AIRS SIG Newsletter

Acute, Intensive, Residential Service (AIRS)

Volume 1, Issue 1

July, 2021

Inaugural Newsletter:

Welcome from the AIRS SIG Co-Chairs

Welcome to our first issue of the AIRS SIG Newsletter! We are excited to see the development and expansion of the SIG and see this newsletter as another reminder of the growth and relevance of this SIG and the individuals providing services in these treatment settings. As we reflect back, we realize that we are a year into starting the AIRS SIG *and* into the second year of life with COVID-19. Many members of the SIG have said how valuable the SIG listserv was as a resource while providing acute, intensive, and residential care to youth and families amid a pandemic. While we thought the AIRS SIG would be a benefit, we never realized its importance related to delivering care during a pandemic that changed practice models, modified treatment setting and staff models, and impacted the delivery of care. Throughout the pandemic, we know that one service line that never "paused" (or really even slowed down) was inpatient mental health care. Similarly, day-treatment programs had to pause or pivot to modify programing, census, and staffing models along with creating and delivering a new model for care through hybrid or full telehealth formats. As a result, we found ourselves reaching out to others for guidance, affirmation, clarity, support, and reassurance. This is ultimately the goal of a professional organization which allows its members an opportunity to connect, mentor, collaborate, and support each other. We plan for the SIG to remain a valuable resource for members and have many thoughts about how to kick that off and sustain these resources which are highlighted throughout the newsletter.

INSIDE THIS ISSUE:

Welcome from the Co-Chairs (cont.)

Beyond getting the listserv up and running over the past year we were offered the opportunity for a special issue in Division 53's journal *Evidence-based Practice in Child and Adolescent Mental Health* (EPCAMH) focused on acute, intensive, and residential mental health services for youth. We received over 20 submissions for our special issue and are grateful to Alysha Thompson, Michelle Patriquin, Elizabeth Reynolds, and Elisabeth Frazier for their help with this project. Thank you to all who submitted. This special issue will highlight research and interventions that promote the implementation of evidence-based treatment and measurement-based care in inpatient psychiatric hospitalization, partial hospitalization, intensive outpatient, and resident treatment settings.

Below is an overview of the goals and aims of the AIRS SIG. We look forward to future activities and encourage you to reach out to us or other SIG members with questions about the SIG or SIG activities.

Stay well!

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Mission

The Acute, Intensive, and Residential Service Special Interest Group (AIRS SIG) of the Society of Clinical Child and Adolescent Psychology (SCCAP) is dedicated to the promotion of policy, practice, research, training, consultation, and leadership directly relevant to the psychological assessment and treatment of individuals in acute, intensive, and residential behavioral health settings. The primary goal of the AIRS SIG is to provide a professional forum that supports clinicians, researchers, educators, and administrators interested in the development of psychological science, practice, policy, and procedures designed to promote the well-being of individuals experiencing engagement in high levels of treatment beyond traditional outpatient settings such as inpatient psychiatric hospitalization (IPH), partial hospitalization programs (PHPs), intensive outpatient programs (IOPs) and residential treatment facilities (RTFs). As a unified network of concerned scientists, practitioners, administrators, and educators, the AIRS SIG is interested in developing, organizing, implementing, measuring, and disseminating theory, treatments, and knowledge that will improve the delivery of psychological services to individuals receiving mental health care in acute, intensive, and residential treatment settings.

The AIRS SIG is a professional forum for clinicians, researchers, educators, and administrators interested in the development of psychological science and practice designed to promote the well-being of individuals experiencing psychological, functional, and social difficulty and requiring behavioral health care in inpatient, day-treatment, and residential treatment settings. To this end, the AIRS SIG is interested in (a) educating others about acute and intensive treatment settings, (b) promoting awareness of the services offered in these settings and across levels of care, (c) implementing evidence-based assessment and treatment in these settings, (d) supporting research relevant to the psychological assessment and treatment of youth in these settings, (e) developing models of service delivery in these settings, (f) defining best practices for use, and (g) disseminating information about the psychological assessment and treatment of youth in acute and intensive treatment settings. The AIRS SIG is also interested in pursuing these goals through collaboration with other professional organizations in a manner consistent with the goals of the Society of Clinical Child and Adolescent Psychology and the American Psychological Association (APA).

The Rise in Youth Mental Health Crises and Impact on Acute, Intensive, Residential Services

Alysha D. Thompson, PhD; AIRS SIG Chair Elect,

The past year and a half has been marked by significant stress and change as we have adjusted to living within the COVID-19 pandemic. Initially, work with youth in acute, intensive, and residential services (AIRS) was dramatically impacted as we have pivoted to ever-changing recommendations regarding safeguards against the spread of COVID-19. We shifted entire IOP and PHP programs to telehealth and figured out ways to create smaller groups on inpatient and residential milieus to mitigate risk of spread. We've gotten into a new routine and now are faced with a second pandemic: the rising rates of mental health crises for youth across the country.

Mental health crises such as suicide attempts and aggressive behavior have increased over the past year and a half, leading to a rise in mental health related visits to emergency departments from 2019 to 2020[1]. Data from Washington state indicates that there has been an even further increase from 2020 to 2021[2], something that I have heard in conversations with many of you around the country is true in your states as well. Our emergency departments are full, with some youth waiting days to weeks for an available inpatient bed[3]. I believe that we are just beginning to see the impact of COVID-19 on youth mental health, tapping AIRS programs throughout the country to provide care to youth in crisis.

This sharp rise in mental health crises has meant that the AIRS SIG community has been working in overdrive; our already limited capacity for inpatient beds throughout the country[4] has been stretched and since new inpatient beds can't be created overnight, we have had to adapt. Psychologists are being tapped to create programming for youth waiting for inpatient psychiatric beds on medical floors or in emergency departments while continuing to maintain the other programs they work on. Entire new programs have been developed to create intensive step-down options from the emergency department to triage the waves of youth in crisis. In short, it has been a year of ingenuity as teams adapt and adjust to the increase in mental health crises for youth.

AIRS services are now needed more than ever. In this time in which we are required to constantly adapt and address new issues quickly and effectively, I have been so grateful to have this emerging community to turn to for support and ideas we all work toward providing excellent care to the youth that we work with. Ultimately, given the severity of mental illness seen in our programs, our efforts may be life-saving. Thanks to you all for the work you are doing across the country to provide care to youth in crisis as we continue to adapt and adjust to life within and after the COVID-19 pandemic.

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[1] Leeb, R.T., Bitsko, R.H., Radhakrishnan, L., Martinez, P., Njai, R., & Holland, K.M. (2020). Mental health–related emergency department visits among children aged <18 years during the COVID-19 pandemic — United States, January 1–October 17, 2020. *Morbidity and Mortality Weekly Report, 69*, 1675–1680.

[2] Washington State Department of Health. (2021). COVID-19 Youth Behavioral Health Impact Situation Report. Accessed online June 3, 2021. https://www.doh.wa.gov/Portals/1/Documents/1600/821-135-YouthBehavioralHealthSitRep-May2021.pdf

[3] Tanner, L. (2021). ER visits, long waits, climb for Mass. Kids in mental health crisis. WBUR. https://www.wbur.org/edify/2020/12/07/long-waits-kids-mental-health-crisis

[4] Krishna, S., Shapiro, D., & Houston, M. (2016). Policy statement on psychiatric hospitalization of children and adolescents. American Psychiatric Association Official Action. Accessed online June 3, 2021 https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2016-Psychiatric-Hospitalization-of-Children-and-Adolescents.pdf

Welcome from the AIRS Education Committee

Kelly Walker, Ph.D. & Nathaniel Van Kirk, Ph.D.

The Education Committee's goal is focused on the development and dissemination of educational materials and programs relevant to the psychologist's role in intensive service settings. Over the next year, we will be collaborating with the community to build an electronic resource library, providing educational/practice related materials to the AIRS community, addressing policy and procedures, training/webinar recordings, along with treatment and training resources. In October, we will be hosting an upcoming *virtual coffee break* discussion focused on the opportunities and roles of psychologists in inpatient settings, which will build off our membership and roles surveys that will be sent to the community over the summer.

We look forward to working with all of you in the SIG community over the coming year and If you have ideas for educational/webinar topics or areas of interest, please let us know through this survey (https://redcap.link/AIRS-Educ)!

Welcome from the AIRS Science Committee

Michelle Patriquin, PhD, ABPP & Elizabeth Reynolds, PhD

We are thrilled to serve as co-chairs of the Acute, Intensive, and Residential Service (AIRS) SIG Science Committee. We are committed to advancing the evidence base for AIRS settings. We hope to support a community of professionals to collaborate, develop, and systematically engage in research to enhance the interventions provided in these settings and the measurement strategies for assessing outcomes. As part of our committee's work, we will highlight research relevant to AIRS settings that has been published by our AIRS SIG members in this section of the newsletter. Our overarching goal is to increase visibility of the outstanding science that is being conducted in AIRS settings across the country and that this can help generate new research collaborations, promote clinical translation of these findings, and continue to improve youth outcomes in AIRS settings. If you have a published article that you would like us to highlight in the AIRS newsletter, please email it to us (ereynol9@jhmi.edu; mpatriquin@menninger.edu). We look forward to working with you all!

Take PRIDE in Your Treatment!

Ashley Warhol, Psy.D. & Elisabeth Frazier, Ph.D., Practice Committee Co-Chairs

In honor of Pride month (June), the practice committee would like to offer some tips and tools on how to provide affirming care to gender diverse clients in your acute care setting. Research has shown that LGBTQ+ youth, and gender diverse youth in particular, are at greater risk than their straight/cisgender counterparts for negative outcomes, including: lower GPA; higher school absences; suicide and self-injurious behavior; mental health difficulties (e.g., depression, anxiety, PTSD, etc.); substance use; sexually risky behavior; bullying and/or assault; rejection; and homelessness (Human Rights Campaign, 2018).

One third of transgender individuals have had at least one negative experience with a healthcare provider (e.g., harassment or refusal of treatment) due to their transgender identification (James et al., 2016). When gender diverse individuals have negative experiences with mental and physical healthcare, it creates barriers to further healthcare utilization. However, when youth receive gender affirming care, they tend to show improved mental health outcomes (De Vries, Steensma, Doreleijers, and Cohen-Kettenis, 2011; Turban and Ehrensaft, 2018). This makes creating a safe and affirming space in your acute care agency crucial to the improvement of mental health and social outcomes, potentially providing opportunities for a corrective, validating experience that could improve treatment engagement and outcomes.

In 2015 the American Psychological Association (APA) recognized the importance of providing affirming and competent care to gender diverse individuals, and the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* were released. The APA took their efforts a step further in 2018 with the publication of *The Gender Affirmative Model: An Interdisciplinary Approach to Supporting Transgender and Gender Expansive Children.* In addition to educating yourself and your colleagues by reading the aforementioned literature, here are some steps you can take to create a safe environment for all of your patients and provide gender-affirming treatment.

Direct Patient/Family Care Considerations:

- Create a non-judgmental milieu environment filled with respect for diversity.
- Ask each patient their preferred pronouns and then reply with your own. Use correct pronouns and respectfully correct others if they use incorrect pronouns. If you make a mistake, apologize and repair.
- Familiarize yourself with commonly used, gender diverse pronouns such as Ze/Hir/Hirs (pronounced zhee/here/heres), Ze/Zir/Zirs (pronounced zhee/zhere/zheres), Xe/Xem/Xyrs (pronounced zhee/zhem/zheres), etc. (Yarbrough, Kidd, and Parekh, 2017)
- Let go of a binary conceptualization of gender and embrace gender diversity.
- Help educate patients, families, and colleagues that gender identity, gender expression, and sexual orientation are different constructs.
- Ensure that clinical staff are aware that mental health needs may be secondary, or unrelated to, transgender identity and may have resulted from experiences of discrimination and stigmatization. Focus on the problems that brought the patient to your program, which may or may not be related to gender identity.
- If a patient is taking hormones, consult with the prescribing provider prior to making any changes.
- Provide access to bathrooms of the patient's identified gender.
- Educate and assist parents in supporting and validating their child's gender identity and gender expression.

Agency Level Considerations:

- Conduct an agency self-assessment to gauge readiness and areas to target.
- Create and enforce non-discrimination policies that include gender diverse individuals.
- Provide regular training to staff on topics relevant to working with gender diverse people, including use of chosen name and pronouns, as well as confidentiality.
- Update intake and other agency forms to be representative of all gender identities, expressions, and sexual orientations.
- Promote visibility through the use of posters, signage, lanyards, etc.
- Ensure access to affirming community providers.
- Consider adopting supportive treatment documents (e.g., Gender Support Plan [Gender Spectrum, 2016])
- Assign gender diverse individuals to a program and room that is consistent with their self-identified gender, and/or utilize single occupancy rooms as available.
- Consider developing a policy specific to your agency's stance on conversion therapy.

Agencies can also pursue national recognition through the Human Rights Campaign through one of two avenues: the All Children, All Families project (specific to child welfare/congregate care settings) or the Healthcare Equality Index (specific to healthcare facilities and inpatient hospitals). As part of this process, agencies are required to conduct a self-study on current practices and are encouraged to push the envelope to become innovators in the treatment and support of LGBTQ+ youth and families.

Additional resources for the clinical treatment of gender diverse individuals include: A *Clinician's Guide to Gender-Affirming Care: Working with Transgender and Gender Nonconforming Clients* (Singh, Chang, & dickey, 2018) and *Counseling Transgender and Non-Binary Youth: The Essential Guide* (Krieger, 2017).

Do you have questions or are you seeking consultation? Contact Ashley Warhol, Psy.D. at awarhol@devereux.org or Elisabeth Frazier, PhD, at elisabeth_frazier@brown.edu for more information.

American Psychological Association (2018) A glossary: Defining transgender terms. *Monitor on Psychology, Vol 49*, No. 8, page 32.

Clay, RA (September 2018). Embracing a gender-affirmative model for transgender youth, *Monitor on Psychology, Vol 49*, No. 8, page 29

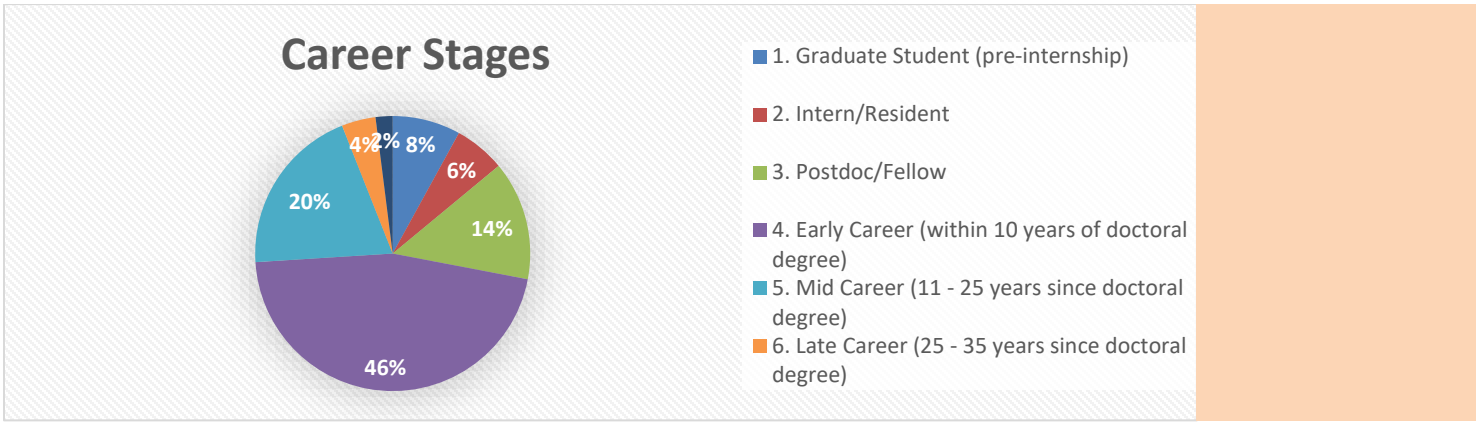
De Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*, *8*(8), 2276-2283.
Turban, J. L., & Ehrensaft, D. (2018). Research review: gender identity in youth: treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, *59*(12), 1228-1243.

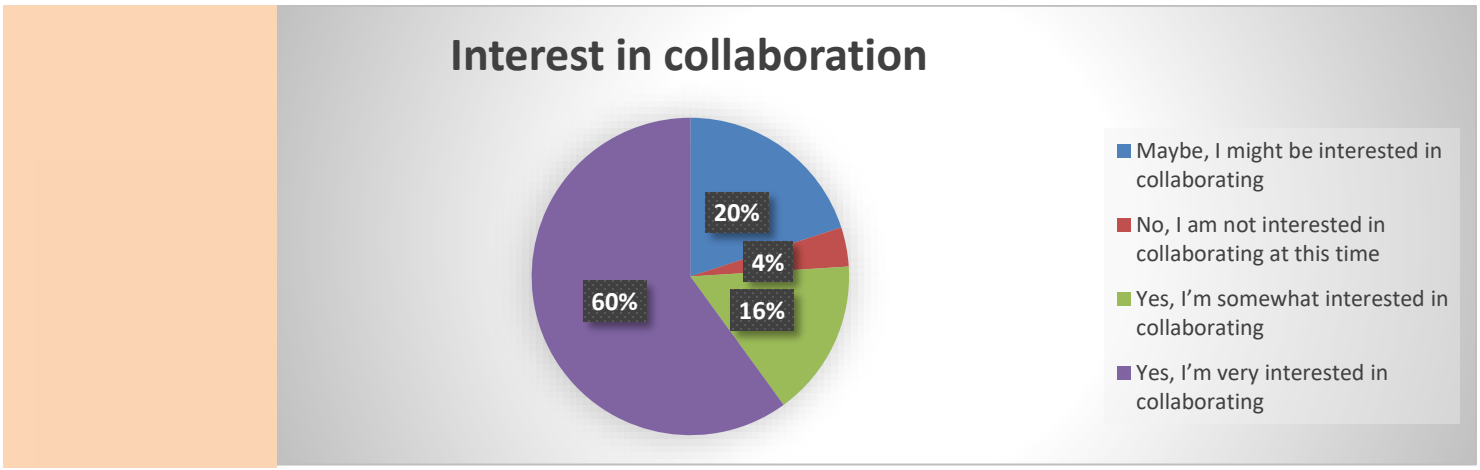
Yarbrough, E, Kidd, J., & Parekh, R. (Nov 2017). Definitions of Gender, Sex, and Sexual Orientation and Pronoun Usage. American Psychiatric Association. https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/definitions-and-pronoun-usage

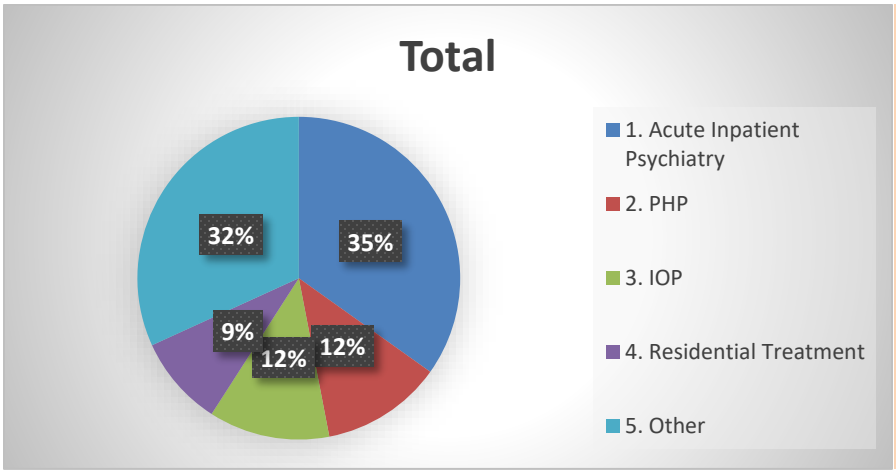
Membership and Marketing Welcome and Update

Kristin Scott, PhD and Carl Waitz, PsyD

Our total membership is 135 professionals representing at least 75 institutions with at least 35 publications relevant to AIRS services! We have grown by about 24% so far this year. In May and June, we conducted a survey of our members, and we received responses from about 37% of our membership. Here's what we found:







Among other requests, expressed interest in sharing clinical interests and contact information on the website. This is something we will be looking into in the coming months, and we hope to facilitate collaboration between members—which is clearly an interest for most of us.

Thanks to all who participated in the survey!

Welcome and "Tips from the Trenches" From the Early Career Members at Large

Meredith Reiman, PhD and Mackenzie Sommerhalder, PhD

We are thrilled to write the first article for our soon to be running series, "Tips from the Trenches." As early career psychologists working in acute inpatient settings, we are immersed not only in the chaotic, difficult work of an acute setting but also navigating the beginning of our careers. Thus, the idea of "Tips from the Trenches" was born to showcase the difficulties, milestones, vulnerabilities, and successes that come from working as an early career psychologist in an acute and intensive setting.

Our first article highlights the importance of self-care not only from the view as an inpatient psychologist, but also the transition from graduate student to licensed psychologist. It is a particularly challenging time of year in acute and intensive care settings, within a pandemic no less. We are often educated on the importance of self-care as psychologists; however, the nature of the acute care setting may pose unique challenges to maintaining a sense of balance through practicing self-care. Below are some tips for maintaining your own self-care and balance between home and work:

1. Acute and intensive care settings provide round-the-clock continuous care. It is helpful to set boundaries around your personal time to avoid engaging in patient care 24/7.

- Set your work schedule around your preferred daily rhythm. Patient care occurring 24/7 allows you to come and leave work when you like. Some individuals may prefer to be on site from 7am to 4pm, while others may prefer 10am to 7pm.
- Actually take a lunch break. Eat lunch out of your office, or offsite, when possible.
- When possible, avoid staff gathering areas (e.g., break room/lounge) during high traffic times. This may help avoid staff approaching you for "shop talk" while you are trying to heat up food or make your coffee. Even better… get an individual coffee maker for your office!
- Set parameters around receiving and sending email and phone notifications. For example, you may silence notifications to your phone after "business hours" and only log in "after hours" when you choose. If you are responding to emails "after hours," consider scheduling for the email to be automatically delivered during "business hours" the following day to model/communicate to others your boundaries.

2. All patient care activities that occur within an acute and intensive care setting can feel emergent. These tasks often compete for your time, and require you to identify what is truly urgent or a priority for *your* time. Consider using the DBT Treatment Targets Hierarchy (Linehan, 1993) as a model for how to make decisions for your own work by rank ordering problems from "life threatening" to "quality of life/work" interfering.

3. In this work, it can be hard to remember what typically developing children or children not affected by mental health issues look like. Delighting in children is something that can be helpful to incorporate into your daily work. "Delighting" in a child is simple— do not focus on achievement, accomplishments, or goals, but rather focus on watching the child experience joy and share in that joy.

"Tips from the Trenches" Cont.

At work, you can seek out children during the day who are on the playground, in the gym, or playing a goofy game on the unit and join with them. It can be a good reminder that underneath the pain, trauma, and struggle that we work through each day, there is a beautiful, delightful child who is able to run, play, and laugh.

4. As you settle into your profession, most psychologists want to reach a greater balance between work and personal life—one that is inherently blurred in graduate school. So how do we set boundaries of "shop talk" with our graduate school friends and other people? This even extends to other people in life who know of your profession and seek solicited advice about their child, nephew, or family friend. How do you remain gracious, kind, and firm in your boundaries between personal relationships and work?
   - Set structured time for consultations. Scheduled monthly or bimonthly virtual meetings for case consultation can be helpful to cut out the shop talk in personal conversations. If it does come up, you can redirect gently, "I'm glad you brought up your hard case, I'm excited to talk about it more at our next consultation meeting."
   - If establishing structured time for consultations is challenging due to time differences, etc., it can be helpful to set boundaries within each particular relationship. For example, try not to respond to work-related text messages, and instead suggest a phone call and put strict limits around the times of day that you are willing to speak about consultations. For some, this might mean avoiding work conversations right before bed.
   - For others like family friends or people in the community who ask questions about their children, it is also okay to set a boundary. You can respond with a validating statement ("that sounds incredibly difficult"), give them hope for change ("and there's a lot of great interventions that address that problem, it's not as uncommon as you may think"), and suggest they seek professional help ("there are some great clinicians in the community that work with similar problems, it might be helpful to reach out and schedule an appointment").
   - It is also okay just to *not* share what you do when you meet people if you do not wish to talk about work. Sharing vaguely about what you do "I work with kids" or "I work at the hospital" without offering additional information is satisfying enough for most people without them asking further follow-up questions.

Welcome from the AIRS Trainee Members at Large

Leyla Ergder, PhD and Linda Oshin, PhD

Hi graduate students! AIRS SIG is a great platform for you to learn about training opportunities in acute/intensive clinical care settings and get access to resources specific to these settings. The AIRS SIG membership also provides multiple networking opportunities with other acute/intensive clinicians. The AIRS SIG holds events that connect trainees and provide a sense of community and support (such as meetings/get-togethers on internship applications, etc.). You can also benefit from resource libraries specific to AIRS training opportunities (getting access to a list of AIRS practicum, internship, and fellowship sites).

Please come and meet us at a virtual coffee hour in August (time TBD) to chat about internship application process at AIRS sites). Thank you and see you soon!

Meet the SIG Board Members

Co-Chairs

Jarrod Leffler, PhD, ABPP: *Consultant, Division of Child and Adolescent Psychiatry and Psychology, Department of Psychiatry & Psychology, Mayo Clinic*
Aaron Vaughn, PhD: *Associate Professor of Pediatrics, Senior Director of Behavioral Health Programming, Cincinnati Children's Hospital Medical Center*

Chair-Elect

Alysha Thompson, PhD: *Assistant Professor, University of Washington Clinical Director, Psychiatry and Behavioral Medicine Unit, Seattle Children's*

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Coordinator of Diagnostic Services & Clinical Training, Devereux Advanced Behavioral Health

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Katelyn Affleck, PhD: *Clinical Assistant Professor in Psychiatry and Human Behavior, Staff Psychologist, Bradley Hospital, Consulting Psychologist. Lifespan Behavioral Health Team, Rhode Island Training School*

Membership and Marketing Members at Large

Kristin Scott, PhD: Pediatric Psychologist, UT Southwestern, Child & adolescent inpatient psychiatry unit
Carl Waitz, PsyD: *Attending psychologist, Boston Children's Hospital, Acute Inpatient Service, Clinical Instructor at Harvard Medical School*

Education Committee Co-Chairs

Kelly Walker Lowry, PhD: *Director of Partial Hospitalization and Intensive Outpatient Programs at Lurie Children's Hospital and an Assistant Professor of Psychiatry and Behavioral Sciences at Northwestern University, Feinberg School of Medicine*
Nathaniel Van Kirk, PhD: *Director of Inpatient Group Therapy at McLean Hospital and serves as the Coordinator of Clinical Assessment at the OCD Institute residential treatment program.*

Science Committee Co-Chairs

Michelle Patriquin, PhD, ABPP: *Director of Research and Senior Psychologist, The Menninger Clinic Assistant Professor, Baylor College of Medicine*
Elizabeth Reynolds, PhD: *Director of Acute Psychological Services; Co-Director, Pediatric Medical Psychology, Associate Professor of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine*

Practice Committee Co-Chairs

Ashley Warhol, PhD: *Director of Clinical Services & Internship Training at Devereux Advanced Behavioral Health*
Elisabeth Frazier, PhD: *Clinical Assistant Professor of Psychiatry and Human Behavior, Brown Attending Psychologist - E. P. Bradley Hospital*

Early Career Members at Large

Mackenzie Sommerhalder, PhD: *Assistant Professor, Director of Acute Clinical Services – University of Maryland School of Medicine*
Meredith Reiman, PhD: *Staff Psychologist II, Adolescent Acute Inpatient Program, Cincinnati Children's Hospital*

Trainee Members at Large

Leyla Erguder, PhD: *Postdoctoral Fellow – Brown, Clinical Child Psychology Specialty Program, Adolescent Intensive Service*
Linda Oshin, PhD: *Postdoctoral Fellow, Dialectical Behavior Therapy Program-Rutgers University*

Do you have ideas for what you want to read in the next edition?
Do you have thoughts about the AIRS SIG or the questions in the field?
Let us know!
Ideas and thoughts welcome over email:
Cassandra.esposito@cchmc.org & Katelyn_affleck@brown.edu