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Cover Photo by Nicole Sussman, MD, AACAP resident member
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

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children’s mental health. For more information, please visit www.aacap.org.

MISSION OF AACAP NEWS

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

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Update on AACAP Actions

Karen Dineen Wagner, MD, PhD

I would like to summarize major actions taken by AACAP on a number of important issues pertaining to children’s mental health, workforce, and physician fee schedules.

Separation of Children from Families at the U.S. Border

AACAP strongly opposes the separation of children from their families at the U.S. border.

AACAP Letter on proposed changes to the Flores Settlement Agreement (FSA) that could endanger children held in Border Control custody to Secretaries Nielsen, Department of Homeland Security (DHS), and Azar, Health and Human Services (HHS), dated November 6, 2018.

AACAP (Association members) “Call to Action” on Separation of Children from Families at the Border to President Trump, dated June 18, 2018.


AACAP Joint Letter with 17 other major mental health organizations, including American Psychiatric Association (APA) and National Alliance on Mental Illness (NAMI), opposing policies that result in the separation of children from families at the U.S. border to U.S. Attorney General Sessions, HHS Secretary Azar, and DHS Secretary Nielsen, dated June 20, 2018.

AACAP Approved Policy Statement on Separating Immigrant Children from Their Families. Sent in a press release, emailed to all members, and posted on AACAP’s homepage June 24, 2018.

AACAP Joint Letters with 13 other major health organizations, including American Academy of Pediatrics (AAP), APA, and American Medical Association (AMA), calling for congressional oversight hearings on the separation of migrant children and families. Sent to leadership of relevant U.S. House and Senate committees, dated July 24, 2018.

President’s Message on Organizations Working at the Border sent to all members and posted on AACAP’s homepage August 13, 2018.

Brief of Amici Curiae, including AACAP, filed in U.S. District Court, Eastern District of Virginia, involving the constitutionality of U.S. Immigration and Customs Enforcement policy of transferring parents to detention facilities away from their children, dated August 22, 2018.

I have appointed a resource group on youth separated from families at the border, chaired by Karen Pierce, MD, to further address this topic.

Medicare Physician Fee Schedule (Evaluation and Management Codes E/M)

AACAP was not in support of the Centers for Medicare and Medicaid (CMS) proposal to provide a single, blended payment for all E/M services, levels 2-5.

AACAP Joint Letter with 162 other major medical and health professional organizations, originated by AMA, asking CMS not to finalize in 2019 the Evaluation and Management proposals in the Medicare Physician Fee Schedule proposed rule until recommendations are reviewed from the AMA CPT/RUC Workgroup, convened in response to these proposals. Sent to Administrator Verma, Centers for Medicare & Medicaid Services (CMS), dated August 27, 2018.


AACAP Joint Letter with 37 other major medical professional organizations, originated by The Patient-Centered Evaluation and Management Services Coalition, urging CMS to delay the revision of the E/M payment and documentation system as proposed in the Medicare Physician Fee Schedule proposed rule until the agency reviews the recommendations that will be made by the AMA-convened CPT/RUC Workgroup early next year. Sent to Administrator Verma, Centers for Medicare and Medicaid Services (CMS), dated September 10, 2018.

Good news – CMS has delayed implementation of the E/M Coding Proposals.

Workforce/Loan Relief

AACAP recognizes the considerable cost of medical student education and its negative impact on the workforce.


Mental Health Liaison Group (MHLG) Joint Letter with AACAP and continued on page 274
Update of AACAP Actions continued from page 273

39 other mental health organizations, supporting the “Mental Health Professionals Workforce Shortage Loan Relief Act of 2018,” H.R. 6597, as championed and drafted by AACAP. Sent to U.S. Reps. John Katko (R-NY) and Grace Napolitano (D-CA), dated August 21, 2018.

- MHLG Joint Letter with 47 other major mental health organization including AACAP, AAP, American Psychological Association, and NAMI supporting the inclusion of language in H.R. 6 to increase the substance abuse workforce. Sent to House and Senate leadership on September 21, 2018.

It is the efforts of our members and AACAP staff that allow us to address the mental health needs of children and adolescents and to meet the professional needs of child and adolescent psychiatrists. I am privileged to have the opportunity to work with such dedicated individuals. Please regularly check AACAP’s homepage and be sure to follow us on Twitter (@AACAP) and Facebook (American Academy of Child & Adolescent Psychiatry) to stay up-to-date with the latest children’s mental health news and AACAP updates in real time.

Karen Diana Wagner

Dr. Wagner is Professor and Chair, Department of Psychiatry and Behavioral Sciences, University of Texas Medical Branch, Galveston, and is AACAP President, 2018 to 2020. Disclosure: Dr. Wagner has served as councilor and AACAP delegate to the Texas Society of Child and Adolescent Psychiatry, on the Scientific Advisory Board of the Anxiety Disorders Association of America, and on the Scientific Council of the Brain and Behavior Research Foundation (no financial compensation was received). She has received honoraria from AACAP, the American Psychiatric Association, the American Society of Clinical Psychopharmacology, the Nevada Psychiatric Association, UBM Medica US, and CME Outfitters. She may be reached at kwagner@aacap.org.

Honor Your Mentor in the March/April issue of AACAP News

In the March/April issue of AACAP News, you have the opportunity to honor your mentor(s). Whether you’re a medical student, resident, active researcher, or practitioner, or retired—someone made a significant impact on your career.

We’re asking all of you to take the time to honor your mentor and tell others why they were important to you, and how they influenced your life.

In 100 words or less, tell us who served as your mentor. Email submissions to communications@aacap.org by January 10, 2019.

Please include your name, affiliation (if appropriate), the name of your mentor(s), a short testimonial or anecdote, and a photo.
Saving the Lost Generation of Syria

Approximately one percent of the world’s population is currently uprooted, with 22.5 million refugees seeking safety in another country and 65.6 million people forcibly displaced worldwide. A refugee is a person who lives outside his/her country of nationality and unable to return due to persecution of race, religion, nationality, membership of a particular social group, or political opinion. Over half of the world’s displaced population are children. The stresses to which most refugees are exposed can be thought of in different stages of their lives – (1) from their home country of origin, then (2) during the migration flight to safety, and (3) to the resettlement period in a host country. In their home countries, many youth have been forced to flee their homes due to exposure to war or armed conflict, and have therefore witnessed violence, torture, traumatic loss of loved ones, and separation from friends and school. Parental distress is common, along with general feelings of insecurity. Migration can also pose dangers with separation from family, unstable sources of food or housing, and potential for trafficking or sexual violence. The post-migration phase of resettlement can often be referred as a period of “secondary trauma,” as youth struggle to adapt to a new culture, language, peer group, as well as acculturative stress and generational stress with their parents or caregivers. With globalization and the recent wars in Syria, Afghanistan and Iraq, as well as the conflicts in central America’s northern triangle (El Salvador, Guatemala, Honduras), we have more refugees and unaccompanied minors landing in our backyards. The role of the child and adolescent psychiatrist becomes more prominent, as many will be asked to help the increasing number of war-affected youth locally and globally. This article from the International Relations Committee will focus on the plight of refugees, their mental health needs and strengths, and how child and adolescent psychiatrists can play a role locally and abroad.

Suzan Song, MD, MPH, PhD
International Relations Column Coordinator; Director, Division of Child/Adolescent & Family Psychiatry; Associate Professor, George Washington University Medical Center

Yassar Kanawati, MD

The war in Syria has reached intolerable levels of human suffering and despair. Hundreds of thousands of Syrians have been killed, hundreds of thousands have been trapped in besieged areas, and tens of thousands have been tortured. UNICEF estimates that some 8.4 million Syrian children, more than 80% of the Syrian child population, have now been affected by the conflict in Syria. The numbers of wounded survivors, many with amputations, severe burns, or paralysis, cannot yet be assessed; at least 13 million Syrians have been forcefully displaced within Syria and into its neighboring countries. Gross violations of international law, such as chemical attacks on civilians, targeting of healthcare facilities and healthcare personnel, widespread breach of medical neutrality, and blocking access of whole communities to food, water, medicine, and healthcare have been used as methods of war. The global health community cannot stand by. It is our responsibility to save the lost generation in Syria, the survivors of multiple and severe traumas and losses. This article sheds light on best practices for trauma recovery, including psychological treatments to Syrian refugees carried on by Syrian American Medical Society (SAMS).

Many studies have examined the effects of exposure to war, conflict, and terrorism on young children. They have all revealed a wide array of consequences including post-traumatic stress symptoms, psychosomatic symptoms, depression, anxiety, disturbed play, and behavioral, emotional and sleep problems.
Beverly Stoute, MD: Winner of AACAP’s 2018 Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award

This treatment went beyond the typical confines of the psychotherapy office. As Unit chief at the time, she spurred the hospital staff to resolutely work toward naming and reworking their initial views of Preston as a “dangerous and out of control Black youth to that of a needy, traumatized boy afraid to trust.” This shares striking similarity to the letter titled “My Dungeon Shook,” by early 20th-century, African-American writer James Baldwin who wrote it to his nephew. In this work, Baldwin recognizes his nephew’s budding sense of identity and need for familial love and contrasts with a nation loathe to recognize his humanity.

Dr. Stoute sketches moving observations of her own place as a Black woman, mother, and healer in Preston’s shifting transferences as he masters powerful, destructive, and rewarding feelings. Her writing provides a potent example of how clinicians must acknowledge the lived experience of race in ourselves and others in treatment. Otherwise, potentially intractable conflicts and their behavioral manifestations may remain.

Conversation about race in America is difficult, she explains, even as we are confronted with increasingly sharpened discussions about race in America. When discussing the place of race and its exploration in training and psychotherapy, Dr. Stoute remarks that “analysts have had a hard time talking about race in treatments with patients. . . [These] conversations are inherently anxious. Most people aren’t trained to bring up race as a factor.” Dr. Stoute muses that as people, psychiatrists are embedded in the culture in which they exist and, as such, are bound by the very racial attitudes that inhibit one’s curiosity about others. “While the field is changing, we have a long way to go to educate people.”

When asked what was behind writing and submitting this paper, Dr. Stoute begins with offering her value of the lived experiences of children and of the psychoanalytic process. “I want to show that at least in some small way, and with some work that I did, that analytic thinking is relevant; that African-Americans can be looked at in that way; and that maybe if we’re lucky and I present this paper, more African-Americans will want to be child analysts. If I can show you as a Black psychoanalyst that analysis is relevant to us too, then more of us would want to be in this field and then we will have a universal theory of the mind; then we will have a field that represents the universality of the human mind, not just a few. What it means to me is that people actually want to hear that now in 2018. That’s why I took a chance [with this award submission].”

Dr. Stoute grew up in New York before attending Harvard College, where she graduated magna cum laude in Biology. She later moved to New Haven for medical school at Yale University, followed by a residency in general psychology at Yale New Haven Hospital. After completing her training, Dr. Stoute served as a faculty member at the Child Study Center at Yale University.

Weaving together psychoanalytic perspectives on development and racial identity, early reflections of James Baldwin on race in America, and personal narratives of the lived racialized experiences of her family, Dr. Stoute provides a deeply compelling clinical paper about her daily psychodynamic treatment of a 13-year-old Black boy, Preston, on the inpatient psychiatry unit of her hospital.

Many of us would recognize Preston with his enumerable early abandonments, disruptive behaviors at his school, and fraught interactions with the intensive inpatient hospital staff tasked with his care. Although this treatment was “not a classical analysis,” Dr. Stoute carefully outlines a psychoanalytically informed approach to understanding Preston’s trauma, behavior, and evolving identity as a young Black boy. In addition, she utilizes relevant social research about the poor ability of educators and police to mentalize Black boys and the “cool pose” that Black boys adopt defensively.

AACAP’s Psychotherapy Committee is pleased to announce Beverly Stoute, MD, as the recipient of AACAP’s 2018 Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award for her paper, “Racial Socialization and Thwarted Mentalization: Reflections of a Psychoanalyst from the Lived Experience of James Baldwin’s America.”

Beverly Stoute, MD

Cecil R. Webster, Jr., MD

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psychiatry and fellowship in child and adolescent psychiatry at the New York Hospital-Cornell Medical Center. Dr. Stoute later completed her adult and child and adolescent psychoanalytic training at the New York Psychoanalytic Institute. She currently maintains a full-time private practice in Atlanta, Georgia, after leaving New York City with her family for warmer climates in 2013. She is an Adjunct Associate Professor of Psychiatry and Behavioral Sciences at Emory University School of Medicine and a training and supervising analyst at the Emory University Psychoanalytic Institute.

The Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award was established in 2001 to recognize the best published or unpublished paper by an AACAP member that utilizes psychodynamic frameworks and principles to illustrate and elucidate the inner world of children and healing. The Rieger Award offers a $4,500 prize and recognition at a Distinguished Awards Luncheon. The recipient is also invited to make an Honors Presentation about his or her work during AACAP’s Annual Meeting.

Dr. Webster is a child and adolescent and adult psychiatrist in Boston. He is currently a lecturer in psychiatry at Harvard Medical School and McLean Hospital, and Clinical Program Director for Diversity Health Outreach Programs at the Massachusetts Institute of Technology. Dr. Webster is a member of AACAP’s Child Psychotherapy Committee and a current candidate in child and adult psychoanalysis at the Boston Psychoanalytic Society and Institute. He may be reached at mail@cecilwebstermd.com.

References

Dr. Kanawati is a board-certified child/adolescent and adult psychiatrist, with a focus on addiction psychiatry. She finished her psychiatry residency and fellowship at Wayne State University and is currently an Assistant Professor at Emory Medical School and Morehouse School of Medicine. Among her areas of expertise are depression and mood disorders, ADHD and disruptive disorders, and PTSD and the effects of trauma and war on family members. In November 2012, Dr. Kanawati visited Amman, Jordan, where she assessed the psychiatric needs of Syrian refugees with the support for the Syrian American Medical Society Psychosocial Support Team. She may be reached at yassar.kanawati@att.net.
What Is “Fortnite,” and How Does It Affect Your Patients?

Paul Weigle, MD

You have probably heard many patients tell you about this year’s smash hit video game, Fortnite. Fortnite is generally played in a ‘Battle Royale’ online multiplayer arena mode from the first person perspective. A hundred players fight to the death until only one player is left alive, echoing The Hunger Games. After parachuting onto a small island, players must scramble to find military weapons and mine for resources to build structures to defend themselves against their opponents, while the gaming area slowly shrinks, pushing players into closer proximity with their opponents. The game is rated T for teens, meaning its violent content may make it inappropriate for youth aged 12 and under. The game has been a stunning success, and boasts 45 million players, an incredible number far greater than the entire population of Canada.

What makes it so popular? Fortnite does not introduce any revolutionary game concepts, but it blends together the most engaging elements of popular games such as Minecraft, Call of Duty, and Player Unknown Battlegrounds into a game that is uniquely accessible to new players. Fortnite is free to play on all modern gaming consoles, computers, tablets, and smartphones. It is easy to learn and to start playing, and quickly becomes habit-forming.

The action is fast and furious, and the game allows players to have nearly limitless choices regarding how to play the game, inspiring creative strategies. Fortnite is an intensively competitive game played against other gamers, which encourages users to vie for rewards and status. The game can also be played cooperatively in groups of two or four, providing limited socialization. Communities form around play; child and adolescent enthusiasts often talk about it in school and coordinate to play with their friends online. Fortnite features elusive treasure chests with randomized contents, giving the game an element of gambling. Like many video-games, Fortnite is very challenging, but players who give the game their full focus and devote a significant time to play are rewarded with greater success and community status. The amount of dedication and luck required to win is considerable, so when players do so, they feel intense gratification.

For those children and teens who play Fortnite in moderation, it can be a fun and harmless pastime. However, for the many who play excessively, Fortnite can quickly become an unhealthy or even toxic habit. The same elements that make Fortnite engaging can also turn it into an obsession, particularly for school-aged players. Excessive play displaces vitally important everyday behaviors such as school-work, chores, socializing in person, family time, adequate sleep and physical activity, which often leads to significant problems in everyday life. Heavy gaming has also been linked to a junk food diet, a lack of exercise, and increased risk of obesity, as well as pain in the cervical or lumbar spine related to poor posture during play, or “gamer slouch,” and occasionally even repetitive stress injuries such as “Nintendo thumb.” Regularly, players will respond by limiting gameplay when it interferes with their daily functioning, or have such limits imposed by attentive parents, but many players are unaware of the problems their gaming causes, refuse to cut down, or may be unable to do so. These players are prone to develop an addictive habit consistent with Internet Gaming Disorder (IGD).

IGD is a provisional diagnosis in the DSM 5 in which excessive play dominates the player’s time, and players become preoccupied with gameplay, stop engaging in other hobbies, are unable to control their habit, lie to minimize how much they play, and become dysphoric when unable to play, often causing relationship problems. Those
The same elements that make Fortnite engaging can also turn it into an obsession, particularly for school-aged players. Excessive play displaces vitally important everyday behaviors such as school-work, chores, socializing in person, family time, adequate sleep and physical activity, which often leads to significant problems in everyday life.

Most susceptible to IGD are boys with ADHD or autism, and those whose parents do not supervise or limit their play. Youth with internet gaming disorder are at high risk to develop subsequent depression, social anxiety, and school failure. Gaming Disorder, an analogous condition, will be diagnosable in the ICD-11 when it is implemented later this year.

Since Fortnite and games like it can have addictive qualities, child psychiatrists should advise parents to be proactive in monitoring their children’s video-game play to ensure that kids have adequate time for other activities such as academics, exercise, socializing, and sleep. This typically involves supervising the amount of time kids are playing video games and limiting total combined screen time to a reasonable amount, depending on the age and characteristics of the child (e.g. two hours on a school day and more on a weekend day). It may be helpful for parents to encourage other activities, and give kids reminders of when it is time to stop play. Parents should check to ensure that their kids maintain proper posture and take regular physical activity breaks. Youth frequently engage in electronic media activities at night when their parents think they are sleeping, and in these cases it may be necessary for parents to prevent this by taking the game controllers into their own bedrooms or locking them up at night. Parents who feel unable to adequately or safely enforce limits on their children’s gaming may turn to child psychiatrists for advice on how to do so. Several studies have shown that cognitive behavioral therapy (CBT) and motivational interviewing therapies for treatment of substance abuse can be adapted to effectively treat IGD.

It is worth repeating that Fortnite and other games do not have to be a divisive issue in the home, and can be a chance for parents and children to spend enjoyable time together. Playing video-games with kids gives parents a better idea of what the games are all about and a chance to talk about proper online behavior as well as media choices and habits. It can be illuminating and enjoyable for child psychiatrists to sample these games as well, as long as we do not get hooked into compulsive play ourselves!

Dr. Weigle is associate medical director at Natchaug Hospital of Hartford Healthcare and teaches at UConn School of Medicine and Quinnipiac Medical School. He serves as co-chair of AACAP's Media Committee and on the National Scientific Advisory Board for the Institute of Digital Media and Child Development. He may be reached at pweigle@sbcglobal.net.
The recent conviction of Dr. Larry Nassar for the sexual abuse of young athletes at Michigan State University and the allegations of sexual abuse against team doctor Richard Strauss by over 100 student athletes at Ohio State University are just two examples from the media that put a spotlight on the widespread abuse of young people in sports. Inevitably, people are left wondering, “Why didn’t anyone speak up sooner?” Much research points to the power of the culture of silence that perpetuates abuse in both the workplace and in the training area. Increased awareness can be effective in breaking the silence, by encouraging good people not to “look the other way.”

In 2016, the International Olympic Committee (IOC) issued an extension to the 2007 consensus statement on harassment and abuse in sport, advocating that “all athletes have a right to engage in ‘safe sport’, defined as an athletic environment that is respectful, equitable and free from all forms of non-accidental violence to athletes.”¹ Yet, research within the last decade demonstrates the prevalence of sexual abuse in sports between 2-48% of all athletes.² “Non-accidental violence” is defined as psychological abuse, physical abuse, and neglect. Although all athletes are at risk, it appears that “elite, disabled, child and lesbian/gay/bisexual/transsexual (LGBT) athletes are at highest risk.”³ The statement also notes that cultures of “secrecy” and “deference” often facilitate abuse.¹

The IOC identifies psychological abuse as “the gateway to non-accidental violence,” noting that abuse most often occurs within the context of a “power differential” and that “it is impossible to conceive of any form of harassment or abuse that does not have psychological underpinnings.”¹ Perpetrators of abuse can range from the team physician to coaches, teammates, and even parents. The “bystander effect” occurs when observers fail to recognize or stop the abuse, thereby leading to an acceptance of psychologically abusive coaching techniques and resulting in more severe sequelae for victims.¹ “Intense selection rivalries among peer athletes,” especially at the level of elite sport, can also foster a culture of silence.¹

Marks et al. point out that the unique nature of the coach-athlete relationship may increase the potential for sexual abuse. The “grooming process” of athletes involves “building trust, gradually pushing back the boundaries of acceptable behavior and slowly violating more and more personal space through verbal familiarity, emotional blackmailing and physical touching.”² In addition, psychologically abusive tactics such as “belittling, humiliating, shouting, scapegoating, rejecting, isolating and threatening behaviours as well as being ignored, or denied attention and support” contribute to power imbalance and discourage open discourse.¹

Several risk factors have been identified which can be categorized as pertaining to the athlete, coach, and sport. It is important to note that there is no evidence that the amount of clothing, touching, or type of sport are risk factors for sexual abuse.¹² Being a younger woman, having low self-esteem, a poor and distant relationship with parents as well as a strong talent in the sport, and a dedication to the coach are athletic risk variables. Older male coaches with good reputations who are trusted by parents also have increased opportunities for sexual abuse. Locations where isolation may occur such as trips away from home, being alone in the coach’s room or car, and group events that involve alcohol can also contribute to increased risk.²

Disclosure of the abuse is both the most important and most difficult part of the
process and can be mitigated by fear. Parent et al. state that victims who face disbelief or a lack of support on the part of family and friends experience more negative general consequences than do victims who receive a positive response and support from significant people around them.1 Research has shown long-term negative consequences of childhood sexual abuse resulting in both poorer mental and physical health. Victims who experience sexual abuse are increased risk for depression, self-harm, posttraumatic stress disorder, and even suicide.1,4 Mountjoy et al. state that the impact of such experiences extends to the family, friends, colleagues, and peers in home, work, and leisure venues, persisting long after the athlete has left his or her sport role.1

The IOC notes that “cultural change can be effectively addressed via advocacy and campaigning” with “dissemination of evidence-based education and training programmes” directed at all levels of the organization including sports executives, coaches, agents, fitness personnel, families and peers, clinicians, and healthcare providers.1 Bystander education programs have been found to be effective in changing attitudes and beliefs about sexual and partner violence on college campuses.1

The IOC has instituted safeguards by initiating a clear structure for participants to report any incidents of harassment or abuse. An IOC welfare officer was present in the Olympic village at the games in Rio as well as in Lillehammer, who ensured that reported incidents were dealt with in a confidential procedure that was linked to local law enforcement agencies.6

At the national level, the National Collegiate Athletic Association has the Sport Science Institute that works closely with the Committee on Competitive Safeguards and Media Aspects of Sports. On their website, they provide resources for sexual assault and interpersonal violence.7 Through the United States Department of Justice, notalone.gov provides various resources to protect students from sexual assault at all grade levels including colleges and universities.

The National Center for Missing and Exploited Children, a private, nonprofit organization, has its website, safeto-compete.org, with various resources for parents and advocates.8

The responsibility falls on adults at every level from administrators, sports executives to families and clinicians. Bystanders can play a crucial role in changing the expected norms for training environments. As child psychiatrists, we can be instrumental in helping to initiate evidence-based training programs that can protect young people. We must support the stakeholders in this process in never “looking the other way.”

References
Promoting Health and Success by Preventing Mental Illness

Robert P. Holloway, MD

When we review the literature, we can find evidence of many ways to prevent mental illness by changing the daily lives of children considered most at risk. We should look at efforts AACAP members and communities have made so far and build on them. There are schools in the San Francisco Bay Area that have implemented twice daily quiet times in which students can either choose to remain silent or meditate for 15 minutes. They found that over a three-year period, suspensions and fighting decreased, and academic performance increased. That is a remarkable return on investment for something that costs so little to implement. We could easily advocate that local school districts replicate and assess this model on their own. But let’s say there was a cost associated with this proposal. How do we successfully advocate for that investment? We must illustrate to the school district the dark and extremely expensive cost of mental illness on society, including decreased productivity and educational outcomes, increased incarceration, and morbidity and mortality. If we can prevent some mental illness, particularly in children, it creates a healthier and higher-functioning population, not “just” happier people.

Fortunately, we do not need to advocate alone. Some investments that improve children’s mental health could also benefit physical health and fitness, and academic performance. What if we could demonstrate that a certain diet would benefit all these areas? Could we give our kids better food that would help them grow to have healthier hearts, muscles, teeth, bones, and brains? If so, we would be foolish to miss that investment opportunity. We know that yoga can benefit mental and physical health. In fact, yoga can be used to practice therapeutic techniques like diaphragmatic breathing, which is shown to reduce pain, anxiety, and help with focus. It is an intervention that could benefit all students and can be utilized in physical education classes or other classes. Let’s start pilot programs, replicate existing programs, and study their outcomes. Let’s join our colleagues and other agencies that are using Adverse Childhood Experience (ACE) studies to improve lifetime health and educational outcomes. Let’s keep learning from our research, sharing our knowledge, and advocating for prevention of mental illness.

As child and adolescent psychiatrists, we have vast knowledge of mental health, general health, and child development. Together, we can use our collective knowledge to create a healthier society. We must engage educators to show them the potential academic benefit of reducing mental illness. We must engage other medical societies to show how our efforts would also improve their patient outcomes. We have to show the caring and empathetic members of our society the best paths to move forward and show skeptics that healthier individuals lead to healthier and higher-functioning populations. This effort need not be divisive or partisan, as it will truly benefit everyone. Who’s in?

References

Dr. Holloway is a child and adolescent psychiatrist practicing at Children’s Hospital, Los Angeles, specializing in chronic pain, transgender youth, and homeless youth. In addition, he is a member of AACAP’s Advocacy Committee as well as being an active advocate in, and former president of, the California Academy of Child and Adolescent Psychiatry. He may be reached at roberthmd@yahoo.com.
Enhancement in practice includes increasing access to child psychiatry for children and families in need. This important function of AACAP’s “Transformation in Practice Cluster” of committees includes promoting efficient delivery of services by child and adolescent psychiatrists through collaborative and integrated care. The Healthcare Access and Economics Committee (HCAE) is committed not only to supporting our members in promoting access to (and being reimbursed for) traditional child mental health services but to enhancing our practices to serve with our fellow medical and mental health partners in integrated care systems and practices.

To this end, HCAE works with insurers to promote payment for integrated care services and collaborates with other committees in our cluster on all facets of integrated care, including advocacy, coding, health information and technology, and measurement-based care. Our committee also works to enhance the role of child and adolescent psychiatrists in integrated care settings through our work with the Patient-Centered Primary Care Collaborative (PCPCC) and our outreach to leadership in the fields of pediatrics, psychology, and advanced practice nursing, each of which are actively engaged in training in and development of integrated care systems and practice arrangements. Our goal remains active engagement for best utilization of our services and promoting our unique role in integrated care service delivery.

Working in this area, we note that our members, components, and committees are still in the process of considering and developing our roles in integrated healthcare systems and practices, as we assess if it is time to draft a policy statement that would represent AACAP’s diverse membership.

Our committee has decided to convey this subject to our members through AACAP News for comment and input in helping us plan further. Whether or not you are currently practicing integrated care, preparing to practice integrated care for a portion of your practice, or whether you seek to continue a practice in traditional service delivery, your views are welcome. Some suggested questions for comment are as follows:

1) Should AACAP overtly promote a leadership role in integrated healthcare systems, or rather speak of our unique clinical role in integrated healthcare systems, letting our leadership roles be nuanced, implicit, and evolving?

2) Should our statements on integrated healthcare systems be a statement of who we are and a commitment of what we will offer to integrated care, or rather an aspiration or goal for which our field and members should strive?

On behalf of AACAP, our committee will continue working to support a wide range of services and approaches to delivery of child mental health services, which values who we are, how we wish to deliver care to our patients, and which allows us to continue to transform and enhance our practices as we choose. Further explication of our role in healthcare systems shows one way forward in increasing access to care for our patients.

Statement of purpose: To identify roles of child and adolescent psychiatrists in transformation of practice and on the integrated care team. Child and adolescent psychiatrists are ideally suited to inform and facilitate the transition of our health care system from traditional and managed models of care to collaborative and integrative care delivery. Partnership with mental health and medical professionals promotes access to the highest quality, value-based and evidence-based care. This ensures that children and adolescents receive high quality care, with special attention to youth with severe and complex psychiatric and medical issues.

How child and adolescent psychiatrists support and enhance integrated care teams: Child and adolescent psychiatrists provide expertise and intensive training in medicine and the biopsychosocial model, knowledge of brain/body interactions, training in psychopharmacology, proficiency in individual and family psychotherapies, work with community agencies, and experience in consultation-liaison training with multiple medical and mental health disciplines. Services to the integrated care team include integrated treatment team planning, case review of complex and severe patients, education on specialized topics of care, and collaboration with other consultants to integrated treatment teams in medical settings, schools, and community systems of care. Child and adolescent psychiatrists share leadership with primary care in integrated care settings and team with professionals in a number of models and practices.

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Engagement and training with mental health and medical professionals: Evidence-based models, such as the Washington Collaborative Care Model, show the clinical effectiveness of psychiatric consultation to integrated care teams. Child and adolescent psychiatrists build and enhance programs dedicated to collaborative team education of trainees and practitioners. We collaborate in research on efficacy, safety, and value of psychotropic medications and clinical interventions. We pursue opportunities which engage us with partnering behavioral health and medical professionals, such as advanced practice nurses, psychologists, social workers, counselors, pharmacists, and primary care professionals. In integrated care settings, child and adolescent psychiatrists participate in consultative, collaborative, and supervisory roles in care planning and service delivery. We continue to co-define and promote ideal collaborations with our partners on integrated care teams and in community systems of care, bringing much needed child and adolescent psychiatry expertise to each team with which we serve.

Clinical, administrative, and payer partnerships: Child and adolescent psychiatrists promote access to care through advocacy in multiple settings, including participation with clinical, administrative, and payer partners in shaping healthcare delivery systems. Continued development of clinical, business, and managerial skill sets in sustainable integrated care models enhances opportunities for child and adolescent psychiatrist consultation and leadership within integrated care systems.

Dr. Borer is co-chair of the Healthcare Access and Economics Committee. He is past chair of the Assembly and is the Academy’s delegate to the Patient Centered Primary Care Collaborative (PCPCC). He is in private practice in Dover, DE, where he is working on integrated care initiatives. He may be reached at bugginborer@comcast.net.

Dr. Sarvet is co-chair of the Healthcare Access and Economics Committee. He 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 may be reached at barry.sarvet@baystatehealth.org.

For more information on CASII, contact the Clinical Practice Program Manager at clinical@aacap.org.

www.aacap.org/CASII

CHILD & ADOLESCENT SERVICE INTENSITY INSTRUMENT

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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ASSEMBLY EXECUTIVE COMMITTEE

AACAP, Advocacy, and Grants, Oh My!

“\textit{In the past, one California ROCAP used the grant as seed money to develop a 10-year program. The opportunities are endless, and all ROCAPs are encouraged to apply.}”

These grants have been the impetus to creating programs that have continued annually and grown exponentially in their reach. In the past, one California ROCAP used the grant as seed money to develop a 10-year program. The opportunities are endless, and all ROCAPs are encouraged to apply.

The deadline for the next cycle of grants is January 15, 2019, and information can be obtained from AACAP’s website or gov@aacap.org. Start writing!

Dr. Oatis is in private practice in Manhattan and continues to supervise and teach residents and child fellows at the New York University Langone Child Study Center. He graduated from the Mt. Sinai triple board program (pediatrics, adult and child psychiatry) in New York before joining the NYU faculty where he directed a pediatric consultation liaison service for almost nine years. He may be reached at mdoatis@aol.com.

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A CACAP’s Assembly Advocacy and Collaboration Grant is a direct member benefit from AACAP, with the support of the Department of Government Affairs and the Assembly Executive Committee, given annually to regional organizations of child and adolescent psychiatrists (ROCAPS) to expand, enhance, or develop programs or events with other state organizations with shared missions and goals. A ROCAP may apply for grants up to $4,000. 2019 grant applications require collaboration between your ROCAP and a partnering organization and will be due by January 15, 2019.

In 2018, nine Advocacy and Collaboration grants were awarded:

- Colorado partnered with SMART Colorado to host a workshop educating parents about marijuana, its effects on the adolescent brain, and ways to mitigate risks.
- Connecticut presented an educational hearing challenging the argument that psychologists prescribing medication would fill the shortage in access to care and provided possible solutions to the shortage of access to mental health services in the state.
- Greater St. Louis is producing a video on promoting awareness of refugees’ mental health to combat the stigma of mental illness and identifying resources in mid-Missouri.
- Illinois is hosting a seminar to discuss the developmental, social, and emotional impact of the definitions of gender on transgender and gender diverse youth, while reviewing research on treatment options, medical interventions, and social/emotional support for the family and community.
- Louisiana is collaborating with Autism Spectrum Disorder (ASD) service providers and advocates in the Greater New Orleans area to create a peer mentoring system specifically for ASDs and intellectual disabilities.
- New Jersey collaborated with local groups of psychiatrists, pediatricians, and advocacy groups to host an event at the state capital to discuss the effects of marijuana on youth and educate members of the New Jersey state legislature.
- New Mexico hosted an asylum evaluation training symposium for mental health providers as a path to creating statewide infrastructure and a coalition for families fleeing persecution.
- Northern California collaborated with Teach for America in lower-income schools focusing on immigrant populations and children who have emotional and behavioral issues to provide training on mental health needs and community resources for families, teachers, staff, and students.
- South Dakota hosted a program with child psychiatrists, patient advocacy groups, pediatricians, and other interested stakeholders to develop an advocacy network regarding mental health access for children and adolescents.
NOMINATING COMMITTEE

FAQs About AACAP’s Nominating Committee and the Election Process

Gregory K. Fritz, MD

AACAP’s Call for Nominations is open and runs through February 1, 2019. During this time period, AACAP members may nominate themselves or another member to run for offices on the Executive Committee and Council. In the interest of greater transparency and maximum fairness to all involved, I’d like to clarify how the Nominating Committee functions. As chair of the Nominating Committee, I want to respond to several questions about the process that we heard at the Annual Meeting in Seattle.

1. Who makes up the Nominating Committee, and how do they get there?

The Nominating Committee consists of the Immediate Past President (chair) and four members who have been elected by the membership in the general election; they serve staggered two-year terms. Every October, the Council creates a large list of potential candidates to run for the Nominating Committee and each Council member ranks their top six choices. The four individuals with the highest scores, who agree to run, are placed on the May election ballot, and the two who receive the most votes are elected for a two-year term. Other than the Immediate Past President (chair) and the President, there is no prescribed series of steps to become an AACAP Officer?

The President-Elect becomes President after the two-year term. Other than President-Elect, there is no prescribed or de facto office that is required or leads to a higher office. Experience, demonstrated leadership, and commitment to AACAP are important factors that the Nominating Committee considers, but no AACAP office (other than President) is entitled to nor expected by any individual.

AACAP is proud of the level playing field and total lack of campaigning associated with our elections. Our biggest concern is the relatively small percentage of members that vote in each year’s election (between 23-26%). If you have any questions, comments, or suggestions about the election process, please contact me at Gregory_fritz@brown.edu.

2. How does the Nominating Committee come up with a slate of candidates?

The job of the Nominating Committee in even years is to select four candidates to run for two Councilor-at-Large positions. In odd years, in addition to four candidates for the two Councilor-at-Large positions, the Nominating Committee is responsible for selecting two candidates to run for each of the offices of President-Elect, Secretary, and Treasurer. After the Call for Nominations closes on February 1, the Nominating Committee reviews the nomination letters that have been received. The Nominating Committee then meets in-person to finalize the slate in late February or early March. The Chair confirms the individuals’ willingness to run, and the Executive Office gets the candidates’ materials for the election booklet. The election runs throughout the month of May.

The Nominating Committee strives to create a diverse slate for each election. It takes race, ethnicity, and geographic region into account.

3. How does a person get considered for an office by the Nominating Committee?

To consider an individual for candidacy for a particular office, the Nominating Committee must receive, by February 1, a nomination letter and CV; verbal suggestions or expressions of interest are not sufficient. Any member of AACAP can write such a letter; self-nomination letters are also appropriate, as are letters from a member of the Nominating Committee. (Nominating Committee members are not eligible to run for office themselves until two years after their term ends). However, after February 1, no new names will be accepted for consideration from either AACAP members or from within the Nominating Committee.

4. Does a person need to be a Distinguished Fellow to be run for office?

A member must be a Distinguished Fellow to run for President-Elect, Secretary, and Treasurer. A member does not need to be a Distinguished Fellow to run for Councilor-at-Large.

5. Can AACAP staff nominate people or participate in the process?

No. Executive Director Heidi Fordi has clarified that neither she nor any other staff member will make suggestions, be present during the Nominating Committee’s meetings, or discuss their preferences for specific individuals. The Nominating Committee may request administrative assistance (materials, disclosures, details about AACAP activities, etc.) from staff in the Executive Office, but deliberations are to be absolutely confidential.

6. Is there a prescribed series of steps to become an AACAP Officer?

The President-Elect becomes President after the two-year term. Other than President-Elect, there is no prescribed or de facto office that is required or leads to a higher office. Experience, demonstrated leadership, and commitment to AACAP are important factors that the Nominating Committee considers, but no AACAP office (other than President) is entitled to nor expected by any individual.

AACAP is proud of the level playing field and total lack of campaigning associated with our elections. Our biggest concern is the relatively small percentage of members that vote in each year’s election (between 23-26%). If you have any questions, comments, or suggestions about the election process, please contact me at Gregory_fritz@brown.edu.

Dr. Fritz is the Past President of AACAP. He may be reached at Gregory_fritz@brown.edu.
CALL FOR NOMINATIONS

AACAP’s Nominating Committee is presently soliciting names for nominations for President-Elect, Secretary, Treasurer, and two Councilor at Large positions. The deadline for nominations is February 1, 2019. Nominations should be sent directly to executive@aacap.org. You must be an AACAP voting member to nominate an individual.

If you wish to recommend someone for this position, please send the following to executive@aacap.org:

1. A letter of interest from the candidate
2. The candidate’s current CV
3. The candidate’s Disclosure of Affiliations Statement

If you wish to recommend yourself, please send the following to executive@aacap.org:

1. A letter of interest
2. Your current CV
3. Your Disclosure of Affiliations Statement

Nominating Committee
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gregory_fritz@brown.edu

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Get in the News!

All AACAP members are encouraged to submit articles for publication! Send your submission via email to AACAP’s Communications Department (communications@aacap.org). All articles are reviewed for acceptance. Submissions accepted for publication are edited. Articles run based on space availability and are not guaranteed to run in a particular issue.

- **Committees/Assembly.** Write on behalf of an AACAP committee or regional organization to share activity reports or updates (chair must approve before submission).

- **Opinions.** Write on a topic of particular interest to members, including a debate or “a day in the life” of a particular person.

- **Features.** Highlight member achievements. Discuss movies or literature. Submit photographs, poetry, cartoons, and other art forms.

- **Length of Articles**
  - Columns, Committees/Assembly, Opinions, Features – 600-1,200 words
  - Creative Arts – up to 2 pages/issue
  - Letters to Editor, in response to an article – up to 250 words

**Production Schedule**

AACAP News is published six times a year – in January, March, May, July, September, and November. The 10th of the month (two months before the date of issue) is the deadline for articles.

**Citations and References**

AACAP News generally follows the American Medical Associate (AMA) style for citations and references that is used in the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP). Drafts with references in incorrect style will be returned to the author for revision. Articles in AACAP News should have no more than six references. Authors should make sure that every citation in the text of the article has an appropriate entry in the references. Also, all references should be cited in the text. Indicate references by consecutive superscript Arabic numerals in the order in which they appear in the text. List all authors’ names for each publication up to three. Refer to Index Medicus for the appropriate abbreviations of journals.

For complete AACAP News Policies and Procedures, please contact communications@aacap.org.
In April of this year, I had the privilege of participating in the Advocacy Day of California Psychiatric Association (CPA) as one of the Resident-Fellow Member representatives from the Southern California Psychiatric Society.

Advocacy Day was a great opportunity for residents and fellows to gain exposure to mental health policy issues and communicate directly with state legislators, alongside experienced advocates. Prior to participating in Advocacy Day this year, I had little knowledge about the process of legislative reform. By the end of the day, I had seen first-hand the impact that psychiatrists can have on policy decisions affecting mental healthcare.

We spent the morning becoming familiar with CPA-sponsored bills and current mental health-related legislative issues. We learned about AB 2143 (Caballero), a bill that amends statutes for existing state programs to provide loan forgiveness incentives for licensed psychotherapists to gain dual licensure as physician assistants or psychiatric mental health nurse practitioners. This is a strategy developed by the CPA, which would expand the workforce of mental health providers who are able to prescribe psychotropic medications, thereby increasing access to mental healthcare.

A companion bill, for which CPA is the sponsor, to expand access to mental health care is AB 2018 (Maienshein), which amends current statute for education loan forgiveness incentives if residents in psychiatry select a training program that strongly emphasizes community mental health experience. These residents would be immediately eligible for these incentives as opposed to becoming eligible after completion of residency. Greater recruitment of physicians to the field of psychiatry would help address the shortage of psychiatrists that exists in both California and across the country.

AB 1971 (Santiago, Chen, and Friedman) is a controversial bill that proposes to reform the existing Lanterman-Petris-Short (LPS) law, governing involuntary care in California. Current LPS law targets people with severe mental illness, developmental disabilities, and people with “chronic alcoholism” and allows involuntary commitment of patients if they are assessed to be a danger to self, danger to others, or gravely disabled as a result of a mental health disorder. This bill would expand the definition of grave disability to include being unable to provide for his or her medical treatment as a result of a mental health disorder. This bill has raised the ire of patients’ rights groups, including civil libertarians, among others, who oppose involuntary care.

AB 2328 (Nazarian) is a bill that would establish statewide standards for a continuum of care of substance use treatment for youth. The bill identifies two funding sources, namely, Medicaid (or Medi-Cal in California) and the recently approved referendum, Proposition 64 (or Adults Use of Marijuana Act). A continuum of care is an entitlement program under Medicaid while Proposition 64 generates revenue to support prevention and treatment of substance use in youth.

Lastly, we learned about another CPA-sponsored state budget proposal, Primary Care Psychiatry, which would allocate training scholarships to primary care physicians to enhance their knowledge base and psychiatric skills. UC Davis and UC Irvine have developed such a program.

After additional training and discussion of the above legislative bills and proposals, we were teamed up with experienced advocates. William Arroyo, MD, led a team of three residents and one fellow to meet with staff of Senator Robert Hertzberg and Assemblyman Adrin Nazarian at the state capitol building. The residents learned about the role that psychiatrists, including residents, can assume in advocacy to help establish positive changes within the mental healthcare system. Participating in Advocacy Day of the California Psychiatric Association was a valuable learning experience for young psychiatrists in regard to the basics of advocacy and the shaping of mental health policy. Residents reported that it was an honor to participate in helping to advocate for legislation that will impact many patients throughout California and increase access to mental healthcare.

Dr. Arroyo is a senior advocacy leader. He may be reached at wmarroyo@pacbell.net.

Dr. Chang is a third year resident.
AACAP’s Douglas B. Hansen, MD, 44th Annual Review Course emphasizes the most recent material relevant to the general practice of child and adolescent psychiatry and serves as an up-to-date review of child and adolescent psychiatry as well as addresses important clinical research. The course is designed to update practitioners on state-of-the-art standards of diagnosis and treatment.

www.aacap.org/ReviewCourse-2019

QUESTIONS? Email meetings@aacap.org
Back to Project Future

Debra E. Koss, MD

In 2011, Martin Drell, MD, then AACAP President, established Back to Project Future (BPF) as his Presidential Initiative. The BPF Steering Committee was tasked with developing a focused plan to guide AACAP leadership and staff into the coming decade. The project brought together a diverse group of AACAP members to develop a consensus of priorities. The discovery process included extensive outreach to members from all AACAP components, including representatives from AACAP Committees, the Assembly, and leadership, as well as input from our membership who were invited to participate in two member forums at AACAP Annual Meetings. Furthermore, other stakeholders, including the American Psychiatric Association (APA), the American Association of Directors of Psychiatric Residency Training (AADPRT), and the American Academy of Pediatrics (AAP) were asked for their input.

Through research and deliberation, the Steering Committee ultimately proposed a series of goals, recommendations, and action steps pertaining to the areas of Service/Clinical Practice, Training and Workforce, and Research. The final report, Plan for the Coming Decade (https://www.aacap.org/App_Themes/AACAP/docs/member_resources/back_to_project_future/BPF_Plan_for_the_Coming_Decade_2014.pdf), was reviewed and approved by Council in 2013 with the intent that BPF would serve as a “roadmap.”

In 2015, a BPF Implementation Task Force proposed AACAP priorities for the subsequent two years, which the Council refined slightly prior to their adoption. Now, more than midway through this 10-year journey, I find myself reflecting on the relevance of the initial report within the context of an ever changing healthcare system, the extent to which we’ve made progress in addressing BPF priorities, and the impact of BPF on our organization.

Our specialty continues to face many of the same challenges the BPF Steering Committee identified. We continue to have a child and adolescent psychiatrist workforce shortage that directly impacts the ability of families and children to access quality mental health care. This year, we again saw too many child and adolescent psychiatry fellowship slots go unfilled. Likely, the causes are multifac- torial, but one must consider the impact of staggering educational debt, extended time required for fellowship training, inadequate reimbursement for mental health services and treatment, and threats to physician scope of practice. At the same time that we face a workforce shortage, the number of children and youth seeking mental health care is increasing. Although stigma continues, there have been advances, including a growing public awareness about mental illness and the importance of early intervention and treatment.

“The BPF final report continues to serve as a resource document rich in detail that addresses these concerns and many others. Clearly BPF remains just as relevant today as it was at the start of the decade.”

In addition, the Affordable Care Act’s mental health parity provision and expansion of coverage increased the number of insured Americans. The current administration is threatening these advances. Fiscal and political tensions continue to challenge our health care systems. A population health perspective has led to an interest in healthcare innovation, including integrated, collaborative care models, and tele-psychiatry. Transforming health care in this way will require adjusting medical education and training so child and adolescent psychiatrists are prepared to work within these newer models. The BPF final report continues to serve as a resource document rich in detail that addresses these concerns and many others. Clearly BPF remains just as relevant today as it was at the start of the decade.

BPF moved beyond just analyzing these challenges and opportunities. It presented a “roadmap” that outlined potential solutions and actions so AACAP could simultaneously promote the mental health of children, youth, and families while supporting the professional needs of child and adolescent psychiatrists. After all, we are a professional member organization. The Steering Committee and Council recognized that to be functional, this comprehensive report would need to be distilled into a set of specific and timely priorities. Selecting those requires reviewing current challenges and opportunities on a regular basis and assessing AACAP resources. Since 2013, each incoming Council and Executive Committee has repeated this process, with the BPF report serving as a resource document. The new set of priorities approved by each Council has served to guide the actions of AACAP Council, committees, components, and staff to ensure effective and efficient collaboration. This process of prioritization is one legacy of BPF.

A systematic review of 2018-2019 priorities reveals key areas of productivity. To highlight a few:

“Addressing the Workforce Shortage” remains a priority for AACAP in 2018-2019. BPF provides a series of recommendations and actions to inform and guide specific strategies. Some are immediately relevant in 2018. The Department of Government Affairs continues to organize our advocacy efforts and directly lobby for new loan forgiveness programs for child and adolescent psychiatrists.
The Research, Grants, and Workforce Department has recently updated AACAP’s Workforce Maps to represent the critical shortage of child and adolescent psychiatrists across the United States.

The Advocacy Committee, created in 2015, continues to collaborate with the Government Affairs team to develop resources that define the role of child and adolescent psychiatrists and the impact of workforce shortages on children’s mental health. These materials are being used to inform and engage lawmakers in meaningful discussions, asking for their support for loan forgiveness programs to address our workforce shortage. AACAP members who attended the 2018 Legislative Conference asked lawmakers to co-sponsor legislation to ensure that child and adolescent psychiatrists are eligible for the National Health Service Corp Program. As a result of these combined efforts, AACAP secured an additional nine U.S. Representatives as co-sponsors for this much needed bill. AACAP’s Assembly also passed, and Council approved, a motion to address the workforce shortage. In part, this motion asks that AACAP develop proposals for alternative training pathways recruiting directly out of medical school, focusing specifically on the child and adolescent population, and resulting in a specialty certification in child and adolescent psychiatry with a single specialty board exam.

Other accomplishments that are driven by current priorities include: developing the Learning Management System (LMS) for AACAP members to support additional training opportunities; promoting evidence-based models, such as telepsychiatry, to improve access to care; strengthening collaboration with the AAP to promote integrated, collaborative care; and pursuing funding for additional K-12 grants to increase the opportunities for child and adolescent psychiatry researchers. While a complete list of accomplishments is beyond the scope of this article, I refer members to AACAP’s website for a list of current priorities as well as a means for keeping on top of what AACAP is doing in real time.

As a member of the BPF Steering Committee, the BPF Implementation Task Force, and now Chair of the Assembly, I have seen the positive impact that BPF has had on our organization. As a result of developing and reviewing this comprehensive plan, members of the Steering Committee, Implementation Task Force, and Council recognized the critical importance of establishing priorities. Much work remains to be done, but if we are to be effective, we must continue to establish priorities and be laser-focused in our actions. We must identify areas where we, as child and adolescent psychiatrists, hold specific areas of expertise, areas where our voices are necessary to call attention to the needs of children and youth, and areas where a timely response is required. Extending ourselves beyond the scope of our resources runs the risk of “stretching ourselves too thin” and being unsuccessful in our pursuits.

As a “road map,” BPF was not meant to be prescriptive, but rather aspirational. The BPF Plan for the Coming Decade serves as a call to action to all AACAP members. In the face of overwhelming challenges to deliver quality mental health care to children and adolescents, we must remain steadfast in our advocacy efforts. We must galvanize our grassroots, organize our actions, and use our resources effectively. As child and adolescent psychiatrists, we are uniquely positioned to serve as physician thought leaders informing the development of healthcare systems and policies that support the role of child and adolescent psychiatrists as physician team leaders in multidisciplinary health care teams, as well as promote improved access to quality mental health care for children, adolescents, and families. Collectively, we can make a difference!

Dr. Koss is a Clinical Assistant Professor of Psychiatry at Rutgers-Robert Wood Johnson Medical School and also maintains a private practice in Sparta, NJ. She is currently serving as AACAP’s Assembly Chair and co-chair of AACAP’s Advocacy Committee. She may be reached at dekoss6@gmail.com.
Cannabis Medicalization and Legalization: Clinical Practice Implications for the Child and Adolescent Psychiatrist

Kevin M. Gray, MD

While policies regarding cannabis differ state by state, the last decade has seen a notable shift toward liberalization of American state laws. As of this writing, 29 states have authorized some form of medicalization, and nine states have legalized recreational use among individuals age 21 and over. These policy changes reflect a number of intersecting factors, ranging from social justice to revenue generation to evolving perspectives on the risk/benefit profile of cannabis.

Humans have used cannabis for thousands of years; it remains among the most used psychoactive substances in the world. Its characteristic psychoactive effect, or “high,” is produced by delta-9-tetrahydrocannabinol (THC), one of several dozen cannabinoids and one of hundreds of overall chemical compounds the cannabis plant contains that are ingested during cannabis use. Another cannabinoid, cannabidiol (CBD), is also present in many strains of cannabis but does not produce a “high.” It has been the subject of increasing interest as a potential therapeutic agent. Many strains of recreationally used cannabis differ state by state, and for medical use, the cannabinoid system modulators, the topic of “medical marijuana” has gained traction. Of note, most randomized controlled trials of cannabinoids as therapeutics involved oral administration of reliably-dosed pharmaceutical-grade specific cannabinoids, rather than smoked or vaporized cannabis. Extremely few studies have had children and adolescents as participants. The FDA has approved oral THC to treat chemotherapy-induced nausea and to stimulate appetite in HIV/AIDS in adults. A THC+CBD oromucosal spray is under FDA review for the treatment of spasticity in multiple sclerosis in adults. A CBD oral solution has recently demonstrated positive randomized controlled trial findings as an adjunctive treatment for schizophrenia in adults and for Lennox-Gastaut syndrome and Dravet syndrome-associated seizures in both children and adults. Yet, to date, no randomized controlled trial findings indicate a role for any cannabinoid treatment in child and adolescent psychiatric practice.

Changes in cannabis’ legal status and advances in developing cannabinoid therapeutics must be considered against the backdrop of known risks associated with cannabis use, particularly during adolescence. As with a number of other addictive compounds, adolescents, amid a critical stage of brain development, are more prone to developing cannabis use disorder than adults. One in six adolescent cannabis users, compared to one in eleven adult cannabis users, develops cannabis use disorder. Additionally, adolescent cannabis use may acutely impair cognition, judgment, and psychomotor coordination. Chronically, particularly when used heavily and frequently, it is associated with persistent cognitive deficits and reduced educational attainment, as well as increased incidence and worsened clinical course of psychotic, mood, anxiety, and substance use disorders.

These factors have implications for child and adolescent psychiatry. Patients and families may perceive cannabis as benign or even therapeutic, and may under-appreciate cannabis-associated risks for children and adolescents. The emergence of cannabinoid therapeutics may be conflated and generalized into a perception that cannabis, in any form and used by any population, may have more benefits than risks. Many families may even ask about potential psychiatric recommendation for cannabinoid therapeutics for various conditions in children and adolescents.

As with many complex and evolving topics, the most prudent approach is one that avoids polarization and false dichotomies. Open, nonjudgmental dialogue encourages engagement and allows the clinician to present a reasoned perspective grounded in evidence. Cannabis and cannabinoids are neither all good nor all bad, but on balance, the present state of evidence indicates significant risk and unclear benefit with cannabis use during adolescence. As clinicians and researchers, we can be enthused about breakthroughs in cannabinoid therapeutics while also being concerned about the...
adverse effects of cannabis use during adolescence, particularly when initiated at an early age and progressing to heavy and frequent use. As evidence-focused practitioners, we prescribe and recommend treatments based on high-quality randomized controlled trial findings. We also recognize high-quality translational, neurodevelopmental, and epidemiological research indicating that adolescent cannabis use may be associated with significant adverse outcomes. It is critical that we navigate this topic with balance and reason, modeling a scientifically principled approach to decision-making for patients and families.

References
Poetry

The Art of prescribing

by Lourdes J. Chahin, MD

More than a Science, prescribing is an Art
The Art of integrating your knowledge and your heart
It is the Art of convincing…
-the ones who refuse to take the medication they need
-as well as those who insist on taking what they don’t
Even in this era of specific genome-markers
Prescribing is still an Art
only the wise clinician can master
It is an Art and a Privilege
To handle a double sword weapon:
on one side it can help, on the other one can hurt

It is an Art of duty:
It is the Art of keeping the oath you once took
to do no harm, as Hippocrates would
It is being tuned into your patient’s needs
It is listening carefully and choosing accordingly
It is not being afraid to use an agent, just because it has a bad rap
as long as it’s indicated and you place it in good hands
It is to stick to your morals and ethics and convictions
It is to have the best interest of your patients in mind
It is to never prescribe a medication to other
which you’d never take yourself if you so had
To me, prescribing is an Art

THE DOCTOR

the doctor, he’s serious
familiar with the limits of intervention
diagnosis a round hole for square pegs
even Anatomy a distraction

hope for help the goal
working together toward a theme of progress
recognize the power of behavior
your behavior, everybody’s behavior

imagination a powerful behavior
examine each wish or thought, the daily parade
including those what try to stray
or you want to run away from

relationships too, those others
living and dead, the entire cast
leading players to perfect strangers
yourself, the doctor

– Chuck Joy, MD
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
AACAP’s 66th Annual Meeting takes place October 14-19, 2019, at the Hyatt Regency Chicago, in Chicago, Illinois. 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, or administration.

Abstract proposals must be received at AACAP by February 14, 2019, or by June 4, 2019 for (late) New Research Posters. Please note that the New Research Poster call deadline is earlier this year due to the Annual Meeting being held earlier in October. The online Call for Papers submission form will be available at www.aacap.org in December 2018, and all submissions must be made online.

Questions? Contact AACAP Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

Pathways is AACAP’s new online learning portal, which allows you to access top rated courses to earn CME credit on your schedule. Pathways serves as your continuing medical education home, giving you access to a variety of online courses and activities, including:

- Clinical Essentials on Substance Use Disorder
- Free JAACAP CME
- Lifelong Learning Module 15
- On Demand Douglas B. Hansen, MD, 43rd Annual Review Course

In addition to these great online activities, Pathways transcript feature allows you to track your CME certificates from AACAP and other organizations in one place. To learn more about these exciting CME opportunities, visit www.aacap.org/onlinecme.
You’re Invited to Exhibit!

Don’t miss the chance to connect with specific demographics within the child and adolescent psychiatry community in 2019!

Tabletop exhibits are available at the 2019 Pediatric Psychopharmacology Update Institute and the Douglas B. Hansen, MD, 44th Annual Review Course. The tabletops are placed in high-traffic areas near the coffee break or an area directly adjacent to the meeting room, providing exhibitors with the great opportunity to meet attendees. The vast majority of our attendees are practicing physicians.

Exhibit opportunities details are below:

**Pediatric Psychopharmacology Update Institute**
*Early Treatment Intervention: When, What, and For How Long?*
Boris Birmaher, MD, and Gabrielle A. Carlson, MD, Co-Chairs
January 25-26, 2019
New York Marriott at the Brooklyn Bridge – Brooklyn, NY

**Douglas B. Hansen, MD, 44th Annual Review Course**
March 23-25, 2019
Hyatt Regency Baltimore Inner Harbor
Baltimore, MD

The *Invitation to Exhibit* for AACAP’s 66th Annual Meeting, October 14-19, 2019 at the Hyatt Regency Chicago, Chicago, IL, will be mailed in May.

For more information, please, [www.aacap.org/ExhibitandSponsor](http://www.aacap.org/ExhibitandSponsor) or contact:

Katherine Chen
AACAP Meetings & Exhibits Manager
Phone: 202.966.9574
Fax: 202.966.5894
Email: exhibits@aacap.org

AACAP’s Newest Lifelong Learning Module

AACAP is proud to announce the release of *Lifelong Learning Module 15: Relevant Clinical Updates for Child and Adolescent Psychiatrists*. With the purchase of this module you will have the opportunity to earn **38 AMA PRA Category 1 Credits™** (8 of which will count towards the ABPN’s self-assessment requirement).

**SPECIAL PROMOTION**
Order Module 15 when you pay your 2019 membership dues by January 31, 2019 and

**SAVE $60!**
Look on your dues renewal form for more information.

You can order either version of Module 15 online via our publication store at [www.aacap.org](http://www.aacap.org).

For questions about Module 15 or maintenance of certification, please contact [cme@aacap.org](mailto:cme@aacap.org).

**NEW THIS YEAR**
Module 15 is now available electronically. You can choose to purchase an electronic-only version of Module 15 or still opt to receive the printed version. (Please note that those who purchase the printed version will also have access to the electronic version.)
Session Recordings and Notebooks are available for purchase from past and current AACAP meetings!

- Pediatric Psychopharmacology Update Institute
- Douglas B. Hansen, MD, Annual Review Course
- Annual Meeting Institutes and other sessions

For a complete list, visit the Past Meeting Resources and Publications page at www.aacap.org/cme_and_meetings.

Session recordings include PowerPoint slides. To order, please visit: aacap.sclivelearningcenter.com.

You can also contact:
Multiview Canada
50 Minthorn Blvd, Suite 800
Thornhill, ON L3T 7X8
ATTN: Multiview Media Support
Phone: 972.402.7098
Fax: 905.889.6566

To order Notebooks:
Order online through the Publication Store at www.aacap.org

New Online CME also available!

- Clinical Essentials on Substance Use Disorders (5 hours CME credit)
- On Demand: Douglas B. Hansen, MD, 43rd Annual Review Course (15 hours CME credit)
- Journal CME (1 hour CME credit per monthly issue)

Visit www.aacap.org/onlinecme

Questions? Call 202.966.7300, ext. 2007 or email CME@aacap.org
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 govaffairs@aacap.org.
In the wake of zero tolerance immigration policies, scenes abound of wailing children and parents. These scenes awaken images that I encountered while volunteering as a physician during El Salvador’s civil war of the 1980s. As a child of post-World War II German immigrants, I could not be complicit with my U.S. government’s “Cold War” military response to Salvadorans’ plea for their rights. Instead, I responded to the Salvadoran church’s call for physicians less likely to be targets of dollar-backed bullets at a time when priests and health workers were persecuted for helping the poor.

From 1980-1992, the United States spent millions of dollars training and funding a Salvadoran military that led to the murder, displacement, torture, and disappearance of countless civilians in the name of “democracy.” Among the disappeared were thousands of children separated from families fleeing the slaughter of “scorched earth” policies, snatched by soldiers obeying orders, brought to orphanages staffed by well-intentioned caregivers, adopted as “orphans” to create new families internally or abroad. A search was born at that time; mothers, fathers, sisters, brothers crying, “Where are our children?” and children crying, “Where is my mommy?”

It was not until the post-war era that searching ones found the space to speak of their reality to a United Nations Truth Commission that documented the disappearance of an estimated 3,000 children. Their names are engraved on San Salvador’s Wall of Remembrance and in the hearts of family members that never stop searching. To grieve would be to abandon hope. The sole Jesuit to survive the dollar-backed murder of his Salvadoran university colleagues, Father Jon Cortina, joined the search - a dangerous act at a time when perpetrators of disappearance were granted amnesty. He created an organization I have been privileged to volunteer for – Pro-búsqueda/For-the Search of Disappeared Children. Their tireless staff listened to the cries of mothers and now-grown children separated by military might, documented their stories, cared for their mental health, reunited families with the help of DNA testing, and demanded justice in courts to this day.

In the 1990s, with skills learned from Argentinian colleagues who had provided care to mothers and grandmothers of the disappeared, I joined the efforts of Pro-búsqueda. Argentinian mental health professionals found traditional interventions to lead to emotionless re-telling of traumatic experiences. They collaborated with actors and artists to develop means of sparking collective creativity among small groups of survivors. In El Salvador, I facilitated groups of Pro-búsqueda staff and clients with this process. Survivors emerged from silent terror to draw, dramatize, and play together. One group drew a swastika- donned fist smashing a glass to pieces, separating a family onto separate shards. “In one moment, a child is separated from its mother and thrust into the arms of a soldier,” a group member declared. I see this image today at the U.S.-Mexico border. In an instant the mother/child bond is ruptured. The mother is criminalized as U.S. Immigration and Customs Enforcement (ICE) agents follow orders to deliver her children to “caregiving” institutions in the name of national security. The cry “Never Again” goes unheeded as mothers and children once again cannot be consoled.

The cry and search for justice was born in the 1980s, when poor Salvadorans began to seek basic rights they had been denied. In a Cold War era, the response was U.S.-backed military might that led thousands to flee. As they crossed rivers, they met the strafing of helicopter fire or became confined to camps in Honduras. Those who fled to San Salvador touched the soul of martyred Archbishop Romero who became the “voice of the voiceless” until he was silenced by dollar-backed bullets. Whereas some found asylum in Canada, Europe, and Australia, of the thousands who crossed the Rio Grande, only 2% were granted refugee status. I will never forget the day I accompanied...
a thirteen-year-old Salvadoran boy and his lawyer to immigration court in New York City. We requested asylum at a time when boys were systematically taken from rural buses and converted into child soldiers. The judge responded, “Do you want all Salvadoran boys to come to this country?” He had likely been instructed not to “open the floodgates” and not to grant the promise of asylum from a U.S.-backed military.

Instead, undocumented adolescents in Los Angeles without a “legal” future, confronted by endemic gang violence, defended themselves by creating the gang, Mara Salvatrucha/MS 13. In 1992, when fragile peace accords were signed, U.S. policy opened prison doors, deporting gang members to El Salvador. A newly formed civilian police force was no match for the MS 13, who now reigns supreme. As a result, the Northern Triangle of El Salvador, Honduras, and Guatemala is the homicide capital of the world. Gangs extort money from women selling tortillas from their home. They murder a man who cannot pay “rent” as his son and grandson stand by. They abduct children on their way to school. They torture a boy of a mother who does not know an ex-gang member’s whereabouts. I hear their stories as a volunteer with Physicians for Human Rights’ Asylum Network that pairs those few asylum seekers with legal representation with mental health professionals who document their invisible traumatic wounds – wounds inflicted by gangs that resurrect the horror of the death squads of the 1980s.

Today at the U.S. border, the policy of snatching children from “terrorist” parents is resurrected. I call Pro-Busqueda’s San Salvador office to lament, “It’s happening again.” We continue the search for a place and time when family unity is respected and, in the words of Holocaust survivor Elie Wiesel, “No Human Being is Illegal!” As a physician, I have vowed to do no harm. As a pastor, I resurrect the call of the prophets and of Archbishop Romero to hear the cry of God’s people for peace with justice. As a U.S. citizen, I call out for a time when my government will take responsibility, make reparations, stop the repression, and respect the human rights of all.

Dr. Kessler is an ordained pastor in the Evangelical Lutheran Church in America. She currently serves as a community psychiatrist in the Highbridge section of the Bronx where she works with children and their families with Astor Services for Children. Since 1987, when Dr. Kessler first volunteered in El Salvador during its twelve-year civil war, she has worked with the Central American community in New York, and as a voluntary consultant to mental health programs in El Salvador and in Mexico. She has documented her work in a chapter of the book, Disaster Psychiatry: Intervening when Nightmares Come True. For more than a decade, Dr. Kessler has served as a volunteer with Physicians for Human Rights’ Asylum Program. She is also an avid volunteer faculty evaluator for the Weill Cornell Center for Human Rights. She may be reached at luisecarolk@gmail.com.
Positive Health Indicators
June 1, 2018 – September 30, 2018

A brief summary of the strengths, successes, and overall well-being of AACAP programs, products, and events.

PRESIDENTIAL INITIATIVE ON DEPRESSION AWARENESS AND SCREENING IN CHILDREN AND ADOLESCENTS

Karen Dineen Wagner, MD, PhD, made depression and screening in children and adolescents the focus of her two-year presidential initiative.

Activities between June 1 and September 30, 2018 include:

CHILD AND ADOLESCENT PSYCHIATRIC CLINICS OF NORTH AMERICA

➤ An upcoming special issue of Child and Adolescent Psychiatric Clinics of North America will include 16 chapters authored by various AACAP committee co-chairs on childhood and adolescent depression in special populations including; children of military families, juvenile justice, African American, hearing impaired, transitional age, Latino, substance use, Native American, and LGBTQ. This effort is led by Warren Ng, MD.

AACAP WEBSITE AND OTHER ONLINE RESOURCES

➤ AACAP’s consumer-oriented Depression Resource Center and Facts for Families on Depression in Children and Teens, were updated in June 2018 and October 2018 by the Consumer Issues Committee.

➤ Updates and revisions to the Parents Medication Guide on Depression are led by Graham Emslie, MD.

➤ Kai Ping Wang, MD, wrote an article for AACAP News, CPT Coding, for the May/June 2018 issue.

➤ Dr. Wagner has presented about her presidential initiative at regional organizations of child and adolescent psychiatry and other national meetings.

DEVELOPMENT

➤ A total of $255,796 was raised in the period from June 1 to September 30, 2018. Of this total amount, $27,796 was raised from individuals and $228,000 from corporate donations.

➤ Life Member Appeals: At the request of the Life Members committee, the Development department mailed appeal letters to increase revenue to the Life Members Fund. During the reported time period, the Life Members Fund received $11,260 in donations.

➤ 65th Anniversary Campaign: AACAP turned 65 in 2018 and in celebration a series of mailed and email appeals launched on August 3. To date, AACAP received $5,060 in donations from the 65th Anniversary Campaign.

➤ John E. Schowalter, MD, Endowment: The John E. Schowalter Endowment steering committee had a call to discuss plans on how to best use resources and acquire new funds for the endowment.
GOVERNMENT AFFAIRS & CLINICAL PRACTICE

Lobbying Works!

➤ AACAP successfully advocated for a new federal spending package for FY 2019, increasing funds for NIH by $2 billion and SAMHSA by $584 million. $3.8 billion will fight the opioid crisis, $200 million more than last year.

➤ In addition, authorization of a new, greatly expanded opioid program is poised for enactment. This includes key AACAP-led priorities: requiring states to suspend, instead of terminate, Medicaid for children in the juvenile justice system; extending Medicaid coverage for foster youth until age 26; requiring CHIP to cover mental health benefits; and substance use disorder services for pregnant women and children; and easing numerous regulatory burdens for telehealth providers.

➤ Keeping Immigrant Children and Families Together
In June, AACAP joined numerous organizations, successfully and immediately ending the Trump Administration policy that separated immigrant children from families. One AACAP action alert generated hundreds of urgent messages overnight to the White House.

➤ New Bill Would Provide Loan Relief for Child and Adolescent Psychiatry Fellows
AACAP worked closely with the House Mental Health Caucus co-chairs, Reps. John Katko (R-NY) and Grace Napolitano (D-CA), to draft and introduce bi-partisan loan relief legislation for mental health professionals, including child and adolescent psychiatrists.

➤ AACAP’s Advocacy Liaison (AL) Network Continues to Grow
Monthly AL Network conference calls recently focused on developing issue expertise on countering marijuana legalization, gearing up for the midterm election and ways for AACAP members to engage their elected officials and educating on the regulatory process at the state and federal level.

➤ Making the Case for School Safety
AACAP President-Elect Gabrielle Carlson, MD, and Schools Committee co-chair Sheryl Kataoka, MD, recently testified before the Federal Commission on School Safety on a panel titled “Curating a Healthier and Safer Approach: Issues of Mental Health and Counseling for Our Young.”

➤ Countering psychology prescribing legislation, AACAP weighed in with regulatory authorities in Iowa, asking that psychopharmacology for psychologists come only from psychiatrists. Additionally, AACAP is insisting that required collaboration between a prescribing psychologist and child and adolescent psychiatrist in Iowa is needed for pediatric patients.

➤ Regulatory “Wins!”
AACAP successfully advocated for CMS to retain quality measures on seclusion and restraint in in-patient psychiatric settings, after it proposed their elimination. More recently, AACAP is working individually and with multiple coalitions to counter controversial and unexpected CMS proposals that would revise the Evaluation and Management coding framework, if finalized. AACAP is lobbying to delay implementation of the proposals until a panel of experts, convened by the American Medical Association and including AACAP, can develop workable alternatives to the proposals.

➤ Integrating Behavioral and Mental Health into Primary Care
The Patient-Centered Primary Care Collaborative (PCPCC), launched a new behavioral and mental health integration task force. Its focus is practical ways to bridge payment, coding, and other barriers to mental healthcare services being fully included in integrated care, all to overcome barriers facing patients and AACAP members.

➤ New AACAP Clinical Practice Guidelines (CPG) Development on Track
AACAP’s Committee on Quality Issues is proceeding with the writing of new Atypical Antipsychotic Prescribing, Anxiety, and ADHD CPGs. In addition, systematic reviews on Depression in Children, and Substance Use Disorders in Adolescents, both successfully nominated to AHRQ by AACAP, will soon form the basis of future CPGs.

➤ Online CASII Launching!
Working across departments, AACAP’s Task Force on CASII/ECSI, developed online e-learning training for the Child and Adolescent Services Intensity Instrument (CASII)©.

➤ AACAP-PAC Ends Strong 4th Fiscal Year
AACAP-PAC, once again, raised over $50,000 this cycle from 200+ contributions for pro-child and adolescent psychiatry candidates for Congress. Thanks to these generous, voluntary contributions, AACAP-PAC was able to financially support 28 candidates this year, a record number!
INFORMATION SYSTEMS AND WEB SERVICES

➤ IT developed and built a website portal for AACAP’s Women’s Committee.
➤ IT developed and built a website portal for AACAP’s Health Information Technology Committee.
➤ The IT team installed a new wireless system in AACAP’s Office.
➤ AACAP is completing a comprehensive audit of iMIS, our membership management system, with the goal of increasing efficiency and functionality.

JAACAP

➤ As of September 30, 555 new manuscripts have been submitted in 2018, surpassing the same period in 2017 by 101 manuscripts (454). If submissions continue apace, we can expect more than 700 new submissions in 2018. The all-time high, set in 2016, was 678 submissions.
➤ 354 revisions were submitted in the first 9 months of 2018 – more than 2.5x the same period in 2017 (126), and nearly double total revisions submitted in 2017 (179).

MEETINGS AND CME

➤ AACAP’s 65th Annual Meeting in Seattle closed pre-registration with 3,646 attendees – including 27% of all AACAP members!
➤ We expect to exceed our budgeted projections by about 200 attendees.
➤ The Annual Meeting Exhibit Hall sold out for the fifth year in a row and exceeds our budgeted goal by over $40,000.
➤ Pathways Online Learning Portal launched the first Clinical Essentials online CME program on substance use disorders, the On-Demand version of the Douglas B. Hansen, MD, Annual Review Course, the first electronic-only version of the Lifelong Learning Module, and the Annual Meeting Self-Assessment Exam, and evaluation process. All of AACAP’s CME programs are officially hosted on Pathways. To date, over 2,200+ users logged into the system.

MEMBER SERVICES AND COMMUNICATIONS

➤ 2018 membership numbers are falling into place, and we are on course for another solid membership year.
➤ 2018’s Distinguished Fellow Campaign was a huge success! Goal was 30 – ended with 64!

COMMUNICATIONS

Our communications goal is to properly message, promote, and protect AACAP and its members. Highlights from June 1 through September 30, 2018 include:

➤ President’s Message: Organizations Working at the Border
  ● News Clips (August 15)
  ● All Member Email (August 13)
  ● Homepage (August 13)
➤ AACAP Speaks Out on Behalf of Breastfeeding
  ● AACAP joint letter with 53 other medical organizations, including AAP & AADCAP
  ● News Clips (July 16)
  ● Sign on/Joint letter (July 13)
  ● All Member Email (July 13)
FOR YOUR INFORMATION

➤ Separating Immigrant Children from Their Families

- AACAP News (July/August issue)
- Press Release (June 26 & July 10)
- All Member Email (June 25)
- News Clips (June 25)
- Homepage (June 25)
- Approved by Council (June 23)
- AACAP Policy Statement (June 23)

AACAP’s Consumer Issues Committee developed, reviewed, and updated the following:

New Facts for Families:

➤ Chores & Children (New!)
  No. 125: June 2018

➤ What is a Psychiatric Emergency? (New!)
  No. 126: July 2018

Updated Consumer Friendly Resource Centers:

➤ Depression Resource Center – (Updated June)
➤ Disaster Resource Center – (Updated June)

RESEARCH, WORKFORCE AND GRANTS

➤ AACAP Psychodynamic Faculty Training and Mentorship Initiative (New Award!)
  (16 applications received – 6 awarded)
  Through the Samuel and Lucille B. Ritvo Charitable Fund, a three-year AACAP Psychodynamic Faculty Training and Mentorship Initiative was established. The goal of the award is to train faculty on incorporating more psychodynamic psychotherapy training in child and adolescent psychiatry training programs. Mentors have been matched with selected participants and Annual Meeting programming is underway.

➤ AACAP Educational Outreach Program
  The Educational Outreach Program for General Psychiatry Residents provides up to $1,000 in travel support for general psychiatry residents to receive a formal overview to the field of child and adolescent psychiatry, establish child and adolescent psychiatrists as mentors and experience AACAP’s Annual Meeting.

- AACAP Educational Outreach Program for Child and Adolescent Psychiatry Residents supported by AACAP’s Endowment – 32 awarded 87 applications received
- AACAP Education Outreach Program for Child and Adolescent Psychiatry Residents supported by the John E. Schowalter, MD, Endowment Fund – 1 awarded
- AACAP Educational Outreach Program for Child and Adolescent Psychiatry Residents supported by AACAP’s Life Members Fund – 17 awarded
- AACAP Educational Outreach Program for General Psychiatry Residents supported by AACAP’s Endowment – 15 awarded 69 applications received

➤ Life Members Mentorship Grants for Medical Students provides up to $1,000 of travel support medical students to attend the Annual Meeting. Medical students receive an introduction to child and adolescent psychiatry while attending the Mentorship Program, medical student networking events, scientific sessions, and Life Members events. AACAP received 62 applications and awarded 13 medical students with the Life Members Mentorship Grants.

➤ AACAP’s Beatrix Hamburg, MD, Award is presented each year for the best new research poster by a child and adolescent psychiatry resident. Maria Andreu Pascual, MD, is the recipient of the 2018 Beatrix Hamburg Award for her poster, “The Effect of Traumatic Events on the Longitudinal Course of Youth With Bipolar Disorder”.

➤ The Mentorship Network connects medical students and residents with child and adolescent psychiatrist mentors. To date, 284 AACAP members signed up as mentors and 405 trainees and ECPs requested a mentor.
**Pay Your Dues Online**

Save time by renewing for 2019 online at www.aacap.org.

Follow these three easy steps!

2. Click on the Pay Dues Online at the bottom of the homepage or by visiting your profile.
3. Pay your dues!

   It’s that easy!

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**In Memoriam**

Patricia Crowther, MD, Easton, MD

John Fayyad, MD, Beirut, Lebanon

Mary Hagamen, MD, Concord, MA

Allen Marans, MD, Bethesda, MD

Sidney Werkman, MD, Washington, DC
Welcome New AACAP Members

Adela Adelayo, MD, Peoria, AZ
Babak Akbarian, MD, Lubbock, TX
Shalan Al-abbadi, FBMSPsych, Baghdad, Iraq
Anjani Amladi, MD, Sacramento, CA
Maria Andrea Arriola, MD, Pittsburgh, PA
Arielle Arriaraj, MD, Long Island City, NY
Steve Asbaghi, MD, New York, NY
Thomas L. Atkins, MD, Ann Arbor, MI
Aniqa Azim, Portland, OR
Sara Bachani, MD, Chicago, IL
James Barrecchia, MD, New York, NY
Desiree Baumgartner, MD, Saint Louis, MO
Karina Beinerte, MD, London, United Kingdom
Robin Peter Berger, MBBS, MRCPsych, Edinburgh, United Kingdom
Tirsit Berhanu, Chicago, IL
Noemi Bermudez, Hollywood, FL
Ashley-Marie Berry, MD, Pittsbugh, OH
Stephen Bettweiser, MD, Lebanon, NH
Amit Bhadia, MD, Chicago, IL
Jana D. Bhuiyan, MD, Denver, CO
Adam Bied, MD, Centerenac, NY
Mary Bissada, MD, Nashville, TN
Kavita S. Bommasamudra, MD, Glen Oaks, NY
Ryan Brown, MD, Austin, TX
Kacy Ashley Bugam, Baltimore, MD
Andre Burey, MD, New York, NY
Shane Burke, MD, Peoria, IL
Benjamin Burns, MD, Grand Rapids, MI
Jessica Butala, MD, Pittsburgh, PA
Kenya Caldwell, MD, Durham, NC
Rebecca Campbell, Bremerton, WA
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*Gift made in honor of Boris Birmaher, MD, for his years of service as the Program Committee Chair*
AACAP Policy Statement

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

Appropriate Use of Psychiatric Medication for Youth in Foster Care

Approved by Council October 2018

Background

Foster youth are more likely than their non-foster peers to be prescribed psychiatric medications.1 Determining whether a medication regimen is appropriate is an important yet challenging task. While much attention has appropriately been devoted to high prescribing rates, foster youth are also at risk for unidentified and untreated behavioral health concerns.2,3,4 Determining the appropriateness of prescribing patterns entails more than comparing utilization rates of foster youth with non-foster youth. Some degree of higher prescribing may be appropriate given the increased mental health needs of foster youth.

Recommendations

The American Academy of Child and Adolescent Psychiatry (AACAP)

- Advocates for the judicious use of psychiatric medication, as part of a comprehensive treatment plan, for foster youth diagnosed with a psychiatric illness. Caution should be exercised to ensure that medications are not being used in place of effective psychosocial interventions to support foster youth in addressing their emotional and behavioral problems.
- Recommends consulting with a child and adolescent psychiatrist when foster youth psychiatric prescription concerns arise.
- Supports more research into how best to treat the behavioral conditions most common to foster youth, training on those interventions, and advocacy to better address the complex behavioral health needs of foster youth.

Practical and Concrete Implications of the Policy

Child and adolescent psychiatrists should support child welfare agencies' responsibility to develop evidence-based mental health resources for foster youth. Specifically, where possible, they should ensure that foster care youth are receiving appropriate behavioral health services in general including psychotropic medication where indicated. Child and adolescent psychiatrists may also serve as consultants to child welfare agencies when concerns arise over the appropriate use of psychiatric medications.

References:


The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children’s mental health.

For more information or to review AACAP’s Policy Statements visit [www.aacap.org](http://www.aacap.org).
POLICY STATEMENTS

AACAP Policy Statement Requirements

Policies should:
1) Help shape and articulate AACAP’s position on important policy issues
2) Be clear, concise, and as brief as possible (no more than 500 words, excluding references)
3) Cite current and credible references (5 or less)
4) Be updated at least every 5 years

Format for Policy Statements:

1) **Background**: A summary of the information that provides the rationale for the position taken, including:
   a. The issue that warrants a policy statement by AACAP; the significance of the issue;
   b. Scientific or clinical evidence that leads to the stated position citing several current references (seminal science or reviews)
2) **Recommendation(s)**: A clear, crisp, unambiguous, jargon-free statement of AACAP’s policy or position on the issue.
3) **Practical and concrete implications of the policy** as they impact practice, legislation, or daily life.
4) **AACAP Boilerplate**: The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children’s mental health.

Policy statements should not describe the various committees or individuals that collaborated on the document.

Procedures for Developing AACAP Policy Statements

1. An individual AACAP member or body interested in creating a policy statement submits to the Executive Committee a “letter of intent” to create a policy prior to developing a draft policy statement. (This allows Executive Committee input of the desirability, appropriateness, etc. of the policy – without constituting any form of approval prior to the substantial work of creating a final draft policy statement.)
2. A final draft policy statement is submitted to the Policy Statement Advisory Group (PSAG) (to ensure that the language, tone, format, etc. conform to AACAP policy standards).
3. The author responds to the suggestions made by the PSAG and resubmits the edited draft until PSAG approval is achieved.
4. The Executive Committee receives the PSAG-approved policy statement and decides whether or not to forward it to Council. Feedback on this decision is given to the author, and resolution of problematic issues is undertaken.
5. The Executive Committee-approved policy is emailed to Council members, who have a two-week discussion period to convey concerns and ask questions followed by a one-week voting period to approve or disapprove the policy. (A simple majority determines the outcome).
6. A policy draft that is disapproved by Council vote may be re-written and resubmitted to the PSAG, with an explanation of what was changed; The process begins again with steps 2-5.
7. Upon Council approval, the new policy is printed in *AACAP News*, distributed/publicized as recommended, and placed on the AACAP website.
8. The expectation is for policy statements to be reviewed as needed, but no longer than 5 years, with the decision to renew, update, or sunset. Updated policy statements will be sent to the PSAG, Executive Committee, and Council for approval.
9. Committees are encouraged to collaborate with and get feedback from other relevant committees when drafting or updating a policy statement.
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.
Bay Area Clinical Associates (BACA) is a physician-owned and led organization offering evidence-based mental health services to youth and their families in the San Francisco Bay Area. BACA currently offers outpatient and intensive outpatient services in San Jose, Oakland and Menlo Park and is exploring other sites as well. We are looking for full-time psychiatrists to join our multidisciplinary team in each of our clinics.

Our mission is to set a new standard in providing evidence-based, multidisciplinary, integrated care. We provide all therapy and medication services at one convenient location. We do see adults, but generally only those ages 26 and younger or the parents of the children we treat. Psychiatrists are team leaders and will generally work with 2-3 LMFTs/LCSWs in delivering care. We are looking for committed individuals dedicated to the BACA mission and interested in doing more than just writing prescriptions all day. BACA is a fun, friendly place to work and we go on a first name basis for patients and staff. BACA offers the opportunity for clinicians to run groups and develop innovative treatment programs. As a psychiatrist at BACA, you will provide care to patients both in the outpatient and intensive outpatient programs (IOP). For the outpatient clinic, you will provide individual and family therapy, parent training and medication management. In the IOPs, psychiatrists serve as team leaders and perform evaluation and management visits along with psychotherapy; LCSWs/LMFTs offer individual and family therapy in the IOPs as well.

www.baca.org
OUTPATIENT CHILD PSYCHIATRIST
Boston, MA

Job Description:
Boston Children’s Hospital’s Department of Psychiatry is offering an exciting opportunity for child and adolescent psychiatrists who are interested in working in a teaching children’s hospital affiliated with Harvard Medical School and joining us to provide high quality evidence-based innovative psychiatric care. While we continue to welcome inquiries from anyone who might be interested in joining the Department, we are currently interested in filling the following position. OUTPATIENT CHILD PSYCHIATRIST This full time position is for the physician interested in providing diagnostic and treatment services in our Outpatient Psychiatry Service. We have particular interest in the psychiatrist with interest and expertise in working with medical neuropsychiatric problems (e.g., comorbid neurologic and physical illnesses). This position will also have a role in expanding our telepsychiatry services. We are looking for an individual with a collaborative nature who can build working partnerships both within and outside Department. This position will include an appointment at Harvard Medical School along with teaching opportunities. For each of this position academic rank and salary will depend on experience and qualifications. Women and minorities are encouraged to apply. Applicants should submit their application electronically – including CV and brief statement detailing relevant experience – to Patricia Ibeziako, MD, Director for Clinical Affairs in Psychiatry, Boston Children’s Hospital.

Job Requirements:
Candidate for this position must be board eligible/certified in general and child/adolescent psychiatry.

Company: Boston Children’s Hospital
Job ID: 11585034
http://jobsource.aacap.org/jobs/11585034

OHIO
CHILD AND ADOLESCENT PSYCHIATRIST, DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY AT UNIVERSITY HOSPITALS OF CLEVELAND/CASE SCHOOL OF MEDICINE
Cleveland, OH

Due to the expansion of the Department of Psychiatry’s Child & Adolescent Division, we are seeking additional full-time board certified or board-eligible Academic Psychiatrists to join one of the premier Child Psychiatry programs in the country.

Candidates with academic and teaching experience are preferred. Qualified candidates for Instructor should hold a doctoral degree and completed at least several post-doctoral or fellowship years. Candidates at the Assistant Professor level should demonstrate promise for research and teaching excellence: Associate Professor Candidates should have established a significant professional reputation; candidates for Professor should be internationally recognized for leadership and scholarship in their discipline.

Responsibilities include a varied mix of inpatient and outpatient services, possibly including medication management and/or investigational treatments, as well as training and supervising skilled health professional and psychiatric residents.

Salary is commensurate with qualifications.

University Hospital Cleveland Medical Center, in Cleveland, Ohio, is the 947-bed primary teaching affiliate of Case Western Reserve University.

In employment, as in education, Case Western Reserve University is committed to Equal Opportunity and Diversity. Women and members of underrepresented minority groups are encouraged to apply. Case Western Reserve University provides reasonable accommodations to applicants with disabilities.

Application Information:
Contact: John Hertzler, MD, Department of Psychiatry Case Western Reserve University Phone: 216-983-3272 Fax: 216-844-5883 Email Address: John.hertzer@uhhospitals.org

PENNSYLVANIA
INPATIENT – CHILD/ADOLESCENT PSYCHIATRIST
Mt. Gretna, PA

Job Description:
WellSpan Health is an integrated health system that serves the communities of central Pennsylvania and northern Maryland. The organization is comprised of a multi-specialty medical group of more than 1,200 physicians and advanced practice clinicians, a regional behavioral health organization, a home care organization, six respected hospitals, more than 15,000 employees, and 140 patient care locations. WellSpan is a charitable, mission-driven organization, committed to exceptional care for all, lifelong wellness and healthy communities. Inpatient – Child/Adolescent Psychiatrist with WellSpan Philhaven: Inpatient location in Mt. Gretna, PA Dedicated clinical team that is comprised of an RN/BSN, case worker, psychologists and psychiatric clinical therapists Specialists are available for testing and consultation as needed Physicians typically carry a caseload of 13 patients Average LOS is 11 days with flexibility based on clinical necessity and appropriate aftercare disposition WPH inpatient service has an excellent working relationship with payers, agencies, schools and stakeholders Our inpatient service is part of a broad continuum of child and adolescent services that includes PHP, IOP, community-based services (wrap-around) and traditional outpatient WellSpan Philhaven offers a diverse Medical Staff: 50 psychiatrists (18 C&A psychiatrists); 20 APC’s and 50 psychologists We offer 53 programs in 27 sites in South Central PA WellSpan Philhaven providers will utilize EPIC when Philhaven converts in May 2019 Weekend on call is voluntary & paid additionally on top of base Other work options are available as desired Benefits: Competitive salary, sign on bonus and educational repayment plan Health, dental, vision, life and disability insurance Retirement savings plan with employer contribution and employer match Paid medical malpractice insurance and tail coverage 5 weeks of time off + 6o holidays Continuing Medical Education stipend $3,000 Paid relocation Paid renewals for PA & DEA licenses 2 paid
continued on page 316
Classifieds continued from page 315

medicalsocietyduesFor confidential consideration, please contact: Steven Jacobs, Physician Recruiter:
(717) 851-1537 | sjacobs4@wellspan.org

Job Requirements:
Must have graduated from an ACGME accredited psychiatry residency and child/adolescent fellowship Must be BC/ BE in Psychiatry Must have or be able to obtain a PA medical license Must have or be able to obtain a DEA license

Company: WellSpan Health (894076)
Job ID: 11626093
http://jobsource.aacap.org/jobs/11626093

TENNESSEE
MEDICAL DOCTOR OF ADDICTION MEDICINE, FAMILY PRACTICE, INTERNAL MEDICINE, OR PSYCHIATRY
Knoxville, TN

Job Description:
Our Mission “Improving the lives of the people we serve; helping children, adults, and families with addiction, mental illness, and social challenges.”

Who We Are The Helen Ross McNabb Center (HRMC) is based in Knoxville, the state’s third largest city, and is ideally situated minutes from the Great Smoky Mountains National Park. HRMC is a regional system of care providing psychiatric/mental health, addiction, and social services for children, adults, and families. Services offered range from prevention to acute psychiatric residential services. The focus of work for psychiatrists includes inpatient and outpatient client care as well as crisis stabilization. Our doctors are always a component of a multi-disciplinary team of providers. We are seeking a Medical Doctor of Addiction Medicine, Family Practice, Internal Medicine, or Psychiatry with a Buprenorphine waiver (or we will help you attain one) to serve as the Co-Occurring Medical Director of our Substance Use Programming. Our services include: short term Inpatient Medically Monitored Crisis Detoxification, 28 to 90 days Residential Rehabilitation, MAT and other Outpatient Substance Use services. We use a team approach with APNs, master’s level clinicians, RNs, milieu counselor and case managers - all overseen by a Medical Director. We diagnose, educate, treat, and aim towards helping clients and their families in their struggle with addiction. Who You Are You are energetic, enthusiastic, and client-driven. You are comfortable working in teams with diverse backgrounds, and understand the importance of collaboration to deliver the best possible psychiatric and addiction services to our clients. You have experience with Medication Assisted Treatment and co-occurring disorders. You persist in accomplishing objectives, have excellent attention to detail, and you are comfortable setting priorities. You believe that you can contribute to client success and the success of HRMC. You are looking for a work family to join for the long term. Practice Locations Centerpointe Residential and Medically Monitored Crisis Detoxification Program in Knoxville, TN, and Morristown, TN. Vision To be a premier provider of high quality behavioral health and social services through a continuum of care focusing on our clients first and foremost, delivering quality services, demonstrating effectiveness, inspiring our staff, and building upon the spirit of our founder. Clinical Philosophy Services are designed for the express purpose of helping people live successfully in their own communities. We are striving to utilize best practice standards throughout our delivery system. We recognize and embrace the use of co-occurring treatment practice for individual who experience both mental health and addiction issues. Approach to Care An ecological approach to the treatment of problems takes in consideration the biological, medical, psychosocial, and community impact on the person being treated. Our clients benefit from highly trained and experienced practitioners who work within a team approach with colleagues and our clients/patients.

Benefits All prescribers receive 4 weeks of vacation per year when working a 40 hours work week or prorated if schedule varies. Our 403b retirement plan is very lucrative and we have very affordable individual health insurance and other benefits to round out the compensation package. HRMC values and rewards longevity. Professional training and leave is paid with prior approval. Other benefits: 10 days of additional sick leave per year Work-life balance Paid on-call reimbursement Friendly work environment Flexible Spending Account Affordable dental, vision, and life insurance Reimbursement for Medical Malpractice Insurance costs Free life insurance policy Free long term disability insurance Tennessee The Tennessee landscape is like no other. In East and Southeast Tennessee, there is abundant acreage of mountains, foothills, national parks, waterways, and forests to support a love of nature and outdoor activities. The southern culture is warm, friendly, and familial focused. There is no state income tax in Tennessee. There are few traffic issues in our area, there are multiple large universities, sports team, arts, and leisure activities for you to enjoy. The Helen Ross McNabb Center is so much more than just a place to work. We are mission driven to serve the most disenfranchised populations as well as meeting the rest of the needs of the community. www.mcnabbcenter.org

Job Requirements:
Who You Are You are energetic, enthusiastic, and client-driven. You are comfortable working in teams with diverse backgrounds, and understand the importance of collaboration to deliver the best possible psychiatric and addiction services to our clients. You have experience with Medication Assisted Treatment and co-occurring disorders. You persist in accomplishing objectives, have excellent attention to detail, and you are comfortable setting priorities. You believe that you can contribute to client success and the success of HRMC. You are looking for a work family to join for the long term.

Company: Helen Ross McNabb Center (1125692)
Job ID: 11613728
http://jobsource.aacap.org/jobs/11613728
Indication and Important Safety Information

INDICATION

JORNAY PM is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years and older.

IMPORTANT SAFETY INFORMATION

WARNING: ABUSE AND DEPENDENCE

CNS stimulants, including JORNAY PM, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

CONTRAINDICATIONS

• Known hypersensitivity to methylphenidate or other components of JORNAY PM. Hypersensitivity reactions such as angioedema and anaphylactic reactions have been reported in patients treated with methylphenidate products.
• Concurrent treatment with a monoamine oxidase inhibitor (MAOI), or use of an MAOI within the preceding 14 days because of the risk of hypertensive crisis.

WARNINGS AND PRECAUTIONS

• Serious Cardiovascular Reactions: Sudden death, stroke, and myocardial infarction have been reported in adults treated with CNS stimulants at recommended doses. Sudden death has been reported in pediatric patients with structural cardiac abnormalities and other serious heart problems taking CNS stimulants at recommended doses for ADHD. Avoid use in patients with known structural cardiac abnormalities, cardiomyopathy, serious heart arrhythmias, coronary artery disease, and other serious cardiac problems.
• Blood Pressure and Heart Rate Increases: CNS stimulants may cause an increase in blood pressure and heart rate. Monitor all patients for hypertension and tachycardia.
• Psychiatric Adverse Reactions: CNS stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with a pre-existing psychiatric disorder and may induce a manic or mixed episode in patients with bipolar disorder. In patients with no prior history of psychotic illness or mania, CNS stimulants, at recommended doses, may cause psychotic or manic symptoms.
• Priapism: Prolonged and painful erections, sometimes requiring intervention, have been reported with methylphenidate products in both pediatric and adult patients. Priapism has also appeared during a period of drug withdrawal. Immediate medical attention should be sought if signs or symptoms of prolonged penile erections or priapism are observed.
• Peripheral Vasculopathy, including Raynaud’s Phenomenon: CNS stimulants used to treat ADHD are associated with peripheral vasculopathy, including Raynaud’s phenomenon. Careful observation for digital changes is necessary during treatment with ADHD stimulants.
• Long-Term Suppression of Growth: CNS stimulants have been associated with weight loss and slowing of growth rate in pediatric patients. Monitor height and weight at appropriate intervals in pediatric patients.

ADVERSE REACTIONS

• Based on accumulated data from other methylphenidate products, the most common (≥5% and twice the rate of placebo) adverse reactions for pediatric patients and adults are: appetite decreased, insomnia, nausea, vomiting, dyspepsia, abdominal pain, weight decreased, anxiety, dizziness, irritability, affect lability, tachycardia, and blood pressure increased.
• Additional adverse reactions (≥5% and twice the rate of placebo) in pediatric patients 6 to 12 years treated with JORNAY PM: headache, psychomotor hyperactivity, and mood swings.

PREGNANCY AND LACTATION

• CNS stimulant medications, such as JORNAY PM, can cause vasoconstriction and thereby decrease placental perfusion.
• The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for JORNAY PM and any potential adverse effects on the breastfed infant from JORNAY PM or from the underlying maternal condition. Monitor breastfeeding infants for adverse reactions, such as agitation, insomnia, anorexia, and reduced weight gain.

Please see additional safety information in the Brief Summary of Prescribing Information for JORNAY PM on adjacent pages.

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JORNAY™ (methylphenidate hydrochloride) extended-release capsules, for oral use, ClI Rx only

BRIEF SUMMARY: Consult Full Prescribing Information for Complete Product Information

IMPORTANT SAFETY INFORMATION

WARNING: ABUSE AND DEPENDENCE

CNS stimulants, including JORNAY PM, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

INDICATIONS AND USAGE

JORNAY PM is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years and older.

DOSEAGE AND ADMINISTRATION

JORNAY PM should be taken only in the evening. Adjust the timing of administration between 6:30 pm and 9:30 pm to optimize the tolerability and efficacy the next morning and throughout the day.

The recommended starting dose for patients 6 years and above is 20 mg daily in the evening. Dosage may be increased weekly in increments of 20 mg per day up to a maximum daily dose of 100 mg.

Capsules may be swallowed whole or opened and the entire contents sprinkled onto applesauce.

Do not substitute for other methylphenidate products on a milligram-per-milligram basis.

CONTRAINDICATIONS

Hypersensitivity to methylphenidate or other components of JORNAY PM. Hypersensitivity reactions such as angioedema and anaphylactic reactions have been reported in patients treated with methylphenidate products.

Concomitant treatment with monoamine oxidase (MAO) inhibitors, or within 14 days following discontinuation of a monoamine oxidase inhibitor, because of the risk of hypertensive crisis.

WARNINGS AND PRECAUTIONS

Potential for Abuse and Dependence. CNS stimulants, including JORNAY PM, other methylphenidate-containing products, and amphetamines have a high potential for abuse and dependence. Assess the risk for abuse prior to prescribing, and monitor for signs of abuse and dependence while on therapy.

Serious Cardiovascular Reactions. Sudden death, stroke, and myocardial infarction have been reported in adults treated with CNS stimulants at recommended doses. Sudden death has been reported in pediatric patients with structural cardiac abnormalities and other serious conditions. Patients who develop pericardial chest pain, unexplained syncope, or arrhythmias during treatment with JORNAY PM.

Blood Pressure and Heart Rate Increases. CNS stimulants may cause an increase in blood pressure (mean increase 2 to 4 mmHg) and heart rate (mean increase 3 to 6 bpm). Individuals may have larger increases. Monitor for hypertension and tachycardia.

Psychiatric Adverse Reactions. Exacerbation of Pre-existing Psychosis. CNS stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with a pre-existing psychotic disorder. Induction of a Manic Episode in Patients with Bipolar Disorder. CNS stimulants may induce a manic or mixed episode in patients. Prior to initiating treatment, screen patients for risk factors for developing a manic episode (e.g., comorbid or history of depressive or a family history of suicide, bipolar disorder, or depression). New Psychotic or Manic Symptoms. CNS stimulants, at recommended doses, may cause psychotic or manic symptoms (e.g., hallucinations, delusional thinking, or mania) in patients without a prior history. If such occur, consider discontinuing JORNAY PM.

In a pooled analysis of JORNAY PM clinical trials (N=81), 5% of patients included: any insomnia (41%), decreased appetite (27%), affect lability (22%), headache (15%), upper respiratory tract infection (17%), upper abdominal pain (9%), nausea or vomiting (9%), increased diastolic blood pressure (8%), tachycardia (7%), and irritability (6%). Three patients discontinued treatment because of affect lability, panic attacks, and agitation and aggression. Because of the trial design (6-week open-label active treatment phase followed by a 1-week, double-blind, placebo-controlled withdrawal), the adverse reaction rates described in the double-blind phase are lower than expected in clinical practice. No difference occurred in the incidence of adverse reactions between JORNAY PM and placebo during the 1-week, double-blind, placebo-controlled phase. Study 2 was a 3-week, placebo-controlled study of JORNAY PM (N=81), mean dose 52mg in pediatric patients 6 to 12 years. Most Common Adverse Reactions (incidence of ≥ 5% and at a rate at least twice placebo): any insomnia, decreased appetite, headache, vomiting, nausea, psychomotor hyperactivity, and affect lability or mood swings. One patient in the JORNAY PM group discontinued from the study due to mood swings. Table 1 provides the incidence of adverse reactions reported in Study 2 (incidence of ≥ 2% and at least twice placebo) among pediatric patients 6 to 12 years in a 3-week clinical trial.

Table 1: Adverse Reactions Occurring in ≥ 2% of JORNAY PM-treated Pediatric Patients and Greater than Placebo in a 3-Week ADHD Study (Study 2)

<table>
<thead>
<tr>
<th>Body Organ System</th>
<th>Adverse Reaction</th>
<th>JORNAY PM (N=81)</th>
<th>Placebo (N=80)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric disorders</td>
<td>Any insomnia</td>
<td>33%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Initial insomnia</td>
<td>14%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Middle insomnia</td>
<td>11%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Terminal insomnia</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Insomnia, not specified</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>Affect lability/Mood swings</td>
<td>6%</td>
<td>1%</td>
</tr>
<tr>
<td>Metabolism and nutrition disorders</td>
<td>Decreased appetite</td>
<td>19%</td>
<td>4%</td>
</tr>
<tr>
<td>Nervous system disorders</td>
<td>Headache</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Psychomotor hyperactivity</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Cardiovascular disorders</td>
<td>Blood pressure diastolic increased</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>Vomiting</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Nausea</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Infections and infestations</td>
<td>Nasopharyngitis</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Pharyngitis streptococcal</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Injury, poisoning and procedural complications</td>
<td>Contusion</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Musculoskeletal and procedural complications</td>
<td>Back pain</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td>Rash</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

marketing reports at different times and at therapeutic doses in all age groups throughout the course of treatment. Signs and symptoms generally improve after reduction in dose or discontinuation of drug. Careful observation for digital changes is necessary during treatment. Further clinical evaluation (e.g., rheumatology referral) may be appropriate for certain patients.

Long-term Suppression of Growth. CNS stimulants have been associated with weight loss and slowing of growth in pediatric patients. Careful follow-up of weight and height in patients ages 7 to 10 years who were randomized to either methylphenidate or placebo over 14 months, as well as in naturalistic subgroups of methylphenidate-treated and placebo-treated patients over 36 months (to the ages of 10 to 13 years), suggests that consistently medicated children (i.e., treatment for 7 days per week throughout the year) have a temporary slowing in growth (on average, 2 cm less growth in height and 2.7 kg less growth in weight over 3 years), without evidence of growth rebound during this period. Closely monitor growth (weight and height) in children treated with CNS stimulants, including JORNAY PM. Patients not growing or gaining height or weight as expected may need their treatment interrupted.

ADVERSE REACTIONS

Clinical Trial Experience. Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared with rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice. Clinical Trials Experience with Other Methylphenidate Products in Children, Adolescents, and Adults with ADHD. Commonly reported (>2% of the methylphenidate group and at least twice the rate of the placebo group) adverse reactions from placebo-controlled trials of methylphenidate products include: appetite decreased, weight decreased, nausea, abdominal pain, dyspepsia, dry mouth, vomiting, insomnia, anxiety, nervousness, restlessness, affect lability, agitation, irritability, dizziness, vertigo, tremor, blurred vision, blood pressure increased, heart rate increased, tachycardia, palpitations, hyperhidrosis, and pyrexia. Clinical Trials Experience with JORNAY PM in Pediatric Patients 6 to 12 years with ADHD. The safety of JORNAY PM was evaluated in 280 patients 6 to 12 years of age who participated in two controlled clinical studies of patients with ADHD. Study 1, conducted in pediatric patients 6 to 12 years of age, was comprised of a 6-week open-label dose-optimization phase in which all patients received JORNAY PM (n=125; mean dose 50 mg), followed by a 1-week, double-blind controlled phase in which patients were randomized to continue JORNAY PM (n=65) or switch to placebo (n=54).

During the open-label JORNAY PM treatment phase, adverse reactions reported in > 5% of patients included: any insomnia (41%), decreased appetite (27%), affect lability (22%) headache (19%), upper respiratory tract infection (17%), upper abdominal pain (9%), nausea or vomiting (9%), increased diastolic blood pressure (8%), tachycardia (7%), and irritability (6%). Three patients discontinued treatment because of affect lability, panic attacks, and agitation and aggression. Because of the trial design (6-week open-label active treatment phase followed by a 1-week, randomized, double-blind, placebo-controlled withdrawal), the adverse reaction rates described in the double-blind phase are lower than expected in clinical practice. No difference occurred in the incidence of adverse reactions between JORNAY PM and placebo during the 1-week, double-blind, placebo-controlled phase. Study 2 was a 3-week, placebo-controlled study of JORNAY PM (n=81; mean dose 52mg) in pediatric patients 6 to 12 years. Most Common Adverse Reactions (incidence of ≥ 5% and at a rate at least twice placebo): any insomnia, decreased appetite, headache, vomiting, nausea, psychomotor hyperactivity, and affect lability or mood swings. One patient in the JORNAY PM group discontinued from the study due to mood swings. Table 1 provides the incidence of adverse reactions reported in Study 2 (incidence of ≥ 2% and at least twice placebo) among pediatric patients 6 to 12 years in a 3-week clinical trial.

Table 1: Adverse Reactions Occurring in ≥ 2% of JORNAY PM-treated Pediatric Patients and Greater than Placebo in a 3-Week ADHD Study (Study 2)
Postmarketing Experience  The following adverse reactions have been identified during postapproval use of methylphenidate products. Because these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Blood and Lymphatic System Disorders: Pancytopenia, Thrombocytopenia, Thrombocytopenic purpura
Cardiac Disorders: Angina pectoris, Bradycardia, Extrasystole, Supraventricular tachycardia, Ventricular extrasystole
Eye Disorders: Diplopia, Mydriasis, Visual impairment
General Disorders: Chest pain, Chest discomfort, Hyperpyrexia
Immune System Disorders: Hypersensitivity reactions such as Angioedema, Anaphylactic reactions, Auricular swelling, Bullous conditions, Exfoliative conditions, Urticaria, Pruritus, Rash, Eruptions, and Exanthemas
Investigations: Alkaline phosphatase increased, Bilirubin increased, Hepatic enzyme increased, Platelet count decreased, White blood cell count abnormal, Severe hepatic injury
Musculoskeletal, Connective Tissue and Bone Disorders: Arthralgia, Myalgia, Muscle twitching, Rhabdomyolysis
Nervous System Disorders: Convulsion, Grand mal convulsion, Dyskinesia, Serotonin syndrome in combination with serotonergic drugs
Psychiatric Disorders: Disorientation, Hallucination, Hallucination auditory, Hallucination visual, Libido changes, Mania
Urogenital System: Priapism
Skin and Subcutaneous Tissue Disorders: Alopecia, Erythema
Vascular Disorders: Raynaud’s phenomenon

DRUG INTERACTIONS

MAO Inhibitors  Do not administer JORNAY PM concomitantly with MAOIs or within 14 days after discontinuing MAO treatment. Concomitant use of MAO inhibitors and CNS stimulants can cause hypertensive crisis. Potential outcomes include death, stroke, myocardial infarction, aortic dissection, ophthalmological complications, eclampsia, pulmonary edema, and renal failure.

USE IN SPECIFIC POPULATIONS

Pregnancy  Risk Summary  Published studies and postmarketing reports on methylphenidate use during pregnancy are insufficient to inform a drug-associated risk of adverse pregnancy-related outcomes. No teratogenic effects were observed in embryo-fetal development studies with oral administration of methylphenidate to pregnant rats and rabbits during organogenesis at doses up to 2 and 9 times the maximum recommended human dose (MRHD) of 100 mg/day given to adolescents on a mg/m² basis, respectively. However, spina bifida was observed in rabbits at a dose 31 times the MRHD given to adolescents. A decrease in pup body weight was observed in a pre- and postnatal development study with oral administration of methylphenidate to rats throughout pregnancy and lactation at doses 3.5 times the MRHD given to adolescents. The background risk of major birth defects and miscarriage for the indicated population is unknown. However, the background risk in the U.S. general population of major birth defects is 2% to 4% and of miscarriage is 15% to 20% of clinically recognized pregnancies. Clinical Considerations: Fetal/Neonatal Adverse Reactions CNS stimulant medications, such as JORNAY PM, can cause vasoconstriction and thereby decrease placental perfusion. No fetal and/or neonatal adverse reactions have been reported with the use of therapeutic doses of methylphenidate during pregnancy; however, premature delivery and low birth weight infants have been reported in amphetamine-dependent mothers. Data Human Data A limited number of pregnancies have been reported in published observational studies and postmarketing reports describing methylphenidate use during pregnancy. Due to the small number of methylphenidate-exposed pregnancies with known outcomes, these data cannot definitively establish or exclude any drug-associated risk during pregnancy. Animal Data In studies conducted in rats and rabbits, methylphenidate was administered orally at doses of up to 75 and 200 mg/kg/day, respectively, during the period of organogenesis. Teratogenic effects (increased incidence of fetal spina bifida) were observed in rabbits at the highest dose, which is approximately 31 times the MRHD of 100 mg/day given to adolescents on a mg/m² basis. The no effect level for embryo-fetal development in rabbits was 60 mg/kg/day (9 times the MRHD given to adolescents on a mg/m² basis). There was no evidence of specific teratogenic activity in rats, although increased incidences of fetal skeletal variations were seen at the highest dose level (6 times the MRHD given to adolescents on a mg/m² basis). The no effect level for embryo-fetal development in rats was 25 mg/kg/day (2 times the MRHD given to adolescents on a mg/m² basis).

Lactation  Risk Summary  Limited published literature, based on breast milk sampling from five mothers, reports that methylphenidate is present in human milk, which resulted in infant doses of 0.2% to 0.7% of the maternal weight-adjusted dosage and a milk/plasma ratio ranging between 1.1 and 2.7. There are no reports of adverse effects on the breastfed infant and no effects on milk production. However, long-term neurodevelopmental effects on infants from CNS stimulant exposure are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for JORNAY PM and any potential adverse effects on the breastfed infant from JORNAY PM or from the underlying maternal condition. Clinical Considerations: Monitor breastfeeding infants for adverse reactions, such as agitation, insomnia, anorexia, and reduced weight gain.

Pediatric Use  The safety and effectiveness of JORNAY PM in pediatric patients less than 6 years has not been established. The safety and effectiveness of JORNAY PM have been established in pediatric patients ages 6 to 17 years in two adequate and well-controlled clinical studies in pediatric patients 6 to 12 years, pharmacokinetic data in adults, and safety information from other methylphenidate-containing products. The long-term efficacy of methylphenidate use in pediatric patients has not been established. Long-Term Suppression of Growth Growth should be monitored during treatment with stimulants, including JORNAY PM. Pediatric patients who are not growing or gaining weight as expected may need to have their treatment interrupted. Juvenile Animal Toxicity Data Rats treated with methylphenidate early in the postnatal period had decreased sexual maturation despite a decrease in spontaneous locomotor activity in adulthood. A deficit in acquisition of a specific learning task was observed in females only. The doses at which these findings were observed were at least 2.5 times the MRHD of 100 mg/day given to children on a mg/m² basis. In a study conducted in young rats, methylphenidate was administered orally at doses of up to 100 mg/kg/day for 9 weeks, starting early in the postnatal period (postnatal Day 7) and continuing through sexual maturity (postnatal week 10). When these animals were tested as adults (postnatal weeks 13-14), decreased spontaneous locomotor activity was observed in males and females previously treated with ≥ 50 mg/kg/day (approximately ≥ 2.5 times the MRHD of 100 mg/day given to children on a mg/m² basis), and a deficit in the acquisition of a specific learning task was seen in females exposed to the highest dose (5 times the MRHD of 100 mg/day given to children on a mg/m² basis). The no effect level for juvenile neurobehavioral development in rats was 5 mg/kg/day (0.25 times the MRHD of 100 mg/day given to children on a mg/m² basis). The clinical significance of the long-term behavioral effects observed in rats is unknown.

Geriatric Use  JORNAY PM has not been studied in patients older than 65 years of age.

DRUG ABUSE AND DEPENDENCE

Controlled Substance  JORNAY PM contains methylphenidate, a Schedule II controlled substance.

Abuse  CNS stimulants, including JORNAY PM, other methylphenidate-containing products, and amphetamines, have a high potential for abuse. Abuse is characterized by impaired control over drug use, compulsive use, continued use despite harm, and craving. Signs and symptoms of CNS stimulant abuse include increased heart rate, respiratory rate, blood pressure, and/or sweating, dilated pupils, hyperactivity, restlessness, insomnia, decreased appetite, loss of coordination, tremors, flushed skin, vomiting, and/or abdominal pain. Anxiety, psychosis, hostility, aggression, and suicidal or homicidal ideation have also been observed. Abusers of CNS stimulants may chew, snort, inject, or use other unapproved routes of administration, which can result in overdose and death. To reduce the abuse of CNS stimulants including JORNAY PM, assess the risk of abuse prior to prescribing. After prescribing, keep careful prescription records, educate patients and their families about abuse and on proper storage and disposal of CNS stimulants, monitor for signs of abuse while on therapy, and re-evaluate the need for JORNAY PM use.

Dependence  Tolerance  Tolerance (a state of adaptation in which exposure to a drug results in a reduction of the drug’s desired and/or undesired effects over time) can occur during chronic therapy with CNS stimulants including JORNAY PM. Dependence  Physical dependence (a state of adaptation manifested by a withdrawal syndrome produced by abrupt cessation, rapid dose reduction, or administration of an antagonist) can occur in patients treated with CNS stimulants, including JORNAY PM. Withdrawal symptoms after abrupt cessation following prolonged high-dosage administration of CNS stimulants include: dystrophic mood, depression, fatigue; vivid, unpleasant dreams; insomnia or hyperactivity; increased appetite, and psychomotor retardation or agitation.

OVERDOSAGE

Signs and Symptoms  Signs and symptoms of acute methylphenidate overdose, resulting principally from overstimulation of the CNS and from excessive sympathomimetic effects, may include the following: nausea, vomiting, diarrhea, restlessness, anxiety, agitation, tremors, hyperreflexia, muscle twitching, convulsions (may be followed by coma), euphoria, delusions of grandeur, hallucinations, hyperactivity, mydriasis, dysphoria, palpitations, cardiac arrhythmias, hypertension, hypotension, tachypnea, mydriasis, dryness of mucous membranes, and rhabdomyolysis.

Management of Overdose  Consult with a Certified Poison Control Center (1-800-222-1222) for up-to-date guidance and advice on the management of overdose with methylphenidate. Provide supportive care, including monitoring. Treatment should consist of those general measures employed in the management of overdose with any drug. Consider the possibility of multiple drug overdoses. Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. Use supportive and symptomatic measures.
## ADVERTISING RATES

<table>
<thead>
<tr>
<th>Placement</th>
<th>Cost</th>
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</thead>
<tbody>
<tr>
<td>Inside front or inside back cover</td>
<td>$4,000</td>
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<tr>
<td>Full Page</td>
<td>$2,000</td>
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<td>Half Page</td>
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<td>Third Page</td>
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<tr>
<td>Quarter Page</td>
<td>$700</td>
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