Welcome from the APAHC President!

Back in March 2011, I attended my first APAHC conference. Nobody suggested that I go and nobody I knew was going. I’m not quite sure why I signed up, but I was intrigued at the prospect of participating in a boot camp of other early career psychologists trying to navigate life in an academic health center. In retrospect, it was one of the best professional decisions in my life. Flash forward 8 years, with service on the Board of Directors in various roles, it’s a bit surreal to realize that my 2-year term as APAHC President is coming to an end this calendar year.

The Grand Rounds is absolutely one of the reasons I will remain connected to this organization. Of all the professional publications I receive, it is one of the few that I read cover to cover. That’s not only a testament to great content and editing, but also a statement of how vital I find APAHC to be to my professional identity. Clearly I’m not the only one who thinks so: our membership has grown significantly, our biennial conference in New Orleans earlier this year was very well reviewed, our listserv remains one of the best “hive minds” in our field, and our membership roster reads like a who’s who in health, pediatric, rehabilitation, and clinical psychology. And yet somehow, through all the superlatives, we have built an association that gets described as one of the most friendly and collegial out there.

It has been a real honor to work with our outstanding Board and to get to know so many of you in the process. I hope you enjoy the latest issue of our newsletter. As always, we look forward to your input and engagement.

Zeeshan Butt, PhD
President, APAHC

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- Social media and research
- Lessons learned in advocacy: Cultural considerations for American Indian suicide
- Behavioral Health services in Pediatric subspecialties
- APA conference photos
- CFAS corner
- Board election results
Letter from the Guest Editor

I am honored to have been asked to be the guest editor for the fall 2019 Grand Rounds newsletter. I joined a fantastic team (your Grand Rounds Editor-In-Chief, Lauren Penwell-Waines) and received top-notch technical support from Andrea Garroway, who made this an easy-on-the-eyes publication.

What an interesting series of articles we have to share with you in this Grand Rounds. All align with the current APA focus on advancing psychology in order to benefit society and improve people’s lives. We feature the APAHC presence at the most recent APA conference and our reoccurring CFAS Corner from Laura Shaffer & Bill Robiner. We also feature an international team examining social media use and early career psychologists with great insights into research and clinical practice.

Our first article elaborates on a topic we all need to be discussing – social media presence. 42% of the current worldwide population (about 3.2 billion people; Emarsys, 2019) is using social media so whether you are a fan or a foe, it is time to learn more about it. Nicole MacKenzie, Perri Tutelman, Yvonne Brandelli, and Christine Chambers teach us about how to use social media to promote our work and how they have elevated attention to “It Doesn’t Have to Hurt,” a campaign to disseminate information about pediatric pain management strategies.

Our second article highlights three critical areas that should be on all of our radars: championing evidence-based treatment of diverse groups, forming community relationships, and advocating for improved suicide management. Sarah Rhoades-Kerswill and Ashley Cole, two ECPs from Oklahoma, share with us their vast knowledge on best-practices concerning American Indian suicide research, prevention, and treatment.

Lastly, Sasha Jaquez shared her experience in integrative behavioral health care and how to set-up a new team and psychology presence in a subspecialty pediatric clinic. Given the importance of psychology partnering with our medical colleagues, this is a can’t miss article.

As psychologists in academic health centers, we can lend our voices to advocating for those who are misunderstood and under-represented and can spread the evidence-based knowledge we have to our medical colleagues and to the public. What an incredible mission for us all to get behind and advance within our own institutions!

Lauren will be back in the editorial chair for your next Grand Rounds, and I know she is always on the look-out for your contributions. If you are part of a program, clinic, or research team APAHC members should know about, contact Lauren to discuss being included in the next newsletter.

~ Ashley Junghans-Rutelonis, PhD; Guest Editor

Sound Bites Related to the Newsletter:

*3.2 billion social media users with average of 2 hours, 22 minutes per day spent on social networks or messaging
*Twitter estimates an average 30 million active monthly users
*60% of doctors see social media as a way to deliver better healthcare to patients & 88% of healthcare providers use social media/internet to research new medical information
*30,000 suicide death annually in the U.S. and ~ 1 million worldwide
*2,000 middle schoolers who experienced cyberbullying were ~ 2 x as likely to attempt suicide.
*The National Suicide Prevention Lifeline’s website/social platform features animated avatars in conjunction with survivor stories. https://suicidepreventionlifeline.org/
*Incidence rate of 30% and 60% of mental health disorders among pediatric dermatology patients
*75% of youth diagnosed with a mental health disorder are seen in a primary care setting
Social media are defined as internet-based tools that allow individuals to connect and communicate with other people and communities. Popular social media platforms where researchers commonly communicate, including Twitter, Facebook, LinkedIn, ResearchGate, and YouTube, can provide an accessible platform to stay up to date with new research, while also facilitating communication with colleagues and the public. With the ease of use, accessibility, and interactive nature of social media, its benefits can be easily harnessed and applied to the field of psychological research. Social media not only provides a platform from which psychological researchers can disseminate findings in psychological research, but also provides a simple platform from which to engage other researchers and knowledge users. In this article, we review the unique ways in which researchers in psychology can communicate, share information, and expand their professional reach via use of social media.

Expanding Professional Reach in Research through Social Media

Social media provides an opportunity to engage with the broader academic community, patients, caregivers, and advocacy groups. While research findings are traditionally disseminated at conferences or via publications, social media presents the unique opportunity to connect with an audience who would be less accessible through traditional means. Social media also provides an interactive space to share research and converse with others in an accessible forum. For example, Facebook is most commonly used to engage knowledge users in research, whereas Twitter is most popular for reporting research findings and promoting academic work (Dol et al., 2019). This knowledge-sharing environment has been shown to facilitate the exchange of high-quality information, allowing researchers and health care providers to make informed practice decisions (Rolls, Hansen, Jackson, & Elliott, 2016).

Social media is also a unique platform by which researchers can network with existing and new colleagues.

Social networks such as LinkedIn also provide a platform by which users can connect to consult or share expertise, and use of such a network may present opportunities for speaking or publication opportunities (Tutelman, Dol, Tougas, & Chambers, 2018). Social media presents many avenues by which researchers and health care providers can engage with colleagues and the public to promote existing and ongoing research. Engagement with these groups not only facilitates an opportunity to network with a diverse group of individuals but provides a low-barrier option to connect with individuals who may not have access to research through traditional means.

Opportunities for engagement using social media extend into use as a recruitment tool for research studies. Research has also shown social media platforms such as Facebook to be a cost-effective method to recruit a diverse patient group (Akard, Wray, & Gilmer, 2015). Recruitment via social media can be beneficial when researchers have connections with specific individuals and organizations, particularly when trying to recruit a specific (and potentially hard to reach) population.

(Continued on page 4)
Finally, social media recruitment also offers the option of paid advertisements, where ads can be targeted toward the demographic of interest.

**Social Media for Research Dissemination**

Scientific output is growing at an exponential rate; as of 2009 there were over 50 million published scientific articles with an estimated 2.5 million additional new articles published each year (Jinha, 2010). Social media has emerged as a key tool to help scientists increase the visibility of their research, to keep up to date with the latest advances in their fields (Dol et al., 2019), as well as to influence policy (King, Schneer, & White, 2017). The digital impact of a published article can be measured using alternative metrics (“Altmetrics”). Altmetric scores provide information about the who, what, where and when of how scholarly output is being shared online and are increasingly used in tandem with more traditional citation metrics (such as impact factors, h-indices etc.) to quantify scholarly impact (Gordon, Lin, Cave, & Dandrea, 2015). Scientists can track the Altmetric scores for any scholarly output with a digital object identifier using the free Altmetric Bookmark tool.

Many journals in the medical sciences (e.g., Annals of Surgery, BMJ, JAMA, NEJM) have now implemented “visual abstracts” in the online dissemination of new research articles. Visual abstracts are simple graphic depictions of the key findings or topics covered in the article and may be created by the journal, by the authors, or as a collaboration between the two (see Figure 1 for an example). A recent study compared the impact of tweets from a journal Twitter account that included either only the title of the article versus tweets that contained the title and a visual abstract. Over a 5-month period, tweets with visual abstracts had significantly higher impressions (i.e., views), shares, and article visits on the publishers’ website (Ibrahim, Lillemoe, Klingensmith, & Dimick, 2017). Resources for scientists interested in creating visual abstracts for their publications have been developed (Nikolian & Ibrahim, 2017).

Social media activities have become increasingly important for scientific impact in academia. For instance, there is a developing evidence base that suggests a relationship between the dissemination of research articles over social media (including Altmetrics scores) and traditional measures of scholarly performance, such as views, downloads, and citations (Allen, Stanton, Di Pietro, & Moseley, 2013; Eysenbach, 2011; Hayon et al., 2019; Lamb, Gilbert, & Ford, 2018); some studies have produced mixed findings regarding the impact of citation rates, and more longer-term comprehensive studies are needed (Tonia, Van Oyen, Berger, Schindler, & Künzli, 2016)). Social media activities are also playing a role in

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*Figure 1. An example of a visual abstract (Tutelman et al., 2018).*
academics’ promotion and tenure (Cabrera, Roy, & Chisolm, 2018; Moher et al., 2018). In 2016 the American Sociological Association recommended that professors’ social media presence should contribute to decisions regarding promotion and tenure (McCall, Smith-Doerr, & Lamont, 2016), and since then, other scientific organizations have followed suit (e.g., American Anthropological Association, 2017). The Mayo Clinic recently amended their criteria for academic advancement to include social media and digital activities (Cabrera, 2016), and it is likely that many more academic institutions will consider social media activities and public engagement as part of formal promotion and tenure evaluations in the near future. Cabrera and colleagues provide an outline and best practice recommendations for developing social media portfolios for promotion and tenure (Cabrera et al., 2017).

**Building a Social Media Profile**

Given the diversity of social media outlets and the various reasons for engagement, building a professional online profile may seem like a daunting task. Below are some suggestions for those building and developing their social media presence.

Prior to building a professional online profile, it is recommended one consult with their ethical principles and institutional policies. Various organizations have created “best practice” recommendations for online presence and social media use, including the American Psychological Association and the American Medical Association (American Medical Association, n.d.; Lannin & Scott, 2014; Tutelman et al., 2018), including setting privacy restrictions and using pseudonyms on personal accounts (Lannin & Scott, 2013), and including conversations about online boundaries with clients as a part of the informed consent process (Tunick, Mednick, & Conroy, 2011).

To maximize one’s social media engagement, it is recommended that one personalize their content (i.e., reduce the formality and target the interest of the intended audience), present it in a captivating way (i.e., use hashtags to categorize the topic, including visuals, links, and threads when appropriate; Côté & Darling, 2018), and participate (i.e., start or join conversations within one’s network; Center for Disease Control and Prevention, 2011). Furthermore, it is important to post regularly to build one’s social media presence.

**Personalize**

**Present**

**Participate**

A recent study by Côté and Darling (2018) found researchers are largely followed by other researchers on Twitter, at least until the 1000 follower mark, wherein the audience becomes more varied (i.e., general public, policy makers). In order to reach those diverse samples, it is thus important to continuously nurture one’s social media presence. How-to guides and articles exist that detail effective strategies for writing posts and using social media as a research tool (American Psychological Association, 2010; Center for Disease Control and Prevention, 2011; Kosinski, Matz, Gosling, Popov, & Stillwell, 2015; Tutelman et al., 2018). Similarly, tools exist that can help researchers determine the most relevant hashtags for their message. For instance, Symplur has developed the Healthcare Hashtag Project, which provides a platform to connect researchers, [https://www.symplur.com/healthcare-hashtags](https://www.symplur.com/healthcare-hashtags)
Research and retweets: Using social media to promote research, collaboration, and connections in psychology

(Continued from page 5)

clinicians, and the public to relevant healthcare conversations².

Another way to engage and build one’s reach is to live tweet at conferences using designated conference hashtags (e.g., #APAHC2019). Not only does this promote networking with other attendees, it also helps disseminate conference content beyond the physical walls of the meeting. As an example, Collins and colleagues (Collins, Shiffman, & Rock, 2016) found that 74% of scientists had participated in a conference remotely via Twitter. Another avenue for engagement are Twitter chats. These are moderated online events organized around a particular topic and accessed by a specific hashtag, where researchers, clinicians, and often patients gather virtually to discuss a topic in real time using a pre-specified hashtag (e.g., #ThisIsHealthPsych). One way to learn about upcoming Twitter chats is to visit Symplur, the online social media healthcare-related database.

Examples of the Integration of Psychological Research and Social Media

Social media also has been used as a successful medium for knowledge translation. Dr. Christine Chambers’ lab, at Dalhousie University, successfully created and launched a social media campaign known as It Doesn’t Have to Hurt (#IDHTH). Evidence-based pain management strategies were written up in terms which were easy for parents to understand, and disseminated through social media accounts. #IDHTH partnered with Yummy Mummy Club, a social media and blog site for parents, and shared research on pain management for children through tweets.

Facebook posts, and blog posts, using the hashtag #ItDontsHaveToHurt (see Figure 2). This hashtag has now become associated with evidence-based information on pain management for children and was a successful enterprise in sharing health psychology research with other professionals, academics, and parents alike. Growing from this initiative, Dr. Chambers has also recently begun a national knowledge mobilization network, Solutions for Kids in Pain (SKIP) with the mission to improve children’s pain management by mobilizing evidence-based solutions by sharing existing evidence through coordination and collaboration, with social media as an outreach method.

As the scientific community continues to grow online, it is critical for researchers to consider their place in the social media landscape. The medium not only provides rich opportunity to disseminate research and promote one’s own work, but also facilitates a space where colleagues can connect and collaborate easily and remotely.

Figure 2. A social media post from the #ItDoesntHaveToHurt campaign.
Laura Shaffer, PhD
President-Elect
University of Virginia

Amy Williams, PhD
Member-At-Large
Wayne State University
School of Medicine

Elizabeth Cash, PhD
Secretary
University of Louisville
School of Medicine

Donna LaPaglia, PsyD
Division 12 Representative
Yale University School of Medicine

Board Election Results
Terms Begin January 2020
CFAS Corner

Laura Shaffer, PhD, & Bill Robiner, PhD, APAHC CFAS Representatives
University of Virginia School of Medicine; University of Minnesota Medical School

The last CFAS Corner discussed the CFAS News APAHC listserv members are forwarded every week. This edition provides context for that newsletter by giving an overview of CFAS and APAHC’s involvement which is essentially Psychology’s one official presence in a national academic medicine organization.

The Council of Faculty and Academic Societies (CFAS) is one of three governing councils of the Association of American Medical Colleges (AAMC). There are approximately 350 representatives appointed by approximately 171 medical schools and 75 academic health professional societies, APAHC among them. Medical schools and faculty organizations can each appoint two faculty representatives. APAHC is the only CFAS member society representing psychologists. More information about CFAS and APAHC’s involvement is available in Cubic and Shaffer (2017).

**CFAS’s charge is threefold:**

1) identify issues critical to faculty in medical schools
2) provide a voice concerning these issues to the AAMC to inform programs, services, and policies
3) communicate back to faculty about matters central to academic medicine and at the forefront of work at the AAMC.

**Meeting Attendance.** Dr. Laura Shaffer attended the CFAS Spring Meeting in Atlanta where she and APAHC colleague Dr. Serina Neuman gave highly rated presentations on mentoring targets of sexual harassment and gender-related macroaggressions, respectively. Both of APAHC’s representatives, Drs. Robiner and Shaffer, will attend the AAMC Learn, Serve, Lead meeting this November. They will present a poster abstract with Drs. Wendy Ward and Liz Cash on leadership roles and training needs of women psychologists in academic health centers.

**AAMC Leadership Forum.** Each June, the AAMC invites approximately 100 stakeholders to attend a forum concerning a critical issue affecting the academic medical community. Dr. Shaffer attended the 2019 Leadership Forum entitled **Reaffirming Our Commitment to Ending Gender Harassment in Academic Medicine** as one of five faculty invited to represent CFAS. The forum included sessions on gender inequities in academic medicine, allyship, organizational challenges and accountability, bystander intervention, promoting culture change, and efforts at the AAMC to address gender harassment and equity in medical schools throughout the United States.

**CFAS Service.** Beyond networking and contributing to discussions at meetings, APAHC representatives serve on CFAS subcommittees including the Faculty Resilience and Evaluation subcommittees. Dr. Shaffer is also an appointed member of the Program subcommittee and was invited to be an abstract reviewer for Learn, Serve, Lead.

**Letter Sign-Ons.** The AAMC extends invitations through CFAS to APAHC and other society members to sign on to advocacy letters. Examples of causes APAHC has supported to date include recommendations for increased NIH funding and opposition to budget cuts to NIH support for Finance and Accounting (F&A a.k.a. indirect) costs. Another example of an opportunity to sign on was in support of the American Dream and Promise Act of 2019 (H.R. 6) or the Dream Act of 2019 (S.874) to ensure that members of the health care workforce approved for DACA and other undocumented young people are able to continue their employment, training, and research in the health professions. APAHC leadership and CFAS reps met with representatives from APA in September to develop a system for consultation regarding how to handle future requests.

We hope this helps you better understand what we are up to as your representatives and the opportunities we have to raise the voices of psychologists in academic health centers. Please let us keep hearing from you!

Who are American Indians?

It is first important to define and contextualize American Indians. Many different names have been used to describe the original inhabitants of the North American continent, including American Indian, Native American, First Nations, Native Peoples, Aboriginal, and Indigenous. We use American Indian (AI) throughout, which is the term that was selected by the National Congress of American Indians in 1944 (NCAI, 2019). Currently, there are 2.7 million (0.8% of the U.S. population) individuals in the U.S. who exclusively identify as AI, and 5.2 million (1.7% of the U.S. population) individuals when allowing for multiracial identification (Census, 2017). Currently, there are 573 federally recognized tribes in the U.S. (BIA, 2019); thus, AIs are not a homogenous group or culture. Furthermore, not all tribes or nations are recognized by the federal government. Some tribes are recognized by state governments, whereas other tribes exist as cultural entities without government recognition. AIs also have distinct, rich cultures with unique perspectives on the human experience and ways of relating with the world. While we discuss suicide and associated risk factors, we also wish to impart knowledge of AI resiliency and strengths. Each AI person living today has survived in spite of generations of violence, trauma, and governmental policies aimed at ending the AI way of life. Hence, the intergenerational transmission of resilience among AI peoples is strong.

Trends in AI Suicide Rates

Historically, suicide was rare in AI communities prior to European contact (Kirmayer, 1994). It can be difficult to obtain accurate estimates of contemporary suicide rates for AIs because they are often misclassified as other ethnic/racial groups (Arias, Heron, & Hakes, 2016). Of the available national statistics, the crude rate for suicide deaths among AIs across age is 13.65 per 100,000 (CDC, 2017). A closer examination reveals that AI young adults are disproportionately affected by suicide, and the crude rate for suicide deaths is 24.28 per 100,000 among AI young adults ages 15-34 years (CDC, 2017). Using the National Violent Death Reporting System (NVDRS) data, approximately 10% of AI suicide deaths occur among those between the ages 10-17 and 26% occur among those between the ages 18-24 (Leavitt et al., 2018). AIs are nearly twice as likely to die by suicide compared to non-Hispanic White (NHW) counterparts (Leavitt et al., 2018). AIs are also less likely to be in current or previous mental health treatment compared to NHWs (Leavitt et al., 2018). The reasons why AIs, particularly AI young adults, are disproportionately affected by suicide...
involve an understanding of risk factors.

**Suicide Risk Factors**

As is the case in general populations, empirical work has identified the following risk factors for suicide in AI communities: previous suicidal behavior, poverty, being un- or under-employed, rural settings, substance use, and feelings of not belonging (Alcántara & Gone, 2007; O’Keefe, Tucker, Cole, Hollingsworth, & Wingate, 2018; Walters, Simoni, & Evans-Campbell, 2002). Among AIs, historical trauma (also known as *historical loss*, *historical grief*, and *intergenerational trauma*) has been identified as a unique contributor to suicide risk (Gone, 2009; Walters et al., 2002; Whitbeck, Adams, Hoyt, & Chen, 2004). Historical trauma entails cumulative psychological distress experienced across generations resulting from massive group traumatic experiences, including genocide, forced relocation, and forced assimilation of AI peoples (Brave Heart, 1999a, 1999b). Similar to other forms of trauma, historical trauma has been associated with increased stress, and alcohol and substance use (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015; Wiechelt, Gryczynski, Johnson, & Caldwell, 2012).

Mental health research would be remiss to exclude the effects of historical trauma. Research has linked historical trauma with increased depressive symptoms and suicidal thinking for AIs (Tucker, Wingate, & O’Keefe, 2016; Tucker, Wingate, O’Keefe, Hollingsworth, & Cole, 2016). Tucker and colleagues (2016) demonstrated that having a strong ethnic identity and preferring to socialize with other AIs were each indirectly associated with increased depressive symptoms through increased historical loss thinking among AI young adults. In a follow-up study, Tucker and colleagues (2016) demonstrated that historical loss thinking indirectly influenced suicidal ideation through increased rumination in AI young adults. Collectively, these findings indicate that historical trauma negatively impacts mental health for AI young adults. It is imperative that AI suicide prevention programs include cultural components, such as historical trauma.

“Mental health research would be remiss to exclude the effects of historical trauma.”

**Culturally Relevant Suicide Prevention and Intervention Efforts**

While suicide rates in AIs have increased over time, few evidenced-based suicide interventions and treatments exist. Below, we discuss three culturally-focused interventions/treatments to address suicide in AI communities.

The American Indian Life Skills (AILS) curriculum is a widely known suicide prevention program for AIs (T. LaFromboise & Howard-Pitney, 1995). This curriculum uses a social-cognitive and stress coping model to address avoidant styles of coping. The program is school-based and includes versions for middle school and high school students (T. LaFromboise & Howard-Pitney, 1995). Originally developed with Zuni youth, AILS has been expanded to 56 lessons that can be tailored to each school and/or tribe. AILS focuses on seven core elements: building self-esteem, emotions and stress, effective communication and problem-solving, recognition and elimination of self-destructive behavior, understanding why people attempt suicide, how to help a friend who is thinking about suicide,
Lessons Learned in Advocacy
Cultural Considerations for American Indian Suicide: Research, Prevention and Intervention

and planning for the future. Outcomes of the AILS include decreased hopelessness, suicidal behavior, and suicide. Participating in the AILS has also been associated with increased confidence in anger control, peer suicide intervention, problem-solving skills, public collective esteem, stress coping skills, community support, social resources, self-efficacy, and self-awareness (T. LaFromboise & Howard-Pitney, 1995; T. D. LaFromboise & Malik, 2016; May, Serna, Hurt, & DeBruyn, 2005). While the AILS shows promise for addressing suicide prevention in AI populations, it is not directly a clinical intervention.

Dialectical Behavior Therapy (DBT) is one of the few evidence-based interventions for targeting suicidality in youth (MacPherson, Cheavens, & Fristad, 2013; McCauley et al., 2018). Beckstead and colleagues (2015) adapted DBT for American Indian/Alaska Native youth at an inpatient substance use program. The mindfulness activities central to DBT that were culturally adapted included attending a weekly sweat lodge, smudging ceremonies, and talking circles. A spiritual counselor who attended DBT and mindfulness implementation training also explained traditional practices and activities as they related to core DBT and mindfulness skills. Results of this study demonstrated that the majority of participants had clinically significant improvements in both internalizing (i.e., depression and anxiety) and externalizing (e.g., substance misuse, truancy, school performance, and aggression) symptoms (Beckstead et al., 2015). While this study did not exclusively focus on treating suicidal behavior, it provided initial utility for blending an evidence-based treatment with cultural practices to produce positive outcomes among AI youth.

The White Mountain Apache Surveillance Model (WMASM; (Cwik et al., 2014; Cwik et al., 2016) was developed in partnership with researchers at Johns Hopkins University and has demonstrated effectiveness for AI suicide prevention. This model uses community-based surveillance of suicide and suicide-related behavior, as well as case management, to identify individuals at high risk for suicide. A specially trained team of White Mountain Apache tribal members collects reports of suicidal ideation, suicide attempts, and non-suicidal self-injury, and then follows-up with treatment referrals. In the first five years of surveillance, the suicide death rate was 40 per 100,000 in this community; however, suicide death rates have been reduced by nearly half in recent years (Cwik et al., 2014; Cwik et al., 2016) (see Figure 1). The WMASM highlights the large impact of community-driven suicide prevention programs by identifying those at risk and making treatment referrals.

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Figure 1. Celebrating Life Prevention Program results
Lessons Learned in Advocacy
Cultural Considerations for American Indian Suicide: Research, Prevention and Intervention

(Continued from page 11)

Considerations, Strategies, and Practices for Addressing AI Suicide

Psychology and related fields (e.g., social work, public health) should cultivate additional researchers and providers to aid AI communities in addressing suicide. This could be accomplished through increased educational and programmatic opportunities that focus on increasing the number of AI students matriculating into advanced degree programs, with particular emphases on strong training in research methodology, evidence-based practices, and cultural knowledge. (See side bars for recommendations.)

To further these aims, we recommend:

- Providing increased training and support to early career investigators advancing research in AI communities. For example, increasing the number of applications for NIH Research Supplements to Promote Diversity in Health-Related Research.
- Increasing cultural knowledge in grant review criteria and among grant reviewers.
- Ensuring that AI populations are sufficiently represented in grant-funded projects and priorities.

What can you do? Steps for building connections with tribal communities:

1. Contact local tribes to build collaborative partnerships. Relationships are crucial in many AI communities, and trust often has to be earned.
2. Contact local tribal or area health boards, which often serve as liaisons between tribes and researchers. The National Indian Health Board (NIHB) maintains a list of area health boards:
3. Contact local Indian Health Services (IHS) facilities for information on working with local tribes.
4. Review existing AI research and treatment guidelines:
   - APA ethics code commentary on culturally appropriate recommendations for research and practice within AI communities by the Society of Indian Psychologists (Morse & Blume, 2013).
     [https://pdfs.semanticscholar.org/1199/4b1842ff72681c38b0f980468a04a49fd49d.pdf](https://pdfs.semanticscholar.org/1199/4b1842ff72681c38b0f980468a04a49fd49d.pdf)
   - Guidelines for research with tribal youth by the National Congress of the American Indian (NCAI, 2016).
   - Principles for engaging in research with Native American communities by the University of New Mexico and several tribal communities (Straits et al., 2012).
Advocating for Behavioral Health Services in Pediatric Subspecialty Clinics

Sasha Jaquez, PhD; University of Texas at Austin, Dell Medical School

It is well known that behavioral and physical health needs are largely interrelated; however, obtaining behavioral health care can still be challenging for many patients. Integrated behavioral health (IBH) recognizes both medical and behavioral health are important to well-being and strives to provide services in one setting for all factors (Agency for Healthcare Research and Quality, n.d). While there is a strong push to integrate behavioral health services into primary care settings, integrating into pediatric subspecialty clinics is lagging. With an estimated one-fifth of all youth having a diagnosable psychiatric disorder, it is common for youth to be referred to subspecialty clinics where they present with untreated behavioral health concerns and comorbid physical health conditions. This leads to the need for IBH models in pediatric subspecialty clinics (Williams, Klinepeter, Palmes, Pulley, & Foy, 2004). While different models for integration of IBH into subspecialty clinics do exist, there are significant gaps in their implementation and use despite an identified need for providing behavioral health care to youth presenting with comorbid behavioral and physical health conditions (Samsel, Ribeiro, Ibeziako, & DeMaso, 2017). Integrating or adding behavioral health care into an existing medical system requires change across administration, workforce, and clinical operations (SAMHSA-HRSA, n.d). Below are steps to consider when exploring integrating into pediatric subspecialty clinics.

First, time should be spent at the administration level to ensure IBH services will fit in the mission statement and work plan of the existing medical model (SAMHSA-HRSA, n.d). This includes buy-in from clinic/hospital administration and medical providers and identification of sustainability to support IBH inclusion. Once these have been identified, other logistics related to fitting an additional specialty into an existing subspecialty clinic can be addressed. Types of service models and levels of integration should be considered and agreed upon by all those involved.

Next, it is important to identify IBH provider specifics and how they will be added to the workforce. If an existing behavioral health provider is identified who will engage in program development, it is imperative to discuss productivity expectations and ramp-up time. If not, work on getting the position approved and posted for hire (SAMHSA-HRSA, n.d). In the meantime, additional support staff should be identified for scheduling and insurance verifications, as these processes are often significantly different than for medical providers. Clinic logistics such as space and initial resources should be discussed and agreed upon. This is also a great time for an IBH provider to share, with the medical team, other possibly overlooked services (e.g., school advocacy and support, implementing screenings, or research and training).
Advocating for Behavioral Health Services in Pediatric Subspecialty Clinics

Once administration and clinic logistics have been appropriately managed, the behavioral health provider should begin to integrate onto the team. Integration might include spending time shadowing the medical provider to gain a better understanding about the subspecialty clinic and offering behavioral health consults to medical providers on difficult cases. Being a new behavioral health provider in a subspecialty clinic may be overwhelming at times, but reaching out to other providers in similar subspecialty clinics can be invaluable. Collaboration will build professional networking opportunities and allow the behavioral health provider to learn from others in the field. For more details and a flow chart, see SAMHSA-HRSA Center for Integrated Health Solutions’ Quick Start Guide to Behavioral Health Integration.

Subspecialty clinic IBH implementation can look differently in more established partnerships, like with gastroenterology (Lamparyk, Debeljak, Aylward, & Mahajan, 2018), or in areas like hematology/oncology which have documented standards of care (Wiener, Kazak, Noll, Patenaude, & Kupst, 2015). Still other clinics, like dermatology and allergy (Klinnert et al., 2018), are newer to IBH and have less available research about needed behavioral health support. However, research continues to support that families report increased satisfaction when IBH services are offered early in medical or surgical treatment and hospitalization (Kitts, Gallagher, Ibeziako, Bujoreanu, Garcia, DeMaso, 2013; Lavakumar, Gasterlum, Choo, Gerkin, Kahn, Lee, et al., 2015), suggesting support for increased integration and sooner contact with behavioral health providers, including in pediatric subspecialty clinics.

APAHC was honored to have Dr. Catherine Grus present the APAHC address at APA this year. Dr. Grus is the Acting Chief Education Officer at APA where she has been on staff since 2005. In this role she leads the association’s efforts to promote psychology in education and education in psychology. She has been instrumental in efforts related to advancing interprofessional education for psychology students, primary care practice, competency assessment, and supervision. Dr. Grus is a tremendous ambassador for psychology in health professions education and serves on the National Academy of Medicine’s Global Forum on Innovations in Health Provisions Education, Interprofessional Professionalism Collaborative, and Federation of Associations of Schools of Health Professions.

In her address, The Education and Training Landscape: Current and Future Possibilities, Dr. Grus explored current trends impacting psychology education and training. Changes in technology such as the digitalization of libraries, development of telehealth, and big data are shaping how psychologists train, practice, and research. The move to competency based education also has significant implications. According to the APA Center for Workforce Studies, 27% of health service psychologists identified hospitals or medical centers as their primary work settings. In addition to continuing efforts to train learners to be interprofessional team players, there is a need to train psychologists to lower health care costs, assist with implementation of value based care models, and work to improve population health. Collaborative efforts to improve competence in interprofessional professionalism and practice include the Interprofessional Professionalism Collaborative involving psychology and 11 health care professions, the development of the IPP toolkit, IPEC competencies and primary care competencies. Last is the trend to embrace the full continuum of psychology training to better address the shortage of mental health professionals and expansion of other mental health disciplines. To this end, APA is moving forward with accreditation of masters programs and is developing tools such as the Individual Development Plan available on the APA website to help learners chart their psychology careers. These are just some of the boundless opportunities facing psychology training and education as the health care landscape continues to evolve.

(See images on page 15)
Thank you to the following for their picture contributions: Lance Anderson on UpSplash for the Chicago image, Sharon Berry, Ashley Junghans-Rutelonis, Amit Shahane, Dr. Catherine Grus discussing the Education and Training Landscape—Current and Future Possibilities, Ron Rozensky was presented with the Fowler Award for dedication to advancing the APA mission by APA President Rosie Phillips Davis. Dr. Rozensky is also pictured here with Drs Sharon Berry and Steve Tovian, Drs. Ashley Junghans-Rutelonis, Sasha Jaquez, and Jason Boye after their presentation discussion program development in children’s hospitals. Drs. Sharon Berry and Lisa Kearney enjoying their time at APAHC.
Cultural Considerations for American Indian Suicide References


Behavioral Health Services in Pediatric Subspecialty References


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