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Front Cover: We are very excited and proud to announce that we hit an important milestone in AACAP’s history. In December, we crossed the 10,000-member mark! And we’re still growing!!!
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership
December 2014

MISSION OF AACAP NEWS

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

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Presidential Address: CAPturae Belonging

Every great dream begins with a dreamer. Always remember, you have within you the strength, the patience, and the passion to reach for the stars to change the world.

—Harriet Tubman, freedom fighter

I am deeply humbled and honored to be your next AACAP President, daring to dream to meet the challenge of today. Let’s start with where we are, in the midst of a global pandemic and ongoing mental health crisis, not to mention everything else that has turned our world upside down. However, despite being spread out across the country and globe, in our homes or offices, through our computers, laptops, and phones, we are connected and together at this moment. The pandemic has challenged us in many ways, but we’ve found new ways to connect because we instinctively need one another and that sense of belonging. The title of the presidential initiative is CAPturae Belonging, starting with CAP for child and adolescent psychiatry. My address has 3 parts: a reflection on AACAP, a little about me, and an introduction to the presidential initiative.

Who better to understand the magic of connections than child and adolescent psychiatrists and mental health providers who co-create spaces for healing and change? What have been your most meaningful connections in the past 2 years? This has been an unbelievable time, and personally, I am grateful for my forever friends, family, and especially my AACAP family. The fearless leadership of our immediate Past President, Dr. Gabrielle A. Carlson, and Executive Director, Heidi B. Fordi, with our Executive Committee, Drs. Bennett L. Leventhal, Cathryn A. Galanter, and Melvin D. Oatis, and our AACAP Directors, has risen to every challenge. This AACAP pod, even virtual, has been a beacon of light and hope for me. Dr. Carlson’s visionary leadership helped us through the darkest days of the pandemic. She enlightened us with the warm wisdom of her Screenside Chats, reminiscent of U.S. President Franklin D. Roosevelt’s Fireside Chats. She led by shining light on the sickest children with her presidential initiative on emotion dysregulation. She championed our efforts toward health equity and combating racism with her presidential working group, among many other accomplishments.

As we look back over the past 2 years and think about the silver linings and the lessons learned, we can see how important we are to one another and the importance of a sense of belonging. Mother Theresa said: “If we have no peace, it is because we have forgotten that we belong to each other.”

The one thing we crave the most, especially in a year with social distancing, is our love and connection to family, friends, community, and home. AACAP has always been my professional home, giving me a sense of family, community, and belonging. I love our annual meetings when we can connect with friends and colleagues and meet new kindred spirits who share the passion of children’s mental health. AACAP, whether in person or virtual, is our home and community.

In these challenging times with the dual pandemics of COVID-19 and mental health, we face a divided country with an overdue reckoning of racial injustice and inequity, economic uncertainty, and our own painful personal losses. We face the unfinished promise of our nation and our people. How are you responding to these times? Well, you are here, and we are here together to meet the challenges. In the words of 2021 AACAP Catcher in the Rye Humanitarian Award recipient, Secretary Hillary Rodham Clinton: “When we all help each other out, when we stand together, we are stronger together.”

I had the privilege and honor giving this address to AACAP Annual Meeting attendees on the eve of becoming your next AACAP President. How does one lead in these times? I believe we should lead together, with a collective voice, to be truly inclusive and representative of all of us. I see myself as a servant leader, as coined by Robert Greenleaf.

The core tenets of his philosophy include, among others, listening, empathy, healing, self-awareness, stewardship, and commitment to the growth of people and community. We all have a stake in this, and so the principle of stewardship engages us to share leadership. As your president, my role is to bring out our best and have you, our incredible AACAP members and staff, shine your light to lead the way. I think about the wise words of our Poet Laureate Amanda Gorman’s poem at U.S. President Joseph R. Biden’s Inauguration: “For there is always light, if only we’re brave enough to see it. If only we’re brave enough to be it.”

As a gay Asian American first-generation immigrant child and adolescent psychiatrist, among other things, I am, first and foremost, a human being. My many identities enrich me, but don’t fully define me. What unites all of us as child and adolescent psychiatrists within AACAP is our shared mission and passion for serving children, youth, and families. It isn’t lost on me what this moment means. That I am standing here speaks to what AACAP represents and its commitment to championing diversity, equity, and inclusion. One doesn’t arrive in these moments without a heart of gratitude. Some say that gratitude is always light, if only we’re brave enough to see it. If only we’re brave enough to be it.”
your vision, allyship, sponsorship, and generosity. I remember the passion and grace of our incredible former Executive Director, Virginia Q. Anthony, who would always stop by the Lesbian and Gay Child and Adolescent Psychiatric Association (LAGCAPA) reception with the presidential entourage to join the party.

When I look back on our history/history, we have come a long way as an organization, but we have much work still to do. We are far from our promise and our destiny. We are making strides and we can build on that momentum to take the next steps. We have had transformational dreamers and innovators with diversity of thought and representation since our founding in 1953. Our first woman president was AACAP’s fifth president in 1959, Dr. Marion Kenworthy. She was a visionary who inaugurated our first journal editor, Dr. Irene Josselyn, in 1962. Both accomplished and inspired so many to dream and created incredible legacies in AACAP and child and adolescent psychiatry. Groundbreaking and pioneering work was also accomplished by Drs. Jeanne Spurlock and Ian Canino, who started the Diversity and Culture Work Group in 1994. They’ve inspired generations of child and adolescent psychiatrists and leaders to carry the work forward with open minds and hearts to one another’s diversities and cultures.

To lead us into the new millennium in 2001, it was only fitting that Past President Dr. Marilyn B. Benoit’s initiative was titled Embracing the Opportunities in Child and Adolescent Psychiatry.

She focused on the underserved half-million kids in foster care at that time as well as the “wow” moments that inspire us to child and adolescent psychiatry. In 2014, Past President Dr. Paramjit Toor Joshi invited us to her presidential initiative, Partnering for the World’s Children, because we are one humanity and there are no borders in our hearts or dreams.

All these leaders, plus all the individuals of all genders, races, ethnicities, and identities who championed them and advanced child and adolescent psychiatry, share in the accomplishments that led us to where we are today.

I want to share a bit of my history in the hopes that you will see parts of yourselves in my story. I come from a family of dreamers, as immigrants often are. As I shared the wisdom of Harriet Tubman earlier, “every great dream begins with a dreamer.” With limited command of English, my parents courageously emigrated in search for a better life with their 3 young children from Hong Kong, China, to Canada. Neither of my parents had completed high school, so my father started work as a cook and my mother a seamstress, but that didn’t define nor limit them. I’m so proud of them and love them for risking it all to find a better world for us. I grew up working in my parent’s coffee shop and met all different types of people, each with their own story to tell over a cup of coffee. My parents told us that if we didn’t do well in school, we would have to continue working in the coffee shop. Needless to say, we all studied hard. I’m the youngest of 3 boys, a close second by 10 minutes with my identical twin brother, Ronman, the artist. Double trouble, or double good trouble, I hope, as I’ve always been inspired by the civil rights hero, Representative John Lewis.

I went to medical school in Toronto during the late 1980s at the height of the HIV/AIDS epidemic, the other pandemic that has shaped my life course. It was another time in history when politics, society, and medicine collided. What I saw in hospitals were the painful effects of stigma, homophobia, marginalization, and shame. It shook my sense of humanity but galvanized my commitment to justice and compassion in medicine. Being a creature of my times and a gay man, I saw medicine through the lens of the HIV/AIDS pandemic and pursued HIV care within family medicine to answer that call to help. However, what captivated me the most, once again, was listening to the human stories of suffering, courage, and love amidst it all.

It was while doing family medicine that I had my “wow” moment and fell in love with child and adolescent psychiatry. I had the privilege of emigrating twice, but this time it was my choice in becoming American. I was pursuing my dreams in New York City, the city of dreamers. I was lucky to do my child training at Bellevue Hospital/NYU and even luckier that I was introduced to AACAP through the regional organization, the New York Council on Child and Adolescent Psychiatry. I remember going to my first meeting. I was so intimidated as a trainee, feeling like an outsider, but once I walked into the room everyone welcomed me. So much for New Yorkers! They made me feel at home and like I belonged. So, when I attended my first AACAP meeting my home got larger and so did my family.

New York also happened to be one of the epicenters of HIV/AIDS and pediatric AIDS, where visionaries like my mentors at Columbia University, Drs. Jennifer Havens and Claude A. Mellins, created incredible programs to serve women and children living with HIV/AIDS, bringing light to the darkness. I was able to combine two of my callings: HIV/AIDS and child and adolescent psychiatry.

As I mentioned, I am a creature of my times, and the COVID-19 pandemic has revealed many ugly truths about our society and ourselves. The long-standing pandemic of racism has colored the tragedies of the COVID-19 pandemic, disproportionately affecting Black, Indigenous, and Latinx individuals, families, and communities. The tragic murder of George Floyd sparked a national reckoning of over 400 years of continuing anti-Black racism that has been baked into the fabric of our society. We have also seen other communities targeted

“Instead of calling it my presidential initiative, I will be so bold as to call it our presidential initiative in the spirit of belonging. This isn’t about me; it’s about us. Our presidential initiative will build on the foundation of DEI work established under President Carlson’s leadership and take it to the next level.”
by racism with the sudden increase in anti-Asian hate, reminiscent of post 9/11 Islamophobia. We have also witnessed the assault on the rights of transfolk, sexual minorities, women, and voters.

In 1963, Reverend Dr. Martin Luther King, Jr. wrote: “Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality tied in a single garment of destiny. Whatever affects one directly affects all indirectly.”

Now to pull the threads together and share my vision for the Presidential Initiative: CAPture Belonging. As we move through our collective journey of diversity, equity, inclusion, (DEI) and justice work, it can hopefully bring us to a destination of belonging. Finally giving us a single garment worthy of us all.

What do I mean by belonging? Belonging is the feeling of security and support when there is a sense of acceptance, inclusion, and identity as your authentic self. This was adapted from a definition by Baumeister and Leary.

Instead of calling it my presidential initiative, I will be so bold as to call it our presidential initiative in the spirit of belonging. This isn’t about me; it’s about us. Our presidential initiative will build on the foundation of DEI work established under President Carlson’s leadership and take it to the next level. The tremendous efforts of the Working Group to Promote Health Equity and Combat Racism led by Drs. Oatis, Lisa M. Cullins, and Tami D. Benton, with Director Carmen J. Thornton, have highlighted the 4 priorities of awareness, advocacy, workforce, and professional development, as well as national partnerships and linkages. In addition, AAACP’s leadership with Drs. Douglas K. Novins and Robert R. Althoff and Director Mary K. Billingsley has taken the important step of envisioning an antiracist journal with the first Deputy Editor for Diversity, Equity, and Inclusion, Dr. Wanjiku F.M. Njoroge, and the first Assistant Editor for Health Equity and Antiracism, Dr. Eraka Bath. Important work has been accomplished, but we are far from done. I’ve asked Dr. Oatis to lead the presidential initiative, and he has graciously accepted to advance these efforts.

What work do we need to do? We need to continue doing the work toward being antiracist as an organization. The goal is to have this work embedded within our culture, so it is who we are, what we do, and how we work together. The antiracism work never ends, nor the commitment to our values of diversity, equity, inclusion, and justice. As Dr. Camara Phyllis Jones, Senior Fellow at the Satcher Health Leadership Institute, teaches us, there are 3 levels of racism: personally mediated, institutional, and internalized.

Since systems and structures are often inherently inequitable, it requires active efforts to address them. To help us advance, we will be looking inward and outward to help identify systemic and structural solutions to these challenges.

AAACP is our home and who we are, and that’s where we start. Two quotes come to mind: “Be the change that you want to see in the world.”—Mahatma Gandhi “Yesterday I was clever, so I wanted to change the world. Today I am wise, so I am changing myself.”—Rumi

In taking the next steps in this DEI journey, we will expand the charge of the current work group to encompass more components of our organization with a broader agenda and input from our members. The working group will be renamed the JEDI (justice, equity, diversity, and inclusion) Workgroup, and its membership will be expanded to have the greatest impact within AAACP. Learning and unlearning will be critical, with annual DEI and implicit bias training for our Council members and other leaders. To know that we are making progress, we will measure a baseline for DEI and set goals. Systemic and structural racism and oppression requires us to review and update our governing documents, such as our AAACP Bylaws, mission statement, and operating documents, to reflect our commitment to diversity, equity, and inclusion. Evaluating current diversity and representation within our Executive Committee, Council, Assembly of Regional Organizations, committee leadership, and leadership of our publications will help us see ourselves in reflection. Transparency is critical in this process, so reviewing the pathways to leadership and opportunities within AAACP for everyone is key. I’m still learning on my own DEI journey, but I’ve learned that it’s not just the complexion that needs to change but the culture to truly embody inclusion and belonging. It is about all of us, not some of us, and that’s important to belonging.

The second priority of our initiative is you, our membership. You are our line, strength, and inspiration. Part of working toward being antiracist, diverse, equitable, and inclusive is developing a way to harness the power of our membership and our collective voice. Amplifying our members’ voices and developing a method of soliciting representative membership feedback on organizational decisions and priorities is critical to our future. We will explore developing a process to do this. By better understanding the diverse needs of our membership, we can benefit from the diversity of thought, experience, and perspective that our organization has to offer. We are making important decisions on behalf of child and adolescent psychiatry, and hearing your voices is critical to our success.

The third priority is to support AAACP’s continued investment in the development of our members. We will explore developing a Leadership Academy to support child and adolescent psychiatrists throughout their careers in research, advocacy, education, and clinical services. As our professional home, AAACP is invested in your growth, development, and evolution. The practice of child and adolescent psychiatry is constantly evolving, and the development of a Leadership Academy would help equip our members, profession, and organization to solve the big problems with child and adolescent psychiatrists at the table.

The last priority is one where President Dr. Carlson has already sounded the alarm: a response to the national crisis in mental health for children, adolescents, and families. This work requires us all. However, not all communities and populations are affected equally, and finding solutions, especially to address health
equity issues and the underlying social determinants, is critical.

Many minoritized communities of color, who are disproportionately black and brown, are disadvantaged by decades of racism and neglect. It’s important for us to contribute to solutions for all children and families. Engaging in clinical practice transformation and harnessing the power of advocacy and partnership will be integral components of our response.

As your home, AACAP will provide resources, strategies, and tools developed with the wisdom of our members. Partnering with all our stakeholders, pediatricians, mental health providers, youth, families, and communities, will be key. The American Rescue Plan Act of 2021 offers an opportunity to address neglected mental health priorities with initiatives such as integrated pediatric care, telehealth, suicide prevention, community mental health, and substance use disorders treatment.

Let’s do this together with an eye to our values of diversity, equity, inclusion, and justice for all.

I invite you to join me in our collective presidential initiative: CAPture Belonging. Through our DEI journey and by investing in each other, our community, and our connectedness, we can dare to dream and meet the challenges before us. We will promote health equity and justice and combat racism and other forms of oppression and change the world in the words of Harriet Tubman.

I want to thank my dear forever friends, family, AACAP family, and my patients and their families who have taught me and invested in me along the way. I am grateful for all the mentoring and support AACAP has gifted me, most importantly, to be myself and contribute to our collective passion for advancing children’s mental health and child and adolescent psychiatry.

Finally, I want to thank my parents, who dared to dream, and I dedicate this to my mother, whom I lost suddenly this year. She taught me the transformative power of love. I hadn’t seen her in a year and a half, but we often spoke by Zoom. She would always ask me, “Are you happy?” I told her that thanks to her, “I am living my dream.” There is a word in Chinese, my mother tongue, for happy that is literally two words:

“Open (开) + Heart (心) = (开心).”

So, with an open heart, I invite you to join me in CAPture Belonging.

• Be you
• Be AACAP
• Belong

Thank you.

Warren Y.K. Ng, MD, MPH
President

A version of this Presidential Address was delivered on October 25, 2021, at the 68th Annual Meeting of the American Academy of Child and Adolescent Psychiatry held virtually.
Seclusion and Restraint Abuses in ‘Under the Radar’ Group Homes and Psychiatric Residential Treatment Facilities (PTRF). How Much Do We Know? What Should We Do?

Kim J. Masters, MD

How would you react if you were coercively taken from your home by staff sent from a group home and placed in one of their treatment facilities that routinely used seclusion, restraint, shaming? (Teen Challenge)\(^2\)

How would you react if you were transported from your home by PTRF staff and secluded for a week on a arrival at the facility in a basement room with blood and scratch marks on the wall. (Paris Hilton testimony to Utah lawmakers).\(^2\)

How would you react if as a patient the PTRF strip searched you naked even though you had been previously sexually assaulted? What if then you were left in isolation and padded rooms as treatment that caused so much distress that your hands swelled up from injury banging on the walls? (North Carolina RTC (Strategic Behavioral Health, NC) one of many NC funded RCT whose abuse was reported in a USA today investigation).\(^3\)

How would you react if you were in a group home and pregnant and forced to give up your child for adoption? Teen Challenge\(^1\)

How would you assess a PTRF that refused permission for a teenager to attend her father’s funeral and that resulted in her jumping off a balcony to injure herself, because it was the only way to get permission to go? Solstice East, Asheville, NC\(^4\)

Introduction

Recently, Seclusion and Restraint abuses have been reported in several facilities, group homes and psychiatric residential treatment centers throughout the United States.

Many were not accredited by the Joint Commission (JC) or the Center for Medicare and Medicaid Services (CMS). Regulation and monitoring defaulted to individual States. How they carry out this mission is influenced by their legislative bodies and Governors who appoint the heads of these supervisory bodies. Budgets are always a problem due to the low funding priority for institutional psychiatric care, especially ‘troubled’ children, and adolescents.

While the facilities described here require parental consent for ‘treatment’, patient ‘assent’ is routinely coerced, or not offered.

Authoritarian Treatment Models that Lack Empirical Efficacy

- A ‘shame’ model based on the ‘fallen’ moral nature of the adolescent patient. In Ireland, where I live part time, this approach is like the now discredited Irish Churches’ homes for pregnant teens from 1920’s to 1990’s. Its methods included prolonged isolation, shame-based teaching and chores, and humiliation in front of other confined teenagers.

- A Synanon group addictions program used in some Utah treatment centers as described by Paris Hilton from her own experience. This is best described as the PTRF’s program is directed by the leadership expressed through peer group confrontation of individual patients, peer punishments recommendations, and ‘group consequences’ like room seclusion for days for misbehavior or to force confession of secrets. Neither model has adequate research data for efficacy.

- Evidenced based and affirming treatments: the Six Core Strategies, Collaborative Problems solving, Sanctuary Care, or Safewards are not provided.

Teen Challenge Group and Its Family Care Homes

According to the New Yorker Investigation\(^1\)

“The organization, which is affiliated with the Pentecostal Assemblies of God church, is made up of (at least 1000 centers) for adolescents and adults seeking to overcome “life-controlling issues,” such as drug use, depression, or sexual promiscuity. Many people are sent there by courts at taxpayer expense, as an alternative to juvenile detention or jail.”

This designation evidently, allows exceptions to evidenced based treatment, seclusion and restraint protocols, and basic patient rights, and as the article indicates, limits the investigative powers of State Social Service Agencies, so long as parents place their children in these facilities. Some of these children come from foreign and domestic adoptions that disrupted because their adoptive parents could no longer manage their behavior. Without doubt, the experiences described in the article would increase the role of complex trauma PTSD for these children.

Some Findings from the New Yorker Investigation of Teen Challenge

- Patients are designated ‘students’ on whom a shame-based Bible curriculum is mandatory. Assent to this form of care is either coerced or not offered.
There are no standardized mental health evaluations or evidenced based effective treatment protocols

Transportation from the adolescent’s home is sometimes provided by ‘Teen Challenge’. In one instance at least, a frightened 16-year-old young woman was taken from her home by a 6’2” male Teen Challenge ‘Transport worker’, at 3 AM as parent watched.

Admission to a Teen Challenge home is reported to include being stripped naked to search for drugs regardless of a prior history of sexual abuse or trauma

During the first six weeks, ‘the student’ is designated a ‘Little Sister’ and kept six feet away from everyone including staff.

The ‘Student’ is supervised by 2 ‘Big Sisters’ – teens in the program for 6 months or more – and not permitted to enter any room without them.

Not allowed to look at boys

Coerced to report ‘all misbehaviors’ of other ‘students’ on moral grounds of not condoning misbehavior.

Punishments include writing a correction paragraph up to 150 times and forced Silence – not talking to anyone.

If a teen is discovered to be pregnant, then she can be transferred to another Teen Challenge home for pregnant teenager where, apparently, she will be characterized and treated in biblical terms as a ‘fallen woman’, someone in need of becoming a repentant ‘Mary Magdalene’, and forced to give up her child for adoption through a process in which the adolescent has no legal representation and the program has well trained lawyers.

State review of these activities is mostly blocked because of the religious exemptions claimed by the facilities.

Abuse in Utah Based Facilities:

As reported by Paris Hilton in the Washington Post, included staff slapping her and confinement in basement seclusion.2

Dr. Phil is being sued by a patient whom he coerced into going to the Escalante Ranch in Utah where she claimed she was raped. The article includes other abuse complaints about the facility.5,6

Abuse over many years at the Provo Canyon School7

Abuses in North Carolina:
Solstice East, Asheville North Carolina8

Refused permission to attend father’s funeral while in the facility so escaped by climbing onto a balcony to fall and have injuries requiring her to go to an Emergency Room.

The Citizen Times reported:
Interviews with eight former clients who lived in Solstice East as far back as 2013 provided disturbing accounts of bullying by staffers and their peers. Some of them are sexual assault survivors and said they were traumatized during strip searches and rules sometimes required staffers to remain within an arm’s length of them even when they went to the bathroom, took a shower, or slept.

All of them said staffers threatened clients with restraint holds or time in an isolated, window-less room in the basement for relatively minor transgressions such as cursing or talking back. One former client claimed she once spent 17 consecutive days in the basement, that’s how we knew they got medication late. In some instances, workers administered medication without a signed order from a physician or licensed prescriber, which is required by law.

Solstice East workers used restrictive interventions against clients for up to five hours at a time. “Between March and October 2020, 21 restrictive interventions were utilized over a total of 10 clients, indicating a trend that was not addressed.”

Solstice East workers failed to take a client to the hospital after she swallowed gulps of shampoo even though an on-call nurse recommended they do so, in case she had ingested something else, too. Records say Solstice East did not contact the child’s guardian immediately to let them know what happened.

The USA Today Investigation about other North Carolina RTC Facilities3

Staff member at Jackson Springs Treatment Center near Fayetteville, NC, who had served time for second degree murder punched a boy in the face and broke his eye socket and was not provided medical treatment.

Sexual exploitation of 14-year-old girl at Carolina Dunes Behavioral health near Wilmington, so she sabotaged her discharge to stay for night encounters with him.

The USA Today investigation found that:

Children sent to these facilities across the country were more likely not to graduate high school and to end up in prison.

NC warehoused children in Psychiatric Residential Treatment Facilities instead of providing treatment and that the NC legislature repeatedly cut mental health.

Investigators found:

From March 2020 to October 2020, Solstice staff made 115 medication errors, including 71 times when clients missed getting their medicine and 44 times when they got medication late. In some instances, workers administered medication without a signed order from a physician or licensed prescriber, which is required by law.

Solstice East workers used restrictive interventions against clients for up to five hours at a time. “Between March and October 2020, 21 restrictive interventions were utilized over a total of 10 clients, indicating a trend that was not addressed.”

Solstice East workers failed to take a client to the hospital after she swallowed gulps of shampoo even though an on-call nurse recommended they do so, in case she had ingested something else, too. Records say Solstice East did not contact the child’s guardian immediately to let them know what happened.

The USA Today Investigation about other North Carolina RTC Facilities3

Staff member at Jackson Springs Treatment Center near Fayetteville, NC, who had served time for second degree murder punched a boy in the face and broke his eye socket and was not provided medical treatment.

Sexual exploitation of 14-year-old girl at Carolina Dunes Behavioral health near Wilmington, so she sabotaged her discharge to stay for night encounters with him.

The USA Today investigation found that:

Children sent to these facilities across the country were more likely not to graduate high school and to end up in prison.

NC warehoused children in Psychiatric Residential Treatment Facilities instead of providing treatment and that the NC legislature repeatedly cut mental health.
funding to prevent supporting community resources.

What To Do?
National Disability Rights Network created an online critique and summary, “Conditions of Treatment in For Profit Residential Treatment facilities.”

and there is the Congressional Accountability for Congregate Care Act 2021.

Let us have our own conversation about this too. Child Psychiatrists are required in Psychiatric Residential Care Facilities. Should we:

■ Develop training and support materials for child psychiatrists working in PTRF or group home facilities about ways to impact treatment and staff education?

■ Discuss these issues during training of Child Psychiatrists?

■ Encourage discussions among components and committees of the AACAP?

■ Have an Academy conduit for member suggestions and questions about PTRF and Group home psychiatric responsibilities and opportunities for preventing abusive practices?

■ Other approaches?

If you are interested, email me kmaster105@gmail.com or contact Rob Grant at ACCAP rgrant@aacap.org.

References
9. Congressional Accountability for Congregate Care Act 2021. https://mail.google.com/mail/u/0/#search/cbelloni%40jbcc.harvard.edu?projector=1

Dr. Masters received his undergraduate degree in English from Princeton University and his medical degree from Harvard Medical School. He completed his general psychiatry residency and child psychiatry fellowship at the University of California in San Diego. Dr. Masters is board certified by the American Board of Psychiatry and Neurology in general psychiatry and child psychiatry. He is a fellow of both the American Academy of Child and Adolescent Psychiatry and the American College of Physicians. He is a member of the Association of Child Psychiatry and Psychology in Great Britain, and a member and fellow of the American Psychiatric Association.

Honor Your Mentor

in the March/April issue of AACAP News!

Honor your mentor in the March/April issue of AACAP News! Whether you’re a medical student, resident, active researcher, or practitioner, or retired—someone made a significant impact on your career. We’re asking all of you to take the time to honor your mentor and tell others why they were important to you, and how they influenced your life. In 100 words or less, tell us who served as your mentor. Email submissions to communications@aacap.org by February 15, 2022.

Please include your name, affiliation (if appropriate), the name of your mentor(s), and a short testimonial or anecdote. Photos are encouraged as well.
ADHD Updates – What Can We Learn from the Expert?

Dr. Newcorn: keep in mind which potential risks our readers need to each medication may be able to fill, and indications, what specific treatment gaps love to hear about the evidence, FDA newest medication options? We would last 1-3 years - what are some of the in ADHD psychopharmacology in the are the most significant developments

Dr. Lorberg and Dr. Whitworth: What are the most significant developments in ADHD psychopharmacology in the last 1-3 years - what are some of the newest medication options? We would love to hear about the evidence, FDA indications, what specific treatment gaps each medication may be able to fill, and which potential risks our readers need to keep in mind.

Dr. Newcorn: There are several.

Just this past year, we have had three new drugs approved for ADHD –

- Qelbree (viloxazine extended-release [ER]),
- Azstarys (serdexmethylphenidate/dexamethylphenidate); and
- Dyanavel XR tablets (racemic amphetamine (AMP) 3.2 d-AMP/1 l-AMP).

A number of studies examined safety and efficacy of medications for ADHD in preschool age children as a result of the recent FDA mandate that new drugs for ADHD be studied in preschool age children.

Several key studies supported the positive impact of ADHD pharma-cotherapy on key functional outcomes in ADHD.

Several other studies used a placebo substitution design together with longer term treatment to demonstrate efficacy of medications for ADHD well beyond the duration studied in the acute trials.

Let’s talk about the new to market ADHD medications, as well as several other relatively newer pharmacologic options.

Viloxazine ER (Qelbree) is a repurposed antidepressant (approved and used for depression in the UK and several other European countries until the early 2000s, and then withdrawn for commercial reasons not related to safety).

Viloxazine ER was FDA approved in April 2021 for the treatment of ADHD in children and adolescents 6 years and older.

The drug is thought to exert its therapeutic effects via norepinephrine reuptake inhibition; however, the drug also has effects on several post-synaptic serotonergic receptors, which could also contribute to therapeutic efficacy (though more extensive study is required).

In addition to the research in children and adolescents leading to FDA approval, clinical trials have also been conducted in adults, and these data were recently submitted to FDA for review; however, as of now, Viloxazine ER is not FDA approved for use in adults.

As a previously approved antidepressant, with positive effects in anxiety, it is possible that this medication could be useful in people with ADHD and internalizing disorders. Although there are not yet data in individuals with ADHD + depression, I am sure we will be seeing studies investigating this topic in the near future.

In clinical trials, the response to various doses of Viloxazine ER was similar, suggesting that only minimal titration may be needed. This also suggests that you might see response relatively quickly. In fact, one recent study showed that response to Viloxazine ER was evident by two weeks.

Viloxazine is not metabolized by CYP2D6, so response is not affected by genetic variants in this system – further differentiating it from atomoxetine.

Viloxazine is a strong inhibitor of CYP1A2; and a much weaker inhibitor of CYP3A4 and CYP2D6 and can potentially impact plasma levels of drugs metabolized through these substrates (e.g., clozapine – CYP1A2; duloxetine – CYP3A4; atomoxetine, risperidone, venlafaxine, others – CYP2D6).

Serdexmethylphenidate/dexamethylphenidate (Azstarys) is a fixed-dose combination medication which was FDA approved for ADHD treatment in children and adults 6 years and older in March 2021.
Azstarys consists of the prodrug of dexmethylphenidate (serdexmethylphenidate) combined with immediate release dexmethylphenidate. There are three combination doses, which correspond to 20 mg, 30 mg and 40 mg of dexmethylphenidate XR (i.e., Focalin XR).

Serdexmethylphenidate is activated by conversion to dexmethylphenidate in the lower GI tract.

The prodrug provides smooth and extended duration of coverage, but it takes a very long time to get started; combining it with IR dexmethylphenidate ensures rapid onset, with effects seen after 30 minutes. Duration of effect is up to 13 hours.

Serdexmethylphenidate alone (i.e., only the prodrug) received a schedule IV designation from the DEA, based on research showing very little likability compared to traditional stimulants and other potentially abusable drugs. However, the combination product is still a schedule II drug due to the inclusion of dexmethylphenidate.

Racemic amphetamine XR tablet (Dyanavel XR), also approved in patients 6 years and older in November 2021, is a tablet formulation of a medication previously only available as a liquid suspension.

This is a racemic formulation consisting of d- and l-amphetamine in a ratio of 3.2/1.

The tablets can be swallowed whole or chewed, with a similar pK profile – adding a new option for drug administration relative to other AMP formulations.

Statistically significant improvements were seen in Permanent Product Measure of Performance Total (PERMP-T) scores as early as ½ hour, and as long as 13 hours after administration, compared to placebo.

Dyanavel XR is expected to be commercially available in the first quarter of 2022. There are several other medications that were recently approved and are already in use.

D,L-methylphenidate delayed/extended-release formulation (Jornay PM) is given at night.

Release of active drug is delayed for about 10 hours – no more than 5% of total drug is available during that time – so the medication is not active at night and begins to exert its effects first thing in the morning.

The medication was shown to have beneficial effects on early morning behavior in children, while retaining an extended duration of effect.

Early morning is a time of day associated with significant impairment and distress for children and families, so covering this time well is quite important.

Multilayer beaded d,l-methylphenidate formulation (Adhansia XR) has extended duration of action out to 16 hours.

Multilayer bead, with 20% immediately available and 80% delivered over the rest of the day.

Adhansia XR is the longest acting methylphenidate. This is important because there have not been methylphenidate formulations with the potency and duration of effect seen with the longest acting amphetamine formulations – e.g., lisdexamfetamine (Vyvanse) and triple bead mixed amphetamine salts (Mydayis) – which has constrained use of MPH in adults.

It is well-known that, although most people will respond to either stimulant class, there is differential response in a sizable minority of patients. It is therefore important to have a long-acting MPH formulation for use in adolescents and adults.

In addition, there are probably another 6-10 new stimulant formulations being developed, in both the methylphenidate and amphetamine classes. These new medications address additional gaps in the pharmacologic armamentarium – including:

- sculpting of medication delivered over the course of the day,
- alternative delivery options for amphetamine (as there are currently fewer options available), and
- tamper-resistant formulations, which have the potential to mitigate risk for misuse and abuse.

Dr. Lorberg and Dr. Whitworth: Could you speak about ongoing R & D work with nonstimulant molecules?

Dr. Newcorn: Absolutely.

Centanafadine is a triple reuptake inhibitor (serotonin, dopamine, norepinephrine) that is currently in phase 3, and therefore closest to the market.

Research in adults has so far been promising, but the pivotal trials in children and adolescents are just now being undertaken.

Like the other nonstimulants, effect size seems to be in the moderate range, and smaller than it is for stimulants.

Dr. Lorberg and Dr. Whitworth: Could you share your thoughts about effect size in clinical trials – what it does and does not tell us about how to use medications in clinical practice?

Dr. Newcorn: That is a question I have been thinking a lot about.

First, remember that effect size (ES) is a statistic which includes all comers. ES in clinical trials describes the mean magnitude of the difference between active drug and placebo, taking into account the standard deviation in response – meaning it includes the full range of variability in response.

If you have a drug that works about the same for most everybody, ES will give you a good idea how the drug will work for your patient.

But... and this is important... if you have a drug that works really well for some people but not so well for others, you will have a drug with a moderate ES that could produce a really robust response in the subgroup of people it is really good for – which means that it could be an important therapeutic option for some people, but not a great option for others.

Why does this matter? Well, in clinical practice, we are interested in...
Typically, practitioners use the new medications in patients who haven’t responded to other existing drugs – and, of course, that makes sense for several reasons. That approach will probably work for stimulants, since the new drugs are different formulations of existing medications. They will each have certain unique features that may impact response or tolerability, but their mechanism of action will be similar to that of existing stimulant formulations.

But that approach – using the new medication in people who did not have a response to existing medications (typically stimulants) – is likely to bias against response to novel nonstimulants. The reason is that the small group of people who don’t respond very well to any medications are in the group who you are targeting with the new drug – which is likely to make the new drug not perform so well. Of course, sometimes you do see preferential response to a nonstimulant over previously trialed stimulants.

Hopefully over time, we will get a better idea how to match treatments to patients, as we learn more about the distinguishing properties of each of the treatments, and predictors of optimal response.

In the 2nd part of this update, we will ask Dr. Newcorn to comment on the issues of ADHD pharmacogenetics testing, most important ADHD research developments, and to educate the readers about APSARD, https://apsard.org (The American Professional Society of ADHD and Related Disorders).

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Dr. Colin D. Whitworth is a psychiatrist in Worcester, Massachusetts, and is affiliated with UMass Memorial Medical Center.

Dr. Lorberg and Dr. Whitworth: Could you comment more on how specifically you would use the newer medications?

Dr. Newcorn: I have had some experience using each of these medications in my clinical practice, but still just a few cases with each. I could, however, tell you what my expectations would be.

Typically, practitioners use the new medications in patients who haven’t responded to other existing drugs – which typically requires reductions of 40-50% in ADHD symptoms. If, for example, you can identify which patients are going to respond very well to a certain drug, and which patients are not, you could utilize a personalized approach to treatment with a drug that has a moderate ES and achieve an excellent response in selected individuals. Right now, that is somewhat lofty thinking because we don’t really know how to predict which patients will respond preferentially to which drugs. But it’s an important goal for the future, and an especially relevant one for optimizing treatment with non-stimulants.
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Mentorship programs, such as those introduced through the American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting, have traditionally served to connect trainees to the field of Child and Adolescent Psychiatry (CAP). Highly sought-after programs, such as the Medical Student and Resident (MSR) Two-Day Mentorship Program, Owl Mentorship, and Career Development Forum have provided trainees with countless opportunities for promoting interest and awareness in career development, advocacy, professional networking, and mentorship. However, over the last year, the pandemic has introduced many challenges for trainees and mentors alike, including how to navigate virtual accommodations and strive for connection in a time of isolation. Below we share perspectives on mentorship which highlight the importance of creativity and adaptation during this virtual era.

Matching into Residency

Navigating the residency application process felt even more daunting after learning that the process would be virtual. AACAP has connected me to mentorship opportunities I otherwise would have struggled to find. I attended my first Annual Meeting three years ago and met a medical student, now psychiatry resident, who welcomed my questions about residency applications. She provided insight to residency programs’ virtual open houses and social media accounts that became a huge aspect of this year’s recruitment. At this past virtual Annual Meeting, I attended the MSR Two-Day Mentorship Event. Side conversations around tables were instead transformed into direct Zoom messages in breakout rooms. This is how I connected with one of my current mentors, who exchanged emails with me offering advice throughout the interview cycle. The MSR Committee just launched a Peer Mentorship Program, and the CAP fellow I was paired with spent an hour on the phone giving me rank list advice. Beyond just answering questions, all of my mentors would check in with me and were ready to celebrate with me when I matched. Amidst the challenges and changes to adapt to, the bright spot of this virtual era has been these meaningful connections I made despite the distance. Mentorship was crucial in my residency application journey, and I am grateful for the people who offered me support and guidance along the way. —Carly

Matching into CAP Fellowship

If there is one word that could convey the ethos of residency over this past year, it would be adaptability. My fellowship interview season was completely upended by COVID-19. The transition to virtual communication created uncertainty and increased feelings of vulnerability for applicants. For me, this meant that I could not gain that intangible “gut feeling” along the interview trail. Instead, it was paramount to embrace support and programming that could adjust to the needs of trainees applying during this cycle. Throughout the application cycle, I received continued guidance and encouragement from many supervisors at my home program via Zoom and telephone. In addition, AACAP and specifically the MSR committee was able adapt its traditional programming geared towards trainees and host them virtually both during the Annual Meeting and through new virtual mentorship avenues such as the CAP Fellowship Match Webinar. Through the MSR committee, I was connected to Training and Education Committee members who without hesitation provided me with reassurance and guidance in the matching process. Receiving their support made me confident in my choice. Whether or not future CAP fellowship applicants will apply virtually, they will likely benefit from the multitudes of mentorship available through AACAP as I did. —Sarah

Transitioning to Early Career Psychiatrist

On the hunt for my “best first job”, never did I anticipate the journey that lay ahead. As a foreign-born IMG, I needed to serve 3 years in a federally designated underserved area to complete a J1-waiver. With stringent timelines and limited jobs available, “waiver hunting” can be tremendously stressful,
and the pandemic added yet another layer of uncertainty. I emailed as many Department Chairs from underserved areas as possible, only to find that most places were on hiring freeze. Following rounds of interviewing, I was told that my application was dropped due to “fiscal reasons”. Then all of a sudden, time stood still, both my parents were hospitalized with COVID in India. As my father was battling for his life in the ICU, I found myself paralyzed by indecision.

As my opportunities shrunk, I recognized the need for peer mentorship during transition, and we launched our MSR Peer Mentorship Program. Led by CAP fellows and ECPs, our program offers mentorship to help trainees navigate these crucial periods. The connections with peers and the AACAP IMG Caucus led me to new avenues, and my network quickly expanded. It was then that I realized that the search for the “best first job” lay on all the meaningful relationships, mentorships, and friendships that I had cultivated – the first ingredients needed to support the transition to an ECP. –Ani

**Becoming a Virtual Era Mentor**

During the COVID-19 pandemic, I hit a milestone: practicing for a decade as an attending CAP physician-educator. In my first five years as an attending, I learned about learning, and how to pitch my teaching and mentorship in a way that would engage my learner. In my second five years, I learned to be the one engaged with my learner, listening carefully, gaining an appreciation for the unique person sitting across from me, and reflecting this back to them so they feel confident to take the next steps in their journey.

As that decade marker approached, “sitting across from me” became a metaphor. As each trainee I saw on my computer screen struggled amid the pandemic in their own way, remaining passive was not an option. To truly be transformative, the relationship must be charged with more energy. How? Network them with phenomenal people. Encourage them to write or present. Help them finagle an elective or research time to develop their interests or give them encouragement to inject their creativity and personality into what they do. Doing this, I’ve helped “fill their bucket” in this field. Now, my own growth area has become to sponsor and champion my mentees. That’s my task for the next decade. –Brian

**Final Thoughts**

The 2020-2021 academic year brought upon significant uncertainty to trainees. The changing landscapes of virtual recruitment, institutional policies, and social climate made the inherently anxiety-laden process of seeking a professional home even more daunting. Some adaptations, such as alleviating travel and financial burdens, seemed positive. Others however, such as the inability to complete visiting rotations or in person interviews, led to all parties struggling for guidance.

During this period of stress, creative trainees and educators pioneered an array of innovations, stepping up to bolster support from individual advising, space and equipment provisions, proactive contingency planning, to institutional expansions of virtual resources. In the end, what worked?

We learned that individual connections and tailored mentorship are indispensable. As members of an organization dedicated to fostering the future of CAP, AACAP members can directly shape the future of our workforce by contributing your wisdom. Whether it is a single exchange or a longitudinal relationship, we encourage all readers to become mentors online: (https://www.aacap.org/AACAP/Medical_Students_and_Residents/Mentorship_Matters/AACAP_Mentorship_Programs.aspx) and at the AACAP Annual Meeting. We must all step up to support trainees – be their guiding spirits as they navigate career transitions in the virtual era.

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Brian Kurtz, MD, joined Cincinnati Children’s Hospital Medical Center in 2011 and served as the director of the child and adolescent psychiatry consultation/liaison service at Cincinnati Children’s Hospital Medical Center from 2011-2019. He helped lead the Child and Adolescent Psychiatry Residency training program at Cincinnati Children's Hospital Medical Center as assistant director from 2016-2019 and as director starting in 2019. He is a member of the Training and Education Committee of AACAP and a member of the Master Educator Committee of the Association for Academic Psychiatry. brian.kurtz@ccchmc.org

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Examining the Untamed Landscape of Adolescent Use of Dietary Supplements: Supplements for Boosting Energy and Losing Weight

Dietary supplements help many people aiming to maintain good health and well-being. Educated with good information and advice from health professionals, some adults and children have found supplements to have truly improved their overall quality of life. Yet, like all good things not done prudently or in moderation, the risks of supplements may in some cases outweigh their benefits. This is especially true in the case of the adolescent population whose access to reliable information about supplements is low while their motivation for taking somewhat extreme measures to improve both their physical appearance and performance can be very high.

Combined with a confusing and lax regulatory context, adolescents often have too many opportunities to “self-medicate” with supplements, an unhealthy situation that is, in the end, the fault of adults who should be taking better care of their charges. A respected academic in the field of public health has recently laid down a marker about supplements that we should all respect: “Unless all supplements are required to be tested for safety, efficacy, potency, and purity with scientific rigor, no consumers or clinicians can assume that supplements are safe and effective.”

Unfortunately, studies of adolescent use of supplements are few. Also, many consumers assume (along with a 40% of doctors!) that if a product is available on the market that it’s gone through some sort of meaningful safety screening. But we do know, nonetheless, that some of these substances may pose safety risks (either intrinsically or in large doses) and that adolescents are taking to these supplements, sometimes with great enthusiasm (witness the trendy appeal of “Monster” brand energy drinks to teens). Moreover, adolescents follow the example of their parents, many of whom we know are dedicated consumers of these products – and who also bring these products in the homes to where their children live. Moreover, exposure to supplements at this young age can act as a “gateway” to their increased use when children become adults.

This article offers a sampling of some of the issues and potential dangers adolescents face in surveying dietary supplements for their health goals. This article will look at two supplements for weight loss and energy; a companion article following will treat supplements associated with the related goals of strength training and muscle building. Adolescents often turn to supplements to help their physical appearance and athletic performance. For teens, this often results in a focus on weight loss and increased energy. Below are examples of supplements used for these respective goals.

Garcinia Cambogia (supplement for weight loss). Garcinia Cambogia is also known as the Malabar tamarind, a tropical fruit. The mix of pros and cons of taking this as a supplement for weight loss point not only to potential dangers of supplements, but also to our often very incomplete understanding of the properties of these supplements. The fruit’s weight loss benefits come from hydroxy citric acid (HCA); an active ingredient found in the fruit’s rind. This may be effective in blocking citrate lyase, an enzyme used by the body to create fat. It also can raise the levels of serotonin in the brain, which might contribute to feeling less hungry. On the other hand, as more information is gathered about the supplement, the evidence for its weight loss properties seems to have diminished. Taking this supplement may result in dizziness, headache and diarrhea. Individual instances associate the supplement with more serious side effects, like muscle damage, acute
hepatitis, and acute liver failure requiring liver transplantation. And one recent study connects the use of *G. Cambogia* to mania with psychosis.5

**Caffeine/Energy Drinks with Caffeine.**
Caffeine is a ubiquitous substance: it is the most widely consumed supplement in the world, mainly through beverages (like coffee and tea). Adolescents are particularly at risk because of the combination of two factors. First, companies selling trendy caffeinated beverages often use advertising that is deliberately attractive to adolescents. Second, although a daily amount of up to 250 mg of caffeine is relatively safe, popular energy drinks (brands like Monster and Red Bull) start consumers off with a very high levels of caffeine. While a high dose of caffeine comes in at 250-500 mg, one 16 oz can of Monster contains 160 mg (with energy drinks coming in at 10 mg of caffeine per ounce compared to traditional soft drinks at 3 mg per ounce).6,7 With regulations not requiring manufacturers to list the amount of caffeine in their beverages, young consumers often have no idea how much caffeine they may be drinking. If it’s cool and other kids are drinking it, a teen may think, why not have another?

Garcinia Cambogia and Caffeine barely scratch the surface of the vast health territories covered by supplements. Yet they act as useful short “case studies” that make the potential variety and severity of supplement misuse more vivid and understandable. As mentioned at the outset of this article, some supplements can certainly be helpful and beneficial when used properly. This only highlights the need for reliable resources in this area to help us guide our patients and offer evidence-based treatment recommendations.

**References**

Nada Milosavljevic MD, JD, is a child and adolescent psychiatrist at Massachusetts General Hospital and an instructor in psychiatry at Harvard Medical School, Boston, MA. She is the author of Holistic Health for Adolescents (WW Norton) and serves on the Adolescent Psychiatry Committee. nadamilo31@gmail.com
A nationwide shortage of mental health care services combined with a 31% rise in pediatric Emergency Psychiatric visits during the pandemic led to the recent declaration of a national state of emergency in pediatric mental health by American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Pediatrics and the Children’s Hospital Association. Child Psychiatry Access Programs (CPAP) increase the capacity of pediatric primary care providers (PCPs) to treat common psychiatric disorders, thus extending the child psychiatry workforce. CPAPs have been developed in 46 states, the District of Columbia and the territory of Guam, scaffolded by the National Network of Child Psychiatry Access Programs. Programs from Massachusetts, Michigan, Mississippi, North Carolina and Texas, described lessons learned during the pandemic at the recent annual meeting of AACAP.

The Massachusetts Child Psychiatry Access Program (MCPAP) was piloted in 2004 and formalized in 2005 as the nation’s first statewide CPAP. It had 6 regional hubs; each with a consulting team based in an academic medical center. It was funded by the state budget initially with commercial insurers later contributing for their covered members accessing this service. The core components were 1) immediate telephone consultation 2) expedited outpatient consultation 3) resource and referral service 4) continuing mental health education for PCPs. Based on a Quality Improvement initiative after a decade, the number of call centers were consolidated from 6 to 3 for operational efficiency, care navigation services were streamlined and outreach to PCPs was added as a core component. MCPAP has also extended specialty mental health care services: 1) MCPAP for moms for perinatal psychiatry 2) MCPAP-ASAP-Adolescent Substance Use and Addiction Program 3) MCPAP-ASD/ID for Autism Spectrum Disorder and Intellectual disabilities. During the pandemic, MCPAP has pivoted with telepsychiatry and by (1) MCPAP-ASAP offering telehealth evaluation and counseling (2) MCPAP-Early Childhood Mental Health program development with funding by the American Rescue Plan (3) Commitment to Diversity-Equity-Inclusion initiatives (4) Piloting consultation through electronic medical records (5) Piloting child and adolescent psychiatry fellowship experience in CPAP.

The Michigan Child Collaborative Care (MC3) Program was launched in 2012 with seed funding from Medicaid Match funding in collaboration with the Michigan Department of Health and Human Services. It began as a telepsychiatry consultation service in 13 counties, built on a framework of triage through a community mental health affiliated Behavioral Health Consultant, with the goals of providing pertinent resources, and if appropriate, same-day consultation with a child and adolescent psychiatrist (CAP) to discuss diagnostic and treatment concerns. In 2013 MC3 expanded to 22 counties and began offering perinatal consultation with additional funding by Michigan’s Mental Health and Wellness Commission. The program has now expanded to all 83 Michigan counties with Health Resources and Services Administration (HRSA) funding. Core services include educational offerings; one-time telepsychiatry evaluations; continued child and

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perinatal consultation services; and a secure online platform allowing providers to initiate consultations 24/7. MC3 offers additional supports to targeted high needs areas, e.g., the Flint area, state Tribal Health Centers. Though the volume of consultations dropped initially during the pandemic, by November of 2020, it returned to prior levels. Over the past decade, MC3 has offered more than 18,000 services to over 15,000 patients, with over 3000 enrolled providers. MC3 continues to support providers in the care of patients with a significant burden of psychiatric illness, acuity, and trauma.

With funding from HRSA through the first pediatric mental health care access cohort of programs, the Mississippi Child Access to Mental Health and Psychiatry program (CHAMP) was launched in August 2018. Its consultation warm line was launched in August 2019 to serve the state’s most under-resourced area, the Mississippi Delta, to provide diagnostic evaluation, medication management, and/or treatment planning consultations for PCPs serving children through age 18 years. An additional referral resource was included through partnership with a statewide organization, Families as Allies to assist families of children encountering school and advocacy issues due to behavioral concerns. During the pandemic, CHAMP responded by expanding statewide, extending hours, and by increasing the age of patients served to 21 years. Today, CHAMP has almost 300 primary care providers enrolled and has conducted over 400 consultations. CHAMP conducts continuous provider engagement, offers educational training to PCPs via Project ECHO, and creates learning opportunities for medical residents and fellows to assist with conducting consultations to train the next generation of the psychiatric workforce.

North Carolina (NC) has the second largest rural population in U.S., including approximately 920,000 children. In national surveys, NC ranks sixth with the highest prevalence of mental illness in youth and lowest in rates of access to care for children. The North Carolina Psychiatry Access Line (NC-PAL) program was developed in 2017 to provide telephone consultation to PCPs across the state. Initially, it was piloted in 6 counties in Central North Carolina (NC) and in 2018 with support from the State of North Carolina and HRSA, NC-PAL expanded statewide and added a perinatal access line. The parallel creation of these access lines has afforded a unique opportunity to collaborate with a dyadic approach, caring for behavioral health needs of children and their parents. Currently, 700 health care providers including primary care physicians in obstetrics, pediatrics, family medicine, and internal medicine, midwives, nurses, mental health specialists, case managers, social workers and lactation consultations are enrolled in NC-PAL. In the past 3 years there were over 1,300 consultations across 46 counties. During the pandemic there was increase in utilization of NC-PAL and transition of educational activities to virtual through Zoom with 95 providers receiving intensive mental health training through the REACH Institute’s curriculum in 2021. Additionally, there was an expansion of outreach activities, including a focus on children/youth with intellectual/developmental disabilities as well as the development of the Attachment Network of NC to engage community stakeholders around peer consultation, education and advocacy for infant/early childhood mental health.

Texas has only one county with a sufficient supply of CPAs. Hence in June 2019, the Texas Legislature passed Senate Bill 11, creating the Texas Child Mental Health Care Consortium (TCMHCC), to leverage expertise from the state’s 12 medical schools, state agencies and non-profit organizations, to create the Child Psychiatry Access Network (CPAN). CPAN provides a peer-to-peer consultation line that is available to any PCP in the state, a referral service that provides individualized recommendations, and an educational component. Phone consultations began in May 2020 during the pandemic, coinciding with starting up 4 other major projects: rotations for trainees in community mental health centers, expansion of Child and Adolescent Psychiatry Fellowships, a school based mental health treatment program, and 2 statewide research networks, focused on childhood depression and trauma. By August of 2020, all 5 programs were functional, and are currently expanding.

Changes During the Pandemic

Each CPAP adapted services in response to the mental health crisis during the pandemic. Several programs experienced increased call volumes and increased provider enrollment and engagement. Some CPAP programs extended their hours of operation, and a few programs in Massachusetts, Texas, and Mississippi involved trainees in their phone consultations. Some CPAPs offered online consultations alongside telephone consultations as a convenience. Services were also extended to include transitional age youth in some CPAPs, and some offered bridging care due to acute shortage of mental health services. The use of telepsychiatry during the pandemic has helped to improve pediatric mental health access in the primary care setting, schools and local communities for racially diverse children and for children from rural and other underserved communities.

In 2021, HRSA granted $10.7 million of American Rescue Plan funds to expand CPAPs to additional states and territories in the US, with the goal of addressing health equity related to racial, ethnic, and geographic disparities. Nationally CPAPs are poised to transform mental health care through telepsychiatry consultation, resource/referral coordination, ongoing medical education, research and training for future and current PCPs and CAPs.

References


Qualified tuition reduction at in-state institutions

Mental Health

Behavioral health

FEATURES

Essential Functions:
- care of child and adolescent behavioral patients at the innovative Banner – University Medicine Behavioral Health Clinic in Tucson, Arizona.
- Adolescent Psychiatrist to join our dynamic department led by Dr. Jordan F. Karp. The selected individual will be responsible for the clinical
- Trends in mental health concerns reported to two statewide pediatric mental health care access programs during the COVID-19 pandemic. Psychiatric Services (in press).


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Dustin E. Sarver, Ph.D, University of Mississippi Medical Center, Jackson, MS

Andrea Diaz Stransky, MD, Duke University School of Medicine, Durham, NC

Clinical Faculty: Child & Adolescent Psychiatry – Outpatient with Banner Health and UArizona

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.

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Save the Dates
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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.

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Reflections from 2021 AACAP Virtual Meeting

Rishab Chawla

As an MS2 and first-time attendee, I did not even know where to start in creating my conference watchlist, and by the end I had a massive backlog of content I did not know what to do with. I thank my mentor Bharat Sanders (MS4, MCG) for directing me to the sessions that aligned well with my goals.

A session that struck a chord with me was Dr. Jose Mantilla-Rivas’ (University of Pittsburgh CAP-1) Pecha Kucha “Connection in Isolation.” I related deeply to his feeling that he could not apply to himself the same standards of care and nurturing he provides others. For much of my adolescence and young adulthood, I have been so receptive to the pain of my friends. But when it is I who is suffering, I feel like I do not want to burden anyone else. His words helped me realize that in order to proclaim the wellness mantra “take care of yourself,” we must all strive to create an environment throughout medical training in which we are all valued and made to feel worthy enough to do so.

After viewing “Cultural Influences and Intergenerational Trauma” led by Tufts CAP PD Dr. Neha Sharma, I started to reflect more on why at times I had felt I could not be vulnerable around my loved ones. I would hide my emotional struggles to avoid judgment of community members because it was frequently reinforced to prioritize others’ opinions over my wellbeing. Religion was a source of great personal fulfillment, and yet it was also a catch-all shield to avoid unravelling the nuances of any difficulties I experienced. Every word spoken at the session was invaluable as I previously did not have the vocabulary to articulate the very concepts that hit so close to home (e.g., “acculturative family distancing,” “parent-child role reversal,” etc.).

Dr. Deepika Shaligram’s (CAP at Boston Children’s Hospital) concluding remarks, “Males also have less of a permission to have emotional suffering…is contrary to the idea of being strong” also set off another chain of flashbacks for me. I was bullied in childhood for having “girly” interests or otherwise for not fitting the hegemonic masculine mold, from what music I chose to listen to, the clothes I wore, to even what I would eat for lunch — as if certain modes or attributes of self-expression were just effeminizing.

It was not until several years later that I realized the absurdity of a song or color determining one’s gender, or that gentleness is an inherently feminine trait. The homophobic slurs I had received primarily served to gatekeep the boundaries of acceptable expressions of masculinity.

Going forward, I would like to study the internalization of Western norms of masculinity from a very young age across various channels of socialization such as family, film, and pop culture, as well as the effect of one’s cultural or ethnic background on such. Though research in the area may be sparse, I fear that the reinforcement of binarized gender stereotypes in childhood has negative mental health implications. Over the past few years, however, there have been notable cracks in the fortress of toxic masculinity including Justin Baldoni’s 2017 Ted Talk and Gillette’s 2019 commercial. For the 2022 AACAP Meeting, I would like to propose a session tracing this trajectory and exploring what it means to be a man.

Rishab Chawla is an MS2 at the Medical College of Georgia in Augusta, GA. He is passionate about health policy and is involved in the group Students for a National Health Program (SNaHP) and the AMA Medical Student Section. In his free time, he enjoys narrative writing and spending time outdoors. His mentor is Bharat Sanders (MS4, MCG).
Using the Creative Arts to Extinguish the Matchbox of Games that Fuel the Fire Called Burnout

In 2019, I attended my first AACAP annual meeting in Chicago as a fourth-year medical student, eager to discover more about the field of child and adolescent psychiatry and to gather with colleagues from around the country and world. This past October, I attended my third annual meeting, the second time in a virtual setting and now as a practicing psychiatry resident. While we are all thirsting for in-person conversation and connection, it has been inspiring to not only witness, but to experience first-hand, the powerful and pervasive impact collaboration can have, from near and far.

During this year’s conference, I rather spontaneously signed up for an event titled, “Drawing Together: Connecting Child and Adolescent Psychiatrists Through Art” led by Stephanie M. Davidson, MD – it sounded interesting, and I had the hour in my schedule free. Little did I know that this short evening program would refuel passion and reframe my mindset on the very experiences that typically kindle the fire called burnout.

Just the week before the annual meeting, I had a patient experience that left me feeling defeated, frustrated, and exasperated. In this field, it is not uncommon to run into patients whose behavior seems to suck the air right out of us. Whether it’s a patient with antisocial personality disorder, a child with complex trauma, or a teenager with oppositional defiant disorder, let’s face it – sometimes patients can behave with disrespect, hatred and even aggression. In a job where most of our time, energy, and effort is spent caring for others, occasional mistreatment from patients can leave us with nothing left to give – igniting a sizzling burnout into fuller flames.

During the “Drawing Together” wellness workshop at the 2021 annual meeting, we were asked to engage in interactive art activities to help shape our sense of connectedness and process challenging moments. For one of the breakout sessions, we were prompted to think about a recent difficult clinical encounter and create a literal or abstract representation (e.g., visual art, written word, music) of some aspect of the experience. I chose to reflect on the patient I mentioned earlier, the one who left me defeated as I tiptoed out of the room.

I entered the patient’s room as I do every day, calm and prepared with my empathy hat on, unsuspecting of what was to come – a patient lying in restraints yelling, cursing profanities, and making verbal threats, not to just anyone, but to me. The patient had been involuntarily committed by another physician and was taking out their anger on me stating that they would do everything in their power to make my life total agony. The words that struck me most were piercing, “fine, you keep me here against my will, watch me, I’ll play your game! Just get ready to lose!” I remember being filled with anger; after all, that is a natural human defense mechanism to protect oneself when treated cruelly. My colleagues helped me channel that anger into humor, another common defense mechanism used in the medical field. But no amount of irritation, laughter, or even grief would lead to the same cognitive reprocessing and resiliency offered when my thoughts were transformed into art:

I am a human, lying in a bed. 
You are a doctor, with knowledge in your head.

My arms and legs restrained, 
You are so well trained. 
I am stuck, unable to go; 
You are free, leaving me so. 
This is a game, I am a piece; 
You are a player, the timer is ticking. 
I plea for help and shout for release; 
All you do is stand there, so I guess I’ll start kicking.

As I write this article, I am reminded of the same humility this poem imparted on me a few short months ago. I was called today for a behavioral code on an adolescent, who was acting out violently and aggressively toward staff. Just an hour later in meeting one-on-one, that same patient looked into my soul with eyes of desperation, filled with sadness, pity, and fear. The same words rang true, “I am stuck, unable to go. You are free, leaving me so.” The simple act of writing a poem shifted my mindset from anger and frustration to empathy and understanding. Whether it’s the child today or the adult yesterday, behind the costume they put on for the “game” lies a suffering human, frantically seeking support and compassion. It is when we view it from this perspective that we can recognize these threatening behaviors are often just an overt symptom of an underlying illness, manifested most often in the most vulnerable moments when they feel a threat or loss of control.

In the field of child and adolescent psychiatry, we pride ourselves nowadays on using trauma-informed care. But we often forget a very important aspect of that – recognizing and processing our own workplace trauma, an unspoken part of the job description. As this AACAP annual meeting experience taught me, there is something powerful to be said for time devoted to clinicians processing emotionally taxing encounters.
As Dr. Davidson, chair of the Drawing Together event, wrote in a 2020 article on using arts as a tool in training, art-based tools have been shown to boost resiliency and alleviate burnout through giving clinicians a rare opportunity to tolerate the discomfort of unfamiliar topics in a safe space. While in training, art education itself can help augment curricula already in place to meet the new ACGME standards for physician well-being. Art presents a new opportunity to help trainees “learn the value of the clinician’s emotional response in the psychiatric evaluation (PCI), assist in self-reflection to allow for management of emotional content from difficult therapy sessions (PC4), and promote curiosity and openness to different points of view (PROF1).”

There is evidence to support that using the arts can lead to further development of empathy and in turn decrease stress and burnout while boosting resiliency. It is no secret that physicians face emotional challenges in their day-to-day work, and stories through narrative medicine and diary writing can certainly support those emotional needs. In fact, poetry in particular has been associated with decreased symptom burden in therapists who have developed secondary PTSD. Engaging in the arts can cultivate a cognitive skillset known as empathetic imagination, which helps clinicians to imagine the experiences and responses of another person, thereby supporting their own ability to process difficult experiences. By helping to humanize the person being cared for, art can lessen the burden of the caregiver, bringing to light a new perspective of the person behind the patient.

With burnout levels approaching more than half of all residents nationally and 80% of physicians internationally, the incorporation of emerging tools to extinguish the fire is imperative. We must acknowledge that just as much as our patients are humans, we too, as physicians, are. My patient described it as a game, others may call it symptom pathology; regardless, as a collective team of professionals, we must acknowledge the presence of this simmering matchbox that flickers constantly in the background of our everyday job. As the French sculptor Auguste Rodin, once said, “The artist must create a spark before he can make a fire and before art is born, the artist must be ready to be consumed by the fire of his own creation.”

References

Megan Single, MD, serves as a member of the AACAP Medical Student and Resident Committee while training as a second-year general psychiatry resident at the University of Florida. She graduated from University of Kentucky College of Medicine in 2020 and plans to pursue fellowship in child and adolescent psychiatry. msingle194@gmail.com

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Toxicology Testing for Children, Adolescents, and Emerging Adults (CAEAs) Undergoing Treatment with Controlled Substances

Many children, adolescents, and emerging adults (CAEAs) in psychiatric treatment are at risk for substance use disorders by nature of their underlying conditions. The reason for this elevated risk is multifactorial and some youth misuse substances, including prescription medications, as a quick solution to mitigate the effects of untreated psychiatric illnesses (Turner et al, 2018). In contrast, the use of appropriate medications for psychiatric disorders may limit the risk of substance use disorder. This paradigm has emerged specifically in the case of stimulant medications used to treat Attention Deficit Hyperactivity Disorder (Boland et al, 2020).

Toxicology testing may often be used when there is significant concern regarding hazardous substance use and/or substance use disorders in psychiatric patients who may not be forthcoming about their use. However, clinicians in some areas of the country are required to perform regular and systematic toxicology testing of individuals taking prescribed central nervous system (CNS) stimulants and other controlled substances in compliance with policies set by insurance companies or by their clinics. There is little consensus among physicians and few guidelines from professional organizations regarding the indications for toxicology testing in routine clinical practice. Among these, the American Academy of Child and Adolescent Psychiatry practice parameters, the National Institute of Health Care Excellence and the American Academy of Pediatrics treatment guidelines for Attention-Deficit/Hyperactivity Disorder (ADHD) do not recommend routine toxicology testing to start or continue CNS stimulants. As a result, clinicians are often left with limited guidelines (Levy et al, 2006).

Why Perform Toxicology Testing on Youth Who are Treated with Controlled Substances?

Toxicology testing in conjunction with a patient interview and physical exam is advised when there are marked changes in behavior or mental status in young people who are suspected of not being forthcoming about their substance use, as it may support diagnoses suggestive of such toxidrome. Early identification of substance use via validated screening tools and subsequent toxicology testing, can help to detect problematic patterns of use in individuals, and thus provide critical support for decision-making processes regarding the treatment plan.

Toxicology testing may be advantageous in individuals with a mixed clinical presentation that includes both psychiatric symptoms and signs indicative of substance use. In certain scenarios, these results may clarify more complicated diagnoses involving mood and psychotic disorders. Specifically, toxicology testing should be performed in all patients with first episode psychosis to rule out any potential contributions by or associated with substance use.

Reasons to Avoid Toxicology Testing on Youth Who have been Prescribed Controlled Substances

The decision to perform toxicology testing is dependent on clinical settings and may be unnecessary at various levels of care. For example, toxicology testing is unlikely to alter the disposition in emergency department settings when substance use is not suspected. In the outpatient setting, it is not required to order a toxicology testing for patients managed with a prescription CNS stimulant if they are forthcoming regarding their substance use. Finally, superfluous testing procedures can impose barriers to the therapeutic alliance and increase conflict in the parent-child relationship.

The current literature on this topic does not support routine toxicology testing. In uncomplicated cases involving aggression or impulsivity, toxicology testing offered little pertinent information and did not influence treatment planning.

“ Toxicology testing may be advantageous in individuals with a mixed clinical presentation that includes both psychiatric symptoms and signs indicative of substance use.”
“Toxicology testing may also present additional disadvantages for both patients and prescribers. The burden of cost and the overall cost/benefit ratio should be considered in each case.”

(Fortu et al, 2009). In another study, 91% of patients evaluated in an emergency department who presented with a positive urine toxicology also self-reported use of specific illicit drugs in the preceding 24 hours. The authors concluded that routine toxicology testing provided no additional information beyond that already available in the patient history (Olschner et al, 1997). Moreover, structured interviews and direct patient reporting were shown to have higher sensitivity and specificity than toxicology testing in youth (Gignac et al, 2005).

Limitations of Drug Testing

Toxicology tests are designed to provide qualitative and quantitative results (Levy et al, 2014). A qualitative test should be sufficiently sensitive to identify substance exposure. As such, qualitative tests are susceptible to cross-reactions and thus demonstrate limited test specificity and increase the chance of false positives. For example, patients prescribed quetiapine may test positive for methadone (Cherwinski et al, 2007). Similarly, one would anticipate that patients taking amphetamine or dextroamphetamine to treat ADHD (Cherwinski et al, 2007), might test positive for amphetamines. By contrast, quantitative drug tests are confirmatory in nature; however, they are typically more expensive, time-consuming and require access to specialty labs—thus, making their accessibility limited. Finally, test sensitivity and specificity variations can be found between laboratories.

A false-negative test might result from specimens that have been diluted, submission of a non-valid sample, or adulterating with agents known to interfere with the assay. Furthermore, due to the rapid development of new “designer” drugs, available toxicology tests may not be able to identify all relevant substances, including synthetic cannabinoids, e.g., K2/Spice, and hallucinogenic agents, even in many cases with chromatography, which when coupled with mass spectrometry is regarded as the “gold standard” in confirmatory testing. Delayed specimen collection could also have an impact on the test results due to the short half-life of many substances tested. Moreover, tests for each specimen type (e.g., saliva, urine or blood) may have very different sensitivity limits to detect substance use.

Toxicology testing may also present additional disadvantages for both patients and prescribers. The burden of cost and the overall cost/benefit ratio should be considered in each case. Difficulties locating a testing site and time taken away from other activities may represent additional hurdles for patients and their families. Providers may encounter unnecessary delays in prescription approvals secondary to insurance authorizations as well as additional time required for transmission of reports.

Conclusions

There are few clinical scenarios where toxicology testing of CAEAs is needed or indicated to prescribe non-opioid controlled substances. Toxicology testing may prove beneficial for monitoring of substance use for an individual with known substance use disorders, or when there is a significant and acute change in mental status indicating that the patient might be struggling with substance use. Moreover, toxicity results for a youth known to use substances can facilitate discussions regarding next steps including a higher level of care or additional supports needed to mitigate or prevent continued substance use.

Appropriate treatment of mental health illness(es) may alleviate psychiatric symptoms and in turn reduce the desire for substance use. Thus, eliminating the need to conduct toxicology testing of these individuals. Of concern is that routine toxicology testing may result in significant negative consequences when it is not of value. Therefore, advocacy to limit such testing is well advised. As with all mental health treatment, therapeutic rapport is the cornerstone of good care and thus, can be utilized to discuss concerns regarding substance use with toxicology testing being of last resort. It is important to acknowledge that toxicology testing rarely changes the course of treatment beyond what has been self-reported during a routine psychiatric evaluation. Thus, unless clear signs indicate concerns for substance use in psychiatric patients who may not be forthcoming about their use, toxicology testing is not recommended for routine treatment of CAEAs even in the case of prescribing non-opioid controlled substances such as CNS stimulants.

References


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FOR YOUR INFORMATION

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org.
An Introduction to the AACAP Resource Center for Outbursts, Irritability and Emotional Dysregulation

You may be aware of AACAP Past President’s, Gabrielle Carlson MD’s Presidential Initiative, Emotional Dysregulation in Children and Adolescents: Coming Together to Treat the Sickest Kids, but do you know about the AACAP Resource Center for Outbursts, Irritability and Emotional Dysregulation?

Dr. Carlson worked with her Presidential Task Force, co-chaired by Manpreet Singh, MD, and AACAP members to develop many resources to support our patients and members in addressing emotional dysregulation. These resources can now be found in a centralized location on the AACAP website, the AACAP Resource Center for Outbursts, Irritability and Emotional Dysregulation.

This new Resource Center (RC) is one in a collection of AACAP’s seventeen. RCs bring together AACAP’s resources on topics related to children’s mental health that might be useful to patients, families and professionals. RCs are developed by AACAP’s Consumer Issues Committee (CIC), co-chaired by Drs. Sandra Fritch and Carlene MacMillan, often in a partnership with an AACAP Committee and are updated annually.

You can find an RC on the AACAP website either by typing the name of the RC into the AACAP search bar or by going to the Families/Youth section of the website and then choosing Resource Centers. RCs all follow the same format. They begin with a landing page that has an “about” and FAQ section. From there, the reader can choose from three sections: Youth, Parent/Caregiver, Clinician. Each section has materials that are best geared to that user.

Within those categories, the RCs include helpful information including relevant Facts for Families, rating scales, articles, books, videos, Apps.

The Outbursts, Irritability and Emotional Dysregulation RC was developed by a sub-group of members of the Presidential TF including Dr. Carlson herself and Drs. Avanti Bergquist, Jacqulyn Chua and Michael Houston with the support of the staff led by Mary Billingsley and Rob Grant.

The Parents’ section includes links to relevant AACAP Facts for Families (FFF) including FFF on Temper Tantrums, several rating scales, vetted books, Apps, and videos as well as related websites. The Youth section includes FFF, videos, and Apps. The Clinician section includes Treatment Resources including relevant rating scales, AACAP resources including recommended AACAP and JAACAP Resources, such as articles and the Clinical Essential on Emotion Dysregulation, and a list of recommended articles including the two special editions of Child and Adolescent Psychiatric Clinics of North America Emotional Dysregulation and Outbursts in Children and Adolescents Parts 1 and 2 (available to all members as a member benefit), videos, books, apps, FFF and related websites. All the outside resources were carefully vetted by AACAP members with expertise with this population so that our members can choose from an array of useful tools to further their knowledge and educate patients and families.

The AACAP Resource Center for Outbursts, Irritability and Emotional Dysregulation brings together so many helpful educational materials for you and your patients struggling with severe emotional outbursts. We hope you will take some time to get acquainted with this RC and others, either now, or in the future.

Cathryn A. Galanter, MD, is Associate Professor of Psychiatry and Training Director of the Child and Adolescent Psychiatry Fellowship Program. She’s also the past Secretary of AACAP. cathryn.galanter@downstate.edu
Supporting Youth Affected by Climate Change

No. 137; January 2022

What is climate change?
Climate change is the overall change in weather patterns from an increase in the Earth’s temperature. Healthcare experts agree this can affect human health, including mental health. The cause of climate change today is mostly due to humans burning fossil fuels for energy. This leads to increased levels of carbon dioxide in the atmosphere. High levels of carbon dioxide in the atmosphere then causes the Earth’s temperature to go up. These changes are often referred to as “global warming.” Climate change has also led to other extreme weather events such as destructive hurricanes, flooding, tornadoes, wildfires, and severe winter storms.

Climate change affects people differently in different parts of the world. For example, extreme heat, poor air quality, wildfires, floods on the coast, and droughts are things that happen due to a worsening climate. These disasters can affect families and children with limited resources even more.

Major changes to weather patterns caused by a warming planet affects health in many ways. These disasters may require people to move, leave their communities, schools, friends and families. There is also a direct trauma that happens for youth surviving a disaster like a major storm or wildfire. Youth who do not experience a climate emergency may still have social or emotional changes related to this world-wide problem.

How does climate change affect youth mental health?
• Youth may have to live through a frightening experience like an extreme weather event, and they may fear for their safety and have strong reactions that last even after the weather event is over.
• Evacuations or closures for weather or fire events can disrupt school, access to medications, loss of prized possessions and pets, and community connections.
• When youth think about climate change, they may experience feelings of anxiety, anger, helplessness, and guilt.
• Many children and teens follow the news through digital connections, so they are much more aware of changes in their broader world. This can worsen their anxiety.
• Many youths feel especially affected by climate change and wonder about their futures in this world, and may have anger towards previous generations for their actions leading to climate change.

What can be noticed in youth affected by climate change?
Anxiety related to climate change may come in many forms. Anxiety can be normal and appropriate given the severity of climate change. Youth may want to talk about environmental issues and their concerns about the future, and may want to engage in social activism. Families and young people should seek out help when anxiety affects their daily life. For instance, some people experience panic attacks, trouble sleeping, extreme separation anxiety, or obsessive thinking related to climate change.

What can parents and caregivers do for youth?
• Listen carefully to their thoughts and feelings about climate change.
• Understand that youth may have different feelings about climate change than adults, given their view of the future.
• Tell the truth about climate change in a way that the child or teen will understand.
• Be aware of the kind of information or news the child or teen is seeing or listening to.
• Support their desire to make lifestyle changes or help them take action.
• Monitor for any warning signs such as very high anxiety levels, fatigue, trouble sleeping, negative thoughts about a future, or obsessive thinking that interferes with their daily lives.
• Discuss a family safety plan that can be used during a severe weather event.
• Following extreme weather events, check in with your child or youth about any anxiety, and offer additional support if needed.

AACAP Resources:
• Disaster and Trauma Resource Center
• Disaster Liaison Network Resource Library
• Facts for Families: Disaster: Helping Children Cope
• Facts for Families: Anxiety and Children
• Facts for Families: Normal or Not: When to Get Help

Additional Resources:
• NASA’s Global Climate Change Website
• SAMHSA’s Disaster Distress Helpline
• NCTSN Wildfire and Tornado Resources

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

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

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 10,000 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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If you need immediate assistance, please dial 911.

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AACAP Awards Millions In Federal Funding For Child Substance Use And Addiction Research To Eight Scholars

NIDA awards over $7 million in research training for Substance Use and Addiction for Child and Adolescent Psychiatrists

Washington, DC, January 4, 2022 – The American Academy of Child and Adolescent Psychiatry (AACAP) announced today the final selected awardees for the 2021-2025 AACAP Physician Scientist Program in Substance Use K12 Career Development Award. In recognition of the dearth of child and adolescent psychiatrists trained to conduct clinical and basic research, especially in the area of substance use, AACAP and the National Institute on Drug Abuse (NIDA) have joined forces to create a four-year program with over $7 million in dedicated federal grant funding to train aspiring investigators in the area of substance use and addiction research.

Between 1998 and 2020, 24 scholars in four cohorts have completed this NIDA/AACAP program. Those scholars have significantly contributed to the advancement of the field of child and adolescent substance use research and clinical practice. Together, previous K12 scholars have contributed over 900 publications to the scientific and clinical literature and presented over 1,500 scientific presentations. Subsequent to their training, this productive group has obtained more than 200 new research grants to support their research.

AACAP has selected an expanded fifth cohort of eight scholars for the AACAP Physician Scientist Program in Substance Use K12 Career Development Award, supported by NIDA. Scholars for the premiere career development program hail from a diverse array of backgrounds and will serve as leaders in the field of pediatric substance use research. They have demonstrated remarkable professional achievement early in their careers and a commitment to research.

Scholars advanced through a highly competitive selection process, including a comprehensive written application and review of their proposed research project. A complete list of awardees appears below:

Colin W. Burke, MD
Harvard University
Massachusetts General Hospital
Primary Mentor: Timothy Wilens, MD

Natalia Ramos, MD, MPH
University of California Los Angeles
Primary Mentor: David Miklowitz, PhD

Ryan Sultan, MD
Columbia University
New York State Psychiatric Institute
Primary Mentor: Frances Levin, MD

Jesse D. Hinckley, MD, PhD
University of Colorado Denver
Primary Mentor: Christian Hopfer, MD

David C. Saunders, MD, PhD
Columbia University
New York State Psychiatric Institute
Primary Mentor: Jonathan Posner, MD

Carol Vidal, MD, MPH
Johns Hopkins University
Primary Mentor: Carl Latkin, PhD, MS

Aviva K. Olsavsky, MD
University of Colorado Denver
Primary Mentor: Kent Hutchison, PhD

Kevin M. Simon, MD
Harvard University
Boston Children’s Hospital
Primary Mentor: Sharon Levy, MD, PhD

Awarded scholars and their mentors will meet with AACAP’s K12 Principal Investigator and Advisory Committee for AACAP’s K12 Annual Retreat each June throughout the program. Awardees will present their research plans to the K12 committee and refine career development and research training programs together with their research mentors, which will enable them to establish academic careers as independently funded investigators in basic science, clinical, or translational research related to child and adolescent psychiatry addiction research.

Questions regarding the program may be directed to the grant Principal Investigator, Kevin Gray, MD, by email: graykm@musc.edu.

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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.
Frances Haugen, American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry Convene Roundtable on Adolescent Mental Health and Social Media

Washington, D.C. – Frances Haugen joined leaders from the American Academy of Pediatrics (AAP) and American Academy of Child and Adolescent Psychiatry (AACAP) in a roundtable discussion addressing the role of social media in children and teens’ mental health. The discussion comes on the heels of AAP, AACAP and the Children’s Hospital Association declaring a national emergency in children’s mental health and against the backdrop of the ongoing COVID-19 pandemic, which continues to harm children’s health in ways both seen and unseen.

Frances Haugen, who blew the whistle on Facebook’s practices of prioritizing company profits over public safety, spoke about her experiences and highlighted the need for transparency in the technology industry so that researchers can accurately study the impact of the platforms on children and teens. Leaders from AAP and AACAP shared their expertise about the role of social media in the lives of children and teens and raised concerns about the rampant spread of false information about COVID-19 on many social media platforms.

"The problems we are facing today with social media are solvable. Tech companies know how to make their platforms safer for everyone, but they won’t make the necessary changes because they prioritize their bottom line above all else — even our children’s safety and wellbeing," said Frances Haugen. "For years, tobacco companies preyed on our children, continuing to advertise to them and addict them even after harm had been proven. The documents in my disclosures prove that Meta knows its products are harming our kids. We must not let Big Tech run the tobacco playbook on our kids. We must demand rigorous transparency requirements and safety regulations so that social media giants can no longer manipulate our kids and teens every hour of the day. We cannot let the status quo continue – our kids deserve better and we demand it."

"Pediatricians have long been raising concerns about the impact of social media use on children’s mental health and development, and we appreciated being able to have a conversation about the opportunities and challenges presented to us by these technologies,” said AAP President Moira Szilagyi, MD, PhD, FAAP. "It is in our power to create a digital ecosystem that works better for children and families, and we are always looking for new ways to make progress in achieving that goal. Pediatricians are also confronting unprecedented levels of misinformation and disinformation about COVID-19 that proliferates on social media platforms, and we will continue to do all we can to stop its spread."

"For some time now, child and adolescent psychiatrists care for children and teenagers presenting with mental and physical ailments exacerbated by the content they are exposed to via social media,” offers Warren Y.K. Ng, MD, MPH, AACAP President. "But youth today increasingly look to social media to connect with one another and learn about the world around them. AACAP welcomes the opportunity to work with health and policy experts in creating solutions that leverage the positive aspects of social media platforms. The challenge we face is significant. Working together, we will continue to find and develop new and innovative ways to mitigate the negative mental health consequences of social media use. We hope that today’s meeting leads to positive impact and change."

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About the 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.

About the American Academy of Child and Adolescent Psychiatry
The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children’s mental health. For more information, please visit [www.aacap.org](http://www.aacap.org).
Op-Ed: One Huge Cost of Letting the Expanded Child Tax Credit Die? Harm to Developing Brains

Rebecca Schwarzlose and Joan Luby, MD

This opinion piece ran in the January 10, 2022 Los Angeles Times

Decades of research tell a clear and sobering story: Poverty is harmful to the developing brain.

The research demonstrates how experiencing the adversity of poverty in childhood places children at risk for later hardships. It also shows how modest investments to protect today’s children from this adversity can lower the roadblocks and burdens they may face as tomorrow’s adults.

The federal government has been actively making such investments since July, when monthly payments of up to $300 per child were made through the expanded child tax credit authorized by the American Rescue Plan, a COVID relief package. These payments reached 27 million children from families with taxable earnings too low to benefit from the annual tax refund provided by the previous child tax credit. The result has been an unprecedented reduction in childhood poverty and hunger.

Yet the expanded child tax credit is poised to become another Beltway failure. The provision expired at the end of 2021. If it is not renewed or replaced with something equally supportive of struggling families, an estimated 9.9 million American children will fall back or sink deeper into poverty.

President Biden has proposed extending the policy for another year through his “Build Back Better” plan, but disagreement in Congress over the details of the extension threatens its future.

Studies in our lab and others’ have shown that living in poverty affects brain development, restricting the natural growth of the hippocampus and amygdala, two structures deep within the brain that support learning and guide emotional responses.

Research suggests that these structural effects may be long-lasting. Using brain scans, scientists have shown that adults in their 60s who were under economic strain in childhood tended to have smaller hippocampal structures than their peers who did not face this childhood adversity, irrespective of their financial circumstances later in life.

The brains of children are particularly vulnerable to environmental exposures because they are rapidly growing and changing, and highly influenced by experience. That is why children must be protected from public health hazards such as lead in drinking water and neurotoxins in baby food that increase their risk for neurological and emotional problems. But neuroscience research shows us that poverty can be toxic to children as well.

Although poverty may affect brain development through many routes — including poor nutrition and reduced cognitive stimulation — extreme and chronic physiological stress is clearly one of them. Studies that measure children’s cortisol levels suggest that chronic stress is the missing link connecting childhood poverty to reduced growth of the hippocampus. Research shows that programs such as the expanded child tax credit, which provide financial assistance directly to families in need, measurably...
reduce this harmful strain on children in poverty.

We already know too well that children’s exposure to poverty and food insecurity casts a long shadow, placing them at greater risk for mental illness and substance abuse later in life. A child growing up in poverty is 69% more likely to develop a mental illness than peers who have more financial security. Data from a study we have conducted for 17 years show how the effects of early-life poverty on brain development across childhood place children at greater risk for cognitive difficulties and problems with emotion regulation in adolescence.

These studies do not tell us about the capabilities or potential of individual children or adults who grew up amid the adversity of poverty. Instead, they tell us about risk to a population, about burdens that these children are more likely to face because we have failed to protect them.

Although many people will appreciate the value of protecting children from poverty’s harmful effects, most will see it as an unattainable goal. Thankfully, it is not.

Many other countries have mitigated the effects of childhood poverty with subsidized child care, universal preschool and child allowances, or monthly payment programs. With the expanded child tax credit, the U.S. briefly joined their ranks. U.S. Census Bureau data show that 59% of low-income families receiving this money spent it on food and 91% spent it on necessities, including utilities and rent, or on education.

Yet no check will be sent out this month. If Washington does not take swift action, we will lose the significant progress the country has made in reducing the damaging effect of poverty on American children.

Extending the expanded child tax credit or replacing it with a comparable child allowance would reduce the number of children in poverty by an estimated 40% and generate an estimated $800 billion in long-term savings and benefits to society, including improvements in health, higher educational attainment and earnings, and reduced use of child protective services and criminal justice services.

Protecting children from poverty is not only a moral imperative—it is also a wise investment in a brighter and more equitable future for us all.

Rebecca Schwarzlose is a cognitive neuroscientist in the department of psychiatry at Washington University School of Medicine and author of “Brainscapes: The Warped, Wondrous Maps Written in Your Brain — and How They Guide You.”

Dr. Joan Luby is a professor of child psychiatry and a practicing child psychiatrist at Washington University School of Medicine. lubyj@wustl.edu

Share Your Photo Talents With AACAP News

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

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

If you would like your photo(s) considered, please send a high-resolution version directly via email to communications@aacap.org. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
ARIZONA
Company: Clifford Beers (1288843)
Title: Psychiatrist
Job ID: 16076471
URL: https://jobs.aacap.org/jobs/16076471

Job Description:
This position will be responsible for delivering collaborative, comprehensive care to individuals of all ages with behavioral issues, intellectual and other developmental disabilities, and often complex comorbid medical disorders. Key Responsibilities: Evaluate and provide comprehensive treatment for psychiatric disorders. Monitor effectiveness of prescribed treatment modalities. Collaborate with multidisciplinary team members related to behavioral and physical health. Provide appropriate consultation to other (sub) specialty practitioners. Maintain up-to-date clinical records. Submit requested agency and state data and reports following prescribed standards and timelines. Adhere to rules and regulations as required by TJC and other regulatory agencies. Stay up-to-date of new developments in the psychiatric treatment of children and adolescents. Leverage telehealth technologies as appropriate. Provide in-service training as needed. Perform other duties as directed by supervision.

SKILLS:
Must demonstrate the following skills:
Experience in and proven ability to document work in Electronic Medical Records.
A proven ability in providing high quality services to the community.
A proven ability to perform psychiatric evaluations and medication management.
Experience in and proven ability to maintain thorough and complete documentation regarding the diagnosis and targeted behavior(s) for which medications are prescribed as well as anticipated effects / side effects.
Experience and proven ability to record client’s progress such that it meets regulations, is compliant, accurate and efficient.
A proven ability to provide emergency medical consultation.
A proven ability to multitask between clinical service delivery and administrative duties in a manner that does not interfere with the quality of services. Demonstrates knowledge about and is able to supervise, train, and coach key medical and non-medical staff in their area of expertise.
A proven ability to build and maintain relationships between other providers to ensure the optimal health of the client.
A proven ability to work within a multi-disciplined team.

Job Requirements:
EDUCATION: Board Certified or eligibility in child & adolescent psychiatry. Hold and maintain an unrestricted license to practice in CT.
REQUIREMENTS: Valid driver’s license and reliable transportation.

CONNECTICUT
Company: Hartford HealthCare (1181796)
Title: Child and Adolescent Psychiatrists
Job ID: 16224630
URL: https://jobs.aacap.org/jobs/16224630

Job Description:
Child and Adolescent Psychiatrists
Join a leading Behavioral Health Network in New England. The Hartford HealthCare Behavioral Health Network (BHN) has opportunities to practice in your choice of setting and discipline in locations across Connecticut and close to NYC. Our expansive Behavioral Health Network which ranges from one of America’s Ivy League Academic Behavioral Health Centers in an urban setting to small rural outpatient settings, offers a diverse array of Psychiatrist opportunities. Positions available in: In-patient Pediatric and Adolescent ED and Consult Liaison Partial Hospitalization (PHP) Intensive Outpatient (IOP) Extended Day Treatment Clinical Day Treatment (CDT) About the Hartford HealthCare Behavioral Health Network: The Hartford HealthCare BHN is an expansive psychiatric treatment, research, and academic network that includes the world-renowned Institute of Living and the Olin Neuropsychiatry Research Center. An experienced GME organization, the BHN currently hosts two psychiatry residency programs and three psychiatry fellowship programs. The BHN, with a staff of over 225 MDs and APRNs is recognized for coordinated, high-quality care. Our providers see 750,000 outpatient visits and 110,000 inpatient days of care a year across 50 locations and 300 inpatient beds. With ten Clinical Day Schools providing 45,000 days of care and education and six residential locations providing 45,000 residential patient days, it is also recognized as a major partner in the communities across CT. The BHN offers: A career trajectory through academic, research, and leadership opportunities. A mentorship program and virtual grand rounds. A well-structured and highly integrated healthcare system that allows easy collaboration amongst providers, allowing for more time with patients, and more positive outcomes. The opportunity to work with Residents and Fellows.
About Hartford HealthCare: The Hartford HealthCare network employs over 2,500 providers in over 400 practice locations throughout Connecticut, seven acute care hospitals including one of the largest academic and surgical hospitals in the northeast, thriving community teaching hospitals, one of the largest behavioral health networks and physician-led, multi-specialty medical groups in New England. Our location: Connecticut is located within two hours of Boston and New York City, and offers access to the finest schools in the nation, four beautiful seasons of recreational activities, access to New England beaches and ski resorts, and options to live near the shore, in leamy suburbs, or in vibrant urban areas. For more information: Please send email with CV to: Mary Ann Tanguay, maryann.tanguay@hhchealth.org or call/text at 860-716-9850. Click to learn more about: Working at Hartford HealthCare. Click to learn more about: Working at Hartford HealthCare.

DELAWARE
Company: Universal Health Services, Inc. (1287679)
Title: Child & Adolescent Psychiatrist
Job ID: 16138031
URL: https://jobs.aacap.org/jobs/16138031

Job Description:
Dover Behavioral Health System is seeking a BE/BC child and adolescent psychiatrist for an exclusive inpatient position in Dover, Delaware. The new associate will join an experienced multidisciplinary team on a child and adolescent inpatient unit. Responsibilities of the position will include admission evaluations, treatment team leadership, discharge summaries and daily care of patients. Telehealth opportunity is available. This is a fantastic opportunity for a new graduate or experienced psychiatrist. Call is nine weekends per year. Inpatient experience is preferred. J1 visa sponsorship is available. The region offers a...
plethora of recreational activities allowing for a professional career and a fulfilling personal lifestyle while in close proximity to Philadelphia, Washington DC and beaches of Delaware and Maryland. We are proud to offer: Generous compensation, Highly rewarding bonus structure, Malpractice insurance, Paid Time Off, Matching 401k, CME Health insurance, Relocation Commencement bonus, Fellowship stipend, Employee stock purchase plan For consideration, please contact Stephanie Fiqueroa, In-house Physician Recruiter, Universal Health Services, at stephanie.figueroa@uhsinc.com or (484) 695-9913. Candidates may also apply directly at www.uhsinc.com/careers/physician-career-opportunities

Dover Behavioral Health System is owned and operated by a subsidiary of Universal Health Services (UHS), one of the nation's leading hospital management companies. Dover is a 104-bed freestanding Psychiatric facility located in Dover, DE. Dover delivers comprehensive mental and behavioral health treatment services to children, adolescents and adults. The lush campus is filled with green space, offering patients and families an opportunity to step outside to take in the natural setting. Dover offers patients a therapeutic environment to focus on healing and rehabilitation from their emotional and behavioral issues.

FLORIDA

Company: University of Florida College of Medicine - Jacksonville (1288509)
Title: Child Psychiatrist - Clin AST/ASO/Full Professor
Job ID: 16056232
URL: https://jobssource.aacap.org/jobs/16056232

Job Description:
The University of Florida College of Medicine - Jacksonville, Department of Psychiatry is currently recruiting for a Clinical Assistant/Associate/Full Professor Child Psychiatrist (iMD) to fill a faculty position in the Child and Adolescent Division. This is a full-time, (1.0 FTE), multi-mission, non-tenure track faculty position. This position will provide outpatient services for the Division of Child and Adolescent Psychiatry and pediatric collaborative care both in person and through telepsychiatry. There is also the opportunity to develop specialty services and programs within the child psychiatry ambulatory environment. In addition, this position will play a key role in teaching medical students, psychiatry pediatric residents, and in developing scholarship to promote the missions of the Division of Child and Adolescent Psychiatry at the University of Florida College of Medicine - Jacksonville. Rank will be commensurate with qualifications.

Job Requirements:
The department is seeking a dynamic individual with outstanding clinical skills. The applicant should possess experience and/or training or other background in pediatric psychiatry and behavioral health including skills in the evaluation of lifespan trajectories, psychiatric and medical comorbidities, and/or the application of clinical knowledge and skills/interventions to address the needs of children with complex medical and psychiatric needs. The successful candidate must be able to work effectively across multi-disciplinary teams and diverse populations.

FLORIDA

Company: University of Florida (1279571)
Title: Clinical Assistant/Associate Full Professor - Pediatric Consultation Liaison
Job ID: 16118588
URL: https://jobssource.aacap.org/jobs/16118588

Job Description:
The Department of Psychiatry at the University of Florida (UF), College of Medicine in Gainesville, Florida is seeking an Assistant or Associate Professor in Pediatric Consultation Liaison Psychiatry. The position is a 12-month, full-time (1.0 FTE), non-tenured multi-mission faculty position, involving 50% time in inpatient consultation-liaison services and 50% in outpatient services, including collaborations with pediatric sub-specialties. The position is expected to address clinical and teaching needs as well as opportunity for scholarly activity. The department is seeking a dynamic individual with demonstrated potential for developing a strong consultation liaison service within UF Shands Children's Hospital and strong collaborative ties across pediatric medical and psychiatric services. The applicant should possess experience and/or training or other background in pediatric psychiatry and behavioral health including skills in the evaluation of lifespan trajectories, psychiatric and medical comorbidities, and/or the application of clinical knowledge and skills/interventions to address the needs of children with complex medical and psychiatric needs. The successful candidate must be able to work effectively across medical specialties and with multi-disciplinary teams and diverse populations. This also includes close coordination and collaboration with our adult psychiatry consult liaison service at UF Shands Hospital. Faculty in the Department are engaged in UF and national collaborations that afford rich opportunities for career development. The Departments of Psychiatry and Pediatrics offer extensive opportunities for clinical research/scholarly collaborations. There is also opportunity for program development involving outpatient consultation and collaboration with various pediatric specialty areas.

As a faculty member in the College of Medicine, the candidate will also contribute to its educational mission by participating in graduate and/or medical education, particularly the teaching of child and adolescent psychiatry fellows during their consult liaison rotations and seminar teaching for our fellowship. Finally, the successful candidate must be willing to engage in service at the level of the department, college, and larger profession and demonstrate a strong commitment to issues of diversity, equity, and inclusion. ABOUT THE UNIVERSITY OF FLORIDA (UF). COLLEGE OF MEDICINE Faculty in the Department of Psychiatry at the University of Florida are engaged in groundbreaking projects covering a variety of interests through our Centers, labs, and collaborations with other departments. The Division of Child and Adolescent Psychiatry includes a large outpatient center with various specialty clinics within (including one associated with our Center for Autism and Neurodevelopment), a very active inpatient service, and additional programs such as a pediatric psychiatry collaborative program, school consultation program, and community consultation services. The Department of Psychiatry spans services across adult, addiction, and child/adolescent specializations, including a freestanding psychiatric hospital, a large consult liaison service at the main UF Shands Hospital, the Florida Recovery Center operated by our Addiction Division, and multiple research centers including the Center for Addiction Research & Education and the Center for OCD and Related Disorders (COARD). UF is also an active site for the NIH-landmark Adolescent Brain Cognitive Development (ABCD) Study. Shands Children's Hospital is ranked the number 1 children's hospital in the state of Florida in US News and World Report. The Department of Pediatrics has national rankings in a number of pediatric specialties by USNWR. UF is an active campus in the heart of a growing city. UF is one of the Top 10 public universities in the
nation and one of the largest medical centers in Florida. UF is a leader in the Southeast for innovative, evidence-based treatment programs for a variety of mental health disorders with a strong commitment to the conduct of clinical science. UF College of Medicine is ranked 43rd in the nation by US News and World Report. UF is ranked #15 among public medical schools in the U.S. with $349 million in total research and sponsored program funding and researchers exploring topics across nine research centers and institutes. Why Choose Medicine At UF? ABOUT GAINESVILLE The City of Gainesville holds many distinctions. Located in the northern part of Florida, Gainesville is home to the state’s largest and oldest university (UF), and is one of the state’s centers of education, innovation, healthcare, arts & culture, sports, and more. You can find the city routinely listed as one of the best college towns, best places to live, and best places to retire. Known for its preservation of historic buildings and the beauty of its natural surroundings, Gainesville’s numerous parks, museums, and lakes provide endless entertainment to thousands of visitors and locals every year. Things to do in Gainesville, Visit Gainesville.

**Job Requirements:**
Eligible applicants require a MD, DO, or equivalent degree, with completion of psychiatry and child/adolescent psychiatry fellowship that has included rotations in pediatric consultation liaison psychiatry. Board certification or eligibility in child/adolescent psychiatry is required. Documentation and/or pediatric training and/or pediatrics training are beneficial but not required. Documented evidence of scholarly activity or interests are desirable. Evidence of effective mentoring and collegial interactions with clinical colleagues will also be important considerations.

**GEORGIA**

**Company:** Memorial Sloan Kettering Cancer Center (1157323)  
**Title:** Pediatric Psycho-Oncology Psychiatry Faculty Position  
**Job ID:** 16102631  
**URL:** https://jobsource.aacap.org/jobs/16102631  
**Job Description:**  
MEMORIAL SLOAN-KETTERING (MSK) CANCER CENTER invites applications for a full-time psychiatry position in the Department of Psychiatry and Behavioral Sciences. This position will provide inpatient consultation-liaison services and integrated outpatient psycho-oncology care to MSK’s pediatric cancer population. Candidates must have clinical experience and appropriate training in working with medically ill infants, school age, adolescents and young adults and their parents and caregivers, at all stages of illness and in survivorship. Candidates must demonstrate the skills to excel within a well-established interdisciplinary pediatric psychosocial and palliative care team. This position provides a unique opportunity for a blend of patient care, teaching/fellowship training, research, and program development. The Department of Psychiatry and Behavioral Sciences currently has over 40 full-time faculty with wide interests in psychosocial oncology clinical care, teaching, and research. Board certification or eligibility in Child and Adolescent Psychiatry is required; board certification or eligibility in Consultation-Liaison Psychiatry is preferred. Triple board program trained candidates are encouraged to apply. This search is open to potential candidates at all levels of career experience and appointments will be made at an academic level commensurate with the appointee’s experience. This position will be a dual appointment in the Department of Psychiatry and Behavioral Sciences and the Department of Pediatrics. All faculty hold academic appointments at the Weill Cornell Medical College. Salary is competitive and commensurate with experience. MSKCC provides excellent benefits including faculty housing benefits. MSKCC is an Equal Opportunity/Affirmative Action Employer. Women and minority candidates are encouraged to apply. Email a cover letter, curriculum vitae, and contact information for at least 3 references to: Christian J. Nelson, PhD, Chief, Psychiatry Service Attending Psychologist, Member c/o Laurie Schulman Memorial Sloan Kettering Cancer Center Department of Psychiatry and Behavioral Sciences 641 Lexington Avenue, 7th Floor New York, NY 10022 Email: schulmal1@mskcc.org.

**Job Requirements:**
Education, Training, & Experience Board Certified or Board Eligible in child/adolescent psychiatry Ability to obtain an active

**GEORGIA**

**Company:** The Southeast Permanente Medical Group (1123444)  
**Title:** Child/Adolescent Psychiatrists-Atlanta, Georgia  
**Job ID:** 16073938  
**URL:** https://jobsource.aacap.org/jobs/16073938  
**Job Description:**  
The Southeast Permanente Medical Group (TSPMG) is seeking child/adolescent psychiatrists to join our busy inpatient and outpatient practice for locations throughout the metropolitan Atlanta area. Our behavioral health department is one of the largest groups in Atlanta with over 30 psychiatrists and 70 therapists. The Kaiser Permanente medical centers give our patients access to primary care and a wide range of specialties. Additional support for our physicians includes nursing staff, clinical pharmacy specialists, crisis therapists and ability to offer treatment options for our patients. Minimal call schedule. The Southeast Permanente Medical Group (TSPMG) is one of Georgia’s largest independent, physician-owned, multi-specialty medical groups. More than 500 physicians and 150 associate practitioners work together in a unique integrated care model to provide high-quality care to over 300,000 Kaiser Permanente members. Care is delivered at 26 medical offices featuring state-of-the-art equipment, labs, imaging services, and pharmacies. We also provide surgical services and around the clock care at some of the area’s top hospitals. TSPMG offers a competitive salary, a generous retirement package, paid time off, health, dental, vision, and life insurance, long and short-term disability, relocation allowance, and more. We also offer numerous clinical and non-clinical learning opportunities and physician leadership development. Atlanta, our home for more than 30 years, is a thriving metropolis that blends southern charm with modern art, music and culture. Learn more about our beautiful southern city at [http://www.atlanta.com/](http://www.atlanta.com/). We are an equal opportunity employer. All applicants will be considered for employment without regard to race, color, religion, age, sex, sexual orientation, gender identity, national origin, veteran or disability status. We maintain a drug and nicotine free workplace and perform pre-employment substance abuse testing.

**Job Requirements:**
Education, Training, & Experience Board Certified or Board Eligible in child/adolescent psychiatry Ability to obtain an active
medical license in the state of Georgia Functions well in a team environment, contributing to and supporting organizational goals Desire to be part of a growing and high-volume psychiatry practice.

GEORGIA
Company: Mercy Care (1290416)
Title: Child & Adolescent Psychiatrist
Job ID: 16144713
URL: https://jobsource.aacap.org/jobs/16144713

Job Description:
The mission of Saint Joseph's Mercy Care Services is to serve the poor, marginalized, and underserved clients in Atlanta. Sponsored by the Sisters of Mercy and Saint Joseph's Health System, Saint Joseph's Mercy Care Services was created in 1985 by volunteer nurses and physicians. Today Mercy Care is a Federally Qualified Healthcare Center (FQHC) and provides an efficient, integrated system of primary care, dental, behavioral health, vision, education and social services-reaching thousands of poor, uninsured, underserved, and homeless patients and clients in Atlanta each year. As a Federally Qualified Health Center, operating an Integrated Behavioral Health Care Model, we operate four fixed-site Mercy Clinics and six other clinics in community partner facilities or aboard our Mobile Health Coach. Several programs such as Street Medicine and Case Management involve teams of staff directly delivering care in the community. We are seeking dedicated professionals working together within great teams to deliver high quality care to our patients. Mercy Care is located in Atlanta and the metro area offers many attractions, diversity, city to suburban living, and a great southern climate. *As a Federally Qualified Healthcare Center (FQHC), this position is eligible to apply for Loan Repayment through HRSA and National Health Service Corps in exchange for providing health care in urban, rural, or tribal communities with limited access to care: https://nhsc.hrsa.gov/sites/default/files/NHSC_loan-repayment/nhsc-lop-fact-sheet.pdf.** Award amounts are up to $50,000 for two years of full time service, and with continued service NHSC clinicians may be able to pay off all of their student loans.*

POSITION SUMMARY: Under limited supervision by the Clinical Director of Psychiatry, the Child & Adolescent Psychiatrist provides diagnosis, psychiatric treatment and consultation within an integrated care setting. This psychiatrist will also provide general psychiatric care in the programs at Mercy Care, and may also participate in Street Medicine programming. The psychiatrist provides administrative oversight as needed, supporting psychiatric APRNs through collaborative agreements, participating in health fairs or community events on weekends as requested 3-4 times a year. Full time position. EDUCATION REQUIREMENTS: Graduation from an ACGME accredited Psychiatry residency program, with at least one year of experience in serving vulnerable populations. ABMS board certification or board eligibility in Psychiatry is required. Licensure to practice medicine within the state of Georgia is required. Completion of a ACGME accredited Child & Adolescent Psychiatry training is preferred. Bilingual candidates in Spanish & English appreciated. EXPERIENCE REQUIREMENTS: Familiarity and experience in treating medically underserved populations. Must have experience working with youth and families with both mental illness and substance use disorders within a multi-disciplinary setting. Experience dealing with patients of diverse backgrounds. JOB KNOWLEDGE: Clinical expertise and competence in providing direct services and medical consultation is required. Must be able to build strong, cohesive outcomes focused on working relationships with special needs populations and Integrated Behavioral Health team colleagues.

MASSACHUSETTS
Company: Universal Health Services, Inc. (1287679)
Title: Child & Adolescent Psychiatrist Position at Arbours Hospital in Boston
Job ID: 16138020
URL: https://jobsource.aacap.org/jobs/16138020

Job Description:
Arbour Hospital, located in Jamaica Plain, MA (Boston) is seeking a board eligible/board certified child and adolescent psychiatrist. Responsibilities are primarily inpatient with opportunity for a mix of outpatient. This is a full-time position and is Monday – Friday. No call requirement. This is a fantastic opportunity for a new graduate or experienced psychiatrist. Arbour Hospital is located in a Boston suburb called Jamaica Plain. Locals call Jamaica Plain “JP” and is known as the classic streetcar suburb that has become one of Boston’s most dynamic neighborhoods. Surrounded by the Emerald Necklace, Arnold Arboretum, Franklin Park and Jamaica Pond, it is the perfect place to visit, shop, and dine. It’s a great place to work and live! We are proud to offer: Competitive compensation packageMalpractice 30 Days Paid Time Off Matching 401k 5 days and $3k CME Health insurance package Relocation Commencement bonus Employee stock purchase plan Arbours Hospital is a subsidiary of Universal Health Services, Inc. (UHS) one of the nation’s leading hospital management companies. For consideration, please contact Stephanie Figueroa, Physician Recruiter, Universal Health Services, at stephnie.figueroa@uhscinc.com or 484-695-9913.
MINNESOTA

Company: Mayo Clinic (1222567)
Title: Child Psychiatrist
Job ID: 16055884
URL: https://jobsource.aacap.org/jobs/16055884

Job Description:
Child Psychiatrist 169379BR Rochester, Minnesota Responsibilities: Mayo Clinic in Rochester, MN seeks a junior or mid-career Child & Adolescent Psychiatrist to join the Department of Psychiatry and Psychology. This role will primarily comprise of outpatient delivery of care to patients from Rochester and the surrounding communities, as well as national and international patients. The psychiatrist will also provide intermittent coverage of hospital services. Exceptional clinicians with interest and demonstrated skills in innovative models of care, research and/or educational endeavors are encouraged to apply. The Child & Adolescent Psychiatrist will join 11 other Child & Adolescent Psychiatrists in the Department of Psychiatry and Psychology, as well as pediatric psychologists and neuropsychologists and a team of master’s level clinical psychologists, social workers, advanced practice registered nurses, physician assistants. Vibrant clinical research teams exist in several subspecialty areas and there are significant departmental and institutional resources for interested researchers. Abundant education/supervision opportunities are available with trainees from Mayo Medical School, our outstanding Psychiatry and Child & Adolescent Psychiatry Residency Programs and Psychology post-doctoral programs, as well as with residents from other departments. Why Mayo Clinic? Join the authority in medicine and partner with the nation’s best hospital (U.S. News & World Report 2021-2022), ranked #1 in more specialties than any other care provider. At Mayo Clinic, we believe there is a better path to healing that humanizes the practice of health care and inspires hope in the people who need it most. You will be part of an amazing diverse team committed to solving the most serious and complex medical challenges – one patient at a time. Diversity and inclusion are integral to Mayo Clinic’s mission to provide excellent, culturally responsive care in a welcoming environment to patients from a wide variety of backgrounds. We aim to diversify our workforce to represent the communities we serve and continue to create an inclusive work environment where differences are valued, allowing individuals to achieve and contribute to their fullest potential. This commitment to diversity is woven into the fabric of Mayo Clinic — we embrace these values as we serve our patients, employees, students, suppliers, and communities. Become part of the legacy that embraces our differences and enables us to provide the best care to patients from all over the world. Mayo Clinic offers a variety of employee benefits. For additional information please visit Mayo Clinic Benefits. Eligibility may vary. License or Certification: Candidates must be eligible for licensure in the state of Minnesota and be board-certified/board-eligible through the American Board of Child Psychiatry and Neurology. Benefit Eligible – Yes Schedule - Full Time Remote Worker – No International Assignment - No Site Description: Mayo Clinic is located in the heart of downtown Rochester, Minnesota, a vibrant, friendly city that provides a highly livable environment for more than 34,000 Mayo staff and students. The city is consistently ranked among the best places to live in the United States because of its affordable cost of living, healthy lifestyle, excellent school systems and exceptionally high quality of life. Department - Psychiatry & Psychology Country - United States Job Posting Category - Physicians & Scientists Career Profile Page - All Physicians Specialties Specialty - Psychiatry & Psychology Recruiter - Madalyn Dosch Equal Opportunity Employer As an Affirmative Action and Equal Opportunity Employer Mayo Clinic is committed to creating an inclusive environment that values the diversity of its employees and does not discriminate against any employee or candidate. Women, minorities, veterans, people from the LGBTQ communities and people with disabilities are strongly encouraged to apply to join our teams. Reasonable accommodations to access job openings or to apply for a job are available.

NEW YORK

Company: Buyer Advertising (1059546)
Title: Psychiatrist Unit Chief
Job ID: 16095819
URL: https://jobsource.aacap.org/jobs/16095819

Job Description:
Psychiatrist Unit Chief Acute Inpatient Services, Pediatrics Division Behavioral Health Services NYC Health + Hospitals Kings County * Brooklyn, NY Physician Affiliate Group of New York (PAGNY) is one of the largest multi-disciplinary groups in the country whose main purpose is to nurture and embody the healthcare providers who take care of the most fragile and vulnerable patients throughout New York City. Comprised of over 4,000 physicians and healthcare professionals, we partner with NYC Health + Hospitals (H+H), the largest public health system in the United States, to provide services that do more than just diagnose and treat; we uplift the spirits and dignity of patients because we love what we do, and it shows. NYC Health + Hospitals/Kings County, located in the heart of Brooklyn, accommodates more than 518,076 outpatient visits, more than 141,328 emergency room visits, and with 627 beds, more than 25,000 inpatient admissions annually. The hospital maintains a strong academic affiliation with SUNY Downstate Medical Center in order to maintain its high standards of healthcare delivery. Kings County is located in the East Flatbush/Prospect-Lefferts section of Brooklyn, close to the 2 and 5 subway lines. Our patients are diverse, with the majority being afro-Caribbean. Most of our patients are native English speakers. Knowledge of French/Haitian Creole is helpful, but not required. Responsibilities include: Serving as administrative and clinical lead of the assigned inpatient unit Overseeing all aspects of patient care on the unit Working with inter-disciplinary teams to ensure safety and quality on the inpatient unit Establishing and overseeing inter-disciplinary teams and team meetings Ensuring that community meetings and other therapeutic groups take place as scheduled Participating in Behavioral Codes on the unit, providing leadership to the staff and patient community Participating in Medical Codes on the unit until the Code Team arrives Providing direct care for a specific number of patients on the unit, including appropriate and timely documentation Working with all teams to monitor length of stay particularly ensuring that patients who are refusing medications are taken to court promptly, and patients who have reached their 18th day are referred for state hospitalization for continuing treatment Identify patients who would benefit from AOT and work with their team to ensure that the application is completed Working with medical consultation team to ensure that medical problems are properly managed Ensuring that legal statuses are up to date and accurate Providing clinical consultation to other teams (when present) on your unit Providing assistance to other psychiatrists
NEW YORK

Company: Buyer Advertising (1059546)
Title: Psychiatrist - Inpatient Adolescent
Job ID: 16095868
URL: https://jobsource.aacap.org/jobs/16095868

Job Description:
Psychiatrist Inpatient Adolescent Pediatrics Division Behavioral Health Services NYC Health + Hospitals/Kings County Physician Affiliate Group of New York (PAGNY) is one of the largest multi-disciplinary groups in the country whose main purpose is to nurture and embolden the healthcare providers who take care of the most fragile and vulnerable patients throughout New York City. Comprised of over 4,000 physicians and healthcare professionals, we partner with NYC Health + Hospitals (H+H), the largest public health system in the United States, to provide services that do more than just diagnose and treat; we uplift the spirits and dignity of patients because we love what we do, and it shows. NYC Health + Hospitals/Kings County, located in the heart of Brooklyn, accommodates more than 518,076 outpatient visits, more than 141,328 emergency room visits, and with 627 beds, more than 25,000 inpatient admissions annually. The hospital maintains a strong academic affiliation with SUNY Downstate Medical Center in order to maintain its high standards of healthcare delivery. Kings County is located in the East Flatbush/Prospect-Lefferts section of Brooklyn, close to the 2 and 5 subway lines. Our patients are diverse, with the majority being Afro-Caribbean. Most of our patients are native English speakers. Knowledge of French/Haitian Creole is helpful, but not required. Responsibilities include: Provide direct care for a specific number of patients on the unit, including appropriate and timely documentation Complete admission assessments for all patients within 24 hours of inpatient admission, and reassess patients in a timely fashion. Document re-assessments in progress notes consistent with policy Participate in treatment plan meetings and ensure timely documentation Participate in Behavioral Codes on the unit, providing leadership to the staff and patient community Participate in Medical Codes on the unit until the Code Team arrives. Ensuring appropriate use of de-escalation, including appropriately and timely use of restrictive interventions, as per policy, to ensure patient safety Work with all teams to monitor length of stay particularly for continuing treatment. Identifying patients who need to be referred for state hospitalization for continuing treatment. Identify patients who would benefit from AOT and work with their team to ensure that the application is completed Work with medical consultation team to ensure that medical problems are properly managed Ensure that legal statuses are up to date and accurate Participate and conducts tier reviews as per policy Participate in Performance, Quality Assurance, and Clinical pertinence activities Work with UM department to conduct MD to MD reviews and participate in any appeals to ensure authorization of inpatient stay. Maintain focus on key strategic priorities including patient experience, access to care, increased market share, and improving financial stability. Assist in preparation for surveys. Maintain awareness of the standards for certifications by the various regulatory agencies. Qualifications include: Board Certified or Board Eligible in Psychiatry MD or DO from an accredited school of Medicine. Completion of residency training in an accredited program in psychiatry. NYS Medical License Proof of Covid-19 vaccination is required prior to hire. Benefits include: Competitive compensation package 10% 401K company contribution after one year of service Choice of a three-tiered nearly FREE medical plan. Excellent dental insurance including orthodontics coverage. Generous paid time off program. CME days and dollars. Eligibility for loan forgiveness through the National Student Debt Forgiveness Center. Visa candidates are considered. Medical Malpractice policy coverage. For immediate confidential consideration, please email your CV to: Moralesj@pagny.org or apply online at: https://www.pagny.org/careers/behavioral-health/brooklyn/6251

OREGON

Company: Albertina Kerr (1147754)
Title: Child and Adolescent Psychiatrist
Job ID: 16239986
URL: https://jobssource.aacap.org/jobs/16239986

Job Description:
Albertina Kerr empowers people with intellectual and developmental disabilities, mental health challenges and other social barriers to lead self-determined lives and reach their full potential.
When you join Kerr, you become part of a team motivated to provide innovative and excellent programs, services and care. We’re seeking a Child and Adolescent Psychiatrist to provide comprehensive psychiatric medical care to individuals served in Youth and Family Services’ community based, outpatient, and inpatient programs, as assigned. You’ll provide psychiatric evaluation of patients, prescribe and manage medications, and coordinate care with other staff and community members. Our psychiatrists work as part of an interdisciplinary team including Child and Family Therapists, Registered Nurses, Psychiatric Technicians and others to provide direct care and support patients experiencing an acute psychiatric episode. Learn more about our subacute program here. You will primarily support children and adolescents served in our Crisis Psychiatric Care (subacute) and Outpatient programs and may provide support for group home clients. This position works four days per week with some weekend on-call duties. Weekday schedules are flexible and will be determined during the hiring process. This role is largely in person, with some elements of telemedicine due to the current pandemic. All Kerr employees are required to be fully vaccinated or meet the requirements for a medical or religious exception prior to beginning work. Essential Duties: Provide direct patient care including face-to-face psychiatric evaluation, consultation, day-to-day treatment and discharge, follow up, and similar tasks. Provide appropriate and timely response to clinical requests for service and review them for medical necessity and clinical relevance. Provide consultation and clinical supervision to other members of the team. Participate in decisions and provide advice on case management, care coordination, therapeutic planning, making clinical diagnoses and similar therapeutic case management tasks. Work effectively with physicians, nurses, therapists, social workers, counselors, psychiatric technicians and others to ensure appropriate quality of care is provided to all patients. Review and approve mental health assessments of individuals. Review and approve medical appropriateness of services and supports. Complete documentation and orders in a timely fashion in keeping with established guidelines.

**Job Requirements:**
License to practice medicine in Oregon, with a least 2 years’ experience, which may include time in fellowship. Must hold full prescriptive authority in Oregon/independent Oregon medical license and DEA number. Be board certified or board eligible in Child and Adolescent Psychiatry. Current CPR or BLS certification.

**Pennsylvania**

**Company:** Job Target (875155)

**Title:** Director of the Autism & Developmental Medicine Institute

**Job ID:** 16188753

**URL:** [https://jobsource.aacap.org/jobs/16188753](https://jobsource.aacap.org/jobs/16188753)

**Job Description:**
Responsible for developing and directing Geisinger’s Autism & Developmental Medicine Institute (ADMI) to encompass a program of translational and clinically driven research, with an emphasis on moving research discoveries into clinical practice for the benefit of our patients. Establishes and leads execution of a strategic plan for ADMI, including financial stewardship that promotes its growth and enhances its national reputation. Fosters strong relationships with clinical providers, research groups, and trainees across the health system through interdepartmental research collaborations and meaningful educational programs. Will direct providers, faculty, residents, and other clinicians to optimize the care of patients, support research endeavors, and provide effective and meaningful educational programs across the department. Provides leadership, strategic planning, and direction related to the mission and vision of ADMI. Responsible for development and oversight of ADMI’s operating budgets, including procurement and financial monitoring of external research grants. Works collaboratively with executive clinical, research, administrative, and finance leaders across the health system to establish appropriate budgets for staffing and delivering all components of ADMI’s multidisciplinary clinical, research, education, and community outreach programs. Act as liaison with hospital administration and other hospital platforms to promote innovative care, teaching, and research in clinical departments. In collaboration with clinical and research departments, supervise and evaluate all ADMI physicians and research faculty in professional and assigned administrative duties. Develops, maintains, and oversees a productive and nationally competitive research program, including recruitment of high-quality faculty. Cultivates relationships with relevant external academic and research centers and represents ADMI in national networks and consortia. Participates in and oversees publication and external presentation of research results relevant to ADMI. Serves as a representative for ADMI at relevant meetings with state and national leaders to promote its activities and enhance the reputation of the health system. Responsible for adherence to accrediting and regulatory agency standards, policies, and procedures, including ethical conduct related to human subjects research. Participates in the research training of clinical associates, residents, and fellows to promote innovative care and encourages collaborative research projects with clinical staff. May oversee one or more residency or fellowship programs. Responsible for all quality improvement efforts at ADMI. About Geisinger: Geisinger fosters an atmosphere of clinical excellence while offering the best of life in small-town America – great schools, safe neighborhoods with affordable housing, and a wealth of cultural and recreational activities. The surrounding natural beauty provides opportunities for fishing, skiing, canoeing, hiking and mountain biking. Urban life is easily accessible, with New York, Baltimore, Philadelphia or Washington DC just an afternoon’s drive away. Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information, visit [jobs.geisinger.org/admi](https://jobs.geisinger.org/admi) or contact Christa L Martin, Chief Scientific Officer, via Drew Slocum, Senior Corporate Recruiter, by emailing [dslocum@geisinger.edu](mailto:dslocum@geisinger.edu). Master’s Degree required (Doctoral degree preferred) Minimum 7 years of research experience required Minimum 5 years of leadership experience required Apply Here PI162362158

**Utah**

**Company:** The University of Utah Department of Psychiatry (956175)

**Title:** Academic Child/Adolescent Outpatient Psychiatrist, Rank DOQ

**University of Utah Health (HMHI) - Job ID:** 16154024

**URL:** [https://jobsource.aacap.org/jobs/16154024](https://jobsource.aacap.org/jobs/16154024)

**Job Description:**
Academic Child/Adolescent Outpatient 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 Outpatient Psychiatrists to join its faculty. We are seeking qualified professionals to help us meet the challenges of providing high-quality psychiatric services in a market with growing mental health care needs. The Huntsman Mental Health Institute (HMHI), in a number of satellite outpatient clinics along the Wasatch Front. 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 vibrant music scene, excellent restaurants, one of the largest LGBTQ communities in the country, the Utah Symphony/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 outpatient psychiatry. Completion of a residency in Psychiatry and a Triple Board residency or a Child and Adolescent Psychiatry fellowship is required. The candidate must be board certified or board eligible in Psychiatry and Child and Adolescent Psychiatry. Obtaining board certifications is a requirement for retention.

Responsibilities: Clinical care: Use excellent clinical skills in psychiatry to serve the mental health needs of the outpatient clientele; Show a strong commitment to clinical care; Call is an expected clinical responsibility for all faculty members.

Provide cross coverage for vacations and meetings. Specific assignments will be coordinated through the Division Chief of Child Psychiatry. Investigation: Engage in scholarly activities; Develop durable materials (papers, courses, presentations, posters, games) based on scholarly activities. Education: Engage in patient care activities with learners. (Residents, medical students, and fellows, and trainees from other disciplines); Serve as medical student and resident mentor; Teaching/supervising medical students, residents, fellows, and other trainees during psychiatric clinical rotations.

Administrative: Responsibilities associated with clinical care provided; Administrative service to the Department of Psychiatry, the School of Medicine and the health system, including peer review and participation on committees; Report to and be reviewed annually by the Division Chief as part of School of Medicine faculty appointment. The percentage of effort spent in education, investigation, and administrative activities will be negotiated annually. Specific assignments will be coordinated through the Division Chief of the Psychiatry department. Candidates should apply on-line by sending a letter of interest and curriculum vitae to: https://utah.peopleadmin.com/postings/124665 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 under-represented 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 BuildingSalt Lake City, UT 84112801-581-34CFR part 106. 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 outpatient psychiatry. Completion of a residency in Psychiatry and a Triple Board residency or a Child and Adolescent Psychiatry fellowship is required. The candidate must be board certified or board eligible in Psychiatry and Child and Adolescent Psychiatry. Obtaining board certifications is a requirement for retention.
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