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New Research Poster Deadline: June 6, 2024
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For the latest information visit www.aacap.org/AnnualMeeting-2024

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**COVER:** Taken shortly after the Menninger Plenary in New York City, this picture CAPtures some of the instrumental voices in children’s mental health: (left to right) Tami Benton, MD, president; Jennifer Siebel Newsom, California’s First Partner and one of AACAP’s 2023 Catchers in the Rye award recipients; Warren Ng, MD, past-president; and Heidi Fordi, AACAP Executive Director & CEO.

Photo by Kat Sharma, AACAP Communications Coordinator.
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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

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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: Bringing the Village to the Children: Child Psychiatrists’ Role in the Transformation of Children’s Mental Health

Tami D. Benton, MD

I am honored and privileged to be here with you today as the 36th president of the American Academy of Child and Adolescent Psychiatry.

Thank you for the confidence that you have placed in me to lead this organization as your President for the next 2 years. I’d like to congratulate the 35th President, Warren Y.K. Ng, on a successful initiative, “CAPture Belonging,” and to express my appreciation for his mentorship and support. I will count on our continued partnership to continue the forward momentum that we have realized that the idea of “taking a village to raise a child” meant that all adults needed to be seeking solutions.

When AACAP, AAP, CHA, and other partner organizations declared a Children’s Mental Health Emergency in the fall of 2021, they focused national attention on the longstanding crisis of children’s mental health. This declaration also brought renewed attention to the barriers that children and families face when seeking care. AACAP’s team, led by Gabrielle A. Carlson, recognized the urgent need to call for national action to address this crisis.1

The unprecedented attention that has followed this declaration has given us an opportunity to come together as a community to transform the current ailing system of mental health care into something new—a system that provides care that is accessible and effective, one that fosters mental health and well-being for America’s children.

When national experts were invited to find solutions to this crisis, the maxim “mental health is health” had not quite permeated the mainstream. We as child psychiatrists were not asked to lead. However, as the crisis progressed, parents, teachers, coaches, primary care providers, ministers, and the myriad adults who work with youth began to understand just how complex children’s mental health is—and how urgently solutions are needed. And they realized that they needed child and adolescent psychiatry’s leadership more than ever before. They realized that the idea of “taking a village to raise a child” meant that all adults needed to be seeking solutions.

Throughout this crisis, we also learned that child and adolescent psychiatrists must engage and lead—albeit in very different ways. We learned that we must partner with others if we want to elevate our voices, amplify our impact, and shape the national agenda.

If we are to create the equitable, effective, evidence-based mental health care system that we envision, we must recognize that social determinants of health may disrupt or facilitate healthy emotional development. We must also recognize that to influence outcomes, we must look outside our field and partner with groups that impact these factors.

We must partner with families, other medical colleagues, schools, justice organizations, child welfare agencies, legislators, policy makers, and community members. We must rally around our children where they live, play, attend school, work, and grow.

And we must recognize that schools, foster care agencies, juvenile justice, faith-based communities, halls of congress, and the many other places that impact the lives of children are “in our lanes.”

For the next few years, our presidential theme’s focus will be on elevating child psychiatry leadership and partnerships to transform children’s mental health care.

Together, we can create the system that we envision—a system in which children thrive. A system built around them, for them, that allows for hope, aspiration, and strong growth regardless of barriers or opportunities placed in their midst. There has been much talk about social determinants, and much of that talk has focused on how it limits children.

So, on the subject of social determinants, I’d like to share my own story with you—because social determinants led me to choose child and adolescent psychiatry as my profession, and led me here today. Although I did not know until medical school that child and adolescent psychiatry existed as a field, anyone who knew my history probably could have predicted I would choose child psychiatry as my profession.

I am from a proud family of humble means. My family, like most Black families in our country, believed that education was the way out of poverty. They also believed that parents should make sacrifices to ensure that their children had educational opportunities.

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I grew up within my own village, an extended family of aunts, uncles, and cousins, spending each summer with my grandparents, who were sharecroppers from Georgia and Arkansas. They worked hard to own almost nothing—they didn’t even own the land on which they lived. My parents left the South in search of something more, and migrated to Cincinnati, Ohio, as young adults. Yet, each summer I learned something more by returning to the South and staying connected to my grandparents. My grandparents taught me important lessons about hard work, family, and gratitude, as well as early lessons about racism and othering. For example, as a boy, my grandfather told me that my relatives were called “boy” by a White child, instead of Mr. English, and I was bewildered by the expected response of “yes sir” from my grandfather to a child. I learned and understood early on that all people were not equal.

But it was the events of my seventh year that would change my life forever. I am the eldest of five children, and my youngest sister, Kelly, was only 2 months old when my mother died of postpartum cardiac complications at the age of 27 years. My father, who had lost his own mother just 1 year before my mother’s death, became a widower with 5 children. And 1 week later, he lost his job for taking the day to attend his wife’s funeral. I don’t have words to express my profound sense of loss at that time. In a matter of days, our safety nets were shredded, and there was no village to protect us.

As Catholics, our social service agency was assigned by our religious affiliation and they determined that a single father could not care for 4 daughters and that we should be placed with foster families. Rather than supporting us through loss, the solution was to inflict additional trauma, whether intentional or not. My father knew that separating us was not going to be good for our family, and to avoid this outcome, we disappeared from an unsafe “system” and were sent back to a village that could help us begin to heal. Staying with grandparents, until they felt it safe to reunite us with our father, offered some but not total protection. Upon our return to our father’s care, the system again intervened, this time determining that the living quarters of my family’s home did not have enough space to accommodate all of us. Three of my siblings were placed in foster care for a year, where they experienced harsh treatment and neglect by uncaring adults who sometimes deprived them of food, clothing, or a bed at night. In part this was due to the ignorance of a system that had one-size-fits-all lenses, and those lenses did not accommodate the many ways in which families might move through trauma. Eventually, with the support of my extended family, we were reunited as a family, complete with scars of devastating personal loss compounded by those that were systemically inflicted.

My family experienced most of the adversities that we know impede healthy social and emotional development. We experienced loss, separation, system involvement, neglect, and abuse—all traumatic events. We also know that these traumas are frequently multigenerational, as my father had experienced his own traumas of racism and discrimination, early military service, and loss.

It would be many years before we recognized and articulated adverse childhood experiences (ACEs), assigned scores, and associated them with adverse outcomes. Based upon my ACE score, the chances of me standing here before you today were limited at best. So how did I get here? Resilience and community.

Fortunately, I had a family and a community. I had my grandparents, great aunts, uncles and cousins, and friends. My family were all working class people with limited means. But we had something very important: shared values. We were not wealthy, but we were never homeless, hungry, or alone. We had a community of caring people who stepped in to help out. We had teachers who believed that we could accomplish things. We had mentors and coaches who taught us about teamwork and achievement and who created a sense of belonging. We had a faith community that welcomed us and a parent who was invested in doing his best to keep his family together. My father always maintained employment so that we had access to health care, and he always believed that the American dream was attainable and that you can advance beyond your origins. We had a village rallying around us, planting seeds of hope, nurturing aspirations, and taking care to show how much we were loved.

My introduction to child and adolescent psychiatry occurred within this context.

My first clinical rotation as a third-year medical student was in child and adolescent psychiatry, although I had requested obstetrics and gynecology. The very first day of my psychiatry rotation was with Elizabeth Weller, in her childhood bereavement clinic, which was funded by the National Institutes of Health to study children who had experienced the loss of a parent. My very first observed interview was with a 7-year-old boy and his 5-year-old brother who had just lost their mother.

It was a transformative experience. I had never seen anyone talking to children about their emotional experiences—especially sad ones. And I learned that child psychiatrists could proactively provide children and their parents with a road forward for healthy emotional development after a parent’s death. In fact, my own experience had been that adults did not talk with children about those experiences at all but, rather, complimented you for being brave and moving on in the face of devastating loss. I learned that there were ways for elders in a village to provide comfort, not trauma, in the midst of great loss.

Elizabeth’s research educated and enlightened our field about the impact of parental loss and bereavement. And it showed us that children grieve differently from adults. It helped forge new ways of thinking about moving through grief to a place of hope, an essential building block of resiliency.

On a personal level, Elizabeth’s example as a clinician, researcher and parent, as well as her encouragement, led me to child and adolescent psychiatry and the career that I have now—which is not the outcome that would have been predicted by my “ACEs score.” Elizabeth continued to support my career, giving me a vision for my future that I could not see for myself—including the vision of me standing here today. With her encouragement and support, I completed the Triple Board Program, and I continue.
to enjoy a rewarding and productive career in child and adolescent psychiatry.

Most of you who know me are likely hearing my story for the first time. I am sharing my story today because I want you to know who I am as your president. I want you to know what drives and inspires me—and I want you to know why I am so committed to my role as president, to child and adolescent psychiatry, and to all of you. Lived experience is a powerful force for modeling not only what can be, but how it can take root and grow.

I have learned much about growth in these lessons that have informed a proposed strategy for improving children’s mental health in our country.

This strategy is based on my own lived experiences, my interdisciplinary training as a child and adolescent psychiatrist, and my many years of research and practice with children and families. These experiences have informed my view about what we will need to do to promote children's mental health.

I was fortunate to have a strong village—a community of caring people who were committed to my development. My village includes my parents, family, friends, teachers, coaches, and faith community, and also my health care providers. That includes mentors, preceptors, both good and bad, and the myriad contacts I made as I began a career in child and adolescent psychiatry. My village continues to grow even today, and, as I look out over this audience, I realize that you are also all a part of it.

As child and adolescent psychiatrists, we know that much of our work relies on others. If we did not know this before, we learned it during the early days of the COVID-19 pandemic, which was a stark reminder of how much we depend upon other communities to ensure mental health for children. Without schools, families, foster families for youth in child welfare systems, and a continuum of resources and providers for mental health care, we were unable to provide needed care. We learned that we must be partners with the systems caring for children in order for them to benefit from our treatments. We learned that we cannot stand outside of these systems.

We must lean in, collaborate, and lead. We must become integral to the villages in which our children are growing.

The declaration of the Children’s Mental Health Emergency opened the door to unprecedented opportunities for child and adolescent psychiatrists. These opportunities require us to be proactive, outward facing, and collaborative. They require us to lead on a national stage.

This is our time to envision and to create the system of care that will promote the health of our nation’s children. We know that 90% of health outcomes are driven by social and environmental factors, which we refer to as social determinants of health. We are professionals trained to understand the medical, psychological, social, and environmental factors that foster emotional development.

The pandemic and the resulting declaration of the national emergency reminded us of who we are as an organization of medical professionals. During a worldwide pandemic exacerbating a pre-existing mental health crisis, we responded with bravery, brilliance, commitment, courage, flexibility, and commitment. We created new services and methods for patient care. We developed new systems and expanded our reach through education and partnerships with other organizations, professionals, and families. And we increased our advocacy for mental health care locally, nationally, and globally.

We must continue to bring our expertise to national platforms to inform policies and practices for children’s mental health. And we need to work closely with our legislators, educators, social services, and legal partners, as well as patients and their families. This is our time to make substantial and real change for our nation’s children.

I have spoken with many of you about the presidential theme for the next few years. And I have asked for your suggestions and ideas, as well as considerations for our strategy for the future.

First, we will build on the momentum of CAPture Belonging by continuing to bring all of our members’ expertise, compassion, and voices together in an equitable and inclusive way. To quote Rep. Coleman-Watson, we will "ring the alarm" for children’s mental health. The declaration of the national emergency was only the beginning—we are still ringing the alarm.

We will also strengthen our partnerships with existing allies such as the AMA, APA, AAP, and ACP. Together, we will influence policy and practice and will shape national polices related to the health and well-being of children.

And, finally, we will engage our members and their expertise to establish the new partnerships and allyships that will be needed to create change, beyond health care. These partnerships will include families, youth, communities of faith, neighborhoods, the justice system at every level, social service agencies, federal partners, and more. These partnerships will be based on a shared commitment to promote healthy physical, social, and emotional development.

I want to emphasize that this is only the beginning. We are members of a global community, and we must collaborate with and learn from each other.

We also know that interdisciplinary leadership is an acquired skill—it is a skill that must be learned. If we are to be present among national and international decision makers, we will need the tools for a skilled workforce to be effective.

We have knowledge. We have expertise. And our training spans many fields and disciplines.

Going forward, we will need collaborative leadership skills, information networks, and the support of our AACAP committees, members, and staff.

We are already preparing our members to engage in strategies to “bring the village to the children.” With the leadership of Wanjiku Njoroge and Barbara Robles-Ramamurthy, we are editing an issue for Child and Adolescent Psychiatric Clinics of North America titled “Bringing the Village to the Children.” This issue is authored by our

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members and interdisciplinary partners and will help us to begin visioning for this presidential theme.

Our October 26 Town Meeting, “Transforming Care for America’s Children: Systemic Partnerships for Children’s Mental Health,” will begin a discussion that will also professionals from child and adolescent psychiatry, social work, child welfare, and juvenile justice, as well as youth advocates, demonstrating the principles of effective collaborations for youth mental health.

The presidential task force, led by Lisa Cullins, Melvin Oatis, Carmen Thornton, and me, have been foundational for this work. We will ensure diversity, equity, and inclusion (DEI) in our work and will embed DEI principles in our mission. And through the DEI fellowship, we will ensure that we have capable leaders who will carry our work forward.

Finally, I want to reflect on an experience that we have all had in our work with young people. The experience I am about to describe contributes to the demoralization and burn-out that we have all experienced at times, and I want to assure you that we will address these important issues during the next 2 years.

We have all met a child or adolescent whose potential to be a healthy, happy, productive contributor to our society is clear. We see this potential, despite sometimes tragic circumstances. We know what is needed to support resilience and emotional health—and we also know that most of the time, children and families are navigating a complex landscape that will be unlikely to recognize that potential, or to foster resilience. This landscape is increasingly characterized by community violence, school shootings, political conflict, family separation, othering of vulnerable groups, climate fears, discrimination of racial and sexual minoritized groups, substance use, and disparities in health care access and health care financing, especially for mental health.

The maladies on this list do not all fall under the scope of practice of child and adolescent psychiatry, but they are integral determinants of mental health that are key moderators for our practice. We are often asked to “fix” the downstream effects of these social determinants of health. But let me ask you: can we start “upstream” with prevention?

Yes, we can. To quote Barack Obama, “We are the ones that we’ve been waiting for.” We can be part of the solution! We can craft a vision for the health of children. And we can do more than inform the decisions—we can be decision support and enable this important work. It will include makers.

We can be leaders envisioning a system that is equitable and inclusive—a system that supports the mental health of our nation’s children.

But we cannot do it alone. We need to work together, and with other partners. We need to share ideas and expertise to make real, lasting changes.

I want to thank all of you for giving me the opportunity to join the AACP leadership team for the next few years. I promise to uphold the vision and mission of our academy, and to partner with all of you to reach our goals.

When I joined AACP as a trainee, I did not imagine that I would have such an amazing career, opportunities, friendships, and experiences with a community of colleagues with whom I share such a profound sense of purpose. I am excited about our future and look forward to partnering with each of you to bring the village to the children—and transform their mental health.

Dr. Benton is with Children’s Hospital of Philadelphia, Pennsylvania and is president of the American Academy of Child and Adolescent Psychiatry, 20242026.

References:


The JAACAP family of journals aims to promote the well-being of children and families globally by publishing original research and papers of theoretical, scientific, and clinical relevance to the field of child and adolescent mental health.

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The American Academy of Child and Adolescent Psychiatry Welcomes Tami Benton, MD as New Incoming President for 2023-2025

Washington DC November 8, 2023:

The American Academy of Child and Adolescent Psychiatry (AACAP) is elated to announce Tami Benton, MD, Psychiatrist-in-Chief and Executive Director of the Department of Child and Adolescent Psychiatry and Behavioral Sciences at Children’s Hospital of Philadelphia (CHOP), as its 36th president for the 2023-2025 term. Dr. Benton is a beacon of commitment and passion in the field of children’s mental health, and her presidency promises to usher in an era of transformation and focus on “Bringing the Village to the Children.

Dr. Benton remarked on her new position, “I am profoundly honored to serve as AACAP’s president. My theme, informed by more than 30 years of practice, AACAP membership, and the insights shared by our community, will be centered on enriching children’s mental health. I look forward to collaborating closely with each member of AACAP to realize our shared vision.”

Her dedication to children’s mental health is evidenced by her extensive involvement and accomplishments within AACAP. Dr. Benton has held numerous pivotal roles, including AACAP’s president-elect, councilor-at-large, secretary, and co-chair of the HIV Issues committee, among others. She was also the recipient of AACAP’s Virginia Q. Anthony Outstanding Woman Leader Award and the Jeanne Spurlock Award for Leadership in Diversity and Culture.

Dr. Benton is not only recognized for her work within AACAP but also for her exemplary leadership and guidance at CHOP in the behavioral and mental health space. Her career resonates with her mission of nurturing diverse physician leaders and the next generation of pediatric and mental health care. This has laid the foundation for partnerships between communities and academic centers – essential in eliminating disparities in the field.

Dr. Benton succeeds the 35th President, Warren Ng, MD, and wishes to express gratitude for his mentorship, support, and pioneering AACAP’s “Capturing Belonging” initiative. As she embarks on her presidential term, she anticipates building on the momentum of AACAP and forging a brighter future for children’s mental health.

AACAP remains devoted to its mission of bolstering Diversity, Equity, and Inclusion within the field of Child and Adolescent Psychiatry and Children’s Mental Health. With Dr. Benton at the helm, the organization is poised to further elevate its objectives and bring transformative change to children’s mental health care.

For more information about AACAP and its initiatives, please visit www.aacap.org or contact Rob Grant, rgrant@aacap.org.

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Honor Your Mentor

Tell us why your mentor was important to you and how they influenced your career, and we’ll feature your submission in the March/April issue of AACAP News. In 100 words or less, send your Honor Your Mentor submission to communications@aacap.org. Please include your name, affiliation (if appropriate), the name of your mentor(s), a short testimonial or anecdote, and a picture if you have it. **Deadline for submissions is 3/1/2024.**
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Sorry to bury the lead, but we’ll start with an update of the the Psychodynamic Faculty Initiative (PsyFI). Now in its 6th year, and officially past the “pilot program” stage, the program up until recently has been maintained by Samuel and Lucille B. Ritvo Charitable Fund and administered through AACAP’s Department of Research, Grants, and Workforce. The 2022 AACAP Annual Meeting in Toronto was our first post-pandemic in-person meeting, netting us 3 mentees awarded the mentorship initiative, and our first international mentee (from the Netherlands). PsyFI appears to be back in full force, as this year 6 applicants were selected as mentees, the maximum allowable in the program. Planning Day was the Monday of the 70th AACAP Annual Meeting in New York. With six pairs of mentees and mentors, the PsyFI Leadership Team of Rachel Ritvo, Marty Drell, and Michael Shapiro modified the agenda and schedule to allow for more discussion amongst and between mentee-mentor pairs. It was a lively discussion, and truly humbling to hear about all the great endeavors and accomplishments already achieved by mentors and mentees alike (shout out to Horacio Hojman!). Being in one room with so many individuals passionate about teaching psychodynamic psychotherapy was a truly uplifting, hopeful experience that doesn’t translate as well to video conferencing. One of this year’s mentors, Leon Hofman, was the recipient of the 2022 Rieger Psychodynamic Psychotherapy Award for his paper, “Helping Parents Spare the Rod: Addressing Their Unbearable Emotions.” As a mentor, he brings his manualized psychodynamic psychotherapy for children with disruptive behaviors, Regulation Focused Psychotherapy for Children (RFP-C), to Pam McPherson’s program in Shreveport, Louisiana as part of her PsyFI project. The full list of this year’s mentees and mentors is below:

2023-2024 PsyFI Cohort:

- Mentee: Vittoria DeLucia, MD
  University of Maryland Sheppard Pratt. Mentor: Angel Caraballo, MD Adult, Adolescent, and Child Psychiatry and Psychotherapy Private Practice

- Mentee: Maura Dunfey Hwang, DO
  Children’s Hospital of Philadelphia. Mentor: Victor M. Fornari, MD Zucker School of Medicine at Hofstra/Northwell

- Mentee: Manal F. Khan, MD
  UCLA Semel Institute of Neuroscience and Human Behavior. Mentor: Steven Schlozman, MD Geisel School of Medicine at Dartmouth

- Mentee: Prema Manjunath, MD
  JPS Health Network-Fort Worth. Mentor: Timothy Rice, MD Icahn School of Medicine at Mount Sinai

- Mentee: Ajay Marken, MD
  Family Health Centers at New York University Langone. Mentor: Horacio Hojman, MD, MBA Brown University

- Mentee: Pamela McPherson, MD
  Louisiana State University Health Shreveport. Mentor: Leon Hoffman, MD Pacella Research Center New York Psychoanalytic Society and Institute (NYPSI)

Additionally, for the third year in a row, a small collective of prior PsyFI recipients presented their projects during a Clinical Perspectives at the AACAP Annual Meeting. Titled, “From There to Here, From Here to There, Psychodynamics are Everywhere!” this presentation was Chaired by Laura Prager (Boston Children’s Hospital) with Discussant Craigan Usher (Oregon Health & Science University). The primary theme of these projects was clinical practice and teaching of psychodynamic principles in “unconventional” settings, namely acute inpatient (Priya Punnoose, Children’s National), Consult-Liaison and Emergency Room (Meghan Schott, Children’s National) and community-based systems of care and treating refugee children who have experienced the traumas of war (Malak Rafla, Cambridge Health Alliance). It was a well-attended session, with Craigan Usher dutifully tying the themes of maintaining psychodynamic thinking, practice, and training alive in child and psychiatry. We look forwarding to sponsoring an upcoming submission based on last year’s projects.

Now for the “new” news. The Psychodynamic Faculty Initiative will now be fully endowed by the Leatherman-Drell-Ritvo Fund (LDRF) for the Advancement of Psychodynamic Child and Adolescent Psychiatry. First announced in 2020 – it might have been missed, was something else going on? – as the Leatherman-Ritvo Endowment Fund for the Advancement of Psychodynamic Understanding and Psychodynamically Informed Child Therapies, the renamed LDRF will now...
fully fund the PsyFI mentorship program. As announced by President Warren Ng at the plenary session of the 70th AACAP annual meeting in New York, the LDRF was established with funding to date of $300,000 in combined gifts from Edward Leatherman, M.D. in honor of Marty Drell, M.D. and from the Ritvo Family Fund in memory of Samuel Ritvo, M.D. and Lucille B. Ritvo, Ph.D. Further donations are promised in a matching funds campaign to be launched in 2024.

The creation of the Leatherman-Drell-Ritvo Endowment for the Advancement of Psychodynamic Child and Adolescent Psychiatry marks a new era for AACAP’s advocacy for psychodynamic child and adolescent psychiatry. Funds will sustain both the Psychodynamic Faculty Initiative mentorship, PsyFI, and a new grant program, Projects Advancing Psychodynamic Child and Adolescent Psychiatry (PAPCAP). This endeavor will help to finance projects in the spirit of PsyFI, but not limited to PsyFI participants, enabling us to advance innovative and creative approaches to the challenges faced in sustaining and advancing psychodynamic psychotherapy for children and adolescents. Grants will be available to all AACAP members, and could be used for educational, clinical, research or initiatives that further promote psychodynamic child and adolescent psychiatry. With this support, AACAP will continue to preserve and promote psychodynamic understanding and psychodynamically-informed therapies, build a vibrant community of psychodynamic child and adolescent psychiatrists, and lay the foundation for the ongoing growth of this essential field.

Applications for the PsyFI Mentorship Program and PAPCAP Grants will be accepted through May 1, 2024.

Michael Shapiro, MD is Co-Chair of the AACAP Psychotherapy Committee, and will be starting at Children’s Specialty Group / Children’s Hospital of the King’s Daughters at Norfolk, Virginia in 2024. He can be reached at michael.a.shapiro@gmail.com

Martin Drell, MD is past president of AACAP and the Carl P. Adatto, MD

Professor of Community Psychiatry at Louisiana State University Medical School in New Orleans, Louisiana. He may be reached at mdrell@lsuhsc.edu

Rachel Ritvo, MD is former clinical assistant professor of Psychiatry and Behavioral Sciences at George Washington University and Children’s National Medical Center, recently retired from the faculty of the Washington Baltimore Center for Psychoanalysis and retired from private practice in Kensington, MD. She may be reached at rzritvomd@gmail.com

For more information on the PsyFI program, see the AACAP PsyFI website at AACAP Psychodynamic Faculty Initiative. Questions about applying can be directed to Anneke Archer, the AACAP Staff member in charge of the Initiative. Her email is aarcher@aacap.org

For more information on the Leatherman-Drell-Ritvo Fund, please see the official AACAP Announcement: https://www.aacap.org/AACAP/Press/Press_Releases/2020/Leatherman-Ritvo_Endowment_Fund.aspx

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**CALL FOR NOMINATIONS**

AACAP’s Nominating Committee is presently soliciting nominations for two Councilor-at-Large positions. The deadline for nominations is **February 15, 2024**.

If you would like to recommend yourself or someone else for this position, please send the following to **executive@aacap.org**.

- The candidate’s current CV
- The candidate’s Disclosure of Affiliations Statement
- The candidate’s letter of interest

The [job descriptions](#) can be found on AACAP’s website. For any questions, please contact **executive@aacap.org**. You must be an AACAP voting member to nominate yourself or an individual.

**NOMINATING COMMITTEE**

**Chair**
Warren Y.K. Ng, MD, MPH

**Members**
Cathryn A. Galanter, MD
Jeffrey I. Hunt, MD
Dorothy E. Stubbe, MD
Eric R. Williams, MD
From Vision to Impact: A Reflection on Six Years of AACAP Asian Caucus

The AACAP Asian Caucus, established just six years ago, represents a pivotal milestone in the organization’s commitment to fostering diversity and inclusion within child and adolescent psychiatry. The genesis of this caucus follows the trailblazing initiatives of the Black Caucus and Hispanic Caucus, both founded in 2010, as well as the International Medical Graduate Caucus, established in 2012. Recognizing the importance of providing a dedicated platform for Asian American child psychiatrists, the AACAP Asian Caucus emerged to address the unique needs, challenges, and perspectives within the community. Since its inception, the caucus has been crucial in promoting collaboration, advocacy, and professional development, creating a supportive network for its members, and contributing to the rich tapestry of diversity within the AACAP community.

Since its inaugural meeting during the 65th AACAP Annual Meeting, the AACAP Asian Caucus has experienced remarkable growth and has made significant strides in promoting inclusivity within the field. The productive outcomes of that initial gathering are evident in the increased visibility of presentations featuring the AAPI (Asian American and Pacific Islander) population in subsequent meeting programs. (chart 1) The caucus’s commitment to fostering understanding and addressing the unique mental health needs of Asian American children and adolescents has resonated throughout the AACAP community. The expanding presence of AAPI-focused content not only reflects the caucus’s dedication to advocacy but also signifies a broader acknowledgment within the organization of the importance of diverse perspectives and cultural competence in our clinical practice.

Left; the first Asian Caucus Meeting at the 65th AACAP Annual Meeting in Seattle, WA.
Above: Asian Caucus members presented the special interest group study titled “Addressing Mental Health in Asian American Children and Adolescents: Clinical Practice, Research, and Professional Development” at the 65th AACAP Annual Meeting in Seattle, WA.
Over the past six years since its inauguration, the Asian Caucus has been instrumental in organizing quarterly meetings, participating in advocacy efforts during the COVID-19 pandemic, and contributing to AACAP publications, including articles addressing COVID-related discrimination against Asian Americans. The caucus’s mentorship program has been successfully established, and liaisons to different AACAP committees have been formed.

A pivotal goal of the Asian Caucus is the establishment of mentorship programs and the encouragement of greater representation of Asian Americans in the field of child and adolescent psychiatry. This initiative aims to address service disparities and ensure a proportional presence of Asian American mental health professionals. Concurrently, the caucus is dedicated to identifying areas requiring further research to enhance comprehension of Asian American mental health issues.

In pursuit of these objectives, the Asian Caucus is actively engaged in the development of clinical pathways and guidelines for the provision of culturally competent care when working with Asian American youths. Simultaneously, efforts are directed toward fostering a professional community wherein Asian/US-educated Asian American psychiatrists can partake in mentorship and professional activities to advance the field.

Looking ahead, the key priorities of the Asian Caucus include reducing stigma, enhancing access to mental health services, and promoting cultural competence in the field. The caucus remains steadfast in its commitment to ongoing research, mentorship, and advocacy to effectively address the unique mental health needs of the Asian American community. Currently, the Caucus listserv is joined by more than 300 AACAP members and is still growing. To join the listserv, please email the current co-chairs, Yesie Yoon (yesieyoon@gmail.com) or Jang Cho (jangchomd@gmail.com)

Jang Cho, MD is a child and adolescent psychiatrist in private practice in Seattle, WA.

Annie Li, MD is a Clinical Associate Professor in the Department of Child and Adolescent Psychiatry at NYU Grossman School of Medicine.

Neha Sharma, DO is the Program Director of the Child and Adolescent Psychiatry Fellowship Program at Tufts Medical Center in Boston. She is the General Child and Adolescent Psychiatry Clinic Director and the inaugural co-chair of the Diversity Equity and Inclusion Subcommittee for Tufts’ Graduate Medical Education.

Steven Sust, MD is a clinical assistant professor in the Department of Psychiatry and Behavioral Sciences at Stanford Medicine Children’s Health.

Yesie Yoon, MD is a board-certified child and adolescent psychiatrist and the founder of Maum Psychiatry, PLLC in New York.

Representing Asian Caucus at the CAPture Belonging Pavilion during the 70th AACAP Annual Meeting in New York, NY.
The structure of the American family is ever changing, bringing new meaning to what the mind’s eye manifests as a “normal family.” One such composition that has gained significant traction in recent years is that in which grandparents are called to raise their grandchildren as their own. The following article is the first in a series on adolescents in diverse family structures and explores grandfamilies and considerations for practitioners caring for such a familial structure.

Siblings Julian, Isabel, and Harry are cared for by their paternal grandmother, Roberta. Roberta’s son and his partner have struggled with addiction and domestic violence over the years and as a result, lost custody of their three children during early childhood. Roberta is now their sole legal guardian, and the children are not permitted to have contact with their biological parents, who are both currently incarcerated. Julian is 15 years old with diagnoses of attention-deficit hyperactivity disorder, combined type, and oppositional defiant disorder. He presents much older than his stated age and performs well academically. He has struggled with irritability and obstinance since entering treatment, although this has improved over time. He is exploring his gender identity and sexuality and finds it challenging to secure safe spaces for support, especially with his grandmother, who he feels does not understand him. He often discusses how he can easily conceal information from her due to her age, posing significant risk to his safety and wellbeing. Isabel is 13 years old and diagnosed with social anxiety disorder, separation anxiety disorder, and attention-deficit hyperactivity disorder, combined type. She is in psychotherapy to specifically address her anxiety symptoms, and her diagnosis of separation anxiety disorder is in remission. She has struggled with behavioral challenges at school, including physical aggression with peers, and has a 504 plan in place. When angered, she often becomes aggressive with her grandmother and/or siblings. Roberta is struggling to find support for these unsafe behaviors. The youngest of the three siblings, Harry, is 12 years old with a diagnosis of attention-deficit hyperactivity disorder, combined type. With medication management, Harry has historically performed well academically, although he has been struggling more recently with shifts in peer and teacher interaction due to a new hybrid schooling model in the aftermath of the COVID-19 pandemic. Roberta is not sure how to fill this social void due to time and transportation restrictions.

Roberta attends weekly psychotherapy appointments with all three children, as well as their medication management appointments every one to three months. Roberta also must attend her own doctors’ appointments due to her chronic health conditions. At times, she struggles to keep up with the heightened energy of her grandchildren due to her own limited mobility and energy stores. She frequently shares that she has limited social support aside from frequent contact with her Department of Children and Family Services Social Worker and health care providers. The COVID-19 pandemic posed great challenges for the family due to Roberta’s difficulty in learning to navigate the technology of virtual schooling. Nevertheless, the children seem to have adapted well over time. The children love their grandmother but acknowledge challenges in their relationship due to the large generational gap and a discomfort in addressing certain topics with her.

This case highlights the complex relationship between grandchildren and their grandparents as caregivers, a common arrangement with rising prevalence. From 2005 to 2015, the number of children being raised by their grandparents increased from 2.5 to 2.9 million (1,2). Common contributors to this rise included substance use disorders, physical/sexual abuse, neglect, medical illness, death of parent(s), and incarceration (1). Current
The COVID-19 pandemic unfortunately contributed to further complications and increased psychological stressors for grandfamilies (5). Grandparents were called to not only take over the day-to-day care of raising their grandchildren, but also to take on the role of educator and companion. The lack of executive function and technological skill required to keep up with virtual schooling, paired with a lack of social support and teacher engagement placed many custodial grandchildren at significant risk throughout the pandemic and beyond (6).

The distress placed upon grandfamilies is far reaching; thus, how do we assist providers develop practices to better care for our patients with their grandparents serving in a parental role? The literature supports the use of health promotion interventions, case-management-based intervention programs, empowerment training, support groups, and educational programs as efficacious, grandparent-based interventions to aid grandfamilies. It is advantageous to consider interventions that are designed to preempt the difficulties of transitioning to becoming a grandfamily to address the shifts in expectations and role confusion that come with this territory (3). Additionally, treatment of individual mental health disorders, as well as joint family therapy, can be helpful in leading to positive family outcomes by decreasing caregiver stress, improving how grandparents parent, and decreasing internalizing and externalizing behaviors of custodial grandchildren (6). Lastly, the literature is shifting to highlight custodial grandparents’ strengths and how strengths-based language even in time-limited medication management visits can truly be effective. These strengths, such as resourcefulness, resilience or positive adaptation, and empowerment, serve as major protective factors for fostering the growth of healthy grandfamilies (3).

Despite an abundance of challenges faced, Julian, Isabel, Harry, and their grandmother Roberta came to be adept in securing resources to support their family. They found that services provided on both an individual and family-based level aided their personal and familial growth and wellbeing. For instance, meeting with Julian alone to explore his gender identity or with Henry one on one to discuss his social challenges created a safe space to validate their experiences, meeting with Julian or Henry together with their grandmother empowered them to expand the range of topics addressed with her and bolstered the growth of her level of support and understanding. The family took advantage of resources such as the Grandfamilies & Kinship Support Network: A National Technical Assistance Center, a kinship navigator program that links families with benefits and services in their area from case management to concrete goods (i.e. child safety items, transportation, shelter, clothing, utilities, etc.) (https://www.gksnetwork.org/resources/kinship-navigator-programs-around-the-united-states/). In addition, their care team was empowered to learn more about how best to serve grandfamilies in an evidence-based manner by learning what it means to “create a kin first culture” and provide grandfamilies with well-deserved high quality, and compassionate care (https://www.grandfamilies.org/Resources/Creating-a-Kin-First-Culture/Lead-With-a-Kin-First-Philosophy).

References:

John Sargent, MD is Professor of Psychiatry and Pediatrics at Tufts University School of Medicine and Director of the Division of Child and Adolescent Psychiatry there. He is a notionally regarded expert in Family Therapy and a former Chair of the Academy’s Family Committee.

Jasmin Scott-Hawkins, MD, MPH is a recent graduate of Harbor-UCLA’s Child and Adolescent Psychiatry Fellowship Program. She practices outpatient community-based psychiatry with a few clinics located in Los Angeles and Ventura County. She is Medical Director of the SUD Program at Rancho San Antonio Boys Home in Chatsworth, California.

Liwei Hua, MD, PhD is an integrated Child and Adolescent Psychiatrist at South Bend Clinic in South Bend, IN. She is also AACAP liaison to the AAP Council on Adolescents and Young Adult Health.
Lifelong Learning Committee Update

As AACAP’s Lifelong Learning Committee, presently co-chaired by Donald Bechtold, MD and Jeffrey Hunt, MD, celebrates its 20th anniversary, we reflect on the committee’s history, progress, accomplishments, and future. Looking back, we want to honor all of the co-chairs and members of this committee, both past and present, as well as the AACAP staff whose dedication and tireless contributions have been essential to the committee’s functioning and development. To date, this group has developed 20 Lifelong Learning Modules and has already started work on developing its 21st module, in addition to many other products and services benefiting the membership. Our mission and history are reviewed below.

I. What is the mission of the Lifelong Learning Committee
The Lifelong Learning Committee was launched with the stated mission to meet the professional needs of child and adolescent psychiatrists, primarily focused on assisting AACAP members in staying up to date with the latest literature in child and adolescent psychiatry and with the American Board of Psychiatry and Neurology’s (ABPN) Maintenance of Certification/Continuing Certification (MOC/CC) requirements. These requirements include CME, self-assessment, and improvement in medical practice components. The Lifelong Learning Committee pledges to be non-discriminatory in fulfilling its mission, attuned to ensuring that the research and literature chosen for each Lifelong Learning Module includes literature that addresses the cost of explicit or implicit racism, its contribution to health disparities, and its consequent impact on the well-being of children of color and their families. The Lifelong Learning Committee also pledges to ensure that the Committee is inclusive and reflective of the membership and the communities that we serve.

A. Modules
The Committee produces an annual Lifelong Learning Module that is ABPN-approved for self-assessment and CME credit, while providing members with access to recent literature published in the past year that all child and adolescent psychiatrists should know. The latest module’s articles are presented during the Annual Meeting by experts in the field. This Institute has been one of the most popular events at the meeting.

B. Other Self-Assessment Activities
In conjunction with the CME Committee, the Lifelong Learning Committee also develops other self-assessment opportunities in the form of the Annual Meeting Self-Assessment Exam and Annual Meeting Workshops on psychopharmacology and psychotherapy. Members who complete these self-assessment CME activities fulfill all their required self-assessment credits for the year.

C. Additional Lifelong Learning Committee Products
The Lifelong Learning Committee also develops Improvement in Medical Practice (PIP) tools based on AACAP’s Practice Parameters, Clinical Practice Guidelines, and Clinical Updates. These tools assist AACAP members in fulfilling either the clinical or feedback module of the PIP requirement. They are available on AACAP’s website to all members, free of charge (www.aacap.org/pip).

D. Continuing Certification
Designated AACAP staff have developed expertise in the ABPN’s Continuing Certification process and requirements in order to help AACAP members navigate the ABPN’s Continuing Certification program. Additionally, a dedicated section of the website assists with Continuing Certification information and provides links to access the materials developed by AACAP (www.aacap.org/cc).

E. Other Activities of the Lifelong Learning Committee
The Lifelong Learning Committee participates when the American Board of Medical Specialties or ABPN calls for comments on proposed changes and participates in relevant leadership meetings with the ABPN annually.

II. History of the Committee
A. Founding Co-Chairs: Sandra B. Sexson, MD and the late Andrew T. Russell, MD; Founding members: Barbara Coffey, MD, Cynthia Santos, MD, Don Bechtold, MD, Jack Naftel, MD, Jack O’Brien, MD, Ulrich Schoettle, MD

Dr. Sandra Sexson, the inaugural co-chair of the committee, reflected on the Task Force/Workgroup on Maintenance of Certification (MOC) meeting in October 2003 which she attributes as the start date of this committee. The need was identified to provide AACAP members with a lifelong learning product that was user friendly, helpful, and met the ABPN’s requirements for components of Maintenance of Certification. The Task Force evolved to become a Work Group which then became the Maintenance of Certification (MOC) Committee, and finally today’s Lifelong Learning Committee.

The Committee’s initial goal was to develop a learning resource that was not just an examination that would keep members up to date. Dr. Sexson’s continued on page 20
AACAP Announces Search for JAACAP Open Editor

The American Academy of Child and Adolescent Psychiatry (AACAP) is seeking a dedicated and energetic visionary to serve as Editor of JAACAP Open, the Academy’s new peer reviewed open-access journal. AACAP’s Ad Hoc Committee on Editorship and Publications, led by Matt State, MD, PhD is overseeing the search process.

The Ad Hoc Committee is accepting letters of interest from potential candidates. Interested parties must submit the following:

1. One page summary statement, of approximately 300 words, describing interest in the position and thoughts on future advancements for JAACAP Open
2. Curriculum vitae
3. One Letter of Recommendation
4. Disclosures

Please email all materials to Carmen J. Thornton, MPH, MCHES, AACAP Director of Research, Grants, & Workforce and Interim Director of Development at cthornton@aacap.org no later than Wednesday, February 8, 2024 at 5:00 pm ET.

A full announcement and description of the JAACAP Open Editor position can be found on the AACAP website.
research found that Emergency Medicine’s model using journal articles would lend itself well to child and adolescent psychiatry. The content for each yearly module was established to ensure that most topics would be covered over the span of a 10-year period, with half of each Module dedicated to these topics, and the other half seminal articles that were released within the past year, totaling about 35 articles. Later the development of the modules evolved to eliminate this topical focus and include only seminal articles on a range of topics published within the last year.

The Lifelong Learning Committee’s present process is that each member of the Committee nominates 10 to 15 articles with the aim to assemble a broad range of 225+ articles which are then carefully peer-reviewed by committee members. From these literature reviews, approximately 35 articles deemed the most important for child and adolescent psychiatrists to know are selected for the final module. The Committee then drafts article annotations and test questions for each article.

Accomplishments
In 2017, the Lifelong Learning Committee, chaired by the late Andrew T. Russell, MD, and Sandra B. Sexson, MD, received AACAP’s Catchers in the Rye for a Component award. This award was established in 1996 to recognize an AACAP component for their outstanding efforts on behalf of children and adolescents. The award recognized the Lifelong Learning Committee for its commitment to improvement in patient care and for its impact on the membership.

The Lifelong Learning Committee owes its success to the dedication of its leadership and members, and AACAP’s staff. The committee would not be able to function let alone achieve what it has without the dedicated and stable support from its AACAP staff extraordinaire, Elizabeth Hughes-Klimper and Quentin Bernard III. Elizabeth has been supporting the committee from its start and is the longest serving staff member on any AACAP committee. Quentin’s involvement with the committee is almost as long.

III. What is it like to be a member?
I have been a member of the committee for my entire professional career. I became a member in 2012 as a resident and international medical graduate and, later, as a child and adolescent psychiatry fellow, early career psychiatrist, and now as a mid-career psychiatrist. From the start, I felt welcomed and supported by this extraordinary group of mentors and experts in our profession. The joy and reward from being on the committee arises not only from the intellectual stimulation, but, most importantly, the professional friendships developed over the years. I have grown professionally and always look forward to bringing innovative ideas and developments to my home institution and sharing them with medical students, residents, child and adolescent psychiatry fellows, and colleagues. Most importantly, what I gain from the committee and share with others can positively influence patient care. I always look forward to our committee meetings as they are fun, intellectually stimulating, and educational. I have honed my skills at critically evaluating research and making meaningful recommendations from such research. There has never been a meeting in which I did not learn something new that I could apply in my own clinical practice. I cannot imagine my professional career without this community of amazing psychiatrists that I know I can always rely on for mentorship, guidance, and support in any stage of my career. I am forever grateful for the opportunity to know and work with Drs. Sexson and Russell, and for their dedication and the standards they set for the committee.

Here are a few reflections from our committee members on what it is like to be on the committee and what they like about it.

Donald Bechtold, MD, current co-chair, member of the committee since the inaugural meeting in 2003
“It’s a lot of work but it’s worth it. Continuing education from literature and learning from and with each other is priceless. And the comradery with Elizabeth and Quentin and the committee members is such that you always look forward to the opportunities to connect.

Jeffrey Hunt, MD, current co-chair
“It has been an honor to be a co-chair of the Lifelong Learning Committee first with Sandra Sexson and now with Don Bechtold. The mission of the committee is very important, and all the members work incredibly hard to ensure that we choose the key new articles for each new module. The process of choosing and reviewing the articles each year is a tremendous way to stay up to date.

The most fun part of the Lifelong Learning process is getting to know all the other committee members at the annual in person meeting. In particular, the discussions and debates about the merits of a particular article are very stimulating!”

Cynthia W. Santos, MD member of the committee since the inaugural meeting in 2003
“Serving on this committee has been a joy, and that is why I have stayed for so many years. I learn a lot by having to review many articles and decide which ones are really important for everyone in the field. This helps me feel that I am contributing to our field. Most importantly, working with an amazing group of people over the years has been incredibly rewarding—Beginning with our initial fearless leaders, Sandra Sexson and Drew Russell, to our current leaders, Don Bechtold and Jeff Hunt and especially our AACAP staff members, Elizabeth and Quentin, who are amazing at keeping us all on track and keeping up with all the details. I enjoy the diversity of people and viewpoints over the years that contributes to our robust discussions. We work really hard on this committee, but the benefits have been many.”

Lee Aschner, MD
“The Lifelong Learning Committee provided me with the opportunity to enhance my knowledge of literature and gain perspectives of respected colleagues at all stages of their career. Working together led to friendships
with colleagues around the country. I also benefited from learning leadership skills through the examples of Drs. Sandra Sexson and Drew Russell. There was a lovely esprit de corps that developed among committee members, making meetings something to look forward to.”

Peter Ferren, MD
“I have learned how to advocate, negotiate, listen, and compromise through our lively group process of diverse perspectives toward a shared goal.

What I like most about being on the committee is the opportunity and responsibility to identify seminal literature from more obscure child psychiatry topics and references as well as increasingly promote diversity, equity, and inclusion topics to influence membership learning in directions that are hard to explore on one’s own.”

Charles Wulff, MD
“It is a privilege to have the opportunity to work alongside others in helping to contribute to the ongoing learning of my peers, as well as to build my own knowledgebase and skills.

I find the Lifelong Learning Committee to be a worthwhile experience which has allowed me to grow my knowledgebase and skill in critically reading scientific literature as a newer attending, amongst a supportive and knowledgeable group.”

Horacio Hojman, MD MBA
“The committee is extremely rich in knowledge, efficacy, teamwork, and collegiality.

I really enjoy it very much because it also allows me to be up to date with clinical and research articles in the field. The discussion and feedback of articles that we share among us is invaluable.

The Lifelong Learning Committee is an example of hard work and dedication from all its members, specifically Quentin and Elizabeth who always put us on the right path for the committee to be smooth, dynamic, and comprehensive. I am honored in being a Lifelong Learning committee member.”

IV. What the future of lifelong learning holds
As we look into our next decade, the Lifelong Learning Committee is poised as a respected committee contributing much to the AACAP community. Hopefully, the Lifelong Learning Committee will continue to contribute significantly to the professional development of child and adolescent psychiatrists.

A. Use of technology
All products that the committee developed are now available digitally, except the self-assessment workshops offered live during the Annual Meeting. The committee is always looking for innovative approaches to improve AACAP members’ access to Continuing Certification resources. In July 2023, a new Psychopharmacology Self-Assessment Workshop was offered virtually during the summer for the first time.

B. Intersection with ABPN
The vast majority of AACAP members have selected the article-based pathway for Continuous Certification. Though the processes are distinct, there have been several instances of Lifelong Learning Module articles being included for inclusion in the article-based pathway.

Irena Bukelis, MD is an associate professor in the Division of Child and Adolescent Psychiatry and Behavioral Neurobiology at the University of Alabama at Birmingham (UAB). She completed her general psychiatry residency training and child and adolescent psychiatry fellowship training at UAB. Currently, Dr. Bukelis serves as an associate psychiatry residency program director at UAB. Her clinical and teaching responsibilities are largely at Children’s of Alabama. She is a graduate of Kaunas University of Medicine in Kaunas, Lithuania. Dr. Bukelis is an AACAP distinguished fellow and serves on AACAP’s Lifelong Learning Committee. Her special areas of interest are autism, ADHD, psychodynamic psychotherapy, and physician wellness.

Sadly, three of our members have passed.
In memoriam:
Andrew T. Russell, MD
Jack O’Brien, MD
Ulrich Schoettle, MD

Full List of Members:
Amy Ursano, MD
Andrew Russell, MD
Barbara Coffey, MD
Charles Wulff, MD (current member)
Chelsea Carson, MD (current member)
Clarence Chou, MD
Cortney Taylor, MD
Cynthia Santos, MD (current member)
Dale Peeples, MD (current member)
Don Bechtold, MD (current member)
Fatima Imara, MD
Gene Beresin, MD
Heather Laughridge, MD (current member)
Horacio Hojman, MD (current member)
Irena Bukelis, MD (current member)
Jack Naftel, MD
Jack O’Brien, MD
Jasmine Williams, MD (current member)
Jeffrey Hunt, MD (current member)
Lee Ascherman, MD
Lindsay Moskowitz, MD
Mahnaz Pezeshpour, MD
Matthew Koury, MD
Mike Ellis, DO
Miranda Harris, MD
Patrick Molitor, MD
Peter Ferren, MD (current member)
Peter Ly, MD
Pieter Van Wattum, MD
Rachel Fleissner, MD
Sameera Azeem, MD (current member)
Sandi Sexson, MD
Saundra Stock, MD
Sibel Algon, MD (current member)
Tyrone Bristol, MD
Ulrich Schoettle, MD
Introduction and Overview:
Laura Prager, MD and Sharon Weinstein, MD Co-Chairs

As child and adolescent psychiatrists, we want to offer our young patients and their families the mental health care they need and deserve. We also want to be paid for our work. No matter where we practice—an academic medical center (AMC), a private practice, a community clinic, a school, a private or public company—most of us are engaged in a fee for service business, regardless of whether we are paid by the patient or an insurance company, or salaried by a hospital or clinic. And most of our livelihood has been, and remains, directly tied to our clinical productivity.

But how and where we care for patients has changed and continues to change. Child and adolescent psychiatrists who finished training a generation ago generally stayed at the AMC where they trained to care for patients (as therapists and psychopharmacologists), do clinical research, and teach other trainees. Many started a private practice to supplement their income. Some joined the staff of a community clinic or worked on a for-profit inpatient unit. Very few decided to get an MBA.

The world is different now. There are more and more patients who need our services but fewer child psychiatrists in the pipeline. AMCs are increasingly more like large corporations where focus is on the bottom line. Salaries are a bit higher but there is no money for teaching, supervision, administration, or advocacy. The pandemic brought us the option of remote and hybrid work, which allowed us to see more patients, but also robbed us of the chance for curbsides and camaraderie.

Both graduating child psychiatry trainees and early career child psychiatrists often feel both lost in the changing landscape and worried about having the way they practice limited by institutional directives. They routinely ask such questions as: How do our attendings do it—seeing sick patient after sick patient in back-to-back thirty-minute visits without any time to confer with other providers or work with the family members or school staff? How can I support myself on an academic salary without moonlighting on nights and weekends to pay for daycare for my young children? How can I get grant funding to do research if I have no protected time to explore my research interests and to apply for a grant? Will I be lonely if I go into solo private practice and overwhelmed by paperwork if I am willing to take insurance? What are my options if I want to practice in a community setting? If I want to advocate for underserved populations, how can I get a job that allows me to make an impact on more than one patient at a time? I like residency training—can I get paid to do that?

On April 29, 2023, NECCAP brought thoughtful, talented, innovative physician entrepreneurs together to talk about these new opportunities, and to answer the questions posed above. We invited all NECCAP and AACAP members to join us for what we hoped would be an informative, thought-provoking program.
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Speakers in our first group are trying to create novel business networks that will redistribute insurance funds and cash from government programs to provide access and care to a wider population of patients, while delivering value to their shareholders. The speakers in our second group include an informatics expert who explained the existing insurance morass, why child psychiatrists shy away from accepting insurance payments, and what some insurers have done to address that problem, a practitioner who expanded on the private practice model with the goal of creating a group practice—with varying degrees of success, and, Boston’s first Chief Behavioral Health officer who shared with us how he works within a well-intentioned but flawed system of care while emphasizing the great need for mental health equity.

The Growing Trend of Digital Health Start-Ups: Tackling the Pediatric Mental Health Crisis

Mona Potter, MD and Dana Sarvey, MD

The COVID-19 pandemic exacerbated many of the existing challenges in child, teen, and young adult mental health treatment, prompting the Surgeon General of the United States to call for a “swift and coordinated response” to the problem. This prompted a rapid and prolific rise in digital health companies. This presentation focused on the experience of two child and adolescent psychiatrists who moved out of an academic medical center into the digital health space to tackle the youth mental health crisis.

Mental health digital startups as a group have been the top-funded clinical programs, peaking in 2021 at $4.8B. While funding for pediatric digital behavioral health companies has lagged behind that of adult-focused companies, there has been growing interest, particularly in the past few years. In this presentation Dr Potter shared her experience building InStride Health, a start-up in the clinical care delivery space, focusing on the seed, early start-up, and growth phases. She emphasized the need to build a strong founding and leadership team and stated her four initial priorities: considering funding mechanisms, determining the role of technology, defining scope and target market, and building the financial model.

In the final part of the presentation, Dr. Sarvey focused on her reasons for taking on a Medical Director role at InStride Health. Benefits included an opportunity for innovation, working with a cross-functional team, operational learnings, and flexible work schedule. She also highlighted how this new work environment allowed for technology that increased efficiency, reduced physician burnout, and promoted measurement-based care. Although the startup moved at a faster pace than the AMCs, what remained consistent across practice settings was the commitment to establishing a strong alliance with patients and families, and the ongoing need for care coordination coupled with evidenced-based decision making.

School-community Partnerships to Promote Mental Health Equity

Joe English and Juliana Chen, MD

School districts are on the frontlines of the youth mental health crisis. In response to skyrocketing mental health needs, equity gaps, and overburdened on-campus resources, district leaders are pursuing innovative approaches to supporting student mental health. Mr. English and Dr. Chen described a new Massachusetts-based mental health service model, Cartwheel Care, which uses telehealth to expand access to short-term mental health services for hundreds of middle and high school students through school-community partnerships. In its first year of operation, the model provided timely access to care to referred students, successfully connected patients needing longer-term services to community-based providers and achieved high rates of patient engagement and satisfaction. In addition, early data suggest that telehealth solutions can promote health and educational equity while reducing staff burnout. The Cartwheel Care model shows promise for much broader impact and reinforces the unique importance and value of school-community partnerships.

Buyer Beware-The Challenges and Opportunities of Entrepreneurial Pursuits in Mental Health Care Delivery

Robert Accordino, MD, MSc

Dr. Accordino has led clinical teams as the physician executive at one venture-backed leading mental healthcare technology start up and one public company. He emphasized that in mental healthcare, there is a huge mismatch between those who need care and those who can provide care. This situation is worsened by the fact that a disproportionate number of these providers do not accept insurance. Technology can be a very powerful tool to democratize access to care that is insurance-accepting and tracks outcomes to ensure patients are actually getting better. However, it is a tool—not a replacement for actual clinical care. In the private sector, helping patients does not always align with the ambitions of investors and others who are profit-seeking. Dr. Accordino also highlighted the inherent tensions of mis-aligned incentives between profit-seeking investment in scaling mental health services and ensuring that these services are high quality. Since 2017, there has been $10B invested in venture capital funds to mental health technology companies which has led to tech-enabled delivery of care to hundreds of thousands of patients. While access has certainly improved, there has not been enough of a focus on the quality of that care. Dr. Accordino offered the following advice to those physicians considering involvement with private sector entities in this space:

1. As a physician leader, you are the chief advocate for both patients and clinicians. Profit seeking and scaling the business may often be at odds with the pursuit of clinical excellence, which takes time and considerable effort. Before taking on a role—in a full time or part time advisory capacity—be sure to take a deep dive into the clinical journey with a focus on understanding how decisions are made and if your perspective will be welcomed and taken seriously. It is your job to set appropriate guard rails and policies in place and to ensure that clinical
quality is and remains the central focus. Overall, clinical quality as a guiding principle will always win.

2. As a chief medical officer, your relationship with your chief executive officer (CEO) is essential. You want to work with a CEO who is appropriately deferential when it comes to clinical questions and that your CEO welcomes your perspective.

3. Read the fine print before signing any contract!

Psychiatrists and the Insurance Market: Aligning the Incentives

Nicole M. Benson, MD, MBI

The American Academy of Child and Adolescent Psychiatry has called attention to the severe shortage of child and adolescent psychiatrists across the US. In addition to the scarcity of child and adolescent psychiatrists, many psychiatrists do not accept health insurance reimbursement, compounding the difficulty in accessing care for patients. A key explanation for the limited insurance participation is related to low reimbursement rates through the insurance market and the fact that, even for the same code, psychiatrists are reimbursed less than other medical specialties. Other reasons for limited insurance market participation may include the high demand for private pay mental healthcare and administrative burden required for insurance reimbursement, particularly for those in solo practice. In the setting of low insurance market participation by psychiatrists, out-of-pocket expenses have increased for patients over the last several years, particularly for those receiving out-of-network services. As a result, for patients, there may be few options available for in-network treatment. And, even if in-network providers exist, patients may choose to see the first available clinician, whether in or out-of-network. It remains to be seen how policy levers or incentive programs could impact insurance participation. Adequate reimbursement for mental healthcare is key to making insurance participation worthwhile, particularly for those providers outside of academic settings.

Solo Private Practice: pleasures and pitfalls

Amy Funkenstein, MD

Dr. Funkenstein is in a solo private practice in suburban Boston. She discussed the financial incentives for early career child psychiatrists that are inherent in building a private practice. She highlighted the need to define the goals of a practice, to understand the challenges the provider faces when hiring and firing employees, and to appreciate the value of an assistant. It was important for her to streamline her practice by choosing what specific services to provide in order to make the practice manageable and profitable.

The way that residency is structured disempowers doctors through low wages, long hours, and a hierarchical system that leaves new attendings without the skill set to self-advocate or recognize their value. She spoke of the need to empower early and mid-career psychiatrists to find profitable ways to practice and to develop a practice that speaks to their values and interests as psychiatrists, particularly when this type of self-advocacy feels challenging within the bureaucratic hospital system. She highlighted that until insurers are willing to reimburse psychiatrists commensurate with their experience and value, private practice will remain a necessity for many to manage the financial burdens post-residency.

Navigating Mental Health Equity

Kevin Simon, MD

Dr. Simon talked about his goal: “Navigating Mental Health Equity in Boston.” In June 2022, he was honored to be appointed as the first Chief Behavioral Health Officer for the City of Boston, tasked with shaping a city-wide strategy addressing behavioral health concerns among youth. His lecture drew upon his career journey, offering insights into the broader national landscape of mental health, and the unique regional attributes. He delved into society’s social and political determinants of mental and behavioral health, emphasizing the steps taken by Mayor Wu’s administration in Boston. These steps included establishing his role, pioneering the Center for Behavioral Health and Wellness under the Boston Public Health Commission, and spearheading RFPs, which will culminate in expanding the behavioral health workforce, launching public campaigns to diminish stigma, and introducing youth-centric activities promoting positive social interactions, such as providing 7,000 job opportunities for Boston’s youth aged 14–18. An imperative takeaway was the child and adolescent psychiatrist’s pivotal role in addressing and mitigating public health challenges and structural violence. Dr. Simon examined the deep-rooted impacts of structural violence on young individuals of color, identifying its manifestations in everyday life and the consequent mental health ramifications. The session aimed to empower attendees with strategies to counteract structural violence and champion health justice through effective public health interventions.

Summary:

This program was virtual, well-attended, and generated many questions and comments from the participants. It was hailed as both novel and necessary for all child psychiatrists, especially for those in training and in the early stages of their careers.

We include below a comment from one attendee whose expression of thanks resonated with all the panelists as it aligns with one of the primary goals of this program—to shed light on what is happening to our field in the present—the good and the bad—and allow us to think together about what we envision for our future.

Phenomenal Conference!

I am so grateful. The morning was mind bending in that we get to peek around the corner to take an unvarnished look at how child psychiatric practice is evolving. The presenters today were all exceptional in their clarity and grasp of the issues from their perspectives. Most of what was said today I have not heard spoken or acknowledged in a public professional forum, only backroom discussions...

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References:

Mona Potter, MD and Dana Sarvey, MD


Robert Accordino, MD


Nicole M. Benson, MD, MBI


Amy Funkenstein, MD


Kevin Simon, MD


Honor Your Mentor

Tell us why your mentor was important to you and how they influenced your career, and we’ll feature your submission in the March/April issue of AACAP News. In 100 words or less, send your Honor Your Mentor submission to communications@aacap.org. Please include your name, affiliation (if appropriate), the name of your mentor(s), a short testimonial or anecdote, and a picture if you have it. Deadline for submissions is 3/1/2024.
Faculty:

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Lecturer (part-time), Harvard Medical School

Nicole M. Benson, MD, MBI
Associate Chief Medical Information Officer, McLean Hospital
Medical Director for Digital Solutions, System Behavioral & Mental Health at Mass General Brigham
Assistant Professor, Department of Psychiatry, Harvard Medical School

Juliana Chen, MD
Medical Director, Cartwheel Care
Child, adolescent, adult psychiatrist
Faculty at Harvard Medical School
Robert Wood Johnson Clinical Scholar
Former SAMHSA Minority Fellow

Joe English
Co-Founder and CEO, Cartwheel Care
Founder-Hope in a Box, a nonprofit that helps educators build diverse and inclusive English classrooms in more than 1,000 schools across the country.
Author-education issues for Politico, Education Week, Entrepreneur Magazine, and the United Nations

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Child, Adolescent, Adult Psychiatrist in private practice–Lexington, MA
Distinguished Life Fellow of APA and AACAP

CALL FOR PAPERS

AACAP’s 71st Annual Meeting takes place October 14-19, 2024, at the Seattle Convention Center in Seattle, WA. 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, 2024**, or by **June 6, 2024** for (late) New Research Posters. The online Call for Papers submission form for the February deadline will be available at [www.aacap.org](http://www.aacap.org) in December 2024, and all submissions must be made online.

**QUESTIONS?** Contact AACAP Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
Recapturing Belonging: Combatting Burnout in the Field of CAP

Jessica Stephens, DO, Pooja Amin, MS-2, Carly Kawanishi, MD, Abishek Bala, MD

In the aftermath of the COVID-19 pandemic, Medscape’s Psychiatrist Lifestyle, Happiness, & Burnout Report (2022) revealed noteworthy rates of burnout and depression amongst psychiatrists. According to the same report, work hours, excessive bureaucratic tasks, lack of control/autonomy, lack of respect from colleagues, and increasing use of electronic health records (EHR) were reported as contributing to rates of burnout. Those at increased risk for burnout and depression include female psychiatrists and those earlier in career or training (Summers et al., 2020). Below, we share reflections of individuals within the Child and Adolescent Psychiatry (CAP) community highlighting the importance of re-capturing purpose and belonging to combat burnout and re-inspire meaning for the work we do.

Growing up, I experienced functional impairments from attention deficit hyperactivity disorder (ADHD) symptoms; however, due to my parents’ belief that mental health disorders are self-conceived impediments rather than objectively diagnosable medical conditions, I did not receive the appropriate evaluations and treatment until I entered college. Learning from psychiatrists with lived experiences and emphasizing belonging to the physician community have been suggested as a part of future directions to improve overall well-being and burnout (Summers et al., 2020). Below, we share reflections of individuals within the Child and Adolescent Psychiatry (CAP) community highlighting the importance of re-capturing purpose and belonging to combat burnout and re-inspire meaning for the work we do.

Compassion
Growing up, I experienced functional impairments from attention deficit hyperactivity disorder (ADHD) symptoms; however, due to my parents’ belief that mental health disorders are self-conceived impediments rather than objectively diagnosable medical conditions, I did not receive the appropriate evaluations and treatment until I entered college. As I progressed through my training and things got difficult, remembering how I felt back then and re-affirming my “why” reminds me to be nothing but compassionate and to keep going. (Pooja)

Mentorship
I was drawn to CAP because I value the themes of hope and possibility that fuel the treatment goals for these young patients. I am inspired by the unshakable optimism of the child and adolescent psychiatrists I’ve met. Like them, I plan to partner with youth and their families as they navigate the barriers holding them back from blossoming as individuals. However, despite my motivation, I have struggled with burnout from colliding with the systemic barriers my patients face, as well as from the demands of psychiatric care, I found myself standing up for myself and my need for medication and therapy. My personal journey instilled in me the commitment to serve and advocate for children and adolescents. As a Child and Adolescent Psychiatrist, I would have the power to speak up and support children who are struggling like I did, as well as help them find their voices. As I look forward to continuing my training through medical school and beyond, I realize that it is easy to forget how far I have come. I went to medical school to help children who struggle with their mental health because I have been there in their shoes. I hope to always remember what it felt like to be in that seat, across from the psychiatrist, scared and frustrated because nothing we tried was working. As I progress through my training and things get difficult, remembering how I felt back then and re-affirming my “why” reminds me to be nothing but compassionate and to keep going. (Pooja)
the medical training system. I have found respite in connecting with others and have experienced healing through shared vulnerability. I am grateful for my mentors who open-heartedly shared their own struggles with imposter syndrome. Through normalizing these feelings, they’ve given me the language and courage to do the same for the students I work with.

As part of my work with AACAP’s Medical Student and Resident (MSR) Committee, I’ve seen growing positive regard surrounding conversations of vulnerability. One of the primary well-being events the MSR Committee co-sponsors at the Annual Meeting is a program highlighting how self-compassion can be used to combat self-critical thinking. This year, we plan on creating a longitudinal self-compassion initiative that extends this conversation past our once yearly meeting. We hope to make space for a community open to the triumphs and challenges of embracing self-compassion and vulnerability. To continue chasing the passion that brought each of us to CAP, it’s so valuable to connect and lift each other up. (Carly)

Community
My journey into the field of CAP has been a deeply personal and enriching one, fueled by a profound desire to make a positive impact on young lives. From the very outset, my passion for working with children was rooted in a simple yet profound goal to witness at least one genuine smile on a child’s face each day.

What drew me specifically to CAP, however, was the field’s commitment to a purely holistic approach. In CAP, we don’t just treat symptoms; we nurture the complete well-being of a child. We understand that each child is not an isolated entity but a part of a larger tapestry. These families we serve are not strangers; they are our neighbors. This close-knit connection to our community adds a unique dimension to our work, making it all the more meaningful.

One profound realization I’ve had on this journey is that when we care for one child, we are in fact caring for an entire ecosystem. Each child brings with them not just their individual lives, but also the dynamics of their family, the nuances of their neighborhood, and a snapshot of society as seen through their unique lens. This has allowed me to appreciate the diverse perspectives that exist within our society and, in turn, find my place within it.

In CAP, I’ve discovered a field that not only fulfills my aspiration to bring smiles to children’s faces but also provides me with a window into the intricate interplay of individuals, families, neighborhoods, and communities. It’s a field that continually inspires me, reminding me of the meaningful impact we can have when we strive to understand and heal not just individuals, but the world they carry with them. (Abishek)

Final Thoughts
As trainees and psychiatrists early on in career, we recognize the increasing rates of burnout, its permeating impact, and the importance of prioritizing well-being. In sharing these reflections, we are re-inspired by our passion for working with children and their families and reminded of the importance of our connections, both professionally and personally. We encourage readers not only to look inward and reflect upon personal experiences leading to a passion for the field, but to engage with the CAP community. We must unite in support of one another in combatting burnout and utilize creative approaches to re-capture our passion and belonging.

Disclosures: The authors have no direct or indirect financial interests or affiliations to disclose.

References

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Carly Kawanishi, MD is a PGY-3 Resident at the University of Colorado.

Abishek Bala, MD is an Assistant Professor of Psychiatry and the Assistant Program Director of Child and Adolescent Psychiatry Fellowship at Central Michigan University

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Tell us why your mentor was important to you and how they influenced your career, and we’ll feature your submission in the March/April issue of AACAP News. In 100 words or less, send your Honor Your Mentor submission to communications@aacap.org. Please include your name, affiliation (if appropriate), the name of your mentor(s), a short testimonial or anecdote, and a picture if you have it. **Deadline for submissions is 3/1/2024.**
Approaches to Working with Families Around Youth Problematic Media Use

From 3 AM social media engagement to addictive gaming, providers frequently identify problems associated with screen media habits in our patients. These difficulties cause or exacerbate psychiatric illness but helping correct them can be quite challenging, and typically must involve timely interventions, a strong therapeutic alliance, and significant family effort.

She highlighted how families can understand common patterns of conflict, externalize the problem, identify challenges, and experiment with win-win solutions.

Clinical Perspectives 77 at the 2023 AACAP Annual Meeting: “Approaches to Working With Families Around Youth Problematic Media Use”, chaired by Erin Belfort, MD, sought to arm providers with the necessary tools to do just that.

First up, Elizabeth Englander PhD, presented “Time for That First Phone? Working With Families.” Dr. Englander cited how the median age of first smartphone ownership has dropped to 12, and parents have little guidance on how and when to introduce smartphones into the lives of their children. Dr. Englander recommends that ownership of a first smartphone comes with a contract indicating how the phone is to be used, and reasonable consequences of those rules being broken. Such rules may include phone use is only allowed once schoolwork and chores are finished, that children must answer their parents calls and texts immediately, that children be careful to avoid online dangers, treat others online with kindness, and that the parent will check through the phone intermittently in order to supervise the child’s activity. Dr. Englander provided a framework for how parents (and clinicians) can teach children to navigate online conflict and cruelty, sharing photos appropriately, deal with FOMO, attain a healthy screen/life balance, and use the phone to engage in positive activities.

Second, Dr. Belfort described how time-honored family counselling tenets can solve contemporary family conflict in “Family Therapy Principles Applied to Working With Families Around Media Use.” She indicated how destructive conflict over screen media habits between parents and children can be, and the importance of uniting families around mutually beneficial solutions. It’s vital for clinicians to adopt “the Stance” of being curious rather than judgmental, assuming good intentions and tolerating multiple perspectives, and allying with the family as a whole rather than one member against another. She highlighted how families can understand common patterns of conflict, externalize the problem, identify challenges, and experiment with win-win solutions.

Next, Gino Mortillaro MD, presented “Pitfall Isn’t Just a Video ‘Game: Tips for Identifying and Managing Problematic Gaming” in which he highlighted industry tricks that make video games increasingly habit forming or even addictive. The pinnacle of these may be the loot crate, or randomized digital game content which provides randomized reinforcement akin to a slot machine. Such reward in-game items can be priceless to gamers, who have purchased them outright for sums up to hundreds of thousands of dollars. Dr. Mortillaro described how asking patients to describe their gaming habits can help facilitate engagement and alliance, and how clinicians can screen for problematic internet use (PIU) by asking patients what they don’t like about their gaming habits, and assessing for signs analogous to those of substance use disorder, such as by using a gaming-focused version of the CAGE questionnaire.

Meredith Gansner, MD, integrated her clinical experience and research for “Managing Digital Emergencies: Problematic Internet Use in the Acute Psychiatric Settings.” Preliminary findings indicate that 4% of acute psychiatric admissions among youth are directly due to PIU, with an additional 10% related to homicidal or suicidal ideations in response to screen media confiscation. Helping families agree upon a screen media plan for when youth return home is vitally important but challenging and failure to do so can delay timely discharge or risk a rapid readmission. Dr. Gansner also highlighted the utility of psychoeducation regarding mental health and screen use and education regarding coping skills which do not involve use of screens. Special consideration must be given to youth who engage in online content encouraging eating disordered behavior, self-harm, or suicide, which may require parents to monitor online activities more closely. Youth hospitalized for medical reasons may require a hospital screen media plan with clear rules about how and when devices may be used, what will cause a loss of privileges, selective access to games less likely to provoke frustration, reminders of when it’s time to come off, and subsequent redirection to replacement activities during transition.

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Should Psychiatrists Advocate Banning Screens From Kids’ Bedrooms?

Justin Marshall, MD

At AACAP’s 2023 Annual Meeting in New York City, a debate was held between psychiatrists to deliberate this very question. The session was chaired by Paul Weigle, MD, who started the debate by asking attendees their thoughts. 54% of participants agreed with the proposition that psychiatrists should advocate banning screens from kid’s bedrooms, 25% disagreed, and 21% of respondents were unsure. Whichever team could convince the most attendees to change their mind would be declared the winner.

Team Proposition, in favor of banning screens from kids’ bedrooms, consisted of Argelinda Baroni, MD, Lauren Hale, PhD, and Dale Peeples, MD. They reviewed evidence that removing screens from bedrooms helps enable youth to get sufficient sleep, citing strong links between evening screen time and poor sleep quality. They emphasized the risks of unsupervised access to the internet, the negative physiological effects of screen light on circadian rhythms, and sleep disturbance caused by notifications from cellular devices. The team did not endorse a complete screen ban, just one to keep screens out of the bedroom.

Team Opposition, Gino Mortillaro, MD, Raymond J. Pan, MD, and Michael Tsappis, MD, argued against the proposition. They conceded that screen media negatively impacts sleep but contended that a complete ban may compromise the alliance between the psychiatrist and the youth and increase family conflict. Dr. Tsappis made that point that banning screens from the bedroom, “removes the opportunity to learn how to regulate one’s self,” and that in some families’ homes a bedroom screen ban is infeasible, such as when youth require a quiet place to complete homework on a computer.

In the rebuttal phase of the debate, Dr. Pan of Team Opposition agreed that overuse of screens negatively impacts the health of youth, but argued instead for moderation of screen use and appropriate boundaries/limits, rather than a complete ban. Team Proposition’s Dr. Baroni stated that the opposition could not dispute the negative effects of screen time because “science is on our side.” Dr. Hale pointed out that the bedroom screen ban supports the moderation Dr. Pan suggested. Dr. Hale argued that there is strong scientific evidence in favor of psychiatrists recommending such a ban and it would be wrong to alter our “best medical advice,” based on individual circumstances.

Both sides then took questions from the audience. When asked if the ban should be for parents as well, Dr. Baroni argued such restrictions are easier enforced when perceived as fair and equal among all family members. Dr. Pan agreed that screen limits should be consistent among all family members when possible, as the biggest determinant of child media habits is parent media habits. Another attendee made the point that immediate confiscation of devices such as phones or tablet can precipitate a mental health crisis such as suicidality. Dr. Baroni recommended utilization of the online American Academy of Pediatri’s family media planning tool at healthychildren.org to assist in initiation of screen related rule setting. Discussant Andrew Rosenfeld endorsed resources on the new Screen Media Resource Center at AACAP.org for parents looking to set screen media limits for their children. Dr. Tsappis advocated utilizing stepwise titration and family compromise when making significant changes to screen time rules.

During closing arguments, Team Proposition emphasized concerns surrounding poor sleep in adolescents as a result of unrestricted bedroom screen time. Dr. Peeples added that screens should be utilized in public spaces in the home, as bedroom use risks unhealthy habits and poor sleep. Dr. Mortillaro of Team Opposition argued against a complete ban of screens in the bedroom and instead argued for a more narrow bedtime ban. He cited potential advantages the internet affords adolescents who benefit from a private place to explore their identity. Dr. Mortillaro argued that a complete ban lacked needed nuance and risks denying youth a quiet place to do homework, particularly in the event of another quarantine.

Finally, the proposition was again put to audience vote, revealing a significant shift in the results with now only 36% of respondents agreeing that child psychiatrists should advocate to ban all screens from the bedroom, and 55% advocating against the idea with the remaining 9% being unsure, a decisive victory for Team Opposition.

The question of whether to remove screens from bedrooms will no doubt continue to be one that child psychiatrists must address in clinical practice. However, this lively debate delved beyond the surface of the problem and explored underlying issues which affect such a decision. The debate highlighted the need for adequate evaluation and personalized interventions, changing the minds of many attendees in the process.
With over 6,000 registered attendees (in-person and virtual), the AACAP’s 2023 Annual Meeting marked the largest meeting to date of the child and adolescent psychiatry (CAP) community, providing countless opportunities for lifelong learning, networking, mentorship, and career development. In addition, this meeting boasted a record number of trainee participation, including medical students, general psychiatry residents, triple board residents, child psychiatry fellows, and pediatric residents with an impressive total of 1,492 trainees registered for in-person and virtual components. Thinking back to my first experience with AACAP at the 2018 Annual Meeting in Seattle, I realize how pivotal attendance at this meeting was for my personal and professional development as a medical student, coming away from the meeting with an extended family and opportunities which paved my path into the field of CAP. Below we share various reflections of first-time attendees of the Annual Meeting highlighting a unique perspective and the importance of inclusivity and engagement of trainees, the future leaders of the field. (Jess)

**Inspiration**

Attending my first AACAP Conference was a whirlwind of excitement! It was thrilling to engage with peers and mentors in person after prior virtual connections participating in the Medical Student and Resident (MSR) Committee and Asian Caucus meetings. As a fourth-year student applying to CAP, this meeting offered an invaluable chance to connect with like-minded individuals from across the globe. On my first day I attended the AALI Idea Forum PechaKucha presentations and was blown away at each presenter’s creativity, timing, and insightful exploration into a variety of meaningful topics. The panel discussions and audience engagement made the session so powerful, and I left inspired, hoping to one day build the courage to create and present my own PechaKucha in the future. The amazement did not end there! Later that evening at the extravagant Welcome Reception, I coincidentally met my PsychSign mentor, for the first time in-person while waiting in line for food. In that moment, I realized that CAP is such a tight-knit and supportive community. While presenting my own poster on YouTube Kids and depression, I was excited to learn so much from those who stopped by and discussed the study’s implications and significance. I will never forget the people I met and the memories I made this year. I felt extremely welcomed as a student, and hope more students attend in future! (Jasmine)

**Inclusivity**

My experience at my first Annual Meeting felt like being introduced to a large, welcoming family which was excited to see me succeed as a future CAP. Although I was thrilled to meet practitioners and trainees who shared my interest in the field, I was initially intimidated by the scale of the conference as well as the scale of the accomplishments touted by many attendees. However, each interaction helped assuage these feelings. Sitting down next to experienced psychiatrists at clinical consultation breakfasts, I found that I was invited to provide input on each topic as a peer and these accomplished attendees were excited to hear my insights from relevant lived experiences, even as a trainee.

In addition, the Annual Meeting’s mentorship events familiarized me with the AACAP’s culture of interprofessional support at every level. Residents advising curious medical students, like myself, simultaneously benefited from the expertise of attendings and program directors who were excited to share decades of knowledge with each eager learner. I found that the MSR Two-Day Mentorship Program created a kinship between AACAP attendees which deconstructed the traditional hierarchical relationships I often observe as a medical student. It is these relationships which will form the foundation of a strong professional bond that extends far beyond the end of Annual Meeting, and I look forward to returning as a member of the AACAP family. (Thomas)

**Mentorship**

As a first-generation medical student, navigating the complexities of medical school and the path to residency proves challenging. It is difficult finding experiences residency programs value, while still piquing my interest and providing practical knowledge. The AACAP Annual Meeting uniquely
addressed all these points. Despite having previously attended other conferences, the emphasis on mentorship at the AACAP conference stood out. Throughout the week, I connected with numerous medical students and residents, receiving valuable peer advice and support. The standout experience was the AACAP Two-Day Mentorship Program. Meeting psychiatrists and peers from various diverse backgrounds and geographic locations provided the opportunity to address lingering questions and connect with CAP colleagues internationally. We discussed how to engage in research and still maintain a healthy work-life balance. The assistance and encouragement I received surpassed all expectations. I left the conference equipped with a network of support and a renewed sense of purpose. The AACAP conference was a pivotal chapter in my medical education, shaping my perspective and confirming my trajectory as I continue along this demanding yet rewarding path. (Veronica)

**Engagement**

As a Puerto Rican IMG MS 4 student currently applying for psychiatry residency with interests in CAP, I realize how profoundly attending the AACAP Annual Meeting expanded my understanding and appreciation for children's mental health. The sense of unity and collaboration among the attendees was palpable and truly inspiring. One of the things I truly appreciated was the opportunity to engage in-person with AACAP members I had previously only interacted with through virtual MSR meetings. I enjoyed fostering new relationships through the mentorship events hosted by the MSR committee. I especially loved being able to represent my beloved Puerto Rico by wearing a traditional “jibarita” costume at the “Diversity and Inclusion Fashion Show Event.”

Opportunities for engagement, such as the “How to get published” workshop were a highlight, offering invaluable insights and mentorship from esteemed leaders in psychiatry. It was a gateway to exploring research opportunities in my areas of interest and learning about the intricate process of choosing the right publication outlets, an enlightening experience that opened up new avenues for my professional growth. Equally impactful was the “AACAP’s Advocacy Toolkit” workshop. My passion for global mental health advocacy found new direction and energy through the strategies I learned there and I feel empowered with tools to effectively communicate my advocacy message and to inspire action in others.

The AACAP Annual Meeting was a key part of my journey, packed with learning, and a lot of fun! This whole experience was crucial in guiding my career in psychiatry and has strengthened my desire to really make a difference in mental health care. (Ariana)

**Final Thoughts**

As echoed in the sentiments of trainees above, this year’s AACAP Annual Meeting was truly remarkable in many ways! For us, the sheer volume of trainees in participation at the meeting, many of which were first-time attendees, was inspiring. As members of an organization dedicated to the enhancing the field of CAP, it is important to reflect on our community and ways in which we can directly foster the future of our workforce. Whether through sharing wisdom and mentorship or providing opportunities for engagement of trainees (https://www.aacap.org/App_Themes/AACAP/Docs/medical_students_and_residents/AACAP-MSR-orientation-flyer-10.20.2023.pdf) in Annual Meeting program submissions, committee projects, research, advocacy, or awards, we encourage all AACAP members to support year-long trainee involvement in the field of CAP.

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Finally, Clifford Sussman, MD, shared lessons from his clinical work as a gaming disorder specialist in “No Brakes, No Breaks: Clinical Work With Youth and Families Around Problematic Use of Screens.” He described how gaming is so habit forming not only because of the magnitude of dopaminergic reward stimulation, but because of the speed by which gaming behaviors activate that stimulation. Many of his patients have dropped out of high school or college due to problematic gaming, Comorbid ADHD, ASD, and/or anxiety are common. His work focuses on helping them stop gaming when it’s time and delay gratification when they experience urges to restart. He helps patients learn to delay gratification by scheduling regular time for low-stimulation activities. Treatment often starts with a digital detox which typically provides dramatic results in just a few days, followed by reintroduction of screen media characterized by a healthy balance regulated by parents, and towards a balance achieved by self-regulation. To this end he uses elements of CBT and motivational interviewing, managing environmental cues (e.g., removing screens from bedroom), and sometimes medicating comorbidities such as ADHD.

The age of the internet is upon us, and PIU all-too frequently complicates the treatment of our patients. The research, experience, and understanding of Drs. Englander, Belfort, Mortillaro, Gansner, and Sussman constitute a large step forward in helping contemporary providers understand and navigate PIU in our clinical practice.
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As AACAP’s Resident Advocacy Scholar in September 2023, I participated in a range of advocacy efforts that enhanced my knowledge of healthcare policy and legislation. Working closely with AACAP’s Government Affairs and Clinical Practice Department afforded the opportunity to learn more about the organization, as well as gaining a better understanding of the political factors that affect patients I see every day in my clinical work. From attending large-scale conferences, to meeting with congressional staffers, crafting policy statements, and networking with other child psychiatrists in the field, the breadth of experiences gained in these four weeks was unparalleled for a young physician-advocate as myself.

During the rotation, I attended two hallmark events at the Department of Health and Human Services. The first was a conference entitled “Connecting at the Intersection of Faith, Community & Mental Health: The Urgency of Now!”. Topics discussed included: best practices of faith-led mental health initiatives; developing mental and behavioral health centers as an extension of houses of worship; faith, addiction, and recovery; and suicide prevention in young adults.

Thereafter, I represented AACAP at the Naloxone Demonstration Event, which featured a live demonstration of proper naloxone nasal spray administration in cases of suspected opioid overdose.

Additionally, I’ve worked on two policy statement drafts for AACAP: “The Impact of Social Media Use of Youth Mental Health,” which details the current trends of social media usage in children and adolescents and its posited effects, and “Implementation of 988”, which expands upon the recent crisis line roll-out. I further provided edits on a policy statement addresses the lapses in care for transitional age youth.

Part of my advocacy efforts included reviewing current bill proposals and submitting QFR’s (questions for the record) to be addressed at Congressional legislative hearings. I also met with AACAP staff and members to respond to the House Committee on Ways & Means’ request for information (RFI) on disparities in access to healthcare in rural and underserved communities.

These efforts were particularly interesting to me as I learned more about the legislative process and how politics and medicine can collide. It was especially important to me to be able to extend the voices of my patients and my community to our country’s leaders.

On behalf of AACAP, I met with various stakeholders, advocating for increased access to mental healthcare for children across the country, highlighting the need for timely solutions to the current stimulant shortage, and addressing the importance of increasing and diversifying the workforce. These offices included those of: Congresswoman Yadira Caraveo (D-CO-08), Congressman Lloyd Doggett (D-TX-37), Senator Edward Markey (D-MA), Congresswoman Doris Matsui (D-CA-07), Congresswoman Bonnie Watson Coleman (D-NJ-12), Congressman Raul Ruiz (D-CA-25), Congresswoman Grace Napolitano (D-CA-31), Congressman Juan Ciscomani (R-AZ-06), and Congresswoman Suzan DelBene (D-WA-01).

Finally, throughout my 4-week elective I was able to learn about the organization itself much more closely as I met with various department leads across AACAP. Through these meetings, I was able to better familiarize with the goals, operations, and procedures of the organization and form new connections. Perhaps my favorite part of this experience was networking with incredibly passionate and knowledgeable team members. I would recommend this fellowship to any trainees who are curious about advocacy and want to hit the ground running!

Israel I. Taylor, MD is from Miami, FL and a current first year fellow in Child and Adolescent Psychiatry at MedStar Georgetown University Hospital. She earned her Doctor of Medicine (MD) and Master’s in Public Health (MPH) at the University of Miami, in a combined dual-degree program. She has special interests in advocacy, serving Black youth and families, medicine and the arts, and wellness.
In a recent literature review, Sagot and Flugrad (JAACAP, Nov 2023) defined physician advocates as those who effect change “by identifying SDH (social determinants of health) that adversely impact individuals and/or communities, using expertise to inform those who can enact change or initiate change themselves by addressing community and system-level issues through legislation/policy”[1]. Unfortunately, my training as an internist, psychiatrist, and now child psychiatrist has provided little formal guidance in the how and what of effective physician-driven advocacy. And it appears I am not alone in this experience. Most ACGME program and specialty-specific requirements have limited advocacy language and most don’t require specific experience in advocacy during training. And while some Milestone projects or program requirements do provide a related framework and recommendations, there is no standardization to incorporating advocacy learning in most training programs[1].

As I have moved along my training timeline and since becoming a Child and Adolescent Psychiatry fellow, I feel more keenly the tension in practicing medicine today. The wellbeing of youth is uniquely vulnerable to the oftentimes imperfect systems within which they exist. I am a leader-advocate for my patients and their families. I am also a cog in a machine, attempting to improve mental health outcomes for children and adolescents in systems that feel disjointed and self-serving. I applied for the American Academy of Child and Adolescent Psychiatry (AACAP) Resident Advocacy Scholar Fellowship out of a recognition that I was experiencing a problem that a new experience might help redefine.

The AACAP Resident Advocacy Scholar program is meant to serve as an experiential learning opportunity for advocacy training of child and adolescent psychiatry fellows, in the form of an elective rotation at the AACAP national office in Washington, DC. I have had the great fortune of being able to spend almost six weeks with the AACAP Government Affairs and Clinical Practice Department. During my time, I have been allowed the opportunity to read through and offer comments on proposed bills relating to subjects such as rural workforce development, social media and artificial intelligence impact on youth mental health, and improving over-the-counter naloxone access. I was able to attend the American Medical Association (AMA) 2023 Interim House of Delegates, where I witnessed the coming together of various specialty physician leaders.
to push and decide together what the AMA will stand for. I also had the chance to be part of legislative meetings with Congressional staff and attend political events with members of Congress around Washington, DC.

I learned that I could offer a useful first-hand perspective to the AACAP office on the experiences of medical trainees and of the clinical practice of medicine. Again and again, I heard in various settings that federal legislators want to hear from their constituents and that my voice as a physician, and the stories I can share of my patients, can hold great weight in what bills are put forth, how they are crafted, and who is included. I also had the chance to work with a few AACAP committees and learn just how important those roles can be in informing AACAP what is relevant, what is important, and what the organization should push for.

Finally, I’ve observed just how carefully, deliberately, and passionately the Government Affairs and Clinical Practice department works to promote for its physicians and our patient population. Special thanks to Ben Melano, Alexis Geier-Horan, Emily Rohlffs, Karen Ferguson, Heidi Buttner Fordi, and the rest of the AACAP staff for their mentorship and warmth during my time here. I will be forever grateful for this experience and how I suspect it has already altered my career course from here.

**Reference:**


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**Poem**

**Melissa Chen, MD**

**D.O.**

my muscles
and tendons
are thick ropes
overlying each other,
the ends held taut by my bones.

a baby with
respiratory syncytial virus
creates a kink

the woman on the
operating table
bearing the loss
of her child too soon
creates a neat,
square knot

---

**Poem**

**Lourdres Chahin, MD**

**I will write**

Until my thoughts run dry
Until my passion dies
Until the ink
running through my veins
evaporates

Until I see my last moon
Until I say my last word
Until I forget who I am
Until I exit the door
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Virginia Q. Anthony
Life Members Fund
Cyrus E. Adams, MD
Virginia Q. Anthony
Marilyn B. Benoit, MD
Lois T. Flaherty, MD
Bernard Hoffman, MD
Margery R. Johnson, MD
In Memory of Leoneen Woodard-Faust, MD
Carrie Sylvester, MD, MPH
Stewart Teal, MD
Joel P. Zrull, MD
Where Most Needed
ANONYMOUS
Virginia Q. Anthony Fund
Virginia Q. Anthony

$370 to 450
Life Members Fund
Victor M. Fornari, MD, MS
Alan Paul Sandler, MD
Alberto C. Serrano, MD

$240 to $250
Campaign for America’s Kids
Richard P. Barthel, MD
Scott Benson, MD
Gail Ann Edelsohn
Peter J. Geier, MD
Alfredo J. Soto, MD
Life Members Fund
Norma Green, MD
Where Most Needed
Norma Green, MD

$156 to $200
Campaign for America’s Kids
Andrés S. Martin, MD, PhD
Leatherman-Ritvo Fund
Leon Hoffman, MD
Life Members Fund
Gabrielle A. Carlson, MD
Richard Deamer, MD
Douglas A. Kramer, MD, MS
John Lingas, MD
Samuel and Miriam Meyer
Howard Rudominer, MD
Where Most Needed
Jesse Lee Costales, MD
Jorge E. Fernald, MD
Charles R. Privitera, MD

$105 to $150
Campaign for America’s Kids
Joseph Horrigan, MD
Joan Sturgis, MD
Where Most Needed
Gabrielle A. Carlson, MD
Life Members Fund
Gregoria Marrero, MD
Jean Van DeFelder, MD

$55 to $100
Marilyn B. Benoit Child Maltreatment Award
Richard L. Gross, MD
Made in honor of Geoffrey Brown, MD
Campaign for America’s Kids
Ann E. Alaoğlu, MD
Adrienne D. Allen, MD
Erika Bath, MD
Jill Z. Braford
John M. Diamond, MD
Nerissa Galang-Feather, MD
Stuart Goldman, MD
Michael S. Greenbaum, MD
Andrew Harper, MD
Charles K. Hawley, MD
Robert L. Hendren, DO
David Gerald Inwood, MD
Kathleen Myers, MD, MPH
Joseph H. O’Leary, MD
Abigail B. Schlesinger, MD
Justin Schreiber, DO
Victoria L. Snider, MD
Stephen M. Taylor, MD, MPH
Claudio O. Toppelberg, MD
Jose T. Zaglul, MD
Lisa Zbaraschuk, MD

Carlson Psychopharmacology Award Fund
Barbara B. Rosenfeld, MD
John E. Showalter M.D. Fund
Adrian Sondheimer, MD
Life Members Fund
Alan Bedell, MD
Myron L. Belfer, MD, MPA
William H. Beute, MD
Jill Z. Braford
Frances Burger, MD
Martha Collins, MD, MPH
John M. Diamond, MD
Thomas Dickey, III, MD
Gail Eisenbauer, MD
Robert L. Hendren, DO
Anthony H. Jackson, MD
Richard Morse, MD
Herschel D. Rosenzweig, MD
Stephen Zinn, MD

Continued on next page
### Virginia Q. Anthony Fund
Scott M. Palyo, MD

### Where Most Needed
Myron L. Belfer, MD, MPA
Pamela Campbell, MD
Laura S. Dibble, MD
John A. Gallalee, MD
Gregoria Marrero, MD
Gregory Sayer, MD
David Seabrook
Carrie Sylvester, MD, MPH
Susan M. Taccheri, MD

### Workforce Development
Wun Jung Kim, MD, MPH

### $27 to $50
Campaign for America’s Kids
Jim and Johnette Barnes

### Made in Memory of Amy Lamb
James E. Bedford, MD
Susan L. Donner, MD
Robia A. Fields, MD
Philip Randall Frank, DO
Jennifer M. Harris, MD
Jose M. Hernandez, MD
Mohsin Riaz Khalique, MD
Boris Lorberg, MD
D. Richard Martini, MD
Shashi Motgi, MD
Kevvin Vincent Quinn, MD
Gregory Sayer, MD

### Endowment Fund
Kevin Vincent Quinn, MD

### Life Members Fund
Howard S. Benensohn, MD
Mark W. Hinshaw, MD

### Where Most Needed
Eileen Bazelon, MD
Leslie Susan Dixon, MD
Alexandrea Kreps, MD
Meg Lawrence, MD
Mannohman Pothuloori, MD
David C. Ruck, MD
George H. Stewart, MD
Aparna Vuppala, MD
Abby Lois Wasserman, MD

### Up to $25
Campaign for America’s Kids
Susan Abbott, MD
Aurif Akhtar Abedi, MD
Karen A. Abrams, MD
Paul T. Abrinko, MD
Peter Adams, Jr., MD
Lori Adel, MD

Adeola Adelayo, MD
Khalid Imran Afzal, MD
Naser Ahmadi, MD, PhD
Ambreen Ahmed, MD
Abimbola Akanji, MD
Daniel A. Alcata, MD
Loren Ammdursky, MD
Sarah Andrews, MD
William Arroyo, MD
Cecilia J. Astorga-Switzer, MD
Harmohinder S. Athwal, MD
Ramiz Audi, MD
Mark Banschick, MD
Debora A. Barney, MD
Alycia Bartley-Heinsen, MD
Jonathan Beard, MD
Apurva Bhatt, MD
Sunrut Bilge-Johnson, MD
David Binder, MD
Boris Birmaher, MD
Gabrielle Blackman, MD
Todd Bolinger, MD
Shane Boosey, MD
Angela Brantley, MD
Catherine Schuyler Brennan, MD
Lynne M. Brody, MD
Jody L. Brown, MD
Sarah F. Brown, MD
Patrick M. Burke, MD, PhD
Patricia Cahill, MD
Julio G. Calderon, MD
Lee Carlisle, MD
Ruxandra Carp, MD
Robert P. Chayer, MD
Lance D. Clawson, MD
Barbara J. Cofiey, MD, MS
William Cohen, MD
Susan Grover Colasurdo, MD
David O. Conant-Norville, MD
Circe Cooke, MD
Adele Cox, MD
Ashley Crumby, MD
Eugenie Curiel, MD
Arman Danielyan, MD
Michael De La Hunt, MD
M. Carmel Deckelman, MD
Mary Lynn Dell, MD, DMin
Rose Demczuk, MD
Tom DiMatteo, Sr., MD
Zana Dobroshi, MD, PhD
Floriane D’Oleire, MD
Kevin John Donahoe, MD
Brian Donatelli, MD
Kathleen Rae Donise, MD
Olimpia Dorries, MD
Lisa Ann Durette, MD
Khurram K. Durrani, MD
Marlow Easterling, MD
Sarah Edwards, DO
Glen Raymond Elliott, MD, PhD
Graham J. Emslie, MD
Nonso Enekwechi, MD
Glenda J. Ericksen, MD
Bradley Erickson, MD
Betsy Estefan, MD
Lisa R. Fortuna, MD, MPH
Christopher Fox, DO
William P. French, MD
Wendy Froehlich-Santino, MD
Amy B. Funkenstein, MD
Meghan Gaare, MD
Sumana Gadde, MD
Hilary M. Gamble, MD
Dianelys Garcia, MD
Alissa Renee Rescigno Garcia, MD
Aditi Garg, MBBS
Sandra Gascon-Garcia, MD
John G. Gelinus, Jr., MD
Daniel A. Geller, MD
Joan Gildin, MD
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Lisa I. Goldstein, MD
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Marilena A. Jennings, MD
Kenyaatta M. Jones, MD
Benjamin W. Jordan, MD
Heather Marie Joseph, DO
Sylvia R. Karasu, MD
Miky Kaushal, MD
Tanja Kees, MD
Amy Kim, MD
Barbara Ann Kim, MD
Joo Young Kim, MD
Fiana Klein, DO
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.
Trastorno por Déficit de Atención / Hiperactividad (TDAH):
Guía para familias sobre medicamentos
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.

Get in the News!

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

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

**Production Schedule**

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

**Citations and References**

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

For complete AACAP News Policies and Procedures, please contact communications@aacap.org.
Policy Statement on Prevention of Bullying

Background

Bullying is defined as intentional, individual, or collective aggressive behaviors that intimidate and cause the physical or psychological discomfort of another individual or group. It usually occurs within the context of a power imbalance, or perceived power imbalance, and can be direct, indirect, and/or digital. In recent surveys, 20% of students ages 12-18 reported being bullied at school. Bullies and victims are at risk for negative physical and emotional health outcomes. Bullying victimization and perpetration are correlated with adverse outcomes including mood and eating disorders, lower academic achievement, school absenteeism, alcohol and drug use, and self-injurious and suicidal behaviors. Emerging data indicates that certain subpopulations of students are at increased risk for experiencing bullying.

The number of bullying prevention programs has increased substantially since the 1990s, and nearly all states have passed laws specifically related to bullying. School-based responses to bullying, such as Zero Tolerance policies, school assemblies, and peer mediation have not proven to be effective and may even create potentially harmful effects for the victim. In contrast, programs aiming to prevent violence and disruptive behaviors by promoting a positive school climate, such as School-wide Positive Behavioral Interventions and Supports (PBIS), have had a significant impact on decreasing the frequency of bullying.

To ensure a comprehensive system of care approach to bullying prevention, the American Academy of Child and Adolescent Psychiatry recommends:

- Coordinated efforts by health-care providers, policymakers, educators, public and community agencies, and families to develop evidence-based strategies for prevention of bullying and its sequelae.
- Promotion of public awareness about the nature, impact, and prevention of bullying, including the monitoring, detection, and reporting of all forms of bullying.
- Development of safe schools through school-wide interventions such as PBIS, and incorporating
• Assessment of current state-based and school-based anti-bullying policies' efficacy, including a review of the language to better serve vulnerable populations, such as LGBTQ students.
• Continuous monitoring of the effects of anti-bullying policies on school-based metrics such as reports of bullying, incidences involving violence, attendance, and class participation.
• Referral for victims and perpetrators who experience physical and psychological symptoms linked to bullying for mental and physical health evaluation and treatment.
• Urging state and federal policy makers to adopt, implement, and evaluate on an ongoing basis policies and programs for preventing, identifying, and responding to bullying on their platforms and publication of their anti-bullying policies on their websites.

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.

Approved by Council October 2023

Become an AACAP Distinguished Fellow Today!

Becoming a Distinguished Fellow represents excellence in your professional career and your positive contribution to our field. Distinguished Fellow is the highest membership honor AACAP bestows upon its members.

Requirements:

■ Must be board certified in child psychiatry
■ An AACAP GENERAL MEMBER of at least five consecutive years
■ Making outstanding and sustained contributions in any three of the five following areas:
  ▶ Scholarly publications
  ▶ Outstanding teaching
  ▶ Five years of significant and continuing contribution to patient care
  ▶ Organizational or social policy leadership at community, state, or national levels
  ▶ Significant contributions to AACAP for at least five years in one or more of the following: AACAP Committee/Component, AACAP Assembly of Regional Organizations, an AACAP Regional Organization

Distinguished Fellowship Nomination Package Requirements:

■ Current copy of Curriculum Vitae
■ Copy of Child Psychiatry board certificate
■ 3 recommendation letters written by AACAP Distinguished Fellows

Please submit completed nomination submissions to membership@aacap.org.
Policy Statement on the Impact of Social Media on Youth Mental Health

Background

Over the past decade, there has been a substantial increase in social media engagement among children and adolescents. This trend has been further amplified during the COVID-19 pandemic, as social media and online gaming became the default method of socialization. Social media use is nearly universal among young people; up to 95% of teenagers are active online. Despite a minimum age requirement of 13 years on most U.S. platforms, nearly 40% of children aged 8-12 are on social media. In parallel with increasing social media engagement, rates of depression and anxiety among youth have surged, although this relationship is not fully understood. Given its ubiquitous nature, and the particularly important period of brain development between childhood and young adulthood, the impact of social media usage on youth mental health remains an important topic.

Children and adolescents are affected by social media in different ways depending on individual factors as well as trait strengths and vulnerabilities. Social media platforms do offer benefits to youth—they often serve as avenues for forging connections, receiving, and offering emotional support and expressing creativity. Youth in crisis are more likely to share suicidality on social media than directly to caregivers, concerned peers often alert adults, which frequently leads to vital referrals to emergency services and child and adolescent psychiatry. However, children and adolescents are also prone to experiencing adverse effects of social media, including disruptions of sleep which increase susceptibility to depression, fostering unrealistic social comparisons damaging self-esteem, adopting avoidant coping, cyberbullying, encouragement of eating-disordered behavior or self-harm, and sexual exploitation. For example, experimental research confirms that viewing idealized social media images can lead to body dissatisfaction among youth. At this time, there is enough evidence to conclude that social media can negatively impact the mental health of youth.

To protect against the potential harmful effects of social media exposure on child and adolescent mental health, the American Academy of Child and Adolescent Psychiatry (AACAP)
• Requiring technology companies to strengthen protections for youth online privacy, create effective controls allowing youth and caregivers to manage screen access and content, and share relevant data for further independent research on social media’s effect on youth mental health.

• Increasing federal funding for future research on the potential benefits and harms of social media use on youth mental health.

• Minimizing children’s and adolescents’ exposure to problematic content, including that which promotes self-harm, prejudice, cyberbullying, health misinformation, and unrealistic beauty- or appearance-related content.

• Collaborative engagement between social media platforms and child and adolescent psychiatrists, pediatricians, counsellors, teachers, and parents in the development of guidelines for age-appropriate content, safe and developmentally suitable functionalities, and the development of age-appropriate digital literacy training to precede social media engagement among children and adolescents.

• Encouraging caregivers to maintain ongoing discussions with youth about digital citizenship, potential pitfalls of social media, online safety, and family expectations. Caregivers should strongly consider restricting screens from bedrooms and establishing screen free periods at home such as during mealtimes, homework time, and the hour before bedtime.

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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.

Approved by Council October 2023

Honor Your Mentor

Tell us why your mentor was important to you and how they influenced your career, and we’ll feature your submission in the March/April issue of AACAP News. In 100 words or less, send your Honor Your Mentor submission to communications@aacap.org. Please include your name, affiliation (if appropriate), the name of your mentor(s), a short testimonial or anecdote, and a picture if you have it. Deadline for submissions is 3/1/2024.
FOR YOUR INFORMATION

ILLINOIS

Company: UW Health Northern IL
Job ID: 19582893
URL: https://jobs.utah.acap.org/jobs/19582893

Job Description:
Enjoy a rewarding practice in the heart of the Midwest with the only provider of inpatient child psychiatric services in northern Illinois and southern Wisconsin, the opportunity to have an academic appointment through the University of Illinois College of Medicine at Rockford. UW Health Northern Illinois in Rockford, IL is currently seeking a Child & Adolescent Psychiatrist for a growing hospitalist-based practice. Our Center for Mental Health provides resolute and unopposed support to over 270 providers of the Swedish American Medical Group. Aspects of your role include: 16-bed child and adolescent inpatient unit located in our state-of-the-art Women’s and Children’s Hospital 42 inpatient beds ED dedicated psychiatry rooms 24-hour crisis intervention team for ED call Academic appointment and teaching available with University of IL College of Medicine at Rockford

Job Requirements:
Swedish American offers a highly competitive salary guarantee with wRVU production and other incentives. Our comprehensive benefits package includes: Flexible insurance package with health, dental, vision, disability, and life Generous vacation and CME benefits Flexible retirement program with corporate contribution Professional society dues and association fees Interview and relocation expenses Rockford and northern Illinois offer world-class attractions, outstanding recreation opportunities and beautiful parks — all at a cost of living significantly below those of most metropolitan areas. And for a quick visit, Chicago, Milwaukee, and Madison are each just 90 minutes away or less. The Greater Rockford area offers superb cultural, recreational, and outdoor amenities along with an eclectic arts community of theater, symphony, museums, and dance. With an award-winning park district, Rockford also offers unrivaled outdoor recreation, markets and ethnic festivals plus Golf Digest-ranked golf courses, endless bike trails and extensive indoor and outdoor sports centers. In addition, we have excellent private, parochial, and public-school options including the Renaissance Academy with graduates ranked in the top 5% nationally. For more information on how you can advance your career with UW Health Northern Illinois, or to submit your CV and cover letter for consideration, please contact Emily Pfau at epfau@uwhealth.org or call (779) 696-7019.

MICHIGAN

Company: Pine Rest Christian Mental Health Services (1368382)
Job ID: 19582571
URL: https://jobs.utah.acap.org/jobs/19582571

Job Description:
Pine Rest is actively recruiting Child and Adolescent Psychiatrists to provide care in a variety of roles—inpatient, outpatient, partial hospitalization, residential treatment, urgent care, and specialty clinics—in conjunction with the groundbreaking of our New Pediatric Center for Behavioral Health. The Pediatric Center for Behavioral Health will have: Three 22-bed units with specialty programming There will be a dedicated 10 bed NDD Unit Psychiatric Urgent Care Center for children ages 5-17 Telepsychiatry for providers, families, and patients in rural areas Specialized psychotherapy services Specialty clinics for ASD, ED, SUD and psychotherapy for children SUD programming ASD assessment and testing Pine Rest is a teaching hospital with a psychiatry residency and fellowships in addictions, child and adolescent, geriatrics, and forensics through Michigan State University and a dedicated APP Psychiatry Fellowship Program. Join us in continuing our 113-year tradition of providing exceptional and compassionate care to all children and families in need. If interested, please submit your CV to: Susan Sanford, Physician Recruitment susan.sanford@pinerest.org

MISSOURI

Company: Washington University School of Medicine (1368441)
Job ID: 19583021
URL: https://jobs.utah.acap.org/jobs/19583021

Job Description:
Overview The outpatient psychiatrist will provide outpatient care, supervise, and educate trainees in child and adolescent psychiatry. The position reports to the Chief of CAP Outpatient Services. Key roles and responsibilities: Responsible for supervising psychiatry residents and fellows. Provide outpatient psychiatric care five days per week (direct patient care 75%, administrative 25%). Mentor, supervise, and evaluate clinical trainees and staff clinicians, including interdisciplinary team members. Keep abreast of new models and trends in mental health care and use this to ensure we are providing the highest-quality, equitable care. Stay apprised of Washington University School of Medicine and Barnes Jewish Hospital, (BJH) policies and operations relating to outpatient clinical care. Opportunity for weekend moonlighting in an inpatient setting at St. Louis Children’s Hospital Core Experience and Attributes: Well-informed on national trends and best practices in outpatient mental health with significant leadership experience managing a multidisciplinary outpatient clinical operation in an academic environment, teaching hospital, or other setting which otherwise demonstrates ability to manage and expand a progressive, multi-site, academic practice. Ability to interact with and supervise advanced practitioners in the provisioning of clinical care. Ability to oversee the delivery of outpatient mental health services, which enhance revenue, operate efficiently and effectively, and are responsive to clinical and administrative staff and patient needs. Ability to establish, monitor, and evaluate key performance indicators/metrics and implement plans to intervene, as needed. Commitment to medical education and supporting learning opportunities for students, residents, fellows, and other learners. Ability to work with training programs to
design and conduct educational missions. Demonstrated ability to interact with, relate to, and support the activities of faculty and other clinical and administrative staff as individuals and members of an organized team. Leadership as characterized by the ability to develop a common vision for diverse constituents, communicate effectively, engage key stakeholders, and take ownership and responsibility for ideas and actions Diversity is a core value of the School of Medicine. We believe that the educational environment is enhanced when diverse groups of people with diverse ideas come together to learn and work, therefore we seek candidates with a demonstrated sensitivity to and understanding of the diverse academic, socioeconomic, cultural, disabled, and ethnic backgrounds of the institution’s students, employees, and patients we serve. A management style that emphasizes teamwork, communication, accountability, collegiality, flexibility, trust, and patience. Personal characteristics, which include outstanding verbal communication skills on an individual and group basis, excellent writing skills, professional appearance, and an executive demeanor with high emotional intelligence.

Job Requirements:
Qualified candidates will possess a MD, MD/PhD, or DO degree and hold or be eligible for an unrestricted license to practice medicine in the State of Missouri. Candidate should be certified by the American Board of Psychiatry and Neurology (ABPN) in Psychiatry and Child Psychiatry (or Board eligible).

OHIO

Company: Dayton Children’s Hospital
(1363842)
Title: Are You the Next Child/Adolescent Psychiatrist (Outpatient) at Dayton Children’s Hospital?
Job ID: 19455417
URL: https://jobsource.aacap.org/jobs/19455417

Job Description:
Child/Adolescent Psychiatrist (Outpatient) at Dayton Children’s Hospital Dayton Children’s Hospital is seeking a dedicated and compassionate Child/Adolescent Psychiatrist to join our outpatient behavioral health team. As a Child/Adolescent Psychiatrist, you will play a crucial role in providing high-quality mental health care to children and adolescents in an outpatient setting. This is an outpatient clinic position with typical hours of Monday-Friday 8am to 5pm. There is ample paperwork/administrative time built into the schedule. There is the ability to perform tele-psychiatry for follow-up visits, 90 minutes for new evaluations and 30 minutes for medication management follow-up. Responsibilities: Conduct comprehensive psychiatric evaluations to assess the mental health needs of children and adolescents. Develop and implement individualized treatment plans based on assessment findings, utilizing evidence-based practices. Provide medication management and prescribe appropriate psychiatric medications when necessary. Collaborate with a multidisciplinary team including therapists, social workers, psychologists, and other healthcare professionals to ensure coordinated and comprehensive care. Monitor and evaluate treatment progress, making necessary adjustments to treatment plans as required. Participate in case conferences and contribute to the formulation of treatment goals for patients. Provide education and support to patients and their families regarding mental health conditions, treatment options, and community resources.

Job Requirements:
Qualifications: Must have completed a child/adolescent psychiatry fellowship. Medical degree from an accredited medical school. Completion of an accredited residency program in psychiatry. Must be Board certified and eligible to obtain an unrestricted Ohio medical license. Strong clinical skills and knowledge of evidence-based practices in child/adolescent psychiatry. Excellent people skills with the ability to communicate effectively with patients, families, and healthcare professionals. If you are passionate about providing high-quality mental health care to children and adolescents and want to be part of a collaborative and supportive team, then we invite you to apply for the role of Child/Adolescent Psychiatrist (Outpatient) at Dayton Children’s Hospital by sending your CV to cooks3@childrensdayton.org. Join our team and help are effective in the lives of children and adolescents today! Apply now! For Additional Information, Contact: Sharisse N. Cook, MBA-HRM, CPRP Provider Sourcing Specialist Dayton Children’s Hospital 1 Children’s Plaza Dayton, OH 45404-1815, (937) 641-3752 cooks3@childrensdayton.org www.childrensdayton.org

OREGON

Company: Albertina Kerr (1367225)
Title: Child & Adolescent Psychiatrist
Job ID: 19498780
URL: https://jobsource.aacap.org/jobs/19498780

Job Description:
Join Kerr as a Child and Adolescent Psychiatrist to better the lives of youth and their families. Our psychiatrists love having flexible schedules and are inspired by the impact they make as part of a collaborative team. When you join, we'll collaborate with you to determine your ideal schedule for this 0.8 FTE position. About 70% of duties will be performed in-person with a mix of telemedicine as desired. Compensation for this 32 hour per week position is $250,000 annually. Kerr offers a continuum of mental health services for children, teens, and their families. You’ll collaborate with individuals served in our inpatient subacute level facility. You’ll provide comprehensive psychiatric care to youth experiencing an acute psychiatric episode. This includes psychiatric evaluation, medication management, and care coordination with a multidisciplinary team, including therapists and nurses, and community members. Benefits Paid medical, dental, and vision employee benefits Paid Time Off and Holidays 401(k) retirement savings plan with up to 4% employer match Satisfies employment requirement for student loan Public Service Loan Forgiveness Program (PLSF) Funds available for CME Reimbursement for Oregon Medical License fees, annual board fees, and DEA license fees Additional compensation for weekend call coverage performed from home 24-hour Employee Assistance Plan (EAP) that provides resources for everything from mental health to pet insurance and financial counseling

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. Ability to obtain current CPR or BLS certification.
FOR YOUR INFORMATION

TEXAS

Company: Cook Children’s (1330228)
Title: Child and Adolescent Psychiatrist
Opportunities—Cook Children’s
Job ID: 19586148
URL: https://jobsource.aacap.org/jobs/19586148

Job Description:
The department of Psychiatry and Behavioral Health at Cook Children’s Medical Center is growing and is seeking board certified/board eligible Child & Adolescent Psychiatrists to join our team! We have a well-established, outpatient and inpatient pediatric program which provides a full range of early intervention, rehabilitation, medical, and mental health services for children. Our interdisciplinary team is currently comprised of nine child & adolescent psychiatrists, child psychologists, advanced practice providers, developmental pediatricians, as well as speech, physical, and occupational therapists. The treatment philosophy of the program is a Collaborative Problem-Solving model. Inpatient and outpatient opportunities are available and offer a variety of clinical activities, including evaluation, ongoing treatment and follow-up, consultation, and education in a stimulating atmosphere of close collaboration with other disciplines in the care of the child. Learn more about our department here: Behavioral Health Psychiatry (cookchildrens.org)

Fort Worth, TX is one of the leading population growth centers in America with an expanding job market and diverse professional population. We offer a competitive salary with a complete benefits package, including medical/dental/vision, generous vacation time, retirement, relocation and more. Cook Children’s Hospital is a free standing, private children’s hospital offering exceptional pediatric care with all subspecialties represented. Cook Children’s is an EOE/AA, M/F/Disability/Vet.

Job Requirements:
Candidates must be board certified/board eligible in Child and Adolescent Psychiatry, and eligible to obtain an unrestricted Texas Medical License before commencement of employment.

9-8-8 Suicide & Crisis Lifeline – IS LIVE!

The resources and information on this page – https://www.samhsa.gov/find-help/988 – are designed to help states, territories, tribes, mental health and substance use disorder professionals, and others looking for information on understanding the background, history, funding opportunities, and implementation resources for strengthening suicide prevention and mental health crisis services.
AACAP Has What You Need To Complete Your Continuing Certification Requirements

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LIVE/VIRTUAL MEETINGS
Pediatric Psychopharmacology Update Institute
Douglas B. Hansen, MD
Annual Update Course
Annual Meeting
www.aacap.org/meetings

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Clinical Essentials - a series of courses on relevant topics from highly rated speakers
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www.aacap.org/cc
February is

BLACK HISTORY MONTH