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Photo: U.S. Representative Brad Ashford (D-NE)
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AACAP Member Registration Opens Online: 
August 1, 2016
General Registration Opens Online: 
August 8, 2016
Early Bird Registration Deadline: 
September 15, 2016

AACAP's
63rd ANNUAL MEETING
OCTOBER 24–29, 2016 I NEW YORK, NY

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Cover Photo: U.S. Representative Brad Ashford (D-NE) and a very ambitious, energetic, and enthusiastic AACAP Legislative Conference family member. Congressman Ashford was more than accommodating in letting our young “advocate” sit in his chair. Mr. Ashford sat on his desk the entire meeting!
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

FUNCTION AND ROLES OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
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.

MISSION OF AACAP NEWS
The mission of AACAP News includes:
1. Communication among AACAP members, components, and leadership.
2. Education regarding child and adolescent psychiatry.
3. Recording the history of AACAP.
4. Artistic and creative expression of AACAP members.
5. Provide information regarding upcoming AACAP events.
6. Provide a recruitment tool.
Making the Rounds and Making a Difference

Regional organizations typically wax and wane in terms of energy, initiative for projects, and member involvement, and I was told this was the beginning of a period of rejuvenation for their organization. If so, they are well on their way. The attendance was excellent, enthusiasm was high, and the camaraderie seemed to be enjoyed by all. I led a discussion on the pros and cons of electronic medical records for child and adolescent psychiatrists. As is usually the case, the topic provoked a lively give-and-take that only partially fell along generational lines. I also got the chance to talk about my favorite topic and the focus of my Presidential Initiative – pediatric integrated care.

I am an unabashed proponent of integrated care, with my enthusiasm admittedly exceeding the existing evidence supporting its effectiveness. However, unless we find a way to dramatically enlarge the number of professionals who are interested in and competent to deal with some — if not all — pediatric mental health problems, we will continue to be a part of a system in which 60 to 80 percent of children with psychiatric disorders get no treatment at all. Integrated care – at least conceptually – improves access by involving primary care providers in children’s mental health assessment and treatment. When I speak to groups of child and adolescent psychiatrists on the topic, the responses to my enthusiasm are typically mixed, with some skepticism balancing positive views. Such was the case in Wisconsin, and it made for lively interactions.

In May, I had the pleasure of speaking to members of the New York Council on Child and Adolescent Psychiatry (NYCCAP) about my Presidential Initiative at its End of the Year event at the invitation of Scott Palyo, MD. With most of its child and adolescent psychiatrists in the New York City area, NYCCAP is the largest and most active of AACAP’s regional organizations. The highlight of this event was Victor Fornari, MD, receiving the Wilfred C. Hulse Award for his outstanding contributions to the field of child and

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adolescent psychiatry. Heartfelt testimonials from colleagues attesting to Victor’s commitment and dedication to patients and their families, and his effective mentoring, were only outshined by Victor’s moving acceptance speech.

I also spoke at the annual meeting of the Regional Council of Child and Adolescent Psychiatry of Eastern Pennsylvania and Southern New Jersey in Philadelphia in early June. This event was the 22nd Annual Herman Staples Memorial Lecture and Dinner, at which it has become a tradition to have the AACAP president speak. Another part of this great tradition is to recognize the child and adolescent psychiatry graduates from the training programs in the region, many of whom were in attendance. I enjoyed this special chance to welcome our newest colleagues into our community.

The response to my presentation on integrated care was especially animated in this crowd, as many in the regional council are themselves involved in integrated care projects. Others underlined the challenges—financial, educational, and clinical—that need to be faced and resolved if integrated care is ever to make a large-scale difference in children’s mental health.

It is eye opening to see the differences that exist around the country in mental health resources, systems of pediatric mental health care delivery, and the activities and philosophies of regional organizations. The one thing that is consistent wherever I have been is the evident passion and commitment to our profession. The corollary to that is the energy with which we embrace and defend our opinions. We are a lively, at times opinionated, but always respectful group with great ideas about how to improve children’s mental health.

I am convinced that AACAP, our professional home, reflects the diversity of opinion, practicality, and commitment of its members, and I am finding it very gratifying to be AACAP President.
Implementing Integrated Care Models in Clinical Programs

A s healthcare systems across the nation transition to a population health model, measuring and improving outcomes becomes increasingly important. Unmet psychiatric needs present a significant barrier to improving physical health and impact outcomes negatively (Asamow 2015). A proactive and systematic approach to mental healthcare is key to successfully improving health outcomes within Accountable Care Organizations (ACOs). Several models with varying levels of integrated mental healthcare have been proposed to achieve this. A significant portion of the evidence for these models comes from adult care settings, though there is reason to believe that they would be effective within pediatrics (Asamow 2015).

Irrespective of the model used, the building blocks for integrating care into pediatrics primary care include: 1) use of screening to systematically assess mental health needs, 2) appropriate interventions being put into place based on the screening, 3) care coordination, 4) access to child and adolescent psychiatry (CAP) consultation in various forms when appropriate, 5) access to CAP specialty services when indicated, and 6) ability to assess outcomes of the services provided (AACAP 2012). At our organization, the formation of ‘UCSF Health’ signaled the transition to a patient-centered, effective, and affordable care delivery system for providing accountable care. Programs that integrate mental health into primary care are underway, including in pediatrics.

Pediatric ACOs employ medical homes and health care teams that utilize stepped care and 4-Quadrant clinical integration as common concepts to structure services provision (Collins et al. 2010). The 4-Quadrant model of care takes into account the physical and mental health needs of the population served. We have adapted this model in designing the services provided within pediatric settings as illustrated in Figure 1.

Embedding child and adolescent psychiatry in primary care clinics (pediatrics and adolescent medicine) has been instrumental in expanding mental health services for patients that fall within Quadrants I/III. Patients are seen in the same physical space and in close coordination with pediatric providers (co-located and coordinated care).

Patients too complex to be managed within primary care and/or those with specific chronic medical illnesses lie in Quadrants II/III. The Pediatrics-Psychiatry Assessment and Consultation Team (PPACT) is modelled on ‘medically provided behavioral health care’ and leverages increased coordination of services. PPACT is a multi-disciplinary team that includes developmental behavioral pediatricians, child and adolescent psychiatrists, nurse practitioners, as well as trainees from diverse programs. PPACT clinics offer multidisciplinary consultative assessments of children and adolescent in Quadrants II/III. Specialized clinics within PPACT are being setup to see patients referred from subspecialty areas such as Cystic Fibrosis, Cochlear Implants, etc.

For patients who fall within Quadrant IV, improved coordination between intensive mental and physical health services can address some of their needs. However, barriers to accessing care remain. There might be a role for special programs to address the needs of these patients; e.g., seizure disorder, oncology, etc. Children with epilepsy are known to have three to nine times the burden of mental illness when compared to the general population, especially for depression and anxiety disorders, including suicide (Dunn and Austin 2004). In partnership with the Pediatric Epilepsy clinic, we are pioneering one such program, CCoPE. Utilizing the 4-Quadrant model, we proposed a stepped care program utilizing the building blocks mentioned earlier:

Figure 1: 4-Quadrant model and its application to service structures at UCSF

<table>
<thead>
<tr>
<th>Quadrant II:</th>
<th>Quadrant IV:</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Behavioral Health</td>
<td>High Behavioral Health</td>
</tr>
<tr>
<td>Low Physical Health</td>
<td>High Physical Health</td>
</tr>
<tr>
<td>PPACT* (General Pediatrics)</td>
<td>CCoPE*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant I:</th>
<th>Quadrant III:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Behavioral Health</td>
<td>Low Behavioral Health</td>
</tr>
<tr>
<td>Low Physical Health</td>
<td>Low Physical Health</td>
</tr>
<tr>
<td>Primary Care/Adolescent Medicine</td>
<td>Primary Care/Adolescent Medicine</td>
</tr>
<tr>
<td>PPACT* (Subspecialty Pediatrics)</td>
<td>PPACT* (Subspecialty Pediatrics)</td>
</tr>
</tbody>
</table>

*PPACT: Pediatrics/Psychiatry Assessment and Consultation Team

CCoPE: Care Collaboration in Pediatric Epilepsy

continued on page 160
Implementing Integrated Care Models continued from page 159

1) Use of systematic screening:
   - Quality of Life Childhood Epilepsy (QOLCE) and Behavioral Assessment System for Children-3\textsuperscript{rd} edition (BASC-3) administered yearly
   - Specific illness category scales as indicated (e.g.: CYBOCS, PHQ-9, GAD-7, SCARED, Vanderbilt)

2) Appropriate interventions being put into place:
   - Predetermined scale score cutoffs use to assign to Quadrants I-IV
   - Reassessment of Quadrant assignments conducted yearly or as needed
   - Care coordination in monthly team meetings

3) Access to CAP consultation: See Figure 2

4) Access to CAP specialty services: See Figure 2

5) Ability to assess outcomes: Pilot Data to be collected

The collaborative team includes a child and adolescent psychiatrist, nurse practitioner, social workers, neuropsychologists, neuropsychologist, and clinic coordinator. The resources required to successfully implement such a program can be significant. These patients are often seen within systems with several pre-existing resources and the ability to reorganize or optimize them can impact their feasibility.

In parallel with integrating services within outpatient settings, there has been an increasing interest in outcomes driven mental health care in inpatient hospital settings. There is evidence for clinical pathways (CPs) that use available research to guide practice patterns within local systems, improving outcomes in those settings (Kinsman et al. 2010). CPs are already being used for various physical health conditions including asthma, diabetes, etc. (Campbel et al. 1998). While this practice is not common in CAP, there may be a role for developing CPs for mental health care in the inpatient hospital setting. Several members (34) of the Physically Ill Child Committee have volunteered to participate in the formation of the ‘Pathways in Clinical Care (PaCC)’ workgroup. Our mission is to create and disseminate consensus based pathways in clinical care for commonly encountered psychiatric/behavioral challenges in a pediatric hospital setting to guide care within a multidisciplinary context. We have outlined the structure and process of developing CPs for topics that include self-harm, psychosomatic illness, and delirium. Work is underway to gather available evidence to inform these CPs. We aim to define outcome measures to gauge their effectiveness. Collaboration across sites, as in the PaCC workgroup, can facilitate designing and testing models for effective systems of care.

References


Dr. Brahmbhatt is an Assistant Clinical Professor at the UCSF School of Medicine in the Department of Psychiatry. Dr. Brahmbhatt is the Deputy Director for Child and Adolescent Psychiatry Consultation-Liaison Service (PPACT). She completed her general psychiatry residency from Albert Einstein Medical Center in Philadelphia and her child psychiatry training from Massachusetts General Hospital in Boston. She has previously served as the director of pediatric consultation-liaison psychiatry at U.C Davis.
Atypical or Second-Generation Antipsychotics

A
typical or second-generation antipsychotics (SGAs) are effective at reducing irritability and aggression, whether those symptoms occur during an episode of mania or other mood disorders, psychosis, or as part of autism spectrum disorder or attention-deficit/hyperactivity disorder. Unfortunately, the medications are associated with significant weight gain and, with it, increased cardiometabolic risk as measured by alterations in glucose, triglycerides and cholesterol.

If we assume that the child’s condition is not better addressed by a lower risk intervention, and that the SGAs need to be used, the question arises, how do you inform parents/children about the associated weight gain plus metabolic risk, and is there anything that can done to prevent it?

I have asked two colleagues who often speak at the AACAP Psychopharmacology Institute to weigh in (forgive the pun) on the subject. Harold E. Carlson, MD, professor of Medicine and Head of Endocrinology at Stony Brook University School of Medicine and Christoph U. Correll, MD, professor of Psychiatry and Molecular Medicine at Hofstra Northwell School of Medicine and Medical Director, Recognition and Prevention (RAP) Program, Department of Psychiatry, the Zucker Hillside Hospital.

They provided the following information:

Drs. H. Carlson and Correll: Second-generation antipsychotics often cause rapid weight gain in children – not everyone, but more than half. The average weight gain on olanzapine can be up to two pounds per week, while it is about one pound or so per week for risperidone and quetiapine, and only a little less per week for aripiprazole. Moreover, weight gain occurs both early and is continuous until it levels off, often many months and many pounds later.

In order to gain this amount of weight, the olanzapine-treated patient has to be eating about an extra 1,000 calories per day, the risperidone-treated patient about 500 calories more per day and the aripiprazole-treated patient about 250 extra calories per day, at least for the first month or two.

We all know that we should try to avoid the drugs that are associated with the greatest weight gain (olanzapine and clozapine) and use the lowest effective dose of whichever drug we choose. Beyond that, we recommend healthy diet and exercise to prevent and treat weight gain associated with SGAs:

1) Enlist the support of the entire family, not just the child, in promoting good dietary choices and eating habits in ALL family members; e.g. structured meal times (not just grazing in the refrigerator when anyone wants), family participation in meal planning and decision about what kind of food to have around (it is hard to tell a child not to eat cookies for a snack when the cupboard is full of cookies and everyone else is eating them). Always, fruits and vegetables are better snack choices than sweets. For example, a snack of one apple or one banana adds 50-120 kcal (depending on the size) to the daily calorie intake, whereas three cookies would likely add 160 to 300 kcal (depending on the cookie).

Other suggestions:

■ Drink water instead of soft drinks
■ Eat breakfast every day
■ Serve small portions
■ Eat foods with low glycemic index (www.glycemicindex.com) and eat slowly
■ Reduce/avoid saturated fat intake
■ Eat at least 25-30 g of soluble fiber daily
■ Avoid snacking when full
■ Limit fast foods to less than 1 meal per week

There are some useful educational websites that families can access to help them with meal planning:

www.youtube.com/watch?v=cVPmEao0NTU

The University of Cincinnati has information in English med.uc.edu/docs/default-source/default-document-library/healthy-eating-and-physical-activity-plan.pdf?sfvrsn=0 and Spanish (med.uc.edu/docs/default-source/default-document-library/healthy-eating-and-physical-activity-plan-(spanish).pdf?sfvrsn=0); or www.eatright.org/resources/for-kids/

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Some recent studies, mostly in adults, have suggested that snacking after dinner is particularly likely to lead to weight gain, so evening snacks should be minimized or eliminated.

2) Both child and adult studies have clearly shown that sleep deprivation plays an important role in weight gain, since not getting enough sleep both stimulates appetite and alters metabolism, therefore, assuring that the child gets a good night’s sleep may help minimize weight gain on the antipsychotic.

3) Strongly encourage 30-60 minutes of exercise per day (maybe starting off with a lower goal in youth not used to exercising). Encourage parents to exercise together with the child, like going for a brisk walk, “running” errands or playing sports together. Increasing activity should be accompanied by limiting screen time to <2 hours/day (including television, computer, texting, video games).

Dr. G. Carlson: To emphasize the importance of limited snacking, some years ago when we kept children (ages 5-12) longer on our inpatient unit, a couple of our residents and I looked at weight changes for those who had been in hospital and treated with SGAs (2/3 had been prescribed risperidone) longer than five weeks (n=70). Twenty-nine (41%) lost weight, 16 (22.9%) gained >7% of their body weight. The remaining were in neither category. The difference? Children could order whatever they wanted for meals but few and only healthy snacks were served in hospital. Those who gained more weight had more pass-time home where they ate a good deal more.

Next question to Drs. Carlson and Correll: What do you do if the above strategies are ineffective or unfeasible?

Drs. Carlson and Correll: We suggest administration of metformin, which is the best studied augmentation option in kids (it has FDA indication for type 2 diabetes in children down to age 10). Our advice is, if the child is already significantly overweight and is to be started on an SGA, metformin should be started either at the same time or at the first clinical visit after starting the SGA when relevant early weight gain is observed. If the child’s BMI is normal, one can wait and see if weight gain becomes an issue (children with the most weight gain note increased appetite and food consumption immediately with concomitant weight gain).

Metformin is generally started at a dose of 500 mg/day (one tablet) of the sustained release preparation, known as metformin ER. There may be gastrointestinal side effects (nausea, cramping, diarrhea) for the first few days, but these symptoms usually resolve spontaneously and are minimized when administering the metformin together with a meal. After about one to two weeks, the metformin dose can be gradually increased in 500 mg increments every one-to-two weeks until the total daily dose is 1,500 mg for those weighing <50 kg and 2,000 mg/day in those weighing ≥50 kg. With each dose increase, there may be a transient return of gastrointestinal side effects. Remember that metformin should not be given to patients with significant renal impairment, since there is a risk of lactic acidosis when metformin is given to such patients. Therefore, always check creatinine and make sure it is <1.3 mg/dL before starting metformin.

Dr. Correll added: In case that metformin is either not tolerated or only insufficiently reduces antipsychotic related weight gain, consider adding topiramate. Start at 25 milligrams and increase the dose in weekly intervals by 25 milligrams using bid dosing up to 100 milligrams twice daily. However, make sure to monitor the potential for cognitive impairment.

Dr. G Carlson: There has been lots of publicity about risperidone causing boys to develop breasts (gynecomastia). The impression one gets is that with the first dose of risperidone or its metabolite, paliperidone, a boy will wake up as well endowed as Dolly Parton. In addition, there is considerable confusion about hyperprolactinemia and gynecomastia. Could you clarify that for us?

Drs. H. Carlson and Correll: True gynecomastia is defined as male breast enlargement due to the proliferation of glandular breast tissue. Male breasts may also enlarge due to increases in adipose tissue, not glandular tissue. This is called pseudogynecomastia or lipomastia, which can be distinguished from true gynecomastia by palpating the breast. Glandular breast tissue (true gynecomastia) is characterized by a palpable, firm plate or button of subareolar tissue, while the breast in pseudogynecomastia feels the same as subcutaneous adipose tissue elsewhere on the body. By virtue of their ability to cause generalized weight gain, SGAs can result in pseudogynecomastia, while their ability to raise serum prolactin can result in true gynecomastia. YOU CANNOT TELL THE DIFFERENCE JUST BY LOOKING! A knowledgeable clinician needs to palpate the tissue.

Data from clinical trials suggest that only about five percent of boys taking risperidone will develop true drug-induced gynecomastia. Those data do not clarify how the diagnosis was made or the pubertal status of the subjects. Importantly, the development of true gynecomastia is gradual. It starts with breast tenderness, so that should be reported as soon as it occurs, as should any enlargement or nipple discharge (“galactorrhea”); drug-induced gynecomastia is more likely to be reversible if it has been present for only a few months.

While we do not really understand the mechanism for developing drug-induced gynecomastia, we speculate that risperidone can cause gynecomastia via hyperprolactinemia, which occurs because it blocks the D2 dopamine receptor in the pituitary gland. Hyperprolactinemia may then suppress gonadotropins (LH, FSH), which causes testosterone suppression in some patients (and drawing testosterone levels is unlikely to help because there is much inter-individual variability in these endocrine effects), thus disturbing the balance of testosterone and estrogen that protects men from breast development. This
mechanism, however, does not operate in prepubertal boys who have low levels of gonadotropins and testosterone. True gynecomastia in this age group is therefore very rare.

Nearly all boys receiving risperidone will have an elevated serum prolactin level, at least in the first few months of drug administration; with the passage of time (months), the serum prolactin levels tend to gradually diminish, and may in some patients eventually return to normal, even though the drug is continued. Since some level of hyperprolactinemia is nearly universal in boys taking risperidone, finding an elevated serum prolactin in such a patient is not helpful in predicting the occurrence of gynecomastia. Ninety-five percent of boys with hyperprolactinemia due to risperidone will NOT develop drug-induced gynecomastia. Bottom line: lab tests do not predict gynecomastia, so it is necessary to frequently ask the patient about breast symptoms.

In patients who do develop true gynecomastia while taking risperidone, lowering the serum prolactin level to normal should help. This can be accomplished by switching from risperidone to a more prolactin-neutral drug, such as quetiapine, lurasidone or aripiprazole, or by adding aripiprazole (2-10 mg) on top of the risperidone regimen; aripiprazole is a partial dopamine receptor agonist, and counteracts the prolactin-raising effect of risperidone, even when risperidone is continued.

Most importantly, a very common cause of true gynecomastia is pubertal gynecomastia, which occurs in 60-70 percent of normal teenage boys (usually around 13-14 years of age), and has nothing to do with drugs or prolactin. It lasts one to two years and then most often resolves on its own; however, it may not resolve in all cases, and about 10-20 percent of boys without any antipsychotic treatment history may have persistent pubertal gynecomastia at age 20 years. Additionally, teenage boys may abuse other substances, which can cause true gynecomastia, including marijuana and anabolic steroids, and the physician should inquire about this possibility. Much less commonly, true gynecomastia can be due to other medical problems, such as testicular or adrenal tumors, hypogonadism, hyperthyroidism, hemodialysis treatment, or liver disease. It is really difficult to distinguish medication-associated gynecomastia from pubertal gynecomastia. To differentiate medication associated gynecomastia from pubertal or other causes, make sure to establish a timeline of the breast tissue changes related to risperidone treatment. If in doubt, and if you and the patient/family want to continue risperidone or paliperidone, consider referring the patient to a pediatrician or pediatric endocrinologist, providing all necessary information.

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DID YOU KNOW?
About 1 in every 38 people living in the United States resides in New York City.
60th Congress of AEPNYA in San Sebastian: A Shared Initiative with AACAP!

AEPNYA’s 60th Congress, June 1-4, 2016 in Donostia / San Sebastian, Spain, was a shared initiative with AACAP. Leading the meeting were AACAP members Joaquin Fuentes, MD, President, and Bennett L. Leventhal, MD, Vice President. From the world-class programming, picturesque views, and gastronomic adventures, the meeting was a great success!

637 PEOPLE REGISTERED FOR THE CONGRESS. They are classified as follows:

- **349** From Spain (103 identified as AEPNYA members)
- **155** From USA (102 identified as AACAP members)
- **78** From the European Union (excluding Spain)
- **55** From Other Countries (13 identified as AACAP members)

32 COUNTRIES WERE REPRESENTED IN TOTAL.
Apart from the wealth of new things I learned, from lunch breaks with local delicacies and fresh juices to a Pintxos tour in the old city of Donostia, the organization went to great lengths to provide the possibility of tasting the local culture in its purest form. All of this set in the beautiful city of Donostia, with its stunning architecture and relaxed atmosphere, made this congress a great experience.

– Frank van der Boom, MD
AEPYNA AND AACAP
An Innovative Model for Integrating Substance Use Treatment in Schools

Kristie Ladegard, MD, Amanda Ingram, LCSW, CAC III, and Meg Benningfield, MD

Since legalization of marijuana in Colorado, youth marijuana use increased by 20 percent which is 74 percent higher than the national average (National Survey on Drug Use and Health [NSDUH] 2014). According to this same survey, the top 20 states with the highest rate of marijuana use for youth ages 12 to 17 years of age are those that have medical marijuana or have legalized recreational marijuana. Substance abuse continues to be a significant problem for American youth and is quite pronounced in certain areas of the country. An estimated 1.3 million adolescents (5%) endorsed symptoms of a substance use disorder (SUD) as defined by DSM-IV; however, these data may underestimate the need for treatment in adolescents. According to an analysis of 2011 NSDUH data, 13.6% of youth in school ages 12-18 years, met the DSM-V revised criteria for a substance use disorder, with 4.6% endorsing mild SUD (2-3 symptoms), 4% moderate SUD (4-5 symptoms), and 4.9% severe SUD (6-11 symptoms). Fewer than 4% of these youth received substance abuse or mental health treatment and fewer than 8% received any intervention including being seen in a medical office or emergency department, juvenile detention, or self-help group (Dennis et al. 2014). These figures illustrate a huge gap in treatment availability that could be addressed by co-locating services in schools.

Substance abuse prevention in schools has a long history. Generally provided in the middle school setting, programs can be divided into the following four categories: knowledge-based curricula, social competence curricula, social norms approaches, and combined methods. Social competence based-prevention programs have been best studied. These curricula provide benefit by increasing the knowledge regarding the risks of drug use, decision-making skills, self-esteem, and resistance to peer pressure. These programs have shown to reduce drug use, however, effect sizes are typically small and benefits diminish over time (Faggiano et al. 2013).

Schools offer an ideal setting to provide not only prevention services, but also treatment to address the mental health and substance abuse needs of underserved youth. Screening and brief intervention models have also been explored in school-based settings. These interventions typically comprise one to three sessions of motivational interviewing. For youth with less severe substance use, the opportunity to reflect on the consequences of their use in this context can significantly decrease the harm related to substance use. However, systematic studies of brief interventions in adolescents have found these treatments to have medium-to-small effects that decay over time (Carney et al. 2010).

Youth with more severe substance abuse require more robust and comprehensive treatment. In Denver, investigator Christian Thurstone, MD, has partnered with clinicians in the schools to provide evidence-based treatment for SUDs. Denver Health and Hospital Authority have about 17 school-based clinics in Denver Public Schools. The clinics consist of a nurse practitioner, social worker (who offers mental health treatment), nurse, health educator, psychiatrist, and medical assistant. In August of 2015, Denver Health received a grant to fund three full-time substance abuse therapists in these clinics as well as a part-time child and adolescent psychiatrist (CAP) who subspecialized in addiction psychiatry. When the first substance abuse therapist set foot in the school clinic, the school social worker already had a list of 20 students for her to see. These were students with multiple challenges including: failing grades, poor attendance, several suspensions for fighting, drug use on school grounds, and disrespectful behaviors. The substance abuse therapist and CAP completed diagnostic evaluations of each of these students. Consistent with what is known about this group of patients, most of them had several comorbid diagnoses including depression, anxiety, conduct disorder, and psychosis. Nearly all of these students reported symptoms consistent with complex posttraumatic stress disorder (PTSD). In every case, students had a comorbid mental illness in addition to their substance use.

Due to the high volume of students needing substance use treatment and to the severity of their conditions, the substance use therapist was quickly filled to her capacity of 35 clients with a wait list of 10. About 90 percent of the clients aged 11 to 19 years were using marijuana, and a small number reported continued on page 168
using alcohol, cocaine, ecstasy, mushrooms, and LSD. All clients volunteered for treatment and parental consent was obtained for youth under 15 years of age.

Treatment followed an evidence-based protocol, consisting of at least eight weeks of 60-minute individual therapy sessions. Therapy included components of motivational interviewing, contingency management, cognitive behavioral therapy, and acceptance and commitment therapy. In addition, some patients also received components of dialectical behavioral therapy, eye movement desensitization reprocessing, animal assisted therapy, somatic experiencing, and family therapy, which was tailored to their needs. During each session, clients provided an instant urine drug screen. Using a contingency management model, they earned the ability to draw for gift cards from a fishbowl for negative drug screens and for engagement in pro-social behaviors. Clients rated symptoms at the beginning of each session using standardized instruments (Child PTSD Symptom Scale, PHQ-9-A for depression, ADHD checklist, and the SCARED for anxiety). After four therapy sessions, symptoms reduced from severe to mild in intensity. Within the first eight weeks of treatment, 50% of clients were completely abstinent from all substances. About 25% were reducing their substance use by 50%. The remaining 25% had maintained the same level of substance use and did not progress to harder substances.

The program was viewed positively by students as well as teachers and other school staff. Students began to self-refer for treatment after hearing how their peers valued the program. Teachers noticed that the students were calmer, participated more in class, and had higher grades and attendance rates after participating in treatment.

Across the United States, the majority of substance abuse treatment currently provided for adolescents is court-mandated and accessed through the juvenile justice system. Youth therefore experience delays in receiving treatment, which promote greater severity of substance use as well as other externalizing symptoms—potentially resulting in greater difficulty in achieving remission of symptoms. In addition, engagement with the juvenile justice system intensifies stigma as well as other potential negative consequences for these youth. In the Denver school-based model, students did not have to be placed on diversion or probation to access services. The team was able to provide preventative care instead of being reactive. Students can now walk into a clinic, knock on the door, and ask for help, without getting involved with the “system” first.

Providing treatment in the schools has the benefit of reaching the most vulnerable students who lack the resources to access care in community clinics. These students can receive treatment on-site during their school day allowing for significantly increased access to care. Another population that benefits greatly from co-location of services in schools is the group of students who lack the motivation to seek out treatment. These students may be willing to engage when treatment is convenient and quite literally meet them where they are. In Denver, school staff reported that students they had been trying to get into treatment for years were finally willing to participate. The preliminary positive outcomes of this program are exciting and promising for our field, and highlight the importance of child and adolescent psychiatrists collaborating with schools to help provide care to a vulnerable and underserved population.

References

CONSUMER ISSUES COMMITTEE

My Introduction to The Life: Domestic Minor Sex Trafficking

George (Bud) Vana, MD

While on call in the hospital as a triple board senior resident in pediatrics, I was called to evaluate a 17-year-old girl in blue paper scrubs who was agitated and pacing around the room. Upon seeing me approach her room she remarked, “Who are you? What do you want?” and, then, “I’ll wipe that look off your face.” As I approached her, she quickly interrupted to say, “DCYF doesn’t care about me. They’re just going to send me back to a group home, then I’m going to run. They can’t keep me there.”

Her remarks and agitation made sense, especially given her history as a victim of domestic minor sex trafficking and that she was in the hospital for DCYF (the Department of Children, Youth and Families). Domestic minor sex trafficking (DMST) was poorly recognized at Hasbro Children’s Hospital before a few years ago. Dana Kaplan, MD, a child abuse fellow at Aubin Child Protection Center said, “Two years ago in my first year of fellowship, our institution began to see an influx of patients who disclosed involvement in DMST, which is another form of child sexual abuse.”

The population is extremely difficult to study but has attracted more interest in academic centers and the child protection field recently. Children in DMST have a difficult time getting away from the life, their term for living as a victim of DMST. They are at high risk for being victims of violence and also of returning to DMST when they try to leave it. Providers describe seeing these patients start to receive expensive items like smartphones and get new tattoos and other body art, which can act as brands for their pimps. Frequently, they will turn 18 years of age and be arrested in prostitution rings.

The Aubin Center, along with various agencies in the state of Rhode Island, is working on ways to address DMST. It was clear that coordination was needed and Dr. Kaplan reports, “I began working to develop a medical protocol to respond to victims of DMST in order to better address the specific needs of this patient population.” Treatment of these children’s mental health problems is complicated because they have often been in and out of foster care and have had irregular mental health and primary medical care. At the Aubin Center, the child protection doctors sometimes become the closest thing to a medical home for these patients. Katherine Liebesny, MD, a second year child and adolescent psychiatry fellow at Bradley Hospital has spent time working at the Aubin Center. She said, “As their placements are often unstable, [their] mental health treatment can be equally fragmented. A child [and adolescent] psychiatrist in the team can serve to liaise with outside systems to advocate for continuity of care or become a branch of this ‘child safe primary care’ model and serve as a stable mental health provider for these patients.” She describes the need to use creative interventions working with these patients. She has had the most success incorporating motivational enhancement and interpersonal therapy techniques with critical attention to disruptions of attachment and trauma. She has found these techniques useful for medically focused conversations, such as starting long-acting birth control.

The work of the Aubin Center, Hasbro Children’s Hospital, and the state of Rhode Island has made it clear that these patients need an inclusive team for the best outcomes. Amy Goldberg, MD, a child protection pediatrician and researcher in this field said, “Through a perpetual state of physical, sexual and/or emotional abuse, DMST victims form traumatic bonds and strong emotional attachments with their traffickers, making disclosure and identification difficult and re-victimization common. The systems approach must be collaborative, informed, and multidisciplinary to meet the complex needs of this poorly understood and marginalized patient population.”

For this patient, I asked her if she had someone she could trust whom she could call. She mentioned a name of a social worker she had worked with. It was about 6:30 pm on a Friday, and I had doubts as to whether she would be able to get through. I discussed the plan with the nurses who brought a phone into her room. I hovered around the general section of the hospital where her room was located, busy with other tasks, all the while preparing for what might happen if the receiver on the other end did not pick up the phone. When I peeked back at her room 20 minutes later, she was happily reclined in her hospital bed watching television. It reassured me that this was going to be an okay night for her. She was discharged the next day to a group home where she stayed for a period of time, and then she turned 18 and entered the adult world unlikely to return to the pediatric hospital. She might have left the pediatric world, but she made an indelible mark on my training and showed me how much more needs to be learned about how best to help these patients.

I would like to acknowledge Anish Raj, MD, First Year Triple Board Resident at Hasbro Children’s Hospital who also contributed to this article.

Dr. Vana is a triple boarder at Brown University who just finished his second year of residency. He is interested in the intersection between medical and psychiatric care for children with autism spectrum disorder and learning disabilities, foster children, and victims of child abuse and exploitation. He may be reached at bud.vana@gmail.com.
Integrating Telemental Health with the Patient-Centered Medical Home Model

Introduction

The United States healthcare system is in a time of dramatic change. As emerging technologies and medical advancements become a reality, the healthcare system faces increased demands to curb costs and improve outcomes. Developing a strong primary care system is necessary for reforms and the patient-centered medical home model (PCMH) has been promoted to address the necessary system changes (Jackson 2013). The PCMH model recognizes the interdependence of mental health and physical health. Access to an expert mental health care workforce is limited in many parts of the country however, making the integration of mental health into the PCMH difficult. Telemental health is one approach to achieving integration and is one of the most active telemedicine applications used in the United States. Both psychotherapy and medication management are provided via telemental health with increasing evidence of their effectiveness in improving care and outcomes (Hilty et al. 2013).

Patient-Centered Medical Homes

Many patients, providers, and policymakers have only a limited understanding of what differentiates PCMHs from other types of clinical practice. The American Academy of Pediatrics (AAP) introduced the “medical home” concept in 1967 to centralize the care of and the medical records for children with special healthcare needs. The concept has since been generalized to different patient populations. In order to qualify as a PCMH, primary care practices must provide comprehensive care and be responsible for the majority of patients’ care. Inevitably, patients will require specialty care outside of the medical home and care coordination between providers in the healthcare system becomes essential. As such, multidisciplinary teams form the backbone of PCMH model. The members of these teams may be a part of the actual practice itself or be providers and resources in the community. In addition to the coordination of care between team members, the PCMH model requires the implementation of quality and safety programs and encourages the use of evidence-based practices and the measurement, assessment, and improvement of its processes and outcomes (AHRQ 2014).

Mental and Behavioral Health Care Integration

As the body of research supporting the efficacy of PCMHs grows, so does the recognition that mental health care must be integrated with physical health care. Approximately 26 percent of American adults suffer from diagnosable mental health disorders in any given year (NIMH 2008) and many of these disorders develop in childhood and adolescence. The majority of patients seek treatment with their primary care physicians (PCPs) rather than mental health providers. The high rate of mental health disorders in primary care has a profound impact on patients’ physical health. Patients with chronic physical health conditions frequently have more medical complications if their co-morbid mental health conditions are not adequately treated. Patients with mental health disorders frequently present to their PCPs with physical health complaints rather than mental health complaints, which can lead to unnecessary tests and procedures. Mental and physical health care must be integrated to optimize patient outcomes. Given that the PCMH goals are to provide comprehensive, coordinated care, and improve outcomes, this integration makes logical sense for PCMH teams.

The Role of Telemental Health

Despite the need for PCMHs to integrate mental health care into their practices, the shortage of qualified mental health providers, particularly in rural and impoverished areas, significantly limits access to care. By using technology, mental health providers can join as remote team members. The models for integrating telemental health into primary care generally fall into three categories.

Direct Service Models. Mental health providers can provide direct care for patients. Patients are evaluated and managed by mental health providers via telehealth technology. If the telemental health site is located within the PCMH’s clinical space and the mental health provider is an active participant in the PCMH team, the provider helps the PCMH meet the goals of offering comprehensive care using a multidisciplinary team and improving access to services.

Multiple benefits exist for providing direct care through telemental health. Patients may be more comfortable being seen by a specialist, but within the familiar environment of their PCMH clinic. Patients may be more willing to seek mental health care if the care is not associated with the stigma of going to a mental health setting. Finally, patients are often seen closer to their homes, limiting travel and the costs associated with time off work or school (Loh et al. 2013).

One limitation of telemental health in this model is that it does not actually expand the access to mental health services. While it may be more convenient for patients to be seen at the PCMH site, they may have to wait just as long to see a provider via telemental health as they would in person. Telemental...
health may only redistribute the mental health workforce.

Consultation Models. Consultation care can be used to integrate telemental health services into the PCMH. In this model, the mental health provider does not offer ongoing care of the patient, but instead evaluates the patient via telehealth and provides the PCP with treatment recommendations. Alternatively, the mental health provider may discuss the case with the PCP as a “curbside” consult. Several programs employing either one or both of these methods have been developed. Regardless of how these relationships are structured, the consulting mental health provider can fill the need for mental health integration in the PCMH either as a remote team member or as a specialist with whom the team coordinates care. Most models also incorporate training for the primary care teams with the goal of PCPs becoming more confident in managing common psychiatric problems, while the psychiatrist assists with more challenging cases. The didactics can be an instrumental component in quality and safety programs within PCMHs.

Reimbursement is a limitation of consultation models. While consulting mental health providers can be reimbursed on a fee-for-service basis for consultations in which the patient is seen, subsequent follow-up discussions or other “curbside” consults with PCPs often cannot be billed. Payment reform models may address this limitation in the future, but are not yet readily available.

Collaborative Care Models. Finally, the mental health provider can treat patients collaboratively with the PCP, primarily by providing supervision to an on-site care manager and maintaining a shared treatment plan. The collaborative care model relies on a care manager who administers screening tools, tracks treatment response and adherence, monitors patients to ensure adequate follow-up, and identifies patients who may need a referral to the consulting mental health provider.

Of the three models, the collaborative care model is most consistent with the principles of the PCMH. By definition, the collaborative care model provides comprehensive care by using a multidisciplinary team approach. Not only does a shared treatment plan help ensure care coordination, but tracking and monitoring patients through a care manager leads to quality and safety measures.

Much like the consultation model, reimbursement in traditional fee-for-service environments does not support the collaborative care model. Furthermore, extensive work must be done to establish the relationships, build the clinical processes, and support the care manager’s role for this model to be successfully implemented.

Conclusion

While it is widely recognized that the United States healthcare system faces incredible change, no one can predict what form the evolving system will ultimately take. Patients, providers, and policymakers demand a system that improves access to care, improves outcomes, and reduces total health care costs (Berwick 2008). PCMHs have been accepted as a standard of care for patients with chronic and complex medical problems and are being promoted for general patient populations. Including mental health care will be vital to the success of expanding PCMHs. Telemental health is uniquely poised to address the limited access to mental health services that many patients in PCMHs face. The improved accessibility to mental health care that is created via telemental health will strengthen the approaches to population health and team-based care implemented in PCMHs, making telemental health and PCMHs ideal partners.

References


Dr. McWilliams is a child and adolescent psychiatrist at Children’s Hospital and Medical Center in Omaha, Nebraska. She completed her training at the University of Iowa and has a master’s degree in Health Care Delivery Science from Dartmouth College. She has been providing telemental health care to rural Nebraskans and Iowans for the past six years. She may be reached at mcwilliamsj1974@gmail.com.
How Can We Increase Access to Care? –
A Letter From a Busy Child and Adolescent Psychiatrist to a Primary Care Physician

Mark S. Borer, MD,
Chair, Assembly of Regional Organizations of Child and Adolescent Psychiatry

As child and adolescent psychiatrists, we can be leaders, as the evidence base is showing, in effective care delivery within integrated care settings. Our leadership must be nuanced, and for access to child and adolescent psychiatry in a time of shortage of child and adolescent psychiatrists, our service delivery may include increased access through multidisciplinary and collaborative teams moving toward integrated care. Psychiatric leadership in the patient centered medical home (PCMH) must also recognize that the primary care physician is often the clinical and contractual head of the integrated care team, and may also be the distributor of reimbursement in that setting.

As we were reminded at our ROCAP Spring Assembly meeting, as physicians—psychiatrists and child and adolescent psychiatrists—we continue to owe a duty to the individual patient, and this duty must resonate with our efforts to contribute to population health. Our presence to patients and families in the PCMH and other integrated care centers will reverberate throughout the networks of care.

Dear Dr.____________________,

I have enjoyed consulting with you regarding your patients and have appreciated your referrals to my practice (clinic).

As you know, child and adolescent psychiatrists are in short supply in the community, and we are trying to remain as available as possible to those who need us. As we continue to recruit and retain more child and adolescent psychiatrists to practice locally and be available to you, I would like to offer you some additional child and adolescent psychiatry-led and child and adolescent psychiatry-informed options to help your practice get your kids and families assessed, help you get them linked to various community services, and improve your patient outcomes.

First, I work with several advanced practice psychiatric nurses (in my office/in my community) with whom I collaborate (consult) who may be able to help us with assessment of some of your kids and families. They are available not only in their own offices, but may also be available on site with you weekly, in collaboration with my office, to help with case reviews, talk with your in-office medical and mental health professionals, do warm handoffs, meet with your care manager to help coordinate care, and be available to consult regarding your integrated treatment plans. They are in close contact with me, and to manage both my time and your costs, I will be available to your practice on site (monthly/biweekly)—and by phone or telemedicine in between times—to review with your team and the psychiatric advanced practical registered nurse (APRN) the most complex cases, including those you may be having assessed through a telemedicine service. All these services will help improve access to care for your patients and practice professionals, and will lead to better treatment, less need for outside referrals, less referrals to high level care, and, thus, lower cost to your practice.

If your practice has a psychologist, social worker, or counselor consulting with your medical team or embedded in your practice, I can bring the same expertise you expect when you make referrals to my office to consultation with your mental health professionals. I am not here to duplicate their work, but to enhance the accuracy of complex diagnostic pictures, medication regimens, and medication-treatment coordination. Through our meetings, on site and through telemedicine (provided by our office/provided by an outside service) our hope is to increase your and your team’s comfort with dealing with children with psychiatric difficulties within your own office, and increasing your comfort with prescribing for some of these children, particularly those who have already been assessed and stabilized by a child and adolescent psychiatrist.

You may be approached by a number of different mental health professionals and other prescribers offering to help in your practice; some may offer slightly lower cost per hour services. The question to ask is who is their team and who do they turn to for complex diagnostic, treatment, and prescribing issues? How do they coordinate a full range of mental health professionals, support your medical approaches with your dually diagnosed patients and those with substance use disorders, and will they bring the same value and cost savings to your practice?
I am able to value each member of your team, while bringing child and adolescent psychiatry expertise that the evidence shows is critical to your patient outcomes.

My office is still able to work with some of your patients on a referral basis, as we always have. But, if you want to reduce those wait times and get the same kind of team approach that you take with your medical team in your own practice, then know that I am available to you as you face these big changes in approach to treatment and payment reform, especially value-based reimbursement plans. Together, we can work toward achieving the Triple Aim, one patient and family at a time.

Sincerely yours,

Your name?

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**Dr. Borer** is a child and adolescent psychiatrist practicing in central Delaware. He is currently Delaware’s Delegate to the AACAP Assembly, where he serves as Chair, as well as a member of AACAP’s Health Care Access and Economics Committee. He is also the AACAP Delegate to the PCPCC (The Patient Centered Primary Care Collaborative). He may be reached at bugglinborer@comcast.net.

**How do you envision your practice five or ten years from now?**

**Are you sharing your vision with your ROCAP? Let your Delegate know your thoughts for our Fall Assembly Meeting.**

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_We’re here to help!_
2016 AACAP Legislative Conference Recap – Successfully Advancing Children’s Mental Health

Ronald Szabat, Esq., Michael Linskey, Emily Rohlffs, and Zachary Kahan

Upwards of 240 AACAP members and family advocates came together on April 14-15, 2016, to unite for positive change in children’s mental health. Overall, this year’s attendees had over 40 scheduled face-to-face meetings directly with Members of Congress, hundreds of meetings with Congressional staff, and over 50 family and youth advocates ready to lobby for change. All this set a new AACAP record!

The well-organized conference opened on Thursday, April 14, 2016, with an hour-long Resident, Newcomer, and Family Orientation. Those attending the orientation learned everything from the layout of Capitol Hill to the basics of the legislative process. Everyone was duly impressed with how quickly and smoothly the presentation progressed from the simple to the complex. By design, the session achieved its goal of making everyone comfortable in conveying AACAP’s issues to lawmakers.

Taking their new found advocacy background to the next level, attendees then participated in a two-hour Special Advocacy Training. Led by AACAP Director of Government Affairs and Clinical Practice Ronald Szabat, participants learned real-time advocacy strategies and mastered new skills (e.g., bridging to a topic at hand) through a series of audience-participation mock congressional visits. Laughter and real learning were hallmarks of this fun and interactive session.

This exciting day was capped off by AACAP’s annual Legislative Conference Reception where AACAP leaders recognized Representative Chris Collins (R-NY) and Scott Dziengelski of Representative Tim Murphy’s (R-PA) office as AACAP’s 2016 Friends of Children’s Mental Health Award recipients. Throughout 2016, these two incredible individuals have demonstrated their desire, knowledge, and passion for improving our nation’s mental health system. Rep. Collins introduced H.R. 1859, the “Ensuring Children’s Access to Specialty Care Act,” which would make surgical corrections to the National Health Service Corps (NHSC) to allow pediatric subspecialists, including child and adolescent psychiatrists, to be eligible for the NHSC loan relief program. It would also list children and adolescents as an underserved population. As Legislative Director to Rep. Murphy, Mr. Dziengelski was principally responsible for technical drafting negotiations surrounding the Congressman’s landmark mental health reform bill.

On Friday morning, attendees were deeply versed in the details of the legislative goals for improving children’s mental health. Conference participants focused on specific ways in which federal law must change to address the current shortage of child and adolescent psychiatrists. Right now, nearly every state has a severe shortage of child and adolescent psychiatrists, with the majority of counties in the United States having zero. Conference attendees also learned and stressed the importance of including key federal regulatory language, such as “serious emotional disturbance” and specific references to “child and adolescent psychiatrists” in all major mental health reform bills. Without these simple key terms, children, and child and adolescent...
psychiatrists would not be eligible for or included in federal funding and programmatic activities through needed legislative change.

H.R. 1859 and S. 2782, the “Ensuring Children’s Access to Specialty Care Act,” are imperative for improving America’s child and adolescent psychiatrists workforce. Heads were nodding in agreement as attendees learned that the average wait-time to see a child and adolescent psychiatrist is over 7.5 weeks and that the actual need for child and adolescent psychiatrists almost quadruples the current supply. The goals of this legislation are to bring pediatric subspecialty fellows or trainees within the NHSC loan relief eligibility, list children as an underserved population for needed medical services, and ensure that pediatric subspecialty training sites and programs meet NHSC loan relief criteria.

Attendees also made a plea for co-sponsorship and support of Rep. Murphy’s H.R. 2646, the “Helping Families in Mental Health Crisis Act.” Among a series of policy changes to fix America’s broken mental health system, this comprehensive mental health legislation would establish a new assistant secretary for Mental Health and Substance Abuse Disorders. The bill aims to immediately address intergovernmental coordination of mental health services and programs, which is badly needed. In large part due to AACAP’s successful Legislative Conference and effective advocacy, the House of Representatives overwhelmingly passed H.R. 2646 on July 6 by a vote of 422-2.

H.R. 2646, H.R. 1859, and S. 2782 all have the requisite key wording of “serious emotional disturbance,” child and adolescent psychiatrist references, and NHSC workforce provisions to ensure that children and child and adolescent psychiatrists have access and eligibility to programmatic activity. As attendees learned, not all comprehensive mental health bills are comprehensive, as some do not have the needed wording to guarantee that programs and funds flow to children and child and adolescent psychiatrists.

AACAP is very proud of its advocacy by members, family, and youth. The conference was tremendously productive and successful in advancing children’s mental health. If you wish to review AACAP’s 2016 Legislative Priorities in more depth, contact a member of AACAP’s Government Affairs team at gov@aacap.org.

Missed the conference this year or ready for the next AACAP wave to take our messages to Capitol Hill? Then mark your calendars now to attend next year’s Conference – May 11-12, 2017!
In residency, we learn a lot about medication management, psychotherapy, and building rapport with our patients, but rarely do we learn about the legislation or regulations that can either expand or restrict the work we do and the access our patients have to the mental health care they need and deserve. According to a study in 2007, physicians voted less than the general population. In addition, out of 435 members of Congress, only 14 physicians currently serve in the U.S. House of Representatives (only one of them, Jim McDermott, MD, is a child and adolescent psychiatrist)—a total of three percent. In the Senate, there are three physicians and no psychiatrists, again only representing three percent of the total voting body. It is clear that child and adolescent psychiatrists (CAPs) need to increase their collective voice and receive the necessary training to play a more active role in shaping policy and the political process. With this in mind, we decided to work with AACAP’s Government Affairs and Clinical Practice director, Ron Szabat, to initiate the Resident Scholars program at AACAP. It was clear from day one in the Government Affairs and Clinical Practice Department how little we knew, and how much we would gain while at AACAP. For example, we learned that if the term “serious emotional disturbance” is not included in federal legislation, the legislation would not apply to children and adolescents from birth up to the age of 18-years-old. We would have thought from our medical training that using the term “serious mental illness” could refer to a person of any age with a mental health disorder, but we quickly realized that legislative language and medical language are not congruent. Another example of what we learned was finding out that the term “psychiatrist” in a bill does NOT include “child and adolescent psychiatrists.” In our time at the AACAP office, we saw how the Government Affairs team would carefully dissect legislation, looking for these small wording differences to make sure that child and adolescent psychiatrists and our patients are not left out.

The time at AACAP was spent not only reading though complex legislation, it also included a wide-range of responsibilities that included attending collaborative meetings with other physician organizations, legislative meetings with Congressional staff, political events with Members of Congress, and policy-focused events around Washington, DC. One meeting that stood out was working with other pediatric groups to develop legislative strategies to ensure children have increased access to child and adolescent psychiatrists by making CAPs eligible for the National Health Service Corps. It was also clear that as child and adolescent psychiatry trainees, we served as a resource to the AACAP office and provided valuable clinical insight. Important also was that during meetings with federal legislators we could tell our stories, and the stories of our patients, to emphasize why we need legislation, such as mental health reform.

We hope that other trainees will see the value in this unique training that comes from spending a month at the AACAP national office in Washington, DC. It is our hope that with more opportunities like this, trainees can increase their voice and the voice of their patients in advocating for increasing access, reducing stigma, reducing debt burden, and much more. Please do not hesitate to contact either AACAP’s Government Affairs team or one of us if you want more information about the program or our experiences.

We want to thank Ronald Szabat, Esq., Michael Linskey, Emily Rohlfs, Zach Kahan, and the rest of the AACAP staff for their hospitality during our month. As AACAP members, we are very lucky to have such a highly qualified and hard-working staff.

Reference

Laura Willing, MD, just completed her fifth year as a child fellow and the advocacy chief resident at the University of North Carolina in Chapel Hill. Next year she will serve as the APA Jeanne Spurlock Congressional Fellow in Washington, DC.

Justin Schreiber, DO, MPH, FAAP, just completed service as a fifth year triple board resident and co-triple board chief at the Children’s Hospital of Pittsburgh and Western Psychiatric Institute and Clinic in Pittsburgh, PA. Next year he will remain in Pittsburgh to work as a child and adolescent psychiatrist and pediatrician.
LEGISLATIVE RECAP
LEGISLATIVE RECAP
More Evidence Lithium Decreases Self-Harm and Suicide in Bipolar Disorder

Adults with bipolar disorder receiving maintenance treatment with lithium were not only less likely to demonstrate suicidality, they were also less likely to commit self-injury than those receiving valproate, quetiapine, or olanzapine, according to a study published in JAMA Psychiatry by British researchers using data from electronic health records collected between 1995 and 2013 in the United Kingdom.

Of the 6,671 individuals aged 16 and over with bipolar disorder who were included in the cohort (meaning they had received a bipolar disorder diagnosis and were treated with one of the four drugs listed above for at least two filled prescriptions), 2,148 received lithium, 1,670 valproate, 1,477 olanzapine, and 1,376 quetiapine.

Rates of self-injury were expressed per 10,000 person-years at risk (10K-PYAR). Self-harm rates were 205 per 10K-PYAR (95% CI 175-241) for those prescribed lithium; 392 (95% CI 334-460) for those prescribed valproate; 409 (95% CI 345-483) for those prescribed olanzapine; and 582 (95% CI 489-692) for those prescribed quetiapine.

The overall suicide rate in the study was 14 per 10K-PYAR, and while the rate of suicide was lower for those prescribed lithium, the suicide rate was low enough that rates could not be statistically compared. The authors also measured rates of unintentional self-injury (like falls or car accidents), which were also lower for lithium compared to valproate and quetiapine, though not necessarily for olanzapine.

What is not entirely clear is whether these better outcomes with lithium are the results of improved mood stabilization or from a separate decrease in impulsive aggression and risk taking. The lower rates of unintentional self-injury (and previous research on lithium and suicide) may point towards the idea of lithium decreasing impulsive aggression.

Of course, these are adult data, but child and adolescent psychiatrists are no strangers to having to rely on (or at least consider) adult treatment data given the relative dearth of studies in children compared to adults. Given concerns about heterogeneity in the bipolar diagnosis across study sites in pediatric bipolar studies, the pediatric bipolar treatment data are already complicated to interpret. Available data have tended to favor the use of atypical antipsychotics over more traditional mood stabilizers in pediatric populations, though this might point to a more general trans-diagnostic tranquilizing effect from antipsychotics rather than actual superior effectiveness in children with episodic hypomania or mania. However, the recent publication of the long-awaited Collaborative Lithium Trials (CoLT) study supports the use of lithium as a well-tolerated and relatively weight-neutral agent for reducing manic symptoms in pediatric patients with rigorously defined type-1 bipolar disorder.

We sometimes find ourselves prescribing for our sickest and most impaired patients with our best intentions rather than with a tremendous evidence base. At the same time, further studies strengthening past suggestions that lithium may reduce suicidality, as well as self-injury, may inform our treatment choices when little else than our experience guides our hands.


FDA Issues New Warnings on Olanzapine, Aripiprazole

The Food and Drug Administration (FDA) released two significant warnings regarding two commonly used atypical antipsychotics in May 2016 after worrisome cases were identified using the FDA Adverse Event Reporting System (FAERS), the database that supports the FDA’s post-marketing safety surveillance system by collecting information on adverse events and medication error reports submitted to the FDA. Such warnings describe events that are extremely rare but nonetheless of adequate clinical importance for prescribing psychiatrists to educate and monitor their patients for these conditions.

Aripiprazole

On May 3, 2016, the FDA issues a warning that aripiprazole use may be associated with an increased risk for compulsive or uncontrollable urges to gamble, binge eat, shop, and have sex. A search of the FAERS database identified 184 case reports (167 in the United States, including both adults and children) of impulse-control problems since November 2002 when aripiprazole was first approved by the FDA. Of the 184 case reports, 167 were from the FAERS and 17 were available in the medical literature.

The most common behaviors were pathological gambling (N=164), but also included compulsive sexual behavior (N=9), compulsive eating (N=3), and multiple problems with impulse-control (N=4). None of these conditions were present prior to aripiprazole. None had concurrent substance use disorder or symptoms of mania at the time they developed impulse-control problems. Each condition resolved shortly after discontinuing aripiprazole. In four of the cases in the medical literature, continued on page 182
compulsive behaviors went away with discontinuing aripiprazole, and reappeared when aripiprazole was resumed.


Olanzapine

On May 10, 2016, the FDA issued a warning that olanzapine use may be associated with an increased risk of a rare but serious skin reaction known as DRESS (Drug Reaction with Eosinophilia and Systemic Symptoms) Syndrome. A search of the FAERS database identified 23 cases of DRESS Syndrome reported with olanzapine since 1996. Only cases that are reported to the FDA are included in the FAERS, so there is no way to know how many other cases may have occurred and were not reported. One patient reportedly died from DRESS Syndrome, though this patient was taking multiple medications in addition to olanzapine that may have contributed to the death.

DRESS Syndrome, also known as drug-induced hypersensitivity syndrome, is an idiosyncratic drug reaction that can affect both the skin and various organs. It typically includes a long latency period between initiation of the drug and onset of the rash (more than two to three weeks) and may be associated with fever, rash, and involvement of at least one organ system. DRESS Syndrome is different from Stevens-Johnson Syndrome or Toxic Epidermal Necrolysis, though DRESS Syndrome is also associated with use of carbamazepine and lamotrigine. Management involves withdrawal of the offending medication and sending patients to the emergency room for further evaluation. Systemic corticosteroids are frequently the first line treatment. Mortality rate may be up to 10%.


Dermatological Emergencies, Cleveland Clinic.

Biomarkers for Concussion Getting Closer to Clinical Utility

While psychiatrists generally are not the ones seeing patients in the emergency room following a closed head injury, biomarkers for mild or moderate traumatic brain injury (TBI) may not be so far away from clinical use, as several companies are trying to commercialize biomarkers for FDA approval. Two such promising biomarkers include glial protein glial fibrillary acidic protein (GFAP) and neuronal protein ubiquitin C-terminal hydroxylase L1 (UCH-L1). Both of these proteins are present in serum less than an hour after a mild TBI and are able to distinguish between patients with mild TBI and other trauma patients without acute brain injury and can also help distinguish patients who will have intracranial lesions on computed tomography (CT) scans and which might require neurosurgical intervention.

A recent study in JAMA Neurology went further and explored the time course and diagnostic accuracy of the serum glial and neuronal biomarkers for detecting mild-to-moderate traumatic brain injury (MMTBI), traumatic intracranial lesions on CT, and neurosurgical intervention for brain trauma. Trauma patients (N=584) with or without MMTBI were followed over 7 days with a total of 1,831 blood samples collected. Of the 325 patients with MMTBI, 97.8% scored a 13-15 on the Glasgow Coma Scale, as the study focused mainly on milder TBI. Intracranial lesions were found in 35 of the 325 patients with MMTBI and none of the controls. Neurosurgical interventions were performed in 7 patients with MMTBI and none of the controls.

GFAP was detectable within one hour of injury and peaked at 20 hours while concentrations steadily decreased over 72 hours. GFAP levels were still detectable seven days after injury. UCH-L1 was also detectable within an hour and peaked around eight hours with further decreases over the next 48 hours. There were small peaks and troughs over the next seven days. While the statistical results are beyond the scope of this summary, both proteins strongly predicted the presence of MMTBI, intracranial lesions on CT exam, and the need for neurosurgical interventions and would be expected to be used to separate those with and without these outcomes.

Given these properties, the authors speculate that UCH-L1 might be most useful very early on as a point-of-care test in settings such as in the ambulance, on the playing field, or on a battlefield. They speculate that GFAP may help predict outcomes in both acute and subacute settings and for those who do not present immediately to the Emergency Department. These markers may eventually be able to predict other longer term outcomes and may help physicians decide whether a patient should be discharged from the Emergency Department or admitted to the hospital for further monitoring or intervention.

Youth Substance Abuse and Co-occurring Disorders
Edited by Yifrah Kaminer, MD, MBA
American Psychiatric Association 2016
Paperback: 316 pages – $65.00

Youth Substance Abuse and Co-occurring Disorders is a newly published book that presents key biological, psychosocial, and clinical topics pertaining to the understanding and treatment of psychiatric comorbidity in adolescents with substance use disorders (SUDs). As 70-80% of adolescents with SUDs have a comorbid psychiatric disorder, this is an important topic for child and adolescent psychiatrists. This book is well suited for clinicians, clinical researchers, and students of mental health, public health, and medicine.

The book contains 14 informative and well-organized chapters. Each chapter is comprehensive in its review, with easy-to-navigate sections and helpful “Key Points” at the end of the chapter.

Chapters 1 and 2 introduce co-occurring disorders in adolescents. Chapter 1 pays particular attention to developmental pathways and patterns in developing SUDs, looking closely at how psychological regulation is acquired during development and the clear relationship between psychological dysregulation and SUDs. Chapter 2 expands on the relationships between SUDs and co-occurring psychiatric disorders, first exploring barriers in current clinical practice and then outlining effective delivery of evidence-based treatments.

Chapter 3 covers screening, assessment, and treatment options for adolescents with SUDs. General screening tools and comprehensive assessment instruments are reviewed. Treatment options considered include brief interventions, cognitive behavioral interventions, brief motivational interventions, 12 step programs for adolescents, family therapies, contingency managing, and adaptive treatment and aftercare.

Chapters 4-12 look at major co-occurring disorders, such as conduct disorder and delinquency, attention-deficit/hyperactivity disorder (ADHD), depressive disorders, bipolar disorders, anxiety disorders, posttraumatic stress disorder (PTSD), suicide and self-harm, schizophrenia, and eating disorders. Each chapter reviews the epidemiology, etiology, assessment, prevention, and treatment options for each co-occurring disorder. For convenient reference, complete diagnostic criteria for DSM-5 disorders are provided. Important concepts and key data are also summarized using figures and tables.

Chapter 13 considers youth gambling, whereas chapter 14 explores pathological preoccupation with the Internet. Though not official DSM-5 diagnoses, these conditions represent important, prevalent non-substance-related addictive disorders in adolescents. While offering a helpful review of current literature, these chapters also highlight the importance of ongoing work in these emerging areas.

Youth Substance Abuse and Co-occurring Disorders is a well-organized and accessible review of key concepts in the assessment and management of SUDs in adolescents. It offers a valuable launching point in our effort to address the “worldwide public health challenge” of SUDs in youth.
Honors Presentation: Sidney Berman Award
“Where There’s a Will, There’s a Way”

William (Will) Dikel, MD

“Creating a School Mental Health Plan that meets the needs of Students who have Psychiatric Disorders”
—William Dikel, MD

William (Will) Dikel, MD, a proud Minnesotan child and adolescent psychiatrist, has devoted his entire career to creating a mentally healthy school environment where kids of all ages can thrive. A man on a mission, he has traveled far and wide, well beyond the confines of his home state to provide useful, common-sense consultation to schools that want to do better for their students. In recognition for his outstanding contributions to School Mental Health, the AACAP Schools Committee unanimously selected Dr. Dikel as the 2015 recipient of AACAP’s Sidney Berman Award for the School-Based Study and Treatment of Learning Disorders and Mental Illness.

Dr. Dikel uses an individualized approach with each school consultation. He starts at the top to insure there is a real commitment to change, endorsed and followed through at every level. Clarifying roles becomes a critical ingredient toward success. He wants schools to avoid the “Kitty Genovese Syndrome” in which everyone who hears a cry for help ignores it assuming someone else will respond. He elaborates: “If someone collapses and needs CPR, you don’t vaguely yell, ‘Call 911!’ BUT RATHER You (a specific person) call 911.” In schools, this means that all personnel (principal, guidance counselor, teacher, etc.) must know exactly what their responsibilities are, and what they will be held accountable for in helping students under their care. Each member of the team will thereby feel valued for his or her contributions to creating an optimal school environment. The school principal must establish an open-door, two-way-street atmosphere within the school among staff, teachers, parents, and, yes, students. A principal must encourage honest feedback with an Ed Koch’s “How am I doing?” demeanor. Toward that end, regular staff meetings must be convened to identify potential problems early and proactively implement solutions.

For those students with clearly diagnosed mental health problems, the principal must foster open communication with the treating child and adolescent psychiatrist and teacher after obtaining parental consent in order to enhance outcomes. For example, a youngster diagnosed with attention-deficit/hyperactive disorder (ADHD) who is on medication will greatly benefit from an integral approach in monitoring treatment that involves a child and adolescent psychiatrist. I personally know how valuable feedback from my patient’s teacher can be in optimizing treatment. Treatment in a vacuum is never good.

In summary, each and every person on the educational team, from principal on down, needs to understand his/her specific role and the importance of honest, free, and unhindered interaction within the school milieu to improve students’ education and, ultimately, their mental health. As the saying goes, “When there’s a Will (pun intended), there’s a way.”

John T. McCarthy, MD

Dr. McCarthy has been a member of AACAP’s Schools Committee since 2002. He is a retired associate clinical professor of Child and Adolescent Psychiatry of the New York University School of Medicine’s Child Study Center, where he ran the School-based Mental Health Program for the child psychiatry fellows and directed the Consultation-Liaison Program.

DID YOU KNOW?

The New York subway system is the largest mass transit system in the world with 468 stations and 842 miles (1355 km) of track.

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AACAP’s Lifelong Learning Committee has developed a series of ABPN-approved checklists and surveys to help fulfill the PIP component of your MOC requirements. Choose from over 20 clinical module forms and patient and peer feedback module forms. Patient forms also available in Spanish.
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Annual Review Course — Up to 21 CME Credits
Annual Meeting — Up to 50 CME Credits
• Annual Meeting Self-Assessment Exam — 8 CME Credits (all of which count towards self-assessment)
• Annual Meeting Self-Assessment Workshops — 8 CME Credits (all of which count towards self-assessment)
• Lifelong Learning Institute featuring the latest module

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Questions? Contact Elizabeth Hughes, Assistant Director of Education and Recertification, at ehughes@aacap.org, or Quentin Bernhard III, CME Manager, at qbernhard@aacap.org.
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ANNOUNCING NEW ENHANCEMENTS TO THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY PROFESSIONAL LIABILITY PROGRAM:

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- **Fire Legal Liability Coverage:** Limit of liability increased to $150,000 for fire damage to third party property
- **Emergency Aid Coverage:** Reimbursement up to $15,000 in costs and expenses for medical supplies
- **Insured’s Consent to Settle** is now required in the settlement of any claim – No arbitration clause!
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- **10% Claims Free Discount** for those practicing 10 years, after completion of training, and remain claims free
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1953 Society Members
Anonymous (4)
Steve and Babette Cuffe, MD
James C. Harris, MD, and Catherine DeAngelis, MD, MPH
Paramjit T. Joshi, MD
Joan E. Kinlan, MD
Dr. Michael Maloney and Dr. Marta Pisarska
Jack and Sally McDermott (Dr. Jack McDermott, in memoriam)
Patricia A. McKnight, MD
Scott M. Palyo, MD
The Roberto Family
Diane H. Schetky, MD
Gabrielle L. Shapiro, MD
Diane K. Shrier, MD, and Adam Louis Shrier, D.Eng, JD

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Check It Out! AACAP’s 63rd Annual Meeting in New York City is Right Around the Corner!

Join us October 24-29, 2016, for the world’s largest gathering of child and adolescent psychiatrists. Start planning today!

Reserve Your Hotel Room

AACAP’s 63rd Annual Meeting takes place at the New York Hilton Midtown and the Sheraton New York Times Square in New York, NY. Make your reservation TODAY!

Hotels

New York Hilton Midtown
1335 Avenue of the Americas
New York, NY 10019
Phone: 212.586.7000
www.aacap.org/AnnualMeeting/2016/hotel (to reserve your hotel room)
Rate: $375 single/double per night

Sheraton New York Times Square
811 7th Avenue 53rd St.
New York, NY 10019
Phone: 212.581.1000
www.sheratonnewyork.com (for detailed hotel information)
www.aacap.org/AnnualMeeting/2016/hotel (to reserve your hotel room)
Rate: $375 single/double per night

Early Bird Rate (limited quantities): $345 single/double per night, but must be pre-paid in full with a non-refundable deposit.

Check-in is at 3:00 pm and check-out is at 12:00 pm.

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

Both the New York Hilton Midtown and the Sheraton New York Times Square will host scientific sessions for AACAP’s Annual Meeting. Located directly across the street from each other, both hotels sit in heart of non-stop excitement in midtown Manhattan. After attending AACAP’s stellar educational offerings, you will be steps from Times Square, Broadway, Radio City Music Hall, Central Park, the Museum of Modern Art, and hundreds of restaurants with cuisines ranging from Austrian to West African and everything in between!

You can count on AACAP to provide the latest research in child and adolescent psychiatry with a wide variety of programs to meet all of your educational needs. Get up to date on all of the changes in the field, including Healthcare Reform, CPT Codes, the effects of marijuana use on kids, emergency room medicine, and international perspectives on child and adolescent psychiatry. Plus, earn up to 50 CME credits! Check AACAP’s website for a complete list of programs and speakers or download the Registration Magazine in August.

Register for the Annual Meeting Starting in August

Registration for the Annual Meeting will open on August 1, 2016, for AACAP members and August 8, 2016, for nonmembers. Be sure to register early to secure all of your preferred events. Save $25 by registering online at www.aacap.org/AnnualMeeting/2016.

Book Your Travel to New York City

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

New York City is served by two main rail stations: Grand Central Terminal and Penn Station. Both are served by numerous bus and subway lines, including Metro-North Commuter Railroad, Long Island Railroad (LIRR), Amtrak, New Jersey Transit, and PATH (Port Authority Trans Hudson).
Why I ♥ NY!

Richard R. Pleak, MD: I ♥ NY for our panoply of cultural, civic, food, and nature opportunities. This October, AACAP meeting attendees can listen to great music in Carnegie Hall (4 blocks away: Danish String Quartet, American Composers Orchestra), Lincoln Center with the New York Philharmonic, or Radio City Music Hall (3 blocks away); go see terrific art at MoMA (1/2 block away), the Museum of Design (7 blocks away), the new Whitney, and the Metropolitan Museum; visit the World Trade Center memorial fountains; and walk or bike up and into Central Park (5 blocks away) for a great escape from the skyscrapers! And of course, there is wonderful food from the street vendors to some of the highest rated restaurants in the world. Local Arrangements will have suggestions to all these and more.

Scott M. Palyo, MD: I ♥ NY because New York is a fantastic city and its diversity makes it appealing to everyone. Whatever your interests-food, parks, theatre, music, art, shopping, people watching-New York has it all. Our subway system (as well as the easy access to cabs and Uber drivers) makes our meeting site easy to go wherever you want to go. Besides the newer sites such as One World Trade Center, New Museum, and the Highline, there is also much to see in the other boroughs. Feel free to explore, there is always something to see wherever you end up.

Gabrielle L. Shapiro, MD: I ♥ NY because of its energy and multicultural identity. New York has something for everyone and the best of everything!

Iliyan Ivanov, MD: I ♥ NY: Travel North – visit part of Manhattan that your tourist guide will not tell you about. West Harlem and Upper Manhattan host a number of art galleries and music venues that showcase authentic New York feel, art, and culture. Travel is easy – take the 1 train north from Columbus circle for a short 30-minute ride depending on your destination.

Plan A – A day trip to the Spanish Society of America (155th St. and Broadway) that houses original Goya and Velasquez paintings; then stroll down Broadway by the historic Trinity cemetery to the newest gallery on the block “Gitler & …” on 149th St. The gallery started a public art project of murals of birds endangered by climate change to raise awareness and honor the memory of one of America’s greatest (and New York’s own) artists John James Audubon. So, while in the neighborhood look for the bird murals and also check out the New York Times story on this project.

You can finish it off with a late lunch at Harlem Public – the best burger joint in town – on 148th St. and Broadway, or stroll further south and take pictures of the most incredible sample of Gothic architecture when you visit the campus of City College on 137th St. and Amsterdam Avenue.

Plan B – A night out – take the 1 train to 125th St. Just a couple of blocks from the station is the new location of the Gavin Brown Enterprise – world renowned gallery that has presented the most recognized contemporary artists (the 2015 solo show of Alex Katz was a must and a true cultural landmark). The gallery is located on 126th St. and Amsterdam Avenue in the historic Mink Building (an ex-factory turned art hub where “Uptown meets Downtown”). Late afternoon arrival will give you enough time to enjoy the art and prepare for dinner with music. Two blocks away to the east is “Showman’s” – New York’s most authentic jazz club featuring mostly Harlem based artists and offering home-made dishes. For BBQ stroll west to the end of 125th St. to find “Dinosaur BBQ” – excellent brisket and blues. If you are in a mood for an adventure you can visit the historic “Cotton Club,” which is free standing on the south side of 125th St., just 100 feet east from Hudson River.
### Wellness Initiative

In an effort to encourage the personal good health and wellness of our AACAP members, the Program Committee is infusing a wellness theme into the Annual Meeting this year. Special activities include:

- A morning run, walk, and bike in Central Park
- Yoga classes each morning
- Meditation classes each afternoon/evening
- Scientific CME sessions on wellness for your patients
- Healthier food selections at our special events

We hope attendees take advantage of these opportunities to improve their own wellbeing. These events are open to all attendees and their spouse/significant other. See below for scheduling details.

**Tuesday, October 25**

<table>
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<tr>
<th>Time</th>
<th>Event Description</th>
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<tr>
<td>4:30 pm–5:15 pm</td>
<td><strong>Meditation Class</strong>&lt;br&gt;Meditation sessions will last for 45 minutes at the end of each day. There will be a 30-minute practice with various techniques of focusing the mind. Time will also be given to discussing meditation postures, barriers to meditation, and cultivation of a personal practice. These meditation sessions are designed for all levels of practice.</td>
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**Wednesday, October 26**

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<th>Time</th>
<th>Event Description</th>
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<tr>
<td>6:30 am–7:30 am</td>
<td><strong>Yoga Class</strong>&lt;br&gt;Sivananda Yoga is a classical approach to the practice of yoga. Classes consist of physical yoga postures, breathing exercises and relaxation techniques. Classes are designed for all levels of practices from beginner to advanced. All are welcome, but space is limited and will be on a first come-first served basis. Mats will be provided.</td>
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**Walk in Central Park**

Join **Angel A. Caraballo, MD**, President of the New York Council on Child and Adolescent Psychiatry and member of the Program Committee, as well as fellow attendees for a brisk walk through Central Park to start your day off on the right foot! Meet in the Lobby of the New York Hilton Midtown at 6:30 am.

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<th>Time</th>
<th>Event Description</th>
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<tr>
<td>10:00 am–1:00 pm</td>
<td><strong>Symposium 12: Health Prevention and Promotion: More than Common Sense?</strong></td>
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**Thursday, October 27**

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<th>Time</th>
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<tr>
<td>6:30 am–7:30 am</td>
<td><strong>Yoga Class</strong></td>
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**Bike Ride in Central Park**

Join **JAACAP Editor-in-Chief Andres Martin, MD, MPH**, for a bike ride in Central Park as Dr. Martin prepares for his cross-country ride in 2017 for Break the Cycle. Meet in the Lobby of the New York Hilton Midtown at 6:30 am. AACAP will provide up to 30 bikes complimentary on a first-come, first-serve basis.

**Friday, October 28**

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<th>Time</th>
<th>Event Description</th>
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<tr>
<td>6:30 am–7:30 am</td>
<td><strong>Yoga Class</strong></td>
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**Run in Central Park**

Join **Douglas K. Novins, MD**, JAACAP Editor-Elect, and your fellow attendees for a run in Central Park and start your day off right! Meet in the Lobby of the New York Hilton Midtown at 6:30 am.

**Saturday, October 29**

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<th>Time</th>
<th>Event Description</th>
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<tr>
<td>6:30 am–7:30 am</td>
<td><strong>Yoga Class</strong></td>
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<th>Time</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>5:30 pm–6:15 pm</td>
<td><strong>Meditation Class</strong></td>
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**Clinical Perspectives 27: TED Talks Meet Perspectives: (Clinical) Ideas Worth Spreading**

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<th>Time</th>
<th>Event Description</th>
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<tr>
<td>8:30 am–11:30 am</td>
<td><strong>Workshop 26: CARING at Columbia Head Start: Promoting Resilience Through Creative Art and Play and a Prevention Model for At-Risk Preschool Children and Families</strong></td>
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**Workshop 36: The Buddha in Therapy: Integrating Mindfulness Into the Treatment of Children, Adolescents, and Their Families**

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<th>Time</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>7:00 pm–7:45 pm</td>
<td><strong>Meditation Class</strong></td>
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Integrated Care Programs

Workshop 9: Collaboration With Primary Care: Developing Clinical Skills and Overcoming System Challenges
Wednesday, October 26,
3:00 pm–6:00 pm (ticket)
Chair: Barry Sarvet, MD
Speaker: Read Sulik, MD
Sponsored by AACAP’s Committee on Collaboration With Medical Professions and Healthcare Access and Economics Committee

Clinical Perspectives 26: Life Members Wisdom Clinical Perspectives on Integrated Care, Health, Resilience, and the Future of Child and Adolescent Psychiatry
Thursday, October 27,
2:00 pm–5:00 pm (open)
Chair: Douglas A. Kramer, MD, MS
Discussants: Marilyn B. Benoit, MD, Yiou Kee Warren Ng, MD
Speakers: Margaret Cary, MD, MPH, Gregory K. Fritz, MD, James J. Hudziak, MD, Michelle L. Rickerby, MD
Sponsored by AACAP’s Family Committee and Life Members Committee

Thursday, October 27,
2:00 pm–5:00 pm (open)
Chair: Sourav Sengupta, MD, MPH
Speakers: Beth A. Smith, MD, Eyal Shemesh, MD, David Buxton, MD, Read Sulik, MD
Sponsored by AACAP’s Committee on Collaboration With Medical Professions

Working Together in 21st Century Pediatrics: Collaborative Care in Action with Experts in Anxiety and Depression
Thursday, October 27,
6:00 pm–10:00 pm (ticket)
Chair: Rachel Zuckerbrot, MD
Speakers: Boris Birmaher, MD, Diane Bloomfield, MD

Symposium 34: Community Crisis and Community Resilience: The Children of Flint, Michigan
Friday, October 28,
8:30 am–11:30 am (open)
Chairs: Sheila M. Marcus, MD, Dayna LePlatte, MD
Speakers: Anne Kramer, MSW, Dayna LePlatte, MD, Lauren O’Connell, MD, MSC
Sponsored by AACAP’s Infant and Preschool Committee

Special Interest Study Group 8: Community Crisis and Community Resilience: The Children of Flint, Michigan
Friday, October 28,
8:30 am–11:30 am (open)
Chair: Gregory K. Fritz, MD
Speakers: Boris Birmaher, MD, Diane Bloomfield, MD, Lawrence A. Stone, MD

AACAP President Gregory K. Fritz, MD, has made integrated care the focus of his two-year presidential initiative. Part of that initiative involves educating child and adolescent psychiatrists about models for integrated care and how best to collaborate with others in primary or specialty medical care. Here is a sampling of the programs on the Annual Meeting schedule dedicated to this topic.
Residents, Trainees, and Medical Students
ATTEND AACAP’S ANNUAL MEETING FOR FREE!

Serve as a MONITOR for one full day or two half days of the meeting to receive free registration and half-price on most ticketed events.

October 24-29, 2016
New York Hilton Midtown and Sheraton New York Times Square
New York, NY

For more information about the Monitor Program, visit www.aacap.org/AnnualMeeting/2016. Registration opens August 1 for AACAP members and August 8 for nonmembers. Become a member TODAY to get priority monitor scheduling!

Promote Your Book at This Year’s Annual Meeting!

Join us at our “Meet the Author” booth in the Exhibit Hall. All attendees are welcomed to participate. Sign up for a one-hour time slot to promote your book. Limited time slots are available beginning on Wednesday, October 26 and ending on Friday, October 28. The cost is $300 per hour for each book, which defrays costs of booth rental. Be the first author to sign up!

More information can be found at: www.aacap.org/exhibits/2016.
Congratulations!

AACAP wants to acknowledge the hard work and success of all the speakers who presented at our 2016 Spring Meetings.

The following speakers received the highest average ratings on evaluations from the 2016 Psychopharmacology Update Institute: Translating Evidence-Based Studies Into Clinical Practice. This Institute was chaired by Melissa P. DelBello, MD, and Laurence L. Greenhill, MD, and held at the Sheraton New York at Times Square, January 29-30, 2016.

Timothy E. Wilens, MD: Psychopharmacological Strategies for Adolescent Substance Use Disorders (4.8 on a 5 point scale)

John T. Walkup, MD: Clinical Studies That Shape the Psychopharmacological Treatment for the Child With Anxiety Disorder (4.87 on a 5 point scale)

Be sure to look for the latest installment of the Psychopharmacology Update Institute at AACAP’s 63rd Annual Meeting in New York, NY, and in San Francisco, CA, January 20-21, 2017!

The following speakers received the highest average ratings on evaluations from AACAP’s Douglas B. Hansen, MD, 41st Annual Review Course. This Institute was chaired by Gabrielle A. Carlson, MD, and James J. McGough, MD, and held in Long Beach, CA, March 12-14, 2016.

Eraka Bath, MD: Forensic Issues (4.84 on a 5 point scale)

John T. Walkup, MD: Generalized Anxiety Disorder, Social Phobia, Separation Anxiety, Obsessive Compulsive Disorder, Movement Disorders, and Posttraumatic Stress Disorder (4.80 on a 5 point scale)

Thanks to all of the chairs, presenters, and participants of these valuable meetings!
Membership CORNER

Congratulations to Graduating Residents and Medical Students

Please provide us with your updated contact information after graduation.

You can update your information online at www.aacap.org.

This Could Be Your Last Issue!

Renewed for 2016? If not, you could be holding your last issue of AACAP News!
Logon to www.aacap.org and renew today. Contact Member Services at 202.966.7300, ext. 2004 to renew by phone.

In Memoriam

Jose Marrero, MD
Palm City, FL

Nelli Mitchell, MD
Rochester, NY

Herman Spater, MD
Larchmont, NY

DID YOU KNOW?

New York City’s 520-mile coastline is longer than those of Miami, Boston, Los Angeles, and San Francisco combined.
Welcome New AACAP Members

Hetal Amin, MD, O’Fallon, IL
Kammarauche Asuzu, MD, Durham, NC
Alan Atkins, La Canada Flintridge, CA
Manpreet K. Bassi, Sacramento, CA
Emeric Bojarski, MD, Carlisle, MA
Celeste Brown, Charlotte, NC
Hector Sam Cardiel, West Orange, NJ
Sara Chun, Washington, DC
Un-Sun Chung, MD, PhD, Deagu, Republic of Korea
Esther Currie, MD, Sacramento, CA
Eva Diaz, MD, Denver, CO
Michael A. Donath, Sacramento, CA
Justine L. Ellis, MD MBBS, Annandale, NSW, Australia
Veronica Faller, North Reading, MA
Luis A. Fernandez, Sacramento, CA
Brittany Furr, New York, NY
Itzayana Garcia, Los Angeles, CA
Tracy Grabman, MD, Knoxville, TN
Ronald Graveland, MD, Wezep, Netherlands
Olivier Halkon, MD, Lausanne, Vaud, Switzerland
Shariq Haque, MD, Parsippany, NJ
Blaire Ashley Heath, Placenta, CA
Reena Henderson, DO, Little Rock, AR
Benjamin Hines, MD, Morgantown, WV
Taman Hoang, Sacramento, CA
Julia Hoang, MD, Huntington Beach, CA
Kali Hobson, MD, Portland, OR
Daniel Hosker, MD, Rochester, MN
Iyantta Howell, MD, Livonia, MI
Lance Irons, Norfolk, VA
Brett Johnson, MD, Chula Vista, CA
Alexandra Junewicz, MD, New York, NY
Mitchel G. Katz, MD, Rocky Hill, CT
Jasmine Kaur, MD, Wichita, KS
Joel Kestenbaum, MD, Belle Harbor, NY
EunHye Kim, MD, Seoul, Republic of Korea
Kodjovi Kodjo, Elkridge, MD
Bishoy Kolta, MD, Atlantic City, NJ
Jordan Koncinsky, Salt Lake City, UT
Hal Kronsberg, MD, Somerville, MA
Reena Kumar, DO, Milwaukee, WI
Lauren Kwan, Sacramento, CA
Svante Niklas Langstrom, MD, Stockholm, Sweden
Grace Lee, DO, Tampa, FL
Rachel Leidner, MD, Dallas, TX
Kimberly S. Lin, Pittsburgh, PA
Yee Lo, Sacramento, CA
Erica Lubliner, MD, Bakersfield, CA
Gabriel Lugo, MD, Lakewood Ranch, FL
Irene Ly, Elk Grove, CA
Ramkrishna Makani, MD, Absecon, NJ
Neetu Malhi, Fresno, CA
Lauren Manning, Portland, ME
Martin Manoukian, Sacramento, CA
Noah Matilsky, MD, Portland, OR
Morgan Anne McCoy, Philadelphia, PA
Megan McLeod, MD, Buffalo, NY
Nadia Mendiola, MD, San Antonio, TX
Carlos Molina, MD, Cleveland, OH
Lorin Mowrey, Phoenix, AZ
Megan Mrozowski, MD, New York, NY
Kathy Mu, DO, Houston, TX
Kristin Nguyen, Rochester, MN
Daniel Nicoli, MD, Portland, OR
Rebecca Nkrumatt, Sacramento, CA
Kristine Olivier, MD, New Orleans, LA
Sameeraa Pahwa, New Orleans, LA
Shivani Patel, Temple, TX
Lauren Provini, New Haven, CT
Saumya Rachakonda, MD, Brooklyn, NY
Manivel Rengasamy, MD, Pittsburgh, PA
Monica Rettenmier, MD, Nashville, TN
Juan A. Rivolta, MD, Brooklyn, NY
Kylie Roberts, Corpus Christi, TX
Claudia Rocha, Sacramento, CA
Nicole Christina Rouse, Riverside, CA
Callum J. Rowe, Sacramento, CA
Gabriela Sanchez, MD, Pasadena, CA
Kevin Sanders, MD, Nashville, TN
John-Lloyd Santamaria, Sacramento, CA
Anna Scandinaro, Hummelstown, PA
Hannah Schroeder, Christiansburg, VA
Meryam Sheriati, MD, Baldwin, NY
Jeonwon Shin, MD, Morton, IL
Kevin Mauclair Simon, MD, Atlanta, GA
Ramon Solikhah, MD, Neptune, NJ
Maya Strange, MD, Reno, NV
Evan Trager, MD, Corona, CA
Jalia Tucker, Chicago, IL
Jack Turban, III, New Haven, CT
Marcia Unger, MD, Sacramento, CA
Olivetta Uradu, Washington, DC
Codie Vassar, Milwaukee, WI
Sergey Veretennikov, Sacramento, CA
Richa Vijayvargiya, Melbourne, FL
Benjamin Weger, Rockford, IL
Emily S. Weibel, Sacramento, CA
Matthew Weingard, MD, MPH, Alexandria, VA
Alison Weiss, MD, Chicago, IL
Alexa Whatmough, St. Louis, MO
Jorge A. Zapate, MD, Solana Beach, CA
Beneficiary Designations: A Gift to AACAP That Costs Nothing Now

Alan Mark Ezagui, MHCA, Deputy Director of Development

It is never too early to consider using your retirement assets to make a difference. Many of our members have IRAs, 401(k)s, 403(b)s, or another qualified plan, yet these assets are often overlooked when considering how to help AACAP do more to help children with mental illnesses. A beneficiary designation on a retirement plan costs nothing now, and at the same time allows you to include AACAP in your future charitable giving without having to consult an attorney.

And, in making such a gift, you also become a member of AACAP’s 1953 Society.

It is also one of the easiest estate gifts to make. Your plan administrator at your hospital, Human Resources Department at your academic institution or other employer, or the financial institution that holds your (IRA) assets can provide you with the necessary beneficiary designation form to complete. You still retain complete ownership of your account to spend during your later years and any leftover funds will go to AACAP.

You can even name multiple beneficiaries: AACAP can be a full or partial beneficiary of any portion of those assets. Another option is to name AACAP as a contingent beneficiary to inherit those assets should your primary beneficiary not survive you.

Also, naming AACAP as a beneficiary of your retirement plan will help you save on estate and income taxes. How? Retirement plan assets that are left to heirs other than a spouse are taxed; however, a tax exempt organization (i.e., a 501(c)(3), such as AACAP does not pay taxes. Furthermore, taxes on retirement assets must be paid at death which leaves less money for heirs. Thus, if you plan on making a gift to charity in your estate plan, giving retirement assets tax-free is a great way to maximize the value of your estate for your heirs, while also making an even bigger difference for children with mental illnesses, helping them achieve their life’s full potential.

Finally, other assets you can use with beneficiary designations are life insurance policies, investment accounts, and bank accounts.

For more information on how you can make a difference for these children, please contact AACAP’s Development Office 202.966.7300, ext. 140 or by email at development@aacap.org. You can also find more information in the 1953 Society section of our website, www.aacap.org/1953Society.

Lifelong Learning Module 10 Expires August 31, 2016

AACAP’s Lifelong Learning Module 10: Abuse and Neglect, Adoption and Foster Care, Custody and Divorce, Dissociative Disorders, Personality Disorders, Reactive Attachment Disorder, and Relevant Updates for Child and Adolescent Psychiatrists expires on August 31, 2016. Be sure to complete your module exams before the deadline to earn a total of 38 AMA PRA Category 1 Credits (8 of which can be used towards the ABPN’s self-assessment requirement for MOC).

If you currently have Module 10, complete your exams online or mail in your answer form before August 31st to receive credit (complete instructions are included within your module). Exams cannot be submitted for grading after August 31.

It’s not too late to buy a copy of Lifelong Learning Module 10. The deadline to order Module 10 is July 31, 2016. Visit our online publication store at www.aacap.org to place your order.
Thank You for Supporting AACAP!

AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, 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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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.
The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to introduce a new and improved JobSource, an advertising and recruiting tool to assist AACAP members and related experts looking for new career opportunities, and to help employers find the most qualified child and adolescent psychiatrists.

The new JobSource is simple and easier to use. Get to everything you need with just a few clicks. Visit us online at www.aacap.org and find JobSource under Quick Links or Member Resources.

With questions, please contact Samantha Phillips, Membership & Communications Coordinator, at sphilips@aacap.org.
AUSTRALIA

SENIOR STAFF SPECIALIST OR STAFF SPECIALIST (CHILD AND YOUTH PSYCHIATRIST)
Cairns

Mental Health and Alcohol, Tobacco and Other Drugs Service, Division of Family Health and Wellbeing, Cairns, Cairns and Hinterland Hospital and Health Service.

Remuneration value up to $394 542 p.a., comprising salary between $194 686 - $206 416 p.a. (L25-L27) or Remuneration value up to $360 771 p.a., comprising salary between $162 802 - $189 106 p.a. (L18-L24), employer contribution to superannuation (up to 12.75%), annual leave loading (17.5%), communications package, professional development allowance, motor vehicle allowance, professional development leave 3.6 weeks p.a., professional indemnity cover, private practice arrangements plus overtime and on-call allowances. (Applications will remain current for 12 months).

Duties/Abilities: Cairns is in the heart of the tropical north and is the primary gateway to northern Australia. Cairns is an ideal base to explore the wider region with front door access to the Great Barrier Reef, rainforests and outback locations with an International Airport located only several minutes’ drive north of the city centre. This position will require the provision of excellent, specialist child and adolescent psychiatric knowledge and skills to facilitate the delivery of quality child and adolescent mental health care to children, young people and supporting their families in recovery model of care. This role will provide diversity, challenges and rewards, combined with the opportunity to contribute to new initiatives and the enhancement of an integrated, developmentally appropriate model of care for children and youth and their families across the continuum. Cairns and Hinterland Hospital and Health Service will not be accepting applications submitted through recruitment agencies. Medical Practitioners are encouraged to apply online or directly to Recruitment Services.

Enquiries:
Dr. Maree Ploetz 07 4226 5273

Job Ad Reference: CA207135
www.smartjobs.qld.gov.au

CALIFORNIA

ADOLESCENT INPATIENT AND OUTPATIENT OPPORTUNITY
San Francisco, CA

Adolescent and Adult Inpatient/Outpatient Opportunity Practice Near Golden Gate Park in San Francisco

Dignity Health Medical Group - Saint Francis/St. Mary’s, a service of Dignity Health Medical Foundation, is a dynamic and growing group providing high quality medical services to patients. We are affiliated with St. Mary’s Medical Center, dignity-health.org/stmarys/medical-services/adolescent-psychiatric-services.

We are seeking a BE/BC Adolescent Psychiatrist who is energetic and thrives on the opportunity of expanding our existing Adolescent services in San Francisco! Leadership experience/interest is a plus for a possible Medical Director Opportunity.

Opportunity Highlights: Adolescent and Adult Psychiatrist Practice at the hospital’s McAuley Institute, the only dedicated adolescent inpatient program in San Francisco Also practice outpatient/inpatient adult psychiatry Growth in San Francisco Also practice outpatient/inpatient adult psychiatry Growth to a Medical Director role Practice with established community Psychiatrists In-House Hospitalists available 24/7/365 for medical H & P and management of acute medical conditions. Our Medical Foundation is aligned with one of the largest health systems in the nation and the largest hospital system in California.

For more information, please contact and send your CV to:

Dignity Health Medical Foundation
Lori Hart, Physician Recruiter
Email: providers@dignityhealth.org
Phone: 888-399-7787
www.dignityhealth.org/physician-careers

Company: Spin Recruitment Advertising
Job ID: 8212638
http://jobsource.aacap.org/jobs/8212638

ILLINOIS

HEAD OF CHILD AND ADOLESCENT PSYCHIATRY
Chicago, IL

The Northwestern University Feinberg School of Medicine (NUFSM) and Ann & Robert H. Lurie Children’s Hospital of Chicago are seeking an outstanding child and adolescent psychiatrist to hold the Osterman Endowed Chair as Head of the Department of Child and Adolescent Psychiatry at Lurie Children’s and Division Head at NUFSM. An energetic and forward-thinking leader is sought for this multidisciplinary program with missions of clinical care, education, research, and advocacy in a nationally ranked freestanding state-of-the-art children’s hospital located on the medical school campus in the heart of Chicago, overlooking Lake Michigan. Funding is available for research and faculty development. Successful application requires leadership and administrative experience in an academic medical center, preferably including a children’s hospital, a sustained record of academic accomplishments, excellent skills in collaboration, and leadership in national professional organizations. Current certification by ABPN in child and adolescent psychiatry is required. This Associate or full Professor position is a full-time continuing faculty appointment.

Rank, track, and salary are commensurate with qualifications and experience. Hiring is contingent upon eligibility to work in the United States and medical licensure in Illinois. Applications will be evaluated as received. Anticipated start date is December 2016.

Send your CV with a letter describing relevant experience and interests to Alexis Puzon (apuzon@nm.org).

Northwestern University and the Lurie Children’s Medical Group are Equal Opportunity, Affirmative Action Employers of all protected classes, including veterans and individuals with disabilities. Women and minorities are encouraged to apply. Hiring is contingent upon eligibility to work in the United States.

Mkd 111715
INPATIENT (WITH OPTIONAL OUTPATIENT) CHILD AND ADOLESCENT PSYCHIATRIST
Park Ridge, IL

Inpatient (with optional outpatient) Child and Adolescent Psychiatrist Suburban Chicago Advocate Childrens Medical Group at Advocate Childrens Hospital in Park Ridge, Illinois, seeks a full time flexible BE/BC Child and Adolescent Psychiatrist with excellent interpersonal skills and a passion for improving the lives of children. Come join an outstanding multidisciplinary team to provide care for and an opportunity to lead one of the few and truly unique child and adolescent inpatient psychiatry units in the Chicagoland area! This would be primarily an inpatient role providing services to patients in the 12-bed C/A inpatient psychiatric unit, partial hospitalization program, and patients on the general medical floors through consultative work. (Outpatient work would be optional.)

Assist in being part of an extraordinary and nationally renowned hospital network focused on development of its child behavioral health services. There are opportunities for growth and leadership and additional responsibilities may include hospital staff education, community education and partnerships, and assisting in the supervision and teaching of a wonderful group of dedicated psychiatry and pediatric residents. A devoted team of clinicians, support and administrative staff are there to assist in any way to ensure a comfortable, respected and balanced work/life environment. On Call Schedule: ER phone call 5-6 days with 1 weekend per month. No in-house call, coverage by phone. Patient population is a wonderful payor-mix blend. 1-2 average patient admissions per call. Regretably J 1 Visas are not available.

Please forward CV and detailed cover letter to: Nancy Mathieu
Nancy.Mathieu@advocatehealth.com
Visit www.advocatechildrensmedicalgroup.com for more details.

Job Requirements:
Qualified applicants will have completed an American Board of Pediatrics (ABP) accredited fellowship and be BE/BC by the ABP in this subspecialty. Consider joining our team committed to providing evidence based, compassionate care. Advocate Children's Hospital is the largest network provider of pediatric services in Illinois and among the top 10 in the nation. Through a special, holistic approach, Advocate Children's Hospital combines some of the country's most respected medical talent with exceptional and compassionate care. Compensation package is available through Advocate Medical Group, one of the largest physician-run organizations in the state. Candidates with strong ties to the area are welcomed! This is a full time position.

Company: Advocate Health Care / Advocate Childrens Medical Group
Job ID: 8198731
http://jobsource.aacap.org/jobs/8198731

MASSACHUSETTS
RESEARCH DIRECTOR, FUSS CENTER FOR NEUROPSYCHIATRIC DISEASE AND PROGRAM IN BEHAVIORAL SCIENCE
Boston, MA

Boston Children's Hospital Department of Psychiatry is seeking a Director for its newly created Tommy Fuss Center for Neuropsychiatric Disease Research (Tommy Fuss Center). The successful candidate will also assume leadership of all Psychiatry research in the dual role as Director of the Department's Program in Behavioral Science (PBS). The current PBS research portfolio spans Developmental Neuroscience, Developmental Psychopathology, Health Psychology, and Community Psychology. The Tommy Fuss Center is an exciting new opportunity that significantly enhances the PBS research portfolio by targeting the understanding of the developmental pathways leading to major neuropsychiatric disorders. The primary goals of the Center will be to develop strategies to identify young children at risk for anxiety, depressive, and psychotic disorders along with innovative approaches to therapy that could limit the progression of these disorders, thereby promoting more positive developmental outcomes. The Center will be highly interdisciplinary and translational and will provide for both innovative research by scientists at all levels and training of the next generation of talented researchers to carry these efforts forth into future. With over 140 faculty members (42 psychiatrists and 104 psychologists), the Department of Psychiatry's active and diverse programs in clinical services, education, and research encompass all aspects of the field of child and adolescent behavioral health. The Department is seeking leadership from a gifted mid- to senior level academic child psychiatrist or psychologist with an active research program that promotes the mission of the Tommy Fuss Center to advance understanding of developmental pathways leading to major neuropsychiatric disorders.

Job Requirements:
The successful candidate will demonstrate scholarly excellence through research productivity and a record of successful competition for external funding, a strong record of mentoring, and excellent leadership skills. A strong collaborative nature will be required to sustain and build partnerships both within and outside the hospital setting. The proposed position will be at either the rank of Professor or Associate Professor at Harvard Medical School.

Company: Boston Children's Hospital
Job ID: 8201241
http://jobsource.aacap.org/jobs/8201241

MINNESOTA
CHILD AND ADOLESCENT OPPORTUNITY
St. Paul/Minneapolis, MN

Growing Psychiatric Healthcare System Seeks Psychiatrists PrairieCare, a physician-owned psychiatric healthcare system in the Minneapolis/St. Paul metropolitan area, is recruiting child, adolescent and adult psychiatrists for its Brooklyn Park, Chaska, Edina, Maple Grove, Maplewood and Rochester sites. Child/Adolescent clinical duties may include treating youth in inpatient, partial hospital, intensive outpatient, residential and clinic settings. Adult patients are served in intensive outpatient programs and busy outpatient clinics with therapist, social work and nursing support on site. Opportunities to consult with primary care clinicians through an innovative “integrated health and wellness” model available as well. Academic appointment on the adjunct faculty of the University of Minnesota Medical School possible for interested candidates. Reports to Chief Medical Officer. Requires BC/BE in Psychiatry and an
unrestricted license to practice medicine in Minnesota. With multiple sites across Minnesota, PrairieCare is rapidly growing and boasts one of the region’s largest groups of psychiatric physicians. Our organization is focused on offering dedicated clinicians the opportunity to practice high quality psychiatric care in a supportive, team-based group practice. The Twin Cities metro area has approximately 3.5 million people, over thirty institutions of higher learning, an outstanding K-12 school system, multiple professional sports teams and a thriving fine arts community. Minnesota has four beautiful seasons and is consistently ranked as one of the healthiest states with some of the most enjoyable amenities. PrairieCare provides an excellent compensation and benefits package.

View us online at www.prairie-care.com.

Send CV and letter of interest to: Kait Semon, Medical Staff Coordinator; PrairieCare; 9400 Zane Ave N; Brooklyn Park, MN 55443; or via email to ksemon@prairie-care.com.

Company: PrairieCare (878184) Job ID: 8057401
http://jobs.source.aacap.org/jobs/8057401

NEBRASKA
CHILD AND ADOLESCENT PSYCHIATRIC HOSPITALIST
Lincoln, Nebraska

Bryan Physician Network, the employed medical group of Bryan Health, has a Child and Adolescent Psychiatric Hospitalist opportunity. Average Daily Census of 13-22 28 bed child and adolescent unit provides acute crisis stabilization for youth 3-18 Wide range of diagnoses treated. The 7 days on and 7 days off schedule allows for travel and time with family that few other jobs can accommodate. Dedicated team of experienced social workers and therapists, psych pharmacists and other professionals work closely with our Psychiatric Hospitals Competitive compensation and benefits package. Bryan Health is the regional leader in providing mental health services and offers 66 inpatient mental health beds, a dedicated mental health emergency department, drug and alcohol treatment facility, partial hospitalization, individual and family counseling, biofeedback, and many other outpatient services. If you desire to have an incredible impact on the youth in a community, this is where you want to be! According to Forbes, Lincoln is the 7th Best Place in the country for Business and Careers! Lincoln, Nebraska, has earned a reputation as one of the Midwest’s most beloved cities. Home to fine culinary and artistic treasures, a budding live music scene, breath-taking parks, numerous golf courses, miles of biking trails, and a friendly Midwestern attitude, Lincoln offers the exhilaration of a large city and the serenity of a smaller town all in one place. Suburban living offers charming family neighborhoods, top-notch public and private K-12 schools, and a cost of living 10.2% below the national average! Downtown Lincoln is a vibrant, growing “urban oasis” evidenced by the resurgence of young professionals choosing to live and play in the city. Lincoln offers something for every lifestyle!

Contact in Confidence: Brenda McGinn brenda.mcginn@bryanhealth.org 402-481-4526 www.bryanhealth.com/careers/physician-opportunities

Company: Bryan Health (912612) Job ID: 8137891
http://jobs.source.aacap.org/jobs/8137891

NEW JERSEY
PRIVATE OUTPATIENT CHILD AND ADOLESCENT PSYCHIATRY OPPORTUNITY
Cedar Knolls, Millburn and Montclair, NJ

Child/Adolescent Psychiatrist positions are available for our Cedar Knolls, Millburn and Montclair, NJ, locations, to join our private upscale fee-for-service comprehensive child, adolescent and adult psychotherapy Centers. Candidate will be part of a multi-disciplinary team and will provide psychiatric evaluation, medication management and, if desired, psychotherapy, in a supportive collegial atmosphere. Salary and benefit package is generous, and includes excellent medical and dental insurance benefits, generous vacation and CME time, retirement plan and more. Candidate must be board certified or board eligible in child/adolescent psychiatry.

E-mail cv to abbazn@aol.com.

Company: ADHD, Mood and Behavior Center (980325) Job ID: 8215592
http://jobs.source.aacap.org/jobs/8215592

VIRGINIA
CHILD AND ADOLESCENT Psychiatrist
Shenandoah Valley

The Commonwealth Center for Children & Adolescents (CCCA) invites you to consider a Child and Adolescent Psychiatry position in the beautiful Shenandoah Valley. CCCA is Virginia’s only public acute psychiatric hospital for children and adolescents. CCCA is 48-bed hospital serves youngsters with a variety of serious psychiatric disorders from across the state of Virginia. Treatment is provided in a relationship-based, collaborative, trauma-informed treatment model of care, in which the psychiatrist is the head of the child’s treatment team on a 12-bed unit.

As Psychiatrist, you will direct a multidisciplinary treatment team consisting of a psychologist, social worker, nurse, substance abuse counselor, direct care staff, and teachers, providing treatment for children and adolescents with complex, co-morbid, and severe mental illnesses. Expertise in psychiatric evaluation and treatment, including psychopharmacology, is essential.

CCCA serves as the inpatient child psychiatry training center for the University of Virginia Department of Psychiatry & Neurobehavioral Sciences child psychiatry fellows and general psychiatry residents, and abundant education and supervision opportunities are available, including a clinical faculty appointment at the University of Virginia for eligible candidates.

For further requirements and to apply, please visit the Virginia Jobs at http://jobs.virginia.gov/. The position offers a competitive salary with full state benefits including vacation and educational conference time, retirement plan, medical and dental insurance, disability plan, life insurance, etc.

Please contact our Human Resource office at (540) 332-2116 for further questions. CCCA is an equal opportunity, affirmative action employer.
SAVE THE DATES!

JANUARY 20-21, 2017

Gabrielle A. Carlson, MD, and Manpreet Kaur Singh, MD, MS, Co-Chairs
The Westin St. Francis San Francisco - San Francisco, CA

Register by December 7 at www.aacap.org/psychopharm/2017.
Questions? E-mail meetings@aacap.org.
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