Inside...

President’s Column: An Uncertain Future • Gabrielle A. Carlson, MD, and Jonathan Carlson ...... 157

Diversity and Culture Committee: COVID-19: The Impact on Health Disparities to Children of Color and What We Can Do About It • Balkozar Adam, MD, and Laine Young-Walker, MD...166

A View in Focus: Asian Americans in the COVID-19 and Anti-Asian Racism Syndemic • Annie S. Li, MD, and Jang (Jean) Cho, MD...168

Play Therapy in the Time of COVID • Martin J. Drell, MD ..........174

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TABLE of CONTENTS

COLUMNS
Neera Ghaziuddin, MD, Section Editor • neerag@med.umich.edu

President’s Column: An Uncertain Future • Gabrielle A. Carlson, MD, and Jonathan Carlson ........................................... 157
Psychotherapy Column: Susan Donner, MD, Reflections on the 2019 Rieger Psychodynamic Psychotherapy Paper Award • Susan Donner, MD .................................................................................................................. 159
American Academy of Child and Adolescent Psychiatry (AACAP) and American Psychiatric Association (APA) Detail Steps Necessary for Safely Reopening Schools This Fall .......................................................... 162

COMMITTEES/REGIONAL ORGANIZATIONS Ellen Heyneman, MD, Section Editor • eheyneman@ucsd.edu

Health Information and Technology (HIT) Committee: HIT Committee Discusses EHR Optimization • Marissa Schiel and Pamela Hoffman ......................................................................................................... 164
Diversity and Culture Committee: COVID-19: The Impact on Health Disparities to Children of Color and What We Can Do About It • Balkozar Adam, MD, and Laine Young-Walker, MD ........................................................................ 166

FEATURES Alvin Rosenfeld, MD, Section Editor • arosen45@aol.com

A View in Focus: Asian Americans in the COVID-19 and Anti-Asian Racism Syndemic • Annie S. Li, MD, and Jang (Jean) Cho, MD .......................................................................................................................... 168
COVID-19 Pandemic: Challenges to the Filipino Children and Families • Rhodora Andrea M. Concepcion, MD, FPPA (Life), FPSCAP .................................................................................................................. 170
Poetry • Diane Kaufman, MD .............................................................................................................................. 171

OPINIONS Megan Baker, MD, Section Editor • bakermegane@gmail.com

Will There Be Enough IMG CAPs to Combat COVID-19? • Balkozar Adam, MD ................................................................. 172
Play Therapy in the Time of COVID • Martin J. Drell, MD ................................................................................................. 174

MEETINGS Wanjiku Njoroge, MD, Section Editor • wanjiku.njoroge@yale.edu

2020 Annual Meeting Virtual Exhibit Information ........................................................................................................ 180

FOR YOUR INFORMATION Communications & Member Services • communications@aacap.org

Membership Corner ......................................................................................................................................................... 181
In Memoriam ....................................................................................................................................................... 181
Welcome New AACAP Members .............................................................................................................................. 182
Thank You for Supporting AACAP! .......................................................................................................................... 184
AAAP Policy Statement: Opioid Use Disorder Treatment for Youth ................................................................................ 186
Facts for Families: Suicide Safety: Precautions at Home ............................................................................................. 187
Facts for Families: Caffeine and Children ...................................................................................................................... 189
Classifieds ......................................................................................................................................................... 192

COVER: I took this picture of a young boy on the streets of Krakow, Poland. – Bhaskar Sripada, MD
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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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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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An Uncertain Future

Gabrielle A. Carlson, MD, and Jonathan Carlson

Telemedicine has been extremely helpful in organized medicine’s response to the COVID-19 pandemic. It is not without its pitfalls, however. Not surprisingly, there are some clear instances in which there is no substitute for old fashioned face-to-face care.

The treatment of child and adolescent patients by physicians appears to mirror, in many ways, how educators have been approaching schooling, and how they are being advised to do so in the coming months.

In late June, the American Academy of Pediatrics (AAP) released a statement strongly advocating for an end to remote learning whenever it is finally safe to do so. The AAP cited growing evidence that viral transmission by children is slim, but more importantly, the group claims, remote learning has exposed a dangerous lack of productivity and social isolation amongst children.

In recent months, the AAP, like AACAP, has also been navigating how its physicians see children. A spokesperson for the AAP said they have been leaning on “national infectious disease experts” to advise on how doctors should proceed safely. However, they are actively urging parents to bring their children in for their regular physicals and vaccines.” Following safety protocols of course.

Academy guidance memos we reviewed, say since the start of the pandemic, pediatricians have seen a drop in visits, that have resulted in “delays in vaccinations, delays in appropriate screenings and referrals, and delays in anticipatory guidance to assure optimal health.”

Doctors are also being advised to proactively identify children who have missed visits, and get them in.

We polled several of our child and adolescent colleagues around the world to get their views. For instance, Dr. Bernadka Dubicka, Chair of the Child and Adolescent Faculty of Royal College of Psychiatrists in the UK (akin to AACAP), said something similar. While she estimates 90 percent of patients in the UK are being seen remotely, she too has seen a “massive decrease” in referrals, a drop from about 40 a day to only four. It is slowly picking up she says, but alarming nonetheless.

As for telemedicine, she adds, some families forget or don’t like remote appointments, and the setup has blurred work/life boundaries for medical staff too.

In Sweden, Dr. Astrid Moell, who is on the front lines as a trainee, says some colleagues have had to put on full protective gear during emergency visits “due to aggressive patients with low control of their behavior,” such as spitting and biting, increasing the risk for infectious spread.

Educators and physicians alike are still learning the evolving science as it relates to children and the potential for COVID-19 transmission.

Children were not initially thought to be a factor in the pandemic. That changed this past May, when a small but a growing number of kids began developing what health officials are now calling pediatric multisystem inflammatory syndrome—possibly linked to COVID-19 infection.

And children, while still thought to be in the least likely age group to suffer from with some patients due to their behavioral challenges and my limited capacity to set limits on their behaviors during telehealth sessions,” she said. She also points to the inability to provide additional services such as in-home behavioral services for patients.

This theme continues in Singapore, where Dr. Daniel Fung, Chairman Medical Board of the Institute of Mental Health in Singapore and president of the International Association of Child and Adolescent Psychiatrists and Allied Professionals (IACAPAP), points to the need to put patient assessments—such as those for autism—on hold, because certain observations and spoken instructions are hard to do with face coverings or from afar.

As for the direct impact on patients’ lives during COVID-19, Fung says home isolation has made some children more irritable and depressed. An observation similar to the concerns of America’s pediatricians, and the in-person schooling guidance by the AAP.

One can’t ignore however, the risks that still remain with in-person care.

In Sweden, Dr. Moell, who is on the front lines as a trainee, says some colleagues have had to put on full protective gear during emergency visits “due to aggressive patients with low control of their behavior,” such as spitting and biting, increasing the risk for infectious spread.

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And children, while still thought to be in the least likely age group to suffer from the least likely age group to suffer from...
COVID-19, are known as spreaders (as has been seen with other diseases.)

As for schools in America, it’s still an evolving and uncertain path. Even with the AAP guidance to get back in the classroom, what that will look like is in flux.

This June, Virginia’s State Superintendent of Public Instruction announced a phased approach to fall classes, beginning with classroom exposure for young children, followed by older ones. Six feet will be advised between desks, and staff will be advised to wear face masks where distancing can’t be maintained. Even so, the state superintendent admitted the state is winging it.

“The guidance in “Recover, Redesign, Restart 2020” is also flexible, because we can’t predict with absolute certainty how the threat of the coronavirus will evolve over the summer and early fall,” said schools chief James Lane in a statement.

In other parts of the globe, such as the European Union, school reopenings have seen mixed results. Some with no noticeable jumps in infection. Others, like a handful of schools in France, had to immediately close after a sudden spike. According to reporting by CBS News, it’s unclear if teachers or students spread the disease, and it appears the infections likely happened before school reopened.

The topsy-turvy reality could be said for doctors’ offices too.

Lending to the notion that until more is known about the disease, a less than perfect handling of children in school or medical settings is a likely continued reality.

Gabrielle A. Carlson, MD, and Jonathan Carlson, Chief Investigative Reporter – WGCL-TV (Atlanta, GA)
Susan Donner, MD, Reflections on the 2019 Rieger Psychodynamic Psychotherapy Paper Award

Susan Donner, MD

The child psychiatric literature has very limited information about effective treatment modalities for preschool children with severe and multiple developmental delays. Additionally, care for these children is often highly fragmented. AACAP member Susan Donner, MD, a private practitioner in Woodland Hills, California, and Associate Professor at the David Geffen School of Medicine at UCLA, presents a case of a preschool child with a developmental delay, whom she treated with a dyadic therapeutic play therapy model. Her paper “Making Meaning Through Play: Psychotherapeutic Intervention in a Pre-School Child with Global Developmental Delay,” won the 2019 AACAP Rieger Psychodynamic Psychotherapy Award and will be published in the 2021 Psychoanalytic Study of the Child.

Dr. Donner describes a three and a half year-old girl, “Paloma,” who had been given a diagnosis of Autism Spectrum Disorder and Global Developmental Delay and had been designated “unteachable.” She had been provided services from 18 months of age for multiple developmental deficits and delays, including poor motor coordination, very low muscle tone, poor articulation, very weak receptive and expressive language, hyperactivity, and frequent tantrums and screaming.

Dr. Donner writes about the dyadic therapeutic play therapy model she used, in which the child patient and the parent are seen together multiple times a week. Such treatment can focus on the child’s developmental and emotional state, provide a safe, stable relationship, with the therapist serving as a developmental object scaffolding that helps the child build their intrapsychic structure and significantly decreases oppositional behavior by verbally linking words and co-created meanings of difficult feelings, problems, and memories. This provides the child with tools to understand and govern their own emotions and behaviors and allow for feelings, thoughts, and fantasies to become apparent so that anxiety and aggression can be understood and modulated. Simultaneously, this therapy gives the child a chance to develop and integrate speech and language with other brain functions, such as attention, empathy, memory, mentalization, sequencing, and emotional regulation.

Dr. Donner had wondered whether AACAP had a place for her work, since she is not a researcher and cannot yet translate her work into a recognized mode of “evidence-based practice.” She was hoping that the Rieger Psychodynamic Psychotherapy Award would provide a vehicle for more infant, child, and adolescent psychiatrists to look at the power and effectiveness of early intervention and prevention, even when the treatment is derived from the psychoanalytic tradition of individualized and tailored treatments.

In the early part of treatment, as Dr. Donner worked at organizing her observations of Paloma’s symptoms to clarify the diagnosis, it became evident that Paloma was not on the autism spectrum. Her attention-deficit symptoms could be related to Attention-Deficit Hyperactivity Disorder or to tremendous anxiety or limited capacity for verbalizations.

Dr. Donner describes the issues that have arisen with current nosology around sensory processing disorders. Overall, Paloma’s treatment seemed fragmented. Though she was receiving physical therapy, occupational therapy, speech and language therapy, and behavior therapy, none of her well-meaning therapists were adopting a holistic view of the child and her family, nor were they communicating with each other. No shared formulation existed that allowed different interventions to become a more integrated treatment plan.

Dr. Donner emphasized her use of the literature on dyadic treatments and the focus on relationships at the core of the intervention citing Mona Delahouzee’s Social and Emotional Development practical guide, Stanley Greenspan’s Floortime model and Stephen Porges, “Poly vagal theory.” As Dr. Donner was making sense of Paloma’s hyperactivity, recognizing the anxiety and panic that were exacerbating it, Paloma’s father was concerned she would need Ritalin. Dr. Donner quoted AACAP’s practice parameters and PATS (Pharmacotherapy of the Preschool ADHD) study, that the first recommendation was avoiding medications when therapy is likely to provide good results (Gleeson, 2007). She described how psychotherapeutic treatment involves play, which allows for feelings, thoughts, and fantasies to become apparent so that anxiety and aggression can be modulated and understood. In treatment, Dr. Donner also took on the role of lead clinician or coordinator to help align goals amongst the various practitioners. She observed that Paloma’s knowing that her team was communicating with one another helped her be more positive and helped her parents, who were quite overwhelmed, to understand which interventions would need to be a priority at a particular time. It is beyond the scope of this column to review the detailed formulation presented in the paper. In general, Dr. Donner’s formulation guided her to offer herself as a developmental object for mother and child, building language and ego capacities in order to decrease action...
and increase symbolization. Gradually, her role expanded as Paloma continued to develop and moved from dyadic dynamics to “Oedipal” triadic dynamics. Over two years of treatment, the patient moved from incomprehensible language, lack of body tone and control, and a whirlwind of nonstop and ineffective movement, to success at school, ballet, and clearer, more organized, reciprocal discussions of Barbie and Ken’s family dynamics and privacy preferences. Dr. Donner writes that so many of today’s multi-faceted treatments for impacted children focus on behaviors without linking them to their meaning to the child and the child’s experience. Connecting these together and mentalizing the overall family and treatment systems allows the child to be able to mentalize herself and take an active role in creating both meaning and a narrative for her life that creates both direct and indirect benefits.

Dr. Donner was surprised at the dramatic progress this preschool child with Global Developmental Delay was making in this psychoanalytic treatment in the domains of symbolic play, emotional regulation, and mentalization (typical target goals in a psychoanalytic treatment), but also in domains that she never imagined could be affected like speech and language, motor coordination, sequencing, memory, etc. She felt that Paloma was developing at a pace and in ways that are not published in the literature, and she wanted to think more about what was happening in this treatment modality that was allowing this child, with the diligent interventions in therapy and the support of her parents and her larger treatment team, to develop an integrated and coordinated sense of herself that allowed her to engage and persevere in learning at school and in all of her treatments in spite of her complex developmental deficits and delays. Most importantly, she felt this child always had such strength and determination, even when she had so little language and self-control, that she motivated Dr. Donner to be an advocate for her and other children and families with global developmental complexities.

Dr. Donner attributes her desire to become a child psychoanalyst to a month she spent as a medical student at the Yale Child Study Center where she was inspired by Jim Leckman, Linda Mayes, Mel Lewis, Joe Woolston, and Preston Wiles, many of whom were interested in, or trained in, psychoanalysis. For family reasons, she stayed in California and has been in Los Angeles for almost 30 years. Trained at UCLA, Cedars-Sinai, and the New Center for Psychoanalysis, she feels blessed to have truly great teachers and supervisors in her adult psychiatric, child and adolescent psychiatric, and later infant, child, adolescent, and adult psychoanalytic training. She is now in the mode of “paying it forward” with teaching at UCLA, New Center for Psychoanalysis and the Western Consortium of Child and Adolescent Psychoanalysts.

Dr. Donner believes that it is an honor to have her work be recognized with this award and be included among the honorees. Norbert Reiger, MD, who worked much of his professional life in the Los Angeles area, was a tremendous child and adolescent psychiatrist and advocate throughout his life and has left us this legacy and responsibility to continue “to locate the child within” with this award and beyond.

Dr. Donner serves as one of the mentors of the AACAP Psychodynamic Faculty Training and Mentorship Initiative (PFTMI). She works with faculty at Oregon Health Science University to strengthen their psychodynamic psychotherapy program. She is doing the same for the fellowship program at UCLA. ■

Dr. Susan Donner is a child, adolescent, and adult psychiatrist and psychoanalyst in private practice in Woodland Hills, CA. She is a Training and Child, Adolescent, and Adult Supervising Analyst, Chair of Child and Adolescent Psychoanalytic Training, and Director of the NCP 0-21 Child and Adolescent Clinic at the New Center for Psychoanalysis in Los Angeles. A graduate of Harvard University and UCSF School of Medicine, she is an Associate Clinical Professor in the Department of Psychiatry and Biobehavioral Sciences at the UCLA Geffen School of Medicine. She is the 2019 winner of the AACAP Rieger Psychodynamic Psychotherapy Award. She has written a number of chapters and articles and presented papers on such topics as child development, attachment disorders, psychoanalytic perspectives on the use of medications, and clinical aspects of child, adolescent and adult psychoanalytic treatment. Dr. Donner may be reached at sldonnermd@gmail.com or (818) 883 1020 (office).
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American Academy of Child and Adolescent Psychiatry (AACAP) and American Psychiatric Association (APA) Detail Steps Necessary for Safely Reopening Schools This Fall

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WASHINGTON DC, JULY 15, 2020 – The American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) recognize that education, including school attendance, is an essential component of successful and healthy development for all children and adolescents. Access to universal, high-quality education is always the goal, but is especially true in the COVID-19 era, when many have had their education compromised and experience higher levels of stress from social isolation.

We recommend that school reopening plans proceed with appropriate care and include the following precautions:

1. Public health agencies must make recommendations about returning to school in the classroom, based on scientific evidence and local community circumstances, devoid of politics, with careful and thoughtful decision-making, and with the best interest of students, teachers and staff. One size cannot fit all.

2. The return to school must include appropriate protections for all children, families, school personnel, and other members of the community.

3. When classroom-based education is not possible, techniques that optimize social interactions alongside educational objectives should be prioritized.

4. The education of children with special needs requires additional resources to adapt instructional techniques. This vulnerable population includes children with emotional, learning, and physical disabilities as well as those in foster care, poverty, and for whom English is a second language, to mention but a few.

5. The mental health of students must be continually addressed because mental health is an intrinsic part of overall health and well-being. This includes the opportunity for mental health care for all educators, and school staff, as well as parents who are teaching at home.

6. Fairness and equity require that sufficient access to equipment, services, and technology, to address systemic and/or cultural disadvantages in educational and mental health supports, amplified by COVID-19, are provided.

7. Additional financial support to schools and the community is needed for a safe and supportive educational process. This increase in funding should address the structural requirements necessary to create safe environments to ensure a full array of education and mental health supports.

8. All necessary components must be in place to ensure effective systems for the early identification of and intervention for the increased number of high-risk students as a result of the pandemic.
In these uncertain times, making educational decisions based on science and community circumstances ensures the mental health needs of our children and adolescents are being addressed, allowing them to feel engaged, safe, secure, supported, and loved.

#

American Academy of Child and Adolescent Psychiatry
The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children’s mental health. For more information, please visit www.aacap.org.

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HIT Committee Discusses EHR Optimization

In a recent issue of AACAP News, Dr. Tambyraja from the Health Information Technology (HIT) committee discussed a recent article that explains the KLAS Arch Collaborative, which attempts to understand clinician satisfaction as it relates to electronic health record (EHR) adoption and customization. It was found that, surprisingly, psychiatrists tend to personalize their EHR experience less than other medical specialties. Unsurprisingly, this article found that physicians who personalized their EHR experience tended to report greater satisfaction. While we understand that EHRs were built for the task of billing, they have become mandatory and therefore essential for various tools of documentation, writing orders, and communication between providers and patients. The added changes due to COVID-19 have further stressed the use and need of EHRs, so this article is meant to assist providers to improve personalization of their EHR and experience.

Below we review categories of EHR optimizations including documentation, orders, patient portal management, and workflow management. The degree to which these optimizations may be employed depends on the EHR. Additionally, institutions may set rules as to which EHR privileges providers require to make modifications. We suggest reaching out to your institution’s informatics department or to your EHR managers as appropriate to learn more about the options available to you.

There are different ways to improve efficiency and reduce burden for note writing. Various EHRs provide tools for note optimization. Various templates can be used to sort what is always necessary or frequently included.

<table>
<thead>
<tr>
<th>Type of Note Optimization</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>Smart phrases, templates</td>
<td>Mental Status Exam shortcuts/templates for commonly seen values</td>
</tr>
<tr>
<td></td>
<td>Diagnosis templates for common psychiatric issues and recommendations</td>
</tr>
<tr>
<td></td>
<td>Templates for setting up a biopsychosocial formulation</td>
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<td>Phrases or pick lists to review psychiatric risk and protective factors</td>
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Using data from other places that can be refreshed/kept current

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<th>Examples</th>
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<tbody>
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<td>Using data from other places that can be refreshed/kept current</td>
<td>Vitals pulled into notes that refresh for each visit</td>
</tr>
<tr>
<td></td>
<td>Past medical, social, or family history</td>
</tr>
<tr>
<td></td>
<td>Questionnaires for patient reported symptoms (e.g. PHQ-9) or data from patients/others (e.g. most recent Vanderbilt scales included in current note)</td>
</tr>
<tr>
<td></td>
<td>Connect patient instructions and visit documentation to limit double documentation</td>
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Order writing is a common part of any patient encounter. Orders may be grouped or may be developed to include common information in order to improve efficiency.

<table>
<thead>
<tr>
<th>Types of Order Optimization</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>Labs</td>
<td>Bundle labs that you always order together such as those used for atypical antipsychotic monitoring</td>
</tr>
<tr>
<td>Medications</td>
<td>Have orders set to default to print or electronic prescribing as preferred</td>
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<tr>
<td></td>
<td>Pair three individual month prescriptions for stimulant prescribing</td>
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<tr>
<td>Order sets</td>
<td>Admission orders can be optimized based on the needs of the service; consider options for vitals, diet, common labs, and safety monitoring</td>
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<td>For outpatient, consider order sets for diagnoses that allow bundling of common labs and medications options</td>
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<tr>
<td></td>
<td>For discharge orders, include common information that is given to all patients such as emergency or crisis contact numbers</td>
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A useful, though often underutilized, tool within many EHRs is the patient portal, by which patients and providers may share communication regarding presentation of illness. Providers may also offer resources or instructions for further reflection for the patient during a less hectic time than during the visit itself. Below is a table describing some potential uses for a patient portal.

<table>
<thead>
<tr>
<th>Type of Patient Portal Optimization</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>After visit documentation</td>
<td>Patient instructions for reminders regarding specific medication instructions</td>
</tr>
<tr>
<td></td>
<td>Resources on new diagnosis from a trusted source</td>
</tr>
<tr>
<td></td>
<td>Review of medication changes and upcoming appointments</td>
</tr>
<tr>
<td>2 way patient communication</td>
<td>Patient can message the doctor when treatment is causing non-emergent but questionable side effects.</td>
</tr>
<tr>
<td></td>
<td>Patient given self-report, parent and teacher rating scales prior to visit to have completed for visit.</td>
</tr>
<tr>
<td></td>
<td>Providers can send information to the patient and PCP regarding changes in treatment course so everyone is on the same page.</td>
</tr>
<tr>
<td>Patient centered scheduling</td>
<td>Some platforms permit patients to request new appointments or reschedule when something happens, providing better flexibility and fewer chances of no-shows.</td>
</tr>
</tbody>
</table>

In addition to the common tasks of documentation and placing orders, providers spend time using the EHR to review notes, communicate with other providers, and of course bill. There are strategies that can be used to make the EHR work by making tasks more efficient or by setting reminders.

<table>
<thead>
<tr>
<th>Type of Workflow Management Optimizations</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of records</td>
<td>Use filters to more easily sort through a patient record based on desired criteria</td>
</tr>
<tr>
<td>Inbox management</td>
<td>Develop quick or common responses to messages</td>
</tr>
<tr>
<td></td>
<td>Set favorites for individuals or groups with whom you commonly communicate</td>
</tr>
<tr>
<td></td>
<td>Set reminders for follow-up or completing tasks</td>
</tr>
<tr>
<td>Billing</td>
<td>Set favorites for billing codes that are more frequently used</td>
</tr>
<tr>
<td>Toolbars</td>
<td>Add, remove or rearrange items on toolbars to better meet workflow needs</td>
</tr>
</tbody>
</table>

We hope that these examples help provide ideas for optimization strategies for you to incorporate on your own or through assistance from your institution or EHR vendor in order to enhance your satisfaction with the EHR experience and make the EHR work for you so that you can focus on patient care. If you are interested in learning more, please consider attending the HIT committee’s workshop on EHR optimization at AACAP’s annual meeting this fall.

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Dr. Pamela Hoffman, MD, is a Child and Adolescent Psychiatrist in Providence, RI. Dr. Hoffman was board certified by the American Board of Psychiatry.
With the current COVID-19 crisis, many children are losing people they love and have relied on for support and stability. For those who haven’t lost loved ones, the lack of structure can be disorienting. Their way of life—school, sports, birthday parties, even casual trips to the park—has disappeared. They are struggling with fear, anxiety, and uncertainty. Their caregivers act as their makeshift teachers. These are the same caregivers who are often trying to balance work, or grapple with recent unemployment.

We must take a step back from what can seem like a constant stream of chaos to evaluate how this is affecting our children and their families. This column will pay special attention to children of color and explore ways to address their increased risk for emotional suffering. Minority populations and those who live in poverty are at a higher risk of losing a loved one. This pandemic is taking a terrifying toll on communities of color, beginning with African Americans and including Latinos and Native Americans. The data that has been released so far is not conclusive regarding other minority populations such as Asian-Pacific Islander communities.

Chinese-Americans and their children have been the victims of xenophobia following the spread of the coronavirus from China.

Although not all states or cities provide data on the race and zip codes of deaths related to COVID-19, those that do reveal a disproportionate percentage of African Americans dying from the virus. Available data show disturbing trends of majority COVID-19 deaths in African American communities. This reflects the fundamental effect of structural racism on the existing health inequalities in our country. The vulnerability of these populations did not start with COVID-19, and won’t end with it. Unfortunately, this is just another manifestation of health disparities, economic inequality, and the racism and prejudices these minority communities have faced for decades, in particular in African American communities.

We need to look at poverty, housing instability, and environmental toxins. We need to consider those who are forced to choose between their health and working during the pandemic at nursing homes, grocery stores and factories. We need to analyze food deserts, hospital inaccessibility, and the lack of green space for children to play or gather. High levels of chronic stress also predisposes many in African American communities to medical and mental health issues. Research has shown a high prevalence of diabetes mellitus, heart and lung diseases, obesity, as well as hypertension among African Americans. In addition, they may suffer from psychiatric disorders, including depression, anxiety, and substance abuse. Poor access to high-quality medical care facilities is often underscored by being uninsured or underinsured, all of which affects their overall health and wellbeing. This may lead some African Americans to elect not to get tested for the coronavirus because of the fear of paying a high-cost hospital bill.

In addition, many African Americans still struggle with trusting our healthcare system because of the lasting trauma caused by the Tuskegee study.

The first step we can take is a simple one. We must work to ensure that the racial and ethnic background of COVID-19 patients is always collected. This is imperative. It will help us better track cases and deaths, understand aggravating factors and help us provide assistance to those most in need.

As clinicians, we have an ethical and moral obligation to be aware of and respond to the needs of our patients, particularly during this unprecedented time.

“The vulnerability of these populations did not start with COVID-19, and won’t end with it.”
the American Medical Association—to provide valuable information for clinicians who are caring for these families.

Those resources can help us as we navigate the best ways to reach our patients during the pandemic and in its aftermath. Our role is to support the children and families we treat and give them the tools to address their distress, anxiety, and grief. Sometimes it’s as basic as developing structure and routine to help ease the children’s apprehension and provide them with much needed predictability. Similarly, helping parents establish self-care habits will help them better support their children. Addressing the root causes of the inequities is much more complex. Counseling them after a loss of a loved one whose death was hastened by those inequities will take time and dedication.

Let us be open to what the children and families want to share with us. Let us understand their loss and the centuries of racism that may fuel it. Let us commit to tackling our own biases and work with our colleagues and our patients to achieve the equity of care they deserve.

References and Resources
2. Health Equity Resource Center AMA
3. AACAP Resource Library on Coronavirus
4. COVID-19 / Coronavirus Resources - psychiatry.org
6. Coronavirus (COVID-19) resources - AMA

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AACAP’s Autism Spectrum Disorder and Intellectual Disability Resource Committee developed the Autism Spectrum Disorder and Intellectual Disability Resources to serve as a resource for AACAP members on preventive work, treatment of and rehabilitation for children and adolescents with an intellectual disability.

Access training and education materials, find practice resources, and watch training videos on the subject at www.aacap.org.
A View in Focus: Asian Americans in the COVID-19 and Anti-Asian Racism Syndemic

It was the first weekend of June and I was preparing my slides for AACAP’s Virtual Forum on Health Disparities during COVID-19. A notification came through my phone. “Did you see this?” my cousin questioned me via text. With an emoji finger pointing to a picture below, I shifted my attention to a photo of a flyer taped to a gray lamppost. In red, the title read “Chinese are destroying Bay Ridge.” I glanced at the remaining content and viscerally reacted with an all-too-familiar cocktail of hurt, fear, anger, sadness, and frustration. I jumped on my computer, wrote to my elected officials, posted it on social media to alert others of the incident, and reported it on #stopaapihate website. Minutes later, my councilman replied and acknowledged his awareness of the flyers. His office had reported it to the NYPD and members of his staff were going around the neighborhood to physically remove the flyers. A day later, neighbors posted another flyer across the neighborhood that read “Bay Ridge does not welcome racism. Bay Ridge loves all of its neighbors.”

Acts of hate, racism and xenophobia towards Asian Americans rose across the world with the onset of the COVID-19 pandemic. In March 2020, Dr. Russell Jeung of San Francisco State University’s Asian American Studies Department, along with the Asian Pacific Policy and Planning Council (A3PCON) and Chinese for Affirmative Action (CAA) created a reporting site to compile data. In the United States, over 2,000 incidents were reported as of June 2020, spreading across 45 states and Washington DC, with 37% occurring in public venues including streets, parks and transit.1,2 Discrimination involved derogatory verbal harassments, accusations for bringing Coronavirus to the country, Uber drivers declining rides for Asian-American passengers, physical violence of spitting, punching and acid pouring, and more extreme, a father and his two young children being stabbed at a shopping center in Texas.1,2 Of these incidents, 6.3 percent of them involved Asian-American youths and children.3

The Asian-American community reacted with outrages of fear, anger and sadness. Many questioned their identity as Asian Americans, finding themselves perceived as the “yellow peril” yet again. It brought back discriminatory sentiments of the late 1800s, when East Asians were considered unfit and unclean to belong in mainstream society. At the height of the yellow peril, the government passed the Chinese Exclusion Act of 1882, barring Chinese from seeking immigration and naturalization into the United States. It also revitalized the not-too-distant memories of 1942, when Executive Order 9066 led to incarceration of Japanese Americans in World War II. Even more recent was the death of Vincent Chin in 1982, when a group of angry, unemployed auto industry workers assaulted and killed Mr. Chin under the pretense that East Asians took away their jobs.

“Our Asian-American youths are also vulnerable to discrimination, and inside many homes, families are having conversations on how to stay safe from coronavirus and racism. During this time, it is important for all of us as child and adolescent psychiatrists to reach out and check in on our Asian-American colleagues, patients and families.”
brought the virus to the United States and the “model minority” who ought to remain quiet against the discrimination faced. The bottom line: Asian Americans are perpetual foreigners and as actor John Cho puts it, “our belonging (in the US) is conditional.” No more has this been felt than by Asian-American physicians, many working on the front lines during this pandemic. Patients have refused Asian-American healthcare workers to take part in their care. Worse, strangers follow them post-work shifts and harass them with racial slurs. This was the experience of anesthesiology resident Lucy Li in Boston, MA, and many more. No matter how successful, Asian-American physicians were being turned away and shunned from the patients they took an oath to serve.

Our Asian-American youths are also vulnerable to discrimination, and inside many homes, families are having conversations on how to stay safe from coronavirus and racism. During this time, it is important for all of us as child and adolescent psychiatrists to reach out and check in on our Asian-American colleagues, patients and families. We need to create a space for them to voice their fears, share their experiences and process the impact discrimination has on their well-being. It can be traumatic for many. A simple “How are you doing with all the Anti-Asian sentiments happening around us?” can go a long way.

Acknowledgment is a powerful initial action step. As physicians, it is also within our domain to advocate. We can empower our patients and families to report any acts of hate and xenophobia to local law enforcement agencies and to an online database at www.stopaapihate.com. We can reach out to the AACAP Advocacy Committees and write to elected officials to support policies and legislations that denounce anti-Asian racism. In March, U.S. Representative Grace Meng introduced a House resolution (H.R.6721) to condemn all forms of racism, calling on public officials to denounce any anti-Asian sentiment, and demanding investigations and data collection into coronavirus related violence and discrimination.

We can all do our part in allying with the greater social justice movement, in speaking up about concerns, and empowering ourselves to affect change. We can no longer remain silent. Now more than ever, we need to stand together and work to combat hate and all forms of racism in the era of the COVID-19 pandemic and beyond.

References

Dr. Annie S. Li is a board certified General and Child and Adolescent Psychiatrist and is Assistant Professor of Clinical Psychiatry at Weill Cornell Medical College in New York. She received her medical degree from Albert Einstein College of Medicine and went on to complete her general psychiatry residency at New York Presbyterian-Weill Cornell Medical Center and her child and adolescent psychiatry fellowship at the combined New York Presbyterian Hospital - Columbia University Medical Center and Weill Cornell Medical Center Program.

Dr. Cho is a co-founder and co-chair for the Asian Caucus of AACAP and serves as an active member of the Diversity and Culture Committee. She is particularly interested in cultural psychiatry and invested in working with children of diverse backgrounds. She is currently in private practice in Yakima, Washington.
COVID-19 Pandemic: Challenges to the Filipino Children and Families

Rhodora Andrea M. Concepcion, MD, FPPA (Life), FPSCAP

Coronavirus infections are spreading rapidly in the Philippines and across the globe; the virus has already infected millions of people worldwide, and has taken the lives of hundreds of thousands.

On March 15, 2020, Philippine President Rodrigo Duterte placed the country’s National Capital Region under a “community quarantine,” initially intended to last for only two weeks. As the number of patients identified to be positive with COVID-19 rose very quickly, the national government implemented stricter efforts to protect the Filipino population. By March 17, 2020, President Duterte had placed the entire Luzon region under “enhanced community quarantine”. Nevertheless, until now, the majority of the Philippine regions that have identified cases of Covid-19 are still only in general community quarantine.

Under this provision, strict home quarantine was implemented in all households. Classes and all means of public transportation were suspended. Public establishments were closed. Provisions for food and essential health services were regulated. An increased number of uniformed personnel enforced the quarantine procedures. Any event that would draw a crowd was cancelled.

Over this period, parents and children have faced challenges and have expressed concerns about how this pandemic is impacting their lives and how it is affecting their children and teens’ physical, mental, and emotional health.

In these trying times, supporting and managing the mental and emotional health of children and families became an even more important priority for Philippine psychiatrists. During the COVID-19 pandemic, healthcare workers including adult, adolescent, and child psychiatrists, are being pushed to their limits as they selflessly care for patients. Not only are they under enormous strain at work, they also face the fear of bringing the virus home to their families.

Psychiatrists in the Philippines are getting creative about telehealth as the safest and most practical option in the current situation. Webinars have become the trend. For now, the pandemic has changed the way we communicate and hold psychotherapy sessions with patients, with children, adults, and families. It has also changed the way we hold public events. Looking at the safety benefits of telehealth, there can be an expanded use of telemedicine after the pandemic ends because it works well for the majority of medical practitioners and patients.

The Philippine Society for Child and Adolescent Psychiatry provides a series of monthly webinars on the theme “Challenges in the Care of Children and Families in Living the New Normal” that started in the second quarter of 2020 and will run until the last quarter of 2021.

Related topics on the theme, and help guides, are presented and discussed by child and adolescent psychiatrists in the two-hour-long monthly webinars that reach a wide audience that includes not only psychiatrists, but medical practitioners from other specialties and allied professions, healthcare workers, parents, teachers, students, and the general public.

Media interviews through different online platforms are also granted by psychiatrists on important psychosocial and mental health issues surrounding the current times.

The main objectives of these series of webinars are:

A. To help children and families:
   1. Find positive ways to express disturbing feelings such as fear and sadness
   2. Communicate their unique ways of expressing emotions
   3. Convey their individual styles of coping
   4. Draw important lessons from the experience

B. To guide mental health professionals, parents, guardians and teachers, and to allay the worries and anxiety of these young populations amidst the public health crisis and in the post-crisis situation.

Dr. Concepcion is President, Philippine Society for Child and Adolescent Psychiatry.
REACH OUT

Reflecting upon reality, please remember that it’s vital
to eat, exercise & express our emotions in healthy ways.
Open up & try not to be closed off — it’s okay to not feel okay & it won’t last forever.

Allow yourself to be authentic & avoid turning to drugs & alcohol.
Unburden yourself from isolation — reach out to those who care & reach into your heart’s love & gratitude.

Have compassion for yourself & others. We are all going through a tough time & some far more than others.
This moment now gives way to tomorrow — together we will weather the coronavirus storm.

Hope & help are here. Don’t be ashamed to call those warmline & hotline numbers.
Diane Kaufman, MD
Creative Life Lines

Mental Health & COVID-19
Will There Be Enough IMG CAPs to Combat COVID-19?

“The COVID-19 pandemic is a crisis felt in homes and hospitals, at the local level, and across the globe. This public health calamity has spawned a mental health emergency of its own. More than ever, we are in a dire need for child and adolescent psychiatrists to battle the deadly disease.

Instead, child and adolescent psychiatry is severely lacking an adequate number of providers to care for American children. Even before COVID hit, there were only around 8,300 child and adolescent psychiatrists to treat more than 15 million children. From big cities to rural pockets, large swaths of the country are missing the services of a child and adolescent psychiatrist. Children are suffering as they wait months for an appointment.

The Association of American Medical Colleges (AAMC) projects a shortage of between 33,800 to 72,700 specialists by 2030. Psychiatry and child psychiatry are two of the specialties expected to be hit particularly hard by the shortage. But we don’t have to wait 10 years to see that. We see it today.

Historically, International Medical Graduates (IMGs) have played a crucial role in filling the gap. They provide psychiatric care to children and adults alike. Now is no different. They can play a significant role as patients flock to our clinics and hospitals.

Let’s begin by understanding who IMGs are. As a group, most IMGs are foreign-born, though some are US citizens or permanent residents. They work alongside American graduates to take care of our children. IMGs make up roughly 25 percent of the psychiatric workforce. They represent America’s changing demographics, reflecting the diversity of their patients and sharing their rich cultural experiences with their colleagues. They often work in underserved areas, where vulnerable children need psychiatrists most. In addition, research shows that patients treated by IMGs report equivalent outcomes.

Being an IMG doesn’t come without challenges though, and it’s up to the rest of us to offer support and guidance so they can overcome them, just as they overcame the many obstacles they faced to immigrate to a new country, pass their medical equivalency exams and land a residency. New IMGs may experience some trouble understanding the healthcare system, uncommon disease patterns, novel technology, or pioneering treatment approaches. While they are learning the medical aspects of their psychiatric training, they are also navigating new social norms, cultural practices, demanding expectations, all while mastering the nuances of the English language. Unfortunately, they often also face discrimination, which we must speak out against. We can be their mentors and colleagues.

The majority of IMGs succeed in the transition, yet there is trepidation when it comes to their future in child psychiatry. At the most recent IMG Caucus, which took place during AACAP’s 66th annual meeting, participants expressed concern related to the decreasing number of IMGs accepted to psychiatry residency training in 2019. Overall, there were fewer IMGs who participated in the Match than the year before, but the silver lining is that slightly more found greater success in first-year residency matches. Still, the 2020 Match results do not list psychiatry as one of the top specialties friendliest to non-citizens IMGs. The IMG Caucus group also worried about the effect of having fewer IMGs in the psychiatric pool on recruitment of IMGs to child psychiatry fellowships.

Although the responsibility to choose residents does not fall to AACAP leaders, we should raise these concerns with them and those who work on residency recruitment. Several of the AACAP leaders are IMGs and have led the way in the field of child and adolescent psychiatry. By limiting resident options for IMGs, not only are we missing out on some of the most talented and dedicated in the field, but we are doing a disservice to our patients. We are only adding to the critical shortage rather than offering a solution.

Thankfully, AACAP is working to encourage graduate and medical students to pursue child psychiatry as a profession. We need to support that and provide other recruitment opportunities for IMGs and American graduates alike. What is at risk if this shortage persists is nothing short of the future of our children.

“Now is the time to loosen regulations to allow more IMGs to stay in the country and help us combat COVID-19 on the front lines. In addition, we should facilitate the entrance of IMGs who are non-citizens to start their residency in July 2020. We need them.”

“No one knows when COVID-19 will be contained. Even when it is, the aftermath will be felt long after. We need every doctor we can to help.”
That risk has been exacerbated by COVID-19 and the urgency has heightened. The U.S. Citizenship and Immigration Services suspended a number of services that IMGs rely on to renew their visas. Without current visas, IMGs are at risk of being deported or having to leave the country on their own. If they overstay their visa, they may be barred from entering the U.S. again. The closures at USCIS can result in additional delays of months or years. This has put IMGs in a precarious position as they work to help their patients but grapple with their anxiety about the future. For those who have family abroad, they can’t rely on them for support because they are unable to visit the country during these difficult times.

Now is the time to loosen regulations to allow more IMGs to stay in the country and help us combat COVID-19 on the front lines. In addition, we should facilitate the entrance of IMGs who are non-citizens to start their residency in July 2020. We need them. AACAP has joined hands with ten other organizations, including the American Psychiatric Association, in supporting IMGs. The organizations recently wrote a letter to the Acting Director of USCIS advocating for extending visas for a year, resuming the premium processing that was put on hold on March, 2020, and expediting approval of extensions and changes of status for non-US citizens IMGs practicing or otherwise lawfully in the US.

No one knows when COVID-19 will be contained. Even when it is, the aftermath will be felt long after. We need every doctor we can to help.

References

Dr. Adam is a child and adolescent psychiatrist and clinical associate professor of Psychiatry at the University of Missouri-Columbia. She may be reached at adamb@health.missouri.edu.

The newest episode of SCREENSIDE CHATS is now available to watch or download!

The second in a two-part series, watch Episode 10: Going Back to School – Kids with Special Needs with AACAP Schools Committee member Jeff Bostic, MD, EdD, and AACAP President Gabrielle A. Carlson, MD. This episode covers insights to help students most in need as teachers and schools deal with the COVID-19 pandemic.

Watch Going Back to School – Kids with Special Needs or download from the Apple App Store or Google Podcasts app!
Play Therapy in the Time of COVID

Bart is an attractive and smart eight-year-old boy who was brought in for therapy due to acting out at school. His teachers reported that he tends to have angry outbursts that seem to have no precipitants. He is overly competitive, a bad loser, and bullies other kids. The parents agree with the school’s assessment, but feel that his behaviors are much worse at school than at home.

For the assessment (done shortly before COVID-19), Bart agreed to come in, but preferred that his mother remain in the session. The first session began with him talking about a bunny who liked carrots from the neighbor’s garden. Unfortunately, the garden was guarded by owners with rifles and killer dogs who did not like the bunny’s carrot eating habits. The bunny talked about how clever he needed to be to avoid being killed. The session was facilitated by the serendipity of me having a bunny puppet which Bart used to tell me the story cited above. The session was extremely fun and interesting. Reading in between the lines, it was my sense that his behaviors had worsened around the time mom got busier at work, and father started making trips abroad to pursue entrepreneurial ventures. The parents did not share my enthusiasm for this theory.

The next session was also held with the mom, and dealt with the bunny’s clever plans for securing carrots. These included negotiations between the neighbors and the bunny that led to peaceful coexistence and a supply of luscious carrots.

After this session, the COVID-19 pandemic struck, which made it so that Bart didn’t go to school and could not come to my office. We conducted the next session over my iPhone, again with mom. Bart insisted that he wanted to be able to see me, so I used FaceTime. At the end of the session, which included a lengthy session of play around a gigantic LEGO castle he had built, I was pleased when he accepted my invitation to an individual session, something I had been asking him to consider since the evaluation began.

I logistically prepared for the session by scotch-taping my iPhone 6S, with its four-inch screen, to my large hole puncher so that I could see him and be seen by him while having my hands free to write notes. He began by creating a cartoon with emojis. He created a shark garage band. The sharks had gigantic teeth and what appeared to me as very anxious eyes. As the session progressed, the number of shark band members increased. Each had their own instrument: two had guitars, one a French horn, a violin, and a grand piano that was subsequently removed for not being loud enough. It was replaced by a set of very loud drums.

“No cellos?” I asked mischievously.

He laughed and added microphones and a wall of amplifiers.

“Boy, this will be a very loud band!” I exclaimed.

“Yes.”

“Oh,” I interrupted. “I told you I’d tell you when I talked to your mom on the phone. We had a call last week to see how she and your dad thought things were going. She said that it’s hard to tell how school is because you have no school. She said that things were reported as being better before school closed, although the teachers said that you were still bossy and too loud.”

He did not respond to this and explained that the shark garage band was part of a game called “Balloon TD 6,” which I had never heard of.

“Tell me about the game?” I asked.

“The enemies are balloons. If they kill you, you lose lives. I’ll show you them.”

He then put up balloons, a bigger blimp, and an ultra-blimp. “They all have powers.”

“What powers?”

“I’m terrible at explaining things.”

“Why do you feel like that? You seem to be doing a good job as far as I am concerned.”

“I have the highest score. The highest in the world. One billion. The next highest level is 200.”

“Wow. That’s something,” I added.

He then added robots to the garage band and a tuba (actually a French horn). Alien robots who were swearing (drawn with swear symbols where their mouths were) followed.

“What are they saying?” I asked.

“Why are they swearing?” The screen paused.

“What happened?” I asked.

“The sound goes out when the aliens swear. Oh. I have to go to the bathroom.”

He was gone for quite some time. As he was away, I wondered if this call on my iPhone was using up my data plan or whether the Wi-Fi at work was on as the coverage was traditionally poor in my office, which is far from the router. He returned.

“Number one or two?” I asked.

“two” he answered.

“I figured... By the way, I wondered if the sound went out when the aliens swore because they didn’t want what they were saying to be heard?” I asked.
As he sat down, I noted that he had gotten a drink and that his T-shirt had a vicious T-Rex with a rock guitar in its tiny dinosaur front arms.

“Cool shirt!” I commented.

“Do you want to hear the aliens?”

“Sure.” He put the sound back on.

“What are you drinking?” I asked.

“Ginger ale.”

“I think I’ll eat the alien.” He proceeded to do so.

“Now he’s inside of you. How’s that feel?” I asked.

“My stomach acid kills aliens.” He continued to eat aliens until he put up a new alien that had stuff on his head.

“What’s on his head?” I asked, not being able to tell on my small screen.

“His head is exploding!”

“How come?”

There was another pause.

“Doesn’t the alien want to talk about his head exploding?” I asked.

There was no answer, but more aliens continued to appear on the screen.

“If I eat all of them, a space cannon appears. It’s angry I’m eating all the aliens. The space cannon wants to take over the galaxy.”

“I am still wondering what the aliens are doing? They seemed angry before you started eating them.”

“I don’t know. By the way, which filters do you like?”

He then switched through a set of perhaps eight filters with differing shades. “Which shade do you like?” he asked.

I decided I liked the “dramatic cool” filter.

A flexing biceps then appeared on the screen. He flexed his own biceps and said “I’m killing it!”

His hair then had fire symbols on it.

“Heard you are on fire!” I remarked.

He laughed and began to sing: “I have fire in my hair. I’m the devil and have diamonds (appearing on the screen as he sang). I have diamond eyes.”

“How did you become a devil?”

He didn’t answer, but confetti rained down and ‘zz zz zz’ appeared on the screen which I took as sleep.

“What are they doing? I wonder what the aliens are doing?”

“I guess so.” And then he sang a song featuring chicken butt.

“I’m confused. Are you faking being poor?”

“Welcome to the Garage Band” he continued without answering any of my questions.

“Does the band play angry music?”

“Sharks are peaceful.”

“And yet, I pointed out the sharks are yelling. Each gets a microphone and amplifiers so the sharks can yell louder.”

He then sang a song in a scat style without words. It was not an angry song nor did he yell it.

“And the sharks need more amps” he said.

“To yell even louder!” he responded.

“What ever they say is going to be loud” I added. “I wonder what they want to say?”

He answered: “We are idiots! Their name is the Diamond Band.”

“So they are rich?”

“Yes.” He then covered them with more diamonds to accentuate their wealth.

“They are not angry. No.” he added while covering the bands with confetti. “What else should I add?... More diamonds?”

He doubled the number of amps as he sang over and over! “We are the diamond band.” As he sang, he continually added more diamonds.

“Where do the diamonds come from?” I asked.

“From rich people. They like really good music and we like diamonds. They give good concerts and the prize is diamonds and amplifiers. And we get richer and richer. We need more noise, more noise. We broke the sound barrier!”

The play escalated with more and more characters appearing on the screen. They are all swearing and angry, but they don’t know why. He agrees that he too is angry and doesn’t know why.
“Let’s continue the therapy and see if we can figure that out. Do you agree?”

“That makes sense.”

“How do you like the therapy?” I added as I often do at the end of sessions.

“I like the therapy. Can we have a session next week?”

“Surely. I’ll work out the time with your mom.”

Conclusion: Play therapy is fun and creative. The therapist and patient build their sessions out of what is available to them. They are usually “face to face” and use whatever is in the therapists’ office. COVID-19 made it so the sessions couldn’t be face to face. I was supposed to Zoom the session, but my clinic hadn’t installed a camera on my computer. This meant I got to use my iPhone’s FaceTime app, which I am comfortable with but had never used for therapy. It worked out well. Bart’s use of the emojis (which I don’t know how to use) made the session unique. In the session, I tried, as usual, to identify the themes. I had already identified his anger and his not being able—or not being willing—to say what the anger was about. The angry and anxious-eyed sharks, the swearing aliens, and the addition of more and more amplifiers to the point of “breaking the sound barrier” seemed linked to the theme of anger. In the session, I used my most frumpy and obtuse Columbo – the-detective style, and just wondered over and over about why the figures were angry. His eating the swearing aliens made me think that was a way for Bart to “eat his sorrows/anger.” The session also reinforced my sense of Bart having troubles with his early narcissistic development. This theory was based on his initial tale of the little bunny in a big threatening world of killer dogs and rifle-toting owners, who managed to outwit them, along with others, such as the fact that the aliens wanted to take over the galaxy, his flexing of his biceps (“I’m killing it!”) his having the highest score “in the world” on his game and his richly-elaborated theme of people being either rich or poor with rich being highly preferable. Who wouldn’t like fame and fortune and all those lovely diamonds? I can’t wait to see where the play will lead us in the next session.

Addendum: During the next session, he continued with the same themes of the garage band and angry aliens. These themes were interrupted only twice during the session, once to go to the bathroom (number two again) and the second time when he suddenly stopped the play and exclaimed loudly: “Dr. Drell, do you have any idea on how many hours my mother works a day? She works 12 hours per day.” After his remarks, he returned to his play like nothing had happened and refused any attempts on my part to ask him about his feelings about what he had said.

Dr. Drell is 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. Dr. Drell may be reached at MDrell@lsuhsc.edu.

Share Your Photo Talents With AACAP News

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.
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.
**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](http://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](http://www.aacap.org/pip).

**Live Meetings**

(www.aacap.org/cme)

- **Pediatric Psychopharmacology Institute**
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- **Douglas B. Hansen, MD,**
  **Annual Update Course**
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- **Annual Meeting**
  — Up to 50 CME Credits
- • **Annual Meeting Self-Assessment Exam**
  — 8 self-assessment CME Credits
- • **Annual Meeting Self-Assessment Workshop**
  — 8 self-assessment CME Credits
- • **Lifelong Learning Institute featuring the latest module**

**Online CME**

(www.aacap.org/onlinecme)

- **Clinical Essentials**
  – Up to 6 CME credits per topic
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- **Current Topics in Pediatric Psychopharmacology: An Online Advanced Course**
  – Up to 8 CME credits
- **Journal CME**
  – (FREE) Up to 1 CME credit per article per month

**Questions?**

Contact us at cme@aacap.org.

www.aacap.org/moc
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These self-study online CME courses feature premium quality materials that have been curated by our experts to deliver the most high-yield content on the topic.

Current Topics in Pediatric Psychopharmacology
Earn up to 8 CME credits while updating your knowledge on clinically relevant, evidence-based pediatric psychopharmacology. Listen to top rated speakers from past AACAP Institutes lecture on topics including ADHD, aggression, bipolar disorder, and more.

On Demand: 2020 Douglas B. Hansen, 45th Annual Update Course
This engaging course is worth up to 17 CME credits and includes lectures on trauma, threat-assessment, severe mental illness, and more.

Visit www.aacap.org/onlinecme to learn more
Don’t miss this opportunity to save money at the 2020 Virtual Annual Meeting

Even though we’ll all be meeting virtually this year, there are still plenty of opportunities for exhibitors to promote their products, services, and job opportunities as part of this meeting.

AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount off their 2020 Virtual Annual Meeting registration.

Referrals apply to first-time AACAP exhibitors who purchase a virtual booth at AACAP’s Virtual Annual Meeting.

Exhibitors will have the opportunity to connect with the largest virtual gathering of child and adolescent psychiatrists and other medical professionals, as well as advertise on the Virtual Annual Meeting website. Historically, AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. To review the full exhibitor information, with more details on this opportunity, please visit www.aacap.org/AnnualMeeting-2020.

Show your support for AACAP and save today!

Questions? Email exhibits@aacap.org or call 202.966.7779.
Is Renewing Stressing You Out?

AACAP offers flexible payment solutions to meet your needs.

Take advantage of our monthly installment payment program. Contact Member Services at 202.966.7300, ext. 2004, or email us at dues@aacap.org to discuss your personalized payment plan options.

AACAP Coronavirus Resources

NEW! Check out AACAP’s new section Resources for Helping Kids and Parents Cope Amidst COVID-19.

AACAP’s Coronavirus Resource Library contains updated resources for parents, patients, and clinicians to help with the impact of the coronavirus (COVID-19).

In Memoriam

James Pessin, MD
New York, NY

Samuel Tambyraja, MD
Akron, OH

Edward Ritvo, MD
Los Angeles, CA

Joan Kinlan, MD
Washington, DC

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.
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182 AACAP NEWS
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AACAP Policy Statement

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

Opioid Use Disorder Treatment for Youth

Approved by Council June 2020

Background/Rationale

Although opioid use rates among youth are decreasing from a high of 9.2% of school-attending 12th graders in 2009, nevertheless 3.1% (800,000) youth aged 12-17 years reported opioid misuse in 2017, and 0.4% (99,000) met criteria for an opioid use disorder (OUD). In 2017, 4,094 youth aged 15-24 years died of an opioid overdose. Most youth with OUD have co-occurring psychiatric disorders which makes child and adolescent psychiatrists well positioned to identify and address OUD in their patients.

Buprenorphine/naloxone is a medication that is FDA approved for the treatment of moderate to severe OUD in adolescents and has been shown in randomized controlled trials to increase abstinence in youth. Naltrexone extended release and methadone are FDA approved for the treatment of moderate to severe OUD in adults although no randomized controlled trials have been done with these medications in youth. A case series with naltrexone extended release, however, demonstrated promising results. Medication to treat OUD has also been shown to improve treatment engagement in youth. In addition to medication, psychosocial treatment is an important evidence based intervention for youth with substance use disorders, having demonstrated acceptability and effectiveness for youth with OUD.

The American Academy of Child and Adolescent Psychiatry recommends:

● Increasing implementation of valid screening and assessment tools for youth who present with psychiatric disorders to improve the identification of OUD. Examples of evidence based screening tools for adolescent substance use include Screening to Brief Intervention and Brief Screener for Alcohol, Tobacco, and Other Drugs.
● Increasing youth’s access to medication for the treatment of OUD by:
  – Obtaining waivers to prescribe buprenorphine.
  – Decreasing insurance and regulatory barriers to the use of medication to treat OUD in youth under the age of 18 years.
  – Offering youth choice in their preference of medication to treat OUD and duration of treatment.
● Offering psychosocial treatments to youth with OUD and their caregivers to enhance retention in treatment and prevent relapse.
● Treating OUD concurrently with treatment of psychiatric disorders to maximize improvements.
● Providing education on overdose risk factors and prescribing naloxone for the prevention of opioid overdose in youth and caregivers.

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children’s mental health.

For more information or to review AACAP’s Policy Statements visit www.aacap.org.
Suicide Safety: Precautions at Home

Suicide is one of the leading causes of death for children, teens, and young adults in the United States. Although attempting and completing suicide is more common in children with depression and other mood disorders, impulsive suicide attempts can occur in those with no known history of mental illness. We now know that families can make homes safer, helping to protect children and teens. Even if you have made your home safer, if your child is talking about thoughts or plans of suicide, they should be urgently evaluated by a qualified mental health provider. Although, it is not possible to make a home perfectly safe, following these suggestions can help reduce the risks and chance for a suicide attempt.

Sources of Risk in the Home

Weapons

Research shows that having a gun or weapon in the home increases the risk of dying by suicide.

- Guns should be stored unloaded in a locked safe. Bullets should be also locked, but in a separate place.
- Gun safe keys or combination to the lock should be kept only by the adults in the house.
- Consider purchasing trigger locks for guns.
- When children and teens go to friends or relatives’ homes, ask about gun ownership and storage.
- Lock away knives, razor blades, and other sharp objects from children and teens.

Medications

Parents and caregivers should be in charge of the medications that are kept in the home.

- Keep all medications, both prescribed and non-prescribed (over the counter), in a locked box.
- An adult should hand out and control all prescribed and over the counter medications to children and adolescents.
- Keep track of all bottles of medication as well as the number of pills in each container, including those prescribed as over the counter medications (such as pain relief, allergy pills, vitamins, and supplements, etc) for every person and any pets in the home.
- Dispose of all expired and no longer used prescribed medications by bringing them to your local pharmacy or fire station.
- Ask the parents of your child’s friends how their medications are stored in their home.

If substances that can be abused are kept in the home, they should be monitored and locked.

- Keep track of bottles of alcohol and lock them away. It is not enough to put these items “out of reach.”
- If marijuana is kept in the home, lock all forms of it in a lock box that only adults in the house have the lock or combination to.
- Talk with the parents of your child’s friends about how they store alcohol or marijuana in the home.

Other items can be used for self-harm and suicide.

- Keep your vehicle keys with you at all times or consider locking them in a lock box when not in use.
- Lock all toxic household cleaners, pesticides, and industrial chemicals away.
- Consider limiting ropes, electrical wire, and long cords within the home or lock them away.
- Secure and lock high level windows and access to rooftops.

(continued)
Parents and caregivers should monitor the online activities of their children, watching for:

- Researching methods of suicide
- Purchasing of any materials or items that could be used for self-harm
- Spending time in chatrooms or social media sites dedicated to self-harm or suicide
- Receiving texts or direct messages from peers about suicide, calls for help or peer bullying

The risk of dying by suicide can be decreased when families and caregivers reduce access to ways children can harm themselves. Following these steps can help to improve safety in your home. If you are concerned that your child has been exhibiting signs that they are thinking about suicide, or expressing feelings of hopelessness or depression, please seek help from a child and adolescent psychiatrist or other mental health professional immediately for an emergency evaluation.

# # #

If you find Facts for Families® helpful and would like to make good mental health a reality, consider donating to the Campaign for America’s Kids. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to Campaign for America’s Kids, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 9,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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If you need immediate assistance, please dial 911.

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Ensure AACAP’s Future!

Visit www.aacap.org/1953_Society to learn more!
Caffeine and Children

Most children and adolescents drink or eat some form of caffeine every day. Caffeine can be found naturally in some plant-based foods and drinks, and is also added to many manufactured products.

Youth most often get caffeine from soda, coffee, and tea, but parents should know that there are many different types of products with large amounts of caffeine available. Checking product labels and ingredient lists is the way to know for sure how much caffeine is in the product. It is important to know different products contain varying amounts of caffeine. Also, your child may not respond to caffeine the same way as another child.

Sources of caffeine include:

- Many sodas
- Coffee
- Tea, including iced teas and sweet tea
- Energy drinks
- Chocolate and some coffee flavored foods (ice creams, yogurts, coffee bean candies)
- Other beverages (water, juices) and snack foods (mints, gummy candy, chewing gum, peanut butter, energy bars) with added caffeine
- Lip balms and some skincare products
- Some non-prescription/over the counter medications
- Supplements (weight loss, energy, and work-out related supplements, combination CBD/caffeine products)

Children and adults may experience a range of effects after using caffeine including:

- Insomnia
- Jumpiness, hyperactivity, and anxiety
- Nausea and lack of appetite
- Headache
- Tremor and dizziness
- Increased energy and reduced fatigue
- Improved focus and task completion

Caffeine Overdose

Symptoms of caffeine overdose can include vomiting, high blood pressure, racing heart, heart rhythm problems, and, less commonly, disorientation and hallucinations. Each year, thousands of people, some of them children, receive emergency treatment related to caffeine use. Youth with certain health conditions such as heart problems, seizures, or migraines may be more at risk for caffeine-related problems than others.

Even without overdose, others experience problems with long term use. Some risks associated with long-term caffeine use may include:

- Sleep problems (difficulty falling asleep and poor sleep)
- Irritability and mood problems
- Increased stress hormone levels
- Needing higher doses of caffeine to achieve the desired effect
- Cravings and withdrawal symptoms (including tiredness, headaches, mood changes, and problems concentrating) when everyday caffeine is stopped
- Increased risk of panic, anger, violence, risk-taking, and substance use problems
- Increased sugar intake when using sugary caffeinated products
- More difficulty quitting other substances (such as nicotine) and limiting alcohol use when combined with caffeine

(continued)
Ways to Help Youth Decrease Caffeine Intake

Children view advertising for caffeinated products on many different platforms, and they are also watching how their parents and friends use caffeine. It is best for parents to educate their children about common sources of caffeine and how to read food and drink labels. Talk openly and freely about your child’s caffeine use to understand their ideas about the risks and benefits of caffeine.

There is no proven safe dose of caffeine for children. Product regulations are based on practices dating as far back as the 1940’s. At this time, pediatricians advise against caffeine for children under 12 and against any use of energy drinks for all children and teens. They also suggest limiting caffeine to at most 100 mg (about two 12 oz cans of cola) daily for those 12-18 years old.

If you are concerned about your child’s caffeine use, talk with your child’s pediatrician, child psychiatrist or mental health professional about whether more intensive help or guidance is needed.

If you find Facts for Families® helpful and would like to make good mental health a reality, consider donating to the Campaign for America’s Kids. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

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Virtual Forum

Using the Current Public Health Crisis as an Opportunity for Advocacy

Thursday, September 17 | 8:00pm – 9:30pm EDT

The American Association of Child & Adolescent Psychiatry is hosting a Virtual Forum on Advocacy and we want you to come!

Join us Thursday, September 17 from 8:00pm - 9:30pm EDT to learn the nuts and bolts of advocacy as a physician! If you’re interested in shaping children’s mental health policy at the federal and state levels, then this event is for you!

Register to learn about:
- The basics of the public policy process;
- Strategies to engage federal and state legislators;
- Working in coalition; and
- Partnering with AACAP in advocacy efforts

Register Now
DON'T MISS A THING

Check out AACAP's Social Media

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American Academy of Child & Adolescent Psychiatry

AACAP NEWS CLIPS

We'll send you an email every Monday, Wednesday, and Friday with the need-to-know on child psychiatry news.

Email Reilly Polka, AACAP Communications Manager, at rpolka@aacap.org with questions.
FLORIDA
Company: Florida Health Care Plans, Inc. (1217594)
Title: Child / Adolescent Psychiatrist
Job ID: 13787790
https://jobsource.aacap.org/jobs/13787790

Job Description:
FHCP is seeking an experienced Child/ Adolescent, BC/BE Psychiatrist for our Edgewater Facility. Our outpatient behavioral health department uses a team-based approach including full scope of support staff with tenured case managers, therapists and crisis intervention team. Suboxone license/ Buprenorphine waiver a plus. Work with extraordinary colleagues who share your dedication to medical excellence! Position Details Flexible 40-hour work week, 4-10's or 5-8's, no office hours nights, or weekends Outpatient Only Call is one week (1) in five (5) 14-18 Patients per day Compensation Details Generous Base Salary Bonus Opportunities Exceptional Benefit Package Licenses, Fees, Dues paid Generous PLT & CME 401K match up to 4% after 12 months Relocation Assistance FHCP is celebrating 45 years of service and is voted Best Health Plan by News Journal readers for 27 consecutive years with a NCQA Rating: “Commendable” Accreditation and a 5 Star rating for our Medicare Advantage members. Equal Opportunity Employer/ Protected Veteran/Disabled

Job Requirements:
Board Certified or Board Eligible Current Florida License Suboxone License / Buprenorphone Waiver

OHIO
Company: Red Oak Mental Health (12170806)
Title: Medical Director
Job ID: 13792666
https://jobsource.aacap.org/jobs/13792666

Job Description:
Job Summary: Under administrative direction, manages and leads the medical functions of the Medical Somatic Services of the agency; provides medical oversight, enforces health statutes and rules; provides supervision of certified nurse practitioner(s) and acts as a liaison to local medical community; provide direct patient care; and performs related duties as required. Essential Functions and Duties: Approves medical policies and procedures; determines medical goals and scope of practice for the service; approves protocols and standardized procedures; and ensures that the med/som service goals integrate with the agency as a whole. Educates and advises staff on standards of practice and communicable diseases and prevention requirements. Conducts medical and somatic examinations, makes diagnoses and prescribes therapy; Prescribes, administers, and manages pharmacologic treatment for clients; Reviews lab reports; Participates in staff conferences consulting or recommending appropriate treatment approaches; Confer in person with patients, guardians and relatives regarding illness and treatment; Cooperates with other community health and hospital personnel; Keeps medical records and prepares psychiatric reports; Provides in-service training to clinical staff as requested.

Job Requirements:
Qualifications/Requirements: Possession of a valid license as a physician in the State of Ohio; Knowledge of psychiatric medicine, clinic management & agency procedures; Ability to skillfully diagnose and treat juvenile and adult psychiatric patients, analyze situations and adopt an effective course of action; Ability to prepare records and reports; establish and maintain effective working relationships with others; maintain objectivity and confidentiality.

NORTH CAROLINA
Company: Solstice East LLC (1217788)
Title: Contract Psychiatrist
Job ID: 13792547
https://jobsource.aacap.org/jobs/13792547

Job Description:
Solstice East RTC, Equinox RTC and Journey Home East are seeking a Contracted Psychiatrist for their adolescent residential treatment centers in the Asheville area. The position hours are flexible and could involve part-time or full-time hours depending on desired caseload, ranging between 10 to 70 students. Must be licensed in the State of North Carolina, and a specialty in Child and Adolescent Psychiatry is preferred. Prior experience with adolescents in a behavioral health setting is strongly desired but not required. Contracted Psychiatrist will provide psychiatric services to patients in the above-named programs through a combination of on-site visits and telehealth. They will work in collaboration with other psychiatrists, nursing staff, therapists and clinical directors at the programs through in-person communication, electronic communications and weekly treatment team meetings. The Psychiatrist will be responsible for: Completing psychiatric evaluations and ongoing assessments; Performing follow up visits which average 1 per month for each patient; Reviewing and signing off on treatment plans and intake documentation; Ordering and interpreting lab work; Prescribing medications; Using our electronic health record and electronic Medication Administration program; Consulting with staff regarding psychiatric or medical emergencies among patients, which includes some on-call responsibilities.

Job Requirements:
Must possess a current license to practice medicine in the State of North Carolina.

OREGON
Company: Spin Recruitment Advertising (876472)
Title: Child Psychiatrist
Job ID: 13769974
https://jobsource.aacap.org/jobs/13769974

Job Description:
Child Psychiatrist Opportunities Portland, Oregon Northwest Permanente, P.C. invites you to consider opportunities with our physician-managed, multi-speciality group of over 1,500 physicians and clinicians. We
have Board Certified/Board Eligible Child Psychiatrist opportunities in the Portland, OR area. Our physicians care for over 600,000 members throughout Oregon and Southwest Washington. We use a combination of face-to-face and the latest virtual modalities to provide evidence-based, psychiatric treatments, including primary care consults, crisis interventions and medication consultation. We are open to physicians interested in working onsite, virtually, or a combination of onsite/virtual. What’s special about Northwest Permanente? We are “Physician led and owned”. We practice data-driven, evidence-based medicine. We have a salary model that puts the patient’s needs first. There are no outside insurers limiting the care you feel is best for your patients. We don’t use production goals to determine your compensation or value as a physician. We are a B-Corporation which reflects our strong commitment to our community, patients and environment. Our physicians work in a team-based care model and are supported by a well-trained cadre of experts. Many of our teams are even paired, 1 to 1, with a Care Coordinator and RN or LPN. We have incredible benefits, including: Competitive salary and incentives such as student loan assistance and signing bonus. Our retirement plans are supported through an additional 21% income, invested across our Defined Contribution, 401K, and Cash Balance Pension plans. Annual educational leave and long-term, sabbatical benefits. Generous benefits package. Inquire for details. We invite you to apply at: nwpermanente.com. For more information, call Jason at (503) 813-2242 or email jason.r.dulin@kp.org. We are an equal opportunity employer and value diversity within our organization.

TEXAS

Company: TTUHSC El Paso- Psychiatry (1211405)
Title: Assistant Professor- Child and Adolescent Psychiatry
Job ID: 13757861
https://jobsouce.aacap.org/jobs/13757861

Job Description:
Assistant or Associate Professor-Child and Adolescent Psychiatry. Texas Tech University Health Sciences Center at El Paso, Department of Psychiatry is recruiting a Board Certified (Child and Adolescent Psychiatry) Assistant/Associate Professor in our Child and Adolescent Psychiatry clinical/teaching program. The applicant must have an MD or DO degree, successful completion of ACGME-accredited residency program in General Psychiatry and successful completion of ACGME-accredited fellowship program in Child and Adolescent Psychiatry. Applicants must have a demonstrated record of effectiveness as a teacher, a record of peer reviewed publication and/or peer-reviewed creative activity which has contributed to the field of psychiatry and to the candidate’s intellectual and artistic development. There should be a record of professional service appropriate to the discipline and a promise of growth in teaching and research or artistic and creative activity. The applicant will provide patient care for child and adolescent outpatient and consultation-liaison services, supervise Resident/Fellow clinics and participate in teaching programs for Residents, Fellows and Medical Students. The applicant will participate in academic research and scholarly activities in the Department of Psychiatry, participate in committees and other administrative duties as assigned, ensure compliance with HIPAA and billing regulations, adhere to institutional and departmental policies and procedures and demonstrate professionalism in accordance with the Paul L. Foster School of Medicine’s Declaration of Faculty Professional Responsibility. An academic degree (MD/DO), Board Certification in General Psychiatry andChild and Adolescent Psychiatry and licensure in Texas is required. El Paso is a highly diverse, culturally rich area located at the tip of the Rocky Mountains, bordering two states (New Mexico and Chihuahua). The Paul L. Foster School of Medicine has a highly valued creative curriculum that effectively implements the psycho-social-cultural model to patient care. Qualified applicants should upload a letter of interest and their curriculum vitae online to: http://www.texastech.edu/careers/faculty-positions.php and search for Requisition ID 209568R. You can also contact Martha Aguilar at martha.s.aguilar@ttuhsc.edu for assistance.

Job Requirements:
Minimum Qualifications: MD/DO. Successful completion of ACGME-accredited fellowship program in Child and Adolescent Psychiatry. Applicants must have an MD or DO degree, successful completion of ACGME-accredited residency program in General Psychiatry and successful completion of ACGME-accredited fellowship program in Child and Adolescent Psychiatry. Applicants must have a demonstrated record of effectiveness as a teacher, a record of peer reviewed publication and/or peer-reviewed creative activity which has contributed to the field of psychiatry and to the candidate’s intellectual and artistic development. There should be a record of professional service appropriate to the discipline and a promise of growth in teaching and research or artistic and creative activity. The applicant will provide patient care for child and adolescent outpatient and consultation-liaison services, supervise Resident/Fellow clinics and participate in teaching programs for Residents, Fellows and Medical Students. The applicant will participate in academic research and scholarly activities in the Department of Psychiatry, participate in committees and other administrative duties as assigned, ensure compliance with HIPAA and billing regulations, adhere to institutional and departmental policies and procedures and demonstrate professionalism in accordance with the Paul L. Foster School of Medicine’s Declaration of Faculty Professional Responsibility. An academic degree (MD/DO), Board Certification in General Psychiatry and Child and Adolescent Psychiatry and licensure in Texas is required. El Paso is a highly diverse, culturally rich area located at the tip of the Rocky Mountains, bordering two states (New Mexico and Chihuahua). The Paul L. Foster School of Medicine has a highly valued creative curriculum that effectively implements the psycho-social-cultural model to patient care. Qualified applicants should upload a letter of interest and their curriculum vitae online to: http://www.texastech.edu/careers/faculty-positions.php and search for Requisition ID 209568R. You can also contact Martha Aguilar at martha.s.aguilar@ttuhsc.edu for assistance. As an EEO/AA employer, the Texas Tech University System and its components will not discriminate in our employment practices based on an applicant’s race, ethnicity, color, religion, sex, national origin, age, disability, genetic information or status as a protected veteran.

TEXAS

Company: TTUHSC El Paso- Psychiatry (1211405)
Title: Assistant Professor- Child and Adolescent Psychiatry
Job ID: 13757865
https://jobsource.aacap.org/jobs/13757865

Job Description:
Assistant or Associate Professor-Child and Adolescent Psychiatry. Texas Tech University Health Sciences Center at El Paso, Department of Psychiatry is recruiting a Board Certified (Child and Adolescent Psychiatry) Assistant/Associate Professor in our Child and Adolescent Psychiatry clinical/teaching program. The applicant must have an MD or DO degree, successful completion of ACGME-accredited residency program in General Psychiatry and successful completion of ACGME-accredited fellowship program in Child and Adolescent Psychiatry. Applicants must have a demonstrated record of effectiveness as a teacher, a record of peer reviewed publication and/or peer-reviewed creative activity which has contributed to the field of psychiatry and to the candidate’s intellectual and artistic development. There should be a record of professional service appropriate to the discipline and a promise of growth in teaching and research or artistic and creative activity. The applicant will provide patient care for child and adolescent outpatient and consultation-liaison services, supervise Resident/Fellow clinics and participate in teaching programs for Residents, Fellows and Medical Students. The applicant will participate in academic research and scholarly activities in the Department of Psychiatry, participate in committees and other administrative duties as assigned, ensure compliance with HIPAA and billing regulations, adhere to institutional and departmental policies and procedures and demonstrate professionalism in accordance with the Paul L. Foster School of Medicine’s Declaration of Faculty Professional Responsibility. An academic degree (MD/DO), Board Certification in General Psychiatry and Child and Adolescent Psychiatry and licensure in Texas is required. El Paso is a highly diverse, culturally rich area located at the tip of the Rocky Mountains, bordering two states (New Mexico and Chihuahua). The Paul L. Foster School of Medicine has a highly valued creative curriculum that effectively implements the psycho-social-cultural model to patient care. Qualified applicants should upload a letter of interest and their curriculum vitae online to: http://www.texastech.edu/careers/faculty-positions.php and search for Requisition ID 209568R. You can also contact Martha Aguilar at martha.s.aguilar@ttuhsc.edu for assistance. As an EEO/AA employer, the Texas Tech University System and its components will not discriminate in our employment practices based on an applicant’s race, ethnicity, color, religion, sex, national origin, age, disability, genetic information or status as a protected veteran.
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Job Requirements:
Minimum Qualifications: MD/DO.
Successful completion of ACGME-
accredited residency program in General
Psychiatry Successful completion of
ACGME-accredited fellowship program
in Child and Adolescent Psychiatry
Board certification in General Psychiatry
and Child and Adolescent Psychiatry
by the American Board of Psychiatry
and Neurology Licensure or eligibility
for medical licensure in Texas Preferred
Qualifications: Bilingual (Spanish/English)
Demonstrated track record in research
and peer-reviewed publications for
rank of Associate Professor or higher
Regionally or nationally recognized
clinical expertise for rank of Associate
Professor or higher.

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
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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
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authors’ names for each publication (up to three). Refer to Index
Medicus for the appropriate abbreviations of journals.

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