State Health Care Exchanges: Frequently Asked Questions ..........250
60th Anniversary Special Section ...............................................259
Annual Meeting: Focus On. . . ..................................................272
Back to Project Future: Get Ready...
Onward Into the Coming Decade!..............................................279
SAVE THE DATES
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Advocacy in Action: Developing Youth Leaders for Improved Transitions to Adult Care

Celeste Nichole Lopez, M.D.

She was a 16-year-old type 1 diabetic in the emergency room on the wrong side of a bottle of Captain Morgan that had left her in severe diabetic ketoacidosis. That moment vividly captured the memory of a patient that initiated my connection between pediatric mental and medical illness during my pediatric internship, and prompted my transition to psychiatry. The patient had been struggling with depression, which interacted with her medical illness to put her in a critical place on multiple fronts. This was a child who had been previously well managed on her insulin regimen with her parents’ help, who was now transitioning to independent choices about friends, substance use, and management of her chronic medical illness that could mean the difference between becoming a young adult or reaching an early death.

Each year in the United States, an estimated 500,000 adolescents with special health care needs turn 18 years old, but the system of care is fragmented, disorganized, and ill-prepared to support new generations of chronically-ill young adults who are surviving longer than ever before. There are drops in self-reported health status after this transition, as health issues are at higher risk of being unmonitored (Tsybina 2012). For example, 30% of young adults with kidney transplants lose their grafts as they transition to adult medical care. Thus, the health care needs of adolescents with chronic conditions are often unmet as they transition into adulthood. They are at especially high risk for developing mental illness in addition to their medical illness.

In 2005, Gary Maslow, M.D., Ph.D., and Wendy Froehlich, M.D., led a group of highly motivated, triple board residents at Hasbro Children’s Hospital (affiliated with Brown University Alpert Medical School) to initiate a peer mentoring group called The Adolescent Leadership Council (TALC) to address the unique issues of transitioning from pediatric to adult medical care among adolescents with chronic medical illness, who are at a higher risk of developing mental illness. Through my current Child and Adolescent Consult Liaison faculty mentors at Stanford University Medical Center, Dr. Wendy Froehlich, Dr. Richard Shaw, and child psychologist Dr. Lauren Schneider, I have had the good fortune to collaborate on the development of a similar program at Stanford called the Packard Adolescent Leadership Council (PALC).

These programs are founded on Dr. Richard M. Lerner’s principle of Positive Youth Development (PYD), a novel framework for approaching the transition to adulthood for youth with chronic illness that has been successfully deployed in the development of programs and interventions for other at-risk youth (Maslow 2013). From the PYD perspective, the focus is on developing strengths in youth that may contribute to improved disease management and the ability to advocate for oneself in the health care environment, as opposed to focusing on adolescent risk behavior.

The initial challenge of creating a group with these goals was establishing funding for its support. We were fortunate to be awarded a grant from the Lucile Packard Foundation for Children’s Health, Innovations in Patient Care, in order to address a currently unmet need, with an approach that is new at Lucille Packard Children’s Hospital and has exhibited success at other children’s hospitals. Our colleagues in social work, child psychology, Child Life, general pediatrics, and the pediatric subspecialty clinics were all instrumental in recruiting adolescent participants. Other residents and physicians identified patients they felt would be a good fit for the program’s goals, as well as distributed flyers about the group so that patients were able to self-refer if they were interested in joining. The Stanford University Office of Accessible Education also assisted by helping us to locate undergraduates who had chronic medical illness and were interested in becoming mentors. Since the inception in January 2013, we have recruited seven mentors and six adolescent participants and are continuing to recruit more.

The primary group activity is monthly dinner meetings that bring together high school participants and college student mentors, both with chronic illness. Both TALC and PALC are designed to engage youth in leadership activities in the context of longitudinal relationships with adults who possess the important life skills necessary to take care of their medical conditions. High school students receive mentoring from the college student mentors and the college student mentors receive mentoring from each other and from professional staff, including psychiatric and pediatric residents. Topics discussed include diagnosis, living with an illness, interacting with

“Both TALC and PALC are designed to engage youth in leadership activities in the context of longitudinal relationships with adults who possess the important life skills necessary to take care of their medical conditions.”

continued on page 230
Developing Youth Leaders continued from page 229

doctors, school issues, friends, and family relationships. The goals of the project are to decrease loneliness and isolation, and increase transition readiness, as reflected by improved adherence, competence, confidence, and positive attitude towards treatment of chronic illness and assessed using standardized questionnaires (Child Attitude Toward Illness Scale [CATIS], Transition Readiness Assessment Questionnaire [TRAQ], and UCLA Loneliness Scale). Participants act as leaders in designing strategies for reaching out to a broader community in order to educate other adolescents, parents, or physicians about the topic. For example, when discussing interactions with doctors, the group developed a list of suggestions for doctors and suggestions for teens on how to communicate more effectively, which is now being developed into part of a newsletter.

As a trainee, the most rewarding aspect of this project has been allowing the group members to develop into the group leaders and take ownership of the group and its directions. Adolescents that were initially shy and withdrawn are progressively becoming more self-confident and self-aware through this process. For example, one young man who did not speak at all during his first meeting, walked into the last meeting smiling and greeting the group, bursting with excitement to talk about the night’s topic and share his experiences. The same young man also has been staying after meetings to socialize and share ideas with other group members in an informal way that is bringing benefit to the entire group. Parents have also expressed their appreciation for this opportunity to help their children become prepared for this transition from pediatric to adult health care that brings the parents themselves much trepidation. One mother told me that since she has joined this group, her daughter has been asking more questions about her illness, medications and doctors, and has shown genuine interest in her own care.

Since the inception of TALC at Brown, Dr. Maslow has initiated another group at Duke University called ATLAS and there is currently a group being initiated at UCLA. If others are interested in learning more about these issues and potentially initiating a group at the hospital affiliated with their own training program, please contact me at cnlopez@stanford.edu.

References

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Dr. Lopez’s work with PALC at Stanford is a wonderful example of the amazing advocacy work that AACAP trainees are engaged in throughout the country. To find out more about ways to get involved, check out AACAP’s Trainee Advocate Program at www.aacap.org/TAP.

Lifelong Learning Module 7: Neuroscience, Pediatric and Neurologic Consultative Issues, Bereavement, Death and Dying, Deaf, Medical/Psychiatric Interface (Factitious Disorders, Sleep Disorders, Somatoform Disorders), and Relevant Updates for Child and Adolescent Psychiatrists expires on October 15, 2013. Be sure to complete your module exams before the deadline to earn a total of 30 AMA PRA Category 1 Credits (2 for pre-test, 28 for post-test) to use towards the CME and self-assessment requirements of maintenance of certification.

If you currently have Module 7, complete the exams and fax them to the CME Coordinator at 202.966.5894 or mail them to 3615 Wisconsin Ave. NW, Washington, D.C. 20016 before October 15th. Exams received after October 15th cannot be accepted for grading.
ETHICS

Social Networking and CAP: Random Ethical Musings

Child and adolescent psychiatry (CAP) is an intriguing and fascinating field. If we work with the blurred boundaries resulting from the power of social media, we can definitely have an ethical mess on our hands—or a learning opportunity for those who can see the Tumblr half full! As CAPs, we get to know the most intimate details of a teenager’s life, yet, often feel hesitant to explore their virtual alter-ego. Confidentiality is one of the most essential ethical principles driving our code of conduct. Previously, it was probably realistic to say that no one knew more about the patients’ lives than their CAPs; individuals could express their darkest feelings without any fear of being judged in a therapist’s office. The exclusivity of this relationship not only provided solace to distressed adolescents but also gave them a sense of stability. However, this was probably only accurate during the infancy of various social networking websites.

With such websites blossoming now with youthful exuberance, we find ourselves following and being followed on Facebook, Twitter, Tumblr, LinkedIn, MySpace, and others. Almost every second, people know post something extremely private to an online audience that is ever-ready to reinforce these glorious posts with a like or unlike button. The growth of these sites has been exponential, and their impact on the physician-patient relationship still understudied. Facebook now has around 1 billion users.

How do we manage issues related to our patients’ online worlds? What do we do if our patients want to add us on a social networking website? Is that even avoidable in the context of the virtual world? Acceptance of such requests may violate privacy; of course, we could argue that the patient initiated this communication and, by doing so, is accepting of this breach of confidentiality. However, the responsibility of maintaining physician-patient boundaries lies with the physician, not the patient. Also, is this connection any different if we get connected with patients using a professional identity such as in LinkedIn (compared to our personal identity, such as in Facebook), since information about our practice is already in the public domain?

“The responsibility of maintaining physician-patient boundaries lies with the physician, not the patient.”

The blurring of boundaries with this tsunami of social networking websites brings up interesting ethical conundrums in the psychiatric treatment of children and adolescents. An integral part of psychotherapy is to talk about repressed emotions to manage conflict. The time between sessions allows the patient to think about these feelings before processing them with his/her therapist. What if our patients process these uncomfortable emotions with their peers online, as a quicker-fix? While this may be normal adolescent behavior, confessions were generally shared among small groups and were not permanently recorded in the past. As psychiatrists, we strive hard to maintain patient privacy; what if patients cross these boundaries and have online discussions on the proceedings of particular therapy sessions? Given the violation of confidentiality and privacy, such disclosures may instigate negative reactions in the psychiatrist and complicate the therapeutic relationship.

Another interesting clinical theme involves ethical repercussions of clinical applications of virtual resources. For example, a patient seeks support from his/her virtual friends; yet has a history of not disclosing issues during therapy sessions until a crisis erupts. Would it be considered beneficence to check the online posts to ensure a ‘thorough’ risk assessment? Or would it account for non-maleficence to not do so and respect the privacy of the patients? Over the past decade, these changes in the means of communication and availability of information have raised several ethical dilemmas that often have no clear answers.

Similarly, another relevant clinical scenario involves patients posting their intentions to hurt themselves on social networking websites before they attempt to end their lives. One of our hospitalized adolescent females had apparently posted a “goodbye letter” on Facebook, which had been brought to the attention of her parents by a friend. While she denied any suicidal intentions, she was hospitalized involuntarily based on the letter. Ethically speaking, does the committing agency have the right to see such a private post meant only for her ‘friends’? Of course, such a friend could be a good source of collateral information; yet, how do we assess what the patient is telling us currently versus what she posted online, which could have been done in a completely different state of mind?

It is often amazing to learn what these social networking websites mean to a typical adolescent we see in our clinics. One adolescent casually answered this... continued on page 232
Social Networking and CAP continued from page 231

by saying, “What do you mean? I have to stay updated on what my friends are up to; I check my Facebook every hour!” The general consensus among our patients is similar. They want to stay updated on what their friends were doing, and keep everyone fully informed through status updates and pictures—for all we know, this could include a friendly stranger they only met at a party! On the positive side, the socially reticent individuals may find it easier to use this opportunity as a virtual journal and may open up more on a website than in person, as they may escape the immediate ‘judgmental’ attitude of others. Similarly, peer groups from such websites may provide tremendous support to certain people, such as those with social anxiety.

All of us have patients who have been cyber-bullied, and suffered from fear and intimidation. Several of our patients who keep daily journals, jot down their darkest emotions in it. The act of expressing themselves in a journal without the fear of being judged helps them process things effectively. So are these social networking websites a modern-day journal without the inherent confidentiality feature? Should such comments be taken seriously by the clinician or left alone like a private journal?

Let’s add to this the numerous physician-grading websites that post patient opinions of their physicians. Before the initial appointment, our patients have often attempted to search us online.

While potentially effective in helping patients find a new physician, these websites incorporate another interesting concept—that of trust, which is always an integral part of a physician-patient relationship. Coming to an appointment with a pre-existing biased opinion derived from these websites could compromise the amount of trust patients place in their physician. It can become increasingly difficult for such patients to trust us to be doing what’s best for them.

It is also instinctive for any clinician to desire more information about a patient before the initial assessment interview. Is it ethical to search them on Google or Bing? Some of the websites create a virtual timeline for every profile—does this suffice as a supplementary database to obtain information on the patient’s course of life, such as their pre-morbid personality? But, how far can we go on with this without crossing any physician-patient boundaries? Of course, the same applies to patients looking up their physicians. If the correct privacy settings are not applied, a physician’s online profile is also equally accessible. How does looking at their marriage photos, or photos from their wild parties impact transference in this relationship? Thus, even before their first meeting, patients may have already established a relationship with the psychiatrist, based on their online profiling.

To conclude, there’s probably no single way to answer the questions posed above; however, it is fairly clear that we will encounter these questions every day. While the traditional solution to politely refuse a friendship request and discuss the rationale behind this decision may still be one of the best solutions, it may work for every web-based ethical dilemma. No matter how we respond, we still run the risk of damaging or enhancing (as we see it) the physician-patient relationship. It is a skill, a challenge and even an occupational hazard that CAPs have to learn to deal with and master, especially in this age of social networking.

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We thank Arden Dingle, M.D., program director of Child and Adolescent Psychiatry at Emory University and chair of the AACAP Ethics Committee, for her feedback regarding the article.
Sala S. N. Webb, M.D.

Some call it acculturation. Others refer to it as assimilation. Or maybe adaptation could be useful in describing this phenomenon. I personally like the term camouflage as this definition allows for the exterior to blend in with the surrounding environment without much alteration of the internal substance. No matter what one may call this process, it is not easy; even if one enters into it voluntarily.

Step back with me into your own story. Recall the time and place of your childhood. Remember those struggles you faced as you moved from latency into adolescence: determining your own individuality and sense of self; your role in your family and your place in the world. Now magnify this experience a thousand times. Add in the navigation of language, money, music, standards, expectations, food, and social mores—all different from what you have just barely mastered in your family (country) of origin. This scarcely begins to delineate the experience of minority populations submerged into another dominant culture.

We are a nation built primarily by immigrants. The places of origin have varied over time, but most come to these shores seeking something better: a better life for themselves and their families. And, it is this same spirit that makes this country great. There is truth in the old adage that a chain is only as strong as its weakest link. Therefore, can it not be said that a country is only as strong as its most vulnerable populations? And who is not more vulnerable than minorities and children?

The 2009 U.S. Census tabulates that among children under the age of eight, European-Americans no longer constitute the majority, and by 2030 this will hold true for the category of persons eighteen and younger (U.S. Census 2009). With the new Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice, an effort spear-headed by the Committee on Diversity and Culture, AACAP has smartly placed itself towards the head of the pack when it comes to recognizing, understanding, and providing education on this very complex but vital issue.

This parameter provides focused information that clinicians can use to enhance their practice. It elaborates on the influence of cultural nuances in addressing barriers to accessing mental health care, as well as recognizing provider biases that could impact the accuracy and efficacy of the assessment and treatment. It encourages clinicians to acknowledge the cultural differences in symptom description and presentation, to look for the impact of micro and macro traumas, and to evaluate for the effects of acculturation.

In our field, language is of the utmost importance. We diagnose dysfunction

“With the new Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice, an effort spear-headed by the Committee on Diversity and Culture, AACAP has smartly placed itself towards the head of the pack when it comes to recognizing, understanding, and providing education on this very complex but vital issue.”

continued on page 234
Cultural Competence in Child and Adolescent Psychiatric Practice
continued from page 233

When it comes to parenting and behavioral interventions, these are more effective when they are tailored to align with the family’s values and beliefs. Clinicians ought to strive to utilize evidenced-based treatments that have been validated in their intended target population and be cognizant of the characteristics of ethnopharmacology.

The intent of these guidelines is to highlight areas that warrant closer attention and to provide recommendations for strategic implementation, which, based upon available research, should render a more positive and fulfilling experience for both providers and patients. Think of it as your prism, through which you can transform a seemingly ordinary ray of light into shimmering magnificent colors.

To further enhance their level of cultural competency, practitioners must consider the influence and inclusion of extended family members in addition to incorporating the child’s and family’s strengths into the treatment plan. Providers should be aware that minority and culturally-diverse populations often welcome being treated in their own communities.

The AACAP Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice is now available online at www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Cultural_Competence_Web.pdf; and will be in an upcoming issue of the Journal of the American Academy of Child and Adolescent Psychiatry.

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PSYCHOTHERAPY

The Evidence for “Evidence-based” Child and Adolescent Psychotherapy

Before psychiatry residency, I completed a Ph.D. in neuroscience, which was an immersion in the creation and evaluation of evidence. Performing research, above all else, involves cultivating skepticism about what is claimed versus what the data actually show. As a trainee physician, I am presented with “evidence-based” guidelines and treatments on a daily basis. This movement seems unstoppable. And why not? Shouldn’t we use what works? Questioning “evidence-based” care (the language seems beyond reproach!) risks being seen as, at best, naive, and, at worst, reckless.

But reality is not so clear-cut. As I will discuss, “evidence-based” psychotherapies are often validated in populations that do not represent general practice, with manuals that are rarely used by practicing clinicians. Psychodynamic psychotherapy, not usually considered “evidence-based,” has substantial empirical support. Particularly in child and adolescent psychotherapy, the language of “evidence-based” treatments is often more sizzle than steak, and the unquestioned push toward “evidence-based” treatments carries many hazards for our field.

It is helpful to examine how the term “evidence-based” evolved. The original term for what the American Psychological Association (APA) now calls “evidence-based” treatment was “well established.” This evolved to “probably efficacious,” then “empirically validated,” and, finally, to the current “evidence-supported” and “evidence-based” terminology (Wachtel 2010). These terms are increasingly authoritative, conveying a level of proof and certainty that is misleading. Statistically, we are no more certain that “evidence-based” psychotherapies work than those that were “probably efficacious” just a few years ago. This is problematic because, unlike “probably efficacious,” calling something “evidence-based” sets up a split in the listener’s mind: the natural assumption is that all else is not based on evidence. In child and adolescent psychotherapy, the “evidence-based” umbrella is assumed (or explicitly stated in many cases) to include cognitive and behavioral treatments, but not psychodynamic psychotherapy, play therapy, eclectic therapy, and others. Several assumptions are used to justify this divide.

The first assumption used to support “evidence-based” psychotherapies is the “hierarchy of evidence.” This paradigm for evaluating research quality places randomized controlled trials (RCTs) above non-randomized trials. This is a reasonable assumption for medications, and, indeed, if all research could be performed by comparing a single discrete treatment against placebo, this would be the case. But when looking at psychotherapies, this hierarchy is at best dangerously deficient in creativity. The science linking global warming to man, the theory of evolution, and the link between smoking and lung cancer, to name a few examples, cannot be demonstrated by RCTs. Indeed, as Wachtel and others have noted, this difficulty was used by the tobacco industry for years to argue that cigarettes did not cause lung cancer (Wachtel 2010). Saying an RCT is better than other study methods amounts to confusing research technique with quality. By rigidly adhering to the notion that anything other than RCTs are less valid, we ignore scientifically sound work that is often quite relevant to actual practice. For example, consider the excellent and statistically-rigorous work at the Anna Freud Center, which reviews progress and change in long-term child and adolescent psychodynamic psychotherapy in a general clinical population (Fonagy and Target 1996).

Another assumption is that psychotherapeutic treatments must be manualized to be studied. Manuals are used in accord with the medical model: treatments must be standard to be researched. There are many problems with this in practice. Manuals are, with rare exceptions, validated for a single diagnosis in a research population. In a typical research population, clients have one diagnosis, self-refer, and rarely no-show. In addition, the socioeconomic status of clients is higher and co-morbid substance use is rare (Weisz and Jensen 2001). It has been estimated that “evidence-based” care does not offer any treatments for one-third to one-half of adults seeking care (Westen et al. 2004). This is even more problematic in child and adolescent psychotherapy, where symptoms are often fluid across diagnoses, comorbidity is high, and psychopathology increases as socioeconomic status declines.

This might be why, despite the “evidence,” actual therapists do not use manuals. Manuals are used only half the time by less than 10% of practicing psychotherapists (Cook et al. 2010).

“I fear that by arbitrarily separating child and adolescent psychotherapy into “evidence-based” treatments and all else, we risk jettisoning a wide range of treatments that work well but may not have been studied quite as intensively.”

continued on page 236
The Evidence for “Evidence-based” Child and Adolescent Psychotherapy continued from page 235

Research has shown that an overly rigid approach to manualized psychotherapy leads to worse outcomes in adults (Castonguay and Goldfried 1996), a finding that is easily understood using psychodynamic thought, but more difficult to account for using cognitive or behavioral thinking. Manuals are designed for low-to-mid-level practitioners, so it is not surprising that practitioners rarely use manuals after training (Cook et al. 2010). Perhaps what is most troubling is that our understanding of the brain’s response to therapy is a rapidly evolving field. Manualized therapies are anchored in the time they are developed, and cannot incorporate evolving ideas without more research, which academic practitioners may have little incentive to perform. To date, there has not been a solution to this problem.

The eM.P.H.asis on RCTs and manualized psychotherapies, while well-intentioned, has had a negative effect on the practice of psychotherapy. The “evidence-based” mantra has been used by funding agencies to limit treatment duration and frequency, and is increasingly being used to limit many types of treatment. This seems to be a gross misinterpretation of the literature that has demonstrated that short-term, once-weekly therapies work for some, but left longer, more intensive treatments are largely uninvestigated. Worse, by ignoring research that does indicate more intensive psychodynamic psychotherapy is more effective in certain populations (Fonagy and Target 1996), and that gains in psychodynamic psychotherapy actually increase after treatment ends (Shedler 2010), we are limiting our ability to take the best care of our sickest patients.

These assumptions have contributed to the increasingly pervasive belief that cognitive and behavioral therapies are superior to psychodynamic therapies, particularly in child and adolescent psychotherapy. What does the evidence actually show? There have been few head-to-head comparisons of psychotherapies in adults, and fewer in children. When comparisons are performed, a consistent finding is that all bona fide therapies (typically defined as well-established or manualized psychotherapies) work equally well (Weisz et al. 2006). Even in head-to-head studies where cognitive behavioral therapy (CBT) seems to be superior, the differences become negligible after correcting for investigator allegiance (Miller et al., 2008), a significant finding in this field where academic practitioners rarely use manuals after training (Cook et al. 2010) and child and adolescent psychodynamic psychotherapies are comparable (Midgley and Kennedy 2011).

It is my contention that the “evidence-based” movement is one designed to buttress anxiety. In this field where uncertainty is abundant, it should come as no surprise that proponents of “evidence-based” child and adolescent psychotherapies are often dogmatic. I fear that by arbitrarily separating child and adolescent psychodynamic psychotherapy into “evidence-based” treatments and all else, we risk jettisoning a wide range of treatments that work well but may not have been studied quite as intensively.

Let us continue to research what works and what does not, but, in the meantime, I encourage us to adopt a more truly scientific approach to our patients, not just their disorders and symptoms: to embrace their uncertainty, not as something to shy away from in the interest of time and clarity, but as an opportunity to explore and understand the uniqueness of our patients, and to provide them the best treatment possible.

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Child and Adolescent Psychiatry in Australia and New Zealand

History of the National Organization

The national organization of child and adolescent psychiatry in Australia and New Zealand is the Faculty of Child and Adolescent Psychiatry (FCAP), part of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). As a bi-national organization, the RANZCP is responsible for training, educating, and representing psychiatrists in Australia and New Zealand, and the FCAP is responsible for undertaking these activities specifically for child and adolescent psychiatrists, with the aim of improving mental health outcomes for infants, children, adolescents, and their families. The Australasian Association of Psychiatrists, as it was previously known, was first established in 1946 and converted to a College in 1963. The Section of Child Psychiatry (now the FCAP) was formed in 1964 and a child psychiatry training program was introduced in 1973. There are nearly 5,000 members of the RANZCP, of which approximately 400 are child and adolescent psychiatrists. In addition, there are 77 trainees currently undertaking advanced training in child and adolescent psychiatry.

Activities

The FCAP organizes a range of scientific, educational, and administrative activities to help support its members in providing the highest level of psychiatric care. The annual conference, this year titled “Snakes and Ladders” to reflect the profound “ups and downs” experienced by children and families, provides an opportunity for mental health professionals to hold informed and valuable discussion about a wide range of issues pertinent to child and adolescent mental health. The FCAP also sets the curriculum for the child psychiatry training program and is strongly engaged in a range of policy and advocacy work as a way of creating better mental health outcomes for our community. In recent years, the FCAP has contributed to various key government policy initiatives on a diverse range of subjects including: children in out-of-home care; suicide prevention; the impact of online media on mental health; indigenous health; and child protection. The FCAP also develops and maintains position statements on a broad range of issues.

Training and Education

The RANZCP conducts training and exams for doctors wanting to qualify as psychiatrists. The psychiatry training program takes a minimum of five years full-time training, during which time trainees work in hospitals and clinics under the supervision of experienced psychiatrists. Trainees who successfully complete the program are eligible to become Fellows of the RANZCP (FRANZCP). This qualifies them to practice independently as consultant psychiatrists in Australia or New Zealand. Training is undertaken in three stages. In stage three (final 24 months), trainee psychiatrists can choose to undertake a Certificate of Advanced Training in child and adolescent psychiatry.

The College also oversees training and accreditation for overseas-trained psychiatrists who wish to work in Australia and New Zealand. Such psychiatrists either undertake specialist assessment to become Fellows of the College, or are registered for a short-term period to fulfill ‘area of need’ positions. The College further administers the Continuing Professional Development (CPD) for practicing psychiatrists.

The FCAP has a further role in contributing to the education of other mental health professionals. A recent initiative includes contribution to a working group developing online training tools for mental health professionals (including psychologists, social workers, mental health nurses, and Aboriginal and Torres Strait Islander health workers) who deliver focused, psychological strategies services to children under the Access to Allied Psychological Services (an Australian government initiative to expand access to those requiring short-term intervention).

Practice and Health Care System

In New Zealand, the health system is largely public. In Australia, the health system is a mixed system, which includes both private and public services. For private services, some costs are met by the government through reimbursement through the Medicare system. In both countries, child and adolescent psychiatrists work in community settings, in multi-disciplinary community clinics, or in private practice, although some work in specialized in-patient units for children or adolescents with more severe and complex disorders. Practitioners draw on diverse skills ranging from psychopharmacology to psychotherapy and family therapy,
and work alongside a broad range of professionals including teachers, school guidance officers, child safety workers, psychologists, and pediatricians.

The FCAP, through its advocacy work, has a role in ensuring that services are properly funded and accessible. In Australia, this includes ensuring that Medicare rebates are set at an appropriate level and cover the range of services appropriate to meet the needs of patients. The FCAP plays a key leadership role in defining how child and adolescent mental health services are delivered through regular liaison with government bodies. It has been instrumental in forming the Children’s Mental Health Coalition, which brings together professionals working in the area of children’s mental health to provide a collective voice.

A recent initiative supported by the FCAP is the inclusion of behavioral and emotional health checks in the Healthy Kids Check for three-year-olds, due for implementation during 2013 in Australia, as a way of assessing young children whose parents may be worried about their development, whether social or behavioral.

**Future Directions**

As an overarching priority, the FCAP will continue to develop partnerships with key child and adolescent mental health organizations and government bodies to influence and shape the future of child and adolescent mental health services in order to ensure delivery of optimal care.

**Priority groups**

The mental health of children of parents with mental illness, children in out-of-home care, siblings of children with a disability or chronic illness, and children with intellectual disability are the priority groups identified by the FCAP where increased advocacy, awareness, and improved practice and clinical skills are required. Recent workshops have been held and resources developed to help address these issues. Meeting the mental health needs of young people during the developmental transition from childhood into adulthood between the ages of 12 and 25 years is a further area of focus.

**Prevention and early intervention**

In 2010, the FCAP published the report *Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents*, which stated the importance of preventing mental illness in infancy, childhood, and adolescence, both to improve children and young people’s mental health and to help prevent the onset of mental illness in adult life. Together with lobbying for comprehensive policy change and program implementation, a crucial priority for FCAP is to ensure that appropriate training and information is provided to psychiatrists and trainees to identify and consider appropriate prevention and early intervention strategies. Priority areas include working closely with vulnerable mothers and conduct disorder and anxiety disorders in adolescence, areas for which prevention and early intervention are most likely to be effective in avoiding problems in adulthood.

**Indigenous populations**

The FCAP recently undertook a project to assess what can be done to better support the needs of indigenous infants, children, and adolescents, a particularly vulnerable group. Priorities include enhancing psychiatrist contribution through ongoing involvement as part of the indigenous community to promote understanding and respect; acknowledge the difference between indigenous and western cultures; and recognize the impact of dispossession has had on the mental health of Aboriginal people. There is a need for more indigenous mental health workers, greater access to culturally appropriate services, and further investment to deliver initiatives developed in consultation with indigenous communities. The RANZCP is encouraging more indigenous medical students to consider careers in psychiatry; encouraging psychiatrists to work in rural and remote areas; and concentrating on ensuring that appropriate training, education, and resources are available to all its members.

**Relationships with the Asia-Pacific region**

The College continues to actively develop and build contacts and relationships within the Asia Pacific Region, acknowledging its position in the Asia Pacific and the benefits of collaboration with other nations. The Asia Pacific Mental Health Forum, held at the College Congress in May 2013, gave officials from over 15 countries the opportunity to share their views on the most urgent issues and priority areas in mental health for the region. Practical ideas to address workforce shortages and reduce stigma were among the issues discussed to outline how child and adolescent mental health can be enhanced through regional partnerships.

To view further information, please visit [www.ranzcp.org](http://www.ranzcp.org) or contact ranzcp@ranzcp.org.

Dr. Kowalenko is chair of the RANZCP Faculty of Child and Adolescent Psychiatry. He has been a practicing psychiatrist in Australia for 25 years, and is currently a clinical senior lecturer in the Department of Psychological Medicine at the University of Sydney. He serves as deputy chair of the Australian Infant, Child, Adolescent, and Family Mental Health Association.

Dr. Patton is the president of RANZCP. He is clinical director of Mental Health and Addictions Services, and director of Area Mental Health Services with Waitemata District Health Board in New Zealand. He is acting clinical advisor to the general manager of Mental Health Services in Northland DHB.

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**SCHOOLS COMMITTEE**

**TOUCHPOINTS: Defining Moments in the Life of a School-based Kiddie Shrink and Tribute to My Mentor, T. Berry Brazelton, M.D.**

**John McCarthy, M.D.**

“Do something!” a woman pleaded as she entered my room even before introducing herself. She appeared angry, frustrated, and ready for a fight. Concerned, I waited patiently for her story to unfold. A single mom of two adolescent boys, she worried about her eldest son, Russell, a 15-year-old in 10th grade whose school performance had recently deteriorated. Mom, a hard working paralegal and erstwhile musician, had taught him to play guitar in kindergarten. Russell became an accomplished and passionate guitarist. Now, as a teenager, he developed a seemingly intense interest in acid and punk rock; and therein laid the rub. Mom feared that her talented son might be drawn to these performers’ propensity for experimenting with dangerous, potentially addictive, and lethal drugs. Having recently read about a well-known rocker’s fatal overdose further reinforced her fears for her son. I validated her feelings and concerns and said something like, “Who wouldn’t be worried, especially after everything you’ve done to raise two sons alone?” To which she responded, “Yeah, but I guess he’s becoming a man and I may need to give him space to make his own decisions and trust he’ll be ok.”

I then met Russell privately as his mother exited my room somewhat calmer and more hopeful than when she had entered 45 minutes earlier. A handsome youngster, sporting a short, spikey hairdo and wearing jeans and a Bob Dylan T-shirt, Russell nonchalantly came in and sat down as he uttered, “Hey.” He wore no jewelry or tattoos, spoke softly, and made good eye contact. I asked him what he liked to do for fun when he was not in school. With a sparkle in his eye and with great exuberance, Russell proceeded to tell me how central playing guitar was to his life since he was little. Bob Dylan was his hero, which explained the T-shirt he wore. Russell gave credit to his mom for teaching him how to master this instrument and encouraging him to push the envelope in expanding his abilities musically. Russell candidly acknowledged that sometimes his passion for music got in the way of his grades in school. Recently, he became fascinated with musicians like Van Halen and Jimi Hendrix, who had added new dimensions to guitar playing that Russell had attempted to adapt to his style of playing. Russell knew only too well the cost of mastering this genre had on his school performance. There was not a whiff of substance abuse, or emotional or behavioral problems in his presentation. I felt, from my observations of Russell during that hour, that he was a pretty well-adjusted, personable youngster with enormous talent.

At the conclusion of our meeting, I requested that both Mom and Russell return for follow-up in a week. I invited Russell to bring his guitar so I could hear him play. When they returned, Russell gave me a performance that astounded me with his incredibly sophisticated playing, one I never forgot. In my time with Mom, I reinforced her notion that she needed to trust Russell to figure a way to balance his love for music with his need to do his best in school. Russell acknowledged that his job going forward would be to further develop his skills both musically and educationally. Both concurred and thanked me for helping them. Elated, I had witnessed and been a part of an important touchpoint in their lives.

Thanks to my mentor, T. Berry Brazelton, M.D., I recognized the above encounter with a mother and her son not only as a crisis but also as a unique touchpoint opportunity for me to facilitate an effective and growth-promoting solution. Mom, as a caring, competent parent, came to view Russell’s rebellion as potentially dangerous, NOT as a normal process of growing up. Her

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“Touchpoints become a window through which parents can view the great energy that fuels their child’s learning for the next. When seen as natural and predictable, these periods of regressive behavior are opportunities for parents to understand the child more deeply and to support her growth, rather than become locked in a struggle.”

T. Berry Brazelton, M.D.

from “Learning to Listen: A Life of Caring for Children,” by Merloyd Lawrence, 2013

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continued on page 243
AACAP’s Toolbox for Clinical Practice and Outcomes: A Resource for Practicing Clinicians and Trainees

ACAP’s Pediatric Psychopharmacology Initiative (PPI) and the Consumer Issues Committee (CIC) have collaborated to develop the Toolbox for Clinical Practice and Outcomes, a resource to help child and adolescent psychiatrists practicing in the community. This team was headed by Julie Zito, Ph.D., a founding member of the PPI; Cathryn Galanter, M.D., chair of the Consumer Issues Committee; and also included AACAP members, Nilda Gonzalez, M.D., Katherine Grimes, M.D., M.P.H., and Elias Sarkis, M.D. Their aim was to provide AACAP members with the tools they need to be thoughtful, comprehensive, safe, and evidence-based medication prescribers. The Toolbox is broken into several sections with practical tools: “Medical History and Medical Requests,” “Baseline (and repeat) Monitoring of Clinical Symptoms,” “Baseline Medication Consent,” “Medication Monitoring,” “Outcome Scales,” and “Medication Information Resources” for professionals and families. The use of rating scales not only promotes analyzing outcomes, but also helps in developing a standard of practice to monitor our patients’ symptoms, functioning, and medication side effects. Development of a standard of practice is crucial, particularly during the early years of training.

The Toolbox went live on the AACAP website in spring 2012. It is readily accessible from the AACAP Members Only webpage. From there, you click on the Toolbox icon. When you arrive at the landing page for the Toolbox, you can click on one of three links: 1) a letter introducing the Toolbox by former AACAP President Laurence Greenhill, M.D., who was very supportive of this endeavor; 2) the Roadmap, which organizes all the Toolbox forms; or 3) “Enter the Toolbox,” which offers all the PDF files of the forms organized by category. For example, under “Medical History and Medical Requests,” there are intake questionnaires. Also, to monitor clinical symptoms and functioning, screening tools for conditions such as ADHD, mood disorders, and anxiety disorders include Children’s Global Assessment Scale (CGAS), Columbia Impairment Scale, Patient Health Questionnaire (PHQ-9), Scale for Child Anxiety-Related Disorders (SCARED), and Vanderbilt screening forms. In order to monitor medication response and side effects, with parent/patient reporting, one can use the Medication Monitoring forms, which are specific for drug classes, e.g. stimulants, antidepressants, or antipsychotics. Clinicians may also find links to outcome scales such as the Swanson, Nolan and Pelham Teacher and Parent Rating Scale (SNAP IV), the Sarkis scale and the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Last, there are reliable information sources that can be accessed, as well as safety report forms (Medwatch) and the National Alliance for the Mentally Ill (NAMI) Handbook for Parents.

As a trainee who was working on a project to introduce the use of the Toolbox in a newly organized outpatient clinic, Dr. Shah found the Toolbox helpful because of the great stock of resources available. What follows is her experience using the Toolbox in her outpatient clinic.

An advantage of utilizing the Toolbox was being able to maintain a database of information on my patients that trainees could use to track symptoms and outcomes. Through the use of this resource, I was able to pick up a previously undetected disorder in one of my patients who initially presented with symptoms of depression. When I administered the parental and child versions of the SCARED, she also was found to suffer from social phobia. I was able also to monitor responses to stimulant treatment for some patients with ADHD more systematically. With each dose change, the parent and teacher filled out either the SNAP or Vanderbilt.

There were a few challenges that either I experienced, or that I expect other trainees might encounter while utilizing the Toolbox. In a busy, high demand clinic, gaining access to the contents of the Toolbox was sometimes time consuming. For example, I had a specific opportunity to use the Toolbox, with a newly established clinic patient who was endorsing symptoms of depression and anxiety. Since the materials were online, I was at the mercy of our Internet connection, which was not providing optimal service that day. Also, due to the plethora of available tools, in the beginning it took time for me to navigate...
Some concerns led me to wonder if the contents could be better organized on the website. Perhaps forms to be filled out by youth, with a separate form for parents. I learned later that there is a plan to make that designation more apparent. Also, in some settings, the use of any form might require prior approval. That was one of the hurdles I encountered while trying to establish the use of the Toolbox as a resource in a government-run facility where I work in an outpatient setting.

Future considerations include developing recommendations to systematically use rating scales in order to study how children respond to treatment. Another suggestion is to include modified rating scales for those children with intellectual disabilities or who fall under the autism spectrum disorders, as this is an extremely important population that child and adolescent psychiatrists treat. Another consideration could be to include versions of these forms on the website in other common languages, such as Spanish.

All of these experiences led me to believe that, overall, the Toolbox could be very helpful in private practice or in a clinic where the tools are integrated into their monitoring system. The Toolbox is valuable to guide us in achieving the overarching goal as clinicians, which is to practice safe medicine. It is important to emphasize that the use of the Toolbox is beneficial as an adjunct to comprehensive assessment and ongoing treatment. Resources such as this are not meant to replace clinical judgment or hinder the therapeutic process. Currently, as a trainee and an early career psychiatrist, the use of the Toolbox, along with AACAP practice guidelines, has greatly influenced my outlook and practice on how to better treat and monitor my patients.

Dr. Shah recently completed her child and adolescent psychiatry training at SUNY Downstate and is now attending at Monmouth Medical Center, Long Branch, New Jersey. She may be reached at Hinna.Shah@nychhc.org.

Dr. Galanter is the chair of the AACAP Consumer Issues Committee, and program director and visiting associate professor at SUNY Downstate/Kings County Hospital Center, Brooklyn, New York. She may be reached at Cathryn.galanter@downstate.edu.

Dr. Zito is professor of pharmacy and psychiatry at the University of Maryland, Baltimore. She was a founding member of the Pediatric Psychopharmacology Initiative in 2000-2001.

Dr. McCarthy is a retired clinical associate professor of Child and Adolescent Psychiatry from New York University School of Medicine (2002-2011). He is Triple-Boarded in Pediatrics, Psychiatry, and Child and Adolescent Psychiatry. Dr. McCarthy has been a member of AACAP’s Schools Committee since 2003. He may be reached at mcbaby311@gmail.com.

TOUCHPOINTS continued from page 241

A developmental crisis involved letting go and trusting that her son would make healthy life choices. Russell struggled mightily to assert his independence to expand his horizons as an adolescent, even in the face of his mom’s concerns for his safety. Russell’s crisis was to accept the possibility of making mistakes in finding his way to adulthood, while still retaining his mother’s deep love and acceptance. Both parent and child expressed relief that I viewed their crisis as a predictable but healthy process of development and NOT pathological, requiring medication and/or therapy. I learned that by developing rapport through listening actively to mom and Russell, I could facilitate their navigating successfully this developmental crisis and further solidify their relationship. This was indeed a defining moment for all of us. I am happy to report that both continue to be close 20 years after that critical encounter. Mom, his biggest fan, is now a grandmother, and Russell is a very popular, well-adjusted guitar-playing musician and father of an infant boy. I know this because I recently attended his sold-out concert and was part of a standing ovation with tears of joy for how he had turned out.

On May 10, 2013, I attended Dr. Brazelton’s 95th birthday in Cambridge, Massachusetts, primarily to thank him for allowing me to do a two-year Child Development Fellowship at the Child Study Unit. He taught me how to really connect with children and their parents, and how to make every encounter with them matter. Sharp as ever and in mentor mode, he said, “I’m not done yet and neither should you be.” Excellent advice, I would say, for a man a quarter of a century my senior.
The New York Council on Child and Adolescent Psychiatry (NYCCAP) is an active AACAP Regional Organization of Child and Adolescent Psychiatry (ROCAP) with many committees to foster and support its members’ growth. Over the past several years, involvement of trainees, including medical students, general psychiatry residents, and child and adolescent psychiatry fellows has increased within the regional organization. Representatives from each of these groups serve on the Board of NYCCAP. NYCCAP has expanded the opportunities for involvement for the next generation of child and adolescent psychiatrists and establishing a Member-in-Training (MIT) subcommittee. In just two years, the subcommittee has grown to 90 members comprised of medical students, residents, and child and adolescent psychiatry fellows from 12 training programs in the New York City metropolitan area. Representatives from this subcommittee come to the NYCCAP monthly board meeting, and board members provide guidance and support.

The MIT subcommittee develops many activities and events for trainees throughout the year. In July of each year, NYCCAP hosts a Welcome Night event to welcome first year child fellows to the Council. This event is usually very well-attended and provides a unique opportunity for the trainees to meet NYCAP board members, as well as peers and mentors. In addition, the subcommittee organizes the annual Career Night, to expose trainees to different career paths and senior mentors in child and adolescent psychiatry. Besides sponsoring monthly MIT subcommittee meetings, NYCCAP also sponsors additional educational and child psychiatry oriented activities for the fellows. Board members, like current president, Iliyan Ivanov, M.D., and Training Committee chair, Cathryn Galanter, M.D., have joined the subcommittee’s events, such as visiting the New York City Museum of Modern Art to see the “Century of the Child” Exhibition, participating in Movie Night, or meeting with trainees at monthly meetings.

NYCCAP offers many travel scholarships to help support trainees to attend the AACAP Annual Meeting and Advocacy Day. Each year, we sponsor three AACAP Annual Meeting Scholarships, four to six AACAP Trainee Memberships, and co-sponsor two AACAP Advocacy Day grants. These scholarships and grants make traveling feasible for trainees who otherwise could not afford to attend. In addition, trainees have opportunities to share their experiences and submit articles about a variety of topics to the New York Council Newsletter. Trainees feel empowered by their participation, and as a result, they have become increasingly active in NYCCAP.

NYCCAP is a large ROCAP with over 800 members. Its aim is to support and actively involve trainee members in the activities of the New York Council and AACAP. As child and adolescent psychiatrists, we owe it to ourselves and to AACAP to attract and nurture the future generation of child and adolescent psychiatrists. As the saying goes “someone’s sitting in the shade today because someone planted a tree a long time ago.”

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So Many Antipsychotics, So Little Information

The proliferation of antipsychotic drugs has made the rational and reasonable selection of medication choice increasingly challenging. At present, there are eight FDA approved “first generation” neuroleptics and seven “second generation” or “novel” neuroleptics approved for pediatric and adolescent age ranges. Most clinicians and prescribing practices have come to favor the “novel” neuroleptics for their decreased extrapyramidal side effects and their perceived therapeutic advantage over traditional first generation agents. This has come with some clear, significant costs, including marked weight gain and metabolic/lipid abnormalities, not to mention the premium paid for expensive new medications. But are these perceived advantages (and disadvantages) real?

The answers ideally would be the product of randomized trials in head-to-head studies, but this would be very costly, is not favored by manufacturers, and is just not going to happen in adults, let alone children and adolescents. Earlier studies in adult populations looking at pooled first versus second generation agents have raised serious questions as to the actual clinical advantage of newer agents (except clozapine) over older ones. They have also found that while side effects differ, both generations of drugs come with real down sides. Finally, differences in efficacy and side effect profiles might not justify the huge differential in cost (at least, in adults). A closer, more detailed study comparing individual agents is needed.

Leucht et al.’s June meta-analysis article in The Lancet provides this closer look by comparing individual agents across the two “generations.” While there are unfortunately no comparable data in children and adolescents, their review of over 43,000 patients across 212 studies provides some real insights into the advantages and disadvantages that have been described in the earlier pooled studies. These were predominantly chronic adult patients, with an average duration of illness of 12.4 years and an average age of 38.4 years. Certainly not the typical patient for child and adolescent psychiatrists, but it is the best we have.

The authors report that “the primary outcome was the mean overall change in symptoms, which was assessed in the first instance by change in Positive and Negative Syndrome Scale... Secondary outcomes were all-cause discontinuation, weight gain, use of anti-Parkinson drugs as a measure of extrapyramidal side-effects, prolactin increase, QTc prolongation, and sedation.”

In adults, all of the agents were statistically effective with a moderate effect size. The effect size was greatest for clozapine, followed by amisulpride, olanzapine, and risperidone, respectively. Clozapine’s effect size was far greater than the others. Only olanzapine and risperidone are approved in pediatric patients. Haloperidol, quetiapine, aripiprazole, and ziprasidone were clustered in the middle and at the bottom was chlorpromazine. Among these, all but ziprasidone are approved for certain pediatric usages.

Side effect profiles varied far more. Haloperidol, lurasidone, and ziprasidone were the only agents that did not cause weight gain, while clozapine and olanzapine topped the weight gain list. Risperidone increased prolactin the most, and haloperidol was the most often discontinued, presumably because of side effects. Adults also particularly disliked chlorpromazine because of associated sedation and weight gain. Importantly, clozapine, serindole, olanzapine, quetiapine, aripiprazole, iloperidone, amisulpride, and asenapine did not cause significantly more extrapyramidal side-effects than placebo. Additionally, aripiprazole, quetiapine, asenapine, chlorpromazine, and iloperidone did not cause significantly increased prolactin concentrations compared with placebo.

What can be drawn from this adult meta-analysis is that no agent is without pluses, and some have far more serious minuses. The data in adults suggests that all things taken into consideration, aripiprazole has the most advantageous profile (good results, fewer side effects). Extrapolating the overall results to children and adolescents, recognizing that there are clear limitations in doing so, this would also probably propel aripiprazole to the head of the list for pediatric prescribers treating psychosis. It is already at the head of the list for adolescent bipolar disorder. Also, the more benign profile makes it a very good candidate for primary consideration for other usages (for instance aggressive behaviors), but the data are not there for adults or children. Aripiprazole is one agent where newer and more expensive appears to be justified, though insurance companies may lag behind in recognizing these advantages.


continued on page 246
Primary Prevention Always Preferred

The biological etiology and pathophysiology of bipolar disorder and schizophrenia has been the subject of intensive investigative research for the past several decades. Gradual progress has been made in identifying risk factors, genetic diathesis, and structural underpinnings for both disorders, and it is clear that they share some common factors. Despite real progress and the advent of an increasing array of agents, for many patients, their course is a challenging and chronic one. The challenges faced by those with early-onset illness are typically worse than those with later onset illness. For disorders with such high morbidity, primary prevention must be a priority.

About a decade ago, Brown, in the Archives of General Psychiatry (2004), described an almost three-fold increased rate of schizophrenia in the offspring of mothers who had influenza during their pregnancy. In an equally important new finding, in June’s JAMA Psychiatry (formerly Archives of General Psychiatry), Parboosing et al. report on a parallel finding for bipolar disorder in the adult offspring of mothers who had had influenza during their pregnancies.

In their nested case-control study of over 19,000 offspring, using structured interviews, they were able to identify and enroll 92 adults with bipolar disorder whose mothers had had influenza. They compared this group to a matched control group.

After correcting for appropriate variables, they found that the adjusted odds ratio of having an adult offspring with bipolar disorder was 3.82 for mothers who had had influenza. It also appeared that the risk went across all trimesters. This new finding, combined with the almost three-fold risk for increased rates of schizophrenia for mothers with influenza, means that a major primary prevention intervention for two of the most serious of mental disorders can be a simple, inexpensive flu immunization. As child and adolescent psychiatrists, we see many families of childbearing age, and the opportunity to provide this important education should not be missed.


Trauma and Psychosis: an Unwanted Partnership

Psychiatry is filled with chicken-and-the-egg types of questions. Whereas basic knowledge of modern biology assures us that in fact the egg came first, the same cannot be said for all other relevant questions of causality and temporality. A connection between psychosis and traumatic experiences has been long established, but the direction of causality has not been well established. Does trauma make our patients more vulnerable to psychosis? Does psychosis make our patients more vulnerable to trauma? Either possibility seems to have a logical merit.

Kelleher et al. recently asked this question in a report published in the green journal. Using data from the large Saving and Empowering Young Lives in Europe study, the authors assessed 1,112 youth aged 13-16 years over the course of a year for both psychotic experiences and trauma exposure. Across the assessments, about 4-7% of the youth reported psychotic experiences, and 8-10% experienced being physically attacked. About half of these attacks were by schoolmates, and the other half were fairly evenly split between relatives, strangers, and other acquaintances.

So which conclusion did the authors find best supported by the data? As so many things are in mental health, the relationship between trauma appears to be bidirectional, with earlier trauma predicting later psychosis, and vice versa. The effect of trauma on psychotic symptoms was heavily dose-related.

The most encouraging finding in the study was that cessation of trauma appeared to predict decrease in psychotic symptoms. This gives us some hope that by working with our patients and our communities to decrease the risks for bullying and violence, we may be able to make an important impact on the psychotic experiences our patients have.


The Earliest Biomarker of Depression Reported Yet

The easiest way to make the eyes of a busy clinician glaze over is to start expounding upon findings in neuroimaging studies, which seem frequently irrelevant to clinical practice (in the present, anyway) and contradictory depending on the analysis methods chosen by the researcher. But even now, years before neuroimaging is ready for primetime, certain studies scream for attention as they offer true insight into the nature of psychiatric illness and hope for biomarkers (and biomarker-based treatments) for our future patients. Meanwhile, Gaffrey et al. provide even more evidence to debunk one of the most ridiculous persistent myths in medicine: that small children cannot get depressed.

In this large case-control study of 54 medication-naive children aged 4-6 years, youth with and without depression underwent fMRI to measure functional brain activity during emotion face processing. Regardless of the emotional content of the faces, children with depression showed right-lateralized increases in activity in the amygdala, thalamus, inferior frontal gyrus, and the angular gyrus. The increase in the amygdala seemed to correlate with problems with parent reported emotion regulation and negative affect.

Such a novel finding does not change our treatment plans just yet. But as we are providing psychoeducation to families, more and more of us are able to
include both psychosocial and biological factors in our explanation as to why a child may be suffering from an illness that a parent may struggle to understand. And, while most of the field would agree that the use of medications should be extremely conservative in young children, a biological basis for the illness better justifies the use of a biological intervention in those instances in which such an approach is necessary.


**News Quickies**

Children whose mothers smoked during pregnancy grow up to have higher rates of substance use. Animal models suggest that the exposure is actually causal, with early exposure to nicotine altering development of the reward system. When 177 adolescents with prenatal exposure to smoking and 177 controls matched on sex and maternal education level were studied with fMRI, the exposed adolescents had a weaker response in the ventral striatum during reward anticipation. One of the best ways to decrease adolescent substance use might be to keep their mothers from smoking during pregnancy.

Another fMRI study of 19 severely irritable and 23 healthy children showed that children with severe mood dysregulation (a precursor of the new DSM-5 diagnosis Disruptive Mood Dysregulation Disorder), the irritable children had a marked decrease in their ability to shift spatial attention during a frustrating cued-attention task compared to their healthy peers. This decrease in function correlated with deactivation of the amygdala, the left and right striatum, the parietal cortex, and the posterior cingulate. This lack of mindfulness might partially explain why irritable children struggle so much with regulating their mood.

Not all anti-bullying policies are the same. A large study of over 30,000 11th graders in Oregon found that lesbian, gay, bisexual, and transgender youth attending schools with anti-bullying policies that did not include specific considerations for sexual orientation were more than twice as likely to attempt suicide.

Youth who experience sexual abuse are at risk for a myriad of poor psychiatric outcomes. A chart review at the University of Cincinnati found that correcting for demographics and medication usage, adolescents admitted to the psychiatric hospital with a history of sexual abuse were 40% more likely to be overweight or obese than their peers who were not victims of sexual abuse. Physical abuse, for all of its other sequelae, did not correlate with increased weight.

Bedtimes are important! A study of the bedtimes of 11,178 7-year-old children from the United Kingdom Millenium Cohort Study showed that the lack of a regular bedtime was associated with poorer performances in reading, math, and spatial testing, especially in girls.

**References**


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**FACULTY CHILD AND ADOLESCENT PSYCHIATRIST**

**Roanoke, Virginia**

Virginia Tech Carilion School of Medicine and Carilion Clinic, a physician led multispecialty academic healthcare organization with over 600 physicians, has an opening for an ABPN BE/BC Child and Adolescent Psychiatrist with a minimum of three years post-training experience. This inpatient/outpatient faculty position is associated with the new allpsychiatric medical school and Carilion Roanoke Memorial Hospital, a 700-bed teaching/tertiary referral center with 12 acute child and adolescent psychiatric beds. Responsibilities include direct clinical services, teaching medical students, supervising residents and fellows, and integrating research with clinical practice. Call coverage is shared with five child and adolescent psychiatrists.

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Healthcare Reform Is on the Move: Are You Ready?

Bob Hilt, M.D., and Barry Sarvet, M.D.

Our healthcare system is changing. You may not notice it very much now, but across the United States, as the Affordable Care Act is implemented, significant differences in the financing of healthcare are taking hold and driving changes in the way healthcare services are organized and delivered. In a nutshell, new stakeholders are being created, changing the way child and adolescent psychiatric services will be purchased. Child and adolescent psychiatrists (CAPs) will need to pay attention to what these stakeholders want: access to care, coordinated care, containment of cost, and measurable achievement of quality outcomes for populations of patients. “Off-the-grid” private practices will likely be able to conduct business as usual. However, CAPs whose practices rely on insurance reimbursement contracts will likely be experiencing these changes soon.

Broadly speaking, these changes present both opportunities and challenges for our profession. As a scarce resource, CAPs cannot deliver what is needed for entire communities and populations singlehandedly—hence there is a need for CAPs to carve out roles as part of a high-performing healthcare team.

Opportunities

1) **Broader public health impact:** By assisting behavioral health care delivery within the Pediatric Healthcare Home, CAPs will get an opportunity to favorably impact the care of all children treated within a primary care system rather than just those who have become our individual practice patients. Working as a team, with primary care clinicians and professionals from other child-serving systems, creates an ability to enhance the health and well-being of all youth in the area through a broad range of prevention, early intervention, and shared care initiatives.

2) **Enhanced role satisfaction:** Within the integrated care of a Pediatric Healthcare Home, there will be opportunities to become physician leaders. CAPs are well suited to employ their consultation and teaching skills within the primary care system. Those of us who experience professional isolation working in a non-integrated practice may find it refreshing to work closely with other professionals in pursuit of shared patient care goals.

3) **Promoting family-focused care:** CAP experience with family development and family dynamics, and experience working within and among various systems of care, could be quite valuable to a Pediatric Healthcare Home system. Helping primary care to address the strengths and needs of the family, promoting dyadic and family therapies, promoting behavior management training, and referring family members for their own mental health treatment as indicated can all be accomplished through CAP consultation with primary care practitioners.

4) **Using health information technology to help kids:** CAPs can help primary care design embedded treatment algorithms in an electronic medical record (EMR) to guide primary care practitioners to the safest and most effective care. Technological advances in electronic data sharing can improve communication and coordination, and direct symptom and history entry by patients/families/teachers can both improve outcomes tracking and reduce provider data entry time.

Challenges

1) **Moving from Solo to Team-Based Care:** Healthcare Homes will likely lead to a shift from relative CAP professional autonomy as solo practitioners to a team-based approach to care. In a team approach, non-complex care would be provided by less specialized or costly providers, and CAPs would be asked to work with the more complex cases.

2) **Less direct family and patient interaction, more consultation:** In the context of a Pediatric Healthcare Home, the primary care physician will likely serve as leader of a multidisciplinary team that attends to both the medical and mental health needs of patients. CAPs in this system would often see children just for consults or limited periods of time for stabilization, while the primary care physician (PCP) (with or without another provider serving as the child’s therapist) will continue to serve as the primary treatment team leader. This would limit some opportunities for close child and family relationships, although children with significant mental illness would likely be preferentially steered into ongoing care with CAPs.

3) **Less autonomy in clinical diagnosis and treatment:** Healthcare Home systems will emphasize evidence-based assessment and tracking of treatment responses. Clinical practice will thus become more open to scrutiny by the Accountable Care Organizations, and practitioners will be sharing responsibility for treatment outcomes. A well-run healthcare home will use this information to improve practices in a
plan-do-check-act cycle that may be unlike what typically occurs in a solo practice.

“It is in the best interests of CAPs to become familiar with the Affordable Care Act and what it may mean for their own practices.”

Taking Steps to Prepare

We do not anticipate that healthcare reform will alter the current practice of all CAPs, as there will always be room for the traditional model of practice. However, if healthcare reform were to proceed without us, the profession would have missed a golden opportunity to employ our expertise in improving the care of children throughout the whole care system. Those of us who would like to engage with this health care reform will increasingly be consolidating into large entities responsible for managing the healthcare of large panels of patients, ensuring timely access to mental health care, systematic screening, and achievement of quality goals. A lone CAP, no matter how talented and industrious, cannot meet the mental health needs of these organizations, and these organizations will prefer to manage a relationship with a single mental health organization who can meet all of their needs.

1) Reach out: Due to our limited availability, many CAPs have had minimal contact with the primary care providers in their areas. Positive collegial relationships with PCPs are both a prerequisite and an outcome of integrated child psychiatry practice. The easiest place to start is participating in advocacy coalitions which include pediatricians and other stakeholders. One could also try offering a “lunch and learn” to primary care groups updating them about treatment of common psychiatric issues.

2) Take stock: Even if you are closed to referrals because your practice is full, consider how you engage with your surrounding medical community. Do you know the pediatric primary providers in your local community? Do you routinely send notes to your patient’s PCPs regarding what meds you are prescribing? Can you develop an efficient workflow to accomplish PCP communication on a routine basis? Do you need an EMR?

3) Open up: Being “full” has always been the goal of running a private practice—but this would not be the goal of being a consultant within a coordinated care medical home where consultant availability is part of what would need to be paid for. A way to find out if you enjoy the consulting role includes setting aside a small amount of time per week to do consultations for a particular pediatric practice (with an advance agreement that you will not assume ongoing responsibility for these patients). With payment reform, a primary care practice may be in a position to purchase a small session of your time per week or month for you to do consultation for them.

4) Get bigger: Primary care practices will increasingly be consolidating into large entities responsible for managing the healthcare of large panels of patients, ensuring timely access to mental health care, systematic screening, and achievement of quality goals. A lone CAP, no matter how talented and industrious, cannot meet the mental health needs of these organizations, and these organizations will prefer to manage a relationship with a single mental health organization who can meet all of their needs.

5) Information services: a strategic investment: Integrated healthcare requires robust sharing of information between specialists and PCPs. Health information exchanges (HIEs) are forming around the country in order to enable efficient clinical information sharing between EMRs of different healthcare entities. Becoming familiar with the HIEs and the EMR systems used in your area can create opportunities for more efficient communication of the clinical information that is appropriate to share with other healthcare providers. CAPs can help guide this process by advising on the confidentiality requirements around mental health information.

Conclusion

It is in the best interests of CAPs to become familiar with the Affordable Care Act and what it may mean for their own practices. Healthcare reform that leads CAPs to working more closely with primary care offers an opportunity for our profession to better address mental health disorder prevention, to provide early intervention, and to increase mental health promotion. The role of the CAP can expand through healthcare reform to not only provide comprehensive treatment for children with challenging mental health problems, but also to help the overall care system deliver more timely and more effective interventions for those with less severe pathology. The bottom line is to become aware that change is taking place and CAPs should be informed, prepared, and “at the table.”

Dr. Hilt is an associate professor of Psychiatry at the University of Washington/Seattle Children’s Hospital; program director for the Partnership Access Line consult service; and co-chair of the AACP Committee on Collaboration with Medical Professions. He serves on the editorial boards for both Pediatric Annals and Psychiatric Annals. He may be reached at Robert.Hilt@seattlechildrens.org.

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To learn more about healthcare reform and the ACA, please contact the Department of Government Affairs and Clinical Practice at 202-966-7300 and/or review the 2013 AACP publication, “ACOs and CAPs: Preparing for the Impact of Healthcare Reform.”
STATE HEALTH CARE EXCHANGES

Frequently Asked Questions

What are state health insurance exchanges?

One of the ways the Affordable Care Act (ACA) aims to expand access to insurance coverage is the creation of state-based health insurance exchanges. A health insurance exchange, also known as a health insurance marketplace, is essentially an online shop for individuals and small businesses (up to 100 employees) to compare and purchase private health plans. The exchanges will also help consumers determine if they are eligible for programs such as the Children’s Health Insurance Program (CHIP) or tax credits for private insurance.

Are states required to create exchanges?

All states are required to have exchanges through which consumers can purchase health insurance. States can choose to create their own exchange (state-based exchange); partner with the federal Department of Health and Human Services (DHHS) to operate an exchange (state partnership exchange); or opt to have the federal government set-up and operate the exchange (federally-facilitated exchange). The majority of states (26) have elected to have federally-facilitated exchanges, while 16 states and Washington, D.C. will operate their own exchanges. Eight states have chosen to partner with the federal government in the state partnership exchange.

When will exchanges begin operating?

Open enrollment begins October 1, 2013, and the exchanges are required by law to be operational by January 1, 2014.

What choices will the consumer have for health plans sold through the exchanges?

Consumers will be able to choose between multiple health insurance plans when shopping through an exchange. The exchanges are required to rank the health plans from bronze to platinum to indicate what level of coverage the plan offers.

FEDERALLY-FACILITATED EXCHANGE

Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Montana, Missouri, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin, Wyoming

STATE-BASED EXCHANGE

California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington

STATE PARTNERSHIP EXCHANGE

Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, Utah, West Virginia
The chart to the right shows the percentage of health care costs coverage by each level plan.

**What benefits will the health plans purchased through the exchanges offer?**

All health plans offered through the exchanges (for both individual and small groups) will offer a comprehensive package of items and services called “essential health benefits.” Essential health benefits must include items and services within at least the following 10 categories:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care

Insurance companies that wish to participate in an exchange must cover these benefits in order to be certified and participate in the exchanges, and all Medicaid state plans must cover these services by 2014. However, flexibility has been left to states in defining and implementing their essential health benefits package within the 10 required categories, including the choice of a “benchmark” health care plan from which to model their comprehensive package of benefits. The DHHS recommended that states choose to model their benefits package on one of four existing health plans:

- the federal employee health benefit plan;
- the state employee health benefit plan;
- the health benefit plan of the three largest small businesses in the state; or
- the health benefit plan from the largest Health Maintenance Organization (HMO) in the state.

All essential health benefits must also comply with the Mental Health Parity and Addiction Equity Act of 2008. For more information about essential health benefits, read AACAP Comments on Essential Health Benefits, submitted to the DHHS.

**How do I find out what’s happening in my state?**

States have great latitude in designing and implementing their health insurance exchanges, allowing states to decide on structure (new or existing public agency, non-profit entity), governance (Exchange Board, advisory committee, existing health agency), inclusion of state mandated health benefits (such as treatment for autism spectrum disorder), and other key elements. Consequently, no two state exchanges will look the same or follow the same processes.

To help you identify what is happening in your state, including the current status of implementation and points of contact, see AACAP’s Toolkit on State Health Insurance Exchanges.

The Kaiser Family Foundation is tracking the development of exchanges in each state. To view a profile of your state, visit kff.org/state-health-exchange-profiles.

**How can I become a network provider in the health plans sold through the exchanges in my state?**

The process to participate in the health plans sold through the exchanges will not differ from the process you follow to participate in other health insurance plans. Go to your state’s exchange website for more information on becoming a network provider.

**How can my patients get help purchasing health insurance through the exchange?**

All exchanges are required to establish a “navigator program” to help individuals and small employers with the application and enrollment process. Navigators will also conduct public education activities to raise awareness about the exchange and provide referrals to other consumer assistance resources. Information about the navigator program in each state can be found on the exchange website.

Additionally, exchanges will certify existing organizations, such as community health centers, as certified application counselors (CACs) to ensure that they are qualified to help people apply for Medicaid, CHIP, and plans sold through the exchange.
The Boston Marathon Bombing
Our Personal Perspectives

Alana Nagle, M.D., and Sara Coffey, M.D.

The Boston Marathon is a proud tradition, which takes place on Patriots’ Day, a state holiday, typically filled with fun, family events: the Red Sox play an 11 a.m. game at Fenway Park, the battles of the American Revolution are reenacted on the greens in Concord, and school spring vacation begins. Patriots’ Day unofficially heralds the beginning of spring in New England after a cold, dark winter; it is a day of hope and renewal.

In the wake of the Boston Marathon bombings, we have been processing these horrific events as individuals, parents, Bostonians and newcomers to the city, and child and adolescent psychiatry fellows at Cambridge Health Alliance. This column offers two perspectives: First, Dr. Nagle will discuss her experience as a native Bostonian. Then, Dr. Coffey will discuss her perspective as a Midwestern transplant to the city. In both of our cases, the dynamic interaction between being a child psychiatrist and the communities we serve is evident.

Dr. Nagle: My perception of Patriots’ Day was forever altered on April 15, 2013. I was returning to Boston aboard a flight with a live TV feed and watched, horrified, as CNN showed graphic images of the bombings. Upon landing, I discovered several texts from frantic friends and relatives wanting to confirm my safety. I am known as a proud Bostonian, someone born and raised here, someone passionate about this city and its events. And so I struggled to handle this violation of my city and my identity, and grappled with my own conflicting emotions — helplessness, anger, confusion, and especially, sadness.

Over the next two weeks, I worked within the neighboring schools as a child and adolescent psychiatry fellow. Bearing witness to those suffering within the community, many of whom were personally affected by the bombings, was both moving and emotionally draining. Watching school leaders addressing students about safety, I was struck by their courage as they too needed time to heal and had their own confusion about the events. As I helped to counsel students in the Boston area, some of whom had known the younger suspect, the students had a range of emotional and psychological responses. I considered how to understand these responses within a developmental context so that I could be most effective in helping them.

An interesting response was denial. Some teens felt strongly that since they could not reconcile the peer they had known with their conception of a terrorist, the allegations about him must be false. Some developed conspiracy theories, but in one-on-one discussions, these adolescents were often able to move from a cognitive, intellectual approach to a more emotional, insight-driven understanding. Such a stance was necessary in responding to the frequent expressions of shame and embarrassment several adolescents expressed around empathizing with the nineteen-year-old bomber and being concerned about whether he was in pain or being treated fairly. Emphasizing the importance of allowing themselves to acknowledge those feelings and not berating themselves for their obvious identification seemed to comfort those struggling to resolve their conflicted emotions. Advising them to seek out trusted adults helped validate their emotional needs. My advice highlighted the importance of self-care and creating appropriate boundaries to block out the frenzy of media coverage to avoid further traumatization and allow time for healing.

Another troubling question that teenagers asked was whether the suspect would face the death penalty. To peers similar in age, this question seemed a vital concern and made sense within a developmental context: Their own mortality is not often a prominent issue, and their still-developing brains and cognitive skills may result in a seeming indifference to the fragility of their own lives. To suddenly have to consider a peer facing a death sentence must have seemed a jarring affront to the natural order of things. In the context of identifying with a well-known and well-liked peer who was now being described as a terrorist, what most of the adolescents seemed to struggle with was the question of “Who am I?” In a community shaken by the betrayal of one of its own, it seemed that these adolescents began to doubt their ability to safely define themselves and whom they should trust.

Dr. Coffey: In the days after the Marathon bombings, I had the opportunity to work with a community of students and families personally affected by this horrific experience. Public schools were on vacation the week of the bombings and much groundwork was needed to prepare students and staff for their return to school. On the first day back to school, I attended several school assemblies and listened as one principal, a thoughtful, charismatic leader, spoke with his students about the core principles of the school and the strength of its student body. However,
it was not until the final assembly that I realized I too had been a student during a tragedy like this. As I observed the freshman class fidgeting and sulking, giving rounds of applause in place of nervous laughter, I was reminded of my own experience. Eighteen years earlier, I had been a freshman in high school during the Oklahoma City Bombing. I remembered, around 9 a.m., feeling a rumble underneath my feet, even though I was miles away; televisions were wheeled into the classroom as the entire school became aware of the bombing. Lacking cell phones, we worried about where our families were. My mom was a social worker that often visited the demolished building. I remember being in the halls without supervision; I left school early with another friend. I felt totally confused, unaware of my surroundings. But that is all I remember. My own experience as a student in the midst of tragedy remained hidden from me — until I sat quietly in an assembly of other students 18 years later.

I do not remember how my high school handled the bombings. I know several students lost parents in the bombing. A close friend lost her father, and each year she struggled as he was not there for some special event, e.g., to see her off to prom or attend her graduation. Conversations with my current supervisors helped me understand that just like the students I see in my practice, I too lacked some abstract reasoning about the Oklahoma tragedy at the time. I too was more concerned about how the bombing would affect my life pragmatically, rather than having an existential fear of what this means now. I sat and listened to student after student ask how this event, and the resulting increased security measures, would impact their daily lives: “What doors can we exit from? Can I open a door for a friend? What if I need to come in to the school early for practice?” I was reminded of the importance of a developmental perspective in understanding how we process these events. As a mother, I am concerned for the safety of my child. As an adult, I wonder how something like this can happen in a community that is so supportive and accepting. I also realize what unresolved feelings I had from my experience as a high-school student and how my clinical work in the context of the marathon bombings has offered me another opportunity to understand my own past. As a child and adolescent psychiatry fellow, I have learned how important a psychiatrist can be in helping children and adolescents work through the difficult feelings elicited by trauma and help a whole community heal.

Dr. Nagle is a 1st year Child and Adolescent Psychiatry fellow at the Cambridge Health Alliance. She completed her adult psychiatry training at Harvard Longwood Psychiatry Residency Training Program. Her professional interests include infant and early childhood mental health. She may be reached at anagle@challiance.org.

Dr. Coffey is a Child and Adolescent Psychiatry fellow at Cambridge Health Alliance. She completed her adult training at the University of Chicago. She is the proud mother of Dylan, a lovely, energetic toddler. She may be reached at scoffey@challiance.org.

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Sincerely,

John Schowalter, M.D.
Chair
Life Members Subcommittee

If a close friend lost her father, and each year she struggled as he was not there for some special event, e.g., to see her off to prom or attend her graduation. Conversations with my current supervisors helped me understand that just like the students I see in my practice, I too lacked some abstract reasoning about the Oklahoma tragedy at the time. I too was more concerned about how the bombing would affect my life pragmatically, rather than having an existential fear of what this means now. I sat and listened to student after student ask how this event, and the resulting increased security measures, would impact their daily lives: “What doors can we exit from? Can I open a door for a friend? What if I need to come in to the school early for practice?” I was reminded of the importance of a developmental perspective in understanding how we process these events. As a mother, I am concerned for the safety of my child. As an adult, I wonder how something like this can happen in a community that is so supportive and accepting. I also realize what unresolved feelings I had from my experience as a high-school student and how my clinical work in the context of the marathon bombings has offered me another opportunity to understand my own past. As a child and adolescent psychiatry fellow, I have learned how important a psychiatrist can be in helping children and adolescents work through the difficult feelings elicited by trauma and help a whole community heal.

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Sincerely,

John Schowalter, M.D.
Chair
Life Members Subcommittee
“I was recently fortunate enough to become a grandmother. The first time I held my granddaughter made me think of all the children and the promise we ought to make to them.”

Irmgard Borner, M.D.

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Here you are!
A miracle in an enchanting and mysterious world.
Created by our deep desire and longing just for you!
— a perfect wonder
— filled with promise!

You were not asked to be
but followed our calling
and placed your trusting faith in our care.
Your promise – just to be and grow and to absorb what we will bring to you.
And we who yearned for you

We promise –
To hold, protect and comfort you
To nourish body, mind, and soul.

We promise –
to guide you, not to stifle you to show the world to you in all its beauty and its wonder.

We promise –
to listen carefully to you to pay attention to your words and actions and what you want to say but do not know yet how.

We promise –
That we will not let our dreams for you get in the way to find your own.

We promise –
We will let you grow to dare to trust yourself and others to speak your mind and not to be afraid.
And if one day fear will grab a hold of you

We promise –
We will stay with you until the darkness passes.
And if the time should come that you would want to tear away from us

We promise –
We will let you go.
But our love will follow you wherever you might be.

We promise –
that even sleepless nights worries, grief, and sorrow will not deter us from our promise that we will be grateful every day for all the joy and wonder you bring to our lives.

By her grandmother, Irmgard Borner

Individuals interested in submitting poetry should e-mail Poetry Coordinator Charles Joy, M.D., at crjoy1@gmail.com.
Parental Alienation and DSM-5

William Bernet, M.D.

There has been discussion and debate for several years as to whether parental alienation (PA) should be included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The proposal that PA be considered a formal diagnosis was submitted to the DSM-5 Task Force in 2008, as published in The American Journal of Family Therapy (Bernet et al. 2010), and ultimately was published as a monograph (Bernet et al. 2010). Basically, we recommended that PA be included in DSM-5 as either a mental disorder in the front part of the book or as a relational problem in the chapter of DSM-5 titled “Other Conditions That May Be a Focus of Clinical Attention,” or as a proposed diagnosis in the chapter of DSM-5 titled “Conditions for Further Study.”

Our definition of PA is a mental condition in which a child – usually one whose parents are engaged in a high-conflict separation or divorce – allies himself or herself strongly with an alienating parent and rejects a relationship with the target parent without legitimate justification. Although at times there has been controversy regarding parental alienation syndrome, there is almost no disagreement regarding the more generic concept of PA. Almost every mental health professional who works with children of divorced parents acknowledges that PA – as we define it – affects thousands of families and causes enormous pain and hardship. There is extensive qualitative, descriptive research regarding PA and more limited quantitative research. We ultimately developed a bibliography of about 900 references regarding PA from the professional literature of 36 countries on six continents.

In response to our proposal, senior personnel of the DSM-5 Task Force told us that they did not want PA to be a separate diagnosis with its own code number. They thought that PA was an example of a diagnosis that already existed, parent-child relational problem. With the recent publication of DSM-5, we are pleased to see that PA can now be identified and coded in several different ways using new diagnostic terminology. Although the actual words “parental alienation” do not appear, the spirit of PA is strong and well represented in DSM-5 (American Psychiatric Association 2013). If a clinical or forensic practitioner determines that a child is affected by PA, the following diagnoses should be considered.

“Parent-child relational problem” now features discussion in the text of DSM-5 (p.715). The discussion explains that cognitive problems in parent-child relational problem “may include negative attributions of the other’s intentions, hostility toward or scapegoating of the other, and unwarranted feelings of estrangement.” That is a pretty good description of the child’s experience in PA, since the child persistently attributes negative intentions to the rejected parent’s feelings and behaviors. Also, the child is persistently hostile to the rejected parent and scapegoats that parent, i.e., blames that parent for anything bad that happens. It is unfortunate that the authors of DSM-5 used the phrase “unwarranted feelings of estrangement.” Almost all authors on this topic use “estrangement” to mean warranted or justified feelings and “alienation” to mean unwarranted or unjustified feelings.

Child affected by parental relationship distress is an important new diagnosis in DSM-5 (p.716). It should be used “when the focus of clinical attention is the negative effects of parental relationship discord (e.g., high levels of conflict, distress, or disparagement) on a child in the family, including effects on the child’s mental or other physical disorders.” That is a very good description of how parental alienation comes about. That is, PA usually arises during the course of high-conflict separation or divorce, and it almost always involves persistent disparagement of the rejected parent by the alienating parent.

Child psychological abuse is another new diagnosis in DSM-5 (p. 719). It is defined as “nonaccidental verbal or symbolic acts by a child’s parent or caregiver that result, or have reasonable potential to result, in significant psychological harm to the child.” In many instances of PA, the behavior of the alienating parent constitutes child psychological abuse.

Delusional symptoms in partner of individual with delusional disorder is the DSM-5 terminology for shared psychotic disorder or folie à deux (p. 122). The definition is: “In the context of a relationship, the delusional material from the dominant partner provides content for delusional belief by the individual who may not otherwise entirely meet criteria for delusional disorder.” In some cases of severe PA, the alienating parent’s obsessions reach the intensity of a delusion regarding the rejected parent, which the alienating parent shares with the child.

Factitious disorder imposed on another is the DSM-5 terminology for factitious disorder by proxy or Munchausen disorder by proxy (p. 325). Its definition is “falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.” In some cases of

continued on page 256
Parental Alienation continued from page 255

PA, that would describe the behavior of the alienating parent.

The concept of parental alienation is clearly expressed in *DSM-5* – particularly in parent-child relational problem and child affected by parental relationship distress – although the actual words are not in the book. That is a great improvement over DSM-IV-TR, especially with the addition of the new diagnosis, child psychological abuse. Child and adolescent psychiatrists should make use of these diagnoses when they evaluate and treat children who experience PA. If therapists are feeling frustrated by cases involving PA, they should consult recently published books (Gottlieb 2012; Baker and Sauber 2012). Forensic child psychiatrists will be interested in a comprehensive new book edited by Lorandos, Bernet, and Sauber (2013).

**Reference**


**Dr. Bernet is an emeritus professor in the Department of Psychiatry, Vanderbilt University School of Medicine, Nashville, Tennessee. He can be reached at william.bernet@vanderbilt.edu.**

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Since 2010, the Life Members Fund has made an investment in 37 residents and 31 medical students. This has been achieved through its two grant awards, Education Outreach for Child and Adolescent Psychiatry Residents and Mentorship Grants for Medical Students. **Sixty-eight lives you impacted,** who will become the next generation of child and adolescent psychiatrists.

*Donate.*

We’re at a time of healthcare change when our skills have never been more important, but the deficit of available child and adolescent psychiatrists is growing. Who better than Life Members to be the leader in solving this deficit?

To donate, visit [www.aacap.org/AACAP/Life_Members/Donate.aspx](http://www.aacap.org/AACAP/Life_Members/Donate.aspx).

*New.*

There is another way you can donate. Learn more about the **1953 Society.** It’s AACAP’s new bequest and estate gift program.
Since 2005, AACAP has held an Advocacy Day during which AACAP members partner with families and youth to raise awareness of children’s mental health issues on Capitol Hill. Participation of families and youth has grown significantly over the years, from six parents in our first year to more than 70 parents and youth this year. The partnership between a child and adolescent psychiatrist and parent or youth increases the influence of our message on policymakers, providing both a clinical and personal perspective. The experiences of Debra Koss, M.D., and Kathy Nauta highlight this unique partnership, as well as the long-term impact of the connections forged at Advocacy Day.

This was my second year participating in the AACAP Advocacy Day, with my 15-year-old daughter, Alexandra. Psychiatrists, fellows, and families who are supporting a family member suffering from mental illness come to Washington, D.C., to educate their legislators on the topic of mental illness. It is a meeting of the minds, a joining of forces by those who are affected by mental illness and those who are helping to treat those who are suffering from mental illness. The two days are filled with collaboration and camaraderie, as we strategize on how best to present to our congressmen and women the current issues we are facing.

The journey for those who suffer from mental illness and for their caretakers is a long and arduous one. We often feel alone and isolated in our daily struggles, constantly wondering if we are making the right decisions. We have doctor and therapist appointments to attend on a weekly basis, as well as issues with finances, medication, schools, insurance, social stigma and bullying. This life is an exhausting and emotional roller coaster, and sometimes it feels like you are the only one on the ride and no one wants to come on with you.

That is why I feel so strongly about the importance of AACAP’s Advocacy Day. It is a wonderful experience of bringing people together from all walks of life with a common goal, a desire to improve the lives of those debilitated by mental illness. I have such a feeling of empowerment and inclusiveness when I enter the conference. I meet other families from all over the country who are dealing with many of the same issues that I am. It is almost like going to a family reunion, but with the irony of having never met these people before. We know that we are both fighting the good fight the best we can.

Each state delegation has a group of psychiatrists, residents and families that then visit with their Senators’ and Representatives’ health care aides to talk about specific bills that are coming before Congress. Each of us has such a vital role in these meetings in bringing the mental health issues to life. The psychiatrists and residents bring their perspectives from the medical point of view, and their input is invaluable. They can speak to a myriad of issues not limited to medical school, school loans, starting a practice and the specific details of dealing with insurance companies, and how all of the above impacts their ability to give their patients the best care possible. However, I feel that the family perspective really changes the dynamic of the meeting. I feel that when my family participates in these meetings, the aides really stop and listen. They do not make us feel rushed and they do not interrupt because they know that this is the reason we are here. We have a real story to tell, and our story is raw and difficult to hear.

Our congressmen and women live in a political bubble in Washington, and...
there is some truth to the stereotype that our representatives have lost touch with their constituents. But to be fair, I think we can say that about many people when it comes to discussing the topic of mental illness. If you are not living with mental illness or taking care of someone with mental illness, it is a very hard topic for most people to fully grasp.

I have started to do some advocacy work on a local level, specifically in my county and school district. I have generally found that there is still a low level of knowledge and awareness about mental illness, and stigma still exists. Unfortunately, it has taken a tragedy of the magnitude of the Newtown, Connecticut, shooting to open people’s eyes and minds to a discussion about mental illness. I participated in AACAP’s Advocacy Day in May 2012 and in May 2013, and the political aides were much more attentive and interested in what we had to say this year, post-Newtown.

But, what most people in the United States do not realize, including our congressmen and women, is that smaller tragedies are occurring in our towns every single day. We are taking our family members to emergency rooms and hospitals to be stabilized. We are rushing them to their psychiatrists and therapists when we are unable to control them on our own. We are being called to their schools at a moment’s notice because they are out of control and then find out that they are not welcome back. We have had to call 911 to get help from our local police. I am not comparing these incidents in any way to the devastation of the Newtown shooting. I am just trying to say that the discussion and dialogue about mental illness must continue because our suffering and our personal tragedies continue on a daily basis.

AACAP’s Advocacy Day is so important to me because it gives my daughter and me a chance to be heard when, very often, most people are uncomfortable with what we have to say. We are the heart and soul of those congressional meetings, and they cannot and should not do it without us.

AACAP Advocacy Day continued from page 257

NYU Langone Medical Center (NYULMC) is one of the nation’s premier centers of excellence in healthcare, biomedical research and medical education. Located in the heart of New York City, the Medical Center consists of the NYU Hospitals Center including Tisch Hospital, The Rusk Institute of Rehabilitation Medicine, the Hospital for Joint Diseases, and the NYU School of Medicine.

The Child Study Center, Department of Child and Adolescent Psychiatry is currently seeking a Residency Program Director for the Child and Adolescent Psychiatry residency training program at NYU, Bellevue Hospital Center, and Rockland Children’s Psychiatric Center (RCPC). As one of the oldest and largest child psychiatry residency training programs in the country, NYU / Bellevue / RCPC has an international reputation for excellence in training and provides residents with a wide range of clinical, research, and educational experiences in both public and private hospitals, clinics, and schools. Reporting to the Vice Chair for Education, the Residency Director will have primary responsibility for program development and supervision of approximately 20 residents. The individual in this position is also responsible for bringing innovation and creativity into the training program through such means as resident and faculty retreats, resident research, and scholarly projects. Specific responsibilities include but are not limited to:

- Recruiting, interviewing and selecting residents
- Providing didactics and clinical supervision
- Maintaining compliance with ACGME requirements and representing the department on Graduate Medical Education committees
- Defining, updating, and planning the resident curriculum and clinical rotations
- Supervising the education faculty and all attending physicians and psychologists who teach residents at affiliated sites
- Regular review of resident achievement
- Monitoring resident progress toward successful matriculation
- Providing mentorship for residents
- Planning and supervising medical student electives
- Supervising the chief residents, residency coordinator and the Associate Residency Directors at NYU, Bellevue, and RCPC

This position requires an M.D. who is board certified in Child and Adolescent Psychiatry and possesses a minimum of five years of relevant experience. A clear track record of leadership and administrative experience, and demonstrated history of expertise in education and training are also required.

For consideration, please send your CV to: Ursula.Diamond@nyumc.org
New Jersey Council of Child and Adolescent Psychiatry

Debra Koss, M.D.

As AACAP approaches its 60th anniversary, the New Jersey Council of Child and Adolescent Psychiatry would like to take a moment to review our own history. New Jersey hosted the very first meeting of child psychiatrists at which the resolution to form a separate professional organization was made. This meeting, which marked the beginning of the American Academy of Child Psychiatry, took place on February 24, 1952, in Atlantic City, New Jersey. In the years to come, psychiatrists from New Jersey continued to meet informally to discuss issues relevant to delivering mental health care to children and adolescents. Later, with AACAP’s encouragement to form Regional Organizations, New Jersey’s child psychiatrists went on to develop plans for formal dinner meetings.

In 1972, the New Jersey Council of Child and Adolescent Psychiatry (NJCCAP) was officially established with the adoption of a constitution and its first by-laws. Members met to share clinical experiences, with the intent to advocate for children with mental illness. One of NJCCAP’s earliest recorded advocacy initiatives focused on early intervention for students with learning disabilities.

Today, NJCCAP is comprised of approximately 200 members practicing in a wide range of service settings including clinical practice, academia, public policy, and research. NJCCAP members have been instrumental in the development of a nationally recognized policy for the treatment of children with mental health needs in our foster care system. Members have also led innovative program development in school-based mental health programs and disaster response and training.

NJCCAP provides opportunities for networking as well as educational programming for child and adolescent psychiatrists throughout their careers. Recent educational programming has included updates in neuroimaging and training about the new CPT codes. NJCCAP also supports recruitment and mentorship opportunities for medical students and trainees, as well as outreach to early career psychiatrists. Members provide lectures, lead small group discussions, and provide individual and small group mentorship.

“NJCCAP provides opportunities for networking as well as educational programming for child and adolescent psychiatrists throughout their careers.”

Since its inception, NJCCAP has expanded its grassroots advocacy efforts. Today, members are actively involved in state and federal advocacy initiatives. In 2011, NJCCAP was honored to receive an AACAP’s Catchers in the Rye Award acknowledging its efforts to advocate for improved access to mental health services for children and adolescents throughout New Jersey. NJCCAP has successfully applied for, and received, four AACAP Advocacy and Collaboration Grants. Funds from AACAP’s Campaign for America’s Kids have supported a range of activities, including the Forum on Children’s Health, which served to bring together health care providers, parent advocates, and state policy makers to identify strategies to improve access to children’s mental health services. These forums served as a springboard for the formation of the New Jersey Primary Care Child Psychiatry Task Force that led to the development of a pilot program for a collaborative model of care and legislation that now hopes to expand the scope of these collaborative services statewide.

NJCCAP remains proud of its association with the birth of AACAP. We thank AACAP for the organizational support that has allowed us to flourish. We thank our members, past and present, for their dedication to clinical service, training, research, and advocacy. Child and adolescent psychiatrists will be facing many challenges as well as opportunities in the coming decade. NJCCAP is committed to providing our members with the leadership and support needed to make this transition, to further establish and strengthen our partnerships with other stakeholders, and to remain steadfast in our efforts to advocate for the mental health and well-being of the children and families we serve.

Dr. Koss may be reached at dekoss@embarqmail.com.

Did you know?

The official nickname of the city of Orlando is “The City Beautiful,” although it is also known as “O-Town.”
According to the 2008 National Resident Matching Program results for child and adolescent psychiatry, one in four of the residents who matched in child and adolescent psychiatry fellowships in the United States originated from or received part of their medical training in another country. The vast majority of U.S.-trained child and adolescent psychiatrists (CAPs) remain in the United States. There are some, however, who transition back to their country of origin or elsewhere. Additionally, the AACAP Annual Meeting has consistently been the largest gathering of CAPs in the world, including a growing number of ‘international’ attendees. The above, along with the rich cultural diversity of the United States, presents a vital ongoing role for the AACAP to have a presence in the development of child mental health (CMH) internationally and to have a global angle in its other myriad of activities.

Achievements of IRC
Achievements to-date include:

- Assessment of the international activities of AACAP members (2003)
- Assessment of the needs of international attendees to the AACAP Annual Meeting (2008)
- Development of an ‘International Events’ link for the Annual Meeting webpage
- Allocation of ‘fellowships’ to psychiatrists in developing countries (2008)
- Advocacy for the involvement of international mentors and mentees in AACAP’s Mentorship program
- Organization of international symposia and clinical perspectives in many areas including: disaster, youth suicide, immigration, education, and provision of child mental health services
- Submissions to AACAP News in a number of areas; a series of articles showcasing the history, scope, and functioning of CAP organizations and the practice of child mental health outside the United States, and the career dilemmas of early career psychiatrists with interest in international CAP
- Fostering connectivity through the Networking for International Attendees Reception at the Annual Meeting
- Collaborative work with other AACAP committees: Training and Education Committee, Diversity and Culture Committee, and the Family Committee
- Ongoing work with the Membership Committee on ‘international’ membership

Future Goals of IRC
The IRC will continue to support collaboration between AACAP and CAP organizations, lead international initiatives within AACAP and provide an international perspective (where appropriate) to initiatives within AACAP. However, there has been a natural evolution of the role of IRC, with greater request by members to assist them in accessing opportunities for international exchange and experiences in CMH. The IRC has been assessing the emerging need with plans to increase access through several initiatives. This and other developments have warranted a re-evaluation of the charge of the committee such that it continues to reflect the needs of the AACAP community in an increasingly connected world.
AACAP is 60 Years Old and MCCAP is 23 Years Young: An Evolutionary Process

Andrew Cook, M.D.

This year, the AACAP will be 60 years old. Here in Maine, the Maine Council of Child and Adolescent Psychiatry (MCCAP) will be 23 years young. People often have preconceptions about rural states. They are frequently seen as idyllic, relaxed, a “Vacation Land” that is peaceful, and undisturbed by the ravages of urban violence or drug use. On the other hand, there are concerns that there will be a scarcity of trained professionals, challenges in obtaining coverage and supervision, and the need for increased awareness of boundaries. The truth is somewhere in the middle. Violence, trauma, poverty, and drug and alcohol abuse are as prevalent as they are elsewhere. Resources are either scarce or inaccessible due to the dearth of public transportation. At the same time, parents, families, teachers, and mental health professionals frequently go the extra mile to provide the necessary treatment and care that children and adolescents need to address their mental health challenges.

In 1977, right out of residency, I moved to Maine with my family. At that time, there were only five child psychiatrists in Maine.

I hung up a shingle, and within a few months was providing child, adolescent and adult psychiatry inpatient and outpatient services to children and adults from Portland to Rockland to Augusta.

By the late 1980s, I began to inquire about setting up a Maine Regional Council. While the “New England Council” (NECCAP) generously invited Maine AACAP members to its meetings, the drive to Boston was 2-5 hours one way, and though the lectures were excellent, the issues regarding funding, resources, treatment and practice of psychiatry were remarkably different. Private practice was the exception in Maine, with hospitals, residential facilities, and community mental health centers providing most of the psychiatric care. Academic psychiatry was in its naissance, lacking the critical mass to fully blossom. Child and adolescent psychiatrists in Maine began questioning the ability of the NECCAP to meet the needs of a rural state. Peter Goldfine, M.D. called a meeting to explore the organization of an autonomous regional organization. I assumed that one of our two academic psychiatrists or Diane Schetky, M.D., would assume the lead role. However, I quickly learned that if you identify a problem, you must be prepared to be a part of the solution. We applied to join the Council of Regional Organizations and were accepted in 1990 as the Maine Council of Child and Adolescent Psychiatry (MCCAP).

Our mission, as stated in the By-Laws:

1) To provide a forum for the exchange of ideas relative to the practice of child psychiatry and the needs of children and adolescents in the state of Maine;
2) To stimulate and advance contributions to the knowledge of treatment of psychiatric disorders in the children and adolescents;
3) To encourage the greater participation and interest in the AACP among the child and adolescent psychiatrists in Maine;
4) To provide programs for continuing education of its membership.

The MCCAP continued through the 90’s as a small group of 15 or so child psychiatrists that met 2-3 times a year, at a restaurant in Bath, where both the food and the educational topics were of the highest quality. Frequently, we were able to persuade speakers visiting Maine Medical Center (MMC) to stay an extra day to join the council for their meetings. The incentive was a gift certificate to L.L. Bean. The primary function of the council was the development of supportive professional and personal relations, in a state where that was not available on a routine basis. Our membership and attendance frequently was close to 100%. Participation in the Assembly of Regional Organizations and the AACAP Annual Meetings provided vital support and connection with mainstream child and adolescent psychiatry.

The first accomplishment of the MCCAP was to submit, in 1991, a proposal to credit women for part-time participation in residency programs. Child and adolescent psychiatry lagged behind surgery and many other medical subspecialties in crediting women for their training when they took time off to care for their children.

There were some lean years in the late 1990s; then, after 2000, with an influx of child and adolescent psychiatrists, the number of members grew to about 65. Many areas of the state attained a critical mass of child and adolescent psychiatrists and begin developing their own subgroups of the MCCAP. The “down east” psychiatrists took the proverbial bull by the horns and began to develop a significant advocacy role for the council. Simultaneously, the State Office of Child and Family Services hired two child and adolescent psychiatrists as medical directors. They, in turn, worked with the MCCAP on topical issues, such as the use of atypical antipsychotic medications in children and adolescents.

During this time the MMC Residency Training program, led by Doug Robbin, M.D.’s team, grew in size, breadth, and expertise. There are currently eight full-time child and adolescent psychiatric staff, with six child and adolescent psychiatry residents and one Pediatric Psychiatry Portal Program resident.

In looking back, the MCCAP was not without growing pains. However, I think we can safely say that it is currently a vibrant organization that continues to meet its mission. The membership has exhibited real leadership, advocacy on behalf of children and adolescents with mental health needs, and commitment to expanding the knowledge and professional competence of its members.

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Early Days of Child and Adolescent Psychiatry in Maine

G. Adair Heath, M.D.

The early years were maybe the good old days we just did not know it then. Our patient contacts were not regulated by the clock or a CPT code; we met as a multidisciplinary team of social workers, psychologists, and counselors, discussing each patient in detail at intake and at regular intervals. The team knew each other’s patients and collaborated in the child’s and family’s care.

When I arrived at Maine Medical Center in 1970, it was a small team with me as the only child psychiatrist, three social workers with Masters (this included Betty Lockwood who was part-time) and three counselors (Bachelor- and later Master-level counseling). There were only two other child psychiatrists in the state. In 1971, I became board-certified in Child Psychiatry. I was the first, and only board-certified child psychiatrist until Diane Schetky, M.D., moved here and Peter Goldfine, M.D., became board-certified. This was a dubious distinction, unique privilege, and tough position to be in for a young man in his thirties and only a few years out of training.

An area that has changed over the years is the clinical approach to treatment. Diagnosis was primarily psychodynamic/psychoanalytic but treatment, in the community/public sector, was empirical, collaborative, and chiefly based on the Child Guidance team model. The DSM-III only came in 1978. Looking back, I under-diagnosed ADHD and depression, and over-diagnosed conduct disorder. We sparingly used medications, which was good and bad. Using the tricyclics was a challenge due to the concern about cardiac effects. EKG’s were required at baseline and to titrate the dose.

From 1970 until sometime mid-decade, the only inpatient psychiatric unit for children was a very dodgy unit at Pineland; a huge facility for those with mental retardation. This place was a snake pit. When you called to beg for an admission, the first triage question was whether the child had caused injury resulting in the loss of blood to themselves or others. Adolescents would be admitted for a few nights and placed on adult inpatient units where the adolescent was poorly served and was in possible jeopardy. In the late 70s, the Pineland unit was closed. Due to the lack of political will to develop a comprehensive replacement inpatient unit, there followed an interim period where the residential treatment centers of Sweetser and Spurwink, without any real preparation or adequate funding, became de facto inpatient units. This response was a mixed blessing since very disturbed, and sometimes violent, children and adolescents were expected to be treated in open settings, without any inpatient back-up.

This all changed when Jackson Brook Institute, a for-profit psychiatric hospital, opened their doors and quickly became primarily a child/adolescent facility that was sustained through Medicaid and other insurance. We suddenly went from only being able to hospitalize the very sickest patients when they were in crisis to a situation where Jackson Brook was accepting referrals directly from guidance counselors in schools; encouraging admissions and inpatient workups for troublesome children and adolescents. These excesses in funding and practice gave our field a bad name and provided disruptions in, and barriers to, effective treatment for children and families in need.

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I moved to Maine in 1986 from an affluent suburb in Connecticut where I had been in private practice. I cased the coastal village of Rockport and its surroundings before finalizing my decision to relocate to Maine. I met with the only child psychiatrist in the area who worked at the local community mental health center. He made it quite clear that I would never make it in private practice in the area. Intent upon moving to Rockport, with two adolescent sons in tow, I chose to ignore his advice. I reasoned that between being a child, adolescent, and adult psychiatrist; a female; unafraid of court work; and my willingness to accept Medicaid and Medicare that I would survive in private practice. I would soon learn that I was the only child and adolescent psychiatrist in private practice in the northern part of the state, which Mainersthen defined as starting shortly above Portland. My location half way up the coast would draw patients from all over the state. I had hoped to get away from the child custody cases involving allegations of child sexual abuse that had flourished in Connecticut. However, no sooner then I had hung my shingle I was inundated by referrals from the Department of Health and Human Services (DHHS) for evaluations of young victims of alleged child sexual or physical abuse and requests for parental fitness evaluations.

I wanted to learn more about the culture of Maine and how people lived, so I made house calls on some of the families referred by DHHS. Much of poverty in Maine is hidden behind closed doors and the experience was an eye opener for me. There were homes where I dared not sit down, and sinks piled high with greasy dishes, empty beer cans, and spoiled food were not unusual. I recall one home visit in which I had been asked to evaluate a parent who had already lost custody of four of her children. The mother remained seated like a Buddha on the barren living room floor in a haze of cigarette smoke. She did nothing to curtail her toddler who picked up a container of gasoline and was about to take a swig from it. I leaped to my feet and intervened. The mother kept assuring me she was a good mother “because my kids ain’t burned the house down yet.”

Public transportation in Maine was and is still lacking. Rather than have a child miss a lot of days of school to get to my office and back to his island home via infrequent ferry boat service, I decided to go to him. Weather permitting, I would often sail 10 miles across the bay to his island on Fridays. His Dad would meet me at the dock in his pick-up and then we would all meet around the kitchen table with cups of herbal tea and talk about issues related to their recent adoption of my patient and his older brother. Once, the parents asked me to participate in an early morning school conference and I agreed, not realizing what I was in for. I flew over to the island in 40 knot winds on the bouncy mail plane, which landed on a dirt strip. My return trip was on a heeling ferry with waves crashing over the deck in the brewing storm. It was the fastest crossing ever and when we reached the mainland we could not land because the water level was too high and we had to wait for the tide to recede.

Another memorable case was a 4-year-old girl I treated who had been sexually abused by her father. She and her mother lived off the grid on Deer Isle in a house with no running water. Her mother did not have a car but would borrow a beat-up one from her neighbor to make the two-hour drive to Rockport each week, all the while hoping it did not break down. She said that she was willing to make the drive because she wanted to be certain that her daughter was treated by a professional who knew something about child sexual abuse. Mother and child did well. At termination, I commented on her daughter’s extensive vocabulary. She explained that she would keep her daughter entertained with word games during their weekly four-hour round trip to see me.

In my early years in Maine, some people would assume that because I practiced in the boonies I must lack expertise. Several times family members, typically affluent, would insist upon getting a second opinion. They would travel four hours down (or up as some Mainerstheir maine) to Boston to see a reputable child and adolescent psychiatrist, only to be told that yes, their child was in good hands with me and to continue with the treatment plan.

Resources and Resourcefulness: Maine’s state hospital adolescent unit shut down shortly after I arrived. Until private psychiatric facilities for children opened up years later, there were no hospital facilities for children in need of acute inpatient psychiatric care. Somehow, I managed patients in their home settings and only twice did I have to hospitalize patients in out-of-state facilities.

Getting coverage for my practice when I traveled out of state was an issue, and I would often have to sign out to a pediatrician or adult psychiatrist. I often felt isolated from my colleagues but dealt with this by using the telephone and attending AACAP and American Academy of Psychiatry and Law (AAPL) meetings. Eventually we started Maine Council of Child and Adolescent Psychiatry (MCCAP), but Maine’s vast geography would prove to be an obstacle to ensuring good turnouts at our meetings. Gradually, more child and adolescent psychiatrists opened practices around the state, but most seemed to gravitate to institutional work and preferred living in cities where there were other psychiatrists. For the most part, I was on call every night. However, my patients respected my private life and rarely abused their access to my home phone and later cell phone. As cell phone service improved, I was able to take calls in my kayak or sailboat and only lost one cell phone to Penobscot Bay.

continued on page 264
My Early Days as a Child and Adolescent Psychiatrist in Maine continued from page 263

Living in a small town entails encountering patients or their families whenever one leaves home. Patients may be classmates or team-mates of one’s children. It may be necessary to patronize businesses run by patients’ parents and they may appear on Boards on which you serve, or seated next to you at concerts or school events. You soon learn to ask your spouse not to ask how you know someone. These experiences piqued my interest in boundary issues, crossings, and violations; and I would go on to write articles and many columns in AACAP News on the topic, as well as serve on ethics committees.

Back in 1972, as I was completing my fellowship in Child and Adolescent Psychiatry, the Training Director of the department offered me the following parting advice: “Stay out of court at all costs.” At the time, I prided myself on being able to dodge my first subpoena by delivering my second son the day before I was to appear in court. My attitude would soon change in my first job as director of the Child Psychiatry Clinic at the University of Oregon Health Sciences Center. Many of the children that came through the clinic had psychiatric conditions that involved legal issues calling for expert testimony. I realized how little I and our trainees knew about court decorum or testifying. At the time, there was almost no literature related to child and adolescent forensic psychiatry. I resolved to write a book on the topic to help other child and adolescent psychiatrists become more conversant and comfortable with the issues.

I moved East in 1977, and instead of gestating babies, began gestating books and articles on child and adolescent forensic psychiatry, while also starting a private practice. My other resolve had been to get lawyers and psychiatrists to better understand one another’s language, to think before becoming adversaries in a courtroom, and to help them work better together. In 1987, this dream would come to fruition at Maine Medical Center where for many years a law professor and I taught a seminar on Child and Adolescent Psychiatry and the Law. It was attended by law students and child and adolescent psychiatry residents who would also work together on cases and participate in mock trials. When the seminar was discontinued after about 10 years, I continued to teach at Maine Medical Center. As few residency programs offered training in forensic child psychiatry and the law, I also traveled to several residency programs out of state as a visiting professor.

Had I not been living in Maine with two adolescent sons, I would have pursued an additional Fellowship in Forensic Psychiatry out-of-state. Instead, I continued my forensic education through annual courses offered at AAPL meetings and journals, and managed to pass the exam for additional certification in Forensic Psychiatry. My forensic practice expanded from child custody, abuse, and termination of parental rights cases to civil litigation, juvenile criminal cases, filling in as staff psychiatrist at a maximum/medium security prison, and, my later years, being an examiner for the State Forensic Service. I have been retired for six years but still get calls asking for names of experts in child and adolescent forensic psychiatry. It is my impression that while much more is being taught about forensics in residencies there is still a great need for qualified child and adolescent forensic psychiatrists.

Dr. Schetky may be reached at articpoppy1@gmail.com.
Adoption and Foster Care Committee: From Our Last Decade and Into Our Next

George Fouras, M.D.

The first sentence of the mission statement/charge for the Adoption and Foster Care Committee captures the sentiment that drives our efforts and achievements: The committee will inform the AACAP of the psychiatric, psychological, medical, developmental, educational, and remedial needs of youth in the child welfare system and completed adoptions.

At the end of AACAP’s 50th Anniversary, the Committee was chaired by Alvin Rosenfeld, M.D., and Steve Nickman, M.D. Under their guidance, the Committee continued to grow, bringing greater awareness of child welfare to our organization. They had accepted a grant from the Evan B. Donaldson Adoption Institute to create the Marshall Schechter Memorial lecture series on adoption. Several lectures were funded at AACAP Annual Meetings as a result of this generous offer.

Practice Parameter

Members of the committee were given the task of developing the first parameter having to deal with youth in child welfare in 2005. Our original shepherd from the Work Group on Quality Issues (WGQI) was our dear friend, Uli Schoettle, M.D., who was passionate about these kids. After much hard work, this important document is near completion and we hope to have it accepted by the AACAP Council soon.

Psychotropic Medication Utilization and Oversight

The Committee participated in the development of the AACAP Policy Statement “Psychiatric Care of Children in the Foster Care System,” which was adopted by council in September 2001 and has been cited by several other organizations and the Government Accountability Office (GAO) in their recent report on this issue. In addition, the Committee has sponsored several submissions for the AACAP Annual Meeting over the years to educate members on this issue and to highlight model programs being used in several states.

This topic became of critical importance after the publication of the Rutgers study on atypical antipsychotic utilization between the general Medicaid population and youth in foster care, showing a roughly 900% difference. AACAP and Administration for Children, Youth, and Families (ACYF), along with other stakeholders, were already at work on this issue when the broadcast of a segment the ABC News show 20/20, which coincided with the release of the GAO report, aired in November 2011. As a result, AACAP held its first institute on youth involved with the child welfare system in October 2012, with Commissioner Bryan Samuels of the ACYF as one of our presenters.

Promoting Involvement of Youth

The Committee believes strongly that the participation of youth involved with child welfare is critical to its mission. As a result, the Committee has sponsored programs featuring youth and families as part of the presentation/submission, e.g., speakers Mia and Sharon Behrens. Miss Behrens was the subject of the article “Wild Child” published by Lenore Terr, M.D. In addition, Ms. Jetaine Hart, from Foster Care Alumni of America, was one of the best received speakers for the Committee’s recent institute.

Membership

The Committee believes strongly that young members are critical to its growth and the promotion of its mission and strives to increase the participation of both early career psychiatrists (ECPs) and MITs on the committee.

Collaboration With the American Academy of Pediatrics (AAP)

In 2006-2007, AACAP was invited by the AAP to send a liaison to the newly formed Task Force on Foster Care and Adoption. After five productive years, the Task Force completed its work and was sunset. From that group, the permanent Council on Foster Care, Adoption, and Kinship Care (COFCAK) was created. AACAP was again invited to send a liaison to this council, with our initial attendance occurring in April of 2013.

Members of the Adoption and Foster Care Committee look forward to the next ten years and will endeavor to bring AACAP membership interesting programs and learning opportunities, encourage greater involvement for our MITs and ECPs, and ensure that youth are active participants in the system of care.

References


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ASSEMBLY OF REGIONAL ORGANIZATIONS OF CHILD AND ADOLESCENT PSYCHIATRY

An Update: 2003 – 2013

Warren Y.K. Ng, M.D.

AACAP News

The inaugural Assembly of Regional Organizations met for the first time on October 17, 1973 in Washington, D.C. Dr. Haizlip, the founding chair of the Assembly wrote an article about the creation of the Assembly for AACAP’s 50th Anniversary celebration. Dr. Haizlip wrote that the Assembly is an integral part of AACAP and provided real grassroots input and representation to the leadership of AACAP.

For the past 40 years, the Assembly has given a voice to the diversity, richness, and breadth of our membership. It has balanced and complemented the leadership of AACAP through the Executive Committee, Council, and Committees. The chair of the Assembly joined the AACAP Executive Committee in 1999 and became a voting member after 2001. The Assembly’s impact on the leadership of AACAP has been evidenced by former chairs of the Assembly elected to AACAP Executive Council positions, including president, president-elect, and secretary/treasurer. Delegates in the Assembly represent their regional organizations and enrich and contribute to AACAP’s organization, culture, policy, and future goals.

Since AACAP’s 50th Anniversary in 2003, the Assembly continues to fulfill its mission to be inclusive and represent our membership and create a stronger organization. The visionary leadership of our Assembly chairs in the past decade has included Steven Cuffe, M.D., David Fassler, M.D., Martin Drell, M.D., Michael Houston, M.D., and Louis Kraus, M.D. Some of the highlights accomplished by the Assembly in the past 10 years since the 50th Anniversary include:

2005: Assembly votes to plan Spring Assembly with Advocacy Day
2006: AACAP offers free websites to all Regional Organizations (ROs)
2006: West Virginia Regional Council of the AACAP joins the Assembly
2006: Assembly Task Force on Orientation created to revise the orientation manual and improve the orientation process; it becomes a standing committee in May 2009
2007: AACAP Advocacy and Collaboration Grants program starts
2007: D&O insurance offered by AACAP to the ROs
2008: Two Resident Representative positions are added to the Assembly Executive Committee as non-voting members
2010: Regional Organization Task Force, created to work with struggling ROs, becomes a standing committee in 2011
2013: An ECP position replaces one Resident Representative in alternating years to the Assembly Executive Committee as a nonvoting member

Did you know?

Since 1986, Give Kids The World has provided a dream vacation to Central Florida to more than 100,000 children with life-threatening illnesses and their families, coming from all 50 states and 73 countries around the world.
AACAP Committee on Quality Issues: Evolution of the Development of the AACAP Clinical Practice Guidelines

As introduced in the July/August issue of AACAP News, the Committee on Quality Issues (CQI) has recently revised its process for the development of AACAP Practice Parameters (patient-oriented type). This new process, approved by AACAP Council on June 21, 2013, was created to conform to current Institute of Medicine standards for clinical practice guideline development. These standards address establishing transparency, management of conflicts of interest, composition of development committees, methods for systematic reviews of evidence, establishing the evidence for and corresponding strength of recommendations, external review, and updating.

Several elements of AACAP’s previous practice parameter development process remain in the new process, as follows:

- Appointment of parameter development committee members who are balanced with respect to expertise, academic vs. private practice background, geographic location, and demographic characteristics
- Documentation of the parameter development process
- Involvement of physicians and physician organizations
- Systematic literature review
- Broad, iterative review of parameter drafts
- Specification of the appropriateness of the parameter recommendations to specific clinical conditions and settings
- Specification of the limits of the generalizability of the parameter recommendations

In addition, the new process adds the following elements intended to enhance the rigor and transparency of the former parameter-oriented parameters henceforth to be known as Clinical Practice Guidelines (CPGs):

- CQI co-chairs and members will be required to be free from pharmaceutical industry involvement throughout the course of guideline development, whether salary or research funding, additional income, or in-kind services
- CQI members will be trained in systematic review techniques by acknowledged methodologic experts
- As recommended by the Agency for Healthcare Research and Quality (AHRQ), guideline recommendations will be derived from specific clinical questions in PICO(TS) format; i.e., patient, intervention, comparison, outcome, (and when applicable, timing and setting)
- Separate CQI individuals/groups will review evidence (Systematic Reviewer) and write guidelines (Guideline Writing Groups)
- The Systematic Reviewer and Guideline Writing Groups will receive input from research experts, clinical experts, AACAP members, and key stakeholders
- Expert clinical opinion (i.e., clinical consensus), when needed in the absence of rigorous research evidence, will be determined by a formal survey of a panel of clinical experts (Clinical Consensus Panel)
- Guideline recommendations will be rated by the Guideline Writing Groups according to the quality of the supporting evidence, using a standardized evidence hierarchy
- Consensus about guideline recommendations will be determined by blind iterative voting by the Guideline Writing Groups
- After guideline publication, new evidence will be identified in a targeted fashion if there are important changes in the supporting evidence

Because clinical practice guidelines occupy a high position in the hierarchy of “pre-processed” evidence (2002) and as such have the potential for great influence in clinical care, the transparency and rigor of the guidelines must be carefully preserved. The new guideline development process as outlined above was specifically designed to meet this goal and in so doing, enhance the “trustworthiness” of the guidelines for the AACAP membership.

The full development process for the new AACAP Clinical Practice Guidelines will be posted on the AACAP Web Site and will be presented briefly at the 60th Anniversary Program – Perspectives from AACAP Committees and more extensively for member feedback at the Member Forum, both at the AACAP 60th Annual Meeting. We welcome your input to this new process!

References

Oscar G. Bukstein, M.D., M.P.H., and Heather J. Walter, M.D., M.P.H., are co-chairs of the Committee on Quality Issues.
The History of the AACAP Financial Planning Committee

The first record of a Finance Committee being formed “to advise the treasurer” was in 1967. Its members included Abram Blau, M.D., chair, Sidney Berman, M.D., Irene Josselyn, M.D., Othilda Krug, M.D., and William Langford, M.D. This legendary group was one of four Academy “ad hoc” committees. There is little information on this committee until 1976, when a “Committee on Finance” is noted that includes Frank Rafferty, M.D., chair, Willard Boaz, M.D., Gerald Brody, M.D., Robert Kohrman, M.D., Wilson Rippy, Jr., M.D., and Thomas Webster, M.D. It appears that the committee divided with Drs. Rafferty, Kohrman and Webster possibly focusing on annual finances and the others with additional members discussing longer term issues. These two committee structures evolved to a single group advising the treasurer largely on multi-year planning, rather than the details of the annual budget which became the focus of the Executive Committee and Council. In the early financial history of the Academy, one name, William “Bill” Stark, M.D., is everywhere, whether as a liaison to Council for the financial committees, or playing a key role on the Building Committee from conceptualization, to fundraising. Over the last 20 plus years of my direct experience, the committee had no formal financial or decision-making authority other than to advise the elected treasurer on longer-term financial matters. In 2012, the core members of the FPC were designated to be the Audit Committee of AACAP, which gave it a formal role in monitoring compliance, business integrity, and administrative processes.

Despite its advisory status, the members included former AACAP officers and the executive director and current president routinely attend meetings. Members are carefully chosen for their business acumen and respected judgment. As a result, the recommendations the FPC forward to the treasurer and Executive Committee are taken seriously and often accepted. The committee meets once or twice, and convenes three times a year by phone to track investment performance. The major topics of discussion over my years on the committee have been:

1) What is an adequate one-year reserve for operations?
2) What do we count in the reserve fund?
3) Once AACAP’s reserves are deemed adequate, should AACAP expand its activities?
4) How should the Academy’s funds be invested?
5) When should our dues be raised?
6) What is the role of real estate in the Academy’s finances?
7) What are the audit needs of the Academy?
8) What are the Academy’s budget processes, including a review of insurance needs and employee benefits?

The goal of the FPC/Audit Committee is to recommend policies that ensure the long-term financial viability of AACAP, promote compliance, assess business risks, and assure the integrity, efficiency, and fairness of internal business processes. The FPC discussions have been very open and forthright; committee members have given generously of their time, and have been passionate in their support of the long-term mission of AACAP.

Submitted by Michael Jellinek, M.D., chair Financial Planning and Audit Committee

For the committee members: Alan Axelson, M.D., Victoria Pham D.O. (resident member), John Schowalter, M.D., Gene Weiss, M.D.

Don’t Miss the Presidential Interview!

Martin J. Drell, M.D., talks to James C. MacIntyre, M.D., chair of the Back to Project Future Task Force, a presidential initiative to develop a “road map” for our field and help guide AACAP’s leadership, members, and staff over the coming decade.

Presidential Interview, Saturday, October 26th in Orlando
10 Years Into AACAP’s Efforts on Maintenance of Certification: Goals and Accomplishments

Sandra Sexson, M.D., and Andrew Russell, M.D.
Co-Chairs, Lifelong Learning Committee

Since the American Board of Psychiatry and Neurology (ABPN) outlined the recertification requirements for child and adolescent psychiatrists, AACAP has worked continuously to develop and refine a way for its members to comply with the requirements. AACAP established the Lifelong Learning Committee with clear objectives, and it has accomplished its first ten-year cycle of MOC activities.

The Committee’s primary goal is to provide members with continuous educational opportunities. While initially targeted at those engaged in the MOC effort, we have found the products and resources are equally useful to our members interested in regularly updating their knowledge and clinical expertise. To emphasize this additional focus, our committee was renamed the Lifelong Learning Committee.

The first educational opportunity is a series of lifelong learning modules on specific disorders, the latest research, and any topic relevant to child and adolescent psychiatrists in practice. This printed book contains recent journal articles and book chapters selected by the committee after an exhaustive search of the medical literature. It includes a self-assessment exam which provides CME and ABPN-approved self-assessment credit. The last 10-years have produced modules on all the major topics in the ABPN recertification outline:

- Module 1 (2004): Disruptive Behavior Disorders, Violence and Homicide
- Module 2 (2005): Eating Disorders, Feeding/Elimination Disorders, and Substance-related Disorders
- Module 3 (2006): Anxiety Disorders, Trauma (Non-Abuse/Neglect-Related), Selective Mutism
- Module 4 (2007): Schools, Forensics, Community Systems of Care, Consultative Issues, Ethics, Culture, Public Policy/Advocacy
- Module 5 (2008): Mood Disorders, OCD, Suicide, Tourette’s Disorder
- Module 6 (2009): Autism, Psychotic Disorders (Non-Affective)
- Module 7 (2010): Neuroscience, Pediatric and Neuropsychological Consultative Issues, Bereavement, Death and Dying, Deaf, Medical/Psychiatric Interface (Factitious Disorders, Sleep Disorders, Somatoform Disorders)
- Module 8 (2011): Modalities of Non-Pharmacological Treatments
- Module 9 (2012): Typical and Atypical Development in Childhood and Adolescence: Protective and Risk Factors
- Module 10 (2013): Abuse and Neglect, Adoption and Foster Care, Custody and Divorce, Dissociative Disorders, Personality Disorders

Over 8,000 modules have been sold over the last ten years, grossing $1,000,000. However the cost of the modules is established to cover the costs of developing the module, arranging for permission to print current articles/chapters, and the actual costs of printing and dispensing the modules.

In addition to the module each year, AACAP offers a specialized Institute at each Annual Meeting devoted to the topic of the module. The Institute features speakers who are experts in their fields discussing the selected literature and providing their insights.

Another goal of the Lifelong Learning Committee is to help our members meet the ABPN’s performance in practice requirements for maintenance of certification. Performance in Practice (PIP) is ABPN’s two-part quality improvement program designed to help physicians find where they might be able to improve their practice. PIP focuses on reviewing one’s charts and comparing to best practices (AACAP Practice Parameters), and collecting peer and patient surveys aimed at giving feedback on one’s practice.

The Lifelong Learning Committee has developed numerous tools, checklists, and surveys to help with PIP. The chart review checklists are based on the Practice Parameters of ADHD, Anxiety, Bipolar Disorder, Depression, OCD, Schizophrenia, and others, with more topics to come. The patient surveys have been translated into Spanish as well. These forms may be found on AACAP’s website.

With a dedicated staff and MOC section of the website, all of your questions can be answered.

We look forward to the next ten-year cycle of MOC and Lifelong Learning! Our plan is to focus each year on the most up to date and relevant publications within each year, so each year’s module will truly be an update across the field. The Committee will work to see that all the major issues addressed in the ABPN outline will be addressed over the 10 year period as well. Additionally this year the Committee, working with the CME Committee, will institute a Self-Assessment Examination available to members once they register for the Annual Meeting. This self-assessment exam gives members the opportunity to receive 8 hours of CME and self-assessment credit by taking a 100-question multiple-choice exam online prior to the Annual Meeting. The feedback given from the exam should inform one’s choice or direction for further CME and study. The participant may choose to use the Annual Meeting to attend sessions where they were deficient based on the feedback of the exam, or use future CME opportunities as well. This new self-assessment exam will be made available to those not attending the Annual Meeting as well as non-members.

We thank all of the current and past members of the committee for their commitment to the MOC process, and for their dedicated hard work.
Attendees at this year’s Annual Meeting can look forward to an outstanding lineup of keynote presentations from our distinguished experts.

- Jim Dunn, PhD, Chair in Applied Public Health, CIHR and the Public Health Agency of Canada
- Jim Hudziak, MD, Professor of Psychiatry, Medicine, and Pediatrics, University of Vermont College of Medicine
- Kathleen Merikangas, PhD, Chief, Genetic Epidemiology Research Branch, Intramural Research Program, NIMH
- Christopher Mushquash, PhD, Assistant Professor of Psychology, Lakehead University & Northern Ontario School of Medicine
- Charles H. Zeanah, Jr., MD, Vice Chair, Child and Adolescent Psychiatry, Tulane University School of Medicine

Please visit www.cacap-acpea.org and click on the conference link for up-to-date information.
Join Us
at AACAP’s 60th Annual Meeting!

Gabrielle A. Carlson, M.D.
AACAP Program Committee Chair

I’m looking forward to welcoming you and your family to Orlando for AACAP’s 60th Annual Meeting, October 22-27, at the Walt Disney World Dolphin Hotel.

We have a wide variety of submissions and some innovative topics too. As a reminder, the large majority of our sessions are accredited for continuing medical education (CME) credit—attendees can receive up to 50 CME credits by attending the entire meeting. Plus, take the self-assessment exam after you register and earn an additional 8 CME credits (see your registration confirmation e-mail for more instructions).

In response to member feedback, we will continue to offer the following:

- Complimentary wireless Internet throughout the meeting space at the hotel
- An improved Annual Meeting App that not only allows you to fully navigate the meeting without paper, but allows you to complete all of your session evaluations electronically as well
- Audio recording options that include the speaker’s PowerPoint slides
- Data Blitz and Poster Docent programs to help attendees get more out of our new research poster sessions
- PDFs of the Book of Scientific Proceedings and Program Book available for all attendees

The traditional schedule has been reorganized slightly. This year the Welcome Reception is on Wednesday and receptions and reunions are on Friday evening. The Karl Menninger, M.D. Plenary is on Wednesday afternoon and the Lawrence A. Stone, M.D. Plenary is on Friday afternoon.

With important changes in the field like DSM-5, changes to CPT codes, and the Affordable Healthcare Act, mental health care professionals cannot afford to miss this Annual Meeting. If you already know the great value of the Annual Meeting, we want to make sure that your friends, colleagues, and students do too! In order to make sure that as many people as possible can participate in the Annual Meeting, we are launching a discount program where all members can offer up to two non-physician colleagues a $125 discount off the cost of non-member registration! Visit http://www.aacap.org/AnnualMeeting/2013 for more information!

Be sure to register by September 16 to take advantage of early rates.

See you in Orlando,

Gabrielle A. Carlson, M.D.
Focus On…

I am so looking forward to AACAP’s 60th Annual Meeting in Orlando, October 22-27! This year’s program provides an in-depth look at current issues in clinical practice, cutting-edge research, public policy, education, and advocacy. And don’t forget, it is AACAP’s 60th birthday!

The Annual Meeting continues to attract increasing numbers of international colleagues and we have seen a marked growth both in the number and quality of presentations that address global issues in children’s mental health – a topic close to my heart and the theme of my Presidential Initiative, Partnering for the World’s Children.

Below is a list of coming attractions at the Annual Meeting that I think may pique your interest. I look forward to seeing you all in Orlando!

Institute 1: Advanced Clinical Psychopharmacology in the DSM-5 Era (ticket)
Tuesday, October 22: 8:00 a.m. – 5:00 p.m.
Chair: James J. McGough, M.D., M.S.

60 Years of Child and Adolescent Psychiatry in Educational Systems: Old School, Now School, New School (open)
Tuesday, October 22: 9:00 a.m. – 12:00 p.m.
Presenters: Shashank V. Joshi, M.D., Sheryl Kataoka, M.D.
Sponsored by the AACAP Schools Committee

Symposium 1: International Symposium: Violence and Children’s Mental Health: Experiences From Africa (open)
Tuesday, October 22: 1:00 p.m. – 4:00 p.m.
Presenters: Carol M. Larroque, M.D., Maha Emadeldin, Ph.D., Increase Ibukun Adeosun, M.D.

Networking for International Attendees (by invitation only)
Tuesday, October 22: 5:30 p.m. – 7:00 p.m.
Sponsored by the AACAP International Relations Committee

60th Anniversary Program Part 1: Looking Ahead from the Past: Perspectives From AACAP Committees (open)
Wednesday, October 23: 8:00 a.m. – 11:00 a.m.
Chairs: Marilyn B. Benoit, M.D., Robert L. Hendren, DO, John Schowalter, M.D.
Sponsored by the 60th Anniversary Committee

Clinical Perspectives 9: Challenges and Opportunities Working With International Medical Graduates (open)
Wednesday, October 23: 8:00 a.m. – 11:00 a.m.
Presenters: Aradhana Bela Sood, M.D., Siham Muntasser, M.D., Rama Rao Gogineni, M.D., Fauzia Mahr, M.D., Ellen H. Sholevar, M.D., Hesham Hamoda, M.D., M.P.H.
Sponsored by the AACAP Diversity and Culture Committee

Clinical Perspectives 11: International Clinical Perspectives: Task Shifting: A New Frontier in Child and Adolescent Mental Health (open)
Wednesday, October 23: 8:00 a.m. – 11:00 a.m.
Presenters: Ayesha I. Mian, M.D., Gordon Harper, M.D., Anula D. Nikapota, FRCPsych., Ritu Goel, MBBS, John Fayyad, M.D., Peter S. Jensen, M.D.
Sponsored by the AACAP International Relations Committee
Clinical Perspectives 13: Crossing the Borders, Ethically! Understanding Global Ethical Principles and Dilemmas (open)
Wednesday, October 23: 1:00 p.m. – 4:00 p.m.
Presenters: Vishal Madaan, M.D., FAAP, Mitali Wadekar, M.D., Albert John Allen, M.D., Ph.D., Pier Bryden, M.D., Arden D. Dingle, M.D.
Sponsored by the AACAP Ethics Committee

60th Anniversary Program Part 2: Looking Ahead From the Past: Perspectives From AACAP Regional Organizations and the History and Archives Committee (open)
Thursday, October 24: 8:30 a.m. – 10:30 a.m.
Chairs: Marilyn B. Benoit, M.D., Robert L. Hendren, D.O., John Schowalter, M.D.
Sponsored by the 60th Anniversary/Local Arrangements Committee

Workshop 13: ABCs of Advocacy: Becoming an Effective Advocate for Children’s Mental Health (ticket)
Thursday, October 24: 8:30 a.m. – 11:30 a.m.

International Relations Committee (open to all AACAP members)
Thursday, October 24: 2:00 p.m. – 4:00 p.m.

Special Interest Study Group 4: CPT Coding Development and Implementation for Child and Adolescent Psychiatrists (ticket)
Thursday, October 24: 5:00 p.m. – 6:30 p.m.
Presenters: Benjamin Shain, M.D., Ph.D., Sherry Barron-Seabrook, M.D., M.S., Nathan Herman, M.D.
Sponsored by the AACAP Healthcare Access and Economics Committee

Special Interest Study Group 6: International Medical Graduates: Adaptation, Training, and Contribution (ticket)
Thursday, October 24: 5:00 p.m. – 6:30 p.m.
Presenters: Siham Muntasser, M.D., Aradhana Bela Sood, M.D., Hesham Hamoda, M.D., M.P.H., Ellen H. Sholevar, M.D., Fauzia Mahr, M.D.
Sponsored by the AACAP Diversity and Culture Committee

Clinical Consultation Breakfast 7: CPT Frequently Asked Questions and Answers 2013 (ticket)
Friday, October 25: 7:00 a.m. – 8:30 a.m.
Presenters: Sherry Barron-Seabrook, M.D., M.S., Benjamin Shain, M.D., Ph.D.
Sponsored by the AACAP Healthcare Access and Economics Committee

Symposium 25: After 5 Months of Using DSM-5, It’s Time for a Diagnostic Tune-Up! (open)
Friday, October 25: 8:00 a.m. – 11:00 a.m.
Presenters: Gabrielle A. Carlson, M.D., Susan E. Swedo, M.D.

Town Meeting: Healthcare Reform: How the Affordable Care Act Will Affect You and Your Patients (open to all AACAP members)
Friday, October 25: 11:15 a.m. – 12:45 p.m.
Presenters: J. Michael Houston, M.D., D. Richard Martini, M.D.

Symposium 33: After 5 Months of Using DSM-5, It’s Time for a Diagnostic Tune-Up! Part 2 (open)
Friday, October 25: 1:00 p.m. – 4:00 p.m.
Presenters: Gabrielle A. Carlson, M.D., Susan E. Swedo, M.D.

International Medical Graduate Child and Adolescent Psychiatry Caucus (open)
Friday, October 25: 5:30 p.m. – 7:30 p.m.
Presenters: Zheya Jenny Yu, M.D., Ph.D., Balkozar Adam, M.D.
Sponsored by the AACAP Diversity and Culture Committee

Member Services Forum 7: CPT Update: Strategies for Implementing the New Codes (open to all AACAP members)
Saturday, October 26: 8:30 a.m. – 11:30 a.m.
Presenters: Sherry Barron-Seabrook, M.D., M.S., Benjamin Shain, M.D., Ph.D., David I. Berland, M.D.
Sponsored by the AACAP Healthcare Access and Economics Committee

Workshop 43: Somatic Symptoms Disorders: DSM-5 and Treatment Updates (open)
Saturday, October 26: 8:30 a.m. – 11:30 a.m.
Presenters: Daniel T. Williams, M.D., Ken Gorifile, Ph.D.
Clinical Perspectives 39: Feeding Disorders and DSM-5 (open)
Saturday, October 26: 1:00 p.m. – 4:00 p.m.
Presenters: Irene Chatooor, M.D., Rachel Bryant-Waugh, Ph.D., Loredana Lucarelli, Psy.D., Glenn Berall, M.D., Massimo Ammaniti, M.D.

Clinical Perspectives 41: Global Perspectives on Teaching and Learning About Child and Adolescent Psychiatry (open)
Sunday, October 27: 8:00 a.m. – 11:00 a.m.
Presenters: Norbert Skokauskas, M.D., Ph.D., Paramjit T. Joshi, M.D.
Sponsored by the AACAP International Relations Committee and the Training and Education Committee

Karl Menninger, M.D. Plenary
Partnering for the World's Children
Wednesday, October 23: 4:15 p.m. – 6:00 p.m.

Plenary Speaker:
Paramjit T. Joshi, M.D.,
AACAP President-elect

Dr. Joshi focuses on areas of her Presidential initiative that have to do with enhancing AACAP’s relationship with international organizations, collaborations and sharing of educational resources, making AACAP’s website more accessible to international colleagues, support for international medical graduates, and examining AACAP’s membership categories. Dr. Joshi wants to utilize existing relationships between AACAP and other child psychiatry organizations in order to facilitate opportunities for our members and to foster the global work of the organizations. As part of this initiative Dr. Joshi wants AACAP to embrace the future from a global perspective.

Paramjit T. Joshi, M.D., AACAP President-elect (2011-2013), is Endowed Professor and Chair of the Department of Psychiatry and Behavioral Sciences, at the Children’s National Medical Center and Professor of Psychiatry, Behavioral Sciences & Pediatrics, at the George Washington University School of Medicine.

The Karl Menninger, M.D. Plenary is supported by Ronald K. Filippi, M.D., in honor of his mentor, Karl Menninger, M.D.

Lawrence A. Stone, M.D. Plenary
From Psychiatry to Clinical Neuroscience
Friday, October 25: 4:30 p.m. – 5:30 p.m.

Plenary Speaker:
Thomas R. Insel, M.D.

Psychiatry is a discipline in transition. The recent revolution in tools for gene sequencing and brain imaging confers new opportunities for defining the biology of mental disorders. As we begin to understand mental disorders as neurodevelopmental disorders, diagnosis and therapeutics will increasingly involve genetics, neuroscience, and cognitive science. This transition promises much better outcomes for our patients but to realize this clinical benefit, we will need much different training for our residents. This presentation describes some of the opportunities and challenges if psychiatry is to become a clinical neuroscience.

Thomas R. Insel, M.D., is director of the National Institute of Mental Health (NIMH), the component of the National Institutes of Health (NIH) charged with generating the knowledge needed to understand, treat, and prevent mental disorders. Over the past decade, during his tenure at NIMH, the world’s largest funder of research on mental disorders has supported large-scale practical trials, increased its focus on autism, and put highest priority on applying new insights from genetics and neuroscience to understanding mental disorders.

The Lawrence A. Stone, M.D. Plenary is named in honor of AACAP past president and Life Fellow, Lawrence A. Stone, M.D. It recognizes his leadership, vision, and passion to the mission of AACAP. Mrs. Marnette Stone endowed this plenary in loving tribute to her husband.
Guide to Exhibits

Make plans to visit the Exhibit Hall where you can discover new products, network with colleagues, and access numerous resources. It is an excellent opportunity for attendees to access up-to-date information on products and services affiliated with child and adolescent psychiatry.

Plan your trip to the Exhibit Hall before the meeting by viewing an interactive exhibit hall floor plan on AACAP’s website at: http://www.aacap.org/exhibits/2013

Don’t miss this valuable part of the Annual Meeting!

Remember, AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount on their 60th Annual Meeting registration. All referrals must be first time AACAP exhibitors and must purchase a booth for AACAP’s 60th Annual Meeting.

Exhibitors can advertise in several Annual Meeting publications and connect with more than 4,000 child and adolescent psychiatrists and other medical professionals. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. To review an Exhibitor Prospectus with more details on these opportunities as well as forms to sign up, please visit http://www.aacap.org/exhibits/2013

QUESTIONS?
exhibits@aacap.org or 202.966.7300, ext. 155.

The Exhibit Hall is located in Atlantic Hall B, on the First Level of the Walt Disney World Dolphin Hotel.
Orlando Attractions

Are you looking to submerge yourself in Disney, or do you want to get off the beaten path? Good news, we have found something for everyone!

Disney

If you’re ready to get the total Disney experience, look no further! Walt Disney World has one-of-a-kind restaurants, thrilling rides, cultural exhibits, and fantastic shopping to say the least! This family-friendly resort has something for everyone. The only problem you might have is deciding where to start (after you’ve attended all of the scientific sessions, of course!)

For more information about Disney or to purchase Disney tickets for you and your family, visit www.disneyworld.disney.go.com. As an Annual Meeting attendee, Disney offers special rates for Park admission on your rental car, and check out more restaurants, shopping, and theme parks just 20 minutes away!

Travel To and Around Orlando

Orlando is served by the Orlando International Airport (MCO). For more information about the airlines serving this airport, flight schedules, and ground transportation options, visit www.orlandoairports.net.

Orlando International Airport (MCO)

- Distance from Hotel: 28 miles
- Taxi: $65 (USD)
- Mears Transportation: $34 (USD)
- www.mearstransportation.com 407.423.5566

Airfare and Car Rental Discounts


Hotel Parking

Self-parking at the Walt Disney World Dolphin Hotel is $15 (USD) per day. Overnight valet parking is $20 (USD) per day.

Climate

One of Orlando’s biggest draws is the year-round sunny, mild weather. In keeping with the “Sunshine State”, Central Florida maintains a comfortable average annual temperature of 72°F (22°C) and a mostly dry climate from October to May. October’s average high in Orlando is 85°F (29°C) and the average low is 66°F (19°C). The average October precipitation is 2.42 in (6.15 cm).
Disney Shuttles

Guests of the Walt Disney World Swan and Dolphin Resort enjoy complimentary transportation throughout the Walt Disney World attractions. Disney shuttle buses arrive at the main entrance of the hotels approximately every 20 minutes to all Walt Disney World® Resort hotels and attractions.

Don’t Forget to Book Your Hotel!

Walt Disney World Dolphin Hotel
1500 Epcot Resorts Boulevard
Lake Buena Vista, FL 32830
Phone: 888.828.8850
Website: www.swandolphin.com
Rate: $229 single/double per night, plus $10 resort fee per night

You will find the Walt Disney World Dolphin Hotel has magical surroundings, superior service, luxurious facilities, and redesigned guest rooms featuring the Heavenly Bed®. Enjoy the Mandara Spa, 17 spectacular restaurants and lounges, five pools, a white sand beach, two health clubs, tennis, nearby golf, and many special Disney benefits, including free transportation to all Disney Parks and attractions.

We will also have a small block of rooms at the Walt Disney World Swan Hotel, the Dolphin’s sister property. To reserve a room at the Swan, please call 888.828.8850. The room rate and hotel policies at the Swan are the same as the Dolphin.

Hotel Policies:

■ All hotel rooms will be charged a Resort Service Package fee of $10 + tax, per day. This fee includes usage of the telephone, health club, and Internet.

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

■ This rate is available until October 1st, or until the group block sells out, whichever comes first. We recommend making your reservation early to secure your room.

■ A deposit equal to one night’s stay is required to hold each individual’s reservation. Such deposit shall serve to confirm the reservation for the date(s) indicated and, upon check-in, shall be applied to the first night of the reserved stay. This deposit is refundable if notice is received at least 7 days prior to arrival and a cancellation number is obtained. All deposits shall be charged at the time the reservation is made.

■ All rooms are charged sales tax of 12.5%.

■ Check-in is at 3:00 p.m. and check-out is at 11:00 a.m.

The Walt Disney World Dolphin Hotel is the headquarters for the Annual Meeting and all educational events will take place there. Located in the heart of the Walt Disney World® Resort, the award-winning Walt Disney World Swan and Dolphin Resort is a deluxe Disney hotel and your gateway to Central Florida’s illustrious theme parks and attractions. The Disney resort is located in between Epcot® and Disney’s Hollywood Studios™ and close to Disney’s Animal Kingdom® Theme Park and Magic Kingdom® Park.

The Walt Disney World Dolphin and Swan Hotels may now be sold out. Please contact A Room With A View at 1-800-780-4343 or ARWAV@charter.net. A Room With A View has information on hotel rooms within a short distance of the Walt Disney World Dolphin and Swan Hotels and that are connected to the Disney transportation system. In the event that rooms become available at the Walt Disney World Dolphin and Swan Hotels due to cancellations, A Room With A View will notify Annual Meeting registrants and help transfer reservations to the Walt Disney World Dolphin and Swan Hotels in the order in which they were booked. This is a FREE SERVICE for all AACAP Annual Meeting registrants.
Celebrate Halloween Early in Orlando!

Mickey’s Not So Scary Halloween
Don your favorite costume and get ready to trick-or-treat at this Halloween-themed event held in Magic Kingdom theme park!
www.disneyworld.disney.go.com/events-tours/magic-kingdom/mickeys-not-so-scary-halloween-party

SeaWorld’s Halloween Spooktacular
An ocean of Halloween fun for the whole family!
www.seaworldparks.com/en/seaworld-orlando/Spooktacular

Universal Orlando®’s Halloween Horror Nights
This premier Halloween event has an all-new haunted house, spine-chilling street experiences, and outrageous live shows.
Event may be too intense for young children and is not recommended for children under the age of 13. No costumes or masks allowed.
www.halloweenhorrornights.com/orlando

Legoland’s Brick-or-Treat
This spooky, kooky event features themed treat stations with candy, snacks, and a few surprises along the way!
florida.legoland.com/en/Plan/Special-Events

Central Florida Zoo & Botanical Gardens Zoo Boo Bash
Trick or treat in the wildest neighborhood in town! It’s a safe and fun event for the young and old. Kids are invited to bring goody bags and wear costumes. There will be face painting, a haunted hayride, photos at the pumpkin patch, and live animal demonstrations.
www.centralfloridazoo.org/
Onward into the Coming Decade!

James C. MacIntyre, II, M.D.
Chair, Back to Project Future

The Back to Project Future (BPF) Steering Committee recently completed its final report, Plan for the Coming Decade, and submitted it to AACAP President Martin Drell, M.D., for his review and consideration. This represents the conclusion of 18 months of focused effort on this Presidential Initiative by many AACAP members and staff. Many thanks to all the BPF Steering Committee members, three BPF subgroup leaders, all subgroup members, and AACAP staff for all their support, dedication, and work!

BPF Final Report – What’s in it?

The final report represents a consensus of the BPF Steering Committee based primarily on material written by the three BPF subgroups (Service/Clinical Practice, Training and Workforce, Research). The report also incorporates input from BPF’s Distinguished Consultants and Honorary Editors. The written report is organized into five sections. (see side bar for details)

Section I - Executive Summary and Background/Introduction: Provides summary and background information for BPF. The section also includes a summary of the results of the 2012-2013 AACAP Member Practice Survey, which provides a snap-shot of current CAP activity and practice.

Section II - Overview of the Coming Decade: This is a summary of the major issues and themes in CAP anticipated during the decade. The overview also briefly describes how the issues and themes are addressed in the Plan for the Coming Decade.

Section III - Plan for the Coming Decade: This section makes up the majority of the report and lays out the plan, including the BPF Vision Statement, BPF Core Values and Principles, and the Master List of BPF Goals. The bulk of this section consists of the BPF Goals, Recommendations, and detailed Action Steps developed by the BPF Steering Committee and subgroups. Readers should understand that the Goals, Recommendations, and Action steps are not cast in concrete — they represent a carefully constructed consensus of thinking by the BPF Steering Committee and subgroups in 2013. Readers should consider the Plan as a broad menu, with many choices of routes on the roadmap. Specific topics or issues of interest in child and adolescent psychiatry can be located using the Master Goal List. Each goal is numbered and has a brief descriptor in parentheses that helps the reader understand the broad content of the goal. Topics or issues can also be found using the topical Index of Recommendations in the report’s Appendix.

Section IV - Special Topics: This section contains brief overviews and analyses of six areas in child and adolescent psychiatry that were selected by the BPF Steering Committee in view of their importance to the field in the coming decade.

Section V - Next Steps/Implementation: In this section, the BPF Steering Committee outlines possible next steps for AACAP leadership to consider moving BPF forward to an implementation phase.

AACAP’s 60th Annual Meeting in Orlando will include several events designed to highlight and promote the completion and release of the BPF final report. Dr. Drell and James MacIntyre, II, M.D., have organized a special Back to Project Future Town Meeting for members only.

BPF Town Meeting - Have you wondered about what your practice will be like in the coming decade? Have you thought about how training, certification, and life-long learning may change for child and adolescent psychiatrists? How will you be using new technology in your practice? What research needs to be done to advance our knowledge and skills? This special Town Meeting features President Drell and the BPF leadership group, who will present an overview of BPF’s final report Plan for the Coming Decade. Presenters will discuss selected items from the report, including the BPF vision, guiding principles, over-arching goals, specific recommendations, and action steps, covering the areas of service/clinical practice, training/workforce, and research. Presenters will respond to questions and share some of the controversies and struggles encountered during the project. This is your opportunity to get the first look at the road map for child and adolescent psychiatry in the coming decade.

continued on page 280
Next Steps/Implementation Phase

A draft of the BPF report was sent to members of AACAP Council and the incoming officers (2013-2015) to help AACAP leadership understand the breadth and scope of the report—particularly the BPF Goals, Recommendations, and Action steps. The next step will be a careful review and consideration of the final report by AACAP’s Council and Executive Committee. The Academy leadership’s first decision should be to consider whether the project’s report and Plan for the Coming Decade should be moved to an implementation phase. If the project receives necessary approval and buy-in from AACAP leadership (i.e. Council and Executive Committee), then decisions will need to be made regarding the budget and allocation of resources (e.g., staff time, travel and meeting costs, etc.) to support the project’s implementation.

The time is now for AACAP leadership, members, and staff to study the roadmap presented in Plan for the Coming Decade and make the decision to begin the journey!

Dr. MacIntyre is chair of the BPF Steering Committee and editor-in-chief for Back to Project Future’s report. He has served as both secretary and treasurer and on Council for AACAP and in the Assembly of Regional Organizations of Child and Adolescent Psychiatry as an officer and delegate. He chaired the AACAP Consumer Issues Work Group (now the Consumer Issues Committee). Dr. MacIntyre works full-time as an attending child and adolescent psychiatrist for Carolinas HealthCare System (a nonprofit system) in Charlotte, North Carolina. He may be reached at james.macintyre@carolinashealthcare.org.
Dr. Christopher Kratochvil and Dr. Harold Koplewicz
co-chairs, AACAP’s Development Committee

I wanted to thank you for the opportunity to participate in the May, 2013 AACAP Advocacy Day. As a parent representative from North Carolina, I speak on behalf of other parents and their children when I visit the legislators and their legislative assistants. It is important to me to give a voice to those that can’t speak for themselves; our most vulnerable citizens – those with intellectual and developmental disabilities.

It is very important to share the alarming statistics about increases in children and adolescents with diagnoses, and the lack of health care professionals to provide services. Having parent representatives participate, I believe lends credibility to the “ask” and telling our story gives a face to the issues. I want the individuals with whom I meet to remember “Duncan’s story” and have it echo in their conscience long after we have all left D.C. I want them to remember his story when they are crafting bills, voting, deliberating. As I told one legislative assistant, an old Native American proverb says, “We will be forever known by the tracks that we make.” The ability to continue to provide care for the most vulnerable children in our community hangs in the balance of their decisions: decisions that change lives and help a child on the journey toward reaching his/her full potential.

My hope is that through me, they will hear our son’s voice, Duncan, as he says “Kids like me need help. Special programs are important; day treatment, residential programs, these places saved me and changed my life. I don’t know what would have happened to me if it weren’t for the things I learned at these programs and the love they showed me. It’s the best thing that ever happened to me and I know lots of kids that need a chance for special help. I’m also lucky to have good doctors and therapists that work with me now.”

There are lots of Duncan’s. They need a chance to reach their full potential and map their personal journey. I hope that the legislators that I meet hear the voices of the children in need and say, “YES” to their future.

Thank you for letting me participate.

Sincerely,
Loy Barbre McGill
For Your Information

Our Youngest Fundraiser

Walt Disney once said, “Our greatest natural resource is the minds of our children.” The child and adolescent psychiatrists who make up the American Academy of Child and Adolescent Psychiatry (AACAP) have dedicated their careers to protecting and healing that most valuable natural resource through treatment, advocacy, and research for childhood mental illness. Nine-year-old Dean Sorantino understood the value of that work when he decided to raise money for AACAP’s Campaign for America’s Kids in honor of his fourteen-year-old brother, Nicholas, who suffers from a tic disorder.

Dean had a simple proposition: he would go door-to-door and ask his neighbors to sponsor him as a soccer player, asking them to give either a flat donation or to pledge a dollar amount for every goal he scored that season. Dean scored 11 goals and raised $300 which he sent to AACAP along with a hand-written note saying, “I hope the money I raised helps kids like my brother because I want them to feel better.”

Dean is not only a fundraiser, but a donor as well, reaching into his own pocket to help achieve his $300 goal. He told AACAP he felt proud when he sent in the money he raised, and that he plans to keep raising money for charity in the future.

Dean understands that fundraising is a powerful tool to help make the world a better place for children with mental illness. He used his creativity and turned something he loved into a way to help people.

We hope you’re inspired! And, if you want to be like Dean and fundraise for AACAP, we have created an exciting way for you to do so. You can turn an upcoming event in your life, such as a birthday, marathon, bike ride, talent show, graduation, bar mitzvah, or anything you can think of, into a way to help children in need.

If you would like to follow nine-year-old Dean’s example and raise money and awareness for research, advocacy, and workforce development at AACAP, please visit [donate.aacap.org](http://donate.aacap.org) to find out how!

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AACAP’s Communications Office connects journalists with AACAP members. If you would like to work with the media, please contact the Communications Office with your area of interest at communications@aacap.org.

The following is a snapshot of AACAP members’ recent work with the media.

- **Rachel Matheny, M.D.**, wrote a blog post for WU Child and Adolescent Psychiatry Blog. The blog post, “Paddling... Does it Still Happen?” was published on May 4, 2013.
- **David Fassler, M.D.**, was interviewed by Clinical Psychiatry News. The article, “CDC Report Estimates One in Five Children Have a Mental Disorder,” appeared on May 16, 2013.
- **Ademola Bello, M.D.**, is mentioned in an article in the Penn State News. The article, “Pediatric Psychiatry Residents Bring Medical Perspective to Clinic Students,” appeared on May 22, 2013.
- **Michael Brody, M.D.**, was interviewed by The Baltimore Sun. The article, “Game of Thrones Enters the Therapist’s Office,” appeared on June 7, 2013.
- **Douglas Kramer, M.D.**, wrote an article for Psychiatric Times. The article, “Guns, Violence, and Mental Health: Did We Close the State Mental Hospitals Prematurely?” appeared in June 2013.
- **Louis Kraus, M.D.**, was quoted in an article in The New York Times. The article, “AMA Recognizes Obesity as a Disease,” was posted on June 18, 2013.
- **Rama Rao Gogineni, M.D.**, wrote a blog post for The Philadelphia Inquirer. The post, “What is Disruptive Mood Dysregulation Disorder?” was posted on July 1, 2013.
- **John T. Walkup, M.D.**, was interviewed by iTriage Health Blog. The post, “Is My Child too Young for Antidepressants?” was posted on July 2, 2013.
- **Carol Lebeiko, M.D.**, was interviewed by The Columbus Dispatch. The article, “Children Face Severe Psychiatrist Shortage,” appeared on July 14, 2013.
Renew Early for 2014

Don’t make another New Year’s resolution to stop procrastinating.

Jump start 2014 by renewing your AACAP membership between October and December of this year. Members are mailed invoices on October 1st to encourage early renewal.

Put Your Membership on Cruise Control

Take advantage of AACAP’s automatic dues renewal.

Contact dues@aacap.org to enroll in the automatic dues renewal program.

Have a Colleague Who’s Not a Member of AACAP?

Share the value of your membership with a non-member colleague or resident and give them a glimpse into the only community focused on serving the needs of child and adolescent psychiatrists.

Are they attending the Annual Meeting in San Francisco? If so, bring them by Registration to inquire about membership and learn of incentives offered only to non-member meeting attendees. Attendees must be eligible for AACAP membership to qualify.

Too shy? Let us do the talking for you. Send their name and contact information to membership@aacap.org and we’ll introduce them to AACAP.

According to Article VI, Section 1 of the bylaws:

a) The Nominating Committee shall consist of the Immediate Past President and four General or Fellow members of AACAP who are neither officers nor members of Council. The Immediate Past President shall serve as chair of the committee. The other members of the Nominating Committee shall be elected. Each year Council shall propose a slate of four General or Fellow members of AACAP, of which two shall be elected by the general membership to serve a term of two years each.

The AACAP’s Nominating Committee is presently soliciting names for nominations for two Councilor-at-Large positions. The deadline for nominations is February 1, 2014. Nominations should be sent directly to any member of the Nominating Committee. Their contact information is as follows:

Martin J. Drell, M.D., Nominating Committee Chair
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Department of Psychiatry
1542 Tulane Avenue, Room 236
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Fax: (504) 568-6006
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AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, advocacy, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. Thank you to the following donors for their generous financial support of our mission.

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NEW YORK

CHIEF OF PSYCHIATRY

Premier HealthCare (PHC) seeks a full-time Chief of Psychiatry for our 5 nationwide recognized outpatient medical practices located throughout New York City. In addition to maintaining your own caseload of patients, provide leadership to our psychiatry team. Our Psychiatry Team consists of 15-20 highly experienced Child and Adolescent Psychiatrists and Adult Psychiatrists. As the Chief of Psychiatry, you will be directly supervising our Senior Psychiatrists, each who oversee one of our 5 Practices.

PHC, a member of the YAI Network, is recognized by the US Surgeon General as a national model for the provision of health care, and by the National Council on Disabilities for raising the national standards of health care services for children and adults with developmental and intellectual disabilities. PHC has also earned national certification as a Level 2 Patient-Centered Medical Home by the National Committee on Quality Assurance (NCQA).

PHC is unique in its quality of medical, dental, mental health, rehabilitation and specialty care provided to individuals with developmental disabilities and their families. With medical professionals and physicians affiliated with major hospitals in the New York metropolitan area, PHC has practices conveniently located in the Bronx, Brooklyn, Manhattan, and Queens. PHC is an Affiliated program of The Seaver Autism Center for Research and Treatment at The Mount Sinai School of Medicine.

Our model is community-based psychiatry. The healthcare needs of people of all ages with intellectual and developmental disabilities, including autistic spectrum disorders, are provided with an integrated and comprehensive approach. Premier HealthCare sees a fascinating patient population with little substance abuse and fairly high compliance with appointments and medication.

Premier Healthcare fosters a culture of interdisciplinary collaboration, ongoing opportunities for professional development, and a positive work environment with supportive supervision. PHC is technology and outcomes driven.

Requirements:

Applicants must be BC/BE in Child and Adolescent Psychiatry or Adult Psychiatry, with 5 Years experience as a Psychiatrist and leadership experience. EHR and managed care experience a strong plus.

To apply, please e-mail your CV to Damian Crocevera, Physician Recruiter, at damian.crocevera@yai.org. For more information about Premier HealthCare and all of our Child & Adolescent Psychiatry opportunities, please visit our website at www.yai.org.

OREGON

CHILD AND ADOLESCENT PSYCHIATRIST

Full-time or part-time positions are available for a board certified or board eligible child psychiatrist at the Children’s Farm Home campus of Trillium Family Services (TFS). TFS is the leading provider of mental and behavioral health treatment for Oregon’s most vulnerable children who need intensive psychiatric services. Duties include assignments in residential, day treatment, outpatient, and telepsychiatry programs.

The Children’s Farm Home campus is in the heart of the Mid-Willamette Valley, beautifully situated on 300 acres of farmland adjacent to the Willamette River. Competitive salary based on board certification and experience with comprehensive benefits package is provided.

Must have successfully completed a general psychiatry residency and post-doctoral fellowship in child psychiatry; and must be licensed by the Oregon Board of Medical Examiners, and have DEA certificate to prescribe schedule II medications including benzodiazepines and stimulants. All staff psychiatrists must have a minimum of 2 years of experience working with child and adolescent psychiatric patients. In addition to having a general knowledge of child psychiatric assessment and treatment, all staff psychiatrists are expected to be familiar with the TFS policies and procedures as they pertain to the care of their assigned cases. They are also expected to be familiar with governmental guidelines, community standards for psychiatric care, and American Psychiatric Association professional standards regarding ethical behavior. This general level of knowledge will enable staff psychiatrists to meet the goal that they be able to work independently without the need for constant supervision. The TFS medical director will assist staff psychiatrists regarding questions pertaining to any of the aforementioned knowledge requirements.

For more information, please visit our website at: www.trilliumfamily.org.

To apply, please call DeeDee Gordon at 541-758-7735, or e-mail dgordon@trilliumfamily.org.

Trillium Family Services is an equal opportunity agency in the provision of client services and employment opportunities.
The Editorial Board of *AACAP News* is soliciting photographs from AACAP members to be published on its front page, inside standing alone, or accompanying relevant articles or stories. The published photographs should—in some artistic way—illustrate themes pertaining to children, childhood, parents and children, parenting, or families. All AACAP members are invited to submit up to two photographs every two months for consideration.

A committee of five experienced photographers who are AACAP members—David Corwin, M.D., James Harris, M.D., Fred Seligman, M.D., Ludwig Szymanski, M.D., and Alvin Rosenfeld, M.D.—will select the photos to be used. Photos not selected will be included in the voting for the subsequent two issues, along with all newly submitted photos. Unused photos will be retained by the AACAP to be used if and when a story they might illustrate is to be published. The *AACAP News* may edit photos to enhance them or make them suitable for publication. If you would like your photo(s) considered, please send a high-resolution version to Dr. Rosenfeld, the *AACAP News* photo editor, at ARosen45@aol.com. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
SAVE THE DATES!

JANUARY 10-11, 2014

Laurence L. Greenhill, M.D., and Jean A. Frazier, M.D., Co-Chairs
Sheraton New York Hotel and Towers – New York, NY

Register by December 6 at www.aacap.org/psychopharm/2014 to get the Early Bird Rate. Questions? E-mail meetings@aacap.org.
ADVERTISING RATES
Inside front, inside back or back cover ................ $4,000
Full Page ................................ $2,000
Half Page ................................. $1,600
Third Page ......................... $1,100
Quarter Page ......................... $700

CLASSIFIED ADVERTISING RATES
- $12 per line (approximately 6-8 words per line).
- Classified ad format listed by state.
- Typesetting by AACAP.
- Commission for advertising agencies not included.

ADVERTISING DEADLINES
November/December 2013 ........ September 27
January/February 2014 ........ November 27
March/April 2014 ............... January 27
May/June 2014 ................. March 27

DISCOUNTS
- AACAP members and nonprofit entities receive a 15% discount.
- Advertisers who run ads three issues in a row receive a 5% discount.
- Advertisers who run ads six issues in a row receive a 10% discount.

To place your advertisement contact Caitlyn Camacho, Communications & Marketing Coordinator at ccamacho@aacap.org or phone 202.966.7300, ext.: #154.