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– Approved by AACAP Membership December 2014

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

MISSION OF AACAP NEWS
The mission of AACAP News includes:
1. Communication among AACAP members, components, and leadership.
2. Education regarding child and adolescent psychiatry.
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5. Provide information regarding upcoming AACAP events.
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Pediatricians, Child and Adolescent Psychiatrists and Children’s Hospitals Declare National Emergency in Children’s Mental Health

AACAP, AAP, and CHA call on policymakers at all levels of government to act swiftly to address mental health crisis

Washington, D.C., October 19, 2021 – Today, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children’s Hospital Association (CHA) together representing more than 77,000 physician members and more than 200 children’s hospitals, declared a national state of emergency in child and adolescent mental health and are calling on policymakers to join them.

The COVID-19 pandemic has taken a serious toll on children’s mental health as young people continue to face physical isolation, ongoing uncertainty, fear and grief. Even before the pandemic, mental health challenges facing children were of great concern, and COVID-19 has only exacerbated them.

“Children’s mental health is suffering. Young people have endured so much throughout this pandemic and while much of the attention is often placed on its physical health consequences, we cannot overlook the escalating mental health crisis facing our patients,” said AAP President Lee Savio Beers, MD, FAAP. “Today’s declaration is an urgent call to policymakers at all levels of government – we must treat this mental health crisis like the emergency it is.”

The numbers paint an alarming picture. Between March and October 2020, the percentage of emergency department visits for children with mental health emergencies rose by 24 percent for children ages 5-11 and 31 percent for children ages 12-17. There was also a more than 50 percent increase in suspected suicide attempt emergency department visits among girls ages 12-17 in early 2021 as compared to the same period in 2019.

Additionally, many young people have been impacted by loss of a loved one. Recent data show that more than 140,000 U.S. children have experienced the death of a primary or secondary caregiver during the COVID-19 pandemic, with children of color disproportionately impacted.
“We were concerned about children’s emotional and behavioral health even before the pandemic. The ongoing public health emergency has made a bad situation worse. We are caring for young people with soaring rates of depression, anxiety, trauma, loneliness, and suicidality that will have lasting impacts on them, their families, their communities, and all of our futures. We cannot sit idly by. This is a national emergency, and the time for swift and deliberate action is now,” said AACAP President, Gabrielle A. Carlson, MD.

Amy Wimpey Knight, president of CHA added, “We are facing a significant national mental health crisis in our children and teens which requires urgent action. In the first six months of this year, children’s hospitals across the country reported a shocking 45 percent increase in the number of self-injury and suicide cases in 5- to 17-year-olds compared to the same period in 2019. Together with the AAP and the AACAP we are sounding the alarm on this mental health emergency.”

In the declaration, the groups emphasize the disproportionate toll on young people in communities of color and how the ongoing struggle for racial justice is inextricably tied to the worsening mental health crisis.

“Children and families across our country have experienced enormous adversity and disruption. The inequities that result from structural racism have contributed to disproportionate impacts on children from communities of color,” the groups stated in the declaration.

The organizations are urging policymakers to take several actions, such as increasing federal funding to ensure all families can access mental health services; improving access to telemedicine; supporting effective models of school-based mental health care; accelerating integration of mental health care in primary care pediatrics; strengthening efforts to reduce the risk of suicide in children and adolescents; and addressing workforce challenges and shortages so that children can access mental health services no matter where they live.

# # #

American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. www.aap.org

American Academy of Child and Adolescent Psychiatry

The American Academy of Child and Adolescent Psychiatry (AACAP) 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.

Children’s Hospital Association

The Children’s Hospital Association is the national voice of more than 200 children’s hospitals, advancing child health through innovation in the quality, cost and delivery of care. For more information visit www.childrenshospitals.org.
A Declaration from the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, and Children’s Hospital Association

As health professionals dedicated to the care of children and adolescents, we have witnessed soaring rates of mental health challenges among children, adolescents, and their families over the course of the COVID-19 pandemic, exacerbating the situation that existed prior to the pandemic. Children and families across our country have experienced enormous adversity and disruption. The inequities that result from structural racism have contributed to disproportionate impacts on children from communities of color.

This worsening crisis in child and adolescent mental health is inextricably tied to the stress brought on by COVID-19 and the ongoing struggle for racial justice and represents an acceleration of trends observed prior to 2020. Rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020 and by 2018 suicide was the second leading cause of death for youth ages 10-24. The pandemic has intensified this crisis: across the country we have witnessed dramatic increases in Emergency Department visits for all mental health emergencies including suspected suicide attempts.

The pandemic has struck at the safety and stability of families. More than 140,000 children in the United States lost a primary and/or secondary caregiver, with youth of color disproportionately impacted. We are caring for young people with soaring rates of depression, anxiety, trauma, loneliness, and suicidality that will have lasting impacts on them, their families, and their communities. We must identify strategies to meet these challenges through innovation and action, using state, local and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment.

That is why the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics (AAP), and the Children’s Hospital Association (CHA) are joining together to declare a National State of Emergency in Children's Mental Health. The challenges facing children and adolescents are so widespread that we call on policymakers at all levels of government and advocates for children and adolescents to join us in this declaration and advocate for the following:

- Increase federal funding dedicated to ensuring all families and children, from infancy through adolescence, can access evidence-based mental health screening, diagnosis, and treatment to appropriately address their mental health needs, with particular emphasis on meeting the needs of under-resourced populations.

- Address regulatory challenges and improve access to technology to assure continued availability of telemedicine to provide mental health care to all populations.

- Increase implementation and sustainable funding of effective models of school-based mental health care, including clinical strategies and models for payment.

- Accelerate adoption of effective and financially sustainable models of integrated mental health care in primary care pediatrics, including clinical strategies and models for payment.

- Strengthen emerging efforts to reduce the risk of suicide in children and adolescents through prevention programs in schools, primary care, and community settings.

- Address the ongoing challenges of the acute care needs of children and adolescents, including shortage of beds and emergency room boarding by expanding access to step-down programs from inpatient units, short-stay stabilization units, and community-based response teams.

continued on next page
• Fully fund comprehensive, community-based systems of care that connect families in need of behavioral health services and supports for their child with evidence-based interventions in their home, community, or school.

• Promote and pay for trauma-informed care services that support relational health and family resilience.

• Accelerate strategies to address longstanding workforce challenges in child mental health, including innovative training programs, loan repayment, and intensified efforts to recruit underrepresented populations into mental health professions as well as attention to the impact that the public health crisis has had on the well-being of health professionals.

• Advance policies that ensure compliance with and enforcement of mental health parity laws.

Outbursts, Irritability & Emotional Dysregulation Resource Center

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Fairy Tales and Their Impact on Children’s Development

The Minds of Children

Fairy tales portray a variety of experiences that support the development of children’s character. They suggest that, despite adversity, a rewarding and good life is possible, if one does not run away from the hazardous struggle. These stories promise that if a child courageously engages in a taxing search, benevolent powers will help them succeed. The stories also warn that those who are too fearful may risk having to settle for an ordinary life. Today, many children meet fairy tales in film and TV shows where they are depicted in a frivolous, beautified, and simplified manner that masks their deeper meaning.

Throughout human history, apart from the experiences within the family, children’s intellectual life was typically stimulated by myths, religion, and fairy tales. Traditional literature augmented children’s imagination and stimulated their fantasies, identity formation, and social development. The myth of Oedipus, for example, highlighted by Freud, dramatized age-old problems inherent in our complex, ambivalent feelings about our parents.

In fairy tales, internal processes are externalized onto the pages and rendered more comprehensible as represented by characters of the story and their challenges. Fairy tales do not describe the world as it is, nor do they instruct children what they ought to do. Rather, fairy tales are helpful because children can find their own solutions by contemplating what the story implies about their own inner conflicts.

Fairy tales, folk legends, and myths embody the collective experience of a society, transmitting past wisdom to future generations. In myths, the hero is presented as someone who should be emulated. In contrast, in fairy tales, figures and events personify and express universal inner conflicts. They offer in a subtle manner how conflicts might be solved.

What Children Learn from Fairy Tales

A child learns from fairy tales that figures who seem threatening, parents or strangers, might magically change into helpful friends. Belief in the truth of fairy tales inspires courage and hope, despite the ominous appearance of strangers. For example, the hero of many fairy tales succeeds in life because of their courage in befriending an unpleasant figure. Fairy tales both delight and instruct children by allowing them to project their need for protectors in the stories. This allows children to create their own versions of tales out of the chaos in their own minds or family situation.

However, fairy tales can also be damming: For instance, the evil queen from Snow White demands the secret murder of her stepdaughter after a magic mirror proclaims the younger woman’s beauty. The stepmother from Hansel and Gretel sends her stepchildren into the woods because there is not enough to eat. Cinderella sits amid her fireplace cinders, sorting peas from lentils, her ash-speckled body appeasing a wicked stepmother who wants to dull her luminosity with soot.

Joseph Campbell observed in The Hero with a Thousand Faces that the accomplishment of the mythic hero represents macrocosmic human triumphs. On the other hand, the protagonist of the fairy tale achieves a domestic, microcosmic triumph that appears to be a personal victory. Can we conjecture those myths glorify men’s accomplishments, while fairy tales focus on women? According to Otto Rank, mythic heroes are never female. Campbell limited his early analysis to male heroes, although many of his examples were female. He acknowledged childbirth as one form of heroism.

A Paradigmatic Fairy Tale: Little Red Riding Hood

Little Red Riding Hood is one of the fairy tales that potentially has various effects on children’s ego maturation and their fantasy world.

Published in 1697, Charles Perrault’s tale, Le petit Chaperon Rouge was the first literary version to appear in writing. The original folk tale depicts an unnamed peasant girl who meets a werewolf on her way to visit her grandmother.

The wolf asks the little girl whether she is taking the path of pins or needles. She indicates that she is on her way to becoming a seamstress by taking the path of needles. The werewolf quickly departs and arrives at the grandmother’s house, where he devours the old woman and places some of her flesh in a bowl and some of her blood in a bottle. After the peasant girl arrives, the werewolf invites her to eat some meat and drink some wine before getting into bed with him. Once in bed, she asks many questions until the werewolf comes close to eating her.

At this point she insists that she must go outside to relieve herself. The werewolf ties a rope around her leg so she doesn’t escape and sends her through a window. In the garden, the girl unties the rope and wraps it around a fruit tree. Then she escapes and leaves the
werewolf holding the rope. In some versions of this folk tale, the werewolf eats the girl. But the girl proves that she can fend for herself.

In Perrault’s version Little Red Riding Hood appears spoiled and naïve. She wears a red cap – in older versions the story is called Little Red Cap. The color red symbolizes violent emotions, including sexual impulses. The tale – in its many versions – expresses a warning: girls who invite strange men into their parlors deserve what they get.

Little Red Riding Hood offers a variety of archetypes: the contrast between the evil wolf (a male) and the innocent girl (a female). She is human and thereby represents the civilized world, while the beast is wild. She is young, her grandmother old. The forest represents the unknown, and their home represents safety, society, and family. The narrative also demonstrates the emerging sense of independence. Our identity and sense of self changes with time, and, as the fairy tale intimates, inversions are part of human nature.

Fairy tales runs through us like a current from one generation to the next. They communicate, often unconsciously but powerfully, psychological truths and struggles. Our intuitive understanding tells us what it means to be wolf, grandma, woodsman, and Little Red Riding Hood. Fairy tales, like Little Red Riding Hood, offer lessons in safety, vulnerability, and the need to exercise wise choices in the face of danger.

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Examining the Untamed Landscape of Adolescent Use of Dietary Supplements – Muscle Building and Weight Training

The regulatory context of dietary supplements for adolescents is essentially equivalent to the Wild West: many outlaws running about with a few bastions of safety protected by rare vigilant sheriffs who take their duty to the public safety seriously.

Because regulation of supplements in the United States has not kept pace with rapid industry growth over the past three decades or so, public health professionals usually find themselves behind the curve, compensating and reacting to problems long after they occur. In this vacuum of regulation, adolescent consumers of supplements encounter little to deter their experimentation with supplements while simultaneously being induced by advertising, peer pressure, and poor self-image (e.g., weight or strength). In the short term, our message needs to be: ALWAYS consult your doctor when taking supplements. We also need to inform children where supplements are present in the things they tend to consume, which is often in some of their favorite drinks.

While conscientious health care providers will follow directives from reputable sources, the landscape of this domain is so various and confusing that scouts on the outskirts of this territory need to continue to message to the public in order to inform them of the most serious or prevalent trends to watch out for. Another good outcome from this messaging is to encourage resources and appropriate legislation that will tame the unchecked proliferation of supplements that sneak into the diets of our children under cover of ignorance or in the “sheep’s clothing” of being derived from natural substances.

While Part 1 of this two-part series looked at supplements used by adolescents for weight loss and energy, Part 2 will focus on another pair of health goals of keen interest to teens, especially teen athletes: muscle building and weight training.

Creatine: A naturally produced substance in the body derived often from eating meats and fish, creatine can be attractive to teens involved in athletics because of its ability to enhance strength through increasing muscle mass as well as helping muscles to recover more quickly while exercising. While these upsides are attractive, studies of creatine and its impacts are few and possible downsides of consuming more than naturally occurring amounts are many – especially when taken with caffeine. They include things like weight gain, anxiety, headache, kidney problems, nausea and vomiting. And are adolescents using it? One study finds that an average of 20% of teens using the substance with 44% use among high school seniors. A recent article contends that creatine has not been shown to be particularly harmful for adolescents and that calls against its use can be exaggerated—which points to another side effect of the haphazard regulatory environment for supplements: an overwhelming amount of both reliable and unreliable information can exaggerate both the potential upsides and downsides of supplements and confuse both consumers and clinicians.

Dehydroepiandrosterons (DHEA): DHEA is a prohormone, which means it is a substance that can be converted into anabolic steroids. Adults use it (and it can be safe for them) as a precursor compound to make other hormones further down the metabolic chain. It helps to make testosterone and estrogen. DHEA can also be used by adolescents in muscle building formulas. This can potentially cause endocrine disruptions in developing teens, which means that these substances can either mimic or disrupt hormones naturally occurring in the body. Side effects include adverse impacts on puberty, metabolism, immunity, and reproduction. A recent study found that increased salivary DHEA levels were associated with...
more self-reported anxiety symptoms in adolescent girls. The findings “suggest relevance for DHEA in the development of anxiety in the pubertal period, as well as a robust relationship between DHEA and emerging symptoms of pathological worry during adolescence.”

While the ubiquitous nature of unregulated supplements may be frustrating to health care professionals, there is a tried-and-true approach that has been applied to people of all ages which may also be applicable to teens looking to improve their health. Underneath these trends on supplements and many of their worrisome symptoms that children should know about lies the need to communicate that the most important thing kids can do is have a healthy, balanced lifestyle, which is the most likely means of achieving the strength, health, resilience, and well-being that they rightfully strive for and deserve.

**References**


Dr. Nada Milosavljevic is a Psychiatrist in Newton, MA, with special training and skill in diagnosing and treating people with mental illness. As a Psychiatrist, Nada Milosavljevic, MD, JD, performs mental health assessment, helps patients manage long-term mental health conditions, offers medical treatment and therapy for a wide variety of psychological disorders, provides patient and parent education, and offers referrals to other medical specialists as needed. Psychiatry is a medical specialty centered on diagnosing and treating patients suffering from a wide variety of mental illnesses and cognitive disorders. Significant diseases and conditions treated by Psychiatrists include anxiety, depression, suicidal thoughts, obsessive-compulsive disorder (OCD), delusional thought processes, self-harm disorders, eating disorders, specific phobias, drug, alcohol, and gambling addiction, and mood disorders. Medical tests, procedures and therapies provided by Psychiatrists include mental health evaluation and diagnosis, psychotherapy, cognitive behavior therapy (CBT), electroconvulsive therapy, medication prescription, exposure therapy, grief counseling, marriage counseling, and referral to other specialists as needed.

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There’s that word again. It is ingrained in our vernacular that it is easy to lose sight that we are literally living through unprecedented times.” During the COVID-19 pandemic, there has been a mental health reckoning in this country’s family units, and their families are integral interventions we all require. Support in time of need, and encouragement to continue moving forward, are integral interventions we all require to optimize our mental and emotional health, no more so than now. In my short time as a CIC member, the thoughtfulness and comprehensiveness of producing resources to support families in need has been the gratifying experience I envisioned. The result has been a mental health reckoning in this country that AACAP has been dedicating itself to and preparing to address. Perhaps one of the great positive impacts that emerges from this pandemic is the national recognition and willingness to prioritize mental health care beyond our academic organizations and societies. Could you imagine that? Here’s to a new type of unprecedented times.

Stephen Mateka, DO, completed his medical school and general psychiatry residency training at Rowan University-School of Osteopathic Medicine in New Jersey. He completed Child and Adolescent Psychiatry fellowship training at the University of Michigan. He currently serves as medical director of child and adolescent inpatient services at Inspira Hospital in Bridgeton, NJ. He enjoys spending time with his wife, family, and friends.
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LEADERS IN PSYCHIATRIC MEDICAL LIABILITY INSURANCE
Combining Cognitive Therapy With Behavioral Economics to Better Treat Student Athletes

Athletes train for years to reach their peak fitness and defeat their opponents. What most do not realize is that often, athletes’ most challenging opponent to overcome is their own minds. Recently, professionals like Naomi Osaka and Simone Biles have publicized what is needed to mentally prepare to perform on the athletic stage.

From the perspective of a high school athlete, the life balance between academics and athletics can be pretty tough. My first time picking up a tennis racket was during my daycare days where we were encouraged to try different sports for fun and exercise. Over the next 12 years, tennis grew to be a huge part of my life. My family became avid tennis watchers. I enrolled in summer camps and lessons throughout the year and coached younger children on tennis fundamentals. My freshman year, I made the varsity team as the only underclassman singles player. I felt an intense amount of pressure to excel to prevent disappointing my coaches, teammates, or family. Halfway through the season, I began to buckle under the paralyzing effects of AP exams, practices, matches, missed schoolwork from all-day tournaments, and other extracurricular commitments. Overwhelmed, burned out, and exhausted, my nerves were frazzled. I couldn’t focus as my brain filled with self-doubt. Why am I not playing as well as I usually do? It felt like years of practice were gone in an instant.

Searching for some understanding of what was happening and how I could overcome my performance anxiety, I started to learn more about behavioral economics and sports psychology. I found three concepts in behavioral economics that were evident in sports.

- **Loss Aversion**: Tendency to prefer avoiding a loss to receiving a commensurate gain; losses estimate to be felt twice as much as gains. In sports, when an athlete is falling behind in score they begin to care more so they increase their effort by taking aggressive, riskier shots, while simultaneously increasing concentration and thus accuracy to catch up on the loss.

- **Representativeness Heuristic**: Tendency to see false patterns, like streaks, that cause them to incorrectly estimate the probability of an event. When athletes, fans, and coaches believe in the ‘hot hand’ fallacy, they assume that a player making a series of shots in a row is based on their skill and overvalue the player when it’s actually chance.

- **Present Bias**: Tendency to prefer immediately acquiring a smaller present reward than waiting for a larger future reward, explaining procrastination. Sometimes it can be tempting for athletes to lose hope and blow off fitness regimens, by eating unhealthfully or skipping practice, which is why athletes must remain motivated and form good habits.

I had a chance to interview Dr. Stephanie Hartselle, who is a Child and Adolescent Psychiatrist, and learned about how evidence-based therapies such as Cognitive Behavioral Therapy (CBT) can be taught to patients to help them identify thought errors, emotions, and behaviors that interfere with mood and performance. She knew less about the behavioral economic theories and together, we discussed how both can be applied and combined for psycho-education to further student athletes’ understanding of how thought errors and unconscious biases can be identified and corrected. In particular, I was struck by what a large contribution fear of judgment can make; whether it be from coaches, teammates, or spectators. The fear of humiliation, disappointing others, and wasting hard work combined with the limited rational decision-making in the moment while receiving imperfect information in high-intensity, stress-inducing games can cause athletes to not think clearly and ‘choke’. With such high expectations, when an athlete’s performance falls short of perfection, their mental filter can pick out and catastrophize only the negative moments and they perceive themselves as a failure. This all-or-nothing thinking can be correlated to the Loss Aversion Bias; even if they were to win, they are never satisfied with their performance, only seeing what they could have done better. Similarly, the Representativeness Heuristic can cause athletes to over-generalize negative events, like injuries or slip-ups, and jump to conclusions or engage in fortune-telling expectations of failure. The Present Bias is another form of all-or-nothing thinking that can lead to self-sabotaging behavior. Athletes tend to tie their self-worth to their wins, so when they are not performing at their usual level, they lose enjoyment for their sport and thus motivation. Such emotional distress could cause them to cope in unhealthy ways or avoid their responsibilities. These types of emotional reasoning leave athletes in a constant self-deprecating mindset where their emotions overpower the facts, interfering with their ability to compete. There
are a variety of distress management techniques to combat cognitive errors. One way to reduce negative thought patterns is through mindset reframing like cognitive reframing, mindfulness, radical acceptance, visualization, and re-evaluating values. By incorporating both CBT concepts with behavioral economic theories, psychiatrists can more specifically help athletes increase self-confidence and find a greater purpose beyond winning. Physically, coping mechanisms like purposeful relaxation, creating a routine for each point, and movement in between points can help manage adrenaline and nerves during games. Lastly, having the support of strong relationships and a self-care plan can help athletes prioritize themselves over achievement and realize sports are only a facet of their life.

Regardless of the level or sport, performance anxiety can take a heavy toll on elite, collegiate, and high school athletes. For the longest time, I had no idea why this was happening to me and often blamed myself. Learning about behavioral biases and cognitive therapies provided me clarity on the sources of my anxiety and effective ways to cope, and in my last season, I was able to win tournaments and take on the role of team captain. Understanding these concepts will build a foundation for well-being that empowers athletes to perform at their best and happiest.

From Dr. Hartselle: Ms. Rekhani had interviewed me for a high school project and in speaking with her, I learned much about the behavioral economics pertaining to sports. Many of us feel that the student athlete who has lost their confidence can be very challenging to treat, given the problems of identity, achievement and the cycle of anxiety that can escalate and become debilitating. She introduced me to these concepts and important resources that helped expand my ability to provide psychoeducation to my patients, their families and even their coaches spanning more than just the thought errors with which we work. As AACAP members, we are constantly working to expand our knowledge base and toolkit and I am grateful for the exchange of ideas and concepts brought by Palak. We can strongly recommend the books and resources below for those interested in further reading.

References

Dr. Hartselle is a Clinical Associate Professor in Psychiatry at Brown University. She is a member of AACAP’s Consumer Issues Committee. She can be reached at stephanie_hartselle@brown.edu.

Palak Rekhani is a high school senior and varsity tennis player in Grand Rapids, Michigan. She plans to study Behavioral Economics in college. She can be reached at palakrekhani9@gmail.com.

NEW SCREENSIDE CHATS

In the last episode of Screenside Chats, roles are reversed where incoming AACAP President Dr. Warren Ng interviews current AACAP President Dr. Gabrielle Carlson about the outcomes of her presidential initiative, about children and outbursts, treatment and interventions, and much more. The national emergency in children’s mental health is also discussed, so tune in as we come to a close on these informative Screenside Chats.

www.aacap.org
The Importance of Post-Pandemic Media Planning with Adolescent Patients

Meredith Gansner, MD

The COVID-19 pandemic has forced youth worldwide to make significant changes in their lives. Children and adolescents have adjusted to wearing masks, remote schooling, and mass cancellation of eagerly-awaited activities like concerts and parties. In response, many articles have been published citing expert opinions about the potential developmental impacts of these changes. However, perhaps because youth in the United States were already spending an estimated nine hours per day on screens prior to the pandemic, there has been less published about changes in youth digital media use throughout 2020 and how youth might struggle when scaling back their digital media use to return to in-person activities.

Beyond the switch to remote schooling, there are multiple reasons why youth screen time likely increased over the course of pandemic. While 41% of U.S. adolescents already used social media to connect with others over shared hobbies prior to 2020, the pandemic placed many extra-curricular activities on hiatus, prompting digital media use to become the primary mechanism for nurturing existing peer relationships and forging new ones. Subsequently, the Internet also became the default location for adolescents to explore their identities and connect with others over shared viewpoints, without the risks that COVID-19 brought to in-person gatherings. For example, social media sites offered youth an increasing awareness of systemic injustices like widespread racism, allowing them to unite with others in activism and identify with international movements. For vulnerable youth, however, particularly those that have existing psychiatric diagnoses, excessive Internet use may also have played a more problematic role as a maladaptive coping skill.

Early research suggests that overall, youth mental health worsened during the pandemic. The CDC reports increases in adolescent suicide attempts, particularly for girls, and a recent meta-analysis concluded that both anxiety and depressive symptoms worsened for youth in the course of the pandemic. Unfortunately, this escalation in mental health symptoms coincided with both an inability to access normal coping skills (e.g., hanging out with friends or participating in a team sport) and a decrease in the availability of in-person mental health supports whether through school, in-home services, or an office setting. Youth with active psychiatric symptoms already appear to be at higher risk of developing co-morbid PIU, defined as uncontrollable use of the Internet. For youth in mental health treatment, PIU may develop as a means to distract from affective symptoms; anxiety symptoms, for example, appear to improve in the short-term following episodes of worsening PIU symptoms. Through its emphasis on social isolation, the stress of the COVID-19 pandemic likely only exacerbated the co-morbidity between PIU and psychiatric illness in youth.

Even in the overall adolescent population, early studies have demonstrated a rise in youth PIU internationally following school closures as a result of the pandemic. Chinese schoolchildren were found to have higher rates of problematic digital behaviors based on scales assessing smartphone and social media addiction, as well as Internet Gaming Disorder. A multi-national survey study also reflected higher levels of compulsive social media use and gaming addiction in adolescents during COVID-19 lockdowns. Unpublished data collected by this author from a longitudinal ecological momentary assessment study show that rates of PIU in youth in mental health treatment increased during the pandemic, particularly for those with more active psychiatric symptoms. While both the COVID-19 pandemic, and subsequent research on the pandemic’s impact on youth mental health, are still ongoing such that definitive conclusions cannot yet be drawn, these preliminary results are concerning as they have significant clinical implications. For many of our patients, reversing a pandemic-learned habit, like reliance upon a social media site to manage depressive symptoms, will not be as simple as requesting that children separate from devices so that they can return to their normal “in-person” activities. A well-meaning attempt by a parent to limit access may have significant consequences like aggression, self-harm, or psychiatric hospitalization. Like any maladaptive coping skill, youth and their families will require specific psychoeducation and guidance from healthcare providers on how to address problematic digital media use.

The first step in management is identification of problematic use. Even prior to the pandemic, it was recommended that pediatric mental health clinicians screen patients regularly for signs of dependency upon digital media. However, warning signs that may have been readily evident to a clinician during in-office visits (e.g., a teenager who is unable to separate from an iPhone during an appointment, parents who report episodic dysregulation each time they attempt to intervene upon a school-age child’s gaming) may no longer be as apparent in the pandemic. Televisits make it challenging for clinicians to notice for themselves whether a patient has difficulty separating from a device given that patients are required to use digital technology for the visit. Parents, too, may presently be less aware of the degree to which a child has become dependent upon digital media to regulate mood and affect. If parents have been working from home while simultaneously supervising remote learning, divided attentions may limit their appreciation of the amount of time a
child is spending on screens throughout the day. Similarly, because the pandemic led to many adolescents having decreased engagements outside the home (e.g., cancelled extra-curriculars, limited social gatherings), a parent may not have encountered a child’s active resistance to non-digital activities that might have alerted them to a potential issue. Therefore, to identify problematic use during the COVID-19 pandemic, clinicians should be intentional in asking both parents and patients to reflect upon child’s media use. A brief screening tool that asks about overall Internet use such as the 3-item Problematic and Risky Internet Use Screening Scale (PRIUSS) or Problematic Internet Use Questionnaire Short-Form (PIUQ-SF-6) may be helpful as a starting point for identifying concerning behavior. However, because research has found that individuals often have poor insight into their pathological Internet use, clinicians will likely also have to rely on neutral questioning surrounding digital habits in combination with collateral information gathered from school and guardians.

For youth with symptoms that suggest problematic use, guided media planning should be incorporated as part of their treatment, including more intensive work with the family unit. Because the population of youth that we treat appears more susceptible to dependency on digital devices per day, if new (or temporarily suspended) rules regarding screens are being implemented or re-implemented, these rules also need to be reviewed with the child, including expected consequences for their not being followed. Incorporating the child’s input at each of step of the plan’s creation may also help by offering an element of controlled choice surrounding use, as well as an opportunity for the youth to share aspects of digital media use that are helpful when distressed. This media plan should not represent a static, immutable document, but rather guidelines that require frequent re-visitation and adjustment by the family unit as the youth improves in their symptoms.

Ideally, many of the systemic changes imposed upon youth by the COVID-19 pandemic will be transient. However, the pandemic has provided mental health clinicians valuable information about youth response to stress in the digital age. Even in traumatic circumstances where access to in-person supports may not be limited, our patients are likely to overuse digital media as a method of self-regulation. Thus, not only as children and adolescents adjust to the return to classrooms and other in-person activities this academic year, routine screening for problematic media use and family media planning are important skills for all mental health clinicians to develop and implement into practice.

References

Meredith Gansner is an instructor of psychiatry at Harvard Medical School and attending child psychiatrist at Cambridge Health Alliance. Her research includes problematic digital media use of adolescents with significant psychiatric illness, and the use of digital phenotyping in assessing and managing Problematic Internet Use. For her research, she has been awarded Henry G. Altman Award for Excellence in Medical Education, a Dupont Warren Fellowship Grant, and the Eleanor and Miles Shore Faculty Development Award through Harvard Medical School. She is also an active member of the American Academy of Child and Adolescent Psychiatry media committee and has written articles about problematic digital media use for The Psychiatric Times, Cognoscenti, The Boston Globe and Slate Magazine.
Poetry Therapy: Interview with John Fox, PPM

Chuck Joy

Although no poetry therapist myself, as a child psychiatrist and a poet I was able to respond to Mercyhurst University’s interest in expanding its offerings in expressive therapies by teaching an undergraduate course on Poetry Therapy some years back. Aware as I was of John Fox and his accomplishments in the field, I chose his book Poetic Medicine (Jeremy Tarcher/ Putnam, NY, 1997) as the textbook for that course. Since then, John and I collaborated on a couple projects during my terms as Erie County Pennsylvania’s sixth Poet Laureate, both of which involved experience and training in Poetry Therapy. Subsequently I have furthered my interest in Poetry Therapy by joining the board of directors of the Institute for Poetic Medicine (IPM) and now I’m eager to share information about Poetry Therapy with you, my child psychiatry colleagues, in conjunction with our AACAP Art Committee, whose brief includes representing expressive therapies within our Academy. The method of sharing I have chosen is to interview the man himself, John Fox.

So John, can you tell us a little about yourself?

Since the age of thirteen, I have followed a path that poetry and poem-making matter. Rather than a primary focus on my own writing, I chose to emphasize service to others through personal healing, transformational (spiritual) potential, and community-oriented meaning and purpose. I grew up in Cleveland, Ohio, born with neurofibromatosis, which involved multiple surgeries to my lower right leg culminating in amputation below the knee at age 18. Around that time I felt the continued call to writing, and entered the creative writing program at Boston University, 1973, where I encountered significant teachers and mentors such as George Starbuck, Ram Dass, Elizabeth Kubler-Ross, Stephen Levine, Paramhansa Yogananda, and Neem Karoli Baba, to whom I remain forever grateful. Continuing on the life-path of writing-to-heal in 1985 I trained two and a half years with Joy Shieman, a pioneer in the field of Poetry Therapy at El Camino Hospital Mental Health Unit. Later, I had the opportunity to write books on the subject published by Tarcher/Putnam, such as the book you used as a text, Chuck, Poetic Medicine.

Poetry Therapy, what does it mean to you?

Poetry Therapy is a way to empower people to connect with their own inner resources, listen to their own conscience, and begin to give voice to their actual authentic lives, bringing beauty to a more central place. Using poetry and poem-making in a therapeutic manner provides for a durable, personal container that makes a place, a space for self-reflection, for expression of raw and often unspeakable feelings, for expressing one’s relationship to the world both natural and human, expressing relationships to life and those within it. The practice of Poetry Therapy occurs in a non-judgmental, accepting environment within a group or a therapist-client context that makes operative the word “therapy” whose etymological roots include the word “attend”. When we listen with openness to someone’s poem, or our own, we learn what it truly means to attend.

Please tell me more.

I look at Poetry Therapy as intimately linked to the most essential human experience – breathing. When we breathe there is the in-breath, inhalation. That in-breath is very much like the capacity of words and experience to evoke. All kinds of things spring up within a person when a poem, a therapeutic poem, is thoughtfully created and put out on the air by a human voice. With the out-breath, exhalation, the naturally balancing follow-on to the evocative current, we express. In a poetry therapy session a person may write from a suggested-prompt line and discover much that was previously amorphous in the back of the mind as material comes forward to rest solid on the page.

Can you provide some examples of your experience with Poetry Therapy?

I’m really pleased with the many opportunities I have had to make a healing difference in the lives of patients and medical professionals, including with your Poet Laureate projects, especially given my personal experiences with hospitalization and surgery in childhood and teenage years, the years most of concern to child psychiatrists. I have presented at many medical schools and hospitals domestically and internationally. My work is featured in the PBS documentary Healing Words: Poetry and Medicine. I contributed “Healing the Within” to The Healing Environment published by the Royal College of Physicians in the United Kingdom (2003). Poetic Medicine is replete with a wide-range of direct experiences/stories by people using poetry to recover from trauma, to discover one’s creativity and truth.

What is the Institute for Poetic Medicine?

The Institute for Poetic Medicine (IPM) is a 501(c)3 non-profit organization dedicated to awakening the healing creative voice inside each person, founded by me in 2005, www.poeticmedicine.org. Through workshops, professional development, publications, training, and community building in the practice of Poetry Therapy, IPM supports the growing awareness and use of Poetry Therapy as a healing tool, encompassing the use of language (spoken and written) as a therapeutic, artistic, and...
transformational medium. IPM is especially dedicated to people considered by the general culture to live at the “margins.”

Thanks, John. I find my association with IPM an effective way to enlarge my support of poetry therapy in general as well as a personal benefit with poetry therapy messages through email and Facebook, and announcements about workshops near far and virtual, most recently addressing finding voice regarding climate change. Although still no poetry therapist myself, I practice poetry therapy for personal wellness and growth and encourage others to do the same, such as with this article. If members have questions, they know where to find me: crjoy1@gmail.com.

John Fox, Certified Poetry Therapist, is a poet and author of Finding What You Didn’t Lose: Expressing Your Truth and Creativity through Poem-Making and Poetic Medicine: The Healing Art of Poem-Making. He teaches regularly at the collegiate and post graduate level as an adjunct faculty member of the California Institute of Integral Studies, Sofia University (formerly The Institute of Transpersonal Psychology,) and Holy Names University, Oakland. He taught for twenty years as adjunct at John F. Kennedy University – first through the Graduate School of Professional Psychology and then since 1997 in the Arts & Consciousness Department.

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

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

If you would like your photo(s) considered, please send a high-resolution version directly via email to communications@aacap.org. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
Visit www.aacap.org/AnnualMeeting-2022 for the latest information!

Save the Dates
Call for Papers Deadline: Feb 15, 2022
New Research Poster Deadline: June 7, 2022
Preliminary Program Available: June 15, 2022
Call for Papers

AACAP’s 69th Annual Meeting takes place October 17-22, 2022, at the Metro Toronto Convention Centre. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

Abstract proposals must be received at AACAP by February 15, 2022, or by June 7, 2022 for (late) New Research Posters. The online Call for Papers submission form for the February deadline will be available at www.aacap.org in December 2021, and all submissions must be made online.

Questions? Contact AACAP Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

AACAP’s Newest
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AACAP is proud to announce the release of Lifelong Learning Module 18: Relevant Clinical Updates for Child and Adolescent Psychiatrists. With the purchase of this module you will have the opportunity to earn 38 AMA PRA Category 1 Credits™ (8 of which will count towards the ABPN’s self-assessment requirement).

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Any questions? Please contact Quentin Bernhard III, CME and Recertification Manager, at 202.587.9675 or at cme@aacap.org.

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Order Module 18 and pay your 2022 membership dues by January 31, 2022 and

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Selecting Locations for AACAP’s Annual Meeting

We have just completed another, highly successful virtual AACAP Annual Meeting. For me, it was an excellent experience. I am still trying to integrate all that I learned from the sessions I attended. Although the virtual meeting experience was good, I am guessing that many of us agree that we have missed a lot by not having the opportunity to meet in person over the past two years. There is a gaping hole in the virtual AACAP Annual Meeting experience when we consider both the usual scheduled events and the many, incidental interactions with trainees, colleagues, and friends. AACAP’s Annual Meeting brings us together as a supportive community for education, networking, and fun. As I end my four years as the AACAP Treasurer and consider my 35+ years of experience managing AACAP’s Annual Meeting, I thought it might be helpful if I share some insights with you about how we select Annual Meeting locations. This is a topic of conversations that I have with many of you, sometimes positive and, at other times the subject of significant criticism. Please know that we work hard to make good choices for our members and AACAP.

By most standards, AACAP’s Annual Meeting has grown substantially in recent years to be a medium-to-large meeting by industry standards. Due to our large size, AACAP’s Annual Meetings usually require that we must consider some of the largest hotels in the country. As the size of our meeting grows, and scope and complexity of our meeting increases, the hotel options are dwindling because there are remarkably few hotels that can accommodate a meeting of our size. Additionally, we are competing with other similar groups for October dates (the busiest meeting month of the year). In order to manage this competition, we generally sign contracts for the Meeting at least five to six years in advance. While we do a good job of anticipating the needs for the Annual Meeting, it is still very difficult for us to account for the many changes in our meeting over the course of intervening years, even without considering the massive effects the pandemic has left on the meetings and travel industries and the changing health and legal policies across the US.

Each time AACAP begins the process of selecting a future Annual Meeting location, the Executive Committee, Executive Director, and Director of Meetings discuss the options for that particular year and then conduct a complex, exhaustive, competitive bidding process. We consider many recommendations from a variety of sources, most importantly from AACAP members who have favorite cities they want us to consider. With these suggestions in mind, we consider many factors as we request and evaluate bids. These include: available dates, sleeping room rates, history of AACAP meetings in the city, timing and location of other organization’s meetings that are already booked, size and scope of the airport(s), size and flow of the meeting space, other costs in the city for meeting services (ie food and beverage, audio visual equipment, internet, taxes, and labor), quality of the venue, safety around the venue, accessibility to local attractions and restaurants, financial concessions from the venue, and much more. Trust me when I say that no bid for the Annual Meeting is perfect, and there are always painful tradeoffs when making a final decision to select a city.

Once the bids are collected, the Executive Director and the Director of Meetings prepare a detailed comparison of our options, including information about all of the factors above. This is reviewed with the Treasurer to make sure that the costs and potential contracts are consistent with AACAP finances, and then reviewed by the Executive Committee which works with staff to arrive at a small list of “finalists.” Council is also apprised of the status of future meeting contracts at each meeting. Once the city is selected, AACAP’s attorney and the Treasurer further review the contracts before they are signed by our Executive Director.

AACAP prides itself in having a thorough and thoughtful process for making this business decision and ensuring that the needs of our members and the organization are top of mind when selecting an Annual Meeting city. From time to time, members question the location for the Annual Meeting based on political and other social issues in the community where we are meeting. These may include specific, objectionable, local laws and policies that may be problematic for children, adolescents, families, our members, and other groups important to AACAP. While AACAP leadership is sensitive to these many concerns, some of these may not be evident at the time of site selection (6 years in advance) while others may be the focus of specific AACAP advocacy efforts thus making our presence in the community an important strategic decision.

As we are now all-too-aware, situations can change quickly, whether it be a pandemic, political events, a terrorist attack (9/11), or some other unfortunate event. Each of these is important and requires careful consideration by AACAP. Some reflexively suggest that we should cancel or move the AACAP Annual Meeting on relatively short notice. Please know that cancelling an Annual Meeting contract, particularly in the year of the meeting is exceedingly difficult; it is a contract,
after all, with specific obligations for each party. For starters, cancellation has significant consequences for our organization. These include cancellation fees ($1,000,000 or more) and logistical challenges. The financial penalties are obvious but moving the location for an Annual Meeting is nearly impossible within a year or two of the event as venues of the size and scope of AACAP’s Annual Meeting are booked far in advance. While AACAP may “want” to move the Annual Meeting, rather than cancelling or moving the meeting, we seek other solutions, including detailed negotiations with our contractors as well as with members in order to find the best possible balanced solution. If we can manage a move or cancellation (as we did in 2020 and 2021), we will do so. But, these are very unusual circumstances that are not likely to recur. If we must stay with our original site for the Annual Meeting, we must work with AACAP members, especially those in the city and state to develop an advocacy plan to address AACAP’s concern publicly and effectively. To the extent possible, we will use the influence of ours and other national organizations, along with community leaders, to foster change. We share the passion of our members and fully appreciate the role of the Annual Meeting in the expression of our interests, concerns, and policies. Please be assured that, to the extent possible, AACAP will do all it can to be proactive while also recognizing that contracts and other obligations do not give all the freedom and flexibility that you and we may like.

AACAP leadership listens very carefully to AACAP members. AACAP membership is a very large (now, nearly 10,000!) and diverse group with many perspectives. One of the wonderful characteristics of AACAP is that we try to make a place in our “professional home” for everyone. Most of the time, we succeed. Occasionally, we must make practical compromises to protect the organization so we can make the “good trouble” or “good fight” in conditions that will lead to success.

I hope that I have addressed some of the issues with respect to the Annual Meeting site selection and management. If you have any additional questions or suggestions, please reach out to our team at meetings@aacap.org. I can assure you that each and every idea will receive careful consideration from your staff and leadership. In the meantime, I look forward to meeting you in-person when AACAP meets in Toronto, October 17-22, 2022!
Session Recordings and Notebooks are available for purchase from past and current AACAP meetings!

✦ Pediatric Psychopharmacology Update Institute
✦ Douglas B. Hansen, MD, Annual Update Course
✦ Annual Meeting Institutes and other sessions

For a complete list, visit the Past Meeting Resources and Publications page at www.aacap.org/AACAP/CME_and_Meetings/Past_Meeting_Resources_and_Publications.aspx.

Session recordings include PowerPoint slides. To order, please visit: aacap.sclivelearningcenter.com.

You can also contact:
Multiview Canada
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➢ On Demand: 2021 Douglas B. Hansen, MD 45th Annual Update Course

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Dear Oprah and Prince Harry,

I want to thank you for your documentary, “The Me You Can’t See.” It’s a show that sheds light on the reality of mental illness, normalizes, and destigmatizes it. In addition, your show highlights how pervasive mental illness is, especially during the COVID-19 Pandemic, which has revealed to humankind how vulnerable we are to losing our mental health. I genuinely hope that after reading this letter, you will partner with local community centers and mental health organizations in the Mental Wellness Movement. A movement of Mental Health De-stigmatization, developing innovative approaches to cultivating Preventative Mental Health Strategies (PMHS) within our communities and rebuilding our National Mental Healthcare System (NMHS), which is severely strained during this COVID-19 Pandemic.

When I watched the first episode of, “The Me You Cannot See,” you mentioned that mental health is just as important as physical health, a perspective I hope most people would agree upon after experiencing this Pandemic. However, I would like us to take this one step further and envision my viewpoint: mental health is superior to physical health. Our brains and minds are at the very core of who we are as human beings; it’s the computer system that governs our emotions, thoughts, and behaviors. Our mental health is vital in enabling us to meet our developmental milestones and accomplish our full potential. When our mental health is compromised, several aspects of our lives get impacted: our ability to learn, be creative, manage finances, maintain family roles & relationships; and even our spiritual life gets negatively affected. A significant lesson we as a society ought to ascertain as pearls from this Pandemic is that our mental health must be made a top priority, not just at the individual level but also at the national level. Without this, our society as a whole could crumble when faced with future challenges similar to the COVID-19 Pandemic.

A society that does not value mental health is deteriorating. Many brilliant minds who could help shape our country would turn to poor coping mechanisms such as addiction to illicit drugs, sex, social media, and self-harm. Others might even suffer from diagnoses like anxiety, depression, or PTSD, which are debilitating to both the individual and every environment they interact with. In some circumstances, untreated mental illness leads to death from suicide, drug overdose, or other medical complications like Sepsis from IV drug use, Myocardial infarctions, or Acute Alcoholic Hepatitis. Most people know a family member, colleague, or celebrity who passed away from one of the above conditions. Prior to the Pandemic, according to the NIMH, 1/5 adults (51.5 million people) had a mental illness in 2019. According to the NCS, a study that same year, 49.5% of adolescents in the US aged 13-18 had a mental health illness. According to the CDC National Vital Statistics, suicide is the 2nd leading cause of death of people ages 10-34 years old. However, our society continues to turn a blind eye to making Mental Health a top priority.

The COVID-19 Pandemic has brought to light how important mental health is to everyone. The suffering endured by us as individuals, our children, families, and neighbors are palpable. The unemployment rates increased exponentially; we saw beautiful neighborhood shops and restaurants close down due to financial constraints. Places of worship and community gatherings closed down to prevent the spread of infection. We had moments to pause and visualize the inhumanity of racism within our Nation and the opportunity to join the social justice movement towards ending systemic and institutional racism or continue to be in denial and turn a blind eye to the greatest tragedy in our Nation’s history.

We have seen elderly Asian Americans get attacked because people are looking for someone to blame for the COVID-19 Pandemic. We watched the Capitol insurrection as angry civilians terrorized and vandalized Congress because they denied the results of a democratic election. We have seen several people lose their homes because they cannot afford to pay their mortgages or rent. We have seen several children who have to repeat a grade because they missed a year of their education or could not keep up with the requirements to make it to the next academic grade. We have seen several families lose their siblings, parents, aunts, uncles, or grandparents to COVID-19 disease. We continue to see the violent murder of African Americans by the Police, whose primary job is to maintain law and order, not create disorder. We continue to see mass shootings in our schools and communities. This magnitude of anguish, rancor, and hostility towards our fellow humankind instills fear, disgust, and hopelessness in honest citizens of these United States of America, with a devastating impact on our collective mental health.

How do we remain resilient amid all these adversities? We have to fall back to the eight wellness dimensions: emotional, physical, social, intellectual, occupational, environmental, spiritual, and financial. Several members of our society had at least one of these mental health dimensions affected by the COVID-19 Pandemic.

Petronella Taku Mbu, MD
A diagnosis of anxiety, depression, PTSD, and substance use disorder has reached numbers we never envisioned. Healthcare worker burnout has weighed heavily on our ability to care for the sick as we are not functioning at optimal capacity. Several children and adults turn to drug use which is a poor coping mechanism with devastating side effects. Vigilant adults and teenagers who recognized their declining mental health have reached out to their primary care physicians and even psychiatric ED’s seeking treatment. Only to learn about insufficient services within our mental healthcare field.

Children who need inpatient psychiatric beds are boarded for days while waiting for inpatient beds. In March 2021 at Nationwide Children’s Hospital, we had 183 boarders on our pediatric service alone, not including our extended observation service, which is also used to board patients with complex behavioral presentations. During some days in May, we had >40 patients boarding on a single day. Children who need community-based services such as intensive home therapy are told they need to do it online, which is ineffective when kids are dysregulated or hyperactive. Children with substance abuse diagnoses are told we have very few substance abuse treatment programs in the community, and treatment is available by zoom. Children referred to outpatient psychiatric treatment are told to wait 3-9 months before their first psychiatric intake appointment. Children who need partial hospitalization or intensive outpatient services have to wait 1-3 months before getting into their first appointments. We refer patients back to their primary care for treatment, but their doctors have little or no medical training on treating mental health disorders.

Most people who reflect on the impact of the COVID-19 Pandemic on their lives would deduce that their mental health has to be a priority. However, the question leaders of the medical field, precisely the mental health field, have to pose is: can our current Mental Care System meet the patient demand? Prior to the Pandemic in 2017, according to the AMA, we had 8300 practicing child and adolescent psychiatrists. According to the AACAP work task force published in 2018, 1/5 of children have a Mental Health disorder. Only 20% of these children receive care from a specialized mental healthcare provider. 50% of lifetime mental illness begins by age 14. The ratio of Child Psychiatrists to 100,000 children ranges from 1-60/100,000 with high to severe shortages in all 50 States.

One can only begin to imagine the volume of patients who need mental health care during this Pandemic and have no access. It’s a critical time for us to rethink the current Mental Health infrastructure. There has to be a radical change in our National Mental Healthcare System to meet the demand of patients this fall and in future crisis and pandemics. I genuinely hope that after reading this letter, you will become a part of the Mental Wellness Movement. A movement to destigmatize Mental illness, instill resiliency through Community Preventative Mental Health Strategies, and most importantly, bring about the radical change in the architecture of the Mental Healthcare System within the medical field.

Sincerely,

Petronella Taku Mbu, MD
AACAP ECP Committee Member
AACAP ECP Representative to the Assembly
Mental Health Advocacy and Contagion: A Double Edged Sword?

Children and adolescents have suffered terribly during the pandemic. Caregiver loss, virtual school, disruption of daily structure, and overreliance on screen time all contributed to a deterioration of mental health. A study in Journal of the American Academy of Pediatrics found that from April 1, 2020 through June 30, 2021, over 140,000 children in the US experienced the death of a parent or grandparent caregiver. These losses disproportionately affected children of racial and ethnic minorities. The number of children’s mental-health related ED visits has been increasing steadily since April 2020. The proportion of children’s ED visits related to mental health increased 24% for children aged 5-11 and 31% for children aged 12-17. Among adolescents, mean weekly number of ED visits for suspected suicide attempts were 22% higher during summer 2020 and 39% higher during winter 2021 than reported during corresponding periods in 2019, largely driven by an increase in adolescent female suicide attempts.

In direct response, on October 19th, 2021 the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics (AAP), and the Children’s Hospital Association (CHA) declared a national state of emergency in children’s mental health. The declaration called for federal funding for better recognition and treatment of pediatric mental health conditions, a loosening of regulatory barriers to care, improvement of school-based care, and expansion of inpatient bed capacity, among other solutions.

As a child and adolescent psychiatry fellow, I first became aware of the national emergency in child and adolescent mental health via a colleague’s story on Instagram. Undoubtedly, many teens learned of the declaration on their social media accounts as well. I support the declaration, but I did pause to wonder how seeing the declaration affected teens themselves. Youth who are suffering from depression and anxiety may have felt validation upon realizing how many of their peers have had similar struggles. Others may have been inspired to seek help.

However, there may be additional unintended effects of the declaration. Some teens may interpret the declaration as an expectation that they are likely to suffer from depression and anxiety with which they will be unable to cope. Media-related mental health contagion has been recognized as early as 1774, when the book “The Sorrows of Young Werther” achieved popularity. The book portrays Werther’s suicide as heroic and identification with the character led many young readers to attempt suicide themselves. The book was banned in many countries after this suicide contagion effect was recognized. A contemporary example is found in the Netflix program “13 Reasons Why,” which dramatized its teen protagonist’s suicide. News-reporting about suicide can also cause contagion effects, which is why several public health organizations have published guidelines for responsible reporting to mitigate the effect. Other mental health contagions have been described with the widespread dissemination of videos of functional tics and self-diagnoses on social media platforms leading to similar symptoms in previously asymptomatic teens. One theory explaining mental health related contagion effects is social learning theory – which posits that behaviors observed in peers (and amplified by media) are perceived as normal and desirable, leading observers to emulate them.

Additionally, social referencing refers to the process by which infants utilize the affect observed in adults to regulate their attitudes and behaviors toward situations in their environment. Declarations made by authority figures may produce a type of social referencing in adolescents. Today’s adolescents may reference this expert declaration of a state of emergency and come to believe that their world is dangerous or morose.

The American Foundation for Suicide Prevention’s (AFSP) guidelines for suicide reporting states: “Do not refer to suicide as a “growing problem”, “epidemic”, or “skyrocketing” as this has shown to cause contagion.” The declaration of emergency in mental health is not specifically a declaration of emergency in suicide, but such language may conceivably result in a similar contagion effect on youth. Adolescents may interpret this state of emergency as a prediction that they are likely to develop mental health problems for which insufficient help is available. Such a declaration might in part become a self-fulfilling prophecy, in direct opposition to its intended effect.

One of the most important responsibilities of child and adolescent psychiatrists is to advocate for the mental health of youth through educating the public and policymakers. The AACAP gives our profession the ability to collectively to support vital initiatives in youth mental health. However, we must continually weigh the potential effects of public declarations on youth themselves, especially as today’s internet-connected teens are more likely to be aware of them than ever before. Is it possible that other
measures could have been taken to persuade policymakers while minimizing risk of contagion and hopelessness among youth themselves? This question becomes increasingly important as we continue advocating for our patents in this new digital era, mindful to first doing no harm.

References

Jane Harness is a second year Child and Adolescent Psychiatry Fellow at the University of Michigan. She is interested in the intersection of media and youth mental health.

Paul Weigle, MD, DFAACAP, is associate medical director at Natchaug Hospital of Hartford Healthcare and associate professor of psychiatry at UConn School of Medicine. He serves as the co-chair of the AACAP’s Media Committee, and on the Institute of Digital Media and Child Development’s National Scientific Advisory Board. He can be reached at paul.weigle@hhchealth.org.

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

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

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

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

For complete AACAP News Policies and Procedures, please contact communications@aacap.org.
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NEW SCREENSIDE CHATS

In the last episode of Screenside Chats, roles are reversed where incoming AACAP President Dr. Warren Ng interviews current AACAP President Dr. Gabrielle Carlson about the outcomes of her presidential initiative, about children and outbursts, treatment and interventions, and much more. The national emergency in children’s mental health is also discussed, so tune in as we come to a close on these informative Screenside Chats.

www.aacap.org
Welcome New AACAP Members

Victor Abraham, II, Norwalk, CT
Simge Acar, Istanbul, Istanbul
Gaukhar Amandossova, MD, Lubbock, TX
Maria Amir, Oak Park, IL
Marshal Ash, DO, Dayton, OH
Sezai Ustun Aydin, MD, Westfield, NJ
Joel Barrett, Jr., MD, Lubbock, TX
Joseph Beckworth, III, MD, Charleston, SC
Kaylin Beiter, New Orleans, LA
Winston Bell, Boston, MA
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Ecesu Cetin, Bakirkoy, Istanbul, Turkey
Deborah Choi, Woodstock, MD
Zobia Chunara, Dayton, OH
AshLeigh Clarkson Thomlinson, Quapaw, OK
Sally Cleworth, BMBS, New Lambton, NSW
Parnaz Daghighi, Houston, TX
Sarah Daily, MD, Jamaica Plain, MA
Genevieve Davis, DO, Ann Arbor, MI
Stacy De Leon, Las Vegas, NV
Elizabeth DeGroot, DO, Ann Arbor, MI
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Christine Donohue, Belmont, MA
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Zachary J. Friedrich, New York, NY
Justin Garcia, MD, Minneapolis, MN
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Pathways to JAACAP Leadership

The strength of the Journal and its impact in child and adolescent psychiatry relies on the rigorous and thoughtful review and editing of submitted manuscripts. Peer review assists the editors in making editorial decisions and is an essential component of formal scholarly communications. JAACAP seeks new peer reviewers on an ongoing basis. A demonstrated history of strong peer reviewing is an essential qualification for consideration for future editor and editorial board roles. Editors and editorial board members, appointed on a rotating basis, support the Journal’s peer review activities, serve as advisors to the Editor-in-Chief, and act as ambassadors for the Journal in their communities.

As we discuss in more detail in our forthcoming annual report on JAACAP’s antiracist journey, our senior editorial team has continued efforts outlined in 2020 (Our Vision: An Antiracist Journal) to make the JAACAP editorial board and masthead inclusive and representative of our community of scientists and practitioners as well as the communities we serve. To increase the transparency of pathways to leadership, we have created a new portal on the Journal’s website that provides information about the process of recruiting new team members, lists upcoming openings, and allows individuals to express an interest in serving as a peer reviewer for the Journal and being considered for a future editorial role. We invite those interested in serving as peer reviewers or in editorial roles to learn more about available opportunities to volunteer and complete an expression of interest form. Upcoming openings are listed below and will be updated on our website on an annual basis.

Visit https://www.jaacap.org/editorial-opportunities to learn more.

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*Nominations are subject to AACAP Council approval.*
Thank You for Supporting AACAP!

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

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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org.
AACAP’s Diversity Equity and Inclusion Emerging Leaders (DEI) Fellowship

Overview
The American Academy of Child and Adolescent Psychiatry (AACAP) has a significant commitment to promote mental health equity and combat structural racism. The goal of the AACAP Diversity Equity and Inclusion Emerging Leaders (DEI) Fellowship is to support AACAP in strengthening its diversity leadership and workforce development efforts across the organization and the Journal of the American Academy of Child and Adolescent (JAACAP). Starting in 2022, this two-year fellowship will offer mentorship and leadership experience in the following AACAP areas:

- AACAP Council
- JAACAP

In subsequent years the Fellowship will include positions in other AACAP priority areas such as:

- Clinical Practice
- Government Affairs/Advocacy
- Program Committee
- Research

Responsibilities
Through the DEI Fellowship, Fellows will complete projects of their choosing and be assigned a mentor who is a member of the AACAP Council or JAACAP. Upon completion of the project, the Fellow must complete an article for AACAP News. Fellows must also attend AACAP meetings related to their area (i.e., Council Retreat, Annual Meeting, JAACAP Meetings). The DEI Fellowship will be Chaired by Drs. Lisa Cullins and Cheryl Al-Mateen, outgoing Co-Chairs of AACAP’s Diversity and Culture Committee. Drs. Cullins and Al-Mateen will serve as secondary mentors and advisors to the Fellowship Program. Fellows must also actively participate in AACAP’s Diversity and Culture Committee by regular attendance on one of the quarterly AACAP Caucuses Zoom meetings in addition to monthly Diversity and Culture Committee Zoom meetings.

Examples of Projects Include:

**AACAP Council DEI Fellows** will have the opportunity to engage with a host of related AACAP Committees to assess and monitor AACAP’s Workplan to Promote Health Equity and Combat Racism in the Era of COVID-19.

**JAACAP DEI Fellows** will have the opportunity to build their peer review skills with the support of senior editors, participate in a mentored scholarly project focused on race, racism, social justice, and health equity in children’s mental health, and learn about scientific publishing.

Fellowship Application & Deadlines
An applicant may apply for both the JAACAP or AACAP Council DEI Fellowship but will be selected for only one. The deadline for receipt of all applications is **December 10, 2021**, and the final selection will be made by **December 23, 2021**. The Fellowship will commence in January 2022.

Fellowship Deadlines for the other AACAP priority areas are to be determined and will recruit no earlier than Summer 2022.

Fellowship Eligibility
- Must be a Child and Adolescent Psychiatry Fellow (this includes General Psychiatry Residents in their 4th year or Triple Board Residents or Post Pediatric Portal Residents in their final year of training).
- Must have demonstrated interest in diversity and equity.
- Must be a member of an Underrepresented Minority (URM) group.
- Must commit to attending AACAP’s Annual Meeting and other related meetings as related to Fellowship Area.
• In addition, JAACAP DEI Fellows:
  ◊ must have a demonstrable interest in pursuing a research career.
  ◊ individuals in NIH-Funded T32 postdoctoral fellowships or equivalent are also eligible.

**Stipend**

Up to $2,000 will be provided to each Fellow to cover costs associated with travel to the appropriate AACAP/Fellowship related meeting including the AACAP Annual Meeting (October 2022), June Council Retreat (June 2022), Council of Science Editors Annual Meeting (early May 2022).

**Fellowship Application**

Please send application materials to Carmen J. Thornton, Director, Research, Grants and Workforce, at training@aacap.org. Please clearly specify if the application is for the AACAP DEI Council or JAACAP DEI Fellowship. Applications must include the following:

1. A personal statement (three pages or less) on how this Fellowship supports their training and career goals. Statement should include a proposed DEI Fellowship project.
2. The candidate’s curriculum vitae.
3. Proof of training enrollment.
4. At least two letters of recommendation or support (including a letter from the Program Director supporting the application).

**Selection Committee**

Will consist of the DEI Fellowship Chairs and appropriate members of the AACAP Council or JAACAP.

For more information contact the AACAP Department of Research, Grants and Workforce at 202-587-9663, or training@aacap.org.
FOR YOUR INFORMATION

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.

American Association of Child & Adolescent Psychiatry

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
Children and Masks: Tips for Parents and Teachers

By David Fassler, MD and Christopher Streeter, MD

As children return to the classroom, many schools are requiring masks for both students and teachers. At others, they are optional, but recommended. Here are some tips and suggestions for parents and teachers:

1. Follow current CDC guidelines regarding children and masks. Recommendations can and will change over time as the pandemic evolves and more data becomes available.

2. Explain to children why we need to wear masks, using words and concepts kids can understand. Gear your explanations to the child’s age, language and developmental level.

3. Acknowledge and validate the child’s thoughts and feelings about wearing masks. Let them know that you think their questions and concerns are important and appropriate.

4. For young children, look for fun and colorful masks.

5. Give kids choices about which mask to wear. Make it part of their daily wardrobe selection.

6. Kids will observe and learn from the behavior of the adults around them. Model appropriate mask wearing, consistent with current guidelines and local regulations.

7. Some children, including those with ADHD or developmental delays, may have more difficulty keeping masks on throughout the school day. Parents and teachers should be patient, tolerant and understanding, to the extent possible. Use positive reinforcement to support and encourage appropriate mask wearing.

8. If children have ongoing questions or concerns about masks, talk to their pediatrician or the school nurse.

Changing guidance and routines can be challenging for both kids and adults. Fortunately, most children are quite resilient. They will adjust and adapt to wearing a mask with little difficulty. Parents and teachers can help by listening to their questions and responding in an honest, consistent and supportive manner.
For more information:

AACAP Resource Library on Coronavirus

Face Masks | American Academy of Pediatrics

Talking to Children About Coronavirus

Face Masks for Children During COVID-19

Mask Mythbusters: Common Questions About Kids and Face Masks

Mask Up! Talking to Young Children about Wearing Masks

Your Guide to Masks | CDC

Activities, Gatherings & Holidays | CDC

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.

Christopher Streeter, MD is a board certified child and adolescent psychiatrist working with young people at St. Luke’s Children’s Center for Neurobehavioral Medicine in Boise, Idaho. He is also an assistant professor of psychiatry at the Idaho College of Medicine, and an adjunct instructor for the University of Washington psychiatry residency programs.
innovative Banner – University Medicine

adolescent behavioral patients at the

possible for the clinical care of child and

Job ID: 15626828
URL: https://jobsource.aacap.org/jobs/15626828

Job Description:
The Department of Psychiatry at the Banner – University Medicine Behavioral Health Clinic is actively seeking a fellowship-trained Child and Adolescent Psychiatrist to join our dynamic department led by Dr. Jordan F. Karp. The selected individual will be responsible for the clinical care of child and adolescent behavioral patients at the innovative Banner – University Medicine Behavioral Health Clinic in Tucson, Arizona. The physician hired will gain a faculty appointment at the University of Arizona consistent with rank and credentials. Essential Functions: Clinical responsibilities include outpatient care and shared call coverage (taken from home); opportunities to participate in Consult/Liaison service Academic time provided Teaching and mentoring of students, residents, and fellows 0 FTE | M-F Minimum Qualifications: Board Eligible/Board Certified by the American Board of Psychiatry and Neurology Fellowship-Trained in Child and Adolescent Psychiatry Desire to practice and engage in an academic setting Position is open to experienced psychiatrists as well as new grads completing their child and adolescent psychiatry fellowship (excellent loan repayment available) Compensation Highlights: Banner - University Medical Group offers a generous salary and recruitment incentives, along with an industry-leading benefits package: Competitive salary with incentives and paid time off Sign-on and relocation bonus $100k Loan Repayment Comprehensive benefits such as medical, dental, vision, retirement, pharmacy, and more Qualified tuition reduction at in-state institutions Paid malpractice Paid CME Opportunities for career advancement/leadership development Our Community: The blooming community of Tucson, Arizona is nestled within the Southern Rocky Mountains and the lush Sonoran Desert. With 350+ days of annual sunshine, it is easy to soak some sunny Vitamin D with championship golf courses, scenic hiking, cycling-friendly community, horseback riding, rock climbing, mountain biking, fishing, and kayaking. Selfcare enrichment abounds in refreshing spa resorts, art galleries, enriching culture, and entertainment. Tucson is also a designated UNESCO City of Gastronomy with many exciting culinary adventures in our restaurant scene and Southern Arizona’s wine country. We encourage you to mention this site when you submit your CV to Dr. Jordan Karp, c/o Linda Montano at doctors@bannerhealth.com For more information, visit https://practicewithus.bannerhealth.com The safety of our team members and patients is of utmost importance, so Banner is requiring the COVID-19 vaccine for all team members. As members of the health care field, we are in the business of caring for people, so we take seriously our commitment to ensure our patients and teams are safeguarded from this rapidly changing and dangerous disease. As an equal opportunity and affirmative action employer, Banner University Medical Group (BUMG) recognizes the power of a diverse community and encourages applications from individuals with varied experiences and backgrounds. BUMG is an EEO/AA - M/W/D/V Employer.

COLORADO

Company: Denver Health (1199393)
Title: Denver Health: Inpatient Child and Adolescent Psychiatrist
Job ID: 15677023
URL: https://jobsource.aacap.org/jobs/15677023

Job Description:
Job Summary Denver Health Medical Center is looking for a child/adolescent psychiatrist to serve on our 21 bed inpatient child/adolescent psychiatric unit. This psychiatrist must be board eligible/certified in child and adolescent psychiatry. Denver Health physicians have a faculty appointment at the University of Colorado School of Medicine, and Denver Health is a teaching hospital. This physician will provide expert assessment and clinical care in child and adolescent psychiatry which includes the following: (1) Diagnoses and treats children and adolescents with complex, co-occurring medical, psychiatric and substance use disorders; homelessness, poverty; and treatment-resistance (2) Obtains relevant medical histories, makes appropriate diagnoses, implements and directs effective psychiatric treatments including during high-risk and/or life-threatening conditions (3) Assesses and mitigates the risk of suicide or violence among patients at risk due to psychiatric illness, including schizophrenia, bipolar, depressive, anxiety, substance use disorders, and personality disorders. (4) Leads multidisciplinary teams of case managers, discharge planners, nursing, occupational therapy, psychotherapists, and other professionals to provide clinical care. (5) Teaches medical students and advanced trainees from other health disciplines including in nationally accredited training programs. (6) Consults with non-psychiatric medical providers in the care of patients with psychiatric disorders. (7) Directs care teams in identifying appropriate levels of care for complex patient presentations. (8) Applies treatment statutes for involuntary psychiatric and/or substance use disorder treatments. (9) Interprets the results of relevant laboratory and imagining studies and applies them to the diagnosis and treatment of psychiatric symptoms. (10) Maintains medical license, board-certification, BLS certification, and other relevant licensure/certification. (11) Supports an inclusive work environment. Provides high quality clinical care and works to meet productivity metrics as directed by direct supervisor. (12) Supports department initiatives related to quality, safety, financial viability, and other initiatives as directed by the ADOS or DOS. Works collaboratively with operational colleagues to maintain quality, safety, and financial viability. (13) Has weekend, overnight, and holiday responsibilities according to department needs. Essential Duties and Responsibilities: 1. Provide expert care, scholarly work, and training in child/adolescent psychiatry 2. Physicians at Denver Health are faculty members of the University of Colorado School of Medicine serve as teachers for students seeking clinical experience at Denver Health and provide education for post graduate medical trainees. 3. Focus on Superior Patient Care by 1) practicing evidence-based, high-quality state-of-the art medicine; 2) encourage increased patient understanding, involvement in care, and treatment decisions; 3) achieve and maintain optimal patient access; 4) insist on departmental...
focus on superior patient service; and 5) participate in or support education and research. 4. Collaborate on Care Delivery by 1) including staff, other physicians and management in both service and patient care improvements; 2) treat all members with respect; 3) demonstrate the highest levels of ethical and professional conduct; and 4) behave in a manner consistent with Denver Health goals. 5. Listen and Communicate by 1) providing clinical information in a clear and timely manner; 2) requesting information and resources needed to provide care consistent with Denver Health goals; and 3) provide and accept feedback in a respectful manner from all staff. 6. Take Ownership by 1) providing leadership to improve outcomes quality and service quality; 2) work to ensure personal, departmental and organization compliance with all legal and educational requirements; and 3) steadily improve the efficiency and economic aspects of your practice. 7. Quality Metrics.1) Focus on clinically relevant outcome measures; 2) Change by embracing innovations to continuously improve patient care, service and organizational efficiency. Minimum Qualifications Education and Experience: 1. Graduation from an Accredited Medical School and completed Accredited Residency Programs and fellowships for specialist, or equivalent. 2. Board Eligible/Certified In Child/Adolescent Psychiatry. 3. Demonstrated experience and qualifications as indicated below. 4. Medical license to practice in State of Colorado. 1. Medical license to practice in State of Colorado.

**Job Requirements:**

Education • Doctorate Degree (Required) 1. Graduation from an Accredited Medical School and completed Accredited Residency Programs and fellowships for specialist, or equivalent. 2. Board Certified. Credentials • Physician (Required) 1. Medical license to practice in State of Colorado. 1. Medical license to practice in State of Colorado.

**COLORADO**

Company: 09802565 (1224115)

**Title:** Open Rank - Behavioral Health Clinician (LPC, LCSW) – Children's Hospital Colorado

**Job ID:** 15597201

**URL:** https://jobsourcing.aacap.org/jobs/15597201

**Job Description:**

University of Colorado – School of Medicine OPEN RANK Behavioral Health Clinician (LPC, LCSW) – Children's Hospital Colorado  The University of Colorado Denver Anschutz Medical Campus seeks individuals with demonstrated commitment to creating an inclusive learning and working environment. We value the ability to engage effectively with students, faculty and staff of diverse backgrounds. The University of Colorado Anschutz Medical Campus, one of four campuses in the University of Colorado System, is the major academic medical center in the Rocky Mountain region. The Anschutz Medical Campus is home to the University of Colorado Hospital, Children's Hospital Colorado and a new Veterans Affairs Hospital, making it one of the largest and most comprehensive biomedical research and clinical care centers in the western United States. With world-class health sciences research, educational and clinical facilities, the CU School of Medicine has established distinctive and highly productive programs, receiving research awards of more than $350 million per year, including more than $200 million from National Institutes of Health and other federal agencies. The School's total annual clinical and research revenue exceeds $1.2 billion per year. The University of Colorado School of Medicine, Department of Psychiatry has just welcomed their new Department Chair, C. Neill Epperson, MD and is in the process of growing the Department of Psychiatry with new programs and expanding existing programs. Department of Psychiatry Diversity Equity Inclusion Information: The purpose of the Diversity, Equity and Inclusion (DEI) Committee is to hold the Department of Psychiatry's faculty, staff, and trainees accountable for promoting a culture of inclusive excellence and respect. We are committed to continuous education, sustaining cultural humility, and action related to DEI topics including systematic review of policies and procedures to ensure they are in alignment with the department's DEI mission and vision. Position Summary: This position is responsible for direct patient care and safety including diagnostic, assessment, treatment, and discharge planning for children, adolescents, and their families in Outpatient clinics at the Anschutz Medical Campus and/or at one of the Children's Hospital of Colorado Networks of Care. Although there may be opportunities to engage in training, supervision, and/or scholarship, this role is considered a Clinical Only position. Please note, this is an open rank position and could be categorized as Instructor, Senior Instructor, Assistant Professor or Associate Professor based on experience and qualifications as indicated below. Duties and Responsibilities: Provides direct patient care to children, adolescents, and their families, including completing diagnostic evaluations, as well as providing individual, family, and group therapy. Develops and implements evidence-based treatment plans and engages in ongoing treatment monitoring. Collaborates with internal and external providers involved in a patient’s care in order to coordinate on the treatment plan and progress. Maintains timely communication with team members, supervisor, and divisional leadership. Attends team meetings and educational in-services. Enters appropriate notes and charge captures that comply with state and federal standards in the medical record for all patients seen. Diversity and Equity: Please click here for information on disability accommodations: http://www.ucdenver.edu/about/departments/HR/jobs/Pages/JobsatCUDenver.aspx Office of Equity: https://www1.ucdenver.edu/offices/equity The University of Colorado Denver | Anschutz Medical Campus is committed to recruiting and supporting a diverse student body, faculty and administrative staff. The university strives to promote a culture of inclusiveness, respect, communication and understanding. We encourage applications from women, ethnic minorities, persons with disabilities and all veterans. The University of Colorado is committed
to diversity and equality in education and employment.

**Job Requirements:**
Qualifications: Minimum Qualifications Master's degree in counseling, social work, or related field. 1-3 years of related clinical experience Instructor: 1-3 years of related clinical experience at rank or equivalent experience. Minimum degree qualifications: LPC or LCSW Senior Instructor: 1-3 years of related clinical experience at rank or equivalent experience. Minimum degree qualifications: LPC or LCSW Assistant Professor: 4-7 years of related clinical experience at rank or equivalent experience. Minimum degree qualifications: LPC or LCSW Associate Professor: 4-7 years of related clinical experience at rank or equivalent experience. Minimum degree qualifications: LPC or LCSW Knowledge, Skills and Abilities Clinical skills in evidence-based assessment and treatment in an outpatient mental health setting. Ability to work effectively as part of a team and independently. Capacity for flexibility and adaptability in different work situations. Excellent written and verbal communication skills. Ability to work effectively on multiple tasks and maintain a well-organized work environment. Applicants must meet minimum qualifications at the time of hire.

**FLORIDA**
Company: Meridian Behavioral Healthcare, Inc (1278606)
Title: Child and Adult Psychiatrists
Job ID: 15638041
URL: https://jobsource.aacap.org/jobs/15638041

**Job Description:**
Come to sunny Florida! Wouldn’t it be incredible if you were to live and work here in the Sunshine State? The many great benefits of living in North Central Florida includes low cost of living, no state income taxes, living in the heart of Florida means you are never far from beautiful rivers, wildlife preserves, hiking trails, museums, art galleries, prairies, kayaking, fishing, bird watching, bicycling, a quaint and historically significant town, a state’s flagship university, and less than two hours from numerous beaches and world-renowned entertainment. Gainesville was voted 2021 #1 Best City to Live in Florida and #38 Best City to Live in America. Meridian has offices throughout North Central Florida and is an environmentally friendly city with many outdoor activities, and don’t forget the nearby beaches! Meridian Behavioral Healthcare, Inc. is actively looking to hire a Child and Adolescent Psychiatrist to join our outpatient clinical team! Please contact Lauren Cohn, Executive Vice President/Chief Operating Officer at lauren_cohn@mbhci.org or 352.374.5600 ext 8353 for more information or apply now! We offer Psychiatrists: Highly Competitive Salary Monthly Productivity Bonus Potential Additional Income Potential if desired (optional on call, additional clinics) Telemedicine and in-person flexibility Flexible work schedules (full and part-time available) Education Allowance Opportunities with Clinical Studies Generous Personal Time Off Malpractice Insurance with tail Meridian Behavioral Healthcare, Inc. is Meridian is a private, non-profit organization with roots in the community mental health movement, which began in the 1960s, to bring education about mental illnesses and substance use disorders and treatment of those affected to the local level. Our mission is evident in all we do, from developing a continuum of treatment services that are evidence-based for a range of illnesses to participating in our communities as a partner in enhancing the quality of life. It is Meridian's goal to improve the well-being and health of our patients and community, touching over 23,000 lives in the North Central Florida area through over 600,000 direct care visits a year. Job Summary This is an advanced professional clinical position providing psychiatric services to Meridian's target populations. This position requires that the psychiatrist work with patients and within a multi-disciplinary staff to provide patient care and oversee services provided by lesser credentialed clinical providers. Work is performed with a high degree of independence and reviewed through observation, peer review, conferences and reports. GENERAL Duties: Provides timely and appropriate psychiatric, substance abuse and/or medical evaluation for patients to determine treatment needs. Provides medication management and ongoing care consistent with current practice standards. Provides services using Telehealth applications to provide remote health care when appropriate. Provide consultation and training to fellows, residents, students, nurse practitioners, physician assistants and other clinical staff, as needed. Professional services may be provided, as needed, in an outpatient, inpatient or residential treatment setting. Complies with needed chart reviews, consultations and staffing required by Meridian policy or 3rd party standards. Performs other duties as required to meet program and departmental goals and objectives.

**HAWAII**
Company: Hawaii Permanente Medical Group (1141941)
Title: Child & Adolescent Psychiatry Opportunities in Hawaii
Job ID: 15644985
URL: https://jobsource.aacap.org/jobs/15644985

**Job Description:**
The Hawaii Permanente Medical Group, Inc. is seeking BC/ BE Child & Adolescent Psychiatrists to join its Kaiser Permanente Integrated Behavioral Health Department on the islands of Oahu and Hawaii’s. POSITION HIGHLIGHTS Exceptional opportunity to practice in an innovative, collaborative, and fully integrated health system General outpatient psychiatry including urgent, triage, and mental health integration in a diverse population Teaching opportunities available.

**JOB REQUIREMENTS:**

**ILLINOIS**
Company: OSF HealthCare (1163205)
Title: Child Psychiatry
Job ID: 15670246
URL: https://jobsource.aacap.org/jobs/15670246

**Job Description:**
Child Psychiatry The Department of Pediatrics at the University of Illinois College of Medicine at Peoria (UICOMP) seeks an additional Child Psychiatrist to enhance a growing division. The position includes teaching medical students and residents, and opportunities to pursue research. Be a part of the largest downtown academic medical center that includes the Children's Hospital of Illinois. Fourteen residencies (including Psychiatry) and five fellowship
programs are located at OSF Saint Francis Medical Center in collaboration with the University of Illinois College of Medicine Peoria. We offer the medical sophistication of a major referral center and cultural diversity in a family oriented community without big city hassles or cost of living. Rank and compensation commensurate with qualifications. The Community Peoria, the largest Illinois metropolitan area outside of Chicago, is home to a large collection of medical research, educational and clinical facilities including the University of Illinois College Of Medicine at Peoria and Jump Trading Simulation & Education Center. Peoria offers a range of residential opportunities whether you are looking for something out of the way, in the woods, along the river or right in the heart of the city. Peoria is also home to several performance venues, museums, art galleries and more than two dozen historic landmarks of both local and national fame. About OSF HealthCare Children’s Hospital of Illinois Children’s Hospital of Illinois in Peoria is the third largest pediatric hospital in Illinois and the only full service tertiary children’s hospital downstate. With 136 beds and more than 141 pediatric subspecialists, the Children’s Hospital of Illinois cares for more children in Illinois than any hospital outside of Chicago. The Children’s Hospital has over 7,000 admissions; 2,500 newborn deliveries, and 18,000 emergency department visits each year and is staffed by University of Illinois faculty. More at https://www.osfhealthcare.org/childrens/. Please contact or send CV to: Stacey Morin, OSF HealthCare Physician Recruitment Ph: (309) 683-8354 or (800) 232-3129, press 8 | Fax: (309) 683-8353 E-mail: stacey.morin@osfhealthcare.org. For additional information please see the University’s Notice of Nondiscrimination. Job seekers in need of a reasonable accommodation to complete the application process should call 773-702-1032 or email equalopportunity@uic.edu with their request.

**ILLINOIS**

**Company:** University of Chicago (943784)

**Title:** Child Psychiatrist

**Job ID:** 15615359

**URL:** [https://jobs.source.aacap.org/jobs/15615359](https://jobs.source.aacap.org/jobs/15615359)

**Job Description:**

Child Psychiatrist The University of Chicago: Biological Sciences Division: Department of Psychiatry and Behavioral Neuroscience Position Description. The University of Chicago’s Department of Psychiatry and Behavioral Neuroscience is searching for a full-time faculty member at any rank. The appointee will join a multidisciplinary section focusing on patient care and outpatient responsibilities of providing psychiatric care to children, adolescents and their families. Other duties will include teaching and supervision of trainees and students, and scholarly activity. We especially welcome applicants familiar with outpatient psychiatric care and open to consultation liaison work. Academic rank and compensation (including a generous package of fringe benefits) are dependent upon qualifications. Prior to the start of employment, qualified applicants must: 1) have a medical doctorate or equivalent, 2) hold or be eligible for medical licensure in the State of Illinois, 3) Board certified or eligible in Child and Adolescent Psychiatry, and 4) have residency training in Child and Adolescent Psychiatry. To be considered, those interested must apply through The University of Chicago’s Academic Recruitment job board, which uses Interfolio to accept applications: [https://apply.interfolio.com/81849](https://apply.interfolio.com/81849). Applicants must upload: CV including bibliography, cover letter. Review of applications ends when the position is filled. Equal Employment Opportunity Statement We seek a diverse pool of applicants who wish to join an academic community that places the highest value on rigorous inquiry and encourages diverse perspectives, experiences, groups of individuals, and ideas to inform and stimulate intellectual challenge, engagement, and exchange. The University’s Statements on Diversity are at [https://provost.uchicago.edu/statements-diversity](https://provost.uchicago.edu/statements-diversity). The University of Chicago is an Affirmative Action/Equal Opportunity/Disabled Veterans Employer and does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, age, status as an individual with a disability, protected veteran status, genetic information, or other protected classes under the law. For additional information please see the University’s Notice of Nondiscrimination. Job seekers in need of a reasonable accommodation to complete the application process should call 773-702-1032 or email equalopportunity@uchicago.edu with their request.

**INDIANA**

**Company:** Parkview Health (1226356)

**Title:** Board Eligible / Board Certified Child and Adolescent Psychiatrist

**Job ID:** 15627101

**URL:** [https://jobs.source.aacap.org/jobs/15627101](https://jobs.source.aacap.org/jobs/15627101)

**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 “A”s 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...
FOR YOUR INFORMATION

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: Salem Hospital (1278797)
Title: Child Psychiatrist Opportunity, Near Boston, MA
Job ID: 15638775
URL: https://jobs.source.aacap.org/jobs/15638775

Job Description:
Mass General Brigham – Salem Hospital has an exciting opportunity for a child psychiatrist to join a thriving and growing psychiatric service in Salem, MA, about 15 miles north of Boston. Salem Hospital is part of the prestigious Mass General Brigham health care system, and the Department of Psychiatry is closely aligned with the Massachusetts General Hospital (MGH). There are opportunities for this to be an inpatient, outpatient or combined position, depending on the candidate’s interest and experience and matching this with Department needs. Salem Hospital provides a full spectrum of psychiatric care, including adult inpatient psychiatry, an older adult inpatient unit, a child and adolescent inpatient unit, separate partial hospital programs for adults and for adolescents, and several outpatient clinics. Inpatient care is provided at the Epstein Center for Behavioral Health, a spectacular, newly renovated facility that provides unique outdoor recreational space for patients.

The Department is involved in clinical research in collaboration with our Mass General Brigham colleagues, and is a hub for the Massachusetts Child Psychiatry Access Project (MCAP), a state-supported outpatient consultation service for area pediatricians. We have a vibrant educational program, and teaching opportunities and an academic appointment are available. Physicians in the department enjoy a collegial and supportive practice environment. Compensation is very competitive. The call schedule is very reasonable and requires no in-house coverage.

Job Requirements:
Massachusetts medical license BC/BE
Child Psychiatry Massachusetts Controlled Substance Registration Federal DEA certificate

MASSACHUSETTS

Company: Cambridge Health Alliance (1177750)
Title: Child & Adolescent Inpatient Psychiatry Expansion
Job ID: 15702213
URL: https://jobs.source.aacap.org/jobs/15702213

Job Description:
Cambridge Health Alliance (CHA), a well-respected, nationally recognized, and award-winning public healthcare system, is one of the region’s leading providers of behavioral and mental health care. The new CHA Center of Excellence for Child & Adolescent Inpatient Mental Health Care at Somerville will provide a transformative continuum of patient-centered care for diverse youth with mental health needs. Including specialized autism spectrum/ neurodevelopmental beds at our Somerville Campus. CHA is passionate about helping children and their families, join our expanding team and make a difference! Psychiatry Opportunities: Inpatient Child/Adolescent Psychiatrists Inpatient Neurodevelopmental Child/Adolescent Psychiatrists Psychology Opportunities: Inpatient Child/Adolescent Psychologists Pediatric Neuropsychologists CHA is a teaching affiliate of Harvard Medical School (HMS) and academic appointments are available commensurate with medical school criteria. Please visit www.CHApromoters.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. In keeping with federal, state and local laws, Cambridge Health Alliance (CHA) policy forbids employees and associates to discriminate against anyone based on race, religion, color, gender, age, marital status, national origin, sexual orientation, relationship identity or relationship structure, gender identity or expression, veteran status, disability or any other characteristic protected by law. We are committed to establishing and maintaining a workplace free of discrimination. We are fully committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment or career development. Furthermore, we will not tolerate the use of discriminatory slurs, or other remarks, jokes or conduct, that in the judgment of CHA, encourage or permit an offensive or hostile work environment.

NEW YORK

Company: Four Winds Hospital (1130907)
Title: Psychiatrists
Job ID: 15592873
URL: https://jobs.source.aacap.org/jobs/15592873

Job Description:
Child Psychiatrist Four Winds Hospital, a leading provider of inpatient psychiatric treatment for children, adolescents and adults in the Northeast, is looking to hire additional full-time inpatient Child Psychiatrists. NO overnight or weekend On Call responsibilities. The job is a Monday through Friday. Competitive salary. Great benefits. Warm work environment with collaboration, teaching and ongoing support. More information available upon request. Come for a visit, shadow Dr. Sarah Klagsbrun, the Medical Director, for the day and see what Four Winds is all about! (Feel free to reach out directly to S.Klagsbrun@FourWindsHospital.com) Four Winds Hospital has 150 child & adolescent beds and 30 adult beds. Our staff work as collaborative teams with a non-corporate, family feel. Four Winds is located on a campus in Westchester County. We have seven units in different cottages that are not locked. Each unit has a narrow age range. Our older adolescent units are even divided into three units with different treatment approaches (ABA, DBT and Collaborative Problem Solving). We celebrate all the holidays.
with our patients: Halloween consists of a costume parade and trick-or-treating. Thanksgiving is filled with a traditional meal for patients and families and Christmas morning means every patient receives a Holiday Gift. Patients come from all over: Albany, Connecticut, Manhattan, Queens, Brooklyn, Bronx and New Jersey with varied backgrounds. Our mission is to provide the best clinical care, the most advanced treatment and have deep empathy for the pain experienced by the mentally ill and their families. Psychiatrist Moonlighter Four Winds Hospital is looking to hire additional Moonlighting Psychiatrists. Warm work environment with collaboration, teaching and ongoing support. More information available upon request. Four Winds is located on a campus in Westchester County. Patients come from all over: Albany, Connecticut, Manhattan, Queens, Brooklyn, Bronx and New Jersey with varied backgrounds. Our mission is to provide the best clinical care, the most advanced treatment and have deep empathy for the pain experienced by the mentally ill and their families. Monday – Friday from 6PM – 7AM (13 hour shifts) Saturdays & Sundays from 7AM - 7PM and from 7PM - 7AM (12 or 24 hour shifts) • Pleasant work environment • Comfortable accommodations • Dinner provided • Malpractice insurance covered • Shuttle to and from Katonah train station • NYS license and a minimum PGY-4 status required • Competitive salary For more information please contact at 914-763-8151 ext. 2222 or email CV to rsibrizzi@fourwindshospital.com. Website: www.fourwindshospital.com Medical Director: Dr. Sarah Klagsbrun S.Klagsbrun@FourWindsHospital.com

TEXAS
Company: Grant Cooper and Associates (1277263)
Title: Medical Director for Health Informatics and Digital Technology – Child and Adolescent Psychiatry
Job ID: 15593434
URL: https://jobs.source.aacap.org/jobs/15593434

Job Description:
The UT Southwestern Medical Center Department of Psychiatry is seeking a Child and Adolescent Psychiatrist for a unique opportunity to provide vision and leadership in the development of adaptable, agile, cost-effective technology initiatives and department-wide information systems solutions for our department. We seek a candidate who can enable clinicians in our department to use the most contemporary strategies in digital technology to improve access and quality of care to our patients. The physician-leader will also guide our department’s telehealth strategies, primarily focused upon our Community Psychiatry Workforce Expansion project to improve access to pediatric psychiatry in rural north Texas. This leader will also guide our telephone consultation programs currently available to pediatricians but proposed as an offering to internists, as well. This position will provide direct patient care as well as clinical supervision via telemedicine to psychiatry trainees, and also participate in Faculty activities at UT Southwestern Medical Center. This psychiatrist will also provide education to other disciplines through didactics, case conferences and consultation. The successful candidate’s appointment within the Department of Psychiatry also requires regular participation in educational activities with medical students and residents. In addition, the physician will have the opportunity for collaborations that allow for the pursuit of innovative clinical programming and research initiatives. This position also serves to facilitate translational research in technological innovation.

Job Requirements:
Qualifications An unrestricted license to practice medicine in the State of Texas, or the ability to obtain prior to appointment; Board certified in child and adolescent psychiatry, or board eligible with a commitment to obtain certification within two years; Eligible for credentialing and privileging by Children’s Medical Center, and other collaborating agencies in our community; Eligible for appointment as an assistant professor or higher in the Department of Psychiatry; Demonstrated leadership, clinical teaching, evaluation, and communication skills; Ability to influence/motivate others at all professional and administrative levels; Must be an innovative self-starter with a commitment to excellence; Must possess tenacity, self-motivation and initiative necessary to drive the development and maintenance of established and new programs; A track record of being able to lead, direct, and influence a team regardless of reporting lines, as well as be a team player. Desired Characteristics Interest and training in contemporary IT systems, including EHRs, is preferred. Skilled in generating and analyzing data from IT systems, including managing data in a way that does not compromise patient privacy. Able and willing to communicate and consult about data and digital technology. Interest in the use of digital technology, such as cell phones, in improving health outcomes. Experience in the use of emerging technologies such as a digitally-collected biomarkers and digital phenotyping in the diagnosis and management of mental illness is preferred. Master’s degree in Health Informatics or Information Systems preferred.

UTAH
Company: The University of Utah Department of Psychiatry (956175)
Title: Academic Child/Adolescent Inpatient Psychiatrist, Rank DOQ - University of Utah Health (HMHI/SOM)
Job ID: 15684586
URL: https://jobs.source.aacap.org/jobs/15684586

Job Description:
Academic Child/Adolescent Inpatient Psychiatrist, Rank DOQ University of Utah Health (HMHI) - School of Medicine - Psychiatry The Huntsman Mental Health Institute and the Child Psychiatry Division in the Department of Psychiatry at the University of Utah School of Medicine are looking for dedicated and motivated full-time Child and Adolescent Inpatient 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. The Huntsman Mental Health Institute (as part of 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 and professional accomplishments. Faculty members provide clinical services for the University of Utah’s Huntsman Mental Health Institute (HMHI). The University of Utah is located 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 lively music scene, excellent restaurants, one of the largest LGBTQ communities in the country, the Utah Symphony/
education, investigation, and administrative activities will be negotiated annually. Specific assignments will be coordinated through the Child Psychiatry Division Chief. Candidates should apply on-line by sending a letter of interest and curriculum vitae to: https://utah.peopleadmin.com/postings/124696. Inquiries may be directed to: Philip Baese, MD, Child Psychiatry Division Chief philip.baese@hsc.utah.edu. Huntsman Mental Health Institute, 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 values candidates who have experience working in settings with students, staff, faculty and patients from diverse backgrounds and possess a strong commitment to improving access to higher education, employment opportunities, and quality healthcare for historically underrepresented groups. 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. The University of Utah is an Affirmative Action/Equal Opportunity employer and does not discriminate based upon race, ethnicity, color, religion, national origin, age, disability, sex, sexual orientation, gender, gender identity, gender expression, pregnancy, pregnancy-related conditions, genetic information, or protected veteran’s status. The University does not discriminate on the basis of sex in the education program or activity that it operates, as required by Title IX and 34 CFR part 106. The requirement not to discriminate in education programs or activities extends to admission and employment. Inquiries about the application of Title IX and its regulations may be referred to the Title IX Coordinator, to the Department of Education, Office for Civil Rights, or both. To request a reasonable accommodation for a disability or if you or someone you know has experienced discrimination or sexual misconduct including sexual harassment, you may contact the Director/Title IX Coordinator in the Office of Equal Opportunity and Affirmative Action: Director/ Title IX Coordinator/Office of Equal Opportunity and Affirmative Action (OEO/AA), 135 Park Building, Salt Lake City, UT 84112, 801-581-8365. oeo@utah.edu. Online reports may be submitted at oeo.utah.edu. For more information: https://www.utah.edu/nondiscrimination/ To inquire about this posting, email: employment@utah.edu or call 801-581-2300.

Job Requirements:
Applicants should hold or be eligible to apply for a current, unrestricted license to practice medicine in the State of Utah and have expertise in child and adolescent inpatient 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. The candidate must be board certified or board eligible in Psychiatry and Child and Adolescent Psychiatry. Obtaining board certifications is a requirement for retention.

Utah Opera, professional basketball, baseball, and soccer teams, Ballet West (one of the premiere ballet companies in the country), a vibrant art and theater community, and many other cultural attractions. Qualifications: Applicants should hold or be eligible to apply for a current, unrestricted license to practice medicine in the State of Utah and have expertise in child and adolescent inpatient 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. The candidate must be board certified or board eligible in Psychiatry and Child and Adolescent Psychiatry. Obtaining board certifications is a requirement for retention.
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