AMERICAN PSYCHIATRIC ASSOCIATION

Diversity & Health Equity at APA

Fall 2024 Update

#AchieveMentalHealthEquity

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Chief's Corner

In this issue, we bring you a closer look at transformative efforts and inspiring voices in the field of mental health equity. From spotlights on groundbreaking initiatives to deep dives into lifestyle psychiatry, each section is designed to provide updates, insights, and actionable guidance to strengthen our shared commitment to health equity. Highlights of this issue include:

Mental Health Equity Champion Dr. Amir Ahuja sharing his journey and dedication as a leader in LGBTQ+ mental health, Dr. Gia Merlo discussing the intersections of lifestyle, environment, and mental health in this insightful interview, an advocacy update on maternal mental health, a recap of impactful milestones achieved through the APA Moore Equity initiative, highlights of our efforts to nurture the next generation of psychiatrists who exhibit cultural humility and a look into how Dr. Denis Antoine views the impact of natural disasters on mental health and communities. Thank you for your dedication to advancing health equity in psychiatry. Dive in, stay inspired, and let's continue to create positive change, together!

"A tiny change today brings a dramatically different tomorrow." – Richard Bach.

Regina James, M.D.
Chief, Division of Diversity & Health Equity
Deputy Medical Director
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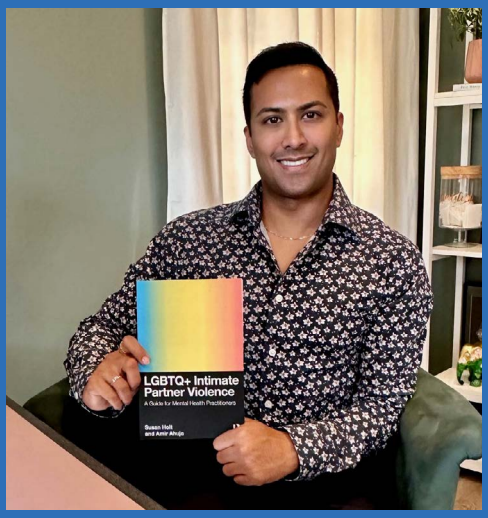

Mental Health Equity Champion Spotlight

Amir Ahuja, M.D.

By Fátima Reynolds, MPH

Dr. Ahuja is a Board-Certified Psychiatrist and Fellow of the American Psychiatric Association. He is a leading voice for the LGBTQ+ community. As the Director of Psychiatry at the LA LGBT Center, the largest of its kind in the world, he oversees a team that serves over 2,000 patients. In addition, he is the Past President of AGLP: The Association of LGBTQ Psychiatrists, the nation's leading organization for LGBTQ+ healthcare providers and their patients and is the current Associate Editor of the Journal of Gay and Lesbian Mental Health. He is a former board member of GLMA: Health Professionals Advancing Equality.

Dr. Ahuja has been in Private Practice for years in Beverly Hills, CA, and New Jersey. His academic interests include Health Disparities and Health Equity, Conversion Therapy, Intersectionality, and Addictions. His latest book just came out and is a guide for practitioners on assessing and treating LGBTQ+ Intimate Partner Violence available at the following: **Amazon**, **Blackwells**, **VitalSource**, **AbeBooks**, *and* **Thriftbooks**. *His next book will be about connections and how they can create and maintain better mental health.*

Thank you for speaking with us, Dr. Ahuja. Can you share your journey into psychiatry and what inspired you to focus on mental health within the LGBTQ+ community?

The reason I was drawn to psychiatry was an early exposure to how adverse experiences as children and adults can affect one's mental health. My grandmother and mother are refugees from Africa and had experienced trauma and depression. Seeing them struggle helped me realize how powerful mental health could be. I gravitated towards an LGBTQ+ focus from a place of organizing and wanting to be in the equity space. LGBTQ+ people face a lot of disparities. Being part of the community, I can see the lack of family structure, lack of social support, and discrimination, that lead to poor mental health outcomes. So, it was a natural fit and an opportunity for me to champion this. It also comes from wanting my own therapist or primary care doctor to speak the same language as me in terms of cultural competence and feeling that I can provide that for someone else.

How have you seen the mental health landscape change throughout the course of your career?

For the LGBTQ+ community it has changed significantly. It has opened up in a way that did not exist when I was growing up. There is more acceptance of LGBTQ+ identity, of coming out, and of mental health disparities. The landscape has particularly changed for young LGBTQ+

people as they come out and into their own, whether they are trans, gay, lesbian, bisexual etc.

> **"Continue to be engaged as much as you can. To the extent that you don't like what is happening in psychiatry or the world, you can sit back and complain or you can do something about it."**

To get into that identity is formative work and to see the support and fostering of this has been nice because it is a different landscape. There is also less anti-LGBTQ legislation, which helps because we know that these types of policies can have a negative impact on people's mental health. That changing throughout my lifetime has been big. Also, we have all been lucky to witness more public examples of LGBTQ individuals being successful and open about their mental health and overcoming it. That is part of how I got to this book that I wrote "Intimate Partner Violence: A Guide for Mental Health Practitioners." For our forward we interviewed Greg Louganis, the diver, and he talked to us about his experience. He is one of the few people open about being LGQBT+ and experiencing IPV. These examples are helpful for people to see that others have struggled like they are and have gotten past those struggles and succeeded despite hardship.

What initiatives or changes have you advocated for or championed as the former president of the AGLP?

I was in the role for four years. We just changed over in May, and Pratik Bahekar, M.B.B.S. is the new president. During my time we worked on creating a membership pipeline for medical students and residents, increasing our membership by 200 people. This brought in more diversity, increasing transgender-identifying, women-identifying, and racial minority members. We have found some best practices in attracting more diverse members and getting more people involved. For example, not counting anyone out such as medical students and starting as early as high school. Whether you go into psychiatry or not, we will give you some experience that could make you more mental healthcare minded. It is helpful to foster those passions. We also started a mentorship program and offer scholarships. We think about encouraging a lifelong commitment, offering support at every step such as the stage where you are growing your practice all the way to staying involved in retirement. We also improved our social media presence and focused efforts on the AGLP journal. We are getting more submissions and working on getting Medline status. I am one of the associate editors now and my role is transitioning into academia and helping the journal become cited more and become the premier journal for LGBTQ+ mental health.

Are there any emerging issues or unique submissions you have reviewed as editor of the journal?

We are seeing more rigorous data. In the past we received a lot of qualitative data, as there was a lack of funds for randomized controlled trials. There is a lot more attention being paid to specific groups under the umbrella of queer health. There is more data needed, but there is for sure more quality data emerging, especially focusing on youth of color.

As the Director of Psychiatry at the Los Angeles LGBT Center, can you discuss a bit about the non-profit experience for a psychiatrist?

The LGBT center was a natural fit as a non-profit in terms of mission. There was not a consistent psychiatry department at the center so we created this role and the department, so our patients could have consistency versus a revolving door of people. It is hard to build trust and rapport, especially with patients who are mistrustful of institutions. We grew from 500 to 2,000 patients and have six permanent providers. We are expanding to different sites throughout the city and are engaging in different communities where they are. For example, we have a Spanish-speaking clinic in East LA. There is also a transgender wellness Center and we hope to bring Psychiatry there soon.

There are benefits to non-profits in terms of not having a mill of patients. Being a provider, it is refreshing to have more control over what we can do for patients, and not have money be the primary focus of treatment. Although resources are limited I wouldn't want to work anywhere else. We provide care for a wide variety of people, though caring for the less fortunate who would not be able to get care otherwise is particularly satisfying.

You were the chair for the LGBTQ+ anti-bullying symposium at the APA annual meeting, could you share some insight about gaps in current approaches and future research?

Bullying was interesting because I was both heartened and saddened by the fact that around the world, the statistics are pretty similar. If you look at England, Australia, and France, they have similar statistics to the United States. We know bullying has a negative impact on mental health, increasing substance use and suicidality. The good news from the research in the symposium is that it does not take a lot to intervene. It takes one supportive teacher, having a gay/straight alliance in your school, or welcoming LGBTQ+ signage, to have a positive effect. Small moves can make a big difference. We know that Gen Z and Gen Alpha are more LGBTQ+ friendly, so as these new generations of educators come in I would hope that we will be able to see and measure progress.

How can clinicians improve their understanding of gender identity to provide better support and care to transgender and nonbinary communities?

Cultural competence is really important. Small things really help, such as learning statistics and getting to know transgender and nonbinary people who can convey their experience firsthand. I want there to be a more robust educational shadowing program at the LGBT center, since a wonderful way to increase cultural competence would be doing rotations at our center, **Howard Brown**, **Fenway**, or other LGBTQ+ centers around the country. You get to see many LGBTQ+ patients in a short amount of time which gives you exposure to a lot of different experiences of trans and queer people. Educating yourself is also important, and you can read books such as **Transgender Mental Health** by Eric Yarborough MD, or you can subscribe to LGBTQ+ mental health journals. Both of these are valuable ways to become informed and stay informed as the research gets updated.

Could you share any experiences in your career that were transformative for you?

The biggest change for me was the first APA conference I attended with AGLP. It taught me that there was a community out there, and I was not alone in being an LGBTQ psychiatrist and also in having a motivation to want to change

things for our patients and for us. The feeling that you're in this together is huge. Connection and community are the core of what we are talking about as a solution, so we need to do better for ourselves first and then for others. Psychiatry can be an isolating job, and these experiences help you learn a lot and have people relate to what you are going through. I was also on the board for GLMA, which further showed me there is a world out there of equity-minded healthcare providers and kept me motivated out there to keep doing this.

Is there anything else you are particularly passionate about at the moment?

Currently, the topic of Intimate Partner Violence is a passion of mine. With this book, we are making an appeal to people about how important this is. It isn't talked about enough, so I am very passionate about that. The next thing I want to write about is connection. The LGBT center grew out of an HIV clinic in the 1980s. It was largely males of a certain age who were diagnosed in the 80s and 90s. So, a lot of them are in their 60s and single, having lost their friends and partners in the epidemic. They aren't close with their families and are dealing with mental health problems. They are isolated and I think about how to help these people find a community. My sense of the research now is that while we are online more than ever but this does not replace real connection. There is no replacement for in-person communication. People don't make the effort to do this enough and we need to take inventory of our connections. We need to ask ourselves, are we doing a good job? Having a goal and a plan like a personal trainer would with our physical health and evaluating how well we are doing. Part of what I want to know is beyond people, what other connections help mental health, like spirituality and nature?

Any final thoughts for our readers?

Continue to be engaged as much as you can. To the extent that you don't like what is happening in psychiatry or the world, you can sit back and complain, or you can do something about it. You won't always win every fight, but in the end you can say you did what you could. If you don't achieve it, you can also pass the baton to the next person. I encourage everyone to make what they are envisioning in the world happen.

Lifestyle Psychiatry and Social Determinants of Mental Health Spotlight, an interview with **Gia Merlo, M.D. MBA, MEd**

By Elvis Gyan, PhD

Dr. Merlo is clinical professor of psychiatry at NYU Grossman School of Medicine, associate editor of the American Journal of Lifestyle Medicine, fellow of the American College of Lifestyle Medicine (ACLM) past chair of the Mental and Behavioral Health Member Interest Group, member of three committees in ACLM (Research, Climate Change, and Positive Psychology), contributing author to ACLM's board review course, and founding chair of the APA Caucus on Lifestyle Psychiatry and has recently been appointment chair of the APA Presidential Workgroup on Lifestyle Psychiatry. She recently published a general-audience book, **Restack: A New Approach to Dismantle the Blocks Holding You Back**. *In her new book Restack, Merlo urges us to embrace our humanness with our* **imperfections** *and provides tools and practical suggestions to Restack yourself in a way that is psychologically freeing.*

Additionally, Merlo has published three academic books (Oxford University Press and Taylor and Francis) including Lifestyle Psychiatry: Through the Lens of Behavioral Medicine expanding the area of Lifestyle Medicine to include social determinants of health, psychological principles and the bidirectionality of physical and mental health. Dr. Merlo completed her Master of Health Profession Education in the Research Track at Johns Hopkins University where she serves as an adjunct instructor helping other health professionals with their capstone projects.

How do you think lifestyle factors, such as diet and physical activity, intersect with social determinants like socioeconomic status in influencing mental health outcomes?

There are many intersections, and we must look at what social determinants of health are. I know your audience will know this, but I usually just talk about the nonmedical factors that affect health: physical and mental health. And I think that we, historically, as healthcare providers who are psychiatrists and focusing on mental health, are aware of that concept of a downward drift. So, for those of us who may have mental health issues, the larger proportion of people with mental health issues will go down in socioeconomic status, in their earning capacity, because of their burden of mental health and their struggles. And then we have this false sort of situation that happens that more people in the lower socioeconomic status may have more mental health issues.

Then, on the other side of the equation, we also see many people who are already living in a place where they are struggling with resources, as well as with mental health issues. We see both sides of the spectrum and must remember that. As a person who has worked in urban areas for many decades, I can attest that we see a lot of children also struggling because they have

been born into this environment where they have fewer resources in their communities. That does not mean that they do not have resources in their families. One of the parts I wrote in my recent book, "Restack: A New Approach to Dismantle the Blocks Holding You Back," is that family support when people have fewer financial resources is stronger. And it is a model in my world that families can support each other and communities.

It can go either way. The intersection is very wide and deep, and we need to be aware of it because often, as healthcare professionals we tell our patients to just do these lifestyle interventions. Just buy whole foods. But if you have a food desert in your community, you will not be able to. I have had families sitting in my office crying and saying, "it takes me three buses to go to a grocery store, which takes three hours a day. I am not doing that." So, what they do is they buy food where they are, and guess what? What they get is ultra-processed foods and foods that we would not consider healthy.

Can you describe a situation where you've addressed both lifestyle modifications and social determinants (e.g., housing stability, access to healthy foods) in the treatment plan for a patient with a mental health condition?

Let me tell you something that resonated with me and stuck with me for many decades. I am a child and adult psychiatrist, and I had a child patient come into my office, diagnosed with ADHD. It is a prevalent diagnosis. One in 10 or 12 kids will have that diagnosis. Many of them will be on stimulant medication. But this child came in because they were disruptive in the school, and here they were in my office. I found him to be a bright-eyed, positive child. His mother and his sister were sitting outside.

As a child psychiatrist, I always have snacks and healthy foods available as we cannot talk effectively if the child is hungry. If they are missing their snack, or if they are missing their dinner, or because they are in my office, right? It is just cruel and unusual punishment. So, I always have those available, and the first thing he did was go for that jar, and he looked at it. I could see him being very polite, just sitting and talking to me but staring. I said, "You know, let us have a snack before we get started." He looked at me and said, "Can my mom have one? Can my sister have one?" I said, "Of course." We went outside, and I could see that he wanted food for himself but wanted to give it to his mom and sister. Then he came back, and he sat down with me. It was my first meeting, and I started asking him questions as he ate his snack. I asked, "Is there snack time at home?" He says, "Oh, no, my family, we don't eat at home. That is not what we do. We are never hungry." And then I said, "Oh, you are never hungry?" and he says "No. That's not our thing." Then we went on and I asked what happened and why he was there. He says, "Let me lay it to you on the line. It is straightforward. The kid was trying to take my lunchbox and my food. I got the food from school, and if I hadn't fought him, he would have taken it, and I would not have eaten it. I was hungry then, so I would not have been able to eat it. And if I just let him go, it would have been the same problem. I would be expelled and not be able to eat. So, what do I have to lose? Let me fight him. I will get expelled anyway and unable to eat because I'm hungry at school." Instead of giving him a diagnosis of ADHD because he met all the criteria of that diagnosis, I went out into the waiting room and talked to the mother. We talked about resources, trying to get the resources she needed, and getting the other child the resources they needed because that is what they needed more than anything else.

In your experience, how does social support or social isolation, a key social determinant, impact the effectiveness of lifestyle interventions in managing mental health conditions?

It is absolutely important. Our surgeon general produced the loneliness epidemic, which was put out in 2023. It is a multi-100-page document that talks about social isolation as being pivotal in our health. One of the studies they cite talks about social determinants. Social isolation can be more deadly and cause more mortality than even smoking 15 cigarettes a day or having alcoholic beverages. Some data supports the idea that socialization is highly problematic for our under-resourced neighbors and partners. We find that if you are unhoused, that causes a severe problem because you do not have community support nearby. If you become incarcerated, lose your job, or cannot function in the environment and do not have those financial resources, then you lose all contact with people. There's housing insecurity and other aspects.

Once you start addressing those issues and getting people to connect again with community centers and other places, those resources can also support people. I know staying with families is sometimes hard if you have already moved away from them. However, creating social support can be pivotal. It is especially important because we sometimes lose our social connection, which could affect our ability to be cognitively and mentally healthy.

What strategies do you use to educate patients about lifestyle changes when they are also dealing with challenges related to social determinants, such as financial stress or lack of access to healthcare?

So financial stress is a severe problem. In how we function in healthcare, we have limited time to talk to and support our patients and their families, and it is a family issue. It is not a patient issue. We must get the family together, and one of the first things I do is ask if you can bring all the family members together or if we get them on the phone. Then, we talk to the family together. I need to know who a decision maker in the family is because sometimes they do not show up at the office. Who is the person earning money? Who is the person that's shopping? Who is the person that is paying the rent or wherever they are living?

At times, we arrange conference calls during the session. As a child psychiatrist, I understand the crucial role of family involvement. You can communicate with a child extensively, but the involvement of adults in their lives is indispensable. I follow the same approach as adults, ensuring their loved ones are engaged. Once you identify the decision-makers, you are conversing with individuals who can bring about positive changes in their families.

Afterward, it is helping them develop the resources and providing contact numbers to provide resources. They can get extra resources in every state in this country. In supporting patients, identifying where food banks are available is important. For example, people may not realize that some churches also have them; often, they are not advertised in the system. Financial stress is difficult, and you cannot talk about lifestyle first. You must address this. Lifestyle interventions will only happen after you address these issues.

How do you integrate an understanding of social determinants of mental health when recommending lifestyle interventions, ensuring that these recommendations are both practical and culturally sensitive for diverse patient populations?

That is important. I understand my job because I must ask more questions before discussing the interventions. Knowing who you are dealing with and what their cultural needs, biases, and belief systems are can be beneficial. Even after I ask questions, if there is a time limitation, I usually give two options and say, "If these don't work, what else do you think?" I engage my patients in the conversation because most patients come to us already thinking deeply about these issues. They are struggling in a significant way, and they know it. Ask them first what they have tried, what has worked, and what has yet to. Let them tell you. I cannot tell you how many families come to my office and say, “Thank you for understanding that I have tried it already. I may not have the financial resources. I may not be of your religion or the way that you think. But I do have my strengths in that area.” Another caveat is that cultural and religious diversity in families is important. Diverse groups believe there are ways to be an upright approach to health care. In medicine and medical school, they very, very rarely talk about those cultural diversities. It is becoming more common, but it is important for us to understand that even if we intervene if it does not fit into their cultural belief system, it is not going to be followed. Then, they will lose our trust in them, and we will, therefore, lose the ability to help them.

Any final comments you’d like to share?

I want to talk to you about this book that came out recently. In the lifestyle medicine movement, we often talk about six pillars of what we need to do in lifestyle psychiatry. The way that I conceptualized this book is for a general audience. I will first talk about the foundation of brain health. Then, I talk about mental blocks, and then I talk about external barriers before I talk about the solutions, because if we have internal mental blocks, trauma, issues with our emotional regulation, or cognitive deficits that are not allowing us to live life, and then we also have external barriers, that's where the social determinants of health and burnout come in. I focus heavily on this because the current approach to giving interventions to people without understanding that they are going to be ignored before we address all these issues is very problematic.

Even in our financially under-resourced populations, there will still be internal and external issues around these other internal barriers. We may address the social determinants of health, but we may still have these other issues.

Moore Equity RT on maternal mental health with Dr. Diana Ramos, Surgeon General of California

Advocacy in Action: An Update on Maternal Mental Health

"Advocacy in Action" supports the APA Board-Approved Recommendations on Strategic Planning that included "working to end disparities in mental healthcare" and "advocating for health equity and policies for undoing racism and discrimination within local, state, and federal government, and health professional organizations."

Through this section our goal is to bring to the forefront mental health equity legislation that you, our members, tirelessly advocate for to end disparities and attain mental health equity for all. For this quarter, we thank our Advocacy, Policy & Practice Advancement colleagues for their update focused on health equity and maternal mortality legislation.

APA recognizes and supports the use of inclusive language beyond "woman, mother or motherhood," for example, birthing persons or pregnant people. This article will be using the terms utilized in the legislation APA is currently advocating for, but APA supports the wider and ongoing discussion around gender equity.

As a core component of APA's advocacy strategy, promoting federal legislation that improves health and mental health outcomes for minority and underserved populations is central to combating the current lack of equitable healthcare available to all Americans.

Maternal mortality is a mental health issue, and legislative policies combating maternal mortality can directly increase health equity in the United States.

Over the past two decades, the maternal death rate in the United States has more than doubled. Underlying mental health conditions, including substance use disorders, are now the leading cause of maternal mortality and morbidity in the U.S. (as of 2021, 23%). One in five women will suffer from mental health conditions during pregnancy and the postpartum period, but only 25% of them will receive treatment. As a result of this and other barriers to care, the maternal mortality rate increased nearly 40% from 2020 to 2021 (23.8 to 32.9 deaths per 100,000 live births)

Currently, the maternal mortality rate is more than twice as high for Black women than non-Hispanic white women across all income levels and socioeconomic factors. Black mothers are twice as likely to experience maternal mental health conditions but half as likely to receive treatment. The risk of maternal mortality is 10 times higher in the U.S. than in comparable wealthy and democratic nations, and more than 20 times higher for Black and Native and Indigenous.

Maternal mental health conditions include anxiety and depression, PTSD, bipolar disorders, obsessive-compulsive conditions, and substance use disorders, among others. Untreated maternal MH/SUD is associated with high-risk pregnancy and a range of negative outcomes for the pregnant person and their offspring, including spontaneous abortions, fetal distress, preterm birth, and negative neurodevelopmental trajectory. Yet, pregnant persons are often considered "therapeutic orphans" due to low rates of psychiatric treatment and a lack of research on best practices.

These negative health outcomes and the strong economic case to address maternal mental health drive bipartisan efforts to address this crisis. Maternal morbidity across all U.S. births in 2019 alone cost America an estimated $32.3 billion (extending from pregnancy through the child's fifth birthday). The conditions with the largest costs were maternal mental health conditions at $18.1 billion. The cost of untreated maternal mental health per mother-child pair is $32,000.

APA supports addressing maternal mortality as a key component of improving mental health equity. Last year during the APA Federal Advocacy Conference, Dr. Dionne Hart and Dr. Regina James presented a session with Government Relations titled "Health Equity: Maternal Mortality and Maternal Mental Health." This was an opportunity for members to receive facts and figures, an overview of the federal legislative landscape and bills, a clinical perspective on how it impacts the patients we serve, and a congressional meeting how-to. Approximately 150 APA members were in attendance and participated in this hands-on session.

The current 118th Congress continues to advance important policies to tackle American maternal mortality and perinatal mental healthcare access. There is bipartisan support for legislation to address the maternal care crisis, including several bills endorsed and advocated for by APA.

The Preventing Maternal Deaths Reauthorization Act (H.R.3838/S.2415), introduced by representatives Michael Burgess (R-TX), Robin Kelly (D-IL), Buddy Carter (R-GA), Diana DeGette (D-CO), Kat Cammack (R-FL), and Kathy Castor (D-FL), and by senators Shelley Moore Capito (R-WV) and Raphael Warnock (D-GA), has passed the House and awaits a full floor vote in the Senate where it has strong support. The legislation ensures continued support for state maternal mortality review committees (MMRCs) examining pregnancy-related deaths and promotes disseminating best practices to providers. MMRCs are multidisciplinary committees that convene at the state or local level to comprehensively review deaths that occur during or within a year of pregnancy (pregnancy-associated deaths). They are vitally important to help Congress and Americans understand the size and scope of the current maternal mortality crisis.

Take action and urge the Senate to pass this bill into law! Click Here

Fiscal Year 2025 (FY25) federal appropriations for maternal health programs have also seen historic increases due to advocacy on and support for addressing this issue. Despite political turmoil, existing programs like the Maternal Mental Health Hotline and new programs designed to address maternal mental health conditions have been included in both Republican and Democratic proposals for federal funding.

As part of APA's advocacy on these issues, in 2023 APA hosted a briefing on Capitol Hill to educate congressional members and staffers on "Maternal Mortality and the Mental Health Crisis." In collaboration with the offices of representatives Lauren Underwood and Robin Kelly, it focused

on the above legislative initiatives to confront the crisis and included APA members as expert panelists. That event also highlighted APA's **Maternal Mental Health White Paper and Toolkit** developed in partnership with the CDC Foundation. Beyond this one event, APA members have also served on related panels and forums to lead the conversation on this issue, such as through the **APA Looking Beyond webinar series**.

APA continues to work with congressional champions and partners across the mental health, maternal health, and house of medicine to support these key programs. As Congress moves through a contentious election cycle, it is affirming to see maternal mortality and mental health equity as an area of bipartisan support. Such efforts are currently buoyed by the Biden administration, as the White House has built out supportive actions within agencies through the Biden-Harris **Blueprint for Addressing the Maternal Health Crisis**. APA remains committed to advocating for increased health equity through maternal mortality and other equally vital policies as the political landscape evolves.

Visit APA's 2024 Election Resource Center at **https://www.psychiatry.org/psychiatrists/advocacy/election-resource-center.**

The 4th Annual APA MOORE Equity in Mental Health Initiative

By Fátima Reynolds, MPH

On June 14th APA got an early start with the Moore Equity Initiaitve by kicking off with the first roundtable titled **Combating the Nationwide LGBTQI+ Youth Mental Health Crisis**. The panel included **Tami D. Benton, M.D**. (President, American Academy of Child and Adolescent Psychiatry), **Shamieka Virella Dixon, M.D.** (Division Chief of Adolescent Medicine, Levine Children's Hospital), and **Roberta Laguerre-Frederique, M.D.** (Director of Prevention & Outreach Services, St. Christopher's Hospital for Children) and moderated by **Regina S. James, M.D.** (Deputy Medical Director & Chief of the Division of Diversity and Health Equity, American Psychiatric Association), The discussion focused on the contributing factors to the LGBTQ+ youth of color suicide crisis, and emphasized the importance of education, outreach, and advocacy in addressing these challenges. Attendees left equipped with effective strategies to support LGBTQI+ youth and promote a more inclusive environment that prioritizes their mental health and well-being, reinforcing a collective commitment to combating this pressing public health emergency.

The next roundtable hosted on August 1st, featured a fireside chat with the U.S. Department of Labor's Assistant Secretary for Employee Benefits Security, **Lisa M. Gomez, J.D.**, who shared her insight on how the U.S. department of labor can support the mental health of young people and equip the workforce system with resources and connections to ensure that youth employment programs are a bridge to the wellness services young people need.

The final roundtable: Closing the Wide Racial Schizophrenia-Spectrum Disorder Diagnosis on Youth of Color on August 19th featured panelists, **Gemma Espejo, M.D.** (Assistant Professor of Psychiatry and Human Behavior, University of California), **Adrian Preda, M.D. DFAPA** (Editor in Chief, Psychiatric News), **Nitin Gogtay, M.D.** (Deputy Medical Director and Chief of the Division of Research, APA). The discussion focused on barriers and challenges for childhood schizophrenia and youth mental health grounded in principles of racial equity and the role of power and privilege in the perpetuation of mental health inequities.

Following the virtual offerings, the community-based activities launched on July 20th with APA's seminal event the **5K Run, Walk and Roll** at Wheaton Regional Park. In its fourth year, the event seeks to bring more awareness to mental health inequities facing young people of color and honor mental health equity advocate Bebe Moore

Campbell. A hearty congratulations goes to the top 3 fundraising teams this year: **The Caucus of Black Psychiatrists** ($10,830), **Caucus of American Indian, Alaskan Native, Native Hawaiian Psychiatrists** ($$9,030) and **MAYO Psych IDEA Team** ($3,825). Altogether, participants, including APA member psychiatrists and their teams raised $77,429 which will be awarded to non-profits applying for **APA community grants**. This grant program supports organizations that deliver innovative programming, promote awarenes, increase equitable access or enhance the quality of culturally and linguistically appropriate mental health services.

On Wednesday July 24th, the second annual **Mental Health Youth Summit** took place in partnership with **Marion Barry Youth Leadership Institute** The event kicked off with 400 youth in attendance and showcased various speakers including APA CEO and Medical Director, **Dr. Marketa Wills**, and one of our partners from the JED Foundation, **Dr. Zainab Okolo**. Smaller group sessions hosted by **SchoolTalk DC** and WISE Center, equipped youth with conflict resolution skills, mindfulness techniques and information on the impact of trauma on the brain.

On Saturday, September 14th, community members gathered at Virginia Commonwealth University's Mary and Frances Youth Center for the third annual **Moore Equity in Mental Health Community Fair**, as the final event. The health fair was free to the community and aimed to connect Richmond residents with vital mental health resources, while also providing a day of family fun. Attendees

enjoyed a variety of engaging activities, including an interactive workshop on creating a mental health coping toolbox hosted by **LeTeisha Gordon** from **A Better Day Than Yesterday**, an informational session from local psychiatrist **Dr. Sherin Moideen**, member of the **Psychiatric Society of Virginia** and a jump rope contest hosted by **Dr. Jay Barnett**, the initiative's grand marshal. The mental health fair not only served as an informative hub for mental health services but also as a celebration of community spirit and resilience, showcasing performances by All Star Stomp n Shake cheer-leading squad composed of youth groups of various ages and led by coach Shaia Scott.

Experts were on hand to answer questions, share resources, and connect individuals with support systems tailored to their needs, such as the local food bank *Feed More, the National Hispanic Medical Association* and the VCU student group involved in spreading awareness around mental health and suicide prevention: *Golden Rams*.

The APA's MOORE Initiative continues to be a beacon for mental health awareness, emphasizing equity and access to care. With each passing year, the event amplifies different community resources, reflecting each location's commitment to improving mental health support for all. Learn more about the Initiative **here**.

Integrating Mental Health Care Into Disaster Recovery Efforts

By Madonna Delfish, MPH

This past May, the National Oceanic and Atmospheric Administration (NOAA) forecasted an above-normal 2024 Atlantic hurricane season, predicting between 17 to 25 named storms.[1] Hurricane Beryl, the first major hurricane of the season and the earliest Category 4 storm, made an unusually early appearance this year, unleashing relentless destruction in its wake. The Eastern Caribbean, particularly the Grenadines, bore the brunt of this catastrophic event, suffering extensive damage across the region. As the season progresses and storms continue to intensify, the looming threat of further tragedy and loss remains ever-present.

Natural disasters like hurricanes often leave behind more than physical devastation, while homes, schools, and entire communities are left in ruins. The psychological impact of such events can endure long after the debris has been cleared, affecting the mental health of survivors for months or even years after the disaster.[2,3]

In an effort to address the psychological aftermath of Hurricane Beryl, APA coordinated a training session focused on Psychological First Aid, with particular emphasis on perinatal mental health and substance use considerations. This collaborative effort, organized in conjunction with the Grenada Planned Parenthood Association was led by esteemed APA member Dr. Denis Antoine, aimed to equip local mental health providers with the tools necessary to support those most impacted by the hurricane.

Dr. Antoine facilitated a two-hour training session for community mental health professionals in Grenada, preparing them to be deployed to one of the hardest-hit areas in the wake of Hurricane Beryl. This initiative ensured that those on the front lines were not only prepared to address the physical needs of survivors but also equipped to provide crucial mental health support—particularly for vulnerable populations such as pregnant women and individuals with substance use disorders.

In situations like this, the significance of integrating psychological care into disaster recovery efforts cannot be overstated—the APA's Disaster Mental Health page offers valuable resources and educational opportunities. to learn more visit: **www.psychiatry.org/psychiatrists/practice/professional-interests/disaster-and-trauma**

Additional Resources:

APA Looking Beyond Webinar: Climate Change-Driven Mental Health Inequities

https://store.samhsa.gov/product/tips-survivors-disaster-or-other-traumatic-event-managing-stress/sma13-4776

https://www.samhsa.gov/resource/dbhis/cultural-competency-program-disaster-emergency-management

https://mdpsych.org/resources/disaster-psychiatry/

https://www.redcross.org/get-help/disaster-relief-and-recovery-services/recovering-emotionally.html

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Preparing A Pathway for Future Psychiatrists

By Jordan Brown

Members of the American Psychiatric Association (APA) are investing in the future of psychiatry through quality patient care and thought leadership, but did you know they are also investing in young academics interested in pursuing psychiatry? For five decades, APA has been a grantee of the Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship (MFP). This program has provided a platform for many APA members to engage with and provide mentorship to these future leaders in psychiatry. Over the past two years, APA has introduced new pathways for future leaders: the Summer Medical Student Program (SMSP) and the Future Leaders of Psychiatry Program (FLIPP), which target interested medical students and undergraduates, respectively. These two components of SAMHSA MFP have had positive impact on more than 150 young academics.

In 2023, we recruited APA members from around the nation to be mentors for these undergraduate and medical students. Our participants specifically asked for psychiatrists who come from similar ethnic and cultural backgrounds - and many members answered the call, including Dr. Luis Torres, Dr. Jonathan Shepherd, and Dr. Aashima Sarin. In 2024, we added talks on reproductive (by Dr. Jennifer Okwerekwu), correctional (by Jerome Greenfield), and emergency (by Meaghan Schott) psychiatry to SMSP based on feedback from our cohorts.

Additionally, this year, we piloted our Future Leaders Academy for our undergraduate program (Future Leaders in Psychiatry Program – FLIPP) in the greater Los Angeles area. This academy featured inspirational presentations by Drs. Eraka Bath, Daniel Cho, Lisa Fortuna, Ippolytos Kalofonos, Sheryl Kataoka, and Peter Ureste. Students had the opportunity to share lunch with Dr. Deborah Deas, the Mark and Pam Rubin dean of the School of Medicine, vice chancellor for health sciences and distinguished professor of psychiatry at the University of California, Riverside. The APA SAMHSA MFP components are working to ensure that a pathway is built to bring awareness and education to future psychiatrists who can contribute to reducing mental health disparities and improving behavioral health outcomes for underserved racial and ethnic populations.

We invite all APA members that wish to support our SAMHSA MFP components (psychiatry fellows, medical students and undergraduates) to become a program speaker. Please **click here** to express your interest. We would like to thank the APA members and partners that delivered sessions and were mentors to future leaders. Together we can achieve mental health equity by investing in our future leaders of psychiatry.

Culture Corner: Traditional Chinese Medicine

By Madonna Delfish, MPH

Traditional Chinese Medicine (TCM) provides an excellent complementary alternative to contemporary treatments for physical and mental health needs. Integrating TCM with modern healthcare enriches the available treatment options and aligns with the shift towards a more holistic and integrated approach to care1; this cultural blend enhances the healing process, combining time-tested methods with current medical advancements.

One of the standout practices in TCM is Qigong, pronounced (Chee Gong), a traditional Chinese health practice that uses slow movement, meditation, and breath regulation to enhance mental wellness and reduce psychological symptoms like depression and anxiety[2]. Research has shown that Qigong can promote relaxation and reduce stress by calming the mind and regulating the nervous system. The slow, flowing movements combined with deep breathing help to release tension and foster a sense of calmness[3]. By focusing on the breath and movement, practitioners can achieve a meditative state that helps quiet the mind and reduce the effects of stress.

Regular practice of Qigong can help improve emotional well-being by enhancing self-awareness and fostering a sense of inner peace. It can also help reduce feelings of anxiety, depression, and mood swings. This practice can help patients develop a stronger mind-body connection, leading to greater awareness of how thoughts and emotions affect the body and enhancing feelings of self-efficacy and well-being.

Qigong is accessible to people of all ages and fitness levels, making it an excellent addition to any wellness regimen. Its gentle movements and meditative components make it suitable for individuals with varying physical abilities and health conditions.

Want to learn more about how to start a Qigong practice? **Click here**

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