AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

WWW.AACAP.ORG

Back to Project Future

PLAN FOR THE COMING DECADE

A Presidential Initiative of Martin J. Drell, M.D.

Steering Committee

Alan Axelson, M.D.
Michael Houston, M.D.
Paramjit Joshi, M.D.
Sheryl Kataoka, M.D.
Debra Koss, M.D.
James MacIntyre, M.D., Chair
Richard Martini, M.D.
David Pruitt, M.D.
Neal Ryan, M.D.
Heather Walter, M.D., M.P.H.
Virginia Anthony (through August 2012)
Heidi Fordi, C.A.E.

Service/Clinical Practice Subgroup

Michael Houston, M.D., Co-Leader
Richard Martini, M.D., Co-Leader
Sukhjit Brar, M.D.
Mark Chenven, M.D.
Robert Hilt, M.D.
Larry Marx, M.D.
Barry Sarvet, M.D.
Heather Walter, M.D., M.P.H.

Training and Workforce Subgroup

David Pruitt, M.D., Leader
Gene Beresin, M.D.
Arden Dingle, M.D.
Geri Fox, M.D.
David Kaye, M.D.
Boris Lorberg, M.D.
Ken Rogers, M.D.
Sourav Sengupta, M.D.
Saundra Stock, M.D.
Chris Varley, M.D.

Research Subgroup

Neal Ryan, M.D., Leader
Kiki Chang, M.D.
Melissa Del Bello, M.D.
Mary-Margaret Gleason, M.D.
Mirjana Jojic, M.D.
Young-Shin Kim, M.D.
Daniel Pine, M.D.
Hanna Stevens, M.D.
John Walkup, M.D.
Bonnie Zima, M.D.

AACAP Staff

Adriano Boccanelli
Yoshie Davison
Elizabeth Hughes
Kristin Kroeger Ptakowski
Ashley Partner
Jill Zeigenfus Brafford

Honorary Editors

Richard Cohen, M.D.
Norbert Enzer, M.D.

CONTENTS

Section IV: SPECIAL TOPICS

Section V: CONCLUSIONS

Section VI: NEXT STEPS – IMPLEMENTATION PHASE

APPENDIX

ATTACHMENTS (PDF files)

Message from the President

AACAP's original *Project Future* was underway in 1979 as I finished my training and the report was published in 1983 when I first became a training director of child and adolescent psychiatry (CAP). At the time, I was not especially pleased with the report's strong message for change. I was quite content doing psychotherapy with children and adolescents. *Project Future* pushed me to rethink and broaden my goals and view of CAP. The report challenged me to think about which patients I should be treating and how best to train the residents in my training program.

At the time, I summarized *Project Future*'s call for change in this way: "It says that I should stop doing everything I like and start doing everything I don't like." Despite these feelings, I took on the challenge of *Project Future* and diversified the training for residents. I adopted the systems theory influence and biopsychosocial approach (George Engel) as the theoretical model for my training program. The training program retained its focus on psychotherapy and included much more! Much of what was taught was new to me and I learned side-by-side with my trainees.

Over the years, much of what *Project Future* recommended has come true. The field of CAP has grown and blossomed through research, education, training, and advocacy. CAP has much more to offer the children, adolescents, and families that we treat.

As I worked on various Academy components over the years, I have developed a deeper understanding of our field, its strengths and weaknesses, and the many challenges facing CAP. I have learned how the Academy works and solves problem over time. As a member of the Academy's leadership for several years, I am aware of members' concerns and worries about the many changes in healthcare. Being in New Orleans, I am no stranger to change; coping with the ravages of Hurricane Katrina, the closing and privatization of my State Hospital system, the recession, a continuing reduction in state funds to the medical school, and the British Petroleum oil spill. Through all these changes and crises I have wrestled with a host of feelings and how best to deal with them. When I am forced to choose between the anxieties and hopelessness of an external locus of control versus the anxieties of an internal locus of control, I generally choose to act.

The passage and implementation of the Affordable Care Act (ACA) is an impetus for change across all of healthcare in this country. I felt the Academy needed to prepare itself and its members for these changes. My response was to plan a major Presidential Initiative during my term that I called Back to *Project Future* (BPF). The BPF initiative came after several previous AACAP Executive Committees had called for strategic planning to be done. BPF was organized to be a time-limited but inclusive planning process that would focus on all the changes associated with the massive complexities and inevitable unintended consequences of the ACA.

BPF was created to predict and plan for the field of child and adolescent psychiatry across the next decade (2013-2023). As a Presidential Initiative, its span of activities was limited to the two years of my Presidency versus the five years devoted to the original *Project Future*. It was planned with fewer committees and to use the "digital revolution" to speed things along. The focus of BPF is to identify where healthcare is going, its impact on child and adolescent psychiatry, and to create priorities and plans to assist members and the Academy in navigating the coming decade more smoothly.

I chose James MacIntyre, II, M.D., to be the chair of *Back to Project Future*. Former AACAP Executive Director Ginger Anthony, Dr. MacIntyre, and I created a structure for BPF that would ensure a successful, timely, and "on time" project that could be done during my term as President. This report, *Plan for the Coming Decade*, was created by the BPF Steering Committee and its subcommittees, with input from the BPF Distinguished Consultants, Honorary Editors, AACAP committees and members, and several outside organizations. The BPF report will serve as a roadmap for the Academy's journey over the next decade. Hopefully, all of us will arrive in 2023 stronger than ever, with the resources, abilities, and capabilities to do much more. Fasten your seatbelts—it is going to be an exciting ten years!

Martin J. Drell, M.D., AACAP President (2011-2013)

Section I
INTRODUCTION

EXECUTIVE SUMMARY

Charge and Process

In late 2011 ***Back to Project Future*** (BPF) was established by AACAP President Martin Drell, M.D., as one of his Presidential Initiatives during his term (2011-2013). Dr. Drell appointed James MacIntyre, II, M.D., chair of the BPF Steering Committee, and was given overall responsibility for the initiative. The Steering Committee was charged with developing a plan to help guide AACAP leadership, members and staff in the coming decade. The BPF Steering Committee completed its work with a final report, ***Plan for the Coming Decade***, in September 2013.

Back to Project Future was designed and organized to create a time-limited and highly-focused structure and process that enabled a diverse group of AACAP members to come together to develop a consensus of priorities and action steps for AACAP that spanned three key areas: *Service/Clinical Practice*, *Training and Workforce*, and *Research*. The report's findings and recommendations were developed to be useful to: child and adolescent psychiatrists in practice, child and adolescent psychiatrists in academic institutions, child and adolescent psychiatrist researchers, public policymakers, and primary care physicians and allied child mental health professionals. The report defines a "shared vision" and "roadmap" of where the subspecialty of child and adolescent psychiatry and AACAP will be in 2023 and how to get there from 2013.

Framework and Vision Statement

Plan for the Coming Decade uses a framework of goals, recommendations, rationales, and action steps. These elements collectively support the BPF "Vision Statement." The elements are defined as follows:

- **GOAL** – *Statements containing key elements needed to support and achieve the BPF "Vision." "Goal" statements are broad and more aspirational than "Recommendations."*
- **RECOMMENDATION** – *Statements containing core concepts (idea kernels) that move the "Goal" toward a specific plan of action.*
- **RATIONALE** – *Narrative statements and sections that provide a context and critical perspective on the importance of the "Goal" or "Recommendation."*
- **ACTION STEP** – *Specific actions, activities and initiatives that support the goals and recommendations. These constitute specific steps needed to implement a "Recommendation."*

The Steering Committee developed the following Vision Statement for the project:

The Back to Project Future *Presidential Initiative will develop prioritized recommendations that define and promote high quality preventive and clinical services, education and training, research, and advocacy in child and adolescent psychiatry across the coming decade (2013-2023). These recommendations will be used to guide AACAP in:*

- *promoting mentally healthy children, adolescents, and families;*
- *defining the professionalism, ethics, training, and skills of child and adolescent psychiatrists;*
- *promoting the development of broadly effective interventions and treatments for children and adolescents;*
- *supporting child and adolescent psychiatrists' practice in systems of care and other child serving systems.*

Goals & Recommendations (the "Roadmap") for the Coming Decade

The majority of the report consists of a comprehensive description of goals, recommendations, and action steps developed by the BPF Steering Committee and Subgroups to be the "roadmap." The goals, recommendations, and action steps represent the consensus of the BPF Steering Committee and Subgroups in 2013, and are submitted for further study and consideration by AACAP leadership, members, and staff. Some goals, recommendations, and action steps are more fully developed than others. This section should be viewed as a resource document – a broad menu with many choices of "routes" on the roadmap.

The *Back to Project Future* goals for the coming decade are:

Goal 1 (Core knowledge and skills) – As providers of quality clinical care to children, adolescents, and families, child and adolescent psychiatrists will develop and maintain competence and lifelong learning throughout their careers in a core knowledge base and skills that incorporates research findings and advances in the field.

Goal 2 (Unique role and advocacy) – Child and adolescent psychiatrists, as physician specialists in both mental health and mental illness in children, adolescents, and families, should articulate, promote, and preserve their unique role, skills, and expertise in healthcare and advocate for the mental health rights and needs of children, adolescents, and families.

Goal 3 (New healthcare systems and models) – As experts in pediatric mental health, child and adolescent psychiatrists must be prepared to both practice child and adolescent psychiatry and provide leadership in new and emerging healthcare systems and models of healthcare delivery.

Goal 4 (Expanded access to care) – Child and adolescent psychiatrists and AACAP should support the development of new models of practice that improve access to quality psychiatric care for all children, adolescents, and their families.

Goal 5 (Role as educators and collaborators) – Child and adolescent psychiatrists should be trained and supported throughout their careers to be educators and to collaborate with child serving systems of care.

Goal 6 (Research) – AACAP will promote the full range of research to improve the prevention and treatment of psychiatric disorders throughout childhood, adolescence, and early adulthood.

Goal 7 (Recruitment and shortages) – AACAP will continue to promote increased recruitment into child and adolescent psychiatry and develop additional strategies to address the critical shortages and maldistribution of child and adolescent psychiatrists.

Goal 8 (Technological advances) – Evolving technological advances must be incorporated into the training, teaching methodology, and clinical practice of child and adolescent psychiatry.

Goal 9 (Global perspective) – AACAP and child psychiatrists should increasingly promote the international and global perspective to meet the mental health needs of children, adolescents, and families around the world.

Goal 10 (Diversity and culture) – Child and adolescent psychiatrists should enhance their cultural competency and awareness to meet the needs of our nation's changing demographics.

Goal 11 (Ethics) – Child and adolescent psychiatrists will incorporate and adhere to the AACAP's ethical and professional standards (Code of Ethics, AACAP 2009) in clinical practice, training and research.

Conclusions

The richness and density of the complete BPF report is important and necessary for future study and consideration by AACAP leadership, members, and staff. The following takeaway points summarize and focus on several key themes that are addressed throughout the report:

- **(Affordable Care Act)** ***The ACA is here and its implementation and roll-out means major changes to child and adolescent psychiatry (CAP) practice, role and payment over the next 5-10 years.***
- **(Training and Practice)** ***CAP training and practice will need to change and incorporate new technology (e.g., e-health, telepsychiatry, etc.) and changes in healthcare delivery.***
- **(CAPs Role)** ***CAPs must continue to be the diagnosticians and treatment coordinators for the most complex and severe cases.***
- **(CAP Shortages)** ***In order to be relevant in the evolving healthcare system, CAPs need to extend their "reach" by using newer technology (e.g., telepsychiatry) and collaboration/consultation with other healthcare providers and child-serving systems of care.***
- **(Lifelong Learning)** ***AACAP must offer relevant education to students and members throughout their careers. AACAP's CME and MOC programs must be adapted and tailored to the coming changes that are facing AACAP members.***
- **(Advocacy)** ***AACAP and its members must expand advocacy efforts at all levels (local, state, and national) to promote quality psychiatric care for children, adolescents, and families and to increase funding for graduate medical education and research.***
- **(Member Needs)** ***As the "professional home" for CAPs, AACAP must remain committed to providing its members all the support and assistance needed to manage the significant changes anticipated in role, training, and practice during the coming decade.***

Structure of Report

Section I **– "Introduction"** contains the project's "**Executive Summary"** and a brief "**Background"** section describing the organization and development of BPF.

Section II **– "Overview of the Coming Decade"** summarizes the major issues and themes in CAP anticipated during the decade. This overview also briefly describes how the issues and themes are addressed in the *Plan for the Coming Decade*.

Section III **– "Goals & Recommendations (the "roadmap") for the Coming Decade"** contains the "BPF Vision Statement and BPF Core Values and Principles." The majority of this section is a comprehensive resource document, "Goals, Recommendations, and Action Steps," containing the detailed recommendations and action steps for each goal in *Plan for the Coming Decade*. The collective "Goals, Recommendations, and Action Steps" constitute the "roadmap" for AACAP and the field of child and adolescent psychiatry.

Section IV **– "Special Topics"** contains brief overviews and analyses of six areas in child and adolescent psychiatry that were selected by the Steering Committee in view of their importance to the field in the coming decade.

Section V **– "Conclusions"** contains the key takeaway points from the report that were developed by the BPF Steering Committee. This section also has the BPF Steering Committee's priority "Recommendations with Action Steps" from the report to help focus the first two years of implementation (2013-2015).

Section VI **–** "**Next Steps/Implementation"** describes possible implementation strategies for ***Back to Project Future.***

Next Steps/Implementation

With the submission of this report to President Martin Drell, the ***Back to Project Future*** Presidential Initiative will have met its initial charge—to develop a plan and roadmap for the coming decade in child and adolescent psychiatry. The project's report needs review and approval by AACAP's Council. If approved by AACAP leadership (i.e., Council and Executive Committee), then project implementation decisions will need to be made regarding

the budget and allocation of resources (e.g., staff time, travel and meeting costs, etc.) to support the project's goals, recommendations and action steps.

Dissemination

The BPF Steering Committee believes that this report will be of interest to many different groups. There are two principal types of audience for this report—primary and secondary. Primary audiences to receive the report would include: AACAP leadership, Council, Assembly of Regional Organizations of CAP, members, and staff. Secondary audiences to receive the report could include: other professional medical organizations, allied health organizations, parent/advocate organizations, and foundations/philanthropic groups. The BPF Steering Committee hopes the report will stimulate important dialogue with each of these audiences and help advance the field of CAP throughout the coming decade.

BACKGROUND AND PROCESS

The project was conceptualized by Martin Drell, M.D., and designated as one of his Presidential Initiatives during his term as AACAP President (2011-2013). ***Back to Project Future*** (BPF) is named in recognition of the importance and relevance of the first *Project Future* conducted by AACAP during 1978-1983. The 1983 report, ***Child Psychiatry: A Plan for the Coming Decades***, from the original *Project Future***,** identified several priority needs for child psychiatrists: to embrace and invest in research and research careers; to treat children with the most debilitating of mental illnesses; to collaborate more with pediatricians; and to invest more in systems of care. The report also defined a set of values and a new identity for child and adolescent psychiatry in the 1980s and 1990s. In re-reading the original *Project Future* report and remembering its impact on the field, Dr. Drell recognized many similar circumstances, familiar themes and recommendations between 1983 and 2011. In reflecting on the current state of child and adolescent psychiatry (CAP), Dr. Drell decided it was time to go *"back to Project Future."*

Back to Project Future was designed and organized to create a time-limited and highly-focused structure and process that enabled a diverse group of AACAP members to come together to brainstorm and develop a consensus of priorities and action steps for AACAP that spanned three key areas: *Service/Clinical Practice*, *Training and Workforce*, and *Research*. The report's findings and recommendations have been developed to be useful to: CAPs in practice, CAPS in academic institutions, CAP researchers, public policymakers, and primary care physicians and allied child mental health professionals. This report is intended to assist and guide the AACAP leadership, membership, and staff in responding to the changing social and economic realities that face CAPS in the coming decade. This report defines a "shared vision" and "roadmap" of where the subspecialty of CAP and AACAP will be in 2023 and how to get there from 2013.

Back to Project Future's overall purposes included:

- To estimate the psychiatric needs of children, adolescents and their families in the coming decade (2013-2023).
- To develop a general concept of the knowledge and skills that will be needed CAPs in the coming decade.
- To identify the major issues faced by the profession and to formulate recommendations to address these issues in the coming decade.
- To develop a set of consensus recommendations with trends and an action plan to guide the AACAP (leadership, members, and staff) as it moves forward into the coming decade (2013-2023). The consensus recommendations will provide guidance, direction and support for the AACAP in three focal areas—*Service/Clinical Practice*, *Training and Workforce*, and *Research*.

In order to develop and produce a comprehensive and practical report, the Steering Committee created and adopted a "framework" for ***Back to Project Future*** with the following elements: goals, recommendations, rationales, and action

steps. These elements collectively support the BPF "Vision Statement." The complete "framework" is titled "Goals and Recommendations (the "roadmap") for the Coming Decade" (Section III). The elements are defined as follows:

- **GOAL** – *Statements containing key elements needed to support and achieve the BPF "vision." "Goal" statements are broad and more aspirational than "Recommendations."*
- **RECOMMENDATION** – *Statements containing core concepts (idea kernels) that move the "Goal" toward a specific plan of action.*
- **RATIONALE** – *Narrative statements and sections that provide a context and critical perspective on the importance of the "Goal" or "Recommendation."*
- **ACTION ST**EP – *Specific actions, activities and initiatives that support the goals and recommendations. These constitute specific steps needed to implement a "Recommendation."*

This BPF report represents a final consensus of the BPF Steering Committee's work. The report incorporates the input and work of the three BPF Subgroups as well as other groups and individuals. For the final review and revision process of the report the Steering Committee used the following questions to make decisions about the content in the final report:

- Does the draft report chart a course (serve as a "road map") for AACAP and CAP?
- Does the report include what's new and coming in the next 10 years?
- Does the report address what needs to change or be redefined in CAP?
- Does the report identify what needs to be preserved or protected?
- Does the report address how to train and prepare CAP residents and early career psychiatrists (ECPs) to be innovative, creative, entrepreneurial and technologically adept in the coming decade?
- Does the report speak to how best to leverage technology to support/enhance training and clinical practice?

A complete description of the background and comprehensive process involved in developing ***Back to Project Future*** and the project's written report is contained in the Appendix (see "Background and Process").

Section II:
OVERVIEW OF COMING DECADE

What's Facing Child and Adolescent Psychiatry?

Child and adolescent psychiatrists (CAPs) are facing both challenges and opportunities over the coming decade. Advances in our understanding of psychopathology, diagnoses, and treatment have greatly improved CAP's ability to treat the most impaired children and adolescents. At the same time stigma, work force shortage, and inefficiency in the delivery of care cause more than three-quarters of our nation's most vulnerable children to not receive the care that they need. While recent efforts to integrate the delivery of mental health care within primary medical care are promising, CAPs can be isolated within their own practices or marginalized within larger systems of care. Financial pressures and shortages of CAPs can lead CAPs to be used and seen primarily as prescribers of medication, using only a portion of their training and skills.

Healthcare reform as implemented through the Affordable Care Act (ACA) has the potential to radically change the way healthcare and mental health care are accessed and delivered. The changes that have been proposed within the ACA and that are already beginning can improve the efficacy and efficiency with which health care is accessed and provided. The integration of mental health care within primary medical care is part of those changes. How this integration will be implemented is not clear. What is clear is that CAPs need to be actively engaged in the design, implementation, and ongoing function of these new models of healthcare delivery.

In the coming decade, our nation will experience continued population growth and increasing need for mental health care for children and families struggling with mental illness. While there continues to be stigma against people with mental illness and those who support them, there is also an emerging trend toward increased public knowledge and understanding and more accurate perception of mental illness. As a result of mental health parity and expansion of insurance coverage through the ACA, the number of children and adolescents seeking care will increase. The changing demographics of our nation will continue to increase the ethnic and cultural diversity of our patients. Our country is experiencing disproportionately higher growth in geographic regions such as the Southwest that have fewer CAPs. CAPs will be working with increasing numbers of non-English speaking families. We are also increasingly aware that our society will likely continue to struggle with economic and racial disparities. Our communities will continue to struggle with trauma and violence. We know well how greatly these psychosocial factors can influence children's mental and physical health.

We are at the cusp of great change in our health care system. Much of the expansion of health coverage through the ACA will be through Medicaid and other public sector systems. CAP trainees and practitioners must be prepared to work with these populations and within public sector systems of care. Numerous innovative models of care are emerging, including integrative and collaborative care models and telepsychiatry. CAPs must carefully consider how best to collaborate with mid-level practitioners and advance practice nurses (APRNs). CAP practitioners and training programs will likely continue to operate in an environment of ongoing resource scarcity. We will witness a transition away from the fee-for-service model and towards demonstration of value. It will no longer be enough to advocate for more resources. We will have to demonstrate greater value for our efforts.

We are already fortunate to benefit from an explosion in neuroscience and psychological research that benefits CAPs' work with children and families. Over the next decade, we are likely to experience continued rapid growth of our knowledge base. We must help all CAPs keep pace with these innovations and help them better translate and disseminate these findings to our patients in the community. While advances in neuroscience and our understanding of psychopathology improve the quality of our care, efficient means of integrating these developments into practice must continue to evolve. The future also presents us with opportunities by providing improved models of care delivery to a larger number of individual patients and their families, using newly developed skills, techniques, and technologies.

In summary, CAPs of the future must extend their reach to meet the increasing public health need and demand for high quality services. CAPs will also need to develop skills and knowledge in consulting and collaborative relationships, leadership skills, advocacy, and improving access for those populations that have been difficult to reach. CAPs will also need to preserve their unique values and strengths—including psychotherapy skills and the ability to work therapeutically with individual children, adolescents, and their families.

What Are the Key Issues?

Several key issues emerge for CAP in the coming decade. First is the need to reaffirm our **professional identity**. Over past few decades the field of CAP grew by great leaps and bounds. While our workforce has never been able to meet the mental health needs of our nation's children, we grew from a small academic based profession in the 1960s to a workforce of more than 7,000 CAPs in 2013. Within that same time period, CAPs shifted focus from providing mostly individual and family therapy to providing a wider range of biological, social, and psychological therapies. The earlier intervention level was typically focused on the relationships between the CAP, the patient, and his or her family. One of the key aspects of the ACA is improvement in the efficacy and efficiency of healthcare delivery. Many of the models proposed for achieving these improvements call for integration of specialty based care, such as CAP, within the medical home or primary care setting. Specialists such as CAPs will have greater involvement in **models of collaborative care** where, in addition to treating children and adolescents with severe psychiatric illness, we will also serve as a consultants and team members for primary care based clinicians who will be responsible for treating psychiatric illness within the primary care setting.

National healthcare reform is changing the way we conceptualize, prevent and manage illness. With the ACA come **medical homes**, **Accountable Care Organizations (ACOs)**, and movement away from tertiary care facilities to an increased community locus of care. The medical educational system will also undergo radical reform with a new career development emphasis for all specialties starting with medical school, extending through graduate medical education and into post-graduate licensure, credentialing, and life-long learning. The Accreditation Council for Graduate Medical Education (ACGME) has created a new conceptual framework, the **Next Accreditation System (NAS)** which includes **"Milestones"** to mark the developmental progress of each resident's education and training. This new framework will have significant impact on all training and education programs.

There is increasing awareness of the incidence and prevalence and risk for psychiatric disorders with appreciation that over 50 percent of these disorders begin in childhood. CAP remains the greatest shortage specialty with only about 7,000 active practitioners and 400 graduates a year. Currently, there is significant maldistribution of CAPs with the largest numbers practicing in urban/metro areas. Large rural areas of the country have almost no CAPs. There is a needs to be both an increased workforce with a greater reach and a multidisciplinary healthcare model to adequately care for the many children and families needing treatment. The rapid growth of knowledge in our field also requires that CAP practitioners maintain the highest degree of **evidence-based knowledge**, **skills**, and **attitudes**. Many of these changes will require CAP clinicians and educators to re-define the professional identity of CAPs and to assume new skills.

The nation's health care system is moving from a past emphasis on procedures to a future **emphasis on quality and value** in healthcare throughout a person's life. This shift emphasizes long-term mental and physical health in the context of the greater society—an approach inherent in basic CAP core values. It also brings a new emphasis on prevention, early detection and intervention that requires better public education about development, mental health and illness in order to promote truly patient-centered care. Major health care system reorganization will require development of better quality outcome measures at both individual and population levels. CAPs will need to choose the most appropriate **outcome measures** for the provision of care in particular settings and populations. These outcomes will guide the transition from traditional one doctor-one patient practice to the more **patient-centered**, **multisystem**, **collaborative**, and **cross-disciplinary team approach**. The CAP workforce of the future needs to be able to navigate these complex systems of care and also to appreciate the need to demonstrate value.

The **demographics of the U.S. population** are changing significantly and will affect CAPs (e.g., growing numbers of non-English speaking immigrants). Providing health care access to populations underserved for cultural, economic,

or geographic reasons needs to be a priority for CAPs in the coming decade. The **advances in technology** that have changed the way we live and practice medicine will continue to accelerate. CAPs will need to integrate **electronic medical records** into practice and become fully literate and facile with the use of **telepsychiatry, web based screening and treatment**, and the uses of **social networking**.

Health care reform will bring major changes from national, state, and local governments; insurers; corporations; and other public institutions. CAPs must understand, prepare for, and actively influence health care reform. CAPs should be prepared to work collectively with other groups on **advocacy**, **health care policy**, and fiscal and legislative proposals at local, state, and national levels. With such major change occurring, **mentoring** during and after residency will be increasingly important for CAPs. Future leaders in this climate of reform will require mentorship and networking, especially during the transition from training to practice. CAPs have the opportunity to participate in and lead health care reform based on their traditional strengths in working collaboratively with other systems and unique position as practitioners who can integrate perspectives from physical and mental health, education, policy, and research.

Where Will Research Go in the Coming Decade?

To set the stage for the goals, recommendations, and action steps that follow, consider where research in child mental health is likely to go over the next decade. How can AACAP promote research over the next decade that will have a large positive impact on the prevention and treatment of mental disorders in youth?

Prevention and treatment are core interests of CAPs. The methodology for prevention and treatment studies continues to improve but these improvements are largely incremental. The past several decades have brought improvements in statistical methodology (e.g., adoption of random effects regression approaches instead of traditional last observation carried forward analyses), assessment instrumentation, and overall design strategies more closely mapping real-world treatment approaches (e.g., equipoise stratification). But it would take little time for the researcher of two decades ago to get up to speed on these improvements. Our treatment approaches, both pharmacological and psychotherapeutic, have changed somewhat, but again these changes are normal progress rather than large unexpected leaps.

There are also reasons to think that the decade ahead may see prevention and treatment studies that use novel and potentially powerful new methods in combination with current methods. These are likely to come from advances made in developmental neuroscience. For example, treatment targets that are related to measurable neural system endophenotypes may allow identification of particular treatment-responsive groups now hidden by our current categorical symptom-based diagnostic system (e.g., the RDoC initiative). A better understanding of the genetic underpinnings for psychiatric disorders in children offers the potential to find novel treatment approaches or apply "personalized medicine."

Improvements in technology also have led to a number of ongoing trials of computer and smart phone approaches to psychotherapy or psychotherapy augmentation—a likely area for progress over the coming decade.

External trends and dynamics have significantly decreased the quantity of prevention and treatment studies. Many psychiatric medications are coming off patent and, thus, will never be further studied by industry. National Institutes of Health (NIH) funding has decreased overall, and has been reduced specifically for clinical treatment studies. The funding climate for treatment studies is unlikely to improve soon. There is, however, substantial reason to hope that we are likely to see improvement later in the decade for research funding.

In addition to new approaches to prevention and treatment, there will be gains in the area of services development research, such as case identification, access to services, training of therapists, monitoring of therapeutic progress, design of service delivery systems, specific needs of different subgroups, and expanding care delivery systems to meet unmet needs (e.g., juvenile justice, etc.).

Much of services research over the next decade will be an extension of current methodologies. Incorporation of new technologies, including smart phones, will offer interesting new opportunities. The decade ahead will be an exciting

time for services research with the changes that will come from the ACA. The ultimate shape and extent of these changes is not yet clear but are likely to be positive and substantial. Experts in child psychiatry services research are needed to study and understand the impact of these changes on the care provided by CAPs.

The range of science important to improve our care of youth with mental disorders is broad. Improvements in our understanding of epidemiology and nosology of disorders, as well as basic questions on assessment of symptoms, stress, social interactions, etc. will synergistically improve our other studies in youth.

The decade ahead should be an exciting one for basic and translational research in normal development, developmental neuroscience, imaging, and genetics. Some of this work will be led by CAPs and some will not, but it is critical that we have CAP researchers who can participate as full team members in these investigations—the clinical perspective and clinical experience provided by CAP is critical to formulating the right questions. The clinical promise of these studies is straightforward—understanding genetic and environmental risk factors and the neural circuitry involved in psychiatric disorders can lead us closer to understanding the causes of disorders and, thereby, give us more specific treatment targets. Developmental neuroscience approaches are critical to understanding the developmental-specific aspects of the development of psychiatric disorders. Imaging and other approaches that more directly evaluate brain circuitry and function can give us more specific targets for our treatment. Predicting how and when basic and translational work will impact CAP practice is challenging. The promise is enormous and the path from understanding more about the mechanism of disease to developing a treatment is long.

Finally, continuing development during childhood and adolescence makes clinical work and research both more complicated and more interesting. By working with children, CAPs have the opportunity to intervene when neural systems are more plastic, when behavior is more malleable, and before long-term sequelae of psychiatric disorders have become ingrained. Thus, with continuing research in our field and the ongoing work of practicing CAPs, there is substantial opportunity to improve the mental health of our nation's youth in this coming decade.

What Issues, Challenges, and Opportunities Are Ahead?

The scope of changes facing the field of CAP over the coming decade is profound. Within each of the challenges and issues lie true opportunities to improve the delivery of mental health care. CAPs will be challenged to change fundamental aspects of how they have traditionally worked. Opportunities to work in private practice will not altogether disappear but will be more limited. If CAPs are to meet the mental healthcare needs of our nation's children and adolescents, rather than resisting the changes that are coming, they need to assist in the design, development, and implementation of models of care that can increase access to effective treatment for large numbers of children who currently receive none.

With the advent of new and emerging healthcare systems, CAPs will have opportunities to work in close collaboration with pediatricians and allied health professionals in many new settings including schools, community health centers, and medical homes; and within ACOs. This aligns well with the aims and priorities of primary care specialties (e.g., American Academy of Pediatrics [AAP], American Academy of Family Physicians [AAFP]), providing for potentially fertile opportunities for CAP. The great challenges will be to train the workforce in new areas, such as working within population health and public health frameworks. This will have a major impact on CAP residency training and continuing medical education (CME) in healthcare financing, implementation, and organization. The field will need leaders in both public and private sector programs and training program administration.

In the future, training programs and maintenance of certification (MOC) will require new educational tools for teaching, learning, and credentialing. The opportunities are great for innovations in information technology, simulation, and new educational techniques and pedagogy. The use of telepsychiatry and digital media for teaching and distance learning can bring expertise to students and practitioners in regions with limited resources. At the same time, there will be tremendous challenges for the educational system to demonstrate the effectiveness of learning and a greater focus on the outcomes of educational products. Currently, there are no "gold standards" for assessment, in real time, of knowledge, skills, and attitudes in medical school, residency, fellowship, or post-graduate education.

Methods for assessing clinical effectiveness need to be developed by CAPs that recognize the increasing regulatory burden facing CAPs at all levels of training and clinical practice.

Given the continued shortage of CAPs, the field needs to promote the specialized and unique role of CAP. As a field, we must educate medical and allied health professionals and the public about children's mental health issues and also the unique skills, roles, and services provided by CAP in a variety of settings (e.g., hospitals, schools, courts, community agencies, teaching institutions). CAPs will need to increase their role in educating all medical students about critical knowledge in CAP. The serious shortage of CAPs also will require our participation in partnerships with pediatricians, family physicians, nurses, and other allied health professionals. The challenges here will be: how such partnerships are developed and how to pay for such efforts. There are opportunities in the healthcare reform movement, but a great challenge will be to contain healthcare costs, since payments will likely decrease in the future. At the same time, CAPs need to challenge the continued expectation to "do more with less." Over the past few decades, this dynamic has resulted in CAPs having less time with patients and an increased fragmentation of care. CAPs and AACAP need to work with other groups and organizations (e.g., patient/family groups, AAP, AAFP, American Psychiatric Association [APA]) to advocate for appropriate recognition of CAPs and adequate payment for services. Learning how to partner and advocate with these groups will be increasingly necessary for CAPs.

Implementing healthcare reform requires new multi-disciplinary models for teaching and life-long learning. However, graduate medical education (GME) funding is at risk and facing potential severe cutbacks. The great challenge for the field of CAP is to improve our educational system with evidence-based teaching, new models of effective educational methods, and reliable and valid learning assessment methods in times of fiscal constraint. Innovative, cost-effective methods of teaching and learning at all educational levels will be needed.

Access to quality psychiatric care for all children, adolescents, and their families must also be a priority. While this continues to be a challenge with insurance company and payor restrictions, CAPs need to increase advocacy efforts targeted toward: greater parity in mental health care; expanded use of telepsychiatry and digital media for assessment, consultation, and treatment (including payment for these media); greater public education about mental health, and signs and symptoms of mental illness; and destigmatization of psychiatric disorders and those individuals and families suffering with mental illness.

As a professional medical organization, AACAP exists in part to serve its members. In the coming decade, AACAP will be challenged to both help protect the interests of CAPs and also assist and support CAPs in adapting to the changes that will occur within the nation's healthcare systems. The opportunity lies in adapting our current training and skills to newer models of delivering care. Just as the individual is challenged to adapt to the changes within his/her environment, so will the basic identity of CAPs be challenged to develop new ways of viewing ourselves.

How Are These Issues, Challenges, and Opportunities Addressed in *Back to Project Future*?

The ***Back to Project Future*** (BPF) Steering Committee and Subgroups have created a set of **goals** with **recommendations** and **action steps** to be a roadmap for the coming decade, which becomes an action plan for the field of CAP.

In this report, we recommend an increased emphasis on preparing our trainees and workforce to practice in new and emerging healthcare systems. This may be through innovative clinical rotations during residency and fellowship or through in-service and life-long learning as practitioners in the workforce. These experiences should cover a broad array of multidisciplinary and multisystem settings, including primary care consultation and integration and telepsychiatry. As we develop these new training experiences, we must also develop appropriate tools for assessment that meet the standards of national accrediting bodies and the learning needs of our trainees and workforce.

New and evolving models of healthcare delivery will be population-based within integrated systems of care. In order for CAPs to lead this process as pediatric mental health experts trained in medicine, public health, child development, and the diagnosis and treatment of psychiatric disorders, they must be prepared to collaborate in teams

and understand the financial models that are the basis of healthcare reform. The ACA expands healthcare coverage and increases the number of young patients seeking mental health services, particularly in the Medicaid population. CAP should be prepared to meet this need by making a commitment to these patients and by addressing issues related to prevention and early intervention, as well as treatment. The emphasis will be on caring for more patients with less money while providing evidence of better clinical outcomes. This is also an opportunity for CAP to provide entrepreneurial leadership and advocate for models of payment that cover not only Medicaid but also insurance networks. ACA financing models will become increasingly complex; and will include partial capitalization, bundled payments, shared savings, and other interventions aimed at reducing overall healthcare costs. Added to this will be the introduction of payment systems based on meeting specific parameters regarding efficiency and quality of delivered care. Initially, the greatest impact of these changes will be on those CAPs working within larger systems of care; however, eventually many of these innovations will affect CAPs solely in private practice.

Access to care will involve new models that extend the reach of CAP through collaboration with primary care and pediatric subspecialty physicians; with child based systems of care including education, juvenile justice, and welfare; and by expanding the knowledge and clinical skills of other providers. Mental health care for children will be shared among multiple professionals and the roles of CAPs will include those of educator, consultant, collaborator, and specialist in the diagnosis, assessment, and treatment of recurrent and debilitating psychiatric disorders.

We recommend continued efforts to address the shortage and malistribution of CAPs. This will involve improving knowledge, skills, and attitudes of primary care clinicians and mid-level practitioners regarding children's mental health care. We will need to continue outreach to bright and passionate undergraduate students, medical students, and residents, including development of undergraduate courses and programs in child and adolescent mental health, and outreach to osteopathic medical students and international medical graduates. This may involve developing flexible pathways to produce CAPs such as shortening training and increasing opportunities for non-traditional clinicians (e.g., Post-Peds Portal) and using creative funding mechanisms to support CAP training. We will also need to continue our work with government agencies to incentivize CAP involvement in underserved areas through mechanisms including loan repayment for all CAPs and visa waivers for international medical graduates. While there has been an increase in the number of CAPs completing training over the last decade, the numbers of funded CAP resident positions needs to be increased to help address the serious shortage of CAPs.

In this report we also recommend increased development of resources to promote life-long learning. In an environment of changing educational and accreditation processes, we will need to support members with their preparation and certification. We recommend developing resources that centralize access to excellent educational and training materials. CAPs need to be mentored throughout their careers, from trainees to mid-level to senior-level positions.

As we start the decade, we believe CAPs are well positioned to assume leadership roles in providing mental health services to children, adolescents, and families. Approving and beginning to implement prioritized recommendations and action steps in **Goals and Recommendations (the "roadmap") for the Coming Decade** will start AACAP and its members on the "journey" to address the many complex issues, challenges, and opportunities that lie ahead in the coming decade.

Section III
GOALS & RECOMMENDATIONS (THE "ROADMAP") FOR THE COMING DECADE 2013-2023

Vision Statement

The *Back to Project Future* Presidential Initiative will develop prioritized recommendations that define and promote high quality preventive and clinical services, education and training, research, and advocacy in child and adolescent psychiatry across the coming decade (2013-2023). These recommendations will be used to guide AACAP in

- promoting mentally healthy children, adolescents and families;
- defining the professionalism, ethics, training and skills of child and adolescent psychiatrists;
- promoting the development of broadly effective interventions and treatments for children and adolescents;
- supporting child and adolescent psychiatrists' practice in systems of care and other child serving systems.

Core Values and Principles

All elements of the **BPF "framework" (i.e., goals, recommendations, rationales, and action steps)** support the following **values and principles**:

- Represent innovative and forward thinking concepts and projections for the coming decade.
- Incorporate emerging technologies.
- Capture a new core professional identity and role of child and adolescent psychiatrists.
- Project a new public image of child and adolescent psychiatrists.
- Promote high morale and interest for trainees (medical students and residents) and child and adolescent psychiatrists in practice.
- Reflect the move toward an international/global perspective on child and adolescent psychiatry.
- Address the changing population demographics and characteristics for children, adolescents and families in the United States across the coming decade.

Master Goal List (2013-2023)

Goal 1 (Core knowledge and skills) – As providers of quality clinical care to children, adolescents, and families, child and adolescent psychiatrists will develop and maintain competence and lifelong learning throughout their careers in a core knowledge base and skills that incorporates research findings and advances in the field.

Goal 2 (Unique role and advocacy) – Child and adolescent psychiatrists, as physician specialists in both mental health and mental illness in children, adolescents, and families, should articulate, promote, and preserve their unique role, skills, and expertise in healthcare and advocate for the mental health rights and needs of children, adolescents, and families.

Goal 3 (New healthcare systems and models) – As experts in pediatric mental health, child and adolescent psychiatrists must be prepared to both practice child and adolescent psychiatry and provide leadership in new and emerging healthcare systems and models of healthcare delivery.

Goal 4 (Expanded access to care) – Child and adolescent psychiatrists and AACAP should support the development of new models of practice that improve access to quality psychiatric care for all children, adolescents, and their families.

Goal 5 (Role as educators and collaborators) – Child and adolescent psychiatrists should be trained and supported throughout their careers to be educators and to collaborate with child serving systems of care.

Goal 6 (Research) – AACAP will promote the full range of research to improve the prevention and treatment of psychiatric disorders throughout childhood, adolescence, and early adulthood.

Goal 7 (Recruitment and shortages) – AACAP will continue to promote increased recruitment into child and adolescent psychiatry and develop additional strategies to address the critical shortages and maldistribution of child and adolescent psychiatrists.

Goal 8 (Technological advances) – Evolving technological advances must be incorporated into the training, teaching methodology, and clinical practice of child and adolescent psychiatry.

Goal 9 (Global perspective) – AACAP and child psychiatrists should increasingly promote the international and global perspective to meet the mental health needs of children, adolescents, and families around the world.

Goal 10 (Diversity and culture) – Child and adolescent psychiatrists should enhance their cultural competency and awareness to meet the needs of our nation's changing demographics.

Goal 11 (Ethics) – Child and adolescent psychiatrists will incorporate and adhere to the AACAP's ethical and professional standards (Code of Ethics, AACAP 2009) in clinical practice, training, and research.

Goals, Recommendations & Action Steps (The "Roadmap")

Introduction

This section is organized as a comprehensive resource document that can be studied and referred to by the AACAP leadership, members, and staff. The following pages contain the detailed recommendations and action steps for each "Goal" identified in the *Plan for the Coming Decade*. The collective goals, recommendations, and action steps constitute the "roadmap" developed by the ***Back to Project Future*** (BPF) Steering Committee and Subgroups. This section presents many possible options, choices, and "routes" on the "roadmap" as AACAP moves forward into the coming decade. The number and extent of specific recommendations and action steps reflects the careful and systematic work of the BPF Subgroups and BPF Steering Committee.

Recommendations and action steps that have been prioritized for implementation during 2013-2015 are identified. Broad topics/issues of interest in child and adolescent psychiatry can be located using the report's "Table of Contents" and the "Master Goal List." Each goal statement has a brief "descriptor" in parentheses to identify the broad content/scope of the goal. Readers can also find specific topics or issues using the topical "Index of Recommendations" in the Appendix.

Goal 1 (Core knowledge and skills) – As providers of quality clinical care to children, adolescents, and families, child and adolescent psychiatrists will develop and maintain competence and lifelong learning throughout their careers in a core knowledge base and skills that incorporates research findings and advances in the field.

GOAL 1 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: *Historically, child and adolescent psychiatrists (CAPs) have been well trained across a broad array of theories and techniques focused on understanding the complex and multidimensional aspects of child development and psychopathology. This knowledge base, which combines the most established practices of medicine, neurobiology, and psychosocial sciences, provides a foundation for CAPs to be uniquely qualified to understand the complexities of genetic and epigenetic aspects of development and psychiatric disease. We must preserve this foundation while providing the means to efficiently integrate advances within these areas into training and into the practices of mid career and senior career CAPs. There is also concern that economic forces (e.g., insurance payors, pharmaceutical industry, etc.) are influencing practice decision-making by selectively reinforcing biologic therapies. This trend works to the detriment of the child and to the profession of CAP.*

(2013-2015 Priority) **Recommendation 1.1 – AACAP will support the integration of evidenced-based treatments and advances in both neurobiology and psychosocial sciences into members' practices.**

Rationale: *Advances within the medical and neurosciences fields are occurring at a dramatic rate. This new and exciting information must be translated to CAPs in a timely and organized manner so that it can be used in practice. Unfortunately, there can be a disconnect in CAP between those engaged in "research" and those engaged in "practice." This divide needs to be bridged through active cooperation and collaboration between clinicians and researchers—focused on the effective translation of science advances into clinical practice.*

Action step 1.1.1 **–** Create an AACAP Task Force (e.g., representatives from *JAACAP*, AACAP Program Committee, Quality Issues Committee, senior clinicians, etc.) focused on establishing a working relationship between CAP researchers and practitioners to facilitate the translation of science advances into clinical practice.

Action step 1.1.2 **–** Create a Web-based portal for members on evidence-based practices and translational research.

Action step 1.1.3 **–** Ensure that all AACAP *Clinical Practice Guidelines* (formerly AACAP *Practice Parameters*) are updated and revised in accord with Institute of Medicine (IOM) standards.

Action step 1.1.4 – Consider broadening the membership of the AACAP Program Committee to include more CAPs in clinical practice and, also, consider establishing an advisory group to the *JAACAP* Editors composed of CAPs in clinical practice.

Action step 1.1.5 – Ensure adequate representation of psychosocial sciences and treatments at AACAP's Annual Meeting and continuing medical education (CME) programs.

Recommendation 1.2 – Complex issues surrounding 'off-label' use of psychiatric medications and polypharmacy (multi-drug regimens) with children and adolescents need to be examined and best practices defined and disseminated.

Rationale: *Over the last two decades there has been a marked increase in the use of multiple psychotropic medications in children and adolescents. Some of this is clearly related to the development of more effective medication and a greater awareness of their potential benefits. Often times, however, the increased use appears to have been among vulnerable populations of children who might not have access to a full array of psychosocial treatments or whose presentation is complicated by multiple comorbid biological and psychosocial issues. Given the potential risks, and our relative lack of knowledge regarding the benefits of these practices, there is concern regarding patient safety and the public's perception of CAPs.*

Action step 1.2.1 – AACAP needs to advocate for research on the safety and effectiveness of polypharmacy (multi-drug regimens).

Action step 1.2.2 – AACAP should develop a policy statement and guidelines on the use of polypharmacy (multi-drug regimens) in children and adolescents.

Action step 1.2.3 – AACAP should develop CME and other educational programs for members on polypharmacy (multi-drug regimens) and medication monitoring with children and adolescents**.**

Action step 1.2.4 – AACAP should consider developing an evidence-based medication monitoring system that represents best practice in CAP.

Recommendation 1.3 – A fundamental skill of CAPs must include the understanding and provision of multiple models of psychotherapy.

Rationale: *Given changes in payment and the increased use of medication, the provision of psychotherapy by CAPs has been decreasing. This trend is concerning given our understanding of the importance of environmental influences on a child's development and on the development of psychopathology. There is also ample evidence that psychotherapies can also be effective in the treatment of most psychiatric diagnoses. Psychosocial therapies need to be a core skill of CAP's throughout their careers. CAPs must receive appropriate payment for providing those therapies.*

Action step 1.3.1 – CAPs need to promote health care systems that conceptualize the recipient of treatment as part of a family system. Effective treatment focuses on and includes the family.

Action step 1.3.2 – AACAP should advocate for studies to demonstrate that treatment of children and adolescents with the combination of medication and psychotherapy is cost effective.

Action step 1.3.3 – ACCAP should explore collaboration with executives from healthcare companies, insurance companies, and health care systems to promote and advocate for effective mental health care and coverage for children and adolescents.

Recommendation 1.4 - CAPs need to integrate outcome and quality improvement initiatives in every practice setting.

Rationale: *One of the bigger changes in the delivery of healthcare that is predicted to occur over the next decade is the increasing use of quality indicators and quality improvement techniques across are treatment settings. This is a fundamental part of the Affordable Care Act (ACA)—an effort to improve the quality of care provided while*

containing costs. While the core concepts involved are more easily integrated into primary care settings, it is widely expected that specialty practices will need to adopt such strategies in the near future.

***Action step 1.4.1* –** AACAP will provide leadership in developing appropriate quality and outcome measures and tools related to the mental health care of children and adolescents.

***Action step 1.4.2* –** CAPs need to adopt outcome and quality measures and use the tools that have been developed across all practice settings.

***Action step 1.4.3* –** AACAP should promote development of systems to collect outcome data on psychopharmacologic treatment of disorders using standardized protocols (e.g. similar to the PDQ database for pediatric cancer).

Recommendation 1.5 – CAPs need expertise in prevention and treatment of substance use disorders (SUD).

GOAL 1 – TRAINING AND WORKFORCE RECOMMENDATIONS:

Rationale*: Essential knowledge and skills of CAPs include the ability to: provide quality psychiatric assessment and treatment to children, adolescents, and families with a range of psychopathology, from diverse populations, and served by various types of institutions/ systems; learn and incorporate new information and skills systematically and continuously; and teach others relevant information and skills.*

(2013-2015 Priority) **Recommendation 1.6 – AACAP will promote the creation of outcomes-based data on the efficacy and effectiveness of psychiatric treatments for children and adolescent.**

***Action step 1.6.1* –** Develop, implement, and maintain an information center/clearinghouse on psychiatric treatment outcomes that covers the spectrum of care (e.g., psychotherapy, psychopharmacology, environmental interventions, consultation):

- Provide data searchable by various criteria (e.g., patient age, disorder, etc.)
- Collaborate with clinicians to obtain information on clinical practices and results (e.g., solicit information on certain types of therapy based on certain criteria; provide incentives for contributors' participation)
- Collaborate with researchers to design collection practices/criteria, analyze data, and summarize conclusions
- Provide outcomes data with treatment recommendations

***Action step 1.6.2* –** Promote the education of CAPs to use evidence supported treatment interventions, participate in the collection of data, and develop models to monitor and systematize clinical practice:

- Verbal and written educational material (e.g., meetings, website, *JAACAP*) for members
- Training for members throughout the lifespan
- Training the trainers (e.g., program directors)
- Ongoing educational requirement for membership
- Educational programs on using Performance in Practice (PIP) modules and other quality assurance monitoring

Recommendation 1.7 – CAPs will need to be trained in community engagement and public health and population management strategies, including primary and secondary prevention, to influence social determinants of children's and families' mental health.

***Action step* 1.7.1 –** CAP training should include understanding and assessing social determinants of mental health within communities and society.

Action step 1.7.2 – CAP training should include understanding and practicing public health and population management strategies, including primary and secondary prevention, that influence social determinants of children's and families' mental health.

Action step 1.7.3 – CAP training should include understanding and assessing capacities and strengths within children, families, communities, and society.

Action step 1.7.4 – CAP training should include engagement strategies for linking with community organizations and local and state governments. AACAP will promote and support CAPs involvement in community engagement through developing and collecting training and educational resources and common funding and development strategies.

Recommendation 1.8 – AACAP will promote development of resources for members to support maintenance of certification (MOC) and lifelong learning beginning in training and continuing throughout their careers.

Rationale: *Throughout their career, CAPs should maintain competence in core knowledge, as well as develop skills to support their practice and enhance the field. Skill development may occur in a wide variety of areas, such as transition to practice, business, advocacy, leadership, education, and administration, along with clinical practice. CAPs often have multiple roles and responsibilities therefore requiring new skill sets throughout their career. AACAP should support CAPs in the development of knowledge and skills. Additionally, AACAP should help support members achieving and maintaining both licensure and certification. AACAP will use innovative technology to support lifelong learning.*

Action step 1.8.1 – Develop improved Internet technology (IT) systems for teaching, learning, and credentialing at all developmental levels of knowledge and skills for healthcare providers.

Action step 1.8.2 – AACAP should invest in a Learning Management System or other IT supports that allow for online delivery of course materials, testing, evaluation, and certificate generation.

Action step 1.8.3 – AACAP should form a workgroup consisting of continuing medical education (CME) staff, IT staff, and AACAP members from the CME Committee, Maintenance of Certification (MOC) Committee, and Program Committee to evaluate proposals to build a Learning Management System.

Action step 1.8.4 – AACAP should develop more interactive methods of delivering CME to better engage learners and facilitate change in participants' practice.

Action step 1.8.5 – AACAP should consider developing activities that span longer periods of time (i.e., not a one-time institute), including those that ask participants to measure their own work, identify problems, design a personal improvement plan, and conduct follow up assessments. Consider developing a new format at the AACAP Annual Meeting to support self-assessment and practice based improvement.

Recommendation 1.9 – AACAP should continue to support quality CME programs (for members and non-members) to provide self-assessment, improve clinicians' knowledge/skills, and assist with maintenance of certification/licensure.

Action step 1.9.1 – Continue to offer high quality CME at the Annual Meeting and other meetings throughout the year.

Action step 1.9.2 – Continue to develop high quality materials (webinars) and *JAACAP* CME offerings.

Action step 1.9.3 – Develop products or activities delivering a minimum of eight hours of self-assessment credit per year in accordance with Part 2 of American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC). Activities should provide evaluation with peer comparison.

Action step 1.9.4 – Continue to develop materials that support ABPN's MOC such as Performance in Practice (PIP) tools in accordance with Part 4 of the ABPN Maintenance of Certification.

Recommendation 1.10 – AACAP will assess educational needs in the changing healthcare environment, identify gaps, and develop new educational content to promote evidence-based practice.

Action step 1.10.1 **–** AACAP should collaborate with ABPN to ensure activities and products for MOC meet ABPN requirements.

Recommendation 1.11 – AACAP should support AACAP committees and regional organizations in designing and implementing CME activities.

Action step 1.11.1 **–** AACAP should evaluate ways in which CME accreditation of activities might be expanded to certify educational activities of committees and regional organizations with attention to the additional cost and manpower needed to accomplish these tasks.

Recommendation 1.12 – AACAP should expand CME offerings focused on transition to practice skills, financial and business training, leadership, work-life balance, and personal/professional growth.

GOAL 1 - RESEARCH RECOMMENDATIONS:

Rationale: *Knowledge from research without dissemination is of no value. There are a number of critical constituencies, and effective dissemination of research requires thoughtful market segmentation. Target groups will include but are not limited to: the many diverse groups of CAPs in practice, education, administration, and research; youth with psychiatric disorders and their families; federal and non-federal agencies that fund research or make policy; child health advocacy organizations; and the educational and judicial systems.*

Recommendation 1.13 – Review, clarify and expand, as needed, AACAP's research dissemination efforts.

Action step: 1.13.1 **–** Evaluate the efficiency, accountability and effectiveness of *JAACAP*, AACAP's website, and AACAP's Government Affairs Department regarding dissemination of research information.

Action step: 1.13.2 **–** Develop and test best practices for dissemination of research information using market segmentation (i.e., identifying the best approaches for fellows, early career psychiatrists, psychiatrists in hospital practices, psychiatrists working in the community).

Recommendation 1.14 – Expand dissemination of research findings in partnerships with other organizations (e.g., American Academy of Pediatrics, American Academy of Family Physicians).

Rationale: *There are other important organizations and constituencies with strongly overlapping goals in this area. By collaboration we increase our influence.*

Action step 1.14.1 **–** Continue and expand dissemination of research-based *AACAP Clinical Practice Guidelines.*

Action step 1.14.2 **–** Encourage development of new *AACAP Clinical Practice Guidelines* (formerly AACAP *Practice Parameters*) that cover the full range of treatment modalities and methodologies – including some that may have a limited research base at the present time (e.g., integrative medicine).

Recommendation 1.15 – Increase AACAP's efforts to "make the case for research" to government agencies, foundations, hospitals, medical schools, and the public.

Action step 1.15.1 **–** Disseminate research findings showing that investment in child and adolescent mental health research efforts pay off in improvements in prevention, treatment, and service delivery. Specifically, communicating the message that CAPs help youth with psychiatric disorders and that research in CAP is an important investment in and contribution to the nation's health.

Action step 1.15.2 **–** Expand media training (e.g., Annual Meeting, web-based programs, and modules) for AACAP members to increase CAPs effectiveness in communicating research findings with the media and general public.

Goal 2 (Unique role and advocacy) – Child and adolescent psychiatrists (CAPs), as physician specialists in both mental health and mental illness in children, adolescents, and families, should articulate, promote, and preserve their unique role, skills, and expertise in healthcare and advocate for the mental health rights and needs of children, adolescents, and families.

GOAL 2 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: *Payment structures, employer demands, training gaps, and public perception are converging to constrict the professional identity of CAPs primarily to prescribers of medications. These dynamics and forces fail to consider the CAPs unique expertise in differential diagnosis, clinical formulation, evidence-based treatment planning, evidence-based treatment services, and evidence-based preventive interventions. Other disciplines and providers are beginning to fill the service gaps; resulting in a general perception across both private and public sectors that CAPs involvement (whether direct or in an oversight capacity) is not needed for these critical services. Also, since these other providers are less costly, the systems can accrue cost savings. As a result, both the identity of CAPs as holistic clinicians and the quality of care provided to youth are being eroded. Practicing clinicians, AACAP, training programs, and lifelong learning programs have a critical obligation to engage in activities that both preserve and promote the unique role, skills, and expertise of CAPs.*

Recommendation 2.1 – AACAP, training programs and continuing medical education (CME) and lifelong learning programs will promote and preserve the unique role, skills, and expertise of CAPs.

Action step 2.1.1 **–** CAPs must acquire and maintain a core knowledge base with an emphasis on normal/abnormal child development and child/adolescent psychopathology; epigenetics; evidence-based assessment and treatment of psychopathology in children and adolescents; evidence-based mental illness prevention and mental health promotion; pediatric psychosomatic medicine; systems of mental health care for children and adolescents; and basic scientific knowledge such as genetics, pharmacology, etc.

Action step 2.1.2 **–** CAPs should be fully trained in the core knowledge base and translate this information into clinical practice.

Action step 2.1.3 **–** CAPs should maintain their expertise throughout their careers by continual self-evaluation and lifelong learning.

Recommendation 2.2 – CAPs need to understand and participate in the full range of preventive interventions for children and adolescents.

Rationale: *The care of children and adolescents, in all areas of medicine, begins with an understanding of those factors that increase the risk of illness. AACAP and its members should work to address these factors and collaborate with providers and educators to minimize their impact. This includes the development of early intervention and treatment programs by professionals in education and mental health. Primary care for children and adolescents should include interventions that prevent the occurrence and recurrence of psychiatric disorder. The role of the CAP will focus on minimizing risk factors as well as the assessment and treatment of mental health problems.*

Action step 2.2.1 **–** AACAP should be a clearinghouse for information on the prevention of mental illness (e.g., advances in practice, early interventions, benefits of systems based care).

Recommendation 2.3 – CAPs should understand and collaborate with population-based screening efforts.

Rationale: *In population-based models the practice of CAP will be guided by outcome data collected from multiple settings. Diagnoses and treatments will be tested and protocols changed based on the results of these reviews.*

Action step 2.3.1 **–** CAPs should be familiar with the use of rating scales and the integration of population-based data.

Action step 2.3.2 – CAPs should advocate that tools be used to screen for prevention and early intervention with broad populations.

Action step 2.3.3 –CAPs should consider using AACAP's Early Childhood Service Intensity Instrument (ECSII) and the Child and Adolescent Service Intensity Instrument (CASII) in their practice.

Action step 2.3.4 – CAP training programs should insure that trainees are introduced to population-based tools and screening measures.

Action step 2.3.5 – CAPs should collaborate with child welfare, juvenile justice, and educational professionals on prevention and early intervention by providing timely access to practical and understandable advice about the screening and assessment of mental health problems in children and adolescents.

Recommendation 2.4 – CAPs should be informed and supported to act on major advocacy issues in CAP.

Rationale: *The mental health difficulties and needs of most children and adolescents go untreated. In addition, there are small numbers of CAPs compared to the large numbers of families and individuals needing help. CAPs throughout their careers (training through retirement) should be an active and assertive voice for high quality and adequate treatment of those children with mental illness and for the healthy emotional development of all children. While the need for broad based advocacy is apparent, only a small percentage of AACAP members participate in advocacy events. AACAP needs to more actively engage members in advocacy work as a professional responsibility, beginning in training and lasting throughout their careers. AACAP needs to encourage 100 percent of its members to be involved in advocacy efforts at local, state, and national levels.*

Action step 2.4.1 – AACAP should study the advocacy efforts of other organizations (e.g., professional, family, advocate) to market AACAP's advocacy programs and efforts as a vital member benefit, and to develop a plan to increase member involvement in advocacy.

Action step 2.4.2 – AACAP, in partnership with other appropriate consumer and professional groups, needs to develop a strategic agenda for advocacy efforts at both state and federal levels.

Action step 2.4.3 – AACAP should expand the Advocacy Liaison Program and encourage each Regional Organization Child and Adolescent Psychiatry to identify an "advocacy liaison" to coordinate advocacy efforts at the local level.

GOAL 2 – TRAINING AND WORKFORCE RECOMMENDATIONS:

Recommendation 2.5 – Define the diverse roles for CAPs within various healthcare delivery systems in the coming decade.

Rationale: *Multiple forces (managed care, CAP shortage, etc.) are converging to reduce and fragment the role of the CAP in the health care delivery system. Without assertive action, other organizations and systems may redefine and restrict the role of CAP, for example, CAPs becoming solely psychopharmacological consultants with inadequate time to fully assess the child and family, thus relegating therapy to other health care providers. AACAP needs to proactively define and promote the unique role of CAP, and clearly communicate what we have to offer. An integrated model of training ensures that a fully trained CAP can provide a variety of therapies. Our ability to work with children and adolescents within the context of their families, schools, and communities, and to provide continuity of care using multimodal approaches, allows us to effectively tailor our treatments to best fit the patient's needs. For example, rather than allowing market forces to define us as doctors who overprescribe without really getting to know the patients, we can make it clear that our ability to prescribe medication in the context of providing therapy and working within the child's system of care allows us to carefully assess and titrate the need for medication. We are uniquely positioned to provide the best and most effective treatment. We must clearly define our skill set and effectively communicate it to others, in order to reduce stigma, secure reimbursement and funding, improve clinical care, and improve recruitment into the field.*

Action step 2.5.1 – AACAP committees (e.g., Training and Education, Systems of Care) should collaborate and carefully review the multiple roles that CAPs may have within a broader system of care, and how to provide training in these diverse healthcare delivery roles.

Action step 2.5.2 – Continue periodic assessments of members' work practices to identify career development needs.

Action step 2.5.3 – Create descriptions of CAP roles and responsibilities in various systems and various approaches to career development and practices; domestic and international; include information on finances: how to approach developing, implementing, maintaining and managing the economic/business aspects of work.

Action step 2.5.4 – Develop information and resources on multiple types of CAP careers. This could be organized by type of work (e.g., clinical, research, administrative) or type of structure/institution (e.g., self-employed, contractor, non-profit agency, for profit agency, academic, military).

Recommendation 2.6 – AACAP should strengthen the role of CAPs as advocates by providing advocacy education and advanced curricula on political/mental health policy for CAPs and families.

Action step 2.6.1 – Conduct periodic assessment of membership regarding needs in advocacy knowledge, skills, and priorities.

Action step 2.6.2 – Develop and distribute advocacy tools (e.g., "How to be an Advocate") and promote effective advocacy strategies, programs, and initiatives for CAPs.

Action step 2.6.3 – Develop and provide advocacy curricula for trainees (e.g., basic and more advanced, didactic and experiential) that are longitudinal (medical school through CAP fellowship) and incorporates advocacy as an essential and integral aspect of practice.

Action step 2.6.4 – Maintain a resource database on federal and state initiatives (e.g., facts sheets, position statements, data cards). Use various formats and methods to disseminate this information to members (e.g., section on website, webinars, annual meeting presentations).

Action step 2.6.5 – Develop and provide a range of information and resources on advocacy issues (e.g., general or specific topics, local, state or national).

Action step 2.6.6 – Provide funding/awards for political and other types of advocacy to residents and members for various types of advocacy opportunities, national and local, of varying lengths and intensity.

Recommendation 2.7 – CAPs should improve the understanding of social determinants in communities (e.g., poverty, hunger, discrimination, violence, trauma) that influence the mental health of children and families.

Rationale: *CAPs training must include competencies in engaging diverse children and families from a broad range of cultures and including race, ethnicity, class, geography, language, sexuality, and gender. CAPs must also be aware of and engaged with community organizations, including civic, religious, and service groups.*

Action step 2.7. 1 – CAPs will be able to assess social determinants of mental health within their communities and society.

Action step 2.7.2 – CAPs will be able to assess capacities and strengths within children, families, communities, and society.

Recommendation 2.8 – AACAP educator leaders will participate actively in the development and ongoing evolution of the ACGME Milestones that will include competencies relevant to changing healthcare environment.

Recommendation 2.9 – AACAP, in partnership with other organizations, will continue strong efforts to educate insurance companies, other agents, and payors about CAPs' skills and expertise to ensure appropriate payment for all services.

Recommendation 2.10 – Improve the public image of CAPs through public education.

Action step 2.10.1 **–** AACAP should promote media training for CAPs throughout their careers to help them more effectively engage advocacy organizations and news organizations, educate the public on mental health problems facing the country's youth, and promote evidence-based solutions.

Recommendation 2.11 – Improve education of the public about normal development, normal variation, problems, and disorders in children, adolescents, and families.

Action step 2.11.1 **–** Provide curricula for parents and children regarding normal development and identification and accessing services if there are concerns about a child's emotional and behavioral development.

Action step 2.11.2 **–** Provide information to patients and families regarding: patient advocacy organizations, appropriate and effective treatments, and risks and benefits of treatment versus no treatment when participating in clinical research.

Goal 3 (New healthcare systems and models) – As experts in pediatric mental health, child and adolescent psychiatrists (CAPs) must be prepared to both practice child and adolescent psychiatry and provide leadership in new and emerging healthcare systems and models of healthcare delivery.

GOAL 3 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: *As a result of the Affordable Care Act (ACA) the next decade has the potential to bring enormous changes in the delivery of healthcare and mental health care within the United States. The transition to team-based, integrated models of care has already begun in large healthcare systems and is predicted to filter its way through all aspects of public and private healthcare systems. Another consequence of the ACA is the expansion of health insurance coverage to millions of previously uninsured adults, children, and adolescents. Given the long standing shortage of CAPs and other child mental health professionals, increasing demands for access to mental health services will be made upon a system that is largely viewed as fragmented and inefficient.*

CAPs, as physicians trained in medicine, public health, child development, and the diagnosis and treatment of developmental and psychiatric illness in children and adolescents, are uniquely suited to lead in the design, development, and implementation of systems of care that will have the potential to address the mental health needs of our nation's children and adolescents.

Recommendation 3.1 – CAPs need the skills to address the mental health issues within complex systems of care and population-based medicine practices.

Rationale: *Many aspects of CAP training have historically contained many of the components needed for effective leadership within team-based care delivery models. For instance, aspects of school and hospital consultation/liaison training, knowledge of systems theory, development, and group dynamics all lend themselves towards effective team-based care. In addition to these core skills, evolving models of healthcare delivery will require understanding of modern leadership and management theories. Systems of care in both public and private sectors are likely to be increasingly complex with a reliance on population-based surveillance and interventions as a means of increasing access to care without dramatically increasing costs.*

Action step 3.1.1 **–** Through the collaboration of AACAP committees (e.g., Healthcare Access and Economics, Training and Education, Schools, Systems of Care), core competencies in leadership principles related to integrated delivery systems should be developed.

Action step 3.1.2 – Continuing medical education (CME) programs (e.g., Annual Meeting track) in leadership principles should be developed to support members' roles in these new systems and models.

Action step 3.1.3 – AACAP committees (e.g., Healthcare Access, Systems of Care, and Collaboration with Medical Professional) should develop educational models to assist members with understanding and implementing new models of healthcare delivery within integrated systems.

Action step 3.1.4 – AACAP will sponsor and encourage education about the evolving need for population-based medicine strategies—for screening, risk assessment, and interventions.

Recommendation 3.2 – AACAP needs to develop educational materials for CAPs on issues related to complexity of financing models that will be an increasingly integral part of healthcare reform.

Rationale: *The evolution of the financing of healthcare within our country has a complex history. As a result of the ACA financing models will become increasingly complex as models begin to include partial capitalization, bundled payments, shared savings, and other interventions aimed at reducing overall healthcare costs. Added to this will be the introduction of payment systems based on meeting specific parameters for efficiency and quality of delivered care. Initially, the greatest impact of these changes will be on those CAPs working within larger systems of care, however, eventually many of these innovations will affect CAPs working in private practice as well.*

Action step 3.2.1 – AACAP will need to educate its members (using the Annual Meeting, webinars, and *JAACAP* articles) and develop programs and materials about system finance models, service design, and physician compensation/reimbursement.

Action step 3.2.2 – AACAP will need to educate its members about benefit design features in order to advocate assertively for essential benefit design at the state and systems level (e.g., Annual Meeting programs and other educational materials).

(2013-2015 Priority) **Recommendation 3.3 – CAPs need to be familiar and able to work in evolving models of healthcare delivery systems, including the Accountable Care Organization (ACO) and medical home models.**

Rationale: *The ACA has incentivized the use of the "medical home" and "Accountable Care Organization" models to target areas such as quality improvement and cost containment within healthcare delivery models. AACAP members will need to be familiar with these and other evolving models of care delivery. In addition, CAPs should be participating and leading the design of integrated models of mental healthcare delivery.*

Action step 3.3.1 – In the short term, AACAP will need to actively educate its members about the impact of healthcare reform (e.g., Annual Meeting presentations, *AACAP News* and *JAACAP* articles, and webinars developed by the various AACAP committees).

Action step 3.3.2 – AACAP needs to inform and support its members by developing educational materials related to innovations in efficient mental healthcare delivery.

Recommendation 3.4 – AACAP and CAPs need to proactively address the increase in the number of patients seeking mental health services that comes from the expansion of health insurance.

Rationale: *During 2013-2015, as a result of the expansion of insured populations, there will be a dramatic increase in insured individuals seeking treatment. Given our historically fragmented and underserved service models this will stress an already overloaded and outdated system of care. AACAP members need to anticipate this trend and be prepared to advocate at local, state, and federal levels for appropriately designed and funded systems of care.*

Action step 3.4.1 – AACAP needs to develop materials to assist members to be leaders in advocating locally for models of care that will address this dramatically increased service need.

Action step 3.4.2 – AACAP needs to provide leadership in organizing and facilitating meetings with other stakeholders (e.g., consumer and allied professional organizations and federal policy directors) to address ways to improve the care system for children's mental health.

Recommendation 3.5 – AACAP should provide leadership in assessing market forces on the field and practice of CAP.

GOAL 3 - TRAINING AND WORKFORCE RECOMMENDATIONS:

Rationale: *Healthcare systems are preparing for a new reality that will likely involve more individuals who are insured, but lower reimbursements for each of those individuals. This will likely exacerbate the issues caused by the shortage of CAPS. New systems of treatment, such as functioning in a consultation role to other mental health and somatic health providers, will be key for adequately treating the general population as well as preserving the relevance of CAP. Continuing to strengthen the consultation training that is in residency programs is critical. The new era of healthcare will likely mean that healthcare organizations will be responsible for the treatment of populations rather than individuals. This will mean that psychiatrists and other mental health professionals will be required to focus more on prevention rather than treatment. CAPs will need to be better equipped to work in traditional consulting relationships such as school, juvenile justice, and social service settings. They will also need to develop additional skills in less traditional settings such as community health clinics, pediatric offices, and in governmental agencies. Population health and public health treatment paradigms will need to be addressed in residency programs. As healthcare systems become more financially complex and challenged, physicians (including psychiatrists) will need additional financial and business training to be able to adequately protect current services and expand future services. Basic financial literacy will need to be provided for all psychiatrists, with the option of additional training depending on the career goals of the individual psychiatrists. It will be critical that we train enough CAPs as administrators and policymakers so that we can have a future impact in health systems.*

Recommendation 3.6 – Expand consultation and collaborative care training in CAP residency programs.

Recommendation 3.7 - Population health and public health treatment paradigms should be included in CAP residency programs.

Recommendation 3.8 – Teaching/training will be done by teams in settings that integrate CAP and pediatric health.

Action step 3.8.1 – Develop a joint set of training recommendations regarding integrated CAP and pediatric health between the training committees of AACAP and the American Academy of Pediatrics (AAP) and other national training organizations. Recommendations could focus on collaboration on school-based health services, childcare consultation, child welfare (foster care), infant mental health, and screening/assessment in primary care.

Action step 3.8.2 – Develop workshops and Web-based education modules on "Models of Teaching Collaborative and Consultative Child and Adolescent Psychiatry." The programs would train CAPs how to integrate their care into a Patient-Centered Medical Home, and could include case management and consultation/collaboration with primary care providers and other medical and mental health professionals.

Action step 3.8.3 – Develop model curricula for resident training on collaboration with primary care through dialog between AACAP, the Model Curriculum Committee of AADPRT and AAP.

Action step 3.8.4 – Develop a web based clearinghouse for grants (e.g., SAMHSA, NIMH) to support collaborative care.

Action step 3.8.5 – Establish dialog with the ACGME about recognizing need for training in collaborative care while taking into account the realities of limited training time, variable faculty expertise, and opportunity.

Action step 3.8.6 – Identify AACAP expert mentors to serve as "mentors" to members interested in program development in collaborative care.

Action step 3.8.7 – Explore opportunities with other organizations (e.g., AAP, AAFP) to develop needs assessment of their members for training and education in CAP.

Recommendation 3.9 – As healthcare systems become financially complex and more challenging, physicians (including child and adolescent psychiatrists) will need additional financial and business training.

Recommendation 3.10 – Increase training and mentoring of CAPs as administrators and policymakers to increase the impact of CAP in health systems.

Goal 4 (Expanded access to care) – Child and adolescent psychiatrists (CAPs) and AACAP should support the development of new models of practice that improve access to quality psychiatric care for all children, adolescents, and their families.

GOAL 4 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale *–Changes in healthcare delivery at the national and state level will increase access to mental health services for children and adolescents while monitoring both cost and quality. CAPs should expand their clinical service reach by: enhancing the capabilities of other professionals to provide mental health care, working collaboratively to make services available to a broader population of patients, including those on Medicaid, and working to meet the mental health needs in both rural and urban areas.*

Recommendation 4.1 – CAPs should participate in the education and training of other child-trained mental health professionals (e.g., child-trained psychologists, social workers, mental health counselors, Advanced Practice Registered Nurses [APRNs]) in normal development, mental health, and mental illness in children and adolescents.

Rationale: *A variety of mental health professionals are providing services to children and adolescents that include psychotherapies as well as psychotropic medications. There are insufficient numbers of CAPs to meet the growing mental health needs of the population. CAPs can enhance the treatment and assessment of these patients by participating in the training and standards of practice for these other professionals.*

Action step 4.1.1 – CAPs should enhance the capacity of other child-trained mental health professionals to promote mental health and prevent mental health problems in children and adolescents.

Action step 4.1.2 – CAPs should enhance the capacity of other child-trained mental health professionals to provide assessment, differential diagnosis, and clinical formulations for psychiatric disorders in children and adolescents.

Action step 4.1.3 – CAPs should enhance the expertise of other child trained mental health professionals in evidence-based psychological and family therapies and contextual interventions for psychiatric disorders in children and adolescents.

Action step 4.1.4 – CAPs should collaborate with mid-level practitioners, including advance practice nurses (APRNs), in the provision of psychiatric care for children and adolescents, including the safe and effect use of psychotropic medications.

Action step 4.1.5 – CAPs should enhance the capacity of other child-trained mental health professionals to know when consultation and referral to CAP specialty services is indicated.

Action step 4.1.6 – AACAP should collaborate in the creation of educational tools that will guide the practice of other mental health professionals in the assessment and care of mental health and mental illness in children and adolescents, and identify standards of care.

Action step 4.1.7 – AACAP should provide guidelines for CAPs on collaboration with other health, mental health professionals, and mid-level practitioners.

Action step 4.1.8 – AACAP should participate in efforts to create standards of specialization and certification amongst other child and adolescent mental health professionals.

Recommendation 4.2 – AACAP and its members need to form collaborative relationships with ancillary provider organizations.

Rationale: *Organizations that represent mental health professionals will begin to set standards for the care of children and adolescents and create initiatives to meet the need. This process will occur with or without the involvement of CAP and it is, therefore, important that CAPs participate. If CAPs are involved, their level of expertise will be appreciated, their recommendations will be incorporated into the ancillary providers practice, and they will establish a role for the CAP in a system of care.*

Action step 4.2.1 – AACAP leadership should explore opportunities for collaboration and consultation with the leadership from social work, psychology, and other allied children's mental health organizations at the state and national levels, with the goal of improving the mental healthcare delivery system and integrating mental health services into care treatment models.

Action step 4.2.2 – CAP trainees should have experience working collaboratively with other mental health providers throughout their training.

Recommendation 4.3 – CAP practices should incorporate mid-level/advance practice providers as partners.

Rationale: *CAP is an area of growth for APRNs. Standards of practice and certification are being developed. CAPs and AACAP must participate in these processes to define the working relationship between CAPs and APRNs, particularly in the area of psychopharmacology.*

Action step 4.3.1 – AACAP should collaborate on a national level with relevant professional organizations to define the role of mid-level and advance practice providers in child and adolescent psychiatric care.

Action step 4.3.2 – CAPs should participate in and coordinate training in child and adolescent mental health with mid-level/advance practice providers.

Action step 4.3.3 – AACAP should work with the national organizations of APRNs to develop qualifications for certification in child and adolescent mental health.

Recommendation 4.4 – CAPs should be knowledgeable about the development of new population-based models of healthcare delivery, including Accountable Care Organizations (ACO) and the medical home, and be ready to assume multiple roles in these practices.

Rationale: *The Affordable Care Act (ACA) supports the development of population-based models of care as opportunities to deliver services to more patients with less cost and an emphasis on quality. Mental health care for children will be shared among multiple professionals and the roles of CAPs will include those of educator, consultant, collaborator, and specialist in the assessment and treatment of serious psychiatric disorders.*

Action step 4.4.1 – CAPs should engage in preventive services by enhancing the knowledge of clinicians regarding screening tools and other mental health educational resources.

Action step 4.4.2 – CAPs should engage in early intervention by providing readily accessible 'curb-side' and timely "in-person' consultations to clinicians regarding the evaluation and management of mental health problems.

Action step 4.4.3 – CAPs should engage in specialty consultation/coordination by collaborating with clinicians to develop a "family mental health care plan" that can be implemented in their practice.

Action step 4.4.4 – CAPs should engage in specialty intensive services by providing assessment, differential diagnosis, formulation, and treatment of psychopathology in children and adolescents, while working collaboratively with clinicians for return of care to their practice when appropriate.

(2013-2015 Priority) **Recommendation 4.5 – CAPs and AACAP should support collaboration with primary care physicians and pediatric subspecialty physicians by establishing stronger relationships in training and clinical practice.**

Rationale: *Care for children and adolescents will be organized around the primary care specialist or pediatrician who provides most of the patient's care. Referrals to tertiary care specialists will be based on collaborative relationships that emphasize education, consultation, and access in a broader system of care. CAP must be part of this process to ensure access to patients and to ensure participation in the reimbursement models.*

Action step 4.5.1 – CAPs should work with primary care and pediatric subspecialty physicians to clearly define their respective roles in patient and family mental health care coordination.

Action step 4.5.2 – AACAP should encourage CAP training programs to increase training in collaboration with primary care and examine new models of education (e.g., primary care pediatric practice rotations).

Action step 4.5.3 – AACAP should advocate that CAP function as a subspecialty of both pediatrics and psychiatry when considering policy and system planning.

Recommendation 4.6 – CAPs should be willing to participate in Medicaid and insurance networks to provide care to the increased insured population resulting from implementation of the Affordable Care Act (ACA).

Rationale: *The ACA offers coverage to larger numbers of patients and families through the expansion of Medicaid and the creation of insurance networks. More children and adolescents will have access to mental health services, but the nature and quality of those services is not yet known. CAPs and AACAP can lead in this area if they participate in developing payment systems and make a commitment to care for these populations.*

Action step 4.6.1 – AACAP and CAPs, in partnership with other appropriate organizations, should advocate locally and nationally to ensure fair payment for services.

Action step 4.6.2 – AACAP should partner with the American Psychiatric Association (APA) to collect data on payment structure (e.g., CPT codes) and advocate for fair payment. This information should be shared with insurance providers and state agencies.

Action step 4.6.3 – AACAP should help organizations work with the new exchange structures that are feasible for CAPs.

Action step 4.6.4 – AACAP should define outcome data for CAPs and describe the benefits that derive from the use of outcome measures.

Action step 4.6.5 – CAPs should understand the emergence of insurance exchanges and their impact on the provision of child and adolescent psychiatry services.

Action step 4.6.6 – AACAP should introduce the role of the CAP as a leader and entrepreneur in the development, management and coordination of services.

Action step 4.6.7 - AACAP should promote residency training and continuing education for CAPs in business models of integrated care delivery that identify CAPs as business leaders and entrepreneurs.

Action step 4.6.8 – AACAP should work with its members to increase their participation with insurance networks and Medicaid.

Action step 4.6.9 – AACAP should study future reimbursement models for CAP (e.g., development of ACOs with business partnerships between CAPs and other professionals).

Recommendation 4.7 – New models for CAP practice should be developed that go beyond fee for service and include population- and outcome-based programs in organized healthcare systems.

Rationale: *Child and adolescent psychiatrists, along with most pediatric subspecialists, are moving to larger group practices that can incorporate population- and outcome-based programming encouraged by the ACA. The CAP will assume multiple roles depending on the changing needs of the referral sources in the system. Many CAPs will be moving to larger organized healthcare systems in order to meet future clinical and administrative demands. There will always be a place for the solo practitioner in CAP, most likely in fee for service arrangements.*

Action step 4.7.1 – AACAP should develop career webinars and CME programs to educate members on new practice models.

Action step 4.7.2 – AACAP should compile and disseminate information on the multiple new roles for child and adolescent psychiatrists in team based medicine.

GOAL 4 - TRAINING AND WORKFORCE RECOMMENDATIONS:

Rationale*: Persisting shortages in the child and adolescent psychiatry workforce combined with health care reform have stimulated and mandated the development of new models to provide psychiatric care to children living in underserved communities. A decade ago, the Surgeon General called for the use of telecommunications technologies to address disparities in children's access to mental health care. Recent technological advances have answered this call. Telepsychiatry or the use of video-teleconferencing (VTC) to provide care that is usually rendered in person is now a viable alternative for youth who cannot access traditional in-person psychiatric care.*

To realize this potential, a new generation of CAPS is needed to explore new venues for practice with experienced psychiatrists and examine ways to develop flexible practice models to fit lifestyles of early career psychiatrists (ECPs). Many barriers still exist to making telepsychiatry a fluid and natural choice in psychiatric practice.

Recommendation 4.8 – All states should mandate that health insurers pay for telemedicine, including telepsychiatry. These payments should include both staffing and technology costs at the patient site.

Rationale: *Only twelve (12) states currently mandate that health insurers/payors cover direct care delivered through VTC or telemedicine.*

Action step 4.8.1 – AACAP will advocate for parity in payment for telepsychiatry services.

Action step 4.8.2 – AACAP, in partnership with health plans and other stakeholders, will advocate for legislation mandating that payors/health insurers (including Medicaid) cover telepsychiatry.

Action step 4.8.3 – AACAP will promote the development of "toolkits" for regional councils to use for advocating telepsychiatry payment at the state level.

Recommendation 4.9 – AACAP should promote the development of user-friendly, easily accessible telepsychiatry materials that provide a "road map" for establishing a patient base, selecting appropriate technologies, and implementing a business plan.

Rationale: *Practicing CAPs (potential telepsychiatrists), particularly those in private practices, need guidance in approaches to developing a sustainable practice of telepsychiatry.*

Action step 4.9.1 - AACAP will empower a Telepsychiatry Task Force consisting of members from the Private Practice Committee, Systems of Care Committee, Early Career Psychiatrist Committee, Juvenile Justice Reform

Committee, Lifelong Learning Committee, Training and Education Committee, Workforce Issues Committee, and the Telepsychiatry Committee to develop webinars, websites, and "toolkits" to guide psychiatrists in developing their own "How to Do It" road map to establishing a telepsychiatry practice.

Recommendation 4.10 – AACAP should develop easily accessible materials describing telepsychiatry as a viable option in providing quality mental health care to children.

Rationale: *Information on telepsychiatry should be widely distributed to stakeholders in underserved areas who are charged with children's welfare.*

Action step 4.10.1 – The AACAP Telepsychiatry Task Force will develop strategies for disseminating knowledge about the benefits and challenges of telepsychiatry and assist in connecting telepsychiatrists with potential telepsychiatry service sites.

Recommendation 4.11 – Develop Integrated Care Models using telepsychiatry/VTC to bring psychiatric care to children, adolescents and, primary care providers.

Rationale: *Evolving Integrated Care Models will require CAPs to expand their usual models of consultation and liaison with primary care. Practice sites that are distant and/or under-served will need telepsychiatry involved in such models.*

Action step 4.11.1 – AACAP should support a collaboration with the American Academy of Pediatrics (AAP) and the AACAP's Committee on Collaboration with Medical Professionals, Community-based Systems of Care Committee, Physically Ill Child Committee, and the Telepsychiatry Committee to adapt current models (e.g., Unutzer's Collaborative Care Model and Dobbins' Consultation Conference) using VTC and telepsychiatry to improve pediatric and adolescent mental health care in primary care.

Recommendation 4.12 – CAPs should be prepared to assist in natural and man-made disasters using telepsychiatry.

Action step 4.12.1 – AACAP should explore developing educational, networking, and interventional materials to support a "virtual disaster response team" that can collaborate with other agencies using telepsychiatry during the acute crisis and post-trauma recovery stage of disaster response.

Action step 4.12.2 – AACAP should consider creating a special task force consisting of members from the Disaster and Trauma Issues Committee, Military Issues Committee, Media Committee, International Relations Committee, and the Telepsychiatry Committee to develop guidelines on using telepsychiatry during disaster relief, nationally and internationally.

Recommendation 4.13 – AACAP will promote training in the use of technologies and other approaches to expand the reach of CAPs to underserved areas (i.e., telepsychiatry and other developing e-health technologies).

Goal 5 (Role as educators and collaborators) – Child and adolescent psychiatrists (CAPs) should be trained and supported throughout their careers to be educators and to collaborate with child serving systems of care.

GOAL 5 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: *Psychiatric care for children and adolescents may be provided in settings that offer direct and consistent access to patients in ways that go beyond traditional clinical models. Mental health services are provided in schools, through the juvenile justice system, in programs for young clients with developmental disabilities, and in partnership with child welfare agencies. CAPs should actively participate in the creation and operation of these systems in order to enhance the knowledge and clinical skills of the providers.*

Recommendation 5.1 – CAP practices should be integrated with other child-serving systems of care including education, child welfare, and juvenile justice.

Rationale: *The psychiatric care of children and adolescents begins with access. For large segments of the population, routine contact with patients is more easily attained in schools, child welfare agencies, and the courts. Non-CAP mental health professionals provide much of the care in these systems and are seeking consultation from and access to CAP.*

Action step 5.1.1 – AACAP should advocate for each community mental health system to have a CAP involved in its leadership.

Action step 5.1.2 – CAPs should be available to provide child welfare, juvenile justice, and education professionals with timely access to practical and understandable advice about the screening, assessment, and management of mental health problems in children and adolescents.

Action step 5.1.3 – CAPs should be available to provide child welfare, juvenile justice, and educational professionals with timely access to assessment and treatment for psychiatric disorders in children and adolescents.

Action step 5.1.4 – CAPs should reach agreement with child welfare, juvenile justice, and educational professionals on the extent the role of each team member will have in patient and family mental health care coordination.

Action step 5.1.5 – ACCAP should advocate for communication between the pediatric medical home and community based systems of care to ensure appropriate access for vulnerable children and adolescents.

Action step 5.1.6 – Training in child and adolescent psychiatry should include exposure to diverse community-based systems of care.

Action step 5.1.7 – AACAP should advocate with federal, state and local authorities for the integration of CAPs in child serving systems of care.

Recommendation 5.2 – CAPs need to be trained in the supervision and delivery of school-based mental health care.

Rationale: *A child's performance in the classroom, his ability to get along with peers, and his response to the direction of teachers are among the most sensitive indicators of psychosocial functioning. Schools present a unique opportunity to identify those children in need of services and to impact those who are struggling. School personnel and ancillary mental health staff, under the guidance and direction of CAPs, can provide the services necessary to make a difference for these children.*

Action step 5.2.1 – Training in school-based mental health care should include program design, service delivery, screening and models of care.

Action step 5.2.2 – CAPs should work in partnerships with school-based counselors, social workers, nurses, psychologists, special educators, and school administrators.

Action step 5.2.3 – CAPs and the AACAP should advocate for universal mental health screening in schools.

Action step 5.2.4 – AACAP should develop school-based mental health continuing medical education (CME) and educational resources for members (e.g., Annual Meeting programs, webinars).

Recommendation 5.3 – CAPs should understand the complex and evolving systems of funding and use of resources within public systems of care.

Action step 5.3.1 – AACAP will provide continuing education to assist members in understanding the integration of public and private service delivery models, as well as new and developing payment models.

Action step 5.3.2 – AACAP should advocate for blended funding models to support integration of CAPs into child serving systems of care.

Recommendation 5.4 – CAPs should participate in the changes occurring in forensic psychiatry and juvenile justice.

Action step 5.4.1 – AACAP should support the translation of neurodevelopmental research findings to the court room, assist in adjudication of youth offenders and develop guidelines around sentencing, treatment, and rehabilitation of children and adolescents.

GOAL 5 – TRAINING AND WORKFORCE RECOMMENDATIONS:

Rationale: *During their training, most CAP residents are expected to provide training to medical students and residents. It is essential that they learn how to teach effectively and receive feedback on their teaching. Necessary skills include supervision, creating active learning environments in small and large group settings, providing formal educational activities that actively engage students, learning effective use of technology, understanding adult learning theory, learning how to assess skills, and knowing how to provide formative and summative feedback. The entire field of graduate medical education (GME) is changing with the advent of the ACGMEs Next Accreditation System (NAS). The establishment of Milestones, developmental benchmarks for knowledge, skills and attitudes at each stage of professional development will require CAP educators to understand educational methods for each level of student, resident, fellow, or peer. In addition, new methods of valid and reliable assessment of outcomes will increasingly be developed and implemented for use in medical education, residency training, Maintenance of Certification (MOC), hospital credentialing, and potentially medical licensure. Faculty development will be required to teach particular milestones and use advanced information technology to provide real-time assessments of student and physician performance and outcomes. The role of CAP as educator also extends to working with families, school personnel, and communities. CAPs act as consultants to other specialties and need to be able to provide in-service education to other health professionals. Given the shortage of CAPs, they need to be able to educate primary care providers about common CAP disorders. CAPs also need to educate the general public to reduce stigma and help inform parents and youth about mental health, illness and resilience. The importance of a well-educated public is critical to well-coordinated care. CAPs must also learn to be effective advocates for child mental health.*

Recommendation 5.5 – AACAP will develop the AACAP Alliance for Learning and Innovation (AALI) – a community of educators across training levels and including AACAP members from diverse practice environments (academic, private practice, community) to promote superior education and training.

Action step 5.5.1 – Recruit diverse members and perform a needs assessment to identify training gaps in current teaching skills.

Action step 5.5.2 – Develop programming to target the training gaps identified by the needs assessment. This could include both online programming and live programming.

Action step 5.5.3 – Recognize outstanding educators at the Resident, Early Career Psychiatrist, and Master Teacher level through awards given by the Alliance for Learning and Innovation (AALI) and AACAP's other venues.

Recommendation 5.6 – CAPs should learn how to teach effectively using technology and new learning techniques and methods.

Recommendation 5.7 – CAPs will be able to teach a wide range of learners including allied health professionals, non-health professionals, and the general public.

Recommendation 5.8 – AACAP will promote increased training in assessment and treatment of CAP disorders for all physicians, mid-level practitioners and advance practice providers.

Action step 5.8.1 – AACAP's committees will explore opportunities for increased CAP training with the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and organizations representing psychiatric nurse practitioners and physician assistant training programs.

Action step 5.8.2 – Explore with AADPRT, and ACGME opportunities for increasing requirements for CAP in general psychiatry training.

Action step 5.8.3 – Advocate for inclusion of sufficient education in child mental health for all physicians, mid-level practitioner and advance practice provider training programs.

Action step 5.8.4 – Collaborate with other groups/organizations (e.g., AAP, NIH), nationally and internationally, to support the acquisition and sharing of data on treatment outcomes in support of collaborative training:

- Meetings: Joint meetings; overlapping annual meetings
- Funding/Awards: Continue to provide funding/awards to regional organizations to collaborate with pediatrics to disseminate information on evidence/ outcomes
- Other Support: Scholarships/support to have representatives from other organizations present to membership; support AACAP representatives to attend/ participate in other organizations' activities

Action step 5.8.5 – Develop infrastructure/support to collaborate with experts in relevant disciplines (e.g., business, law, economics); medical specialties (e.g., pediatrics, family medicine); and relevant organizations (e.g., children's hospitals, community mental health, patient advocacy).

Recommendation 5.9 – AACAP will provide career development assistance and mentorship for members.

Action step 5.9.1 – Maintain a group of diverse mentors (career type/location) for interested CAPs at any stage of career, and develop and maintain system/resources to educate and support mentors.

Action step 5.9.2 – Expand the AACAP mentorship matching program that currently provides mentors to CAPs in training.

Goal 6 (Research) – AACAP will promote the full range of research to improve the prevention and treatment of psychiatric disorders throughout childhood, adolescence, and early adulthood.

(2013-2015 Priority) **Recommendation 6.1 – Develop and disseminate a clear, broad-based research agenda that covers the breadth of child and adolescent psychiatric (CAP) disorders, with particular emphasis on those disorders that are the most common, have the greatest morbidity and mortality, are in areas where prior research provides the most promising opportunities, and have the greatest public health and societal costs, especially those occurring in understudied or underserved populations.**

Rationale: *Research is critical to preventing and treating psychiatric disorders in youth. A wide range of basic, translational, clinical, and services research is critically needed to improve our nation's ability and capacity to prevent, diagnose, and effectively treat psychiatric disorders in children and adolescents. Research areas include but are not limited to: basic developmental neuroscience; genetics, imaging, and other biomarkers; epidemiology; developmental psychopathology; treatment development including psychosocial treatments, pharmacological treatments, and other novel treatment approaches; implementation and dissemination; national quality measure development; cost-effectiveness; and national child health policy research. Each area is distinctly important, as are translational studies that link several research domains. Within and across domains, a deeper understanding of the developmental processes underpinning each of these areas is necessary to fit specific treatment approaches to each specific developmental period.*

Action step 6.1.1 – Develop and implement an approach to guide the prioritization of research agendas, explicitly communicate the rationale, and integrate transparent mechanisms for refining priorities in response to scientific advances. This process should include members who are representative of the AACAP membership and include opportunities for all members to provide comments (i.e., email updates and surveys).

Rationale: *CAPs in research, clinical care, administration, and in all other aspects of the field have valuable insights regarding priority areas for research. Groups of AACAP members have more wisdom in aggregate than do individuals acting on their own.*

Action step 6.1.2 – Develop a transparent process to develop and maintain a current list of research priorities that is responsive to all of AACAP's membership. The process to develop and maintain this prioritized list would be inclusive of the full range of AACAP members.

Rationale: *The list of research priorities would be updated on a regular basis, perhaps every two years. The prioritization does not need to provide a complete sorting of all prioritized items, but rather might be most useful if it separates recommended research areas into different levels of priority (e.g., "extremely timely and of potentially enormous impact,""timely and important"). AACAP should report only the higher levels—there is little or no advantage to the field for the AACAP to report on a wide range of less promising areas of research. In developing the list, AACAP needs to consider overall funding availability—in times of limited funding it may be more strategic to emphasize fewer areas that represent the greatest opportunity.*

Possible research studies and priority areas:

(1) *Treatment approaches targeting the progression of psychiatric disorders to more severe forms or disorders (e.g., Do antipsychotics given very early prevent progression of psychotic disorders? Does treatment of anxiety prevent progression to Major Depression?)*

(2) *Usefulness of specific biomarkers and other risk factors in predicting disease course and optimizing individualized treatment.*

(3) *Treatment approaches in severely refractory cases. Research in adults and in neurological conditions uses relatively invasive methods that act directly on brain circuitry. Clearly, some of these treatments will not be appropriate for children for many years. Others may be appropriate but only for children who are treatment refractory. Work is needed to define the situations where such invasive treatments are justified, and research needs to evaluate their efficacy.*

(4) *Development of quality improvement interventions using emerging technologies to more rapidly disseminate and sustain evidence based practices in community-based settings.*

(5) *Development and demonstration of effectiveness of short-term/brief psychotherapy modules addressing specific symptoms and problems that may be combined in optimum ways for our patients.*

(6) *Psychotherapy dissemination and effectiveness research.*

(7) *The impact of the new DSM-5. Research will be needed to understand the impact of the changes in DSM-5 diagnostic categories, especially in the area of autism and the carving out of Disruptive Mood Dysregulation Disorder from Bipolar Disorder.*

Action step 6.1.3 – Disseminate AACAP's prioritized list of research opportunities to all members, the National Institutes of Health, other governmental agencies, Congress, clinical and research training programs, allied professional organizations, and others to build a consensus of support.

Action step 6.1.4 – Promote collaboration between AACAP and other stakeholders (e.g., consumer organizations, other professional organizations) to jointly advocate for more funding and targeted research in priority areas.

Recommendation 6.2 – Build capacity in the CAP workforce to: conduct research; use research to inform decisions about the prevention, early detection, treatment, and delivery of child mental health care; and guide health policy decisions to enable, promote, and sustain high quality child mental health care.

Rationale: *CAPs have roles in many diverse treatment settings and contexts (e.g., academic health centers, public mental health programs, collaborative primary care, schools, child welfare, and juvenile justice). CAPs have a unique perspective on: the implications of health policies, access and quality of child mental health care, and the costs (direct and indirect) of providing high quality care to children with psychiatric disorders and their families. A trained work force of CAP researchers is critical to ensuring that researchers with the necessary skills are available to carry out our research agenda.*

Action step 6.2.1 **–** Increase the number of CAPs trained in critical areas of research and promote research literacy in all CAPs.

Rationale: *Expert clinicians need solid research literacy to use scientific advances in their practices. CAPs need to be leaders in studies that use basic science knowledge to improve clinical treatments and preventative interventions. Interdisciplinary approaches are critical to solving the problems of the coming decade.*

Action step 6.2.2 **–** Promote increased research literacy in all CAPs by targeting different segments of CAPs. For example, residents and fellows could be targeted through training directors whereas early-career, mid-career, and later career psychiatrists may be targeted through AACAP's continuing medical education (CME) programs – including Web-based modules and programs.

Action step 6.2.3 **–** Increase opportunities for collaborative work with scientists from other disciplines and expertise in training programs for residents, CAP post-doctoral research fellows and early career psychiatrists (ECPs) involved in research.

Action step 6.2.4 **–** Encourage training programs to develop training in research that spans several domains with the potential to translate work from more basic levels to prevention and/or treatment.

Action step 6.2.5 **–** Explore new models to prepare CAP residents and ECPs and adolescent psychiatrists for careers in research.

Rationale: *While some "research powerhouse" programs have consistently trained successful CAP researchers, most programs have neither a sufficiently large base of CAP researchers nor the infrastructure to succeed despite having residents and early faculty who might be interested in and promising for such a career. We have a shortage of trained CAP researchers, so it is critical to explore new and broader approaches.*

Action step 6.2.6 **–** Explore developing collaboration models between the "research powerhouse" programs and training programs with strong adult psychiatry researchers or strong research departments in allied fields, including basic neuroscience, public health, psychology, etc., to provide a combination of local mentoring and distant televideo mentoring by CAP researchers.

Action step 6.2.7 **–** Develop a model "Research in Child and Adolescent Psychiatry Track" for medical students that includes research and post doctoral (PhD) opportunities to help launch the student's research career while in medical school. AACAP could partner with the Association of Directors for Medical School Education in Psychiatry (ADMSEP) and the Association for Academic Psychiatry (AAP) to disseminate this model.

Action step 6.2.8 **–** Encourage combined MD-PhD programs in medical schools to emphasize as a productive field of research.

Action step 6.2.9 **–** Identify "Training Programs of Excellence" that provide integrated models that have embedded education in research methods, protected research time, include research mentorship, and have the ability to incorporate trainees into labs to help promote early research productivity and on-site learning. Publish and disseminate information about successful methods shared among these programs to all medical schools in the United States.

Action step 6.2.10 **–** Increase mentorship in research by facilitating CAP researcher attendance and presentation at local, regional, and national meetings where medical students with research interests can be informed about

CAP research careers, such as large MD-PhD programs and meetings of American Physician Scientists Association (APSA) and Society for Neuroscience (SfN), etc. Encourage and collaborate with funding agencies to provide financial support for early career researchers to attend scientific meetings and to fund pilot research projects (medical school through post-doctoral).

Action step 6.2.11 **–** Develop a CAP research training curriculum in collaboration with strong research institutions. This could be modeled after current extremely promising efforts of Stanford, MIT, Harvard, and other universities to put advanced college courses on the web.

Recommendation 6.3 – CAPs should participate in research that examines the effectiveness and financial implications of collaborative care models for psychiatric patients.

Rationale: *The Affordable Health Care Act (ACA) will have a large impact on CAP service delivery systems and will affect all AACAP members and their patients. Without scientific understanding and research into how the new law actually changes systems CAPs cannot advocate for changes and approaches that will best serve children and families. This services research is critical to inform policy makers, health systems, clinicians, and families.*

Although new care models are beginning to be disseminated in primary care practices, there is a paucity of research to guide the use of these models for children with psychiatric illnesses, or to identify how these partnerships affect patient outcomes, the cost-effectiveness of these models, and satisfaction with these care models across clinicians, patients, and parents.

Action step 6.3.1 **–** CAPs should study the effect of CAPs partnering with other health and mental health professionals in delivering more efficient care.

Action step 6.3.2 **–** CAPs should study the quality and effectiveness of care in practice networks, groups, and Accountable Care Organizations (ACOs).

Action step 6.3.3 **–** CAPs should develop and evaluate quality indicators for psychiatric care.

Recommendation 6.4 – CAPs should engage in research that develops and disseminates equitable psychiatric care.

Rationale*: Disparities in mental health and mental health care have been documented, and there is a need to develop effective assessments and treatments for underserved groups, especially as health care becomes more available to populations of children previously untreated or undertreated.*

Action step 6.4.1 – CAPs should engage in research that seeks to improve the patient-centeredness of psychiatric care for children and families, by improving culturally and linguistically appropriate care.

Action step 6.4.2 – CAPs should investigate and study novel ways to engage underserved populations in psychiatric care.

Recommendation 6.5 – Promote studies of effective community dissemination of evidence-based psychiatric treatments.

Rationale**:** *As the ACA is implemented, a larger number of patients are expected to be accessing health and mental health care. CAPs will be needed to provide more service and consultation within child-serving systems of care. It will be increasingly important for CAPs to study mechanisms for disseminating evidence-based treatments in these community settings.*

Action step 6.5.1 **–** CAPs should study the effectiveness and cost-effectiveness of telepsychiatry in children and the use of new technologies to enhance dissemination of psychiatric treatments.

Action step 6.5.2 – CAPs should study the implementation and dissemination of prevention, early intervention, and psychosocial and psychopharmacological treatments, especially effective treatments in a broad range of child serving systems of care.

Recommendation 6.6 – AACAP should provide leadership in preparing and training CAPs to understand and interpret research advances throughout their careers (i.e., research literacy).

Goal 7 (Recruitment and shortages) – AACAP will continue to promote increased recruitment into child and adolescent psychiatry (CAP) and develop additional strategies to address the critical shortages and maldistribution of CAPs.

Rationale: *The numbers of CAPs in the United States are insufficient to meet the public health needs of children and families with mental health needs. All projections of need over the past 30 years have concluded that the number of CAPs is woefully inadequate for the 20 percent of the pediatric population with mental health problems. Although the numbers of graduating CAPs has increased over the past 10 years, it has fallen further behind projected needs. In addition, practitioners are maldistributed so that urban core and rural areas are especially lacking in access to CAPs. Given these realities, as well as current primacy placed on the medical home, other primary care health professionals will increasingly be looked to for child mental health assistance. CAPs will need to extend their impact by collaborating effectively with pediatricians, family physicians, nurse practitioners, physician assistants, and others who are on the front lines of pediatric care as well as in other systems of care. Further, CAPs should have a key role in the education and training of these health care professionals*

(2013-2015 Priority) **Recommendation 7.1 – AACAP will provide leadership by advocating for the unique role of CAPs and expanded funding to target the critical CAP workforce shortage and maldistribution.**

Action step 7.1.1 – AACAP will partner with appropriate national organizations, regulatory agencies, and key stakeholders to obtain and maintain funding for key roles and functions of CAP. Examples include but are not limited to graduate medical education (GME) funding, undergraduate medical education funding, and funding to support practitioner activities.

Action step 7.1.2 – Advocate with HRSA and SAMSHA to promote and support CAPs repayment of loans and work in FQHCs in underserved areas.

Action step 7.1.3 – AACAP will support expansion and development of primary care consultation models to target CAP maldistribution (e.g., Massachusetts Child Psychiatry Access Project).

Action step 7.1.4 – AACAP will advocate to remove the cap on the number of GME positions or to allow exceptions for shortage specialties including CAP.

Action step 7.1.5 – AACAP will advocate for developing incentives for medical students to pursue careers in child and adolescent psychiatry (e.g., differential payments from Medicare and Medicaid).

Action step 7.1.6 – AACAP will establish a clearinghouse for loan repayment and funding methods to address the shortage and maldistribution of CAPs. AACAP will explore possible funding for CAPs through National Health Service Corps and also develop a loan repayment model for states to target CAP practice in rural areas.

Action step 7.1.7 – AACAP will advocate for credits and/or funding for providing CAP training experiences in non-traditional GME sites (e.g. schools, correctional facilities, or community settings).

Action step 7.1.8 – AACAP will advocate for incentives for medical colleges to offer innovative GME training programs in CAP (e.g., integrated programs, post pediatric portal programs).

Action step 7.1.9 – AACAP will advocate for states to classify CAP as a primary care specialty in order for general psychiatry residents to extend J-1 Visa waivers into CAP training.

Recommendation 7.2 – AACAP, in partnership with other national organizations (e.g., SPCAP, AADPRT, ADMSEP, APA), will expand efforts to recruit talented medical students and residents into CAP.

Action step 7.2.1 – AACAP, in partnership with other national organizations, will examine and promote the development of flexible training models in CAP.

Action step 7.2.2 – AACAP will conduct a needs assessment on competencies obtained in other residency programs that are required to practice CAP.

Action step 7.2.3 – AACAP, in partnership with other national organizations, will provide a clearinghouse of training resources and curricula for CAP training programs.

Action step 7.2.4 – AACAP, in partnership with other national organizations, will work to ensure that funding continues for CAP training - including exploring innovative ways to fund CAP training and experiences.

Action step 7.2.5 – Promote increased exposure to CAP for undergraduate students (e.g., psychology majors) and medical students. Students in rural areas should be encouraged to consider practicing in their home states.

Action step 7.2.6 – AACAP will actively support the development and implementation of undergraduate college programs in child and adolescent mental health to encourage interest in CAP during formative academic years.

Action step 7.2.7 – AACAP will increase efforts to recruit high quality osteopathic medical students into CAP.

Action step 7.2.8 – AACAP will increase efforts to recruit high-quality International Medical Graduate (IMG) applicants into the field.

Action step 7.2.9 – AACAP will support and encourage Regional Organizations of CAP and American Psychiatric Association District Branches to do more outreach to medical students and residents.

Action step 7.2.10 – AACAP will strengthen efforts to recruit general psychiatry residents into CAP.

Action step 7.2.11 – AACAP will support expansion of alternative training programs such as Post- Pediatric Portal Program (PPPP) or Triple Board.

Action step 7.2.12 – AACAP will expand and support mentorship programs for medical students and residents.

Action step 7.2.13 – AACAP, in partnership with other appropriate national organizations, will work to fund research opportunities for medical students and residents. Funding must include faculty positions to support these programs.

Recommendation 7.3 – AACAP, in partnership with other appropriate national organizations (e.g. SPCAP, AADPRT, ADMSEP, APA), will continue working to destigmatize psychiatry and CAP within the medical community.

Goal 8 (Technological advances) – Evolving technological advances must be incorporated into the training, teaching methodology, and clinical practice of child and adolescent psychiatry (CAP).

GOAL 8 - SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: *Technological innovations have and will continue to revolutionize the way that medical care is delivered in the United States and mental health care is no exception. Advances in areas such as electronic medical records, telepsychiatry, and other health information technology are changing the way that CAPs interact with patients and their families. Understanding the use of these technologies, as well as the ethical issues surrounding the use of these technologies, is critical in the training of future CAPs. It is also important for mid- and senior career CAP's to understand and use these technologies.*

Recommendation 8.1 – Actively educate child and adolescent psychiatrists about the use of health information technology in clinical practice.

Rationale: *No expansion or reconfiguration of the workforce will ever meet the overall needs of youth with mental health treatment needs. Future young people will expect that technology be part of their treatment. New technologies should be explored for their therapeutic potential and to assist practitioners in meeting the mandates of health care reform.*

Action step 8.1.1 – AACAP should expand efforts to gather information and educate members about evolving technology advances (e.g., electronic medical records (EMRs), Web-based tools and therapies).

Action step 8.1.2 – AACAP will disseminate information on the current and future use of mobile apps and online interventions that can be used by youth and families to augment care.

Action step 8.1.3 – AACAP will investigate and disseminate information on the use of Web-based and mobile screening and treatment tools.

Recommendation 8.2 - The use of EMRs needs to be integrated into the practice of all CAPs.

Rationale: *EMRs that function well and are integrated have the potential for improving the quality and efficiency of care—especially in the areas of screening, adhering to standard practices of care, and reducing medication errors.*

Action step 8.2.1 – AACAP, in partnership with appropriate organizations (e.g., American Academy of Pediatrics, American Psychiatric Association), will work to develop EMR standards that support best practices for documentation of CAP treatment and adherence to mental health confidentiality standards.

Action step 8.2.2 – AACAP will work with multiple EMR vendors to develop products with pricing and functionality that is attractive and meets the needs of members' practices.

Recommendation 8.3 - E-prescribing needs to be integrated into the practice of CAP to improve safety and facilitate monitoring and tracking of side effects.

Rationale: *E-prescribing is being adopted across medicine due to its inherent efficiency. It also can reduce prescribing errors and complications related to the use of multiple medication regimens. Given the potential benefits with regard to safety, and the ability to track side effects and outcomes, all AACAP members should be encouraged to integrate E-prescribing in their practices. A major barrier to CAPs routinely using E-prescribing is the slow adoption of capacity to prescribe Drug Enforcement Administration (EDA) controlled substances – especially stimulants.*

Action step 8.3.1 – AACAP will educate members about the benefits of safety and treatment adherence with E-prescribing.

Action step 8.3.2 – AACAP will work with electronic prescribing networks and EMR vendors to collect and analyze data to improve the quality of care.

Action step 8.3.3 – AACAP will work with electronic prescribing networks and EMR vendors to develop programs that would support E-prescribing of all medications – including stimulants.

Recommendation 8.4 – CAPs need to understand the impact on children and families of social media and information available through the Internet.

Rationale: *Patients and their families have never before had access to such a large amount of variable quality information regarding all aspects of mental healthcare and child development. CAPs need to be aware of the types of different information that is available and to be prepared to help patients and families understand it and use appropriate Web-based information and tools.*

Action step 8.4.1 – AACAP will educate members on collaborating with patients and families to assist them in gathering and understanding health information from the Internet.

GOAL 8 – TRAINING AND WORKFORCE RECOMMENDATIONS:

Rationale: *The projected continued shortage of academic CAP challenges us to explore teaching methodology that will effectively reach larger numbers of learners, while still continuing to provide personal supervision and mentoring whenever possible. We need to ensure that the CAP residency curriculum uses effective teaching methodology and incorporates active learning techniques such as case-based or problem-based learning, audience response systems, effective stimulus video, and interactive multimedia modules highlighting child and adolescent psychiatric syndromes. Our trainees should also learn how to teach effectively using technology. Many of our graduates will also be teaching in the community, providing in-service training to allied health care professionals, or training other specialists such as primary care providers. As curricula are developed, care should be taken to consider their adaptability to various training needs and levels, and to include assessment methodology and a way to regularly update the material.*

(2013-2015 Priority) **Recommendation 8.5 – Promote innovative models for training and practice that include e-health (e.g., telepsychiatry, Internet, communication technology) and multidisciplinary collaboration that expands the reach of CAPs to underserved areas.**

Action step 8.5.1 – Develop a curricular needs assessment and gather innovative training models for medical student and CAP residents regarding telepsychiatry.

Action step 8.5.2 – Develop a curricular needs assessment and gather innovative training models for medical students and CAP residents regarding multi-disciplinary collaboration.

Action step 8.5.3 – Develop Web-based multidisciplinary case conferences with edited content and commentary for CAP trainees and practitioners.

Goal 9 (Global perspective) – AACAP and child and adolescent psychiatrists (CAPs) should increasingly promote the international and global perspective to meet the mental health needs of children, adolescents, and families around the world.

Rationale: *In a global world, we can no longer focus exclusively on the mental health of only our nation's children. As the largest children's mental health organization, and with an increasing number of international members, AACAP needs to provide leadership in addressing developmental and psychiatric illness in children and adolescents throughout the world. The Academy's size and strength can be used to assist CAPs in other countries around the globe.*

AACAP is uniquely positioned to provide leadership and to collaborate on common themes with all child and adolescent mental health (CAMH) organizations around the world. Forging such partnerships and relationships with CAMH organizations will be the focus of AACAP President ***Paramjit Joshi, M.D.'s 2013-2015 Presidential Initiative "Partnering for the World's Children."*** *The focus of Dr. Joshi's initiative will strengthen AACAP's relationship with other CAMH organizations around the world and strategically position AACAP as a global organization.*

Each CAMH organization (e.g., International Association of Child and Adolescent Psychiatry and Allied Professions [IACAPAP], World Psychiatric Association [WPA]) has its own members, publications, websites, resources, meetings, etc. As President, Dr. Joshi intends to reach out to other CAMH organizations with the goal of supporting each other, sharing resources, and jointly promoting various efforts. No one organization can do it all and each organization should not have to "reinvent the wheel." For example, AACAP could develop a list of resources on its website that would link to all the other global CAMH organizations and their resources. Each of the CAMH organizations (e.g., IACAPAP, WPA) has developed informative, valuable materials that should be shared with AACAP members.

During the coming decade, the global landscape for CAP and CAMH organizations will be undergoing substantial change. There is a real need for CAP from around the world to unite and work together on behalf of children, adolescents, and families. More than ever, collaboration is essential to maximize the impact and efforts of CAPs to improve child mental health.

Recommendation 9.1 – AACAP should enhance communication and collaboration with international CAPs and share contrasting approaches to the assessment and treatment of psychopathology in children and adolescents.

Action step 9.1.1 – CAPs should collaborate with international colleagues in developing and sharing mental health resources that increase the quality of mental health care around the world.

Action step 9.1.2 – AACAP should encourage international membership and participation in AACAP's Annual Meetings, CME activities, and scholarly publications.

Action step 9.1.3 – AACAP should facilitate international communication and resource- sharing among organizations through its website.

Action step 9.1.4 – AACAP should collaborate with other child international health organizations (e.g., IACAPAP, WPA, UNICEF, WHO) to promote mental health for children and adolescents around the world.

Goal 10 (Diversity and culture) – Child and adolescent psychiatrists (CAPs) should enhance their cultural competency and awareness to meet the needs of our nation's changing demographics.

Rationale: *Children and adolescents are entitled to the best possible mental health care regardless of their ethnic and cultural backgrounds. The population of the United States is becoming more diverse. CAPs should provide care that is sensitive to and consistent with the patient and family's cultural health beliefs and practices. Families must be actively involved in treatment and decision making to ensure alignment of the patient's and family's treatment goals with those of the CAP. AACAP's membership should also reflect the demographics and diversity of the United States.*

Recommendation 10.1 – CAPs must be sensitive to and capable of working with children, adolescents, and families from diverse cultural and ethnic backgrounds.

Rationale: *Cultural competency is an expectation of physicians caring for patients and families in a social environment that is more diverse. CAPs should recognize the importance of history, traditions, values, belief systems, acculturation, and migration patterns; the reasons for immigration, dialects, and languages; and the stressors and traumas that preceded and accompanied immigration. CAPs must be aware of different culture bound syndromes and differing presentation and expression of symptoms in patients and families.*

Action step 10.1.1 – CAPs should consider using the national standards on Culturally and Linguistically Appropriate Services (CLAS) developed by the U.S. Department of Health and Human Services to make their practices more culturally and linguistically accessible within the communities they serve.

Action step 10.1.2 – AACAP should use the CLAS standards to ensure that the principles and activities of AACAP are culturally and linguistically appropriate and accessible.

Action step 10.1.3 – CAP residency training should incorporate elements of cultural competence training using the Substance Abuse and Mental Health Services Administration (SAMHSA) standards.

Action step 10.1.4 – AACAP should consider developing a portal that addresses the impact of cultural issues on the mental health of children and adolescents in various populations.

Action step 10.1.5 – AACAP will expand learning opportunities for members regarding culture and diversity. These opportunities could include Web-based educational resources, Annual Meeting programs, and dissemination of AACAP's *Clinical Practice Guideline* on "Cultural Competency in Child and Adolescent Psychiatric Practice" (AACAP 2013).

Recommendation 10.2 – CAPs need to be trained in the use of formal and informal interpreters for both assessment and treatment with diverse groups of non-English speaking families.

Rationale: *The use of interpreters in the clinical setting involves an inclusive approach that discloses all interactions during the session to all participants. The interpreter should be transparent to everyone involved and should allow the patient and the psychiatrist to communicate directly as if no language barrier existed. The interpreter's goal is to ensure accurate and objective communication between the patient, family, and CAP.*

Action step 10.2.1 **–** CAP resident training should include the use of interpreters.

Action step 10.2.2 **–** AACAP should offer members educational programs and continuing medical education (CME) on the use of interpreters.

Recommendation 10.3 – CAPs need to understand and implement youth and family driven models of healthcare.

Rationale: *Patients and families should be actively involved in all aspects of care. When consumers are empowered and have more control over what happens in treatment, compliance, and outcomes are improved.*

Action step 10.3.1 **–** CAPs should provide patient and family choice and voice in assessment, decision making and the development of the treatment plan.

Action step 10.3.2 **–** AACAP should encourage and seek out parent and youth participation in AACAP programs and presentations (e.g., AACAP's Advocacy Day).

Action step 10.3.3 **–** AACAP's "youth advisory group" should prepare materials to educate CAPs on issues important to youth.

Recommendation 10.4 – CAPs should understand the use of peer counselors as a possible adjunct to standard treatments.

Rationale: *Patients and families experiencing the distress of mental illness often look for advice and direction from someone with whom they can identify. Peer counselors serve this role, representing both the patients who suffer with a psychiatric disorder and the families who struggle to support and care for youngsters with emotional and behavioral problems.*

Action step 10.4.1 **–** CAPs, in partnership with the National Alliance for the Mentally Ill (NAMI) and other local and national organizations, should work to develop mental health services that use peer counselors as part of assessment and treatment.

Action step 10.4.2 **–** CAPs, in partnership with NAMI and other local and national organizations, should work to develop appropriate training for peer counselors in the psychiatric care of children and adolescents.

Recommendation 10.5 – CAPs should be trained to understand and engage children and families from a broad range of cultures, in areas including race, ethnicity, class, religion, geography, language, sexuality, and gender.

Action step 10.5.1 **–** CAPs will appreciate commonalities and differences in experience across a broad range of patient and family populations, and be able to work with families whose cultural and societal beliefs are incongruous with the CAPs' principles and knowledge.

Goal 11 (Ethics) – Child and adolescent psychiatrists (CAPs) will incorporate and adhere to the AACAP's ethical and professional standards (*Code of Ethics*, AACAP 2009) in clinical practice, training, and research.

Rationale: *Ethical dilemmas in CAP are broad and complex – including but not limited to: clinical boundary crossings, conflicts of interest affecting patient care and public perception, risk management, privacy, beneficence, non-maleficence, autonomy, confidentiality, consent, use of media, managed care, juvenile justice, and social justice. Practicing clinicians,*

AACAP, training programs, and lifelong learning programs have a critical obligation to engage in activities that maintain the CAPs' ethical compass in a world of unethical opportunity.

CAPs should be familiar with AACAP's ***Code of Ethics****, know the expected ethical and professional behaviors, and practice them. CAPs* ***s****hould have a systematic approach to ethical and professional issues.*

Recommendation 11.1 – CAPs should have peer supervision and/or mentorship to help develop and maintain a framework for consideration of ethical and professional issues.

Recommendation 11.2 – CAPs should have a working understanding of the ethical and professional framework and expectations of any allied professionals with whom they practice.

Recommendation 11.3 – All clinical practice, training, and research must be carried out with the highest ethical standards.

Action step 11.3.1 – The AACAP should continue to focus attention on ethical issues arising in all aspects of research, including continued attention to ethical issues related to research at AACAP meetings, in training, in pilot research grants, and in *JAACAP*.

Section IV
SPECIAL TOPICS

Introduction

This section of the report contains six brief documents that were invited by the ***Back to Project Future"*** (BPF) Steering Committee. The topical areas were selected in view of their importance to the field of child and adolescent psychiatry (CAP) in the coming decade. The special topics and the contributing authors are listed below:

Collaboration with Primary Care in the Coming Decade – Alan Axelson, M.D.

Child Psychiatrists and Schools in the Coming Decade – Sheryl Kataoka, M.D.

Advocacy and Regional Organizations in the Coming Decade – Debra Koss, M.D.

AACAP *Clinical Practice Guidelines* – The Coming Decade – Heather Walter, M.D., M.P.H.

Impact of DSM-5 in the Coming Decade – Howard Liu, M.D.

Substance Abuse and Child and Adolescent Psychiatry in the Coming Decade – Kevin Gray, M.D., and Alessandra Kazura, M.D., co-chairs, AACAP Substance Use Disorders Committee

COLLABORATION WITH PRIMARY CARE IN THE COMING DECADE

It is the responsibility of the AACAP to use its collective resources to assess the needs of children and adolescents with psychiatric illnesses, as well as the capabilities of its members and the healthcare organizations where they work to intervene in order to mitigate the impact of these illnesses on the development and successful functioning of each individual. As the dynamics of society and especially the healthcare delivery system evolve, it is incumbent on the leadership of AACAP to harness the energy and collective intelligence of its involved membership to map the leading edges of change and anticipate future trends. AACAP also has the responsibility to advocate for changes that are best for children and their access to psychiatric treatment. In addition, it needs to consider the impact on current AACAP members and, especially, future members; and where appropriate enhance these interests.

Concepts that at face value would seem to clearly benefit children, when implemented through the vagaries of the current healthcare system, may have unintended negative outcomes. This is the challenge as we work to develop effective models to work collaboratively with pediatricians.

Child and adolescent psychiatrists (CAPs) and pediatricians have a long tradition of cooperative working relationships. Some AACAP members trained as pediatricians before specializing in CAP, formalizing the bridge between pediatrics and CAP through certification in a Triple Board Program or certification in CAP after training in pediatrics through the recently developed "pediatric portal." Many strong CAP training programs share roots with pediatric residency programs and major children's hospitals. While some settings continue the tradition of close collaboration that originated in shared training, other practice settings lead to more separate patterns of practice, with pediatricians, depending on their personal experience and interest, being more or less involved in treating the psychiatric disorders of their primary care patients.

The current more focused emphasis on the integration of specialty psychiatric practice and adult primary care has been in response to research documenting inadequate treatment of depression and other psychiatric illnesses in the primary care setting, and the impact of these illnesses on the outcome and cost of treating a wide range of diseases in adults including diabetes and cardiovascular disease (Oxman and Dietrich 2005). Programs, such as the DIAMOND project in Minnesota and IMPACT at the University of Washington (DIAMOND; IMPACT; Unützer et al. 2002),

focusing on mental health issues involving senior citizens that bring the services of mental health professionals, care managers and psychiatrists as consultants into primary care group practices, have demonstrated sufficient strength in better functional outcome and improved cost management to gain Centers for Medicare and Medicaid Services support through Innovation Grants to test how the programs can be implemented in a range of practice settings and be supported by the necessary financial incentives that would encourage widespread adoption.

Rather than being initiated by research and demonstration projects, the initiative for the integration of pediatric primary care and CAP services has been generated by the leadership groups of the American Academy of Pediatrics (AAP) and AACAP as they have assessed the needs of their patients, the evolving health care system, and the trends in their respective organizations including workforce issues.

As the AAP developed treatment protocols covering the major diagnostic categories that they treat, AAP work groups addressed the issues of children presenting with attention problems, depression, and anxiety. This effort was grant supported and CAPs participated as consultants on the work groups. The effort was not only motivated by pediatricians assessment of the problems presenting in their waiting rooms, but a rather unique workforce situation where they are projecting an increasing number of pediatricians while predicting a decrease in illness burden and overall rate of growth of their patient population.

AACAP has to deal with an almost opposite set of parameters. The psychiatric illness burden in children is large and possibly increasing to the point that it deserved special mention in the 1999 *Mental Health: A Report by the Surgeon General*. Despite concerted efforts and some success in the area of workforce development, there is no hope of meeting treatment demands through just an increase in CAPs. While CAPs are largely well represented in university-based systems, the usual perception is that CAPs are not generally accessible for pediatric referrals. This is further aggravated by the fact that pediatricians have high participation in health plan networks while in many regions CAPs avoid regular health care network participation. Six years ago, AACAP initiated an outreach program to the AAP inviting it to send representatives to be included as members of AACAP committees and engaging in a joint effort to identify administrative and financial barriers to increased collaboration between pediatricians and CAPs. This resulted in the March 2009 *Pediatrics* publication, *Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration*. While broadly publicized and positively regarded, efforts to work with health plans to actually make the recommended changes have not yielded any breakthroughs. The promises of electronic medical records, electronic prescribing, sharing electronic records between different practice organizations, the development of patient portals, and the tracking of practice patterns and patient outcomes through patient registries are all innovative concepts that are far from implementation in large systems, and probably out of reach for community clinics and private practice settings.

Projects in collaboration and facilitated access to CAP consultation/integration of services have been successfully developed in Massachusetts, Washington, Pittsburgh (PA), and some other locations. Strong systems support and program-based funding seem to be necessary to maintain these programs. The actual influence of CAPs on program delivery depends on the investment, energy, and administrative impact of the CAPs involved and their relationships with their pediatric colleagues and the health care administrators that often have responsibility to manage the pediatric practices. Most of the decisions will be made locally. In some areas, there will be well managed integration with CAPs included in the planning and implementation of the systems. In other areas, integrated care may be reduced to pediatric practice either renting office space to a psychologist or other mental health professional or employing them as part of their staff, providing the prescriptions according to the mental health professionals medication recommendations with little consultative input from CAPs. The direction this takes in each region will depend, at least in part, on the energy and investment of locally based CAPs. AAP and AACAP, need to develop, test, and then provide tools for the implementation of models that improve accessibility, safety, quality, and functional outcomes for children with psychiatric illnesses. Health plans can be partners in the implementation of these new models of care, but the AACAP and CAPs must reach out to them with innovative ideas. This is essential if there is to be wide spread adoption across the broad spectrum of the delivery system. Electronic medical records companies can provide the communication framework that delivers the structure that leads to data and tested hypotheses regarding improved outcomes.

Increased effort in the application of existing strategies is unlikely to have much impact. If the "Disruptive Innovation" that is seen by Clayton Christensen (1997) and others as necessary to tame the cost and quality problems of the current health care delivery systems as heavy on "Disruption" and weak in the planning, funding, and execution of " Innovation," we are likely to be left with something less than what we have.

To develop a more accessible, effective, collaborative primary care/specialty care system during the coming decade will take a concerted cooperative effort on the part of pediatricians and CAPs at the national and local level. CAPs must be aware of the many forces effecting healthcare reform and reach out to appropriate partners.

References

AACAP Committee on Health Care Access and Economics (2009). Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration. *Pediatrics* 123(4):1248-1251

Clayton Christensen (1997) *The Innovator's Dilemma: When New Technologies Cause Great Firms to Fail*. Boston, MA: Harvard Business School Press. www.claytonchristensen.com

DIAMOND, Depression Impact Access Minnesota Offering a New Direction. www.icsi.org

IMPACT. University of Washington, www.impact-uw.org

Unützer J, Katon W, Callahan CM, Williams JW Jr., Hunkeler E, Harpole L, et al. (2002). Collaborative-care management of late-life depression in the primary care setting. *JAMA* 288(22):2836-45

Oxman TE and Dietrich AJ (2005). Evidence based models of integrated management of depression in primary care. *Psychiatric Clinics of North America* 28(4):1061–1077

CHILD PSYCHIATRISTS AND SCHOOLS IN THE COMING DECADE

The field of child and adolescent psychiatry (CAP) faces a critical time during this next decade as health care rapidly and substantially changes in several key ways: what is delivered, how it is delivered, for whom it is delivered, and by whom. Now is the ideal time for CAPs and AACAP to be visionary and take an active part in the rapidly evolving health care reform that will shape practice now and in the near future. CAPs have the opportunity to redesign mental health care delivery to reach far more children and adolescents who have unmet mental healthcare needs and to do it in a way that takes full advantage of our expertise and skills.

It is estimated that only 21 percent of children who have a need for a mental health evaluation have contact with a mental health provider, and approximately 7.5 million children in the United States do not receive the psychiatric care they need (Kataoka et al. 2002; U.S. Public Health Service 2000). With only about 7,000 practicing CAPs in the United States, their role in leadership and system level change and improvement is central to expanding the ability of child systems of care to reach the vast majority of youth who need mental health services. In addition to playing a critical role in specialty mental health and primary care settings, CAPs are uniquely positioned to be the medical experts in child mental health within the non-healthcare sectors, such as education, child welfare, and juvenile justice. CAPs also have a key opportunity, by providing leadership within these child-serving systems, to address the long-standing ethnic and socioeconomic disparities of mental health care, which will continue to be a growing issue as the country's diversity expands (Smedley et al. 2003).

Of the child serving sectors, the education sector has the greatest potential for CAPs to reach across the broad age range of children and adolescents and to support the level of services needed from prevention and early intervention services to treatment of severe psychiatric illnesses (Greenberg et al. 2003). By providing a public mental health framework within the education system, CAPs can provide leadership and work along side other school mental health providers and educators to improve access to mental health services through expanded detection and early treatment of psychiatric disorders on school campuses (Husky et al. 2011). Research has shown that there is more

effective access to mental health treatment when care is provided in schools compared to specialty mental health agencies, likely due to fewer barriers to participating in care (Cummings et al. 2010; Jaycox et al. 2010). There are also studies that suggest that when school-based mental health services are available, they are accessed equally by ethnic minority students and majority populations, unlike in specialty care (Cummings et al, 2010; Kataoka et al. 2007). Schools already provide a broad array of mental health prevention services, with approximately 63 percent of public schools having prevention programs that target problems such as drug abuse and suicide (Foster 2005). In terms of funding for school mental health services, 63 percent of U.S. school districts report that federal sources such as IDEA (the Individuals with Disabilities Act) support mental health services in schools, with 28 percent of districts reporting that Medicaid is in their top five sources of funding for school mental health care (Foster 2005). CAPs have historically had roles as school-based consultants, contributing to the assessment and treatment of individual students, especially those receiving special education services and who have significant psychiatric illnesses preventing them from accessing the standard learning curriculum.

As we look toward the future, new roles for CAPs are emerging in the education sector that affect service provision, training, and research. For example, CAPs working in schools can: oversee all aspects of mental health wellness by working with schools to adopt evidence-based prevention programs; facilitate development of protocols for treatment and referrals; train school staff and lay providers in educational mental health outreach to students and families; and consult directly with students who need a higher level of treatment. In addition, CAPs can play a pivotal role in educating school staff and leaders in understanding psychiatric illnesses and how to provide the needed supports in schools to help all students learn to their potential. One promising model of care in schools is school-based health clinics. These clinics can integrate the health, mental health, and educational needs of students (Clayton et al. 2010; Lui et al. 2010). Just as in primary care settings, these school clinics can also serve as health homes for students.

In order for CAPs to provide such leadership and service in schools, training programs should provide curriculum and rotations that prepare trainees to work collaboratively with school personnel to provide a full range of services (prevention through intervention). CAPs should also be trained to provide organizational consultation to schools. CAP researchers need to evaluate efficient and effective models of delivering mental health care in schools and to develop more school-based interventions that have demonstrated effectiveness not only in decreasing psychiatric symptoms but also improving functional outcomes such as school performance and graduation from high school. Finally, researchers need to examine effective models of integrating health, mental health, and educational needs.

As CAPs and AACAP look to the coming decade, the expanding role of CAPs in the education sector can be expected to shape and change training, clinical practice, and services research.

References

Clayton S, Chin T, Blackburn S, Echevarria C (2012) Different setting, different care: Integrating prevention and clinical care in school-based health centers. *American Journal of Public Health* 100(9):1592-1596

Cummings JR, Ponce NA, Mays VM (2010). Comparing racial/ethnic differences in mental health service use among high-need subpopulations across clinical and school-based settings. *Journal of Adolescent Health* 46(6):603-606

Foster S, Rollefson M, Doksum T, Noonan D, Robinson G, Teich J (2005). School Mental Health Services in the United States, 2002–2003. Rockville, MD: U.S. DHHS, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Greenberg MT, Weissberg RP, O'Brien MU, Zins JE Fredericks L, Resnik H, et al. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist* 58(6-7):466-474

Husky MM, Kaplan A, McGuire L, Flynn L, Chrostowski C, Olfson M (2011). Identifying adolescents at risk through voluntary school-based mental health screening. *Journal of Adolescence* 34(3):505-511

Institute of Medicine (2003). Unequal treatment: confronting racial and ethnic disparities in health care. Smedley BD, Stith AY, Nelson AR eds, Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press

Jaycox LH, Cohen JA, Mannarino AP, Walker DW, Langley AK, Gegenheimer KL, et al. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma- focused psychotherapies. *Journal of Traumatic Stress* 23(2):223-231

Kataoka SH, Stein BD, Nadeem E, Wong M (2007). Who gets care? Mental health service use following a school-based suicide prevention program. *J Am Acad Child Adolesc Psychiatry*. 46(10):1341-1348

Kataoka SH, Zhang L, Wells KB (2002). Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *Am J Psychiatry* 159:1548-1555

Kutash K, Duchnowski AJ, Lynn N (2006). School-based mental health: An empirical guide for decision-makers. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies, Research and Training Center for Children's Mental Health

Liu RY, Ramowski SK, and Nystrom RJ (2010). Health service integration in Oregon school-based health centers: meeting the mental H\health needs of young people. *Advances in School Mental Health Promotion* 3(2):26-36

US Public Health Service (2002). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Department of Health and Human Services

ADVOCACY AND AACAP'S REGIONAL ORGANIZATIONS IN THE COMING DECADE

The principles of advocacy are steeped in AACAP's history, dating back to the creation of the Government Affairs Department in 1975. Since that time, AACAP has had a significant role as the primary voice advocating for children's mental health. In the last decade, AACAP has also formed important coalitions with other provider and consumer groups, which have served to strengthen the effect of advocacy initiatives. In 2005, AACAP hosted its first annual Advocacy Day in Washington D.C., providing members an opportunity to partner with families to "go to the hill" (visit Congress) in order to raise awareness for children's mental health issues. The scope of this advocacy event has grown significantly since its inception. Each year, nearly 300 participants, including members, mental health colleagues, parents, youth, fellows, residents, and medical students meet with members of Congress and their staff to promote an understanding of the serious needs of children and families who are living with mental illness. At the federal level, AACAP's persistence in advocacy has been instrumental in shaping policy pertinent to improving access to care, including the passage of parity and health care reform, and the development of a loan repayment program for child and adolescent psychiatrists (CAPs).

While the efforts of the Government Affairs Department originally focused on Federal initiatives, by 2007 the focus broadened to include state level advocacy and "grassroots" efforts. This included the creation of the Advocacy Liaison Program. AACAP members actively involved in advocacy at the state level were recruited to serve as local resources. AACAP currently works with Advocacy Liaisons representing 75 percent of the Regional Organizations of Child and Adolescent Psychiatry (ROCAP), teleconferencing on a monthly basis to track the progress of new legislation and share policy resources. Ultimately, Advocacy Liaisons bring resources back to their ROCAPs to further develop and implement advocacy action plans at the local level. Examples of advocacy initiatives include mental health forums, visits to state capitols, and the development of position papers. At the state level, members have provided guidance on such topics as improving access to mental health services through collaborative models of care, anti-bullying legislation, and opposition to legislation violating a psychiatrist's scope of practice.

In the decade to come, with the implementation of health care reform and the anticipated need for increased mental health services for children and youth, AACAP will clearly need to expand its advocacy efforts. This is not the time

to rest on past accomplishments nor sit passively and watch while the future of health care is transformed. This is the time when CAPs and AACAP must be prepared to take bold and decisive steps to ensure access to effective mental health treatment for all children. We must also reaffirm the role of CAPs as physician leaders with a broad range of expertise.

In order to accomplish the goals as outlined in *Back to Project Future*, Caps must expand the scope of their advocacy efforts. The urgency of this situation must serve to galvanize each and every AACAP member into action. AACAP must provide members with opportunities to develop advocacy skills through trainings and ongoing mentorship. Members must be well versed in policy and practice so that they can actively engage in the design, development, and implementation of new models of health care delivery. Opportunities for advocacy will exist for CAPS in every practice setting, including service and clinical practice, training and workforce, and research.

Increasingly, CAPs will also be asked to comment on mental health policy and regulations, providing timely responses to crucial issues as they emerge. CAPs will be able to provide valuable expertise and testimony covering a broad range of important topics, including foster care oversight, safe and effective use of psychotropic medication in children and adolescents, and response to gun violence.

Many advocacy issues will be need to be addressed at the level of the ROCAPs, which will be most familiar with local and state issues and also have direct access to AACAP resources. In order to be effective in these initiatives, membership within ROCAPs will need to be revitalized and the Advocacy Liaison Program will need to expand so that ROCAPs will be empowered to fulfill these goals at the state level. The expansion of advocacy efforts and resources will allow our ROCAPs to develop proactive as well as reactive advocacy efforts.

In addition to working within our organization, CAPs and AACAP must look to further establish and strengthen partnerships with other stakeholders. Since 2005, AACAP has convened a "Child Mental Health Summit" that brings together leadership from AACAP, Autism Society of America, Balanced Mind Foundation, Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD), Mental Health America (MHA), National Alliance on Mental Illness (NAMI) and the National Federation of Families for Children's Mental Health, to discuss ways to collectively improve the lives of children, adolescents, and families affected by mental illness. Coalitions, such as the "Mental Health Summit" will provide opportunities for more effective and efficient advocacy initiatives. AACAP needs to continue providing leadership in organizing such coalitions - inviting consumer and allied professional groups to work collaboratively to address the mental health needs of all children. As part of these coalitions, CAPs will need to address the importance of early intervention and prevention programs that will serve to promote health and reduce the consequences of mental illness; and will need to advocate for ongoing funding for research and training in order to improve access to evidence-based treatments. AACAP will need to support the development of collaborative models of care, including work with primary care and school-based mental health services, to help extend the reach of CAP and improve access to care. We will also need to continue in our outreach and education efforts in order to reduce the stigma that is associated with mental illness and that continues to serve as a barrier to seeking to treatment.

As we look to the next decade, it is clear that advocacy initiatives will need to expand in order to ensure that children's mental health needs are addressed at the local, state, and federal level. To help meet this need, AACAP has formed an affiliated non-profit organization, the *American Association of Child and Adolescent Psychiatry.* This new organization will house AACAP's existing Government Affairs Department. This change will not impact any of the current Government Affairs Department's programs; rather, it enables the department to take on additional advocacy activities such as the possible formation of a political action committee (PAC). This change in AACAP structure will help position CAPs to be most effective in their advocacy efforts, despite the challenges in the coming decade. AACAP and the new organization (i.e., Government Affairs Department) will continue to serve as the organizing influence for CAP advocacy efforts.

During the coming decade AACAP members need to become more involved and serve in key roles in grassroots advocacy efforts that will be organized by AACAP's Regional Organizations. CAPs must also work with AACAP to organize coalitions, at both the federal and state level, in order to be more effective and efficient in attaining our advocacy goals.

AACAP *CLINICAL PRACTICE GUIDELINES* (FORMERLY KNOWN AS *PRACTICE PARAMETERS*) – THE COMING DECADE

The development and dissemination of clinical practice guidelines is one of the most important activities of a professional medical association (Rothman et al. 2009). Clinical practice guidelines are defined by the Institute of Medicine (IOM) as "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" (2011). Because of their derivation from a critical review of extant literature, clinical guidelines occupy a high position in the hierarchy of "pre-processed" evidence (AMA 2002), and as such have the potential for great influence in clinical care.

Clinical practice guidelines serve a number of important functions, the most important of which are to improve the quality of patient care and health care outcomes. Guidelines also serve to make clinical decision-making more transparent, reduce variation in practice, promote efficient use of resources, identify gaps in knowledge, prioritize research activities, provide guidance for consumers, inform public policy, and support quality control.

Since 1991, the AACAP Work Group (later Committee) on Quality Issues (CQI) has published 50 clinical practice guidelines (called *Practice Parameters*) that have served to encourage best practices in child mental health. Topics covered by these *Parameters* have included the psychiatric evaluation and treatment of most child and adolescent psychiatric disorders, as well as the assessment and management of mental health problems in vulnerable populations of youth, such as youth with physical illness, youth in juvenile detention facilities, and gay/lesbian/bisexual/transgender youth.

Over the past several decades, the clinical guideline development process has become increasingly rigorous, in accordance with evolving principles promulgated by influential professional organizations such as the American Medical Association (AMA) and the IOM. In the early 1990s these "guidelines for guidelines" tended to be broad and vague (AMA) Policy); accordingly, clinical guidelines created in that decade had a number of methodological flaws Shaneyfelt et al. 1999). Today, guideline standards have evolved to reach new heights of specificity and precision (IOM 2011), generating the imperative for parallel changes in the guideline development process across all medical specialties.

Two critical areas of guideline vulnerability were highlighted in the IOM report; namely *rigor* and *transparency*. Rigor refers to the precision with which the extant literature is systematically searched, critically evaluated, and rated for quality. Transparency refers to the protection of the guideline development process from conflicts of interest, both actual and perceived. Rigor and transparency are critical components of the guideline development process, as the "trustworthiness" (IOM 2011) of the guideline derives directly from fidelity to these constructs.

In 2012, the AACAP Council approved a request from the CQI to revise all previously published AACAP *Practice Parameters* in accordance with the 2011 IOM standards. The new process incorporates a number of standards from the previous process, as follows:

- Appointment of parameter development committee members who are balanced with respect to expertise, geographical location, and demographic background
- Documentation of the parameter development process
- Involvement of physicians and physician organizations
- Systematic literature review
- Broad, iterative review of guideline drafts
- Specification of the appropriateness of the guideline recommendations to specific clinical conditions and settings
- Specification of the limits of the generalizability of the parameter recommendations to specific clinical conditions and settings
- Approval of guidelines by the AACAP Council

In addition, the new process adds the following elements intended to enhance the rigor and transparency of the AACAP clinical practice guidelines:

- CQI co-chairs and members will be required to be free from pharmaceutical industry involvement, whether salary or research funding or additional income
- CQI members will be trained in systematic review techniques by acknowledged methodologic experts
- As recommended by the Agency for Healthcare Research and Quality (AHRQ 2006), guideline recommendations will be derived from specific clinical questions in PICO(TS) format; i.e., patient, intervention, comparison, outcome, (and when applicable, timing and setting)
- Separate CQI groups will review evidence (Systematic Reviewer [SR]) and write guidelines (Guideline Writing Group [GWG])
- The SR and GWG will receive input from advisors who are research experts, clinical experts, AACAP members, and key stakeholders
- Expert clinical opinion will be determined by a formal survey of panels of clinical experts
- Guideline recommendations will be separately rated according to the quality of the supporting evidence
- Consensus about guideline recommendations will be determined by blind iterative voting
- After guideline publication, new evidence will be identified by continuous monitoring of the literature, and guidelines will be updated in a targeted fashion if there are important changes in the supporting evidence

With these changes, the AACAP *Clinical Practice Guideline* development process will enter the next decade in full accordance with state-of-the-art guideline development standards, and, in so doing, substantially enhance the "trustworthiness" of the guidelines among AACAP members and other key stakeholders.

Child and adolescent psychiatrists who are guided by the recommendations of the AACAP *Clinical Practice Guidelines* are likely to improve the quality of their patient care and produce better care outcomes. As innovative methods for guideline dissemination and utilization are developed, such as guideline-based treatment algorithms embedded in electronic medical records, the use of clinical practice guidelines will become increasingly routine.

Over the next decade, AACAPs* Clinical Practice Guidelines *will continue to be a major factor in supporting service/ clinical practice, training, and research, and in promoting optimal care for youth with psychiatric disorders.

References

AHRQ (2011). AHRQ Effective Health Care Program Stakeholder Guide (AHRQ Publication No. 11-EHC069-EF, Rockville, MD: Agency for Healthcare Research and Quality (Available at: www.ahrq.gov/clinic/epcpartner/stakeholderguide/stakeholdr.pdf)

AMA (2007). American Medical Association, Policy H-410.968. Chicago, IL: American Medical Association

AMA (2002). *Users' Guides to the Medical Literature: A Manual for Evidence-Based Clinical Practice,* Guyatt G, Rennie D (eds). Chicago, IL: American Medical Association

Institute of Medicine (2011). Clinical Practice Guidelines We Can Trust

Rothman DJ, McDonald WJ, Berkowitz CD, Chimonas SC, DeAngelis CD, Hale RW, et al. (2009), Professional medical associations and their relationships with industry – a proposal for controlling conflict of interest. *JAMA* 301(13):1367-1372

Shaneyfelt TM, Mayo-Smith MF, Rothwangl J (1999). Are guidelines following guidelines?: the methodological quality of clinical practice guidelines in the peer-reviewed medical literature. *JAMA* 281:1900-1905

IMPACT OF DSM-5 IN THE COMING DECADE

Overview and Structure

In May 2013, the American Psychiatric Association (APA) released the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (DSM-5). The DSM-5 introduces an update of the DSM-IV, organizing psychiatric disorders into a new categorical classification system after an extensive revision process that included field trials in academic and community practice settings and an unprecedented level of public commentary (APA 2013, 5-10). Of interest to child and adolescent psychiatrists (CAPs), the DSM-5 places a greater emphasis on development, with diagnoses related to early childhood situated earlier in the manual and greater integration of age-related criteria and descriptors throughout the manual (APA 2013, Preface xlii).

The DSM-5's chapters are organized into 3 sections. Section I includes DSM-5 basics such as a guide to use the manual, a history of the manual's development, and a summary of the DSM-5 classification structure (APA 2013, 5-25). Section II contains the actual diagnostic criteria and codes (APA 2013, 31-727). Section III describes emerging measures and models such as a cultural formulation, an alternative model for personality disorders, and conditions for further study that do not yet have enough evidence for inclusion in the official diagnostic criteria and codes (APA 2013, 733-806).

In addition, the manual eliminates the axial system from DSM-IV. Axis I, II, and III are now contained in the diagnostic criteria and codes while Axis IV and V are now replaced with specifiers for disability, psychosocial and other contextual factors (APA 2013, 16-17).

DSM-5 Coding and Relationship to Other Classification Systems

DSM-5's new organizational structure does correlate with the proposed *International Classification of Diseases, Eleventh Edition* (ICD-11) (APA 2013, 11-12). The numerical coding in the DSM-5 includes the ICD-9 coding in bold for current coding and the ICD-10-CM coding in parentheses, which clinicians can use after October 2014 when the ICD-10-CM is officially adopted in the United States (APA 2013, 23).

On May 13, 2013, Thomas Insel, M.D., the director of the National Institute of Mental Health (NIMH), and Jeffrey Lieberman, M.D., president-elect of the APA, released a joint statement outlining the "complementary, not competing" relationship between the DSM-5 and the NIMH's classification system, the Research Domain Criteria (RDoC) (Insel 2013, 1). It states that the DSM-5 will remain the consensus standard for practitioners while the RDoC project is "laying the groundwork for a future diagnostic system that more directly reflects modern brain science" for researchers (Insel 2013, 1).

Summary of Major Changes from DSM-IV to DSM-5

The DSM-5 contains a helpful section entitled "Highlights of Changes from DSM-IV to DSM-5" (809-816). This review will only highlight major changes relevant to CAPs.

Neurodevelopmental Disorders

Autism Spectrum Disorder

One of the most extensive changes in DSM-5 is the consolidation of the DSM-IV autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder Not Otherwise Specified (NOS) into a single entity - autism spectrum disorder (APA 2013, 809). The criteria for autism spectrum

disorder are organized around two domains instead of three: impaired social communication/interaction and restricted repetitive patterns of behavior, interests, and activities (APA 2013, 50-51). Another difference is that age of onset has changed from "onset prior to age 3 years" in DSM-IV to "present in the early developmental period," recognizing that the expression of autism spectrum disorder symptoms may vary by social environment and coping skills (APA 2013, 50). Of note, there has been some concern from providers and parenting groups about the possibility that patients who met criteria for a pervasive developmental disorder under DSM-IV will no longer meet criteria for the autism spectrum category in DSM-5, resulting in loss of services (Ritvo et al. 2013). However, one study of 4,453 children with DSM-IV clinical PDD diagnoses found that 91 percent would meet DSM-5 autism spectrum disorder criteria, suggesting that most children would not lose eligibility (Huerta 2012).

Attention-Deficit/Hyperactivity Disorder

The diagnostic criteria for ADHD have been adjusted in DSM-5, with the age of onset requiring symptom onset prior to age 12 rather than age 7 as stated in DSM-IV (APA 2013, 809). In addition, adolescents and adults older than 17 years of age now require only 5 symptoms to meet ADHD criteria rather than the 6 required for childhood and early adolescent ADHD (APA 2013, 809). Finally, due to concerns that the DSM-IV ADHD subtypes were unstable over time, they have been replaced with "current presentation" specifiers of combined, predominantly inattentive, or predominantly hyperactive/impulsive presentation (APA 2013, 60).

Specific Learning Disorder

The separate DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder NOS are now combined into a single specific learning disorder (APA 2013, 809)

Intellectual Disability (Intellectual Developmental Disorder)

Mental retardation has been renamed intellectual disability in DSM-5. Rather than being tied to specific IQ scores, severity is now defined based on adaptive functioning including conceptual, social, and practical domains (APA 2013, 34-36, 809)

Depressive Disorders

Disruptive Mood Dsyregulation Disorder (DMDD)

Due to concerns about the increasing prevalence of pediatric bipolar disorder diagnoses under DSM-IV, DSM-5 introduces a new diagnosis of disruptive mood dysregulation disorder (DMDD) for children between the age of 6 and 18 years old (APA 2013, 810). The diagnostic criteria include the requirement for severe recurrent temper outbursts both verbal and/or physical out of proportion to the stimulus, occurring three or more times per week, with a constant irritable or angry mood between episodes, observed for 12 or more months (APA 2013, 156). DMDD can be distinguished from intermittent explosive disorder (IED) in two ways. Although both disorders are characterized by severe temper outbursts, individuals with DMDD return to an angry baseline whereas individuals with IED return to a euthymic baseline (APA 2013, 160). In addition, DMDD requires a greater duration of clinical symptoms over an entire year instead of the three months required to establish an IED diagnosis.

Trauma- and Stressor-Related Disorders

Posttraumatic Stress Disorder for Children Six Years and Younger

The DSM-5 moved posttraumatic stress disorder from anxiety disorders into a new category of trauma- and stressor-related disorders alongside reactive attachment disorder, disinhibited social engagement disorder, acute stress disorder, and adjustment disorder (APA 2013, 265). In the process, PTSD has been rendered more developmentally sensitive by lowering the threshold for diagnostic criteria in adolescents and children (APA 2013, 812). For example, sexual violence is defined in adults as threatened or actual sexual violence, whereas in children it can also include a developmentally inappropriate sexual experience without violence or injury (APA 2013, 274). In addition, there is a

new set of diagnostic criteria for PTSD in children six years and younger (APA 2013, 272). For example, preschool aged children may demonstrate re-experiencing symptoms through play that is symbolic of the trauma and may not appear fearful during this reenactment (APA 2013, 277).

DSM-5 represents a significant change for CAPs in the coming decade. All CAP trainees and practitioners must learn and incorporate these CHANGES IN THE DIAGNOSTIC CLASSIFICATION SYSTEM.

References

APA (2013). Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition. Washington, DC: American Psychiatric Association

Huerta M, Bishop SL, Duncan A, Hus V, Lord C (2012). Application of DSM-5 criteria for autism spectrum disorder to three samples of children with DSM-IV diagnoses of pervasive developmental disorders. *Am J Psychiatry* 169:1056-1064

Insel TR, Lieberman JA (2013). DSM-5 and RDoC: shared interests. *NIMH Science News* May 13, 2013:1-2 (available online at: www.nimh.nih.gov/news/science-news/2013)

Ritvo ER, Ritvo RA (2012). Commentary on the application of DSM-5 criteria for autism spectrum disorder. *Am J Psychiatry* 170(4):444-445

SUBSTANCE ABUSE AND CHILD PSYCHIATRY IN THE COMING DECADE

Substance use disorders (SUD) are common in adolescents and are especially prevalent and impairing in those receiving psychiatric care. Co-morbid SUD and psychiatric disorders complicate the course and treatment of both conditions, particularly in adolescents. Emerging research in underlying neurobiology and preliminary treatment efficacy has base and has helped interventions. Unfortunately, a confluence of factors (e.g., lack of training for clinicians, limited treatment research on co-morbid youth) has contributed to inadequate assessment and management of SUD in child and adolescent psychiatric (CAP) practice.

The AACAP Substance Abuse and Addiction Committee asserts that SUD assessment and management should be routine components of clinical care and urges action to address this critical issue in the coming decade. The following areas must be addressed:

- CAP training programs must include SUD prevention, assessment, and management as key components of their curricula, ensuring that trainees are both familiar and competed in using evidence-based strategies. AACAP should play the leading role in developing guidelines for this training.
- AACAP must provide SUD and comorbidity-focused training and research updates to members via Annual Meeting programs, *AACAP News*, *AACAP Clinical Practice Guidelines,* and other venues, with the goal of helping practitioners confidently deliver evidence-based prevention and treatment strategies.
- Psychiatric treatment research should include studies focused on assessment and management of adolescents with co-occurring SUD.
- Treatment research for SUD should more consistently focus on adolescents, given their heightened SUD vulnerability and the potential preventative role that early treatment may play.
- AACAP should support the dissemination of evidence-based prevention strategies.
- Efficient assessment and treatment models, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), should be adapted and validated for dissemination and adoption in the clinical care of children and adolescents by pediatricians, psychiatrists, and other clinicians.

- Amidst a changing policy landscape (e.g., "medical" and recreational marijuana state laws), research should focus on the direct and indirect impacts of policy changes on youth. AACAP must advocate for and participate in the development of SUD-related policies in the coming decade.
- Billing/payment systems should encourage (rather than discourage, as many current systems do) the use of evidence-based practices to assess and manage SUD and comorbidity within CAP practice. AACAP should educate its members on the impact of the Affordable Care Act (ACA) on these billing/payment issues.
- Systems of care, often traditionally separating SUD treatment from psychiatric treatment, should focus on integrated care for adolescents with SUD and psychiatric comorbidities.
- AACAP should continue to develop educational and advocacy resources for families of adolescents suffering from SUD.
- AACAP should take the lead in educating other medical providers who see our patients about the course and treatment of SUD in adolescents.
- AACAP should collaborate with other organizations that represent professionals who evaluate and treat adolescents with SUD to develop collaborative and integrated models of care.
- CAPs are encouraged to collaborate on the local level with non-medical practitioners and treatment programs to improve the delivery of care for adolescents with SUD.

For the coming decade, the AACAP Substance Abuse and Addictions Committee envisions research, training, clinical, and policy developments that will seamlessly integrate SUD prevention, assessment, and management into CAP practice. The need for this integration is not new, but novel opportunities offered by an expanding evidence base and enhanced platforms for dissemination position us to make it a reality.

Section V
CONCLUSIONS

"Your dream isn't big enough if it doesn't scare you."
(Mathias Schmelz)

In April 2012, the members of the ***Back to Project Future (***BPF) Steering Committee began their work by reflecting on this quotation. From the beginning, the BPF Steering Committee has challenged itself and the BPF subgroups to think big, lean forward, and "cast a wide net" to capture the important ideas and translate them into "Goals, Recommendations, and Action steps" in BPF's *Plan for the Coming Decade*. This section includes important takeaway points from the report and the Steering Committee's consensus selection of the priority recommendations for implementation in 2013-2015.

Takeaway Points

The richness and density of the complete BPF report is important and necessary for future study and consideration by AACAP leadership, members, and staff. The Steering Committee encourages readers to carefully consider the full report. However, the following takeaway points are offered by the Steering Committee as a way to summarize and focus several key themes that are addressed throughout the report:

- (Affordable Care Act) The ACA is here and its implementation and roll-out means major changes to CAP practice, role and payment over the next 5-10 years.
- (Training and Practice) CAP training and practice will need to change and incorporate new technology (e.g., e-health, telepsychiatry) and changes in healthcare delivery.
- (CAPs Role) CAPs must continue to be the diagnosticians and treatment coordinators for the most complex and severe cases.
- (CAP Shortages) In order to be relevant in the evolving healthcare system, CAPs need to extend their "reach" by using newer technology (e.g., telepsychiatry) and collaboration/consultation with other healthcare providers and child-serving systems of care.
- (Lifelong Learning) AACAP must offer relevant education to students and members throughout their careers. AACAP's continuing medical education and maintenance of certification programs must be adapted and tailored to the coming changes that are facing AACAP members.
- (Advocacy) AACAP and its members must expand advocacy efforts at all levels (local, state, and federal) to promote quality psychiatric care for children, adolescents, and families and to increase funding for graduate medical education and research.
- (Member Needs) As the "professional home" for CAPs, AACAP must remain committed to providing its members all the support and assistance needed to manage the significant changes anticipated in role, training, and practice during the coming decade.

Priority Recommendations & Action Steps for 2013-2015

During the comprehensive review and final editing of the report, the BPF Steering Committee was challenged and encouraged by the BPF honorary editors (Cohen and Enzer) and several BPF distinguished consultants to prioritize selected recommendations and action steps. The BPF Leadership Group and Steering Committee developed

a process to identify a manageable number of "recommendations with action steps" that should be targeted for implementation during the first two years of the coming decade.

The following seven "Recommendations" with their respective "Action steps" were prioritized for implementation during the first two years by a consensus of the BPF Steering Committee:

*** ***(2013-2015 Priority)*** **Recommendation 1.1– AACAP will support the integration of evidenced-based treatments and advances in both neurobiology and psychosocial sciences into members' practices.**

Action step 1.1.1 – Create an AACAP Task Force (e.g., representatives from *JAACAP*, AACAP Program Committee, AACAP Quality Issues Committee, senior clinicians) focused on establishing a working relationship between child and adolescent psychiatry (CAP) researchers and practitioners to facilitate the translation of science advances into clinical practice

Action step 1.1.2 – Create a Web-based portal for members on evidence-based practices and translational research.

Action step 1.1.3 – Ensure that all AACAP *Clinical Practice Guidelines* (formerly AACAP *Practice Parameters*) are updated and revised in accord with Institute of Medicine (IOM) standards.

Action step 1.1.4 – Consider broadening the membership of the AACAP Program Committee to include more CAPs in clinical practice, and also consider establishing an advisory group to the *JAACAP* editors composed of CAPs in clinical practice.

Action step 1.1.5 – Ensure adequate representation of psychosocial sciences and treatments at AACAP's Annual Meeting and continuing medical education (CME) programs.

*** ***(2013-2015 Priority)*** **Recommendation 1.6 – AACAP will promote the creation of outcomes-based data on the efficacy and effectiveness of psychiatric treatments for children and adolescent.**

Action step 1.6.1 – Develop, implement, and maintain an information center/clearinghouse on psychiatric treatment outcomes that covers the spectrum of care (e.g., psychotherapy, psychopharmacology, environmental interventions, consultation):

- Provide data searchable by various criteria (e.g., patient age, disorder)
- Collaborate with clinicians to obtain information on clinical practices and results (e.g., solicit information on certain types of therapy based on certain criteria; provide incentives for contributors' participation)
- Collaborate with researchers to design collection practices/criteria, analyze data, summarize conclusions
- Provide outcomes data with treatment recommendations

Action step 1.6.2 - Promote the education of CAPs to use evidence supported treatment interventions, participate in the collection of data, and develop models to monitor and systematize clinical practice:

- Verbal and written educational material (e.g., meeting, web, journal) for members
- Training for members throughout the lifespan
- Training the trainers (e.g., program directors)
- Ongoing educational requirement for membership
- Educational programs on using Performance in Practice (PIP) modules and other quality assurance monitoring

*** ***(2013-2015 Priority)*** **Recommendation 3.3 - CAPs need to be familiar and able to work in evolving models of healthcare delivery systems including the Accountable Care Organization (ACO) and medical home models.**

Action step 3.3.1 – In the short term AACAP will need to actively educate its members about the impact of healthcare reform (e.g., annual meeting presentations, *AACAP New* and *JAACAP* articles, and webinars developed by the various AACAP components).

Action step 3.3.2 – AACAP needs to inform and support its members by developing educational materials related to innovations in efficient mental healthcare delivery.

*** ***(2013-2015 Priority)*** **Recommendation 4.5 – CAPs and AACAP should support collaboration with primary care physicians and pediatric subspecialty physicians by establishing stronger relationships in training and clinical practice.**

Action step 4.5.1 – CAPs should work with primary care and pediatric subspecialty physicians to clearly define their respective roles in patient and family mental health care coordination.

Action step 4.5.2 – AACAP should encourage CAP training programs to increase training in collaboration with primary care and examine new models of education (e.g., primary care pediatric practice rotations).

Action step 4.5.3 – AACAP should advocate that CAP function as a subspecialty of both pediatrics and psychiatry when considering policy and system planning.

*** ***(2013-2015 Priority)*** **Recommendation 6.1 - Develop and disseminate a clear, broad-based research agenda that covers the breadth of CAP disorders, with particular emphasis on those disorders that are the most common, have the greatest morbidity and mortality, are in areas where prior research provides the most promising opportunities, and have the greatest public health and societal costs, especially those occurring in understudied or underserved populations.**

Action step 6.1.1 – Develop and implement an approach to guide the prioritization of research agendas, explicitly communicate the rationale, and integrate transparent mechanisms for refining priorities in response to scientific advances. This process should include members who are representative of the AACAP membership and include opportunities for all members to provide comments (i.e., email updates and surveys).

Action step 6.1.2 – Develop a transparent process to develop and maintain a current list of research priorities that is responsive to all of AACAP's membership. The process to develop and maintain this prioritized list would be inclusive of the full range of AACAP members.

Possible research studies and priority areas:

(1) *Treatment approaches targeting the progression of psychiatric disorders to more severe forms or disorders (e.g., Do antipsychotics given very early prevent progression of psychotic disorders? Does treatment of anxiety prevent progression to Major Depression?)*

(2) *Usefulness of specific biomarkers and other risk factors in predicting disease course and optimizing individualized treatment.*

(3) *Treatment approaches in severely refractory cases. Research in adults and in neurological conditions uses relatively invasive methods that act directly on brain circuitry. Clearly, some of these treatments will not be appropriate for children for many years. Others may be appropriate but only for children who are treatment refractory. Work is needed to define the situations where such invasive treatments are justified, and research needs to evaluate their efficacy.*

(4) *Development of quality improvement interventions using emerging technologies to more rapidly disseminate and sustain evidence based practices in community-based settings.*

(5) *Development and demonstration of effectiveness of short-term/brief psychotherapy modules addressing specific symptoms and problems that may be combined in optimum ways for our patients.*

(6) Psychotherapy dissemination and effectiveness research.

(7) The impact of the new DSM-5. Research will be needed to understand the impact of the changes in DSM-5 diagnostic categories, especially in the area of autism and the carving out of Disruptive Mood Dysregulation Disorder from Bipolar Disorder.

Action step 6.1.3 – Disseminate AACAP's prioritized list of research opportunities to all members, the National Institute of Health, other governmental agencies, Congress, clinical and research training programs, allied professional organizations, and others to build a consensus of support.

Action step 6.1.4 – Promote collaboration between AACAP and other stakeholders (e.g., consumer organizations, other professional organizations) to jointly advocate for more funding and targeted research in priority areas.

*** ***(2013-2015 Priority)*** **Recommendation 7.1 – AACAP will provide leadership by advocating for the unique role of CAPs and expanded funding to target the critical CAP workforce shortage and maldistribution.**

Action step 7.1.1 – AACAP will partner with appropriate national organizations, regulatory agencies, and key stakeholders to obtain and maintain funding for key roles and functions of child psychiatry. Examples include but are not limited to GME funding, undergraduate medical education funding, and funding to support practitioner activities.

Action step 7.1.2 – Advocate with HRSA and SAMSHA to promote and support CAPs loan repayment and work in federally qualified health centers (FQHCs) in underserved areas.

Action step 7.1.3 – AACAP will support expansion and development of primary care consultation models to target CAP maldistribution (e.g., Massachusetts Child Psychiatry Access Project).

Action step 7.1.4 – AACAP will advocate to remove the cap on the number of GME positions or allow exceptions for shortage specialties including child and adolescent psychiatry.

Action step 7.1.5 – AACAP will advocate for developing incentives for medical students to pursue careers in child and adolescent psychiatry (e.g., differential payments from Medicare and Medicaid).

Action step 7.1.6 – AACAP will establish a clearinghouse for loan repayment and funding methods to address the shortage and maldistribution of CAPs. AACAP will explore possible funding for CAPs through National Health Service Corps and also develop a loan repayment model for states to target CAP practice in rural areas.

Action step 7.1.7 – AACAP will advocate for credits and/or funding for providing CAP training experiences in non-traditional GME sites (e.g., schools, correctional facilities, or community settings).

Action step 7.1.8 – AACAP will advocate for incentives for medical colleges to offer innovative GME training programs in CAP (e.g., integrated programs, post pediatric portal programs).

Action step 7.1.9 – AACAP will advocate for states to classify CAP as a primary care specialty in order for general psychiatry residents to extend J-1 Visa waivers into CAP training.

*** ***(2013-2015 Priority)*** **Recommendation 8.5 - Promote innovative models for training and practice that include e-health (e.g., telepsychiatry, Internet, communication technologies) and multidisciplinary collaboration that expands the reach of CAPs to underserved areas.**

Action step 8.5.1 – Develop a curricular needs assessment and gather innovative training models for medical student and CAP residents regarding telepsychiatry.

Action step 8.5.2 – Develop a curricular needs assessment and gather innovative training models for medical students and CAP residents regarding multi-disciplinary collaboration.

Action step 8.5.3 – Develop web based multidisciplinary case conferences with edited content and commentary for CAP trainees and practitioners.

Bottom line – The time is NOW for AACAP leadership, members, and staff to study the "roadmap" presented in this report and make the decision to begin the "journey" into the coming decade.

Section VI
NEXT STEPS – IMPLEMENTATION PHASE

Leadership "Buy-in" (Review, Approval, and Support)

With the submission of the report, *Plan for the Coming Decade*, to President Martin Drell, M.D., the ***Back to Project Future*** (BPF) Presidential Initiative will have met its initial charge – to develop a plan and roadmap for the coming decade in child and adolescent psychiatry (CAP).

The report defines a "shared vision" and "roadmap" of where the subspecialty of CAP and the AACAP will be in 2023 and how to get there from 2013. The report's *"Goals, Recommendations and Action steps"* (Section III – Goals & Recommendations (the "roadmap") for the Coming Decade) have been developed by the BPF Steering Committee and subgroups to be useful to: child and adolescent psychiatrists in practice; child and adolescent psychiatrists in academic institutions; child and adolescent psychiatrist researchers; public policymakers; and primary care physicians and allied child mental health professionals. The report can also be used to guide the AACAP leadership, membership, and staff in responding to the changing social and economic realities that are facing the AACAP and CAPs in the coming decade.

Initially, the project's report will need to be reviewed and approved by AACAP's Council. The AACAP leadership's first decision should be to consider whether the project's report (*Plan for the Coming Decade*) should be moved to an implementation phase. If the project receives necessary approval and buy-in from AACAP leadership, (i.e., Council and Executive Committee), then decisions will need to be made regarding the budget and allocation of resources (e.g., staff time, travel, and meeting costs) to support the project's implementation.

Takeaway Points and Prioritizing Recommendations

During the comprehensive review and final editing of the report, the BPF Steering Committee was challenged and encouraged by the BPF honorary editors (Cohen and Enzer) and several BPF distinguished consultants to develop takeaway points and to prioritize selected recommendations and action steps. The BPF Leadership Group and Steering Committee developed a process to identify a manageable number of "recommendations with action steps" that should be targeted for implementation during the first two years of the coming decade. Seven "Recommendations" with their respective "Action steps" were prioritized for implementation during 2013-2015 by a consensus of the Steering Committee. A series of takeaway points were also developed to help summarize and focus key themes in the full report (see Section V for details).

Starting the "Journey"

Following a thoughtful review and approval process by leadership, AACAP would need to create an implementation structure and process to start the "journey" for the coming decade. The BPF Steering Committee recommends that AACAP leadership consider creating a new ***BPF Implementation Task Group (ITG)*** charged with providing coordinated leadership to "drive" the implementation process and start the journey (e.g., appoint a small leadership group of three members). This group should have support from a broad representation of AACAP committees.

The ***ITG*** could report to Council and its functions could include providing oversight for all implementation activities and working closely with AACAP leadership and Council to set priorities (i.e., which "Recommendations" and "Action steps" should be implemented in the first phase). The report's menu of "Recommendations" and "Action steps" in Section III are presented by the BPF Steering Committee as ideas for consideration. They should not be viewed as directives to AACAP. The ***ITG*** could also assign responsibilities and monitor the progress and completion of "action steps" in the report.

The ***ITG*** could charge existing AACAP committees, the Assembly of Regional Organizations, and AACAP staff with developing implementation plans for selected, high priority "Recommendations" and "Action steps." The Steering Committee believes that the energy and on-going activity of these groups of AACAP members and staff represent a natural "engine" that could be harnessed and tasked with carrying out the implementation work of ***Back to Project Future***.

The ***ITG*** could establish "milestones" that would be reviewed every two years to coincide with Executive Committee terms and changes in AACAP leadership. The ***ITG*** could report on progress and provide updates on the "journey" to Council and Assembly at Annual Meetings. The ***ITG*** could also organize Member Forums or special Town Meetings at the AACAP Annual Meeting to inform members about the project's implementation and to get feedback and input.

Dissemination of Report

The BPF Steering Committee believes that this report will be of interest to many different groups. There are two principal types of audience for this report – primary and secondary. Primary audiences to receive the report would include: AACAP leadership, Council, Assembly, members, and staff. Secondary audiences to receive the report could include: other professional medical organizations, allied health organizations, parent/advocate organizations, and foundations/philanthropic groups. The report will be posted on the AACAP website and will also be distributed to all groups and individuals who submitted input to the BPF Steering Committee during the project. The BPF Steering Committee anticipates that the report would stimulate important dialogue with each of these audiences and help advance the field of CAP throughout the coming decade.

Many of the report's "Recommendations" and "Action steps" reference the need for AACAP to work "in partnership with other organizations." AACAP staff and leadership will need to nurture and expand strategic linkages and develop collaborations with other groups (e.g., medical organizations, advocate/family organizations) in order to implement these sections of the report.

The time is NOW for AACAP leadership, members, and staff to study the "roadmap" presented in this report and make the decision to begin the "journey" into the coming decade.

APPENDIX

(alphabetical listing)

Acknowledgements

The BPF Steering Committee is grateful to the following individuals and organizations that contributed to the report and thanks them for their efforts and participation in the project.

BPF Distinguished Consultants

Marilyn Benoit, M.D.
Gabrielle Carlson, M.D.
Mina Dulcan, M.D.
Bennett Leventhal, M.D.
John Schowalter, M.D.
Sandra Sexson, M.D.

Outside Organizations

American Academy of Pediatrics
Mental Health America
National Alliance on Mental Illness
Society of Professors of Child and Adolescent Psychiatry

AACAP Committees and Regional Organizations

Art Committee
College Student Mental Health Committee
Council
Diversity and Culture Committee
Healthcare Access and Economics Committee
Medical Students and Residents Committee
Northern California ROCAP
Psychotherapy Committee
Telepsychiatry Committee
Training and Education Committee
Research Committee
Schools Committee
Substance Abuse and Addictions Committee
Workforce Committee

AACAP Members

William Bernet, M.D. (Tennessee)
Mark Borer, M.D. (Delaware)
Ben Green, M.D. (Colorado)
Elise Leonard, M.D. (Arizona)
Jeffrey Wilson, M.D. (Utah)

Others

Victor Strasberger, M.D. (New Mexico)

AACAP Staff

Virginia Anthony (through September 2012)
Heidi Fordi
Kristin Kroeger Ptakowski
Yoshi Davison
Adriano Boccanelli, BPF Project Coordinator
Elizabeth Hughes
Ashley Partner
Jill Zeigenfus Brafford

Acronyms and Abbreviations

AACAP	–	American Academy of Child and Adolescent Psychiatry
AADPRT	–	American Association of Directors of Psychiatry Residency Training
AAFP	–	American Academy of Family Practice
AAP	–	American Academy of Pediatrics
ACA	–	Affordable Care Act (Federal Healthcare Reform)
ACGME	–	Accreditation Council of Graduate Medical Education
ACO	–	Accountable Care Organization
ACP	–	Advanced Clinical Practitioner
ADMSEP	–	Association of Directors of Medical Student Education in Psychiatry
AHRQ	–	Agency for Healthcare Research and Quality
AMA	–	American Medical Association
APA	–	American Psychiatric Association
APRN	–	Advanced Practice Nurses
APSA	–	American Physician Scientists Association
BPF	–	AACAP's *Back to Project Future* Presidential Initiative
CAP	–	Child and Adolescent Psychiatrist; Child and Adolescent Psychiatry
CAP Resident	–	Also referred to as Child and Adolescent Fellow
CASII	–	AACAP's Child and Adolescent Service Intensity Instrument
CHADD	–	Children and Adults with Attention Deficit Disorder
CME	–	Continuing Medical Education
DSM-5	–	APA's Diagnostic & Statistical Manual 5th Edition (2013)
ECP	–	Early Career Child and Adolescent Psychiatrist
ECSII	–	AACAP's Early Childhood Service Intensity Instrument
EHR	–	Electronic Health Record
EMR	–	Electronic Medical Record
FQHC	–	Federally Qualified Health Center
GME	–	Graduate Medical Education
HRSA	–	Health Resources and Services Administration
IACAPAP	–	International Association of Child and Adolescent Psychiatrists and Allied Professionals

IMG	–	International Medical Graduate
IOM	–	Institute of Medicine
JAACAP	–	*Journal of American Academy of Child and Adolescent Psychiatry*
MHA	–	Mental Health America
MOC	–	Maintenance of Certification
NAMI	–	National Alliance on Mental Illness
NAS	–	Next Accreditation System (ACGME)
NHSC	–	National Health Service Corps
NIH	–	National Institutes of Health
NIMH	–	National Institutes of Mental Health
PDQ	–	Physicians Data Query (National Cancer Institute's comprehensive cancer database)
Psychiatrist	–	Generally referring to a Child and Adolescent Psychiatrist
RDoC	–	Research Domain Criteria
RES	–	BPF Research subgroup
RO	–	Regional Organization (local council) of AACAP's Assembly
RRC	–	Residency Review Committee of ACGME
SAMHSA	–	Substance Abuse and Mental Health Services Administration
SCP	–	BPF Service/Clinical Practice Subgroup
SfN	–	Society for Neuroscience
SPCAP	–	Society of Professors of Child and Adolescent Psychiatry
SUD	–	Substance Use Disorders
TWF	–	BPF Training and Workforce Subgroup
UNICEF	–	United Nations Children's Fund
VTC	–	Video Teleconferencing
WHO	–	World Health Organization
WPA	–	World Psychiatric Association

Background and Process

What is *Back to Project Future* (BPF)?

The project was conceptualized by Martin Drell, M.D., and designated as one of his Presidential Initiatives during his term as AACAP President (2011-2013). ***Back to Project Future (BPF)*** is named in recognition of the importance and relevance of the first *Project Future* conducted by AACAP during 1978-1983. The 1983 report, *Child Psychiatry: A Plan for the Coming Decades*, from the original *Project Future***,** identified several priority needs for child and adolescent psychiatrists (CAPs): to embrace and invest in research and research careers; to treat children with the most debilitating of mental illnesses; to collaborate more with pediatricians; and to invest more in systems of care. The report also defined a set of values and a new identity for child and adolescent psychiatry in the 1980s and 1990s. In re-reading the original *Project Future* report and remembering its impact on the field, Dr. Drell recognized many similar circumstances, familiar themes and recommendations between 1983 and 2011. In reflecting on the current state of CAP, Dr. Drell decided it was time to go "back to *Project Future.*"

Back to Project Future was designed and organized to create a time-limited and highly-focused structure and process that enabled a diverse group of AACAP members to come together to brainstorm and develop a consensus of priorities and action steps for AACAP that spanned three key areas: *Service/Clinical Practice, Training and Workforce,* and *Research.* The report's findings and recommendations have been developed to be useful to: CAPs in practice, CAPs in academic institutions, CAP researchers, public policymakers, and primary care physicians and allied child mental health professionals. This report is intended to assist and guide the AACAP leadership, membership, and staff in responding to the changing social and economic realities that face CAPs in the coming decade. This report defines a "shared vision" and "roadmap" of where the subspecialty of child and adolescent psychiatry and AACAP will be in 2023 and how to get there from 2013.

Back to Project Future was organized with a Steering Committee and three subgroups representing the "focal areas" (*Practice, Training and Workforce,* and *Research)* identified by the AACAP Leadership Survey conducted in 2011. The BPF Steering Committee began its work by developing a "vision statement" for BPF. This statement defines the "big picture" for the project and the field, and the statement flows from AACAP's Mission Statement. The BPF "Vision Statement" (see Section III) provides an organizing direction for AACAP and CAP in the coming decade. The three "focal areas" flowed from the vision statement and became the organizing structure for the project. In developing the BPF report the Steering Committee and subgroups focused on three broad questions:

1. Where do we think CAP will be/needs to be in 2023?
2. What does AACAP need to do to support its members across the coming decade?
3. How can AACAP best provide leadership to the field during the coming decade?

Back to Project Future's overall purposes included:

- Estimating the psychiatric needs of children, adolescents, and their families in the coming decade (2013-2023).
- Developing a general concept of the knowledge and skills that will be needed by child and adolescent psychiatrists in the coming decade.
- Identifying the major issues faced by the profession and to formulate recommendations to address these issues in the coming decade.
- Developing a set of consensus recommendations with trends and an action plan to guide AACAP (leadership, members, and staff) as it moves forward into the coming decade (2013-2023). The consensus

recommendations provide guidance, direction, and support for AACAP in three focal areas – *Service/Clinical Practice, Training and Workforce,* and *Research.*

BPF Beginnings

In 2011, President-elect Martin Drell, M.D., surveyed the AACAP leadership and a sample of AACAP members and staff about the "top 10" issues facing CAP in the future. Three focal areas (*Service/Clinical Practice, Training and Workforce,* and *Research)* emerged from an analysis of those surveys. The leadership survey also identified many specific issues that clustered under the three focal areas (see Focal Areas and Issue – Appendix).

From December 2011 through February 2012, the BPF Steering Committee and three BPF subgroups were created, appointments made, and charges developed by Dr. Drell, AACAP president; Ginger Anthony, AACAP executive director; and James MacIntyre, II, M.D., BPF chair. A group of AACAP members were selected to participate based on their diverse backgrounds, credentials, and geographic locations. The BPF Steering Committee was organized to function as a "think tank" and provide leadership and direction to the three BPF Subgroups. The BPF Steering Committee was charged with incorporating input from the three BPF Subgroups, other AACAP committees, and outside organizations to develop consensus goals, recommendations, and action steps for each of the three focal areas.

The BPF Steering Committee articulated the following broad principles for the overall project:

- CAP is a diverse sub-specialty with many real differences depending on type of practice, location/geography, etc. AACAP must continue to embrace that diversity and not press for a "one-size fits all" approach. AACAP should continue to recognize and respect these differences.
- CAP in 2023 needs to be high quality, more efficient, and better coordinated/integrated with other child-serving systems and providers.
- AACAP and its members have a solid foundation for the future of CAP and need to build on that foundation.
- AACAP needs to celebrate its accomplishments and successes as an organization and recognize members' generosity with their time (volunteerism).
- AACAP and CAPs need to preserve optimism about the future to attract/recruit young people to our field.
- Young members are the future of CAP and we must invest in them. We must attract them to CAP and keep them invested in AACAP as their "professional home and family."

The BPF Subgroups (*Service/Clinical Practice, Training and Workforce,* and *Research*) were charged with holding a limited number of meetings and conference calls to brainstorm on their assigned focal area. Subgroup leaders reported to the BPF Steering Committee and worked actively to reach a consensus on the draft recommendations, goals, and action steps developed and proposed by each subgroup. The subgroup leaders and BPF chair functioned as a BPF Leadership Group for the project.

BPF Process

In March 2012, ***Back to Project Future*** created and distributed the BPF "Frequently Asked Questions" (see FAQs – Appendix) to announce and describe the project for AACAP leadership and members. The first meeting of the BPF Steering Committee was held in April 2012. As it began its work, the BPF Steering Committee discussed and considered important trends and forces affecting CAP (see "Trends and Forces" – Appendix). At the initial meeting the BPF Steering Committee also adopted the BPF "framework" (see below) and charged the three BPF Subgroups with developing draft goals, recommendations, rationales, and action steps in their respective focal area. In addition, meetings and conference calls were scheduled for the BPF Steering Committee and the three subgroups to draft the BPF report: *Plan for the Coming Decade*. The Steering Committee and the three subgroups were charged by Dr. Drell

with reaching out to many different groups both within and outside the AACAP to get input. "Stimulus Questions" (see Appendix) were developed to gather and facilitate input to the project in the three focal areas *(Service/Clinical Practice, Training and Workforce,* and *Research*). Different sets of Stimulus Questions were developed and used with the three subgroups, AACAP Council, AACAP Assembly of Regional Organizations, AACAP committees, and other organizations (medical, parent, and advocacy). The suggestions, ideas, and content received in response to the questions became the basis for the written report and plan.

"Charting a course" (road-map metaphor)

To help conceptualize their task and process, the BPF Steering Committee adopted a roadmap metaphor. The committee agreed that ***Back to Project Future*** is charting a course for CAPs and AACAP for the coming decade (2013-2023). The BPF report should be viewed as a "roadmap" for AACAP leadership, staff, and members. Our "destination" is not only a point in time but a place in a new integrated health care system where mental health will be recognized as integral to overall health and CAPs will be seen as physician leaders. As a "roadmap" the BPF report provides "directions" based on the BPF Steering Committee's and three subgroups' assessments of current needs and strengths in the field of CAP. The BPF *Plan for the Coming Decade* provides "directions" (i.e., *BPF Goals and Recommendations*) for our travel from point A to point B. The "roadmap's" recommendations and action steps also describe what we should "pack for the trip and places we should stop along the way." The "places" on our map are the specific *BPF action steps*. "Packing" for our journey includes: AACAP staff and members; human, financial, and technical resources; and collaborative partners that join us as stakeholders. The "traffic and weather conditions" are unforeseen developments and changes in the field of CAP over the next ten years. For example, changes in the health care system, new data from research, changes in our workforce, financial changes, etc.

BPF "framework"

In order to develop and produce a comprehensive and practical report, the BPF Steering Committee created and adopted a "framework" for ***Back to Project Future*** with the following elements – "Goals, Recommendations, Rationales, and Action steps." These elements collectively support the BPF "Vision Statement." The completed "framework" constitutes the "roadmap" (Section III) for the coming decade. The elements of the framework are defined as follows:

- **GOAL** – *Statements containing key elements needed to support and achieve the BPF "vision." "Goal" statements are broad and more aspirational than "Recommendations."*
- **RECOMMENDATION** – *Statements containing core concepts (idea kernels) that move the "Goal" toward a specific plan of action.*
- **RATIONALE** – *Narrative statements and sections that provide a context and critical perspective on the importance of the "Goal" or "Recommendation."*
- **ACTION STEP** – *Specific actions, activities, and initiatives that support the goals and recommendations. These constitute specific steps needed to implement a "Recommendation."*

The BPF Steering Committee also developed the following set of "Core Values and Principles" underlying the framework. All elements of the BPF "framework" and plan strive to:

I. Represent innovative and forward thinking concepts and projections for the coming decade.

II. Incorporate emerging technologies.

III. Capture a new core professional identity and role for child and adolescent psychiatrists.

IV. Reflect a new public image of child and adolescent psychiatrists.

V. Promote high morale and interest for trainees (medical students and residents) and child and adolescent psychiatrists in practice.

VI. Reflect the move toward an international/global perspective on child and adolescent psychiatry.

VII. Address the changing population demographics and characteristics for children, adolescents and families in the United States across the coming decade.

"Opening the funnel" (listening, getting ideas and input)

The BPF Steering Committee and Subgroups were charged by President Drell to reach out to many different groups both within and outside AACAP to get input for the project's report (see "BPF Input schematic" – Attachment). The BPF Stimulus Questions (Appendix) were widely distributed and the "funnel was opened" for input and ideas beginning in May 2012. The BPF Leadership Group made it clear to everyone that "there are no bad ideas" and that the BPF Steering Committee and Subgroups were being open and inclusive, and needed as much input as possible to develop the "framework" and create a credible BPF *Plan for the Coming Decade*. AACAP staff created a special BPF e-mail address to facilitate input from members and others. In June 2012, a special BPF webpage was developed on the "Members Only" portion of the AACAP website. Brief BPF update articles were published in AACAP News. The BPF chair attended meetings and provided regular project updates to Dr. Drell, the AACAP Executive Committee and Council, the AACAP Assembly of Regional Organizations, and all AACAP committee chairpersons. A special *Back to Project Future* Town Meeting for AACAP members was held by the BPF Leadership Group at the AACAP Annual Meeting in San Francisco in 2012. The draft report was also reviewed and critiqued by the BPF Distinguished Consultants. BPF Honorary Editors Richard Cohen, M.D., and Norbert Enzer, M.D., were consulted for their thoughts and reflections about the original *Project Future* and lessons learned that could be applied to ***Back to Project Future***.

BPF Report and *Plan for the Coming Decade*

The BPF final report represents a consensus of the BPF Steering Committee and incorporates the input and work of the three BPF Subgroups as well as other groups and individuals. The BPF Steering Committee used the following questions to make decisions about the content for the final report:

- Does the draft report chart a course (serve as a "road map") for AACAP and CAP?
- Does the report include what's new and coming in the next 10 years?
- Does the report address what needs to change or be redefined in CAP?
- Does the report identify what needs to be preserved or protected?
- Does the report address how to train and prepare CAP residents and early career psychiatrists (ECPs) to be innovative, creative, entrepreneurial, and technologically adept in the coming decade?
- Does the report speak to how best to leverage technology to support/enhance training and clinical practice?

Definition of Terms

Exchange structures – Each health insurance exchange will have multiple health insurance plans that are ranked from "bronze" to "platinum" to indicate the level of coverage and premiums that each plan offers.

Family mental health care plan – A treatment plan that addresses the mental health needs of the child and family.

Health insurance exchange – Also known as a "health insurance marketplace" is an online "shop" for individuals and small businesses (up to 100 employees) to compare and purchase private health insurance plans.

Medical home – This refers to an approach of providing comprehensive primary care in which a care team partners with a child and his/her family to ensure that all of the patient's medical and psychosocial needs are met.

System of care – Refers to an organizational philosophy and framework that involves collaboration across agencies, families, and youth to improve access and expand the array of services to children, youth, and their families. These systems are organized to ensure that services are coordinated, community-based, culturally and linguistically competent, and fully support children, youth, and families with serious emotional disturbances.

Focal Areas for Project Subgroups

May 2012

III. SERVICE/CLINICAL PRACTICE GROUP

Changing Practice Patterns

- Child and adolescent psychiatrist shortages and distribution (metro vs. rural)
- Use of physician extenders
- Partnerships with primary care (pediatrics, family medicine)
- Consultation models
- New models of payment
- Using evidence-based practices
- Psychopharmacology ("off-label" use, multi-drug regimens, etc.)
- New practice models (ACO's, medical home, etc.)
- Psychotherapy offered and provided less
- Reductions in public system (budgets, services, beds, etc.)
- Forensic issues
- Prevention
- Schools
- Outcomes and quality improvement initiatives

State, National and Global Trends Affecting Healthcare

- Healthcare reform
- Cost-shifting
- Legal environment
- Budget deficits and reductions
- Entitlement programs (Medicaid)
- Advocacy
- Patient safety
- Efficiency and measurement

Evolving Technology

- Telepsychiatry
- E-scribing
- EMR/HER
- Internet – impact on teens/children, parents, and general public

II. TRAINING AND WORKFORCE GROUP

- Lack of access to child psychiatrists (e.g., long waiting lists)
- Influence of pharmaceutical industry
- Public perception and image of child psychiatrists (? "pill-pushers")
- Recruitment difficulties
- Child and adolescent psychiatrist shortages and distribution (e.g., retirement of "baby-boomer" generation)
- Partnering with parents
- "Guild" issues

- Diminishing funding
- Consultation models
- Advocacy
- Continuing medical education issues
- Maintenance of certification issues
- Changing curriculum for medical students and residents (psychiatry and child psychiatry)
- Physician extenders
- Training pediatricians to manage mental health problems
- Cultural diversity
- E-training (CME)
- Networking (e.g., Linked-In, Doximity)

III. RESEARCH GROUP

- Sources of support (government, foundations, pharmaceutical industry)
- Advocacy

Basic Science

- Genetics and genomics
- Neuroimaging
- Endophenotypes
- Data mining/machine learning
- Animal models

Nosology and Course

- DSM-5
- Preschool
- Incidence of Bipolar Disorder and PDD-Autism
- Research Domain Criteria (RdoC)

Treatment

- Pharmacology
- Pharmacy pipeline – medications in development
- Translational research (science to practice)
- Expanding the evidence-base
- Psychotherapy
- Computerized therapy
- Cognitive training

Services

- Delay between diagnosis and training
- Healthcare disparities
- Brief telephone calls

Research Training

- Pipeline for researchers
- Cross subsidies
- Loan repayment program

Frequently Asked Questions (FAQs)

What is "Back to Project Future" *(BPF)?*

- The project is one of Dr. Martin Drell's Presidential Initiatives. The project creates a time-limited and highly-focused structure and process that enables participants to come together to brainstorm and work on developing a consensus around priorities and action steps for AACAP in three key areas: *Service/Clinical Practice, Training and Workforce,* and *Research.* The project will be completed when its report is submitted to the AACAP Council for consideration at the 60th AACAP Annual Meeting in 2013.
- The development and prioritization of the action plan will be done by a BPF Steering Committee along with three BPF Subgroups tasked to one of the three key areas (above).
- It is named in recognition of the importance and relevance of the first *Project Future"* conducted by AACAP during 1978-1983. In re-reading the project's report and remembering its impact on the field, Dr. Drell recognized many similar circumstances, familiar themes and recommendations. He decided it was time to go "***back to*** **Project Future.**"

*What was the original "*Project Future*"?*

- The 1983 report, *Child Psychiatry: A Plan for the Coming Decades*, from the original *Project Future***,** identified several priority needs for child and adolescent psychiatrists CAPs): to embrace and invest in research and research careers; to treat children with the most debilitating of mental illnesses; to collaborate more with pediatricians; and to invest more in systems of care. The report also defined a set of values and a new identity for CAP in the 1980s and 1990s.

*What is the purpose of "*Back to Project Future*" (BPF)?*

- To estimate the psychiatric needs of children, adolescents, and their families in the coming decade (2013-2023).
- To develop a general concept of the knowledge and skills that will be needed by CAPs in the coming decade.
- To identify the major issues faced by the profession and to formulate recommendations to address these issues in the coming decade.
- To develop a set of consensus recommendations with trends and an action plan to guide AACAP (leadership, members, and staff) as it moves forward into the coming decade (2013-2023). The consensus recommendations will provide guidance, direction, and support for AACAP in three focal areas – *Service/ Clinical Practice, Training and Workforce,* and *Research.*

How were the focal areas and issues identified?

- AACAP leadership and a sample of AACAP members and staff were surveyed about the "top 10" issues facing CAP in the future. The three key areas (*Service/Clinical Practice, Training and Workforce,* and *Research)* and a list of focal issues emerged from an analysis of those surveys.

What is the role of the project's steering committee?

- The BPF Steering Committee will function as a "think tank" and provide leadership and direction to the three subgroups through a limited number of face-to-face meetings and conference calls. The BPF Steering Committee will use input from the three subgroups and other AACAP committees, to develop and prioritize consensus recommendations with action steps for each key focal area.

What is the role of the project's Steering Committee subgroups?

- The BPF Subgroups of the Steering Committee (*Service/Clinical Practice, Training and Workforce,* and *Research*) will each have a limited number of face-to-face meetings and conference calls to brainstorm and focus exclusively on their assigned focal area. Subgroup leaders will report to the Steering Committee and each subgroup will interact with the Steering Committee to reach consensus on a series of recommendations and action steps.

What is the timetable and what will be the outcomes of the project?

- The project will develop a manageable set of prioritized recommendations and actions for AACAP to consider over the coming decade (2013-2023).
- The findings and recommendations should be useful to the following: CAPs in practice; CAPs in academic institutions; CAP researchers; public policymakers; and primary care physicians and allied child mental health professionals.
- The resulting product can be used to assist and guide the AACAP leadership, membership, and staff in how to respond to the changing social and economic realities that face CAPs in the coming decade.
- The BPF Steering Committee will: a) prepare a written report summarizing its consensus recommendations and a draft action plan; b) publish an article in *AACAP News* or an editorial in JAACAP regarding recommendations; and c) participate in 2013 AACAP 60th Annual Meeting in Orlando, Florida.
- BPF will end with the submission of the Steering Committee's report to Council at the 2013 AACAP Annual Meeting.

Who is involved with the project?

- ***Honorary Editors:*** Richard Cohen and Norbert Enzer
- ***Steering Committee***: James MacIntyre, chair; Alan Axelson; Michael Houston; Paramjit Joshi; Sheryl Kataoka; Debra Koss; Rich Martini; David Pruitt; Neal Ryan; and Heather Walter
- ***Service/Clinical Practice Subgroup***: Rich Martini, co-leader; Michael Houston, co-leader; Mark Chenven; Robert Hilt; Larry Marx; Barry Sarvet; and Heather Walter
- ***Training and Workforce Subgroup***: David Pruitt, leader; Gene Beresin; Arden Dingle; Geri Fox; David Kaye; Ken Rogers; Saundra Stock; and Chris Varley
- ***Research Subgroup***: Neal Ryan, leader; Kiki Chang; Melissa Del Bello; Mary Margaret Gleason; Young Shin-Kim; Daniel Pine, John Walkup and Bonnie Zima
- ***Distinguished Consultants***: A small group of senior AACAP members will be identified to serve as consultants to the Steering Committee and three subgroups.
- ***AACAP staff*** from the departments of Government Affairs and Clinical Practice, Meetings and Continuing Medical Education, Development, and Research, Training, and Education will provide support and assistance.

How do existing AACAP committees get involved with the project?

- BPF Steering Committee and three subgroups will seek input and assistance from selected AACAP committees and members.
- BPF is a time-limited and focused special effort. It does not duplicate or replace the critical function of AACAP committees.

How can AACAP members give input to the project?

- Contact any of the following: **James MacIntyre**, chair of the Steering Committee; **Michael Houston** or **Rich Martini**, co-leaders of the Service/Clinical Practice Subgroup; **David Pruitt**, leader of the Training and Workforce Subgroup; and **Neal Ryan**, leader of the Research Subgroup. Send questions or input to: **bpfquest@aacap.org**
- Visit the special section of the AACAP website for ***Back to* Project Future** where information from the BPF Steering Committee and three subgroups will be posted. Members can also contribute their input, ideas, and feedback.
- Work within existing AACAP committees and send questions, ideas, and priorities to the BPF Steering Committee and three subgroups.

Will groups outside of AACAP have an opportunity for input?

- As with the original *Project Future*, AACAP will solicit input from other professional organizations (e.g., American Psychiatric Association, American Association of Directors of Psychiatric Residency Training) to enrich the discussions and project outcomes.

How do AACAP leadership (Council, Executive Committee, Committee Chairpersons) and members find out what's happening with the project?

- BPF Steering Committee chair reports regularly to AACAP President Martin Drell, and to the Executive Committee and Council as requested.
- BPF Steering Committee will post information on the AACAP website and publish brief updates and articles in *AACAP News*.
- At the conclusion of the project its report will be submitted to the AACAP Council for consideration.

What's Next?

- "Stay tuned" as BPF moves forward to develop a shared vision for child and adolescent psychiatry in the coming decade (2013-2023) and a "roadmap" to guide AACAP leadership, members, and staff in achieving that vision.

Index of Recommendations by Topic

(2013-2015 "priority recommendations are in bold)

Topic/Theme	BPF Recommendation #s
Advocacy	2.4, 2.6, 3.4, 4.6, 10.3, 10.4
CAPs as Educators	4.1, 4.13, 5.5, 5.6, 5.7, 5.8
CME/Lifelong Learning	1.8, 1.9, 1.11, 1.12, 2.1, 2.8, 5.9
Diversity and Culture	6.4, 10.1, 10.2, 10.5
Education of Public	2.11
EMR/Health Information Technology	4.13, 8.1, 8.2, 8.3, 8.4, **8.5**
Ethics	11.2, 11.2
Evidence-based Practice	**1.1**, 1.10, 1.14, 6.5
Forensic CAP/Juvenile Justice	5.4
Identity and Role of CAP	2.1, 2.5, 2.10, 3.10, **7.1**
Integration with Other Systems	5.1
International/Global Perspective	9.1
Medication/Psychopharmacology	1.2
Models of Healthcare Delivery/Practice	2.5, 3.1, **3.3**, 4.6, 4.7, 5.3
Partnerships/Collaboration	3.6, 3.8, 4.2, 4.3, **4.5**, 6.3, 11.2
Payment/Reimbursement/Fiscal Issues	1.12, 2.9, 3.2, 3.5, 3.9, 6.3, **7.1**
Population/Community Focus	1.7, 2.3, 2.7, 3.1, 3.7, 4.4, 4.7
Prevention/Screening	1.7, 2.2, 2.3,
Psychotherapy	1.3
Public image of CAP	2.10, 2.11
Quality Indicators and Outcomes	1.4, **1.6**, 4.7, 6.3, 6.5
Recruitment	**7.1**, 7.2
Research	1.13, 1.14, 1.15, **6.1**, 6.2, 6.3, 6.4, 6.5, 6.6, 11.3
Stigma	7.3
Substance Abuse	1.5
Telemedicine	4.8, 4.9, 4.10, 4.11, 4.12, **8.5**
Training	1.7, 2.1, 2.6, 3.6, 3.7, 3.8, **4.5**, 4.13, 5.2, 5.8, 6.6, **8.5**, 10.1, 10.2, 10.5

Rosters of BPF Participants

BPF STEERING COMMITTEE ROSTER

James MacIntyre, M.D., ***Chair***

Michael Houston, M.D., ***Services and Clinical Practice Group - Co-Leader***

Alan Axelson, ***M.D.***

David B. Pruitt, M.D, ***Training and Workforce Group Leader***

Paramjit Joshi, M.D.

Sheryl Kataoka, M.D.

Debra Koss, M.D.

D. Richard Martini, M.D., ***Services and Clinical Practice - Co-Leader***

Neal Ryan, M.D, ***Research Group Leader***

Heather J. Walter, M.D., M.P.H

Heidi Buttner Fordi, CAE
AACAP
Phone: 202-966-7300 ext. 116
Email: hfordi@aacap.org

Adriano Boccanelli
AACAP
Phone: 202-966-7300 ext. 133
Email: aboccanelli@aacap.org

BPF SERVICES & CLINICAL PRACTICE GROUP ROSTER

Michael Houston, M.D., *Co-Leader*

D. Richard Martini, M.D., *Co-Leader*

Sukhjit Brar, M.D. (Resident)

Mark Chenven, M.D.,

Robert Hilt, M.D.

Larry Marx, M.D.

Barry Sarvet, M.D.

Heather J. Walter, M.D., M.P.H

Kristin Kroeger Ptakowski
AACAP

BPF RESEARCH GROUP ROSTER

Neal Ryan, M.D, *Leader*

Kiki D. Chang, M.D.

Melissa P. Del Bello, M.D., M.S.

Mirjana Jojic, M.D. *(Resident)*

Mary-Margaret Gleason, M.D.

Daniel Pine, M.D.

Young-Shin Kim, M.D.

Hanna Stevens, M.D., Ph.D. *(Early Career)*

John T. Walkup, M.D.

Bonnie T. Zima, M.D., M.P.H.

Yoshie Davison
AACAP

BPF TRAINING & WORKFORCE GROUP ROSTER

David B. Pruitt, M.D, ***Leader***

Gene Beresin, M.D., M.A.

Arden D. Dingle, M.D.

Geraldine S. Fox, M.D.

David Kaye, M.D.

Boris Lorberg, M.D. ***(Early Career)***

Kenneth M. Rogers, M.D.

Sourav Sengupta, M.D., M.P.H. ***(Resident)***

Saundra Stock, M.D.

Christopher K. Varley, M.D.

Yoshie Davison
AACAP

Elizabeth Hughes
AACAP
Phone: 202-966-7300 ext. 106
Email: ehughes@aacap.org

Ashley Rutter
AACAP
Phone: 202-966-7300 ext. 117
Email: arutter@aacap.org

Jill Zeigenfus Brafford
AACAP
Phone: 202-966-7300 ext. 101
Email: jzeigenfus@aacap.org

BPF DISTINGUISHED CONSULTANTS ROSTER

Marilyn B. Benoit, M.D.

Gabrielle Carlson, M.D.

Mina K. Dulcan, M.D.

Peter S. Jensen, M.D.

Harold S. Koplewicz, M.D.

Bennett L. Leventhal, M.D.

Barry Nurcombe, M.D.

John Schowalter, M.D.

Sandra B. Sexson, M.D.

David Shaffer, FRCP, FRCPsych

Stimulus Questions for Discussion/Input From Council and AACAP Committees

July 2012

Service/Clinical Practice (SCP)

- What practice models and types of practice will be utilized in the coming decade?
- What new treatments will be needed or available?
- How will new treatments be incorporated into practice?
- What new medications will be available?
- How will child and adolescent psychiatrists be advocates?
- What would be a "game-changer" for clinical practice in the coming decade?
- What do you imagine will be the biggest developments in the practice of child and adolescent psychiatry in the next 10 years?
- What can be done to prevent child and adolescent psychiatry from becoming irrelevant in future/emerging healthcare systems?
- How can child and adolescent psychiatrists best serve the needs of our nation's children during the coming decade?

Research (R)

- What research is needed to advance child and adolescent diagnosis and treatment in the coming decade?
- Who will be doing the research?
- How should research be funded?
- Who should advocate for needed research?
- What would be a "game-changer" for research in the coming decade?
- What are the biggest obstacles to using research findings to improve patient care for children and adolescents?
- What areas of research in child and adolescent psychiatry are child psychiatrists uniquely qualified to lead?
- Should the research agenda in child and adolescent psychiatry be broadened to enable all Divisions and training programs (large and small) to develop research programs for their program, faculty and trainees?

Training and Workforce (TWF)

1. Who will be practicing child and adolescent psychiatry in the coming decade?
2. Where will child psychiatrists be practicing (geographically)?
3. What changes will be needed to train child and adolescent psychiatrists?

4. How will child psychiatrists maintain their skills and knowledge?

5. How should child psychiatrists be trained as advocates?

6. What would be a "game-changer" for training and workforce issues in the coming decade?

7. What needs to be done to address the geographic and economic mal-distribution of child and adolescent psychiatrists in the United States?

8. Should there be a lifelong teaching and learning curriculum in development for child and adolescent psychiatrists?

9. How should child psychiatry training address the growing tension between the explosion of new knowledge and the real limitations of what can be taught and learned in two years?

Stimulus Questions for Input from Medical Organizations

December 2012

- How can child and adolescent psychiatrists best serve the needs of our nation's children during the coming decade?
- What do you imagine will be the biggest developments in the practice of child and adolescent psychiatry in the next 10 years?
- How can your organization's members collaborate with child and adolescent psychiatrists in new/emerging healthcare systems?
- What research is needed to advance child and adolescent diagnosis and treatment in the coming decade?
- How should research in child and adolescent psychiatry be funded?
- What needs to be done to address the geographic and economic mal-distribution of child and adolescent psychiatrists in the United States?
- How should child psychiatry training address the growing tension between the explosion of new knowledge and the real limitations of what can be taught and learned in two years?
- What would be a "game-changer" for child and adolescent psychiatry in the coming decade?

Stimulus Questions for Input from Parents and Advocates

December 2012

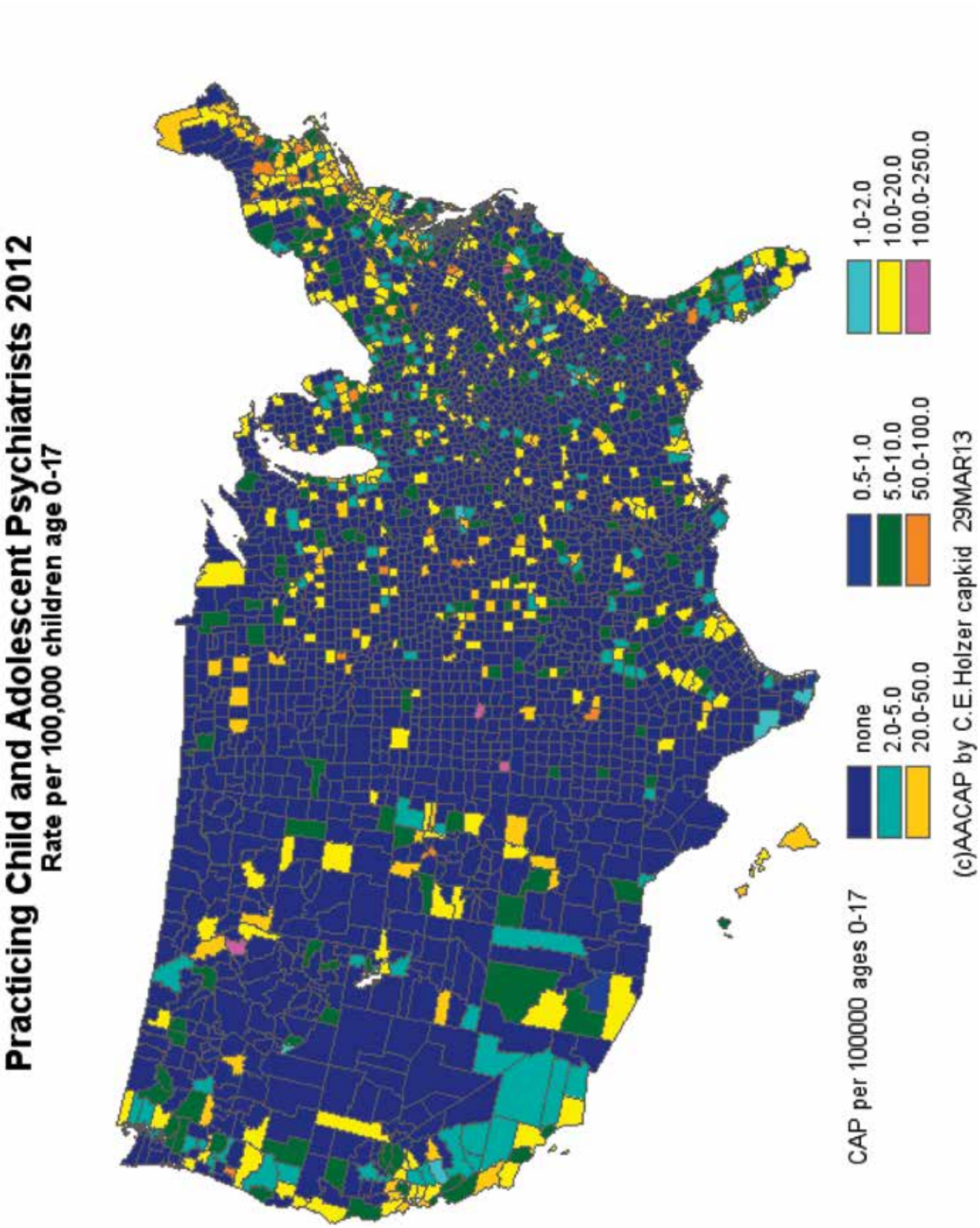
- How can child and adolescent psychiatrists best serve the needs of our nation's children during the coming decade?
- What do you imagine will be the biggest developments in the practice of child and adolescent psychiatry in the next 10 years?
- What role should child and adolescent psychiatrists have in new/emerging healthcare delivery systems?
- What research is needed to advance child and adolescent diagnosis and treatment in the coming decade?
- What needs to be done to address the geographic and economic mal-distribution of child and adolescent psychiatrists in the United States?

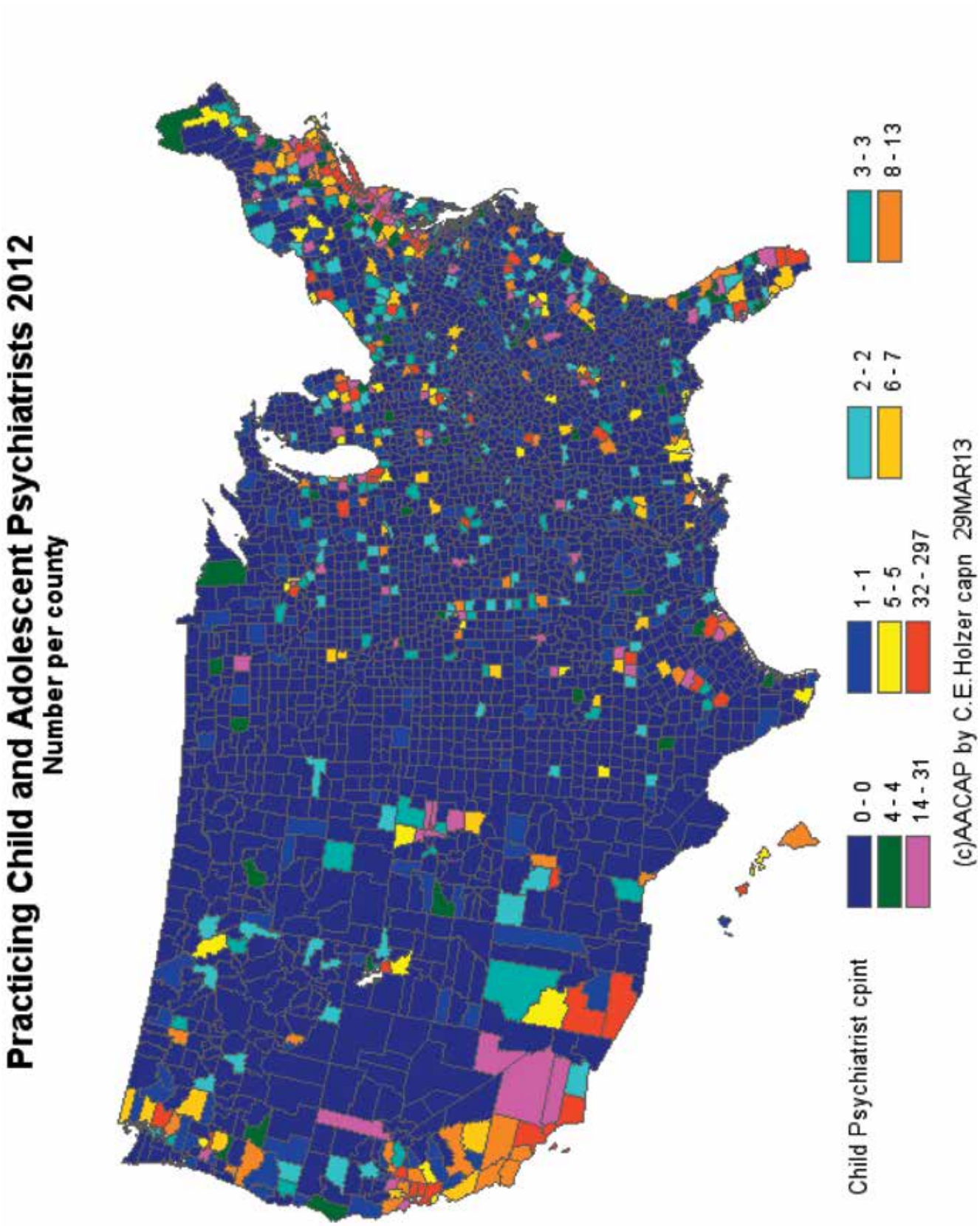
Trends And Forces Shaping/ Changing Child snd Adolescent Psychiatry

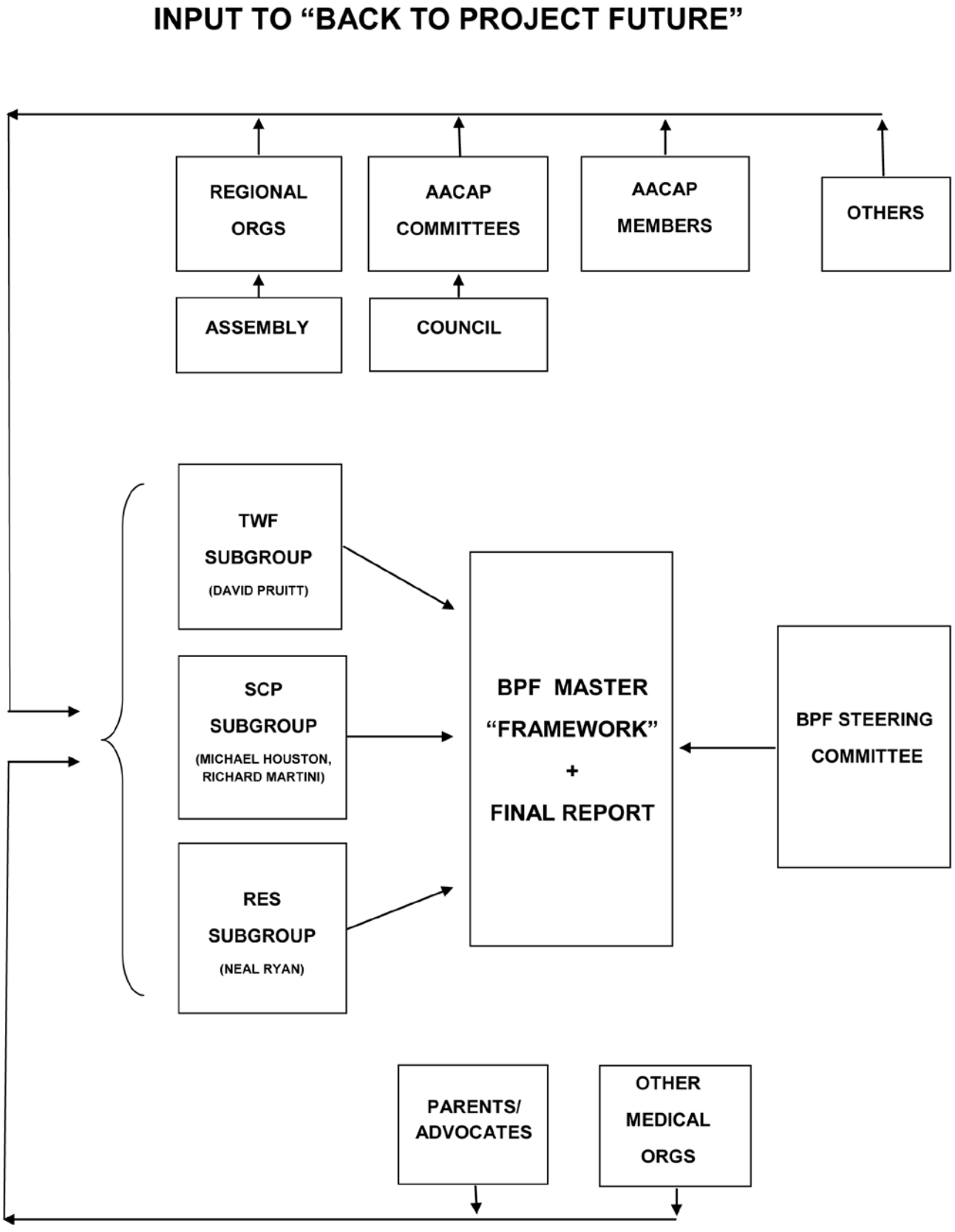
April 2012

- Increasing need for integration, coordination, and partnerships between child psychiatry and primary care (pediatrics, family medicine, internal medicine).
- Increasing numbers of children, adolescents, and families needing mental health services and psychiatric treatment.
- Reductions in psychiatric hospital beds.
- Healthcare reform (Affordable Healthcare Act) – changes to healthcare systems, delivery of services and practice models.
- Global economy (budget deficits, poverty, etc.).
- Use of evidence-based practices, Practice Parameters and Clinical Practice Guidelines.
- New technology (EHR, EMR, Internet, online education, online publications, telepsychiatry, social networking, etc.).
- Increasing knowledge in basic neurosciences, genetic/genomics, neuroimaging, etc.
- Pressure for accountability (accreditation, MOC).
- Gap between research/published studies and practitioner need for effective treatment strategies (tension about "off-label" use of psychotropic medications).
- Reduced funding and support for graduate medical education, research.
- Empowerment of parents and patients in healthcare decision-making and education.
- Reduced reimbursement for child psychiatrists to do psychotherapy.
- Increased pressure for child psychiatrists' time to be allocated to brief sessions of medication management.
- Growing gap between need for child psychiatrists and number being recruited versus number reaching the end of their careers.
- Continuing societal stigma of mental illness and treatment.
- Almost no new medications under development in the pharmaceutical "pipeline."
- Increasing expectation/need for outcome, performance, and quality metrics in medicine (psychiatry, child and adolescent psychiatry).

ATTACHMENTS (PDF FILES)


Practicing Child and Adolescent Psychiatrists 2012
Rate per 100,000 children age 0-17
CAP per 100000 ages 0-17
none
2.0-5.0
20.0-50.0
0.5-1.0
5.0-10.0
50.0-100.0
1.0-2.0
10.0-20.0
100.0-250.0
(c)AACAP by C.E.Holzer capkid 29MAR13


Practicing Child and Adolescent Psychiatrists 2012
Number per county
Child Psychiatrist cpint
0 - 0
4 - 4
14 - 31
1 - 1
5 - 5
32 - 297
2 - 2
6 - 7
3 - 3
8 - 13
(c)AACAP by C.E.Holzer capn 29MAR13


INPUT TO "BACK TO PROJECT FUTURE"
REGIONAL ORGS
AACAP COMMITTEES
AACAP MEMBERS
OTHERS
ASSEMBLY
COUNCIL
TWF SUBGROUP (DAVID PRUITT)
SCP SUBGROUP (MICHAEL HOUSTON, RICHARD MARTINI)
RES SUBGROUP (NEAL RYAN)
BPF MASTER "FRAMEWORK" + FINAL REPORT
BPF STEERING COMMITTEE
PARENTS/ ADVOCATES
OTHER MEDICAL ORGS