Inside...

Picking the Right Type of Treatment ................................................... 109
Opportunities to Integrate Behavioral Health and Primary Care in School-Based Clinics: A New Beginning ................................. 115
The Māori World – Words Matter ....................................................... 120
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TABLE of CONTENTS

COLUMNS

Jean Dunham, MD, Section Editor • jeandunham@gmail.com

Clinical Vignettes: Picking the Right Type of Treatment • Martin J. Drell, MD, and Sylvia Worrell, MD ......................... 109
Psychotherapy: Unto the Third Generation: A New Development Textook for CAPs • Rachel Z. Ritvo ......................... 111
Diversity and Culture: Kurdish Immigrants and Mental Health • Sheinel J. Saleem, PhD, and Sala S. N. Webb, MD ................................. 113

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Schools Committee: Opportunities to Integrate Behavioral Health and Primary Care in School-Based Clinics: A New Beginning • Fareesh Kanga, MD, and Kimberly White, MD ................................. 115
Northern California Regional Organization of Child and Adolescent Psychiatry: What Our Patients Teach Us • Edmund C. Levin, MD ........................................................................................................... 117

NEWS

Stuart Goldman, MD, Section Editor • stuart.goldman@childrens.harvard.edu

News Updates • Stuart Goldman, MD, and Garrett Sparks, MD, MS ........................................................................... 118

OPINION

Christopher Varley, MD, Section Editor • chris.varley@seattlechildrens.org

The Maori World – Words Matter • Hinemoa Elder, MBChB, PhD ........................................................................... 120

FEATURES

Debbie Carter, MD, Section Editor • debbie.carter@ucdenver.edu

Poetry: Burst • Karie Evans ........................................................................................................... 122
Media Page • Harmony Raylen Abejuela, MD ........................................................................... 123

61ST ANNUAL MEETING

Eva Szigethy, MD, Section Editor • szigethye@upmc.edu

San Diego Preview ........................................................................................................... 124
New Research Poster Call for Papers ................................................................................ 127
Medical Students and Residents: Attend the AACAP Annual Meeting and Get Involved! .......................................................................................... 128

FOR YOUR INFORMATION

Membership Corner ........................................................................................................... 129
Upcoming Events ........................................................................................................... 129
Staff Directory ........................................................................................................... 130
AACAP Welcomes Carmen J. Head as the New Director of Research, Training & Education! ........................................................................... 133
Thank You for Supporting AACAP! ........................................................................... 132
Did You Know? ........................................................................................................... 134

COVER: The smiles on their faces looks like “Christmas came early” and that’s what I call that picture. The poverty level in Taki is high and the kids were genuinely excited with any my gift. It was my pleasure to give back. Taki is a village on the border between West Bengal (India) and Bangladesh by the Ichamati River. – Shubu Ghosh, MD
MISSION STATEMENT

Mission of AACAP: Promote the healthy development of children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

Amended and Approved by Council, June 27, 2010

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The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy

- Establishes and supports the highest ethical and professional standards of clinical practice.
- Advocates for the mental health and public health needs of children, adolescents, and families.
- Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.
- Liases with other physicians and health care providers and collaborates with others who share common goals.

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The mission of AACAP News includes:

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

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CONTINUING THE SUPERVISION, I TOLD THE RESIDENT THAT I WOULD LIKE TO TELL HER ABOUT A CASE I SAW THE DAY BEFORE. IT WAS A 13-YEAR-OLD GIRL THAT WAS REFERRED TO ME BY HER FAMILY PRACTITIONER FOR “SKIN PICKING.” THE FAMILY PRACTITIONER SAID THAT SHE HAD DONE WHAT SHE FELT COMFORTABLE DOING. SHE HAD STARTED THE PATIENT ON A LOW DOSE OF AN SSRI SEVERAL WEEKS PREVIOUSLY AND REFERRED HER FOR CBT. THE FAMILY PRACTITIONER SUGGESTED THAT THE FAMILY CONSULT WITH A CHILD AND ADOLESCENT PSYCHIATRIST.

When the mom called, she asked me specifically about the SSRI. She said it was not working and wanted to stop it. I reminded the mom that I did not know the case, but pointed out that the SSRI was at a low dose and that her daughter had not had an adequate trial, as it had been prescribed for less than a month. She agreed to continue it. I asked her to negotiate that with her family practitioner who was still in charge. As I scheduled the first appointment, I was anxious about what I could add. The combination of SSRI’s and CBT sounded fine to me. I planned to handle this as a consultation.

As I entered the waiting area, I introduced me to her husband and 10-year-old son who were sitting on the opposite side of the waiting area. I noted the seating arrangement and asked who was coming into the session with me.

“Just Charisse and me,” Mom answered.

“What about them?” I replied pointing at the men on the other side of the waiting room.

“There’s things we don’t want Rusty [the son] to hear.”

“Well then, what about Dad?” I asked.

“Rusty is hungry and Dad is going to take him out for something to eat.”

“Oh, ok.” I responded with some confusion.

I then turned to the resident and talked about the seating arrangement:

“I’d just met them, and judging by the seating, and until proven otherwise, I suspect a split between the women and the men, with some secrets to boot! I was intrigued.” I then returned to describing what I did next.

“How can I help?” I asked the mom and Charisse.

The mom answered my question. She explained that they wanted help for Charisse’s chronic skin picking, which had been going on most of her life. “We took her to several dermatologists to see what was causing the sores before Charisse told us that it was due to her picking.”

“What makes you come now? It’s been going on her whole life.”

“It’s gotten worse in the last two years,” said the mom.

As the mom paused, Charisse added softly, “I pick when I’m under stress.”

“Well then, what’s stressing you?” I asked.


“I’m confused,” I said. “You said you pick when you’re stressed, so I assumed if you are picking now, something is stressing you.”

“I pick when I’m upset and do it without thinking,” Charisse responded.

“I can buy that, but to me, it still means that something is bothering you, even though you may not know exactly what it is. Did anything happen two years ago?”

Both mom and Charisse said they did not know of anything.

“I will assume that something did happen, even though you can’t remember. Why not think about it?” I said to both of them. I then added that it might be something that Charisse is upset about that she does not consciously know about.

“Two years ago, I started a new school. There was more school work and drama,” said Charisse.

“What kind of drama?”

“Catty girls that I didn’t like. You know ‘messy’ girls.”

“Any other changes?”

continued on page 110
Picking the Right Type of Treatment  
continued from page 109

Mom then said, “I know what happened! My mother died of a heart attack. She was very important to the kids. She drove them to school and back every day. She drove them to school that morning and had a heart attack and was gone. The kids were very close to her.”

“So mom, tell me more about your anger and what triggers it?”

“I’ve always been that way. I’ve been depressed and nervous for years since I was in an abusive relationship with a past boyfriend. He made me nervous. I went for therapy and was put on an SSRI. It helped me, but I stopped it. I’m not sure why. I was depressed after my mom died but I got over it. Didn’t I, Charisse?”

Charisse nodded yes.

The mother continued: “A year ago, I had some surgery and I’ve had some problems since. And my job isn’t the easiest. I come home pretty frazzled. I have few problems with Charisse. She’s a doll. Now Rusty, my son, he’s another story. He’s always pressing my buttons. He gets me going. It’s a good thing my husband is so laid back. He knows how to make me feel better. He’s my comic relief.”

I then told the resident how I wrapped up the session with Charisse and her mother.

“I’d like to see you back again and continue what we’ve talked about today. Please continue the SSRI, noting for Charisse that the current dose is a fairly small one and that it would probably take a few more weeks to work. From what I see today, I take Charisse at her word that she ‘picks’ when she’s stressed and I believe that there are things that are stressful to her and the whole family, including her grandmother’s death. I note that her problems are part of a larger family issue regarding how to deal with feelings. The main issue is whether the family can talk about feelings when they are upsetting. And then there seems to be specific issues about how to deal with anger. Some show it and get angry and take ‘time outs.’ Others get over it quickly, or are ‘laid back.’ Others push people’s buttons. When things like this happen, it’s usually a family problem. Can we have everyone at the next meeting so we can get some information from the guys?”

Turning to the resident, I noted that mom and Charisse agreed to a family session and scheduled a time for the next week.

* * * * * * * *

“Now I ask you...” I said to the resident, “What would happen with this case if a general resident saw Charisse?”

“She’d be put on meds,” said the resident.

“And if a starting child resident saw her?” I asked.

“She’d be put on meds.”

“Would they have gotten the information I did?”

“Probably not.”

“And what makes sense for this case?”

“What you did,” said the resident.

“Which included meds, but more,” I added.

“Yes,” said the resident. “I want to learn how to do what you do.”

“So, let’s make that one of the goals for our supervision.”

“Sounds good to me.”

Dr. Drell is past-president of AACAP and head of the Division of Infant, Child, and Adolescent Psychiatry at the Louisiana State University Medical School in New Orleans, Louisiana. Dr. Drell may be reached at MDrell@lsuhsc.edu.
Unto the Third Generation: A New Development Textbook for CAPs

ACAP’s 60th anniversary celebration in 2013 marked the progression of child and adolescent psychiatry into a third generation. As our profession matures, we are faced with the challenge of conserving the knowledge and skills that serve us well while integrating new research into our theories and practice. Nowhere is this more important than in our understanding of development. Development is a normal process of psychological change and as such can teach us much about how psychological change occurs. Developmental change can also destabilize individual and family psychological adaptations, bringing children or adolescents to clinical attention. Developmental progress can give a youth new capacities to meet the challenges of life, making the support and enhancement of development a useful approach to treatment. Developmental thinking informs all aspects of child and adolescent psychiatric practice but is critical to the teaching and practice of psychodynamic therapeutics, both psychotherapy proper and psychodynamically informed assessment or pharmacotherapy.

APPI press has released this year Normal Child and Adolescent Development: A Psychodynamic Primer authored by Karen Gilmore, MD, and Pamela Meersand, PhD, from the Columbia University Medical School and Center for Psychoanalytic Training. This volume addresses the need for a third generation textbook of development. Drs. Gilmore and Meersand have taught human development to psychiatry residents, psychology doctoral students, and psychoanalytic candidates for more than ten years. They found, as many instructors in today’s child and adolescent psychiatry programs have found, that the textbooks available were from the 1990’s and could not possibly provide a 21st century synthesis of advances in psychodynamic theory and the empirical studies of developmental cognitive psychology and neuroscience. Additionally, there were no texts that clearly explained our contemporary understanding of the transactional and emergent nature of development.

“Developmental thinking informs all aspects of child and adolescent psychiatric practice but is critical to the teaching and practice of psychodynamic therapeutics, both psychotherapy proper and psychodynamically informed assessment or pharmacotherapy.”

Drs. Gilmore and Meersand’s book is a gem for teaching today’s fellows. It is barely 300 pages long. Ten chapters, covering infancy through emerging adulthood, could be assigned in weekly installments to make a ten or twelve week course. The writing is clear. There are bullet point reviews at the end of subsections, as well as summaries of key points at the end of chapters. Video clips illustrating normal development are introduced in the text and conveniently available on the APPI.org website. Additionally, illustrative clinical vignettes enrich the text. Ideally, a course for fellows would take a more leisurely pace through the book, as there is much to digest. The extensive references at the end of each chapter allow readers to go into greater depth on any topic that attracts their interest. While trainees may find that the references provide an entrée into the psychoanalytic literature, they will also be helpful to psychodynamic practitioners wishing to access the neuroscience and empirical cognitive developmental literature.

In the first generation of child and adolescent psychiatry, and well into the second generation, psychoanalytic terminology was familiar and meaningful to fellows who were taught these terms in their adult residencies. In the past decade, the psychoanalytic literature has become less accessible to trainees because of the length of the papers and the unfamiliar terminology (jargon to some). Drs. Gilmore and Meersand retain relevant psychoanalytic language while explaining the terms clearly. Readers of this book will be better able to digest the rich case material that is in the psychoanalytic literature if they should choose to explore it.

A balance is struck in this volume between theoretical issues, e.g., development as phasic versus non-linear, and descriptions of the growth of mental capacities underlying developmental changes. To address the Oedipal phase, the authors have done this by having two

continued on page 112
Unto the Third Generation continued from page 111


Throughout the book, the authors present the body and brain changes that stimulate psychological development and also create symptoms. The chapter on “Preadolescence” is a masterful description of the tweens’ experience of gains in cognitive and social understanding that give greater mental control while the tweens are simultaneously challenged by the increasing hormonal levels of prepuberty and the first signs of sexual maturity. The effect of these changes on peer and family relationships are explored, drawing on empirical studies as well as clinical observations. In preadolescence, “the intimacy of earlier parent-child bonds is slowly loosened; roles and relationships are reorganized and renegotiated. The preadolescent’s loss of parental ego support during a time of increased inner confusion and vulnerability leads to deep feelings of separation and loneliness.” (Gilmore and Meersand 2014, p.198).

The influence of social factors on our perception of developmental phases has been debated for years. Adolescence was first described as a distinct period of life by G. Stanley Hall in 1904. Gilmore and Meersand note Hall’s choice of the decade from 14 to 24 marked the time from the median age of menarche to the typical age of marriage and parenthood at the dawn of the twentieth century.

“Chapter 10: The Odyssey Years” derives its name from a 2007 article by David Brooks in The New York Times. Brooks commented on the trend that entry into adulthood, defined as a time of financial independence, living away from home, marriage and parenthood, has been pushed toward age thirty. Are the twenties a new developmental phase of emerging adulthood? The authors note that this odyssey time is not in response to a bodily change or maturation but more to economic and social trends and to the technology of contraception that allow for adult sexuality without pressures of parenthood. “Whether it is a true developmental phase or a transient epiphenomenon of societal change remains a subject of debate” (Gilmore and Meersand 2014, p.284).

Presenting development in phases is a useful pedagogical approach. It allows the student to jump off from the lay impressions of what is “age appropriate” into the deeper streams of psychological development and the transactional nature of developmental change. In each phase the intricacies and interactive matrix of the child’s relationship with the mother, and to a lesser degree father and siblings, are delineated by the authors. Similarly, they present the development of self and of superego/conscience in each phase, so these can be followed as developmental lines by the reader.

Knowledge of normal child and adolescent psychological development is an essential feature of our specialty. Drs. Gilmore and Meersand have done a brilliant job of updating psychoanalytic theory and integrating advances in the developmental sciences to give us a textbook that maintains a bridge to the work of previous generations, Winnicott, Mahler, Blos, Fraiberg, and the Freuds, while building a bridge with neuroscience and empirical developmental psychology.

Reference

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DIVERSITY AND CULTURE

Kurdish Immigrants and Mental Health

Sheinel J. Saleem, PhD, and Sala S. N. Webb, MD

To appreciate the consequences of war and trauma among Kurdish immigrants, one must at least gain a superficial understanding of their history. Rooted deep in Mesopotamia, Kurdistan has seen many years of conflict and genocide since its fractionation in 1920 under the Treaty of Sevres. Today, the Kurds stand as the largest ethnic group without a country of their own and are geographically divided among Iraq, Iran, Turkey, and Syria. Each of these countries has subsequently marginalized and attempted to eradicate its Kurdish population via their own unique methods.

Iraqi Kurdistan saw its darkest period during the 1980s. This included Saddam Hussain’s Anfal Campaign, in which chemical weapons were utilized to kill thousands of Kurds; as well as the Gulf War, the 1991 Rapareen Kurdish Revolution, and massive exoduses of Kurdish people to the mountains. Subsequent to the establishment of the “no fly zone,” Iraqi Kurdistan experienced several years of inter-fractional civil strife. Consequently, many Kurds fled the country, escaping illegally to Europe. Others were later brought over to the United States in waves, with the largest occurring in 1996 as part of a resettlement program under then President Bill Clinton.

Today, the Kurdish population in the United States is a heterogeneous community, whose members have experienced various types of trauma and where the consequent psychological impact remains evident. Each age group presents a unique pattern of emotional distress and as such requires appropriately tailored interventions.

When analyzing the older generation (age 50 years and above), one can clearly see a spectrum of posttraumatic stress disorders (PTSD) that has become a pervasive component of daily life. This is the result of this generation having spent the majority of their lives in war and adhering to those values essential for basic human survival and preservation of the Kurdish culture. Symptoms like hyper-arousal, great distress upon event recall, severe anxiety, and distrust of others are regarded as part of normal life. Furthermore, no longer struggling to sustain life but rather meeting its emotional demands in a peaceful environment, this generation has also experienced a dysregulated perception of survival and preservation of culture. Life now in the United States, with no concurrent war, requires a different skill set that is focused more on prosperity. For many in the older Kurdish generation, this mental shift has been challenging to cultivate.

Perhaps the most severely affected are those who absconded from the war and immigrated as teenagers. This cohort, for the most part, represents a group of precocious children who were forced into adulthood prematurely and served as forerunners for their families. This group

continued on page 114
was not afforded the ability to properly transition through the stages of development. Consequently, individuals in this group not only experience intrapersonal conflicts related to immigration and coming of age, such as identity development and perception of self, but they also suffer from mental conditions such as depressive disorders, PTSD, bipolar disorders, and psychotic disorders. More often than not, when these youth do seek treatment, they present with rather severe manifestations of these conditions. It remains a cultural perception within the Kurdish community that mental health conditions should be “managed” at home and by the family.

As a group, the younger generation attempts to navigate life in America on their own accord; often experiencing episodes of distress triggered by unwanted intrusions of their traumatic childhood experiences, those that occurred before and after their inter-continental relocation. With this, they may become more susceptible to maladaptive coping strategies such as substance abuse and other risky behaviors.

Perhaps even more frightening and requiring further investigation is the deleterious consequence of the chemical weapons used on the Kurdish people and its genetic impact. While emerging data suggest such weapons have caused mutations that increase susceptibility to malformation and neoplastic progression, little research has been conducted in the area of mental health.

The currently naturalized Kurdish Americans in the United States are in dire need of mental health education and services. Much effort is still required to eradicate the cultural and social taboos of mental illness. Members of the Kurdish community require extensive effort and motivation to utilize all the now available supports and services. Parents need to be educated, not only about those disorders that commonly occur in children such as attention-deficit hyperactivity disorder (ADHD) and autism spectrum disorders but also on the effects that their own unmet mental health needs are having on their children. Mental health screenings therefore need to be conducted at all age levels, and the impact on the third and subsequent generations quantified.

Additionally, there is a great need for dedicated psychiatrists, psychologists, social workers, and other mental health clinicians who can be trained to better appreciate the historical trauma of Kurdish people so they can provide highly personalized therapeutic interventions.

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Dr. Webb is medical director, Webb Psychiatric Consulting, PLLC. She is coordinator of the Diversity and Culture Column. She may be contacted at webbpsychiatric@gmail.com.
Currently, the status of child and adolescent psychiatric involvement in schools ranges from the indirect to a direct and systematic school-based mental health service using evidence-based interventions. All too often, the only interaction between the child and adolescent psychiatrist and school-based personnel occurs with the exchange of information via a standardized rating scale report for attention-deficit hyperactivity disorder (ADHD). Additionally, there can be a significant disconnect between the practicing child and adolescent psychiatrist and the primary care provider. Recently, AACAP’s Back to Project Future (BTPF) delineated a plan to push for better systems of care integration in the context of the emerging health care system driven by the Affordable Care Act (Drell 2014).

Specifically, BTPF calls for collaboration with primary care providers and allied health professionals across settings, including private and public sectors, such as community health centers, schools, and accountable care organizations (ACOs). The goal is to streamline and coordinate services in an efficient and cost-effective manner. The AACAP leadership emphasizes the need for each of us to play a role as formative participants in shaping change to bridge the service gap. Given the dearth of child and adolescent psychiatrists nationwide and the disparity in access to mental health care, there is also an effort to examine force multiplication by maximizing our leadership and consultative capabilities to other health care systems and organizations.

One such model is school-based health clinics, while another is integration into the primary care setting. Many models of school-based mental health and/or primary care integration exist, but what works in Los Angeles or Baltimore may not fit the culture and politics of other locales. This piece documents an early career child and adolescent psychiatrist’s odyssey as she implements a program that embraces both of the core principles previously articulated. Dr. Kanga’s leadership serves as a model of possibility.

Adapting New Models of Mental Health Care into School Clinics

A year following my residency training, I took a newly created position as “director of Behavioral Health” for HealthFirst Bluegrass, Inc., the co-applicant primary care group with the Lexington-Fayette County Health Department. My tasks included overseeing the behavioral health component of the school-based clinics in the county public elementary schools. Truthfully, they lost me at “co-applicant.”

How does one grow a program? Fortunately, some groundwork had been implemented. In four schools, behavioral health clinics existed within the school medical clinics. Two licensed clinical social workers (LCSWs) and one pediatrician with an interest in ADHD and school health split their time among the schools. We also planned to expand into four more schools. Additionally, the LCSWs had concerns regarding isolation and standardization between schools. I had to finalize the expansion and move forward from there.

I joined HealthFirst because its work, establishing mental health clinics with medical clinics in schools, showed incredible foresight. This is also the direction of modern medicine, and meets the goals of the American Academy of Pediatrics’ (AAP) concept of the patient-centered medical home (PCMH). The 2007 AAP seven “Joint Principles” include a personal 1) provider, 2) a provider-directed medical practice (empanelment), 3) whole-person orientation, 4) coordinated and/or integrated care, 5) quality and safety, 6) enhanced access, and 7) payment (California School-Based Health Alliance 2014). Today, organizations like The Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations) can bestow PCMH status

continued on page 116
to an organization if it meets specific criteria. Healthfirst Bluegrass is a major proponent of the PCMH, working intensively on the integration, quality, and enhanced access to care. The “shoulder-to-shoulder” collaboration of a child and adolescent psychiatrist, LCSWs, pediatricians, nurses and teachers, working as a team within schools, positions our patients to have accessible, coordinated, and integrated quality care.

Quality, not quantity, is a cornerstone of the PCMH concept (Greenberg et al. 2014). Objective evaluation is also paramount and requires frequent data input. HealthFirst Bluegrass strives to use these data to monitor quality improvement. While I had certainly used scales in the past to monitor an individual patient’s improvement, I now reviewed scores of rating instruments to identify scales that could be used for an entire institution. We opted to expand our use of the Vanderbilt Assessment Scale, which is free, readily available to the LCSWs and pediatricians and easy to use for parents and teachers. Since it is integrated into the electronic medical record (EMR), the data can be manipulated to demonstrate trends in patient outcomes and provide benchmarks for improvement. Finally, to ensure quality progress notes and simpler peer evaluation, we included detailed note outlines designed in conjunction with the new EMR behavioral health note.

Although more research is still forthcoming, estimates show that PCMH may mount and requires frequent data input. Healthfirst Bluegrass strives to use these data to monitor quality improvement. While I had certainly used scales in the past to monitor an individual patient’s improvement, I now reviewed scores of rating instruments to identify scales that could be used for an entire institution. We opted to expand our use of the Vanderbilt Assessment Scale, which is free, readily available to the LCSWs and pediatricians and easy to use for parents and teachers. Since it is integrated into the electronic medical record (EMR), the data can be manipulated to demonstrate trends in patient outcomes and provide benchmarks for improvement. Finally, to ensure quality progress notes and simpler peer evaluation, we included detailed note outlines designed in conjunction with the new EMR behavioral health note.

At a recent meeting of the Kentucky Primary Care Association (where I was the only psychiatrist!), I was introduced to an emerging behavioral health integration model, which includes the use of a Behavioral Health Consultant. While we are unable to implement this model now, it presents an exciting new opportunity that could eventually be used both in our primary care clinics and our schools.

In addition to learning a new EMR and embracing a new system of providing mental health care, I learned new roles including advocating, improving the EMR, determining a school-based LCSW scope of practice, and even refining the referral process.

We added monthly meetings to provide supervision and promote communication. Recently, I started seeing patients a half day in three of the school ADHD clinics. In March 2014, the LCSWs started parent groups, and, by next school year, we hope to add formal teacher education. Altogether, I have gained new appreciation for being able to prepare a department mission, follow productivity reports, and even write a grant. Turns out, understanding “co-applicant” was just the tip of the iceberg.

At the 2013 Annual AACAP meeting, I walked into the school committee hoping for the key to a successful school program. I walked out of the committee meeting with confidence, supportive colleagues… and this writing assignment! The lesson learned was that school mental health care requires simply putting in place what we know from residency and then adapting it, sometimes to a completely novel way of thinking, to provide the highest quality care.

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References


What Our Patients Teach Us

Edmund C. Levin, MD

“Nina”: Twenty-five years ago I performed a diagnostic evaluation at the request of Nina’s therapist, a non-medical colleague. Nina, at age 28, had been diagnosed in the course of multiple hospitalizations as having schizoaffective disorder, bipolar disorder, borderline personality disorder, and alcoholism. On multiple medications, she was still bouncing in and out of hospitals. When I discovered that she was amnesic for the first 12 years of her life, I suggested her therapist reconsider the patient’s diagnoses and listen carefully for evidence of trauma. It proved to be there, largely in the form of sexual abuse. Over time, the patient’s symptoms remitted, she discontinued her medications, and she made major life changes. Eventually, she quit therapy and moved away. The last her therapist heard from her, about 10 years later, indicated that she was doing well, in a stable relationship, and working.

“Ann”: Several years later I received a call from the mother of a 10-year-old who had been diagnosed with attention-deficit hyperactivity disorder (ADHD) at age four and a half years and bipolar disorder at age five. She was referred to me when the family was able to recognize that she had been getting worse. Due to lack of time, I attempted to refer the case to a colleague. Possibly due to some telephone transference, my referral did not work. The mother cried when I had said in our initial phone contact that I could appreciate how stressful life must be for her family. She telephoned again asking to be seen as soon as I could manage. I agreed and a formal evaluation began two months later.

The evaluation consisted of my reviewing many pages of school and medical records, watching family videotapes, and reading emails exchanged between mother and teachers. There were two sessions with the parents together, four with the mother alone, three with the father, and two with Ann. There were multiple calls involving a pediatrician, two psychiatrists, two neuropsychologists, a social worker, a school psychologist, a special education teacher, and a community mental health psychologist.

- Brief history: Beginning at least by age 3, trauma was involved, largely in the form of emotional abuse and harsh physical confinement for perceived misbehavior.
- Psychotherapy: Little had been done by way of therapy for Ann and even less for the parents.
- Pharmacotherapy: At the beginning of the evaluation, Ann was taking 16 pills per day. Over a five and a half year period, a total of 86 prescriptions had been written for psychiatric, neurologic, and/or behavioral reasons. All told, mixed amphetamine salts, atomoxetine, benzotropine, buproprion, clonidine, divalproex sodium, guanfacine, methylphenidate, olanzapine, oxcarbazepine, or risperidone had been dispensed 103 times.

Following the end of the evaluation Ann was off all medications. She no longer saw me, but worked with a non-medical therapist and a more appropriate school placement had been arranged. The diagnoses she had from age four and a half to age 10 were dropped.

Occasional calls to the parents over the years found Ann much improved, though not “cured.” The father continued to seek medications for her, though not in the numbers or strengths previously prescribed. In one call, when I asked him why she was on an selective serotonin reuptake inhibitor (SSRI), he laughed and said, “Well, Doc, you know we’re all crazy.”

What I learned: These two patients taught me lessons never forgotten. In fact, they have since been reinforced multiple times:

- The effects of trauma are easily confused with major “biologic” psychiatric disorders.
- With medications, sometimes less is more.
- Careful, intense evaluations can be worth their weight in lots of very expensive pills.

Dr. Levin is chair of the AACAP Mentoring Committee and an alternate delegate to the AACAP Assembly of Regional Organization of Child and Adolescent Psychiatry. He may be reached at eclevin@earthlink.net.
Why Systematic Studies Matter

With a lack of systematic studies for many of our clinical interventions, we often rely upon conventional wisdom or clinical judgment to “inform” our clinical practice. The two studies cited below highlight the limitations and possible problems that “conventional wisdom” may have missed.

Aripiprazole and Risperidone: Impact on Weight Gain

Risperidone and aripiprazole have both been shown to be effective agents in the management of children and adolescents who have Autistic Spectrum Disorder (ASD) and have received FDA approval for usage. Conventional wisdom, with some supporting data, has suggested that overall aripiprazole causes less weight gain than risperidone. Given the long term usage and concern about weight gain, for many treating this patient population, this “clinical truth” has dictated recent practice and teaching (including us). Wink et al., in February’s Journal of Child and Adolescent Psychopharmacology, present an important, albeit retrospective, head-to-head comparison of long-term weight gains in the ASD population. As part of a larger study, they looked at 70 children treated with aripiprazole (11.8mg mean) and 72 with risperidone (2.2 mg mean). In both groups, there were changes in BMI of approximately 2 points over a 1-2 year period, but there was no statistically significant difference between the aripiprazole and risperidone treatment groups. While the authors acknowledge the limitations of retrospective studies and the need for closer examination, including lipid profiles, etc., they conclude that the lack of significant differences in weight gain is an important finding since these are the only two FDA approved agents for irritability in ASD. While the prior belief that aripiprazole is more “weight sparing” needs closer study, it should no longer be assumed.


Acetaminophen and Pregnancy

Almost all physicians and pregnant mothers worry about medications during pregnancy. Clearly, the advice to avoid usage is best, but conventional wisdom has been that acetaminophen and most other over-the-counter (OCT) medications are safe to use when needed. Over 50% of pregnant women in the United States and Denmark use OTC acetaminophen. However, recent animal studies have shown that acetaminophen can disrupt endocrine (thyroid and androgen) functions and impact the developing fetus.


Peer Victimization, Cyberbullying, and Suicide

The negative effects associated with bullying have become increasingly clear over the past two decades. The impact on both mental health and physical health have been extensively documented and there are many (but way too few and ineffective) efforts at both prevention and intervention for this common problem that affects 5-20% of all children. In the last decade, this has also evolved into cyber-bullying both directly online and through social media. The toxicity of this type of peer victimization is beginning to become ever more clear as there have been several tragic examples of cyber-bullying leading to suicide.
Getting a clearer picture of the extent and impact of bullying led van Geel et al. to conduct a meta-analysis of 34 studies that involved over 284,000 children. They found that peer victimization increased both the odds ratio for suicidal ideation to 2.23 and for attempts to 2.55 with cyber-victimization being at least as toxic. Clearly, inquiry into victimization has become increasingly part of the routine evaluation of children and adolescents. These results suggest that inquiry into cyber-victimization should be routine as well.

archpedi.jamanetwork.com/article.aspx?articleid=1840250

Could Stimulants be a Part of the Obesity Epidemic?

So often, we find ourselves discussing with children and their families about how stimulants decrease appetite and how they might need to catch up on their calories on the weekends or over the summer. Sometimes, we even prescribe medications to promote appetite in kids struggling to gain weight. We have heard stories of adolescents and young adults using stimulants to lose weight. ADHD has certainly been associated with obesity. Could stimulants actually be the driving factor with this association?

Electronic health record data from Geisinger Health System on over 160,000 children aged 3- to 18-years in central Pennsylvania identified more than 13,000 children with ADHD. Younger children with ADHD in general had higher body mass index (BMI) early on compared to those without ADHD, though this difference appeared to disappear in adolescence. At the same time, children with ADHD who received stimulants were thinner early on compared to those with ADHD who were not treated with stimulants, the stimulant-treated children were actually heavier than the children without ADHD or those not treated with stimulants during adolescence. The effects were more notable when age of onset and duration of exposure to stimulants were examined.

While somewhat confusing and counter-intuitive, this study does improve upon past cross-sectional data with a longitudinal design. However, the study was limited in its ability to control for confounds and for identifying the degree to which children with ADHD that do or do not receive stimulant medications may be very different populations in a variety of ways. That said, such an association will be important for driving further research and allowing us to further focus our interventions on the most at-risk populations.

pediatrics.aappublications.org/content/early/2014/03/11/peds.2013-3427

Obesity Can Be the Difference Between Passing and Failing for Adolescent Girls

Obesity has plenty of detrimental effects on children, though most of the research on these effects has been limited to cross-sectional studies with small samples that are not able to control for other factors. Researchers at several universities in the United Kingdom were able to follow almost 6,000 adolescents from age 11 to 16 years. Achievement tests of English, math, and science were measured at ages 11, 13, and 16. After controlling for a multitude of factors, including socioeconomic status, mental health, IQ, and age of menarche, obese girls at age 11 did much worse at 13 and 16 than their peers with normal weight. Researchers estimated the magnitude of the effect to be about one letter grade, like getting a D instead of a C. The relationship was not nearly as clear for boys over the same time period. Such a difference could have a significant effect on whether an obese pre-teen girl would be able to go to college after graduating.

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http://www.nature.com/ijo/journal/vaop/naa/m/article/ijo201440a.html

Tanning Bed Use Associated with Other Bad Ideas

Despite clear associations with later melanomas, a sizeable minority of adolescents continue to get their beach tans in air-conditioned rooms, according to the 2009 and 2011 national Youth Risk Behavior Surveys, which used a representative sample of 15.5 million high school students each year. The study included more than 25,000 students who answered the indoor tanning questions.

Indoor tanners were more likely to be female, older, and Non-Hispanic White. Among the students 18-years-of-age or older, nearly 30% engaged in indoor tanning. Among both female and male students, indoor tanning was associated with increased binge drinking, unhealthy weight control practices, and having sexual intercourse. Among just the female students, indoor tanning was associated with having sexual intercourse with four or more persons and illegal drugs. Male indoor tanners were more likely to use steroids, smoke cigarettes daily, and attempt suicide.

Given these associations, questions about indoor tanning should be included among our risk assessments for teenagers.

archderm.jamanetwork.com/article.aspx?articleid=1833428
The Māori World – Words Matter

Hinemoa Elder, MBChB, PhD
AACAP Corresponding Member

“He tao rakau, e taea te karo. He tao kī e kore e taea.”

The thrust of a weapon can be parried, a lashing of the tongue cannot.

This proverb from Te Ao Māori (the Māori world) illustrates that Māori think about the meaning and impact of words totally the opposite of the English saying “sticks and stones may break my bones but words will never hurt me.”

These cultural differences are highlighted to emphasize the importance of cultural competency documents making visible the range of cultures we work with via the words that are chosen.

As psychiatrists, we are arguably most comfortable and familiar with considering ethnic cultural presentations rather than considering the culture of psychiatry itself. Kleinman suggested that “cultural analysis be applied to psychiatry’s own taxonomies and methods rather than just to indigenous illness beliefs” (Kleinman 1987). Reflecting on that statement in the context of a globally influential cultural practice parameter that does not include a practice principle about working with indigenous peoples has led to this paper about the worlds of indigeneity and psychiatry (Pumariega 2013).

First, it is important to acknowledge that having cultural competencies is a great step forward and vital in ensuring there are parameters to guide the complexity of working with different ethnic cultural groups. However, we can do better.

Child and adolescent psychiatrists do not set out to become agents of colonization. However, when an institution omits a dedicated principle about indigenous peoples, we risk just that. My contention here is to highlight those risks from an indigenous perspective and look for solutions.

The arguments for a principle dedicated to indigenous peoples are simple. We are first nations’ peoples and we are over-represented in populations with serious and complex mental health issues. These aspects are now presented in more detail with the hope that constructive feedback contributes to our collective understanding, thereby improving our practice.

Indigenous peoples are not defined by colonization; we were on the planet long before that. Equally, we are not an ‘emerging population’ (Pumariega 2013). Many of our intergenerational experiences have come to be understood in terms of what is called ‘historical trauma’ (Walters 2011). This trauma manifests in complex ways that can present similarly to psychiatric conditions and as a possible co-existing consideration. However, one of the problems with defining us solely by historical trauma is that it risks reinforcing that this is what solely defines us. This is not what indigenous communities are focused on. Balancing cognition of what has gone before and how that needs to be attended to with the current and future aspirations and successes are crucial for indigenous peoples’ wellbeing.

Indigenous values and knowledge systems uphold the connectivity of all things and have protocols for all aspects of collective community relations. Our communities continue to work towards healthy, self-determined cultural identity. It is, therefore, counterproductive for medical specialists to risk re-traumatising us with concepts that continue to define us by pathology and helplessness alone.

It would be the exception to find practices where a child and adolescent psychiatrist would never see indigenous peoples. Indigenous peoples are everywhere. We live in every community. As child and adolescent psychiatrists, we need to be culturally competent to work alongside indigenous peoples, recognizing complex evolving and context-specific issues of identity both within and across groups. This involves us developing relationships with indigenous communities. Indigenous peoples are over-represented in populations that we see. For example in Aotearoa, New Zealand, we know that Māori psychiatric patients are more likely to be treated compulsorily, to be secluded and in some instances given higher doses of antipsychotic medication, even when diagnosis and severity are accounted for (Elder & Tapsell 2013). Why does this happen? Is it because Māori presentations are complex? Is it because psychiatrists make different decisions about these patients because they perceive them to be more dangerous or more severely unwell? Could this situation be changed by improved cultural competency? We need research to investigate these questions. What practice-based evidence tells us is that Māori patients and their whānau (extended families) are more comfortable and tell a different story to Māori psychiatrists and to psychiatrists who use Māori cultural support workers, Te Reo Māori (Māori language), and ensure adherence to cultural protocols.

Our work with indigenous peoples must be done with particular care, mindful that we are at risk of being perceived as yet another mode of colonization. This issue has particular tension for indigenous child and adolescent psychiatrists because of how the community interprets the organization they represent.

Quality research plays such a vital role in building our cultural competency. In the past, there has been limited recognition of the reciprocity needed to ensure that research is culturally safe; and that indigenous communities have their own research agendas. There are now well-established relationships with
communities and researchers, including communities growing their own researchers. Indigenous methods are being increasingly recognized as essential in asking and answering research questions in culturally meaningful ways (Pihama, 2010).

Being counted is important. Many epidemiological studies do not record indigenous peoples or group them together without concern for their heterogeneity. Those of us who participate in decisions about research funding can insist on higher standards of ethnicity data collection so that research findings are more useful to indigenous peoples and to us.

We need to know about rights. The United Nations Declaration on the Rights of Indigenous Peoples Article 22 describes the rights of indigenous elders, women, youth, children, and persons with disabilities. Article 24 describes the right to health, and to use traditional medicines and health care. Article 25 describes the right to spiritual relationships with traditional land and resources. Indigenous scholars also emphasize recognition of the humanity and visibility of indigenous peoples as critical (Jackson 2007).

How well are we equipping medical students, residents, and registrars for the challenges and rewards of working with indigenous peoples? For our indigenous students who might feel drawn to child and adolescent psychiatry, how do we ensure that they are provided with appropriate indigenous cultural support?

Many of us are in senior leadership roles. How well do we serve the needs of indigenous peoples when we provide guidance and advocacy? To what extent does the governance structure of our institutions serve the needs of indigenous peoples and what do we do within our spheres of influence to strengthen this?

When we do not write about indigenous peoples, we perpetuate a marginalized position in society. If we make indigenous cultural competency less valued by not including it, we discriminate against this group. This is something none of us want to do.

My hope is that the new iteration of AACAP’s practice parameter for cultural competence includes a principle about indigenous peoples. Until then, indigenous families need us to ensure we think carefully about how we can practice in a culturally competent way when working to serve their needs.

Acknowledgement: Ngā mihi ki a Dr. Josh Sparrow and Moana Jackson for commenting on an earlier draft.

References


Dr. Elder, a Corresponding Member of AACAP, is of Te Aupouri, Ngāti Kuri, Te Rarawa, and Ngāpuhi descent. She is a Māori child and adolescent psychiatrist who has been a Fellow of the Royal College of Australia and New Zealand Psychiatry since 2006 who completed her PhD in 2012. She is currently the Health Research Council of NZ Eru Pomare postdoctoral fellow, and visiting associate professor of Indigenous Research at Te Whare Wānanga o Awanuiarangi. She is a deputy psychiatrist member of the NZ Mental Health Review Tribunal and a specialist medical consultant under the NZ Intellectual Disability Compulsory Care and Rehabilitation Act 2003.
As child and adolescent psychiatrists, we work with patients who put their feelings into actions. Often we are at a loss to find the words to describe the feelings the action conveys. Intentional self-harm in the form of cutting is one of those feeling-driven actions that we struggle to understand. Poetry provides a healthy vehicle for conveying the same feelings through metaphor and evocative language. When Karie Evans, a college student from Kensington, MD, where I live and work, shared her poetry blog with me, I was struck by her poem “Burst.” Here Karie captures with words what so many of our patients, unfortunately, capture through action.

Rachel Z. Ritvo, MD

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**Poetry**

**Burst**

*By Karie Evans*

I just wanted to explode
I wanted to cut my skin and bleed out
not so I could feel,
but so I could breathe, so I couldn’t think
so I could transform

I wanted to rise up
levitate above the earth
with a trail of my blood behind me

I don’t need it
I don’t need my heart to beat
I don’t need my soul to feel
Emotions are irrelevant here

I just want to float by the sun
warm and safe
no thoughts or worries

the absence of everything

Its hard to imagine but it’s like dreaming
you’re just existing
just moving
just
here

Individuals interested in submitting poetry should e-mail Poetry Coordinator Charles Joy, MD, at crjoy1@gmail.com.
CHILD TEMPERAMENT: NEW THINKING ABOUT THE BOUNDARY BETWEEN TRAITS AND ILLNESS

By Dr. David Rettew

W.W. Norton & Company, 2013
273 pages - $34.00 hardcover

Dr. David Rettew, a Harvard-trained child and adolescent psychiatrist who spent over a decade studying child temperament, has authored a well-written book about the increased interest into and continuing study of child temperament. He starts by discussing the history of temperament research particularly since Chess and Thomas’s seminal work. He thoroughly explores the neurobiological and genetic (nature) aspects that contribute to child temperament versus those that are societal and environmental (nurture). Then, Dr. Rettew delves into temperamental traits and their relationship to psychiatric illnesses. When does a child go from being considered “active” to “hyperactive”? At what point does temperamental shyness end and social anxiety disorder begin? When should sadness be considered depression? As the definitions of psychiatric disorders evolve, the boundaries between what are “just” manifestations of temperament and personality and those that are diagnosable conditions are increasingly debated in the professional and lay literatures. Risk factors that predispose a person to psychopathology and those that create the distinction between normal child temperament and impairment are also discussed.

The book’s second part focuses on practical applications, offering case vignettes in clinical settings. It discusses temperament in relation to different parenting styles and in educational settings. The book offers practical suggestions that clinicians, parents, and educators can use with children with different temperaments. Readers will appreciate its clear, straightforward graphs and tables summarizing each section’s main points and its lucid discussion of psychopharmacology, giving a reader a clear sense of the risks and benefits of prescribing psychotropic medications for childhood disorders, justifying why no easy answers are available for questions and concerns regarding using medications to modify temperament. Dr. Rettew succeeds in presenting essential information on the fascinating intersection of child temperament and psychiatric disorders. His thoughtful book could help both adult and child and adolescent psychiatrists, and other mental health providers, as well as other medical professionals, clinicians, parents, and educators, to better treat, understand, teach, and raise children with different temperaments.

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the Resident Editor, Harmony Raylen Abejuela, MD, at harmonyraylen@hotmail.com.
AACAP’s 61st Annual Meeting is just 6 months away and we’re excited! Whether you’re bringing the kids to go to the famous San Diego Zoo, laser-focused on our high-quality programs, or somewhere in between, we have scoped out the best that our destination has to offer and have highlighted some important information here! For complete details about the Annual Meeting, visit www.aacap.org/AnnualMeeting/2014.

San Diego Preview

To Do List

☐ June 16 – Make your hotel reservations at the Manchester Grand Hyatt or Marriott Marquis and Marina in San Diego

☐ June 16 – Review the Annual Meeting programs online

☐ August 4 – Members Only Registration opens for the Annual Meeting

☐ August 11 – Registration opens to nonmembers

☐ September 15 – Early Bird Registration Deadline

☐ September 26 – Last day AACAP room rate guaranteed at hotel

☐ October 20 – First day of AACAP’s 61st Annual Meeting

☐ October 25 – Last day of AACAP’s 61st Annual Meeting

☐ October 31 – Look for the General Evaluation Survey in your e-mail inbox. CME certificate available upon completion of survey.
Hotel

Manchester Grand Hyatt San Diego
1 Market Place
San Diego, CA 92101
Phone: 619.232.1234
www.manchestergrand.hyatt.com (for detailed hotel information)
www.aacap.org/AnnualMeeting/2014 (to reserve your hotel room)
Rate: $239 single/double per night

The Manchester Grand Hyatt San Diego is the headquarters hotel for the Annual Meeting and the majority of educational events will take place there. The best of San Diego is right outside their door! Take a walk along the boardwalk of beautiful San Diego Bay, pick up souvenirs in Seaport Village, or walk to the bustling Gaslamp Quarter for delicious food and drinks!

We will also have a small block of rooms at the San Diego Marriott Marquis & Marina, located directly next door to the Grand Hyatt hotel. To reserve a room at the Marriott, please call 619.234.1500. The room rate and hotel policies at the Marriott are the same as the Grand Hyatt.

Hotel Policies:
✦ When making your reservation, ask for the AACAP ANNUAL MEETING GROUP RATE to qualify for the reduced rate.
✦ This rate is available until September 26, 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 by September 15, 2014 and a cancellation number is obtained. All deposits shall be charged at the time the reservation is made.
✦ Check-in is at 4:00 p.m. and check-out is at 12:00 p.m.

Travel

San Diego is served by the San Diego International Airport (SAN). For more information about the airlines serving this airport, flight schedules, and ground transportation options, visit www.san.org. The airport is just a 10 minute drive from the Hyatt and Marriott and the average price for a taxi is $12-$15.
What to Do in San Diego!

✦ **Balboa Park** is a San Diego must-see, just minutes from downtown, and ranked as one of the Best Parks in the World. The Park is home to 15 major museums, several performing arts venues, lovely gardens and many other cultural and recreational attractions, including the San Diego Zoo. With a variety of cultural institutions laid out among its 1,200 beautiful and lushly planted acres, Balboa Park is the nation’s largest urban cultural park. If you are planning on visiting Balboa Park over the course of a few days, take advantage of the Passport to Balboa Park which includes one admission to 14 museums over 7 consecutive days. If you only have a day, visit the Visitors Center in Balboa Park for a Stay-for-the-Day pass that includes admission to 5 of the museums in one day. Visit [www.balboapark.org/parkpass](http://www.balboapark.org/parkpass) for details.

✦ With more than 70 craft breweries and several local wineries, San Diego takes their beverage producing seriously! Recently named the “Top Beer Town” in America, visitors can hop from breweries and pubs to restaurants and local bars, tasting the best suds the region has to offer. And with a mild Mediterranean-like climate, it is no surprise that wine grapes grow well in San Diego! San Diego wineries exist like hidden jewels along the coast, tucked into the fertile North Country farmland and amidst the rugged terrain of East County.

✦ Rising from the 16 square-blocks are Victorian-era buildings and modern skyscrapers that stand side by side, housing more than 100 of the city’s finest restaurants, pubs, nightclubs and retail shops, as well as offices and residential/work lofts. Downtown San Diego’s **Gaslamp Quarter** is a veritable playground, rich with cultural offerings that include theatres, art galleries, symphony halls, concert venues, and museums in addition to a variety of restaurants and night life.

✦ Founded in 1916, the **San Diego Zoo** has been an icon in San Diego for nearly 100 years. Located adjacent to downtown San Diego in Balboa Park, the Zoo is 100 acres in size and is home to more than 4,000 animals representing more than 800 species from around the world. Go to [www.sandiegozoo.org](http://www.sandiegozoo.org) for detailed information.

✦ Already been to the San Diego Zoo but still have a hankering to see more animals?! Then check out the San Diego Zoo Safari Park! Located just 30 miles north of downtown San Diego in the San Pasqual Valley, **The Safari Park** is an expansive wildlife sanctuary that is home to more than 2,600 animals representing more than 300 species. Over half of the Park’s 1,800 acres have been set aside as protected native species habitat. Visit [www.sdzsafaripark.org](http://www.sdzsafaripark.org) for more information.

✦ The **USS Midway Museum** is a real aircraft carrier and a once-in-a-lifetime memory for everyone! Create a lasting memory exploring the USS Midway, the longest-serving U.S. Navy aircraft carrier of the 20th century! Imagine living aboard a floating city at sea with 4,500 shipmates by exploring galleys, officer’s country, sleeping quarters, and the four acre flight deck. Admission includes a self-guided audio tour to over 60 locations from the engine room to control tower, narrated by Midway sailors who lived or worked in each area. Don’t forget to join us on the USS Midway for the Opening Reception on Wednesday night, included in the cost of registration! Visit [www.aacap.org/AnnualMeeting/2014](http://www.aacap.org/AnnualMeeting/2014) for general registration information as well as details about the Opening Reception!

For more information about other San Diego attractions, please visit: [www.sandiego.org](http://www.sandiego.org).
Don’t miss this opportunity to save money!

AACAP members who refer a new Annual Meeting exhibitor receive a $100 discount on their 61st Annual Meeting registration.

All referrals must be first time AACAP exhibitors and must purchase a booth for AACAP’s 61st Annual Meeting.

Exhibitors can connect with more than 4,000 child and adolescent psychiatrists and other medical professionals or advertise in several Annual Meeting publications. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and many more.

To review an Exhibitor Prospectus with more details on these opportunities, as well as forms to sign-up, please visit www.aacap.org/exhibits/2014.

Questions? exhibits@aacap.org or 202.966.7300 ext: 155.

Show your support for AACAP and SAVE TODAY!

New Research Poster Call for Papers

AACAP’s 61st Annual Meeting takes place October 20-25, 2014, in San Diego, California. Abstract proposals are prerequisites for acceptance of all presentations given at the meeting. Topics may include any aspect of child and adolescent psychiatry including clinical treatment, research, training, development, service delivery, or administration.

Verbal presentation submissions were due February 18, 2014, and are no longer being accepted. Abstract proposals for (late) New Research Posters must be received by Monday, June 16, 2014.

All Call for Papers applications must be submitted online at www.aacap.org. Step-by-step instructions for how to use the online submission system are available at www.aacap.org/AnnualMeeting/2014. If you have questions regarding this process, please call 202.966.7300, ext. 2006 or email meetings@aacap.org.
Medical Students and Residents: Attend the AACAP Annual Meeting and Get Involved!

The American Academy of Child and Adolescent Psychiatry (AACAP) offers numerous award programs and opportunities for medical students and residents to get involved and attend AACAP meetings. Some of the current opportunities are listed below.

### Medical Students

#### Life Members Mentorship Grants for Medical Students – Award Deadline: July 11, 2014

The Life Members Mentorship Grants for Medical Students provides medical students with the opportunity to attend the 61st AACAP Annual Meeting in San Diego, CA, October 20-25, 2014. Partnered with the Mentorship Program, this program provides participants with networking opportunities, exposure to varying specialties, and interaction with Life Members. More information regarding this program can be found on the AACAP website at [http://www.aacap.org/AACAP/Awards/Home.aspx](http://www.aacap.org/AACAP/Awards/Home.aspx) or by contacting the Training and Education Department at training@aacap.org.

### Residents

#### Educational Outreach Program – Award Deadline: July 11, 2014

The Educational Outreach Program (EOP) for both child and adolescent psychiatry residents and general psychiatry residents provides funding support for residents to attend the AACAP 61st Annual Meeting, October 20-25, 2014 in San Diego, CA. The Annual Meeting provides residents with exposure to the field of child and adolescent psychiatry, including research and networking opportunities. More information regarding the EOP program can be found on the AACAP website at [http://www.aacap.org/AACAP/Awards/Home.aspx](http://www.aacap.org/AACAP/Awards/Home.aspx) or by contacting the Training and Education Department at training@aacap.org.

#### Systems of Care Special Program Clinical Projects – Award Deadline: July 11, 2014

Child and adolescent psychiatry residents are encouraged to apply for the 2014 Systems of Care Special Program Clinical Projects, which were created to give residents and fellows the opportunity to learn about treating children with mental disorders within the community-based systems of care. The Clinical Projects includes $1,000 plus shared funding from a training program or regional organization to be part of a learning community focused on system-based practice and attend the Systems of Care Special Program on Monday, October 20, 2014 at AACAP’s 61st Annual Meeting in San Diego, CA. Residents may apply to both the Special Program Clinical Projects and the Educational Outreach Program (EOP); however, individuals cannot receive both awards at the same time. For more information, please visit [http://www.aacap.org/AACAP/Awards/Residency_and_ECP_Awards/2014_Systems_of_Care_Special_Program_Clinical_Projects.aspx](http://www.aacap.org/AACAP/Awards/Residency_and_ECP_Awards/2014_Systems_of_Care_Special_Program_Clinical_Projects.aspx) or contact the Clinical Practice Department at clinical@aacap.org.

### Serving on Committees

Resident members can get involved with national initiatives by serving on one of AACAP’s committees. Serving on a committee is a great way to network with senior members and experience how AACAP members work together to address issues of national concern. AACAP is now accepting applications for residents to serve on committees. Below is a list of committees with open resident member positions. To apply, send an email with a statement of interest for your top three committee choices and a copy of your CV to [executive@aacap.org](mailto:executive@aacap.org) by July 11, 2014. (Note: Residents are only permitted to serve on one committee.)

**Open Committees:**
Membership Corner

Congratulations to Graduating Residents and Medical Students

When planning your graduation ceremony and after-party, be sure to include AACAP! Please provide us with your updated contact and address information so you can put your AACAP member benefits to use for the next phase of your professional career.

Update your information online at www.aacap.org.

Time is running out! Renew for 2014!

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Upcoming Events

October 20-25, 2014
AACAP 61st Annual Meeting
Manchester Grand Hyatt
San Diego, California
www.aacap.org

December 25-26, 2014
Bangladesh Association for Child & Adolescent Mental Health (BACAMH)
7th Annual Conference and General Meeting
Child and Adolescent Psychiatric Disorder: Connectivity
Dhaka, Bangladesh
www.bacamh.org
bacamh@gmail.com

October 26-November 1, 2015
AACAP 62nd Annual Meeting
Henry B. Gonzalez Convention Center and Grand Hyatt
San Antonio, Texas
www.aacap.org

Help Determine the Future of AACAP’s Educational Offerings!

AACAP is considering major changes to our education program management, especially with our online CME programs and ability to track your CME and Maintenance of Certification requirements. And, we need your help!

AACAP is conducting an educational needs assessment and asks for your input on how to best meet your educational needs. Please look for an email in July for more information. Thanks in advance for your input!
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AACAP Welcomes Carmen J. Head as the New Director of Research, Training & Education!

Ms. Carmen J. Head is the new Director of Research, Training, and Education (RTE). She has been committed to helping health and education professionals addressing child, adolescent, and school health issues for eighteen years. She has worked on a number of federally and privately funded programs impacting chronic disease risks, HIV/AIDS prevention, health equity, and supporting youth with physical and learning challenges. Ms. Head has worked at a number of national organizations committed to both youth and health including the National School Boards Association, the Society for Public Health Education, the United Negro College Fund, and the Spina Bifida Association.

In Carmen’s role as Director of RTE at AACAP, she oversees the implementation and growth of AACAP’s research, training, and education portfolio that includes a National Institutes of Health funded K12 grant for early career psychiatrists specializing in child and adolescent drug use and several fellowship and award programs.

Carmen has a special interest in the well being of school age children. She also has interest in addressing social justice issues that impact the mental health of minorities and women. She has served as a keynote and plenary speaker for Smithsonian Institution Lecture Services on public health ethics and has served as distinguished faculty for Tuskegee University’s Summer Institute Bioethics Course. Carmen received a Bachelor of Science Degree in Community Health Education at Howard University and a Master of Public Health Degree from the George Washington University School of Public Health and Health Services. She resides in Northern Virginia. In her spare time, Carmen enjoys community service, volunteering, and travelling.

Share Your Photo Talents With AACAP News

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.
Thank You for Supporting AACAP!

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.

Gifts Received January 1, 2014 to February 28, 2014
We apologize that the donor list for the previous issue of AACAP News (Volume 45, Issue 2) was mislabeled. That list should have read “Gifts Received November 1, 2013 to December 31, 2013.”

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General Contribution
Randie Schacter, DO

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General Contribution
Michael S. Greenbaum, MD

FOR YOUR INFORMATION
Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org or 202.966.7300 ext. 130.
Visit AACAP.org and direct your donation to any of the causes and funds listed and enjoy the freedom of targeting your gift exactly where you want it. To learn more about AACAP’s impact funds: Please contact the Office of Development at 202.966.7300 ext. 140 or development@aacap.org.
Cook Children’s is conducting a national search for a BC/BE Child Psychiatrist to join our team of seven Child and Adolescent Psychiatrists. We have a well-established, outpatient and inpatient pediatric program, which provides a full range of early intervention, rehabilitation, medical, and mental health services for children. Our interdisciplinary team is comprised of child and adolescent psychiatrists, child psychologists, developmental pediatricians, and speech, physical, and occupational therapists. This is a unique position which offers a variety of clinical activities, including evaluation, ongoing treatment and follow-up, consultation, and education in a stimulating atmosphere of close collaboration with other disciplines in the care of the child.

Cook Children’s Medical Center is a non-academic, 457-bed tertiary care pediatric hospital. Cook Children’s physicians enjoy a collegial relationship with more than 300 specialty and primary care associates. Cook Children’s Physician Network is the employed physician component of Cook Children’s Health Care System, a pediatric system of care where physician leadership is fostered and physicians actively participate in the strategic goals as well as the mission of the organization.

Knowing that every child’s life is sacred, it is the promise of Cook Children’s to improve the health of every child in our region through the prevention and treatment of illness, disease and injury.

Physician candidates must be trained and board eligible/board certified in Child and Adolescent Psychiatry and able to secure an unrestricted Texas Medical License.

Submit Applications To:
Debbie Brimer, Physician Recruiter
Phone: 1-877-532-6657
E-mail: debbie.brimer@cookchildrens.org
Website Address: www.cookchildrens.org

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Set up a personal fundraising page, and ask friends and family to make a donation to AACAP in lieu of presents.

To learn more, e-mail: Development@AACAP.org

The setup process is simple and easy.
Call Stephen at 202.966.7300 ext. 140. He will be happy to help you get started!
CHILD PSYCHIATRIST – FULL-TIME

Spectrum Health
Grand Rapids, MI

The Pediatric Neuroscience team at the Spectrum Health Medical Group affiliated with Helen DeVos Children’s Hospital seeks a Child Psychiatrist. The Pediatric Neurosciences team includes a pediatric behavioral medicine physician and three psychologists. The focus of pediatric psychiatry and behavioral services is on serving the needs of the tertiary and quaternary patient population, and on those who require acute care in the hospital setting. There is a current need for expanded services in pediatric psychiatric and behavioral care with a focus on consultative inpatient psychiatry and psychology, outpatient psychiatric and psychologic care for chronic subspecialty patients, acute evaluation of specialized patient populations presenting for complex care and behavioral medicine support of specialized patient populations. The primary role of the new Child Psychiatrist will be inpatient consultation services, however he/she will also provide outpatient clinic visits to medically complex patients several times a week. Primary academic partner of Michigan State University College of Human Medicine offering academic appointments for qualified candidates. Professional environment with support for clinical research exists. Helen DeVos Children’s Hospital is a 236-bed regional children’s quaternary referral center. Applicant should be board eligible or board certified in Child Psychiatry.

Position location is Grand Rapids, MI, the second largest city in the state with a metropolitan population of 750,000. Grand Rapids is located just 40 minutes from beautiful Lake Michigan. Top-rated public and private schools; seven colleges; variety of recreational activities, cultural opportunities and professional sports. Grand Rapids offers a vibrant downtown and family-oriented neighborhoods. Visit hellowestmichigan.com; experiencegr.com and helendevoschildrens.org.

Submit Applications To:
Diana Dieckman
648 Monroe Avenue, NW
Grand Rapids, MI 49503
Phone: 800-788-8410
Fax: 616-486-6655
E-mail: diana.dieckman@spectrumhealth.org
Website Address: www.helendevoschildrens.org

CHILD PSYCHIATRIST – FULL-TIME

Sendan Center
Bellingham, WA

If you envision...
... a stable, prosperous, and deeply fulfilling career
... a relaxed and supportive work culture
... a healthy work / life balance
... colleagues who love this work
... living in an amazing place (one of Sunset Magazine’s 2014 “Best Places”)
... opportunities for mentorship from mid-career providers

If you believe your families deserve...
... the highest quality of mental and behavioral healthcare
... evidence-based treatment
... individualized diagnosis and treatment
... multiple specialists under one roof

... Then we welcome your employment application. We are seeking another child psychiatrist (bc/be) AND child clinical psychologist (license-eligible in Washington state) to join us.

Please send letters of interest and curriculum vitae to: smookherjee@sendancenter.com

Successful candidates will be outstanding clinicians with excellent interpersonal and communication skills.

Submit Applications To:
Sati Mookherjee
Sendan Center
1616 Cornwall Avenue, Suite 103
Bellingham, WA 98225
Phone: 360-305-3275
E-mail: smookherjee@sendancenter.com
Website Address: sendancenter.com
MEDICAL DIRECTOR – FULL-TIME
UC San Diego • San Diego, CA

The Department of Psychiatry [http://psychiatry.ucsd.edu/] within the School of Medicine at UC San Diego is seeking an experienced clinician educator who will provide leadership and direction as the Medical Director at the Child and Adolescent Psychiatry Services Inpatient Unit (CAPS) at Rady Children’s Hospital San Diego (RCHSD). The Medical Director of the CAPS unit reports to the UCSD Department of Psychiatry Chair, the Division Head of Child and Adolescent Psychiatry, and the Clinical Director of Child and Adolescent Psychiatry. Candidates for Medical Director should have experience in inpatient evaluation, diagnosis, and treatment of mental health problems of children and youth as well as administrative experience including supervision of trainees, program development, and collaboration with other professionals on the unit, medical departments within RCHSD and outside institutions.

Candidate must be board eligible in Child and Adolescent Psychiatry and must have a current California medical license. Candidate is expected to have a track record in clinical teaching, and evidence of clinical scholarship is desired. Candidate will be expected to perform required services as outlined by medical staff bylaws, accreditation standards, standards of business conduct and professional practice standards for both UCSD and RCHSD. The specific academic appointment and rank will be determined based on the qualifications of the candidate but the Department will consider applicants ranging from the Assistant Professor level through Full Professor.

PSYCHIATRIST – PART-TIME
Dynamic Interventions
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8-10 hours per week, diagnosis, treatment and prevention of mental health and SUD’s within a small C & A outpatient setting.

Looking for Psychiatrist or Psychiatrist supported by PA or other mid-level professional.

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Submit Applications To:
Tammy Smith
524 South Houston Lake Road, Ste G100, Warner Robins, GA
Phone: 941-845-4036
E-mail: tammy@dynamicinterventions.org
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