Inside...

Report from the President • Gabrielle A. Carlson, MD .......................................................... 73
Media Committee: Social Media and Depression • Paul Weigle, MD ........................................... 78
Honor Your Mentor .......................................................................................................................... 82
Teacher Well-being and the Child Psychiatrist • Jeff Q. Bostic, MD, EdD, Sharon Hoover, PhD, Neal Horen, PhD, and Kristine Goins, MD ........................................................................................................ 95
Growing Up in the Age of Eco-anxiety • Robert Root, MD .......................................................... 102
2020
67TH ANNUAL MEETING
October 19–24
San Francisco, CA

Save the Dates
New Research Poster Deadline:
June 4, 2020
Preliminary Program / Hotel Reservations:
June 15, 2020
Member Registration Opens:
August 4, 2020
General Registration Opens:
August 11, 2020

Visit www.aacap.org/AnnualMeeting-2020 for the latest information!
# TABLE of CONTENTS

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

- President's Column • Gabrielle A. Carlson, MD ................................................................. 73
- Email Message to Members .................................................................................................. 74
- Secretary’s Report • Cathryn A. Galanter, MD ................................................................. 75

## COMMITTEES/ASSEMBLY
**Ellen Heyneman, MD, Section Editor • eheyneman@ucsd.edu**

- PrideCAPA ......................................................................................................................... 77
- Media Committee: Social Media and Depression • Paul Weigle, MD ........................................ 78
- Health Information and Technology (HIT) Committee: Tech Corner: Electronic Medical Records • Rabindra Tambyraja, MD, MBA. ............................................................. 80

## HONOR YOUR MENTOR
**Communications Department • communications@aacap.org**

- Honor Your Mentor ........................................................................................................... 82

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

- Teacher Well-Being and the Child Psychiatrist • Jeff Q. Bostic, MD, EdD, Sharon Hoover, PhD, Neal Horen, PhD, and Kristine Goins, MD ................................................................. 95
- Utilizing Our Knowledge of Adverse Childhood Experiences (ACEs) to Improve Clinical Outcomes • Marilyn B. Benoit, MD, SHSA, LFAACAP ................................................................. 97

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

- A Psychiatrist’s Call for the Rights of Unaccompanied Immigrant Minors • Carol Kessler, MD, MDiv. ......................................................................................................................... 99
- Growing Up in the Age of Eco-anxiety • Robert Root, MD ............................................... 102

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

- New Research Poster Call for Papers ................................................................................ 104
- AACAP Member Review: Clinical Essentials, AACAP’s Series of Online CME Courses • Owen Muir, MD ...................................................................................................................... 105
- Looking for ABPN MOC Part III Pilot Project Articles! AACAP has You Covered with WWW.AACAP.ORG/PILOTPROJECT • Jeffrey Hunt, MD and Sandra Sexson, MD ....................................................... 106

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

- Membership Corner ......................................................................................................... 111
- In Memoriam ...................................................................................................................... 111
- Welcome New AACAP Members ...................................................................................... 112
- Thank You for Supporting AACAP! .................................................................................. 114
- AACAP Releases Letter Responding to ORR, ICE, for use of Confidential Therapy Notes in Cases Against Immigrant Minors ................................................................................................. 116
- Policy Statement: Clinical Use of Pharmacogenetic Tests in Prescribing Psychotropic Medications for Children and Adolescents ............................................................................. 119
- Classifieds ......................................................................................................................... 121

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**COVER:**

“In Miches, a small fishing town in Dominican Republic, children are playing with sticks and objects that the sea brings in. The small fishing boats in the background are sometimes used to transport migrants illegally crossing into Puerto Rico and then USA. Issues of poverty and lack of opportunities will be important issues in their life.”
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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.

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

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Gabrielle A. Carlson, MD

This is being written the week of March 9th—the week, when, to quote the headlines, America shut down. For the next few months at least, we must hunker down. Don’t travel, socialize at a distance if at all, and if there is anything that can be done remotely, do it—including teaching and seeing patients. We won’t be able to go to plays, movies, see a sports event, or attend a concert, medical meeting, book club, marathon or parade. Prescient or anxious citizens have stocked up on toilet paper, macaroni and cheese, and anything that looks like it sanitizes. Leadership everywhere, including our own AACAP staff and executive committee have spent inordinate amounts of time trying to figure out what is best for its constituency and the public (in our case at AACAP, what is best for our members, and the children and families we serve). This is like a horror movie and as one who avoids horror movies when she can, I’d like to turn this one off. If one more authority tells me to wash my hands for 20 seconds (I can do that) and not touch my face (I’m doomed), I will implode. I’m sincerely hoping that by the time this article is published in the March/April edition of AACAP News, there will be a light at the end of what may be a dark tunnel—the length of which is unknown.

Having no particular insights or words of wisdom on this crisis, however, I will do what I find helpful when things are topsy-turvy and that is to create as much normalcy as I can. Let me tell you, then, where my “Emotion Dysregulation—Coming Together to Treat the Sickest Kids” initiative is.

First, I am really pleased that this topic has resonated with so many child and adolescent psychiatrists. I’m not pleased that we have the problem. Dysregulated, explosive children present complicated diagnostic and treatment challenges. But I feel validated that I’m not the only one who sees this as an important issue. For those of you who attended the annual meeting, thank you for your comments!

The first year goals for my presidency and my presidential Task Force on Emotion Dysregulation in Children are to develop or find 1) a consistent label for the explosive behaviors in question, of which there are a myriad right now; 2) the best ways to measure frequency, severity and duration since we can’t assess treatment or outcome without useful, reliable and valid measures; 3) a way to code these behaviors for diagnostic purposes.

As some of you know, I’ve been interested in member feedback about some of these issues and, with the help of the AACAP staff, I have done a survey of doctors who have attended conferences where I have presented. (Epidemiologists—you will need to look the other way right now). However, based on about 400 mostly child and adolescent psychiatrists (a few psychologists and pediatrician attendees who have weighed in), the topic of children with outbursts is an important part of your practice for about 80% of you. Given a choice of terms to call the episodes, the rank order from most to least popular is: 1-outbursts; 2-tantrums; 3-meltdowns; 4-rages; 5-mood swings; 6-manic episodes.

Most of the respondents wanted a rating scale of between 10-15 items. Frequency and duration of outbursts were dimensions respondents wanted to have addressed. However, when it came to gauging whether or not the child was getting worse, the most common dimension selected was increase in aggressive behavior. For my part, I think assessment instruments need to address not only how the child feels (e.g., dysphoric or irritable), but what he or she does with that feeling (mutter under breath, curse out loud, slam doors, turn over desks, attack peers and/or adults). The latter behaviors are what really drive treatment seeking. Frequency is important but one can tolerate a frequently unpleasant mood more easily than even an occasionally severely aggressive behavior.

In terms of satisfaction with our current options for diagnosing children with outbursts, most of you felt that what we have is OK, but that the territory isn’t adequately covered. Given a choice of whether you wanted another diagnosis or whether you wanted to have the option of adding a modifier like “with explosive outbursts”, or “with irritability”, to current diagnoses (e.g., attention deficit hyperactivity disorder with explosive outbursts, or obsessive compulsive disorder with explosive outbursts), most of you said “both”. It is of interest to me that the ICD 11 committee decided to use “oppositional defiant disorder, irritable subtype” instead of disruptive mood dysregulation disorder. The introduction of the subtype concept is consistent with what I’ve thought about.

In coming editions of AACAP News, I will be sharing with you how the initiative is progressing. I am hopeful that the dysregulation caused by COVID-19 will be reversible before long and that all of us stay safe and healthy.
Dear AACAP Colleagues,

I feel like I’m writing from the middle of a horror movie, which, were I watching it, I’d turn off. I’ve always hidden my eyes from scary parts of movies. However, we can’t hide our eyes from this horror. We can’t turn it off. I live on Long Island. Three of my executive committee friends and colleagues live in New York City and the other is holed up in San Francisco. This isn’t just my lane, it’s my highway and land on both sides of it!

We’ve done several things to help the membership navigate the changing COVID-19 environment:

■ We created AACAP’s Coronavirus Resource Library. This includes resources for parents, patients, and clinicians to help with the impact of the coronavirus. We’re constantly adding to the library so be sure to keep checking AACAP’s homepage for the latest information. Please know we’re here to help, and we understand how important it is that you stay connected to AACAP services, products, and programs.

■ At the National Office, our dedicated AACAP staff are continuing to work diligently to meet your needs. To support public health efforts and keep our team safe and healthy, we’ve transitioned to a remote work environment and asked staff who can work from home to do so. We’ll continue to work hard to deliver the services, products, and programs you depend on, and communicate frequent updates on those efforts.

And there are some positive things:

■ Reconnecting with people who write to me out of the blue to ask if I’m OK. Similarly, I started writing to people out of the blue just to say “hello.” This is such a valuable and reaffirming thing to do.

■ In the category of lemonade from lemons, we’re learning a new way of dealing with our patients. We may learn ways that extend our resources and our abilities that we can use when this is over. We should keep track of what’s useful and innovative and what’s not.

■ Finally, we continue to learn the value of toilet paper and soap. It’s funny the things we value in times of crisis. Plus, the cartoons and jokes are hilarious! We need laughter now more than ever.

Just know that you’re not alone, that we’ll get through this, and that your professional home is doing what we can to keep you connected.

Be well and stay safe,

Gabrielle A. Carlson, MD
AACAP President
Secretary’s Report

Cathryn A. Galanter, MD

It gives me great pleasure to update our members about some of the recent activities taking place at AACAP, and in particular, under the Executive Council (EC).

First, a brief overview of the EC. The EC serves in an advisory capacity to the President and Council and includes the President (Gabrielle Carlson, MD), President Elect (Warren Ng, MD), Secretary (Cathryn Galanter, MD), Treasurer (Bennett Leventhal, MD) and Chair of the Assembly (Melvin Oatis, MD). The EC meets in person every other month, with conference calls on the alternating months. Each EC serves together for two years starting at the close of the Annual Meeting.

Second, I wanted to share with you several updates from AACAP that have taken place in the last four months since the Annual Meeting in October.

Presidential Taskforce on the Crisis in Recruitment

AACAP has renewed the Presidential Taskforce on the Crisis in Recruitment, now in its second phase. In case you do not know the backstory, in April 2018, the AACAP Council approved a motion entitled “Addressing the Serious Shortage of Child and Adolescent Psychiatrists” recommending the formation of an AACAP Council Taskforce on the Crisis in Recruitment. In June 2018, Council under the leadership of Past President Karen Dineen Wagner, MD, PhD, approved the motion for a Taskforce to develop recommendations for creating an additional pathway/track into the field of child and adolescent psychiatry. The TF was chaired by Lisa Cullins, MD and included John Walkup, MD, Cathryn Galanter, MD, and Carmen Thornton as AACAP Staff Liaison.

We investigated mechanisms for developing a new program. This included eliciting input from and liaising with multiple stakeholders and organizations including American Association of Directors of Psychiatric Residency Training (AADPRT), the American Psychiatric Association (APA), American Academy of Directors of Child and Adolescent Psychiatry (AADCAP), the American Council of Graduate Medical Education (ACGME), the American Board of Psychiatry and Neurology (ABPN) and most importantly, our members. Because it is crucial that the training program be fully accredited and for graduates to board eligible, the ACGME and ABPN were especially important for collaboration. Discussions revealed a great deal of support, but also some concerns, for example that an abbreviated program might compromise education. The TF identified procedural obstacles. One, that the ACGME only considers a new residency if there are at least 50 programs of 200 residents, a scale far greater than what the Task Force members had envisioned for a pilot program. In June 2019, the Council heard the TF’s recommendations.

Later in 2019, Gaye Carlson, MD, AACAP’s current president, appointed a new TF to be led by Jeffrey Hunt MD and include Sandra Dejong, MD, Mary-Margaret Gleason, MD, Sansea Jacobson, MD, Richard Martini, MD, Cynthia Santos, MD, Erica Shoemaker, MD, and John Walkup, MD. The TF will focus on developing a proposal for the training pathway and will tackle such difficult questions as to whether the training will be five, four or three year, whether it will result in board eligibility for just child and adolescent psychiatry or general psychiatry and child and adolescent psychiatry, and how to build consensus among our members and our collaborating organizations on this training pathway. They will also work with ACGME and ABPN and the American Board of Medical Specialties, to ensure that the program will result in needed certification and accreditation.

Presidential Working Group on Health Resources and Services Administration (HRSA)

Dr. Carlson appointed a Presidential Working Group (PWG) on the Health Services and Resources Administration (HRSA) Workforce Report. The PWG was charged with “determining further actions needed in response to HRSA’s Behavioral Health Workforce Projection.” The PWG was chaired by Bennett Leventhal, MD, and also included Mark Olfson, MD, Wun Jung Kim, MD, and Carmen Thornton, Director, Research, Training & Education, as the AACAP Staff Liaison. For those of you unfamiliar with the HRSA report, in the end of 2018, directed by the Congress, the NCHWA/HRSA issued a report, “Behavioral Health Workforce Projections, 2016 – 2030.” The report projected a national undersupply of general psychiatrists and an oversupply of child and adolescent psychiatrists by 2030. These projections were in conflict with AACAP’s past data and feedback from our members and patients that there is significant need for more child and adolescent psychiatrists. AACAP responded by reaching out to HRSA both alone, and with collaborating organizations. The Working Group carefully reviewed the HRSA data as well as other materials. They developed a number of recommendations to address both the HRSA report and data about the workforce shortage going forward. Their recommendations fell into four categories, 1. Scientific/Data-Driven Approaches 2. Communication Strategies and Actions 3. Political
Strategies and Actions 4. Development and/or Reinforcement of Strategic Alliances. Their recommendations will be further reviewed by AACAP’s President along with her advisors and Council, so that they can make risk-and cost-benefit assessments for each recommendation to determine what is feasible and in the best interest of our members and patients.

AACAP and the Association Advocating on Our Behalf with the Government

Since October, both AACAP and the American Association of Child and Adolescent Psychiatry have been at work signing on bills on behalf of children’s mental health. When AACAP signs on to a bill or Amicus brief, the document is carefully reviewed by AACAP members with content expertise, often from the Advocacy or Children and the Law Committees, AACAP members with content expertise, and AACAP staff from Legislative Affairs. With their support, AACAP’s EC makes the decision whether AACAP or The Association should also support the bill. As an example, in December 2019, the Association signed on to a letter with 19 other medical and mental health organizations to House and Senate in support of the “Children and Media Research Advancement Act (CAMRA)” H.R. 1367. Also in December, the Association and the Mental Health Liaison Group joined a sign-on letter with 39 other medical and mental health organizations, in support of “Effective Suicide Screening and Assessment in the Emergency Department Act of 2019” (H.R. 4861). The letter was sent to the representatives who were sponsoring the bill. From October to January, AACAP signed on to 15 bills.

AACAP Products

The EC along with The Council reviews many of AACAP’s products developed by our Committees. A recent example is the new Anxiety Disorders: Parent’s Medication Guide. The Parent Med Guides are developed in collaboration with the APA by members of the Psychopharmacology Committee along with input from the Consumer Issues Committee and members with content area expertise. If you have not yet seen the new Med Guide, you should definitely take a look! Med Guides can be a very helpful resource for educating families and can be found on the AACAP website or through this link:


These are just a few updates on the work of your EC, Council, and the Academy as of the end of February. It is a pleasure and an honor to serve our president in the interest of our members and the children and family we treat.

Warm Regards,
Cathryn A. Galanter, MD
AACAP Secretary

COLUMNS

Call for Self-Nominations – AACAP Delegation to AMA

Interested AACAP members who are also current members of the American Medical Association (AMA) may self-nominate for future openings on AACAP’s Delegation to AMA. At present, AACAP enjoys two Delegate slots in the AMA House of Delegates (HOD), as well as two Alternate Delegate positions. The AMA HOD meets yearly in Chicago, IL, in June and at a changing location in November of each year.

Ability to travel for up to 6 days in June and 5 days in November each year is required. Former or current leadership service in a state medical society to the AMA HOD or one of AMA’s special sections, councils, or Assemblies, such as the Medical Student Section (MSS), Resident Fellows Section (RFS), or Young Physicians Section (YPS) would be highly advantageous to AACAP. Members of AACAP’s delegation must also actively participate in the AMA Psychiatry Section Council at the AMA HOD Annual and Interim meetings, as well as in preparation for each meeting during the year.

AACAP provides travel reimbursement up to established limits for committee members upon timely filing of expense vouchers and receipts.

In addition to the AMA HOD, AACAP may have up to two Delegates to YPS. A Stubblefield RFS Delegate is also chosen under a separate solicitation, which will be advertised later in 2020 for a position opening after June 2021.

Detailed further information is available at:

Letters of interest and a current CV should be addressed to Gabrielle A. Carlson, MD, President, and be delivered by June 30, 2020, for future consideration, to: gc Carlson@aacap.org.
PrideCAPA COMMITTEE

PrideCAPA

The AACAP affiliate organization formerly known as the Lesbian and Gay Child and Adolescent Psychiatric Association (LAGCAPA) is proud to officially unveil our new, more inclusive name—PrideCAPA—a name which better represents our diverse members and the patients and families whom we serve. PrideCAPA was founded in 1990 by a pioneering group of child and adolescent psychiatrists dedicated to meeting the mental health care needs of sexual minority youth and supporting LGBTQ colleagues and trainees. PrideCAPA founders, with AACAP leadership, established the AACAP Sexual Orientation and Gender Identity Issues Committee in 1990. Since then, PrideCAPA has grown to include over 150 members who have played a pivotal role in developing AACAP position statements on sexual orientation, gender identity, and civil rights, and drafting the AACAP sexual orientation discrimination policy, among numerous other accomplishments. Moving forward, PrideCAPA will continue supporting our LGBTQ youth and families, fighting against discrimination, and providing community for our LGBTQ child and adolescent psychiatrists.

Join PrideCAPA for our yearly business meeting held during the AACAP Annual Meeting in San Francisco this year, or stop for a cocktail during our social reception open to members and non-members alike. Visit our website at PrideCAPA.org or email PrideCAPAMembership@gmail.com for more information on how to get involved!
In only a short time, social media (SM) has transformed the lives of adolescents. Facebook was born in 2004, and Twitter in 2006, but it was with the accessibility that came with the iPhone, released in 2007, that the age of SM truly began. Data from 2019 indicates that 84 percent of teens own a smartphone, and 63 percent use SM daily for an average of two hours.1 The explosion of SM use paralleled a dramatic increase in depression and suicidality. Rates of severe depression, hospitalization for suicidal thoughts, and completed suicide among adolescents have nearly doubled in recent years.

What is the relationship between SM use and depression? Empirical evidence suggesting that SM habits and experiences affect mental health is fairly strong, but the relationship is complex. Teens who spend the most time on SM are at the highest risk for depression, but this isn’t always true of their time on SM. Some studies show that time on SM is related to depression, others show no such relationship or even an inverse one.2 However, research more consistently shows that certain types of use and experiences are risky, while others can be protective. SM can be an excellent platform for adolescents to strengthen existing friendships and make new ones. Some minority and LGBT teens, as well as those with niche interests, struggle to connect with like-minded peers in person. For them, SM may be a lifeline to socialize and avoid loneliness.

Teens who have strong social support on--and--offline tend to assign less importance to SM experiences, use SM in an active manner (e.g., posting and commenting), and enjoy more positive interactions online. For these youth, time spent on SM can actually improve self-esteem and protect against depression. However, teenagers with few friends who place more importance on their online interactions and who use SM passively (reading but not contributing) have more negative interactions online. They tend to feel lonelier the more time they spend on SM, and are at significantly higher risk for depression. It seems that on SM, the rich get richer and the poor get poorer.

Individual characteristics put some teens at particularly high risk for worsening mood on SM. Teens high in social comparison (i.e., those who judge themselves depending on how they compare to peers) tend to be deceived by the idealized SM pages of peers; they believe these accurately represent their peers’ lives. Those who become anxious that they might be missing the positive experiences their peers are having (a.k.a., fear of missing out) are significantly more likely to experience negative effects of using social media including worsening depression.

Certain teens gravitate towards high-risk behaviors on social media. Youth who sext (post or send naked photos of themselves), are also at greater risk. This is especially true of LGBT youth and girls who send pictures of themselves outside of a preexisting romantic relationship (typically as an attempt to start a new one), as they are most likely to have the picture forwarded to others and to feel worse afterwards. Perhaps the highest risk of online interaction is cyberbullying; involvement as a perpetrator, victim, or both, is related to a powerful increase in the risk for depression and suicidality. Using SM in the bedroom can often lead to insomnia, itself a strong risk factor for depression.

Depressed and anxious youth seem particularly susceptible to negative effects of SM. Not only are they more likely to report being ignored, criticized, or attacked online, they are more likely to feel left out and use SM as a tool to avoid their real-world problems; experiences which in turn may exacerbate their illness. Of particular concern is online discussion of depression and suicidality, which tends to result in worsening symptoms over time. Despite this, adolescents with internalizing problems value SM significantly more-so than their peers as a way to socialize, express themselves, or get help for their problems. Asynchronous, effortless, online communications may feel less challenging than in-person interactions, making them particularly attractive to depressed and anxious youth.

Psychiatrists should know that SM interactions can powerfully affect adolescents’ well-being, for good and for ill. The nature of the user and their online experiences determine if it will lead to positive or negative outcomes. Youth who use SM in moderation, and
in combination with real-world socializing and sufficient structured time for sleep, schoolwork, chores, family time, and exercise, enjoy the greatest well-being. Unfortunately, our most vulnerable patients, those suffering from depression, are often at the greatest risk for unhealthy SM experiences, which worsen their mood and increase the risk of suicidal thoughts and behavior. Psychiatrists must take special care to evaluate the impact that SM habits and experiences have on the well-being of our patients with depression, keeping in mind both opportunities and pitfalls.

We must take the time to discuss ways to minimize risk and foster healthy behaviors on SM. We should advise parents to guide and supervise their children’s, tweens’, and youth’s SM, especially for those suffering from depression, to instill health habits and minimize toxic interactions. Sometimes teens avoid coming to parents in response to an online crisis for fear of their phone being confiscated. It may be helpful for parents and teens to have a standing agreement that this will not happen. Phone and computer screens should not be allowed in bedrooms or behind closed doors and should charge in the parent’s bedroom at night. With a bit of knowledge about SM, we can help our patients embrace the benefits their screens offer and minimize their drawbacks.

References

Paul Weigle, MD, is associate medical director at Natchaug Hospital of Hartford Healthcare and teaches on the clinical staff at UConn School of Medicine and Quinnipiac Medical School. He is a distinguished fellow of the American Academy of Child & Adolescent Psychiatry, serves as co-chair of the AACAP’s Media Committee, and on the Institute of Digital Media and Child Development’s National Scientific Advisory Board. He lives in Mystic, Connecticut, with his wife, 16 year-old son and 13 year-old daughter, who helps him manage his Instagram account.
Tech Corner: Electronic Medical Records

Rabindra Tambyraja, MD, MBA

Electronic medical records (EMRs) have become, for better or worse, an accepted reality of modern medicine. Though they provide great advances in communication, safety, and ease of access, there is concern that they have led to a sharp rise in “screen time” for clinicians, rather than time spent with patients. This may be especially true in psychiatry, where we rely far more on narrative and interpretation, than on laboratory values and other “objective” diagnostics.

In recent years, the KLAS Arch Collaborative has partnered with healthcare organizations across the country to deepen our understanding of clinician satisfaction with EMRs. A significant number of psychiatrists were included in this group, and KLAS has been willing to partner with the AACAP Health IT Committee on the analysis of this data.

As a new AACAP Committee, the AACAP Health IT Committee (HIT) posed some exploratory questions to KLAS to assess satisfaction within psychiatry and child psychiatry. The HIT Committee is committed to developing resources to ensure AACAP Members are not just passive consumers of technology, but actively engaged in important questions of how we use technology to advance patient care. As such, assessment of our current state in EMRs is an important starting point.

Overall, psychiatrists report near-average satisfaction among physicians in general. Figure 1 shows that general psychiatrists were in the 45th percentile, and child and adolescent psychiatrists (CAPs) were in the 53rd percentile (each line denotes a specialty). Both groups reported below-average rates of burnout, and high satisfaction and personal fulfillment from their clinical work. There is a slight trend that those at organizations using Epic as their EMR report greater efficiency and satisfaction, though it is important to note the survey does not control for other organizational factors.

Perhaps the most interesting specific finding is that psychiatrists, both General and CAP, report much lower-than-average rates of personalization. This includes activities such as designing documentation templates for speed note-writing (such as a biopsychosocial framework), ordering sets to improve consistency (psychotropic monitoring labs, or 90-day stimulant prescriptions), and designing filters/views to ease chart review activities. Of further note, Figure 2 shows that those who had personalized their EMR experience reported greater satisfaction (though the survey is not designed to assess statistical significance of this). The latter finding makes sense, since (as should be clear to all psychiatrists) a greater sense of agency over one’s work environment should contribute to greater satisfaction.

So, how to make use of this finding to improve our professional satisfaction? First, start from the realization that many EMRs are not designed for the typical workflow of a psychiatrist, but the tools are there. For those of us working in larger organizations, you most likely have a fellow physician in informatics at your organization. This is usually a chief medical information officer (CMIO), medical director of informatics, or other similar title.

“For those of us working in larger organizations, you most likely have a fellow physician in informatics at your organization. This is usually a chief medical information officer (CMIO), medical director of informatics, or other similar title.”

Figure 1. Overall Satisfaction (25,485 total physician respondents; Child and Adult numbers listed in each bar)
Be prepared for a few rounds of “that’s close, but not quite what I need...” At smaller organizations, you may need to contact your EMR vendor directly, and ask them to share what has helped other practices as well. Time spent helping them understand your clinical work, and how the EMR can best support safe efficient practice, will be a major source of satisfaction. Of course, feel free to reach out to any members of the AACAP HIT Committee with questions too. As AACAP’s “nerds in residence”, we are happy to help.

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Dr. Rabindra is the Chief Medical Information Officer for Children’s Minnesota. His primary work focuses on the use of technology to help all children and families achieve optimum health. Clinically, he is a practicing child psychiatrist with expertise in mental health challenges in medically ill patients. He primarily provides consultation services to children and families on the inpatient units.
Honor Your Mentor

Each year in the March/April issue of AACAP News, we take the time to honor our mentors and say thank you to those who have made a significant difference in our professional and personal lives.

Nancy A. Roeske, MD
Submitted by Cyrus E. Adams, MD

My freshman summer at Indiana University, I was fortunate to be selected as Dr. Nancy A. Roeske’s summer paid extern. At the end of the summer, she said I could interview a child by myself while she watched through a mirror. When I went to the waiting room, he refused to budge. I sat down on the floor by him until he finally said “OK I’ll go.” I had found my calling.

Paul Adams, MD
Submitted by Cyrus E. Adams, MD

At Louisville, Paul Adams was the residency training director. When I told him I wanted to explore child fellowships, he convinced me to apply to UCLA. The multitude of faculty who guided me there included Cantwell, Carlson, Tanguay and Tarjan among many others. Fifteen years ago, I came home to work for the hospital where I was born and am proud to be a small part of the new Indiana University psychiatry residency at Vincennes. Also, we recently lost Dr. Leah Dickstein who introduced me to college mental health care, with which I still collaborate with the junior college I attended.

Lois Flaherty, MD
Submitted by Bettina Bernstein, DO

This letter is to honor my mentor, Dr. Lois Flaherty who is an incredible inspiration; the embodiment of all that I strive to be as a child and adolescent psychiatrist professionally as well as personally. Lois has always provided the encouragement and support to listen without judging when that was needed, both when professional and personal challenges arose. Lois continues to be a wonderful role model of how to find the work-life balance; continuing to teach and mentor trainees while finding the time to spend with family and friends including her grandchildren! I thank Lois for being a fantastic mentor and role model as well as a wonderful friend!
Avron Kriechman, MD
Submitted by Ramnarine Boodoo, MD

One of my greatest experiences with mentorship was when I met and was guided by Dr. Avron “Avi” Kriechman at the University of New Mexico. Open with his prodigious knowledge, he was neither intimidating nor self-serving. His gratification came from seeing a student develop. Avi didn’t just talk about the way, he showed it. I can still turn to him today. Perhaps his greatest gift, and the gift of all other mentors in my life, was the gift of courage to pursue Truth, and to stand up for Truth even while knowing the often unpleasant consequences of doing so.

Lisa Ruiz, MD
Submitted by Janie Cao, MD, MPH

I met Dr. Lisa Ruiz as a third-year medical student on my child psychiatry rotation. She not only taught me about child psychiatry but perhaps more importantly, she empowered me as a female physician-to-be and inspired me to stay true to my values. While on her team, she treated me as an equal participant and encouraged me to advocate for the grades that I deserved. She would put patients first even when it was inconvenient, scary, and required personal sacrifice. I would like to honor Dr. Lisa Ruiz—she is a one-of-a-kind role model.

Doug Kramer, MD, MS
Submitted by Meg Cary, MD, MPH

With Doug, mentorship is what arises in the relationship. He co-creates a space for collaboratively sharing curiosities, raising questions, and reflecting on observations. He once offered, “I hope you were able to wander around those thoughts and interior journeys without any fences or trespassing signs.” Thank you, Doug, for scaling fences and venturing into uncertainty with me as I figure out this journey of being a family psychiatrist.

Patrick Driscoll, MD
Submitted by Shinny-yi Chou

Dr. Patrick Driscoll has been promoting the importance of thinking outside the current models of care and consider patients’ welfare and our own passions. His passion for psychodynamic psychotherapy through a contemporary lens is refreshing in an environment where biological psychiatry is considered the gold standard. He speaks sincerely of his own career development and shares his experiences within reservations and is truly an important mentor for our development as well-rounded psychiatrists.
Sansea Jacobson, MD
Submitted by Shinny-yi Chou

Dr. Sansea Jacobson has been a great source of support and a role model over the years. Her passion for trainee well-being has generated national momentum and fueled residents and fellows within our institution to follow in her footsteps of improving our working and learning environments. She is candid and honest in her advice and never imposes her own agenda on our career explorations and developments. She truly has our best interest in mind and is a great residency mom for us all.

Suzie Nelson, MD
Submitted by William Clark, MD

Dr. Suzie Nelson has supported my interest and education in child & adolescent psychiatry throughout my residency and fellowship experience at Wright State University. Her mentorship encouraged my pursuit of child & adolescent psychiatry and her support and leadership has made me a better physician leader. Dr. Nelson has fostered areas of interest by creating new clinical and educational opportunities throughout my fellowship experience. I am extremely lucky to have had such an amazing mentor. I expect her example will lead me for years to come.

Don Ehrman, PhD
Submitted by Maria Daehler, MD

I had the pleasure of working with Don Ehrman, PhD, now 101 years old, as a solo practitioner among psychiatrists and psychologists for the past 15+ years in Palo Alto, California. About 10 of us meet weekly to discuss cases and address the standard business issues of sharing office space together. Don has the gift of sitting quietly, listening to the many conversations from clinicians, and then offering the shortest, most succinct, and usually group process interpretation possible. We hang on his comments and are stretched by his thought provoking statements. Don quit driving to work when he turned 100, so I now drive to his place. There have been many wonderful mentors in my life, and at 55 I appreciate from Don Ehrman that there is still much to learn and live!

Peter B. Henderson, MD and Richard L. Cohen, MD
Submitted by Mina Dulcan

I am fortunate to have had many mentors and role models, but the two who stand out are Peter B. Henderson, MD, and Richard L. Cohen, MD. In the mid-1970’s at the University of Pittsburgh/WPIC, Peter and Dick created a unique GME model of early-entry to CAP and developmentally and family-focused integrated training with adults and youth. Peter, lost too soon to cancer, introduced me to AACAP and AADPRT and how to navigate and succeed in national organizations. Dick provided the model and guidance for my first authored/edited book—a text on education in CAP.
Richard Martini, MD

Submitted by Lisa Giles, MD

I first met Dr. Rich Martini at an annual AACAP meeting during my final months of triple board residency. In the 13 years since that time, I have had the opportunity to work alongside Dr. Martini in building an inpatient and outpatient consultation-liaison service in my home state of Utah. From the beginning, he partnered with me in writing review articles and connecting me to like-minded colleagues in AACAP. His mentorship has made the dream of an academic career centered on pediatric consultation-liaison a reality.

Elizabeth Reeve, MD

Submitted by Brittany Hammond, DO

Elizabeth Reeve, MD, is a mentor who values education along with the well-being of her patients and residents. Her psychiatric expertise is coupled with an uncanny ability to communicate with patients and their families. When patients, parents, and trainees feel stuck, Dr. Reeve is able to easily determine a cohesive and holistic plan. Dr. Reeve regularly spends hours with trainees after clinic dissecting cases, and takes time away from her clinic to lecture on psychopharmacology. On top of all that, she writes academic papers with residents, improving our writing and understanding of research. We are so grateful to have you, Dr. Reeve!

David J. Kolko, PhD

Submitted by Kimberly S. Hsiung

Dr. Kolko has been my research mentor for the last five years and is easily one of the top mentors I ever had. From the start, he invested in turning a storage room into an office space for me, and his door was always open. He has answered my emails on weekends, late nights, and early mornings—often the same day. His unwavering belief in me has revived my self-confidence. Although Dr. Kolko has helped me gain success through publications and presentations, he more importantly showed me the effect of a generous, collaborative attitude—a lesson I will never forget.
HONOR YOUR MENTOR

Edwin J. Cook, MD, and Bennett L. Leventhal, MD
Submitted by Suma Jacob, MD, PhD

I’d like to honor both Edwin J Cook, MD, and Bennett Leventhal, MD. I met each of them when I was an undergraduate, knowing that I wanted to study the brain and behavior but not certain about taking a clinical or research path. If it were not for them and my early research mentors, Wendy Heller, PhD, and Neil Pliskin, PhD, I would not be who I am today. Connect with trainees early to show them what child psychiatry offers! I took the long path of training. I strive to integrate and share these privileges of learning and mentorship every day.

Kathleen Grissett, MD
Submitted by Jeena Kar

As a fourth-year medical student I felt overextended and overwhelmed until I met Dr. Kathleen Grissett. Dr. Grissett is invested in her students’ education and well-being at the same time. It felt like a breath of fresh air when she asked me about my living situation and expressed concern about matters beyond my education. I saw the way she met her patients with empathy and concern — and felt inspired that I could one day have a practice like and also balance having a family. When she took me to breakfast at a local coffee shop before work, I felt hopeful that one day I could be a mentor this amazing to someone else and make someone burnt-out feel eager again.

Dorothy Grice, MD and Maria del Pilar Trelles Thorne, MD
Submitted by Vasiliki Eirini Karagiorga, MD

My journey in child psychiatry has been shaped by the guidance and support of my outstanding teachers Dr. Dorothy Grice and Dr. Maria del Pilar Trelles Thorne. Their inspiration, encouragement, ethics, humility, generosity, their pleasure in mentorship, are extraordinary gifts which uncovered new depths of understanding and wisdom. Their most important lesson was the way they modeled how to be a more effective clinician by being genuine and caring. My mentors strengthened my trust in the power of our profession and its tremendous impact. I am grateful for everything I learnt from them and blessed to have met them in my path. I treasure everything they have taught me!
Hans Steiner, MD
Submitted by Niranjan S. Karnik, MD, PhD

If not for Hans Steiner, I would never have become a child psychiatrist or an academic researcher. During my clinical rotations in medical school, a child psychiatrist asked me about my research interests and mentioned Hans Steiner as someone who was interested in these areas. I sent Hans an email, he invited me to Stanford for an elective, helped me get a Jeanne Spurlock Summer Fellowship, and then recruited me to Stanford for residency and fellowship. Throughout my time at Stanford he was (and still is) the best of mentors. Patient, funny, thoughtful. I now find myself in the role of mentor and try to take the same approach with my trainees.

John T. Walkup, MD
Submitted by Priti M. Kothari, MD

The two-year anniversary of the deadly school shooting in my town of Parkland, Florida, is approaching, and being a local child and adolescent psychiatrist to the community in which I lost siblings of patients and teachers I knew has been demanding. I could not have done it without the help of many colleagues and mentors including Dr. John Walkup. Upon graduating from Johns Hopkins, he encouraged me to open a solo practice and gave me reassurance and support. This was huge. Fifteen years later I still rely on him to be a thought leader in the field. It seems like yesterday I was sitting as an eager fellow, ferociously writing down all his words in a journal I keep to this day. Thank you for allowing me to nominate an excellent teacher, role model and most importantly humble doctor as him.

Michael Bloch, MD, MS
Submitted by Amalia Londono, Andrea Diaz Stransky, and all Solnit Integrated Adult and Child Psychiatry Fellows, Yale Child Study Center

Michael Bloch has mentored numerous medical students, residents, and fellows in child psychiatry. He is the mentor each of us needs, and a fierce advocate for each of us. He takes time to get to know us and works hard to provide us with concrete guidance that will help us grow and pursue fulfilling career paths. Michael is the mentor who might suggest the crucial change that makes a grant fundable, a study feasible, or a dream attainable. The success of his trainees, at all levels, demonstrates his talent as a mentor, but the fondness that his trainees have for him speaks even more highly to his qualities as a mentor, a clinician and a human being. Thank you, Michael!
Anne Benham, MD
Submitted by Andrea Mann, DO

I’d like to honor Anne Benham, MD, at Stanford University. Dr. Benham introduced me to the world of infant and preschool psychiatry. She was instrumental in helping me develop expertise in evaluating and treating young children and their families. She has shared her wealth of clinical knowledge and love for play therapy with child psychiatry fellows at Stanford for years. Through her mentorship, she helped me gain confidence in my evaluation and psychotherapeutic skills. I love how she integrates Cognitive Behavioral Play Therapy with a psychodynamic perspective. It has been an honor to have learned from her over the past several years. Thank you!

Roddy Strobel, MD
Submitted by Zeeshan Mansuri MD, MPH

One morning, as I was about to grab coffee from the coffee machine, Dr. Roddy Strobel, the senior attending psychiatrist, told me that my patient was ready. I quickly put my cup away and proceeded to see the patient. She came in two minutes later with a coffee for me. I was shocked. I didn’t expect this from an attending. How many senior doctors would make coffee for a resident? How many would go and give the coffee to the resident in front of a patient? These random acts of kindness and humility are what make you feel valued and respected and that is what ultimately matters in the end.

Barbara Rila, PhDS
Submitted by Zeeshan Mansuri MD, MPH

I asked Dr. Barbara Rila for help on a project about teaching children from 2nd to 7th grade about emotions. She came up with the brilliant idea of using the movie “Inside Out” as a guide for discussing emotions. We taught the kids about the different levels of emotions and techniques for managing their emotions. Dr. Rila taught me how to talk to children in a manner that they can understand and I want to thank her for all that she does for us and for the community.

Shailesh Jain, MD
Submitted by Zeeshan Mansuri, MD, MPH

Residency is tough: it’s a lot of learning, responsibility and growth packed into a short time frame. You can’t do it all on your own. Dr. Shailesh Jain helped me navigate the intricacies of residency. He believed in me when I was not able to believe in myself and his guidance and support helped me overcome the fear and uncertainties of the intern year. Because of his mentorship and support, I was able to publish more than 40 papers including 15 manuscripts, won 7 awards including the “Resident Recognition Award” from the APA and match to an amazing Fellowship at Boston Children’s Hospital/Harvard Medical School. Thank you very much!
Richard Ferry, MD
Submitted by Dean Martin, MD

It was my first year of Child Fellowship at the University of Utah. I was struggling with a case: an adolescent I felt “wasn’t working” in treatment. I complained in supervision to my attending, Richard Ferry, quoting something I had heard in adult training: that one “shouldn’t be working harder than the patient.” With an alarmed expression, Dr. Ferry looked at me and said “You’re SUPPOSED to work harder than your patient—that’s your job, that’s what child psychiatrists do!” I realized he was right and revised my attitude from that moment on.

William Lexington Grapentine, MD
Submitted by Thomas Miller, MD

During my residency training at Brown University, I had the good fortune to have Dr. William Grapentine as my attending child psychiatrist at Bradley Hospital. Dr. Grapentine was very friendly and encouraging to me during this often stressful time. Even though the training program and hospital were very large, he managed to take the time to individually teach the intricacies of the diagnostic interview. He set a positive example of how to interact with staff and patients in an often lighthearted manner. His mentorship continues to influence me even today.

David Dunn, MD
Submitted by Genalynne Mooneyham, MD

I was fortunate to complete my training in the Triple Board Residency at Indiana University School of Medicine. Our program director Dr. David Dunn was a legend of sorts... we affectionately referred to him as “the child whisperer”. Dr. Dunn would come into a busy clinic room and bring with him an air of calm, a sense of direction, and the type of clinical acumen that you can only hope to achieve. When we would staff our patients, he would readily pull out a journal article that had been meticulously clipped and neatly filed. He made evidenced-based medicine come to life and I am grateful for his investment in my education.

Jennifer Havens, MD
Submitted by Warren Ng, MD

Dr. Jennifer Havens is a force of nature and the ultimate advocate, trailblazer, leader, humanitarian and innovator for childrens’ mental health. She gave me my first job in an amazing program created to serve HIV-infected children, women, and their families. Her passion, mission, determination, and creativity inspired me every day. She is a creator who imagines new programs to serve under-served populations including medically ill, traumatized, and justice-involved youth in the public sector. She is a fierce and outspoken advocate for kids. She’s widely celebrated for her accomplishments and she’s a hero of mine.
Ayame Takahashi, MD
Submitted by Sohail Nibras, MD

Dr. Ayame Takahashi has been an amazing mentor. I have learned so much from her and I can truly say that my confidence in my abilities has greatly increased under her leadership. Her ability to provide genuine feedback in an encouraging manner allowed me to feel as if I can discuss any concerns with her. She has also been a very good advocate for me. She goes out of her way to help trainees achieve their goals. Working with Dr. Takahashi has been an invaluable experience for both my career and personal growth, and I will always be grateful for her support and kindness.

Beverly Bryant, MD
Submitted by Avani Patel

It sounds silly now, but I remember crying in the office of my child psychiatry attending about choosing a specialty. Dr. Beverly Bryant gave me some examples of why she felt I was a strong medical student and why I would make an incredible child psychiatrist. She shared that she would support me no matter what specialty I choose; however, she believed I would find my way to child psychiatry as my heart belongs there. Dr. Bryant stated, “Avani, you just have ‘it,’ and that special something can’t be taught.” Needless to say, she continues to my inspiration and a great mentor!

Cesar Soutullo, MD, PhD
Submitted by Victor Pereira-Sanchez, MD

Dr. Soutullo is a passionate Spanish child and adolescent psychiatrist trained in Cincinnati, Ohio. He started from scratch a pioneer child & adolescent psychiatry unit in Navarra, Spain, which has inspired a number of trainees and psychiatrists in our country of origin and abroad. I was one of the latest residents to be formed by him before both of us moved to the US last year. Since I met him for the first time when I was in Medical School, he was instrumental in my vocation and early career as a would-be child psychiatrist. Thank you, Cesar!

Anne Benham, MD
Submitted by Magdalena Romanowicz, MD

I would like to honor my mentor Dr. Anne Benham. She inspired me to pursue a career in infant and preschool psychiatry, a field that I had known so little about prior to meeting her. She spent many hours tirelessly teaching me how to assess and treat young children and after I left fellowship she continued to mentor me from a distance. Maybe most important, Dr. Benham is a real role model in how she is handling her life. She has a successful academic career, great marriage, three children and many grandchildren. I have always aspired to follow her path.
Cheryl McCullumsmith, MD
Submitted by Ashish Rungta, MD
Dr. McCullumsmith has been instrumental in supporting and helping me through my career. Without her guidance and help, I would not have made it this far. She saw potential when others saw liability. As a department chair of Psychiatry too, she is revolutionizing the practice of Psychiatry at UT.

Charles H. Zeanah, MD
Submitted by Daniel Schechter, MD
Charley Zeanah has been an incredible mentor, colleague, and friend since I was awarded an AACAP Presidential Scholar Award in 1997 and Pilot Research Award in 1999 that allowed me to learn the basics of infant and early childhood mental health evaluations and treatment with families with significant interpersonal violent trauma, abuse and neglect histories. Charley and his wife Paula welcomed me into the field and I rapidly began to think about how to follow his model of integrating clinical work and research. Thanks to the foundation set down with Charley and his team, I am celebrating 20 years of a program of research on the impact of maternal exposure to interpersonal violence across the lifespan on the mother-child relationship during early development and on child social-emotional outcomes. Thanks, Charley!

Michael Rancurello, MD
Submitted by Jeanette M. Scheid MD, PhD
I first met Michael Rancurello as a 2nd year general resident on child/adolescent inpatient rotation. He welcomed a psychiatry "newbie" with an interest in child and adolescent psychiatry. That experience cemented my plans to continue into fellowship. I worked with Dr. Rancurello again during a child fellowship residential program rotation. By that time, I could truly appreciate the sophistication that Dr. Rancurello brought to child case formulation. Dr. Rancurello treated me as a junior colleague, assumed and expected competence, and taught formally and by example. He has remained a model for my work with patients, families, residents, fellows and colleagues.

Pamela McPherson, MD
Submitted by Hannah Scott
Dr. Pamela McPherson: first a teacher and mentor, forever a friend. She has worn so many hats and wears them well. She inspires residents and fellows to continue learning and training throughout their lives. During my fellowship, she invited me and procured a ticket to a sold-out show to hear the Notorious RBG (Ruth Bader Ginsburg) give a talk on her life’s work. It was the highlight of my fellowship and awe-inspiring to sit among two women professionals who I respect and aspire to be like. Thank you, for bringing to light what was within.
Dr. Prasad Raghuram, MD
Submitted by Pooja Shah, MD

Dr. Prasad exhibits great personal and professional attributes. His clinical acumen, professional interactions and academic prowess speaks volumes about his passion for helping children with neurodevelopmental challenges, love for psychopharmacology, and clinical teaching of psychiatry fellows like me. Dr. Prasad is genuinely invested in my academic progress. He has empowered me to identify my own strengths, beliefs and personal attributes. It takes a great mentor to recognize the strengths of the mentee and push them to be the best version of themselves, and he has put substantial efforts in sculpting my career and personal identity.

Dr. Cecilia Devargas, MD
Submitted by Aisha S. Shariq, MD

I want to acknowledge Dr. Cecilia Devargas for being a great mentor. She is very knowledgeable, approachable, and is an excellent role model for trainees. Her clinical interactions are the foundation of her knowledge and set an example for her fellows on how to practice Child Psychiatry. Dr. Devargas takes great interest in fellows learning and is always very supportive of any educational activity the fellows want to be part of. Dr. Devargas is a kind and professional mentor who taught me how to help and be available for my colleagues. I am blessed to have Dr. Devargas as my program director.

Oscar G. Bukstein, MD, MPH
Submitted by Kevin M. Simon, MD

Dr. Bukstein has been a great mentor during my child & adolescent psychiatry fellowship at Boston Children’s Hospital. He has not only been supportive and available for clinical supervision and advice, but has played the role of a sponsor for opportunities initially unbeknownst to me. He additionally, has been encouraging of my pursuit of additional clinical training in addiction medicine, participation within AACAP committees, and probably most important has allowed me the room to grow and be comfortable in prioritizing family. I feel fortunate to have him as a part of my becoming a child & adolescent psychiatrist. Thank you Dr. Bukstein.

Bennett L. Leventhal, MD
Submitted by Russell H. Tobe, MD

Twenty years ago, my naivety to Bennett Leventhal’s great contributions facilitated my disinhibited approach of him as a first-year medical student. Bennett made time and taught me psychiatry. He helped me navigate training and career decisions while shepherding me through challenges. Though few are so knowledgeable and wise, Bennett’s legacy is his generosity, steadfast moral compass, and loyalty. I fully trust not only his concrete guidance but his unwavering commitment to my personal happiness and growth. Though Bennett’s teaching has made me a competent and caring physician, his modeling has shaped my growth as an individual far beyond clinical practice and academics. About this, I am not naïve.
Luz Minerva Guevara, MD
Submitted by Minerva Villafane-García, MD

Doctor Luz Minerva Guevara was in charge of the Child and Adolescent Fellowship Program where I trained in the Department of Psychiatry of the University of Puerto Rico. She took time to know every fellow and encouraged us to continue to grow professionally even beyond training. Dr. Guevara guided us to join AACAP as active participants. Under her mentorship, I attended AACAP Meetings since early in my career and, even in semi-retirement, continue participating in Committee work. Her commitment to service and academic pursuits has greatly influenced my own career as well as that of many others.

Anna Kerlek, MD
Submitted by Colleen Waickman

Dr. Anna Kerlek is my mentor in child and adolescent psychiatry. As a third-year medical student, I emailed Dr. Kerlek to ask for advice about CAP due to my interest in psychiatry and pediatrics. Dr. Kerlek emailed me back within five minutes and had me on the phone within the hour, ready to offer advice. She set up a CAP elective at Nationwide Children's Hospital for me and was an excellent resource throughout the residency application process. She also helped me apply for the AACAP Life Mentors Scholarship, allowing me to attend AACAP's Annual Meeting for the first time this year.

Deborah Weidner, MD
Submitted by Paul Weigle, MD

I’m pleased for the opportunity to honor my mentor, Deborah Weidner, MD. I’ve been fortunate to work with Dr. Weidner during my child fellowship, and again as an attending for nearly ten years, during which she was the ideal supervisor. She taught me how to lead via her own example, which is authentic, compassionate, attentive, decisive and accountable. She instilled a vital sense of purpose, teamwork and community among her medical staff. She encouraged me to take on administrative duties, including my current role as associate medical director. For her mentorship I am grateful.

Alexandra Harrison, MD
Submitted by Muhammad Zeshan, MD

I want to honor my mentor Dr. Alexandra Harrison who is child psychiatry faculty at Harvard. Dr. Harrison nudged me forward through the darkness and peeled away the superficial and suffocating layers of incompetency that might have kept me from achieving my full potential during my first few months of CAP fellowship at Boston Children's. She believed in me when I was not able to believe in myself and helped me overcome a helpless feeling of isolation. Because of her mentorship and supervision, Dr. Harrison and I were able to start the first infant training workshops in Pakistan.
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There are good reasons that teacher well-being (TWB) is important to child and adolescent psychiatrists (CAPs). First, 70-80 percent of children with mental health (MH) needs will never see a CAP, and, unless seen at school, most children with MH needs will not be seen for more than a few visits (Gopalan et al. 2010). Second, children spend 15,000 hours with teachers from kindergarten through high school, and as such, they have significant potential to promote MH. Teachers modeling effective MH practices in their lives and in the classroom can be powerful protective factors for child MH. Unfortunately, educators, who communities rely on to teach social-emotional learning and well-being (WB), are sometimes poorly equipped with these skills. Furthermore, approximately 40-50 percent of teachers leave teaching within five years, which often impacts our patients (Barnes et al. 2007). So TWB programs that can better prepare teachers with coping skills to face the challenges of working in a school and promote good MH practices for students can reduce teacher stress/burnout, turnover, and improve teacher quality of life and positive student outcomes (Greenberg et al. 2016).

We implemented a TWB program in Washington, DC, for new teachers. We used the POISE Well-Being Self-Assessment Scale to help teachers discern their relative WB strength and weakness areas. Please see the POISE Well-Being Self-Assessment Scale chart on the following page.

“POISE” refers to 5 domains of WB (Physical, Occupational, Intellectual, Social, and Emotional) addressed in our TWB workbook (available free at medstarwise.org/resources). Low scores in any of the five-item WB areas suggest targets for support. The workbook chapters can be done in any order, based on unique needs for sleep hygiene, time management, etc. Our TWB program with 40 first-year urban teachers indicated:

- 60-68% reported WB was important in their training
- 80% reported their emotional state affected their classroom behavior
- 62% listened to music more often to improve WB, while less than 40% made significant changes to their sleep, nutrition, or exercise practices
- 51% took WB practices they had learned and applied them in their classroom.
- Of the subgroup reporting interest in WB, 78% made significant changes in their daily routine, and 89% applied WB practices in their own classrooms (Bostic et al. 2019).

Most teachers recognized that their emotional state had a significant impact on their classroom. Indeed, the Emotional domain, particularly mindfulness, recognizing their emotional triggers, and using “HARPS” (Healthy Alternatives, Reframing stressful circumstances, Problem-solving, and relying on one’s Social supports for “reality-checking” and different ideas) helped them manage stress in the classroom. In the Physical domain, teacher use of music playlists while commuting to work and during the day were reported to be particularly useful, as was walking while meeting with others. Teachers favored time-management tactics in the Occupational domain, effective questioning and active constructive response tactics in the Social domain, and in the Intellectual domain, they focused on how they “actually spend the minutes of their lives,” and how this fits with their values.

WB efforts extend beyond teachers. Physician burnout worsened between 2011-14 (Shanafelt et al. 2015), with 60 percent of job satisfaction related to coping techniques, lifestyle, and internal attitudes and beliefs (Bohnert, 2006). Strategies for TWB may be applicable for us, and efforts are indeed underway to develop such curricula. Please feel encouraged to employ any of these TWB practices and share any experiences with us at Jeffrey.q.bostic@gUNET.georgetown.edu.

continued on page 96

1This POISE Assessment is also freely available in a Child/Adolescent version for use in clinical practice at the WISE website.
Teacher Well-Being and the Child Psychiatrist

**POISE Well-Being Self-Assessment Scale**

Please circle the best answer for each item (focusing on the past 2 weeks)
1=not at all, 2=a little, 3=moderately, 4=mostly, and 5=almost always.

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<th>Item</th>
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<tr>
<td>1. I get uninterrupted restful sleep for 6+ hours most nights.</td>
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<tr>
<td>2. I eat and enjoy nutritious foods and how they make me feel.</td>
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<tr>
<td>3. Most days I exercise/physically move for 30+ minutes (7000+ steps).</td>
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<tr>
<td>4. I move about so I’m not sedentary or sitting for more than 1 hour at a time during the work day.</td>
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<tr>
<td>5. Music and/or artistic activities are a regular enjoyable part of my life.</td>
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<tr>
<td>6. My work fulfills my sense of purpose.</td>
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<td>7. I stay focused and present when I do my job.</td>
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<tr>
<td>8. I manage my time well and complete most tasks on time.</td>
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<td>9. I am able to achieve my goals despite obstacles that occur.</td>
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<td>10. I am not easily discouraged by failure.</td>
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<tr>
<td>11. I like to stimulate my mind by doing activities such as reading, listening, or watching.</td>
<td></td>
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<tr>
<td>12. I like to explore my interests more deeply or improve my skillset.</td>
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<td>13. I seek or think of better ways to do things.</td>
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<tr>
<td>14. I journal, write (e.g., poetry or music), or capture pictures and videos of my life story.</td>
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<tr>
<td>15. I rely on deeply held principles or spiritual values to guide my life.</td>
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<tr>
<td>16. I have a strong and reliable network of supportive others at work.</td>
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<tr>
<td>17. I seek input and feedback from others.</td>
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</tr>
<tr>
<td>18. I am aware of what annoys me, and I am aware of what I do that annoys others.</td>
<td></td>
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<tr>
<td>19. I support others and acknowledge their successes.</td>
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<tr>
<td>20. I am able to resolve conflicts in most areas of my life.</td>
<td></td>
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<tr>
<td>21. I can stay with and tolerate my painful emotions and learn from them.</td>
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<tr>
<td>22. I feel calm or serene most of the time.</td>
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<tr>
<td>23. I have developed reliable, effective ways to cope with stress.</td>
<td></td>
</tr>
<tr>
<td>24. I can manage my emotions to stay on task or work when necessary.</td>
<td></td>
</tr>
<tr>
<td>25. I enjoy living in the present and worry little about the past or future.</td>
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**References**


Jeff Bostic, MD, EdD, is a Member of AACAP’s Schools Committee, and part of the WISE (Wellbeing In School Environments) Center at MedStar Georgetown Hospital that works with approximately 30 schools in the DC region.

Dr. Hoover, Department of Psychiatry, University of Maryland Medical School

Dr. Horen, Georgetown University Center for Child and Human Development

Dr. Goins, Department of Psychiatry, Georgetown University Medical School
Utilizing Our Knowledge of Adverse Childhood Experiences (ACEs) to Improve Clinical Outcomes

It is essential that clinicians become educated about, and recognize ACEs and learn strategies for prevention and care of patients who have experienced ACEs. This statement captured my attention, particularly as the two co-authors are from the Centers for Disease Control and Prevention. While in full agreement with the statement, I will take it one-step further: we must pay attention to the ACEs of the parents/caregivers of our patients.

Because of the research done since the landmark 1998 publication of the work of Filetti, Anda, Nordenberg et al., and our own clinical observations and findings, we are aware of the multi-generational transmission of trauma and family dysfunction, leading not only to chronic physical diseases, but also to emotional, behavioral and cognitive disorders resulting from early assaults on brain development. After becoming an adoptive mother, Cissy White, who ran a group called “Parenting with ACEs” in Philadelphia, wrote poignantly about her epiphany that her childhood trauma would interfere with her capability for healthy mothering. To quote from her blog, “Learning about trauma and recovery was important, to be sure. It helped me understand why I struggled with anxiety, nightmares and social issues… but it didn’t teach me how to gain what I lacked as an adult or had missed as a child.” Learning about ACEs helped her to understand attachment and its role in providing stability and security for her daughter, and what type of environment she wanted her child exposed to. Her words were, “This is empowering and motivating!”

The term “toxic stress” has gained a lot of traction in our behavioral health lexicon as we attempt to explain the impact of a chronic elevation in cortisol levels in children affected by the accumulation of ACEs. ACEs are highly correlated with negative health outcomes across the life-span: both physically and mentally, including early death. They affect the immune system, endocrine system, the cardiovascular system, gastro-intestinal system, and brain development, thereby affecting emotional and behavioral regulation, cognitive functioning, and interpersonal and socialization skills. Substance use disorders, suicide and cancer are also elevated in populations with higher ACEs.

The ACEs initially identified by Filetti, Anda et al. included all types of child maltreatment, domestic violence, separation and divorce, and parental mental illness, incarceration and substance abuse. The concept of adverse childhood experiences is no longer confined to this 10-item checklist. Roy Wade, a pediatrician at the Children’s Hospital of Philadelphia is pursuing research on what he terms, “Urban ACEs,” including experiences of racism, being bullied, poverty, and community violence. In the United States, experiences of school shootings, and the active shooter preparedness must be considered, and for children in war-torn countries, the experiences of war conflict, displacement, and the disappearance or death of loved ones must also be included.

**Intervention**

During my tenure as the Chief Medical/Clinical Officer of a national behavioral healthcare organization, it became clear that the histories of our patients with severe emotional and behavioral disorders revealed significant childhood trauma, with most patients having more than four and, in some cases, eight ACEs. A high percentage of the youth we served came from the foster care system and had experienced instability through multiple placements, inpatient hospitalizations, and several residential placements, compounding the trauma in their lives. It became clear to me that we were missing some critical information, as the right questions had not been asked and explored. Consequently, we initiated the use of the ACEs questionnaire at intake, improving our identification of trauma generating experiences. The questionnaire had to be administered by a clinician, not be completed prior to the patient/family being seen, with sensitivity and vigilant observation to discern whether the questions might be traumatically triggering to the patient, and follow-up with appropriate clinical intervention.

Having run my own center previously, I had become aware of the needs of the parents/caregivers of our patients. We learned of their own sexual abuse, loss and grief, neglect, abandonment, exposure to violence and substance abuse…their own untreated psychiatric disorders, especially anxiety, depression and post-traumatic stress disorder. Yet, we were expecting them to participate in parenting classes, do homework and function as healthy parents. One parent was courageous enough to tell me that she resented the fact that we were so nurturing and caring for her two children, but that we failed to do the same for parents! That was an eye-opener. Subsequently, we became more attentive to the mental health and cognitive needs of other caregivers.

I recall an outpatient experience I had with a young mother whose son was referred to Children’s Hospital center by his day care center. The toddler was isolating himself, not eating, and chewed his blanket incessantly. This child was suffering from an anacritic depression: mother was not emotionally available to provide the nurturing and protection he needed. It turned out that this single mother was cohabiting with a drug abusing, physically and emotionally abusive partner. Her own childhood history...
Utilizing Our Knowledge of Adverse Childhood Experiences (ACEs)

was traumatic, with several ACEs. She
was diagnosed with a major depression
which I treated with trauma-focused
psychotherapy, psychoeducation and
antidepressants. No direct intervention
was done with her son. Mother engaged
with treatment, completed high school,
got a stable job, and left the destructive
relationship. Her son thrived. This case
illustrates that we, child and adoles-
cent psychiatrists, have the expertise
to treat adult parents/caregivers. I think
we have been misguided in our think-
ing that we should not treat the parents
of our patients who are in desperate
need of active treatment, not just “par-
ent training.” It is possible to maintain
the boundaries necessary in providing
such treatment.

Bellis et al. (2019) performed a meta-
analysis of poor health outcomes
associated with ACEs in Europe and in
North America. Economic costs in North
America associated with ACEs (two or
more) were estimated at $748 billion,
and in Europe at $581 billion. These
numbers are astounding. Mental illness
outcomes were higher than physical
illness, with 30% anxiety disorders, and
40% depressive disorders. The authors
concluded, “our findings reinforce
previous results that identify childhood
as a crucial time in establishing the
foundations of good mental health.”
Adding, “For those experiencing ACEs,
interventions to improve parenting skills,
to strengthen parent-child attachment,
and to develop children’s resilience can
help to moderate the harmful effects
of ACEs.”

What does this all mean for us as child
& adolescent psychiatrists? We should
focus our efforts at minimizing and pre-
venting the occurrence of ACEs. How?
We must focus more on parental and
family functioning.

Prevention

Bellis et al. (2019) recommended,
“Rebalancing expenditure towards ensur-
ing safe and nurturing childhoods would
be economically beneficial and relieve
pressures on the healthcare systems.”

How can we address ensuring safe child-
hoods? We should begin by supporting
parents/caregivers. Efforts to provide
some extended parental leave for new
parents is a step in the right direction.
Additionally, providing pre-natal par-
ent education about ACEs, assessing
parental ACEs, and addressing trauma
in the lives of future parents could be
an important preventative measure.
After birth, ongoing parental support in
the form of medical, emotional, food,
housing, and teaching healthy parent-
child interactions will also be helpful.
The landmark Olds’ Elmira County
home visitation study and follow-up
show very positive outcomes in the
children of those parents 15 years later.
Efforts to prevent child maltreatment and
other ACEs cannot be forgone without
a major focus on the communities in
which our children live. Government
and private business partnerships are
necessary. Communities’ infrastruc-
ture must support affordable housing,
good neighborhood schools, recreation
facilities, faith communities, family
engagement, and safety with positive
law enforcement engagement.

Child and adolescent psychiatry must
advance its efforts to engage with
obstetricians, pediatricians, primary care
physicians, other behavioral healthcare
providers and educators to build profes-
sional networks that will be vigilant
about early detection of risks for adverse
childhood experiences. Co-located care
can offer a unique opportunity for inter-
vention; Marie-Mitchell and Kostolansky
(2019) advocate that “integrated
behavioral health service models would
optimally include adult mental health
and substance use treatment programs,
as well as mental health promotion
programs for pediatric patients.” Most
places do not have sufficient providers
to meet the needs of the population,
especially in rural communities, many of
which register very high ACEs and multi-
generational drug dependency. We need
to expand training in trauma-informed
care and engage with our school com-
unities to educate school personnel
to identify children at risk, provide
referrals, and to establish environments
that mitigate, rather than exacerbate
children’s ACEs.

Screening tools can be accessed from
the National Child Traumatic Stress
Network: https://www.nctsn.org/
treatments-and-practices/screening-
and-assessment/nctsn-resources.

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A Psychiatrist’s Call for the Rights of Unaccompanied Immigrant Minors

Carol L. Kessler, MD, MDiv

Though concerned about the milieu I might encounter in an Office of Refugee Resettlement (ORR) Detention Center for unaccompanied minors, the desire to serve the youth within its walls was stronger. I have journeyed with the people of Central America since volunteering to train health promoters in a conflict zone during El Salvador’s twelve-year, U.S.-funded civil war. On entering the ORR facility, my initial reaction was relief. I was met with the sound of Central American music, the colors of Central American flags, and decorations for upcoming Halloween festivities.

I decorated my office with photos and crafts from El Salvador and informed my patients of my history with their homeland. One youth reminisced—“I used to work on a farm with fruit trees just like those. I hate being locked up here!” Some opted for voluntary return home. A teen girl shared—“My cousin painted her life in Florida through rose-colored glasses. I couldn’t go to school in Guatemala because I’d have to cross three rivers. I came to join her but I’m locked up instead so I asked to go home.” Others feared that returning home would mean certain death. A teen had been threatened when he tried to protect his mother from her Sinaloa drug-cartel-leader-boyfriend’s blows. Another faced threats for failing to join the Mara Salvatrucha gang.

Youth pushed to the US by threat of imminent harm or lack of access to education were pulled by the promise of liberty and justice for all. A Honduran youth who’d been working since age seven begged his father to allow his journey north to the land where it’s illegal for children not to attend school. He lost his father’s phone number as he crossed the river. Scenes from the ride on the US-bound train through Mexico, “la Bestia”, haunt him—a child struck by a branch falling to his death; an intoxicated man on the tracks getting run over.

Many youth wear a cross or speak of God guiding them. One youth thanks God for leading him from a town filled with drugs and gangs to a country where he might get an education, work, and send money to his family. Prayers to God ask for sustenance of loved ones left behind and for companionship through the night.

It doesn’t take long to see the toll that detention takes on these youths’ psyches—as they are held indefinitely in a web of legal and administrative processes with little control over daily life. The United Nations Committee on the Rights of the Child declares that “immigration detention is never in a child’s best interest and therefore always a child rights violation.” Detention is deemed permissible as a measure of last resort, for the “minimum necessary period,” and “limited to strictly exceptional cases.” A Workgroup for the Best Interests of Unaccompanied/ Separated Children recommends that each child be assigned a trained advocate to ensure that the best interest of the child is at the center of decisions made at the time of apprehension, while in custody, and upon release. Failure to appoint such an advocate makes the ORR the youths’ de facto guardian. This leaves the door open for mental health professionals to intervene in a manner that may be legal, but may not be in accordance with professional, ethical standards of care.

As a child psychiatrist, I uphold the biopsychosocial nature of our field. In underfunded clinics, foster children are frequently brought for a psychiatric evaluation by a foster parent or caseworker who is not privy to the child’s history. I am often told that the child is aggressive with the expectation that I will diagnose and prescribe. I clarify that I can merely perform an examination of the child’s current mental status. To do a psychiatric evaluation, I need copies of foster agency records—history of placement/ pregnancy/ birth/ development/ abuse/ education/family/medical and psychiatric treatment. Were rights not terminated, communication with biological parents is a critical component of the evaluation and treatment planning process. Indeed, US citizen parents have the right to consent or refuse to psychiatric medication prescribed to their children, with a family court judge overriding refusal if it is against the child’s best interest. And so,
A Psychiatrist’s Call

I was pleased to learn that at least one of my colleagues at the ORR facility routinely spoke to unaccompanied minors’ relatives before prescribing medication. This proved to be the exception.

A Guatemalan teen presented for a psychiatric visit after learning from her immigration lawyer that she would be transferred to an adult ICE detention center should another disposition fail to materialize before her upcoming eighteenth birthday. She worried that her irritability and resultant rude behavior would result in incident reports that might interfere with her release to the community. She was frustrated with her case manager’s failure to notify her about a tentative upcoming visit with her uncle/potential sponsor.

The following week, I was shocked when Maria requested to call her father so that she could ask to return to Guatemala. For her, ORR records confirmed her narrative of fleeing home to escape sexual abuse by a neighbor with no possibility of police intervention. I told her that I would use this opportunity to speak with her father to ensure that he was aware of the three psychotropic medications she’d been taking since her detention months ago and to obtain the elements vital for a psychiatric evaluation. He was shocked to hear of her desire to return home, where he had been unable to keep her safe from her older brothers, who abused her while intoxicated. He’d arranged for Maria to flee to her uncle’s home in the U.S. Before ending the call, I learned that Maria’s father hadn’t spoken to any previous psychiatrist and wasn’t aware that she was taking medication.

Maria grew angry as she realized that her father was communicating that it wasn’t safe for her to return home. I called the program director to inform him of the contradiction between the father’s history and the federal records; of the father’s lack of awareness that his daughter was taking psychotropic medication; and of Maria’s need for support. I was told that staff should not be told any personal information and would escort her to her cottage. I advised ORR is Maria’s guardian and that parental consent for psychotropic medication is not legally necessary.

Her statement clarified that “alien youths’ parents’ rights cease at the moment of detention by U.S. Border Patrol. Though my role was to enforce ORR policy, adherence to such policy would violate my professional ethic. My concerns are echoed in an article describing clinicians in facilities that detain child asylum seekers who “initially hoped that they were equipped to treat and support traumatized children… but felt increasingly hopeless in the face of a merciless government policy and the petty tyrannies of a detention environment run along the lines of a penal colony.” The authors note that a pattern of clinical recommendations being ignored and dismissed as biased or inaccurate in a culture that saw the detainees as the case manager had explained it to me. Together, we created a family tree.

David then shared that he was an orphan who’d lived with his grandmother in Guatemala City. There, gang members ordered him to steal a backpack. He was jailed for months, and when released feared gang reprisals. He fled to his aunt’s home in Mexico. Later, he and his cousin sought a safer, brighter future in the U.S. They parted ways en-route. His cousin was detained and eventually released to a family friend in Pennsylvania, where David hoped to join him. And so, I called his aunt in Mexico who shared his cousin’s contact information. Within an hour, David was speaking with his cousin. A seed of hope for release to the community was planted.

I requested that the program director schedule a time for me to meet with youths’ case managers and therapists. She agreed, though she was surprised since my predecessor had assumed the role of independent “prescriber”. I was shocked to be the only one to have concerns about the discrepancy between Maria’s father’s story and that of her federal record. The therapist was primarily concerned that Maria’s urges to self-harm were a means of getting to her office to request more than the minimal required biweekly calls to her father.

The meeting proceeded with brief reports about each “minor.” My inquiry into the status of David’s potential sponsor was deemed out of the scope of my role as a psychiatrist. My concerns about a youth who alleged sexual abuse by a staff member at another ORR facility was deemed a legal matter. Concerns that a youth referred due to symptoms of ADHD was illiterate led me to learn that individualized educational plans are only available in the community. Concerned that many had been waiting for foster homes for more than a year, I was told, “welcome to Dante’s inferno.”

At that moment, I believed that to stay at the center would violate my oath to “do no harm.” I joined my colleagues’ conclusion “that clinicians have an ethical responsibility to challenge the government when harm is done to individuals and groups as a result of bad law and policy. Remaining silent and acting as a bystander in effect colludes with the harmful practices.” I concur with the American Pediatric Association’s recommendation that exposure to detention be eliminated and that the health consequences of detention of immigrant children in the U.S. be longitudinally evaluated.

I am encouraged by the Young Center for Immigrant Children’s Rights’ mission to create a dedicated children’s immigrant justice system. They heed the Inter-American Court of Human Rights’...
call to provide each child with “a guardian ad litem to help him/her adjust to the U.S... and to make decisions in line with the child’s best interests”. They train volunteer child advocates to provide a voice to unaccompanied children similar to that granted to children in the domestic child welfare system who have been abused, neglected or abandoned.

I leave the youth in the hands of the God they depend on, as they wait for a federal specialist to determine their fate—voluntary departure; move to a sponsor or foster care; or graduation to adult ICE detention. I join Doctors for Camp Closure, a non-partisan organization of healthcare professionals who oppose the inhumane detention of migrants and refugees attempting to enter the U.S. I end with the words of Holocaust survivor Elie Wiesel – “No Human Being is Illegal.”

References

Carol L. Kessler, MD, MDiv, is a community child psychiatrist who has been involved in efforts to support the mental health of Central Americans since volunteering in El Salvador during its civil war. She is an ordained pastor in the Evangelical Lutheran Church in America.

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.
Growing Up in the Age of Eco-anxiety

Robert Root, MD

Children in Northern California know what it’s like to live under an apocalyptic haze of hazardous smoke, just like their peers in Southern Australia who are experiencing vast and devastating fires across their neighborhoods. All of these kids understand the fear for their family’s safety and anxiety about losing everything—their homes, treasured possessions and communities.

Imagine a child in Sonoma County who had to be evacuated from approaching wildfires in 2017. It’s safe to say that children have been re-traumatized by the Camp Fire in 2018, or the Kincade Fire of 2019, and undoubtedly will feel the intense anticipatory anxiety as fire season approaches again each September. It will be no different outside Sydney or Melbourne.

Imagine a child in the Bahamas who recently lived through hurricane Dorian; the most destructive weather system ever to reach the Caribbean. These children suffer many of the symptoms of post-traumatic stress disorder (PTSD) including hyper-arousal, sleep disruption, and avoidance behaviors; they may experience nightmares about trying to flee an approaching firestorm or torrential rains. These scenarios are a source not only of recurrent anxiety but a cyclical and seasonal reality. Even media depictions of major storms or floods heighten our experience of stress and threaten our sense of well-being.

Research on stress and trauma demonstrates that fear and arousal levels in children are reduced when caring adults are able to listen to children’s verbalized anxiety. A study I conducted at California Pacific Medical Center in October 2018 interviewing adolescents ages 12-18 showed that 88 percent of these kids reported significant concerns about climate change. The greatest fear expressed was about the impact of sea level rise, which pose an incalculable risk to the populations of New York, London, Mumbai and Shanghai. One teenage girl told me, “It keeps me up at night. I feel utterly helpless!”

What is it like to grow up with such uncertainty about the safety of our environment? Children endured dire circumstances in Cape Town, South Africa and Chennai, India, when these cities faced acute drinking-water shortages. It is unprecedented in human history that this foundational security about the planet around us is shaken—will the Earth continue to be able to nourish us and provide us with clean air and water and plentiful food? Millions of people in diverse regions of the world have now personally experienced the consequences of climate change.

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“The need for a call to action to promote psychological well-being as we look at climate change challenges through the lens of children’s mental health.”

Eco-anxiety has engendered questions about whether children will even have a future and has led some to consider that it could be morally indefensible to bring new children into the world. Young people have sued the federal government for violating their rights to grow up in a world that is “capable of sustaining human life.” Many of us, adults as well as children, are experiencing “climate grief.” We are mourning the Earth as if we are grieving for the gradual decline of a dying loved one. Grief is a normal response to loss. Young children in Australia right now are mourning the loss of animals (millions of kangaroos and koalas perished in the recent wildfires), of their homes, or of a loved one. Older adolescents wrestle with the existential sense of species extinction and the loss of the sustainability of human life. More generally, we feel an evolving sense of the loss of safety, loss of control, and loss of the continuity of our family and “being” into the future. We may feel helpless and numb in the face of the magnitude of these stressors.

Young children have a limited capacity to cope with overwhelming or scary information. Those living in disadvantaged neighborhoods in close proximity to polluting power plants or factories—who are disproportionately children of color—are even more vulnerable to the health and psychosocial risks of climate change. Children deserve both to have their physical health protected, and to have their sense of safety and security in the world restored.

Children need to know that environmental scientists, policymakers, and other concerned citizens of the world are tirelessly tackling these issues. Parents need to be sensitive and responsive to children who voice their fears and anxiety about the future. Let’s encourage climate change education and discussion in the classroom and around the dinner table. Taking positive action is profoundly helpful in lowering stress.

Let us choose to engage and to confront our fears. Renewable energy and reforestation programs offer tangible and achievable steps to combat the climate crisis. The people of Ethiopia remarkably planted 220 million trees in less than 24 hours! High school students inspire others to feel social connectedness in the commitment to confront climate change, as with the Youth Climate Strike. There are steps that families can choose to do together which will give a child some locus of control such as changing to a plant-based diet or changing the home electricity bill to 100% clean energy. Engaging in constructive age-appropriate actions can effectively combat feelings of hopelessness.

Young people in this generation are already confronting unique and intense...
We must be galvanized not to tolerate these threats to our children’s health. We need a call to action to promote psychological well-being as we look at climate change challenges through the lens of children’s mental health. Let’s re-establish our shared humanity—across cultures, continents and the generations, as citizens of the planet.

We must be galvanized not to tolerate these threats to our children’s health. We need a call to action to promote psychological well-being as we look at climate change challenges through the lens of children’s mental health. Let’s re-establish our shared humanity—across cultures, continents and the generations, as citizens of the planet.

There is no greater moral or emotional imperative than to fiercely protect our children. We must do everything we can to help ensure them a healthy, habitable planet—now and for all future generations.

Dr. Robert Root received his medical degree from Yale University School of Medicine and then trained in Psychiatry at the NY Hospital—Cornell Medical Center in New York City. Dr Root works as a Senior Psychiatrist at the non-profit Child Mind Institute in the San Francisco Bay Area.
New Research Poster Call for Papers

Deadline: June 15, 2020

AACAP’s 67th Annual Meeting takes place October 19-24, 2020, in San Francisco, CA. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry that advance the field and can be used to improve the well-being of children and their families, e.g., clinical treatment, research, training, development, service delivery, administration, translational research, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and suicide and violence prevention. Submissions on emotional dysregulation are encouraged to support AACAP’s current Presidential Initiative.

In addition, there are two opportunities to orally present your poster in some special sessions. See more details on the Call for Papers page and indicate your interest on step 1 of the form.

Verbal presentation submissions were due February 13 and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by June 15. The online submission site will open early April. All Call for Papers applications must be submitted online at www.aacap.org/annualmeeting-2020.

If you have questions or would like assistance with your submission, please contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
AACAP Member Review: Clinical Essentials, AACAP’s Series of Online CME Courses

My excitement for these courses began when I started reviewing material for our first course, Clinical Essentials on Substance Use Disorder. Prior to this course, I thought I knew how to approach marijuana, until I saw segment on the exam findings for high THC ‘wax’ and ‘shatter.’ Now, I can catch the really at-risk kids. Not only did this essential information immediately benefit my practice, I am also more confident in accepting patients with substance use issues.

We’ve now expanded our course catalogue to include Clinical Essentials on Autism Spectrum Disorder, Depression, Positive Parenting Practices, and Sleep. All the courses include high-quality, carefully vetted lectures from top-rated AACAP speakers, and supporting materials to enhance learning, such as relevant journal articles, useful links, and self-assessment questions.

I’ve encouraged my staff to review the content of these courses and each have commented on the practical nature of the content and the ease of implementation. My hope for this review is get these courses into the hands of more physicians and medical professionals, so they may continue to expand their skillset and enhance patient outcomes.

To learn more, visit www.aacap.org/onlinecme.

Dr. Muir is the Medical Director at Brooklyn Minds Psychiatry, P.C.; Clinical Assistant Professor, Baylor College of Medicine, and a Member of AACAP’s Task Force on Clinical Essentials

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Visit AACAP’s Learning on Demand at aacp.sclivelearningcenter.com for more information and to see free samples of content available.

No CME credit is available with session recordings. Session availability subject to speaker permission.
Recertification efforts in psychiatry in the United States have continued to evolve since the publication of the Institute of Medicine (IOM) reports in 2000 and 2001. These reports highlighted the marked increase in the number of medical errors across the nation along with the need to make health care more equitable and efficient while improving safety and effectiveness in a more patient-centered manner. The American Board of Medical Specialties (ABMS), including the American Board of Psychiatry and Neurology (ABPN), developed a four-part maintenance of certification (MOC) process with the goal of ensuring continuous learning over the course of a professional’s career. There are four parts of MOC: Part I requires an unrestricted license to practice medicine; Part II requires self-assessment and continuing medical education credits; Part III is a cognitive exam given every ten years with the goal of assessing practice relevant knowledge and its clinical application; and Part IV includes peer review and performance in practice activities. Diplomates are eligible to take the Part III cognitive exam after completing Parts I, II and IV of the MOC process. The process has moved from a 10-year program to what ABPN calls continuing certification. The cognitive test is only one part of continuing certification, making it possible for the diplomat to be certified for an additional 10 years, but only with ongoing completion of other MOC requirements along the way.

“The ABPN MOC Part III Pilot Project is a professional journal article-based assessment activity designed as an alternative to the existing secure, proctored 10-year MOC examination. This initiative involves greater engagement in active learning with clinically relevant and up-to-date medical knowledge.”

The ABPN MOC Part III Pilot Project is a professional journal article-based assessment activity designed as an alternative to the existing secure, proctored 10-year MOC examination. This initiative involves greater engagement in active learning with clinically relevant and up-to-date medical knowledge. The Pilot Project utilizes important articles from professional journals that have been chosen by an ABPN committee (all of whom are AACAP members). The ABPN has chosen 50 articles from which participants must choose at least 30. Participants must answer correctly at least four out of five multiple-choice questions in conjunction with each article that they choose in order to receive credit for the article. They must pass the mini-exams on at least 30 total articles. If a participant fails to answer correctly four of the five questions for a specific article, the participant can choose an additional article from the 50 provided. No matter how many journal articles are available in the library of articles, diplomates must pass 30 article mini-exams out of a maximum of 40 article mini-exams. The mini-exams are open book and the diplomate may use the article to answer the questions. The ABPN notes that the questions will be written so that they cannot be easily answered by just reading the abstract thus encouraging greater retention of knowledge. In addition to completing Part III of MOC, participants will also be awarded 16 hours of non-CME self-assessment credit for Part II of MOC. The ABPN provides a sample article and questions for Pilot Project participants to reference.

There are three categories of cost for Pilot Project journal articles (No Cost: You will be able to access and read the article without paying a fee. Free to AACAP Members: These articles are not open access, but are free if you are a member of AACAP. Purchase May Be Required: In order to access online, you will need to buy the article or have a subscription to the journal). The 50 articles chosen for the CAP pilot are listed on the AACAP website: www.aacap.org/pilotproject. At present, 35 of these articles are free to AACAP members, 12 are no cost, and three are available for a small fee.

The ABPN staff has reported that participating CAP diplomates are satisfied with their experience and have said, “the articles were educational and covered a wide range of pertinent topics,” “the articles were interesting and relevant to clinical work,” and “the questions were fair and helped develop critical thinking skills for incorporating interventions into everyday practice.”

Enrollment is still available depending on your certificate expiration date. Diplomates who anticipate recertification during the years 2019-2024 whose ABPN MOC requirements are up-to-date...
may participate in this program. The Pilot Project will run for a total of 3 years, from 2019-2021 and, if approved by the ABMS, the ABPN plans to offer the option for all diplomates to transition into this program in 2022. If you received a Pilot Project invitation and still want to enroll, please see the ‘Part III Pilot’ section of your ABPN Physician Folios account. Thus far, a large number of ABPN diplomates have enrolled in the CAP Pilot Project and a substantial number have already started and finished the pilot. If the Pilot becomes a permanent option in 2022, diplomates participating in the program will be expected to read a set number of articles every three years on an ongoing basis. Please access the ABPN website for more information: www.abpn.com/maintain-certification/moc-part-iii-pilot-project.

Other AACAP MOC Products

The AACAP Lifelong Learning Committee produces a module of seminal articles annually, some of which have already been chosen by the ABPN for the Part III Pilot Project. Completing these modules annually provide all the CME credits needed, both regular CME and SA CME, for meeting Part II of the present MOC requirements. In addition, the Lifelong Learning Committee sponsors an Institute at AACAP’s Annual Meeting that brings in leaders in the field to discuss the compendium of articles chosen for the Module, providing an additional learning pathway for practitioners to stay abreast of the literature in the field. Also in conjunction with the Annual Meeting, the Lifelong Learning Committee, along with the CME Committee, assemble the Annual Meeting Self-Assessment Exam and Annual Meeting Self-Assessment Workshop, each approved to offer 8 SACME credits. The goal of each activity is to assess a learner’s current level of knowledge regarding child and adolescent psychiatry topics. AACAP’s website also has a section of tools, developed by the Lifelong Learning Committee, that diplomates may use to meet both the clinical and feedback modules of Part IV of the present MOC requirements (www.aacap.org/pip). AACAP members interested in continued learning as well as meeting ongoing lifelong learning ABPN requirements should explore these opportunities at www.aacap.org/moc.
Lifelong Learning Modules

Earn one year’s worth of both CME and self-assessment credit from one ABPN-approved source. Learn from approximately 35 journal articles, chosen by the Lifelong Learning Committee, on important topics and the latest research.

Visit www.aacap.org/moc/modules to find out more about availability, credits, and pricing.

Improvement in Medical Practice Tools

(FREE and available to members only)

AACAP’s Lifelong Learning Committee has developed a series of ABPN-approved checklists and surveys to help fulfill the PIP component of your MOC requirements. Choose from over 20 clinical module forms and patient and peer feedback module forms. Patient forms also available in Spanish.

AACAP members can download these tools at www.aacap.org/pip.

Live Meetings

(www.aacap.org/cme)

Pediatric Psychopharmacology Institute — Up to 12.5 CME Credits
Douglas B. Hansen, MD, Annual Update Course — Up to 16 CME Credits
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
– Course topics include ASD, Depression, Positive Parenting Practices, SUDs, Sleep

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
Clinical Essentials:
A Series of Online CME Courses in Child and Adolescent Psychiatry

- Autism Spectrum Disorder
- Depression
- Positive Parenting Practices
- Sleep
- Substance Use Disorders

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.

Pathways Transcript Feature
In addition to these great online activities, Pathways’ transcript feature allows you to track your CME certificates from AACAP and other organizations in one place.

Visit www.aacap.org/onlinecme to learn more.
Join us for the second ONLINE Douglas B. Hansen, MD, Annual Update Course. Over a 6-week period, our redesigned course will allow you to interact with experts and learn about the most sought-after topics in the field — all on your own schedule, in your home or office. Online registration closes on March 16, 2020.

www.aacap.org/UpdateCourse-2020

QUESTIONS? Email CME@aacap.org
Get in the News!

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

- **Committees/Assembly.** Write on behalf of an AACAP committee or regional organization to share activity reports or updates (chair must approve before submission).
- **Opinions.** Write on a topic of particular interest to members, including a debate or “a day in the life” of a particular person.
- **Features.** Highlight member achievements. Discuss movies or literature. Submit photographs, poetry, cartoons, and other art forms.

**Length of Articles**
- Columns, Committees/Assembly, Opinions, Features – 600-1,200 words
- Creative Arts – up to 2 pages/issue
- Letters to Editor, in response to an article – up to 250 words

**Production Schedule**

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

**Citations and References**

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

For complete AACAP News Policies and Procedures, please contact communications@aacap.org.
Welcome New AACAP Members

Matthew P. Abrams, Orlando, FL
Megan Acito, MD, Westbury, NY
David Adams, Los Angeles, CA
Abidemi Adeghbola, MD, Beachwood, OH
Kyle Ahonen, MD, Olafsea, KS
Dolani Ajanaku, MD, Tampa, FL
Timothy Akhalu, Chicago, IL
Adam N. Ali, MD, Ann Arbor, MI
Christina Allebach, Indianapolis, IN
Bahar Altaha, MD, Scottsdale, AZ
Lance Michael Scott Amols, MD, West Palm Beach, FL

Crestin Andrews, Carmel, IN
Chelsea Atwater, DO, Lexington, KY
Pauline Bagatelas, Providence, RI
Gregory Barnett, MD, Los Angeles, CA
Lesly H. Baugh, MD, Poolsville, MD
Valeria Benitez-Lopez, San Ysidro, CA
Maitreyee Berends, El Paso, TX
Cashana Betterly, MD, Silver Spring, MD
Ragini Bhushan, MD, Washington, DC
Vanessa T. Bobb, MD, PhD, Albany, NY
Scott Borkenhagen, MD, Springfield, IL
Darrian Bost, MD, Indianapolis, IN
Andree M. Bouterie, MD, Houston, TX
Megan Bowers, MD, Washington, DC
Parth Brahmbhatt, MD, Louisville, KY
Kanwarjeet Brar, MD, Indianapolis, IN
Simran Brar, MD, Indianapolis, IN
Tyrone Bristol, MD, Augusta, GA
Alycia Brown, MD, Boone, NC
Cathy L. Budman, MD, Manhasset, NY
Crystal Bullard, MD, Charlotte, NC
Molly Bullington, MD, Indianapolis, IN
Nicole Burkette Ikebata, MD, Roseville, MN
Casey Cai, Dallas, TX
Daniel Caredeo, Danville, PA
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Caitlin Carter, Manhattan, IL
Jennifer Cenker, Columbus, OH
Carolyn Certo Gnerre, MD, Bronx, NY
Alison Cesarz, MD, Del Mar, CA

Suneeta Chacko-Varkey, MD, Westfield, NJ
Madeline Chin, Providence, RI
Nungshintombi Chongtham, MD, East Meadow, NY
Arum Chun, Portland, OR
Bora Colak, MD, MPH, New York, NY
Alexis Collier, Philadelphia, PA
Michael Corso, Columbia, SC
Claudine Couture, MD, Westmount, QC, Canada
Nadia Daly, MD, Boston, MA
Michele Deesing, MD, Irvine, CA
Joel Dey, MD, Cleveland, OH
Jessica DiCarlo, AMD, Houston, TX
Stephanie Ding, Houston, TX
Gustavo S. Doria, MD, MS, Curitiba, PR, Brazil
Nithin V. Edara, Chicago, IL
Karina Espana, MD, Portland, OR
Kene Ezeibe, MD, Red Deer, AB, Canada
Khaja Faisal, MD, West Windsor, NJ
Beenish Faraz, Alexandria, VA
Kendra Ferguson, MD, Baltimore, MD
Evan Fowler, Oak Park, IL
Ann Marie Frederick, MD, North Charleston, SC
Amanda Fuji, MD, Salt Lake City, UT
Fabricia Signorelli Galeti, MD, Moema, Sao Paulo, SP, Brazil
Christopher Gaudiot, MD, Albuquerque, NM
Joshua Mark Gibney, MD, Salt Lake City, UT
Christopher Gideon, Chicago, IL
Kira Gomez, Houston, TX
Carolina Gonzalez, Delray Beach, FL
Morgan Goodyear, MD, Johns Island, SC
Kimberly Ann Gordon-Achebe, MD, Ellicott City, MD
Gregory Gorraiz, Pittsburgh, PA
Larrilyn Grant, MD, Fishers, IN
Nicholas Gregorio, MD, Arlington, VA
Heather Griffin, MD, Grovetown, GA
Kaitlyn Gronauer, Columbia, SC
Aliza Grossberg, Providence, RI

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Claire Guevara, MD, Indianapolis, IN
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Nicole Hadler, Ann Arbor, MI
Kaitlyn Halsema, Corinith, MS
Shariq Haque, MD, Oneonta, NY
Benjamin Harbst, MD, Minneapolis, MN
Hamilton Harris, DO, Indianapolis, IN
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Sayyeda Hasen, MD, Tyler, TX
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114 AACAP NEWS
FOR YOUR INFORMATION

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org.
AACAP Releases Letter Responding to ORR, ICE, for Use of Confidential Therapy Notes in Cases Against Immigrant Minors

Washington, DC, February 21, 2020

On behalf of the 9,600 members of the American Academy of Child and Adolescent Psychiatry (AACAP), we condemn the recently detailed actions of the Office of Refugee Resettlement (ORR) and the Immigration and Customs Enforcement (ICE) that called for otherwise confidential medical information to be used as a means to prosecute immigrant minors.

AACAP responds to this alleged practice with a comment letter addressed to the director and acting director of the ORR and ICE, respectively. As a psychiatric organization dedicated to the healthcare and well-being of minors everywhere, we view this breach of confidentiality as contrary to accepted medical ethics and effective patient care.

AACAP implores the ORR and ICE to end this practice of breaching the confidentiality of patient detainees seeking mental health treatment.

The letter appears on the following pages.

For questions or comments, or to speak to an expert, please contact the communications department at communications@aacap.org, or by phone at 202-966-3594.

-#-

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.
February 18, 2020

Jonathan H. Hayes  
Director  
Office of Refugee Resettlement  
Administration for Children & Families  
U.S. Department of Health & Human Services  
330 C Street, SW  
Washington, DC 20201

Matthew T. Albence  
Acting Director  
U.S. Immigration and Customs Enforcement  
U.S. Department of Homeland Security  
500 12th Street, SW  
Washington, DC 20024

Dear Director Hayes and Acting Director Albence:

On behalf of the 9,600 members of the American Academy of Child and Adolescent Psychiatry (AACAP), I write to condemn recently detailed actions by the Office of Refugee Resettlement (ORR) and the Immigration and Customs Enforcement (ICE) that have betrayed otherwise confidential medical information.

As you know, this past Sunday’s Washington Post front page featured the lead-in to a very disturbing story, “Trust and Consequences,” chronicling the plight of an adolescent who had shared personal information with an ORR-employed therapist relating to his trauma, only to have his confidential conversations shared with ICE officials who used them against him in deportation proceedings. From our understanding of the facts, also detailed today by National Public Radio, this adolescent did not pose an imminent danger to himself or others, but instead expressed anger, as is often felt later by victims of trauma. To use such statements against this detainee, or others similarly situated, is contrary to accepted medical ethics and effective patient care. It is simply not right to do so.

As ORR considers ways to meet the medical and mental health needs of detainees, patient confidentiality must be the cornerstone of treatment, as an assurance first to the detainee and also to the mental health or other medical professionals with whom each will speak. To do less is to prosecute the very victims of violence and trauma seeking refuge in America, turning their sad stories against them.
We ask and implore your agencies to do better by the youth and families seeking asylum and safety in the United States. Please end the practice of breaching the confidentiality of patient detainees seeking mental health treatment.

Sincerely,

Gabrielle A. Carlson, MD
President
AACAP Policy Statement

American Academy of Child & Adolescent Psychiatry
WWW.AACAP.ORG

Clinical Use of Pharmacogenetic Tests in Prescribing Psychotropic Medications for Children and Adolescents

Approved by Council March 2020

Background

Several commercially available combinatorial pharmacogenomic tests are being marketed for psychiatric clinical practice. Commercial entities claim that the testing measures drug metabolism to guide medication choice and dosing to impact therapeutic response and side effects.

In October 2018, the Food and Drug Administration (FDA) issued a safety communication warning against the use of genetic tests with unapproved claims to predict medication response. The FDA stated that changing a patient’s medication regimen based on the results of a pharmacogenomic test leads to “inappropriate treatment decisions and potentially serious health consequences for the patient.”

Only a small fraction of the available commercial products have undergone randomized controlled trials in adults only.

Current studies are limited by:

- Potential conflicts of interest
- Small sample sizes
- Short duration of follow-up
- Lack of blinding
- Lack of appropriate control groups

Additionally, numerous factors affect medication response unaccounted for by genetic variation. Genetic variations are managed clinically with slow and thoughtful medication management.

Furthermore, pharmacogenomic testing provides little meaningful information when two or more medications are used concurrently.

The American Academy of Child and Adolescent Psychiatry recommends:

- Clinicians avoid using pharmacogenetic testing to select psychotropic medications in children and adolescents.
- Future high-quality prospective studies to assess the clinical significance of pharmacodynamic and combinatorial pharmacogenomic testing in children and adolescents. Recommends accessible health clinic programs that provide a full range of services, including confidential counseling and information regarding sexual activity and reproductive health.

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.
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CALIFORNIA
Company: Spin Recruitment Advertising (876472)
Title: Adult & Child Psychiatrists
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Job Description:
I am a PERMANENTE PHYSICIAN. A dedicated doctor who believes in pursing dreams, creating hope and driving progress. Southern California Permanente Medical Group is a physician-led, partnership organization with a patient-centered and evidence-based medicine approach. SCPMG is an organization with strong values who provides our physicians with the resources and support systems to ensure our physicians can focus on practicing medicine, connect with one another and provide the best possible care to our patients.

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Job ID: 13399681
http://jobsource.aacap.org/jobs/13399681

Job Description:
An established practice in Southern California is seeking a board-certified or board-eligible psychiatrist to join its team. This is a great opportunity to join a passionate team with a flexible employment model. Offering additional compensation for board certification and C&A certifications. OPPORTUNITY HIGHLIGHTS Flexible employment model with flexible scheduling 100% outpatient role with no call Access to top-notch resources Comprehensive health and retirement benefits Extensive experience hiring J1 or H1B physicians Located 1.5 hours from greater San Diego, our Southern California city offers access to engaging events and activities throughout the year and beautiful scenery all around. With endless opportunities for outdoor recreation, you’ll enjoy amazing sunsets and a wonderful quality of life. COMMUNITY HIGHLIGHTS Close to Arizona, San Diego, and Mexico Low cost of living and affordable housing options Consistent sunshine year-round Less than 30 minutes from an international airport U.S. News ranks California #7 in “Best States for Healthcare” For immediate consideration please inquire with an updated copy of your CV so we can discuss the position by phone. Also, inform me of your best available times to speak. I look forward to your reply and thank you for your review. Please do not delay as we anticipate a significant response. Please contact Jacob Bass at medcareers@merritthawkins.com or at 866-406-0269 and reference PSY-116277

CALIFORNIA
Company: AMERICAN TELEPSYCHIATRISTS (1205068)
Title: Child/Adolescent Psychiatrist via Telepsychiatry - Must have current MD/DO in CA
Job ID: 13459499
http://jobsource.aacap.org/jobs/13459499

Job Description:
Do you want to never have to worry about catching a virus at work for the rest of your career? Telepsychiatry is the obvious answer. All work is done via telemedicine. You do not have to physically go to the clinic. Contract work (1099). Permanent, ongoing work. Telepsychiatrist Overview: American Telepsychiatrists (http://www.atpsnetwork.com) is seeking two full-time (40 hrs/wk) and two part-time (16 hrs/wk) board certified Child/Adolescent psychiatrist. County Mental Health Clinic Outpatient. Hours are between 8 AM and 5 PM Monday-Friday. No evening or weekend work or on-call. Physically residing within the state of California is not required, but a current unrestricted MD/DO license in CA is required at the time of application (need is now, and so there is no time to apply for a CA license that could take months). If you are interested in working as an Independent Contractor (1099) for American Telepsychiatrists, please contact us for further information. General website: https://www.atpsnetwork.com

Job Requirements:
Telepsychiatrist Requirements: At the time of application, you must hold a current and unrestricted MD/DO license in the state of CA MUST have a current DEA that is registrable to an address in CA MUST be Board Certified in General Psych at the time of applying Must have completed a fellowship in child/adolescent psychiatry at the time of applying Must have NOT opted out of seeing MediCare patients in CA Must have no history of malpractice or hits on the National Database Must have County Mental Health Center experience and be comfortable with Clozaril and already be on the Registry Must be able and willing to prescribe
Schedule II medications Must speak fluent English Spanish is a Major Plus

CALIFORNIA
Company: Director of Administrative Services (1204242)
Title: Chief of Psychiatry
Job ID: 13442145
http://jobsource.aacap.org/jobs/13442145

Job Description:
CalPERS retirement benefits, plus Deferred Compensation and Defined Contribution plans available. Candidates must have at least five years of experience, plus Board Certification or Board Eligibility. Possession of a valid Physician and Surgeon’s certification issued by the State of California. If licensed in another state, candidates may participate in the recruitment and examination process, however, possession of a valid Physician’s and Surgeon’s Certificate issued by the State of California is required at the time of appointment. Possession of a State and/or Federal narcotic license for administration of narcotics.

COLORADO
Company: Denver Health (1199393)
Title: Psychiatrist - Child and Adolescent
Job ID: 13442119
http://jobsource.aacap.org/jobs/13442119

Job Description:
Denver Medical Center is seeking for a child/adolescent psychiatrist to serve on our 21 bed inpatient pediatric psychiatric unit. The psychiatrist must be board eligible/certified in child and adolescent psychiatry. Denver Health physicians have a faculty appointment at the University of Colorado School of Medicine, and Denver Health is a teaching hospital. The physician will provide expert assessment and clinical care in child and adolescent psychiatry which includes the following: Diagnoses and treats children and adolescents with complex, co-occurring medical, psychiatric and substance use disorders; homeless, poverty; and treatment-resistance. Obtains relevant medical histories, makes appropriate diagnoses, implements and directs effective psychiatric treatments including during high-risk and/or life-threatening conditions. Assesses and mitigates the risk of suicide or violence among patients at risk due to psychiatric illness, including schizophrenia, bipolar, depressive, anxiety, substance use disorders, and personality disorders. Leads multidisciplinary teams of case managers, discharge planners, nursing, occupational therapy, psychologists, and other professionals to provide clinical care. Teaches medical students and advanced trainees from other health disciplines including in nationally accredited training programs. Consults with non-psychiatric medical providers in the care of patients with psychiatric disorders. Directs care teams in identifying appropriate levels of care for complex patient presentations. Applies treatment statutes for involuntary psychiatric and/or substance use disorder treatments. Interprets the results of relevant laboratory and imaging studies and applies them to the diagnosis and treatment of psychiatric symptoms. Maintains medical license, board-certification, BLS certification, and other relevant licensure/certification. Supports an inclusive work environment. Provides high quality clinical care and works to meet productivity metrics as directed by direct supervisor. Supports department initiatives related to quality, safety, financial viability, and other initiatives as directed by the ADOS or DOS. Works collaboratively with operational colleagues to maintain quality, safety, and financial viability. Has weekend, overnight, and holiday responsibilities according to department needs.

Job Requirements:
Education and Experience Graduation from an Accredited Medical School and completed Accredited Residency Programs and fellowships for specialist, or equivalent. Board Eligible/Certified In Child/Adolescent Psychiatry. Knowledge, Skills and Abilities Knowledge of and ability to apply professional medical principles, procedures and techniques. Thorough knowledge of pharmaceutical agents used in patient treatment. Able to effectively manage and direct medical staff support activities while providing quality medical care. Able to receive detailed information through oral communications; express or exchange ideas by verbal communications. Excellent written and oral communication, listening, and social skills. Able to interact effectively with people of varied educational, socioeconomic and ethnic backgrounds, skill levels and value systems. Performs in a tactful and professional manner. A wide degree of creativity and latitude is expected. Relies on experience and judgment to plan and accomplish goals.
FLORIDA
Company: First Physicians Group (1151583)
Title: Child/Adolescent Inpatient Psychiatry - Sarasota, Florida
Job ID: 13356221
http://jobsource.aacap.org/jobs/13356221

Job Description:
First Physicians Group of Sarasota Memorial Health Care System is one of the gulf coast’s foremost primary and specialty care groups. With over 230 Physicians & APPs in 29 different specialties and 42 sites in Manatee and Sarasota Counties, it is backed by the tradition and strength of Sarasota Memorial Hospital. We are located in the highly desirable area of Sarasota, FL, which is on the West Coast of Florida and close to some of the most beautiful beaches in the country – Siesta Key, Lido Key and Longboat Key. The community is known for its excellent public and private schools and an impressive array of restaurants and activities for all ages to enjoy. About the Position First Physicians Group is seeking to employ a Psychiatrist who is Board-Eligible or Board-Certified in Child, Adolescent and Adult Psychiatry to cover admissions for the inpatient program in our behavioral health facility. The psychiatrist will also consult on the medical floors at Sarasota Memorial Hospital in rotation with the other psychiatrists in the group. The behavioral health hospital is approximately 60 beds with 13 of them allocated for children/adolescents. This is an excellent opportunity for someone who would like to join a stable and established psychiatry group with well-trained physicians who have been with the practice for many years. Highlights Monday through Friday normal business hours seeing approximately 12 encounters per day. Weekend and after-hours call is shared by all psychiatrists in a 1:7 rotation. Physician can open an outpatient private practice if desired. Patient mix is approximately 55% adults, 27% geriatrics and 18% child/adolescent Fully implemented EHR (Sunrise Clinical Manager/Allscripts) Excellent benefits – Health, Dental, Vision, 403B retirement plan, Life Insurance, Disability and much more. Physicians are generously rewarded with a wRVU productivity model Relocation assistance and other perks will be provided. Physicians employed by First Physicians Group have sovereign immunity. We are a non-profit entity, so physicians can apply for Public Service Student Loan Forgiveness if employed by the group. Please contact Joelle Hennessey at 941-917-2818 or Joelle-Hennessey@smh.com to learn more about this opportunity.

Job Requirements:
Licensed in the state of Florida. BE/BC in Child & Adolescent Psychiatry

MARYLAND
Company: Kaiser Permanente - Mid Atlantic Permanente Medical Group (890794)
Title: Child Psychiatrist - Metro DC (Shady Grove, Maryland)
Job ID: 13349759
http://jobsource.aacap.org/jobs/13349759

Job Description:
Join a Leader in Integrated Healthcare Delivery - Kaiser Permanente Mid Atlantic! The Mid Atlantic Permanente Medical Group is seeking an Child Psychiatrist to join our Shady Grove, MD (Metro DC) practice on a part time basis (28 hours per week - fully benefits eligible) Practice in a large, multi-specialty group of over 1600 physicians and enjoy the many benefits of practicing in our integrated delivery system: • Robust, integrated medical information system • Team approach to providing care with easy access to therapy services and clinical pharmacist • Reasonable, predictable schedules with video medicine capability • Clinical autonomy with excellent sub-specialist support • Energetic focus on excellence and patient centered service, quality, safety, and patient flow • Pension program, excellent medical/dental package and occurrence based malpractice coverage

Job Requirements:
Requirements BE/BC in Adult and Child Psychiatry. Medical Licensing in Virginia, DC and Maryland. Questions, please email cooper.j.drangmeister@kp.org

MASSACHUSETTS
Company: Cambridge Health Alliance (1177750)
Title: Child and Adolescent Psychiatrist Opportunities in Outpatient and Integrated Care
Job ID: 13451439
http://jobsource.aacap.org/jobs/13451439

Job Description:
Child and Adolescent Psychiatrist - Opportunities in Outpatient and Integrated Care Cambridge Health Alliance (CHA), a well-respected, nationally recognized and award-winning public healthcare system, is seeking full-time/part-time Child and Adolescent Psychiatrists. CHA is a teaching affiliate of Harvard Medical School (HMS) and Tufts University School of Medicine. Our system is comprised of three hospital campuses and an integrated network of both primary and specialty outpatient care practices in Cambridge, Somerville and Boston’s Metro North Region. Full-time or half-time opportunities within our outpatient clinic in Revere and in Cambridge Half-time opportunity in child integrated care providing team-based, short term consultation to outpatient primary care practices. Seeking candidates with clinical and/or academic interests in developing evidence-based clinical programs for youth with severe mental illness (first episode psychosis, mood, trauma disorders) Work closely with multidisciplinary staff; including psychologists, social workers, primary care providers, nurses and administrative support Work in a collaborative practice environment with an innovative clinical model allowing our providers to focus on patient care and contribute to population health efforts. Fully integrated electronic medical record (Epic) and robust interpreter service Academic appointments are available commensurate with criteria of Harvard Medical School Opportunities for scholarship and clinical research in community mental health and supervision of Harvard-affiliated trainees. Ideal candidates will be board eligible or board certified in Child and Adolescent Psychiatry and possess a strong commitment to and passion for our multicultural, underserved patient population. Please visit www.CHAProviders.org to learn more and
apply through our secure candidate portal. CVs may be sent directly to Melissa Kelley, CHA Provider Recruiter via email at ProviderRecruitment@chaliance.org. CHA’s Department of Provider Recruitment may be reached by phone at (617) 665-3555 or by fax at (617) 665-3553. CHA is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.

MINNESOTA

Company: PrairieCare Medical Group (1197561)
Title: Child and Adolescent Psychiatrist
Job ID: 13385837
http://jobsource.aacap.org/jobs/13385837

Job Description:
Psychiatric Healthcare System Seeks Child and Adolescent Psychiatrists PrairieCare Medical Group – Southern MN is a physician-owned and led psychiatric healthcare system in Southern Minnesota offering a range of services and programs for children and adolescents in intensive outpatient and clinic settings. PrairieCare Medical Group is proud to be one of the largest Child and Adolescent Psychiatric group practices in Minnesota, with 35 physicians and 125 independently licensed therapists providing care to patients from across the state. PrairieCare offers therapy, social work and nursing support on-site to all physicians, allowing the psychiatrist to focus on providing high-quality, individualized care to patients in a supportive team-based setting. PrairieCare Medical Group – Southern MN is hiring for both Mankato and Rochester: Mankato: This growing city hosts a thriving academic and medical systems and is located about an hour from Minneapolis/St Paul within a naturally beautiful river bluff area that is steeped in historical significance. Rochester: Consistently rated as one of the best cities to live in the United States. It is home to the world-renowned Mayo Clinic, and is distinguished by its culture of caring, spirit of innovation and warm hospitality. Additionally, Minnesota has been ranked in the top 3 states to live in the United States by U.S. News and World Report. PrairieCare Medical Group – Southern MN offers an excellent compensation and benefits package with opportunities for dynamic physician leadership within the growing mission to transform psychiatric healthcare.

Job Requirements:
Board Certified or Board Eligible Interest in Eating Disorders, Substance Abuse and Trauma Preferred

NEW JERSEY

Company: Job Target (875155)
Title: Child and Adolescent Psychiatrist, Outpatient
Job ID: 13432122
http://jobsource.aacap.org/jobs/13432122

Job Description:
Capital Health Behavioral Health Specialists Hamilton, NJ Capital Health Medical Center is seeking a full-time, BC/BE Child and Adolescent Psychiatrist to join Capital Health Behavioral Health Specialists. This is an exciting opportunity to work with a multidisciplinary, collaborative team that includes psychiatrists, therapists, psychologists and dedicated case management staff. The position entails diagnostic evaluations, medication management and psychotherapy of children and adolescents in an outpatient setting. The ideal candidate is fellowship-trained, collegial, enthusiastic and willing to help grow the outpatient behavioral health program at Capital Health. Qualified Candidates: Board-certified or board-eligible in Child/Adolescent Psychiatry New Jersey license or ability to obtain 2020 fellows welcome to apply! Our Physicians Enjoy: Competitive salary and full benefits package Six weeks of paid time off One week of CME Occurrence malpractice insurance Employer-paid licensure fees We are conveniently located between New York City and Philadelphia, allowing the opportunity for treatment of both an urban and suburban population. The multispecialty program is quickly growing and seeks new talent to join Capital Health in treating these patients, as well as expanding the program beyond our primary catchment area.Capital Health Medical Group is a multispecialty practice made up of more than 430 physicians and other providers who offer primary, specialty and surgical care. Working with other physicians within the medical group, as well as other physicians throughout the region and beyond, our experts are dedicated to providing high-quality healthcare carefully coordinated between providers.To submit CV, please visit http://www.capital.attnhr.com/jobs/174207/ Equal opportunity employer. Apply Here PI118794464

NEW YORK

Company: Berkshire Health Systems (1033420)
Title: Child and Adolescent Psychiatrist
Job ID: 13403986
http://jobsource.aacap.org/jobs/13403986

Job Description:
We understand the importance of balancing work with a healthy personal lifestyle. Berkshires, a four-season resort community Endless cultural opportunities World renowned music, art, theater, and museums Year round recreational activities from skiing to kayaking Excellent public and private schools make this an ideal family location Just 2½ hours from both Boston and New York City. Berkshire Health Systems Opportunity BE/BC Child/Adolescent Psychiatrist to also serve as Medical Director. Collaboration with Clinical Psychologists, Neuropsychologists, Clinical Nurse Specialists, Social Workers, Behavioral Health nurses, and other clinicians specializing in mental health Highly effective programs, treating close to 10,000 patients a year. Competitive compensation and benefits package, including productivity option and relocation. Candidates requiring Visa sponsorship encouraged to apply. Berkshire Medical Center, BHS’s 302-bed community teaching hospital and Trauma Center, is a major teaching affiliate of the University of Massachusetts Medical School. With the latest technology and a system-wide electronic health record, BHS is the region’s leading
provider of comprehensive healthcare services. This is a great opportunity to practice in a beautiful and culturally rich area while being affiliated with a health system with award winning programs, nationally recognized physicians, and world class technology.

**NORTH CAROLINA**

**Company:** UNC Health (1203614)

**Title:** Child & Adolescent Psychiatrist

**Job ID:** 13420103

[http://jobsource.aacap.org/jobs/13420103](http://jobsource.aacap.org/jobs/13420103)

**Job Description:**
UNC Physicians Network is seeking a full-time, outpatient only, Triangle-based Child and Adolescent Psychiatrist to join a network that has fully operational support in place including nurse, pediatricians, and licensed clinical social workers. High-quality health care begins with high-caliber people. Our steadfast commitment to the health of our community begins within. If you seek an environment that promotes excellence, leadership and autonomy in clinical practice, then a career with UNCPN may be for you. **JOB DUTIES AND RESPONSIBILITIES** Unique opportunity for a well-qualified, licensed and board eligible or board certified prescriber to join a successful outpatient practice of Psychiatrists, Pediatricians, Advanced Practice Providers and a full array of support staff. REQUIREMENTS Board Certified or Board Eligible Psychiatrist Successful completion of Child/Adolescent Psychiatry fellowship North Carolina MD or DO licensure to be obtained by start date **BENEFITS INCLUDE** • Competitive MGMA salary • Paid CME days & fund reimbursement, and paid annual leave (vacation) • Matching 401(k) and malpractice insurance • 403(b) & 457(b) retirement plans

**VIRGINIA**

**Company:** Integrated Psych Associates of McLean (1193231)

**Title:** Seeking BC/BE Child & Adolescent Psychiatrist McLean, VA

**Job ID:** 13393337

[http://jobsource.aacap.org/jobs/13393337](http://jobsource.aacap.org/jobs/13393337)

**Job Description:**
Integrated Psychology Associates of McLean is seeking a BC/BE child & adolescent psychiatrist (MD/DO) to join an outpatient child & family mental health practice co-owned by a board-certified child psychiatrist and neuropsychologist. Our practice offers therapeutic and pharmacological services to children, adolescents, young adults (age 18-30), and families in the Northern VA and surrounding DC metro area. Our referrals come from a variety of sources and require strong diagnostic skills, evidence based pharmacological interventions, and specific therapeutic interventions (CBT, DBT, IPT, brief dynamic, and family therapy). We are looking for a child & adolescent psychiatrist who is interested in functioning as both therapist and pharmacologist. In our practice model the psychiatrist provides both therapy and medication management (for a 45-60 min hour), with few if any cases being 30 min medication management visits. The psychiatrist can provide individual, couples, family, or group therapy depending on interest and experience. Intakes are 90-120 min depending on the complexity of the case. We have an electronic health record and e-prescribing. Most of our providers aim for at least 20-25 face to face pt hours per week but maintain an autonomous, flexible schedule. Come join a warm, close-knit, integrated team of doctors and students who value collaboration, support, and protecting the function of the MD as first and foremost, a skilled therapist. New graduates from qualified C&A fellowship programs are welcome. If one is not confident in therapy, some degree of training can be provided here, but the candidate will be encouraged to seek independent training and CME in their preferred therapeutic modality. Qualified candidates will hold a medical license (or be license eligible) in the state of Virginia. Typical daily duties include: • Managing one’s own schedule • Taking calls from/Screening prospective clients • Therapy sessions • EHR (icanotes) prescribing, labs, and documentation, rating scales • Communicating/collaborating with the team • Learning how to build one’s own caseload and function in the general practice • Supervision (ii/iii as needed), mentorship and continuing medical education • presentations in schools, and various community mental health fairs • teaching & volunteer outreach opportunities

**Job Requirements:**
Licensed or licensed eligible in Virginia

**WASHINGTON**

**Company:** Kaiser Permanente - Washington Permanente Medical Group (1137470)

**Title:** Kaiser Permanente - Washington Permanente Medical Group

**Job ID:** 13398913

[http://jobsource.aacap.org/jobs/13398913](http://jobsource.aacap.org/jobs/13398913)

**Job Description:**
Kaiser Permanente-Washington Permanente Medical Group, the Pacific Northwest’s premier multi-specialty group, is currently seeking BE/BC Psychiatrists to join our group practice within Adult and Child/Adolescent Psychiatry. Job opportunities are currently available in Tacoma, Olympia, Bremerton, Federal Way and Seattle. Washington Permanente Medical Group is dedicated to providing comprehensive, innovative and patient-centered care to communities throughout Washington. This commitment to quality has led to high patient satisfaction scores; in fact, we were recently ranked in the top four nationally for patient satisfaction. 100% outpatient opportunity ideal for those with knowledge and skills in medication management and team consultation. Call coverage from home 1 weeknight per month and 3-4 weekends per year. 1.0 FTE corresponds to 40-hour work week 75% is direct patient facing time and 25% is desktop and meeting time Competitive salary, bonuses, and generous benefit package offered. Outstanding team in a collegial environment makes this opportunity worth exploring. Team members consist of other health care professionals including Psychologists, Masters Level Therapists, Nurse Practitioners, Nurses and
CLASSIFIEDS

Behavioral Health Specialists Benefits include: Full malpractice indemnification (including tail coverage), medical/dental/vision benefits, 401(k) & pension, paid vacation, CME, long-term disability, and long-term care benefits. Competitive salary offered. Opportunity to become Shareholder after 3 years. No state income tax in Washington State! Washington Permanente Medical Group encourages its staff to maintain care-focused patient relationships and manage innovative practices using state-of-the-art technology while advocating a well-balanced life and personal health. Washington Permanente Medical Group is an Equal Opportunity Employer committed to a diverse and inclusive workforce. For additional information or to submit your CV please go to www.wpmcareers.org or contact Kelly Pedrini at kelly.a.pedrini@kp.org

Job Requirements:
Skills: Excellent clinical and interpersonal skills are essential to quickly and successfully build trusting patient relationships. Interest in Behavioral Health integration. Population based mental health management. Support crisis therapy.

WEST VIRGINIA

Company: Pinnacle Health Group (1114165)
Title: West Virginia Child Psychiatry Opening 180713
Job ID: 13448221
http://jobsource.aacap.org/jobs/13448221

Job Description:
Join one of the best health care providers and teaching hospital in the state Child Psychiatry*. Competitive base salary with wRVU bonus potential plus comprehensive benefits* Occurrence malpractice; No tail coverage required* $20,000 sign-on bonus* Potential for leadership position with stipend for medical director duties for actual hours worked* Nationally recognized 88 bed Residential Treatment Center* Well established and tenured support staff* Accredited Charter School* Integrated approach and Continuum of Care ranging from Sub-Acute Residential to Community Based Programs* Clinical Emphasis on Assessment, Treatment Planning, Discharge and After Care Planning* 2020 graduates encouraged to apply Wild and wonderful . . . almost heaven* The cultural, recreational, and business capital of the Appalachian Mountains* Excellent Public and Private Schools* NCAA Division I Intercollegiate Sports Teams* Driving distance for skiing, water sports, hiking, etc.* Bike friendly community with a network of trails* Art walks, downtown street festivals and brown bag concert series* Come play - multiple family friendly venues and activities Timothy StanleyDirect/ Fax: 404-591-4224

Job Requirements:
Minimum Requirements: MD or DO Medical Degree Eligible to be state licensed in the United States United States Residency and/or Fellowship training

FOR YOUR INFORMATION

Hartford HealthCare

Child and Adolescent Psychiatrist Opportunities In Eastern Connecticut

Natchaug Hospital, part of The Hartford HealthCare Behavioral Health Network, the largest integrated behavioral health network in New England, has multiple opportunities for Child and Adolescent Psychiatrists.

Located in Mansfield, CT, Natchaug is the largest provider of behavioral health services for Eastern Connecticut and is a member of Hartford HealthCare. Our mission is to provide a continuum of accessible, community-based services for those living with psychiatric illnesses, chemical dependency or emotional and related educational disabilities. Our impressive range of services and programs include:

- In-patient Pediatric and Adolescent Psychiatric Services (IPS)
- Intensive-in-home Child & Adolescent Psychiatric Services (IICAPS)
- Partial Hospitalization (PHP)
- Intensive Outpatient (IOP)
- Young Adult
- Extended Day Treatment
- Clinical Day Treatment (CDT)
- Various community programs
- Buprenorphine (Suboxone) clinics

Opportunities In Eastern Connecticut

where we enjoy easy access to Boston, New York City, Hartford, Providence, the Berkshire Mountains and the CT/RI shoreline. Eastern Connecticut boasts the number one public university in New England, nationally recognized college basketball, extensive cultural opportunities, the ability to reside in either suburban or rural settings, and international airports in Hartford and Providence.

Just a few of the Eastern Region locations include: Mansfield, Norwich, and Enfield Connecticut.

The physician will be responsible for providing multidisciplinary team leadership, psychiatric evaluations and ongoing care for children and adolescents. The successful candidate will be licensed in the State of Connecticut and BC/BE in General Psychiatry and Child and Adolescent Psychiatry.

Excellent clinical skills and ability to work well within a team environment are the most important aspects of this position. Experience working in multi-disciplinary teams and providing multi-disciplinary team leadership is essential. In addition, the position will include liaison work with community agencies and providers involved in the care of individuals and families. The HHN also has full-time and moonlighting opportunities available throughout CT.

For more information about Hartford HealthCare’s Behavioral Health Network, please visit: HartfordHealthcare.org/services/behavioral-mental-health

Interested candidates should contact Nicolette Burns, Physician Recruiter at: Nicolette.Burns@hhhealth.org or mobile: 860-670-9378

Career | Family | Patients | Lifestyle | Everything Matters

126 AACAP NEWS
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.
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