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Cover Photo: Three cousins having a fun break from life. This was right after hurricane Irma in Florida, when family came down to visit our newest child who is not pictured. –Megan Toufexis, DO
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.
Part II: Encouraging Positive Outcomes for Adolescent Parents and Their Children

In this second part of a two-part series on adolescent pregnancy and parenting, we will discuss the role of child and adolescent psychiatrists in addressing teen parenting in youth populations.

Sierra is a 17-year-old female patient with a psychiatric history of untreated depression, anxiety, and intermittent explosive disorder. She is the single mother of two beautiful daughters living in a small mid-western town, currently homeless and receiving minimal government support. She grew up in an abusive household where she witnessed domestic violence and was a victim of physical, sexual, emotional, and verbal abuse. Sierra fled her childhood home at age 14 when her family became aware of her first pregnancy and her father’s physical abuse intensified. She dropped out of high school in the process of fleeing to a new town, something she is ashamed to admit. She entered an abusive relationship with an older male, and her second child was the product of rape. For her safety, she fled the area and finds herself yet again in a new town, now with two children to care for.

She has been unsuccessful in securing employment, and her feelings of inadequacy and helplessness are overwhelming. She is now temporarily living in an emergency shelter for homeless adolescents with her two daughters. Sierra is a devoted member of a parenting and safer sex education program at the shelter led by medical students and child and adolescent psychiatry fellows from a local university. Today, she is receiving a certificate of completion and effectively graduating from the program, of which she completed two 12-week cycles. She and her daughters are moving into independent housing and she has maintained employment at a local fast food restaurant for a few months now. She plans to re-enroll in school. Sierra shares that many of the knowledge gaps regarding her mental and sexual health have been filled in by the program curriculum. For the first time in a long time, her smile is filled with hope.

Sierra is not unlike many adolescents across the United States. An estimated 1 in 4 girls will become pregnant at least once by age 20.1 Pregnancy carries with it negative physical, psychological, emotional, economic, and social sequelae for teen mothers and their children. It also results in enormous costs to society (an estimated $9.4 billion in 2010).2 However, there is also literature that motherhood can motivate adolescents to seek better futures for themselves and their children by staying in school, pursuing further education and modeling positive and goal-driven behaviors for their children.3 Although prevention of adolescent pregnancy is preferred, once a pregnancy/birth occurs, the goal is not only to mitigate negative consequences but to encourage positive outcomes.

Programs that can help with these outcomes and provide resources for this vulnerable population include school-based programs, home visiting programs, embedded programs in medical homes, community outreach services, and co-parenting groups. Some services of each of these programs overlap with one another; all aim to support pregnant and parenting adolescents to keep them in school or help engage them in obtaining a stable source of income, prevent repeat pregnancies during adolescence, and learn about child development and how to foster healthy development of their children.4 School-based programs offer comprehensive health care at school, including reproductive healthcare; some offer childcare at school while the mother is in classes; some also offer quick referrals for mental health care when necessary. Home visiting programs can be more convenient for people whose access to transportation is limited; they also allow for the home visitor to witness parents interacting with their children in vivo.4 Embedded programs in medical homes allow parents to seek medical and mental health care for themselves and their children while also receiving psychosocial support, including case management. Some programs include parenting groups that teach parenting and self-care skills and also allow providers to assess for developmental delays and emotion regulation difficulties in the children.4 Community outreach programs take referrals from hospitals, home visiting services, law enforcement, and schools, and go into the community to find these struggling adolescent mothers and work relentlessly to engage them in services that encourage school completion, offer job training, teach life and parenting skills, and bring young mothers together in “family” nights with food and social interaction with other mothers while their children are being cared for.

Co-parenting groups encourage building skills for communication, self-regulation, conflict management and co-parenting. Although many of the programs mentioned encourage participation of the father, this program specifically supports parenting competence in both parents.4

These programs, such as the community outreach program entitled Project Parenthood5 that Sierra completed,
can help adolescent mothers feel empowered to seek a better future for themselves while caring for their children, and in so doing, prevent a negative cycle for their children.\(^5\) As child and adolescent psychiatrists, our knowledge of and familiarity with these programs and resources allow us to better help these young women and their families beyond simply providing psychotherapy and medication management.

**Note:** Due to the COVID-19 pandemic, school-based and community outreach programs are likely to be much more limited. According to the Health and Human Services website, some states have restricted home visits and have been encouraging tele-video visits instead.\(^6\) It is especially important that we support these youth so that they do not fall through the cracks during these unprecedented times.

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**References**


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Seclusion and Restraint Prevention in the Time of the Coronavirus: Implications for Child Psychiatry

Kim J. Masters, MD

Case Example:
George is a seven-year-old with a diagnosis of Disruptive Mood Dysregulation Disorder (DMDD) and Attention Deficit Hyperactivity Disorder (ADHD) who was receiving special education services for learning problems until the coronavirus forced closure of his school, leaving him homebound with his mother, grandmother, and five-year-old sister. He has engaged in impulsive and dangerous behaviors like running out of the house across a busy street, fighting with his sister, climbing up on the roof of his home, and recently trying to swallow his mother’s medication in a suicide attempt. He was taken to the emergency room (ER) of the local hospital where he tested positive for coronavirus and was admitted to the child psychiatry unit.

He resists wearing a mask, being confined to a room, and engages non-stop with other children and staff, all of whom are coronavirus negative.

What is the role of seclusion and restraint in his management? What are other options?

Coronavirus Assessment Issues
- ER screening.
- If Positive Test, then:
  - Admission to child and adolescent (C/A) unit with isolation precautions, such as isolation area, preferred to Isolation in a room, wearing a mask during contact with staff and patients, physical distancing, and possibly using a tablet for group participation, etc.
  - When isolation is not possible, consider transfer to pediatric medical service with C/A consultation. (These units may have negative pressure rooms to reduce viral spread, as well as trained staff in virus management)
  - If Negative test, then:
    - If contact exposure to coronavirus confirmed, then 14-day quarantine as above.
    - If NO contact or travel exposure, then two possible options:
      - In places with widespread prevalence of coronavirus, consider period of quarantine for those who test negative for virus and are otherwise at low risk for becoming infected
      - Or admission to C/A unit with coronavirus management protocols.

Discontinuing Isolation in patients positive for coronavirus or exposure to it. (Centers for Disease Control and Prevention [CDC] guidelines)
- After 10 days, if the patient had no symptoms after a positive coronavirus test
- Patients who had mild to moderate coronavirus symptoms: 24 hours afebrile without antipyretic medications, and improvement in symptoms (e.g., cough, shortness of breath).
- Individual medical evaluation for patients who had severe coronavirus symptoms, or inflammatory cardiovascular disease before discontinuing isolation

Seclusion and Restraint Regulations
CMS (Center for Medicare and Medicaid Services) accredited facilities are governed by CMS and Department of Health and Human Services (DHHS) condition of participation. The Joint Commission (JC) standards are similar. Some States, like New York, have additional statutory and regulatory requirements.

The CMS seclusion and restraint regulations (S/R) permit the use of these procedures during behavioral crises when other de-escalation measures are ineffective. Monitoring, de-briefing and follow-up are essential elements. Psychiatrists (or physicians) are generally responsible for ordering these procedures and doing post S/R evaluations within 60 minutes. During the coronavirus epidemic in the US, Physician Assistant and Nurse Practitioners have been permitted to perform these functions in at least some States.

Isolation Issues
An inpatient unit that has children who are coronavirus positive, must manage isolation, distancing, utilize personal protective equipment (N95 mask, gown, gloves, etc.) and have access to treatment from pediatric medical services. Coronavirus precautions require patients to stay in individual rooms, eat meals in their rooms, wear masks when staff are present, and limit their access to other areas of the unit or hospital. A separate isolation unit would be desirable but is often unavailable.

When a C/A patient does not follow isolation procedures, then standard behavioral management techniques, collaborative treatment planning, parental input, motivational interviewing, contingent rewards, etc. are primary adherence tools. However, Isolation for medical reasons, is not a criterion for the behavioral health use of seclusion and restraint. (Although, some facilities managed by State Health Departments may permit restraint and seclusion for containing the coronavirus. On the other hand, involuntary and PRN medications can be used in behavioral crises.)
Recognizing the dual need for follow-able distancing rules, and engaging patients directly. For example: using individual patient ‘tablets for communication’ in a group setting.

Elements of this rubric can include:

- A message of inclusion to staff, patients, and families in addressing the competing demands of virus health safety and emotional and psychosocial support is needed. Making ‘inclusion’ a rubric for treatment is a way to implement this idea.

Elements of a Treatment Plan for an individual coronavirus patient in this inclusion model:

- Standard presentations of symptoms, diagnosis, and treatment options
- Supplementary addition of virus safety management with maintenance of frequent developmentally sensitive contacts by staff, C/A psychiatrist and family members
- Group activities with distancing
- Physical activity programs
- Education while hospitalized
- Strategies to minimize conflict and S/R episodes

Arranging a discharge

When mental health treatment no longer requires hospitalization, then a discharge plan that considers the mental health, the coronavirus status, and the child aftercare environment should be developed.

- The plan should be under the direction of the Attending C/A Psychiatrist
- It should be created in coordination with inpatient staff including the unit social worker, the consultant pediatrician, the mental health insurance company, the patient, and his/her family
- Post discharge services should be considered, such as psychotherapy, medication, partial hospital services, and wrap around care
- Pediatric follow-up should be arranged
- Contact with the patient’s school should be pursued to plan for education continuation

Summary and Way Forward

These suggestions are based on information available on September 7, 2020. Many of these elements can be applied to all S/R reduction efforts. (For example, the use of tablets for patients to communicate may help diffuse conflicts that lead to confrontations with staff and peers).

There is a lot we do not know, of course. We hope that if you have suggestions or information to improve the care of C/A inpatient coronavirus patients struggling with mental health issues, you might be willing to share them with us. You can email them to kmaster105@gmail.com, and they will be shared with AACAP’s inpatient committee.

References

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The American Medical Association (AMA) released revisions for the office and other outpatient evaluation and management (E/M) codes and guidelines in the 2021 Current Procedural Terminology (CPT) code set. This is the first major update for E/M services in more than 25 years. These proposed changes become effective on January 1, 2021.

The revisions were made to help reduce the administrative burden for physicians, reduce the possibility of audits, and increase the coding accuracy of physician work. Two code families have been revised and a new code has been added:

- **Office and other outpatient service, new patient (99202-99205)**
- **Office and other outpatient service, established patient (99211-99215)**
- **Prolonged service (99417) (new)**

The remainder of the E/M service codes have not been revised.

The E/M office visit code selection revisions include the following:

- Eliminate specifically required bullet points for history and physical exam as required elements
- Allow physicians to choose the code based on medical decision-making (MDM) or total time
- Provide more detail and clearer guidelines to CPT code descriptors

MDM must be used to select E/M codes when using add-on psychotherapy codes. When you perform an E/M procedure with psychotherapy, first select the level of E/M based on MDM (most likely 99213 or 99214) and then the add-on psychotherapy code based on the additional time spent performing psychotherapy (30, 45, or 60 min).

See the CPT and Reimbursement section on the AACAP website (link below) and view the new webinars about these changes. The AACAP Coding and Reimbursement Committee is also available to answer your questions. Please send questions to Karen Ferguson (kferguson@aacap.org).


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The Open Access Publication Movement: Implications for AACAP and JAACAP

By the AACAP Working Group on Open Access: Douglas K. Novins, MD, Bennett L. Leventhal, MD, Heidi B. Fordi, CAE, and Mary K. Billingsley, ELS

Publishing is the final step in the research process, making research and scholarship accessible to readers across the globe. Like many professional medical societies, our Academy has supported the dissemination of scholarship related to our specialty – child and adolescent mental health – through our flagship periodical, the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP). Indeed, JAACAP is one of the most respected international journals in our field and one of the most competitive in which to publish. In recent years, the publishing model we use to make JAACAP available to readers has come under increasing scrutiny and the long-term sustainability of journals such as ours is being questioned. This article provides an overview of the challenges we face and our options moving forward.1

Subscription and Open Access Publication Models

JAACAP is published by Elsevier, one of the world’s largest academic publishers, with most of its content made available to readers through a “subscription model” in which readers gain access to a journal through society memberships and personal and institutional subscriptions. For example, all Academy members receive a subscription to JAACAP as a benefit of our membership; many members also have access to JAACAP through their university’s library subscription. Non-members may opt to subscribe individually, and readers who do not have an individual or institutional subscription can pay a fee to access individual articles.

Over the past 30 years, an alternate publishing model has emerged: open access. There are two primary models of open access, known as “green” and “gold” open access, both of which result in articles being freely available to readers. Under gold open access, the costs of publication are paid by authors through an article processing charge (APC), typically after an article has been accepted for publication (JAACAP currently charges $2,750 to publish a full-length gold open access article, with a 10% discount for AACAP members; an average of 12% of JAACAP research and review articles were OA over the last 3 years). Under green open access, articles are made freely available to readers once a specific period of time has elapsed since publication. Green open access gained an important foothold in the US in 2008 when the National Institutes of Health (NIH) established a policy that requires articles by NIH employees or that report results of NIH-funded research be made open access through PubMed Central, an online repository, within a year of publication. There are similar initiatives in other countries. Major journals provide a variety of options to enable authors to comply with these government and funding-body requirements, including JAACAP.

Some journals only publish articles under a subscription model, some journals only publish articles under an open access model, and some journals, like JAACAP, use some combination of both publishing models (often referred to as “hybrid” journals). The differences between subscription model publishing and open access publishing are illustrated in Figure 1.

Figure 1. Publication Models

Comparison between traditional subscription and gold open access publication models.

1 A similar report was shared with AACAP Council in June 2019
There are advantages and disadvantages to each of these publishing models. Under a subscription model, there are no financial barriers for authors to publish their articles; subscription costs are borne by subscribing individuals and institutional libraries. Journals that publish under an open access model pose financial barriers to authors but not to readers. Because subscription journals generate income through subscriptions, owners and editors have flexibility in setting the scope and scale of the journal, which might be quite broad or especially niche, and in setting expectations for selectivity, choosing to establish standards for quality and quantity as best suits the journal and the readership base. Because open access journals are dependent on article processing charges for revenue, unless they have another source of funding they must publish enough articles to cover operating expenses, meaning owners and editors may feel pressured to scale up, publishing more content to generate more income (for example, the PLoS family of mega journals), and in some cases, this may mean prioritizing quantity over quality. Given this, it is not surprising that, despite the growth of open access, the most prestigious journals today are still typically subscription-only or hybrid journals. In pediatrics, where *JAACAP* is ranked #3, the highest-ranked gold open access journal is *Maternal and Child Nutrition*, at #23. In addition, legitimate gold open access journals are sometimes unfairly confused or conflated with predatory journals, as both charge article processing fees, which some believe diminish their reputations.

**Recent Developments: The Acceleration of the Open Access Movement**

Support for open access as a way to make research easily available and frustration with subscription-model publishing have increased substantially in recent years, which is putting pressure on publishers and professional societies to adapt to this changing landscape. Pressure for change is coming most notably from two influential groups. First, universities have objected to the high costs of the subscriptions they pay to allow their students, staff, and faculty access to scientific journals and are negotiating for lower rates. The contentious negotiations between Elsevier and the University of California have received the most attention in the US, though universities worldwide are going through similar negotiations with publishers. Second, some research funders are demanding that the research they fund be accessible to the public immediately through gold open access journals without the delay associated with green open access. Plan S, which was developed by a consortium of research funders in Europe and will go into effect in 2021, is perhaps the most prominent effort in this regard. Organizations supporting Plan S funded an estimated 7% of research worldwide and 15% of articles published in *JAACAP* over the past 4 years. In late 2019, a draft US federal executive order came to light that would require all articles drawing on federally funded research to be immediately publishable through green open access journals. *JAACAP* and other similar journals would be required to publish these as open access articles, may or may not be able to collect article processing charges, and may see a drop in subscriptions if a greater percentage of content is made freely available upon publication.

Federally funded research represents an estimated 20% percent of articles published in *JAACAP* over the past 4 years. The expectation within the scholarly publishing community is that government and research funding body initiatives like this will only continue to multiply and expand, putting pressure on journals and their associated societies to revisit their publishing models and explore new options. AACAP’s current agreement with Elsevier is protective in that AACAP may not feel the immediate financial effects of shifts in the market, but we may not be able to expect as much from future publishing agreements. Revenue from *JAACAP* goes to supporting not just the expenses of publishing the journal, but also to funding other important Academy initiatives, programs, and member benefits.

**AACAP’s Options**

We see four options for the Academy as we consider our response to the open access movement.

First, we could choose to make no change to our current publishing model and continue to focus on making...
JAACAP a great journal. The major disadvantage to “staying the course” in this manner is that we would be unprepared for a future that is more about open access than what exists today.

Second, we could fully embrace the open access movement and convert JAACAP into a gold open access-only journal. Such an approach would be a bold statement by the Academy that we believe open access, and open access alone, is the future of scientific publishing. Such a move, however, would result in a substantial decrease in revenue for the Academy as open access revenues will likely be significantly lower than under our current contract with Elsevier.

Third, we could focus on enhancing the already-existing open access components of JAACAP. Several prominent journals have robust open access components, including The Proceedings of the National Academy of Sciences and The BMJ. Examples include expanded online-only features, longer form article types, and the benefit of being under the umbrella of a prestigious journal. This likely could be managed with (relatively) modest enhancements to JAACAP’s infrastructure, but would not fully protect us from potential changes that are being driven by the open access movement, with some funders already planning to prohibit use of their grants to publish articles in hybrid journals like JAACAP.

Fourth, we could start a second AACAP journal that is entirely open access. Professional societies that have moved in this direction include the American Medical Association (JAMA Open) and the American Psychiatric Association (Psychiatric Research and Clinical Practice), among many others. Starting another journal would mean AACAP is prepared for further shifts in publishing towards open access, with a more diversified publication portfolio, multiple revenue streams, and a variety of publication options for authors seeking to publish with us. That said, a second journal would be a significant undertaking for the Academy that would put considerable demands on our human capital and existing infrastructure that we would need to find ways to support. Launching a new publication is not an overnight endeavor, and given the alternative financial models of open access journals, in order to maintain the same standards for rigorous, high-quality peer review, research integrity, and writing that readers expect from JAACAP itself, a second journal would not be likely to bring in substantial revenue, and may even cost the Academy money, especially in its early years.

Here are a few key questions for us to consider:

■ Is a second, fully open access journal in the best interest of the Academy, JAACAP, and the larger children’s mental health community?

■ Do we have sufficient human and financial resources to launch and maintain a second journal, and if so, is that where we want to invest these resources?

In light of the significant and growing pressures in scholarly publishing, in 2019, AACAP formed the Open Access Working Group to monitor the evolving situation and advise AACAP leadership. The group includes Editor-in-Chief Douglas K. Novins, MD, Treasurer Bennett L. Leventhal, MD, Executive Director/CEO Heidi B. Fordi, CAE, and Managing Editor Mary K. Billingsley, ELS. In 2019, this group worked closely with an outside publishing consultant to evaluate the feasibility of AACAP launching an open access journal, and now seeks feedback from Academy members on this important topic. The JAACAP editorial team hosted a Member Forum during AACAP’s 2020 Virtual Annual Meeting to discuss open access and other journal features and information. While this is a work in progress, the Academy expects to make a decision in June 2021.

The AACAP Open Access Working Group welcomes feedback from Academy members on this important topic. Please contact the JAACAP editorial office at support@jaacap.org with comments and questions.
Racism and Psychiatry

Destiny Pegram, MD

"You are not a doctor, you are just a n-- ," yelled a patient demanding to be discharged from our emergency mental health services. "Okay," I responded and robotically walked away. Immediately staff were surprised and outraged, "wow, you are one of those people" retorted one of the ED nurses, referring to the patient. She apologized for my experience, however it still hadn’t hit me. “I’m not bothered, I know that’s ignorant.” I replied flatly. Afterwards, I routinely completed my notes and headed off to the call room. As I walked out of the ED, the sadness and shame slowly began to bubble up. “Wow, is that what people think of me? No matter what I do or accomplish, I am just a...” I cried alone in an elevator. I remember the comment made me question my self-worth. I have never shared how that experience impacted me until now.

Having to bear racial remarks does nothing like I handled it with poise because no one knew that I cried. No one knew that the comment made me question my self-worth. I have never shared how that experience impacted me until now.

Racism is real. It occurs both interpersonally and systemically. Our nation has been forced to recognize this as COVID-19 disproportionately ravishes communities of colors,1 leaving them in mourning. While attempting to recover, these same communities are being further traumatized by witnessing an African-American male, George Floyd, being murdered by a white police officer. This triggering event is one that is horrifically familiar and reminds us all of the fundamental inequalities in society.

As psychiatrists, we can no longer sit by and watch the effects of systemic racism kill our patients. Exposure to discrimination leads to increased rates of depression and anxiety and lowers one’s resiliency, self-esteem, and self-worth. Rates of suicide attempts in African American youth are on the rise, while in their peers, they are declining.2 3 However, this vulnerable population continues to receive less access to mental health services.2 3 Our communities of color were suffering from a mental health crisis long before there was a COVID crisis. We must act. In order to dispel racism and its effects, we have to take an anti-racism stance. An anti-racism stance does not involve passively hoping that racism will magically go away with time. Instead, it is an active stance that involves acknowledgement, education, and activism. This has to take place in a top-down fashion with individuals in leadership positions taking the first steps to create more equitable policies and protocols that affect the way we administer care.

In addition to recognizing how racism affects our patients, we have to recognize how racism affects our trainees. Medical school and residency is a particularly stressful time where many of us feel like we are going to reach our breaking point. Having to bear racial remarks does nothing but push you closer to the edge. Having to bear them in silence without the support of colleagues and faculty causes you to feel like you are in a vacuum. It makes a person ponder “is it worth it? Is this what I signed up for?” In a study conducted by Baldwin et al, minority physicians were noted to be 30 percent more likely to withdraw from residency and 8 times more likely to take a leave of absence.4 This is unacceptable. We can no longer turn a blind eye to racism that occurs within training. As we witness many individuals marching and speaking out against racism in regards to police brutality, we have to have honest conversations about the racism that takes place within our institutions of learning. It is important to acknowledge how that contributes to a different experience for students and trainees of color.

For our field to address these issues, we have to have diversity of thoughts and ideas. This can only happen when individuals from diverse backgrounds work together and hold each other, as well as their respective institutions, accountable in regards to issues of race and equity. We also need more research in regards to individuals’ experience of racism while in medical training and how that contributes to those individuals’ health outcomes. There also should be more formalized support for residence in order to create a safe haven for residents to feel comfortable coming forward to discuss experiences of racial trauma. For this to occur, we have to accept that this is happening despite the discomfort that it evokes. It is deeply saddening that it took a grave tragedy to bring attention to this issue. However, it is important that these conversations continue to take place and it is my hope that this article furthers the discussion.

References


Destiny Pegram is a first-year child and adolescent psychiatry fellow at the University of Massachusetts Medical School. In addition to engaging with AACAP’s Diversity and Culture Committee, she is the co-chair of the Massachusetts Psychiatric Society Multicultural and Diversity Committee.
Post-Fellowship Training Programs for Autism Spectrum Disorder and Intellectual Disability: Why are They Necessary, and What Do They Offer?

A

utism spectrum disorder (ASD) and intellectual disability (ID) affect 1.68% and 1.36% of U.S. youth, respectively. Both syndromes can affect quality of life and educational or occupational outcomes. They may also increase vulnerability to co-occurring psychiatric diagnoses, with 71% of youth with ASD and 39% of those with ID meeting criteria for at least one additional disorder.

In theory, we as child and adolescent psychiatrists should be ideally prepared to provide support, care, and treatment for these youth. In reality, ASD and ID represent a notable gap in our training. Up to two-thirds of child and adolescent psychiatry training directors reported in a 2014 survey that trainees see at most five patients with ASD or ID per year, with nearly half describing insufficient resources for ASD and ID training.

This training gap has given rise to a ill-prepared workforce and—by extension—treatment gap. The small number of autism specialists in our field have long wait lists, and thus are not readily accessible to many families. In 2016, Drs. Kelly McGuire and Matthew Siegel reported in AACAP News on an initiative undertaken by the Autism and Intellectual Disability Committee to mitigate this problem. The initiative’s aim was to foster the development of developmental neuropsychiatry training programs for child and adolescent psychiatrists who have completed their fellowship and are interested in pursuing one or more years of additional training in autism and intellectual disability.

Three years later, increasing numbers of programs exist, and are actively interested in recruiting new trainees. But what do they have to offer? Dr. McGuire, now an assistant medical director at New York-Presbyterian’s Center for Autism and the Developing Brain, is herself a graduate of one of these programs: the Whitaker Scholars Program in Developmental Neuropsychiatry at Columbia University Irving Medical Center and New York State Psychiatric Institute.

“The Whitaker Scholars Program was crucial to my career in the field of autism and intellectual disability,” she says. “I was fortunate enough to have great mentors in the field throughout my general and child and adolescent residency training, but it was the Whitaker Scholars Program that facilitated the furthering of my specific interests and goals and provided me with opportunities to develop expertise in autism and intellectual disability.”

Some programs emphasize clinical work. Others emphasize research or systems of care. All share a common goal of preparing trainees to be comfortable and effective in working with people who have autism or intellectual disability.

It is important to note that although these programs provide advanced training, they are not ACGME-accredited “fellowships,” as there is no ABPN-recognized subspecialty for autism and intellectual disability. Nevertheless, they represent necessary opportunities for child and adolescent psychiatrists to develop expertise working with a population that is both substantial and under-served. Any current or prospective child and adolescent psychiatry fellow interested in this population should give them consideration.

Below is a list of some of the training programs. To learn more about these and other opportunities, and to be put in touch with program directors or other points of contact, email Hannah Reed MD (her2124@cumc.columbia.edu) or Kelly McGuire, MD (kkm2129@cumc.columbia.edu), co-chairs of the Autism and Intellectual Disability Committee Career Development Working Group.

Post-Fellowship Autism and Intellectual Disability Training Programs

- Verrecchia Center for Children with Autism and Developmental Disabilities (Brown University)
- Cincinnati Children’s Hospital
- Whitaker Scholars in Developmental Neuropsychiatry Program (Columbia University Irving Medical Center and New York State Psychiatric Institute).
- Kennedy Krieger Institute/Johns Hopkins University
- Lurie Center for Autism/Massachusetts General Hospital Fellowship Program in Autism Spectrum Disorder
- Maine Medical Center
- Stanford Autism Center at Lucile Packard Children’s Hospital
- University of Missouri - Kansas City
- WellSpan-Philhaven Center for Autism and Developmental Disabilities

Amandeep Jutla, MD, and Taiwo Babatope, MD, MPH, MBA
Hilibrand Autism Fellowship in Adolescence and Adulthood (Yale University)

References


Dr. Jutla (amandeep.jutla@nyspi.columbia.edu) is a child and adolescent psychiatrist in the Whitaker Scholars in Developmental Neuropsychiatry autism and intellectual disability training program at Columbia University. He is a member of the AACAP Autism and Intellectual Disability Committee Career Development Working Group.

Dr. Babatope (taiwo.t.babatope@uth.tmc.edu) is the chief child and adolescent psychiatry fellow at the University of Texas Health Science Center at Houston. He is a member of the AACAP Autism and Intellectual Disability Committee Career Development Working Group.

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In and Out of Closets: Telepsychiatry with Adolescents During COVID Crisis

Michael Shapiro, MD

The screen was darker than I was anticipating; I could barely make out my patient’s face looking down at what appeared to be either a laptop or tablet. This was my first telemedicine appointment since the start of the COVID-19 pandemic with “Megan.” Megan was a 17-year-old female with anxiety and depression who normally required a half-hour country drive to get to my appointments. Normally, that was not such a bother to Megan, who lived in a small town in a neighboring county, but valued her occasional to head “into town” to take dual enrollment classes at the community college, go to the mall, or attend our appointments. Her affect, even on bad days, was typically much brighter – literally and figuratively – than what I was seeing now. Thinking it was a technical glitch, I asked Megan if she was having difficulty connecting to the video appointment portal. The issue was not electronic, but geographic: Megan was sitting on the floor in her closet.

It occurred to me this was the first time I might see where Megan lived; perhaps her room wasn’t clean? I was certain she and her younger sister had separate rooms, but maybe I was wrong? When I asked Megan why she was sitting in the closet, she said it was for privacy. Who was home with her? Does her bedroom not have a door? Her room has a door, and only her sister was home, but that didn’t feel safe enough to Megan. That was the word she used, *safe*. She specifically contrasted this new reality with coming to my office, which she referred to as her “safe space,” the place where she could be free to express herself without judgement, ridicule, or whatever else her fearful mind would conjure up. She was so worried that her sister would hear some intimate detail in our appointment that the door to her room, the closet door, and headphones were all necessary. Megan went on to tell me she was “not doing well” with the social isolation; she lacked the ability to see her classmates or neighborhood friends, and she did not want to rely on her family for social support. I suggested she reach out to any online social media apps to connect with others, but even this was unsafe: child predators lurked everywhere, and should Megan give any personal information out she would be victim to identify theft or burglary (so Megan thought). I encouraged her to tell her parents if she was suffering, but this was not safe either.

At our next appointment, also done from Megan’s closet, she disclosed she had self-harmed since the last appointment and was thinking about suicide. She asked about going to the psychiatric hospital across the street from our clinic. It did not occur to me at the time, but as I write this I wonder whether this was an attempt to get closer to the “safe space” of my office; clearly she could not transform her home into a safe space. I told her she should talk to her parents before she decided whether to present to the psychiatric hospital. I was anxious, both anticipating how her parents would react, and because both of her parents were essential workers, they were not available for this appointment. I made an appointment to see her the following day if she was not admitted. The next day, Megan logs into her video appointment, again in the closet, only now she is smiling. She spoke to her parents the night before and ended up “crying her eyes out.” Her parents’ response was warm, empathic, and understanding; she felt better. They also encouraged her to reach out for peers on social media, and she found some chat groups that made her feel included. I was able to talk to Megan’s parents during that video appointment and encouraged them on providing a “safe space” for Megan to talk about her feelings at home. We continued to have appointments, but no further crises occurred.

That was my first foray with closets. My second was with “Anna” a 16-year-old Middle Eastern girl with anxiety and depression. She lived in the same city as our clinic, attended a local high school, and tended to view our appointments as a break from the demands of the rigorous advanced high school program which added to her stress level. Anna often had difficulty being honest with her friends, often fearing she would upset them; their feelings took priority. She seemed remarkably able to be honest and forthcoming with her parents, who themselves identified as relatively liberal compared to their traditionally conservative culture; she had already shunned their religious beliefs and most of their ritualistic practices with barely an observable strain in their relationship. Trying to form more honest peer relationships remained a struggle.

Even prior to COVID, I had encouraged Anna on forming more real friendships by being her true self. Since the COVID crisis, this task was eased by allowing Anna to decide which friends to maintain contact with during social isolation. I soon realized the act of physically going to school presented her with the dilemma about how to avoid certain individuals without offending them, while during COVID that was not much of a problem at all. During our third telemedicine appointment, Anna disclosed...
she had made progress with honesty by “coming out of the closet” to a select few of her friends, and in the process, by coming out to me by telling me this story. Why now? “It was easier on video.” Anna acknowledged the physical separation and ability to control both the environment (“I could turn my phone off if they said something hurtful”) and which individuals she surrounded herself with. I was so happy and excited for her, I almost cried (could she see that on the video?). She told me she was planning on telling her parents next, which she did and of course they were accepting. She also used rapid changes to her education forced upon her by COVID to put less pressure on herself to succeed, because in the current times, she was trying to focus on what really mattered.

Even as I write this, it is difficult for me to explain how two different individuals can react so differently to their literal or metaphorical closet during the same crisis. The biggest difference seemed to be one was forced to isolate in her safe space, and then felt safe coming out; the other was forced to isolate in a space that she perceived to be less safe, and stayed in. It just highlights how important it is for all of us and our patients to be able to carve out a safe space, especially when so much seems unsafe.

Dr. Michael Shapiro DFAACAP is associate professor and medical director of the University of Florida Child and Adolescent Psychiatry Clinic at Springhill Health Center. He serves on the AACAP Psychotherapy Committee and CME Committee. He may be reached at mshapiro@ufl.edu.
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The TikTok Doc

Nat Mulkey (they/them), MS3

It is about 8:00 pm and though I swore I would read the last chapter of my neglected novel, I reach for my phone instead. I open up TikTok and a loud advertisement with catchy music greets me. This is always the first video, but within seconds I can scroll down to my personalized feed. Today, the first video shows a young adult wearing a hoodie in a room lit with pink light. A text box floats above them and reads “things only people with depression will understand,” while an echoey pop song plays in the background. In the next scene, the user is hugging a pillow solemnly in the corner and the text box reads “sometimes you don’t know when you’re sad,” and then “you feel alone when you aren’t.” This video has over 388,000 likes and 6,000 comments. I scroll through a few more videos when a white coat catches my eye. The caption of this video reads “depression has many faces #doctor #pediatrician #teens #depression.” A classical lullaby plays in the background as the doctor lists and acts out symptoms of depression, such as irritability, loss of interest, and change in appetite. This simple video, listing the criteria for depression almost word-for-word from the DSM-5, has 218,000 likes and 1494 comments (and counting).

For those new to the app, TikTok is arguably the most culturally-relevant social media platform today. Users create short videos that incorporate text, dance, music, and other trending jokes or topics. Each video has a brief caption with relevant hashtags. Much of this is similar to other social media platforms, so what makes TikTok special? More importantly, why are so many doctors on it? Why should we care?

What is unique about TikTok is its break from the typical follower-based feed. On apps like Twitter and Snapchat, users rarely encounter content from people who they do not directly follow. While TikTok does have a page devoted to the people you follow, it also has a page called the “for you” page. The “for you” page includes videos from all types of users you do not follow. It is personalized based on prior videos you liked or interacted with. From my personal experience, the algorithm works. After a few days of liking videos from medical students, doctors, and about mental health, my “for you” page was saturated with white-coated professionals and young adults candidly displaying their mental illnesses.

So who are these TikTok doctors? They are an OB/GYN dancing next to popular birth control options, a family medicine resident displaying colorful vaccination facts, and an oncologist celebrating with a newly cured patient. All in less than a minute. Each of these physicians can and do show up on a random young adult’s feed, whether they like it or not. This sort of direct “infiltration” into a young adult’s attention and life is both unprecedented and powerful. Any young adult liking videos about depression, anxiety, or even suicide might have a doctor pop up in their feed addressing these topics directly. This presents doctors and psychiatrists alike a unique opportunity for swift and viral education — even intervention.

In some ways, it is difficult to imagine a psychiatrist using the TikTok platform. Would they theatrically display deep breathing exercises for stress reduction while a “punny” song like Catch My Breath by Kelly Clarkson plays in the background? How does something like this come across to young adults? Gracefully merging this bubbly app with the dark and trauma-filled topics that make up much of psychiatry is no easy task. In fact, the presence of physicians and healthcare workers on TikTok has been criticized as unprofessional. One TikTok of a nurse mocking a patient’s choking symptoms was met with fierce backlash: people shared stories of times when their symptoms were invalidated and major life-threatening diagnoses were missed. Much remains to be seen about how physicians and psychiatrists should use this influential platform.

Fortunately, young adults have been candidly, gracefully, and even humorously addressing mental health and their own struggles on social media for a long time. When it comes to how the medical profession can do the same, there is much we can learn from them.

Nat Mulkey is a writer and fourth year medical student at Boston University School of Medicine interested in Child and Adolescent Psychiatry.
Screen Time During a Pandemic

As a child and adolescent psychiatrist, one often hears parents complaining about kids spending too much time playing video games or watching shows on their phone, or engaging more with friends online than in-person. Prior to the COVID-19 pandemic, excess screen time was a real issue. A 2017 Common Sense Media (CSM) report indicated that two-to-four-year-old children spent a daily average of 2 hours and 40 minutes on digital media, and five-to-eight-year-olds spent almost 3 hours in front of a screen. In 2019, CSM released another report that 8-12 year-olds spent a daily average of 4 hours and 44 minutes on screens. Adolescents averaged 7 hours and 22 minutes a day; this did not include screen time spent on schoolwork and homework.

Now, with most schools having closed in mid-March until the end of the school year, resulting in a mad scramble to post lessons online, schedule online class meets and “office hours,” and provide other online resources to supplement e-learning, screen time has inevitably increased. The six-to-seven hours when children and adolescents were once in school, learning through class lectures and group discussions, with recess/gym and lunch breaks, have all been replaced with e-learning. Since the online assignments generally do not take a whole school day, screen time is also often filling up the remaining school-day hours; this is on top of the hours typically spent online with social media, video games, and streaming services after school. As many parents work from home or go to work as essential workers, with no options for daycare, screens may increasingly be used as “babysitters” and as breaks for haggard guardians trying to work and educate their children at the same time.

However, this article is not meant to criticize the use of screens. Screen time can be used for many positive endeavors. Common uses include social media to keep connected with friends and peers, play video games (alone or online with friends), watch movies/television/streaming sites, “surf the web” on smartphones and computers for information. Adolescents may go online to get answers to personal health or other questions they do not feel comfortable asking their parents or healthcare providers. In addition, completion of homework may require online research and computer use.

That is not to say that concerns about screen time are unfounded. Children and adolescents spending more time on screens experience poorer physical health, including poor diet, obesity risk, decreased sleep, lower self-esteem, and higher rates of depression and anxiety. An additional concern is the set of mental disorders characterized by problematic interactive media use. Video game use disorders represent one manifestation of disordered media use and are now recognized in both the DSM-5 and ICD-11.

How does one approach parent and caregiver guidance? The previous approach of universal, strict daily limits on screen time is no longer applicable. The most recent recommendations from the American Academy of Pediatrics are more dynamic. Recommendations are made recognizing stage of development, variability in family media culture, lifestyles, and the recognition that use of electronic media has both risks and benefits.

Families are advised to create a Family Media Plan (https://www.healthy-children.org/English/media/Pages/default.aspx), a clear and explicit set of guidelines for each member of the family based on age/development, including specific details about forms of electronics used, material accessed, and amount of use permitted. Planning is to be made not only for solitary leisure and entertainment activities but also for creativity and time for the child and caregiver to use or view devices together. Families are encouraged to choose and plan activities that enrich the child’s development. Allowable “zones” are established for where media use may or may not occur. A clear curfew is established, requiring devices to be stored away from the bedroom overnight. Caregivers are reminded to model preferred media use habits as well.

COVID-19 complicates both creation of and adherence to functioning media use plans. Families with previously functioning media use routines have found their systems breaking down with loss of diverse leisure and social contact opportunities, loss of daily structure, and changing sleep schedules. For families without a media plan prior to COVID-19, it is doubtful they have initiated a new
Make or modify a plan: establishing clear, explicit expectations eliminates the risk of debating what the rules “should be” at each moment of restriction. The AAP makes plan creation easy with an Internet-based tool that facilitates plan creation in a clear and organized process with examples and availability in both English and Spanish. There is no need to worry about getting the plan right the first time. If there are ways in which it is not functioning, it can be modified. Likewise, for families with previous systems that have functioned less well since COVID, guidance focuses on making changes to the plan to fit the “new normal.”

Add flexibility to the newly established or refined structure of a plan. Adapting to COVID has been stressful for children and their caregivers. Efforts to tighten the grip of control poses a risk of alienating the child and loss of collaboration as a family. It is validating to acknowledge how stressful the experience has been and to allow an extra permission now and then.

Dedicate separate time, space, and media activities for work or school and for leisure. Video games, social media, and streaming entertainment should be turned off and set aside during schoolwork. This is even truer during school closure. An opportunity to be flexible here would be allowing cell phones for texting friends about a joint school project or problem, i.e. studying together. It helps to remind them that without distraction, the work gets done faster, leaving more time to enjoy themselves without work hanging over their heads.

Prove that there are other activities available beside screens. Caregivers should endeavor to find and explore those activities together with their children. Playing board games, building a puzzle or model, preparing family meals, playing or listening to music, reading, doing crafts, learning a new language, engaging in physical activity outdoors, and enjoying countless other activities together lead to both personal growth and connectedness.

Remember that the Internet is not only a tool but also a place for socializing. Having lost access to valuable contact with friends, the Internet allows for that need to be met through virtual contact like Videochat. Loosening time limits on media in consideration of socializing with friends is another opportunity for purposeful flexibility.

Screen time, as anything else, offers pros and cons that should be carefully weighed, especially during these unprecedented times. While managing media activities is yet another responsibility for already over-extended caregivers, it might just be what the doctor ordered for reinforcing valuable principles of growth and development.

References

Dr. Hua is the Director of Psychiatry Education for Catholic Charities of Baltimore, where she also works as a child and adolescent and adult psychiatrist. She is the co-chair of the AACAP Adolescent Psychiatry committee, as well as AACAP liaison to the American Academy of Pediatrics Committee on Adolescence. LLH228@gmail.com.

Dr. Tsappis is the Associate Director of the Clinic for Interactive Media and Internet Disorders and Attending Psychiatrist for Adolescent and Young Adult Medicine at Boston Children’s Hospital and an Instructor in Psychiatry at Harvard Medical School.
Student Mental Health is a Priority, No Matter What the Return to School Looks Like

Child and adolescent psychiatrists are taught from day one of their training that the best interests of a child are paramount. However, children can only do well when their caregivers and communities are similarly well-supported. In considering the complex challenges of the COVID-19 crisis, the best interests of children can only be met by simultaneously considering the best interests of parents, families, teachers and school staff.

When schools open, in whatever shape or form, those of us who consult with schools will be busier than we have ever been. Even before this COVID-19 apocalypse began, schools were already ill-equipped to meet students’ mental health needs. It has been estimated that more than seven million children in the US have a mental health disorder. Whether schools open, stay closed, or work semi-virtually, the existing challenges will be multiplied and vary according to the specific solutions developed. Just as hospitals faced a crisis when the pandemic began, now school administrators, families, students, and school staff face similar distress, uncertainty, and confusion about how to return to school given the new realities of COVID-19. The solutions will necessarily vary by community, level of COVID infection, school size and resources. Surprisingly, in all that has been written about returning to school, very little has been written about the mental health needs of students, teachers and other school staff.

Mental health is part of overall health, and students must be healthy enough to learn. We know our children should return to school, but they need a safe, secure, and supportive learning environment with professionals who also feel safe and cared about. If the stress and illness burden isn’t too great, we hope that the resilience of youth will prevail. However, those children already burdened by mental health challenges may suffer more. Mental health and education disparities will widen the pandemic’s negative impact in marginalized and under-resourced communities. Fairness and equity require that those bearing a disproportionate impact of the pandemic be provided sufficient access to equipment, services, and technology, and mental health support to address systemic cultural disadvantages in education and mental health worsened by COVID-19.

Decisions related to reopening must be data-driven, relying on the best available medical understanding and public health guidance. Unfortunately, this is already a moving target. In addition, different populations, such as children receiving special education, children in foster care, or non-English-language learners, may require approaches that differ from the general approach. Children at different developmental stages will have specific needs. What is good for some students and their families will not necessarily be good for others.

There are multiple potential mental health consequences stemming from school closures. Learning opportunities have been lost resulting in possible regression of educational and emotional coping skills, particularly in children with special education needs.
some children, the pandemic may have produced heightened fear, anxiety and depression, leading to further difficulty in emotion regulation and behavior, learning and interpersonal relationships. The fears of school staff will need to be recognized and discussed, as these will also impact the students in their care.

School mental health professionals will be essential in helping to shape messages to students and families about school re-entry, to address anxiety, to promote social adjustment to the “new normal,” and to address other unanticipated mental health concerns that are sure to arise during this national trauma experience. Teachers and school personnel should receive training on how to talk with and support children during a pandemic. Intentional strategies to help students adapt to new school environments should be developed. Schools will also need to creatively support teachers in their efforts during this unprecedented time. Addressing the grief of those who have suffered loss will also be critical.

It is hard to imagine how children can return to school safely without providing additional (and substantial) financial support. Added to the costs of the physical needs created by the pandemic, will be the increased costs necessary to bolster a full continuum of educational and mental health supports. Funding of school-based mental health supports will be necessary for prevention of staff burnout and trauma effects, as well as early identification and intervention of mental health problems in the increased numbers of students at high-risk for adverse outcomes.

The American Academy of Child and Adolescent Psychiatry (AACAP) is working hard to ensure that mental health programs, specifically children’s mental health, are included in the next Congressional aid package. AACAP is advocating on multiple fronts. In solidarity with other mental health organizations, a multi-pronged letter was sent to Congressional leaders that outlines several key mental health provisions that need to be included in the next COVID-19 relief package. Such provisions include increasing funding for existing and new mental health programs, ensuring that current telehealth flexibilities become permanent, boosting Medicaid’s Federal Medical Assistance Percentage, and more. AACAP’s Schools Committee, which co-wrote some of this document, is especially concerned with ensuring that the best information on school mental health is available as it is developed.

As child and adolescent psychiatrists, mental health is definitely “our lane.” Every student, every family, and every school staff member will have a COVID-19 story. We need to do our best to hear them all and respond when help is needed.

Dr. Weisbrot is a Clinical Professor of Psychiatry at the Renaissance School of Medicine, Stony Brook University and a Distinguished Fellow, of the American Academy of Child and Adolescent Psychiatry.
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AACAP Coronavirus Resources

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

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

Being an AACAP Owl

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

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

Are you a Life Member who would like to be more involved in Life Member activities? Contact AACAP’s Development Department at 202.966.7300, ext. 140.
Welcome New AACAP Members

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FOR YOUR INFORMATION

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Thank You for Supporting AACAP!

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

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Where Most Needed
Carmen Jon-Mikhael Rowland

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.
Helping Kids Cope with the Holidays During the Pandemic

By David Fassler, MD

This has definitely been a strange and stressful year for kids and families. The upcoming holidays are likely to be particularly challenging. Here are a few thoughts and suggestions:

1. Make your plans in advance, if possible, and tell your kids what’s happening, when and why. Kids can adjust to lots of changes, but uncertainty and indecision increases stress and anxiety.

2. Try and retain as many traditions as possible, even if in a modified form. Make an extra effort to connect by phone, Zoom or FaceTime with friends and relatives you’d normally see.

3. Consider cooking familiar dishes from past celebrations.

4. Make sure kids understand why this year is different and why people aren’t traveling as much as usual. Gear your explanations to their age and developmental level using words and concepts they can understand.

5. If kids get moody or frustrated, acknowledge their feelings in an open, honest and consistent manner. Let them know that lots of people are working hard to bring the pandemic to an end as quickly as possible and that they will be able to travel for the holidays and visit relatives at some time in the future.

Most kids will understand, accept and adjust to the changes. However, preparation, information and ongoing discussion can help make the holidays fun and less stressful for the whole family.

David Fassler, MD is a child and adolescent psychiatrist practicing in Burlington, Vermont. He is also a Clinical Professor of Psychiatry at the University of Vermont Larner College of Medicine, and member of the Consumer Issues Committee of the American Academy of Child and Adolescent Psychiatry.
2016 AACAP BEATRIX A. HAMBURG, MD, AWARD FOR THE BEST NEW RESEARCH POSTER BY A CHILD AND ADOLESCENT PSYCHIATRY RESIDENT

Poster Title: Adverse Childhood Experience Is Associated With Impaired Coronary Distensibility Index and Predicts Major Adverse Cardiovascular Events

This unique research opportunity facilitated an in-depth understanding of neurobiology of youth traumatic stress disorder, and led to the subsequent development of a pilot intervention grant based on the findings of the study.

Findings of our research revealed that impaired coronary distensibility index (CDI) is strongly associated with the severity of adverse childhood experiences’ (ACE) symptoms and predicts an increased risk of major adverse cardiovascular events (MACE) in subjects with ACE. Findings highlight the important role of early intervention and preserving CDI in identifying individuals with ACE at risk for MACE.

2016 AACAP PILOT RESEARCH AWARD FOR ATTENTION DISORDERS
SUPPORTED BY AACAP’S ELAINE SCHLOSSER LEWIS FUND
Project: Trial of Positive Psychiatry in Comorbid Attention-Deficit/ Hyperactivity Disorder With Posttraumatic Stress Disorder

The Pilot Research Award study investigated the impact of reminder-focused positive psychiatry (RFPP) on vascular function, inflammation, wellbeing and attention deficit/ hyperactivity disorder (ADHD) and PTSD symptoms in adolescents with comorbid ADHD and PTSD. There were several novel findings, and the study results were published in a recent paper in the September 2020 issue of The Primary Care Companion for CNS Disorders.

The AACAP Research Committee’s valuable support, mentorship, and funding of this pilot research consolidated my academic career as an assistant professor of psychiatry at UCLA, with strong commitment to AACAP and its stellar mission. The Pilot Research Award played a pivotal role in the successful completion of my training in positive psychiatry, as well as completion of this translational study. I have been continuing my academic CAP clinical and research practice, with active contributions to the field, children and their families, as well as supporting the AACAP community and initiatives.

WORKFORCE IMPACT

I am a firm believer in active contributions to AACAP and improving children’s mental wellbeing. I am extremely grateful to have received these rewarding opportunities, which allowed me to serve as mentor for eight medical student and ten resident AACAP members during the research period.

Visit www.aacap.org/awards to discover available award opportunities!
APA and AACAP Deeply Concerned Over Reports that Parents of Children Separated from Families at U.S. Border Cannot be Found

For Information Contact:
Rob Grant, 202-997-1290
rgrant@aacap.org
Glenn O’Neal, 202-459-9732
press@psych.org

WASHINGTON DC, OCTOBER 22, 2020 – The American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry today issued the following statement in response to media reports that the parents of 545 migrant children separated from their families at the U.S.-Mexico border can no longer be found.

We are appalled by the reports, based on legal filings, that authorities are unable to find the parents of 545 children who were separated from their families at the U.S.-Mexico border under this administration’s punitive “Zero-Tolerance” policy.

The APA and AACAP have long spoken out against the harmful practice of separating children from their parents. It is well-documented in psychiatric literature that even brief family separations can cause significant and often irreparable harm to children, resulting in lifelong setbacks in learning, behavior, and health. The risks to health and development are even more concerning for traumatic and prolonged separations. The federal government must make every effort to quickly reunite these families, and to ensure children have access to adequate mental health services while living with sponsors and in foster homes.

#

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

American Psychiatric Association
The American Psychiatric Association, founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 38,800 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA’s vision is to ensure access to quality psychiatric diagnosis and treatment. For more information please visit www.psychiatry.org.
E-Cigarettes and Vaping

A large number of Middle School and High School students are using electronic cigarettes (vaping) or using Heat Non Burn (HNB) devices to inhale nicotine and marijuana. However, the use of these devices poses significant risks, and recreational nicotine and marijuana use below the age of 21 is illegal throughout the United States.

1. E-Cigarettes / Vaping

Electronic Cigarettes (e-cigarettes) are battery-operated devices that heat up a liquid (the e-liquid). This e-liquid usually contains nicotine but can also contain marijuana or other drugs, and other potentially harmful chemicals. Additionally, the e-liquid can include flavorings (such as fruit, candy, or dessert-like flavors), which can be well-liked and marketed towards youth. When heated, the e-liquid becomes an aerosol, which is then inhaled into the users’ lungs. Using e-cigarettes is called vaping.

2. Heat-Not-Burn (HNB) or Heated Tobacco Products (HTPs)

A Heat-Not-Burn (HNB) product has an electronic heating device that heats up actual tobacco leaves. When the tobacco leaves are heated up, they create an aerosol. The user than inhales this aerosol, which contains nicotine and tobacco.

Parents and Prevention

Parents can help their children learn about the harmful effects of nicotine and marijuana use. Talking to your children at an early age can have an impact, especially as many children have already used e-cigarettes in middle school. Youth are less likely to use nicotine and marijuana if they can ask parents for help and know how their parents feel about these drugs. When talking to your child, it may be helpful to consider the following recommendations:

- Ask what your child has heard about nicotine and marijuana. Listen and try not to interrupt or make angry comments.
- If you choose to talk to your child about your own experience with nicotine or marijuana, be honest about why you used. Be aware that the nicotine products and marijuana available today may be stronger and produce a very different effect than what you experienced.
Explain that research tells us the brain continues to mature into the 20s. While it is developing there is a greater risk that substances will be harmful. Sometimes parents may suspect their child is already vaping. The following are some signs of nicotine use by vaping or HNB devices:

- Carrying vaping or HNB devices
- Starting to use combustible cigarettes
- Stealing money to pay for their vaping
- Showing signs of nicotine toxicity, overdose, or withdrawal
- Strong artificial candy-like or fruity scents
- Skipping school to vape, or decrease in grades due to time spent vaping

### Effects of Nicotine: Know the Facts

Please see [FFF Marijuana and Teens](#) for effects of marijuana.

Many teenagers believe vaping nicotine or using HNB devices to be safer than smoking combustible cigarettes. When talking to your child it is helpful to explain the myths and the facts. They may say “it is less addicting than smoking” or “it’s less dangerous than smoking.” However, research shows vaping can cause serious short- and long-term health problems.

- 1 e-liquid cartridge is equivalent to 20 combustible cigarettes, and vaping delivers nicotine into a persons’ system faster than combustible cigarettes. This increases risk of nicotine overdose when nicotine is used by vaping.
- Nicotine is addictive.
- Nicotine affects brain development including attention, learning, mood regulation and impulse control.
- Use of HNB Devices and Vaping often progresses to combustible cigarette use and all the associated medical risks of lung cancer and COPD.
- Vaping can cause lung disease which has led to teenagers needing lung transplants.
- EVALL is the name given to E-cigarette, Vaping, Associated, Lung, Illnesses.

E cigarettes, Vaping and HNB devices can lead to long term consequences. Preteens and teens rarely think they will end up with long term problems, so it is important to talk to them about the risks of nicotine and marijuana early and often. Talking to them can help delay their first use and helps protect their brain.

If they are using, talk to them openly. Be curious, allow them to talk, and listen, so they will talk more. If you have concerns about your child’s drug use, talk with your child’s pediatrician or a qualified mental health professional.

### Facts for Families

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

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

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

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If you need immediate assistance, please dial 911.

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ACADEMY & ASSOCIATION 101

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

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

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

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

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

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
CLASSIFIEDS

CALIFORNIA

Company: Spin Recruitment Advertising (876472)
Title: Child, Adolescent & Adult Psychiatrists
Job ID: 14100775
URL: https://jobsource.aacap.org/jobs/14100775

Job Description:
I am a PERMANENTE PHYSICIAN. A dedicated doctor who believes in pursuing dreams, creating hope, and driving progress. Southern California Permanente Medical Group is a physician-led, partnership organization with a patient-centered and evidence-based medicine approach. SCPMG is an organization with strong values who provides our physicians with the resources and support systems to ensure our physicians can focus on practicing medicine, connect with one another, and provide the best possible care to our patients. ADULT, CHILD & ADOLESCENT PSYCHIATRISTS Openings in Southern California at SCPMG, you'll enjoy the amazing recreational activities, spectacular natural scenery, and exceptional climate our area is known for, along with stability in today’s rapidly changing health care environment. SCPMG is proud to offer its physicians: 4 1/2 day work week (8-10 hours) • Flexible schedules Education time (1/2 day a week) 1 hour for initial evaluations and 30 minutes for follow-ups. Multi-disciplinary team consisting of Nurses, LCSWs, Psychologists and MAs. Medical, Dental, Vision, Life & Supplemental Comprehensive Insurance Robust retirement plans: Pension Plan, 401K and Keogh Excellent salary and compensation package (bonuses offered) Partnership eligibility after 3 years *Not available for the Inpatient Psychiatrist opportunity. We invite you to make a difference in the community we serve. For consideration or to apply, please visit our website at http://scpmpgphysiciancareers.com. For additional information about these opportunities, contact Jolanta Buschini at Jolanta.U.Buschini@kp.org or call (877) 259-1128. We are an AAP/EEO employer. The Answer to Health Care in America.

ILLINOIS

Company: Riverside Healthcare (1228811)
Title: Outpatient Child and Adolescent Psychiatry Opportunity Located Less than One Hour South of Chicago
Job ID: 14076832
URL: https://jobsource.aacap.org/jobs/14076832

Job Description:
Collegiate team of seven psychiatrists Traditional practice office hours – Monday through Friday, 8:00 am – 5:00 pm on campus Full time hospital employed position with ability to sponsor H1-B and J-1 visas. Opportunity to work with psychiatry residents, medical students and nurse practitioners in training Epic EMR. Supportive administration with open door policy. Take own patient call (very light) during the week but not obligated to come in to the hospital Shared call on the weekends (1:8) Large network of support services in the hospital and community Compensation package includes a base salary plus production, commencement bonus, loan repayment, housing stipend, quality incentive, CME and professional dues, generous paid time off, matching 401K, health/dental/vision insurance, short and long term disability, life insurance.

Job Requirements:
MD or DO, American residency, Collegial, Hard-working

INDIANA

Company: Parkview Health (1226356)
Title: Board Eligible / Board Certified Child and Adolescent Psychiatrist
Job ID: 14016904
URL: https://jobsource.aacap.org/jobs/14016904

Job Description:
Join Our Team To meet the growing demands in our area, Parkview Health is seeking Board Eligible / Board Certified Child and Adolescent Psychiatrists to work at our Parkview Behavioral Health Institute in Fort Wayne, Indiana. Specifics of The Role Schedule: Monday – Friday; Days Call schedule: Every 8 weeks Outpatient with the opportunity to do some inpatient work as a part of a regular schedule if desired. The Team Our collegial group consists of 4 Child & Adolescent Psychiatrists. We are northeast Indiana’s only provider of inpatient mental health services for children and adolescents experiencing emotional or behavioral issues. Parkview Behavioral Health One of 10 service lines for the Parkview Health system. PBH provides tertiary psychiatric care treatment for an 11-county area. Hospital outpatient services include intensive outpatient treatment and partial hospitalization at several facilities. Provides services at two outpatient physician clinics and a community health center. The psychiatric hospital is licensed for 120 beds, consisting of 16 beds for children, 18 beds for adolescent, 37 beds for adults, 18 intensive care adult beds, and a 20-bed unit dedicated to older adult patients. Recognized by Press Ganey with two awards for 2019: the NDNQI Award for Outstanding Nursing Quality® and the Success Story Award®, Named in the 2019 IBM Watson Health™ 100 Top Hospitals® Parkview Health Proudly committed to bringing the highest quality of care to northeast Indiana and northwest. Ohio Region’s largest employer with over 13,000 employees. Health system is comprised of more than 800 world-class providers in more than 45 specialties in over 300 locations. Named one of the nation’s top employers by Forbes Named one of the nation’s 15 Top Health Systems by IBM Watson Health™. Received national recognition from The Leapfrog Group for straight “As” in patient safety Benefits. Our excellent benefit package includes: Highly competitive salaries plus annual incentive compensation opportunity. Commencement bonus. Paid relocation. Student loan assistance. Retirement contribution plan. Flexible spending accounts Medical, dental, vision & life insurance. Long and short-term disability. And many other non-traditional benefits! Apply Today! For additional information or to submit your CV, please contact us at providercareers@parkview.com. Community Highlights Northeast Indiana is in the middle of it all, located just three hours or less by car from Midwest cities including Chicago, Cincinnati, and Indianapolis – but with its own unique vibe and easygoing lifestyle. Here, we offer the opportunity to create your version of the American dream, whether you’re looking to grow your career, family, or home. Fort Wayne, the region’s hub, and Indiana’s second largest city consistently ranks
as one of the best places to live in the U.S. and boasts some of the nation’s lowest cost of living. Putting the Life in Your Work-Life Balance Northeast Indiana has the charm of small-town life, but with big-city amenities, like vibrant downtown Fort Wayne. It has dining and nightlife that rival the most eclectic places across the nation. We are big on outdoor adventures, and we love to explore. If you’re a fan of professional sports, you won’t be bored. If you like fairs, festivals, and happenings, you’ll have every weekend covered. There are so many events to keep you busy every day of the week! We encourage you to come visit our growing health system and vibrant community and we will commit to welcoming you with our big-hearted hospitality.

**MASSACHUSETTS**

**Company:** Cambridge Health Alliance (1177750)

**Title:** Child and Adolescent Psychiatrist Opportunities in Outpatient and Integrated Care

**Job ID:** 14092211

**URL:** [https://jobsource.aacap.org/jobs/14092211](https://jobsource.aacap.org/jobs/14092211)

**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](http://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@challiance.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.

**MICHIGAN**

**Company:** Children’s Hospital of Michigan (1144179)

**Title:** Psychiatrist and Endowed Chair for Youth Behavioral Health

**Job ID:** 1400371

**URL:** [https://jobsource.aacap.org/jobs/1400371](https://jobsource.aacap.org/jobs/1400371)

**Job Description:**

GENERAL STATEMENT OF DUTIES: The department of Pediatrics is seeking a full time highly qualified physician faculty board certified in Child and Adolescent Psychiatry. This is a unique opportunity for a physician to provide leadership for the psychiatry division of University Pediatrics in collaboration with Detroit Medical Center (DMC) Children’s Hospital in Detroit, MI, and a growing Psychiatry program with CMU Health including a new established fellowship in Child and Adolescent Psychiatry. The individual occupying this position will be the incumbent for the Patricia H. Rodzik Endowed Chair for Youth Behavioral Health held within The Children’s Foundation. The funds generated by the endowment are dedicated to providing resources for innovative research, teaching and clinical care at the Children’s Hospital of Michigan in the behavioral health field. The Children’s Foundation provides resources to support research and clinical programs helping children and young adults with mental health disorders. Positions will be at Associate or Full Professor rank, depending on academic credentials. To be considered for this appointment applicants are expected to demonstrate multidimensional qualifications in clinical practice, education, research, and involvement in community-based initiatives focusing on mental health. MINIMUM QUALIFICATIONS: MD or DO degree, certification by an American Board of Medical Specialties or American Osteopathic Association recognized clinical specialty, licensure or eligibility for licensure in the State of Michigan, established credentials or developing potential in clinical practice, strong collaborative and communication skills, and demonstrated commitment to diversity. Applicants applying for advanced rank should have a demonstrated record of teaching and an established area of scholarly activity. DUTIES AND RESPONSIBILITIES: Engage in outpatient and/or inpatient clinical work with University Pediatrics and DMC Children Hospital. Participate on interdisciplinary teams; Provides advising and making recommendations for the care of children and adolescents. Responsible for maintaining medical records in accordance with established policies and procedures in collaboration with other clinicians will develop, maintain, and monitor a clinical case management system to provide continuity of care and follow-up for higher-need patients. Initiate and develop on-going liaison relationships with community health providers, services, hospitals, and other resources. Consult with faculty, staff, learners, and family members, who are concerned about a patient while adhering to confidentiality guidelines. Conduct research and/or scholarly activity relevant to the advancement of medicine and/medical education that leads to publications Demonstrated commitment to diversity by working to develop a culture of inclusion and mutual respect. About CMU College of Medicine: The CMU College of Medicine welcomed its inaugural class in the summer of 2013. The innovative medical school curriculum is designed to prepare students for practice in mid-
northern Michigan and the Upper Peninsula, with particular attention to primary care needs in the region. The program is housed in a new facility with advanced technology for teaching. For more information, visit College’s website.

About University Pediatrics: University Pediatrics is a non-profit practice plan that includes nearly 250 physicians that provide pediatric healthcare services at the DMC Children’s Hospital of Michigan. University Pediatrics also owns and operates three autism treatment centers in southeastern Michigan. Working in coordination with DMC Children’s Hospital of Michigan we strive to improve the health and well-being of all children and their communities by advancing science and the practice of pediatric health care and through advocacy programs. About DMC Children’s Hospital of Michigan: Since 1886, DMC Children’s Hospital of Michigan has provided high quality care to children and adolescents in a caring, efficient, and family-centered environment. With more than 40 pediatric medical and surgical specialty services, the hospital draws patients from nearly every Michigan County, 39 additional states, and 22 countries annually and provides the highest level of pediatric specialty care available for children. EXEMPT STATUS: This position is exempt from overtime pay provisions of the Federal Fair Labor Standards Act. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. All employment decisions are made based on an individual’s qualification for a particular job. Consistent with the principles of equal employment opportunity and are administered without regard to race, color, religion, sex, age, national origin, disability, height, weight, marital status, genetic information covered veteran status, sexual orientation or any category protected by applicable law.

How to Apply:
Email CV to: Human Resources Department
Contact Email: lpanoff@dmc.org
EOE M/F/VET/DISABLED

MICHIGAN
Company: Network180 (1227065)
Title: Psychiatrist
Job ID: 14032515
URL: https://jobsource.aacap.org/jobs/14032515

Job Description:
Network 180 is seeking a Psychiatrist to work within our Behavioral Health Home. The Behavioral Health Home serves adults with severe mental illness and co-occurring substance use disorders through a multidisciplinary, team-based approach. The team operates from a whole person point of view with an intensive focus on care coordination with primary care providers. The entire team meets weekly for a team huddle where all the consumers who have psychiatric appointments scheduled that week are discussed. This is where critical information is exchanged so that the highest level of care coordination and collaboration can occur. During the COVID-19 pandemic, we are providing as many services as possible through Telehealth. Many employees can work from home during this time. For employees who do need to work on-site or see individuals in person, we provide Personal Protection Equipment to our employees and thorough safety and cleaning protocols are in place. Job interviews are being conducted via the internet. We are committed to attracting a diverse and talented workforce to meet the needs of our diverse community. Network180 offers an attractive benefit package including health, dental, vision, retirement plan, life insurance, and short- and long-term disability. Applications accepted until the position is filled. Network180 is an Equal Opportunity Employer. Network180 participates in E-Verify.

NEVADA
Company: Reno Behavioral Healthcare Hospital (1224106)
Title: Inpatient Child and Adolescent Psychiatrist – Reno, NV
Job ID: 13954219
URL: https://jobsource.aacap.org/jobs/13954219

Job Description:
Located in the foothills of the Sierra Nevada Mountain Range, just 45 minutes from world-renown Lake Tahoe, Reno. Behavioral Healthcare Hospital is looking for an inpatient adult psychiatrist and a child and adolescent psychiatrist. Reno Behavioral Healthcare Hospital is the newest hospital in the state. The brand-new, state-of-the-art facility offers inpatient and outpatient programs for psychiatric and addiction treatment for patients of all ages. Reno Behavioral accepts Medicare, as well as most commercial health insurance plans. We are currently seeking to add a Child and Adolescent Psychiatrist to join our Medical Staff. 124-bed free-standing behavioral health hospital Average length of stay = 7 days Flexible schedule – Ability to leave for the day once you have finished rounding. Adult and Youth inpatient psychiatry patients. Flexible caseload. Diverse payor mix. Competitive salary and benefits. Teaching opportunities with residents. Responsibilities include medication management, admissions, follow-up visits, and treatment team meeting attendance. Electronic Medical Record. No state income tax in Nevada.

Job Requirements:
Successful completion of Psychiatry residency or fellowship training program; Current Nevada medical license in good standing or have the ability to obtain required licensure (MD or DO only); and Current Nevada DEA license.

PENNSYLVANIA
Company: Universal Health Services (1096872)
Title: Inpatient Child/Adolescent Psychiatry position, State College, PA area
Job ID: 14065896
URL: https://jobsource.aacap.org/jobs/14065896

Job Description:
The Meadows Hospital, located in Centre Hall, PA (State College) is currently recruiting a Psychiatrist for our Child/Adolescent inpatient unit. Duties will include admission evaluations, treatment team leadership, daily care of patients assigned, and administrative duties as related to patient care. The Meadows is the leading psychiatric treatment facility of Central Pennsylvania. It is at the core of an integrated delivery system providing comprehensive services in a variety of treatment settings. Services are provided for child and adolescent patient populations with psychiatric and chemical dependency diagnoses. With a wide referral network of providers throughout Central Pennsylvania and beyond, The Meadows represents a regional specialty system
structured to meet the continuum of care demanded by patients, professionals, and payers. Position Highlights: Competitive salary & bonus program Sign-on bonus Relocation Malpractice coverage Health, Dental, and Vision insurance Matching 401k Paid Time Off Student loan assistance CME package Employee stock purchase plan Requirements: Board Eligible/Board Certified in General Psychiatry with an active PA license or ability to obtain licensure. For more information either apply through this web site or contact directly: Will DeCuyper In-house Physician Recruiter will.decuyper@uhinc.com (470) 289-2408

Job Requirements:
Board Eligible/Board Certified in General Psychiatry Active PA license or ability to obtain.

TEXAS
Company: TTUHSC El Paso-Psychiatry (1211405)
Title: Assistant or Associate Professor-Child and Adolescent Psychiatry
Job ID: 14042775
URL: https://jobsource.aacap.org/jobs/14042775

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

Job Requirements:
Minimum Qualifications: MD/DO. Successful completion of ACGME-accredited fellowship program in Child and Adolescent Psychiatry. Board-certified in Psychiatry and Child and Adolescent Psychiatry by the American Board of Psychiatry and Neurology Licensure or eligibility for medical licensure in Texas. Preferred Qualifications: Bilingual (Spanish/English) Demonstrated track record in research and peer-reviewed publications for rank of Associate Professor or higher Regionally or nationally recognized clinical expertise for rank of Associate Professor or higher.

UTAH
Company: The University of Utah Department of Psychiatry (956175)
Title: Academic: Child/Adolescent Outpatient Psychiatrist, Rank DOQ - University of Utah Health (UNI)
Job ID: 14036504
URL: https://jobsource.aacap.org/jobs/14036504

Job Description:
The Child Psychiatry Division in the Department of Psychiatry at the University of Utah School of Medicine is looking for dedicated and motivated full-time Child and Adolescent Outpatient Psychiatrists to join its faculty. We are seeking qualified professionals to help us meet the challenges of providing high-quality psychiatric services in a market with growing mental health care needs. University of Utah Health is relied upon by our local and regional communities to improve overall health and quality of life. We do this by maintaining a commitment to outstanding patient care, the highest standard of training for medical students and residents, and continued expansion of our pioneering research programs. Successful candidates will have a faculty appointment in the Department of Psychiatry with rank based on academic experience. Faculty members provide outpatient clinical services as part of the University of Utah Neuropsychiatric Institute (UNI), in several satellite outpatient clinics along the Wasatch Front. The University of Utah is in the capital city, Salt Lake City – one of the most beautiful cities in the world, surrounded by mountains, with world-class skiing, hiking, backpacking, rock climbing, and mountain biking. The city also enjoys the Sundance Film Festival, a vibrant music scene, excellent restaurants, one of the largest LGBT communities in the country, the Utah Symphony/Utah Opera, professional basketball, baseball, and soccer teams, Ballet West (one of the premier ballet companies in the country), a vibrant art community, and many other cultural attractions. Qualifications: Applicants should hold a current, unrestricted license to practice medicine in the State of Utah (or eligible) and have expertise in child and adolescent outpatient psychiatry. Completion of a residency in Psychiatry and a Triple Board residency or a Child and Adolescent Psychiatry fellowship is required. The candidate must be board certified or board eligible in Psychiatry and Child and Adolescent Psychiatry.
Psychiatry. Obtaining board certifications is a requirement for retention. Responsibilities: Clinical care: Use excellent clinical skills in psychiatry to serve the mental health needs of the outpatient clientele; Show a strong commitment to clinical care as well as demonstrated clinical aptitude; Call is an expected clinical responsibility for all faculty members. Provide cross coverage for vacations and meetings. Specific assignments will be coordinated through the Division Chief of Child Psychiatry. Investigation: Engage in scholarly activities; Show durable dissemination of investigatory work. Education: Engage in patient care activities with learners. (Learners include residents, medical students, physician assistant students, and fellows); Serve as medical student and resident mentor; Teaching/supervising medical students, residents and fellows in psychiatric clinical rotations. Administration: Administrative duties associated with clinical care provided; Administrative service to the Department of Psychiatry, the Medical school and the hospital, including peer review and participation on committees, may be requested in order to attain academic promotion; Report to and be reviewed annually by the Division Chief as part of School of Medicine faculty appointment. The percentage of effort spent in education, investigation, and administrative activities will be negotiated annually. Specific assignments will be coordinated through the Division Chief of the Psychiatry department. Candidates should apply on-line by sending a letter of interest and curriculum vitae to: http://utah.peopleadmin.com/postings/10836. Inquiries may be directed to: Philip Baese, MD, Child Psychiatry Division Chief philip.baese@hsc.utah.edu. Department of Psychiatry University of Utah School of Medicine 501 Chipeta Way Salt Lake City, UT 84108. The University of Utah Health (U of U Health) is a patient focused center distinguished by collaboration, excellence, leadership, and respect. The U of U Health values candidates who are committed to fostering and furthering the culture of compassion, collaboration, innovation, accountability, diversity, integrity, quality, and trust that is integral to our mission. The University of Utah is an Affirmative Action/Equal Opportunity employer and does not discriminate based upon race, national origin, color, religion, sex, age, sexual orientation, gender identity/ expression, status as a person with a disability, genetic information, or Protected Veteran status. Individuals from historically underrepresented groups, such as minorities, women, qualified persons with disabilities and protected veterans are encouraged to apply. Veterans’ preference is extended to qualified applicants, upon request and consistent with University policy and Utah state law. Upon request, reasonable accommodations in the application process will be provided to individuals with disabilities. To inquire about the University’s nondiscrimination or affirmative action policies or to request disability accommodation, please contact: Director, Office of Equal Opportunity, and Affirmative Action, 201 S. Presidents Circle, Rm 135, (801) 581-8365. The University of Utah values candidates who have experience working in settings with students from diverse backgrounds and possess a strong commitment to improving access to higher education for historically underrepresented students.

Job Requirements: Applicants should hold a current, unrestricted license to practice medicine in the State of Utah (or eligible) and have expertise in child and adolescent outpatient psychiatry. Completion of a residency in Psychiatry and a Triple Board residency or a Child and Adolescent Psychiatry fellowship is required. The candidate must be board certified or board eligible in Psychiatry and Child and Adolescent Psychiatry. Obtaining board certifications is a requirement for retention.

WEST VIRGINIA

Company: Pinnacle Health Group

Title: West Virginia Child Psychiatry

Opening: 180713

Job ID: 14112732

URL: https://jobs.source.aacap.org/jobs/14112732

Job Description:
Join one of the best health care providers and teaching hospital in the state Child Psychiatry • $260k base salary with wRVU bonus potential plus comprehensive benefits • $20,000 sign-on bonus • Monday - Friday Outpatient Only; No Weekends or Holiday • Occurrence malpractice; No tail coverage required • 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 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 Stanley Direct / Fax: 404-391-4224 800-492-7771 tstanleyweb@phg.com Cell / Text: 770-265-2001

NOVEMBER/DECEMBER 2020 291
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<th>Format</th>
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- March/April 2021: January 2021
- May/June 2021: March 27, 2021
- July/August 2021: May 27, 2021
- September/October 2021: July 27, 2021

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