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AACAP News

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Staff photo with John Walkup, MD, President, AACAP

Inside . . .

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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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MISSION OF *AACAP NEWS*

The mission of 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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Welcome NEW AACAP Leadership!

2025–2027 AACAP Executive Committee

We are pleased to announce our 2025–2027 Executive Committee and newly seated Council members. Leading the Academy's Executive Committee is **John T. Walkup, MD, President, with Timothy E. Wilens, MD, President-Elect.** The Executive Committee also includes **Sala Webb, MD, Secretary; Barry Sarvet, MD, Treasurer; Jose Vito, MD, Chair of the Assembly of Regional Organizations;** and **Tami D. Benton, MD, Past President.**

2025–2026 Council

Our 2025–2026 Council brings together diverse expertise and perspectives from across the field. Council members include **Alicia A. Barnes, DO, MPH; Erin L. Belfort, MD; Avanti Bergquist, MD; Obianuju J. Berry, MD, MPH; Vivien Chan, MD; Jennifer Creedon, MD; Vera Feuer, MD; Sansea L. Jacobson, MD; Sarah Mohiuddin, MD;** and **Shawn Singh Sidhu, MD**

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- **Jad Hilal, MD**

John E. Schowalter Resident Member

- **Carly Kawanishi, MD**

The Emerging Leaders Fellows

- **Taiwo Alonge, MD**
- **Desiree DiBella, MD**

Our leadership reflects AACAP's enduring commitment to advocacy, education, research, and the professional development of child and adolescent psychiatrists throughout their careers. The Academy looks forward to advancing its mission under the guidance of this strong and dedicated group.

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Four Years On: Children's Mental Health Remains a National Emergency

Washington, DC—Four years after the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics (AAP), and the Children's Hospital Association (CHA) declared a national emergency for children's mental health, the issue remains urgent. Children nationwide continue to struggle with anxiety, depression, suicidal thoughts, and other mental health conditions. Too many families face barriers to accessing pediatric mental health services, often experiencing long delays for specialized care. Emergency departments continue to see higher numbers of youth in mental health crisis.

Mental and behavioral health challenges are common in childhood, and access to effective treatment makes all the difference. Families can trust pediatric mental health professionals, including child and adolescent psychiatrists, pediatricians, and children's hospitals to provide proven care that helps young people recover, grow, and thrive. The gap between need and services remains widest in under-resourced communities and among diverse groups of children and adolescents, and those with complex mental health needs. It's critical to invest more in the funding and administration of programs that support youth mental health.

Progress is possible with sustained commitment, dedicated funding, and coordination. The administration has acknowledged the youth mental health crisis and the need to address it–our organizations urge policymakers to do just that. We call on leaders to invest in children's mental health by growing the pediatric mental health workforce, strengthening the Medicaid program, expanding access to a full range of mental and behavioral health services designed to meet children's needs, and ensuring insurance parity and equitable access to care. Prevention, early identification, and timely access to evidence-based treatment change lives.

"The emergency we declared four years ago has not ended. Children still face unacceptable waits and barriers to care," said Tami D. Benton, MD, president of the American Academy of Child and Adolescent Psychiatry. "Child and adolescent psychiatrists know treatment works, and we stand ready to ensure every child has access to the care they deserve."

"Four years since the emergency declaration, there is still much more work to be done to best support the healthy mental development of young people—from reaching them with the care they need earlier on to ensuring pediatricians have the resources to make timely treatment possible, such as through teleconsultations with mental health teams," said Susan J. Kressly, MD, FAAP, president of the American Academy of Pediatrics. "We continue to urge our country's leaders to advance policies that prioritize youth mental health."

"Children's hospitals are on the front lines of this crisis," said Matthew Cook, CEO of Children's Hospital Association. "Hospital staff see the crisis firsthand, and amidst ongoing workforce shortages and funding challenges, they need support. At CHA, we have invested in raising awareness among lawmakers and have championed initiatives like Speak Our Minds to advocate for better mental health care for children. We are committed to collaborating with leaders in the children's health space and with policymakers to continue expanding services, support families, and protect every child's future."

The American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the Children's Hospital Association remain united in purpose. Four years later, the emergency continues, and so does our resolve. Together, we will keep sounding the alarm, advancing science, and building a future where every child has the stability, care, and opportunity to thrive.

■ ■ ■

American Academy of Child and Adolescent Psychiatry

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

American Academy of Pediatrics

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

Children's Hospital Association

The Children's Hospital Association is the national voice of more than 200 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care. For more information visit www.childrenshospitals.org.

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Advancing Psychodynamic Teaching Through AACAP's PsyFI Program




Thien Chuong Richard Ly MD, Eunice Y. Yuen MD PhD, Mahta Baghoolizadeh MD & Naveen Khanzada MD

The **AACAP Psychodynamic Faculty Initiative (PsyFI)** is an Academy initiative (www.aacap.org/PsyFI) dedicated to strengthening psychodynamic psychotherapy training within child and adolescent psychiatry residency programs. Through mentorship, faculty development, and community building, PsyFI supports the creation of innovative training projects that address the evolving needs of the field. Its mission is to cultivate a network of skilled and effective psychodynamic educators and leaders who can advance psychodynamic teaching and practice.

For 2024–2025, the seventh PsyFI cohort, composed of mentors and mentees, gathered at the AACAP Annual Meeting with PsyFI initiatives leaders in Seattle in October 2024 to launch their projects and will conclude with a virtual wrap-up in December 2025. This article shares a summary of the impactful projects developed by this cohort of PsyFI participants.

Developing a Curriculum and Supervision Framework for Psychodynamic Psychotherapy in a Community-Based Child & Adolescent Psychiatry Fellowship Program

Thien Chuong Richard Ly MD, mentee, with **Carl Fleisher MD,** mentor

My project shared similarities with many past PsyFI initiatives by focusing on the development of a didactic curriculum and supervision framework to strengthen psychodynamic psychotherapy training within a local training program. In my case, this centered on a community-based child and adolescent psychiatry (CAP) fellowship program at Samaritan Health Services in Corvallis, Oregon. A comprehensive needs assessment was conducted among fellows and faculty, and the results guided the creation of a foundational psychodynamic psychotherapy didactic series. This series was aligned with Accreditation Council for Graduate Medical Education (ACGME) requirements[1] and drew primarily on American Association of Directors of Psychiatric Residency Training (AADPRT) and AACAP resources,[2] rather than offered alternative options of pursuing specific manualized approaches such as Regulation Focused Psychotherapy for Children (RFP-C) or Mentalization-Based Therapy for Adolescents (MBT-A). The project culminated in an interactive eight-part foundational didactic series paired with a group therapy supervision framework. The series was well received, with survey data showing fellows' anticipated frequent use of psychodynamic concepts in future practice increased from 50% before the training to 100% afterward. Future potential directions include faculty development in psychodynamic supervision, examining the feasibility of individual therapy supervision, and exploring a partnership with the state psychoanalytic center. The project underscores the importance of engaging trainees and faculty in identifying local needs, goals, and resources to tailor a program-specific approach to advancing psychodynamic psychotherapy training in CAP fellowship.

It was a privilege to collaborate closely with my mentor, Dr. Carl Fleisher, who provided regular guidance in shaping the project outline, surveys, curriculum, and delivery of the didactic series. With his expertise in teaching MBT-A, Dr. Fleisher enriched the program by guest lecturing fellows on the topic of mentalization. Personally, this experience also rekindled my own latent interest in MBT from my CAP training. During my PsyFI project year, I completed the Anna Freud Centre's MBT for Children (MBT-CYP) introductory online course,[3] and I look forward to pursuing in-person MBT-A training in Los Angeles in 2026.

…PsyFI supports the creation of innovative training projects that address the evolving needs of the field. Its mission is to cultivate a network of skilled and effective psychodynamic educators and leaders who can advance psychodynamic teaching and practice.

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Educational Pilot Project to Implement Chatogether Family Intervention in Cap Fellowship Training Using Didactic Webinar Series

Eunice Y. Yuen MD PhD, mentee, with **Ayame Takahashi MD,** mentor

Our new era of digital use impacts the entire developmental span of modern families. Despite other positive benefits, excessive technology use can disrupt relational health within a family.[1,2] Compassionate Home, Acting Together (*CHATogether*) is a family-centered intervention consisting of multifaceted psychotherapeutic elements drawn from psychodynamic psychotherapy, drama therapy, and cognitive behavioral therapy (CBT). It specially aims to reconnect the loving attachments within families when adolescents are facing mental illnesses.[3,4] *CHATogether* not only directly impacts patient care but also contributes to the future child and adolescent psychiatrists through emphasizing the family systems lens in assessment and treatment. Supported by Dr. Ayame Takahashi and AACAP PsyFI, we introduce *CHATogether*'s six hourly family sessions using didactic webinar series for CAP fellows at Yale Child Study Center and Southern Illinois University. Using the "*see-one, do-one*" and case supervision approach, we aim to train fellows to implement *CHATogether* in their long-term adolescent patients struggling with relational conflicts with their families. Qualitative study was performed to explore the fellows' learning experiences including challenges and learned lessons. This is an on-going educational pilot initiative which welcomes other CAP fellowship programs to join forces!

Joining the PsyFI family is an incredibly special experience for me as an early career child and adolescent psychiatrist. Mentorship and networking opportunities guide me to envision a new understanding of psychodynamic concepts- from something traditional and classic into something cool, novel, and adaptable to meet nowadays mental health needs. The experiences also cultivated me to think creatively to implement psychodynamic lens in various clinical applications that I may never have imagined previously, such as inpatient care, medication management appointments, and even workplace leadership dynamics. I highly recommend AACAP members, in any career stage, to apply to PsyFI.

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Training Child and Adolescent Psychiatry Fellows in Regulation-Focused Psychotherapy for Children

Mahta Baghoolizadeh MD, mentee, **with Timothy Rice MD,** mentor

Through PsyFI, I developed a project titled Training Child and *Adolescent Psychiat*ry Fellows in Regulation-Focused Psychotherapy for Children (RFP-C): A Pre- and Post-Intervention Study. RFP-C is a manualized psychodynamic therapy shown to reduce externalizing behaviors in children with oppositional defiant disorder.[1] It is based on the premise that disruptive behaviors reflect underlying hidden, painful feelings, and that clinicians can help children improve emotion regulation by interpreting defenses observed during play therapy sessions.[2] My project explores whether RFP-C can be adapted for adolescents in a partial hospital program (PHP) setting and be effectively taught to CAP fellows. Fellows first complete a survey assessing their baseline understanding and comfort with RFP-C skills, then participate in a one-hour didactic session introducing the therapy model. They subsequently apply these techniques with at least one adolescent patient in over 10 hours of supervised clinical work, after which they complete a follow-up survey to evaluate changes in their knowledge and confidence using the technique. Preliminary feedback from fellows has been highly positive, where they have indicated that the training has deepened their comfort and understanding of psychodynamic approaches to managing challenging behaviors. Data analysis at the end of the academic year will more fully evaluate the impact of this training on fellows' knowledge, confidence, and application of these principles.

Through the PsyFI initiative, I have grown tremendously as both a therapist and a therapy supervisor. Before this experience, my exposure to psychodynamic therapy had been modest, and I was not sure whether I had enough foundation to benefit fully from this specialized mentorship. However, I had a general sense of what drew me to psychodynamic therapy and how I wanted to grow as an educator, and the PsyFI organizers successfully paired me with my mentor who shared these interests and easily helped me deepen my understanding of psychodynamic principles and how to teach them effectively. While my research project focuses on assessing the fellows' knowledge, comfort, and skills in the RFP-C model, I have gladly experienced my own parallel growth in the understanding and practice of psychodynamic therapy.

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Foundations of Psychodynamics: Lectures and Case Studies for Aspiring Child Psychiatrists

Naveen Khanzada MD, mentee, with **Jawed M. Bharwani MD,** mentor

"Psychodynamic psychotherapy remains one of the few therapeutic approaches that has continued to withstand the test of time," as said by Drs. Ritvo and Henderson, and with time, that truly has not changed.[1] However, the growing focus on hospital-based metrics, managed care, limited time, and the increasing emphasis on psychopharmacology in training programs have made it more challenging to preserve dedicated time for education and supervision in this area.[2,3]

At the University of Kansas Medical Center (KUMC), an opportunity emerged to build a structured psychodynamic psychotherapy curriculum within the CAP Fellowship Program. My goal was to help psychiatry fellows acquire the essential knowledge and confidence to apply psychodynamic thinking in their clinical work with children and families, despite time constraints and the fast-paced nature of modern practice.

Thanks to the mentorship and support provided by the AACAP PsyFI Award, I was able to reintegrate the psychodynamic principles into KUMC child and adolescent psychiatry training. Teaching psychodynamic psychotherapy to the fellows has been one of the most fulfilling and enriching experiences of my career. This journey was made possible with the guidance and encouragement of Dr. Jawed Bharvani, who supported me throughout the process. My supervision with him fostered reflections, shared growth, and genuine connection. On the other hand, the fellow's group supervision and reading discussions sparked thoughtful conversations that challenged assumptions and expanded our understanding of transference, countertransference, unconscious processes, and developmental dynamics. Teaching this course shaped me in unique ways, professionally and personally. It strengthened my ability to articulate complex ideas, pushed me to reflect more keenly on my clinical work, and reminded me of the reciprocal nature of mentorship and how much we learn from those we teach.

Being part of the PsyFI family has been a meaningful experience for me as an early-career child and adolescent psychiatrist, and I truly encourage my AACAP colleagues to consider applying. The mentorship and connections I have found here have truly transformed the way I understand psycho*dynamic concepts a*nd how psychodynamic ideas can be used in places I never expected. It is undoubtedly an experience that genuinely shapes the way you see and practice psychiatry.

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Summary

We encourage prospective mentees and mentors to consider joining future cohorts of the Psychodynamic Faculty Initiative. Participation offers a unique opportunity to engage in meaningful mentorship, develop innovative training projects, and become part of a supportive community dedicated to advancing psychodynamic education in child and adolescent psychiatry.
For more information and to apply: www.aacap.org/PsyFI

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Updates on Antipsychotic-Induced Weight Gain in Youth: *What Clinicians Need to Know*



- **Christoph U. Correll, MD, Salma Malik, MD, MS, and Boris Lorberg, MD, MBA**

Interviewed by Salma Malik, MD, MS, and Boris Lorberg, MD, MBA

Dr. Christoph Correll is Professor and Chair, Department of Child and Adolescent Psychiatry, Charité University Medicine, Berlin, and Clinical Professor of Psychiatry, Zucker School of Medicine, Hofstra/Northwell, New York. His research focuses on severe mental illness, psychopharmacology, clinical trials, and metabolic health. He has authored over 1,000 papers (>100,000 citations), received more than 40 research awards, and is ranked by Expertscape as the world's most cited expert in multiple categories, including *antipsychotics and weight gain*.

1. Drs. Malik and Lorberg: You've led many of the largest meta-analyses on psychotropic side effects. *What do we know about weight effects across medication classes?*

Dr. Correll: Across classes, the largest and fastest weight gain occurs with second-generation antipsychotics (SGAs), particularly *olanzapine and clozapine*, followed by *risperidone/paliperidone* and *quetiapine*.

- *Aripiprazole, brexpiprazole, cariprazine* are in the lower weight gain risk group, with *lurasidone, lumateperone* and *ziprasidone* having the lowest risk.
- In meta-analyses of youth, *olanzapine* produced >4–5 kg gain within 6-8 weeks, *risperidone/paliperidone* ~2–3 kg, and *aripiprazole* ~1–2 kg (De Hert et al., 2011).
- First-generation antipsychotics (FGAs) generally cause less weight gain than high-risk SGAs but more than low-risk SGAs, though data in youth is limited.

In terms of time course, the weight gain is fastest and lasts the longest for the high-weight gain antipsychotics (especially *olanzapine and clozapine*), but even lower-risk agents can accumulate weight gain over time, with only the lowest-risk group seemingly leading at least on average to little additional weight gain than developmentally accrued during growth, with the best such data being currently available for youth for *lurasidone* (Correll et al., 2022).

For antidepressants, *paroxetine and mirtazapine* show small but consistent weight increases, while SSRIs like *fluoxetine* are weight-neutral or modestly weight-reducing in the short term.

Lithium produces moderate weight gain, whereas anticonvulsant mood stabilizers differ: *valproate* is associated with moderate gain, *lamotrigine* is neutral, and *topiramate* often causes weight loss.

ADHD stimulants usually cause weight loss (especially early on), whereas atomoxetine is largely weight-neutral, and alpha-2 agonists have minimal impact (Solmi et al., 2020).

2. Drs. Malik and Lorberg: *How common is clinically significant weight gain in youth taking SGAs?*

Dr. Correll: Weight gain is the **rule rather than the exception** for many SGAs in youth.

- In pooled trials, **>50% of youth on *olanzapine*** gained ≥7% body weight over 12 weeks; *risperidone and quetiapine* show rates of ~25–40%.
- Even lower-risk agents like aripiprazole have ~15–20% of patients crossing that ≥7% threshold.
- The newer agents—*lurasidone, cariprazine, lumateperone*—tend to have rates closer to placebo but still require monitoring.

Of note, the magnitude and prevalence of developmentally abnormal weight gain is highest in antipsychotic-naïve youth, where, during the first 12 weeks of treatment, weight gain ≥7% body weight occurred in 84.4% with olanzapine, 64.4% with risperidone, 58.4% with aripiprazole, and 55.6% with quetiapine (Correll et al., 2009).

Developmentally abnormal weight gain is higher in children and adolescents than in adults, due to less prior antipsychotic-induced weight gain and possibly due to developmental metabolism and appetite regulation differences. The latter is suggested by recent findings from a Danish population-based study (Hojlund et al., 2025) that focused on antipsychotic-naïve children, adolescents and adults, where the cardiometabolic burden of first use antipsychotic treatment relative to age- and sex-matched controls was significantly higher in children and adolescents vs young adults 18–31 years old, and even higher in children (6–11) vs adolescents (12–17) initiating antipsychotics.

3. Drs. Malik and Lorberg: What patient factors increase risk for antipsychotic-induced weight gain?

Dr. Correll:

- I look at baseline BMI—higher gain risk if *BMI is already high* without prior antipsychotic exposure, indicating greater vulnerability to appetite and food liking, but also, and most replicated in the literature, a higher risk in patients with *lower BMI* who have "more biological room" for weight gain, as well as in underweight patients who may "catch up" rapidly having potentially lost weight due to effects of their psychiatric disorder symptoms. (Pozzi et al., 2022)
- Family history of obesity, type 2 diabetes, or dyslipidemia is important.
- Younger age, in some studies female sex, in others male sex, and non-European ancestry have all been linked to higher risk in some studies.
- Diagnosis plays a role: mood disorders and autism spectrum disorder populations often show greater gain than schizophrenia alone.
- Prior rapid weight gain on psychotropics is also a red flag.

4. Drs. Malik and Lorberg: What baseline assessments do you recommend before initiating SGA treatment in children and adolescents?

Dr. Correll:

- Document the metabolic syndrome criteria: weight, height, BMI percentile for age/sex.
- Waist circumference is hard to measure and does not add much more than BMI percentile.
- Get baseline fasting glucose or HbA1c, fasting lipid panel, and blood pressure.
- In higher-risk youth, I also check liver function as fatty liver disease is a possibility. All these parameters give you both a starting point and a target for early intervention.

5. Drs. Malik and Lorberg: How soon after starting an antipsychotic should clinicians begin monitoring for changes in weight and metabolic status in children?

Dr. Correll: The first **4–12 weeks** are the "danger zone" for rapid weight gain. This period is also very "telling," as the best predictor for future weight gain is early weight gain.

- I re-check weight and BMI percentile at **each visit for the first month, then at least monthly for the first 3 months.**
- After the initial 3 months, I typically monitor weight/BMI every 3 months, and fasting labs (glucose/HbA1c, lipids) every 6–12 months. If a patient is already showing abnormal labs, I shorten the interval to 3–6 months. Any new symptoms—polyuria, polydipsia, fatigue—should trigger immediate metabolic reassessment.
- **If an increase >3% body weight** occurs, that is a sign to act—either with behavioral, medication, or pharmacological strategies.
- Data from the large, PCORI-funded **MOBILITY** study in >1,500 randomized youth with bipolar-spectrum disorders (DelBello et al., in press) suggest that **prophylactic metformin** treatment possibly in all youth starting antipsychotic treatment should be considered.
- GLP1 RAs clearly have greater efficacy and should be considered when metformin's efficacy is insufficient, and weight gain has been substantial (e.g., >/=0.5 SD BMI z-score).

6. Drs. Malik and Lorberg: What trends are emerging in how SGAs affect metabolic/lab markers? What is your threshold for acting?

Dr. Correll:

- High-risk SGAs can increase fasting insulin and triglycerides within weeks, with LDL and total cholesterol rising over months. Monitoring fasting insulin is a sensitive tool to measure insulin resistance by calculating the Homeostatic Model Assessment (**HOMA-IR:** Fasting Insulin * Fasting Glucose / 22.5).
- A proxy measure for tracking emerging insulin resistance is the **ratio of HDL-cholesterol divided by fasting triglycerides.**
- Olanzapine is most consistently associated with adverse glucose and lipid parameter changes, followed by clozapine, risperidone, and quetiapine (even at doses </=50 mg / day, at least in adults (Hojlund et al., 2022).
- My threshold for considering a switch is >/= 5% weight gain plus lab abnormalities that do not improve with lifestyle or pharmacologic support within ~3 months.
- I position higher cardiometabolic risk antipsychotics second- or third line.

7. Drs. Malik and Lorberg: Could you share your thoughts on the pros and cons of switching to a lower-risk antipsychotic (e.g., aripiprazole)?

Dr. Correll:

- The pros are clear: switching from a high- to low-risk SGA often halts further gain and may even allow modest loss.
- The cons are potential psychiatric destabilization and reduced efficacy if the prior agent was uniquely effective.
- I consider switching if metabolic harm is evident and psychiatric control is likely to be maintained with an alternative.

8. Drs. Malik and Lorberg: What role does nutritional counseling play in managing antipsychotic-induced weight gain?

Dr. Correll:

- Nutritional counseling is essential but rarely sufficient alone.
- Components include weight self-monitoring, dietary choices, and physical activity modification.

- Interventions may be more effective if conducted in groups or applying to the entire family, which may increase motivation and consistency.
- However, youth on SGAs often experience **medication-driven hyperphagia** and altered satiety signals, making willpower-based interventions challenging.
- Counseling is more effective when starting ***before*** weight gain and paired with family-based behavioral change.
- Barriers include limited family engagement, socioeconomic constraints, lack of access to pediatric dietitians, and competing psychosocial stressors.
- Medication-induced appetite often overpowers lifestyle efforts, especially when weight gain is rapid, and psychiatric symptoms or specific side effects, such as sedation and EPS, can also complicate adherence to and effectiveness of non-pharmacologic approaches.

Here are some of the resources:

- EPION Metabolic Monitoring Tool
- APA: Lifestyle to Support Mental Health
- NIH Wellness Toolkit
- MHA Self-Help Tools

9. Drs. Malik and Lorberg: What factors should guide the decision to initiate pharmacologic treatment for weight gain in youth prescribed antipsychotics?

Dr. Correll:

- I consider pharmacologic treatment for weight gain if there is a **>/=5% weight gain** from baseline, especially with emerging metabolic abnormalities, and usually after a trial of behavioral intervention (usually 4–8 weeks).
- However, if there is rapid early weight gain in the first month, despite lifestyle monitoring and instructions, early pharmacologic intervention can be necessary.
- Data from the large, PCORI-funded MOBILITY study (Del Bello et al., in press) suggest that prophylactic metformin treatment possibly in all youth starting antipsychotic treatment should be considered in youth with **normal renal functioning (creatinine <1.3)** and with cotreatment with a **daily multivitamin,** as chronic metformin use can lead to **Vitamin B 12 deficiency.**

10. Drs. Malik and Lorberg: How does metformin compare to other pharmacologic options for managing weight gain, related (and not related) to antipsychotic use, in children?

Dr. Correll:

- Metformin is the most studied medication in pediatric SGA-related weight gain. Randomized trials and meta-analyses show **~1.5-3 kg less gain or modest weight loss,** with improved insulin sensitivity.
- The effect may be greater when giving metformin preventively or after only initial weight gain has occurred, but the data are not as robust (Carolan A et al., 2025).
- The extent to which metformin's weight-attenuating effects vary according to the weight-gain liability of specific antipsychotics remains under-researched.
- Topiramate shows some efficacy but has cognitive side effects.
- Bupropion and naltrexone have minimal pediatric data.
- GLP-1 receptor agonists like semaglutide are emerging but have less psychiatric-specific evidence so far, especially in youth, yet a Danish study in press with JAMA Psychiatry (Sass et al., in press) showed 9 kg weight loss vs placebo at 6 months with weekly semaglutide in adults with schizophrenia treated with clozapine or olanzapine who had prediabetes or early diabetes (hemoglobin A1c: 5.4%–7.4%).
- While metformin remains the first-line adjunct treatment, it may be insufficient.

11. Drs. Malik and Lorberg: Semaglutide (Wegovy) GLP-1 med is FDA-approved for chronic weight management in pediatric patients aged 12 years and older with obesity. In which clinical scenarios would you consider using it for pediatric antipsychotic-induced weight?

Dr. Correll: Weekly semaglutide is reasonable for adolescents with obesity (BMI ≥95th percentile) or those with significant metabolic abnormalities when lifestyle interventions and metformin have failed. Due to access/lower cost, safety, ease of use, and available data, I would always try metformin first. GLP-RAs may be considered earlier if metabolic abnormalities are severe and progressive.

12. Drs. Malik and Lorberg: What is the role of psychiatrists in prescribing and managing metformin or semaglutide for antipsychotic-related weight gain and obesity?

Dr. Correll:

- Child and adolescent psychiatrists, NPs, PAs, and other prescribers should feel comfortable initiating metformin for SGA-related weight gain, checking metabolic syndrome parameters at baseline and prior to metformin initiation, and periodically thereafter.
- Semaglutide initiation may be coordinated with pediatricians or pediatric endocrinology for shared care.
- Clinicians may also consider metformin for obesity in youth without antipsychotics when psychiatric treatment is a contributing factor.

13. Drs. Malik and Lorberg: What is the current evidence for using metformin to treat antipsychotic-induced weight gain in children?

Dr. Correll: Consider metformin when weight gain >/=5% occurs at any time of treatment despite lifestyle measures, especially with high-risk SGAs or strong metabolic family history.

- I also use it early for indicated prevention in youth with rapid and relevant early weight gain (e.g., in the first month).
- For ages 10–17 and / or >/=50kg body weight: start at 500 mg once daily with dinner, increase weekly by 500 mg to twice daily and ultimately to 1,000 mg twice daily with meals as tolerated.
- For ages 6–9 or <50 kg body weight, I start lower—250 mg once daily with dinner, increase weekly by 250 mg to twice daily and ultimately to 500 mg twice daily with meals as tolerated. Always titrate to efficacy and tolerability.
- The main side effects of metformin are GI in nature—nausea, diarrhea, abdominal discomfort, flatulence. Slow titration, taking metformin with meals, and using extended-release formulations reduce these issues.
- Most resolve in 1–2 weeks; persistent symptoms may require dose adjustment or discontinuation.

14. Drs. Malik and Lorberg: Looking ahead, what are your thoughts about the future of managing metabolic side effects of SGAs in youth?

Dr. Correll: I very much hope that we will see earlier risk stratification, combination of preventive and interventional strategies, and first-line as well as broader availability and use of weight-neutral or weight-negative antipsychotics. Child and adolescent psychiatrists will remain central—integrating psychiatric care with proactive metabolic management, which is part of our core responsibility. Coordination with pediatric/endocrinology care partners should occur as needed.

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Autism Advocacy in Turbulent Times: Putting the Patients First







Melissa A. Peace, MD, George 'Bud' Vana, MD, Eunice Y. Yuen MD, PhD, Gabrielle Shapiro, MD, Ivy Song, MD, Rebecca S. Daily, MD, Dorothy Stubbe, MD

On April 16th, 2025, a press conference was held at the Department of Health and Human Services in Washington DC. Health and Human Services (HHS) Secretary Robert F. Kennedy Jr. declared an "epidemic" of autism in America. He cited the increase in autism spectrum disorder (ASD) diagnoses from one in every sixty-nine children in 2012 to one in every thirty-one children in 2022[1].

During this press conference, Secretary Kennedy stated, *"Autism destroys families…these are kids who will never pay taxes, they'll never hold a job, they'll never play baseball, they'll never write a poem, they'll never go out on a date"*[2]. As child and adolescent psychiatrists, we are trained to recognize the broad spectrum of autism presentations and understand that such a statement reflects a deeply inaccurate and harmful portrayal of autistic people. While population-level data by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) regarding epidemiology by severity level are limited, clinical experience and recent studies suggest that a growing proportion of individuals diagnosed with autism meet criteria consistent with Level 1—those with intact cognitive abilities and primary challenges in social communication. Levels 2 and 3 reflect increasing support needs, with Level 3 associated with substantial impairments in communication, flexibility, and adaptive functioning, often requiring significant support across settings[3,4]. The observed increase in ASD prevalence is largely attributed to broader diagnostic criteria, increased awareness, and improved identification of individuals with milder symptoms. In short, the increase is largely related to increased Level 1 severity diagnoses[5].

At the same April 16, 2025, press conference, Mr. Kennedy claimed that he plans to announce a "series of new studies to identify precisely what the environmental toxins are that are causing it [autism]" within a few weeks[2]. These new studies are to include a reanalysis of the CDC's Vaccine Safety Datalink (VSD) to revisit the discredited hypothesis linking vaccines to autism[6]. He will also authorize the creation of the Autism Data Science Initiative (ADSI), a $50 million NIH program[7] (7: NIH, 2025). While research is essential—and increased federal investment in mental health is welcome—concerns have been raised about the ADSI's accelerated timeline (just one month for proposal submissions) and its use of an "Other Transactions" authority, which allows NIH to bypass traditional peer review to make internal funding decisions. In anticipation of renewed misinformation, major medical organizations quickly reaffirmed the scientific consensus. Dr. Susan Kressly, President of the American Academy of Pediatrics (AAP), emphasized that vaccines do not cause autism, cautioning that reopening the debate would "do a disservice to autistic people and their families"[8].

In June 2025, Secretary Kennedy dismissed all 17 members of the CDC's Advisory Committee on Immunization Practices (ACIP), citing conflicts of interest and a goal to "re-establish public confidence"[9]). In response, the AAP announced its first-ever abstention from ACIP meetings and reaffirmed its commitment to publish independent, science-based immunization schedules. U.S. Representative Dr. Kim Schrier (D-WA) has voiced concerns about the potentially crippling impact this upheaval poses to children's health and protection against preventable diseases like measles and croup. She also warned that any changes to the ACIP's recommended childhood vaccine schedule could trigger a domino effect, raising serious questions about how schools enforce immunization requirements and how insurance companies determine vaccine coverage—potentially undermining longstanding public health protections[10]. Meanwhile another physician member of Congress, Senator Dr. Bill Cassidy (R-LA) expressed hesitancy toward the selection of individuals to replace the dismissed ACIP members and urged the appointment of those with "more direct relevant expertise"[11].

Importantly, as child and adolescent psychiatrists and members of the American Academy of Child and Adolescent Psychiatry (AACAP), we hold a vital voice in pediatric health advocacy. Unlike the AAP, which does not have a Political Action Committee (PAC), AACAP often stands alone at congressional member roundtable medical association PAC events as the only organization dedicated to advocating for the healthcare needs of children. At the direct patient-care level, we can support our patients and their families by providing evidence-based information on medical topics currently under public debate, including vaccines and ASD. The American Academy of Pediatrics' website, HealthyChildren.org, offers accessible resources summarizing scientific studies published in high-impact journals—all demonstrating that vaccines are safe and not linked to autism or developmental delays[12]. Additionally, AACAP's Facts for Families provides trusted guidance tailored to pediatric mental health, including autism, that can be shared with families. At the institutional or meso-level of advocacy, reputable organizations dedicated to advancing psychiatric care—such as AACAP, American Psychiatric Association (APA), and the Group for the Advancement of Psychiatry (GAP)—can be effectively mobilized around critical issues. On the macro-level of advocacy that interfaces with policy, physicians can reach out to their congressional representatives to equip them with evidence-based information, helping to counter misinformation and guide decision-making. These communications—whether by email or phone—are often logged by congressional offices and used to gauge constituent priorities, which may influence their decision-making[13].

"Primum non nocere," a Latin phrase meaning "first, do no harm," is a fundamental principle in medical ethics. Attributed to Hippocrates, this principle compels a physician to make decisions about medical care that are most likely to help the patient (beneficence) and least likely to cause harm (non-maleficence). Robert F. Kennedy, Jr., as Secretary of Health and Human Services, is causing harm

to children—by stigmatizing and denigrating the quality of life that most autistic individuals experience; and by refueling the debunked conspiracy about vaccines causing autism, which will result in many children remaining unvaccinated and possibly becoming seriously ill or even dying in a measles outbreak. As the medical experts of children's mental health, we need to speak out about the importance of scientific information and evidence-based policies; respect for human dignity, regardless of ability or disability; and advocacy for the funding and access to medical care that promotes the health of children, adolescents, and families.

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NECCAP PRESIDENT'S PROGRAM

A Call to Action: The Vital Role of Teaching Psychodynamic Psychotherapy in Child and Adolescent Psychiatry

Top row, L to R: Sharon Weinstein, MD; Lisa Price, MD; Christina Macenski, MD; Steve Schlozman, MD. Middle row, L to R: Lovern Moseley, Ph.D; Laura Prager, MD; Pam McPherson, Ph.D; Kathleen Baynes, MD. Bottom row, L to R: Jennifer Harris, MD; Theodore Murray, MD; Roberta Isberg, MD

Laura Prager, MD, Kathleen Baynes, MD, Jennifer Harris, MD, Roberta Isberg, MD, Christina Macenski, MD, Pam McPherson, MD, Lovern Moseley, PhD, Theodore Murray, MD, Lisa Price, MD, Steven Schlozman, MD & Sharon Weinstein, MD
Co-Chairs: Laura Prager, MD, Sharon Weinstein, MD & Lisa Price, MD

Overview:

Drs. Laura Prager, Sharon Weinstein, and **Lisa Price** designed this program to draw attention to our field's obligation (perhaps imperative) to teach the next generation of child and adolescent psychiatrists to understand and appreciate the psychodynamic psychotherapy skill set—regardless of the child and adolescent psychiatrist's scope of practice. The invited speakers were talented clinician educators—psychiatrists and psychologists—hailing from a variety of settings including academic medical centers (AMCs), private practice, the Boston Psychoanalytic Institute (BPSI), and AACAP. Each clinician has strong interest in both preserving and nurturing the evidence-based thought process and therapeutic modality that has been increasingly marginalized in training programs nationwide; each one presented a distinct way to teach psychodynamic principles to every level of learner—from medical students to experienced therapists.

Presentations:

Kathleen Baynes, MD

Inspired Supervision: Faculty Development to Keep Ancient Craft Up to Date

Dr. Baynes' presentation highlighted the expectation for residency training programs to provide faculty development, particularly in enhancing the skills of faculty as teachers and educators and encouraged targeted teaching for psychotherapy supervision. She noted that trainee survey data and education research consistently highlight the profound role of supervision in learning and development; yet most psychiatrists who serve as psychotherapy supervisors receive little training in effective supervision. Clinical supervisors without explicit training in supervision may often defer to the style and manner of their own past supervision, which may not meet present demands. There are needs for coaching in role transition, review of the current expectations for learners, or teaching for culturally diverse clinical encounters in order to honor this valued learning space. Dr. Baynes shared an inspiring call to action, noting that psychiatry is uniquely suited to lead in the development of faculty as educators, particularly in the realm of enhancing supervision, because of the longstanding tradition of inter- and intra-personal reflection as a means of improving patient care. She shared models of teaching and learning and supervising trainees within a child fellowship program and the benefits of collegiality, wellness, and perception of meaningfulness of psychotherapy work.

Jennifer Harris, MD & Theodore Murray, MD

Teaching Psychodynamic Psychotherapy Today

Jennifer Harris and Theodore Murray discussed lessons learned from taking over a beloved psychotherapy class that had been running for over two decades and updating it for today's child and

adolescent psychiatry fellows. They reviewed their trainees' lack of baseline knowledge of psychodynamic principles and early skepticism about the value of psychodynamic ideas. Drs. Harris and Murray emphasized the importance of avoiding jargon-filled language and emphasizing more modern concepts like attachment and relational approaches instead of focusing on drives or conflicts. Similarly, they discussed their choice to focus less on verbal interpretations but instead place emphasis on developing the relationship with the child and her family. They also encouraged paying close attention to the following: the role of the unconscious in understanding and tolerating difficult behavior; the role of play in children's emotional processing and cognitive understanding of the world; the how and why to incorporate work with parents in a psychodynamic context. Finally, they also gave specific tips on how to avoid alienating current trainees by choosing diverse examples, highlighting the benefits of telehealth rather than its liabilities, appreciating the fluidity of gender identification, and presenting case examples that show the value of slow progress building over time–not just moments of epiphany. Finally, they emphasized that psychodynamic understanding and skills help psychiatrists in any clinical role and that fellows seem aware of this and interested in learning more.

Roberta Isberg, MD

Psychodynamics for the Busy Psychiatrist

Title: Psychodynamics for the Busy Child and Adolescent Psychiatrist

The principles of psychodynamic psychotherapy can guide the clinician through challenging clinical encounters across a variety of inpatient, outpatient, consultation, and emergency room settings. This presentation described how psychodynamic theory and technique can be taught as part of an integrative child and adolescent psychiatry psychotherapy curriculum in which the foundational skills and common factors of the therapeutic relationship are emphasized along with the unique contributions of different evidence-based approaches, including psychodynamic, CBT, family, trauma-informed, ACT, and psychopharmacological treatment.

Psychodynamic principles can be made accessible to child and adolescent psychiatry fellows in need of practical help with everyday challenges. Six key concepts are presented as guidelines for teaching the relevance of psychodynamic principles to the work of the fellows with a diverse group of patients and families in all settings.

- How early childhood experience and attachment history impact the capacity for emotional self-awareness, self-regulation, attunement to others, and the development of the treatment relationship between patient and provider
- The mechanism of change: Psychodynamic psychotherapy encourages habitual reactions to be experienced in a new context, with new outcomes, through the development of transference, the use of the therapeutic alliance, and therapist awareness of countertransference
- Recognition of unconscious drivers of behavior and defenses against overwhelming experience
- Following the patient's lead, free association, when to use responsive or directive techniques
- Tolerating intense affect: importance of self-reflection and supervision for the therapist

The Evidence for Evidence Based Practices: How positive, collaborative qualities of the therapy relationship (that psychodynamic insight can facilitate) outweigh choice of technique.

Christina Macenski, MD

BPSI Child Track: Why Is This Important?

The Boston Psychoanalytic Society and Institute (BPSI) offers a one-year child track fellowship in psychoanalytically informed psychotherapy. This fellowship focuses on teaching the theory and technique behind psychodynamic therapy, specifically highlighting the treatment of children and adolescents. BPSI's one-year child track fellowship is an institutional effort to increase interest in psychotherapeutic work. This program offers child clinicians at any stage of their careers regardless of whether their background is in psychiatry, psychology, or social work the opportunity to meet weekly with psychoanalytic faculty to review both theory and practice. Following this one-year fellowship, participants can continue in their training at BPSI through more advanced psychotherapy programs.

Pam McPherson, MD

Teaching Regulation Focused Psychotherapy for Children to CAP Fellows

Dr. McPherson shared her experience teaching Regulation Focused Psychotherapy for Children (RFP-C; Hoffman & Rice with Prout, 2015) to child and adolescent psychiatry fellows under the mentorship of Dr. Leon Hoffman, an AACAP Psychodynamic Faculty Initiative (PsyFi) mentor. PsyFi's goal is to strengthen psychodynamic psychotherapy training in child and adolescent psychiatry programs by providing awarded faculty with senior mentorship and by fostering a national community of psychodynamic psychotherapists.

RFP-C is a novel, manualized, time-limited psychodynamic treatment for children who manifest disruptive behaviors and emotional dysregulation. RFP-C play therapy training is the perfect clinical psychotherapy experience for guiding child and adolescent psychiatry fellows through the intricacies of child development.

Repetition, however, is not enough to master play therapy. Deliberate practice includes individualized learning objectives, supervision, feedback, and refinement through repetition. Videos of expert RFP-C therapists engaging in play therapy became models for fellows; videos of fellows' play therapy sessions were used in supervision to promote reflective practices.

Lovern Moseley, Ph.D.

Treating the Whole Child: Incorporating a Holistic View in the Mental Health Treatment of Children & Adolescents

Dr. Moseley's presentation focused on the importance of taking a broader bio-psycho-social-environmental view in the psychodynamic psychotherapy treatment of children and adolescents. She emphasized using the framework provided by the well-known Adverse Childhood Experiences (ACES) study to generate hypotheses regarding etiologies for clinical presentations. Additionally, Dr. Moseley highlighted the unspeakable losses for youth due to the global COVID-19 pandemic. The pandemic reshaped our thinking about typical development in children, adolescents and young adults and coincided with a rise in suicidality in younger children and minority populations, an increase in physical health symptom presentation, major disruptions to family life, impaired academic functioning, and decreased motivation to reengage in community. The presentation also explored ways to rebuild resilience by strengthening resources in multiple domains in the life of children and adolescents, highlighting the benefit of an integrative psychotherapeutic approach, particularly around identifying socio-emotional vulnerabilities that can exacerbate psychiatric symptoms.

Lisa Price, MD-Co-Chair

Child Program in Psychodynamics: Training the Next Generation

Dr. Price discussed the vital role of psychodynamic psychotherapy training for child and adolescent psychiatry fellows. She outlined a successful elective teaching forum, the Child Program in Psychodynamics (Child PIP), which brings child psychiatry fellows from three child psychiatry training programs in the Boston area together with experienced clinicians from those training programs and from BPSI, the local psychoanalytic institute. At each monthly meeting, a child fellow discusses a case with trainees and senior clinicians, affording real-time, psychodynamic group supervision on the case. In addition to the clinical knowledge gained, features leading to the success of the program include nurturing trainees through mentorship, opportunities to present clinical work, leadership roles, as well as dinners at both in person and virtual gatherings. The program's hidden curriculum focuses on community-building within the group, values lifelong learning for trainees as well as seasoned clinicians, and highlights the essential role of play for youth and the child psychiatrists working with them.

Steven Schlozman, MD

Why Development Matters- or… why do we even have to ask?

Dr. Schlozman emphasized how important it is to have an in-depth understanding of human development in the practice of psychotherapy, particularly when clinicians are engaging in psychodynamic therapy with children and adolescents. The challenges that attend incorporating different theories of human development into psychotherapeutic work with children include the rapid changes that a child undergoes as a function of normal growth, as well as multiple competing theories of development and corresponding biologic constructs. Given this complexity, it is important that the therapist remains nimble with different theoretical orientations and does not value one orientation over another. Over emphasis of any single developmental theory runs the risk of confirmation bias and can result in an incomplete understanding of how patients manage their difficulties. Important theoretical constructs include knowledge of brain changes throughout development, as well as appreciation and understanding of the developmental theories championed by Jean Piaget, Eric Erickson, Sigmund Freud, Lawrence Kohlberg, and Uri Bronfenbrenner. As each of these theories has much in common with the others as well as important differences, it is important that the therapist is comfortable toggling from one developmental framework to another based on observations throughout the course of treatment. In this way, the practice of psychotherapy proceeds with greater understanding, greater efficiency, and potentially more positive results.

Summary:

This program was virtual and well-attended. Participants ranged from senior clinicians whose training was primarily psychodynamically—oriented to relatively newly minted child psychiatrists and fellows whose training focused on psychopharmacology and manual-based behavioral therapies. "Inspiring" was the word most used to describe this program by those submitting written comments. Others called it superb and beautifully organized. Many attendees noted how relevant the lessons learned were to their day-to-day practice, teaching, and supervision. Many also commented that the program would inspire them to advocate with their departments for more teaching of psychodynamically-focused therapies.

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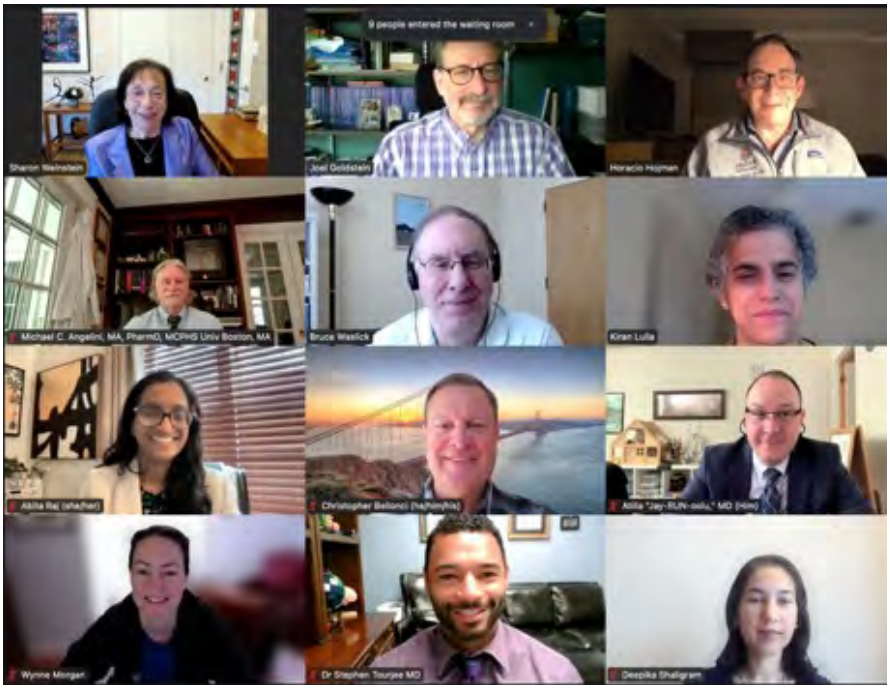
NECCAP PRESIDENT'S PROGRAM

Psychiatric Polypharmacy for Youth: Challenges and Opportunities for Practice Improvement



Top row: L to R: Sharon Weinstein, MD; Joel Goldstein, MD; Horacio Hojman, MD, Second row: L to R: Michael Angelini, Pharm D.; Bruce Waslick, MD; Kiran Lulla, MD, Third row, L to R: Abita Raj, MD; Christopher Bellonci, MD; Atilla Ceranoglu, MD, Fourth row, L to R: Wynne Morgan, MD; Stephen Tourjee, MD; Deepika Shaligram, MD, Not in photo: Veer Iyer, MD

■ **Joel Goldstein, MD, Michael Angelini, Pharm D., Christopher Bellonci, MD, Horacio Hojman, MD, Veer Iyer, MD, Wynne Morgan, MD, Bruce Waslick, MD, Sharon Weinstein, MD**

Co-Chairs: Joel Goldstein, MD—NECCAP President; Bruce Waslick, MD—NECCAP President-Elect; Sharon Weinstein, MD—NECCAP Medical Director

Overview:

The issue of psychiatric polypharmacy is of significant clinical and public health interest. The use of complex medication regimens for youth with mental health problems has increased significantly in the past few decades. There have been several academic studies and federal investigations over recent years, however, highlighting concerns that promote polypharmacy.

This program provided clinical guidance in managing psychiatric care for complex youth as well as background about the systemic challenges that inadvertently promotes polypharmacy. Presenters discussed a wide range of approaches, including prescribing and deprescribing. The presenters reviewed clinical concerns as well as policy concerns, with the positive and negative impacts of government oversight initiatives.

The program included a breakout session to allow participants to consider clinical and systemic challenges related to polypharmacy through discussion of constructed clinical case demonstrating psychiatric polypharmacy for youth, including for youth who are publicly insured and in the child welfare system.

Presentations:

Michael Angelini, MD, Pharm D.

Drug-drug and drug-disease interactions

Dr. Angelini presented a review of drug related interactions that could be considered when initiating pharmacotherapy. Some prescribers may need an update on the risks of using medications regarding both kinetic and dynamic drug interactions as well as overall medication effects on an individual and that was the intent of presenting this information. Introducing a medication into psychiatric treatment may not only have drug-drug interactions but could have side effect or disease related risks and this was another point of the lecture. In general, the presentation was designed to help with recognizing the more common drug-drug and drug-disease interactions so that initial choice of psychopharmacology has diminished risks. The discussion also addressed the relative risk of some drug-drug interactions and how to assess whether changes should be made. For example, since fluoxetine is the primary SSRI used in pediatrics, it requires increased vigilance when used with other medications as it is a potent inhibitor of CYP450 2D6 and moderate inhibitor of CYP450 3A4. Specifically, amphetamine blood levels could increase dramatically when fluoxetine is added due to the 2D6 inhibition. However, escitalopram would have a much lower risk on raising amphetamine blood levels. Another concept is that cyproheptadine should be used only as a prn when combined with proserotonergic agents since cyproheptadine is a broad serotonin receptor blocker. He also presented some examples of misleading information from the research databases, reminding the audience that using more than one source for information is prudent.

Christopher Bellonci, MD

There are concerns about the overuse of psychotropic medications for children and adolescents, particularly for foster youth. This has led to oversight and monitoring protocols to ensure these youth are receiving appropriate psychiatric interventions including evidence-based psychotherapies. Deprescribing is the systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient's care goals, current level of functioning, life expectancy (this definition comes from literature on the elderly), values and preferences. Deprescribing is part of the good prescribing continuum, which spans initiation, dose titration, changing or adding drugs, and switching or ceasing drug therapies. Deprescribing is not about denying effective treatment to eligible patients. It is a positive, patient-centered intervention, with inherent uncertainties, and requires shared decision making, informed patient consent, and close monitoring of effects-the same good prescribing principles that apply when drug therapy is initiated. Deprescribing considers not only the risk associated with individual drugs but also the cumulative risk from multiple drugs due to pharmacokinetic and pharmacodynamic interactions. (Scott et. al. 2015)

Some examples of potential areas for deprescribing include:

- Use of any psychotropic medication for a child age three or younger.
- Use of any antipsychotic or atypical antipsychotic medication for child age five or younger.
- A child aged five or younger who has two or more psychotropic medications prescribed concomitantly.
- A youth aged six or older who has three or more psychotropic medications prescribed concomitantly.
- A child prescribed a dose in excess of FDA guidelines.
- Absence of an indicated DSM-V diagnosis(es) in the child's health care record.
- Medication that is contraindicated given a child's medical history and/or other current medications.
- Two or more concomitant stimulant medicines (the prescription of an extended-release stimulant and an immediate release stimulant of the same chemical entity (e.g., methylphenidate) does not constitute concomitant prescribing).
- Two or more concomitant alpha-agonist medicines.
- Two or more concomitant antidepressant medicines.
- Two or more concomitant antipsychotic medicines.
- Two or more concomitant mood stabilizing medicines (not that youth in foster care with a medical diagnosis of epilepsy or other seizure disorders may be prescribed medications from this medication class to address seizures).

The use of these combinations of medications or other indicators for potential deprescribing are not inherently bad practices but they should raise concern and questions by those providing oversight and monitoring of psychotropic medications, particularly for children in the foster care system.

Joel Goldstein, MD

The role of state government in oversight of clinical practice—benefits and unanticipated challenges.

The federal government has mandated that states employ a process of oversight for monitoring concerns of psychiatric polypharmacy for youth in the child welfare system. The Commonwealth of Massachusetts implemented the MA Pediatric Behavioral Health Medication Initiative (PBHMI) in 2014. PBHMI is a multiagency initiative in The Commonwealth intended to facilitate diminish psychiatric polypharmacy for youth who are publicly insured. The initiative includes youth in state custody as well as youth who are not in state custody but with health insurance through Medicaid/MassHealth. PBHMI defines polypharmacy as a combination of four or more psychiatric medications and combinations within class of medications. In addition, PBHMI maintains age cutoffs that trigger PA submission for younger children. PBHMI is a prior authorization (PA) model program. Highest risk cases are targeted for peer consultation. PBHMI has resulted in a decrease in the prevalence of polypharmacy for youth who are publicly insured. Peer consultation has resulted in medication changes in approximately 50% of referred cases. The process of peer consultation has also highlighted potential cognitive biases that can impact psychiatric care providers and lead to unnecessary polypharmacy.

Horacio Hojman, MD

Psychodynamic Informed Psychopharmacology Practice for Children, Adolescents and Caregivers

Dr. Hojman's lecture at the NECCAP conference was about presenting psychodynamic concepts that help shape psychopharmacological intervention by integrating a developmental framework to deliver a comprehensive biopsychosocial formulation. Guiding the child psychiatrist's understanding of the underlying emotional and relational dynamics influencing the patient's symptoms is an effective way to achieve it.

The patient's developmental history, unconscious conflicts, and attachment patterns, take priority creating a holding environment for a stable foundation towards pharmacological treatment. This approach ensures that medications are introduced at a time when the patient is more likely to benefit from them, and psychological insights can inform the choice of pharmacotherapy, enhancing overall treatment efficacy.

An important concern for CAPs is that still there is a tendency to rush to the use of medication management without exploring the psychodynamics of the child and adolescent in relation to

their caregivers. Unresolved conflicts that can mimic psychiatric signs and symptoms that do not respond to medication management can be missed. CAPs should focus on a psychological narrative first which will give the clinician the opportunity to know the story of the patient and concomitantly rule if medication intervention is needed.

The lecture also addressed how psychodynamics can guide psychopharmacological treatment by addressing complex issues of treatment resistance, non-adherence, and polypharmacy.

Veer Iyer, MD

Medication Treatment in Inpatient Settings

Dr. Veer J. Iyer highlighted the complex balancing act faced by child and adolescent psychiatrists in managing psychotropic regimens in acute care environments. Dr. Iyer discussed national trends showing a significant rise in the use of multi-class psychotropic medications among youth over the past two decades, referencing pivotal studies by Comer, Olfson, and Mojtabai. These data point to a 41% relative increase in multi-drug prescribing for youth with mental health diagnoses, particularly in disruptive behavior disorders, bipolar disorder, and psychosis.

Drawing on real-world observations from the Child and Adolescent Psychiatric Treatment Unit (CAPTU), Dr. Iyer described how over 65% of inpatients arrive on polypharmacy regimens, with 30% discharged on fewer medications after careful review. However, he cautioned that even with improved medication plans, post-discharge stability was affected due to suboptimal outpatient therapeutic supports and caregiver over-reliance on medication as the sole intervention.

Emphasis was placed on systematic deprescribing protocols, rational augmentation strategies, and measurement-based care to assess true benefit versus burden. Dr. Iyer called for a shift toward family-centered dialogue, broader inclusion of non-pharmacologic interventions, and more collaborative research with insurers and regulators to fill evidence gaps in pediatric psychopharmacology. His session concluded with a passionate appeal for systematic and judicious prescribing to safeguard the developmental integrity of young patients.

Wynne Morgan, MD

Best Practices When Working with Child Welfare-Involved Youth and Families

Understanding best practices for working with children and families involved in the child welfare system is a crucial skill for any child and adolescent psychiatrist. Children in this system experience higher rates of mental health issues, including PTSD, depression, and ADHD. These increased rates of mental health disorders are linked to exposure to chronic and cumulative traumatic experiences1. Child psychiatrists must approach these children's behavioral challenges with a trauma-informed perspective. Supporting recovery from trauma and stressor-related disorders involves strengthening relational health to reduce the effects of toxic stress. Collaborating with caregivers to provide psychoeducation and anticipatory guidance about trauma-related behaviors can improve their ability to parent effectively2. Child psychiatrists should consider referrals to trauma-informed therapeutic supports that strengthen the caregiver-child relationship and recovery from trauma. Psychotropic medication should be used cautiously, as youth in the child welfare system are at risk of inappropriate medication use due to multiple factors. Nationally, psychotropic oversight programs have been established for child welfare systems to ensure medications are safely used in this population. At a systems level, child psychiatrists have a key role in working with these oversight programs to promote optimal prescribing practices. In clinical practice, when treating children in foster care, incorporating deprescribing protocols can ensure that each medication prescribed is appropriate and effective. Most importantly, this population demonstrates remarkable resilience, and child psychiatrists play a vital role in fostering resilience factors[3].

Bruce Waslick, MD

Polypharmacy—What We Know—Evidence-Based Practice, Prescribing Patterns & Systemic Pressures

Evidence suggests that Child Psychiatric practitioners are using pharmacotherapy and complex pharmacotherapy increasingly in clinical practice. The term "polypharmacy" refers to use of multiple medications in the same or different classes to address complex psychopathology or treatment-resistant forms of pediatric psychiatric presentations. As an evidence-based practice, there have been a few published high-quality studies using randomized controlled trial (RCT) methodology to investigate the safety and efficacy of polypharmacy approaches in a limited range of pediatric psychiatry indications. However, most of the polypharmacy that is practiced in Child Psychiatry is done with limited-high quality evidence support and lack of support from the Federal Drug Administration (FDA) review and labeling. This presentation focused on demonstrating that the use of polypharmacy in Child Psychiatry practice has increased significantly over the past few decades; that there is a limited evidence base for some polypharmacy approaches demonstrating both short-term efficacy and safety of these approaches (for example, use of alpha-agonist plus stimulant therapy for some patients with ADHD); and provided an overview of how to consider practicing thoughtfully in considering both safety and efficacy of complex medication regimens for youth.

Summary:

In summary, the conference highlighted that complex psychopharmacology interventions are clinically warranted in some but certainly not all youth with more serious mental health problems, and, probably not unlike trends in General Psychiatry, polypharmacy is becoming more prevalent in Child Psychiatry practice. It is clear that the evidence-base for safe and effective polypharmacy in Child Psychiatry practice is limited, and that utilizing complex medication regimens can lead to adverse reactions, including

negative drug-drug interactions as well as negative drug-psychiatric condition interactions. Youth with complex psychosocial histories and a history of adverse childhood experiences are particularly vulnerable to both complex psychopathology and becoming exposed to complicated pharmacological interventions.

This conference highlighted several challenges for psychiatric practitioners working with children and adolescents with more complicated, severe, and treatment-resistant forms of psychiatric problems, including, but not limited to, the following:

1. The challenge of practicing psychiatric care with a perhaps growing but severely limited evidence base for complex psychopharmacology regimens, both in terms of safety and efficacy.
2. The challenge of providers keeping up to date in terms of skills and knowledge of drug-genetics, drug-brain, drug-body, drug-disease, and drug-drug interactions in young people.
3. The challenge of practicing psychiatry and using psychopharmacology as an intervention in the context of complex individual, family, and community dynamics at play in the care of psychiatrically challenging youth.
4. The challenge of providing integrating and optimizing care in the context of often fragmented health care systems, where short duration, intensive treatment occurs in one setting (inpatient or partial hospital level of care) but long-term, less intensive but more continual care in different settings (primary care, outpatient mental health care).
5. The challenges for policymakers and other stakeholders in setting up appropriate and adequate evaluation and monitoring systems that can limit harmful, wasteful, or inappropriate care approaches to medication prescribing in favor of helpful, cost-effective, and safe medication prescribing, especially for the most vulnerable members of the population.

As with many challenging situations, the conference also highlighted opportunities for improving care, including:

1. Ongoing efforts to advance provider education and skill development in pediatric psychopharmacology.
2. Increasing research efforts, ranging from basic science to clinical trials to pharmaco-epidemiological studies aimed at developing knowledge and ideally clinical guidelines maximizing the clinical utility and cost-effectiveness of care and minimizing adverse reactions for patients.
3. Exploring efforts directly aimed at protecting vulnerable populations from the potential harms of ill-advised or overly aggressive medication prescribing for conditions that might be better approached with non-medical interventions.
4. Developing opportunities for highlighting and disseminating effective governmental oversight of polypharmacy in youth with case review for patients being prescribed particularly complex medication regimens by consultants to provide support and considered opinion about the appropriateness and safety of the prescribed medications.

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Is AI Dangerous for Children?

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Artificial Intelligence (AI) is rapidly becoming a part of many children's everyday lives. Children are turning to AI to help with homework, for entertainment, and even for companionship. AI technology is impossible to avoid in everyday products like social media feeds, voice assistants, and video games.

What Are the Potential Benefits of AI for Children?

- Educational Support: AI can explain complex topics in a way children can understand and enjoy. For example, a child may ask AI to describe how to do long-division through the voice of their favorite character. Some schools are even adopting it in their formal training plans.
- Language Learning: Certain AI applications can help children practice their conversational skills in other languages.
- Entertainment: AI can be used for entertainment in many ways, from creating a funny image to generating jokes and making up silly songs. For example, children can ask an AI application to tell them a bedtime story where they are the hero.

What Are the Potential Risks of AI for Children?

- Chatbots can provide engaging conversation and mimic human relationships. Some children may overly rely on chatbots instead of genuine relationships with people in their life. Children may become so attached to the chatbot that when parents try to set limits, they have extreme reactions.
- AI systems collect extensive data about users, including children. Children often do not understand how their data is used and shared.
- AI can be misused to create convincing fake images, videos, or audio (deepfakes) that appear to show a person saying or doing things they never did. This technology can be used to create new forms of cyberbullying.
- Some AI programs claim to provide mental health treatment. While there are AI therapeutic tools being developed with the support of mental health professionals, parents should be cautious because they are still new, and research is ongoing. A qualified mental health professional can help you decide if these programs are appropriate for your child.
- Many schools have strict policies around AI usage and consider it cheating. Schools often use software to detect the use of AI for assignments.
- Learning through doing is crucial in your child's development. Overreliance on AI for answers impairs critical and creative thinking.

Signs That AI Use May Be Unhealthy

- Spending time with AI applications at the expense of other interests or responsibilities
- Decreased face-to-face social interactions
- Outbursts when limits are set around using AI applications
- Lying about using AI
- Breaking school rules about using AI to complete assignments
- Sleep disturbances related to device use
- Sharing inappropriate personal information with AI systems
- Using AI to hurt or bully peers
- Creating sexual or violent content with AI

How to Help Children Use AI Safely

- Explore AI tools together with your child
- Model curiosity and skepticism: teach children to question information from AI
- Set clear rules and boundaries around the use of AI
- Discuss the uses and misuses of AI
- Talk about the difference between AI companions and human relationships
- Encourage children to share and discuss online experiences
- Help children understand that images, video, or audio may be faked by AI
- Learn the rules regarding AI use at school
- Avoid sharing sensitive personal details with AI tools

If you have concerns about your child's use of AI, talk with a trained and qualified mental health professional.

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ELSEVIER

Seasons and Tides: Embracing the Cycles That Shape Our Journey

Megan Single, MD & Carly Kawanishi, MD

Dr. Single recently completed her term as the Jerry M. Weiner (JMW) Resident Member of Council from 2023 to 2025. Dr. Kawanishi is currently serving as the John E. Schowalter (JES) Resident Member of Council from 2024 to 2026. They have both been deeply involved in the Committee on Medical Students and Residents (MSR) throughout their time in the Academy.

This reflection, co-written by two resident members of AACAP Council, traces two intertwining paths that began years apart and ultimately converged—across meetings, mentorship, and moments of meaning within the AACAP community.

Caught in the Current

Dr. Kawanishi: *As I walked up to board my flight to Chicago, I found myself standing beside my former associate program director,* ***Dr. Devi Bhatia.*** *With what would be the first of many moments of spontaneously crossing paths with beloved mentors and friends from different walks of life, I found myself overtaken with joyful gratitude. I was reminded of the power of connection and genuine care that has made the field of child and adolescent psychiatry and the AACAP community feel so magnetic. I was also relieved to feel a hint of positive anticipation building in arriving at the Annual Meeting this year. Up until that moment, there had only been inexplicable heaviness, a stark juxtaposition to the usual mix of nervous excitement that I typically carried to the start of the Annual Meeting week.*

Dr. Single: *As I stepped through the doors of the Hyatt Regency Chicago last week, a wave of déjà vu washed over me. "I've been here before," I thought, as a flashback flickered at the edges of my mind. There wasn't time to linger on it as arrivals at AACAP rarely leave room for reflection, so that memory would have to wait.*

Like every year, I rushed to the bellman to check my bags and dove straight into the familiar rhythm of reunion: hugs with my AACAP sisters, sightseeing before the real work began, last-minute program edits, and color-coded schedules for the week ahead. Yet something felt different this time. Beneath the excitement, unshakable fatigue lingered, a strange, preemptive exhaustion that I couldn't quite name.

Relief came that evening when I realized I wasn't alone. My close friend and Council counterpart, Dr. Carly Kawanishi, *confessed she felt the same. "What is going on?" we asked each other, half-laughing, half-searching for an answer to this existential dread that had taken its hold.*

Dread and internal rumblings aside, the familiar energy of AACAP swept us up. It wasn't until the end of this Annual Meeting that the root of our shared feelings of discomfort were discovered. In searching to make sense of the meaning behind these feelings, we found clarity as we retraced our steps back to the very beginnings of our AACAP journeys.

Riding the Wave Back to the Beginning

Dr. Single: *Remember the flashback I mentioned, the one that came to mind as I stepped into the Hyatt lobby this year? The image was vivid: me, six years ago, sprinting from one corner of that same lobby to the other, trying to keep pace with someone leading me on the ultimate Thursday-night tour of receptions.*

I'll never forget those moments from my first AACAP Annual Meeting—bright-eyed and bushy-tailed, as they say—standing at the threshold of a new and thrilling world in child and adolescent psychiatry. I was a naïve fourth-year medical student, new to the field and a stranger to the Academy. Through luck or fate, one humble email asking for travel support connected me with someone who would shape the next six years of my professional life: ***Dr. Bud Vana,*** *then the outgoing JMW Resident Member of Council. He graciously took me under his wing, shuffling me around receptions, introducing me to the future building blocks of my AACAP journey.*

I remember being both exhilarated and intimidated—who was I to be meeting these "big names" and academic chairs? It was imposter syndrome before the real one even set in; I wasn't a full-fledged doctor yet, and already I felt it. At the Owl Life Members event, I was moved by the stories of those later in their careers, their passion still burning bright. When the co-chair of the event, ***Dr. Cordelia Ross,*** *invited new leadership to help plan future sessions, a fleeting surge of courage pushed me to introduce myself. Again, who did I think I was? But those small moments of others' blind faith and my own brave impostership became launching points for everything that followed.*

Just one minute of courage left me with someone who would later become both a professional and personal role model. Dr. Ross, who was the incoming JMW Resident Member of Council, became a touchstone in my memory of that week, leaving an imprint on my mind—"that's who I want to be when I grow up." Watching her gracefully lead the MSR Breakfast was another defining moment that sparked a craving to belong to what I would later call, "the AACAP family." The candid, self-reflective stories of ***Drs. Sansea Jacobson, Shawn Sidhu,*** *and* ***Jeff Hunt*** *were unlike anything I'd encountered in medical school—full of vulnerability, compassion, and humor. It was medicine with humanity, and it was soul-refreshing.*

Moments later, at the MSR Committee meeting, I was greeted by name by ***Anneke Archer, Assistant Director for Training & Education , Research, Grants & Workforce Development.*** *At the time, I thought she'd pulled me in on a whim; now I know better. Her seed-planting was deliberate, as only seasoned mentors could be.*

Looking back, that first week in Chicago is a blur, but the remaining flashes from the past are the ones that shaped everything to come—moments of connection, courage, and belonging that left me hungry to build a career rooted in those same values.

A page from my medical school journal reveals my first day of third year thoughts: "Doctors never truly know what they're doing. Remind me why I chose this career." The year that followed only deepened that uncertainty. Then came AACAP. At that first meeting, I saw human connection, joy, and authenticity, not outside of work, but within it. I saw physicians leading with self-compassion, humility, and honesty about their shortcomings. AACAP gave me what I had been searching for all along: proof that medicine could be both rigorous and human.

A page from my medical school journal reveals my first day of third year thoughts: "Doctors never truly know what they're doing. Remind me why I chose this career."

That first spark in Chicago didn't fade. No, it caught fire. By fall 2020, nominated to join the MSR Committee, I found myself stepping into a community that felt both familiar and brand new. Soon after, I was co-chairing the Owl Life Members event alongside Dr. Ross, the very mentor who had once inspired me from the podium. Sitting across from our Life Member mentors, hearing their reflections on meaning and longevity, was a grounding reminder of why we do what we do. There's something profoundly restorative about being reminded by those who've already walked the road that purpose persists. I carried that forward, pouring into the next generation the way others had poured into me, through mentorship programs, the newsletter, and countless MSR initiatives. Passing the baton to new leaders, including Dr. Carly Kawanishi and Dr. Aria Vitale*, felt like closing one loop only to open another—the way every act of mentorship ripples forward. And the rest, as they say, is history.*

Dr. Kawanishi: *My first interaction with the AACAP community was at the Annual Meeting in Seattle in 2018. At that time, I was a second-year medical student selected for the Mentorship Grant for Medical Students. I vividly remember my feeling of excitement fighting to overpower the nerves as I entered the Seattle Conference center on that first day.*

I sat in the back row in the first session I attended, afraid to take up space from the actual doctors at this conference. Until that point of my academic career, I had never sat in a lecture that felt so captivating. When I approached the speakers at the end to share my gratitude, Drs. Sansea Jacobson and Shawn Sidhu greeted me with encouraging kindness and enthusiasm for my being at the conference as a medical student. I was stunned by this gesture, thinking: since when has a medical student's presence been viewed with such value? Little did I know that would be the first of many encounters where my position as a student was celebrated, and my imposter syndrome was put in check.

Later, I attended a mentorship event with the Life Members. I couldn't believe that I was in a room full of some of the field's most accomplished and respected people, and that they were volunteering their time to meet with trainees. I was struck by their passion for the field and their enthusiasm for every trainee at the table looking to explore whether this subspecialty felt like the right fit. As the event ended, I met one of the event chairs, Dr. Cordelia Ross, who saw beyond my uncertainty of feeling too green for this crowd and encouraged me to become a part of this "MSR committee" I'd never heard of.

Afterwards I met ***Dr. Jess Stephens****, a 4th year medical student at the time, who became my first peer mentor, helping me navigate my first conference experience. I remember my awe and gratitude as she guided me through the Thursday evening receptions. I watched with wonder at her effortless connection with senior attendings and program directors I felt too shy to approach. As I attended the MSR-sponsored events throughout that week, I met Anneke*

Archer, who took me by surprise by greeting me by name upon first meeting, a warm and unexpected welcome. At the MSR Two-Day Mentorship Event, ***Dr. Myo Thwin Myint*** *was the assigned mentor at my table. Struck by his exuberance and outright joy, I reveled in his wisdom and humility as he shared his lessons learned.*

In all these encounters, I was moved most by the generosity, inclusion, and authenticity these people shared so willingly with trainees. I was left with dismay, feeling that I had nothing to give in return. Little did I know, they were teaching me about generativity, and the true gift of mentorship that lies not in repaying those who have given to you but paying it forward to those to come.

That first Annual Meeting week went by in a flash, but I am grateful for the seeds planted by people who have become some of the most influential mentors to shape my growth. I left Seattle feeling beatifically certain that I had found my calling and felt energized to go back to medical school fueled by my passion to pursue a career in child and adolescent psychiatry. I entered the AACAP world that week feeling like a lonely newcomer, and left feeling like I belonged to something.

With the encouragement of Anneke, I applied to become an MSR committee member while still a medical student. Guided by Dr. Ross and inspired by the dedication of the Life Members, I got my start volunteering when she passed her leadership role for this event on to me. That's where I first met Dr. Megan Single, whose mentorship was influential, as she took me under her wing and empowered me to rise as a leader. She cultivated my courage to lead, gracefully modeled how to pass opportunities to the next generation, and granted me the space to build my skills in doing the same.

Learning to Navigate the Waters

The same mentors who once opened doors for us had unknowingly been preparing us to step through them and to take our own seats at the table and carry their work forward. As the newest Jerry M. Weiner (JMW) and John E. Schowalter (JES) Resident Members of Council, we were charting new waters while honoring those who once steered the direction of our ships.

Just like our first Annual Meetings, our first council meetings brought the same flutter of nerves, that same sense of being small in a big room—only now, we were part of shaping the very space that once inspired us.

Dr. Single: *Arriving in Birmingham for the AACAP Council Retreat in June 2024 as the new JMW Resident Member of Council was both exhilarating and nerve-wracking. I felt the weight of the privilege, but also the familiar dread of being the odd one out.*

While sitting in the lobby to pass the time, a sigh of relief came over me as I spotted one of my beloved mentors, and now dear friend, Dr. Sansea Jacobson. You might recall her from

> *When it came time to deliver my report, the internal panic arrived right on cue. Fortunately, Rob Grant, Director, Communications, Member & WEB Services, with his trademark mix of sarcasm, humor, and unwavering encouragement broke the tension, reminding us that leadership doesn't have to be too serious to be sincere.*

my 2019 inaugural AACAP experience. Her warmth and easy kindness, as she wrapped me in a hug, reminded me that I wasn't just a small fish in a big pond—I was a fish swimming in a bigger school, meant to be in these waters.

At the opening lunch, reuniting with old friends and meeting new leaders, I was again met with that conflicting sense of belonging and not belonging. As the business of the retreat began, I found myself seated among esteemed leaders in the field, witnessing the inner workings of AACAP at its highest level. I felt lost and found all at once. The discussions were foreign, yet people around the table were turning to me, asking for my perspective.

When it came time to deliver my report, the internal panic arrived right on cue. Fortunately, ***Rob Grant, Director, Communications, Member & WEB Services,*** *with his trademark mix of sarcasm, humor, and unwavering encouragement broke the tension, reminding us that leadership doesn't have to be too serious to be sincere. His energy, the heartbeat of Council, lifted me just enough to step forward. If I'm being honest, I had no idea what I was doing. But with my closing remarks, the room broke into applause, and those same respected leaders soon approached me with hugs and gratitude for the work done in the MSR community.*

By the end of the weekend, strangers had become colleagues and distant policy now familiar terrain. The learning curve was steep, and the growing pains unrelenting, but together, they laid the foundation for what was to come: the profound responsibility of representing the trainee voice and advancing the mission of AACAP through a fresh lens.

Dr. Kawanishi: *To say I was nervous flying into DC for my first AACAP Council retreat would be an understatement. However, I was grounded in gratitude, knowing that Megan would be there as the seasoned resident member of Council, and as a mentor and dear friend, once again paving my path. Her supportive reassurance was a welcomed life raft as I found myself swimming through the depths of imposter syndrome again.*

As I awkwardly entered the room for the first Council event, ***Drs. Warren Ng*** *and* ***Sandy Fritsch*** *sought me out, sharing their excitement toward my presence. I reveled in the déjà vu, rediscovering what I had experienced at my first Annual Meeting: how intentional the Academy is in making trainees feel included and valued.*

During a later Council meeting, a question was posed to the group. Taking a deep breath, I raised my hand to volunteer an opinion rooted in the trainee perspective. Representing the trainee voice is a tremendous honor, yet it's something that my former medical student self never would have imagined. My mentors—who saw potential in me when I didn't, believed in me when I couldn't, and walked beside me throughout—helped me grow into roles I never could have imagined for myself.

Beneath the Surface

Back to those feelings of discomfort we were trying to make sense of the inexplicable heaviness, the unshakeable fatigue, the existential dread. We realize now, they were harbingers for an inevitable change in the tides that we hadn't realized was coming, but in reality, was right on cue.

This year's Annual Meeting unfolded with a familiar rhythm, the same pulse of passion and energy we've always loved. We dashed between presentations and symposiums, from chairing panels to leading sessions, and still couldn't get far without an interruption. Once invisible trainees racing through the halls, we now found ourselves pausing every few steps, greeted by familiar faces and spontaneous reunions. Once part of the AACAP family, you quickly learn that you can't walk ten feet without bumping into someone who's shaped your journey—crossing paths with a piece of your own story, and often, someone else's too.

As the week went on, the existential dread lingered, but instead of consuming us, it became fuel for late-night reflection and shared introspection. During those conversations, we discovered the source of our exhaustion. We kept circling back to the theme of seasons—how each chapter carries its own rhythm of growth, change, and letting go. One of us was stepping out of training and into private practice; the other, preparing to finish training and face the unknown. One was rolling off Council; the other, entering the final stretch of a term. It wasn't just our time on Council or our time as trainees that was ending, it was the closing of one chapter and the tentative opening of the next. After a collective thirteen years embraced by the MSR community, we found ourselves at a crossroads, where uncertainty was ironically the only certainty.

Throughout the week, we returned to where it all began: two individuals standing at new thresholds, feeling the same mix of nostalgia, gratitude, and wonder. The emotions underneath were familiar—the new kid's uncertainty, the awe of looking up to leaders, the quiet hope of belonging. We'd felt them as medical students at our first AACAP meetings, again as fellows at our first Council sessions, and now as transitioning professionals, facing our next "firsts." It was time to let go of the identities that once defined us and turn toward the new ones to come.

The Return Current

As the 2025 Annual Meeting week neared its end, the undercurrents of reflection grew stronger. Everywhere we turned, we found echoes of where we'd

been before—familiar faces and feelings, and a sense that the tide had carried us back to where it all began.

Dr. Kawanishi: *This year's meeting in Chicago marked my eighth AACAP conference, but my first as the JES Resident Member of Council. Though much has changed since that first Annual Meeting, I was struck by disbelief that this was my final one as a trainee. I have noticed so many synchronicities, each of which foster my acceptance that this season of life is coming to a close.*

I was deeply honored to step into the role as JES following Dr. Jess Stephens, my first peer mentor, who once again helped me navigate this new experience. Walking into Council in Chicago, I was humbled to be seated at the table with my earliest AACAP inspirations, Drs. Sansea Jacobson and Shawn Sidhu, my biggest cheerleaders throughout. It has been all the more meaningful to share the Resident Member of Council role with Megan, as her steady supportive mentorship and thoughtfully caring friendship have kept me adrift while wading through waves of uncertainty.

It felt serendipitous, then, that on the final morning of the conference, as Megan and I hurried across the skybridge to the Council meeting, we ran into our dear friend, Dr. Myo Thwin Myint. He greeted us with his signature warmth—a hug, a pause, a reflection—before joking, "AACAP is just one big psychotherapy session." We laughed at the uncanny timing; after a week of introspection and connection, it couldn't have felt truer. He was on his way to grab a coffee with a medical student he'd met the day prior, who was seeking guidance after discovering their newfound passion for the field. It was a beautiful full circle moment: witnessing the mentor who helped me find my footing at my first Annual Meeting welcoming a new student into this AACAP community. I felt a surge of excitement for this trainee at the start of their own journey, reminiscing on the joy of unlocking your potential through the wise guidance of mentors.

Thinking back, my second-year medical student self could not have imagined standing where I am today. I never could have guessed that the first connections I made would grow into some of the most enduring and transformative relationships of my early career. With gratitude for the wisdom and faith my mentors generously bestowed upon me, I aspire to follow their example and pass that goodness onward.

Dr. Single: *Not unlike my first Annual Meeting in Chicago, this year's gathering was filled with brief moments that collectively embodied the fabric of nurturing woven through the Academy—the way AACAP connects those who once were, those who are, and those yet to come.*

A simple text exchange turned into something quietly extraordinary—a full-circle meeting six years in the making. There we were: Dr. Bud Vana, once the outgoing JMW when we first met, and me, now the outgoing JMW in the same space where it all began. What started as a quick hello turned into commiseration over table formatting in community EHRs (if you know, you know), and an uncanny recognition that our stories mirrored each other so precisely that it felt surreal.

Just as he had in 2019, Dr. Vana took me under his wing again, ushering me into the Assembly. Over lunch, another wave of déjà vu hit—and suddenly I was that medical student from six years ago, sitting at this very table with Dr. Cordelia Ross, the incoming JMW at the time. The continuum came into focus: Bud, the outgoing; Cordelia, the incoming; and now, me, 6 years later completing the circle as the outgoing JMW myself.

It felt synchronistic, then, that later in the week, during one of our late-night heart-to-hearts, Carly and I found ourselves mentioning Dr. Ross in the same breath—the compass we always seem to find when searching for direction. Just days later, I delivered closing remarks to a room of trainees as I concluded my time as co-chair of the MSR Breakfast—the very event that, six years earlier under Dr. Ross's leadership, had inspired me to take this path. And in a perfect symmetry of beginnings and endings, there I was, seated at the Council table for the final time last Saturday, receiving recognition as my term as the JMW came to an end—beside Drs. Sansea Jacobson and Shawn Sidhu, the very speakers whose words at my first Annual Meeting had sparked it all.

In bringing together these extraordinary connections, I have been struck most by the realization of the mirrored parallel experiences that my dear friend, Carly, and I have had over the years. While our MSR journeys began separately, they intertwined, molding into this beautiful peer mentorship and friendship that has stood the test of time. It has been a true honor to pass the baton to her in many capacities, to share this role on council with her, to watch her blossom in ways I knew she would, and to see all of these full circle moments culminate into the powerful volcanic force we joke that we are–performing under pressure and exploding with enthusiasm!

The Harbor That Held Us

In reflecting on our parallel paths, we realized how much of this journey has been sustained by those who poured into us. Certain names have surfaced again and again, each a touchstone in our AACAP journeys and emblematic of the mentorship and connection that have shaped us. Yet these few represent only a fraction of the many who have guided, challenged, and championed us along the way. We are equally indebted to ***Tami Benton, MD, Past-President, Jill Bradford, Chief of Learning & Strategic Initiatives, Meetings & CME, Beau Carubia, MD, Cindy Chou, MD, Desiree DiBella, MD, Amanda Downey, MD, John Dunne, MD, Heidi Fordi, Executive Director/CEO, Alissa Hemke, MD, Joe Jankowski, MD, Lianna Karp, MD, Lee Lewis, MD, John Lingas, MD, Andres Martin, MD, Anne Penner, MD, Michael Shapiro, MD,*** and ***Ellen Sholevar, MD***—each leaving a distinct and lasting mark on who we've become, their influence continuing to ripple outward through those whose journeys now intersect with our own. The truth is, there are countless others whose influence may not be named but is deeply felt, a reminder that the spirit of AACAP is, at its core, one of shared becoming.

It is the continued engagement of the leaders who see potential before we see it in ourselves that fuels us forward. It is the mentors, the executive leadership, and the broader Academy that make this collective growth not only possible, but inevitable. But it is also us, the peers, and fellow trainees who, despite packed schedules and tired eyes, keep showing up to put the wind in our sails. It's all of these steady hands-on deck, with their tireless work behind the scenes, that keep this ship not only afloat but sailing forward.

As we prepare to watch our roles within this community evolve, it's powerful to reflect on the individuals, and the Academy as a whole, who saw fertile ground, planted seeds of curiosity and courage, and nurtured growth. As Resident Members of Council, our charge has been to cultivate that cycle and to nurture the seeds once planted in us and watch as they grow into a garden of every shade. And as the light shifts, those colors converge into something even more radiant—a reminder that growth, like a rainbow, is born of both rain and reflection.

Where the Sea Meets the Sky

One rule you quickly learn sitting on AACAP Council is that what's said in the room stays in the room. We're going to make an exception—one we are confident our immediate Past President, Dr. Benton, would approve.

As Dr. Benton opened our Council business meeting, she shared that as she roamed the halls of the Annual Meeting, she kept hearing three words to describe AACAP: unified, joyful, and team. Later that week, while compiling photos for our Resident Council report, we noticed a rainbow appear in one of them seemingly out of nowhere. But we can't think of a better image to capture the essence of those three words—unified, joyful, team—for several reasons.

- **Unified.** Rainbows are born of both light and storm, a reminder that beauty often follows challenges, whether in our field, our work, or our own lives. Today, it is this stance of resilience that unifies us in the face of uncertainty.
- **Joyful.** It's hard to see a rainbow without feeling an inner lift. The same is true here. You can't walk into an AACAP meeting and not feel the joy in the room.
- **Team:** A rainbow is made of many distinct colors, each vibrant on its own, yet only when they blend together does the full arc appear—just as our diverse members come together to create something luminous.

Scientifically, a rainbow is a full circle, though we only ever see the visible arc. That feels true of this year's journey too—coming full circle from our first AACAP meetings to our first Council seats and now to a new set of firsts. What's visible are the moments of celebration and connection; what remains unseen are the sustaining threads of mentorship, growth, and continuity that extend far beyond the

moment. Together, these pieces form the circle that keeps us connected, no matter where we stand along it. Even when part of the arc slips from view, we trust it remains unbroken —*luminous, enduring, and shimmering just beyond sight.*

This year's Annual Meeting was both predictable and unpredictable, anchored in the familiar cadence of connection, yet filled with emotion, reflection, and meaning. As we approach the end of one season and beginning of the next, we pause not only to look back at the paths that led us here, but also to express deep gratitude for this community that has fostered our growth and belonging. And while we may be venturing into something new, the irony isn't lost on us: AACAP isn't going anywhere. The same community that embraced us in the beginning and sustained us in the middle will be there at every new horizon. This isn't an ending, it's just another beginning.

And to those just finding their way to the AACAP community, contending with uncertainty in how to navigate these waters—the new medical students, residents, fellows, and emerging leaders dipping their toes into this vast ocean—we offer this: *dive in*. Let the current carry you. You'll find mentors ready to guide you, peers who will become family, and a community that will remind you, time and again, why you chose this calling. The circle is waiting to widen, and the next colors in the arc are yours to bring.

Dr. Megan Single *recently completed her term as the Jerry M. Weiner Resident Member of AACAP Council and Chair of Innovation for the Committee on Medical Students and Residents. She plans to remain active in AACAP through mentorship and advocacy initiatives while building her private practice in North Carolina focused on neurodevelopmental catatonia and complex neuropsychiatric conditions.*

Dr. Carly Kawanishi *is a second-year child and adolescent psychiatry fellow at the University of Colorado. She is the current John E. Schowalter Resident Member of AACAP Council and Chair of Innovation for the Committee on Medical Students and Residents. She is passionate about medical education, mentorship, and physician and trainee well-being initiatives.*

The **NextGen CAPs: Excellence Through Mentorship Video Series**, sponsored by the AACAP Diversity and Culture Committee and supported by the Abramson Fund, highlights the diverse career pathways in child and adolescent psychiatry. Featuring psychiatrists at various career stages, the series explores their roles and diversity, aiming to inspire and engage the next generation of child and adolescent psychiatrists.

Watch video:
https://www.aacap.org/NextGenCaps

Poetry

Still at Risk

Maryam Tariq, MD

Walked in the room, the teen greeted me with a smile

Six weeks have gone by; gosh it has been a while!

Sitting tall next to mom, makeup caused her face to shine

Life is great, fluoxetine is working just fine!

Any thoughts of not wanting to be alive anymore?

The room fell silent, her eyes looking at the floor

I swallowed several pain pills last night!

In hopes that I should never see the daylight

Mom looked at her in dismay: I thought we were in the clear?

She has attempted before; the risk is always there my dear

You have your own struggles; I did not want you to stress

After all I am the one responsible for my mess

A peer at school bullies me all day long

Lost all my friends, I'm worthless, can't be strong

Have you been following up with a therapist?

Unfortunately, the one to take our insurance does not exist.

In this time of acute distress, I recommend inpatient hospitalization

A safe place to re-open conversation and attain medical stabilization

As I move on to my next encounter, in my mind I replay the scene

Had I not asked that question, how different it would have been

This poem was inspired by a clinical encounter during my Child and Adolescent Psychiatry fellowship at the University of Kansas Medical Center. What began as a routine outpatient follow-up revealed, through a single screening question, a recent suicide attempt by a teen who had appeared stable. The piece reflects on the tension between clinical progress and hidden emotional suffering, and the critical importance of asking direct questions ,even when things seem "better."

This poem serves as a reminder of the ongoing vulnerability many young patients face and the power of clinician presence, curiosity, and persistence in uncovering what might otherwise remain unspoken.

When Symptoms Improve but Life Doesn't: Addressing a Critical Gap in ADHD Treatment

Apurva Parikh, MD

You've met this child before. They start a stimulant, and the core symptoms improve—attention steadies, and hyperactivity settles. Yet daily life doesn't budge homework is a battle, transitions spark meltdowns, and school participation remains flat. Teachers note the child is "less distractible," but participation and productivity are unchanged. Parents see fewer restless behaviors, yet mornings and evenings remain chaotic. This is not an outlier; it is one of the most consistent patterns in ADHD research.

And yet, in busy clinics and school meetings, ADHD treatment is often framed as a straightforward sequence: diagnose, prescribe, titrate, adjust. If symptoms decrease, treatment is "working." If symptoms persist, treatment is "not working." But trials repeatedly demonstrate what clinicians see every day: symptom reduction and real-world functioning do not move in parallel. A child's ADHD-RS score may fall sharply while homework remains impossible, social conflict escalates, or mornings are still a battleground.

In practice, we do not treat symptoms. We treat the life the symptoms disrupt. But our language, metrics, and clinical routines remain fashioned around symptom checklists rather than the functional impairments that matter to families and schools. When we focus narrowly on symptoms, we risk missing what actually drives impairment—and we unintentionally create the appearance of "treatment resistance" where none exists.

Why Symptoms Dominate—and Why That Causes Problems

Symptom measures dominate ADHD care for understandable reasons. They drive regulatory approval, clinical trials, insurance requirements, and guideline development. As a result, they shape what clinicians and families learn to monitor. Parents are asked whether symptoms improved. Teachers fill out ratings. We titrate doses based on symptom change.

Meanwhile, the functional domains that make or break a child's life—peer relationships, frustration tolerance, working memory, task initiation, transitions, organization, family routines—are rarely assessed in a structured way. They often emerge indirectly, and only if someone remembers to ask. Families may not volunteer them, assuming they are "behavior issues," "personality," or something outside the scope of ADHD. Because these domains map only inconsistently onto standard symptom measures, a mismatch emerges: symptoms may improve while functioning does not.

This disconnect creates a blind spot. Children whose symptoms improve but whose impairments persist feel like "partial responders." Children with major functional gains but lingering symptoms get labeled "still impaired." Families and clinicians end up talking past each other because they are describing different worlds.

What Research Actually Shows

Across major ADHD trials, a clear pattern emerges when functioning is measured, medications do improve real-world outcomes, though typically with smaller effect sizes than for core symptoms. In the MTA trial, medication management produced improvements in classroom behavior and academic productivity, and combined treatment yielded additional benefits in social skills relative to routine care.[1] Likewise, Swanson and colleagues showed that OROS- methylphenidate improved on-task behavior and classroom productivity in multisite laboratory-school evaluations.[2]

Non-stimulant data show similar trends. In atomoxetine programs, Newcorn and colleagues demonstrated sustained improvements in overall functioning and psychosocial domains over maintenance phases, even at lower doses.[3,4] At the synthesis level, Coghill et al. documented consistent medication-related gains across quality-of-life, family functioning, and school participation, despite substantial variability in the measures used.5 Naturalistic longitudinal work similarly shows that consistent ADHD treatment is associated with better long-term academic, behavioral, and social outcomes, even as many impairments remain relative to peers.[6]

Although impairment defines ADHD, functional endpoints remain inconsistently collected and are frequently omitted from trial reporting.[7] Even newer treatments reflect this gap. Centanafadine, a first-in-class triple reuptake inhibitor, has recently demonstrated positive phase 3 symptom outcomes, with functional data not yet reported—underscoring the field's continued prioritization of symptom metrics over daily-life functioning.

The implication is straightforward: ADHD treatments often work, but our symptom-centric monitoring misses the daily life changes families care about. In practice, "the medication worked" may mean the ADHD-RS score fell while the child is still failing classes, struggling with transitions, or melting down at home. The more clinically meaningful question is not whether symptoms decreased, but whether the child can function more effectively at home, in school, and with peers.

In short, functioning matters, functioning changes, and treating symptom-only benchmarks risks missing the real goal: restoring participation in the environments where children live, learn, and grow.

What Truly Drives Improvement

In clinical practice, the functional problems that families struggle with most often arise from domains that extend beyond the core symptoms of ADHD. These include:

- Executive functioning: task initiation, working memory, organization, time management
- Emotional dysregulation: irritability, low frustration tolerance, reactive outbursts
- Social functioning: reciprocity, impulsive interruptions, misreading cues
- School participation: turning in work, sustaining productivity, navigating transitions
- Family routines: mornings, homework periods, bedtime, sibling conflict

These are not diagnostic symptoms, but they are the impairments shown across trials and longitudinal studies to improve only partially with medication alone.[1-7] They often reflect executive-skill demands, emotional-regulation capacity, environmental context, comorbidities, or school- and family-system factors—rather than stimulant responsiveness.

A Simple Framework to Reorient Care

Clinicians already ask about functioning, but often in broad strokes. A small, deliberate shift—making those questions more explicit—can bring functional impairment to the center of ADHD visits without adding time or instruments. The goal is not to replace symptom monitoring but to ensure that treatment decisions reflect the domains that research consistently shows do not improve in parallel with symptoms.

A brief, practical structure includes three anchor questions:

1. What is the child still unable to do? (Be concrete: initiating homework, managing transitions, morning routines, peer interactions.)
2. Where does impairment actually show up? (Home, school, and peer settings often diverge—and trials show these domains change at different rates.)
3. Which functional goals matter most right now? (For some families it is frustrating tolerance; for others it is organization or classroom participation.)

These questions do not dictate a specific treatment choice. Rather, they clarify which evidence- based domain requires attention next. Persistent difficulty with task initiation may point toward executive-function support; emotional outbursts may reflect affective dysregulation or anxiety rather than stimulant dose; school-only impairment may suggest timing issues or unmet classroom support; peer problems may prompt evaluation of social-cognition or comorbidity. Research across the MTA, atomoxetine maintenance trials, and functional outcome reviews underscores that these domains evolve partly independent of core symptom change—so identifying the functional barrier helps align treatment with the child's actual needs.

Why This Matters for Clinical Practice

Centering visits on functioning offers several practical benefits:

- Families feel heard because the conversation reflects the challenges shaping daily life.
- Schools receive clearer guidance on supports that map onto specific impairments.

- Treatment adjustments become more targeted, especially when symptoms improve but participation does not.
- Clinicians avoid mislabeling cases as "treatment resistant" and instead uncover the underlying domain—executive, emotional, academic, social—that needs attention.
- Children experience improvements that matter developmentally: smoother transitions, better participation, and greater predictability at home and school.

Ultimately, ADHD is a disorder functioning in real-world environments. Symptoms matter, but functioning is where children live—and where the literature shows gains can lag unless identified directly. As the field integrates dimensional measures and balances pharmacologic with behavioral and school-based interventions, placing functional impairment at the forefront is both practical and evidence-aligned. Measuring what matters helps ensure that symptom improvement translates into meaningful change in children's everyday lives.

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Avatar Creation as a Therapeutic Tool in Youth Psychiatry: Insights from Self-Concept and Media Identity Research

Karolina Kalata, MD

The process of self-representation in digital environments has psychological implications for adolescents struggling with body image concerns, gender dysphoria, and self-esteem. McCall and Simmons' role-identity model suggests that media allows individuals to construct idealized versions of themselves, shaping self-concept through virtual self-representations, also known as avatar identification. Recent studies on avatar identification have demonstrated that personality traits, self-esteem, and gender identity influence how individuals modify their avatars, reinforcing the connection between digital self-construction and real-world self-perception.

Objective:

This literature review examines the role of avatar creation in understanding youth self-concept, body image, and identity development, highlighting its potential as a clinical tool in child and adolescent psychiatry.

Key Findings:

- **Self-Concept and Idealized Identity:** Individuals with lower self-esteem or body dissatisfaction often design avatars that reflect how they *wish* to be seen rather than how they perceive themselves in real life. This tendency to create an idealized virtual self may serve as a form of escape or self-enhancement. Over time, however, this growing reliance on an aspirational avatar can contribute to an increasing disconnect between one's real and ideal self-concept and a pattern that has been observed in those struggling with gaming disorder.
- **Personality and Avatar-Self Discrepancy:** Studies indicate that introverts and those with high neuroticism are more likely to create idealized avatars, while individuals scoring high in openness experiment with diverse avatar traits, including gender fluidity and appearance modifications.
- **Gender Identity and Exploration:** Transgender and gender-diverse adolescents frequently use avatars as a means of gender exploration and affirmation, utilizing virtual spaces as a safe environment for self-discovery.
- **Clinical Implications:** Stronger avatar identification has been linked to both positive self-expression and potential psychological vulnerabilities, such as problematic gaming. The literature suggests that integrating avatar-based discussions into psychiatric evaluations could offer valuable insights into youth self-perception and emotional distress. Studies on Serious Video Games (SVGs) and therapeutic gaming interventions have demonstrated that interactive digital tools can improve emotional regulation, impulse control, and cognitive flexibility—key areas of difficulty for individuals with psychiatric illnesses, including disordered eating behaviors. By allowing patients to externalize and manipulate their body image in a virtual space, avatar creation could serve as a valuable clinical tool for assessing body dissatisfaction and identity-related distress.

Recent studies on avatar identification have demonstrated that personality traits, self-esteem, and gender identity influence how individuals modify their avatars, reinforcing the connection between digital self-construction and real-world self-perception.

Avatar creation serves as more than just a recreational activity, with utility as a reflective learning tool that allows individuals to project and explore their self-concept in a controlled environment. By leveraging digital self-representation in clinical settings, psychiatrists can gain a deeper understanding of how adolescents perceive their bodies and identities, opening new pathways for therapeutic interventions in gender dysphoria, eating disorders, and self-esteem-related conditions.

AACAP Joins the Opioid Response Network

AACAP's Continuing Medical Education (CME) and Research, Grants, and Workforce Departments are pleased to announce that in September 2024, AACAP became a subrecipient of the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded *Opioid Response Network (ORN)* (1H79TI088037) through the American Academy of Addiction Psychiatry. This up to 3-year grant, totaling over $155,000, will provide educational resources on substance use and mental health in youth. AACAP's primary activity is to create two AACAP Clinical Essentials courses on youth substance use-related topics such as risk mitigation, opioid use, and stigma. Funding will support the dissemination of the courses free of charge to a multidisciplinary audience.

Clinical Essentials courses are physician member-curated, online, on-demand CME courses consisting of AACAP Annual Meeting recorded presentations. The *Clinical Essentials on Increasing Motivation and Decreasing Stigma Among Youth With Substance Use Disorders* **course** was launched on November 25, 2024. It offers 2.5 CME credits and includes a pre-test, videos, post-test, and an evaluation. The presenters include AACAP members, **Drs. David Atkinson, Jesse D. Hinckley, Peter Jackson, Scott Krakower,** and **Amy Yule.**

Release of the First Clinical Essentials Course

Response to the release of the course has been enthusiastic. As of May 31, 2025, 536 people enrolled in the course. This number represents a significantly larger audience than typical. Of the 536 enrollees, 346 (65%) completed the course evaluation. To date, the course has received an overall rating of 4.7 out of 5 and 40% of learners said they acquired new knowledge, skills, and techniques from the course.

Most of the audience reported their credentials as MDs (299) and DOs (24). However, to align with the ORN grant aims, this course was marketed and promoted to a boarder audience of clinical, substance use, and behavioral health professionals. Attendance has included: nurse practitioners (7), physician assistants (2), counselors (3), registered nurses (2), clinical manager (1), and a certified peer recovery specialist (1). Testimonials about the course from a few learners include:

- "The motivational interviewing techniques and family interventions offered useful information on supporting patients and their families."–Child and Adolescent Psychiatrist
- "I plan to use non-stigmatizing language with my patients and families."–Pediatric Endocrinologist Physician Assistant
- "This was a great course to give me a deeper understanding of how to speak and work with individuals with SUDs."–Nursing Student

More About the Opioid Response Network

Established in 2018, ORN is funded through SAMHSA's State Opioid Response/Tribal Opioid Response—Technical Assistance program led by the American Academy of Addiction Psychiatry (AAAP) in collaboration with a large coalition of more than 46 national professional organizations, currently including AACAP. The ORN provides technical assistance by way of free training and education that is evidence-based and designed to meet the needs of communities or organizations.

The target audience for the technical assistance includes states, cities, Tribal communities, Native organizations, health professionals, organizations, the justice system, law enforcement, and individuals. Through training and education via local consultants with expertise and experience in all states and territories, ORN focuses on applying evidence-based practices in risk mitigation, prevention, treatment and recovery to meet locally identified needs.

Some examples of ORN technical assistance activities:

Prevention

- Training to increase community awareness of substance use disorders
- Training and educational resources on creating anti-stigma campaigns
- Distribution of naloxone/NARCAN® to deter overdose

Treatment

- Training on evidence-based treatments, including the three FDA-approved medications for treating opioid use disorder
- Use of psychosocial interventions and guidance on working in rural areas and with Tribal communities

Recovery

- Training on recovery coaching models
- How to create peer-to-peer recovery services in communities, healthcare settings and correctional facilities

Risk Mitigation

- Address individual and community factors related to risk mitigation, such as naloxone distribution and administration, HIV and viral hepatitis testing, and stigma
- How to form collaboration between risk mitigation and other community efforts

The process of submitting a request for educational resources, training, and consultation begins by submitting a request form at **OpioidResponseNetwork.org.** The request is forwarded to the Technology Transfer Specialist (TTS) in the state/territory, who becomes the point of contact and will determine needs and next steps with the requester.

Become an ORN Consultant

AACAP members who have experience and expertise in the assessment and treatment of opioid use disorders can become ORN consultants. Consultants foster collaboration, provide education and support the implementation of local, evidence-based solutions. Your experience and knowledge in youth mental health, prevention, treatment, risk mitigation, and/or recovery will help others. If you are interested in training, consultation, technical assistance, and program implementation across the continuum of care for youth with or at risk of opioid and other substance use disorders, you may consider joining the team of consultants at **OpioidResponseNetwork.org/JoinUs**.

From the Heart: Cross-Cultural Mental Health Dialogues in Mandarin

Mengyao "Miya" Li, Darlina, MD & Liu, Jessica Ouyang, MD

Many of us can still remember the first time we tried to explain our choice of medical specialty—child psychiatry—to our families. It rarely ended with a single or a few conversations. Instead, it was a process, sometimes stretching over years, of careful translation, patient listening, and gentle reshaping of deeply rooted beliefs.

Miya's grandmother, once the very first obstetrician/gynecologist in her rural hometown in Yunnan Province of China, paused in confusion and asked her, "Why would children need to see a psychiatrist? Aren't they too young to go mad?" Darlina's and Jessica's families had similar questions. They worried that working with people with mental health problems might be dangerous, contagious, or simply a waste of medical training to not become a "real doctor."

At face value, these questions can seem ignorant or insensitive at best, cruel and condescending at worst. Yet their questions reflected what so many in our communities believe: that mental illness is something shameful, something to be feared, something that simply doesn't happen to "good families" or "well-behaved children." In many Asian cultures, mental health has long lived in the shadows, shrouded in stigma and silence. As we began our training to become mental health physicians, slowly and tentatively, we began having these cross-cultural mental health dialogues, sometimes in bits and pieces of English and Mandarin.

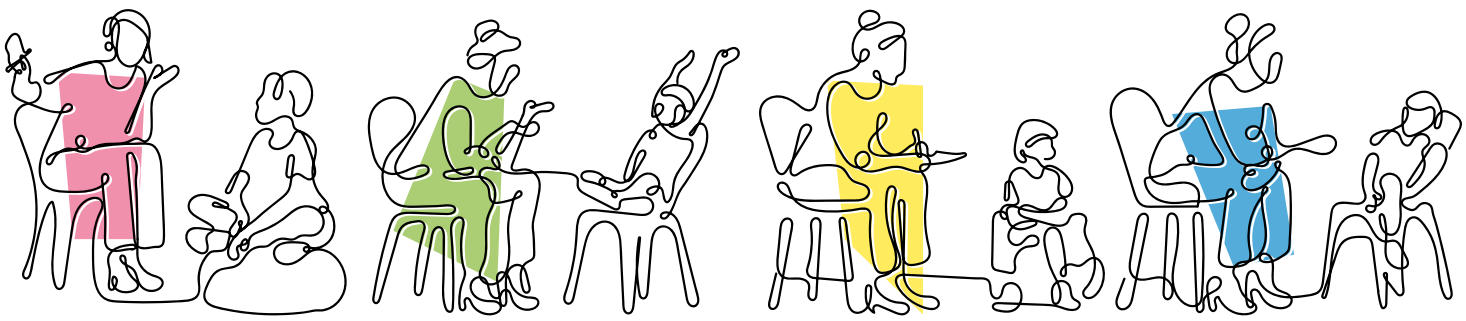
That moment of transformation, when silence turns into speech, is what brought our group together at the 2024 AACAP Asian Caucus meeting. Darlina had been looking for resources to improve her Mandarin language skills with mental health terminology, but she could not find any. At that meeting, she shared that frustration and found many others, from different corners of the country and the world, with a similar goal in mind, creating more accessible mental health resources for Mandarin-speaking patients and their families. By combining our skills, including our podcasting, clinical, and language abilities of different capacities, we collectively created a podcast that speaks to the heart of our communities.

We named the podcast "心理话"—a Mandarin pun that means both *"talking about mental health"* and *"speaking from the heart."* In English, we call it "From the Heart: Cross-Cultural Mental Health Dialogues." The title reflects our dual mission: to provide culturally sensitive, linguistically accessible education for Mandarin-speaking families, and to affirm their lived-experience with compassion.

We chose to record the podcast in Mandarin, the most widely spoken language in Asia, and one that still carries the voices of our childhoods. As first-, 1.5-, and second-generation immigrants, we wanted to speak directly to youth and families caught between cultures, generations, expectations, and learned beliefs. We wanted to provide not only information and knowledge, but also reassurance: *You are not alone. You can talk about this.*

Eight episodes are planned for our first season:

Episode 0: Introducing "From the Heart": In this trailer episode, we share our personal journeys, cultural backgrounds, and paths to becoming psychiatrists.



Episode 1: Mental Health & Stigma: We discuss overcoming the stigma of mental health in Asian culture, and our experiences advocating for mental health in Asian communities.

Episode 2: Your Child's School Performance: We review some reasons for challenges in school performance and offer strategies for communication and support.

Episode 3: Cultural Roots of Depression: We reflect on generational trauma, unspoken expectations, and cultural expressions of emotional pain.

Episode 4: Symptoms of Depression: We describe somatic manifestations of depression, which can occur more frequently in Asian populations, and how to recognize these signs and symptoms.

Episode 5: ADHD: Understanding the Basics: We provide an overview of ADHD and neurodevelopmental disorders, including causes, symptoms, and the diagnostic process.

Episode 6: Thinking about Anxiety: We will cover anxiety and panic disorders, from diagnosis to treatment. We will differentiate between OCD and OCPD.

Episode 7: Understanding Substance Use & Addiction: We will talk about common behavioral addictions in youth, including navigating screen time and problematic video game use. In addition, we will begin discussing substance use disorders.

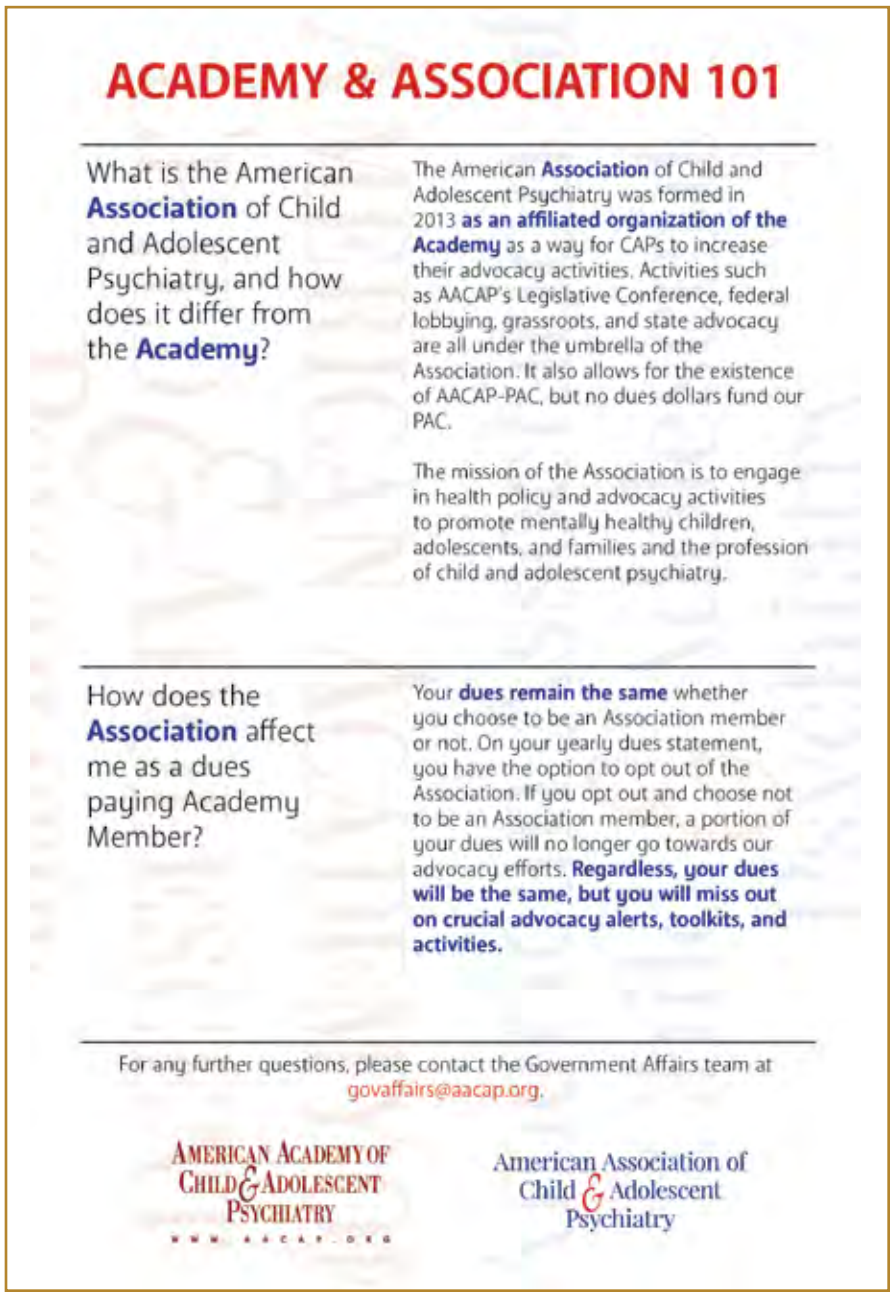
Episode 8: Navigating the Healthcare System: We will reflect upon the challenges of navigating the healthcare system by sharing our personal experiences.

A new episode will be released each month. Our six-member team span across multiple states, ranging from fourth-year medical students to early-career attendings, hope these episodes help Mandarin-speaking patients and their families as well as Mandarin-speaking mental health clinicians who wish to brush up on their language skills. This labor of love began as a professional collaboration, and has become a source of friendship, mentorship, and renewal space to reflect, grow, and honor our dual identities as psychiatrists and cultural bridge-builders.

We warmly invite you to use our podcast as a supplemental educational tool for your Mandarin-speaking patients and their families. Our first episode has been launched on Spotify and Apple Podcasts. Simply search for "Mental Health in Mandarin" to listen.

And if our mission resonates with you—we welcome you to join us. Mandarin-fluent colleagues interested in contributing to future episodes can reach out to us at mentalhealthinmandarin@gmail.com.

Let's keep the dialogue going. Let's speak from the heart.



ACADEMY & ASSOCIATION 101

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

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

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

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

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

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

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
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Being an AACAP Owl

AACAP Members qualify as Life Members when their age and membership years total 103, with a minimum age of 65 and continuous membership.

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

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

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Every effort was made to list names correctly. If you find an error, please accept our apologies and contactthe Development Department at **development@aacap.org**.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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Policy Statement on the Care of Pediatric Patients Awaiting Psychiatric Care in Emergency Departments

Background

Limited availability of inpatient psychiatric beds leads to the practice of "boarding" patients in emergency departments (EDs) or other acute medical settings. The Joint Commission defines "boarding" as the practice of holding patients in the emergency department or another temporary location after a decision has been made to admit or transfer them.

While the Joint Commission recommends boarding times not exceed 4 hours, national averages can be days to weeks or even longer. Risk factors associated with prolonged boarding include younger age, behavioral escalation, homicidal ideation, concurrent chronic physical illness or somatic complaints, comorbid eating disorder, comorbid neurodevelopmental disability, serious mental illness (e.g., mania, psychosis, and severe suicidal behavior), and youth with complex psychosocial situations (e.g. attachment difficulties, foster care involvement, unstable insurance status).

Though boarding in the ED may provide a safe environment, it often lacks access to ongoing, evidence-based mental health evaluation and treatment needed to address clinical needs of this acute patient population. This is a missed opportunity for stabilization and, for some patients, consideration of potential discharge to a lower level of care in the community. Furthermore, prolonged boarding can negatively impact patient and family wellbeing, increase the risk of further behavioral escalation, and can significantly impact ED workflow and resource utilization.

To improve the care of pediatric patients awaiting psychiatric care in emergency departments, the American Academy of Child and Adolescent Psychiatry recommends:

- Working with stakeholders to provide a therapeutic, safe environment for mental health care delivery, support structure, and activities of daily living in emergency departments, inpatient psychiatric units and outpatient mental health care programs.
- Support for training and education of both mental health and non-mental health professionals in the assessment and management of pediatric psychiatric concerns in emergency and crisis settings.
- Advocacy and funding for the research and development of evidence-based diversion protocols and implementation of clinical pathways and alternate services to support youth boarding in emergency and crisis settings.
- Mental health parity for all patients and equity for all populations to have timely access to both higher (inpatient) and lower (partial hospitalization, crisis, or outpatient) levels of psychiatric care that best meet patients' needs.

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 July 202

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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Policy Statement on Expanding Access to Care for the Autism Community

Background

With the continued rise in the prevalence of autism spectrum disorder (ASD), both with and without co-occurring intellectual developmental disorder (IDD), clinical services are experiencing increasing strain, resulting in treatment delays. Health professional workforce shortages in autism-related child healthcare services and the evolving developmental challenges faced by patients with autism across the lifespan both contribute to challenges in delivering timely, individualized care. And, despite most states mandating insurance coverage for ASD-related services, mandates may not apply to all plans and to all ASD treatment options.

Providers typically recommend that families of children with autism seek applied behavioral analysis (ABA) for their child to improve social interaction, communication, and adaptive skills. However, research suggests that a broader range of developmental interventions is also effective in enhancing skills in these domains. Examples of other effective interventions that focus on improving social communication skills include developmental relationship-based interventions (DRBI) and naturalistic developmental-behavioral interventions (NDBI). Given long waitlists, workforce shortages, and restrictive insurance policies, it is crucial for providers to inform families about all effective treatment options and to prioritize timely access to care.

To ensure that all patients and families impacted by ASD/IDD have access to the full range of ASD/IDD interventions, the American Academy of Child and Adolescent Psychiatry (AACAP) recommends:

1. Physicians and other clinicians should consider a full range of evidence-based treatment options—not just ABA—when recommending care for individuals with ASD/IDD.
2. Public policies should support the training of qualified professionals to provide timely, evidence-based interventions and promote appropriate telehealth use to improve access to care.
3. Insurance policies should cover the entire continuum of evidence-based interventions for ASD/IDD across the lifespan, avoiding rigid, predetermined lists of approved treatments.

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 2025

CLASSIFIEDS

Company: Johns Hopkins All Children's Hospital (1336635)
Title: Child & Adolescent Psychiatry: Consultation-Liaison Service/Outpatient
Job ID: 21748297
URL: https://jobsource.aacap.org/jobs/21748297

Job Description:
Johns Hopkins All Children's Hospital (JHACH) in St. Petersburg, FL is recruiting a Child & Adolescent Psychiatrist to join our growing team. This position is predominately outpatient, with allocated time for consultation-liaison (C/L). Highlights of this opportunity include: JHACH is a 259-bed teaching hospital, ranked as a U.S News & World Report Best Children's Hospital in 8 pediatric specialties (2025-2026). We were also ranked as the #1 Children's Hospital in Florida for the third consecutive year. Our current team consists of 4 child and adolescent psychiatrists (including a new hire) and over 20 psychologists. The Pediatric Psychiatry Program at JHACH provides evaluation and treatment for a wide range of conditions and sees new patients ranging in age from approximately three years to age 17. Established patients are seen until the age of 21 in order to assist in the transition to adult care. At present, JHACH does not have an inpatient psychiatric unit. The ideal candidate will have demonstrated experience in pediatric C/L psychiatry along with the desire to play a key role in expanding behavioral health services to hospitalized youth through the delivery of complementary and collaborative services with our Psychology C/L team, including psychologists, psychology interns, and postdoctoral fellows. This individual will provide consultation to our extensive team of pediatricians, pediatric specialists, and pediatric surgeons on a broad range of issues. (Dedicated time will be allotted for the C/L component of the practice). JHACH stands at the forefront of discovery, leading innovative research to cure and prevent childhood diseases while training the next generation of pediatric experts. As the academic component of our practice continues to expand, our preference is to hire a physician that has an interest in clinical care along with medical education/academics. Teaching opportunities are plentiful and include child psychiatry fellows from University of South Florida (USF), JHACH psychology interns and fellows, pediatric residents from the JHACH and the USF residency programs, Nurse Practitioners, and medical students. Qualified candidates are eligible for a faculty appointment at both the Johns Hopkins University School of Medicine and the University of South Florida. There are many opportunities for physicians to develop clinical, educational, and research interests. Tampa-St. Petersburg offers year-round sunshine, abundant cultural and recreational activities, sports venues, and excellent schools. We are centrally located to many of Florida's top attractions, minutes from the beautiful Gulf beaches, 90 miles from Orlando, and four hours from Miami. Florida has no state income tax. To learn details, please contact: Joseph Bogan Providence Healthcare Group (682) 343-4700 (Direct Office Phone) jbogan@provdoc.com

Company: I Am Boundless (1413721)
Title: Medical Director/ Psychiatrist
Job ID: 21758037
URL: https://jobsource.aacap.org/jobs/21758037

Job Description:
About I Am Boundless: I Am Boundless, Inc. is a mission-driven nonprofit organization that provides lifelong support to individuals with intellectual and developmental disabilities (IDD), autism, and behavioral health challenges. We are committed to delivering high-quality, person-centered care that empowers the people we serve to live lives of meaning, connection, and dignity. Position Summary: The Medical Director / Psychiatrist provides clinical leadership and medical oversight for both residential IDD services and behavioral health programs. This dual role ensures medical and psychiatric care is integrated, evidence-based, trauma-informed, and compliant with all regulatory and ethical standards. The ideal candidate brings deep clinical expertise, a collaborative spirit, and a passion for serving individuals with complex needs in a community-based, nonprofit setting. Key Responsibilities: Leadership & Oversight–Serve as the senior clinical authority for all medical and psychiatric matters affecting individuals in residential, group home, and outpatient behavioral health services.–Develop, review, and update medical and psychiatric policies and protocols in accordance with Ohio Revised Code, DODD Rule 5123-2-02, Medicaid, and CARF standards.–Provide oversight to licensed medical professionals and collaborate closely with nursing, therapy, and direct support teams to ensure continuity and quality of care. Psychiatric Services–Conduct psychiatric evaluations, medication management, and crisis interventions for individuals with IDD and co-occurring mental health or behavioral challenges.–Participate in interdisciplinary treatment planning and collaborate with family members, guardians, and outside providers to promote holistic, person-centered care.–Lead or supervise psychiatric staff and clinical decision-making processes within behavioral health services. Quality, Compliance, & Risk Management–Ensure all medical and psychiatric services are documented accurately and delivered in compliance with state and federal regulations.–Contribute to quality assurance efforts, critical incident reviews, and continuous improvement initiatives across service lines.–Serve as a liaison with external medical providers, hospitals, and regulatory agencies. Education & Consultation–Provide training and consultation to staff on topics such as psychotropic medications, mental health diagnoses, crisis de-escalation, and medical conditions common in IDD populations.–Stay current on emerging best practices and innovations in behavioral health and developmental medicine. Required Qualifications:–Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) with active licensure in the State of Ohio–Board certified or board eligible in Psychiatry; additional certification in Child/Adolescent Psychiatry or

Addiction Medicine is a plus–Minimum 3–5 years' experience working with individuals with IDD and/or behavioral health conditions in community-based or residential settings–Strong understanding of person-centered, trauma-informed, and recovery-oriented care models–Familiarity with DODD, Medicaid, and nonprofit healthcare systems–Excellent leadership, communication, and organizational skills Preferred Qualifications:–Prior experience in a Medical Director or supervisory role–Experience working in a nonprofit, managed care, or behavioral health setting–Knowledge of electronic health records (EHR) and integrated care systems Work Environment:–Combination of telehealth, administrative, and in-person visits across residential and outpatient locations in Central Ohio–Flexible schedule with part-time or full-time options, depending on organizational needs and candidate preference–Occasional on-call or crisis consultation availability may be required Compensation & Benefits:–Competitive salary based on experience and role structure (PT/FT)–Comprehensive benefits package including health insurance, dental, vision, PTO, retirement plan, and CME allowance (for full-time roles)–Malpractice insurance provided Join Us: As a vital part of the I Am Boundless leadership team, the Medical Director / Psychiatrist will help shape the future of inclusive, community-based care for individuals with developmental and behavioral health needs. This is more than a job—it's a mission. If you believe in the boundless potential of every person, we invite you to join our team.

Company: ECU Health (1395640)
Title: Child & Adolescent Psychiatrist Jobs in Greenville, NC
Job ID: 21758334
URL: https://jobsource.aacap.org/jobs/21758334

Job Description:
ECU Health Physicians and The Department of Psychiatry and Behavioral Medicine at East Carolina University's Brody School of Medicine, located in Greenville, North Carolina, are expanding and seeking fellowship trained BE/BC Child Adolescent Psychiatrists. Inpatient and outpatient physicians are needed. New graduates and Visa candidates are welcome to apply. ECU Health is opening a state-of-the-art, 144-bed behavioral health hospital very soon. The new facility will serve as a center of excellence dedicated to the mental health needs of pediatric, adult, and geriatric patients. Located less than a mile from ECU Health Medical Center, the hospital will offer comprehensive inpatient and intensive outpatient treatment options. With an affordable cost of living, mild winters and close proximity to the North Carolina Coast, Greenville is an excellent place to call home. Highlights include: Employment by ECU Health Physicians Growing 9-hosptial private not for profit healthcare system with locations across eastern North Carolina Inpatient and outpatient opportunities are available as well as the opportunity to provide some telehealth services Inpatient providers will have hospital privileges at ECU Health Medical Center, Greenville, NC, one of four academic medical centers in North Carolina, and at the new behavioral health hospital Academic appointment with the Department of Behavioral Health and Psychiatry at East Carolina University's Brody School of Medicine Opportunity to participate in the teaching of medical students and/or residents and if desired to conduct research Referral network includes 29 county service area with a population of 1.4 million people Opportunities exist for student loan repayment from the North Carolina Medical Society and The North Carolina Office of Rural Health Competitive Compensation and Comprehensive Benefits including relocation For more information, please contact Shelly Harrington at 252-417-8975 or by email Shelly.Harrington@ecuhealth.org. ECU Health Physicians ECU Health is a mission-driven, 1,708-bed academic health care system serving more than 1.4 million people in 29 eastern North Carolina counties. The not-for-profit system is comprised of 13,000 team members, nine hospitals and a physician group that encompasses over 1,100 academic and community providers practicing in over 185 primary and specialty clinics located in more than 110 locations. The flagship ECU Health Medical Center, a Level I Trauma Center, and ECU Health Maynard Children's Hospital serve as the primary teaching hospitals for the Brody School of Medicine at East Carolina University. ECU Health and the Brody School of Medicine share a combined academic mission to improve the health and well-being of eastern North Carolina through patient care, education, and research. www.ecuhealth.org ECU Health Physicians includes an academic practice model (ECU employment) and a community practice model (health system employment). There is shared leadership and shared services to support the overall group and to ensure alignment for clinical care, research, education, and strategy. This innovative structure creates opportunities within ECU Health Physicians ranging from acute to ambulatory, academic practice to community practice, regional to rural, and everything in between. Greenville, NC Widely recognized as the thriving cultural, educational, economic, and medical hub of eastern North Carolina, Greenville is the 10th largest city in the state with a metropolitan population of nearly 100,000. The Dickinson Avenue Arts District offers vibrant arts, music, culinary and festival scene in the Uptown Greenville district. Greenville is also home to East Carolina University, the Brody School of Medicine, and Pitt Community College. Excellent affordability, convenient location, and natural resources combined with all of the amenities of a metropolitan university town, Greenville is the perfect place to live, work and play! Located inland off of the North Carolina coast, Greenville is 45 miles east of interstate 95, just over an hour to Raleigh, a little over an hour to the pristine beaches of the Crystal Coast of NC Home to East Carolina University (ECU), a vibrant university with an annual enrollment of more than 24,000 students Numerous waterways and the Greenville Greenway System are perfect for boating, kayaking, fishing, hiking and camping Mild climate perfect for year-round outdoor activities Cost of living below the national average, diverse and affordable housing and excellent educational opportunities, both public and private Investment of more than $500 million in downtown Greenville's revitalization bringing new restaurants, shops, businesses, and residents to the area

Company: Maine Health (1410222)
Title: Fellowship Program Director, Division of Child & Adolescent Psychiatry
Job ID: 21764369
URL: https://jobsource.aacap.org/jobs/21764369

Job Description:
The Department of Psychiatry at Maine Health Maine Medical Center Portland (MHMMCP) is seeking a fellowship-trained and board-certified Child and Adolescent Psychiatrist to serve as the Child and Adolescent Psychiatry Fellowship Program Director and join a community-focused practice serving a both rural and urban population. Successful candidates will be gifted clinician-educators committed to improving the lives of children and adolescents, and excited to work with a team of like-minded colleagues. The Child and Adolescent Psychiatry Division offers evaluation and treatment of pediatric patients with a wide range and complexity of illnesses. We work closely with our primary care and specialty care partners. Our clinical staff includes psychiatrists, psychologists, and clinical social workers. Our care continuum also includes Spring Harbor Hospital and Maine Health Behavioral Health, a region-wide comprehensive mental health organization. MHMMCP also includes the Barbara Bush Children's Hospital, the state's only pediatric tertiary care center, and only Level 1 Trauma Center. The Emergency Department has 63 beds, including a 6-bed Acute Psychiatry Unit. In addition to clinical care, we provide a major teaching resource for MHMMC. We train and mentor Psychiatry residents, Pediatrics residents, Tufts University School of Medicine medical students, and Social Work and Psychology interns. We have a culture of continuous quality improvement and our performance in the areas of safety, quality, and satisfaction are consistently excellent. Physicians are expected to apply for faculty appointment to the Tufts University School of Medicine. The Program Director (PD) has full responsibility, authority, and accountability for program administration and operations; teaching and scholarly activity; resident recruitment and selection; evaluation, promotion, and discipline; supervision; and faculty development. The PD is charged with developing and maintaining a training plan aligned with ACGME Common and Program-Specific Requirements and ensuring that all aspects of the program meet accreditation standards. There are robust opportunities to grow and develop teaching experiences and work with both residents and medical students. Our psychiatrists enjoy the benefits of a reasonable call schedule, generous time off and CME days, a substantial CME stipend, generous retirement plans, and comprehensive health insurance options. Maine Health Medical Group is committed to creating an equitable, inclusive environment that is welcoming to diverse faculty. Situated on the Maine coast, Portland offers the best of urban sophistication combined with small-town friendliness. The area provides four season recreational opportunities, such as skiing, hiking, sailing, and miles of beautiful beaches. Just two hours north of Boston, this is a diverse and vibrant community. To learn more about our system please visit www.mainehealth.org and our benefits page.

Company: San Ysidro Health–San Ysidro, CA (1412951)
Title: Child & Adolescent Psychiatrist
Job ID: 21721251
URL: https://jobsource.aacap.org/jobs/21721251

Job Description:
Position Summary: The Child & Adolescent Psychiatrist is responsible for performing psychiatric assessments, medication management, and diagnostic evaluations of patients as part of an interdisciplinary treatment team in a higher level of care program. Evidence-based pharmacological services are provided to children, adolescents, and young adults in the primary care setting. This provider also works in a consultant role with behavioral health clinicians and primary care providers to develop and implement sound treatment plans for patients with physical health, mental health and/or substance use issues, responds to and provides crisis intervention services when needed, ensures behavioral health services are delivered in a culturally appropriate fashion and is consistent with State of California laws and regulations, professional standards of care, agency guidelines, and professional ethical guidelines. Potential leadership opportunities also available. Essential Functions of the Job: Provide direct psychiatric evaluation and evidenced-based pharmacologic treatment, focusing on patients with diagnostic or therapeutic challenges identified in discussion with the patient's BH clinician and / or pediatric provider. Provides consultation to clinical staff and primary care providers (PCPs) as needed regarding the client's care, treatment recommendations, and progress via documentation in the client's record, face-to-face or telephone. Actively participates in Quality Assurance activities of the department with regard to treatment Utilization Review, medication monitoring, peer review, procedures, and processes. Completes all required documentation in a timely fashion including the preparation of reports and written documentation, notes, and medical records, all other forms, and documents as required by the department, company, state, and federal agencies. Participates in the development and delivery of in-service training for primary care-based providers including medical residents and staff regarding the current understanding of best practices for the recognition and treatment of behavioral health conditions in primary care as requested. Performs crisis interventions as needed including but not limited to conducting suicide assessments and making recommendations to medical providers and patients; determines if crisis response services are appropriate for patient safety. Works in coordination with the Chief Behavioral Health Officer and Director of Psychiatry to ensure full integration of services and a team-based approach to care. Participates in treatment team meetings and committees as needed. May be asked to participate in regularly scheduled supervision of fellowship trained PMHNPs via video or in person. Maintains productivity expectations in accordance with clinic/program guidelines. Performs other job-related duties as assigned. Other Responsibilities Complies with established departmental and health center-wide policies and procedures, objectives, quality assurance

program, safety, environmental, and infection control standards. Ability to organize, set priorities, and exercise sound independent judgment within areas of responsibility. Ability to be culturally sensitive and appropriate in working with underserved and marginalized communities. Establishes and maintains effective working relationships with clients, family members, other professional staff, and the public. Enhances professional growth and development through participation in educational programs, current literature, in-service meetings, and workshops Assists in providing supervision of interns and/or unlicensed staff under the specification of license held as requested. Coordinates with other consulting psychiatrists and/or PCPs for vacation coverage as needed to ensure continuity of patient care. Ability to adapt to practice settings which include in person, tele video, and telephonic, with a flexible and patient-centered approach.

Job Requirements:
Job Requirements Education Minimum: Successful completion of M.D. or D.O. Graduation from an accredited Psychiatric Residency Program. Completion of an accredited Child & Adolescent Psychiatry Fellowship Program. Certification/registration: Current non-restricted medical license to practice in the State of California. Active DEA license. Board certified or board-eligible in child and/or adult psychiatry. Experience Minimum: Combination of education and years of experience as specified above. Sensitivity to multi-cultural concerns and the psychotherapeutic process required. Experience with outpatient community psychiatry desired. Verbal and Written Skills Required to Perform the Job: Fluency in English required. Fluency in Spanish preferred. Communicate clearly and concisely, both orally and in writing. **Technical Knowledge:** Knowledge of rehabilitation and recovery treatment modalities. Integrated Treatment and Care for individuals with co-occurring disorders. Demonstrate the ability to be culturally sensitive and appropriate in working with minority communities. Demonstrate respect for diversity. Knowledge of behavioral medicine, health psychology, and substance use disorder interventions including IMPACT and/or SBIRT model. Exercise tact, objectivity, sensitivity, strategy, and judgment in dealing with a variety of people with a variety of co-occurring disorders. Organize, set priorities, and exercise sound independent judgment within areas of responsibility. Establish and maintain effective working relationships with clients, family members, other professional staff, and the public. Working Conditions: Standing/walking/lifting. Assisting patients transferring from a wheelchair Psychiatric care is provided with a hybrid model of in person and tele video. You may be asked to travel to any satellite facilities. You may be asked to work from home on a telemedicine day. If you are unable to work from home, an office space at an alternative site other than your usual clinic may be offered. Universal Requirements Pre-employment requirements include I-9, physical, positive background, reference check results, complete application, new hire orientation, pre-employment PPDs.

Company: Ascension St. Vincent (1396612)
Title: Child & adolescent psychiatrist
Job ID: 21766768
URL: https://jobsource.aacap.org/jobs/21766768

Job Description:
Ascension St. Vincent is looking for a child & adolescent psychiatrist for the St. Vincent Anderson Center. This is a Behavioral Health Facility with a full continuum of care for adults and adolescents We have an 8 Bed Adolescent Inpatient unit, 15 Bed Adolescent Residential Program, Day School Program , Adolescent IOP and traditional outpatient clinic for children, adolescents and adults We also provide Adult Inpatient, IOP and Traditional Outpatient for Mental Health and Addiction Schedule: Monday through Friday 8-4:30- Schedule can be flexible Call Schedule: One night Practice Detail: We are seeking a psychiatrist to join our elite team. EMR System: Athena/Allscripts Competitive base salary, Production/quality bonus potential, starting bonus Relocation allowance, CME, Comprehensive health benefits, Retirement savings plan (403b) with match Malpractice with tail coverage, Generous paid time off About Anderson, Indiana has a rich, multicultural quality of life and low cost of living and is a growing town located just 34 miles northeast of Indianapolis with easy access to some of the greatest attractions. Located in Madison County, you'll discover historic architecture, unique museums, ballet, fine arts, the symphony, live horse racing, live motor racing, Mounds State Park, and much more. With so much to see and do, there really is something for everyone. Indiana has an excellent business climate and some of the lowest housing and utility costs in the country. Indiana is also home to some of the nations' top school districts and offers an abundance of cultural and recreational opportunities including professional sports that will appeal to every family member.

Company: CHI Health Clinic (1345427)
Title: Child and Adolescent Psychiatrist
Job ID: 21769743
URL: https://jobsource.aacap.org/jobs/21769743

Job Description:
CHI Health Clinic and Creighton University School of Medicine are recruiting a Child and Adolescent Psychiatrist for their growing department, located in the metropolitan community of Omaha, Nebraska. Whether you are looking for inpatient or outpatient practice models, the CHI Health network has the flexibility to fit your career goals. This opportunity includes Multidisciplinary Team of Mental Health Professionals Option to build your preferred practice model (Inpatient, Outpatient, or a blend) Hybrid model option for some tele outpatient visits Monday–Friday schedule with a shared call rotation Faculty Appointment from Creighton University School of Medicine Provide clinical supervision and instruction for psychiatry residents and fellows as needed. Serve as a mentor for junior and new hire psychiatrists. Full primary care support and referrals To Learn more about us visit us on the web: https://www.chihealth.com/services/behavioral-care https://www.creighton.edu/medicine/departments/psychiatry Benefits While you are busy caring for your patients, we will take care of you and your family with benefits that include: Medical/dental/vision insurance plans Flexible Spending Account or Health Savings Account

Retirement plans Relocation assistance, if eligible Prescription program Employer paid life insurance Short and long term disability programs Malpractice; including tail coverage Time away As a non-profit; CHI is eligible for the Public Service Loan Forgiveness Program Mental health and well-being programs Are you looking for a place where you can build a rewarding medical career while enjoying a great quality of life? Consider Omaha! Omaha offers a compelling combination of professional opportunities and a family-friendly environment. The cost of living, particularly housing (30% below the national average), is attractive, and the city boasts excellent schools and a vibrant arts and culture scene. As the headquarters for several Fortune 500 companies and with a metro population exceeding 975,000, Omaha provides the amenities of a large city without the drawbacks of a long commute—the average is just 20 minutes. You'll also find a friendly and welcoming community that makes it easy to settle in. For providers, Omaha's growing healthcare sector translates into ample opportunities for professional growth and development. It's a place where you can truly thrive, both personally and professionally. It's no surprise that Omaha is consistently recognized as one of the best places to live and work. Catholic Health Initiatives (CHI) is a member of Common Spirit Health™, a nonprofit, Catholic health system committed to building healthier communities, advocating for those who are poor and vulnerable, and innovating how and where healing can happen—both inside our hospitals and out in the community. Common Spirit was created by the alignment of Catholic Health Initiatives and Dignity Health as a single ministry in early 2019. With a large geographic footprint representing diverse populations across the U.S. and a mission to serve the most vulnerable, Common Spirit is a leader in advancing the shift from sick care to well care and advocating for social justice. Creighton University School of Medicine CHI Health and Creighton University are partners in providing healthcare, education, and research in the Omaha area and beyond. This partnership focuses on improving patient care through collaboration and innovation. CHI Health serves as a primary teaching hospital and research partner for Creighton's health science schools, offering a wide range of opportunities for medical and allied health professionals. To learn more visit: CHI Health & Creighton University Partnership

Job Requirements:

Requirements BE/BC by the American Board of Psychiatry and Neurology–General Adult Psychiatry BE/BC by the American Board of Psychiatry and Neurology–Child and Adolescent Psychiatry Ability to obtain licensure in Nebraska and Iowa BLS .

Company: Presbyterian Healthcare Services (1112471)
Title: Psychiatrist—Child & Adolescent Outpatient (Ruidoso, NM)
Job ID: 21789612
URL: https://jobsource.aacap.org/jobs/21789612

Job Description:
We're determined to put more life in your work/life balance. At Presbyterian, where you work includes more than just your employer—it includes living in one of the most naturally beautiful places in the world: New Mexico. Presbyterian is nationally recognized for our people, facilities, and dedication to our patients—and it's hard to match New Mexico's cultural and geographical diversity. Presbyterian Healthcare Services, a locally owned, not-for-profit healthcare system, is seeking a Board Certified / Board Eligible Child & Adolescent Psychiatrist to join our outpatient behavioral health team in Ruidoso, New Mexico. Why Join Presbyterian? A vital role in a fully integrated, growing community healthcare system. Telepsychiatry capabilities for both clinic and hospital settings. Emergency Department consultation service supported by a robust Clinical Liaison team. Systemwide EPIC electronic medical record system with dedicated onsite support. Supportive leadership & administrative assistance for optimal outpatient clinical flow. More Than a Job—A Lifestyle at Presbyterian, we're determined to reward you with more than just a paycheck. Working here means embracing a low cost of living, countless outdoor activities, and a welcoming community—all set against the backdrop of unrivaled natural beauty. Why Choose Ruidoso? Nestled in the Sierra Blanca mountains, Ruidoso is a charming village known for: Year-Round Outdoor Recreation—Enjoy skiing, hiking, fishing, and mountain biking. Vibrant Arts & Culture—Experience live performances at the Spencer Theater and local art festivals. Affordable Cost of Living—Housing options range from cozy cabins to modern homes. Family-Friendly Atmosphere—Excellent schools, safe neighborhoods, and community parks. Easy Access to Major Cities—Just a two-hour drive to Albuquerque and El Paso. Comprehensive Benefits from Day One Medical, dental, and vision coverage effective immediately. 403b retirement savings program with employer contributions and matching. New Mexico Rural Health Care Practitioner Tax Credit—Eligible physicians may receive up to $5,000 annually in financial incentives. We're determined to make New Mexico feel like home—and we invite you to belong here. Interested? Let's Connect! Tammy Duran | 505-923-5567 | tduran2@phs.org?Apply Online: www.phs.org AA/EOE/VET/DISABLED. PHS is committed to ensuring a drug-free workplace.

Job Requirements:
What We're Seeking: BC/BE in Child & Adolescent Psychiatry with completion of a fellowship program. Commitment to exceptional patient care in a collaborative, team-oriented environment. Highly motivated professionals looking to grow their practice in a supportive setting. Ability to obtain a New Mexico medical license.

Company: University of Hawai'i John A Burns School of Medicine (1414457)
Title: One full-time permanent tenue track faculty member
Job ID: 21789798
URL: https://jobsource.aacap.org/jobs/21789798

Job Description:
The University of Hawai'i John A. Burns School of Medicine, Department of Psychiatry, is recruiting for one full-time permanent tenue track faculty member. For a full description of the position, please visit the Government job website: https://www.schooljobs.com/careers/hawaiiedu and search for position: 85000. For inquiries, please contact Anthony Guerrero, MD at GuerreroA@dop.hawaii.edu EEO Employer.

Company: NFI Massachusetts (1414817)
Title: Board-Certified Child/Adolescent Psychiatrist
Job ID: 21804695
URL: https://jobsource.aacap.org/jobs/21804695

Job Description:
NFI Massachusetts Inc., a leading non-profit human service agency, is seeking a Board-Certified Child/Adolescent Psychiatrist to join our adolescent intensive residential treatment programs in Westborough, MA. We are dedicated to helping adolescents and their families reach their full potential, and we are looking for a psychiatrist who shares our commitment to compassionate, expert care. Why Join Us? Competitive and negotiable salary package, with opportunities for bundling hours for increased earnings ($160-$168/hour, plus on-call stipend) Collaborative work environment with a multidisciplinary team Support from an experienced consulting psychiatrist and leadership is provided. Position Details Part-Time: Seeking a 20-hour per week psychiatrist, with on-site presence preferred three days per week Opportunity for an additional 10-hour consulting/supervising psychiatrist role for a total of 30 hours per week Standard hours: Monday-Friday, 9 a.m. to 5 p.m. After-hours phone consultation on a rotating, on-call basis Program Overview Our co-ed, secure residential programs serve up to 30 adolescents who are working to overcome serious emotional disturbances to reunify with their families and transition back to community living. These programs are licensed by the Department of Mental Health and accredited by The Joint Commission. As the Psychiatrist/Medical Director, you will play a pivotal role in providing mental status examinations, medication management, and ongoing psychiatric care in collaboration with a psychiatric APRN. Key Responsibilities Conduct comprehensive mental health evaluations and provide medication treatments and ongoing review for these adolescents in collaboration with a psychiatric APRN Lead all aspects of psychiatric care within the program Collaborate with a multidisciplinary team, including the APRN, program managers, nurses, clinicians, occupational therapists, and residential staff Offer staff training and consultations to enhance the understanding of medications and mental health Provide support and consultation to staff, youth, and families Qualifications Board Certified or Board Eligible in Child/Adolescent Psychiatry (fellowship completed) Unrestricted medical license in Massachusetts, along with DEA and MA Controlled Substance certificates Experience working with adolescents in a residential or inpatient setting preferred Desired Hire Date: January 1, 2026 About Us At NFI Massachusetts, we strive to maximize potential and help individuals and families achieve the full promise of community living. Join us and make an impact on the lives of youth in need of compassionate and expert psychiatric care. NFI Massachusetts Inc., is proud to be an Equal Employment Opportunity employer. We do not discriminate based upon race, religion, color, national origin, gender (including pregnancy, childbirth, or related medical conditions), sexual orientation, gender identity, gender expression, age, status as a protected veteran, status as an individual with a disability, or other applicable legally protected characteristics. We seek to empower individuals and support the diversity and inclusivity within our workforce. NFI Massachusetts participates in E-Verify to confirm employment eligibility as part of the I-9 verification process.

American Academy of Child & Adolescent Psychiatry
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