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AACAP News

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CAPTURE BELONGING | American Academy of Child & Adolescent Psychiatry www.aacap.org

Inside. . .

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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TABLE of CONTENTS

Cover: **Klingenstein Third Generation Foundation National Medical Student Conference (NMSC)**
The 17th annual Klingenstein Third Generation Foundation National Medical Student Conference (NMSC) was held on February 3-4, 2023 at Brown University in Providence, Rhode Island. The NMSC brings together medical students and faculty from participating medical school programs to highlight and encourage students to enter the field of child and adolescent psychiatry. This year, Brown hosted over 140 medical students and faculty in a hybrid meeting that included student oral and poster presentations, mentorship and networking opportunities, and competitive but friendly games. Students and faculty left the NMSC energized and excited about the future of child and adolescent psychiatry.

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 *AACAP News* includes:

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

AACAP News is an official membership publication of the American Academy of Child and Adolescent Psychiatry, published six times annually.

CAPture Belonging: Fostering Diversity, Equity, and Inclusion in AACAP and Beyond

CAPture Belonging, AACAP's Presidential Initiative on improving diversity, equity, and inclusion, is gaining tremendous momentum and making significant strides within our organization and throughout the field of child and adolescent psychiatry. With a strong presence in AACAP News, News Clips, Social Media, and the AACAP website, there's been a flurry of activity and enthusiasm surrounding this crucial endeavor. Members and stakeholders alike have eagerly embraced the initiative, recognizing its importance in creating a more inclusive and equitable environment for all.

In AACAP News, articles and features continue to spotlight the various initiatives and programs launched under ***CAPture Belonging***, showcasing the commitment of AACAP and its members to fostering diversity and inclusion. News Clips, an essential resource for keeping up to date with the latest developments, consistently features stories and reports on the progress made by ***CAPture Belonging***, further amplifying its impact across the broader healthcare community.

Social Media has proven to be a powerful tool in spreading the message of ***CAPture Belonging***. AACAP's active presence on platforms such as Twitter, Facebook, and LinkedIn allows for engaging conversations, shared resources, and real-time updates on the initiative's achievements.

Additionally, our website serves as a hub, providing comprehensive information, resource libraries, and a resource center related to ***CAPture Belonging***. It offers access to webinars, training and other educational materials, empowering AACAP members to take an active role in implementing inclusive practices and effecting positive change in their respective communities.

In addition to the online platforms mentioned earlier, AACAP is actively promoting ***CAPture Belonging*** at live events, further amplifying its impact and reach. Notable gatherings such as the AADPRT Annual Meeting in San Diego and PAS 2023 in Washington DC provided valuable opportunities for AACAP to showcase and advocate for the initiative.

At the AADPRT Annual Meeting, AACAP took center stage, engaging with educators and leaders in child and adolescent psychiatry., AACAP emphasized the importance of diversity, equity, and inclusion in training the next generation of child and adolescent psychiatrists. The event served as a catalyst for meaningful conversations and collaborative efforts to ensure that diversity and cultural competence are core components of psychiatric education.

PAS 2023, a premier gathering of pediatric professionals, provided an ideal platform for AACAP to showcase the progress and impact of ***CAPture Belonging*** within the wider pediatric community. AACAP's presence at this prestigious event enabled interactions with clinicians, researchers, and policymakers invested in improving the mental health and well-being of children and adolescents. By highlighting the initiative's goals, successes, and ongoing initiatives,. The event served as a testament to AACAP's commitment to advancing diversity, equity, and

inclusion in the broader context of pediatric healthcare.

Through active participation at live events like the AADPRT Annual Meeting and PAS 2023, AACAP has further reinforced its dedication to promoting ***CAPture Belonging***. By engaging with professionals from various backgrounds and specialties, AACAP continues to ignite passion and drive change within the field of child and adolescent psychiatry, ensuring that diversity, equity, and inclusion remain at the forefront of discussions and actions.

The promotion of ***CAPture Belonging*** extends far beyond the mentioned events and platforms. AACAP's flagship journal, Journal of the American Academy of Child and Adolescent Psychiatry (***JAACAP***) plays a pivotal role in disseminating research, insights, and best practices related to diversity, equity, and inclusion. Through thought-provoking articles and editorials, ***JAACAP*** provides a platform for scholars and experts to contribute to the ongoing dialogue on fostering inclusivity within the field.

AACAP's Regional Organizations also play a crucial role in promoting CAPture Belonging at a local level. These organizations, comprised of dedicated professionals across different regions, actively engage with their communities, hosting educational events, workshops, and symposiums that address the unique needs and challenges of their respective regions. By aligning their efforts with the overarching goals of ***CAPture Belonging***, AACAP's Regional Organizations amplify the initiative's impact and extend its reach to grassroots levels.

The dedication of AACAP's leadership and the Presidential Initiative Task Force is instrumental in driving the success of ***CAPture Belonging***. Through visionary leadership, strategic planning, and collaborative efforts, they shape the direction and execution of the initiative. Their commitment to championing diversity, equity, and inclusion within AACAP and the field of child and adolescent psychiatry ensures that ***CAPture Belonging*** remains a cornerstone of the organization's mission and values.

Overall, the promotion of ***CAPture Belonging*** encompasses a wide array of efforts, from the invaluable contributions of ***JAACAP*** and AACAP's Regional Organizations to the tireless work of AACAP's leadership and the Presidential Initiative Working Group. Together, they form a collective force dedicated

to advancing diversity, equity, and inclusion, and their combined efforts are making a lasting impact on the specialty.

AACAP is fully committed to the principles of diversity, equity, and inclusion. This collective effort not only strengthens the organization but also elevates the entire field of child and adolescent psychiatry. By embracing the initiative, AACAP paves the way for a future where every individual, regardless of their background or identity, feels valued and empowered within the field. With continued dedication and collaboration, ***CAPture Belonging*** will foster an inclusive and equitable environment, ensuring the delivery of optimal mental healthcare to all children and adolescents. ■

Psychotherapy and Evidence-based Outcomes in a Residential Treatment Center: A Mix of Individual, Family and Experiential Therapies



Mirela Loftus, MD, PhD, Ian Parker, MSW, and Michael Roeske, PsyD

As we know, the youth mental health crisis has revealed limitations in the availability of services, especially for more severe and chronic cases, leaving clinicians and families overwhelmed and uncertain. Many young people are requiring longer treatment stays than inpatient hospitals can provide and a more intense approach than outpatient services. Residential Treatment Centers (RTC) for adolescents and young adults are designed to address that gap.

To complicate the matter, there are a wide range of options and settings considered residential treatment—including home-like settings, campuses, wilderness programs, substance use detox and rehab centers, state- or privately-owned programs, etc.—as well as a vast range of therapeutic models. This adds to the overwhelm of already stressed families and even clinicians when looking for effective help. A great range of psychotherapies and their integration also occur in residential settings. Despite all these variables and the great need in our communities, evaluation research is uncommon.

In our work together within a national provider of residential treatment, we emphasize mind-body interventions such as yoga, meditation, adventure, and equine therapy, health and fitness groups, music, dance and movement therapy, mixed martial arts, and art therapy. We adhere to a medication philosophy of only using medication when other less intrusive treatments within the psychosocial are not helpful enough. Family therapy and the belief that the caretakers must be part of the solution is considered integral to our psychotherapeutic approach.

Alongside these interventions, we use more traditional therapies of individual therapy and group counseling. The use of interventions from Mentalization Based Therapy (MBT), Dialectical Behavioral Therapy (DBT), Acceptance and Commitment Therapy (ACT), Eye movement desensitization and reprocessing therapy (EMDR), Transference-focused Cognitive Behavioral Therapy (TFCBT), Brainspotting, and Attachment-Based Family Therapy are common.

Altogether, our engagement with youth and their families in our residential setting led us to believe that a systemic therapeutic approach feels right. That is a lens we cannot lose sight of: to view our clients, their symptoms, maladaptive beliefs, and behaviors as either originating from or being exacerbated by their relational systems and for the treatment to reflect these values. And, as any honest clinician will tell you, "it takes a village" to move the treatment process forward. We lean on other members of the treatment teams to maintain integrity in our individual approaches.

Psychotherapeutic collaborations may include our art and equine therapists, and adventure teams to receive feedback about the clients and their progress and ask for suggested interventions. For instance, an art therapist may explain how a patient's inner journey unfolded through clay, painting, drawings, and collages, methods touching deeper than talk therapy can hope to reach. An equine therapist may discuss a youth that relates to our horses more than any person they have met, caring for them, existing in silence with them, and finding a peaceful companion they can lean on (quite literally at times).

Perhaps the most memorable experience involved a depressed, disenfranchised teen, with poor confidence and low self-esteem, who came alive while practicing martial arts, finding a spark, an inner connection, a sense of belonging and an unknown talent. We often tell parents that their child will most certainly not like everything that we do, but if we can expose them to various experiences, work their mind, body, and emotions in harmony, we may just find something they relate to and find a refuge.

Evidence-based Outcomes in Residential Settings

Every clinician wonders if what they are doing is working. Little outcome research has occurred in residential settings, though, where nearly two thirds of patients present with severe comorbidities and histories of multiple treatment episodes. This is troubling given the high risk and costs of services associated with residential care and the seeming explosion of need. To take on these challenges, we have led a sophisticated, systems-wide outcomes monitoring program which is now run through a recently created center for research and innovation.

In 2021, when teens were struggling the most, the anxiety scores on the Generalized Anxiety Disorder scale

Continued on page 130

Psychotherapy Crisis in Canada: What Have We Learned From It?

■ **Ching-Fang Sun, MD, and Timothy Rice, MD**

"Psychiatrists in the US provided invaluable support and resources for the struggles that we have experienced here in Ontario to keep unrestricted, publicly-funded, physician-delivered access to long-term psychotherapy available to patients. Even with recent advocacy successes, we need to continue raising awareness that long-term psychotherapy is a life-saving treatment, not a luxury," said Dr. Renata M. Villela, Ontario Medical Association Section on Psychiatry Chair & Ontario Psychiatric Association Psychotherapy Initiative Lead, Canada. Dr. Villela recently presented at the AACAP's psychotherapy committee meeting to share her advocacy story on this front.

Mental Health Resources Shortage in Canada

While Canada has a universal health care system funded through taxes, public funding for health care services takes place primarily at the provincial level. The availability of mental health care in Canada is in question, especially in the context of the COVID pandemic. According to a Canadian Mental Health Association survey, 40% of responders reported mental health deterioration since the onset of the pandemic, especially in those with a pre-existing mental health issue.[1] Facing the increasing need, Canada's federal government responded by establishing funds such as the Canada Emergency Response Benefit and the Emergency Community Support Fund. Virtual resources such as Kids Help Phone and Wellness Together Canada have also been available. Government resources, however, were generally short-term and low intensity during the pandemic. Actions from the government did not address the underlying severe shortage of mental health care providers.

Psychotherapy is the first-line treatment for various mental illnesses. Unfortunately, limited patients could receive therapy due to the provider shortage. Providers generally encourage patients to seek treatment from a psychiatrist or a primary care provider for pharmacological management and a licensed therapist for psychotherapy. Patients with chronic and complicated psychiatric issues, however, often need a higher level of care, which can mean psychotherapy along with pharmacological treatment. Psychiatrist psychotherapists can be key for treating this vulnerable patient population.

The Sword of Damocles vs. Long-Term Psychotherapy

The current government-funded health insurance in Ontario, the Ontario Health Insurance Plan (OHIP), does not limit the time nor the intensity of psychotherapy. Rather than accounting for clinical need, however, the Ontario government proposed an arbitrary limit on publicly-funded psychotherapy in 2019. The proposal was a one-size-fits-all policy to restrict psychotherapy to 24 hours per year regardless of case complexity to decrease short-term health care costs. The proposal was–thankfully–unsuccessful, but the gesture from the government raised debate regarding the necessity of long-term psychotherapy.

Long-term psychotherapy is essential for patients with complex mental disorders. Many of them are struggling with substance use, trauma-related symptoms, chronic mood disorders, and/or personality disorders. Voices against long-term psychotherapy have attempted to delegitimize the efficacy and the cost-effectiveness of long-term psychotherapy. In fact, long-term psychotherapy is evidence-based with strong support in the literature. Long-term psychotherapy provides savings in many ways, including decreasing absences from work, lower medical costs, and fewer hospitalizations.[2] Short-term psychotherapy such as cognitive behavioral therapy can successfully address cases with mild-to-moderate symptoms. Still, patients with chronic severe mental disorders often need a higher level of care. Long-term psychotherapy is essential for some of these complex patients to maintain baseline function.

Founded by a group of physicians dedicated to mental health care in Ontario, The Coalition For Saving OHIP Funded Physician Delivered Psychotherapy advocates for individuals that could have been impacted by the government's proposed cuts. The Coalition's website (**https://savingohippsychotherapy.squarespace.com/**) provides public health statistic information and down-to-earth messages such as patient testimonials. In conjunction with several groups that included the American Psychiatric Association's Psychotherapy Caucus, the Ontario Medical Association's Committee for the Preservation of Publicly-Funded, Physician-Delivered Psychotherapy, the Ontario Psychiatric Association's Psychotherapy Initiative (**https://eopa.ca/opa-groups/opa-initiatives/opa-psychotherapy-initiative**), and Ontario Patients for Psychotherapy (**https://www.ontariopatientsforpsychotherapy.org/**), stakeholders such as Dr. Villela developed the *Psychotherapy Saves* campaign, presented at national/

international conferences, engaged in social media, and published literature to raise public awareness of the necessity of long-term psychotherapy in the context of mental health resource shortages.

Message From the Ontario Experience

Unrestricted access to public-funding for long-term psychotherapy provided by physicians in Ontario has been secured, at least for now, but the debate heightens concerns about ongoing broader awareness. Unfortunately, there is ongoing stigma and misunderstanding of mental illness. Questioning the necessity of long-term psychotherapy suggests that patients with mental illness did not deserve medical resources. Failing to validate that need could further traumatize patients with pre-existing mental illness and keep those in need from seeking mental health treatment. Additionally, stigma against mental illness causes hesitancy for medical students to pursue a career in psychiatry, which could worsen the ongoing mental health care provider shortage.

Academic activities play a crucial role in educating the public and eliminating myths about long-term psychotherapy. Current studies are mainly focusing on short-term psychotherapy. Researchers are discouraged from initiating long-term psychotherapy studies due to obstacles such as obtaining funds, which results in less literature supporting long-term psychotherapy than their short-term counterparts.[3] Studies focusing on long-term psychotherapy with updated data are the missing piece of the puzzle to bridge research to clinical care.

Besides eliminating stigma against mental illness, enhancing mental health care accessibility should be prioritized to address the increasing need during and after the COVID pandemic. While mental health resources are distributed unequally, telemedicine is a potential solution for the shortage of psychiatrists and therapists in underserved areas. If certain requirements are met, virtual care is currently publicly available as well. During the pandemic, social distancing, quarantine, and isolation policies have pushed telepsychiatry as the "new normal" for providers and patients. Transforming from traditional in-person clinics to virtual appointments is the trend in psychiatry that could resolve a part of mental health disparity. ■

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Psychotherapy and Evidence-based Outcomes in a Residential Treatment Center (*Continued from page 128)*

(GAD) went from severe (16) at admission to mild (9) at week 5, and the depression scores on the Patient Health Questionnaire PHQ went from moderately severe (19) to mild (9) respectively. Similar changes were noted in well-being as measured by the World Health Organization (WHO), in suicidality using the Beck Hopelessness Scale (BHS), and in family and attachment relationships using the Family Assessment Device (FAD) and the Relationship Structures Questionnaire (ECR-RS). It is well known that therapeutic alliance is one of the predictors for treatment outcome. Our teens indicated a very high working alliance through the Working Alliance Inventory-Short Revised (WAI-SR) by week 3 (44) which was maintained at week 5 (44). Ongoing data collection will hopefully further the evidence behind our treatment model and will be reviewed for publishing.

The data collected over time has shown that residential treatment can have a very positive effect. To us, this much is clear: if we truly seek to turn around our current youth mental health crisis, families must be able to find and know how to access and determine what is effective care for their children. And as clinicians, it is imperative that we involve them in the treatment and truly embrace and respect the multiple disciplines that are part of the collective village. ■

Mirela Loftus, MD, PhD, is the Medical Director for the Newport Healthcare Residential Treatment Centers for adolescents and young adults in Bethlehem and Fairfield, CT.

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Michael Roeske, PsyD, is a licensed clinical psychologist and Senior Director of the Newport Healthcare Center for Research and Innovation.

What is New with ADHD Medications?




Boris Lorberg, MD, MBA, Raman Baweja, MD, MS, Haley Godfrey, Ann Childress, MD

Our readers are always interested in learning about newer medication preparations that have been recently approved for ADHD by the Food and Drug Administration (FDA). Drs. Boris Lorberg and Raman Baweja asked Dr. Ann Childress (President of the American Society of ADHD and Related Disorders, a master clinician and clinical investigator) to share her thoughts about newer ADHD medications. Below is our conversation.

BL/RB: What is your general approach to ADHD treatment – what medications do you start with, and at what point do you stop using standard medications and go on to the newer ones that became available more recently?

AC: I usually start with a stimulant, either an extended-release (ER) methylphenidate (MPH) or amphetamine (AMPH), because the evidence is strongest for stimulant efficacy. Most patients will respond equally well to either one, although 40% of patients may be preferential responders to MPH or AMPH. So, if a patient does not have a response or has tolerability issues with one stimulant class, I will switch to the other class.

Most of the new ADHD medications approved by the FDA are delayed-release (DR) or extended-release (ER) stimulants that differ with respect to their onset and duration of effect. If a patient has difficulty getting started in the morning, for example, getting ready for school, I may prescribe Jornay PM®, a DR/ER methylphenidate designed to be taken at night and help control early morning ADHD symptoms and be effective throughout the day.

If a child has difficulty swallowing pills, the following are an option:

- Oral suspension (Dyanavel XR®, Quillivant XR®),
- Oral disintegrating tablets (Adzenys XR®, Cotempla XR®),
- Chewable tablets (Quillichew ER®, Dyanavel XR®).

BL/RB: What are the new ADHD medications that became available recently?

AC: Two AMPH products were recently approved by the FDA:

- Dyanavel XR® chewable tablets (2022) and
- Xelstrym® a transdermal patch (second quarter of 2023).

One MPH product was FDA approved in 2021 - Azstarys®. It contains the following combination:

- dexmethylphenidate immediate-release (IR) and
- its prodrug serdexmethylphenidate.

The combination is designed to first achieve effect within 30 minutes after dosing and then last throughout the day. Although Azstarys® is a DEA Schedule II drug (because of the (IR) dexmethylphenidate), serdexmethylphenidate is a DEA Schedule IV drug.

One new nonstimulant product was FDA approved in 2021 – viloxazine ER (Qelbree®). It is a norepinephrine reuptake inhibitor. An IR version was available in Europe as an antidepressant used for adults for about 30 years, but it is no longer marketed due to commercial reasons. The ER version was approved by the FDA in 2021 for treatment of ADHD in children and adolescents and, in 2022, for treatment of ADHD in adults. Unlike other nonstimulants, viloxazine ER can be sprinkled for patients who have difficulty swallowing tablets or capsules.

BL/RB: What are the efficacy and side effect profile gaps that these new medications fill?

AC: For stimulants, onset, duration of effect, and ease of administration are the main differences. Anyone who has opened a capsule and sprinkled the contents can testify that an ODT, chewable or liquid formulation will be easier to administer. Side effects are similar among the stimulant formulations — they are still stimulants.

Regarding nonstimulants, there are no head-to-head trials comparing efficacy of viloxazine ER with other available nonstimulants. Effect size for viloxazine ER is lower than for stimulants, but it is probably similar to atomoxetine. In the clinical trials, nausea and vomiting were reported less frequently with viloxazine ER (4-5%) than with atomoxetine (10-11%).

BL/RB: In what situations do you consider using newer stimulant preparation?

AC: For patients who need coverage at different times during the day, one formulation may be preferable over another. For example, a patch that does not take effect for two hours after

administration may not be preferable for someone who has difficulty because of ADHD symptoms in the early morning. However, it may be great for someone who sleeps in on the weekends. In addition, you can alter the duration of coverage by decreasing the patch wear time to minimize impact on sleep at night.

I recently published a chapter on stimulants that includes tables describing the newer stimulants that may be helpful (See Table 1).

I already discussed some of the situations above, and there may be other times when a switch is appropriate. I have some patients who have side effects with Adderall XR® who do very well on Adzenys XR® and Dyanavel XR®.

Although Adzenys XR® is bioequivalent to Adderall XR®, and Dyanavel XR® is bioequivalent to two doses of Adderall® given four hours apart, the drug release is different.

- Adderall XR® capsules consist of a few hundred beads, half of which are IR and the other half are ER.
- Adzenys XR® and Dyanavel XR® formulations consist of millions of drug-polymer particles.
  - Half are standard IR.
  - The other half are ER particles that have coatings of variable thicknesses.

So, some ER drug product takes longer to diffuse and absorb in the GI tract — which gives them more of a continuous release. This mechanism may improve tolerability of these drugs.

The same description applies to the MPH counterparts (of Adzenys XR® and Dyanavel XR®) consisting of drug-polymer complexes:

- Quillivant XR®,
- Quillichew XR® and
- Cotempla XR®.

With the current stimulant shortage (both AMPH and MPH), the newer formulations may be more available and in stock at pharmacies.

BL/RB: Do new medications need any special monitoring?

AC: The newer stimulants require the same monitoring as older stimulant formulations including blood pressure, pulse, and growth. The newer nonstimulant has an overall good safety profile and no specific lab and vitals monitoring have been recommended.

BL/RB: Are there any new medication side effects that need to be considered?

AC: Viloxazine ER® has a boxed warning because higher rates of suicidal thoughts and behavior were reported in patients treated with viloxazine ER than in patients treated with placebo. Monitoring for emergence or worsening of suicidal thoughts and behaviors is recommended.

Table 1. Newer ADHD Stimulant Formulations (Adapted from Childress, Child Adolesc Psychiatric Clin N Am)[1]

Drug	Dose Form	Effect Onset	Effect Max Duration	Dosing	Price (As per GoodRx)
Methylphenidate formulations					
Azstarys (SDX/d-MPH)	26.1/5.2, 39.2/7.8, 52.3/10.4 mg caps	0.5 h	12 h	Start with 39.2/7.8 mg & increase or decrease to optimal dose	$406.81: 30 caps, dose 39.2mg/7.8mg
Cotempla XR-ODT (MPH-ER ODT)	8.6, 17.3, 25.9 mg tabs	1.0 h	12 h	17.3–51.8 mg. Incr. by 8.6–17.3 mg/d q7d	$486.86: 30 tabs, dose 17.3mg
Jornay PM (DR/ER-MPH)	20, 40, 60, 80, 100 mg caps	10 h after dosing	23 h after dosing	20–100 mg. Incr. by 20 mg qwk	$326.20: 30 caps, dose 40 mg
Quillivant XR (MEROS) ER susp.	25 mg/5 mL	0.75 h	12 h	20–60 mg. Incr. by 10–20 mg q7d	$325.73: 120ml, dose 25mg/5ml
QuilliChew ER (MPH-ER-CT)	20, 30, 40 mg tabs	2.0 h	8 h	20–60 mg. Incr. by 10–20 mg q7d	$356.73: 30 tabs, dose 20 mg
Amphetamine formulations					
Adzenys XR-ODT (AMPH-XR-ODT)	3.1, 6.3, 9.4, 12.5, 15.7, 18.8 mg tabs	Bioequiv. MAS-XR (1.5 H)	Bioequiv to MAS-XR (12.5 h)	6.3–18.8mg: age 6-12y 6.3–12.5mg: age 13–17y. 12.5 mg: adults	$346.83: 30 ODTs, dose 18.8 mg
Dyanavel XR (AMPH-EROS & AMPH-ER-CT)	2.5 mg/mL ER suspension 5, 10, 15, 20 mg tabs	0.5 h	13 h	2.5–20 mg (aged 6y and older) Increase by 2.5–5 mg q4–7d	$365.84: 120ml, dose 2.5mg/ml. $352.89: 30 tabs, dose 20mg

Abbreviations: AMPH, amphetamine; caps, capsules; CT, chewable tablet; DR/ER, delayed-release/ extended-release; ER, extended-release; h, hours; MAS, mixed amphetamine salts; MEROS, methylphenidate extended-release oral suspension; mg, milligram; MPH, methylphenidate; ODT, oral disintegrating tablet; SDX, serdexmethylphenidate; tabs, tablets; XR, extended release; y, year

BL/RB: What about drug-drug interactions with new medications?

AC: Viloxazine ER® is a strong inhibitor of CYP1A2. Use with substances such as caffeine and melatonin will increase overall exposure of these drugs, but not peak concentrations.

BL/RB: Are there any barriers to using new medications that clinicians need to be aware of – cost, non-formulary status?

AC: Newer medications are expensive, our program coordinator (HG) found out prices of newer medications on GoodRx (see Table 1). Some of these may be more difficult to get into the hands of patients with insurance formulary limitations. However, noting that the patient has difficulty swallowing pills can help get them approved. Many manufacturers have co-pay programs to help limit out-of-pocket costs for patients.

BL/RB: In conclusion, could you comment on the past, present, and future of the ADHD medication options from a 20,000-foot view perspective?

AC: There are very effective treatments available for ADHD. Not all children need newer medications as most do well with older available stimulant and nonstimulant preparations. Newer preparations have new technology for drug delivery and a good PK profile, which provide consistent release of medication and may have better tolerability.

There are many new drug molecules in pipelines that are being examined for efficacy and tolerability in various phases of clinical trials. One of the novel targets being studied is a glutaminergic receptor. So, the future of ADHD medications looks very promising.

BL/RB: On behalf of our readers, we would like to express our deep appreciation for sharing your clinical and research insights about the use of newer medications for ADHD. ■

Reference

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

The resources and information on this page – **https://www.samhsa.gov/find-help/988** – are designed to help states, territories, tribes, mental health and substance use disorder professionals, and others looking for information on understanding the background, history, funding opportunities, and implementation resources for strengthening suicide prevention and mental health crisis services.

AACAP's Position Statement on the Increased Suicide Rate among Black Youth: Behind the Scenes of the Work on this Statement

Raman Baweja, MD, MS, Sarah H. Arshad, MD, Deepika Shaligram, MD, Shikha Verma, MD, Destiny Pegram, MD, Apurva Bhatt, MD, Rameshwari Tumuluru, MD, Balkozar Adam, MD, Cheryl Al-Mateen, MD

Suicide is the second leading cause of death in youth, and the mental health of children and adolescents has only worsened during the COVID-19 pandemic. The Congressional Black Caucus' Emergency Taskforce published a report highlighting a worrisome disparity – the suicide rate among Black youth has been rising faster than in any other racial/ethnic group in the past two decades. Specifically, pre-adolescent Black youth are twice as likely to die by suicide as their white counterparts.[1] Suicide related injury due to attempts rose 122% for African American, adolescent males during the years 1991-2017,[2] and among Black youth who died by suicide between 2015 and 2017, 19.5% used firearms (fatality rate approaches 90 percent), and 34% used strangulation or suffocation. Moreover, black youth have less access to mental health care, are more likely to drop out of treatment, and are more likely to present to medical emergency rooms in crisis, where they are often discharged without being seen by a mental health provider or lost to follow up.[3] Besides the disparities they face in obtaining mental healthcare, black youth also face greater punitive treatment in the educational and juvenile justice systems,[3] are disproportionately involved in and affected by the child welfare/foster care system and face the negative impact of policing and violence. These exacerbate the stigma and mistrust of systems in general, including the mental health system. Overall, these factors limit opportunities for identification and early intervention for the treatment of Black youth, which might also play a role in their unique rising rates of suicide.[1]

Overall, the COVID-19 pandemic has caused significant uncertainty and has seen a rise in mental health crises in addition to highlighting healthcare disparities often due to structural racism. During the pandemic, mean weekly emergency department (ED) visits associated with suicide attempts in adolescents ages 12-17, increased 22.3% in summer 2020 and 39.1% in winter 2021 compared to the corresponding periods in 2019.[4] Additionally, community violence, interpersonal and family conflict, socioeconomic distress, and racial discrimination, which are risk factors for black youth suicide, have been exacerbated during the pandemic.

Part of the mission of the American Academy of Child and Adolescent Psychiatry (AACAP) is to promote the healthy development of all children, adolescents and families. Given this significant concern of increase suicide rate among black youth, AACAP Past-President Dr. Gabrielle Carlson contacted the Diversity & Culture (D&C) Committee Co-Chairs, Dr. Cheryl Al-Mateen and Dr. Lisa Cullins, to organize a task force to work on a position statement to address this disparity. Dr. Al-Mateen spearheaded the project, and discussed the project with the D&C Committee in January 2021, who were determined to draw attention to the root causes of this disparity. She also involved other AACAP committees to better understand the multifactorial needs and be able to provide more comprehensive recommendations, including the Adolescent, Advocacy, Child Maltreatment and Violence, Disaster and Trauma issues, Family, Health Promotion and Prevention, Research, Sexual Orientation and Gender Identity issues, and System of Care. Members. Members from these committees were interested in contributing to this

important topic, and began to attend virtual weekly meetings. Cluster 6 facilitator, Dr. Balkozar Adam, joined the group in March and recommended drafting an additional resource document and writing an AACAP News article to expand the reach and better inform our members about this important topic. The Task force agreed to develop the following 3 documents: 1). An AACAP Position Statement (1 -1 1/2 pages), 2). A resource document to include details on the information gathered on the topic to be shared on the AACAP website with the AACAP members, 3) An AACAP Newsletter article to update the members about the process and the progress being made.

In the weekly virtual meeting, members were able to use their unique perspectives to brainstorm goals and objectives of this task force, and to then divide the work into subgroups. At first the task force was divided into 2 groups: one group to write the position statement, and another group responsible for reviewing the statement and providing final edits. Taskforce members in the writing group were further subdivided in 3 subgroups to write the position statement: the first subgroup reviewed the literature for background evidence, led by Dr. Lisa Fortuna, the 2nd group worked on defining the issues, led by Dr. Seeba Anam, and the last group worked on the official recommendations led by Dr. Tanuja Gandhi.

In order to organize and promote collaboration among the various members of the task force and subcommittees, a Google folder was created to share resources and information, as well as to revise the working document of the position statement. There was a significant amount of information gathered, including research, other policies, and editorials to serve as both background material, further resources, and direct evidence behind the recommendations in the position statement. Over the next 4 weeks, the writing group created a draft of the position statement. The review group, led by Dr. Al-Mateen, reviewed and edited the written statement. Both groups met individually and as a large group to coordinate the various elements of the statement. In May 2021, a collaboration with the APA Council for Children, Adolescents and their Families was established to utilize the APA members' expertise in addressing Suicide in Black Youth.

While the task force is still finalizing the position statement and the resource document, the D&C Committee wishes to share its latest progress with the AACAP members. We believe the current review of Suicide in Black Youth would be of great help to Black youth and families, as well as to the clinicians who care for them. The following recommendations, if implemented by the members of the AACAP community, will provide a road map for immediate action in tackling this worrisome disparity. These include training all health care providers who work with Black youth on universal screening and assessment for suicide, educating them on disparities in provisions of care, including structural racism and ensuring adequate and immediate access to behavioral health services. In thinking about some specific cultural protective factors, providers may also harness some natural community supports such as family or religious systems, and advocate for gun safety education, which may serve as protective factors to prevent black youth suicide. An increase in funding for training and retention of black mental health providers and funding for research to improve prevention and intervention efforts are also necessary for longer-term progress. The D&C committee felt that sharing the progress and recommendation in this article would serve as a necessary step to call to action all members of the AACAP community, to take stewardship in this important, timely and necessary endeavor. ■

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Continued on page 139

MEDIA COMMITTEE

"I Have Systems" – Social Media Contagion in Clinical Practice

Paul Weigle, MD & Kris Kaliebe, MD

"I have 6 systems, each with very different personalities" began Sophie, the friendly, engaging 15-year-old girl who came into my office for treatment of depression. She told me the names of each of her personalities, how they differentiate from one another and interact, with the enthusiasm of a child describing his favorite video game. These rapidly shifting personalities first became known to Sophie after viewing a number of compelling social media clips featuring popular influencers claiming to suffer from "multiple systems," in which several independent beings inhabit one body. Sophie had started leaving school classrooms on a daily basis because some of her 'systems' could not tolerate them, and had fallen behind academically for the first time as a consequence. Other than her explanation for her classroom avoidance, her parents, teachers, and group therapist could discern no evidence of Sophie's different personalities. Sophie kindly asked if I would document her "dissociative identity disorder" in a letter excusing her from class.

In recent years, my patients' endorsement of psychiatric symptoms appear increasingly influenced by their online experiences. In this regard, I'm not alone. As co-chair of the Social Media Institute of this year's AACAP Annual Meeting, I polled attendees with the question "How often do you see patients who seem to believe they suffer from a psychiatric or neurological condition because of something they saw online?" Of over 100 responders, 74% answered "somewhat often" or" very often". When asked, "How often do you see teens who seem to be influenced by social media in regards to their sexual and/or gender identity?", 83% responded "somewhat often" or "very often." Our colleagues regularly interpret their patients' symptoms as a reflection of their online experiences.

Developing humans are particularly inclined to mimic the behaviors of others, a trait which evolved to help them assimilate with peers, and adopt adaptive customs. Throughout human history, we have depended on cumulative culture to survive by incorporating ideas including what situations to avoid, how to interact with one another, and how to forage and hunt.

Adolescent identity formation typically involves "trying on" different roles and identities and assessing the feedback of others and resultant effects on relationships. Teens often mimic the expressions of those they have been exposed to in a phenomenon called social contagion. Assumed roles met with little response tend to be cast off. Assumed identities which are positively reinforced, through the interest and approval of peers or evasions of nonpreferred situations and responsibilities, are more likely to persist.

Mental health contagion via mass media is not a new phenomenon. Johann Wolfgang Goethe's 1774 novel "The Sorrows of Young Werther," whose protagonist responds to unrequited love by killing himself, was implicated in a string of subsequent copycat suicides. Used on a daily basis by most teens, social media has unprecedented potential as a transmitter of social contagion, for better and for worse.

While our patients do support, educate, and inspire one another through social media, digital platforms can also serve as vehicles for the spread of misleading and unhealthy ideas. Self-diagnosis of psychiatric symptoms like disordered eating, substance use, self-injury and suicide may be spread via social media. Girls with poor social support suffering from emotional difficulties may be especially vulnerable to contagion, which is more likely to be long lasting when their resultant identification is met with positive reinforcement e.g. peer recognition, status and affiliation.

Contagion effects are notoriously difficult to study, but research data has provided evidence of social-media transmitted contagion of tic-like movements,[3] eating disordered behavior, self-harm,[2] suicidality,[4] and most controversially, gender dysphoria.[1]

In my experience, adolescent girls with poor social status spending excessive time on social media are most likely to identify with a disorder they learned about via social media. Autism, ADHD, Bipolar, Tics, and Dissociative Identity Disorder are the most common self-diagnoses which seem influenced by social media. We explore patient

concerns by getting a full history and eliciting corroborating data from parents, teachers, therapists, and psychological testing when available. Young patients are often accurate reporters of internalizing symptoms compared to adults in their lives, but at times their history seems inconsistent or unreliable.

These patients often experience legitimate distress and create a narrative to explain the cause. Expressions of everyday inadequacies, worries, and loneliness are more common culprits than rare psychiatric conditions dramatized by social media influencers. Others may consciously imitate what they see online in an attempt to gain the same type of attention or avoid responsibilities. We must evaluate their concerns while being mindful of potential social media influences. It is often prudent to avoid expressing excessive interest in extraordinary symptoms, to evaluate while avoid unintentionally reinforcing them.

Psychiatrists are well aware of our patients' remarkable abilities of self-deception, which may provide temporary relief while diverting energy from the primary problem. Denying a patients' self-diagnosis may engender immediate frustration, anger or confusion, which can be difficult for those of us who dislike confrontation or value the positive regard of our patients. Practitioners must render an honest appraisal while avoiding being drawn into counterproductive debate. Such adolescents have unmet psychological needs, and exploring the realities of their daily lives often reveals the true cause of their distress. We must do our best to ensure their identification with inaccurate psychiatric diagnosis does not enable teens the reinforcement of avoiding stressful situations or win them undue attention or peer status or affiliation. When these patients directly acknowledge and feel empowered to address such life stressors, their investment in a false diagnosis typically fades.

Sophie's eager descriptions of her "systems" failed to resonate with listeners. Her peers in group therapy responded with greater interest when Sophie shared feelings of social isolation and worries of academic failure, and potential solutions. In the coming weeks talk of multiple personalities dwindled as she became increasingly confident in addressing self-defeating thoughts and behaviors. Success in peer relationships and in school assignments paralleled improvements in mood and affect. Her fellow group members enjoy helping her problem-solve and celebrating her accomplishments. They seem to find her enthusiasm contagious. ■

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MILITARY FAMILY ISSUES COMMITTEE

AACAP Celebrates National Month of the Military Child

Rachel Sullivan, MD, and Monica Ormeno, MD

The American Academy of Child and Adolescent Psychiatry (AACAP) joins our nation in celebrating military children to honor the countless sacrifices they make as a result of their parent's service.

Established in 1986 by Defense Secretary Caspar Weinberger, April is the National Month of the Military Child is a time to acknowledge the resilience and strength of military children who face numerous stressors such as frequent relocations, parental separation, and exposure to traumatic events. These stressors can have significant impacts on the mental health and well-being of military children, making it critical to provide them with specialized support and resources. As child and adolescent psychiatrists, we understand the importance of promoting mental health and well-being for all children, including military children.

"Recognizing the National Month of the Military Child is critical in raising awareness of the unique challenges military children and their families face. It is an opportunity to celebrate their strength, resilience, and the sacrifices they make," says Monica Ormeno, DO, co-Chair of AACAP's Military Issues Committee.

AACAP's Military Issues Committee serves as a forum to discuss issues specific to the military and Child and Adolescent Psychiatrists. The group also raises military-specific concerns to AACAP for integration and consideration while highlighting programs, resources, and services for military children. By celebrating the National Month of the Military Child, we can raise awareness about the unique challenges that military children and their families face and promote policies and resources that support their mental health and well-being. As child and adolescent psychiatrists, we stand in support of military families and are committed to providing them with the specialized care and support they need. ■

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AACAP's Position Statement on the Increased Suicide Rate among Black Youth (*Continued from page 135*)

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Cheryl S. Al-Mateen, MD, is Program Director, Child and Adolescent Psychiatry Fellowship Program and Professor of Departments of Psychiatry and Pediatrics at Virginia Commonwealth University School of Medicine. She is a Co-Chair of AACAP Diversity and Culture Committee.

Get in the *News*!

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

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

Production Schedule

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

Citations and References

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

For complete *AACAP News* Policies and Procedures, please contact **communications@aacap.org**.

AACAP's 70th Annual Meeting New York Preview

AACAP's 70th Annual Meeting is just 4 months away and we're excited to bring our community back together in New York! For complete details about the Annual Meeting, visit **http://www.aacap.org/AnnualMeeting-2023**.

As usual, the meeting includes:

- Top experts in the field sharing the latest research
- A wide variety of educational events, including hands-on workshops to learn skills you can use immediately to improve patient care
- Interactive sessions among your peers to discuss the greatest challenges in the field
- Opportunities to enjoy the multicultural City of New York

Program Highlights

- All 9 Institutes are included with registration! Topics include psychopharmacology, bipolar disorder, anxiety, autism, and much more!
- 45 hours of pre-recorded Institute content are released to all attendees starting October 9, and available through November 30, to watch anytime, anywhere, significantly expanding the amount of learning included with the meeting.
- Each Institute includes a two-hour Q&A in New York for direct interaction with the presenters.
- Earn up to 90 CMEs by attending the meeting in New York!
- CAP@Home Virtual Experience is back again, and includes even more than last year!
- Scientific sessions start earlier on Monday, October 23 at 1:00 pm ET.

Important Dates & Deadlines

June 15 – Program schedule available and hotel reservations open

August 1 – Members Only Registration opens

August 8 – Nonmember Registration opens

September 14 – Early bird registration deadline

October 2 – Last day AACAP room rate guaranteed at hotels

October 9 – On-demand Institute content available online

October 23 – First day of AACAP's 70th In-Person Annual Meeting

October 28 – Last day of AACAP's 70th In-Person Annual Meeting

Hotel Reservations

Hotel rooms in New York will sell quickly! Book your hotel room starting June 15, 2023. Visit the hotel page of the Annual Meeting website for more details and information.

New York Hilton Midtown
1335 Avenue of the Americas
New York, NY 10019
Rates: Early Bird (Limited availability) - $369/night
Regular Rate - $399/night
Check-in time: 3:00 PM, Check-out time: 12:00 PM

Sheraton New York Times Square
811 7th Avenue 53rd Street
New York, NY 10019
Rates: Early Bird (Limited availability) - $375/night
Regular Rate - $395/night
Check-in time: 4:00 PM,
Check-out time: 12:00 PM

When making your reservation, ask for the AACAP ANNUAL MEETING GROUP RATE to qualify for the reduced rate.

Both the New York Hilton Midtown and Sheraton New York Times Square Hotels will host scientific sessions for AACAP's Annual Meeting. Situated in the heart of Midtown Manhattan, both Annual Meeting Headquarter Hotels are optimal options to explore this dynamic, multicultural city! Located directly across the street from each other, both hotels sit in heart of non-stop excitement in midtown Manhattan. After attending AACAP's stellar educational offerings, you'll be steps from Times Square, Broadway, Radio City Music Hall, Central Park, the Museum of Modern Art, and hundreds of restaurants with cuisines ranging from Austrian to West African and everything in between. Complement your educational immersion at AACAP sessions with fun-filled adventures throughout the city.

Travel

Plane

New York City is served by 3 airports, the **John F. Kennedy International Airport (JFK)**, **LaGuardia Airport (LGA)**, and **Newark Liberty International Airport (EWR)**. For more information about the airlines serving these airports, flight schedules, and ground transportation options, visit **www.panynj.gov**.

Train

New York City is served by 2 main rail stations: **Grand Central Terminal** and **Penn Station**. Both are served by numerous bus and subway lines, including Metro-North Railroad, Long Island Railroad (LIRR), Amtrak, and New Jersey Transit.

What to Do in New York!

- **Central Park** is a visual masterpiece created by landscape designer Frederick Law Olmsted and architect Calvert Vaux. It has gone through major developments and restoration over time to carry on its initial purpose as an open-air oasis for a metropolitan city. No matter the season or reason for your visit, this national historic landmark is a setting for enjoying many pursuits. For more information, visit **www.centralpark.com**

- Forever at the forefront, the **Museum of Modern Art (MoMA)** is not only devoted to presenting the best in contemporary art, but also to promoting the understanding of modern art and expanding the definition of what is considered "art" in the first place. Whether it's showing you something you've never seen before, or showing you how to see something familiar in a new way, the MoMA is always an eye- and mind-opening experience. For more information, visit **www.moma.org**.

- New York City has an abundance of concert halls, but none is quite so storied as **Carnegie Hall**. Musicians of all walks and genres have entertained crowds in the venerable space; indeed, playing the venue looms as something of an unspoken benchmark in many artists' careers. The Italian Renaissance–style building—with a brick-and-terra-cotta facade and, in its main auditorium, plush red seats, impeccable acoustics and open design (there's no curtain, for a start)—has also hosted politicians, authors, comedians, and religious leaders for more than a century. For more information, visit **www.carnegiehall.org**.
- There's no better place to experience the excitement of New York than **Times Square**. Surrounded by neon lights, giant billboards, Broadway theaters, electronic ticker tape, and television studios, Times Square is truly the heart of Midtown. The TKTS Discount Booth (where theater tickets are sold at up to 50% off face value) is topped with a giant red staircase, open to visitors daily until 1am. Walk to the top of the steps and you'll be rewarded with a sweeping view of the area, including the site of the annual New Year's Eve Ball Drop. Elsewhere in Times Square, the City has created several new pedestrian-only zones furnished with tables and chairs, perfect for people-watching. The neighborhood is central to Midtown West, located near the Theatre District and Broadway shows. For more information, visit **www.timessquarenyc.org**.

- Take a tour around the city! **Tour St. Patrick Cathedral** and other beautiful architecture or stop into **Radio City Music Hall**. You can experience the golden New York culture all within walking distance. The city is full of life and waiting for you to see it all! Countless museums, attractions, and events right at your fingertips.

For more information about other New York City attractions, please visit: **www.nycgo.com**.

CAP@Home: Annual Meeting Virtual Experience

Want to experience the Annual Meeting, but can't make it to New York? New, this year, we're offering CAP@Home, a limited virtual version of the Annual Meeting. CAP@Home includes:

- Up to 63 CMEs
- 9 Institutes on topics such as psychopharmacology, bipolar disorder, autism, anxiety, and much more!
- Live stream of all General Sessions
- Over 300 virtual new research posters

Visit **http://www.aacap.org/AnnualMeeting-2023** for more details.

New Research Poster Call for Papers

AACAP NYC October 23-28 2023

AACAP's 70th Annual Meeting takes place October 23-28, 2023, in New York, NY. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, administration, etc.

Verbal presentation submissions were due F**ebruary 15, 2023**, and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by **June 7, 2023**. All Call for Paper applications must be submitted online at **www.aacap.org**. If you have questions or would like assistance with your submission, please contact AACAP's Meetings Department at 202.966.7300, ext. 2006 or **meetings@aacap.org**.

ANNUAL MEETING • OCTOBER 23-28, 2023

Don't Miss This Opportunity to Save Money!

AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount on their 2023 AACAP Annual Meeting registration. All referrals must be ***first-time AACAP exhibitors*** and must purchase a booth for the AACAP Annual Meeting in New York City.

Exhibitors can connect with more than 5,000 child and adolescent psychiatrists and other medical professionals from around the world, as well as advertise in several of the Annual Meeting publications. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. To review the Invitation to Exhibit with more details on these opportunities, as well as forms to sign up, please visit **www.aacap.org/AnnualMeeting-2023**.

Show your support for AACAP and save today!

Questions? Email **exhibits@aacap.org** or call 202.966.7779.

Medical Students, Residents, and Trainees: Attend AACAP's Annual Meeting for FREE!

Register as a Monitor and we'll waive your general registration fee!

AACAP's Annual Meeting is the largest gathering of child and adolescent psychiatrists in the world. Monitors assist AACAP staff in running the meeting by checking badges, collecting tickets, and supporting speakers in sessions. Monitors are required to volunteer for either one full-day session or two half-day sessions.

Why Become a Monitor?

- **FREE** general registration for the Annual Meeting!
- **Half-priced** tickets for most ticketed events!
- **Networking opportunities** with presenters and peers!

How to become a Monitor?

- Medical students, residents, or trainees interested in monitoring at the Annual Meeting must provide AACAP with a completed verification form supporting their enrollment in a training program before they can sign up to monitor.
- Starting in July, email **meetings@aacap.org** expressing interest in the program and request a verification form.

Register Early?

- Monitor registration opens August 1 for AACAP members only. Nonmember registration opens August 8.
- Increase your chances of getting the Monitor assignment that you want by becoming an AACAP member today!

For more information about the Monitor Program, visit **www.aacap.org/AnnualMeeting-2023.org** or email **meetings@aacap.org**.

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AACAP's Lifelong Learning Committee has developed a series of ABPN-approved **checklists and surveys** to help fulfill the PIP component of your MOC requirements. Choose from over 20 clinical module forms and patient and peer feedback module forms. Patient forms also available in Spanish.

AACAP members can download these tools at **www.aacap.org/pip**.

Live/Virtual Meetings

(www.aacap.org/cme)

Pediatric Psychopharmacology Institute
— Up to 12.5 CME Credits

Douglas B. Hansen, MD, Annual Update Course
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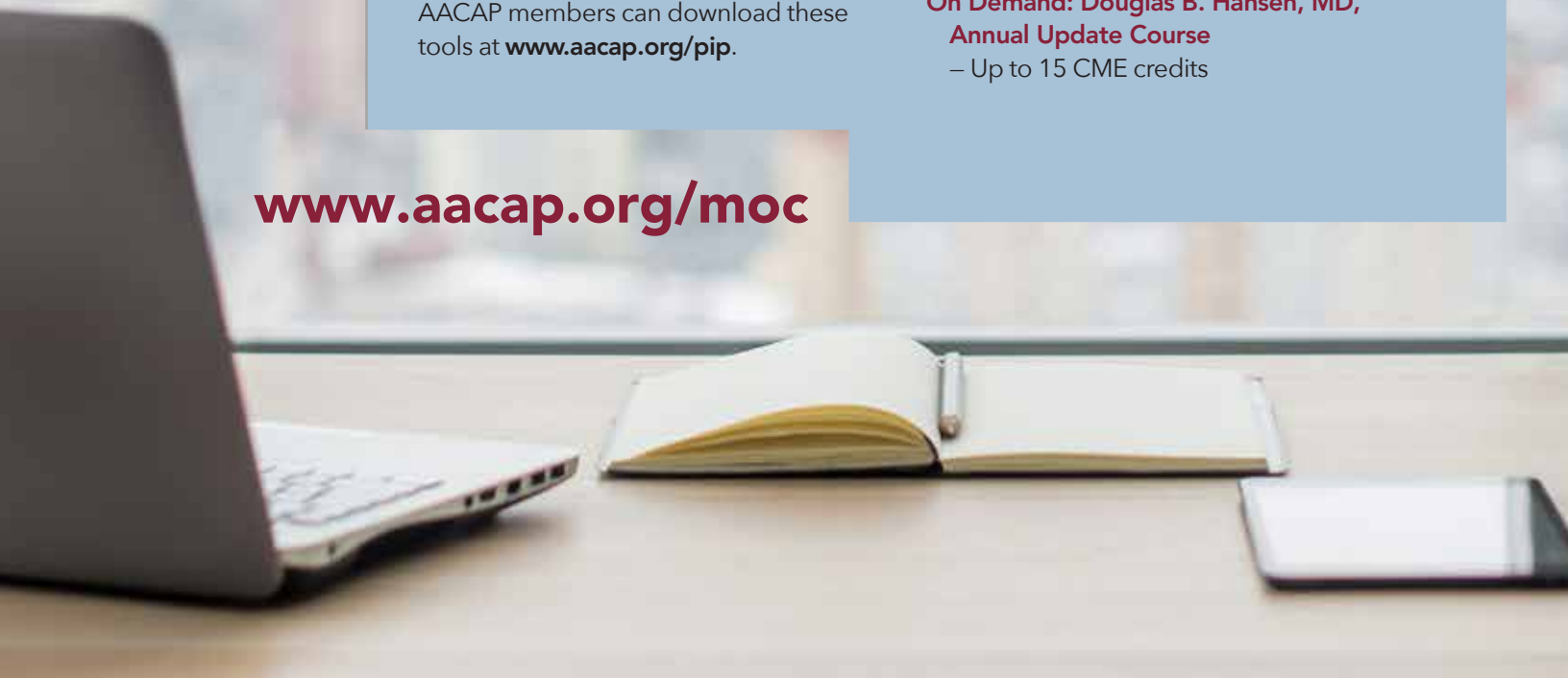

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The Evidence for Psychodynamic Interventions for Infants and Young Children and Their Caregivers




Isabella Vainieri, MD, Michelle Sleed, MD, Elizabeth Li, MD, and Nick Midgley, MD

"What is a normal child like? Does he just eat and grow and smile sweetly? No, that is not what he is like. The normal child, if he has confidence in mother and father, pulls out all the stops. In the course of time, he tries out his power to disrupt, to destroy, to frighten, to wear down, to waste, to wangle, and to appropriate . . . At the start he absolutely needs to live in a circle of love and strength (with consequent tolerance) if he is not to be too fearful of his own thoughts and of his imaginings to make progress in his emotional development."

– Donald W. Winnicott, 1946

It is a well-known fact that the first years of development set the foundation for a lifelong process of psychological and social development. This process does not start at school or at home, but early in the womb. It is associated with simultaneous changes in the brain, a brain which develops more rapidly during the first five years of life than at any other time. The image that "children are like sponges" during this critical developmental period is, after all, not too far from reality.

The baby and young child are totally dependent on the adults around them to take care of them, and this care is strictly necessary for their survival. It is not surprising that, given the critical timing for brain development and the young child's total dependency on the social environment, the first five years of life are a crucial period for human development, where adverse experiences can open the door for life-long negative effects. On the other hand, given the plasticity and flexibility of this period, targeted interventions during this time can lead to immediate and long-lasting positive outcomes. Early interventions are therefore of critical importance.

Historically, many models of early intervention have their roots in psychoanalytic and psychodynamic approaches, which have given early child experiences a central role for psychological wellbeing. From the 1950s, even more interest was given to child development from not only a psychoanalytic point of view (e.g., Anna Freud) but also from psychosocial and behavioural perspectives. Despite the range of early interventions borne out of the psychoanalytic tradition, it is only recently that systematic, evidence-based evaluations of such approaches have been carried out.

The early systematic reviews that summarized the evidence for psychodynamic child psychotherapy (Kennedy, 2004; Midgley & Kennedy, 2011) provided initial indications of the effectiveness of psychoanalytic and psychodynamic psychotherapy for children and adolescents. These publications were followed by several others, right up to the most recent one in 2021, which evaluated the evidence of these interventions for a broad range of mental health difficulties (Midgley et al., 2021). However, these works focused on children and adolescents and excluded studies focused on children under 3 years of age, or those including perinatal interventions. The few studies that have systematically investigated early interventions for infant and caregivers either focused on a specific intervention modality only (e.g., parent-infant psychotherapy) or on specific difficulties (e.g., depression).

Given the increasing need to better inform clinical practice, the Association of Child Psychotherapists (ACP) in the United Kingdom commissioned a systematic review and meta-analysis to a research team at the Anna Freud Centre, led by Dr. Michelle Sleed. The main aim of the review was to systematically synthesise evidence for the efficacy and effectiveness of psychoanalytic and psychodynamic interventions for children under five years of age and their caregivers. Specifically, the team was interested in examining the extent to which psychodynamic interventions are effective/efficacious in the prevention and treatment of mental health difficulties in children under five years of age and their caregivers. The review also aimed to provide a summary of the current models of psychodynamic interventions available for children under five years of age and their caregivers (at least those which have been systematically evaluated) and an overview of the types of families who these programs serve.

With these aims in mind, a detailed search was conducted for studies published between 1990 and September 2021 across ten electronic databases. Studies were included if (a) they were peer-reviewed and published in English; (b) their description of intervention

stated that the approach was informed by psychoanalytic or psychodynamic theories; (c) their primary target of intervention was children under five years of age and their caregivers as well as those in the prenatal period; and (d) the primary concern was with evaluating treatment outcomes. This search led to the screening of more than 14,000 studies, of which 77 were included in the review.

Overall, 22 models of psychoanalytic and psychodynamic interventions were identified. These interventions broadly fell into three categories: contemporary psychodynamic, mentalization-based interventions, psychoanalytically-informed attachment-based interventions, and dyadic (or triadic) psychoanalytic and psychodynamic psychotherapies. The main outcomes of these interventions were to improve parental reflective functioning, parental depression, infant socio-emotional and behavioral wellbeing, infant attachment, parent-infant interactions, and parenting stress.

The review set out to systematically compare the outcomes for families receiving the psychodynamic interventions with those for comparison interventions (for example, an alternative therapy or usual care) by conducting a meta-analysis. Overall, the meta-analysis showed that psychoanalytic and psychodynamic interventions were significantly more effective at helping to improve parental reflective functioning (mentalizing), maternal depression, infant behavior, and infant attachment. No differences in effectiveness between the control and the psychoanalytic and psychodynamic interventions emerged for parental stress and parent-infant interaction.

Overall, these results provide a step forward in establishing the evidence-base for the psychodynamic approach to working with children under five, as well as a first integrated view of the range of theoretical underpinnings for such interventions. These results are encouraging, and the hope is that they will contribute to increasing the range of evidence-based approaches that are considered when working with children under five and their caregivers.

"One important limitation that emerged from this review is that there is an urgent need for evidence from studies with larger sample sizes and higher quality of methodology. In fact, the majority of the studies reviewed were modest in size and focused on pre-post interventions effects with relatively short follow-ups times."

The findings also help set out a clear agenda for future research, as well as the opportunity for clinical developments, such as the need to develop psychodynamic interventions that better support levels of parental stress.

One important limitation that emerged from this review is that there is an urgent need for evidence from studies with larger sample sizes and higher quality of methodology. In fact, the majority of the studies reviewed were modest in size and focused on pre-post interventions effects with relatively short follow-ups times. Few studies conducted rigorous randomized controlled trials using an adequate sample size. In the future, an improvement in the quality of the methodology used for research in the field will aid in producing more evidence and help in better understanding the long-term outcomes of such interventions. This will, of course, require funding bodies to be prepared to support such research. The indications of this systematic review suggest that the psychodynamic approach has preliminary evidence of effectiveness, and so justifies further studies. Such interventions may help to ensure that infants receive the 'circle of love and strength (with consequent tolerance)' that Winnicott identified as so central to their healthy development. ■

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Continued on page 151

Will the Gargantuan California $4.7 Billion Dollar Children's Mental Health Effort Fill the Gap?

Miriam Goldblum, MD, and William Arroyo, MD

The governor of California and the state legislature approved the governor's Child and Youth Behavioral Health Initiative (CYBHI or **Master Plan for Kids' Mental Health**) as part of the FY 21-22 budget in June of 2021. Four months later, a **National Emergency in Child and Adolescent Mental Health** was declared by the AACAP-AAP-CHA coalition. **U.S. Surgeon General**, Dr. Murthy, indicates that the CYBHI is a promising state model, and its priorities align with those of his Advisory on children's mental health.

The level of funding for the CYBHI was initially an unprecedented $4.4 billion dollars which has since swelled to a $4.7 billion dollar initiative for a period of five years. The California Health and Human Services agency oversees this effort by way of a coalition of state departments including Public Health, Health Care Services, Surgeon General, Healthcare Access and Information, Managed Healthcare and further collaborates with state Education and Public Social Services. The initiative targets all 0–25-year-old individuals from all sectors.

Several factors converged to trigger the launch of such an ambitious effort in California. These included an exceedingly healthy economy, unprecedented surplus of tax revenue for the state during the Covid-19 pandemic, a meteoric rise in the need for mental health services among youth during the pandemic, a shortage of mental health professional staff, severe healthcare inequities, a 2020 **state audit** concluded that schools were inadequately prepared to enact youth suicide prevention strategies among others.

While the level of need for mental health services among youth was substantial prior to the recent pandemic, a higher level of need became evident during the pandemic. A **survey** conducted by **KidsData**, a health and well-being data of California's children, revealed that depression-related feelings for at least two weeks was prevalent among 30.4% of seventh graders, 32.6% of ninth graders, and 36.6% among eleventh graders. In a related **survey**, 15.8% ninth graders and 16.4% eleventh graders expressed suicidal ideation. The number of suicides among youth, ages 12-19, in California in 2018 had increased by 15% since 2009. A recent **review of statewide hospitalization discharge data** revealed that the number one primary diagnosis was "mental diseases and disorders."

The shortage of mental health professionals in California was recently reported in a **study** conducted by UCSF in which significant portions of psychiatrists and psychologists are near retirement age. In addition, **nearly a third of California counties** are without a single child and adolescent psychiatrist.

The vison of the CYBHI is an ecosystem in which a broad array of child and family relevant services, including mental health, and communities support the development and well-being of children and their families.

The **approach** of the CYBHI is to: reimagine the ecosystem supporting youth emotional, mental, and behavioral health; focus on prevention and early intervention; expand equitable access; "meet our kids where they are"; scale effective ideas; build a larger, more diverse, and more skilled workforce; catalyze alignment and coordination; and raise awareness and reduce stigma.

Fourteen separate workstreams include: establishing a behavioral health services virtual platform ($633 million); healthcare provider training and e-consult ($167 million); school-linked partnerships ($550 million); enhanced Medicaid benefits to include dyadic services ($745 million); **student behavioral health incentive program** ($389 million); scaling evidence-based and community-defined practices ($429 million); **behavioral health continuum and infrastructure program** ($481 million) which includes an additional 36 youth inpatient beds in Los Angeles, a new 22 inpatient bed unit in Visalia, and a 32 SUD residential unit in Orange; **CalHOPE student services** ($45 million); statewide fee schedule for school linked services; behavioral health counselor and coach workforce ($338 million); expansion of behavioral health workforce capacity ($427 million) which in 2022 includes new 26 new general psychiatric slots, 13 new CAP slots, and 6 addiction fellows; public education and change campaign ($100 million); ACE's and toxic stress awareness campaign ($24 million); and trauma-informed training for educators ($1 million). The timeframe for the rollout of the various components is staggered from 2021-26. More information is in the **CYBHI January 2023 Progress Report**.

Other initiatives which complement the CYBHI is the implementation of the **new State Medicaid Plan** which mandates that managed care plans partner with schools to provide health and mental health services. Additional funding of $290 million has been made available to address urgent and emergent youth needs, e.g., suicide prevention. The

Department of Education announced a massive expansion of school based mental health supports with recent additional funding of $184 million. Additional complementary federal initiatives include the **federal support** for school based mental health services; **Families First Prevention Services Act**, especially in regard to supporting evidence-based practices, and the recent **Omnibus Act of 2023**.

One of the many challenges will likely be the level of funding newly allocated, if any, at the termination of the funding cycle of five years. Some of the direct service components are more likely to be sustained than others especially if such are reimbursable. Another challenge is that competition for hiring and retaining mental health professionals among state, county, commercial and non-profit agencies has been **a major stumbling block** in rolling out services in the recent past.

Despite what appears to be progress achieved in children's mental health, the input of CAP's has been limited. The California Academy of Child and Adolescent Psychiatry (CALACAP) recently met with the director of the CYBHI to learn about the progress, to voice the concern that CALACAP had not been provided opportunities to participate in formal planning, and to exchange additional ideas. CALACAP membership is now invited to participate in further planning; unfortunately, planning meetings are conducted during the day thereby discouraging CAP input. CALACAP also expressed concerns about the implementation of a virtual services platform which had not been subject to rigorous study. Nonetheless, CALACAP remains committed to collaborating with CA-AAP and CYBHI leadership going forward. CALACAP members are cautiously optimistic of this ambitious initiative. ■

One of the authors (WA) had an opportunity to directly participate in the development of one of the components of the CYBHI along with Steven Adelsheim, MD, of Stanford University and Ken Wells, M.D., of UCLA.

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William Arroyo, MD, Adjunct Clinical Assistant Professor, Keck USC School of Medicine, Department of Psychiatry and Behavioral Sciences, and advisor to California Department of Health Care Services.

The Evidence for Psychodynamic Interventions (*Continued from page 149)*

with child welfare involvement. Her work is also focused on assessment of attachment and caregiving. She has contributed to the development and refinement of measures of parental mentalizing and caregiving representations and is particularly interested in the application of these measures in the perinatal period. She trains professionals in the application of these measures for research and clinical practice.

Elizabeth Li is a writing-up year PhD student (2019-2023) at UCL Research Department of Clinical, Educational, and Health Psychology and Anna Freud National Centre for Children and Families. She works as a teaching assistant at UCL Faculty of Brain Sciences and Faculty of Education and Society across six modules in psychology. She was an exchange scholar (Apr-Sep 2022) at Yale University Department of Psychology. Much of her research looks at early adversity, psychological mechanisms, and unmet mental health needs in vulnerable individuals. She is the winner of the British Association for Counselling and Psychotherapy (BACP) New Researcher Award 2022.

Nick Midgley, PhD, is Professor of Psychological Therapies with Children and Young People at University College London (UCL) and the Anna Freud Centre, London, where he is also director of the Child Attachment and Psychological Therapies Research Unit (ChAPTRe) and academic director of the doctorate in Child and Adolescent Psychotherapy. He is the author, among other works, of Mentalization-Based Treatment for Children: a Time-Limited Approach (APA, 2017).

Discrimination and Racial Injustice: Are we moving forward, backwards, or marching in place???

■ **Jonathan J. Shepherd, MD, FAPA, DFAACAP**

Are we moving forward, backwards, or marching in place??? Within a two-week time span, the United States of America celebrated the birth of the great civil rights leader, the Reverend Doctor Martin Luther King, Jr., and the start of Black History Month recognizing the achievements and contributions of Black individuals to the growth of our society. Ironic enough, our country witnessed the brutal beating and murder of an unarmed Black male during that same time frame by officers who pledged to serve and protect the citizens of our communities. Many people struggle with how such atrocities could take place when anti-racism conversations are gaining momentum in various corporate and institutional settings.

Are we moving forward, backwards, or marching in place??? The Supreme Court is poised to tackle the subject of affirmative action to determine if certain practices are discriminatory against all eligible applicants. While at the same time, a major media network pulls a popular Black male journalist from a highly rated news broadcast show for having a consensual romantic relationship with a fellow popular White female journalist. Their private lives are somehow seen as negatively impacting viewership and ratings.

These questions, atrocities, injustices and even the irony of these events since the start of year 2023 make me ponder if I am experiencing anachronism. Are we are moving forward, backwards, or marking time regarding diversity, inclusion, and equity efforts within our communities??? I've concluded that we can have the "right" guide but end up in the "wrong" destination.

Reverend Doctor King, also known as The Drum Major for Justice, made the following remarks in his sermon entitled "The Drum Major Instinct": "there is nothing wrong with the drum major instinct (the desire to be out front, the desire to lead the parade) but be first in love." Greatness comes from humble servitude. Because if you are not careful, the drum major instinct will lead to "snobbish exclusivism" and "tragic race prejudice." "Do you know that a lot of the race problem grows out of the drum major instinct? A need that people must feel superior….and to feel that their white skin ordained them to be first."

So I ask you: is the conductor of the "drum major instinct" within you advancing forward, pulling you backwards, or marking time in relation to your support of diversity, inclusion, and equity initiatives and uprooting the toxic ideologies of discrimination and racial injustice? I urge you to be transformational and not trendy when the opportunities present themselves to exercise fairness to persons within your scope of practice and influence. Allow yourself to be uncomfortable and challenged when Black people point out racism or discriminatory acts. Do not rely on the oppressed group to educate you about the racism principles enacted against them; the oppressed did not create the "drum major instinct" nor should they have to explain how it negatively impacts them.

I appreciate that an individual person marches to the beat of one's own drum. Regardless of the path taken, my hope is the person concludes his / her journey at the destination of equity, freedom, and peace for all. ■

Introducing groundbreaking research on the intersection of mental health and our changing climate, we present an insightful article submitted by esteemed members of AACAP's Climate Change/Climate Anxiety Resource Group. Originally published in *Academic Psychiatry* in October 2022, this compelling study delves into the profound impact of climate change on mental well-being and offers valuable insights for our AACAP members. With an aim to raise awareness and provide essential knowledge, this research highlights the urgent need for addressing climate anxiety in the field of psychiatry. **Acad Psychiatry 2022 Oct**

EDITORIAL

Climate Change and the Professional Obligation to Socialize Physicians and Trainees into an Environmentally Sustainable Medical Culture

Joshua R. Wortzel[1] · Anthony P. S. Guerrero[2] · Rashi Aggarwal[3] · John Coverdale[4] · Adam M. Brenner[5]

"Well done is better than well said."
—Benjamin Franklin

On entering medical school, all trainees take on the mantle of professionalism [1]. Professionalism, the collection of behaviors doctors engage in to communicate their fiduciary responsibility to their patients, is central to the trust at the core of the doctor-patient relationship [2]. Physicians in training learn these professional behaviors, as well as the values that govern them, primarily through observing and emulating their mentors, a process referred to as professional socialization [3]. The behaviors and beliefs that physicians adopt while undergoing professional socialization need to be constantly reexamined to ensure that medicine remains true to its fiduciary role. With this goal in mind, we wish to address medicine's contributions to climate change and the environmentally unsustainable behaviors that physicians are socialized to accept and adopt.

Climate change has been identified as the number one public health concern of the twenty-first century [4], and yet, as of 2013, the US health care system was responsible for 10% of US greenhouse gas emissions, 12% of acid rain production, 10% of smog formation, 1% of stratospheric ozone depletion, and 1–2% of other toxic emissions [5]. These effects on the environment contribute to an estimated loss of 614,000 disability-adjusted life years (DALYs) annually [6], a number comparable to the DALYs incurred by the patients who die annually from medical errors in the US health care system [7]. Climate change negatively impacts nearly all aspects of health [8]. In mental health alone, temperature fluctuations have been correlated with increased prevalence of a number of psychiatric disorders [9], and increased rates of trauma and posttraumatic stress disorder from more frequent and severe natural disasters contribute to increased rates of comorbid substance use and domestic violence [10, 11]. Medicine's contribution to this significant morbidity and mortality is incommensurate with its obligation to do no harm to its patients.

Psychiatry has a unique role to play in addressing medicine's current environmentally unsustainable culture because, first, a number of psychological factors make addressing medicine's carbon footprint difficult for physicians and, second, psychiatry has already started taking a leading role among the medical specialties in addressing its professional carbon footprint. Therefore, in this editorial, we briefly summarize current contributors to the US health care system's large carbon footprint, reflect on social and psychological factors that may support a medical culture that has not prioritized environmental sustainability, consider how this professional culture may endanger the doctor-patient relationship, and discuss how actions in medicine and specifically psychiatry can be adjusted to socialize medical personnel into a more environmentally sustainable practice that can also sustain the integrity of its fiduciary obligations. This discussion builds upon what *Academic Psychiatry* has previously published to call the psychiatric community to action in addressing climate change as a profession [12–15].

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Contributors to the US Health Care System's Carbon Footprint

Many factors contribute to the carbon footprint of the medical profession, though the largest are systemic, arising from the hospital sector (39%) and the development and distribution of prescription medications (14%) [16]. Modernizing hospital care has seemingly become synonymous with generating more trash. For example, over the past two decades, doctors in many nations have moved away from using multi-use medical devices to using single-use disposable devices in efforts to maximize efficiency and minimize health risks.

In one study conducted in Istanbul, disposable items contributed to a 330% increase in hospital waste production between 2000 and 2017, or approximately 0.43 kg of waste/bed-day to 1.68 kg of waste/bed-day [17]. In China and many Western medical systems, hospital waste can even be as high as 3–4 kg of waste/bed-day [18]. Some hospital executives are beginning to make concerted efforts to reduce their waste production and overall carbon footprints [19], though these efforts are still in their infancy.

The activities of pharmaceutical companies generate about 55% more greenhouse gas emissions than the entire automotive sector [20]. Efforts are underway within the pharmaceutical industry to be more environmentally sustainable, including using "green chemistry" to produce fewer environmentally hazardous byproducts, reducing packaging waste, and improving the transportation efficiency of their products [21]. So far these efforts have led to modest improvements in the overall carbon footprint of the pharmaceutical industry [22], though, like hospital systems, there is much room for further improvement.

While much of medicine's large carbon footprint is determined by large systems of care, individual decisions by physicians also have profound effects. For example, in 2018, 25% of the UK population was prescribed a psychotropic medication [23], yet a follow-up review estimated that at least 10% of total prescriptions were unnecessary (e.g., prescriptions were not clinically indicated, there were more effective non-pharmacological alternatives, prescriptions were redundant) [24]. The rationale of polypharmacy in psychiatry is multifaceted and has historically been difficult to address [25]; however, given the sheer number of psychotropics prescribed and the large carbon footprint generated by producing them, efforts to reevaluate psychiatrists' current prescribing practices could significantly minimize this waste and the carbon footprint it generates [26].

Professional travel also merits consideration. Traveling to and from the annual meeting of the American Psychiatric Association (APA) produces 1.2–1.6 metric tons of CO_2 per person [27], which is roughly equivalent to the per capita annual carbon footprint recommended by the Intergovernmental Panel on Climate Change to prevent worst-case scenarios of global warming by the end of this century [28]. Similarly, medical students applying to psychiatry residency before the COVID-19 pandemic produced on average 5.4 metric tons of CO_2 per person traveling to and from their interviews—nearly 4 times their recommended annual footprint [29]. Though telepsychiatry is still in its infancy and requires continued investigation, it too should be considered as a means of reducing psychiatry's carbon footprint [30]. A growing literature in other specialties has documented that the carbon footprints from travel for medical appointments can be substantial, ranging from 0.70 to 372 kg CO_2 equivalents per consultation [31]. To put these numbers in perspective, travel to and from all US ambulatory care visits in 2018 alone [32] generated a carbon footprint that was at least 30 times larger than the total carbon footprint produced by travel for the 2018 APA Annual Meeting [27]. Travel associated with medical training and patient care has historically been considered unavoidable, though COVID-19 pandemic–related travel restrictions that necessitated virtual meetings, interviews, and televisits have called the essentialness of these carbon footprints into question.

Factors in Medicine That Have Contributed to Environmental Unsustainable Health Care

There are multiple reasons why physicians have historically contributed so substantially to climate change. Perhaps the biggest is that many providers are still unaware of the significant environmental impacts of their practice [26]. In a sample of over 400 international members of the American Thoracic Society, 80% identified that climate change was relevant to patient care, yet nearly half reported lacking knowledge about how to address climate change with their patients, and only 30% were aware of what their hospitals were doing to address their carbon footprints [33]. Even for those who are knowledgeable about this topic, cultural forces within medicine, such as an emphasis on time efficiency, run counter to sustainability. In the same international survey, 45% of the responding physicians cited lack of time for why they did not address climate change in their clinical practice [33].

Other psychological factors may also contribute to physicians' significant contributions to climate change. For example, some medical providers, much like the general population, feel powerless to make an appreciable impact on climate change [34]. Some have also been socialized to believe that providing good health care comes at the cost of being less environmentally conscious [34], and those caught in this dialectic may manage this double bind and resultant moral distress through repression and denial [35]. Other physicians cope with their outsized carbon footprints through rationalizing that their good work as healers and helpers provides a "moral offset" that outweighs their contributions to climate

change [36]. However, these means of coping with the status quo are short-lived solutions that will become less tenable as climate change increasingly affects patients' health and as the public becomes more aware of medicine's impact on climate change.

How Medicine's Large Carbon Footprint May Endanger the Doctor-Patient Relationship

Core to the doctor-patient relationship is the mutual understanding that doctors have patients' best interests at heart. When this trust is broken, the doctor-patient relationship is fundamentally injured. As patients learn about all the ways that their physicians contribute to climate change and how climate change negatively impacts their health, they may lose faith in the doctor-patient relationship and disengage from the medical establishment. The relational tension currently observed between parents and their children who are anxious about climate change may offer some insights into what the relationship might come to look like for doctors and their patients. In a recent international study of 10,000 adolescents and young adults polled about climate anxiety, 59% of participants reported feeling very to extremely worried about climate change [37], and many expressed a deep sense of confusion, betrayal, and anger toward adults who they perceive as not doing enough to protect them from an unsafe future. For some young people, this perception has led to a feeling of outright antagonism toward adults who they feel are being emotionally neglectful and even abusive through their inaction to address climate change, and in others it has led to withdrawal from adults who they see as unresponsive to their needs [38]. Parental inaction regarding climate change is contributing to children developing anxious disorganized and anxious avoidant attachment with their caretakers.

The deleterious impact of a disrupted doctor-patient relationship is not just theoretical. We have seen this mistrust manifest most recently on a national scale in patients' mistrust of vaccines during the COVID-19 pandemic [39]; however, in a number of other instances where patients have perceived their physicians' fiduciary responsibilities as compromised, this perception has contributed to negative clinical consequences [40]. Patients' trust in their physicians has been shown to be directly related to patients' willingness to follow treatment recommendations and seek care in a timely fashion [41, 42]. In turn, following treatment recommendations and efficient access to care are directly associated with reduced health care costs and improved clinical outcomes [43, 44]. Beyond the loss of good feeling between patient and physician, the erosion of the doctor-patient relationship fundamentally threatens the quality of care a patient is receptive to receiving from their doctor, much as a child is less able to receive comfort and guidance from a parent whom the child perceives as ineffectual and insecurely attached. While only a theoretical concern currently, the unintended ramifications of medicine's contributions to climate change on the doctor-patient relationship should be considered, and damage to the doctor-patient relationship could hopefully be minimized through early action as a profession to be more sustainable.

Socializing Medical Personnel into a More Environmentally Sustainable Medical Culture

There is no question that, first and foremost, medicine needs to pursue means of reducing its carbon footprint to cultivate a medical culture that is attentive to its effects on climate change. Instituting systems-level policies to enforce greener hospital practices will be essential to this end. Medical systems, particularly outside the USA, have become increasingly aware of their carbon footprints, and they have been working to find ways to reduce their contribution to climate change. For example, in the UK, the National Health Service has set the goal of delivering carbon-neutral health care as soon as possible, and it has already reduced the carbon footprint of its delivery of care emissions by 57% compared to its 1990 levels [8]. Similar efforts have been made in Australia and Germany [8]. Clinicians in multiple specialties have also endeavored to find ways to reduce the individual carbon footprints of their medical procedures. For example, anesthesiologists in the UK have been advocating for the use of fewer disposable devices and have identified anesthetic agents with fewer damaging impacts on the environment [45]. Other organizations, such as the My Green Doctor Foundation [46], offer guidance and educational materials to physicians for how they can reduce their professional carbon footprints, and payment for carbon offsets (i.e., donations to companies for carbon sequestration and development of sustainable energy) is being used to minimize the net impact of professional travel on climate change [47]. The US government has recently established the goal of reducing the carbon footprint of the US health care system by 50% by 2030, and grants and agencies have been put in place to help support these efforts [48].

Psychiatry has taken a leading role in addressing its carbon footprint as a medical specialty. In 2017, the APA published a position statement affirming its commitment to "mitigate the adverse health and mental health effects of climate change" [49]. In 2019, it divested from companies with significant assets in fossil fuels [50], and in 2021, it established a presidential taskforce on social determinants of health, including environmental health, and created a committee on climate change and mental health to start providing recommendations for how, among other goals, it can reduce its carbon footprint. In accordance with this goal, the APA committee proposed an action paper (Malinas P, Wortzel JR, Haase E, Lee J, Fleming J: Toward making the carbon footprint of the APA Annual

Meeting carbon neutral) that was passed by the APA Assembly in November 2021 (Item 2021A2 12.O) to reduce the carbon footprint of the APA Annual Meeting by at least 50% by the year 2030.

However, efforts to reduce medicine's carbon footprint may only be nominal if they are not matched by corresponding changes in the culture of medicine on the individual level. For example, efforts to address racism in medicine primarily through policy changes, such as implementing affirmative action in medical school admissions, have had only limited effectiveness because they have not addressed the implicit racism among individual medical personnel [51]. Similarly, medical professionals need to become educated about their many subtle, personal contributions to medicine's carbon footprint and identify the factors that perpetuate these practices. Educators across a variety of medical specialties [52, 53], including psychiatry [54], are beginning to develop and integrate core learning objectives and classes pertaining to sustainable health care into preclinical and clinical training to help convey the importance of developing a more environmentally sustainable medical culture. In many cases, these curricular changes have been driven by medical trainees themselves who see the importance of learning this material [55]. There have also been efforts to start incorporating environmental sustainability into the quality-improvement programs that are already commonly built into many hospital systems and in which many medical trainees are actively involved [56]. Through these changes, the system-wide interventions to make medicine greener will hopefully be supported by a more widespread medical culture that sees the significance of supporting efforts to address the impacts of climate change on their patients and on the doctor-patient relationship.

Conclusion

The Intergovernmental Panel on Climate Change has determined that the world is at a "code red"—a dramatic reduction in humanity's carbon footprint is needed within this decade to prevent worst-case scenarios of global warming [57]. This reduction is necessary to preserve both human health and the health of the planet and all of its organisms. It is unconscionable that doctors should contribute so significantly to this crisis. Currently, cultural principles and psychological forces conspire to keep medicine environmentally unsustainable. Through education, physicians can foster a medical culture that socializes trainees and current practitioners into a practice of medicine that is more sustainable and preserves the fiduciary responsibility at the heart of the doctor-patient relationship. Doctors all over the world are starting to consider ways in which they can decrease their institutional and personal carbon footprints, and this consideration will role-model for trainees the importance of this task. Academic institutions are also investing in how to explicitly educate medical trainees and personnel to be more sustainable in their practices to propagate a culture that appreciates and supports the institutional changes underway to make medicine greener. Psychiatry as a specialty has been particularly active in this space, though continued efforts on the systems and individual levels are needed to maintain this momentum.

We encourage our readers to investigate how they can reduce their professional carbon footprints and engage in educating their colleagues, trainees, and the general public about this topic. Organizations such as the Climate Psychiatry Alliance [58] are actively considering these issues and offer opportunities to get involved with this work. Resources like My Green Doctor [46] can be used to find ways of reducing personal carbon footprints. Reducing professional travel and strategic use of telepsychiatry can also dramatically reduce carbon production. Psychiatrists also have a particularly important role to play in helping their colleagues in the rest of medicine recognize and overcome the psychological and social barriers that contribute to the perpetuation of a medical culture that is environmentally unsustainable. If medicine can make this transition in modifying its professional culture to be greener and to meet its professional obligations, its actions will speak louder than its words, and we can hope that this transition will not only protect the integrity of the doctor-patient relationship but will also serve to inspire the rest of society to follow suit.

Declarations

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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Poem

By Lourdes Chahin, MD

I am

I am not my age, my race
Nor the size of clothes I wear
I am not my height, my weight
Nor the texture of my hair.
I am not my name
My titles or degrees.
I am not the car I drive
Nor what street I live in.
I am not my portfolio
My assets or net worth
I am not the political party I belong

Who am I then?

I am all the books I've read
And every word I write
I am the sweetness in my laughter
And all the tears I've cried.

I am the songs I sing so loudly
When I know I am all alone
I am all the places I've been to
And the one that I call home.
I am the things that I believe in
And the people that I love.
I am the one who dreams
Of peace and justice in the world.
I am the green thumb lady
The one that listens to the birds
Like the most beautiful concert
She could ever attend.
I am my parent's dreams
my children's roots
and my grandchildren's wings.
I am all the photos in my bedroom
And the memories behind
I am the happiest moments of my life
When I saw my children's faces
For the very first time.

I have come to realize
I am made of so much beauty
But it seems that I forgot
When I decided I am defined
By all the things I am not

Poem

Perspective

By Wendy Welch, MD

All that I am is air in my nose
in two three out two three
fallen figure eight
peaceful reprieve, brief escape
infinite sleep, infinite wake

You call it Disorder
Dissociation
I call it Life-Preserver
Meditation
Before you enter my
Sacred Solitude
Before you disturb my
Tranquil Quietude
Affixing labels I can't pronounce
Pronouncing prognoses I can't denounce
learn my history, learn my wisdom

Don't remove the life-preserver
before teaching them to swim
Don't neglect the foundation
when building the will to live

If you take away my life-preserver
I'm sure I will drown
I'm the one who lived
I'm the one who cursed
the do-gooder fisherman
for breathing life, for awakening me
from my peaceful place of finality

So give me some time to tell you my secrets
show some respect for the brave little girl
who mastered escape, who gave up the fight
the ones who fought would lose their right
To breathe in
To breathe out

Earn my trust, learn from me
so I may someday learn
the joys of awakening from restful sleep
barely aware of morning's first grateful breath
in two three out two three
fallen figure eight
Infinite sleep, infinite wake

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

More Honor Your Mentor Submissions

Nerra Ghaziuddin, MD, and Mohammad Ghaziuddin, MD

Submitted by **Daniel E. Gih, MD**

I want to honor Drs. Neera and Mohammad Ghaziuddin. Mohammad always had an eye for asking key questions and staying academically productive and involved. Both invited me to work on projects and coached me on publications when I joined the faculty. Occasionally I got to speak about ECT for Neera Ghaziuddin when she could not make an event. After transitioning to Nebraska, I've kept in touch with them and saw them in Toronto. This is a lesson to trainees—keep in touch with the people who trained and mentored you. They are invested in your future and success!

Jeffrey Newcorn, MD

Submitted by **Iliyan Ivanov, MD**

We learn from all of our teachers; however, it is less often that we develop a relationship with a mentor that is not only collegial but becomes a part of our larger professional and personal lives. Dr. Newcorn was the mentor for my first Pilot Research Grant from AACAP – and besides being a mentor and a collaborator on almost all subsequent grants and projects, he also became a close friend – a part of the circle of people one calls when things go either unexpectedly awry or unexpectedly great. Dr. Newcorn is a kind of mentor who will not only support you in complicated situations, but he will also strategize with you to find ways to develop your future plans and at the same time would love to know your family and significant others. My late father always fondly remembered how he and Jeff grilled together during one of the division outings to Jeff's house during my fellowship. And after 20 years we did not just share countless clinical consultations, many publications and conference presentations, we also travelled overseas, went for bike-rides, did road trips and saw live music together. So, in this short note I want to honor not just my first mentor in child psychiatry but also my close-circle-of-friends special member Dr. Jeffrey Newcorn.

Andres Ramos H., MD

Submitted by **the University of Tennessee Health Science Center, Child and Adolescent Psychiatry Fellows: Onomeasike Ataga, MD, MPH, Ladoris L. Warren, MD, MBA, MS, Ian W. Michalak, MD, Mary Kay Bartek, MD, FAAP, Marisara Morales-Ortiz, MD**

"He is kind to patients, colleagues and most especially his trainees. He is approachable and can relate to his fellows on so many levels." – Onome

"Your genuineness, humbleness, and kindness are to be admired. You try your best to treat everyone equally which any person can appreciate." – Ladoris

"Dr Ramos is inspirational as a doctor, a boss, a mentor, and a person. He challenges us to grow and learn while always making the process fun and engaging." – Ian

"Dr. Ramos is an awesome clinician and person." – Mary

"Thanks for encouraging us to be the best we can be, and we will always be thankful to you for all the hard work and effort you have put in making us who we will be in the future." – Marisara

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Distinguished Fellowship Nomination Package Requirements:

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

Please submit completed nomination submissions to membership@aacap.org.

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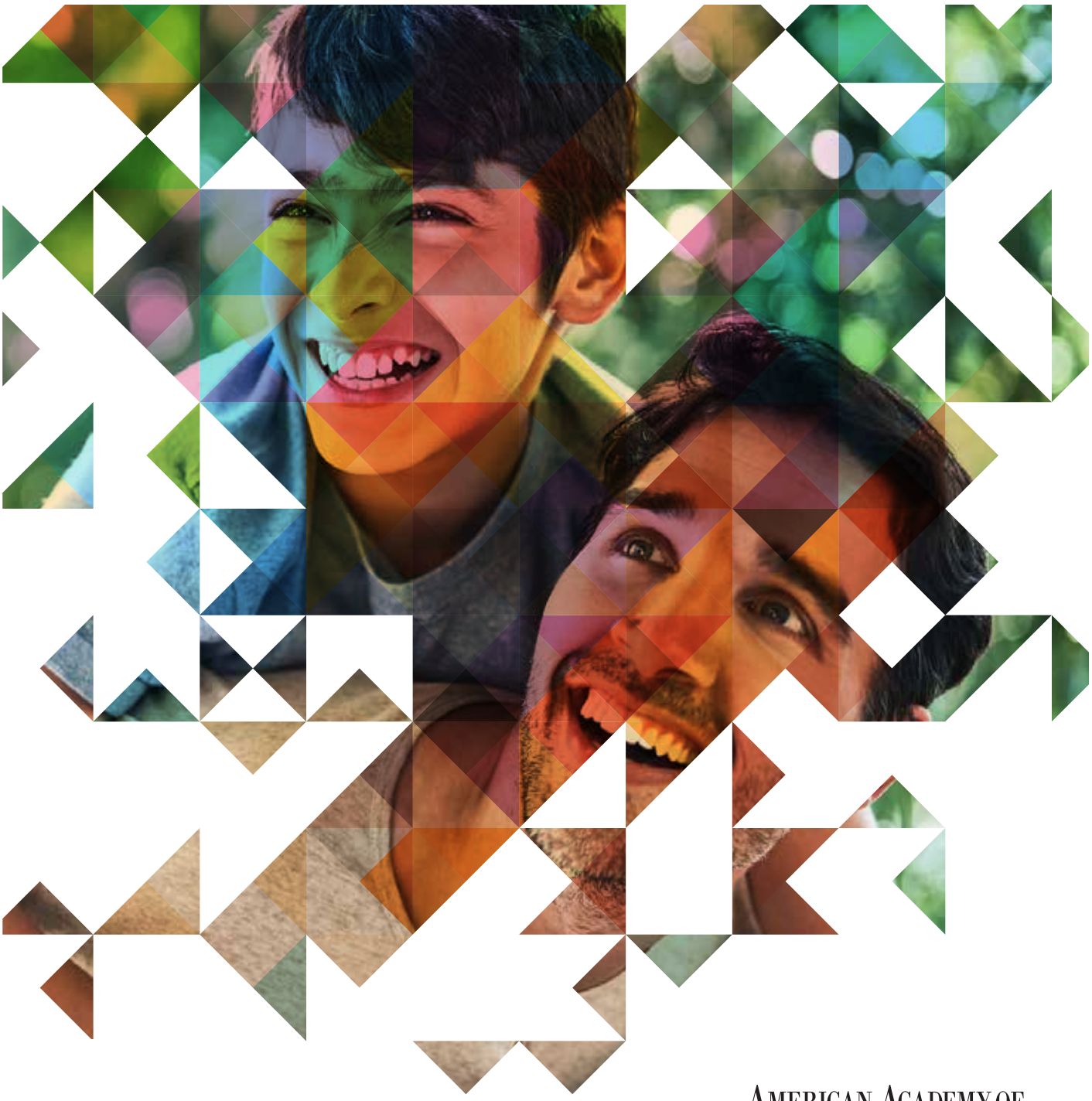

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American Academy of Child & Adolescent Psychiatry

www.aacap.org

American Psychiatric Association

CLASSIFIEDS

CALIFORNIA

Company: Sutter Health - Bay Area (1250789)
Title: Psychiatry, Child & Adolescent – Santa Cruz, CA
Job ID: 18292309
URL: https://jobsource.aacap.org/jobs/18292309

Job Description:
Palo Alto Foundation Medical Group is seeking a full-time, BC/BE Child/ Adolescent Psychiatrist Location: Santa Cruz, CA. Join a dedicated team of Adult Psychiatrists, Child/ Adolescent Psychiatrist, Nurse Practitioners, Therapists and Medical Assistants. Unique integrative behavioral health program, working closely with pediatricians and therapists with a shared EMR Opportunity to grow new programs and develop special interests. No call required. Opportunity to partner and educate other specialties about behavioral health Practice in beautiful beachside community, with close proximity to San Francisco and other greater Bay Area cities. Schedule flexibility. Psychiatry Residency Child and Adolescent Psychiatry Fellowship Palo Alto Foundation Medical Group. We are one of the largest multi-specialty medical groups in the country, made up of over 1,600 physicians in 40+ specialties, in practices throughout the San Francisco Bay Area. Our organization is nationally recognized for our excellence with multiple awards for quality of care, innovation and leadership. Palo Alto Foundation Medical Group is affiliated with Palo Alto Medical Foundation, a not-for-profit health care organization, providing operational and administrative support, including the latest technology, allowing physicians to focus on delivering exceptional patient care. EEO – Equal Employment Opportunity

Job Requirements:
Residency in Psychiatry – Child and Adolescent

CALIFORNIA

Company: Pacific Clinics (1339828)
Title: San Jose – Child & Adolescent Psychiatrist
Job ID: 18335691
URL: https://jobsource.aacap.org/jobs/18335691

Job Description:
Pacific Clinics seeks a BE/BC California-licensed Child and Adolescent Psychiatrist (CAP) to work 20 hours per week in a new integrated health program in San Jose. At least 8 hours per week must be in-person; up to 12 hours per week may be provided via telehealth. (Due to the COVID-19 crisis, all services may initially be remote.) Duties include psychiatric evaluation, medication management, consultation to primary care provider, and collaboration with clinicians providing psychosocial services. The integration of specialty mental health services in this established healthcare clinic is new, offering the CAP opportunities to build consultative relationships, teach, and contribute to program development with sponsorship from the agency's Medical Director (also a CAP). Though calls are unusual, the CAP must be available to staff 24/7 by phone for urgent medication-related situations. If you or someone you know may be interested in learning more about this opportunity please contact Program Director Duyen Pham at **duyen.pham@pacificclinics.org** or Chris Eggleston MD, Medical Director, at **ceggleston@pacificclinics.org**.

FLORIDA

Company: Johns Hopkins All Children's Hospital (1336635)
Title: Child & Adolescent Psychiatry/ Johns Hopkins All Children's Hospital
Job ID: 18352622
URL: https://jobsource.aacap.org/jobs/18352622

Job Description:
Johns Hopkins All Children's Hospital (JHACH) in St. Petersburg, FL, is recruiting a BE/BC Child & Adolescent Psychiatrist to join our team. JHACH is a 259-bed teaching hospital, ranked as a *U.S. News & World Report* Best Children's Hospital in four pediatric specialties (2022-2023). We have been consistently ranked as one of the top children's hospitals in Florida. JHACH is the only US hospital outside the Baltimore/Washington, DC location that is part of the Johns Hopkins Medicine system. Highlights of this opportunity include: The child and adolescent psychiatry program is part of All Children's Specialty Physicians, a growing multidisciplinary group practice at JHACH that includes more than 200 physicians. Our current team consists of three child and adolescent psychiatrists (including the new hire), a mental health NP and over 20 psychologists. We provide evaluation and treatment for a wide range of conditions and see new patients ranging in age from approximately three years to age 17. Established patients are seen until age 21 in order to assist in the transition to adult care. At present, JHACH does not have an inpatient psychiatric unit. 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 responsibilities include child psychiatry fellows from University of South Florida (USF) as well as pediatric residents from the JHACH and the USF residency programs. Candidates will have excellent clinical and interpersonal skills, be team oriented and embrace educational innovation. JHACH is a leader in children's health care, combining a legacy of compassionate care with the innovation and experience of one of the world's leading health care systems. 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 amenities, minutes from the beautiful gulf beaches, two hours from Orlando, and four hours from Miami. To learn details, please contact: Joe Bogan Providence Healthcare Group (817) 424-1010 (Direct) **jbogan@provdoc.com**.

MASSACHUSETTS

Company: Cambridge Health Alliance (1177750)
Title: Neurodevelopmental Child/ Adolescent Inpatient Psychiatry
Job ID: 18331076
URL: https://jobsource.aacap.org/jobs/18331076

Job Description:
The NEW CHA Center of Excellence for Child & Adolescent Inpatient Mental Health Care at Somerville will provide a transformative continuum of patient- and family- centered care for diverse youth with mental health needs. Including specialized autism spectrum/ neurodevelopmental beds at our Somerville Campus. Cambridge Health Alliance is already one of the region's leading providers of behavioral and mental health care. We are passionate about helping children and their families, join our expanding team and make a difference! CHA provides Competitive Salaries starting at $300,000 and Sign on Bonuses! Provide clinical care to patients during periods of inpatient/ partial hospitalization. Develop and maintain comprehensive treatment plans. Participate in teaching opportunities with psychiatry residents, fellows, and other mental health trainees. Work in a collaborative practice environment with an innovative clinical model allowing our providers to focus on patient care and contribute to population health efforts. Fully integrated electronic medical record (Epic) and robust interpreter service. Academic appointments are available commensurate with criteria of Harvard Medical School. Candidates with special interest and training in Neurodevelopment encouraged to apply.

Job Requirements:
Qualified candidates will be BC/BE in psychiatry and share CHA's passion for providing the highest quality care to our underserved and diverse patient population. Please submit CVs through our secure website at **www.CHAproviders.org**, or by email to Melissa Kelley at **ProviderRecruitment@challiance.org**. The Department of Provider Recruitment may be reached by phone at (617) 665-3555 or by fax (617) 665-3553. In keeping with federal, state and local laws, Cambridge Health Alliance (CHA) policy forbids employees and associates to discriminate against anyone based on race, religion, color, gender, age, marital status, national origin, sexual orientation, relationship identity or relationship structure, gender identity or expression, veteran status, disability or any other characteristic protected by law. We are committed to establishing and maintaining a workplace free of discrimination. We are fully committed to equal employment opportunity. We will not tolerate unlawful discrimination in recruitment, hiring, termination, promotion, salary treatment or any other condition of employment or career development. Furthermore, we will not tolerate the use of discriminatory slurs, or other remarks, jokes or conduct, that in the judgment of CHA, encourage or permit an offensive or hostile work environment.

MASSACHUSETTS

Company: Buyer Advertising (1059546)
Title: Child and Adolescent Psychiatrist – Medical Director
Job ID: 18335129
URL: https://jobsource.aacap.org/jobs/18335129

Job Description:
Child and Adolescent Psychiatrist – Medical Director. McLean Hospital, America's top ranked freestanding psychiatric hospital, is inviting applications for a full-time child and adolescent psychiatrist to join our McLean-Franciscan Child & Adolescent Mental Health Programs at Franciscan Children's in Boston, Massachusetts. This program is part of a 25-year partnership between Franciscan Children's and McLean Hospital to provide the highest quality acute child psychiatric care. The position involves half-time medical director role at our child acute residential program, serving ages 4-14, and half-time attending psychiatrist on our child & adolescent inpatient psychiatric program, serving ages 3-19. Our multidisciplinary team provides first-class treatment to children and adolescents and their families in an exciting environment including Harvard-affiliated psychiatry, psychology, and social work trainees, plus opportunities for research and academic pursuits. As part of our expanding team, the child and adolescent psychiatrist will have the opportunity for both leadership & professional collaboration with colleagues at our McLean-Franciscan Child & Adolescent Mental Health Programs, and inclusion in Division-wide programs at the main Belmont campus, Arlington, Cambridge, and Middleborough, MA. Salary and recruitment package in accordance with Hospital policies, and a Harvard Medical School appointment at the academic rank of Lecturer, Instructor or Assistant Professor (full or part time) will be contingent on meeting the requirements for an HMS appointment and candidate qualifications including Massachusetts medical license and being board certified/board eligible. Qualifications: MD or an MD, PhD, and Board Certification in Psychiatry Applicants should submit a letter of interest and curriculum vitae along with the names and addresses of three references by email to: Daniel Dickstein MD; Chief, Simchas Division of Child and Adolescent Psychiatry; McLean Hospital; 115 Mill Street; Belmont, MA 02478; Email: **DDickstein@McLean.Harvard.edu** and the Registrar and Professional Staff Office at **rpsomclean@partners.org**. All McLean team members are expected to consistently demonstrate our values of integrity, compassion, respect, diversity, teamwork, excellence and innovation in their work activities and interactions. We are an equal opportunity employer, and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, gender identity, sexual orientation, pregnancy and pregnancy-related conditions or any other characteristic protected by law. A member of Mass General Brigham.

MASSACHUSETTS

Company: Boston Children's Hospital (1343571)
Title: Boston Children's Hospital, Emergency Psychiatry Service Medical Director
Job ID: 18339196
URL: https://jobsource.aacap.org/jobs/18339196

Job Description:
The Department of Psychiatry and Behavioral Sciences at Boston Children's Hospital is seeking a child and adolescent psychiatrist with exceptional leadership and clinical skills to serve as Medical Director of the Emergency Psychiatry Service. This is a full-time position for individuals interested in

providing consultation, assessment and management of children and adolescents in acute psychiatric crisis. The incumbent will be charged with overseeing a large multidisciplinary team of psychiatric social workers, nurse practitioners, psychiatry and psychology staff and trainees providing crisis care and evaluations in the emergency setting. A strong collaborative nature will be required to sustain existing partnerships and develop new collaborative relationships both across disciplines within the hospital setting and with local and state agencies as well as community organizations. Support will be provided for involvement in scholarly activities, research, and quality improvement initiatives related to emergency and crisis care. This individual must be able to envision current and future needs for mental health evaluation, treatment, and outcome assessment as they relate to children and their families presenting to the hospital in crisis. This position also offers unique opportunities for teaching, collaboration, and consultation to pediatric emergency medicine colleagues and is for the clinician who aspires to be a leader in emergency psychiatry and an educator of child psychiatry fellows, triple board fellows, pediatric residents and medical students. Applicants for these positions must be board eligible/certified in general and child/adolescent psychiatry. The position will include a Harvard Medical School appointment, which is expected to be at the Instructor, Assistant Professor or Associate Professor rank with salary dependent on experience and qualifications. Women and minorities are encouraged to apply. Applicants should submit a letter of interest and curriculum vitae to Patricia Ibeziako MD, Associate Chief for Clinical Services, Department of Psychiatry and Behavioral Sciences at **patricia.ibeziako@childrens.harvard.edu** We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, gender identity, sexual orientation, pregnancy and pregnancy-related conditions or any other characteristic protected by law.

MASSACHUSETTS

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NEBRASKA

Company: CHI Health Clinic (1345427)
Title: Child & Adolescent Psychiatry - Richard Young Behavioral Health Center - Kearney, NE
Job ID: 18399899
URL: https://jobsource.aacap.org/jobs/18399899

Job Description:
CHI Health Richard Young Behavioral Health is seeking a BC/BE Child & Adolescent Psychiatrist to join our dedicated and energetic team in Kearney, Nebraska. Richard Young offers a broad range of services to treat mental illnesses in an optimum therapeutic environment close to home. This opportunity offers: Outpatient and Inpatient coverage 45 bed acute care facility; OP clinic is attached for easy access Well-respected Telehealth program with connections to many locations throughout Nebraska. Excellent Care Continuum backed by Multidisciplinary Treatment Team. Generous Two year Income Guarantee + Relocation Allowance + Benefits. J1 and H1B Visa candidates welcome. Click here to learn more: Richard Young Behavioral Health Qualified Candidates please submit CV to: Hattie Burrell, Physician **Recruiterhattie.burrell@commonspirit.org**

NEBRASKA

Company:
Title: Child & Adolescent Psychiatrist - Omaha, NE
Job ID: 18399912
URL: https://jobsource.aacap.org/jobs/18399912

Job Description:
CHI Health and Creighton University School of Medicine are recruiting a Child & 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: Clinical opportunities located in outpatient clinic attached to hospital Hybrid model within clinic and hospital unit Faculty Appointment - if desired. Full primary care support. Superb support staff of experienced providers, nurses, therapists and administration. Excellent benefits package including CME, relocation, malpractice and tail insurance. Qualified Applicants please submit CV to: Hattie Burrell, Physician Recruiter **hattie.burrell@commonspirit.org**.

OHIO

Company: Graystone Group (1208803)
Title: Assistant Professor, Child & Adolescent Psychiatrist
Job ID: 18385028
URL: https://jobsource.aacap.org/jobs/18385028

Job Description:
Assistant Professor, Child & Adolescent Psychiatrist. The University of Toledo, college of Medicine and Life Science is seeking a full time Assistant Professor faculty to join the Department of Psychiatry as we expand our academic and clinical enterprise. Primary, this appointment will provide both inpatient and outpatient clinical services to children, adolescents, and adults. Provide supervision and teaching to medical students, residents, fellows and other trainees and lead treatment teams as assigned by the Department Chair or Vice Chair for Clinical operations. Minimum Qualifications: Board certified Unrestricted OH medical license Unrestricted DEA license Conditions of Employment: All Toledo employees on all campuses, including those working on campus and working remotely, are required to be fully vaccinated against Covid-19, or have an approved exemption. To promote the highest levels of health and well-being, the University of Toledo campuses are tobacco-free. To further this effort, the University of Toledo Health Science Campus Medical Center is requiring candidates for employment to be nicotine-free. Pre-employment health screening requirements will include cotinine (nicotine) testing, as well as drug and other required health screenings for the position. With the exception of positions within University of Toledo Main Campus and the University of Toledo College of Medicine and Life Sciences, the employment offer is conditional upon successful completion of a cotinine test and Occupational Health clearance. Equal Employment Opportunity Statement: The University of Toledo is an equal opportunity, affirmative action employer. The University of Toledo does not discriminate in employment, educational programs, or activities on the basis of race, color, religion, sex, age, ancestry, national origin, sexual orientation, gender identity and expression, military or veteran status, disability, familial status, or political affiliation. The University is dedicated to the goal of building a culturally diverse and pluralistic faculty and staff committed to teaching and working in a multicultural environment and strongly encourages applications from women, minorities, individuals with disabilities, dual-career professionals and covered veterans. The University of Toledo provides reasonable accommodation for individuals with disabilities. If you require accommodation to complete this application, or for testing or interviewing, please contact the Human Resources Department at 419-530-4747 between the hours of 8:30AM and 5:00PM or apply online for an accommodation request. Computer access is available at most public libraries and at the Office of Human Resources located in the Center for Administrative Support on the Main Campus of the University of Toledo. To apply, please visit **https://careers.utoledo.edu/cw/en-us/job/493615/assistant-professor-child-adolescent-psychiatrist**

WASHINGTON

Company: Department of Health (WA Health) - Child and Adolescent Mental Health Services (1342364)
Title: Consultant Psychiatrist
Job ID: 18287983
URL: https://jobsource.aacap.org/jobs/18287983

Job Description:
This is a Recruitment Pool for Fixed Term Full Time, Fixed Term Part Time and Sessional appointments for 5 years with the possibility of extension(s). WA Health has initiatives to support international and interstate recruitment and expedite employment for critical workforce shortages which includes travel exemptions and financial incentives of up to $8,000 for eligible international applicants and $6,000 for eligible interstate applicants to cover flight and relocation costs. Please see the attached FAQ for further information or contact **CAHS.ConsultantMedicalWorkforce@health.wa.gov.au** for further details. CAHS may consider relocation costs for staff who do not meet the criteria above. CAHS is willing to consider providing visa sponsorship opportunities for suitable applicants. Please visit the Medical Board of Australia website for more information on assessment pathways to registration for international medical graduates: **https://www.medicalboard.gov.au/Registration/International-Medical-Graduates.aspx**. Position Profile: We are seeking to appoint suitably qualified, experienced and enthusiastic medical practitioners for the position of Consultant Psychiatrist with the Child and Adolescent Mental Health Service (CAMHS). In this position, you will deliver specialist mental health services and work collaboratively with the Head of Service in overseeing the clinical management of all referred clients and providing clinical leadership. Western Australian government has made it a priority to implement widespread reform across the Public mental health services for Infants, Children and Adolescents aged 0-18 years. Priorities identified by the ICA Taskforce includes the development of: 12 Models of Care (MoC) cultural safety and social emotional wellbeing principles an Aboriginal Mental Health Workforce model a service guarantee These models will include delivery of services for Infant Child and Adolescent mental health

(0-12 years), Eating Disorders, Personality Disorder; Intellectual Disability, Neurodevelopmental Disorders and/or Neuropsychiatric Conditions focusing upon models of care service delivery and sustainability. This is an exciting time to join CAMHS if you would like to be at the forefront of mental health care to act earlier to help children and adolescents dealing with mental health issues. The Child and Adolescent Health Service (CAHS) is proud to be the leading service provider for pediatric healthcare in Western Australia, as the State's only dedicated health service for infants, children and young people. CAHS is made up of four service areas: Neonatology, Community Health, Child and Adolescent Mental Health Services (CAMHS), and Perth Children's Hospital (PCH). Consisting of over 5,500 employees, our services are delivered at PCH and King Edward Memorial Hospital (KEMH), as well as across a network of more than 160 community clinics across the metropolitan area. The Child and Adolescent Mental Health Services (CAMHS) in Western Australia offers support, advice and treatment to young people and their families who are experiencing mental health issues. Children and families are referred to Mental Health by their treatment therapist, specialist, GP, School or other community organization. CAMHS provides recovery-focused programs, and services for children from birth up until a person turns 18 years old. CAMHS has 3 directorates: Acute, Community and Specialized. Acute CAMHS CAMHS Crisis Connect provides phone and online videocall support for children and young people who are experiencing a mental health crisis, including: Specialist urgent tele-mental health support, Crisis management, Face to face mental health and risk assessment at PCH Emergency Department or via telehealth, Follow up within 24 hours of receiving an assessment or discharge from PCH. CAMHS Inpatient Unit/Ward 5A at Perth Children's Hospital: The state-wide assessment and treatment facility for children and young people up to 16 years old with complex and acute mental health issues. It is a recovery-focused patient and family-centered service, offering a seven-day multidisciplinary program in a safe environment for voluntary and involuntary patients as authorized under the Mental Health Act (2014). Pediatric Consultation Liaison Service and Gender Diversity Service: The Pediatric Consultation Liaison team works with other hospital teams to ensure that the assessment and treatment of patients is comprehensive, timely, responsive and effective. The Gender Diversity Service (GDS) is a specialist outpatient multidisciplinary service for the assessment and care of children and adolescents experiencing diverse gender identity. GDS is the only service in Western Australia which currently provides specialist multi-professional team assessment for, and access to, medical hormonal gender-affirming treatment for adolescents (including puberty suppression, and estrogen, testosterone, and anti-androgen treatments for older adolescents under age 18). Eating Disorder Service: A Tier 4 State-Wide Specialist Service, offering assessment (up to 16th birthday) and treatment (up to 18th birthday if existing client) to young people with severe eating disorders. It is a multi-disciplinary team who provide outpatient care, day treatment, inpatient care and support groups. The program supports children and young people and their families through assessment, recovery and discharge from the service. Our primary intervention is Family Based Treatment (FBT). Community CAMHS 10 Community clinics spread across the Perth wider metropolitan area, offering mental health assessment and multidisciplinary intervention for children and young people up to 18 years. Specialized CAMHS Pathways: A state-wide service providing assessment, treatment and support for children aged 6 to 12 years with complex and longstanding mental health issues and their parents/carers Touchstone: A structured day program for young people aged 12 to 17 years who are struggling to cope with relationships, mood difficulties and impulsive self-harming. Complex Attention and Hyperactivity Disorders Service: CAHDS is a state-wide service that works with children, young people (under 18 years old) and families who have persistent difficulties with attention and behavior.

For Further Job-Related Information: We encourage you to contact Dr. Vineet Padmanabhan on +61 (8) 6389 5800. Application Instructions: Applicants MUST apply online via MedJobsWA - Reference Number 11314.

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