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_Cover:_ “I like this photo of my son because it shows that simply seeing the world upside-down can be so fun in a child’s eyes.”

—Yesie Yoon, MD, Member, Birmingham, AL
MISSION STATEMENT

The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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The mission of AACAP News includes:

1. Communication among AACAP members, components, and leadership.
2. Education regarding child and adolescent psychiatry.
3. Recording the history of AACAP.
4. Artistic and creative expression of AACAP members.
5. Provide information regarding upcoming AACAP events.
6. Provide a recruitment tool.

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This special issue starts with a preface by Karen Dineen Wagner, MD, PhD, President, AACAP, and Warren Y.K. Ng, MD, and include 18 articles on depression written by a collection of over 50 AACAP members!

The release of these important resources coincides with the current Presidential Initiative on Depression Awareness and Screening in Children and Adolescents of Karen Dineen Wagner, MD, PhD.

Thank you to AACAP’s Presidential Task Force, Consumer Issues Committee, and Web Editorial Board for the expertise they contributed in these projects!

You can access the special issue on www.aacap.org.
The Importance of Addressing Perinatal Mental Health in Unaccompanied Immigrant Youth

At 15-years-old, Yahaira did not expect to be a mother, but she became pregnant after being raped during her journey to the United States. The young mother-to-be was among the nearly 70,000 unaccompanied minors who made the long journey to the United States, seeking asylum from the rampant violence of Central America’s Northern Triangle. Once in the United States, she needed access to adequate shelter, education, prenatal healthcare, and mental health services for her depression and posttraumatic stress problems. She faced significant barriers for accessing any of it. Her well-being and that of her child were in jeopardy.

Unaccompanied minors have been migrating to the United States for decades. Recent media and socio-political attention have brought this concern to the surface once again, with reports of increased numbers of unaccompanied minors crossing the border in the past decade. Most recently, the immigration policy resulting in family separation of children from their caregivers once again raised concerns about the treatment of minor immigrants seeking asylum. A subset of this population that has received very little attention includes those immigrants experiencing a pregnancy around the time of their migratory journey.

It is known that mental health disorders are poorly recognized and treated in our country, particularly in this population. Our colleagues from the American Academy of Pediatrics have recently published a policy statement asking for pediatricians and obstetricians to increase their rates of screening for perinatal depression and to improve their coordination of care to provide adequate referrals to mental health treatment. They note that perinatal depression is the most common obstetric complication in the United States. In their report, they cite recent data published in the Journal of the American Academy of Child and Adolescent Psychiatry which demonstrated that maternal perinatal depression predicted early-childhood psychiatric disorders in their children.

Given the limited access to services that undocumented immigrants have, along with the many cultural barriers that prevent those who do have access to actually obtain that care, there is high concern for the lack of proper screening, evaluation, and treatment of perinatal mental health disorders in recent immigrants. In our country, Medicaid provides coverage for almost half of all pregnancies. For undocumented immigrants, care is only covered for emergencies; therefore, they are not able to obtain pre- or post-natal care. After the passage of a Medicaid expansion program which allowed non-citizens to be beneficiaries in order to access pre- and post-natal care in some states, such as Oregon, researchers used the opportunity to look at data from this quasi natural experiment. They found a positive effect on access to adequate prenatal care, diabetes screenings, and fetal ultrasounds. Equally important, improved access of maternal prenatal care was associated with increased number of well child visits, improved rates of recommended screenings and vaccines, and reduced infant mortality.

Access to care is one of many barriers that undocumented immigrants may face when accessing perinatal care. Latina immigrants and their children have high rates of low educational attainment, housing insecurity, poverty, and interpersonal violence. Specific to undocumented immigrants, particularly unaccompanied minors, is the fact that these young mothers are arriving in a new country where they must learn a new language and a new way of living, often with very little social support. These mothers may become highly dependent on their romantic partners, which places them at risk for exploitation and interpersonal violence. In turn, interpersonal violence may affect the mother-child attachment, diminishing the mother’s ability to properly care and nurture her child. Additionally, due to their undocumented status and fear of deportation, these mothers are often discouraged to report these incidents to the authorities, exacerbating the mother’s dependency on their partner and the child’s helplessness and view of the mother as unable to keep them safe.

Another issue that must be taken into consideration is the possibility that the pregnancy occurred as a result from rape, as in Yahaira’s experience. In our clinical experience, as well as reports
from the media, stories have surfaced of young girls and women fleeing their countries after being raped and threatened, experiencing rape during their migratory journey, or experiencing it after their arrival to the United States. Pregnancy and motherhood are a transformative experience, even when the pregnancy is planned. As can be expected, the journey to motherhood after an incident of rape can be a difficult one. These mothers require tactful care and support.

Pregnant immigrant unaccompanied minors will often be placed in foster care homes if a suitable caregiver cannot be found or is not available. It is unclear what the guidelines and requirements for medical care are for pregnant unaccompanied minors who are under government custody, whether in a detention facility or a foster home. Media attention was recently given to stories related to mothers being separated from their breastfeeding infants after the implementation of the family separation policy. Perinatal mental health, even under these violent circumstances around their journey, is not prioritized in this population of young women as they enter the United States.

All of these issues decrease the likelihood that these mothers will seek help when experiencing psychiatric symptoms in the perinatal period. Increased attention thus must be paid by child and adolescent psychiatrists to the perinatal mental health needs of immigrant youth, due to the twofold significance - the immigrant youth themselves as well as their offspring.

References

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Methods to Improve Delivery of Care to Youth with Autism Spectrum Disorders in Emergency Departments

Case
A.B. is a 14-year-old high school student diagnosed with autism spectrum disorder (ASD). She has performed and functioned well in school with supports; however, since transitioning from a small middle school to a much larger high school, she has had behavioral outbursts that led to referral to a local emergency room. Upon arrival to the emergency room, her parents informed the staff that she has a diagnosis of ASD. However, no one assessed her specific needs and was therefore unaware of her sensory sensitivities to loud noises and bright lights. They were also unaware that A.B. struggles with transitions and needs advance notice prior to starting a new task. As a result, when leaving triage to enter into the main emergency room, A.B. became agitated and required PO Haldol with Benadryl.

As discussed in this article, patients with ASD have unique needs, particularly in the fast-paced environment of the emergency room. As health care providers, it is important to appropriately assess, understand, and manage these needs to improve the delivery of care for this patient population.

Background
ASD is a neurodevelopmental disorder characterized by persistent deficits in social communication and social interaction in addition to restricted and repetitive patterns of behavior, interests, or activities.

As discussed in this article, patients with ASD have unique needs, particularly in the fast-paced environment of the emergency room. As health care providers, it is important to appropriately assess, understand, and manage these needs to improve the delivery of care for this patient population.

Factors Affecting Care
Once the decision is made to go to the ED, delivery of care can be challenging due to patient, provider, and environmental factors. For individuals with ASD, challenges include communication deficits, sensory sensitivities, complex behaviors, and difficulty with transitions. Therefore, it is not surprising that the ED environment can be filled with triggers due to the intense noise and movements, bright lighting, crowded environment, and unpredictable schedule.

Interventions
There are a number of factors that account for these increased rates of utilization. First, community-based outpatient psychiatrists often feel uncomfortable or ill-prepared to treat patients with ASD. Second, there is a lack of capacity and access to less intensive levels of care for youth with ASD and behavioral challenges. When these factors are combined, families have few options besides the ED during a time of crisis.
There are training programs available that work with various clinicians to help them develop best practices when treating a patient with autism spectrum disorder who is in crisis.

**Autism Society’s Safe and Sound Initiative** is a collaborative effort with first responders to provide strategies and resources on the topic of safety and emergency preparedness for individuals with ASD, their families, and professionals who work with them.


**Leadership Education in Neurodevelopmental Disabilities (LEND)** operates within a university system to prepare professionals in various disciplines to assume leadership roles working with youth with developmental disabilities.

[mmchb.hrsa.gov/training/projects.asp?program=9](http://mmchb.hrsa.gov/training/projects.asp?program=9)

### Conclusions

In order to improve ED care for youth with ASD, a collaborative approach involving youth and families, clinicians, and educators from multiple disciplines is needed. There are a number of system challenges, including lack of a full-spectrum of effective community-based services for youth with ASD as well as a scarcity of psychiatric and pediatric primary care providers comfortable managing the unique needs of this population. Despite a continued need for a more comprehensive array of services, a three-pronged approach that focuses on training front-line staff, assessing the patient’s acute needs with a structured questionnaire, and ED environmental modifications has been successful when trying to improve the delivery of care to youth with ASD. ■

### Acknowledgements

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### References


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AACAP Psychopharmacology Committee Statement on Ketamine

May 2019

AACAP’s Psychopharmacology Committee monitors closely the availability of antidepressants for children and adolescents. At this time, there are only two FDA-approved medications for adolescents with depression and one for children. There have been a lot of questions by clinicians regarding referring patients for ketamine infusions (which are not approved to treat depression in any age group adult or child) or prescribing esketamine. However, there are a lack of controlled studies in children and adolescents for ketamine or esketamine so clinicians should use extreme caution when prescribing either formulation. Additionally, as in any prescribing of off-label medications, the physician has more responsibility to look at available safety data, or the lack thereof. Therefore, esketamine is not proven to be safe or indicated in children and adolescents, and AACAP’s Psychopharmacology Committee does not currently recommend its use in this population. For your reference, highlights of FDA’s recent decision regarding esketamine follows. To view full prescribing information please see: http://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/SPRAVATO-pi.pdf.

FDA has approved intranasal esketamine for the treatment of treatment-resistant depression (TRD) in adults (18 and older). TRD is defined as failure of at least two previous antidepressants given at adequate doses and for adequate duration. It is approved for use in conjunction with an oral antidepressant (in clinical trials, a new oral antidepressant was initiated at the same time as double-blind intranasal esketamine or intranasal placebo).

Dissociation and sedation are common adverse reactions. Given the risks associated with dissociation and sedation, as well as the risks of abuse and misuse, esketamine is only available through a restricted distribution system under a risk evaluation and mitigation strategy (REMS). Esketamine can only be dispensed from a certified pharmacy, administered in a certified healthcare facility, and provided to patients who are enrolled in a patient registry. Patients must be monitored for two hours after administration until symptoms of sedation and dissociation resolve.

Dose-dependent increases in blood pressure were also observed in clinical trials in adults. Blood pressure should be assessed prior to administering esketamine, about 40 minutes after administration (to coincide with Tmax), and before discharging the patient from clinic.

The dosing schedule for esketamine is as follows: twice/week for first 4 weeks, once per week for the next 4 weeks, then once per week or every other week thereafter. Patients should be re-evaluated after the first 4 weeks to determine the need for continued treatment.

Esketamine is not indicated for pediatric patients. A study of esketamine for rapid reduction of symptoms of depression, including suicidal ideation, in adolescents assessed to be at imminent risk for suicide is ongoing. Therefore, esketamine should not be used in this population outside of current research protocols.

André is an eight-year-old African-American male who I saw for a psychiatric evaluation at the public clinic I work at. He came into the session with his mother and was quiet as she angrily explained all the issues he had with her and at school. She made it clear that she had had enough and that his behaviors needed to stop. She yelled at him to talk with me. He responded by quietly leaning over in his chair and pretending he was asleep. I tried to engage him but was not successful. I left him slumped over and looking miserably depressed.

As I continued my evaluation, I started asking the mom routine assessment questions. At times, I would ask André for his response. He did not respond. I even told him that his not talking meant that his mom got to tell his story for him. He did not respond. I wondered aloud if that was what he wanted. No response.

I continued to ask questions about André’s past and present history. André continued his silence. I then asked about school. Mom said that he was repeating a grade. I asked why. Mom said it was due to days lost to suspensions for fighting. I asked the mom whether he had learning problems. The moment after I asked this, André bolted out of his chair and in rapid succession threw a trash can at me, which missed, and a stuffed animal that did not. As he did this, he called me “a white n_ _ _ _ _” and looked like he was going to rush me. I responded by getting up from my chair and calling for security. The guard arrived and suggested André go for a walk with her. As he had already calmed, I suggested the guard leave and wait outside. I told André that I would rather we talk.

“Did you think I was calling you stupid?” I asked.

“Yes,” he responded.

“I could see how that would make you angry, but I really didn’t say that. I asked if you had learning problems. I was just doing my job, which in part is to find out why you are having troubles at school. Can you sit down so we can talk about your anger?”

He agreed and sat down after which we talked about his anger, which he said he could not control.

“It just comes,” he stated.

I argued that this was what he thought, but I suspected there were usually reasons, like thinking I thought he was stupid. I asked him if he would like help with his anger. He said yes. I agreed to see him the next week and gave him a short, user-friendly manual on anger control. After I gently asked him if he could read, which he said he could, I then told him to look it over and went over the basics of the manual including the identification of feelings, anger triggers, and new ways of dealing with them. I suggested that we could go over the details during our next sessions. He agreed. We left on better terms than we had begun.

At the next session, André came in with his older female cousin. He was hopping mad and explained how he had had a rip-roaring fight with his mom the night before that had led to her slamming him against the wall.

“I didn’t hit her back,” he said with some pride. “And I then ran to my cousin’s and stayed the night with her. She drove me here this morning, as mom was still angry at me.”

“I’m proud that you didn’t hit your mom and that you were able to control your anger. And you figured out that leaving might help, which was a way of not making things worse.”

He smiled and acknowledged what he had done. I then asked where his mom was and what his plans were for today. He said that his mom was at home and that he would stay with his cousin until she calmed down.

“So you’re safe.”

“Yes.”

“And did you have a chance to go over the anger management book?”

“No.”

“Did you bring it? I asked.

“No,” he responded sheepishly

“What’s your look about?” I asked.

“I had been told by a past counselor that it helps if you tear up papers when you’re angry, so I tore up the anger management book.”

“Did it help?”

“Yes.”

“Well, that’s a start, I guess. Next time, why not tear up a magazine instead?”

“There aren’t any magazines at my house.”

“Well, take one from the waiting room before you leave and tear that up instead.”

“Ok.”

continued on page 124
“Would you like another copy of the manual to read?” I asked.

“No, I’d rather we did it together in the session next time.”

“That’s a deal!”

I then spent most of the rest of the session on the phone with mom telling her about what happened. She pretty much verified André’s story. I then told her that I needed to report what had happened to Child Protective Services (CPS). Mom said that she understood. After further discussion, I got her to report herself, which she said she would do. I had the nurse call to verify that she had the next day.

As André left, I chuckled to myself about my work on anger management with him and Xeroxed another copy of the manual for the next session. I wondered what the next session would bring. It came, and they “no showed.”

I would note that if attention-deficit/hyperactivity disorder (ADHD) is the “bread and butter” of child psychiatrists, then so is its co-morbid cousins, oppositional defiant disorder (ODD) and “anger management.” I and many others have been struggling with what to do with anger issues in children for decades.

My first “academic” pursuits were triggered by how to deal with temper tantrums in toddlers. The scholarly question I set before myself was why some cases did not respond to well-designed behavior modification programs delivered by really competent practitioners. The answer for me turned out to be that unresolved conflicts in the caregiver’s lives (n.b., ghosts in the nursery) made it so they could not properly execute the behavioral modification programs. I have staged and integrated behavioral modification, psychodynamic, and family therapy strategies.

I continue to read about and experiment with strategies for treating anger problems. I have created a list of articles that have helped me over the years, including many “oldies but goodies,” psychodynamic and psychosocial articles, especially those that focus on the concept of acting out and milieu management in children.

My strategy of having the mother report herself to child protective services has also evolved over the years to deal with several realities regarding the reporting of abuse cases.

These realities include the fact:

1. That one is a legally mandated reporter and therefore obligated to report
2. That reporting a case does not guarantee the case will be accepted, especially in cases of neglect or when there are no bruises, cuts, welts, or broken bones
3. That the reporting often comes as part of the initial assessment or during emergencies when a treatment relationship has not been fully established between the clinician and the caregivers
4. That the act of reporting, even when you discuss this with the caregiver(s), often blows apart the treatment relationship or chances of nurturing one
5. That organizations often have policies that allow for the delegation of reporting to others, often a nurse or a social worker, rather than the actual mandated reporter

These perceived realities should lead all clinicians to a legal and ethical debate with themselves during which they should try to clarify and balance the best interests of the child, the caregivers, their institutions, the law, and their own professional standards. This review should definitely also include a check of the reporting laws in your state and a discussion with your institution to see if they are comfortable with your approach. I would certainly understand if your own legal and ethical debate comes up with a differing strategy.

My own debate has led me to, in certain cases, especially where the children seem safe and without observable physical harm, to have the caregivers report themselves. It has been my experience that to do so allows for a less adversarial stance towards the caregivers by CPS which allows for more support and clinical involvement. This “kinder and gentler” approach reduces the chances of precipitous actions with unintended consequences such as when children are separated from their caregivers. I always discuss my concerns with the caregiver and make clear my obligation to report. If they refuse my suggestion to self-report, I report. If they say they will report themselves, I follow up to make sure that they have. As Reagan said “trust, but verify.” In most cases, the caregiver calls from my office. In this case, the caregiver was not at the session and was called at home. It is my experience that such handling can often lead to a continuance of the treatment process.

References


Dr. Drell is a past president of AACAP and head of the Division of Infant, Child, and Adolescent Psychiatry at the Louisiana State University Medical School in New Orleans, Louisiana. He may be reached at mdrell@lsuhsc.edu.

AACAP Robert L. Stubblefield, MD, Delegate to the American Medical Association’s (AMA) Resident and Fellow Section

Deadline: May 30, 2019

The award was established through a gift from Mrs. Alice Stubblefield in honor of her late husband and former AACAP President, Robert L. Stubblefield, MD. The award supports AACAP’s resident or fellow member to the American Medical Association (AMA) House of Delegates, with attendance at the June Annual Meeting and the November Interim Meeting each year, for the duration of the awardee’s child psychiatry residency, integrated training, or fellowship program.

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For over 40 years we have provided exceptional protection and have a reputation for outstanding customer service. Our extensive years of experience and industry knowledge allows us to help you by providing worry free coverage so you can concentrate on what you do best – helping people help themselves. When it comes to caring about people, we have a lot in common.

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2019 ASSEMBLY CATCHERS IN THE RYE AWARDS

Recognizing and promoting advocacy for children

The Assembly Catchers in the Rye Awards are AACAP’s most prestigious awards that recognize an AACAP member, an AACAP component, and a regional organization of the AACAP Assembly for outstanding advocacy efforts. In terms of the award:

Advocacy is any activity done by an individual AACAP member, an AACAP component, or an AACAP regional organization on behalf of children and adolescents with mental health problems or for prevention efforts for children and adolescents at risk that directly benefits them or their families. For example, advocacy could include organizing mental health services for an underserved population, advocating for children and families politically, or enhancing the efforts of child and adolescent psychiatrists to provide high quality mental health services. This includes activities through the American Academy of Child and Adolescent Psychiatry.

AACAP recognizes advocacy in three categories:

• **Individual** that is an AACAP member who advocates for children
• **AACAP Component** (committee or task force) that best advocates for children
• **Regional Organization** of the AACAP Assembly whose activities best highlight the contributions of regional organizations on behalf of children.

Nominations should include a brief paragraph describing the nominee’s advocacy work (only one submission per person for each category).

Awards will be presented at the Assembly’s fall meeting during AACAP’s Annual Meeting in Chicago, IL, October 2019. Please forward your nominations to:

Reina Hamayama, Executive Office Coordinator
AACAP
3615 Wisconsin Avenue NW
Washington, DC 20016
or email to rhamayama@aacaop.org

Nominations due by June 27, 2019

The Assembly Catchers in the Rye Selection Committee serves as the reviewing body that makes recommendations to the Assembly Executive Committee who selects the final awardees. The committee consists of a Past Assembly Chair, one Delegate representative from each U.S. zone, an ECP Delegate, and a past recipient of the Catchers award (i.e. individual, committee member, or RO officer affiliated with the Assembly. The award name derives from Dr. John Schowalter’s Presidential Address in which he alluded to J.D. Salinger’s book and Holden Caulfield’s response to what he wanted to be when he grew up . . .

“I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody’s around -- nobody big, I mean -- except me. And I am standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff.”
FEATURES

Klingenstein Thirteenth Annual National Medical Student Conference: A Faculty Perspective

Anita R. Kishore, MD

On February 9, 2019, 120 medical students and their faculty mentors, from every corner of our country, gathered at the center of Stanford’s campus for the 13th annual Klingenstein-sponsored celebration of child psychiatry.

I first became acquainted with the Klingenstein Medical Student Mentorship program and the tradition of the Klingenstein Conference in 2005 when I started at the Yale Child Study Center as a first-year child and adolescent psychiatry fellow. Back then, it was called the Harvard-Yale Games, a riff, of course, on the iconic football rivalry. However, in my first year of participation, I was struck by the ethos of anti-rivalry. The camaraderie, esprit de corps, and mentorship cut across every divide. Then and now, the Klingenstein Conference always has been far and away my favorite conference of the year.

When my turn came to host this conference, the trepidation was real. I worried about the large shoes that I had to fill. How could I live up to the conference’s storied past? Stanford was following in the footsteps of many other fantastic conferences. I had been there and borne witness. Each conference built on the last, surpassing the last. In the end, born of unbridled enthusiasm and passion for the mission, with some hard work and Type A organizing skill thrown in – Stanford students and faculty partnered to host what many described as an epic conference. The students’ presentations alone would have made for a phenomenal day. They were the best I had ever seen. Though truth be told I say that every year, because every year, it is true. The Break the Stigma bike ride was a newcomer to the Klingenstein Conference and helped carry the day by reminding us that we can advocate for children and families by doing what we love, with purpose. The student-led karaoke was the cherry on top, with laughter highlighting the warmth amongst conference participants.

While each component of the conference was amazing in its own right, none felt like the embodiment of our Stanford legacy. The element about which I feel most proud in retrospect was the one I felt fairly anxious about while it was happening. My daughter, 7, with as much spunk as any, was a partial fixture throughout the conference weekend. Not present for the talks but she was there for much of the rest of it. Flitting about, fairy or elf-like, prone to fits of giggles, acting for all intents like she owned the place. After all, as she was overheard saying, “My mommy is in charge.” After I had recovered from the flaming hot cheeks and elevated heart rate that embarrassment sometimes brings, I watched. What I observed was that she was a magnet. When we took group photos and she wanted to be in them, I heard my own mentors say, “Of course she can be in the picture – we’re here for the kids.” It was a helpful reminder. Not just our patients’ kids and families, we are here for all kids and families, including our own.

For the first time ever, this year our conference had a research mission and an Institutional Review Board (IRB) approved pre- and post-conference survey, overlapping other conference missions, to assess outcomes and efficacy. The Klingenstein Conference’s express mission is to increase positive perceptions and understanding of the field. Child psychiatry is sorely underserved and the Klingenstein family has had the foresight to understand that in order to adequately increase the pipeline of child psychiatrists, we have to appeal to medical students.

As program directors we all sense that the Klingenstein Conference works; it inspires students to consider child psychiatry. Preliminary survey results also now suggest that the conference works. Positive
perceptions of child psychiatry and desire to enter the field increase after 48 intense hours of science, mentorship, and merriment. But I was still curious. How? What worked? What was the single most important factor? What made the difference? I don’t pretend to be able to answer that question after a few conversations with students, but what they said surprised me. My students told me in deeper dives into their post-conference perceptions that they were struck by the humanity of the field, the way faculty interacted and treated one another, the fact that we felt comfortable bringing our families to such a gathering. Each of those elements struck a positive chord.

Our medical students, wisely, care about entering specialties where they, and their families, will be cared for, as well they should. I hope that our students’ wisdom will push all medical specialties in that much needed direction. For now, though, I get to feel proud to be a child psychiatrist, where we already do a remarkable job of putting children and families at the center, even our own. Our child psychiatry family believes in taking care of families, including our own. It was not a crafted message. It could not have been because I did not even understand the message until my students helped me see it, weeks later. It just is who we are. I felt proud of my co-director, Shashank Joshi, MD, and I, and the unspoken message that we sent. His son, Sanjan, brought the house down with his dance troupe’s choreographed moves to the music from Fortnite. My daughter, Shanti, helped unfold and lay out linen on all the tables, hung a Break the Stigma sign on our podium, and ran around like she owned the place. What our students saw was a medical specialty that practices what it preaches, a specialty imbued with humanism and humanity.

We inspire medical students to be child psychiatrists by being our best selves; by caring for ourselves, each other, and our families; by allowing them to see us in living color; by teaching them that all children and families matter, including our own.

Dr. Kishore is a Clinical Associate Professor at Stanford University School of Medicine in the Division of Child and Adolescent Psychiatry. She co-directs the Stanford branch of the Klingenstein Medical Student Mentorship Program in Child Psychiatry. She also serves as President of the Northern California Regional Organization of Child Psychiatrists. She is a Distinguished Fellow of AACAP and the American Psychiatric Association. She completed her residency training in psychiatry at the Western Psychiatric Institute and Clinic and her training in child psychiatry at the Yale Child Study Center. She may be reached at anitarkishore@gmail.com.
Klingenstein Thirteenth Annual National Medical Student Conference: A Student Member Perspective

Kevin Lee Sun

I stood at the podium, looking out at the conference attendees and delivering instructions for an upcoming activity. I saw students from different medical schools sitting together, with faculty interspersed among the tables. I started wondering— if medical trainees everywhere were afforded supportive mentorship and a warm peer community to realize their professional goals, would it resemble this precious annual gathering of child psychiatrists and medical students from around the country?

As student helpers of the 2019 Klingenstein Third Generation Foundation (KTGF) National Medical Student Conference at Stanford, John Cannon and I designed and hosted the activities, known as the “Games.” Throughout the day, I saw both diversity and collaboration in thought and execution. In one of the Games, mentors and mentees had twenty minutes to build a diorama representing “peer review,” “therapeutic alliance,” or “resilience.” Working with a

dearth of materials—modeling clay, glitter glue, construction paper, and slime—the teams managed to produce stunningly unique dioramas of mermaids and scuba divers, white coat figurines, monsters from under the bed, and toilets. These were metaphorical evocations of patient care and research that left us all gasping in wonder and crying with laughter.

In his opening remarks, Thomas Anders, MD, exhorted us to “remember the kids.” Students responded to his call, giving incisive, child and adolescent-related presentations. We heard about—among many topics—structural violence against DREAMers, online child grooming, pediatric psycho-oncology, and creative writing interventions for hospitalized adolescents. Learning about my peers’ research projects and clinical experiences, I witnessed a professional community begin to take form, and I was proud to count myself as a part of it.

I heard the word “mentorship” many times through the course of the day, but the idea only really clicked when I heard Klingenstein Fellow and current Stanford psychiatry resident Desiree Li declare, “Mentors should believe in you.” As I reflected on my past and current mentors in child and adolescent psychiatry, I was overcome with emotion, hit by an immense force of gratitude that was both humbling and empowering. I felt all my mentors’ hope and care for me riding within their belief in me.

At the end of the conference, Anita R. Kishore, MD, emailed all of us our conference group photo. She titled it “Our Future—it looks like a pretty spectacular one!” I agree with her. I cannot wait to see what our community of peers will do for the field of child and adolescent psychiatry.

Kevin Sun is a second-year medical student at Stanford. He was the 2018-19 teaching assistant for the Stanford Klingenstein Fellowship program. He also has been a researcher in the fields of mood disorders and autism, with funding from Stanford MedScholars and the NIMH T32 grant. He may be reached at klsun@stanford.edu.
Klingenstein Thirteenth Annual National Medical Student Conference: A Medical Student-Writer Perspective

Natalia Birgisson

My family thought I was dropping out of medical school when I took two years off to write a novel. My friends thought I was wasting precious time that could have been spent doing research that would help me land a competitive residency. Famous physician-authors counseled me to focus on my medical education. Academic advisors gave me a polite smile and wished me luck. Altogether, I felt rather alone during medical school in my calling to be a serious writer. And even if I didn’t think my interests in writing and in child and adolescent psychiatry were related, I did notice that I felt at home with the people in that field of medicine.

I helped organize the Klingenstein Third Generation Foundation’s 13th Annual National Medical Student Conference at Stanford in February. When my mentor, Anita R. Kishore, MD, invited me to read from my novel as a stand-alone oral presentation, I was surprised. I should have understood it was because psychiatrists, perhaps more than any other doctors, understand the importance of exploring the human condition. But it was not until that moment that I thought about how fiction teaches us to put ourselves into other people’s shoes, a skill required in order for psychotherapy to be effective. I was flattered that what for so long had been my “odd hobby” was being recognized and valued at a medical conference. My parents happen to live locally, and I invited them to my presentation.

During the conference itself, I was surprised by how many of my peers wanted to tell me about their own writing lives, about their own creative endeavors. Another student gave an oral presentation about using creative writing with pediatric patients at the Mayo Clinic, and how it helped patients feel more comfortable. At the table I was assigned to sit, I met another student who is starting a medical humanities club at her school. During lunch, Dr. Kishore’s former mentor—who had only just met me—went out of his way to connect me with another medical student writing a novel. The moment we started talking, I knew I had found a lifelong friend, someone who understood both of my careers and who walked that path as well. I have stayed in touch with all of these students, and we have become a part of each other’s writing community.

What was so reassuring to me about the Klingenstein Conference was that I finally understood why psychiatry and writing both call to me (‘appeal’ seems to miss the mark here), why I so enjoy spending time with the residents and faculty in psychiatry. It is a field that forces us to live in uncertainty with our patients, just like writing forces me to contend with the skewed perspectives of my fictional characters. Child and adolescent psychiatry is a field that forces us to recognize that our expertise is only one piece among so many influencing a child’s life, which we often do not have control over.

When my parents joined the conference and saw over a hundred students and faculty members valuing the work I was doing with my novel, something magical happened. When Shashank Joshi, MD, and Dr. Kishore, the two faculty hosts of the conference, introduced themselves to my parents and spoke highly of my writing, it gave them a new perspective. They were proud; they were glowing. It was the best kind of scene that I could have written. For me, writing is about exploring the difficulties of the world and of finding a happy ending. The Klingenstein Conference felt like a happy ending for me—rather, a happy beginning.

Natalia Birgisson is a fourth-year medical student at Stanford. She received the Stanford Medical Scholars Grant to take time off to write her debut novel, which is now under consideration with multiple agents. Her interest in child psychiatry stems from her years volunteering with foster children as a Court Appointed Special Advocate.
POETRY SPEAKS - WILL YOU LISTEN?
RESPONSE TO THE NIHLISTIC QUESTION
WHAT'S THE POINT & DOES ANYTHING MATTER?

REFLECTIONS ON NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) WALKS 2019

WALKING TOGETHER
WE MANIFEST HUMANITY
MY MIND MATTERS!
YOUR MIND MATTERS!
HANDS EMBRACING HANDS
HEARTS TOUCHING HEARTS
FEAR & ISOLATION MELTING AWAY
ENLIGHTENED BY INNER LIGHTS GLOW
HEALING ALL BROKENESS
CREATING SACRED WHOLENESS
EMPATHY'S POWER IS PROFOUND
LEARNING WE GROW & CHANGE
LIVING BRAVELY WE LEARN TO LET GO
THANKFULLY WE LEARN TO LET BE
LOVE'S COURAGE IMAGINES REALITY
NURTURES TO BLOSSOM FREE
OUR HEART'S DEEPEST DREAM
TO END ALL SHAME!

TO STOP ALL BLAME!
TO DISSOLVE ALL PAIN!
WE PROUDLY PROCLAIM
MY MIND MATTERS!
YOUR MIND MATTERS!
DESTINY'S POINT HAS ARRIVED
CELEBRATING THE GIFTS WHO WE ARE
ENVISIONED & EMPOWERED
BLESS & HUMBLY HONORED
AWAKENING HEARTS INTO TOMORROW
WE ARE BELOVED COMMUNITY
UNIQUELY & EVER INSPIRED
SPIRITS SOAR IRREPRESSIBLY
BEAUTY'S FRAGILITY & STRENGTH CO-EXIST
"WE" & "I" BEFRIEND "ME" & "US"
EMBOLDENING LIFE'S PURPOSE TO BE
IN PRAISE OF NAMI WALKS MAY 19TH!

Diane Kaufman, MD
Poet, Artist, Psychiatrist
Arts Medicine for Hope & Healing
Creativity & Healing Wellness Center
Mind Matters, PC, in Hillsboro, Oregon
This is a drawing of one of my patients (12-year-old girl) whose father is awaiting deportation, but because of the government shutdown, everything is delayed. Working with a lot of foster children, I see a lot of hard things, but this drawing speaks volumes.

~Jean Dunham, MD

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Please consider a gift in your Will, and join your colleagues and friends:

1953 Society Members
Anonymous (5)
Steve and Babette Cuffe, MD
James C. Harris, MD, and Catherine DeAngelis, MD, MPH
Paramjit T. Joshi, MD
Joan E. Kinlan, MD
Dr. Michael Maloney and Dr. Marta Pisarska
Jack and Sally McDermott (Dr. Jack McDermott, in memoriam)
Patricia A. McKnight, MD
Scott M. Palyo, MD
The Roberto Family
Diane H. Schetky, MD
Gabrielle L. Shapiro, MD
Diane K. Shrier, MD, and Adam Louis Shrier, D.Eng, JD

Visit www.aacap.org/1953_Society to learn more!
Lifelong Learning Modules
Earn one year’s worth of both CME and self-assessment credit from one ABPN-approved source. Learn from approximately 35 journal articles, chosen by the Lifelong Learning Committee, on important topics and the latest research.
Visit www.aacap.org/moc/modules to find out more about availability, credits, and pricing.

Improvement in Medical Practice Tools
(FREE and available to members only)
AACAP’s Lifelong Learning Committee has developed a series of ABPN-approved checklists and surveys to help fulfill the PIP component of your MOC requirements. Choose from over 20 clinical module forms and patient and peer feedback module forms. Patient forms also available in Spanish. AACAP members can download these tools at www.aacap.org/pip.

Live Meetings
(www.aacap.org/cme)
Pediatric Psychopharmacology Institute — Up to 12.5 CME Credits
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Journal CME — (FREE) Up to 1 CME credit per article per month
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Questions?
Contact us at cme@aacap.org.

www.aacap.org/moc
Pathways is AACAP’s new online learning portal, which allows you to access top rated courses to earn CME credit on your schedule. Pathways serves as your continuing medical education home, giving you access to a variety of online courses and activities, including:

- Clinical Essentials on Depression
- Clinical Essentials on Substance Use Disorder
- Current Topics in Pediatric Psychopharmacology: An Online Advanced Course
- Free JAACAP CME
- Lifelong Learning Module 15
- On Demand Douglas B. Hansen, MD, 43rd Annual Review Course

In addition to these great online activities, Pathways transcript feature allows you to track your CME certificates from AACAP and other organizations in one place. To learn more about these exciting CME opportunities, visit www.aacap.org/onlinecme.

Members are invited to submit up to two photographs every two months for consideration. We look for pictures—paintings included—that tell a story about children, family, school, or childhood situation. Landscape-oriented photos (horizontal) are far easier to use than portrait (vertical) ones. Some photos that are not selected for the cover are used to illustrate articles in the News. We would love to do this more often rather than using stock images. Others are published freestanding as member’s artistic work.

We can use a lot more terrific images by AACAP members so please do not be shy; submit your wonderful photos or images of your paintings. We would love to see your work in the News.

If you would like your photo(s) considered, please send a high-resolution version directly via email to communications@aacap.org. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
New Research Poster Call for Papers

AACAP’s 66th Annual Meeting takes place October 14-19, 2019, in Chicago, IL. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, administration, etc. AACAP encourages submissions on neurodevelopmental interventions (helping children grow healthy brains), translational research, depression, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and violence prevention.

Verbal presentation submissions were due February 14, 2019, and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by June 4, 2019. All Call for Paper applications must be submitted online at www.aacap.org.

If you have questions or would like assistance with your submission, please contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

Don’t miss this opportunity to

AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount on their 66th Annual Meeting registration. All referrals must be first-time AACAP exhibitors and must purchase a booth for AACAP’s 66th Annual Meeting in Chicago.

Exhibitors can connect with more than 4,000 child and adolescent psychiatrists and other medical professionals, as well as advertise in several of the Annual Meeting publications. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. To review the Invitation to Exhibit with more details on these opportunities, as well as forms to sign up, please visit www.aacap.org/exhibits-2019.

Questions? Email exhibits@aacap.org or call 202.966.9574.

Show your support for AACAP and SAVE today!
Attendee To-Do List

- **June 14** – Program schedule available and room blocks open at hotels
- **August 1** – Members only registration opens
- **August 8** – Registration opens to nonmembers
- **September 12** – Early bird registration deadline
- **September 20** – Last day AACAP room rate guaranteed at hotels
- **September 23** – Last day to register online
- **October 14** – First day of AACAP’s 66th Annual Meeting
- **October 19** – Last day of AACAP’s 66th Annual Meeting

HOTELS

Starting **June 14, 2019**, attendees will be able to book their Annual Meeting hotel reservations. Please visit the hotel page of the Annual Meeting website for more details and information.

**Hyatt Regency Chicago**
(Headquarters hotel)
151 East Wacker Drive
Chicago, IL 60601
Phone: 312.565.1234
Phone for Reservations: 312.565.1234 Ext. 4419
Rate: $276 single/double per night
Check-in is at 3:00 pm and check-out is at 12:00 pm

**Radisson Blu Aqua Hotel**
221 North Columbus Drive
Chicago, IL 6061
Phone: 312.565.5258
Phone for Reservations: 800.333.3333
Rate: $260 single/double per night
Check-in is at 3:00 pm and check-out is at 12:00 pm

When making your reservation, ask for the AACAP ANNUAL MEETING GROUP RATE to qualify for the reduced rate.

Situated in the heart of bustling downtown Chicago, both hotels are optimal options to explore the Windy City. All educational sessions for the Annual Meeting are at the Hyatt Regency Chicago, but the Radisson Blu is just one block away and connected to the Hyatt underground.

TRAVEL

**Plane**

O’Hare Airport (ORD), or simply known as Chicago Airport, is an airport located in Chicago, Illinois, 17 miles (27 km) northwest of the Chicago Loop. It serves the Chicago metropolitan area along with **Midway Int. Airport (MDW)**, which is located at just 10 miles (16 km) outside the Loop. The transit time from Central Loop to O’Hare International airport or Midway International Airport is approximately 40 minutes. For more information about the airlines serving these airports, flight schedules, and ground transportation options, visit [http://www.flychicago.com](http://www.flychicago.com).

**Train**

Amtrak serves Chicago with about 50 trains arriving and departing daily at Chicago Union Station. Best known for its majestic Great Hall, often bathed in soft light, Chicago Union Station is the hub for mid-western corridor services and national network trains serving the west. For more information and to book tickets, please visit [https://www.amtrak.com/stations/chicago](https://www.amtrak.com/stations/chicago).
What to Do and See in Chicago!

- **Millennium Park**

  Millennium Park, which is an easy walk from the Hyatt Regency Chicago, is an award-winning center for art, music, architecture, and landscape design. Its prominent features are the Frank Gehry-designed Jay Pritzker Pavilion, the most sophisticated outdoor concert venue of its kind in the United States; the interactive Crown Fountain by Jaume Plensa; the contemporary Lurie Garden designed by the team of Gustafson Guthrie Nichol Ltd, Piet Oudolf and Robert Israel; and Anish Kapoor’s hugely popular Cloud Gate sculpture, affectionately known as “The Bean.”

- **Shedd Aquarium**

  At one of the world’s largest indoor aquariums, you’ll meet 32,500 creatures from aquatic habitats around the world. Explore Shedd’s Abbott Oceanarium, where you can get face to face with beluga whales, dolphins, sea otters, sea lions, and penguins. Polar Play Zone is a permanent exhibit where kids and their families can play, pretend, and discover through hands-on activities. See the aquatic show, starring the dolphins, belugas, and more, and don’t miss the “Jellies” special exhibit. Then meet some of Shedd’s critters during live animal encounters and talk to a diver in the 90,000-gallon Caribbean Reef. Don’t forget to say hi to Granddad, the oldest fish in any aquarium or zoo!

- **Magnificent Mile**

  The Magnificent Mile is a spectacular showcase of style, flavor, entertainment, and fun. With more than 460 stores, 275 restaurants, 60 hotels, and unique entertainment and attractions packed and stacked along its length, the Magnificent Mile has an indulgence for every passion and every pocket.

- **Chicago Architecture Center and Tours**

  Chicago is known around the world for its architecture. Whether you tour downtown or a neighborhood, the expert docents from the Chicago Architecture Center will tell you the stories behind the buildings. Visit iconic skyscrapers, elegant hotels, or the legendary houses of Frank Lloyd Wright. With more than 85 tours to choose from, leaving from the building next to the Hyatt Regency Chicago, we won’t blame you if you can’t pick just one.

- **Willis Tower**

  The Willis Tower (formerly Sears Tower) in Chicago, with its signature black aluminum and bronze-tinted glare-reducing glass, was the tallest building in the world for nearly 25 years. Completed in 1974, Willis Tower set the standard for supertall skyscrapers around the globe, both in its innovative design and graceful styling. With approximately 424,000 square meters of gross floor area, the building is comparatively large for its height, with its foundation and the first 50 floors taking up an entire city block before the building begins to narrow. At the top of the Willis Tower, the Ledge at Skydeck Chicago is at your feet-literally. Dare to stand out on the 103rd floor, with never-before-seen views. Enjoy 360-degree views spanning up to 50 miles and 4 states. Atop the tallest building in the Western Hemisphere, Skydeck Chicago is a “one stop Chicago” experience featuring museum quality interactive exhibits.

- **Navy Pier**

  Every year, over 8 million visitors stop by the historic Navy Pier, Chicago’s lakefront playground with over 50 acres of parks, shops, restaurants, entertainment, and attractions. Enjoy a ride on the Ferris Wheel, musical carousel, Wave Swinger, and miniature golf course. Visit the Chicago Children’s Museum, Chicago Shakespeare Theater or the Navy Pier iMAX® Theatre. Take a ride on a tour boat or dining cruise ship.
Chicago Children’s Museum

There are floors of fun for children, from birth through early-elementary school, and their families to learn and play together. Climb on the schooner, hide in a tree house, construct a skyscraper, tinker with real tools, fish in a river, explore art, and so much more.

Art Institute of Chicago

No trip to Chicago is complete without a visit to the Art Institute, within walking distance of the Hyatt Regency Chicago. The Art Institute of Chicago is home to the greatest collection of Impressionist paintings outside of Paris, including works by Monet, Renoir, Seurat, and Van Gogh. Explore the Renzo Piano–designed Modern Wing and its extraordinary collection of works and visit the Ryan Learning Center, a free space offering programs and art-making activities for the whole family. With a wide variety of special exhibitions, daily gallery tours, performance programs, and more, the Art Institute has something for everyone!

The Field Museum

Discover Sue, the world’s largest and most complete T. Rex ever found! Descend into an Egyptian tomb and see 23 Egyptian mummies and 5,000-year-old hieroglyphics, shrink to 1/100th of your natural size and get a bug’s-eye view in Underground Adventure, come nose-to-nose with the man-eating lions of Tsavo, walk among dinosaurs in Evolving Planet, or explore 13,000 years of history from the Ice Age Mammoth hunters to the temples of the Aztecs in the Ancient Americas Hall.

Adler Planetarium

The Adler Planetarium—America’s First Planetarium—is more than a museum; it is a laboratory, a classroom, and a community exploring the universe together. It’s home to interactive exhibitions, live planetarium shows, hands-on, minds-on STEM education programs, and world-class collections. Stop by to explore space with the museum’s scientists, historians, and educators that inspire the next generation of explorers!

Museum of Science and Industry

The Museum of Science and Industry is the largest science museum in the Western Hemisphere! You’ll experience 14 acres of mind blowing, hands-on exhibits and have the chance to navigate through a mirror maze; manipulate a 40-foot tornado; climb aboard a World War II German submarine; take a run in a human-sized hamster wheel; descend into an Illinois coal mine; board a 727 hanging from the ceiling; transmit your pulse to a 13-foot, 3-D, beating heart; and much more! It’s fun and interactive!

360 Chicago Observation Deck

Soaring 1,000 feet over Chicago’s legendary Michigan Avenue and located on the 94th floor of the John Hancock Center, 360 CHICAGO offers breathtaking views of Chicago’s lakefront, magnificent skyline, and four neighboring states. After only a 40-second ride in North America’s fastest elevators to the observation deck, guests can experience one of the best views in America. 360 CHICAGO is also the only place where locals and visitors alike can enjoy TILT – Chicago’s highest thrill ride. This one-of-a-kind marvel tilts guests out and over the city from the 94th floor observation deck and provides the most thrilling views of Chicago.

Wrigley Field

Home to the Chicago Cubs who won the World Series Championship in 2016. This is the second-oldest ballpark in the major leagues. The ivy-lined outfield walls, historic man-operated scoreboard, and the bleacher bums rallying the team to victory, makes catching a game at Wrigley a must stop for any sports fan.
Helen Beiser, MD, Art Show

Join us at the annual Helen Beiser, MD, Art Show in the Exhibit Hall in Chicago!

Coordinated through AACAP’s Local Arrangements Committee and Art Committee, we invite creative AACAP members and their family to submit artwork to make this year’s show spectacular! You may exhibit up to three pieces of art. We are looking for original works including paintings, drawings, illustrations, potteries, sculptures, calligraphy, poetry, letterpress broadsides, artist’s books, and photographs. The Art Show, open October 16-18, is for exhibition purposes only—no pieces are offered for sale.

Also, all artists are welcomed and encouraged to participate in “Meet the Artists” in the Exhibit Hall (date and time TBD). This event will give you the chance to showcase your art first-hand to the Annual Meeting attendees. Don’t miss out on this exciting opportunity!

For more information, please contact exhibits@aacap.org.

To submit an artwork application, please register and submit artwork online at https://aacap.wufoo.com/forms/rpgnjpn0k4pehc/.
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AACAP’s Annual Meeting is the largest gathering of child and adolescent psychiatrists in the world. Monitors assist AACAP staff in running the meeting by checking badges, collecting tickets, assisting speakers as needed, and coordinating evaluation forms. Monitors are expected to commit to one full-day or two half-day sessions at the Annual Meeting.

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For more information about the Monitor Program visit [www.aacap.org/AnnualMeeting-2019](http://www.aacap.org/AnnualMeeting-2019) or email meetings@aacap.org
The Cultural Climate in Which We Practice

Andrea Mann, DO

Understanding physician burnout has been a topic of increasing interest over recent years,⁴ and is important to understand in the context of a growing national physician shortage.¹ Psychiatry has been designated a health professional shortage area (HPSA) for the past few decades.² HPSA status is given to regions where there is less than one psychiatrist for every 20,000 people.³ To make matters worse, the number of residency positions in psychiatry has been capped for the past 20 years by the Balanced Budget Act of 1997.⁴ It has been estimated that by 2030 there will be a shortage of more than 100,000 physicians.²

Some factors contributing to both psychiatrist burnout and shortage include the following: a growing population with growing healthcare needs, more than half of practicing psychiatrists nearing retirement, low reimbursement rates, increasing medical student loan debt, difficulty coordinating care with other providers, and burdensome electronic medical record documentation requirements.¹,⁴,⁵ Telepsychiatry and collaborative care models are innovative attempts to address the psychiatric needs of the population.⁶,⁷ Unfortunately, these types of solutions alone will not end the psychiatrist shortage.

One approach to decreasing the physician shortage is to increase the number of medical student and residency positions. There have been efforts to increase the number of medical schools and graduating medical school class size. Historically, with the introduction of Medicare and Medicaid in 1965, the federal government began funding physician residency programs. However, despite reports of physician shortages, the 1997 Budget Reconciliation Act froze funding for physician residency positions.

Although there are many laudable components of the Affordable Care Act (ACA), it failed to increase funding for physician residency programs. Instead, the ACA funded “residency programs” and loan repayment for nurse practitioners (NPs). While NPs may be a part of the solution for meeting the health needs of our population, there is growing concern about impendent practice laws, patient safety, and the financial factors driving increased number of nurse practitioner graduates from online programs.

NPs have a small fraction of medical training compared to practicing physicians, generously calculated at approximately 3%. In fact, when the Flexner Report was published in 1910, recommendations were made for more training, not less.

In January 2018, 100 child and adolescent psychiatry fellowship spots remained open. A few months later during the 2018 residency “Match Day,” 34,140 U.S. citizens applied for 30,232 available residency positions. In March 2019, there were 1,740 general psychiatry positions, with an overall fill rate of 98.9%. There are not enough residency positions available to graduating medical students.⁸,⁹ There are also a variable number of general psychiatry residents interested in pursuing an extra one to two years of additional training in child and adolescent psychiatry. Student loan debt likely influences an early career psychiatrist’s decision to subspecialize. In fact, the American Academy of Medical Colleges (AAMC) reported that in 2018, the median medical school debt was $195,000, with over 45.7% of those in debt seeking loan forgiveness programs.¹⁰

We need to support our medical students by decreasing the cost of medical school education, increasing funding for residency positions and fellowships, and providing more opportunities for loan forgiveness. This would encourage physicians to pursue specialties, like child and adolescent psychiatry, that are not as high paying as more procedural-based specialties. This would increase the number of practicing physicians and improve patients’ access to care.

With a growing influx of newly graduated NPs with little clinical experience, there is an increased risk to patient safety and quality of care in child and adolescent mental health. There are few, if any, systematic studies looking at quality of care outcomes between physicians and nurse practitioners in community settings.¹⁰,¹¹ Furthermore, there are currently no studies looking at longitudinal quality of care outcomes and cost between psychiatric nurse practitioners and psychiatrists.

If we plan to influence the future of medicine, as physicians we need to educate the public and our state and national representatives about these issues. NPs wishing to treat children and adolescents with psychiatric conditions should go through a standardized specialty training program or residency with guidelines for diagnosis and treatment of mental disorders, and be expected to take standardized board exams periodically. NPs should not be given licenses to practice independently. Psychiatrists should not be forced to supervise NPs they do not believe are capable of managing children and adolescents. For those NPs that psychiatrists are willing to supervise, the number of NPs they are supervising should be limited in order to optimize safety for patients and providers. The National Institutes of Health (NIH) should provide funding for longitudinal research on quality of care outcomes for NPs and physicians in both academic and community settings. Psychiatrists should be involved in creating practice parameters for NP scope of practice to suit their level of training and expertise. It is imperative that we as physicians should take leadership in setting the standard of care for the safety and protection of our country’s most vulnerable populations.

References


8. NRMP. In: Table AD, ed. 2018 All Schools Summary Report. Association of American Medical Colleges;2018.


Dr. Mann is a Clinical Associate at University of Chicago, Division of Child & Adolescent Psychiatry, and a member of AACAP’s Ethics Committee. She may be reached at amann@bsd.uchicago.edu.

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**AACAP Distinguished Fellowship**

**It’s Time That You’re Recognized for Your Efforts!**

*Distinguished Fellow* status is the highest membership honor AACAP bestows upon members. It’s a symbol of your dedication, enthusiasm, and passion for our specialty. It also serves as a reflection of your commitment to the Academy.

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1. Board certified in child psychiatry
2. AACAP General member for at least 5 consecutive years
3. Made (continue to make) outstanding and sustained contributions in any 3 of the 5 areas noted below:
   - Scholarly publications
   - Outstanding teaching
   - 5 years of significant and continuing contribution to patient care
   - Organizational or social policy leadership at community, state, or national levels
   - Significant contributions to AACAP for at least 5 years in one or more of the following:
     - AACAP Committee/Component
     - AACAP Assembly of Regional Organizations
     - An AACAP Regional Organization

Distinguished Fellowship Nomination Package Requirements:

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- 3 recommendation letters written by AACAP Distinguished Fellows

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Honor Your Mentor Follow-Up

Clarice Kestenbaum, MD  
Submitted by Scott M. Palyo, MD

In honor of Dr. Kestenbaum's 90th year and over 60 years as a physician and psychotherapist, I wanted to take a moment to celebrate all that she has done for me, our patients, and our child and adolescent psychiatry community. Her kindness, patience, and talents have inspired so many to be dedicated, thoughtful healers. No one I have encountered has the grasp on development, psychoanalysis, medicine, literature, culture, and general knowledge and knows how to weave a story around this like Dr. K does. For someone who is embarking on her ninth decade in life, she is, and remains, so youthful, interested in life and people, and passionate about her work. Dr. K. continues to teach so many of us, but more importantly, she continues to learn for herself. That is something we all should strive for.

Clarice Kestenbaum, MD  
Submitted by Virginia Q. Anthony

A wonderful mentor in child psychiatry, who has nurtured and encouraged so many, is Dr. Kestenbaum. Dr. Kestenbaum served as Chair of the Training and Education Committee, Program Committee, and President, among other things. She is a model therapist and became the “go to” clinician/analyst for Columbia Trustees. David Shaffer, MD, her Chairman, and a tenacious researcher, decried that although he carefully selected his residents for research potential, they would take one class with Dr. K and be hooked. He said she was like a Pied Piper.

As President she had many strengths, but one stood out for me. She could capture the pain of patients and their families and eloquently share the possibilities of therapy and healing. She is the best.

Helen and Jack (J. Sanford) Davis, PhD  
Submitted by Virginia Q. Anthony

I write to recognize Helen and Dr. Davis as heroes both for me and AACAP. Helen and Jack created the outstanding residential care facility The Grove School, in Madison, Connecticut. I became friends with them in 1974, through AACAP President Joseph Noshpitz. I cherish them as role models for their generosity, positivity, and humanitarian actions, embracing people and their cultures and educating me about the possibilities.

Jack and Helen were my go-to philanthropists, especially when there was an expense/need that could not be supported by dues. They supported our travel scholarships, including funding the participation of an Iraqi child psychiatrist in our meeting as well as Russian and Cuban colleagues.

Jack was particularly involved in the selection and purchase of our building, always encouraging us to go further.

Helen and Jack, you are my heroes.
Welcome New AACAP Members

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ACADEMY & ASSOCIATION 101

What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP’s Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
Thank You for Supporting AACAP!

AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. We are deeply grateful to the following donors for their generous financial support of our mission.

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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org.

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**Being an AACAP Owl**

AACAP Members qualify as Life Members when their age and membership years total 101, with a minimum age of 65 and continuous membership.

**Benefits:** Annual AACAP Membership Dues are optional. A voluntary JAACAP subscription is available for $60. Receive the Owl Newsletter, which contains updates focused around your community!

Are you a Life Member who would like to be more involved in Life Member activities? Contact AACAP’s Development Department at 202.966.7300, ext. 140.
Learn more about the products and services AACAP has to offer our members at all career stages! We particularly recommend that training directors make use of this resource as an introductory guide to AACAP for their trainees. Visit [www.aacap.org](http://www.aacap.org) to download the PowerPoint.

Thank you to the Consumer Issues Committee for their work on this useful product!

JAACAP seeks interesting images and original artwork by children and youth, including but not limited to those who have personally struggled with mental health challenges. Submissions in which the artist reflects upon their identity, family, and/or community are particularly encouraged.

Questions and pre-submission inquiries should be directed to [support@jaacap.org](mailto:support@jaacap.org) or [connect@jaacap.org](mailto:connect@jaacap.org).
AACAP AWARD SPOTLIGHT:
Amy Yule, MD

2016 AACAP PHYSICIAN SCIENTIST PROGRAM IN SUBSTANCE ABUSE, SUPPORTED BY NIDA
Project Title: “A Randomized Controlled Trial of Quetiapine for Youth with Co-occurring Substance Use Disorders (SUD) and Bipolar Disorder”

The NIDA-AACAP Physician Scientist Career Development (K12) award has provided me with four years of funding to execute a study, and with protected time for research and learning, the award has also supported research collaboration with colleagues, and formal learning through coursework. AACAP’s K12 award has been an incredible opportunity, providing for close mentorship from my primary mentor, Dr. Timothy Wilens, and my mentor through the award, Dr. Frances Levin. The biannual in-person meetings have also facilitated mentorship from the other mentors involved in the award and critical peer mentorship from the awardees themselves.

2012 AACAP PILOT RESEARCH AWARD FOR JUNIOR FACULTY AND CHILD AND ADOLESCENT PSYCHIATRY FELLOWS
Project Title: “The Impact of Exposure to Parental Substance Use Disorders (SUD) on SUD Risk in Growing-Up Boys and Girls at 10 year Follow-up”

The Pilot award funding allowed me to work with mentors at MGH on a secondary analysis of an existing dataset. The opportunity gave me valuable experience with writing a grant proposal, grants management, and the process of working collaboratively with a statistician. I gained valuable experience presenting and disseminating our findings through a poster at the 2013 AACAP Annual Meeting and the published manuscript in Drug and Alcohol Dependence. This project helped me establish myself at my institution as a junior faculty member committed to clinical research.

2008 AACAP EDUCATIONAL OUTREACH PROGRAM FOR GENERAL PSYCHIATRY RESIDENTS

The EOP award supported travel to my first AACAP annual meeting as a 4th year adult psychiatry resident. I distinctly remember the mentorship sessions, and was impressed with the membership’s commitment to trainees. Thank you Schuyler Henderson for leading conversations at our table and your encouragement!

COMMITTEE WORK
Substance Use Committee

It has been an honor to be a part of the Substance Use Committee. Our monthly calls provide a tremendous opportunity to learn about substance trends and practice settings from colleagues across the country. The committee has also provided me with valuable leadership opportunities and experience reviewing and selecting AACAP awardees. Furthermore, through the committee I have had the opportunity to help increase awareness within the AACAP membership about a population I feel passionate about, young people with opioid use disorders.
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Get in the News!

All AACAP members are encouraged to submit articles for publication! Send your submission via email to AACAP’s Communications Department (communications@aacap.org). All articles are reviewed for acceptance. Submissions accepted for publication are edited. Articles run based on space availability and are not guaranteed to run in a particular issue.

- **Committees/Assembly.** Write on behalf of an AACAP committee or regional organization to share activity reports or updates (chair must approve before submission).
- **Opinions.** Write on a topic of particular interest to members, including a debate or “a day in the life” of a particular person.
- **Features.** Highlight member achievements. Discuss movies or literature. Submit photographs, poetry, cartoons, and other art forms.
- **Length of Articles**
  - Columns, Committees/Assembly, Opinions, Features – 600-1,200 words
  - Creative Arts – up to 2 pages/issue
  - Letters to Editor, in response to an article – up to 250 words

**Production Schedule**

AACAP News is published six times a year – in January, March, May, July, September, and November. The 10th of the month (two months before the date of issue) is the deadline for articles.

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**Citations and References**

AACAP News generally follows the American Medical Associate (AMA) style for citations and references that is used in the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP). Drafts with references in incorrect style will be returned to the author for revision. Articles in AACAP News should have no more than six references. Authors should make sure that every citation in the text of the article has an appropriate entry in the references. Also, all references should be cited in the text. Indicate references by consecutive superscript Arabic numerals in the order in which they appear in the text. List all authors’ names for each publication (up to three). Refer to Index Medicus for the appropriate abbreviations of journals.

For complete AACAP News Policies and Procedures, please contact communications@aacap.org.
Residents and Junior Faculty

AACAP Pilot Research Awards
APPLICATION DEADLINE: APRIL 1, 2019
Provides $15,000 to members with a career interest in child and adolescent mental health research.

- AACAP Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows
  (Supported by AACAP)
- AACAP Research Award for Attention Disorders and/or Learning Disabilities
  • for child and adolescent psychiatry fellows and junior faculty
    (Supported by AACAP’s Elaine Schlosser Lewis Fund)
- AACAP Pilot Research Award for General Psychiatry Residents
  (Funded by Industry Supporters)

AACAP Educational Outreach Programs (EOP)
APPLICATION DEADLINE: JULY 12, 2019
Provides the opportunity for residents to travel to AACAP’s Annual Meeting.

- AACAP EOP for Child and Adolescent Psychiatry Residents
  (Supported by AACAP’s Campaign for America’s Kids (CFAK), Endowment Fund, John E. Schowalter, MD Endowment Fund, and Life Members Fund)
- AACAP EOP for General Psychiatry Residents
  (Supported by AACAP’s Endowment Fund)

AACAP Systems of Care Special Program
APPLICATION DEADLINE: JULY 5, 2019
Provides support of $1,000 to present a poster on a Systems of Care related topic during the “Systems of Care Special Program” at the AACAP’s Annual Meeting.

- Clinical Projects Scholarship
  (Co-Sponsored by SAMHSA’s Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee)

Medical Students

AACAP Life Members Mentorship Grants – APPLICATION DEADLINE: JULY 12, 2019
Provides a grant of $1,000 to travel to AACAP’s Annual Meeting. (Supported by AACAP’s Endowment Fund)
• for medical students interested in networking with leaders in the field.

AACAP Medical Student Fellowships – APPLICATION DEADLINE: MARCH 4, 2019
Provides $3,500 to $4,000 stipend for 12 weeks of research training and covers travel to AACAP’s Annual Meeting.

- AACAP Jeanne Spurlock, MD, Research Fellowship in Substance Abuse and Addiction for Minority Medical Students
  (Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign for America’s Kids (CFAK))
  • for medical students focusing on substance abuse and addiction
- AACAP Summer Medical Student Fellowship Program
  (Supported by AACAP’s Endowment Fund)

AACAP Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award
APPLICATION DEADLINE: APRIL 15, 2019
Provides up to $8,000 in funding for a qualified child and adolescent psychiatry resident, fellow, or an early career psychiatrist (ECP) with demonstrated interest in the fields of child welfare, foster care, and/or child maltreatment prevention/intervention. With the collaboration of a mentor, award recipients design a project to raise awareness in these subject area(s).
(Supported by K. Lisa Yang, MBA, in honor of Marilyn B. Benoit, MD)

AACAP Psychodynamic Faculty Training and Mentorship Initiative
APPLICATION DEADLINE: MAY 1, 2019
Provides a stipend of $350 to cover travel expenses to AACAP’s Annual Meeting and an opportunity for residents to design a psychodynamic training project within their child and adolescent psychiatry division with the assistance of a mentor through the subsequent year.
(Supported by the Samuel and Lucille B. Ritvo Charitable Fund)

AACAP Junior Investigator Award
APPLICATION DEADLINE: MARCH 18, 2019
Provides $30,000 a year for two years to a psychiatry junior faculty with a career interest in child and adolescent psychiatry.
(Funded by AACAP and Industry Supporters)
For more information on CASII, contact the Clinical Practice Program Manager at clinical@aacap.org.

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We send you an email every M, W, F with the need-to-know child psychiatry news.

Email communications@aacap.org with questions.

**NEWS CLIPS**

**PARENTAL ALIENATION STUDY GROUP – INTERNATIONAL CONFERENCE**

Philadelphia, Pennsylvania  
September 12–14, 2019

This is the preeminent annual conference that addresses the causes, assessment, prevention, and interventions for parental alienation. Mental health and legal professionals and the public are invited. Also, researchers, targeted parents and grandparents, and child advocates who are interested in high-conflict families and parental alienation.

Day Two of the meeting (September 13) will feature separate tracks for parents, attorneys, researchers, and practitioners.

For more information and registration, visit [http://www.PASG2019.com](http://www.PASG2019.com).
Sidra Medicine is a state-of-the-art facility committed to providing women and children in Doha, Qatar with world-class tertiary healthcare services.

With over 4000 staff representing 93 different nationalities our work culture is built on trust, care, teamwork, efficiency, innovation and transparency. These shared values drive our success and enable us to deliver outstanding care.

The Clinical Director – Psychology (PhD) is responsible for leading high level administrative functions of Psychological Services in the Department of Psychiatry. Responsible for instruction, direction, and performance appraisal to meet the professional standards for all Psychologists employed at Sidra. You will be responsible for developing, teaching and training students and trainees, leading psychological research as well as meeting their clinical duties.

You must be currently licensed in your Country of Origin as a Psychologist to be eligible for Licensing in Qatar. You should have 10+ years’ experience as a practicing Clinical Psychologist, including 5+ in a leadership role.

The Psychologist – Child and Adolescent (PhD) is responsible for providing specialist psychological assessments and interventions for children and adolescents (C&A) patients. You will be responsible for evaluating complex psychological data and formulating a formal psychological treatment plan for the patients. Also responsible for providing specialist psychological advice, guidance and consultation to other professionals.

You must be currently licensed in your Country of Origin as a Psychologist to be eligible for Licensing in Qatar. You should have had 5+ years’ experience as a practicing Clinical Psychologist, including 2+ working in children’s / young person’s psychology. Fluency in Written and Spoken Arabic is highly preferred.

In addition to a competitive, tax free, basic salary employee benefits include:

- Fully furnished Accommodation *(Housing options provided are based on the housing policy)*
- Transportation Allowance
- Airfare Allowance – (1 return flight for yourself and eligible dependents to your point of origin per year)
- Life Insurance
- Health Insurance for yourself and eligible dependents
- Education Assistance for eligible dependents
- A one-off Relocation and Repatriation Allowance
- End of Service Gratuity
- 30 Working days annual leave per annum
- 2 Public Holidays and approximately 10 days Eid break per annum

For a full job description or to apply for either role please visit our careers website and select the relevant job:

http://careers.sidra.org

SIDRA4043 Clinical Director – Psychology (PhD)
SIDRA3151 Psychologist – Child and Adolescent (PhD)

To contact us about these vacancies please email recruitment@sidra.org, quoting one of the above job reference numbers or for information about Sidra please visit our website https://www.sidra.org
CLASSIFIEDS

ALASKA
CHILD PSYCHIATRIST

Job Description:
The Southcentral Foundation (SCF) Child Psychiatrist is responsible for providing direct clinical customer care and works with other clinical staff to establish medical protocols and treatment regimens. The Child and Family Developmental Services (CFDS) Child Psychiatrist provides services in an outpatient setting, in addition to providing consultation services for CFDS Neurodevelopmental staff.

Job Requirements:
Minimum Qualifications: M.D. or D.O. degree required. Licensed as a Physician in the State of Alaska. Current American Board certification specialty appropriate for the service. Meets all requirements in order to obtain associate medical staff membership and required privileges for service. Basic Life Support (BLS) certification is required. ACLS, NRP, ATLS, ALSO and PALS as required for specialty and any certification relating to the scope of practice as required.

Company: Southcentral Foundation
Job ID: 12164749
http://jobsource.aacap.org/jobs/12164749

CALIFORNIA
CHILD AND ADOLESCENT PSYCHIATRISTS
San Francisco Bay Area, CA

Bay Area Clinical Associates (BACA) is a physician-owned and led organization offering evidence-based mental health services to youth and their families in the San Francisco Bay Area. BACA currently offers outpatient and intensive outpatient services in San Jose, Oakland and Menlo Park and is exploring other sites as well. We are looking for full-time psychiatrists to join our multidisciplinary team in each of our clinics.

Our mission is to set a new standard in providing evidence-based, multidisciplinary, integrated care. We provide all therapy and medication services at one convenient location. We do see adults, but generally only those ages 26 and younger or the parents of the children we treat. Psychiatrists are team leaders and will generally work with 2-3 LMFTs/ LCSWs in delivering care. We are looking for committed individuals dedicated to the BACA mission and interested in doing more than just writing prescriptions all day. BACA is a fun, friendly place to work and we go on a first name basis for patients and staff. BACA offers the opportunity for clinicians to run groups and develop innovative treatment programs. As a psychiatrist at BACA, you will provide care to patients both in the outpatient and intensive outpatient programs (IOP). For the outpatient clinic, you would provide individual and family therapy, parent training and medication management. In the IOPs, psychiatrists serve as team leaders and perform evaluation and management visits along with psychotherapy; LCSWs/LMFTs offer individual and family therapy in the IOPs as well.

www.baca.org

ADULT AND CHILD PSYCHIATRISTS – INPATIENT PSYCHIATRIST – GERIATRIC PSYCHIATRIST
Southern California

Job Description:
I am a PERMANENTE PHYSICIAN. A dedicated doctor who believes in pursing dreams, creating hope and driving progress. Southern California Permanente Medical Group is a physician-led, partnership organization with a patient-centered and evidence-based medicine approach. SCPMG is an organization with strong values who provides our physicians with the resources and support systems to ensure our physicians can focus on practicing medicine, connect with one another and provide the best possible care to our patients.

ADULT & CHILD PSYCHIATRISTS
Openings in Southern California

INPATIENT PSYCHIATRIST
Los Angeles, California

GERIATRIC PSYCHIATRIST
West Covina, California

At SCPMG, you’ll enjoy the amazing recreational activities, spectacular natural scenery and exceptional climate our area is known for, along with stability in today’s rapidly changing health care environment. SCPMG is proud to offer its physicians: 4 1/2 day work week (8-10 hours) * Flexible schedules Education time (1/2 day a week) * 1 hour for initial evaluations and 30 minutes for follow-ups Multi-disciplinary team consisting of Nurses, LCSWs, Psychologists and MAs Medical, Dental, Vision, Life & Supplemental Comprehensive Insurance Robust retirement plans: Pension Plan, 401K and Keogh Excellent salary and compensation package (bonuses offered) Partnership eligibility after 3 years * Not available for the Inpatient Psychiatrist opportunity. We invite you to make a difference in the community we serve. For consideration or to apply, please visit our website at http://scpmgphysician-careers.com. For additional information about these opportunities, contact Jolanta Buschini at Jolanta.U.Buschini@kp.org or call (877) 259-1128. We are an AAP/EEO employer. The Answer to Health Care in America.

Company: Spin Recruitment Advertising
Job ID: 12017464
http://jobsource.aacap.org/jobs/12017464

HAWAII
BC/BE PSYCHIATRIST
Wailuku, Maui

Job Description:
Pacific Permanente Group is seeking a BC/BE Psychiatrist for its Inpatient Psychiatric Unit at Maui Memorial Medical Center in Wailuku, Maui, Hawaii. POSITION HIGHLIGHTS 12 bed Inpatient Adult Psychiatric Unit managed by 3 Psychiatrists Consults in ED and on hospital floors Partial Hospitalization Program Psychologist and Psych APRN on staff Average 3 new patients per day, Average LOS in unit 5-7 days Weekly Grand Rounds Call 1:3-4 Future 3 half days outpatient practice per week Excellent work/life balance in a beautiful tropical island setting.

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Classifieds continued from page 157

Job Requirements:  
POSITION QUALIFICATIONS BC/BE in Psychiatry required BC/BE in Child & Adolescent Psychiatry preferred

Company: Pacific Permanente Group  
Job ID: 12152857  
http://jobsource.aacap.org/jobs/12152857

ILLINOIS

FACULTY CHILD AND ADOLESCENT PSYCHIATRIST  
ANN AND ROBERT H. LURIE CHILDREN’S HOSPITAL  
NORTHWESTERN UNIVERSITY  
FEINBERG SCHOOL OF MEDICINE  
Chicago, IL

Ann and Robert H. Lurie Children’s Hospital and the Department of Psychiatry and Behavioral Sciences at Northwestern University Feinberg School of Medicine seeks a child and adolescent psychiatrist for a full-time non-tenure-eligible Clinician-Educator track at the rank of Instructor or Assistant Professor. Responsibilities include primarily outpatient clinical and teaching duties, as well as shared coverage of other clinical services.

Qualified candidates will have experience and excellence in teaching and an interest in an academic environment. Crisis evaluation and treatment experience (ideally pediatric hospital-based) and ABPN certification (or eligibility) in child and adolescent psychiatry required. Fluency in Spanish would be a plus. Hiring is contingent upon eligibility to work in the United States. Applications accepted here: https://facultyrecruiting.northwestern.edu/apply/MTc4

Northwestern University is an Equal Opportunity, Affirmative Action Employer of all protected classes, including veterans and individuals with disabilities. Women, racial and ethnic minorities, individuals with disabilities, and veterans are encouraged to apply. Hiring is contingent upon eligibility to work in the United States.

MASSACHUSETTS

MEDICAL DIRECTOR,  
OUTPATIENT PSYCHIATRY SERVICE  
Boston, MA

Job Description:  
The Department of Psychiatry at Boston Children’s Hospital has an exciting new opportunity for a child and adolescent psychiatrist who is interested in ensuring the provision of the highest quality evidence-based patient-centered care to children and adolescents across our psychiatric care continuum. While we are open to inquiries from anyone who might be interested in joining the Department, we are currently interested in filling the following program leadership position. In this full-time position, we are seeking a talented administrative leader and superb clinician who will be responsible for overseeing the Outpatient Psychiatry Service (OPS) on our Longwood campus as well as at our new Waltham site. We are looking for an individual who can further enhance our sub-specialty OPS clinics, strengthen bridges with our pediatric and surgical integrated care programs and our acute psychiatry services (emergency, consultation, inpatient, residential), and help develop outpatient Telehealth opportunities. This position includes ensuring highest quality teaching and education of child and adolescent psychiatry fellows and general psychiatry residents. Support will be provided for involvement in quality improvement initiatives pertaining to the OPS. This is the ideal position for the physician who envisions an academic career impacting health care through enhancing the accessibility and quality of outpatient psychiatric services for children and their families.

Job Requirements:  
We are looking for a child and adolescent psychiatrist who can work collaboratively to strengthen partnerships with colleagues and programs both within and outside the Department. The candidate for this position must be board eligible/certified in general and child/adolescent psychiatry. Harvard Medical School faculty appointment at the rank of Instructor or Assistant/Associate Professor would be commensurate with experience, training, and achievements. Boston Children’s Hospital is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, gender identity, sexual orientation, pregnancy and pregnancy-related conditions or any other characteristic protected by law.

Company: Boston Children’s Hospital  
Job ID: 12147717  
http://jobsource.aacap.org/jobs/12147717

MINNESOTA

PSYCHIATRIC HEALTHCARE SYSTEM SEEKS CHILD AND ADOLESCENT PSYCHIATRISTS  
Minneapolis/St. Paul Area and Southern Minnesota

PrairieCare is a physician-owned and led psychiatric healthcare system in Minnesota offering a full-range of services and programs for children and adolescents in residential, inpatient...
hospital, partial hospital, intensive outpatient and clinic settings. PrairieCare Medical Group is proud to be one of the largest Child and Adolescent Psychiatric practice groups in Minnesota, with 35 physicians and 125 independently licensed therapists providing care to patients from across the state. PrairieCare offers therapy, social work and nursing support on-site to all physicians, allowing the psychiatrist to focus on providing high-quality, individualized care to patients in a supportive team-based setting.

PrairieCare offers locations across the Minneapolis/St. Paul metropolitan area and in southern Minnesota, a state that has been ranked in the top 3 states to live in the United States by U.S. News and World Report. PrairieCare offers an excellent compensation and benefits package.

Interested Psychiatrists are encouraged to send a CV and a letter of interest to: Kristi Godfrey, Medical Staff Coordinator kgodfrey@prairie-care.com

View us online at Prairie-Care.com

Interested Psychiatrists are encouraged to send a CV and a letter of interest to:

Kristi Godfrey, Medical Staff Coordinator
kgodfrey@prairie-care.com

**Texas**

**Child and Adolescent Psychiatrist**

Fort Worth, Texas

**Job Description:**

Cook Children’s (in Fort Worth, Texas) has an opportunity for a full time BC/BE Child and Adolescent Psychiatrist to join our team of Child & Adolescent Psychiatrists. We have a well-established, outpatient and inpatient pediatric program which provides a full range of early intervention, rehabilitation, medical, and mental health services for children. Our interdisciplinary team is comprised of child & adolescent psychiatrists, child psychologists, developmental pediatricians, and speech, physical, and occupational therapists. This is a unique position which offers a variety of clinical activities, including evaluation, ongoing treatment and follow-up, consultation, and education in a stimulating atmosphere of close collaboration with other disciplines in the care of the child.

**Job Requirements:**

Candidates must be board certified/board eligible in Child and Adolescent Psychiatry, and eligible to obtain an unrestricted Texas Medical License before commencement of employment.

**Company:** Cook Children’s Physician Network (939736)

**Job ID:** 12153322

**http://jobsource.aacap.org/ jobs/12153322**

**Washington**

**Private Practice Opportunity Child and Adolescent Psychiatry**

Bainbridge Island, WA

**Job Description:**

Relocate your practice to stunning Bainbridge Island, WA, a 35-minute ferry ride from downtown Seattle and within easy reach to the Olympic Peninsula.

I am seeking a skilled, community oriented, and caring Child and Adolescent psychiatrist to support a smooth transition with continuity of care as I prepare to retire. This is a turn key opportunity with no compensation requested. For more information visit www.bainbridge-childpsychiatry.com or send an email to linda.semlitz@gmail.com.

**Job Requirements:**

Board eligible, board completion Child and Adolescent Psychiatry fellowship Medical license Washington State.

**Company:** Bainbridge Child Psychiatry (1156563)

**Job ID:** 12216741

**http://jobsource.aacap.org/ jobs/12216741**

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- Commission for advertising agencies not included.

**Advertising Deadlines**

- July/August 2019 . . . . . . . . May 27, 2019
- September/October 2019 . . . . July 27, 2019
- November/December 2019 . . . . September 27, 2019
- January/February 2020 . . . . November 27, 2019
- March/April 2020 . . . . . . . . January 27, 2020

**Discounts**

- AACAP members and nonprofit entities receive a 15% discount.
- Advertisers who run ads three issues in a row receive a 5% discount.
- Advertisers who run ads six issues in a row receive a 10% discount.

For any/all questions regarding advertising in AACAP News, contact communications@aacap.org.
Follow along with all the activities and resources during the month on social media @AACAP and #HeroesofHope