AMERICAN PSYCHIATRIC ASSOCIATION

Diversity & Health Equity at APA

Summer/Fall Quarterly Newsletter 2025

#AchieveMentalHealthEquity

Content

Chief's Corner

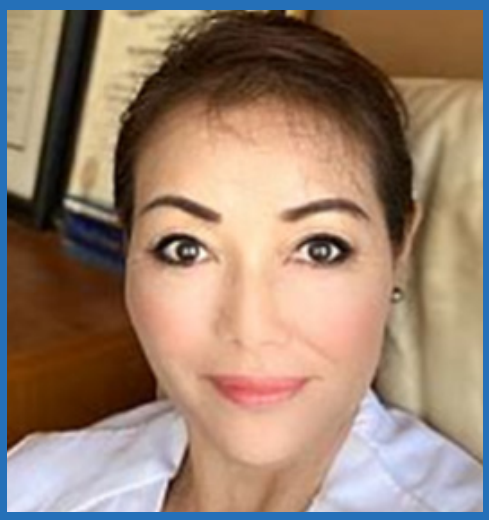
In this issue, we highlight mental health equity champion Dr. Helen Blaisdell-Brennan. She shares her perspective on several areas, from integrating cultural humility and respect for traditional Hawaiian and Pacific Islander healing practices into psychiatric care to the most pressing systemic barriers to achieving mental health equity in Hawaii. Dr. Dia Arpon underscores the critical need to understand and address the complex intersection of rural context and social factors that shape access to and the quality of mental health care, ensuring policies are genuinely responsive to the needs of rural populations. Dr. Alex Threlfall talks about the importance of advocating for mental health care for elderly individuals and bringing attention to the bias against older adults living in nursing homes. College-level participants in APA's Workforce Development Programs, Tyler Parker and Jasmyn Rolison, share powerful reflections on their experience at this year's Future Leaders Academy. Dr. Andrea Watkins shares how she applies a gut health-centered treatment approach to address psychiatric symptoms at their root, with a special focus on the powerful connection between maternal health and nutrition. Dr. Adriana Manygoats de Julio explains how the Diné concept of *Hózhó*—a philosophy of balance, harmony, and holistic living—supports and promotes mental well-being. Finally, be sure to check out our Medical Mind podcast series, *Breaking the Silence: Addressing Youth Suicide,* now streaming.

"When we are able to recognize our own light, we become empowered to use it. When we learn to foster what's unique in the people around us, we become better able to build compassionate communities and make meaningful change." — Michelle ObamaRegina

Regina James, M.D.
Deputy Medical Director | VP, for Diversity and Health Equity | American Psychiatric Association

Thank you to the following APA members for their contributions to this newsletter:

- Dia Arpon, M.D., DFAPA
- Helen Blaisdell-Brennan, M.D.
- Adriana Manygoats de Julio, M.D., M.S.P.H., DFAPA
- Tyler Parker
- Jasmyn Rolison
- Alex Threlfall, M.D.
- Andrea Watkins, M.D., M.P.H.



Mental Health Equity Champion Spotlight

Dr. Helen Blaisdell-Brennan

Madonna Delfish, M.P.H

Dr. Blaisdell-Brennan is a psychiatrist educated and trained at Harvard University, the John A. Burns School of Medicine, and the Neuropsychiatric Institute Residency Program at the University of California, Los Angeles. Combining medicine, science, and a love for Hawaii, Dr. Blaisdell-Brennan is dedicated to assisting individuals with mental health concerns. Her specialization lies in adult psychiatry; she has been trained in medication management as well as CBT and interpersonal therapy at the University of California at Los Angeles. Dr. Blaisdell-Brennan is the Past President of the Hawaii Psychiatric Medical Association. She represents Hawaii in the American Psychiatric Association Assembly. With nearly 20 years of experience in practice, she continues to positively impact her patients' mental well-being through her commitment to providing compassionate and effective care.

Dr. Blaisdell-Brennan thank you so much for joining us today. What inspired you to pursue a career in psychiatry, and how has your personal journey shaped your commitment to advancing mental health equity?

Thanks for having me. I'm drawn by the idea that psychiatry treats not only the mind and body, but also the soul. When psychotherapy and medication are used appropriately and judiciously, psychiatry offers a wonderful opportunity to see people regain – or attain for the first time a fulfilling life.

When you think about mental health equity, what does it mean in the unique cultural, historical, and geographic context of Hawai'i and the Pacific Islands?

Mental health equity means that every person has a fair opportunity to achieve the highest possible level of mental well-being, regardless of socioeconomic status, geographic location, or cultural identity. Hawaii faces unique challenges in reaching this goal. At the time of Western contact in 1778, the Native Hawaiian population was thriving at an estimated 300 to 750 thousand people. In the epidemics that followed Captain Cook's arrival, infectious diseases, led to an estimated 90 percent population loss. The trauma of Western contact has left emotional scars – epigenetic effects. Secondly, there is a shortage of physicians, including psychiatrists, in rural areas, such as the islands of Kauai, Maui, Moloka'i, Lana'i and Hawai'i. The Hawaii Psychiatric Association is actively working with all stakeholders to achieve safe, physician-led care on islands.

You work with individuals and families across diverse communities. What mental health trends or challenges do you see most often among Native Hawaiian, Pacific Islander, and other underserved groups?

We know from a growing body of research that Native Hawaiians and Pacific Islanders face higher burdens of anxiety, depression, and other mental health challenges than many comparison groups. Among our youth, the statistics are especially heartbreaking: in Hawai'i, one study found that 12.9 % of Native Hawaiian adolescents reported having attempted suicide at some point in their lives—compared to 9.6 % among other adolescents. Native Hawaiian youth and emerging adults (ages 15–24) are cited as being 2.3 times more likely to die by suicide than their peers in Hawai'i.[2]That ratio underscores a stark inequity: the risk of death by suicide is amplified in indigenous communities facing systemic stress, cultural displacement, and intergenerational trauma. Even more striking, in the youngest adolescent groups—those aged 10 to 14—Native Hawaiians are overrepresented among completed suicides. That means our youngest are disproportionately bearing the gravest cost of despair. These numbers are not abstract. They are calls to action. We must uplift prevention, strengthen connection to cultural identity and 'ohana, expand access to mental health services, and center Indigenous resilience in healing strategies.

How can clinicians integrate cultural humility and respect for traditional Hawaiian and Pacific Islander healing practices into psychiatric care to build trust and improve outcomes?

That's a fantastic question. Cultural humility matters—no matter who we serve or where we stand. It's essential whether we're working with Native Hawaiians, Native Americans, African Americans, Asian Americans, or any of the many communities that make up our islands and our nation. Cultural humility means recognizing that we don't hold all the answers; our patients do. They bring the wisdom of their 'ohana, their community, and their lived experience into the healing process.

Although my focus has been Native Hawaiian mental health, the principle applies universally. One study among Native Hawaiian adolescents found that those who felt less connected to their culture were at higher risk for suicidal thoughts and behaviors. That reminds us how powerful cultural identity can be as a protective factor. Reconnection—to ancestry, language, and values—can literally save lives.

In clinical work, cultural humility involves curiosity, respect, and the courage to see healing through our patients' eyes. A Hawaiian elder once reminded me: healing begins when we listen – and listen deeply —to our patients. Healing is not just about treatment. It's about connection.

Hawai'i's geography often makes access to care challenging, especially on neighbor islands. How are innovations like telehealth and mobile services helping to bridge those gaps, and what limitations remain?

Absolutely. Telehealth has been transformative for us here in Hawai'i. When Congress relaxed telehealth regulations during the COVID-19 pandemic, it opened a door that had long been closed for people on our neighbor islands. Suddenly, a patient on Kauai or Maui could see a psychiatrist in Honolulu without paying hundreds of dollars for a flight.

What we saw was remarkable—our no-show rates dropped dramatically. And that makes sense. When someone is struggling with depression or anxiety, just getting out of bed, getting dressed, and making

it through traffic can feel overwhelming. Telehealth removes those barriers. Patients can join from the comfort of home, in an environment that feels safe.

It's also a good fit for our younger generation. Many of our youth are already comfortable communicating through screens. When they can simply click a link and meet with a psychiatrist, the connection feels natural. Of course, telehealth isn't perfect. It depends on reliable broadband, and we still have rural connectivity gaps — especially on Molokaʻi, Lanaʻi and parts of Hawaii Island—where internet access is limited. That's something we're working on with state and federal partners, to expand broadband subsidies and infrastructure so every community can be reached.

But overall, telehealth has been a powerful tool for mental health equity. It's allowed us to bring care to people who might otherwise go unseen.

From a policy perspective, what are the most pressing systemic barriers to achieving mental health equity in Hawaiʻi, and what changes would you like to see at the local or federal level?

That's a really important issue. During COVID, we saw how telehealth could open doors that had long been closed — especially for patients in rural and island communities. But now, as some of those federal emergency flexibilities expire, new barriers are beginning to reappear. There are also bureaucratic and funding delays, as in any system. Yet despite those challenges, we've made real progress. And I have to say — the American Psychiatric Association has been a strong partner in this work. The APA has consistently advocated for telehealth flexibility, for interstate licensing compacts, and for reimbursement parity — making sure telehealth visits are reimbursed at the same rate as in-person care. Those are the policies that keep services sustainable for both patients and providers. The more we can expand these frameworks, the closer we come to true mental health equity —when we remove barriers and meet people where they are, healing happens.

In your experience, how can organizations like the APA effectively advocate for policies that support both providers and patients, particularly in rural and underserved areas like the neighbor islands?

I'm so grateful to the American Psychiatric Association for doing those things that can make care better and easier for our patients. For example, APA has been out front advocating for telehealth flexibility, for the interstate licensing compacts, and for reimbursement parity. Dr. Regina James and Gabriel Escontrias regularly visit Hawaii and have offered fellowships to residents from rural and underserved areas.

There is a shortage of mental health providers across the country, what strategies do you believe are most effective for recruiting, training, and retaining a workforce that truly reflects and understands the communities it serves?

That's such an important question, and it's one we think about every day in Hawaiʻi. I work with our psychiatry residents at the Hawaiʻi Residency Program, and our goal is simple — we want them to stay. After four years of college, four years of medical school, and four years of residency, we don't want to lose them to the continental U.S. Our governor has made real progress expanding student loan repayment and forgiveness programs through

state funds, and that's been a huge help. But we can do even more. If we could offer workforce housing assistance — the way some programs support teachers — we could make it easier for young doctors to build a life here. Retaining a workforce that reflects our communities means showing our future physicians that they can serve their people and still thrive. When we invest in that, we're not just keeping doctors in Hawaʻi — we're keeping hope, healing, and connection right here at home.

What community-based strategies have you seen successfully reduce stigma and encourage individuals and families to seek help?

Stigma is still one of the biggest barriers to mental health care, but I've seen that when we start with community, things can really change. The Office of Hawaiian Affairs did something powerful with their "Get Active and Eat Healthy" campaign. They worked with the University of Hawaiʻi and the Department of Health to promote movement, balance, and healthy eating — but really what they were doing was reframing health as something that connects us as a people. I think we can do the same for mental health — create a campaign that says, "Let's talk." Because talking story, reaching out, sharing our feelings — those are acts of aloha. Our ancestors greeted each other with honi, touching foreheads and sharing breath. That breath meant trust, equality, connection — and that's where healing begins. I worked on a study that showed Native Hawaiians often turn to pastors or faith leaders when they're struggling, not necessarily to psychiatrists first. That tells us something important: healing happens in relationship and in trust. So, if we partner with our churches, our hālau, and our community centers, and say, "There's no shame in talking. Connection is how we heal," then we start to change the narrative — and that's how stigma begins to fade.

Looking ahead, how do you see the APA and similar professional organizations playing a role in advancing equity and creating a more inclusive, culturally responsive mental health system?

I think real progress begins at the local level — within each of our APA district branches and state associations — because every region has its own story, its own culture, and its own challenges. Through my work on the APA Communications Committee, I've had the privilege of reading submissions for Psychiatric News from all across the country, and it's fascinating. I'm inspired by Brian Keyes, who writes that Area 1 started Territorial Acknowledgements. I'm impressed by the organization and breadth of services offered by New York, Area 2. Constance Dunlap and Mary Anne Albaugh are the first female team representing Area 3. And Dionne Hart in Area 4 has started annual MLK observances. Area 5 represents the power of the South, and Area 6 never fails to impress with its resilience, especially after the California Wildfires. What connects all of us is our shared mission — to serve patients with compassion and cultural humility.

APA plays a vital national role — through advocacy, education, and giving us a platform to amplify diverse voices — but I also believe that the real work happens locally. Our branches know our people best. We know which systems will work in our communities, and how to shape policies that make a difference on the ground. So, I think of it this way: APA provides the structure, the reach, and the resources, but it's up to us, in each area, to listen deeply, to uplift local leadership, and to build systems that truly reflect who we serve. That's how we move from equity as a goal to equity as a lived experience.

If you could envision Hawai'i's mental health system ten years from now, what would a truly equitable and accessible system look like, and what steps are most urgent to get there?

A truly equitable system means that everyone has access to care, everyone has insurance, and everyone feels seen and heard when they reach out. In Hawai'i, we've made real progress — our uninsured rate is among the lowest in the nation — but access is also about cultural connection.

In ten years, I hope that whether someone speaks to their OB-GYN, their pastor, or their community leader, that person can say, "I can connect you with someone who can help." I want to see Native Hawaiian, Korean, Hispanic and Filipino psychiatrists and counselors across our islands — people who understand the communities they serve.

To get there, we need to train, recruit, and retain providers from our own communities, support them with housing and loan repayment, and strengthen the link between medical, faith, and cultural systems. My dream is that one day, no one in Hawai'i hesitates to say, "I need help," because they'll know — help is right here, close to home.

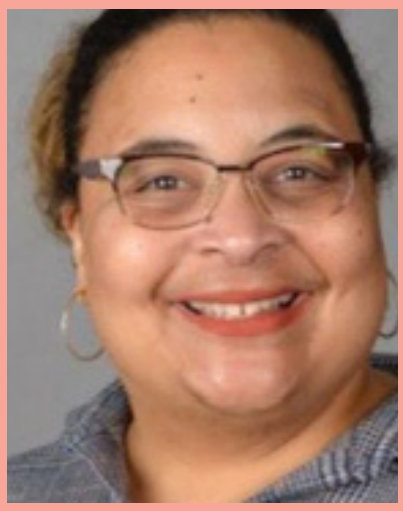
Thank you so much for taking the time to chat with me today. And as we're bringing this conversation to a close, is there anything else you would like to add? Anything else you want your fellow APA members to know, or call to action?

I'm deeply grateful to the American Psychiatric Association for creating space for these kinds of conversations—ones that lift up community, equity, and compassion in medicine.

And as a call to action, I'd just say this: I respect my fellow APA members, recognizing that, beyond our clinical work, we're all volunteers. We're full-time psychiatrists, who give our time, our hearts, and our energy to something bigger—to promoting not only individual healing, but systemic improvements to make care more humane and just.

There are challenges ahead—access, insurance, workforce—but our commitment to one another, and to our patients, is what keeps us moving forward.

So, Onipa'a—be steadfast, be resilient, and keep going. You all inspire me, and I'm truly honored to stand alongside all of you in the American Psychiatric Association.



The Mental Health Link
Social Determinants of Mental Health in Rural Communities

By Dia Arpon, M.D., DFAPA

Dr. Dia Arpon is a psychiatrist in Delaware who has been practicing since 2006. She has a Bachelor of Science degree in biology from the University of Maryland, Baltimore County. She earned a Doctor of Medicine degree from the Medical College of Philadelphia–Hahnemann School of Medicine, now Drexel University College of Medicine. She completed an internship with the Crozer-Keystone Family Medicine Residency program in Springfield, Pennsylvania, and finished her psychiatry residency at Thomas Jefferson University. She is a psychiatrist at LifeStance Health. Dr. Arpon is a member of the APA Caucus of Women Psychiatrists and APA Caucus of Black Psychiatrists.

Rural communities in the United States face unique challenges that significantly impact mental health outcomes, many of which are shaped by social determinants of mental health (SDoMH) such as economic instability, limited access to health care, education disparities, and geographic isolation.[1] These determinants contribute to higher rates of mental illness, increased stigma, and underutilization of mental health services in rural areas.[2] Structural barriers, including provider shortages, transportation difficulties, and inadequate broadband infrastructure, further restrict access to timely and culturally competent care.

One of the primary challenges contributing to provider shortages in rural areas is the tendency for physicians to practice in urban settings, where larger populations and greater resources are concentrated.[2,3] The smaller population size in rural communities makes it difficult to recruit and retain physicians, often resulting in designated health professional shortage areas. For example, during my time in rural Montana, I was the only psychiatrist within a two-hour radius. In addition, limited internet infrastructure poses a significant barrier to accessing care virtually. Telepsychiatry, while promising, becomes impractical without reliable broadband.[4,5] As a result, patients are often forced to rely on in-person visits or emergency departments for mental health needs. This overreliance on emergency care contributes to staff burnout and strains already limited resources. Furthermore, when patients lack reliable transportation, their ability to access routine care becomes severely restricted, increasing the risk of delayed diagnoses, poor treatment adherence, and worsened health outcomes.[2,3]

Another significant challenge in rural communities is the prevalence of food deserts. Often, there may be only a single local grocery store serving

an entire region, making it difficult for residents to obtain fresh fruits, vegetables, and high-quality meat regularly.[6] When available, these items are frequently more expensive than their processed counterparts. As a result, many rural supermarkets primarily offer lower-cost, shelf-stable foods that are high in salt, sugar, and saturated fats. This dietary restriction increases the risk for chronic conditions such as hypertension, diabetes, and cardiovascular disease. For individuals living with mental illness, maintaining a nutritious diet can be even more challenging, compounding the effects of poor nutrition on overall health.[7] Ultimately, this limited access to healthy food options reinforces broader social determinants such as food insecurity and contributes to persistent health disparities.

Addressing the determinants and challenges that plague rural areas requires a concerted effort in advocacy and the implementation of well-defined policies. Advocacy is crucial to ensure that everyone, regardless of their location, has equitable access to resources that enable a high quality of life, such as clean water. Government regulation, particularly in rural areas with geographical challenges, is crucial for preventing water pollution and ensuring the proper disposal of chemicals. To address the shortage of clinicians in rural areas, psychiatrists can form partnerships with faith-based organizations, schools, agricultural networks, and rural health clinics to establish referral networks, offer consultation services, or cohost mental health literacy initiatives. Leveraging telepsychiatry, combined with high-quality internet access, can significantly increase access to care in remote or underserved areas.4 Psychiatrists can champion policies that expand broadband access and sustain telepsychiatry reimbursement, which has proven effective in increasing rural access to mental health care. They can also choose to serve as key voices in shaping rural mental health policies by providing testimony, publishing op-eds, or participating in rural health task forces. It will be important for clinicians to support programs that recruit and retain diverse rural mental health professionals.

In conclusion, understanding and addressing the intersection of rurality and SDoMH is crucial for developing equitable mental health policies and interventions that cater to the needs of these often-overlooked rural populations.

References

1. Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health: Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008. WHO Ref No WHO/IER/CSDH/08.1. 247 pp. Accessed via WHO website.

2. Probst J, Eberth JM, Crouch E. Structural urbanism contributes to poorer health outcomes for rural America. Health Aff (Millwood). 2019;38(12):1976–1984. doi:10.1377/hlthaff.2019.00914

3. Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. Geographic variation in the supply of selected behavioral health providers. Am J Prev Med. 2018;54(6 Suppl 3):S199–S207. doi:10.1016/j.amepre.2018.01.004

4. Spivak S, Spivak A, Cullen B, et al. Telepsychiatry use in U.S. mental health facilities, 2010-2017. Psychiatr Serv.2020;71(2):121–127. doi:10.1176/appi.ps.20190026

5. Whitacre BE, Wheeler D, Landgraf C. What can the National Broadband Map tell us about the health care connectivity gap? J Rural Health. 2017;33(3):284–289. doi:10.1111/jrh.12177

6. Byker Shanks C, Andress L, Hardison-Moody A, et al. Food insecurity in the rural United States: An examination of struggles and coping mechanisms to feed a family among households with a low-income. Nutrients. 2022;14(24):5250. doi:10.3390/nu14245250

7. Teasdale SB, Ward PB, Samaras K, et al. Dietary intake of people with severe mental illness: Systematic review and meta-analysis. Br J Psychiatry. 2019;214(5):251–259. doi:10.1192/bjp.2019.12

Resources

Pathways to Population Health Equity (P2PHE) provides tools for public health leaders to enhance population health, well-being, and equity. It offers various tools to help public health practitioners.

The *Mobilizing for Action through Planning and Partnerships* is a community-driven strategic planning process to achieve health equity. MAPP provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action.

The *Coronavirus Response and Relief Supplemental Appropriations Act* served as a funding opportunity to address COVID-19 health disparities among high-risk and underserved populations, including racial and ethnic minority populations and rural communities.

The *World Health Organization* reports on the social determinants of health on a global scale.

Advocacy in Action
Partnering to Protect Mental Health Care in Nursing Homes

By Alex Threlfall, M.D.

Dr. Alex Threlfall is a board-certified geriatric psychiatrist and medical director for MarinHealth's Older Adult and General Adult PHP/IOP. He is an associate clinical professor (volunteer) in the UCSF Family Medicine Department for the Sutter-Santa Rosa Community Health Family Medicine Residency and on the clinical faculty for the SRCH Advanced Practice Clinician fellowship. He also consults at AgeWell PACE — a PACE program for residents residing in Marin and Sonoma counties. Dr. Threlfall also serves on the board of directors for the American Association for Geriatric Psychiatry (AAGP) and serves as the AAGP Assembly member representative for the APA Assembly. He served as cochair/chair for the AAGP Public Policy Committee for nine years and was cochair of the Program Committee for the 2019 AAGP Annual Meeting. He completed his geriatric psychiatry fellowship at UCSF, psychiatry residency at the University of Pennsylvania, and medical school at Texas Tech University.

Working in advocacy has been a passion and integral part of my practice in psychiatry for nearly 20 years. From chief resident to a prolonged tenure as chair or cochair of the Public Policy Committee for the American Association for Geriatric Psychiatry (AAGP), there have been countless opportunities to advocate. One effort of which I am most proud is bringing attention to the discrimination of older adults living in nursing homes who are effectively stabilized on an antipsychotic for their behavioral and psychological symptoms of Alzheimer's disease and related dementias or some other chronic mental health condition for which antipsychotics are appropriate.

In 2018, it was brought to our attention at the AAGP that the Centers for Medicare & Medicaid Services (CMS) was implementing a quality measure designed to severely restrict the use of antipsychotics in nursing home residents. This measure is a gross governmental overreach of controlling prescription practices in the halls of medicine and is at its core a discriminatory act toward some of our most vulnerable.

Working with the Alliance for Aging Research's Project PAUSE (Psychoactive Appropriate Use for Safety and Effectiveness) and the American Society of Consultant Pharmacists, AAGP leadership aligned itself with CMS to develop a more appropriate measure for the CMS five-star rating algorithm. Unfortunately, despite years of in-person and virtual meetings, these efforts fell short, as the Sisyphean effects of blind bureaucracy won over.

Undaunted, we persevered. In 2023, I coauthored an APA action paper and American Medical Association (AMA) resolution to bring greater

awareness to this mission and focus APA and AMA's attention to correcting this wrong. We encourage all AAGP and APA members to speak with their local representatives to address this discriminatory behavior and publicly pronounce their experiences in local, regional, and national op-eds. It is our hope that sensible evidence-based science will win out, and patients will have access to the care they need.

In honor of Alzheimer's Awareness Month this November, join APA's Division of Diversity and Health Equity for our free webinar series, "Looking Beyond: Addressing Disparities in Alzheimer's Disease Research, Care and Diagnosis."

Alzheimer's Disease Across Populations: Gaps and Opportunities in Research

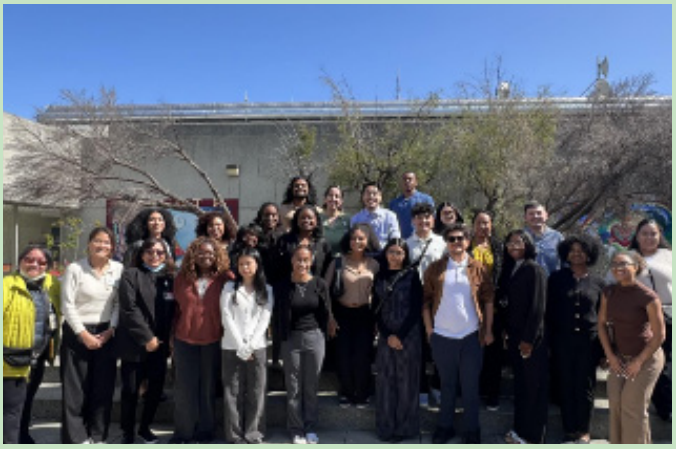
Thursday, November 6, from 7 p.m. to 8 p.m. ET
Zoom registration
1 CME credit

Meeting the Need: Alzheimer's Disease in Rural America

Wednesday, November 12, from noon to 1 p.m. ET
Zoom registration
1 CME credit

Alzheimer's Disease Biomarkers: A New Frontier, But Who Benefits?

Tuesday, November 18, from 7 p.m. to 8 p.m. ET
Zoom registration
1 CME credit



Supporting the Future of Psychiatry

Highlights from the Future Leaders Academy

In June, the American Psychiatric Association SAMHSA MFP team cohosted the second annual Future Leaders Academy in San Francisco, California, with UCSF and UC Davis, for students in the Future Leaders in Psychiatry Program (FLIPP) and the Rising Psychiatry Scholars Program (RPSP).

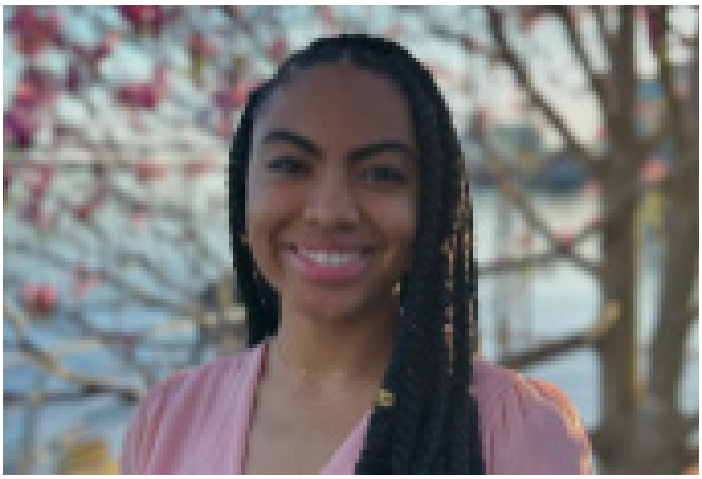
FLIPP and RPSP participants attended lectures on interventional and nutritional psychiatry, panels from current psychiatric residents and attendings at Zuckerberg General Hospital, and seminars on community care models within psychiatry and navigating polarizing conversations. Additionally, they toured the psychiatric in-patient and emergency wards of Zuckerberg General Hospital and UC Davis's MIND Institute, participated in a resume and cover letter workshop in preparation for medical school, and demoed introductory transcranial magnetic stimulation (TSM) procedures at UC Davis's novel TSM clinic.

Below, two participants share their experience:

Tyler Parker is an RPSP participant and former FLIPP participant in his final year at Wake Technical Community College in Raleigh, North Carolina. He is a Navy veteran aspiring to become a psychiatrist focused on Black children's mental health.

Some moments in life feel like oxygen to a dream. This year's Future Leaders Academy was one of them. Returning for my second year, I thought I knew what to expect, but UC Davis breathed new life into my vision of becoming a psychiatrist. Last year, visiting UCLA let me imagine the academic path ahead; this year, stepping inside the hospital and feeling the hum of patient care made it tangible, grounding, and real.

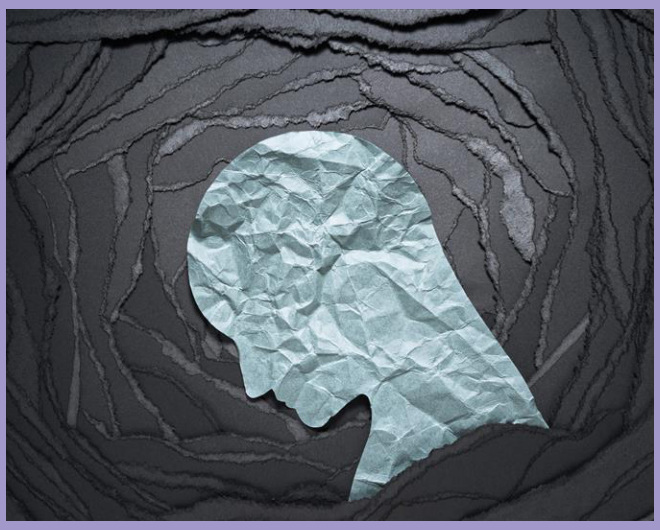
Getting hands-on experience with transcranial magnetic stimulation wasn't just exciting, it was also transformative. Surrounded by mentors and peers, I was reminded that medicine isn't a straight road; it's about faith, resilience, and persistence.
Like a powerlifting static hold, the Future Leaders Academy let me stand under the weight of my dream, preparing for the day I'll lift it entirely. I left California grateful, renewed, and confident that I'll find a way to make this vision a reality.



Jasmyn Rolison is a FLIPP participant and third-year student at Drexel University studying neuropsychosocial studies. She aspires to become a psychiatrist focused on working with underserved communities and promoting education to reduce mental health stigma.

Participating in the Future Leaders Academy (FLA) was truly an invaluable experience that solidified my aspiration to pursue a career in psychiatry. The program not only offered education about psychiatry and its interventions but also gave us the chance to gain hands-on experience, deepening my understanding of mental health care. I also had the honor of hearing from inspiring psychiatrists who generously shared their unique journeys into the field, offering both insight and encouragement. What made this experience especially meaningful was its strong commitment to empowering students as the future of psychiatry by providing access to resources, mentorship, and guidance designed to bridge gaps in pursuing medicine. FLA gave me a clearer path forward, a renewed sense of purpose, and a community of incredible peers from diverse backgrounds. Together, we supported and learned from one another in ways I'll always carry with me throughout my career journey.

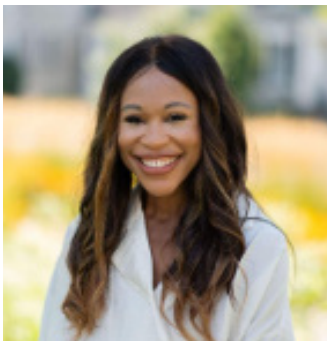
The Future Leaders Academy is made possible thanks to APA members' dedication to advancing the future of psychiatry.



Raise Your Voice

Nourishing Moms, Nurturing Minds: The Link Between Nutrition and Maternal Mental Health

By Andrea Watkins, M.D., M.P.H.



Dr. Andrea Watkins is the owner and CEO of FreedomMind Wellcare and Consulting. She is a nationally recognized physician, wellness and lifestyle coach, guest lecturer, and corporate wellness advocate with a specific focus on the practice of nutritional psychiatry. Dr. Watkins utilizes the treatment approach of gut health to heal psychiatric symptoms from their root causes. She has held several leadership positions to improve quality of care, increase access, and advance the growth of behavioral health programs. She believes that stress management, a balanced lifestyle, and a nutrient-rich diet are essential tools in managing all disease states, including those related to mental health. Dr. Watkins' treatment approach includes empowering her clients to take ownership and develop a sense of agency as it relates to their health through educational tools, medication management, and psychotherapy.

Over the past few years, there has been a growing awareness of the use of nutrition as a treatment modality for mental health issues. As scientific research continues to explore the relationship between food and brain function, it has become increasingly evident that dietary patterns can influence emotional well-being, cognitive performance, and even the onset and severity of mood disorders. Emerging studies in nutritional psychiatry illustrate that inflammation, often driven by poor dietary habits, may be a significant underlying mechanism in a range of psychiatric conditions, including depression and anxiety.1,2 This growing body of evidence offers promising new avenues for addressing mental health disparities, particularly in the perinatal period. In January 2025, Psychiatric News reported that nutrition is now a supported treatment for mental health disorders, and emerging research has found that inflammation is a key source or cause of underlying chronic conditions, including mental health disorders.[1]

In a country in which we continue to experience poor mental health outcomes despite industrialized access to health care, it brings to mind our medical position on the application of diet and nutrition for the management and prevention of perinatal illness. The prevalence of postpartum depression (PPD) ranges from 10% to 15% in modern westernized

countries.[3] The symptoms of PPD carry a significant impact on the quality of life and health outcomes on the mother, infant, and family as a whole.

Given the deleterious effects of PPD on both the mother and the child, it is an opportune time to develop treatment algorithms that address, treat, and prevent PPD for at-risk mothers. Food as medicine is not a new concept; however, modern-day science has just caught up to this essential paradigm. Studies show that diets rich in omega-3 fatty acids, whole grains, leafy greens, and fermented foods can reduce inflammation and support mood regulation.[4,5] A randomized controlled trial found that adults with depressive symptoms who adopted a Mediterranean-style diet supplemented with fish oil experienced significant reductions in depressive symptoms and improved mental health quality of life over six months.[6] How many lives might we save by instituting an anti-inflammatory diet geared toward preventing depression? The time is now, and I look forward to watching medicine, Mother Nature, and science align.

In alignment with this broader shift toward integrative care, APA's Summer 2025 Maternal Mental Health Webinar Bundle offers a timely educational resource. The series explores the importance of culturally grounded postpartum care and highlights how mindfulness-based strategies, including nutrition, can support birthing people during the postpartum period. Continuing medical education credit is available for eligible participants, making this a valuable opportunity for clinicians to deepen their understanding of holistic approaches to maternal mental health. Click here to learn more.

References

1. Miller AH, Raison CL. The role of inflammation in depression: from evolutionary imperative to modern treatment target. Nat Rev Immunol. 2016;16(1):22-34. doi:10.1038/nri.2015.5
2. Firth J, Marx W, Dash S, et al. The effects of dietary improvement on symptoms of depression and anxiety: a meta-analysis of randomized controlled trials. Psychosom Med. 2019;81(3):265-280. doi:10.1097/PSY.0000000000000673
3. Wang Z, Liu J, Shuai H, et al. Mapping global prevalence of depression among postpartum women. Transl Psychiatry. 2021;11(1):543. doi:10.1038/s41398-021-01663-6
4. Lai JS, Hiles S, Bisquera A, et al. A systematic review and meta-analysis of dietary patterns and depression in community-dwelling adults. Am J Clin Nutr. 2014;99(1):181-197. doi:10.3945/ajcn.113.069880
5. Marx W, Moseley G, Berk M, Jacka F. Nutritional psychiatry: the present state of the evidence. Proc Nutr Soc. 2017;76(4):427-436. doi:10.1017/S0029665117002026
6. Parletta N, Zarnowiecki D, Cho J, et al. A Mediterranean-style dietary intervention supplemented with fish oil improves diet quality and mental health in people with depression: a randomized controlled trial (HELFIMED). Nutr Neurosci. 2019;22(7):474-487. doi:10.1080/1028415X.2017.1411320

APA MOORE Equity in Mental Health Podcast Series: Breaking the Silence: Addressing Youth Suicide

Suicide is the second-leading cause of death among young people aged 10 to 24, with rates increasing by a staggering 52% over the past two decades. This vulnerable age group also accounts for the highest number of emergency room visits related to self-harm. Particularly at risk are children, teens, and young adults from diverse or intersectional identities, including Native/Indigenous communities, LGBTQ+ youth, and Black children, who face compounded challenges due to systemic inequities, discrimination, and cultural stigmas around mental health.

Each episode features a dynamic pairing of a host and guest, both drawn from the American Psychiatric Association's (APA) membership. Hosts are leaders within the APA's Minority and Underrepresented (MUR) caucuses, offering perspectives informed by their lived experiences and professional expertise. Guests, also APA psychiatrists or fellows, bring specialized knowledge to illuminate topics such as cultural competence in mental health care, evidence-based interventions, and the importance of community-driven support systems.

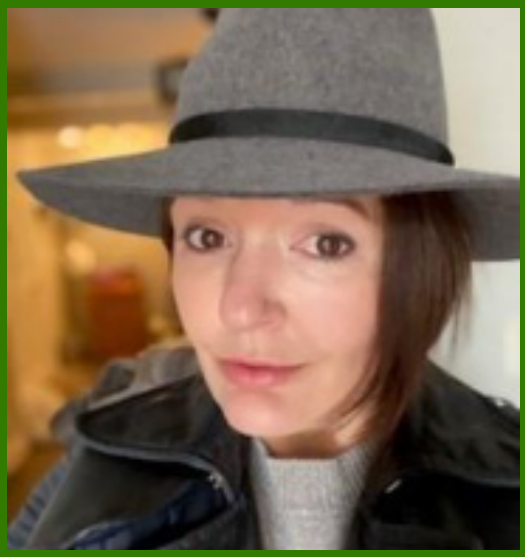
Through storytelling, expert insights, and practical guidance, this series seeks to empower listeners with the tools and understanding needed to make a meaningful impact in combating youth suicide — one conversation at a time.

References

1. Centers for Disease Control and Prevention. Health Disparities in Suicide. Suicide Prevention. Published March 28, 2024. https://www.cdc.gov/suicide/disparities/index.html

Find the special series on APA's Medical Mind, and the Spanish-language episode here: https://www.psychiatry.org/patients-families/la-salud-mental/suicidio-y-autolesion/suicidio-juvenil.

Centers for Disease Control and Prevention. Health Disparities in Suicide. Suicide Prevention. Published March 28, 2024. https://www.cdc.gov/suicide/disparities/index.html



Culture Corner

The Art of Living in Hózhó: Navajo Wisdom for a Balanced Life

By Adriana Manygoats de Julio, M.D., M.S.P.H., DFAPA

Dr. Adriana Manygoats de Julio is a young and passionate Diné (Navajo) and Latinx psychiatrist with a strong history of working in academia, public health, and the military. They are a first-generation college graduate, born and raised in the Navajo Nation, who are dedicated to providing neuropsychiatric care to underserved populations. They trained in neuropsychiatry, health policy, global public health, environmental disaster management, and adolescent/young adult medicine. Currently, they are part of the working group on psychedelics and the representative to the APA Assembly for the American Indian, Alaskan Native, and Native Hawaiian Caucus. They are the medical director for adult intensive services at a Certified Community Behavioral Health Clinic in Denver, Colorado..

The concept of Hózhó embodies a profound and vital philosophy at the heart of the Diné (Navajo) culture, encapsulating beauty, harmony, balance, and order. Hózhó signifies a state of being in which every aspect of existence — physical, spiritual, emotional, communal, and familial — harmonizes. For the Diné, the ultimate aspiration in life is to dwell in Hózhó, and this pursuit not only enriches life but also nurtures mental health.

In the Diné world that embraces Hózhó, individuals work to cultivate harmonious relationships with themselves, their communities, and the natural world around them. This dynamic and holistic approach reveals that mental health is deeply interconnected with one's environment and spiritual ties. When thoughts, words, and actions resonate with the principles of Hózhó, a profound sense of inner peace and tranquility emerges.

DONT MISS OUT

FALL 2025 EVENTS

THURSDAY, NOVEMBER 1 7 to 8 p.m. ET	**Alzheimer's Disease Across Populations:** Gaps and Opportunities in Research	**REGISTER**
FRIDAY, NOVEMBER 7 11 a.m. - 5 p.m. ET	**Social Determinants of Mental Health Convening**	**REGISTER**
THURSDAY, NOVEMBER 1 12 - 1 p.m. ET	**Meeting the Need:** Alzheimer's Disease in Rural America	**REGISTER**
THURSDAY, NOVEMBER 1 1 - 8 p.m. ET	**APA Looking Beyond Webinar "Digital Psychiatry & Mental Health Apps:** Navigating Privacy, Equity, and Access for Vulnerable Populations"	**REGISTER**
THURSDAY, NOVEMBER 1 7 - 8 p.m. ET	**Alzheimer's Disease Biomarkers:** A New Frontier, But Who Benefits?	**REGISTER**