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AADCAP Newsletter

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Dear AADCAP Members:

The past 6 months have been remarkable for the organization and for the country. COVID-19 changed the way that we live and practice medicine, and continues to impact our daily lives. The coronal virus pandemic forced the organization to cancel the meeting in Washington DC and instead organize a three-hour virtual meeting on April 2nd entitled “Leading During the Corona Crisis” That focused on the impact of the coronal virus on divisions of child and adolescent psychiatry. The structure of the town hall included 30-minute presentations on administration, clinical affairs, education and training, and research by committee chairs, followed by open discussion. Dr. Nora Volkow, the Director of the National Institute on Drug Abuse, presented the keynote address on adolescent substance abuse. Over 60 members of the organization participated in the meeting and the discussions were lively and informative. An additional virtual town hall meeting was held on May 21st entitled “Dealing with Continued Uncertainty Around the COVID Pandemic: Guidance for Child and Adolescent Psychiatry Program Directors.” Members as well as colleagues were invited to comment on how the pandemic affected the operation of Divisions and Departments and what additional initiatives were anticipated in the future. The response was again impressive and the experience both educational and fun. We are planning a fall AADCAP meeting to be held in conjunction with the Annual Meeting of AACAP, and just as that organization is moving to a virtual meeting, AADCAP will do the same. A three-hour session will be scheduled on Sunday October 18th with more information to follow.

Recent events forced the country to address the impact of racism on all aspects of American society, particularly as it effects African-Americans. AADCAP released a statement that recognized the tragic consequences of racism and pledged to work tirelessly to correct them. The most relevant issue for our organization is the inequity that exists in the access to and the quality of healthcare. AADCAP is committed to not only raise awareness about this issue, but also to consider ways to address this problem in the provision of psychiatric care for children and adolescents. Dr. Tami Benton, President-Elect of our organization, is forming an AADCAP Task Force on “Racism and Disparities” that will advise us on how to best utilize our roles as leaders in mental health care for children, and effect change in our communities.

The shortage of child and adolescent psychiatrists is a recurrent topic of discussion for AACAP and AADCAP, and multiple initiatives try to address this issue. Recruitment into child and adolescent psychiatry fellowship is now relevant particularly because approximately 30% of the fellowship programs do not fill through the Match each year. AACAP created a Task Force on the Crisis in Recruitment, chaired by Dr. Jeffrey Hunt from Brown University, that is considering a four-year curriculum for child and adolescent psychiatry that would recruit candidates from medical schools. AADCAP members Dr. John Walkup and I are on the Task Force, and the group is interested in the opinions of directors of child and adolescent psychiatry because we will be most responsible for making any proposal work. AADCAP recently received feedback on this issue from membership through the list serve and wrote a summary of the discussion that can be accessed through this newsletter. The summary will also be forwarded to Dr. Hunt and members of the Task Force. Please feel free to add additional comments and questions through the list serve.

AADCAP is a vibrant and growing organization whose membership has a direct impact on the nature and quality of mental health care provided to children and adolescents across the country. The list serve remains a vital tool for us to share ideas and broaden our capabilities. I am impressed by the content of the discussions and the participation by members and am excited to be working with such an outstanding group of professionals.

Sincerely,

D. Richard Martini, MD

President
As representatives and leaders of the American Association of Directors of Child and Adolescent Psychiatry (AADCAP), we express grief, anger, and sorrow over the deaths of George Floyd, Breona Taylor, and Ahmaund Arbery at the hands of law enforcement. Racism has been a persistent and malignant undercurrent in American society, and violence against minorities is part of this picture, particularly for African-Americans.

Our responsibilities as medical professionals include recognizing the tragic consequences of racism and working tirelessly to correct them. We realize inequities exist in the access to and the quality of healthcare, something that was particularly evident in the spread and consequences of the recent COVID epidemic. We must raise awareness about this issue, take action to ensure that the care we provide is sensitive to race and culture, and work to eliminate discriminatory practices in hospitals, clinics, and communities. We must also ensure the provision of non-discriminatory medical and psychiatric services by encouraging diversity among our clinical staff. In the process, we will better understand the patient’s experience, allow the patient and family to better identify with their caregiver, and encourage greater confidence in the treatment process. Among our responsibilities is the training of child and adolescent psychiatrists and future medical health professionals. We hope to instill the same sense of accountability for these principles in the patient care they provide now and in the future.

The events of the past few days tell us that there should no longer be different standards that exploit and victimize minorities in this country, whether through law enforcement and the justice system or by medical providers in the healthcare system. The American Association of Directors of Child and Adolescent Psychiatry promises to oppose all forms of racism and be accountable for programs and policies that promote diversity, inclusiveness, and respect for racial and ethnic differences.

D. Richard Martini, MD
AADCAP President

Tami Benton, MD
AADCAP President-Elect

Victor Fornari, MD
AADCAP Past President
Throughout AADCAP’s first virtual seminar focusing on CoVid 19, I continued to have associations between our current COVID-19 Pandemic and Hurricane Katrina. The fact that the two were resonating with each other made me want to think more about their similarities and differences. Why was I not associating CoVid to the numerous other large-scale societal crises like Vietnam, The Oil Crisis of the early 70’s, or the Dot Com Bust, 9/11, or 2008, all of which I lived through. That seemed simple as CoVid and Katrina impacted me more personally and have had more meaning to me. I am sure that others may be having associations to other crises, like my friend from New York City who had 20 friends die in the twin towers on 9/11. My associations turn to my thinking about the old saying “What’s the difference between ham and eggs?” To the chicken, it is a contribution, while to the pig it is a commitment. All crises have special meanings to those living through them.

Katrina and the current CoVid crisis are similar in that they specifically affected my life as a doctor in addition to family, friends and finances. The others all led to worries while Katrina and CoVid led to uncomfortable levels of anxiety often to the point of being overwhelming. During Katrina, I suddenly began to have occasional bouts of vertigo in the morning upon getting out of bed. Gosh, that’s an awful feeling! Gosh, what a wonderful somatic metaphor for when one’s world is literally spinning. The bouts came and went and still happen rarely during times when I am under great stress. They are a “marker” to me that I need to figure out what I am stressed about. I now know to get up slower from bed and if I have any semblance of vertigo to stare at my finger until the nystagmus abates. I have had no vertigo yet during CoVid, but have had the “aura” of it a few mornings, so I get up out of bed slowly just in case.

My circumstances today are much different than during Katrina. I am 15 years older! If you believe the song: “What a Difference a Day Makes!” can you imagine the impact of a decade and a half of days! During Katrina, I was much younger and “not in a major risk group”. How did that happen? At the time, I was the clinical director of a large mental health hospital system. I evacuated the day before Katrina with the hospital’s staff and patients based on a predetermined plan that was established after a previous hurricane during which there were many logistical problems. Due to this pre-planning, I did not actually have the honor of directly living through the storm in New Orleans.

I had a job to do then and did it. That made things simple for me as a “workaholic” who was not married and whose children no longer lived at home. I had few of the struggles over “work-life balance” issues so focused on in these times. There was an immense amount of work to do which was just fine for me as “doing things” is one of my major defenses against anxiety. I was fighting the good fight. I worked late hours and was quite creative and proud of myself for problems that I had a part in solving in response to the stunning lack of resources at the time.

Remember that, unlike during CoVid, during the early stages of Katrina, there was no internet or phone access as many of the phone towers and other equipment had been damaged. The infrastructure continued to be compromised for some time. It was especially disturbing that in the early aftermath of the storm that, many, including the younger patients, did not know where their families were nor had

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This fall, AADCAP will pilot having its meeting during AACAP’s Annual Meeting.

**MARK YOUR CALENDAR** for Sunday, October 18, 2020 from 12:00 - 3:00 p.m. Eastern time! This three-hour conference will feature topics from our committees—Administration, Clinical Affairs, Research, and Training & Education—plus a special update on racism and disparities in child and adolescent psychiatry.

Committee chairs are actively working on their sessions. We encourage members to invite colleagues. Registration will be required. More information about the meeting will be sent via the listserv in the next month.

**NEW Task Force on Racism and Disparities in Child and Adolescent Psychiatry**

AADCAP President Rich Martini, MD has appointed a new task force to approach the topics of racism and disparities in child and adolescent psychiatry. He’s appointed **Tami Benton, MD** to chair the task force that will determine how to approach these topics and to prepare Department Chairs to address the issues. The task force will prioritize the topics and issues including institutional financial issues. Dr. Benton has received feedback from other institutions’ operations and is requesting feedback from the membership. Currently, task force membership is currently in progress.

**AADCAP Training & Education Committee Report**

Sandra Sexson, MD and Yael Dvir, MD, Co-Chairs of AADCAP’s Training & Education Committee, developed an update on its activities. To view the report, please visit: [http://www.aadcap.org/docs/Training_and_Education_Updates_2020.pdf](http://www.aadcap.org/docs/Training_and_Education_Updates_2020.pdf).

**Alternative Resident Training Proposal**

AACAP’s Task Force on the Crisis in Recruitment, chaired by Jeff Hunt, MD, requested feedback from AADCAP members on a four-year curriculum in child and adolescent psychiatry. After receiving feedback from our members, Dr. Martini drafted a proposal that was vetted by the Executive Committee and AADCAP Committee Co-Chairs before submitting it to Dr. Hunt. To view the full proposal, please visit: [http://www.aadcap.org/docs/Alternative_Residency_Training_Proposal_7-7-20.pdf](http://www.aadcap.org/docs/Alternative_Residency_Training_Proposal_7-7-20.pdf).
Due to the Corona virus pandemic our scheduled meeting in Washington was reformulated as a virtual program and held on April 2, 2020. The meeting titled “Leading During the Corona Crises” focused on the challenges presented by the pandemic and informing the response of academic child and adolescent psychiatry programs.

The full session is available in recorded version on the AADCAP webpage, http://www.aadcap.org/2020_annual_meeting.aspx.

The program began with our past president, Victor Fornari, M.D. opening the meeting and giving very pertinent remarks about the importance of leadership during this trying time. He reflected on important topics that included: the need for attention to safety, projection of calm leadership, remaining connected with our care and administrative teams and the promotion of hope.

Dr. Charley Zeanah, the serving co-chair of the research committee, began the 4 part discussion section with his presentation “Research in the time of COVID 19.” He reflected on recent NIH updates during the changing landscape under COVID pertaining to safety concerns, extension of grant budget periods, extending time of studies, and guidelines around grant supplements. He stressed the importance of close connection with the NIH program officer and informed us on recent NIH stance on issues of donating equipment, ongoing peer review, clinical responsibilities, support of salaries, and competitive emergency supplements.

The Co-Chairs of the Training and Education Committee Drs. Sandra Sexson and Sheila Marcus accompanied by Dr. Nasuh Malas, followed with the presentation “Education in the Era of Covid-19.” The discussion began with need for the recognition of the inherent trauma and stress of the current

AADCAP Virtual Town Hall: May 21, 2020
by David Axelson, MD

The American Association of Directors of Child and Adolescent Psychiatry (AADCAP) hosted a virtual Town Hall on May 21, 2020 from 12 Noon – 2 PM titled Dealing with Continued Uncertainty Around the COVID Pandemic: Guidance for Child and Adolescent Psychiatry Program Directors. This Town Hall provided a forum to discuss issues regarding impact of the COVID pandemic on divisions of child psychiatry. Over 40 participants joined the Zoom virtual meeting to listen to several short presentations and then discuss the impact of COVID on the functioning of academic child psychiatry.

After an introduction by the AADCAP President, Rich Martini, MD, the Town Hall started with short presentations by members of the AADCAP leadership across four domains: Administration, Clinical Affairs, Training & Education, and Research. As these areas overlap, the presentations and discussions would often incorporate issues from different domains. Mike Sorter, MD started with identifying administrative issues that were impacted by COVID. Challenges regarding finances, staffing reductions and staff concerns regarding safety, billing and navigating regulatory changes were discussed. Tami Benton,
The coronavirus disease 2019 (COVID-19) pandemic has precipitated a radical transformative change in the delivery of health care, including child & adolescent psychiatry clinical services. In early March 2020, the cases began to spread in the New York Metropolitan area, such that by mid-March, the decision to shift most services to telehealth preceded other parts of the United States. With the public health measures of social distancing and isolation to mitigate the spread of the contagion, virtually overnight, clinical services became telehealth services. This has included the ambulatory clinics, emergency services and aspects of the hospital based inpatient care. By the end of March, even Intakes for ambulatory care were being performed by telehealth. By early April when it became clear that New York was becoming the epicenter of the pandemic, hospitals were overrun with covid-19 patients. Additional inpatient beds were created, including thousands of additional intensive care unit beds. Testing continued to be scarce. Employers asked their staff to work from home, when possible, and schools were closed. Houses of worship closed to onsite services, theatres were closed and all sporting events canceled. Institutions discontinued visitation of inpatients, personal protective equipment was required for everyone, and partial programs converted to virtual treatment programs. As psychiatric inpatients began to be diagnosed with COVID-19, specialized inpatient services for adults and adolescents were opened to care for these individuals provided that they did not require inpatient medical care. Inpatient units reduced census to allow for social distancing and patients were required to wear face masks. Trainees continued to receive supervision and coursework virtually, and some were deployed to medical floors. Second year child fellows were credentialed to serve as faculty to cover clinical services when needed.

The American Association of Directors of Child & Adolescent Psychiatry (AADCAP) held a Town Hall on April 2nd to discuss the implementation of guidance for Child & Adolescent Psychiatry Divisions around the country. Issues addressing clinical services, education, research and administration were discussed. The New York Council on Child & Adolescent Psychiatry (NYCCAP) began a series of weekly Town Hall Meetings in late April to address specific concerns of how to adapt to the pandemic and provide care to those in need of treatment. The American Academy of Child & Adolescent Psychiatry (AACAP) held a Town Hall on Saturday April 25 addressing important guidance for child & adolescent psychiatry.

During the coming weeks, as the pandemic diminishes with the number of infected individuals, there will be ongoing guidance as to how we re-open our services, and how we will proceed with the education of our trainees. Certain lessons learned may become the way we proceed going forward. We will get through this together.

“...virtual child mental health care would have been as effective as it is: inpatient, outpatient, emergency, and CL! The transition was literally overnight. Tele-health has clearly demonstrated its enormous value. Access to care has been enhanced. Hopefully, guidelines, regulations and reimbursement will allow this to continue even following the pandemic. Now that the tooth paste is out of the tube, it will be hard to go back.”

--Victor Fornari, MD
AADCAP sponsored a Member Forum at the AADCAP 2019 annual meeting entitled “Current Challenges and New Directions for Child and Adolescent Psychiatry Programs: A Review by the American Association of directors of Child and Adolescent Psychiatry.” The session took place on the afternoon of October 15th and was well attended. The format of the presentation was based on the survey of AADCAP members distributed in February 2019, and provided an opportunity to discuss issues that are particularly relevant to the clinical, administrative, and academic challenges faced by child and adolescent psychiatry divisions and departments. AADCAP received 37 surveys, nearly a 30% response rate, from Directors across the country, whose tenure ranged from 6 months to 26 years with an average of 9.5 years in the position. The size of the programs broke evenly into three groups based on number of faculty: 60 to greater than 100, 15 to 40, and 14 or less. Seventy-three percent of the respondents have an academic rank of Professor. The Member Forum presenters were Dr. David Axelson, Chief of Psychiatry and Medical Director of Behavioral Health at Nationwide Children’s Hospital, and Chief of Child & Adolescent Psychiatry at The Ohio State University Wexner Medical Center; Dr. Tami Benton, Psychiatrist-in-Chief and Chair, Department of Child and Adolescent Psychiatry and Behavioral Sciences, The Children’s Hospital of Philadelphia, Perelman School of Medicine at the University of Pennsylvania; Dr. Michael Sorter, Director, Division of Child & Adolescent Psychiatry, Cincinnati Children’s Hospital, University of Cincinnati; and Dr. David DeMaso, Psychiatrist-in-Chief and Leon Eisenberg Chair in Psychiatry, Department of Psychiatry, Boston Children’s Hospital, Harvard Medical School. Dr. Victor Fornari, President of the American Association of Directors of Child and Adolescent Psychiatry and Vice Chair, Child & Adolescent Psychiatry, Director, Division of Child & Adolescent Psychiatry, The Zucker Hillside Hospital & Cohen’s Children’s Medical Center, Donald & Barbara Zucker School of Medicine at Hofstra/Northwell participated in the discussion.

The survey noted that 63% of the Directors believe that reimbursement for services is poor and 57% believe that their programs receive insufficient funding. Dr. David Axelson discussed revenue generation for Divisions of Child and Adolescent Psychiatry using the program at Nationwide Children’s Hospital and The Ohio State University School of Medicine as a model, and outlined how the administrative and budgeting structures determine revenue generation. Sources include hospital and professional billing, inpatient unit monies, grants and philanthropy. Local government contributes through county boards, councils, and children’s services including child protective services. State and Federal Governments can provide service grants from agencies that address mental health and substances abuse. These grants often require partnerships with state agencies and other stakeholders in order to be viable. Divisions must also consider the payer mix and the likelihood of reasonable reimbursement for mental health services delivered. Dr. Axelson recommended that program leadership understand revenue flow structure, consider service grants that are synergistic with the program’s mission, partner with institution-based efforts at development and philanthropy, advocate for investment in child and adolescent psychiatry with leadership including senior administration and the Board of Directors, and pursue new billing codes for peer to peer consultation.

Directors were asked about current operational challenges and the most important issue, identified by 72% of the respondents, was a lack of adequate professional staff to address clinical needs. Dr. Tami Benton recommended increased collaboration with mental health specialists as a means of addressing limited access to child and adolescent psychiatric services. A persistent shortage of psychiatrists will require growing the clinical work force using medical clinicians (APN’s, PA’s) and other mental health professionals (LCSW’s, PhD’s). Psychiatrists cannot continue to be everything to everyone and should restructure their roles in order to maximize their availability for clinical situations that allow them to practice in their areas of expertise and to work at the “top of their license.” Psychiatrists will need to be better managers of broad care teams involving non-physician professionals that include psychiatrists, psychologists (PhD/PsyD), advanced practice nurses (APN’s/DNP’s), and social workers (LCSW’s/MSW’s). In order to accomplish this goal, psychiatrists need to set clear ground rules for
collaboration between PhD’s, LCSW’s and APN’s including and approach to deployment, identifying appropriate clinical and educational leadership in each specialty, and developing a compensation structure that encourages mutually supportive behavior. The relationship between physicians and APN’s is defined by collaborative agreements, with the level of independence of APN’s varying by state and institution. Billing models for APN practice including “incident to” rules, shared/split service, and direct billing, require a group model as opposed to a single clinician model in order to provide consistent services in the context of what is possible in each state.

The survey identified the recruitment and retention of faculty as a challenge for child and adolescent psychiatry programs across the country, with increasingly competitive markets that make it difficult to attract and retain medical staff as practitioners, educators, and researchers. Dr. Michael Sorter approached this issue by emphasizing career possibilities and negotiating a job description with the recruit that is both productive and exciting. There is also an acknowledgement that the recruit must feel comfortable and supported in the environment through the identification of faculty mentors, available lines of communication, and a sense of trust in leadership and the institution. Yet despite these efforts, there continue to be pitfalls for program leadership when promises cannot be met, an unforeseen crisis consumes a faculty member, or hospital and departmental administration present challenges and potential conflicts. Directors can address these issues by helping faculty understand the roles and responsibilities of leadership as well as its limitations. Academic faculty typically have high levels of dissatisfaction due to a lack of professional advancement, low salary, little recognition for teaching and clinical excellence, and family-career imbalance. The result is an escalation in burnout rates due to a perception that the work place is not fair and equitable and that the priorities of the individual and the organization are not aligned. The stress of working with psychiatric patients and their families who are at times aggressive and oppositional, increases the risk. It is important that program leadership creates an institutional culture and mission that supports altruism and an ethical approach to patient care and career development. Directors should acknowledge the problem by putting in place methods for meaningful discussion that promote the talents of clinicians on the team. Interventions target the individual and provide resources that promote resilience and self-care.

Divisions and Departments of Child and Adolescent Psychiatry offer clinical services within children’s hospitals, provide pediatric consultation-liaison services, and are involved in collaborative care with pediatric primary care physicians. Dr. David DeMaso focused on the important relationship among Departments of Pediatrics, children’s hospitals, and Child and Adolescent Psychiatry Programs, and noted the growth of behavioral health services along with an appreciation for the comorbidity between physical and psychiatric illnesses. Collaborative behavioral health care is now a priority in primary and specialty pediatric care settings. Hospital administrators and their pediatric colleagues are funding psychiatry programs as mission critical services. Challenges remain, however. Psychiatry funding is either precarious or insufficient and high revenue generating pediatric specialties have a stronger voice in decision-making. The result is an unforeseen crisis consumes a faculty member, or hospital and departmental administration present challenges and potential conflicts. Directors can address these issues by helping faculty understand the roles and responsibilities of leadership as well as its limitations. Academic faculty typically have high levels of dissatisfaction due to a lack of professional advancement, low
the means to contact them. Many worried that their families were dead. These worries were fueled by the initial news reports that claimed a much higher death toll as well as “general unrest” in New Orleans.

The other staff, who had evacuated with me, handled things in their own ways and clearly had different circumstances and defenses. I was lucky that my house did not flood. It dawned on me that was because my “uptown” house was in the older area near the river, where the land and housing costs are higher. When I bought my house, I did not choose it for that specific reason. Unfortunately, many of the other staff and the families of our patients were not so lucky or affluent.

We all ended up in Jackson, LA in the Dorothy Dix building, of an old rural state hospital. We (meaning the doctors) formed into a “band of brothers and sisters”. We still talk fondly of the “specialness” of those times when fellows and attendings lived in the same buildings, dressed casually, and broke bread and worked together in a less hierarchical manner.

Katrina, early on, posed many questions for me: Would I get a paycheck and if so, how would I get it? When would New Orleans reopen so that I could check my house for damage? Would New Orleans be rebuilt? Would the state be broke and dismantle or de-prioritize the mental health infrastructure? Would I continue to have a job? Would my staff have jobs? This was not being overly paranoid as several faculty, who worked at other hospitals such as “Charity Hospital” that closed were laid off when their salary lines vanished. Before Katrina, I had never heard of “force majeure” clauses in contracts. I do now and still worry about their impact.

It was at first unique living in a small rural town with one grocery store and gas station which was noted most for its excellent boudin balls. I loved my trips to the grocery store and to the gas station. That uniqueness wore off quickly especially when New Orleans started opening up to traffic so that I could go home on the weekends. The change was wonderful although things in New Orleans were in severe disarray with destroyed homes and thousands of blue tarps covering holes in people’s roofs. Few restaurants, early on, were open and those that were open often closed suddenly due to a lack of staff. Sounds a little familiar, doesn’t it?

As I write more, stories about Katrina, known to many by its the initial “K”, come flooding back. Ironically, going to the grocery store during CoVid is just as unique an experience as during “K”, but more anxiety even with my mask and gloves. The thought of dying from CoVid came upon me while recently shopping at Walmart. I realized that somewhere deep in the recesses of my mind, I had the thought that it would somehow be better to die of a virus received at the Whole Foods? Bias and capitalism strike again!

After nine months of evacuation in Jackson, LA, several of which were due to political wavering concerning what to do with my hospital, I returned and continued to have endless things to do especially as my hospital became the first public mental health hospital in New Orleans to re-open largely due to the fact that it was, likely my house, on high ground near the river. It had previously been an LSU staffed facility solely for children and adolescents. It now added on adult units with LSU and Tulane faculty. Katrina, as they said, storm as they say brought us all together!
I was proclaimed a “hero” by some. I liked this and gained from this career wise, but I was uncomfortable. I contended that I was just doing my job and I knew full well that I could have done more. I was equally uncomfortable that my saying I was just doing my job was further proof to many that I, indeed, was a hero and a humble one at that! During CoVid, I am clearly not a hero, unless you consider that I have been forced to learn many new computer skills in a short amount of time.

I note that CoVid is occurring during our age of positive psychology, relaxation, mindfulness, resilience, and post-traumatic growth. This, plus social media has led to widespread proclamations of categories and classes of heroes with public accolades, reinforcements, and tokens of appreciation. The latest of numerous daily “positive” emails sent to me was titled: “Our Heroes Rise Up!”

Katrina was a circumscribed event that affected just one area of the US. CoVid-19 is an equal opportunity crisis that has affected everyone in the world. This sense of everyone being linked together seems different especially as our nation has been so fractious and divided of late. I note sadly that the fractiousness seem to have returned quickly as the U.S. wrestles with the issues of re-opening the economy. Money and health collide once again.

In Katrina, as hopefully will happen with CoVid 19, things slowly improved or should I say got less bad, along with my bouts of vertigo. In some cases, things just changed, perhaps not for the better. On a related historical note, a few years later my hospital, as I had initially feared, was indeed closed, creating another mini crisis for me that was considerable at the time due to my fears with regards to my overall position and salary. In my best, Cassandra (“I told you so”) stance, I proclaim that I wasn’t being paranoid! I just had my time frame wrong!

The current CoVid crisis proves to be even more anxiety provoking to me. The idea of “invisible” things spreading insidiously that can kill you, especially if you are older, does little for my not very well repressed death anxiety. To be truthful, I am not thrilled with being over 70 in the first place. To have people specifically worry about me due to my age is horrifying and embarrassing. Several friends actually yelled at me to stop seeing patients early on because they didn’t want me “to die”!

A macabre part of me likens CoVid to the neutron bomb, an enhanced radiation weapon, which was designed to kill people but not the physical infrastructure. Unlike during Katrina, the physical infrastructure has remained intact during CoVid. All of the devices that have proliferated in the last 15 years--- internet, Wi-Fi, smart phone, social media and other electronics--- have remained working for better and worst. The never-ending CoVid stories about what could or should happen drive me crazy as do the endless flow of official agency CoVid emails that are sent to me each day. They are too long and too redundant and tend to blend together. I seldom get to the end of them despite their importance. They add to my sense of fatigue and malaise.

In the past month, I have gotten calls from people inquiring about the condition of New Orleans as it is allegedly approached its peak. They all said that they heard about New Orleans on the news and were worried about me. I tell them that I frankly do not know. I do not work in any of the hospitals rendering medical care, nor do I know many people who work in them. I hang around the mental health types. There is certainly less traffic and few outward signs of how things are going. There are no “walking dead” slowly ambulating outside to let me know how that things are indeed bad. Until 3 weeks ago, I knew of no one with the virus. I now do, but it is no one I really know. It is friends of acquaintances. I fear this will change soon. When it does, I suspect this will be a different crisis as my healthy denial is further challenged. I read about what’s happening in the hospitals through the media just like those who call me. In the meantime, I read that the New Orleans Convention Center just opened with up 1000 extra beds. That would be seem ominous. Part of me knows this will further challenge my generally resilient defenses. At some point, will they falter? Will my vertigo return? At some point will I spike a fever and began to cough? My seasonal allergies which mimic some of the symptoms of CoVid-19 certainly compound my anxiety.

Sometime a few weeks ago, I also realized that this is the first time in forty years that I was not administratively “in charge” of something that would help focus my workaholic defenses. Realizing this, I also realized that I am now compulsively setting up projects for myself like writing this column. It takes my mind off my existential plight. I remind myself that there
will be no new columns if I am dead, but there will be ones in queue that I am compulsively writing now. Thankfully, it appears that it doesn’t matter what I am doing as long as I keep myself busy and distracted while I wait for Godot and his invisible minions.

Post-Script 1: As I did the first edit on this column, I was told that a good friend had been hospitalized with CoVid. So much for my magical defense of not knowing anyone personally with CoVid! As I did the third edit, my friend was on a ventilator. As I did a 4th re-edit, the good news was that he is off the ventilator. I have the magical thought that I should continue to edit until he’s all better.

Post-Script 2: My therapy practice is doing quite well over various platforms. Everyone is anxious in their own unique ways. Two days ago, I had two patients, one in high school and the other in college. Both expressed concern that all their current hard washing would lead them to have OCD when they were older. Is their fear of future OCD really their biggest concern?

Post-Script 3: Quote: “If perfect is the enemy of the good, then so are less than perfect efforts influenced by financial and other self-interests.”
- Martin Drell, MD

During the AADCAP virtual meeting, I remembered that I created a PowerPoint for a Grand Rounds on March 31, 2006 that David Kaye graciously invited me to Buffalo to sum up my experiences during the first year of Katrina. It is entitled: Lessons Learned From Hurricanes Katrina and Rita. It summarizes many of the realities, questions, and dilemmas that came up at the time. Many of these, I believe, are equally cogent during the current CoVid Crisis. These concerns include issues of federal vs. state rights, race, religion, scapegoating, stigma, mental illness, Maslow’s Hierarchy of Needs, conflicts of interest, the importance and problems of administrative hierarchies, pre and post-planning, Continuing Quality Improvements (CQI), the importance and consequences of communications, fighting over poorly allocated and limited resources, the importance of the quality of information (the problems with fake news, rumors and anecdotes), the importance in knowing which models of planning and care are being used (public health vs. single core models), and the ever presence of politics. A large meta-theme that weaves through the PowerPoint concerns leadership during crises. It deals with the importance of leadership during crises and how the often-primitive, regressive, transferentially influenced needs of the public and their unreasonable expectations of its leaders can impact the leader’s effectiveness, mental health, and longevity. Katrina harmed most of its public leaders! The presentation can be viewed on AADCAP’s website: [http://www.aadcap.org/docs/Remembering_Katrina_PPT.pdf](http://www.aadcap.org/docs/Remembering_Katrina_PPT.pdf).

Finally, I hope that, as leaders, you will keep an eye towards the future and the “opportunity” part of the SWOT (strengths, weaknesses, opportunities and threats) analyses. These will be the worst and best of times! Many positive outcomes and opportunities to improve the system of care will undoubtedly occur as the CoVid crisis unfolds. During the virtual meeting, I heard of examples of emergency preventative activities such as keeping in touch with patients via phone to keep them out of the ERs. Please look for these opportunities and positive outcomes and as a “Band of Brothers and Sisters” advocate for them. If we, as leaders, don’t, I assure that other less altruistic forces will advocate for what is in their “best interests” which will not involve the many children and adolescents with mental health issues. Those who don’t create the future will have it created for them.

Request:
I would love to hear from you on how they have been uniquely affected, for better or worse, and your lessons learned during the CoVid19 crisis. Please send Earl Magee (info@aadcap.org) or me your articles for potential publishing in the AADCAP’s newsletter.

I wish you all the best! Stay well, stay safe, keep your distance, and take care of yourself.

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**Remembering Katrina**

After Katrina, Marty Drell, MD created a grand rounds PowerPoint presentation, “Lessons Learned From Hurricanes Katrina and Rita,” on lessons he learned during the crisis. If you would like to see the presentation, please visit: [http://www.aadcap.org/docs/Remembering_Katrina_PPT.pdf](http://www.aadcap.org/docs/Remembering_Katrina_PPT.pdf).
pandemic situation and its impact on our functioning as individuals, clinicians and educators. Dr. Marcus reviewed the evolving situation of financial support of services for patient care programs. The discussion stressed the importance of innovative techniques to engage residents and students. Various virtual platforms and their use in patient care interventions, training sessions, clinic supervision of trainees, and integration into the EMR were reviewed. Educational opportunities regarding mental health impacts of COVID-19 and the pandemic to other disciplines and patient populations were also described.

Administrative Co-Chairs, Drs. David Axelson and Felicity Adams-Vanke, presented “Administrative Issues in the time of COVID-19”. The facilitated discussion touched on various challenges including: billing for psychologists, telehealth reimbursements, virtual platforms, interface with hospital information systems, end user devices on inpatient units, virtual rounding, successful integration of virtual platforms for emergency room programs and enhanced direct admissions processes. Different strategies for use of PPE including masking of staff, patients, families, visitors, were shared along with the challenges of managing hospital shortages of protective equipment.

The Clinical Committee Co-Chairs, Drs. Robert Chayer and Mike Sorter, summarized additional challenges to clinical care sites. Emphasized were methods to decompress hospital based services through telemedicine contacts and robust case management services. Discussed where the decision processes of balancing patient need and choice of provision of services via phone, video, and face to face sessions. Claudine Higdon, from Northwell, shared their success in converting nearly all outpatient services to virtual platforms. They reported high levels of positive patient family experience and improving ability to manage the challenges of patients with a variety of clinical pathology. The discussion also reviewed some of the concerns and successes of providing video IOP, PHP and day treatment programing.

Our keynote address “Substance Abuse and Youth: a NIDA Update” was given by Dr. Nora Volkow, who serves as the Director of the National Institute of Drug Abuse. She gave a dynamic presentation offering a comprehensive view of recent trends in substance use in youth and the latest findings on impact of substance exposure to brain development and behavior. She described the alarming and dangerous trends of the escalating use of synthetic opioids, methamphetamine, vaping of nicotine and THC. She had multiple examples of the complex interplay of early brain development, environment, genetics, and drug exposure. Her comments on the potential adverse impacts from the interface of the COVID pandemic with substance use disorders were an alert to our work as clinicians in this time of stress.

Transitions of Leadership

The meeting came to a close with Dr. Victor Fornari turning the Presidency of AADCAP over to Dr. Rich Martini. In his departing words as President, Dr. Fornari recognized: Dr. John Sargent for his recent service as Secretary Treasurer, Dr. Lee Ascherman for work as Membership Chair, Dr. Jim Harris for his contributions over the past year and arranging Dr. Volkow as our speaker. Also recognized were the service of the Committee Co-Chairs and all members of the Executive Committee. Dr. Martini gave the final word as he recognized the special contributions of Dr. Fornari in his service to AADCAP as president over the past two years.

A very successful meeting!
In the spring, AADCAP held its 2020 election of President-Elect and Secretary-Treasurer and voted in Drs. Tami Benton and Mike Sorter. Thank you to Drs. John Sargent and Judith Crowell for running in this important election. At the end of our 2020 Annual Meeting, new officers took office. Dr. Martini appointed Dr. David Axelson as the Program Chair and Dr. Sheila Marcus as the Membership Chair. AADCAP welcomes the new Executive Committee:

- **Tami Benton, MD**  
  President-Elect
- **D. Richard Martini, MD**  
  President
- **Mike Sorter, MD**  
  Secretary-Treasurer
- **David Axelson, MD**  
  Program Chair
- **Sheila Marcus, MD**  
  Membership Chair

MD then focused on the impact of the pandemic on providing clinical care. She noted that, in general, there was an initial significant decrease in inpatient services and in person outpatient services, with a rapid movement to telehealth. Victor Fornari, MD discussed the balance between providing services via telehealth vs. in person. Factors to consider include governmental regulations and limitations, regional differences in the epidemiology of the COVID infection, and how to prepare for a 2nd wave of the virus. Sheila Marcus, MD raised the point that early and mid-career child psychiatrists have risen to the challenges of the COVID epidemic. She then introduced two of her faculty members, Nasuh Malas, MD and Joanna Quigley, MD, who discussed issues regarding education and training in both the outpatient and inpatient environment. They described how the Division at the University of Michigan was able to navigate the complexities of the COVID crisis. David Axelson, MD provided discussion points regarding how research could restart and adapt in this new environment, and potential research opportunities with the COVID pandemic.

We then had 45 minutes for questions and discussion. The Zoom format with the Chat function worked surprisingly well for the discussion of these complex issues. There was a nice mix of verbal discussion with comments from the Chat that led to a rich interaction among participants. In the end, the opportunity to share prepared content while also interacting and supporting each other resulted in positive feedback from those that presented and from participants. This bodes well for our virtual meeting this fall scheduled for Sunday, October 18 from 12:00 p.m. to 3:00 p.m. To view the May 21 town hall video, please visit [https://drive.google.com/file/d/101cB7C-hfSR_XKXHd-nwwUTJQX-t_Xyq0/view?usp=sharing](https://drive.google.com/file/d/101cB7C-hfSR_XKXHd-nwwUTJQX-t_Xyq0/view?usp=sharing) or visit AADCAP’s website.
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