lack of housing, lack of economic assistance, and housing unaffordability. The most salient risk factors for family homelessness include a childhood history of foster care placement of mother and history of mother having been raised in household in which primary female caregiver had substance use problem as compared to homeless adults. Other risk factors include minority status, few resources and supports, conflicted relationships of mother, small social networks, frequent use of alcohol or heroin, and psychiatric hospitalization of mother within past two years. Violent victimization was not found to be a risk factor, although a frequently reported event.

Many factors may account for the risk of homelessness in youth which are different from that of family homelessness. These factors include being Hispanic or Black, adolescent pregnancy and being unmarried. Additionally, family conflict and family rejection, sexual orientation issues relevant to LGBTQ communities, sexual activity, school problems, pregnancy, sexual and physical abuse and neglect, and substance use are primary risk factors.

Children living in foster care have additional risk factors for homelessness including the number and duration of foster care placements, and frequency of elopement. Foster care placement is itself a risk factor for homelessness. Youth in group or residential care are also more likely to run away from care than youth in traditional foster care or out of home placement. “Aging out” of the foster care or juvenile justice systems are other factors, most likely due to the loss of concrete social service benefits, including housing.

Additional Adversity Related to Homelessness

The potential for additional adversity among youth experiencing homelessness is vast; such has implications for a complex service array with the goal of ensuring that such youth maximize their potential. The lack of proper nutrition, which is common among homeless children, may be particularly significant for very young children when it occurs during the perinatal period. Growth delay and increased risk for poor health outcomes is strongly suggested by research in such circumstances. Other consequences associated with unmet shelter needs include untreated mental health disorders, language and communication disorders, substance abuse, sexually transmitted diseases, sexual exploitation (including survival sex to meet basic needs), physical victimization and increased suicidality. A research review indicates that the prevalence of mental health problems is greater in school age children relative to pre-school children when comparing homeless and housed populations. The National Sexual Violence Resource center reports that one in three teens on the street will be sexually trafficked 48 hours within leaving their home. The American Academy of Pediatrics has shared findings that youth experiencing recent family homelessness were twice as likely to have levels of emotional distress, self-injury, and suicidal thinking, and over three times as likely to attempt suicide within the last 12 months. The adversity faced by youth experiencing homelessness are vast, and often require coordination across all human service sectors. The impact of adverse childhood experiences linked to homelessness should be viewed in a developmental framework and may have have life-long consequences.

Recommendations for Child and Adolescent Psychiatrists

Treatment planning considerations. In order to address the needs of this population, child and adolescent psychiatrists, not unlike their pediatric colleagues, will likely have to expand their clinical tool set beyond those interventions which one may use, for example, with a child living in stable housing, in tandem with a multidisciplinary treatment team to include the following:
1. Determine the level of housing stability. Inquire about the various settings and frequency of changes in housing. Linkage to housing resources should be facilitated.

2. Determine if youth has experienced out-of-home placement, eg, foster care.

3. Determine if medical care has been received, including that for sexually transmitted diseases in older youth, and is generally accessible. If necessary, access to healthcare should be facilitated.

4. Determine the adequacy of nutrition, degree of general food insecurity. Linkage to nutritional resources should be facilitated if necessary.

5. Determine the level of personal safety, including threats and actual acts of violence, especially during periods of homelessness, to which a youth and/or family has been subjected. Determine if youth and/or family has or is receiving child welfare services. Abide by mandatory reporting laws and regulations related to negligence and abuse.

6. Determine the academic trajectory of a youth and changes in school settings. Advocating for a minimum number of changes in school settings is optimal for educational achievement. Determine if school or school district has provided any special assistance for students who are homeless or in foster care.

7. Identify public resources from which the child and/or family would benefit. The youth's personal and family's priority concrete needs should be identified.

8. Develop treatment plans in collaboration with child or family and include barriers imposed by homelessness.

9. Provide linkage to developmentally relevant supportive services for youth, e.g., recreational.

10. Determine the need for medically necessary services for caregivers, including behavioral health services.

**Advocacy Considerations**

1. Become familiar with data relevant to homelessness in one's state or locality, for example, those published by US Department of Education and/or US Interagency Council on Homelessness.

2. Become familiar with priorities related to homelessness identified by local elected officials and state officials through district offices or state offices, especially those of one's own elected representatives. This can easily be done by reviewing websites of elected leadership at the national (including congressional representatives), state and local government levels, eg, city council, other elected officials. Some legislatures have designated a task force or workgroup of experts to provide guidance on homelessness to state legislatures.

3. Become familiar with laws and regulations pertinent to special assistance provided by schools, eg, McKinney Vento Act, in anticipation of communication with school personnel.

4. Share your stories of patients, who are homeless, with one's personal elected officials. Partnering with other organizations which have a similar agenda related to this issue can maximize advocacy potential; this can be done as an individual or with one's local, state or national medical organization.

5. Discuss the needs of homeless children and families from a developmental perspective, eg, education, recreation, nutritional, among others, with elected officials and/or their staff.


7. Advocate for temporary housing and permanent housing resources relevant to children and families in one's locality with elected officials. Reasonable shelter eligibility has been shown to decrease high-end health costs, eg, emergency services.
8. Become familiar with issues of housing equity\textsuperscript{23} in one’s community. Advocate for housing equity, affordable housing issues, and housing subsidies.

9. Advocate for supportive resources\textsuperscript{24} for adults, eg, mental health or substance use disorder treatment services, who may need such assistance in order to discourage the separation of families or those at risk of separation.

10. Advocate for minimum wages commensurate with local cost of living.

**Summary**

Homelessness among children, youth, and families is a critical aspect of the growing homelessness crisis in the US. Effective strategies that are multi-systemic in nature offer the most promising solutions.

The ramifications of homelessness among children and families has potential long-term effects on these family units and society at large. The existing resilience evident among many of these children and families is buttressed by the access to an array of services, resources, support, and programs. Policy making bodies at all levels of government have a great potential to diminish the adverse impact on these children and families and to maximize their potential contributions to their communities and the general society.

Child and adolescent psychiatrists can influence the developmental trajectory of these children and families with both their clinical expertise and understanding of the array of service systems in their communities. Through active advocacy with state or national medical organizations and other organizations which share similar advocacy agendas, such influence can be maximized directly with policy makers and other decision-making bodies on behalf of this very vulnerable population of children, youth, and families.

**Take Home Summary**

Children and families experiencing homelessness comprise a significant component of the growing homelessness crisis nationwide with a myriad of potential adverse consequences for this population and societal ramifications. Child and adolescent psychiatrists are in a position to mitigate this mushrooming calamity.

**References**


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Connect Corner: Lessons on Resilience from the Animated Film Abominable

Megan Lin, DO, Mylan Kohler, DO, Kelly Yang, MD candidate, Jennifer Yen, MD, FAACAP, Steven Sust, MD

In this issue’s Connect Corner we take time to reflect on resilience; something we all must cultivate in this challenging time. Abominable is an animated film about personal growth, bereavement, emotional expression, and community as told from the perspective of the main character, Yi.

Yi is a young girl on a journey with her friends across China to bring a lost yeti named Everest back home to the Himalayas. Instead of spending time with her mother and grandmother following the death of her father, Yi fills her days running about the city of Shanghai doing odd jobs. She hides the money she earns in her secret rooftop sanctuary, saving up for a journey across China; a journey she had hoped to take with her late father. We learn that her father taught her to play violin and playing became her way to connect with him after he passed. Meanwhile, the magical creature Everest is captured by poachers with the intention of showcasing his existence to the world. When Yi and Everest cross paths, Yi becomes determined to help the young yeti return home. In helping Everest, she connects with a sense of purpose. Yi learns to move towards meaningful connections with family. Initially for Everest, and by the end of the film, for herself as well.

On her journey, she is accompanied by her goofy neighbor, Peng, and reluctantly by Peng’s self-absorbed teenage cousin, Jin. The trio embarks on an epic journey, discovering Everest’s evolving magical abilities to manipulate nature, the power of music, and a newfound loyalty to each other. Along the journey, Yi finally expresses her grief when she plays her violin atop the LeShan Buddha, an important landmark on her proposed journey with her father. White flowers, a color symbolizing mourning in East Asian cultures, cover the Buddha as Yi finds peace and acceptance for her loss. After successfully returning Everest to his home, Yi returns to Shanghai and the film concludes as she, her mother, grandmother, Peng, and Jin all gather for a meal.

The importance of familial connection is a prominent theme in the film and an important factor in promoting resilience.1,2 Familial ties of any kind, such as between Yi, Peng and Jin, serve as reinforcements in times of trouble and emotional upheaval. The relationship between the 3 children is that of a “found family.” Their loyalty to each other is palpable throughout the film as they band together against adversity, despite their initial differences. They would not allow Yi to journey on her own, and cared enough about her wellbeing to join her on this impromptu adventure. No matter what her state of mind, they offer support and love; this allows her to reach out to them in her own time. Learning to prioritize her relationships and knowing when to ask for help further cultivated Yi’s resilience.

The supportive character Jin, a familiar archetype who easily resonates with young audiences, also displays remarkable resilience. In his own character arc, Jin...
starts out as a self-absorbed, social-media junkie glued to his phone, not unlike many modern teens. When he decides to part with his beloved phone in exchange for a boat to reunite with his friends, Jin shows maturity and the ability to adapt to the needs of others. He lets go of his self-absorption to prioritize helping others in need. At Yi’s peak distress over her broken violin, Jin channels empathy and humility in helping Yi realize her unresolved grief. By then, Jin has developed a sense of purpose: to be present for his friends and help with their emotional journeys, showing his own emotional growth throughout the movie.

Regardless of which character the viewer identifies with, they all grow and change throughout the film. These are thoughtful and realistic changes, ones that the viewer can incorporate into their own daily lives. Resilience has been defined as “the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress.” Resilience can be practiced, not only to help children adapt to life’s stresses, but also to foster profound personal growth. Helping others, avoiding isolation, self-reflection, and prioritizing relationships are all means to increase resilience in the face of adversity. These coping skills are important for all ages and stages of development, and cultivating them helps to develop strength of character and self-worth.

The movie *Abominable* is a beautiful depiction of how these adaptations can improve young lives.

**References**

About the Authors

Megan Lin, DO, is a third-year resident in psychiatry at Nassau University Medical Center, New York. She is interested in child and adolescent psychiatry, social media's impact on youth, and mental health advocacy for ethnic minorities.

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Jennifer Yen, MD, FAACAP, is a clinical assistant professor at the University of Texas Health Science Center, Houston and Baylor College of Medicine, Houston Texas. Her primary areas of interest are cultural psychiatry, the use of media for psychoeducation, and mental health awareness. In addition to authoring academic articles, she has also written fiction books highlighting the themes of mental health, intergenerational conflict, and immigrant issues.

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If you are interested in writing for Connect Corner or if there is something you would like to see reviewed, please feel free to reach out to connect@jaacap.org with your suggestions!
CliPPs: Parent Religiosity and Children’s Suicidality?


Reviewed by: Rebecca Ba’Gah, MD, PGY3, Triple Board Resident, University of Kentucky College of Medicine, and Amy L. Meadows, MD, MHS, Departments of Psychiatry and Pediatrics, University of Kentucky College of Medicine.

Background: Suicide rates among adolescents are climbing. This recently published study by Connie Svob, PhD, et al. adds additional factors to consider in a child’s risk assessment for suicide. Although prior studies have examined religiosity in adults, finding lower rates of suicide associated with religious beliefs and practices, little is known about how the parent’s religious beliefs and practices can shape the child’s risk for suicide ideation and attempts.

Methods: The research objective was to examine the associations of parent and offspring religiosity with suicide ideation and attempts in offspring. The study followed 3 biologically related generations (grandparents, parents, and children) for 30 years (spouses were excluded). The first generation was categorized as either high risk or low risk based on history of diagnosed Major Depressive Disorder. Participants in the study’s analysis included 214 individuals in generation 3 who were assessed between age 6 and 18. Religiosity was assessed by examining religious service attendance and religious importance to participants and their parents (generations 2 and 3).

Results: Parent and child religiosity was assessed for relationships with child suicidal ideation or attempt. The child’s own religiosity was inversely associated with suicidal behavior in girls but not in boys. Parental religious importance and religious service attendance of a parent was inversely associated to daughter’s suicidal behavior, but only parental religious importance was inversely associated with sons’ suicidal behavior.

Conclusion/Commentary: Parental belief in the importance of religion may be a more robust factor than religious attendance. Although the study does not examine the mechanism, religious importance seems to play a role in lowering suicidal behavior. Additionally, the fact that religious importance of parents may mitigate the risk of suicidal behavior in both males and females may add important information to a child and family’s assessment. In certain children and families, involving spiritual or pastoral care as a part of a multidisciplinary treatment team may bolster both engagement in treatment and protective factors.

Take Away

Parental religious importance was associated with decreases in child’s suicidal behavior, whereas the child’s own religiosity was only associated with decreases in girls’ suicidal behavior. Asking about both parent and child’s beliefs can add another protective factor to safety planning for suicidal adolescents.

This article review originally appeared in the CLIPPs Edition 7.

References


Additional resources related to this CLIPP:

CLiPPs: Background: Association of Adverse Childhood Experiences With Co-occurring Health Conditions in Early Childhood


Reviewed by: Reviewer: Jake Crookall, MD, Toronto/Sick Kids Hospital

Background: Adverse Childhood Experiences (ACEs) have been repeatedly studied since originally described by Felitti et al.,1 demonstrating strong associations between increasing childhood adversity and a wide array of medical and mental health conditions. Recent review articles have demonstrated associations between 4+ adverse childhood events and 23 different health conditions in adults with particularly strong associations for sexual risk-taking, mental illness, alcohol misuse (ORs 3-6), substance misuse and interpersonal and self-directed violence (ORs > 7).2 A systematic review of pediatric physical health outcomes found associations between ACEs and developmental delay, asthma, somatic complaints, recurrent infections requiring hospitalization, and sleep disruption.3 Another study demonstrated associations between parents’ own ACE scores and their children’s mental health outcomes.4 In the context of these associations, many clinicians, academics and health administrators have argued for increased efforts to prevent, detect and mitigate ACEs.

The article reviewed is the first using this methodology in children ages birth to five.

Methods: The study used a subset of subjects (age 2-5yrs, n=19,957) from the 2011-12 National Survey of Children’s Health (NSCH), a retrospective parent-report phone survey representative of all noninstitutionalized children in the US, with response rate estimates between 23% and 54%.5 The authors used univariate, bivariate and multivariable logistic regression models. Predictors were the sum number of ACEs reported since birth: divorce/separation of parents; household member with substance abuse; household member with mental illness; parent spent time in jail; witness or victim to neighborhood violence; exposure to domestic violence; parent death; discrimination because of race or ethnic group. Outcomes included if parents were ever told by a health care practitioner that their child had any of 18 health conditions, which were grouped into 3 domains of developmental, physical or mental health. Covariates analyzed included demographic factors, access and utilization of health care.

Results: Notably, only 11% of parents reported 1 ACE, 3.8% reported 2 ACEs, and 3.5% reported 3 or more ACEs. In multivariate regression, compared to those with no ACEs, having 1 ACE was associated with 1.42 increased odds of having at least one condition; this increased to OR of 1.57 with 2 ACEs and OR 3.19 with 3+ ACEs. Having 3+ ACEs was associated with 7.19 times the odds of having comorbid physical, mental and developmental conditions. Unadjusted relationship in Figure 1 of the article demonstrates the growing comorbidity of developmental, physical, and mental health conditions associated with increasing number of ACEs reported. Of children who were diagnosed with both a physical and mental condition, 71% had experienced at least one ACE and 32% had experienced 3+ ACEs.

Conclusion/Commentary: This study identified a lower prevalence of ACEs in children ages 2-5 than previously documented for children ages birth to 18, potentially reflecting less cumulative time for children to have experienced ACEs, selection bias in the sample, or parents’ response bias. Most importantly, the study extends the observation that children age 2-5yrs have increased odds of physical, mental, and developmental conditions with increasing number of adverse experiences. Experiencing 3+ ACEs compared to 0 ACEs in the first 5 yrs of life is associated with an approximate 3.19 times adjusted odds of having any medical condition. Importantly, these are associations and do not necessarily reflect causal relationships given there may be confounders that were not adjusted for in this analysis and there may be elements of reverse causality,
such as children with increased medical needs leading to increased parental distress or poverty and maladaptive coping, such as substance use or intimate partner violence. High quality, prospective studies and randomized clinical trials of interventions to reduce ACEs could support evidence of causality.

**Take Away**

CL psychiatrists serve populations with comorbid physical, developmental, and/or mental health conditions and thus are likely to have many of their patients under age 5 experiencing multiple ACEs. This prevalence highlights the need for detailed assessment and interventions to address ACEs for young patients on medical psychiatry services.

This article review originally appeared in CLiPPs Edition 7.

**References**


**CLiPPs: Psychotropic Medication Use in Parents of Children Diagnosed With Cancer**


**Reviewed by:** Roslyn Gerwin, DO, Maine Medical Center.

**Background:** While childhood cancer has an overall survival rate >80%, their parents may continue to struggle emotionally beyond treatment completion. Objective measures to assess parental distress are limited. Emotional support is often not universally available to these families, and recent reviews have differing results on the long-term adverse psychological impact. This study aimed to better characterize the needs of affected parents through a population-based retrospective cohort study of the incidence of psychotropic medication initiation.

**Methods:** Information was obtained on all antidepressant, anxiolytic, and hypnotic prescriptions since 1995 from the Danish National Prescription Registry (DNPER). Cohorts were identified for examining the incidence of psychotropic use based on the child’s cancer status and independent parental risk factors. With regards to the child’s cancer status, 7821 biological parents of children <20 years old diagnosed with cancer between 1998 and 2014, and who resided in Denmark were identified using the Central Population Registry (CPR), were identified. Parents with psychotropic prescriptions 1-3 years prior were excluded, resulting in 6744 parents. A comparison group of cancer-free children with matching birth years was chosen randomly in a 1:10 ratio, resulting in 65,747 parents.

For examining independent contributing parental factors, with similar exclusion criteria, 3290 parents of children with cancer were identified, however those children were <15 years old, and did not capture 16- to 19-year-olds as the above cohort.
An additional parent cohort of children with cancer, Childhood Cancer Registry (CCR) for the years 2003-2015. This allowed for gathering information between 3 main diagnostic cancer groups and whether the child survived.

Sociodemographic information for parents was obtained through the Civil Registration System (CRS) correlating to the diagnosis or index date, as well as 1 year prior.

Statistical analyses were presented as hazard ratios and conducted in Stata version 14. Parents were followed from cancer diagnosis until the first prescription, death, emigration, or June 30, 2015, whichever came first.

**Results:** Parents of children with cancer had a 4% increased incidence of psychotropic medication prescription after 3 years. During the first year after diagnosis, there was increased rate of a first prescription across all 3 medication categories, with significant increase in the rate of anxiolytics and hypnotics use. There was no statistically significant difference according to cancer type, however relapse and death of a child did increase use of medication. Influencing sociodemographic factors included lower education, lower income, and younger parents.

**Conclusion/Commentary:** It may not be surprising that there is more frequent use of psychotropic medications for hypnotics and anxiolytics amongst parents of children with cancer. The study suggested stress and anxiety-related symptoms may be more prevalent in this population than depression severe enough to require use of psychotropics. Previous studies have consistently demonstrated the presence of elevated anxiety and depression, though longer-term post-traumatic stress disorder is less consistently appreciated, suggesting that the impact of psychological distress can decrease with time.

Interestingly, there does not appear to be a correlation with cancer type, and therefore treatment protocols, and use of psychotropic medication. This implies that any experience as a parent of a child with cancer can have impact. Not unexpectedly, relapse and death of a child confer increase incidence of psychotropic medication use, as well as certain factors that may limit resilience.

Limitations of this study include using prescription data as an indicator of psychological distress. Surveillance bias cannot be excluded. And, prescriptions have only been registered since 1995.

This paper also frequently utilized the word “risk” to describe the rates of medication use. This review did elect to describe rate use in terms of “incidence” as “risk” could imply that parents of children with cancer seeking mental health treatment as a negative.

**Take Away**

Education of medical professionals regarding the emotional needs of parents whose child have cancer is essential to adequately anticipate and assess for the stress response of the whole family. This study highlights the importance of further research to develop effective parental and family interventions.

This article review originally appeared in the CLiPPs Edition 9.

**References**


CLiPPs (Current Literature in Pediatric Psychosomatics) are pertinent article reviews from the AACAP Physically Ill Child Committee for psychosomatic clinicians on a range of medical science journals and literature. CLiPPs are edited by Chase Samsel, MD, of Boston Children’s Hospital and Dana-Farber Cancer Institute, Harvard Medical School, Boston, MA. All critical summaries are written by the designated reviewers. If you have any questions or are interested in writing for CLiPPs, please email connect@jaacap.org.
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