Inside...

President's Column: Depression and Depression Screening ......................................................... 121
Member Practice Economics Survey Results .................................................................................. 126
Lights, Camera, Action: Technical Telepsychiatry Skills ............................................................. 127
Career Paths in Child and Adolescent Psychiatry ......................................................................... 134
American Academy of Child & Adolescent Psychiatry

AACAP’s 65th Annual Meeting

October 22–27, 2018
Seattle, WA
Washington State Convention Center

Call for Papers Deadline: February 15, 2018
New Research Poster Deadline: June 15, 2018
Preliminary Program Available: June 15, 2018

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Visit www.aacap.org/AnnualMeeting-2018 for the latest information!
# Table of Contents

## Columns

**Neera Ghaziuddin, MD, Section Editor • neerag@med.umich.edu**

- President’s Column: Depression and Depression Screening • Karen Dineen Wagner, MD, PhD ........................................ 121
- CPT Screening Codes • Kai-ping Wang, MD ................................................................. 121
- Clinical Case Reports and Vignettes: Deprescribing in Child and Adolescent Psychiatry • Megan Baker, MD .................. 123

## Committees/Assembly

**Ellen Heyneman, MD, Section Editor • eheyneman@uscd.edu**

- Healthcare Access and Economic Committee: Member Practice Economics Survey Results • Jason Chang, MD, Barry Sarvet, MD, and Karen Ferguson ............................................ 126
- Telepsychiatry Committee: Lights, Camera, Action: Technical Telepsychiatry Skills • David Roth, MD, and Ujjwal Ramtekkar, MD .......................................................... 127
- Schools Committee: School Anti-Cyberbullying Policy Development in the Caribbean: How Culture Shapes Our Disciplinary Practices • Shirley Alleyne, MBBS ......................................................... 130
- Advocacy Committee: Where Am I? System of Care and Child Psychiatry: A Call for Advocacy • Lisa Durette, MD ........ 132

## Features

**Alvin Rosenfeld, MD, Section Editor • arosen45@aol.com**

- Consumer Issues Committee: Career Paths in Child and Adolescent Psychiatry: Bridging Private Practice and Academic Psychiatry • Alice R. Mao, MD, Stephanie Hartselle, MD, Carlene MacMillan, MD, and Julie Chilton, MD ........................................ 134
- Media Page • Erik Loraas, MD ................................................................................. 136

## Meetings

**Jon (Jack) McClellan, MD, Section Editor • drjack@u.washington.edu**

- New Research Poster Call for Papers ........................................................................ 139
- Promote Your Book at This Year’s Meeting ................................................................. 140
- AACAP’s 65th Annual Meeting Seattle, WA Preview .................................................. 141

## Opinions

**Harmony Raylen Abejuela, MD, Section Editor • harmonyraylen@hotmail.com**

- The Availability of Guns Is the Issue, Not Mentally Ill Shooters • Jack C. Westman, MD, MS ........................................... 148
- The Elephant in the Room • John McCarthy, MD ............................................................ 149

## For Your Information

**Communications & Member Services • communications@aacap.org**

- Membership Corner ................................................................................................. 151
- In Memoriam ............................................................................................................ 151
- President’s Statement: Separating Children from Families • Karen Dineen Wagner, MD, PhD ........................................ 152
- Welcome New AACAP Members ............................................................................ 153
- AACAP Award Spotlight: George ‘Bud’ Vana, MD ............................................... 154
- Thank You for Supporting AACAP! ........................................................................ 155
- Facts for Families: Social Media and Teens .............................................................. 156
- AACAP Award Opportunities .................................................................................. 158
- Classifieds ............................................................................................................... 161

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Cover Photo by AACAP member Pallav Pareek, MD, from North Bend, Oregon.
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

FUNCTION AND ROLES OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy

■ Establishes and supports the highest ethical and professional standards of clinical practice.

■ Advocates for the mental health and public health needs of children, adolescents, and families.

■ Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.

■ Liaises with other physicians and health care providers and collaborates with others who share common goals.

AACAP NEWS
The mission of AACAP News includes:

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

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Depression and Depression Screening

I am excited that the Presidential Initiative Task Force on Depression Awareness and Screening has agreed to help organize articles on depression and depression screening for AACAP News, beginning with this one.

The following article by Kai-ping Wang, MD, specifically delves into the use of screening and symptom instruments. It gives detailed background on specific codes, including when they should be used and the associated reimbursements. It is a helpful overview that serves as a practical breakdown of a nuanced topic.

I would love to hear any feedback you have on depression and depression screening, my initiative, or other ideas you think can help move our efforts forward.

Karen Dineen Wagner, MD, PhD
President, AACAP

CPT Screening Codes

Do you use screening or symptom instruments? Chances are good that you’re leaving money on the table.

The passage of required mental health coverage under the Affordable Care Act led to introducing the brief emotional/behavioral assessment (96127) in January 2015. This code reimburses for each standardized screening scored and documented in the patient’s medical record. Typically, the service is billed at a patient visit. While 96127 closely parallels developmental screening (96110), they are completely different services.

In 2017, Administration and Interpretation of Health Risk Assessment Instrument (99420) was replaced by Administration of Patient-Focused Health Risk Assessment Instrument (96160) and Administration of Caregiver-Focused Health Risk Assessment Instrument (96161). All four codes—96110, 96127, 96160, and 96161—are largely practice expense without any physician work value. This reflects instrument scoring being typically done by administrative staff and does not require a physician or otherwise qualified healthcare professional. Interpretation and diagnosis is separately accounted by another code—usually an evaluation/management code.

The currently published relative value units (RVUs) for the codes being discussed are: 96110, 0.27; 96127, 0.16; 96160, 0.13; and 96161, 0.13. The RVUs differ because these codes were reviewed during different years. Using the 2018 Medicare Physician Fee Schedule conversion factor of $35.99, reimbursements would be 96110, $9.72; 96127, $5.76; 96160, $4.68; and 96161, $4.68.

While insurers may limit the number of instances reimbursed per patient visit and/or per day, per Current Procedural Terminology (CPT) rules you may bill for each use of each standardized instrument properly interpreted and documented in the medical record. For example, scoring two ADHD assessments and a SCARED would allow you to bill 96127 three times in addition to the applicable service code.

Now let’s get a little more confused. (Skip this paragraph if you’re wise!) In the American Medical Association’s CPT Manual, 96110 and 96127 are sectioned under “Central Nervous System Assessments/Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing).” The codes 96160 and 96161 are part of “Health and Behavior Assessment/Intervention” which include “...psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.” For this second group of codes, the CPT manual makes an odd distinction: “the focus...is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.” Many potential instruments theoretically fit either 96127 and 96160.

continued on page 122
### CPT Screening Codes continued from page 121

<table>
<thead>
<tr>
<th>Examples (not comprehensive)</th>
<th>96110¹</th>
<th>96127²</th>
<th>96160³</th>
<th>96161⁴</th>
</tr>
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<tbody>
<tr>
<td>Acute Concussion Evaluation (ACE)</td>
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<tr>
<td>Ages and Stages Questionnaire (ASQ)</td>
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<td>Ages and Stages Questionnaire: Social Emotional (ASQ:SE)</td>
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<tr>
<td>Beck Depression Inventory (BDI)</td>
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<tr>
<td>Beck Youth Inventory – Second Edition (BYI-II)</td>
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<td><strong>X</strong></td>
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<tr>
<td>Behavior Assessment Scale for Children – 2nd Ed. (BASC-2)</td>
<td></td>
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<td><strong>X</strong></td>
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<tr>
<td>Children’s Depression Inventory (CDI)</td>
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<tr>
<td>Conners Rating Scale</td>
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<td><strong>X</strong></td>
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<tr>
<td>CRAFFT Screening Interview</td>
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<tr>
<td>Edinburgh Postnatal Depression Scale (EPDS)</td>
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<td><strong>X</strong></td>
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<tr>
<td>Modified Checklist for Autism in Toddlers – Revised (MCHAT-R)</td>
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<td></td>
<td><strong>X</strong></td>
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<tr>
<td>Patient Health Questionnaire (PHQ-2 or PHQ-9)</td>
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<tr>
<td>Parents’ Evaluation of Developmental Status (PEDS)</td>
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<tr>
<td>Screen for Child Anxiety Related Disorders (SCARED)</td>
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<td><strong>X</strong></td>
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<tr>
<td>Vanderbilt ADHD rating scales</td>
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<td><strong>X</strong></td>
</tr>
</tbody>
</table>

*When assessing caregiver, but billing under patient

¹ **96110 Developmental screening** (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

² **96127 Brief emotional/behavioral assessment** (e.g., depression inventory, attention-deficit/hyperactivity disorder (ADHD) scale), with scoring and documentation, per standardized instrument

³ **96160 Administration of patient-focused health risk assessment instrument** (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument

⁴ **96161 Administration of caregiver-focused health risk assessment instrument** (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

Most psychiatrists employing these codes will be using 96127. If you’re screening parents (or other family caregivers) for mental health issues impacting your patient, then you can use 96161. Psychiatrists working with young children or autism spectrum disorders also use 96110 if they are screening for developmental delays. While psychiatrists are unlikely to use 96160, they may if using a standardized scale to evaluate behavioral effects resulting from head injury.

Please note that with all these codes, you can only report when:
- There is a practice expense (e.g., staff time, screening tool cost).
- The instrument is standardized (i.e., validated tools scored in a consistent manner).
- The results are documented.

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Dr. Wang is the medical director of Pediatric Psychiatry at Valley Health System in New Jersey. He is a member of AACAP’s CPT Coding and Reimbursement Committee. He may be reached at wangka@valleyhealth.com.
Deprescribing is especially relevant in child and adolescent psychiatry. Normal development can lead to changing formulations and the need to reassess treatment plans over time. Biological aspects of disorders may change with neurodevelopment and youths’ growing ability to use cognitive resources to manage their symptoms.

Though my assigned role was to provide individual therapy, I quickly gathered that this modality alone would have a low yield for addressing the current issues with Michael's functioning. I discussed with his parents doing combined therapy and medication management, and outlined my concerns about the risks of long-term use of an atypical antipsychotic without clear benefit or indication. I used a standardized rating scale which validated the youth had mild-to-moderate depressive symptoms. I maintained on the differential that this was potentially a side effect from his medication, presumably lisdexamfetamine, which in one placebo-controlled trial in 278 children caused irritability in 10% and affective lability in 3%.

Working in collaboration with the family, we began the process of deprescribing. During this time, I met with the family every one-to-two weeks for individual therapy and to provide evaluation of, and support for, medication changes. We transitioned lisdexamfetamine to a combination of long-acting and immediate release methylphenidate, with an improvement in irritability and depressive symptoms. This was followed by

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Deprescribing is the structured approach to drug discontinuation. The term was first developed in the fields of geriatric medicine and end-of-life care, before broadening the scope to primary care and, more recently, psychiatry. It is not synonymous with medication cessation; rather, the goal of deprescribing is “parsimonious use,” or use that is sparing or restrained. The deprescribing process is the systematic approach to identifying and discontinuing drugs when existing or potential harms outweigh existing or potential benefits. This is accomplished with consideration of an individual’s goals, functioning, values, and preferences.

Deprescribing is especially relevant in child and adolescent psychiatry. Normal development can lead to changing formulations and the need to reassess treatment plans over time. Biological aspects of disorders may change with neurodevelopment and youths’ growing ability to use cognitive resources to manage their symptoms. Environmental factors are particularly dynamic and important to consider given that youth interact daily with multiple social systems including peers, family, and school. Additionally, there is consistent evidence that children and adolescents are particularly sensitive to certain medication side effects. Minimal data are available pertaining to the safety of long-term use of medications in youth. This is particularly concerning for medications such as atypical antipsychotics that are known to be associated with weight gain, development of diabetes, and metabolic syndrome.

In psychiatry, there are particular challenges to deprescribing including a lack of diagnostic and therapeutic precision, focus on symptomatic rather than functional outcomes, reliance on individuals’ subjective experience of symptoms, and discontinuity in treatment relationships and systems of care. This is further compounded by the relative lack of clinical evidence for medication discontinuation and limited incentives for pharmaceutical companies to dedicate funds for research.

I was introduced to the concept of deprescribing within my first few months as a child psychiatrist. The first outpatient case I was assigned as a CAP fellow was Michael, a lively 10-year-old boy, who was the middle of three children in a nuclear family with two working parents. He had a history of attention-deficit/hyperactivity disorder (ADHD) and oppositional behavior at home and had been previously diagnosed with an unspecified depressive disorder. In the space below, I outline the application of deprescribing to his care and identify important principles I learned for approaching deprescribing in child and adolescent psychiatry.

When we started treatment, Michael was prescribed lisdexamfetamine, low-dose risperidone, and fluoxetine. The history provided by the parents was that when Michael was eight years old, he started lisdexamfetamine for his ADHD (after two brief stimulant trials that were not tolerated due to sleep disturbance). Subsequently, he developed affective lability and irritability for which the psychiatrist started fluoxetine. This quickly progressed to self-harm behavior (slaming his fingers in a drawer) for which he was then prescribed risperidone. This regimen was continued by at least three different child psychiatrists with only minor dose adjustments for almost two years. This was particularly striking as he had not apparently done well with respect to home or school functioning during this time.

Continued on page 124.

Megan Baker, MD
a slow taper of risperidone and then fluoxetine, with no worsening of mood or impulsive behavior. This coincided with the parents participating in a behavior management group, which significantly helped with managing oppositional behavior in the home. Within six months, Michael’s mood, irritability, and oppositional behavior were stable on a regimen consisting of only methylphenidate. His ADHD symptoms, including inattention, hyperactivity, and impulsivity, persisted at home and school, though were not worse than while on his previous regimen. We continued titrating methylphenidate and started clonidine ER to address ongoing ADHD symptoms. As Michael started sixth grade about one year into our treatment, his ADHD symptoms were better controlled than ever before, on a regimen of methylphenidate, clonidine, and melatonin. While he was still taking multiple medications, this regimen posed fewer serious potential risks than his previous combination. Additionally, there is evidence for both efficacy and tolerability for this combination in the management of his primary diagnosis of ADHD.  

The process of deprescribing includes a review of all medications, identification of medications that could be ceased or reduced, collaborative planning of the deprescribing regimen, and providing guidance and support to the patient and caregivers. This case illustrates several important considerations for deprescribing in child psychiatry:

- Providing a comprehensive psychiatric assessment, especially when care is being transitioned from another provider or if the child is already on psychotropic medication
- Evaluating effectiveness of medications for the original target symptoms or indication
- Reviewing the evidence-base, particularly when considering medication combinations, which in many instances have limited empirical support
- Evaluating potential contribution of adverse medication effects as opposed to a co-morbid disorder, such as mood symptoms in the above case resulting from a medication side effect
- Using evidence-based psychosocial intervention, for example parent management training for ADHD and oppositional defiant disorder

Child and adolescent psychiatrists make decisions about the use of medications, at times without diagnostic clarity and with insufficient information about risks and benefits of different treatment options. When providing clinical care, appropriate prescribing should include consideration of deprescribing. The concept of deprescribing should be taught formally in psychiatry training programs. Further research is needed to better characterize when and how deprescribing can be most effectively applied.

**Identifying information regarding this patient has been changed or omitted. Each parent and patient have given permission for the publication of information about their case.**

**References**


Dr. Baker is a Clinical Assistant Professor in the Department of Child and Adolescent Psychiatry at NYU School of Medicine, where she works primary with foster youth in NYC. She is a member of AACAP’s Adoption and Foster Care Committee and a 2018-2019 Public Psychiatry Fellow of New York State Psychiatric Institute at Columbia University Medical Center. She may be reached at bakermegane@gmail.com.
ACADEMY & ASSOCIATION 101

What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP’s Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at govaaffairs@aacap.org.
ACAP’s Healthcare Access and Economics Committee (HCAE) conducted a survey of the AACAP membership between May and September 2017. The goal of the survey was to help gain an understanding of the practice patterns and insurance network participation of child and adolescent psychiatrists. The 900 members who responded represent nearly 10% of AACAP’s then 9,200 members. The HCAE would like to thank the members who took the time to respond. Member respondents closely represented the demographics of the membership as a whole, lending additional validity to the results. We would like to share the results of the survey with the membership of AACAP, as we were able to glean some interesting and useful data from the results.

The first question of the survey was meant to follow up on a previous survey effort from the HCAE Committee to assess adoption rates of electronic health records (EHRs) into child and adolescent psychiatry practices. As of 2017, 73% of AACAP members are using an EHR in their practice setting. Member respondents reported that nearly all of their EHRs have electronic prescribing capabilities, with 40% of AACAP members reporting that they prescribe electronically for both controlled and non-controlled prescriptions. These are very promising results, as they are in line with the adoption rate among all physicians nationwide.1

Based on the responses, about 64% of child and adolescent psychiatrists participate in at least one insurance network. The two biggest revenue sources are private insurance plans (about 58% of respondents) and Medicaid (about 48% of respondents). However, compared to other physicians, our participation rates are still low overall. In 2013, 85% of physicians accepted private insurance and 69% accepted Medicaid.2 Overall, finding ways to increase insurance plan participation among members is one of the long-term goals of the HCAE. We feel the key to increasing participation is two-fold: educating AACAP members so they feel more confident negotiating with insurance plans, as well as working more closely with the plans themselves to help them understand the unique challenges of child and adolescent psychiatry practice. The survey results supported taking this approach as well.

The most common challenges that AACAP members run into when participating with insurance networks included excessive requirements for prior authorizations, limited reimbursement, and having to spend too much time on insurance-related tasks in general.

“The most common challenges that AACAP members run into when participating with insurance networks included excessive requirements for prior authorizations, limited reimbursement, and having to spend too much time on insurance-related tasks in general.”

These are all real-world, day-to-day hurdles that add to physician strain and burnout and demonstrate the reasons child and adolescent psychiatrists decide to opt-out of participation with insurance networks. When asked to choose up to three complications arising with insurance networks, the majority of survey respondents reported that difficulties with prior authorizations, issues related to reimbursement, and other insurance-related burdens are common, everyday issues. Only 6% of respondents responded that they had no complications at all in their interactions with insurance plans. Bridging that gap remains a top priority for the HCAE Committee. Our goal is to identify and create resources that will assist AACAP members with these challenges.

For members who do not participate with insurance networks, the most common reasons for opting out include limited reimbursement and struggles with claim and Current Procedural Terminology (CPT) code submissions. Members are seeking guidance on how to optimize CPT code usage and how to handle excessive requirements from insurance companies. CPT coding is another area that AACAP is involved in, via its Coding and Reimbursement Committee. AACAP has member advisors on both the CPT Editorial Board and the RVS Update Committee (RUC), in addition to a dedicated staff member. One of our primary objectives is to provide educational materials to members on AACAP’s website, and many coding resources are readily available in the Member Resources section, under CPT and Reimbursement.3 We also hold several educational sessions on CPT coding at the Annual Meeting each year.

The HCAE Committee appreciated the opportunity to gain insight into the concerns of AACAP members, which will help guide our work. Once again, we would like to thank everyone who completed the survey, and we hope that you find the results interesting and

continued on page 132
This is the second article in our series on how to conduct telepsychiatry well. In the first installment, we discussed strategies that foster good patient engagement and a strong therapeutic relationship. In this installment, we discuss some technical aspects related to staging and lighting that you need to master to do telepsychiatry well.

Patient arrangement can make or break a session. Telepsychiatrists commonly struggle with managing young children at the origination (patient) site. Often a young child is being treated for conditions that further impair his or her ability to sit still and remain in the frame! Keeping a child with ADHD or autism in the camera frame can be a challenge, but there are simple strategies you can use (keep in mind super glue and velcro are not AACAP-approved options).

A good telepsychiatrist asserts control over the session from the very beginning and spends a few moments at the initiation of the session directing the family arrangement, the camera, and the lighting of the origination site. Keep in mind, you probably gave significant consideration to how you arranged your regular office to facilitate treatment sessions. You chose the furniture, the furniture arrangement, lighting, and decor to create a professional atmosphere conducive to your work. However, in telepsychiatry you have to work with each family to properly set up the room they have chosen to use. In the beginning of the session, help the participants adjust their seating and camera position to ensure everyone feels comfortable and remains visible within the camera frame. Make sure they are close enough to the camera to be seen and heard, but far enough away that they don’t move out of the camera frame with occasional movement. It feels very intrusive when you prompt them to readjust the camera or reposition themselves during the session.

When framing a telepsychiatry session, your two competing priorities are to keep everyone in the frame, and to make their image fill the frame as much as possible. Larger and closer participant images feel more realistic and intimate, but they can easily drift (or wander) out of the frame.

Having participants positioned far away from the camera allows for more mobility, but a solitary subject seems small, distant, and removed from the interaction. When the patient is at a medical clinic using more sophisticated telemedicine equipment that has a pan/tilt remote-controlled camera at the patient site, you have to adjust it at the beginning of the session.

Ideally, you will follow the one-third rule used by television camera operators when positioning yourself and others in the camera frame. Position yourself and/or adjust the camera so your eyes appear to be about one third down from the top of the screen. This will create the natural framing you see when watching television newscasters.

Next you want to create what we call “relative eye contact.” You want to arrange the participant’s picture on your screen so that it sits close to your

**continued on page 128**
Committees/Assembly

Lights, Camera, Action continued from page 127

Camera. This ensures that you appear to be looking at the person when you look at their image on your screen. If your camera is even a few inches away from the patient’s image, you appear to be looking away from them or distracted when you are speaking at their image on your screen. If you have a traditional system like a Polycom with a monitor and separate camera, place the camera close to the monitor. If you are mounting the camera on the wall, place it below the monitor, close to your eye level.

Most people don’t give these framing concerns enough consideration—and it has consequences! We have both repeatedly observed in distance education classes and administrative meetings that many of the participants seem unaware of the camera position. Subsequently, they sit in profile, at a distance, in the shadows, in front of a bright backlight, or surrounded by distracting and/or moving objects. They may have fully intended to participate in the videoconference, but their lack of eye contact, poor visibility, and the appearance of distance send a clearly different message to the rest of the participants. How you appear on camera communicates a lot of nonverbal information about you, your professionalism, and your intentions to the other participants. Ignore this at your own peril!

Similarly, the camera has to remain steady at both sites. Most expensive telemedicine equipment is mounted to a wall or cart, but increasingly people videoconference with a desktop, laptop, or handheld device. Coach your participants to prop their handheld devices up at eye level using something stable such as pillows, books, and picture frames. No one can hold the phone or tablet still for more than a few minutes, especially if two or more people are in the frame. When unstable devices move even a few millimeters, the image you are viewing moves in a distracting and sometimes nauseating way. This distracts the provider and detracts from the experience you can provide your patient.

Properly lighting a videoconference room is also very important. It ensures the experience feels authentic to all of the participants. When done well, the room lighting isn’t noticed. When done poorly, it creates many distractions that take away from the session. Fortunately, once the room is properly lit, the lights just have to be turned on!

The principle goal of good lighting is for everyone to be seen clearly. This means eliminating shadows, glare, overexposure, and abnormal colorations. This is accomplished by thoughtfully controlling the light coming from windows, lamps, overhead lights, and computer screens.
The most common problem is insufficient lighting. Cameras need more light than the human eye to construct a detailed image. As a general rule, you need at least one more light source than you would use when patients are sitting in the same room. The following sequence of pictures demonstrates how much light it takes to be seen clearly by another participant.

The second most common lighting problem is when too much light is originating from behind or beside a participant. This creates shadows, uneven exposure, or backlighting. Control the light from a window with blackour curtains, especially if the light will change during your clinic hours (e.g. sunset). Balance the lighting by positioning an additional light in front of you that points towards you or bounces the additional light off the ceiling in front of you to fill in the shadows and give your face sufficient detail. Often standing halogen torchiere lamps work well for this purpose because you can adjust the amount of light and turn them off during face-to-face sessions in your office.

A common cause of abnormal coloration is the computer monitor. You can balance the colors being cast on your face by adjusting the colors on your screen. For example, if your EMR software is predominantly blue and white, fill the remaining space with a background picture dominated by earth tones. Another common cause of color problems is caused by light bouncing off your walls or bleeding through window treatments. Color choice is more than decorative when decorating a videoconferencing suite. We suggest using light/neutral color for the walls and avoiding white or dark background walls. Glossy paint can create glare, so when possible, use a flat or matte paint.

Paying attention to these technical aspects will enhance the quality and feel of your telepsychiatry sessions. By investing some time and attention on these issues, your telepsychiatry sessions will feel as authentic, comfortable, and engaging as your traditional face-to-face sessions. Sharpening your telepsychiatry skills with practice and attention to these principles helps you feel more confident that you are taking full advantage of this exciting new venue for delivering psychiatric care.

Dr. Roth maintains a private practice in Honolulu, Hawaii, and has been practicing telepsychiatry with patients across the state, California, and Illinois since 2009. This includes a statewide school-based telepsychiatry program for youth with developmental disabilities and/or severe mental illness in Hawaii. He may be reached at drroth@mindbodyworks.com.

Dr. Ramtekkar is currently a physician director in the specialty clinic and telehealth at Compass Health Network and adjunct assistant professor at the University of Missouri School of Medicine, Columbia. He may be reached at drujwal@yahoo.com.
SCHOOLS COMMITTEE

School Anti-Cyberbullying Policy Development in the Caribbean: How Culture Shapes Our Disciplinary Practices

Shirley Alleyne, MBBS

Background

The Caribbean Community (CARICOM) is a grouping of twenty countries in the Caribbean and Central and South America. CARICOM people are of diverse ethnic origins (Indigenous Peoples, Africans, Indians, Europeans, Chinese, and Portuguese) and sixty percent of the population is below the age of 30. The leaders of CARICOM became acutely aware of the impact of internet access to development, trade, and prosperity of the region in the early twenty-first century. The internet was seen as a vital tool to evening the odds for small island developing states in the global trade market. Additionally, the benefits of internet access for youth had been examined extensively with studies demonstrating its positive role in academic progress, independence, and computer literacy. The awareness led to the decision to level the playing field through a strategy to bridge the digital divide. The strategy has translated into a rapid increase in access to the internet and digital technologies across the region. The 2015 United Nations International Telecommunications Union (UNITU) data for the region is a testimony to the success of the strategy with internet access rates as high as 78% nationally and cellular phone penetrance of 100% in a number of the countries of the Caribbean.

Regional Evidence of Increased Connectivity of Youth

The commitment to increase internet access also includes strategic incorporation of technology into schools and homes. Concrete evidence of escalating regional rates of youth connectivity is borne out in the Caribbean Broadband and Database ICT datasheet for Jamaica conducted by the University of the West Indies and partners. The UWI survey found that the majority of internet users were between the ages of 15 and 34, with over 36% accessing the internet from their place of education. The major uses of the internet were for sending and receiving emails (76.9%), followed by social media (71.7%).

Bullying and Caribbean Children

As has occurred throughout the world, misuse of the internet has become a challenge for school systems in the Caribbean. Clinically we have witnessed the adverse mental health impact of flaming, denigration, outing, impersonation, and social exclusion in children as young as age nine. In small communities, cyberbullying often sets the stage for physical bullying, and there is a seamless interchange between these modalities of cruelty. For many of the islands, the population is less than 200,000 persons, with land mass less than 300 square miles, and there exists a culture of strong interpersonal connection. It, therefore, becomes impossible for children and adolescents to escape public scrutiny, and at times ridicule, after incidents of cyber-outing.

In his study of Latin America and the Caribbean, McClanahan found that girls reported appearance-based bullying while boys reported physical bullying. Bullying was noted to be a risk factor for suicidal ideations in Jamaican youths. The Abdirahman review of the Global School-Based Health Report of five Caribbean countries noted that bullied students were much more likely than non-bullied students to report mental health issues and that bullying was related to sadness, anxiety, hopelessness, and suicidal thoughts.

UNITU Caribbean Anti-Cyberbullying Policy Template

In recognition of the health burden of cyberbullying on the child and adolescent population as well as the need for public sensitization and development of prevention protocols, the Rotary Club of Barbados launched an anti-cyberbullying campaign in 2016. As part of the process, school guidance counsellors identified lack of school policies as a major barrier to proactively targeting the root causes of cyberbullying and addressing incidents as they arose. Subsequently, the UNITU commissioned the development of an anti-cyberbullying policy development guide. We developed this guide with the vision of it becoming individualized to reflect each country’s context. As a child and adolescent psychiatrist, it was important that the guide be based on the ‘positive school culture’ and ‘whole school’ concepts. The ultimate goals were for students, staff (teaching and nonteaching), parents, and the wider school community to understand, embrace, and demonstrate the principles of tolerance and acceptance of differences. These principles would be woven seamlessly
throughout the curriculum, providing ample opportunity for reinforcement. Additionally, in recognition of the victim to perpetrator pathway in bullying and the fact that students are often simultaneously victims and perpetrators of cyberbullying, there was a heavy focus on mental health intervention for all students involved. The area of consequences for perpetrators was left open for individualization based on the laws and the pre-existing school policies of each country.

The policy development process was inclusive of the following steps: the establishment of a policy development team of key stakeholders from education and related sectors; a review of the education act for the country, paying particular attention to the limits of authority of the school to address behaviors that occur outside the school domain; a review of national legislation pertaining to cybersecurity; a review of published school cyberbullying policies (local, regional, and international) and effective interventions; the utilization of the template provided in the guide or other suitable templates to develop a draft policy document with wide circulation of the draft policy document to key stakeholders for commentary and consensus building.

School Anti-Cyberbullying Policy Development in Action

Three countries have embarked on the process of developing their school anti-cyberbullying policy, and as the developer of the policy guide, it has been interesting to observe how culture has shaped the varying concerns of key stakeholders. The main areas where these differences have been exemplified are around confidential reporting within schools and penalties for perpetrators. Confidential reporting and the need to minimize the number of persons in the reporting chain has been a uniform concern and most likely is a reflection of the high level of interpersonal connectivity of the societies. Recommendations for penalties for perpetrators has ranged from minimal to more severe. In the case where recommended penalties are minimal, deference was given to the increased impulsivity associated with the developing brain of the child and the need to allow the offending student a second chance by providing psychotherapy and changing schools without a reflection of the incident on their academic record. Simultaneously, others have been more austere, recommending the applications of penalties commensurate with the country’s laws for the identified cybercrime.

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Dr. Alleyne is an Assistant Professor of Psychiatry at The University of Florida, College of Medicine, Jacksonville. She practiced Child and Adolescent Psychiatry in the Caribbean region from 2007-2016 and continues to contribute to mental health in the region. She can be reached at saalleyne@gmail.com.
ADVOCACY COMMITTEE

Where Am I? Systems of Care and Child Psychiatry: A Call for Advocacy

Lisa Durette, MD

Systems of care (SOC) - the very topic often evokes eye rolls and sarcasm. Home-based, family-focused... where in the core principles of SOC is the child psychiatrist? How is it fathomable that a children's mental health system can exist without a child psychiatrist? Where in our training are we taught how to navigate the murky political waters entangled with community SOC? Yet the role of the child psychiatrist as advocate for our profession and the youth we serve can significantly impact the community’s mental health system.

Advocacy can take on many forms. Through the course of my own experiences, I have become a committee chair and have been able to advocate for the importance of having a child psychiatrist included in all SOC and local children’s mental health committees. To be fair, SOC is a community-based model which has the flexibility to address the missing elements of our traditional system: childcare, transportation, wraparound care. SOC’s positive attributes come from their family-driven and youth-guided philosophy. It is a strengths-based community model emphasizing interdisciplinary coordination.

AACAP provides many SOC resources on their website. Many states have adopted a SOC model within their jurisdiction. A child psychiatrist was not included amongst the SOC committee makeup in any of the states I researched. However, administrators, including those from juvenile justice, school, and state mental health systems, as well as prescribers were. How is it that we have allowed state and federally-funded care systems for the youth we serve to exclude the child psychiatrist?

Your local SOC committee is an ideal environment in which to practice advocacy. Search your state’s children’s mental health SOC committee makeup online. You will likely find that information within your state’s department of mental health and/or health and human services website. Is there a child psychiatrist included amongst the members? If yes, reach out and understand their role as well as ways in which you can support your community’s work. If no, your next step may be to find the next meeting. In accordance with public meeting laws, meeting agendas are posted in advance of the meetings. Review the agendas – you will likely find items that pertain to your clinical expertise. Finally, GET INVOLVED! You can typically either call in to the meeting or attend in person. Listen during the first few meetings to identify the players, their roles, and the overall tone and direction of the group. Once you identify a place of entry, begin to participate. Your community’s SOC is funded by YOU as a taxpayer. You have a place at the table. Offer to educate in a supportive fashion. Share AACAP resources, perhaps starting with the Facts for Families. Over the course of time, you can make a significant difference for the youth we serve by including yourself within the committees that determine the funding and provision of children’s mental health within your community.

Dr. Durette is the founder and program director of the UNLV Child and Adolescent Psychiatry Fellowship in Las Vegas. She went to medical school at the University of South Carolina and completed residency and fellowship at the Medical University of South Carolina. Her professional interests are focused in education of the next generation of CAPs, and advocacy work to improve her community’s system of care for youth. She may be reached at lisa.durette@unlv.edu.

Member Practice Economics Survey Results continued from page 126

informative as well. We look forward to continued work on the important issues highlighted by the survey results.

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1. “Practice Fusion.” Available at: www.practicefusion.com/blog/ehradoption-rates.

Dr. Chang graduated from the Rush University Child Psychiatry Fellowship program in 2013. He has been practicing since then in the Chicagoland area. He is part of a large outpatient group practice but also does telepsychiatry work as well as residential. Dr. Chang served on the HCAE Committee from 2012 to 2017 and continues as AACAP’s alternate representative to the AMA CPT Advisory Committee. He can be reached at drjasonchang@gmail.com.

Dr. Sarvet is professor and chair of psychiatry at University of Massachusetts Medical School-Baystate and statewide medical director of the MA Child Psychiatry Access Program. He co-chairs the HCAE Committee and serves on the Health Information Technology Committee. He can be reached at barry.sarvet@baystatehealth.org.

Karen Ferguson is AACAP’s Deputy Director of Clinical Practice and staff liaison to the HCAE Committee. She can be reached at kferguson@aacap.org.
Call for Papers and Children’s Artwork

As part of an ongoing Call for Papers, JAACAP seeks high-impact papers on the mental health of children, adolescents, and families with a particular interest in our new article types for 2018, including Master Clinician Reviews, Commentaries, and Case Conferences.

Special Call for Papers on Depression

In conjunction with the presidential initiative of AACAP President Karen Dineen Wagner, MD, PhD, on depression, JAACAP and JAACAP Connect have issued a special call for papers on this timely topic. The series aims to cover current topics in depression, including but not limited to programs that have initiated depression screening for youth and processes by which youth who screen positive for depression receive treatment.

Call for Cover Artwork

JAACAP seeks interesting images and original artwork by children and youth, including but not limited to those who have personally struggled with mental health challenges. Submissions in which the artist reflects upon their identity, family, and/or community are particularly encouraged.

Questions and pre-submission inquiries should be directed to support@jaacap.org or connect@jaacap.org.

Read the updated Guide for Authors to learn more at www.jaacap.org
CONSUMER ISSUES COMMITTEE

Career Paths in Child and Adolescent Psychiatry: Bridging Private Practice and Academic Psychiatry

Alice R. Mao, MD

Over 25 years ago, my training director asked me what I wanted to do after graduation. I answered hesitantly, “I want to have a private practice, and I like teaching medical students and residents, so the perfect job would allow me to do both.” At the time, it seemed that the only way to have an academic career was to take a full-time academic position. After graduation, I accepted a job in community psychiatry that allowed me to continue teaching and start building a small private practice with my husband. My original plan was to stay in the community psychiatry academic position until my practice had grown and I could be “independent.”

However, as my career evolved, I realized that I could not leave academic psychiatry. The opportunity to teach and to learn from bright and curious medical students and residents and the intellectual stimulation from collaboration with colleagues was too appealing. I feared being isolated in my small outpatient practice. However, I recognized that private practice had many advantages including the freedom to set your own schedule and choose patient population. In contrast to my academic jobs, which focused on special populations in child and adolescent psychiatry, my private practice allowed me to see patients from the ages of three to 80 with a broad range of diagnoses.

Time has passed far too quickly and to my surprise 25 years later, I continue to balance my academic career while maintaining a private practice. My proudest accomplishments are seeing the flourishing of my patients despite mental health challenges and the generations of students and residents who I have trained become successful in their careers.

Although I wouldn’t change my career path, it was not the easiest when juggling parenting responsibilities and family obligations. Since I mentor many residents, I have wondered if there was another way that one could have a private practice but still maintain academic affiliation. I have been intrigued and inspired by some of the outstanding early career psychiatrists that I have worked with on AACAP’s Consumer Issues Committee. Many of them had transitioned from Academic Psychiatry to private practice but were still very actively engaged in academic presentations, publishing papers, and involved in national and international committees. I have asked them to share the factors that have influenced their career choices and provide tips on how to stay academically involved while in private practice.

My hope is that their stories will help to inspire those that are graduating and considering leaving academic psychiatry. Neither career choice is exclusive of the other for these three dynamic women!

Stephanie Hartselle, MD

As I put in notice to my academic job, I was warned by my supervisors that “no one can make it in private practice these days.” Their words echoed my own concerns that I was stepping into an abyss that occurred in my state for reasons beyond insurance stipulations that mandated an outpatient provider accepting certain carriers in any setting and my mentors having avoided that outpatient world for many years. Still, I started small and began building a practice that to my surprise, became more than the expected prescribing psychiatry mill and utilized the training I’d obtained in multimodal therapy. Patients were thrilled to see one doctor who could provide insight on how their circumstances, biological genetics, coping skills, and psychodynamic interactions might be contributing to what most pained them. I was thrilled to watch my panel of patients improve and actually be able to move on. I held on to my moonlighting jobs at the prison and the veteran’s hospital to keep my academic affiliation but learned quickly that becoming a volunteer in the academic system at Brown was just one of the ways to continue my passion for teaching those coming up in training.

As a member of committees and someone involved with legislation at AACAP, I have been able to work on various projects, make numerous academic connections and maintain affiliations with work I wouldn’t have previously considered if I had self-siloed into a small private practice. I spoke with our training director of the Child Psychiatry Residency and ensured that I could continue in a role that met the yearly requirements of teaching that kept my title as Assistant Clinical Professor. Within the Consumer Issues Committee and in working with those in emergency psychiatry, my writing...
and contributions continue to steadily add to the volume of work critical to the forward movement of our work as child psychiatrists. As my CV grows and with the mentorship of full professors with whom I’ve had the privilege of working across the country because of AACAP, I document each contribution in the hope that I will continue to be an academic, straddling both private practice and the educational worlds.

It has not been easy as a working mother, a business owner, private practice psychiatrist, and someone committed to keeping her academic title, but it is something that can be accomplished. Having mentors and guidance in this is critical, and for that, I can thank the community within AACAP and my committee colleagues. If you have the desire to be your own boss, to create your own patient panel, and to give back to the community on a clinical and academic level, private practice and academic affiliation is achievable.

**Carlene MacMillan, MD**

In response to the question I get asked frequently, “What academic institution are you affiliated with?” I initially would reply sheepishly that I was not affiliated with any. My perspective has shifted as colleagues seemed intrigued by my small rebellion. While it makes a lot of sense that psychiatrists wanting to work in inpatient or emergency settings would need the infrastructure that a large academic institution can provide, it is a misconception that an academic affiliation is necessary to have a significant academic career. In contrast, I had experienced that the clinical and administrative demands placed on a junior faculty person can detract from pursuing academic passions and so looked for alternatives. After having twins, timing felt right to test the theory that I could be more academic on my own. Rather than return to my academic post, I decided to form a multidisciplinary group private practice near our home with my psychiatrist husband, Owen Muir, MD. We actively collaborate with colleagues in the United States and London, including at places such as Menninger, McLean, and Anna Freud National Centre for Children in an effort to expand understanding and treatment options for young people with personality disorders. We train and supervise other clinicians, teachers, and other professionals on Mentalization-Based Treatment. It sure feels “academic” to do so. We now have two deep TMS machines and 12 employees, including a post-doc clinical psychologist. In the summer, we host interns from Amherst College. In addition, I am a proud Consumer Issues Committee member, lecture at several medical schools, present at grand rounds and national conferences and am on the advisory board of a non-profit for borderline personality awareness called Emotions Matter. I also take Tuesday mornings off to take my toddlers to swim class, free from any worries about RVUs, publishing orperishing, or jumping through bureaucratic hoops to get a project off the ground.

I have not ruled out the possibility of re-affiliating someday if the right opportunity presented itself but feel confident it is not the only path to making significant contributions to our field.

**Julie Chilton, MD**

The older I get the more I realize how important it is to be true to yourself. When explaining my decision to turn down a prestigious academic job after fellowship, I was told by one of my dearest mentors that he had never chosen a job based on vacation or salary. On paper it sounds superficial for these to be priorities for me, but knowing what I need to be happy, and thus a good psychiatrist, made them critical. A certain income allows me to protect my free time and do what I really care about when I’m not at work, rather than doing what might otherwise supplement my income. Vacation gives me balance and sanity, and time to deepen the quality relationships that allow me to keep good boundaries with patients. But it’s really all about the autonomy. That’s where it’s at.

You can make the life you want to live. It may sound scary, and as unfortunate as it is for our patients, there’s enough of a need for us as child psychiatrists that it’s safe for you to follow your dreams.

I balance having a small fee for service practice in the mountains of North Carolina with gratis “academic” projects I take on in my roles with AACAP, IACAPAP, APA, and the Yale Child Study Center. While my heart belongs to Yale, and I’d do just about anything to please the fellowship training directors that shaped me there, my role as Assistant Clinical Professor gives me a lot of benefits (including street cred in Asheville) and the opportunity to teach fellows via satellite and chair their alumni group. What it doesn’t do is strap me down in any way. I am free, and I am connected.

I’m free to pursue the projects I care about most. Creating resources for teaching child psychiatry in low and middle income countries where there are few to no child psychiatrists, I do this through my role as Associate Editor of a free online textbook ([www.iacapap.org](http://www.iacapap.org)). The bibliotherapy library I curate in my private practice waiting room serves as a great selection pool for the books I choose for review as an Assistant Editor for JAACAP’s Book Forum. And my role giving Grand Rounds and seminars on physician wellness stays informed through my work as a member of the APA Committee on Physician Wellness. Research indicates that giving physicians just twenty percent of their time to what they’re most passionate about prevents burnout. While I aim for perfect, reserving Fridays for my academic pursuits keeps me evidence-based on matters most important to me, not my boss. Since leaving the mothership in New Haven, I’ve given talks in Madrid, Bucharest, Calgary, Geneva, Sydney, New York, Atlanta, and DC. Work hard and follow your passion, and it won’t matter where you call home or what title follows your name.

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**Dr. MacMillan** is the Clinic Director of Brooklyn Minds Psychiatry and the Medical Director of the Ellenhorn Private Assertive Community Treatment team in NYC. She may be reached at carlene.macmillan@brooklynminds.com.

**Dr. Chilton** is an Assistant Clinical Professor at the Yale Child Study Center and in private practice in Asheville, NC. She may be reached at julie.chilton@yale.edu.
Recognizing and promoting advocacy for children

The Assembly Catchers in the Rye Awards are AACAP’s most prestigious awards that recognize an AACAP member, an AACAP component, and a regional organization of the AACAP Assembly for outstanding advocacy efforts. In terms of the award:

Advocacy is any activity done by an individual AACAP member, an AACAP component, or an AACAP regional organization on behalf of children and adolescents with mental health problems or for prevention efforts for children and adolescents at risk that directly benefits them or their families. For example, advocacy could include organizing mental health services for an underserved population, advocating for children and families politically, or enhancing the efforts of child and adolescent psychiatrists to provide high quality mental health services. This includes activities through the American Academy of Child and Adolescent Psychiatry.

AACAP recognizes advocacy in three categories:

• Individual that is an AACAP member who advocates for children
• AACAP Component (committee or task force) that best advocates for children
• Regional Organization of the AACAP Assembly whose activities best highlight the contributions of regional organizations on behalf of children.

Nominations should include a brief paragraph describing the nominee’s advocacy work (only one submission per person for each category).

Awards will be presented at the Assembly’s fall meeting during AACAP’s Annual Meeting in Seattle, WA, October 2018. Please forward your nominations to: Megan Levy, Executive Office Manager AACAP 3615 Wisconsin Avenue NW Washington, DC 20016 or email to mlevy@aacap.org

Nominations due by June 30, 2018

The Assembly Catchers in the Rye Selection Committee serves as the reviewing body that makes recommendations to the Assembly Executive Committee who selects the final awardees. The committee consists of a Past Assembly Chair, one Delegate representative from each U.S. zone, an ECP Delegate, and a past recipient of the Catchers award (i.e. individual, committee member, or RO officer affiliated with the Assembly. The award name derives from Dr. John Schowalter’s Presidential Address in which he alluded to J.D. Salinger’s book and Holden Caulfield’s response to what he wanted to be when he grew up . . .

“I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody’s around — nobody big, I mean — except me. And I am standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff.”

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the Resident Editor, Erik Loraas, MD, 3811 O’Hara Street, Pittsburgh, PA 15213, or by email to loraasek@upmc.edu.

Caring for Autism: Practical Advice from a Parent and Physician
Michael A. Ellis, DO
Oxford University Press 2018
Paperback: 240 - $19.95

*Caring for Autism: Practical Advice from a Parent and Physician* is a thoughtful and useful book for families of children with autism spectrum disorder (ASD). Written by Dr. Ellis, a child and adolescent psychiatrist and father of a child with ASD, the book offers unique and valuable perspectives and insights. The book is organized around 12 rich chapters covering a broad range of topics. It opens with a candid reflection by Dr. Ellis and his wife on caring for a child with ASD. They share early feelings of fear and helplessness and their journey to hope and resilience. The assessment and diagnosis chapter considers common signs and symptoms of ASD, comorbid diagnoses, and aspects of a typical workup. A concise exploration of potential causes of ASD considers the evidence for various theories on the etiology of the disorder. Broad domains of treatment are explored, including psychopharmacology, complementary and alternative medicine, and behavioral therapies. The evidence and efficacy of these interventions are again considered and presented in an accessible way. Key information is highlighted with helpful tables, bulleted points, and brief summaries. Dr. Ellis attends to the practical realities of how ASD impacts families, other children, marriages, and finances. He offers valuable insights on how to navigate the educational system and the utility of individualized education plans. Long term planning includes legal issues, finances, insurance issues, and guardianships. He concludes with a brief reflection on initial feelings of grief in families experiencing new diagnoses of ASD and discusses modes of building meaning and strength. In *Caring for Autism: Practical Advice from a Parent and Physician*, Dr. Ellis offers much more than pragmatic advice; he offers hope and inspiration to families of children with ASD.
2018 ASSEMBLY CATCHERS IN THE RYE AWARDS

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“I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody’s around -- nobody big. I mean -- except me. And I am standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff.”
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**Questions?** Contact Elizabeth Hughes, Deputy Director of Education and Recertification, at CME@aacap.org.
New Research Poster Call for Papers

AACAP’s 65th Annual Meeting takes place October 22-27, 2018, at the Washington State Convention Center in Seattle, Washington. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, administration, etc. AACAP encourages submissions on neurodevelopmental interventions (helping children grow healthy brains), translational research, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and violence prevention.

Verbal presentation submissions were due February 15, 2018, and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by June 15, 2018, and the online submission site will open in early April. All Call for Paper applications must be submitted online at www.aacap.org. If you have questions or would like assistance with your submission, please contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

Don’t miss this opportunity to SAVE money!

AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount on their 65th Annual Meeting registration. All referrals must be first-time AACAP exhibitors and must purchase a booth for AACAP’s 65th Annual Meeting in Seattle.

Exhibitors can connect with more than 4,000 child and adolescent psychiatrists and other medical professionals, as well as advertise in several of the Annual Meeting publications. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. To review the Invitation to Exhibit with more details on these opportunities, as well as forms to sign up, please visit www.aacap.org/exhibits-2018.

Show your support for AACAP and SAVE today!

Questions? Email exhibits@aacap.org or call 202.966.9574.
Promote Your Book at This Year’s Annual Meeting!

Join us at our “Meet the Author” booth in the Exhibit Hall. Sign up for a one-hour time slot to promote your book. We include a 50-word description on a flyer distributed to all attendees as well as a listing in the Annual Meeting Program Book. Limited time slots are available beginning on Wednesday, October 24 and ending on Friday, October 26.

Each one-hour time slot costs:
- $300 per hour (through September 14)
- $350 per hour (through October 5)
- $400 per hour (through onsite)

Be the first author to sign up!

More information can be found at: www.aacap.org/exhibits-2018. Questions? Please contact meetings@aacap.org.

Residents, Trainees, and Medical Students

ATTEND THE AACAP ANNUAL MEETING FOR FREE!

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

October 22-27, 2018
Washington State Convention Center
Seattle, WA

For more information about the Monitor Program, visit www.aacap.org/monitors. Registration opens August 1 for AACAP members and August 8 for nonmembers. Become a member TODAY to get priority monitor scheduling!
AACAP’s 65th Annual Meeting
Seattle, WA Preview

AACAP’s 65th Annual Meeting is just 5 months away and we’re excited! Whether you’re bringing the family, laser-focused on our high-quality programs, or somewhere in between, we have scoped out the best that our destination has to offer and have highlighted important information here. For complete details about the Annual Meeting, visit www.aacap.org/AnnualMeeting-2018.

Attendee To-Do List

☐ June 15 – Review the Annual Meeting program online

☐ August 1 – Members Only Registration opens for the Annual Meeting

☐ August 8 – Registration opens to nonmembers

☐ September 13 – Early Bird Registration Deadline

☐ October 1 – Last day AACAP room rate guaranteed at hotels

☐ October 22 – First day of AACAP’s 65th Annual Meeting

☐ October 27 – Last day of AACAP’s 65th Annual Meeting

☐ November 2 – Look for the General Evaluation Survey in your email inbox. CME certificate available upon completion of survey.
**Hotels**

Starting **June 15, 2018**, attendees will be able to book their Annual Meeting hotel reservations. Please visit the hotel page of the Annual Meeting website for more details and information.

**Sheraton Seattle Hotel**
1400 6th Avenue  
Seattle, WA 98101  
Phone: 888.627.7056  
Rate: $239 single/double per night  
Check-in is at 3:00 pm and check-out is at 12:00 pm

**Grand Hyatt Seattle**
721 Pine Street  
Seattle, WA 98101  
Phone: 888.421.1442  
Rate: $249 single/double per night  
Check-in is at 3:00 pm and check-out is at 12:00 pm

**Hyatt at Olive 8**
1635 8th Avenue  
Seattle, WA 98101  
Phone: 888.421.1442  
Rate: $249 single/double per night  
Check-in is at 3:00 pm and check-out is at 12:00 pm

**The Paramount Hotel**
724 Pine Street  
Seattle, WA 98101  
Phone: 800.663.1144  
Rate: $190 single/double per night  
Check-in is at 4:00 pm and check-out is at 12:00 pm

Located adjacent to the Washington State Convention Center, all four hotels are an inspired choice for exploring the Emerald City. After attending AACAP’s stellar educational offerings, you’ll be 10 minutes’ walk to enjoy iconic Seattle attractions, including Pike Place Market, the Seattle Art Museum, the Seattle Aquarium, the Space Needle and the lively Seattle Waterfront. From high art to sky-high mountains, Seattle is a metro-natural destination that will captivate your spirit of adventure.

**Travel**

**Plane**

**Seattle-Tacoma International Airport (SEA)** is ranked the 9th busiest airport in the USA. Thirty-one airlines serve 83 nonstop domestic and 24 international destinations. 14 miles away from downtown Seattle, 20 minutes from downtown by car and 34 minutes on Link Light Rail. For more information about the airlines serving these airports, flight schedules, and ground transportation options, visit [http://www.portseattle.org/Sea-Tac/Pages/default.aspx](http://www.portseattle.org/Sea-Tac/Pages/default.aspx).

**Train**

Four train routes service Seattle’s King Street Station, located on the south edge of downtown. **Amtrak** has three routes: Coast Starlight travels between Seattle, Portland, and Los Angeles. Amtrak Cascades travels between Vancouver, BC; Seattle; Tacoma; Portland; Salem and Eugene. Empire Builder travels between Chicago; Minneapolis/St. Paul; Spokane; Portland; and Seattle.

*When making your reservation, ask for the AACAP ANNUAL MEETING GROUP RATE to qualify for the reduced rate.*
What to Do and See in Seattle!

■ **Space Needle**
Built for the 1962 World’s Fair, the 605-foot-tall **Space Needle** quickly became an icon of the city that today is recognized far and wide. On the observation level, which you can reach via a 43-second elevator ride, see the doodle-on-a-napkin concept that led to the Space Needle design. Views from the top feature Elliott Bay, the Cascade Mountains, and even Mount Rainier.

■ **Seattle Center Monorail**
Another World’s Fair relic, the **Seattle Center Monorail** links Seattle Center—home of the Space Needle and several other notable attractions—to downtown’s Westlake Center along an approximately one-mile route. The designated historic landmark can reach a top speed of 45 miles per hour and weaves between skyscrapers above the city streets.

■ **Museum of Pop Culture (MoPOP)**
Music, science fiction, and pop culture all come together at the fascinating **Museum of Pop Culture**. The Frank Gehry-designed building looks like a smashed guitar from above, while inside, its colorful exhibits cover everything from the history of indie video games and horror films to Nirvana, the Seahawks, and more.

■ **Chihuly Garden and Glass Museum**
The **Chihuly Garden and Glass Museum** is dedicated to the work and career of locally born, world-renowned glassblower Dale Chihuly, who was introduced to the craft while studying at the University of Washington. It is the most comprehensive collection of his art to date, with interior galleries featuring a variety of his work in the medium. The pièce de résistance is the glasshouse, with a vibrant 100-foot-long sculpture in hues of red, orange, and yellow suspended from the ceiling.

■ **Pike Place Market**
From the iconic market sign and Rachel the Piggy Bank to the gum wall, the original Starbucks cafe, well over 225 local artisans selling their wares, the famous fish-tossing tradition, and music-playing street performers, there are enough sights and sounds at **Pike Place Market** to pack a day (or more). The market added its historic Market Front expansion in 2017, featuring an open-air plaza and fantastic views of Elliott Bay.
Seattle Art Museum – two ways

The Seattle Art Museum is the city’s largest museum dating back to the 1930s and housing a varied collection of artwork that spans multiple eras and geographic regions. Take the time to visit the Olympic Sculpture Park, an outdoor extension of the museum that’s open to the public for free about a mile away at the waterfront.

Smith Tower

Visit the city’s first skyscraper, built in 1914, and ride the historic, manually operated elevators to the 35th-floor observatory, where 360-degree views await. Displays tell the tale of characters who made Smith Tower what it is today, while the tower’s Prohibition-themed Temperance bar serves themed cocktails.

Seattle Aquarium

Down at the Seattle Aquarium on the waterfront’s Pier 59, learn all about salmon, meet a few adorable sea otters, and greet the various sea creatures of the Pacific Ocean, from puffers to giant clams. Watch scuba divers feed the fish, gawk at sharks swimming overhead in the underwater dome, and even touch a sea anemone.

Seattle Great Wheel

Although it was only built in 2012, the Seattle Great Wheel has quickly become a fixture of the city’s skyline—plus it adds an entirely new sightseeing perspective, thanks to its location perched on the end of Pier 57. Enjoy three revolutions around in one of the air-conditioned gondolas to see the city, water, and mountains on the horizon.

Museum of Flight

Aviation buffs, take note: The Museum of Flight is one of the largest air and space collections in the country, with an overwhelming number of things to see—like a Boeing lunar rover and an Air Force One from the Eisenhower era—and do, including NASA space shuttle trainer tours and flight simulators.
■ The Future of Flight Aviation Center and Boeing Tour
This bucket list–worthy experience in nearby Mukilteo lets you tour a working Boeing factory, the world’s largest building by volume, to see 747s, 777s, and Dreamliners in the making. After exploring the factory, learn more about airplane advancements, from jet fuel to in-flight entertainment systems, at the Future of Flight Aviation Center.

■ Pioneer Square
Seattle’s original downtown is full of beautiful old buildings in Romanesque Revival style, underground tours that take you beneath the streets to see the remains of the city’s first buildings, and an ever-growing slate of hip shops and restaurants. Take an afternoon or more to explore Pioneer Square’s ivy-covered buildings and pop into bars, boutiques, and hidden gems, like Waterfall Garden Park.

■ South Lake Union
The always bustling Lake Union, located just northeast of downtown, hosts a variety of seaplanes and boats of all kinds, including the floating home from Sleepless in Seattle. Get out on the water at The Center for Wooden Boats, which offers rentals and tours. And explore the area’s burgeoning restaurant and bar scene.

■ Museum of History and Industry (MOHAI)
Known as MOHAI, this museum on the shores of Lake Union encapsulates what Seattle is all about, with a dash of smart history, a dose of technology, and quirky artifacts around every corner (think a pink truck with toes). Permanent exhibits showcase everything from the city’s maritime history to modern tech innovations.

■ Starbucks Reserve Roastery and Tasting Room
You won’t have trouble finding a Starbucks here in the company’s hometown, but you’ll want to seek out this special Starbucks experience on Capitol Hill. The Starbucks Reserve Roastery and Tasting Room is a Willy Wonka–esque coffee wonderland, where you’ll find exclusive beverages, various brewing methods, a coffee library, and more.

For more information about the many other amazing Seattle attractions and must-sees, please visit:
www.visitseattle.org/things-to-do/sightseeing/.
What members of the Local Arrangements Committee say about their hometown. . .

“Seattle is a major metropolitan area set within one of the most beautiful parts of the country. It has several professional sports teams, excellent performance arts, a culture that supports physical activity, and outstanding restaurants. What really makes Seattle unique is the natural beauty of the region. Without having to drive more than a couple of hours I can see orca whales in the wild, ski, hike up mountains and through old growth forests, and visit two national parks. I have lived in Seattle for five years and continue to be impressed at what it has to offer.”

Shannon Simmons, MD, MPH

“I love living in the Seattle and Pacific Northwest area for too many reasons to list! It is beautiful and diverse. We have everything you could want, whether you prefer mountains or the ocean, suburbs or the city, tech scene or the arts. We are a land of innovation, activism, culture, and did I already mention how amazingly beautiful it is here? We are so excited to welcome our colleagues to the Emerald City and surrounding areas. There is too much to do in this one trip, so we hope to whet your appetite and then welcome you back again and again!”

Avanti Bergquist, MD

“The city of Seattle has a beautiful natural setting, between two mountain ranges, the Olympics to the west and the Cascades, including Mt. Rainier and Mt. Baker, to the east. In addition, we are nestled in between the salt waters of Puget Sound on the west and fresh water Lake Washington on the east. In between is hilly Seattle with lots of opportunities for outdoor or indoor recreation, for example, rock climbing at the REI store near downtown, boating, hiking, cycling, theaters, and fine dining. We have a world class zoo at Woodland Park and lovely Japanese and Chinese gardens, the Washington Park arboretum, and the conservatory at Volunteer Park, also the site of our Asian Art Museum. The main art museum is downtown, a block away from our best venue for all types of music, including the Seattle Symphony Orchestra at Benaroya Hall. In spite of all of our cosmopolitan attributes, we still maintain the feel of a neighborhood community.”

Julia H. Murray, MD

“Seattle is a vibrant city bustling with energy from the influx of tech workers and Amazon’s new buildings. The restaurant scene has bloomed in recent years, with a seemingly unending variety of options.”

John E. Dunne, MD
The criteria for eligibility include:

1. Board certified in child psychiatry
2. AACAP General member for at least 5 consecutive years
3. Made (continue to make) outstanding and sustained contributions in any 3 of the 5 areas noted below:
   - Scholarly publications
   - Outstanding teaching
   - 5 years of significant and continuing contribution to patient care
   - Organizational or social policy leadership at community, state, or national levels
   - Significant contributions to AACAP for at least 5 years in one or more of the following:
     - AACAP Committee/Component
     - AACAP Assembly of Regional Organizations
     - An AACAP Regional Organization

Distinguished Fellowship Nomination
Package Requirements:

- Current copy of Curriculum Vitae
- Copy of Child Psychiatry board certificate
- 3 recommendation letters written by AACAP Distinguished Fellows

Apply by July 1, 2018, to be featured at AACAP’s 65th Annual Meeting! If you have any questions, or would like more information, please contact membership@aacap.org or 202.966.7300, ext. 2004.

AACAP News is Looking for a New Resident/ECP Editor!

The resident/ECP editor of AACAP News is responsible for editing the Media Page, which briefly summarizes any books or media written by AACAP members that are sent to AACAP or solicited by other AACAP News editors. We select a second year resident to fill this position every two years.

Please send your application and questions to Rob Grant at rgrant@aacap.org with a statement of interest, CV, and a letter of recommendation from your residency director. Note attendance is mandatory for at least one in-person meeting.

The deadline to apply is June 29, 2018. We look forward to receiving your application!
School shootings are a distinctly American phenomenon. Unfortunately, the public focus is either on the mental state of shooters or on the availability of guns.

In fact, mass shootings by people with serious mental illness represent less than 1% of all yearly gun-related homicides in the United States. The overall contribution of people with serious mental illness to violent crimes is only about 3%. When these crimes are examined in detail, an even smaller percentage are found to involve firearms. Criminals and angry teenagers and adults use guns.

Still, there is reason to be concerned about the mental health of our young citizens. Most are doing well, but at least one in three are not. At least one in four have experienced neglect and/or abuse at some point in their lives and are predisposed to violence later in life.

The United States ranks 18th of 21 Western countries in overall child well-being. American children are clearly falling short intellectually. They rank 23rd in science, 17th in reading, and 31st in math achievement out of 32 Organization of Economic Cooperation and Development countries. These include Shanghai, China (first in all), Finland (first, second, and sixth), South Korea (sixth, second, and fourth), Canada (eighth, sixth, and tenth), Germany (13th, 20th, and 16th) and Poland (19th, 15th, and 25th).

The Centers for Disease Control’s 2016 Youth Risk Behavior Survey found that nationwide 6% of students missed at least one day of school during the past month because they felt unsafe in school.

Overall child deaths in the United States greatly exceed those in comparable nations, largely because of the prevalence of gun deaths. Of each one million children in the United States, 6,500 die of all causes annually in the United States, compared to 3,600 in Germany and 2,500 in Japan.

In Chicago, more than 440 school-aged children were shot in 2012. Sixty died. “I think people in Chicago have almost gotten numb to the statistics,” said Dexter Voisin, a researcher at the University of Chicago. “For every kid who is murdered, about 100 kids witness a murder or are victims of non-fatal injuries, robberies, muggings and gang-related incidents.”

Mental health professionals are all too familiar with the use of guns in suicides and homicides but focusing on the mental state of shooters misses the point. Criminals use guns. No one would shoot anyone if handguns and automatic weapons were not readily available. The latter are military weapons that have no place in civilian hands.

No mental health interventions will ever prevent the vast majority of shootings in our homes, on our streets, and in our schools. Strict gun control laws will. At the same time, the mental health of our young citizens does cry out for attention. As child and adolescent psychiatrists, we have an obligation to make both of these facts known.

References


Dr. Westman is Professor Emeritus of Psychiatry, University of Wisconsin School of Medicine and Public Health. More information is available at jackwestman.com. He can be reached at jwestman@wisc.edu.
The Elephant in the Room

■ John McCarthy, MD

Currently across America there are student marches against gun violence which has increasingly invaded our schools at all levels. Emma Gonzalez, a Senior at Marjory Stoneman Douglas High School in Parkland, Florida, gave a powerful “speech” that included six minutes, 20 seconds of silence which was how long it took for Nikolas Cruz, a former student, to kill 14 current students, three teachers, and wound 17 more with an AR-15 Style Smith and Wesson semi-automatic rifle on Valentine’s Day 2018. It was a very dramatic presentation. This powerful nationwide protest is a serious plea for our leaders to listen and take effective, swift action. A lot of energy in this movement is led by the school youth; however, there is a giant elephant in the room. Not once so far have I heard anyone discuss or even mention the root causes of why someone desperately angry (NOT necessarily mentally ill) would resort to obtaining a weapon of mass destruction and killing as many humans as possible in the shortest time.

In our schools from kindergarten through college, bullying is widespread and significantly ignored. In some ways, bullying has become a weapon that is more pervasive and destructive. Bullied individuals are targeted and ignored by students, parents, and school personnel. It took five years for Yale child psychiatrist, James Comer, MD, and his team to help two inner city New Haven, Connecticut, public schools to develop programs to effectively eradicate this serious problem of bullying.1 So powerful was this transformation that when a new student (a bully) transferred into one of these schools, he attempted to resume his bullying and disruptive behavior. He was told by his fellow classmates, “We do not do that here!” And that was that. It amply demonstrated what is needed at every educational level: a serious comprehensive program to nip bullying in the bud immediately. This includes cyber-bullying which in some ways is more pervasive and needs to be addressed by everyone. If this kind of energy was devoted to this problem as is now devoted across America for ending gun violence, I predict that significantly fewer students would resort to gun violence as a remedy to their problems.

In my own family, my third grade grandson was bullied by one of his classmates. He promptly told his parents and teacher. They swiftly responded to his complaint and nipped the problem in the bud. My grandson happily learned two things that day: 1) When bullied by anyone, tell an adult immediately and 2) do not give up until somebody listens. The consequences of not telling someone can be deadly.

References

Dr. McCarthy is a retired triple-boarded child and adolescent psychiatrist and longtime member of AACAP’s Schools Committee. He enjoys writing articles for AACAP News, AAP Senior Bulletin, and AACAP’s Owl Newsletter. He may be reached at mcbaby311@gmail.com.

Life Members Reach 170!

No, not 170 years old. But, 170 lives you have impacted.

Impact.
Since 2010, the Life Members Fund has made an investment in 92 residents and 78 medical students. This includes 17 residents and 13 students in 2016! If you attended the Life Members dinner in NYC, you got to meet these young superstar future Owls!

Donate.
Your donations have made this achievement possible. We are in the midst of a mental health crisis, which comes at a time when our skills have never been more important. Yet, the deficit of available child and adolescent psychiatrists is widening. Life Members are closing this gap. Let’s keep it up.

To donate, visit www.aacap.org/donate.

Stay involved. Stay connected to all Life Members activities, programs, and photos by reading the Life Members Owl eNewsletter.
The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to introduce a new and improved JobSource, an advertising and recruiting tool to assist AACAP members and related experts looking for new career opportunities, and to help employers find the most qualified child and adolescent psychiatrists.

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

With questions, please contact Samantha Phillips, Communications Manager, at sphillips@aacap.org.
Congratulations to Graduating Residents and Medical Students

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

Update your information online at www.aacap.org.

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AACAP offers flexible payment solutions to meet your needs.

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We’ll send you an email every M, W, F with the need-to-know child psychiatry news; all you have to do is sign up!

Email Samantha Phillips, AACAP Communications Coordinator, at sphillips@aacap.org today.

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
The American Academy of Child and Adolescent Psychiatry (AACAP) is a medical association representing physicians dedicated to the health of children and families around the globe. As such, we know that children who experience sudden separation from one or both parents, especially under frightening, unpredictable, and chaotic circumstances, are at higher risk for developing illnesses such as anxiety, depression, posttraumatic stress disorders (PTSD), and other trauma-induced reactions.

This is especially the case for children who are fleeing war, violence, and other traumatic situations from their home countries. Parental support is an essential and proven protective factor that substantially reduces risk for adverse health and developmental outcomes for children. Separating these children from their families in times of stress creates unnecessary and high-risk trauma at the very time they need care and support the most.

As child and adolescent psychiatrists, we know that pulling families apart can often cause harm. It is our responsibility as physicians to put an end to the idea and practice of separating vulnerable children from their families, including high-risk immigrant children. AACAP strongly opposes any policy or legislation that separates children and families in these stressful situations.

Karen Dineen Wagner, MD, PhD
President, AACAP
May 11, 2018
Welcome New AACAP Members

Akhil Anand, MD, Westlake, OH
Hannah Apfelbaum, Pittsburgh, PA
Muhammad Ata, Gurley, AL
Maya Ayoub, Providence, RI
Candice Barnett, MD, Honolulu, HI
Alhaji Camara, Milwaukee, WI
Jayleen Chen, MD, Reno, NV
Kevin Chun, MD, Hanover, NH
Andrew Corse, Burlington, VT
Nicholas DeFelice, Chicago, IL
Laura Dieppa-Perea, MD, Boston, MA
Trung Duong, Columbia, MO
Elizabeth J. Erickson, DO, Denver, CO
Tyler Fanning, Portland, OR
Lucy Gao, New Haven, CT
Brian Greenfield, MD, Montreal, Q, Canada
Lucas Hansen, DO, Reno, NV
Brian Hendrickson, MD, Baltimore, MD
Heather K. Henig, MD, Fredericksburg, VA
Daniel Hong, Chicago, IL
Avjola Hoxha, MD, Gainesville, FL
Kevin Wayne Johnson, MD, Tulsa, OK
Sonia Juneja, MD, Rockville, MD
Danielle Kamis, MD, Los Altos, CA
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Aneela Khan, MD, Bryn Mawr, PA
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Aneta Krakowski, MD, Toronto, Ontario, Canada
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Alicia Londono, MD, New Haven, CT
Conor Malloy, Sarasota, FL
Fathima Musthaq, MD, Plymouth Meeting, PA
Nicole Myers, Santa Ana, CA
Anisha Narayan, New Orleans, LA
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Mayowa Olusunmade, MD, Hackensack, NJ
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David Tate, Massillon, OH
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Jennifer Trinh, MD, Philadelphia, PA
Rose Tusa, New Orleans, LA
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Jennifer Vasko, Eden Prairie, MN
Tina Vu, Oklahoma City, OK
Lauren Weinand, Tucson, AZ
Joseph E. Wise, MD, Silver Spring, MD
Caroline Yang, MD, Los Angeles, CA
Sana Younus, MBBS, FCPS, Karachi, Sindh, Pakistan
AACAP AWARD SPOTLIGHT:
George ‘Bud’ Vana, MD

ABOUT DR. VANA

JOINED AACAP: NOVEMBER 2010
WORKS AT: BROWN UNIVERSITY
POSITION: TRIPLE BOARD PGY4 RESIDENT/FELLOW
AACAP AFFILIATIONS: JERRY M. WIENER RESIDENT COUNCIL MEMBER; MSR LIAISON; TRAINING AND EDUCATION COMMITTEE MEMBER

AACAP ADVOCACY DAY TRAVEL SCHOLARSHIP (formerly Advocacy Day)

AACAP’s Legislative Conference is where I got my start, learning how AACAP works and how to get more involved in the organization. I also found excellent mentors there and learned many strategies for how to communicate our patients’ stories. The conference is an opportunity to think about and advocate for the macro issues which affect children’s mental health and child psychiatrists’ practice. AACAP and Regional Organizations support medical students, adult psychiatry residents and child psychiatry fellows in attending Legislative Conference. During the two-day event, the Government Relations team and Advocacy Committee teach attendees how to speak to legislative staff and how to advocate most effectively for our patients’ mental health. I worked as a US Senate page in high school and got to watch the legislative process unfold. It has been great to come back to Washington, DC and to be able to talk about important issues with many of those legislators with whom I worked as a page. We see so much in the news about the dysfunction in Congress lately; it feels important to put a human touch on issues like CHIP funding, loan repayment programs for child psychiatrists, and support for early childhood programs. It is reassuring that there are also legislative staffers who are really passionate about these issues, too. Legislative Conference is a place where I feel like I get energized – thinking broadly about how to help all children then motivates me to do all I can to help my individual patients.

2013 AACAP LIFE MEMBERS MENTORSHIP GRANTS FOR MEDICAL STUDENTS, SUPPORTED BY AACAP’S LIFE MEMBERS FUND

While the Legislative Conference was the bait to get me involved into more AACAP activities, the Life Members Award, Life Member Programming and Life Members Dinner was the trap which has kept me all this time. Meeting the Life Members and learning about their paths through child psychiatry and illustrious careers, I was inspired and that inspiration continues. It was at a Life Member Program that I learned the history of the Triple Board (combined training in General Pediatrics, Adult Psychiatry, and Child Psychiatry) - something which helped solidify my interest and commitment to becoming a Triple Boarder.
Thank You for Supporting AACAP!

AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. Thank you to the following donors for their generous financial support of our mission. ♥

Gifts Received March 1, 2018 to April 30, 2018

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Social Media and Teens

Social media plays a big role in teen culture today. Surveys show that ninety percent of teens ages 13-17 have used social media. Seventy five percent report having at least one active social media profile, and 51% report visiting a social media site at least daily. Two thirds of teens have their own mobile devices with internet capabilities. On average, teens are online almost nine hours a day, not including time for homework.

There are positive aspects of social media, but also potential risks. It is important for parents to help their teens use these sites responsibly.

Potential benefits of social media include:

- Staying connected to friends
- Meeting new friends with shared interests
- Finding community and support for specific activities
- Sharing art work or music
- Exploring and expressing themselves

Potential risks of social media include:

- Exposure to harmful or inappropriate content (e.g., sex, drugs, violence, etc.)
- Exposure to dangerous people
- Cyber bullying, a risk factor for depression and suicide
- Oversharing personal information
- Exposure to excessive advertisements
- Privacy concerns including the collection of data about teen users
- Identity theft or being hacked
- Interference with sleep, exercise, homework, or family activities

Teenagers need support and education to develop the skills to manage their social media use. There are many ways to help your child learn to use social media sites responsibly. It’s important to talk with your child about their social media use and your family rules, including consequences for too much use or inappropriate use and whether you will be monitoring their online activities.

Consider the following suggestions depending on your child’s age and maturity:

- Friending or following your child’s social media accounts with an agreement about whether you will or won’t post or respond to their posts
- “No screen” times such as “no screens at the dinner table,” “no screens in bedrooms” after a certain time of day, or “no social media use until homework is done”
- Ensuring that privacy settings are turned on to limit access to personal information
- Instructing teens not to share full names, addresses, telephone numbers, social security numbers, passwords, and bank or credit card numbers
- having location enabled services turned “off”
- Exploring apps which limit internet access to age appropriate sites.
If you find Facts for Families® helpful and would like to make good mental health a reality, consider donating to the Campaign for America’s Kids. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to Campaign for America’s Kids, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 9,300 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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If you need immediate assistance, please dial 911.

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Please consider a gift in your Will, and join your colleagues and friends:

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AACAP Award Opportunities
FOR MEDICAL STUDENTS, RESIDENTS, AND EARLY CAREER PSYCHIATRISTS

RESIDENTS AND JUNIOR FACULTY

AACAP Pilot Awards
Application Deadline: March 30, 2018
Provides $15,000 to members with a career interest in child and adolescent mental health research
- Research Award for Child and Adolescent Psychiatry Residents and Junior Faculty, Supported by AACAP
- Research Award for Child Psychiatry Residents and Junior Faculty focusing on Attention Disorders and/or Learning Disabilities, Supported by AACAP’s Elaine Schlosser Lewis Fund
- Research Award for General Psychiatry Residents, Supported by Industry Supporters

AACAP Educational Outreach Programs (EOP)
Application Deadline: July 13, 2018
Provides travel support of up to $1,000 for Residents and CAP Fellows to travel to AACAP’s Annual Meeting and network with leaders in the specialty
- EOP for Child and Adolescent Psychiatry Residents, Supported by AACAP’s Endowment Fund, AACAP’s John E. Schowalter, MD, Endowment Fund, and AACAP’s Life Members Fund
- EOP for General Psychiatry Residents, Supported by AACAP’s Endowment Fund

AACAP Systems of Care Special Program Clinical Projects Scholarship, Co-sponsored by SAMHSA’s Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee
Application Deadline: July 13, 2018
Provides support of $750 to attend AACAP’s Annual Meeting and present a poster on a systems-of-care-related topic

AACAP Junior Investigator Award, Supported by AACAP
Application Deadline: March 15, 2018
Provides $30,000 a year for two years for one child and adolescent psychiatry junior faculty

RESIDENTS

AACAP Medical Student Fellowships
Provides a $3,500 to $4,000 stipend for 12 weeks of research training and covers travel expenses for AACAP’s Annual Meeting

AACAP Jeann Spurlock Minority Medical Student Research Fellowships in Substance Abuse and Addiction, Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign forAmerica’s Kids (CFAK)
Extended Application Deadline: March 15, 2018
AACAP Summer Medical Student Fellowship Program, Supported by AACAP’s CFAK
Application Deadline: March 2, 2018

MEDICAL STUDENTS

*All awards contingent upon available funding.

For more information, visit www.aacap.org/awards.
AACAP Cancro Academic Leadership Award recognizes, in even-numbered years, a currently serving General Psychiatry Training Director, Medical School Dean, CEO of a Training Institution, Chair of a Department of Pediatrics, or Chair of a Department of Psychiatry for his or her contributions to the promotion of child and adolescent psychiatry.

AACAP George Tarjan, MD, Award for Contributions in Developmental Disabilities recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with intellectual and developmental disabilities.

AACAP Irving Philips Award for Prevention recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents.

AACAP Jeanne Spurlock Lecture and Award on Diversity and Culture recognizes individuals who have made outstanding contributions to the advancement of the understanding of diversity and culture in children’s mental health, and who contribute to the recruitment into child and adolescent psychiatry from all cultures.

AACAP Norbert and Charlotte Rieger Service Program Award for Excellence recognizes innovative programs led by AACAP members that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents, and serve as model programs to the community.

AACAP Sidney Berman Award for the School-Based Study and Treatment for Learning Disorders and Mental Illness recognizes an individual or program that has shown outstanding achievement in the school-based study or delivery of intervention for learning disorders and mental illness.

AACAP Simon Wile Leadership in Consultation Award, supported by the Child Psychiatry Service at Massachusetts General Hospital, acknowledges outstanding leadership and continuous contributions in the field of consultation-liaison child and adolescent psychiatry.

AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award recognizes the best published or unpublished paper written by an AACAP member using a psychodynamic psychotherapy framework.

AACAP Paramjit Toor Joshi, MD, International Scholar Awards recognize mid-career international physicians who primarily work with children and adolescents providing mental health services outside the United States.

AACAP Ülkü Ülgür, MD, International Scholar Award recognizes a child and adolescent psychiatrist or a physician in the international community who has made significant contributions to the enhancement of mental health services for children and adolescents.

For details about all awards, eligibility requirements, and for access to applications and nomination information, visit www.aacap.org/awards.
Child and Adolescent Psychiatrist

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

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

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

For further requirements and to apply, please visit the Virginia Jobs at http://jobs.virginia.gov/. The position offers a competitive salary with full state benefits including vacation and educational conference time, retirement plan, medical and dental insurance, disability plan, life insurance, etc. Position also offers generous sign on bonus, relocation package, CME allowance, substantial student loan repayment, and generous on-call stipend.

Please contact our Human Resource office at (540) 332-2116 for further questions.

CCCA is an equal opportunity, affirmative action employer.
AUSTRALIA

STAFF SPECIALIST IN CHILD AND ADOLESCENT PSYCHIATRY (Sydney, Australia)

Sydney Children’s Hospitals Network (Randwick and Westmead) – Temporary Full Time up to 31 January 2021 – Salary Package $228,834, p.a. to $309, 164 p.a. inclusive as per Staff Specialist Award. Superannuation of 9.5% is paid in addition to salary.

SCHN are able to assist eligible candidates with visa sponsorship, moving costs, and medical registration as required.

Child and Adolescent Psychiatrists are sought to work in the Department of Psychological Medicine across SCHN, the largest network of hospitals and health services for children in Australia. Career advancement is a priority for our Psychiatrists, through providing support and opportunities for research, teaching and continuing professional development.

About You

The successful candidate will:

• Provide mental health and clinical services as required by SCHN (Randwick and Westmead)
• Focus on delivering excellent clinical care to children and families
• Provide undergraduate and postgraduate teaching, research and supervision
• Participate in quality activities, professional development and continuing education in Child and Adolescent Psychiatry
• Be a qualified Child Psychiatrist or within the final stages of training


Advertising Closes – 29 April 2018

Enquiries: Dr Michael Bowden, Head of Department
Telephone: + 61-2-9845 2005
Email: Michael.Bowden@health.nsw.gov.au

STAFF SPECIALIST IN CHILD AND ADOLESCENT PSYCHIATRY (Sydney, Australia)

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Staff Specialists Award

An exciting opportunity has arisen for a Child and Adolescent Psychiatrist to work in the Department of Psychological Medicine in The Sydney Children’s Hospitals Network. This is a brilliant opportunity to expand your career within a sophisticated environment with the largest network of hospitals and services for children in Australia. Candidates must be qualified as a Child Psychiatrist or be within the final stages of training towards becoming a Child Psychiatrist. Candidates must have Fellowship of the Royal Australian and New Zealand College of Psychiatry or equivalent.

About You

The ideal candidate will be looking for an opportunity to:

• Provide mental health and clinical services as required by Sydney Children’s Hospitals Network (Randwick and Westmead)
• Focus on delivering excellent clinical care to children and supporting their families
• Provide undergraduate and postgraduate teaching, research and supervision
• Participate in quality activities, professional development and continuing education in the area of Child and Adolescent Psychiatry
• Be a qualified Child Psychiatrist or within the final stages of training as a Child Psychiatrist


Advertising Closes – 30 June 2018

Enquiries: Dr. Michael Bowden, Head of Department
Telephone: (61) - 2- 9845 2005
Email: Michael.Bowden@health.nsw.gov.au

SCHN are able to assist eligible candidates with visa sponsorship, moving costs, and medical registration as required.

Further Information

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continued on page 162
CHILD AND ADOLESCENT PSYCHIATRY OPPORTUNITY
(Ann Arbor, MI)

Job Description:
SPECIALTY: Psychiatry – Child and Adolescent; HOSPITAL: St. Joseph Mercy Ann Arbor; Ann Arbor, Michigan

GROUP PRACTICE; PRACTICE MODEL: Employed; STATUS: Full Time; AVAILABILITY 2018 REQUIREMENTS:
Board Certified or Board Eligible; CALL COVERAGE 1:6

Opportunity Highlights:
St. Joseph Mercy Ann Arbor has an excellent full time employment opportunity for a fellowship trained Child and Adolescent Psychiatry physician to join the Adolescent Partial Hospital program located in Ann Arbor, Michigan. Physician will be an active part of the Adolescent Partial Hospitalization treatment team and will provide individual therapy and medication management services to approximately 8 to 10 adolescents admitted to the Adolescent Partial Hospitalization program. Physician will also provide intermittent coverage for adult partial hospitalization patients when needed, and will provide weekend coverage to the SJMHS hospital psychiatric consult service on a scheduled rotation every six weeks. Preference will be shown to candidates who possess familiarity with a psychodynamic paradigm. This is an excellent opportunity for an exceptional Child and Adolescent Psychiatry physician to join the Psychiatry team at St. Joseph Mercy Ann Arbor.

Recruitment Package:
An excellent compensation and benefits package is available for the right candidate.

About the Facility:
St. Joseph Mercy Ann Arbor (SJMAA), a member of the five hospital Saint Joseph Mercy Health System, is an academic teaching hospital and tertiary care center. The hospital, with 537 licensed beds, is situated on a 340 acre campus in the Ann Arbor area. Saint Joseph Mercy Health System is a member of Trinity Health, one of the largest Catholic health care organizations in the United States. Trinity Health is based in Livonia, Michigan. Its staff of physicians, nurses and health care professionals have extensive training in a variety of specialty or tertiary care programs, including cardiology, oncology, obstetrics, orthopedics, surgery, Level I trauma, physical medicine and rehabilitation, women and children’s, and senior health services. SJMAA is home of the renowned Michigan Heart and Vascular Institute at Saint Joseph Mercy Health System, one of the top three cardiovascular programs in the state of Michigan based on volume. In addition, SJMAA is designated by the National Cancer Institute as a Clinical Community Oncology Program, or CCOP, one of only 50 programs in the United States. St. Joseph Mercy Ann Arbor provides medical residency training programs in Internal Medicine, Transitional Year, General Surgery, Obstetrics/Gynecology and Emergency Medicine as well as fellowship programs in Colon and Rectal Surgery, Hospice and Palliative Care, Infectious Disease and Surgical Critical Care. For more information about St. Joseph Mercy Ann Arbor visit www.sjmercyhealth.org.

Community Description:
Ann Arbor, Michigan – offers a bustling downtown and charming tree-lined neighborhoods making it a safe and ideal place to live, learn, work, and raise a family. More than 114,000 residents live within the City’s 28 square miles and Ann Arbor is a hub for excellence in education, boasting five colleges and universities. The City’s acclaimed public school system has adapted a comprehensive academic achievement plan to help ensure all students are successful. People are drawn to Ann Arbor for its eclectic urban setting and its acres of parks and trees. The cosmopolitan college town boasts fine to casual dining and world class shopping. Action packed sporting events come courtesy of the University of Michigan. Cultural experiences including museums, galleries, and a performing arts center make Ann Arbor a destination for art aficionados of any age. Endless opportunities for recreation are available in Ann Arbor, which operates 157 parks, trails, golf, canoe liveries, tennis courts, athletic fields and more. One of the most environmentally friendly cities around, Ann Arbor has a progressive recycling program and takes great measures toward the preservation of the City’s green space. Ann Arbor regularly receives national attention as one of the best places to live in the United States. For more information on Ann Arbor visit www.annarbor.com.

About Trinity Health:
Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation. We serve people and communities in 22 states from coast to coast with more than 90 hospitals and 120 continuing care facilities – including home care, hospice, PACE and senior living facilities and programs that provide nearly two million visits annually. Trinity Health employs more than 131,000 colleagues, including 5,300 employed physicians. Our mission: We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. We support this mission by living our core values of Reverence, Commitment to Those Who are Poor, Justice, Stewardship, and Integrity. Committed to recruiting talented physicians, we are looking for physicians who share our values and want to help us fulfill the health care needs of the communities we serve. At Trinity Health, we value the physician relationship and focus on partnering with our physicians. Whether you are a practicing physician looking to relocate or a medical resident, we offer opportunities with the flexibility to fit your individual needs. If you would like to be part of Trinity Health, we encourage you to explore this opportunity at www.trinity-health.org. If you are interested in this opportunity and would like to submit your CV, please email backkg@trinity-health.org or call Trinity Health Physician Recruitment at (734) 343-2300.

Job Requirements:
Preference will be shown to candidates who possess familiarity with a psychodynamic paradigm.

Company: Trinity Health (1083266)
Job ID: 10841035
http://jobsource.aacap.org/jobs/10841035
OREGON

CHILD AND ADOLESCENT PSYCHIATRIST FOR PSYCH CONSULT AND LIAISON (Portland, OR)

Job Description:
Randall Children’s Hospital, part of Legacy Health, is actively recruiting for a full time Child and Adolescent Psychiatrist to (lead the) provide Psychiatric Consultation Liaison (Program) services for medically complex patients at Randall Children’s Hospital (RCH). This position is a part of our system-wide Psychiatric Consult Liaison (PCL) team and is supported by our contracted 24/7 telepsychiatric PCL services For decades Randall Children’s Hospital has been a regional leader in providing excellent care to infants, children and teens in Portland and the Pacific Northwest and is one of Oregon’s largest providers of high acuity pediatric inpatient and trauma services. Our state of the art facility has a (The) medical staff (is) made up of more than 600 physicians, including pediatric medical and surgical specialists, hospitalists and community pediatricians. The Children’s Emergency Department is Oregon’s busiest, with more than 27,000 visits annually and staffed with Pediatric Emergency Medicine physicians 24 x7. Pediatric Critical Care and Pediatric Hospitalist attending physicians provide coverage in-house to ensure the safest, most responsive care is delivered. Additionally, there is an (Child and) Adolescent acute inpatient psychiatric unit at the Unity Center for Behavioral Health which is a community collaboration of four healthcare systems within the Portland metro area. Randall Children’s Hospital is a teaching facility for medical students and residents. We are committed to delivering comprehensive and family-centered care with compassion and excellence. In 2016 and 2017 RCH was selected by the Portland Business Journal as one of the most admired employers in Oregon. RCH is part of Legacy Health recently selected by Forbes Magazine as one of the top 50 medium sized organizations to work for in the United States. We are a not for profit 501 (c) 3 organization for federal loan forgiveness. As we consider qualified candidates, we are committed to building a culture that values diversity and is reflective of those we care for. Portland is a city that continually ranks in the top five for livability and includes both urban and family-friendly communities. Approximately 17,000 workers bike to work year-around on 350 miles of bikeways making Portland the number one city in the U.S. for biking. Portland has a wide array of nationally recognized parks for hiking and off-road biking. Portland is a sophisticated city offering diverse cultural activities including a wide range of theater, musicals and museums open throughout the year. In the spring and summer months, Portlanders gather on the waterfront for concerts and fun activities If your desire is to step out of the city, take a hike in the spectacular Columbia River Gorge, hit the slopes of Mt. Hood or catch a wave off the Oregon Coast – all a short drive from Portland. Applications are required and can be accessed through our website www.legacyhealth.org. Please apply for position 18-0629. You will be able to insert your CV as you apply. If you have questions, please feel free to contact Vicki Owen at 503 415-5403 or vowen@lhs.org. AA/EO/ Veterans/Disabilities

Job Requirements:
The ideal candidate should be a BE/BC with 3-5 years of clinical experience working with children, adolescents and families. Previous child/adolescent psychiatric consultation liaison experience required.

Company: Randall Children’s Hospital
Job ID: 10898496
http://jobsource.aacap.org/jobs/10898496

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For any/all questions regarding advertising in AACAP News, contact communications@aacap.org.
Netflix released the second season of *13 Reasons Why* on May 18, 2018. Season one controversially and graphically covered the topics of suicide, bullying, violence, and more. While it helped begin much needed conversations on these important topics, we support including mental health, parental and adult guidance, as well as how to seek help in these discussions for more positive responses.

For this reason, we offer resources in hopes of helping children and families at [www.aacap.org](http://www.aacap.org)