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

Online Registration Closes:
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Cover Photo by AACAP member Sandra Nelson, MD, Mayo Health System, Cody, WY
MISSION STATEMENT

The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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

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

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

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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RESIDENT COUNCIL MEMBER COLUMN

AACAP in the Rainy City: A Trainee’s Guide

Alissa Petrites, MD, and Lan Chi Krysti Vo, MD

If you are a trainee contemplating your first AACAP Annual Meeting, you may be worried about getting left out in the rain (and we are not just talking about the infamous climate of our host city). Navigating an event with the scope of the Annual Meeting can be a bit of a learning curve. But with this friendly guide, you will feel the warmth and support of AACAP just as if you were sipping hot chocolate by a crackling Northwest fire.

AACAP is a large organization with a very explicit focus on supporting trainees. This exists in many structures that are in place throughout the year, including the Committee on Medical Students and Residents (MSR), and—coming soon—the Mentorship Network. The Committee on MSR (which includes fellows) advocates for the needs of AACAP’s trainee members, including planning Annual Meeting programming; hence, you will find a particularly strong emphasis on mentorship at the Annual Meeting. Right from the get-go, you can network with AACAP luminaries at Meet the Life Member Mentors. Many of these Life Members, known as Owls, have served in AACAP leadership roles and pioneered significant developments in child and adolescent psychiatry; they are eager to meet you and share their decades of wisdom. Just as you are encouraged to approach these child and adolescent psychiatry legends, this same ethos applies to everyone you encounter at the meeting. Feel free to walk up and introduce yourself! Continue meeting your colleagues at the Medical Students and Residents Networking Hour. Next, attend the Medical Student and Residents Breakfast, where you will hear perspectives on the trainee experience from three inspirational speakers at various career stages. We offer two mentorship-focused events: the Career Development Forum brings together groups focused on specific topics (advocacy, diversity, academic psychiatry, research, etc.), and the Mentorship Program for Trainees provides a home base from which trainees can explore the field, with free-form groups to discuss topics ranging from planning your Annual Meeting experience to planning your career. Also consider joining the Committee on MSR’s meeting, which is a great way to get more involved with our work. There are several other trainee-specific presentations, including Residents as Teachers and Resiliency in Residency and Beyond.

On the logistical side, stay in the conference hotels if you can (book early), or at least share a room with another trainee. The Committee on MSR maintains a list of people interested in sharing a room. Visit https://tinyurl.com/AACAP-MSR-housing to access this list and various other trainee-specific documents. For more updates and information, you can also join AACAP’s unofficial MSR members’ Facebook group. Once you are at the meeting, visit the Medical Student Resource Center for a casual meet and greet with AACAP leaders.

When you register at the meeting, you will receive a badge with what may seem to be an embarrassingly large number of ribbons - wear them! These help people learn about you and are great conversation-starters. Speaking

continued on page 214
AACAP in the Rainy City continued from page 213

of starting conversations, if there is someone you are hoping to meet, poster sessions are a particularly good time to do so. People may be available after presentations, but typically there is a long line, and conversations are kept brief. At a poster session, however, they are standing there ready and waiting to talk! You can identify people you want to meet even before the conference begins using the schedule or AACAP’s App; they will be impressed if you shoot them an email beforehand to set up a time to meet. Also be ready to give your “tell me about yourself” elevator pitch! Lastly, you are encouraged to attend various institutions’ receptions (on Thursday evening); the schedule is listed in the conference program.

There are many events going on simultaneously, and there is no way you can attend them all, so choose what seems the most appealing. It is alright to slip out to hit two presentations during the same time slot, but try to sit near the side or back if you plan to do so. You are encouraged to sign up to be a monitor. This involves minimal added effort on your part and gets you free registration and many other perks. Lastly, for future AACAP meetings, we strongly encourage you to apply for AACAP’s various trainee awards. These provide invaluable support for attending the Annual Meeting and, for many members of the Committee on MSR, have had tremendous impacts on our decisions to pursue careers in child and adolescent psychiatry.

Finally, take some time to enjoy the city! Of course, Seattle has the Space Needle and Pike Place Market, but consider getting a bit off the beaten path: visit the zany Museum of Pop Culture, ride a ferryboat around Puget Sound, sample delicious treats at Theo Chocolate Factory, or take a literally less beaten path with a walk around one of Seattle’s beautiful parks (Volunteer Park, Discovery Park, Seward Park). And while Seattle’s reputation for rain is something of a misconception—it is usually more of a mist, so Seattle actually gets less annual rainfall than recent host cities, New York and Washington, DC—we do still recommend a raincoat.

Dr. Petrites is a fourth year general psychiatry resident at University of Washington and a member of the Committee on Medical Students and Residents. She may be reached at alideus@uw.edu.

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Suicide in African Americans

“While factors such as family dysfunction, exposure to environmental violence or trauma, exposure to substance abuse, and poverty affect all communities at risk, additional factors such as racial discrimination and disenfranchisement must be considered in African-American youth. These unique factors are relevant across all socioeconomic and regional groups of African-American youth.”

The rate of suicide in this age group had increased for African-American children.

Mental illness is likely an important and poorly addressed issue in the African-American community. Being African American is correlated with greater unmet need of mental health services. A fear of stigma related to mental illness, reluctance to trust authority figures, reliance on church and community for help, and the belief that mental illness does not affect the African-American community have all been factors in the reluctance for African Americans to access mental health services. This is confounded by limited mental health resources and poor identification or misidentification of mental illness in African Americans. Further complicating treatment, studies have shown that when present, mental illnesses often manifest with greater severity in African Americans.

Similar to adults, mental illness in African-American youth has not been adequately addressed. Historically, suicide in African-American youth was not seen as significant a problem as it was in same-age non-African-American youth. However, the CDC Data & Statistics Fatal Injury Report for 2016 shows that in the preceding decade while the overall rate of suicides in black youth was less than the rate in white youth, the overall rate of increase in suicide in black youth was greater than the increase in white youth.

Several factors have been suggested to explain the increase in suicide in black youth. Some of these factors, such as poverty, exposure to violence, substance abuse in the home, and unstable home environments are universal to all at-risk individuals. However, some factors are unique to the experience of being African American in the United States. Data have shown that mental illnesses are often unrecognized or under-recognized in African-American youth. Problematic behaviors are often penalized in African-American youth rather than treated with appropriate psychologically sensitive interventions. In general, preventative resources and screening tools are not as available in underserved communities that have greater numbers of minority residents.

In a nation experiencing greater racial turmoil, it is crucial that we also consider the effects of racial discrimination on the mental health of African-American youth. A 2017 study looked at the effect of racial discrimination on death ideation in African-American youth. The study revealed that experiencing racial
discrimination was positively linked to death ideation, depressive symptoms, and anxiety symptoms.

While greater changes need to be made in how mental health is accessed in all communities, there are some important considerations for mental health providers when working with African-American youth. Most important of all is being aware of the change in the statistics related to suicide with a greater recognition of the unique vulnerabilities of African-American youth. While factors such as family dysfunction, exposure to environmental violence or trauma, exposure to substance abuse, and poverty affect all communities at risk, additional factors such as racial discrimination and disenfranchisement must be considered in African-American youth. These unique factors are relevant across all socioeconomic and regional groups of African-American youth. Mental health providers should also maintain an awareness of the data that shows that African-American youth are often misdiagnosed with behavioral problems rather than mood or anxiety disorders which can result in incorrect and often harmful interventions.

Incorporating some of the protective factors into the management of these youth in mental health settings can be invaluable. Utilizing the support from immediate and extended family and friends, and helping support a strong ethnic identity can be valuable tools in conjunction with traditional mental health interventions. Above all, offering education to families and communities can assist in both treatment and prevention of those conditions that may lead to suicide. With the CDC releasing the most recent statistics on suicide in June of 2018, it behooves us to be proactive in our efforts at addressing these disturbing trends.

References

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**ETHICS COMMITTEE**

**Improved Ethics Website**

Check out the updated Ethics website on [www.aacap.org](http://www.aacap.org) with more visuals and live links. The Ethics website can be accessed under Member Resources, Resources for Primary Care, and Families and Youth tabs. AACAP’s Ethics Committee developed the content for the website and worked closely with Paul Hou, Director of Information Systems & Web Services, on the redesign. All materials are open to the public except for Ask Ethics ([askethics@aacap.org](mailto:askethics@aacap.org)), a service reserved for AACAP members.

The changes to the website were made to make it more user-friendly and curriculum-oriented. There are seven quick links: Codes of Ethics, Training and Education, Clinical Practice, Legal and Forensic Issues, State and Federal Resources, Research/Scholarly Activities, Related Ethics Links, and Ask Ethics. The Clinical Practice section includes articles organized by topic, including abuse and neglect reporting, boundary issues, confidentiality, foster care, gender dysphoria, involuntary commitment, and more. State and Federal Resources is a new quick link that includes several website links providing state specific information, such as child abuse and neglect reporting contact information, child custody laws, and civil commitment criteria and procedures. The Related Ethics Links provide links to other professional medical organizations and to a number of ethical societies.

We hope AACAP members and the public find the new look and content of the Ethics Website helpful. Please spread the word to your colleagues inside and outside of child and adolescent psychiatry as well as to family members. We welcome your feedback and suggestions. If you have a recent or classic article you think should be included on the Ethics website, please feel free to email the reference to the Ethics Committee Co-Chairs, Gail A. Edelsohn, MD, at [edelsohnga@ccbh.com](mailto:edelsohnga@ccbh.com), and Maria E. McGee, MD, MPH, at [mariamcgee@creighton.edu](mailto:mariamcgee@creighton.edu).

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Need consultation on an ethical dilemma?

The Ethics Committee offers Ask Ethics ([askethics@aacap.org](mailto:askethics@aacap.org)) as a service to all AACAP members seeking a consultation on ethics. Once the consult request is received, an Ethics Committee member responds promptly to the consultee via email and telephone with a focus on practical considerations and identification of underlying ethical principles. Members seeking consultations are asked for permission to use their de-identified scenarios as a springboard for a future AACAP News Ethics Column. The consultation does not require members to permit their case to be used more broadly for an educational purpose.

Consultation requests that involve legal advice, malpractice concerns, licensure actions, or complaints about members’ behaviors are beyond the scope of the Ethics Committee’s charge.

We are pleased to provide consultation to AACAP members. We encourage residency and fellowship program directors to consider Ask Ethics as a resource for their trainees.

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ADVOCACY COMMITTEE

Juvenile Justice and Advocacy

As has been well documented, the prevalence of mental disorders among youth in the juvenile justice system is remarkably higher than that of their counterparts in the general population. Estimates reveal that approximately 50–70% of the two million youth entering the juvenile justice system have a mental disorder. The opportunities for advocacy are numerous. AACAP has issued many position statements in the recent past that have direct relevance to juvenile justice.

As with many other areas in which child and adolescent psychiatrists are involved, one must take into account the current landscape in which these problems present primarily for the purpose of determining the level of resources which may be accessible to one’s advocacy strategic planning. Unlike the general health arena, juvenile justice is an area in which other human service sectors, beyond those traditionally found in healthcare, must collaborate in order to meet the needs of youth in the juvenile justice system. The different array of professional staff often does not have any substantial health related training or expertise; many may have a background in the area of public safety. The mandates of the juvenile justice and health sectors are different. These mandates and composition of staff pose both opportunities and challenges for child and adolescent psychiatrists. In addition, certain services such as mental health services, including in institutions of juvenile detention and confinement, are a federal requirement to which all youth must have access; this is in contrast to the general community where such services are not a federal requirement. State standards and accreditation standards of detention facilities include access to mental health services. Child and adolescent psychiatrists should understand that both state and federal laws and regulations govern the juvenile justice sector and, as such, should inform advocacy planning.

There are several oversight bodies at local, state, and federal levels, which monitor certain aspects of juvenile detention facilities. For example, in California, every county Probation department reports quarterly data on suicide attempts, completed suicides, number of youth in detention who receive mental health services, and the use of psychotropic among youth detainees to the state agency, Board of State and Community Corrections (BSCC). These reports are posted on the state agency for the general public. The BSCC is charged with ensuring that all facilities adhere to state laws and regulations.

It is advisable that a child and adolescent psychiatrist work within medical organizations of which one is a member, such as a regional organization and/or with multiple organizations that share common interests. There are many local, state, and/or national private nonprofit legal advocacy firms, such as the National Center for Youth Law and the Burns Institute, which have juvenile justice issues as a priority and often seek partnership with medical professionals and/or medical professional organizations for purposes of advocacy. In addition, the MacArthur Foundation offers grants for improving juvenile justice systems and has publications on model programs. AACAP has also published monographs on juvenile justice reform.

An advocacy effort at the regional organization level may involve its leadership to meet with local or state authorities regarding certain concerns, which directly relate to juvenile justice and mental health. For example, several years ago, the Council of the Southern California was very concerned about the additional administrative burden for child and adolescent psychiatrists when new state regulations were issued in regard to the prescribing of psychotropic agents to all children who were dependents of the state. More specifically, the burden on child and adolescent psychiatrists was the requirement to submit to the juvenile court judge a five-page form, which detailed the child’s psychiatric history and proposed medication regimen, among other information. This form served as the basis by which the juvenile court judge would issue an order to have proposed medication regimen dispensed; such an order was issued after an initial review and recommendation by a medical team, which assisted the juvenile court for this purpose. These children were adjudicated in either delinquency or dependency courts. The council believed the burden was extraordinary and that child and adolescent psychiatrists who worked with this population were being identified as the culprits in the emerging statewide concern of “overprescribing” to children who were dependents of the state. The Council contacted the chief of the state child and family court system, who at that time was also the presiding judge of the juvenile court of Los Angeles County. The Council leadership arranged to have a meeting at the home of one of the child and adolescent psychiatrists with the judge. The judge indicated that he would be willing to provide a sample of the completed forms so that the council could give a summary opinion on the use of such a form. Upon review of approximately 70 forms, the council opined that, in fact, there were a substantial number of proposed medication regimens that did not appear to comply with general acceptable standards of care and, therefore, did not make any substantial request to change the review process at that time.

Advocacy on a statewide level might entail a discussion by a state council of...
pending bills in the state legislature, e.g., the termination of Medicaid benefits for a youth upon entry to a state or local detention facility. Although healthcare is an entitlement in all detention and confinement facilities during post adjudication by federal law, the fact that a youth with mental illness will have to re-enroll in Medicaid upon release from the detention facility could result in adverse mental health outcomes as a result of not having health insurance, e.g., Medicaid in this instance. Councils could review bills pending in state legislature that affect treatment of mental illness in the juvenile justice population and offer opinions to the author (state legislator) of the bill. A regional organization could pursue technical assistance from AACAP’s Advocacy Committee in conjunction with the regional organization designated state legislative liaison. In some instances, an opportunity may arise for a regional organization to sign onto an amicus brief regarding a hearing that may take place in state court.

On a national level, a state council may want to communicate in writing with its congressional representatives on a bill that is pending either in the U.S. House of Representatives or U.S. Senate related to juvenile justice and mental health. Such was done by the California Academy of Child and Adolescent Psychiatry in response to some of the recent “repeal and replace” efforts by the two houses of Congress. AACAP staff for the Advocacy Committee assisted with this effort. Another possibility may present itself when the reauthorization of the federal Juvenile Justice and Delinquency Prevention Act is set to expire, as it must be reauthorized periodically by Congress.

In summary, there are multiple opportunities for child and adolescent psychiatrists to advocate in the area of juvenile justice and mental health. An AACAP advocacy toolkit is available online.

References
2. Standards for Health Services in Juvenile Detention and Confinement Facilities.

Dr. Arroyo is Associate Med Dir for Los Angeles County Dept of Mental Health; Clinical Assistant Professor, Keck USC School of Medicine, Dept of Psychiatry. He has served as chair of AACAP’s Task Force on Juvenile Justice Reform; Co-editor of AACAP Monograph on Juvenile Justice Reform; member of CA Juvenile Justice Commission; PI on SAMHSA system of care award; and provides clinical care to young offenders. He may be reached at wmarroyo@pacbell.net.

Life Members Reach 200!

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

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

Stay involved. Stay connected to all Life Members activities, programs, and photos by reading the Life Members Owl eNewsletter.
Exploring Mental Health Parity

Laura Willing, MD

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) mandates equal coverage for mental health and substance use treatment similar to medical and surgical care. However, ten years later, many of our patients still struggle to find affordable mental health care.

Quantitative treatment limits (QTLs) are one way to measure parity. This means that a health plan must not have more restrictive deductibles, co-pays, visit limits, or days covered for mental health and substance use treatment than it does for medical and surgical care. For example, if a plan would cover up to 12 visits a year for a surgical specialist, it must cover up to 12 visits a year with a psychiatrist. Likewise, if the co-pay is $30 for a visit to the cardiologist, the co-pay for a psychiatrist cannot be $60. The same logic applies to inpatient coverage. If an insurance plan will cover 28 days on a medical floor, they cannot limit coverage for mental health reasons to fewer days. Of course, the plan can still limit coverage based on “medical necessity,” but they cannot limit care based solely on the number of covered days in the insurance policy. QTLs are measurable by definition. In general, since 2008, insurance companies have made more progress in creating equity with regard to quantifiable measures such as co-pays and visit limitations.

However, there are also non-quantitative treatment limitations (NQTLs), which are more difficult to measure, identify, and enforce when there is a parity violation. NQTLs include prior authorizations, formularies for prescription drugs, medical management standards for determining medical necessity, and standards for determining provider participation in a network, including reimbursement rates for those providers. For example, if an insurance plan requires preauthorization for all mental health and substance use disorder treatment, but not medical and surgical treatment, that may represent a parity violation. Furthermore, if an insurance plan more stringently requires prior authorizations for stimulants or selective serotonin reuptake inhibitors (SSRIs) as compared to asthma or cardiac medications, that may also represent a parity violation. One area of particular concern for parity in our field is network adequacy and access to care. If an insurance plan does not have an adequate network of psychiatrists and therapists (across the continuum of care), causing patients to be unable to find care or causing patients to have to pay higher co-pays for out-of-network providers, this likely represents parity violation. However, this is difficult to quantify, measure, and prove because it involves comparing the adequacy of the plan’s mental health network to the adequacy of their physical health network.

In addition, it is important to note that in MHPAEA, mental health parity applies only if the insurance plan covers both mental health and substance use disorders as well as medical and surgical care. When the Patient Protection and Affordable Care Act (ACA) was signed into law in 2010, MHPAEA was amended and strengthened. Because the ACA includes mental health and substance use treatment as essential health benefits, all insurance plans must now meet the requirements of mental health parity. Should the ACA be weakened or altered in the future, mental health parity would only apply to those plans that include both mental health care and physical health care.

Knowing how to report parity violations can be confusing because it depends on the type of insurance plan. Usually your state Department of Insurance or the federal Department of Labor are good places to start.

This Department of Health and Human Services (HHS) website will help you, or your patients, determine where to report a suspected parity violation: www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html.


Check out resources for mental health parity from the Kennedy Forum: www.thekennedyforum.org/resources.

Dr. Willing is on faculty at Children’s National Medical Center and George Washington University in Washington, DC. She completed her general psychiatry residency and child and adolescent psychiatry fellowship at the University of North Carolina in Chapel Hill before spending last year as the APA Jeanne Spurlock Congressional Fellow. Dr. Willing is a former AACAP Resident Scholar and a current member of AACAP’s Advocacy Committee. She may be reached at lmw5p@virginia.edu.

In August 1907, Pike Place Market opened for business and today is the oldest continually operating farmer’s market in America.
New Grant Seeks to Expand and Improve Access to Behavioral Health Care for Children in Missouri

Ginger E. Nicol, MD, Laine Young-Walker, MD, Ujjwal Ramtekkar, MD

ACAP members Laine Young-Walker, MD (PI), and Ujjwal Ramtekkar, MD, (co-PI, consultant), are the co-founding directors of an exciting new collaborative care project in Missouri. The Missouri Foundation for Health has partnered with The University of Missouri in funding a $3M, three-year statewide initiative to expand Primary Care Provider (PCP) access to child and adolescent psychiatrists. The Missouri Child Psychiatry Access Project (MO-CPAP) is modeled after similar CPAP initiatives implemented in more than 20 states across the United States, supported by the National Network for CPAPs (NNCPAP), which promotes the development, sustainability, and quality of CPAP programs nationwide.

As many as 25% of the nation’s youth suffer from clinically significant behavioral health problems, with 75% or more receiving behavioral health care from a PCP. In the state of Missouri, many children living in rural communities in particular have no access to behavioral health professionals, thereby significantly decreasing the likelihood of receiving treatment. MO-CPAP has been specifically adapted to fit children’s mental health needs in Missouri by targeting consultation and educational outreach efforts to PCPs. The purpose of this pilot project is to develop a network of PCP users and child and adolescent psychiatrist consultants, with the overarching goals being to 1) create a telephonic consultation service for PCPs, 2) develop educational outreach and support services for PCPs, and 3) link patients and families to behavioral health care coordination and community resources.

Beginning in January, MO-CPAP began the six-month planning phase of the project, which will initially be piloted in Eastern Missouri beginning in the second half of 2018, with expansion to the Central Region in Year 2. PCP support services include timely telephonic consultations with a child and adolescent psychiatrist regarding screening, diagnosis, and management of behavioral health conditions, linkage and referral services to connect patients to community-based behavioral health care and other resources for treatment, as well as ongoing education and training opportunities for participating PCPs.

MO-CPAP benefits from committed partnerships with key stakeholders, including the Behavioral Health Network, National Alliance on Mental Illness-St. Louis (NAMI-St. Louis), Assessment Resource Center (ARC), Washington University Pediatric & Adolescent Ambulatory Research Consortium (WU PAARC), Behavioral Health Response (BHR), and the Greater St. Louis Council for Child & Adolescent Psychiatry. Each organization is represented on the MO-CPAP steering committee, which will meet monthly during the first year of funding to assist with problem-solving, development, and meeting of project milestones.

MO-CPAP is currently in the process of recruiting both PCP and CAP participants. PCPs who are eligible for enrollment in MO-CPAP include pediatricians, family medicine physicians, physician assistants, and advanced nurse practitioners in the state of Missouri. Requirements for child and adolescent psychiatrist consultants include board certification in child and adolescent psychiatry, licensed in the state of Missouri, with at least five years of clinical practice experience. Enrollment of MO PCPs and child and adolescent psychiatrist consultants will begin this spring with a target service initiation date of July 1, 2018. Missouri AACAP members interested in participating as child and adolescent psychiatrist consultants can contact Wendy Ell at ellw@health.missouri.edu or Kate Barbier at umhspsymo-cpap@health.missouri.edu.

Dr. Nicol is President of the Greater St. Louis Council for Child & Adolescent Psychiatry, Assistant Professor of Psychiatry at Washington University in St. Louis, and MO-CPAP steering committee member. She may be reached at nicol@wustl.edu.

Dr. Young-Walker is Professor of Psychiatry and Chair of the Division of Child & Adolescent Psychiatry at the University of Missouri, Columbia. She may be reached at youngwalkerl@health.missouri.edu.

Dr. Ramtekkar is Vice President of the Greater St. Louis Regional Council for Child & Adolescent Psychiatry. He may be reached at drujjwal@yahoo.com.
NEW MEXICO CHILD PSYCHIATRISTS

A Tale of Two Borders

Shawn Sidhu, MD

On Monday, May 7, Attorney General Jeff Sessions delivered a speech to the Association of State Criminal Investigative Agencies outlining new immigration policies. In this speech, Sessions stated, “Last month, I put in place a ‘zero tolerance’ policy for illegal entries on our Southwest border referred by the Department of Homeland Security,” and added “if you are smuggling a child, then we will prosecute you and that child will be separated from you as required by law. If you don’t like that, then don’t smuggle children over our border.”

In the weeks and months that followed, stories, images, and sounds emerged that shook our nation to its core. The American Civil Liberties Union (ACLU) sued the government in a class action lawsuit on the grounds that the separation of families is a violation of constitutional and due process rights. The ACLU lawsuit was filed on behalf of a Congolese woman who was separated from her 7-year-old daughter for five months after seeking asylum at a San Diego border crossing, and another Brazilian asylum-seeker who has been separated from her 14-year-old son since an arrest ten months ago. The Congolese woman reports she could hear her daughter in the next room, screaming “Mommy, don’t let them take me!” The mother was detained in San Diego while her daughter was placed at a youth shelter in Chicago 2,000 miles away with intermittent phone contact.

On February 20, 2018, a 20-year-old female named Mirian arrived at the Texas border with an 18-month-old son after fleeing persecution in Honduras. She reports that agents ordered her to place her son in the back seat of a government vehicle and that both of them cried as he was driven away. She reports that she was never told why her son was being taken away from her. A case manager told her that her son asked about her and “cried all the time” in the days after he arrived at a separate facility. Mirian stated to reporters, “I had no idea that I would be separated from my child for seeking help… I am so anxious to be reunited with him.”

Esteban Pastor, a 28-year-old Guatemalan male, was also separated from his 18-month-old son last summer. He states, “I cried. I begged. No one could tell me anything.” He reports that border agents replied, “Your kid is going to a shelter. You’re going to a jail.” He reports pleading to no avail, “Let me go back to Guatemala. Don’t separate us. I want to go back to my country with my son.” Pastor was deported to Guatemala months later, but his child remained in the United States for two months. The father and son were reunited after being separated for four months after Pastor made two dozen phone calls to authorities, and Pastor reports, “I didn’t know if I would see him again.”

While many Americans were shocked that we had come to this point as a nation, the national response to this policy has been heartwarming and inspiring. On Friday, June 1, thousands of individuals across the country participated in the Families Belong Together National Day of Action. Similarly, on Friday, June 29, thousands across the United States joined in “Keep Families Together” protests to end family separation. These peaceful protests were organized in opposition to the separation of families at the border, and took place in more than 24 cities across the country.

The response from the medical community, including AACAP, has been strong and swift. On June 20, 2018, 17 mental health organizations sent a letter to the U.S. Department of Justice, the U.S. Department of Health and Human Services, and the U.S. Department of Homeland Security with a position statement completely against the separation of children from their parents at the border. AACAP President Karen Dineen Wagner, MD, PhD, issued a President’s Statement on Separating Children from Families in which she highlighted that “children who experience sudden separation from one or both parents, especially under frightening, unpredictable, and chaotic circumstances, are at higher risk for developing illnesses such as anxiety, depression, post-traumatic stress disorders (PTSD), and other trauma-induced reactions.”

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Public pressure resulted in an unforeseen reversal by the current administration on June 20, effectively ending mandatory parental separation. This was a great victory for child and family advocates across the nation, despite the fact that thousands of children remain separated from their parents.

Here in the Southwest, the response has also been overwhelming from mental health providers and community members who want to get involved in helping immigrant families who are fleeing torture and persecution. New...
Committees/Assembly

A Tale of Two Borders continued from page 223

Mexico Child Psychiatrists (NMCP), the regional organization representing New Mexico in AACAP’s Assembly, received an AACAP Advocacy and Collaboration Grant this year to host an asylum evaluation training for local providers. The goal was to train approximately 15 mental health providers in providing evaluations for the purpose of supporting the asylum claims of individuals fleeing persecution.

Our ultimate goal is to establish a broad network of mental health providers who are willing and able to provide evaluations for families fleeing torture and persecution. Thanks to AACAP’s Advocacy and Collaboration Grant, we are well on our way with more momentum than we could have imagined. Most inspiring is that this movement has resulted in real-life changes for individuals seeking asylum, as the majority of individuals who have received mental health evaluations in New Mexico have gone on to win their asylum cases and gain freedom from torture and persecution!

There is an incredible amount of grassroots energy nationwide at this time, and we must all harness this energy as a catalyst for real change in the lives of our patients.

References


Dr. Sidhu is an associate training director in Rural and Community Training in General Psychiatry Residency Program, an assistant psychiatry clerkship director at the University of New Mexico School of Medicine, and an assistant professor in the Department of Psychiatry, Division of Child and Adolescent Psychiatry. He may be reached at shawnsidhu@gmail.com.
DIVERSITY AND CULTURE COMMITTEE

Promoting Diversity Within AACAP Via Caucuses

Jang Cho, MD

Not everyone knows that there are caucuses within AACAP that meet every year during the Annual Meeting. Currently, three caucuses are active in AACAP—Black Caucus, Hispanic Caucus, and International Medical Graduate (IMG) Caucus. Historically, after receiving support from the Diversity and Culture committee, the Black Caucus and Hispanic Caucus were inaugurated in 2010 with two-year trial periods, with the initial goals of providing support to diverse minority members, fostering inclusiveness within AACAP, and offering ways for minority members to be more involved. The IMG Caucus was added in 2012, and finally, the Asian Caucus was recently approved by AACAP and will be having its inaugural meeting during the 65th Annual Meeting in Seattle. This article will highlight goals and functions of each caucus for a more in-depth understanding of their purpose and objectives.

The Black Caucus was inaugurated in 2010 with the intention of providing a space where attendees who are African-American or of African descent to be able to connect, network, and support each other in their careers and become more involved in AACAP activities. Since its inauguration, the Black Caucus has identified goals of expanding submissions for events related to the needs of African-American children on AACAP’s agenda, such as youth in the child welfare system and identity issues in biracial and multiracial children. It also has worked on expanding networking for career purposes for its members and has emphasized the importance of recruiting more psychiatrists of color into child and adolescent psychiatry.

The Hispanic Caucus was also inaugurated in 2010 to provide a space for attendees who are Hispanic or interested in Hispanic issues to network, share difficult clinical scenarios, or brainstorm ideas to improve access to mental health care and care in general for Hispanic children and their families. Since its inauguration, the Hispanic Caucus has been active in promoting advocacy for Hispanic children, and providing mentorship to its members, and working on providing linguistic resources for families and clinicians. The members of the Hispanic Caucus also have aspired to reach out to colleagues in Latin America and to establish a working relationship with other national Latino groups.

The IMG Caucus was started in 2012 with the goal of supporting IMGs within AACAP. Approximately 30% of U.S. child and adolescent psychiatrists are IMGs, representing over 100 countries, variable cultures, and many languages. Since its inception, the IMG Caucus has been working to provide support for unique challenges these IMG child and adolescent psychiatrists face by advocating for IMG-related issues through AACAP, including topics such as professional development, career pathways, faculty and peer mentoring, and visa issues.

The need for an Asian Caucus has been voiced in the past, but the demand has never been this high in recent years. Despite the fact that Asian Americans recently have been noted as the fastest growing racial/ethnic group in the United States, there has not been much recognition of mental health needs for Asian-American children. As the Asian Caucus will have its inaugural meeting during AACAP’s Annual Meeting in October this year, the goal of this establishment would be to promote awareness and advocacy to reduce stigma, and to support members of AACAP to further advance much needed clinical practice guidelines, scholarship, advocacy, and research in Asian-American mental health in children and adolescents in addition to providing forums for the members to discuss career development.

An overarching theme among all the caucuses is that many of the minority child psychiatrists have difficulty becoming involved in AACAP due to feeling marginalized within the organization, and each caucus works towards lowering these barriers for its members. Although each caucus is unique in targeting different minority groups, they all aspire to achieve similar goals of:

“The need for an Asian Caucus has been voiced in the past, but the demand has never been this high in recent years. Despite the fact that Asian Americans recently have been noted as the fastest growing racial/ethnic group in the United States, there has not been much recognition of mental health needs for Asian-American children.”

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1. Providing a forum for attendees from diverse cultures and attendees of color to be able to promote inclusiveness within AACAP, and helping the members to be more involved in the Annual Meeting

2. Providing networking opportunities for the members to be able to mutually support each other in their professional development and to discuss unique challenges members face in their daily professional lives

3. Establishing mentorship that extends to greater AACAP and encourages recruitment of diverse members into AACAP to reduce service disparities

4. Supporting research and advocacy work to recognize the mental health needs of minority population and to develop guidelines to help other psychiatrists be more culturally competent

The caucuses are not only established and supported by the Diversity and Culture Committee as a way to reach out to a diverse population of child psychiatrists but also their activities are reported to the committee as a way of being connected to the leadership of AACAP. Consistent and dynamic activities of each caucus will ensure the promotion of diversity within the organization, and further along, will chip away on the disparities in mental health care for diverse minority children.

Dr. Cho works at Yakima Valley Farm Workers’ Clinic in Yakima, WA. She is a member of AACAP’s Diversity and Culture Committee and is a co-chair for the Asian Caucus. She may be reached at Jangcho@gmail.com.

Seattle is home to the country’s first gas station—a Standard Oil outpost that opened in 1907 at Holgate Street and Western Avenue.

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An American in Paris Americans in Prague: Highlights of the IACAPAP World Congress

Andrés Martin, MD, MPH

The International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) held its 23rd Annual Congress in the Czech capital city of Prague from July 23-27, 2018. The meeting was unique for several reasons, including the venue in Eastern Europe for the first time, and coinciding with the 80th anniversary of IACAPAP, the activities of which have focused on child, adolescent, and mental health initiatives around the globe. The meeting was well attended, with its 1,600 registrants well exceeding the initial prediction of 1,300. The meeting was also well attended by some 50 AACAP members!

AACAP members strongly represented our organization with state-of-the-art lectures. AACAP President Karen Dineen Wagner, MD, PhD, presented with Graham Emslie, MD, and John T. Walkup, MD, at the Pre-Congress Course: Pediatric Psychopharmacology Update. Dr. Wagner further represented AACAP by presenting on her Presidential Initiative on Depression Awareness and Screening at the 5th Leaders Forum: The Future of Child and Adolescent Psychiatry. She also elaborated on her Presidential Initiative at an AACAP invited session with Wun Jung Kim, MD, MPH, who covered the Child and Adolescent Psychiatry Work Force in the United States: The Past, Present, and Future. AACAP President-Elect Gabrielle A. Carlson, MD, delivered a presentation on ‘Mood disorders in children and adolescents: where have we been and where are we going?’.

James Hudziak, MD, gave the opening plenary on Action through Prevention: Rethinking Children’s Mental Health. Representing the early career psychiatrist generation, Kashmira Rustomji, MD, and Judah Weathers, MD, participated as competitively-elected members of the Donald J. Cohen Fellowship Program for International Scholars in Child and Adolescent Mental Health. Lois Flaherty, MD, spoke at a Leaders Forum on the future of child and adolescent psychiatry, as well as chaired a session titled, Yellow Brick Road: Risk-Taking, Resiliency, and Taking Responsibility in Adolescence and Emerging Adulthood. AACAP Past President E. James Anthony, MD, FRCP, was honored in the E. James Anthony’s Lecture: Insights from Developmental Research for the Practicing Child Psychiatrist.

This was the first meeting featuring Daniel S. Fung, MD, from Singapore, in his new role as president of IACAPAP. In this position, Dr. Fung, a long-time AACAP Corresponding Member, will be the recipient of AACAP’s 2018 E. James Anthony, MD, IACAPAP Presidential Travel Award. We are looking forward to continued collaboration between our two international organizations to best serve the children of the world.

AACAP members were also recognized for their contributions to IACAPAP. Hesham Hamoda, MD, MPH, and Andrés Martin, MD, MPH, were elected as two of the organization’s nine vice-presidents. In this new role, they do not specifically represent their national organization (AACAP), but rather represent North America, as well as the Gulf States and the Middle East (Dr. Hamoda), and Latin and South America (Dr. Martin). They each will continue with their other long-term IACAPAP activities, including the IACAPAP Bulletin and social media (Dr. Hamoda), and as co-editor of the freely available online e-Textbook (Dr. Martin). With upcoming IACAPAP congresses to take place in Dubai (2022) and Rio (2024), these AACAP members are looking forward to being even further involved in the years to come.

Members were also recognized for their extraordinary and sustained contributions at the congress’s closing ceremony: Julie Chilton, MD, was awarded the Presidential Medal for her contributions to the e-Textbook and to IACAPAP’s broader virtual curriculum (resources that are easily available at no cost through www.iacapap.org). Dr. Hamoda was awarded the IACAPAP 2018 International Award. Sponsored by the Korean Academy of Child and Adolescent Psychiatry (KACAP), the International Award is presented by IACAPAP in recognition of the accomplishments of an individual who has made outstanding contributions to child and adolescent mental health in the developing world – in this case, the Eastern Mediterranean, Middle East, and Gulf State regions. Congratulations –Mabrouk– Hesham! (Note that Dr. Hamoda’s name all-too-fittingly means ‘generous’ in Arabic مبروك هشام).

The next Congress of IACAPAP takes place in Singapore in 2020 (www.iacapap2020.org), and we hope to see as strong and vibrant an AACAP contingent there. Remember the world is an increasingly connected, flat, and interdependent place: the world needs you!
International Awardee. Past President Per-Anders Rydelius, MD, PhD (Sweden) and outgoing Secretary General Füsun Çuhadaroğlu Cetin, MD (Turkey) present the International Award to Hesham Hamoda MD, MPH.

Family First. After the closing ceremony, presidential medalist Julie Chilton, MD, is accompanied by her parents, Richard and Stefi Chilton, and by Andrés Martin, MD, MPH.

Pictured from left: Maité Ferrin, MD (Spain/UK), Kaija Puura, MD, PhD (Finland), Nick Kowalenko, MD (Australia), Christina Schwenck, PhD (Secretary General, Germany), Hesham Hamoda, MD, MPH (USA/Egypt), Petrus DeVries, MD, PhD (Treasurer, South Africa), Michael Goetz, MD, PhD (Convenor of the Prague Congress, Czech Republic), Daniel Fung, MD (President, Singapore), Andrés Martin, MD, MPH (USA/Mexico), Bruno Falissard, MD, PhD (Immediate Past President, France), Bung Nyun Kim, MD, PhD (South Korea), and Tolulope Bella-Awuah (Nigeria). Not pictured: Flora de la Barra, MD (Chile).

Drs. Emslie, Wagner, and Walkup present the Pre-Congress Course: Pediatric Psychopharmacology Update at the 23rd World Congress of IACAPAP.

Dr. Martin is secretary of AACAP and past editor-in-chief of the Journal of the Academy of Child and Adolescent Psychiatry. He is Riva Ariella Ritvo Professor at the Child Study Center, Yale School of Medicine. He may be reached at andres.martin@yale.edu.
Humans have harnessed naturally occurring genetic mutations since Neolithic times, selectively breeding crops and animals that serve our purposes. For instance, the dachshund, bred in Germany to hunt badgers, took a hundred years to develop. However, manipulating the human genome had remained largely in the realm of fiction until 1990, when the National Institutes of Health (NIH) conducted the first approved gene therapy trial. It successfully—albeit transiently—re-introduced a functional adenosine deaminase gene into the T cells of a 4-year-old female with Adenosine deaminase deficiency Severe combined immunodeficiency (ADA-SCID). The future looked promising. However, in 1999, Jesse Gelsinger died following a catastrophic immune response to an injected adenoviral vector carrying the orornithine transcarbamylase gene, of which he was deficient. Gelsinger’s death stalled the nascent field for the better part of a decade, at least until Clustered Regularly Interspaced Short Palindromic Repeats (CRISPR) arrived.

CRISPR adapts a naturally occurring bacterial anti-viral defense system to permit rapid gene editing. It has given scientists the ability to edit DNA – in essence, to direct the evolution of all species, including our own.

CRISPR is relatively simple, requiring only two components—a guide RNA and a Cas9 (CRISPR associated system) enzyme. The guide RNA directs Cas9 to a specific region in the genome via complementation, where the enzyme, acting as “molecular scissors,” introduces double strand breaks, allowing for random insertions or deletions of the gene (“knock out”) or substitution of a supplied DNA template. Prior gene editing systems had been laborious and expensive; CRISPR is relatively cheaper and fast, which led Hank Greely of Stanford to dub it the Model T of genome engineering—not the first but transformative due to cost and accessibility.

From the onset, CRISPR/Cas9, appeared to hold near limitless promise as well as peril in clinical gene editing applications. It can be delivered into animal or human cells through an in vivo approach in which components are introduced by injection using viral or non-viral vectors. In the ex vivo approach, somatic or pluripotent cells are extracted, modified by CRISPR/Cas9, then infused back into the organism. If genetic alterations occur in somatic cells, the impact is limited to the lifespan of the cell; when germline precursors are edited, the edited gene can be transmitted by heredity to progeny. Ex vivo gene therapy holds a distinct advantage in that modified cells are easily screened prior to reintroduction to ensure successful editing.

While powerful and versatile, CRISPR/Cas9 is not a perfect gene editing machine. Precision in editing is not guaranteed, although subsequent refinements of the guide RNA and Cas9 have improved fidelity. In addition, there is potential for off-target effects which may result from poor quality guide RNAs that bind indiscriminately, resulting in “genomic vandalism” and the potential mutation of genes outside of the intended target. Thus far, CRISPR has held the highest promise for the more than 7,000 human diseases caused by single gene mutations. Research is looking for cures at breakneck speed. The first clinical trials of CRISPR in humans started in 2016 in China with ex vivo treatment of T cells from patients with treatment-resistant cancer to block a checkpoint inhibitor, increasing the chances for cancer cells to be attacked by immune response. The first ex vivo U.S. trial, organized by the University of Pennsylvania, will soon test the safety, feasibility, and efficacy of using modified T cells in multiple myeloma, melanoma, and sarcoma. As vast sums of venture capital money are pouring into CRISPR companies, the technology is likely to improve dramatically in the future.

In this post-genomic era, hundreds of risk loci have been isolated for psychiatric disorders, although with frequent overlap between conditions. Understanding of the gene x gene...
“The link between psychiatric illness and creativity has been widely hypothesized and conceptualized by the ‘inverted-U’ hypothesis of creativity and psychopathology, in which mild-to-moderate levels of genetic risk variants may increase creativity, but more severe risk burden interferes with cognitive output.”

and gene x environment interactions driving clinical phenotypes remains extremely limited, largely owing to a lack of appropriate model organisms that capture the known complexity of these illnesses. With CRISPR, researchers can introduce more than one mutation into a single cell or embryo, permitting a closer approximation of genetic disease architecture than previously available in a fraction of the time. The technique can be employed to rapidly accelerate screening and functional characterization of candidate genes and non-coding RNAs in cultured cells. Guoping Feng of the McGovern Institute has utilized CRISPR to generate a mouse lacking a negative regulator of Wnt signaling with strong association to ASD, resulting in a fraction of the time. The collective knowledge regarding the specific genetic determinants underpinning personality and intelligence also remains rudimentary at best. The link between psychiatric illness and creativity has been widely hypothesized and conceptualized by the “inverted-U” hypothesis of creativity and psychopathology, in which mild-to-moderate levels of genetic risk variants may increase creativity, but more severe risk burden interferes with cognitive output. Alternatively, mild-to-moderate stress may increase creativity and productivity in genetically-predisposed individuals while significant stress yields acute decompensation. The connections are complex: Bipolar disorder can intermingle with creativity and John Nash’s schizophrenia existed in the same person as his Nobel Prize winning creativity. As Edvard Munch once said, “[My troubles] are part of me and my art. They are indistinguishable from me, and [treatment] would destroy my art.” CRISPR-mediated alteration of a collection of risk-conferring polymorphisms may alleviate suffering but at the sacrifice of personality or creativity – a debatable psychosocial cost. Furthermore, as CRISPR is currently under patent and regulated as a drug by the FDA, the costs associated with CRISPR-based therapies could prove significant, raising potential equity issues.

Germline engineering remains among the most tantalizing and controversial of CRISPR applications. In 2017, the National Academy of Sciences published preliminary guidelines for gene-editing research, stating that germline editing trials should be approached cautiously to assist in treating severe monogenic illnesses, such as Huntington’s chorea and beta-thalassemia, with prohibition against germline editing for trait selection or “enhancement.” Designer babies, a staple of fiction about dystopian futures, are a long way off but may eventually confront child and adolescent psychiatrists with serious ethical dilemmas.

Recommended reading: “A Crack in Creation” by Jennifer Doudna, and “Modern Prometheus: Editing the Human Genome with Crispr-Cas9” by Jim Kozubek

Dr. Grzenda is currently a fourth year (research track) and chief resident in adult psychiatry at UCLA/Semel Institute. She completed her medical and doctoral training at Mayo Clinic. She is a current American Psychiatric Association (APA) Research Fellow and Laughlin Fellow. She may be reached at agrzenda@mednet.ucla.edu.

Dr. Rosenfeld is the Features Editor of AACAP News. He may be reached at arosen45@aol.com.

This article grew out of a session on the ethics of genomics at the American College of Psychiatrists, led by Laura Dunn, MD, Stanford, and Dr. Rosenfeld, at which Dr. Grzenda was the Prite fellow resident expert.

Despite its rainy image, Seattle gets less annual rainfall than New York, Houston, Boston, and Atlanta. It does, however, have quite a few cloudy days and days with light precipitation, particularly in the wintertime.
Mechanisms Matter: Why Child/Adolescent Psychiatrists Should Care About Neuroimaging (and Not Be Afraid)

Borrowing from Charles Dickens (no relation), as a child and adolescent psychiatrist who both sees outpatients and does research, I believe it is the best of times and the worst of times. “Best” because research using magnetic resonance imaging (MRI) is advancing what is known about the brain as well as behavioral mechanisms underlying both typical development and child and adolescent psychiatric disorders. It is the “worst” because child and adolescent physicians and trainees often feel left out of these discoveries, as they strain to penetrate the many barriers to reading and understanding neuroimaging articles. Trainees and faculty tell me they struggle with: (1) excessive jargon (like “voxels,” “repetition time,” “axial,” “sagittal,” or “coronal”), (2) laundry lists of brain regions, (3) how almost everything can involve the amygdala, and (4) how it is relevant to my patients now. I find myself summarizing their concerns in one of my least published (but perhaps most important) ideas that I have named “Dickstein’s Paradox,” which states that: “All too often, child and adolescent psychiatrists’ and trainees’ brains are paradoxically turned off—rather than being turned on—when looking at brain imaging research and articles.”

Addressing Dickstein’s paradox by increasing child and adolescent psychiatrists’ comfort with neuroimaging is crucial because understanding these brain mechanisms increases our ability to diagnose, treat, predict, and prevent child psychiatric disorders, resulting in better patient care. The best example of better understanding of illness mechanisms transforming care comes from childhood cancer—specifically acute lymphoblastic leukemia (ALL). Until the 1980s, ALL was a death sentence for most children. Now, the five-year survival rate is over 95%!

What happened? Clinicians, researchers, parents, and payers got together and ensured that every child with cancer was part of research—so that their illness experience became data. In turn, advances in the underlying mechanisms were not just discovered, but got translated into diagnostic and treatment biomarkers and mechanism-driven treatment. These mechanisms did not replace clinical care; they augmented it. Thus, when an astute physician or parent makes a clinical observation that the child is less active, has a swollen belly, or has easy/excessive bruising, a biomarker is more likely to be ordered—an ultrasound or complete blood count. Cancer is diagnosed or ruled out, and—if necessary—a specific treatment protocol is assigned.

We desperately need such mechanism-driven biomarkers in child psychiatry. Without them, suicide has become the second leading killer in the United States starting at age 10, all the way to age 33 years old, whereas cancer is not even in the top three. Every week sees a new article about increasing rates of children and adolescents suffering from autism to ADHD. Despite our best efforts, we have not increased access to outpatient child and adolescent psychiatric care, even for those with insurance and especially for those not on the extreme coasts of the United States.

How will these mechanisms matter in addressing these problems for our field? As highlighted by an article titled “On being a circuit psychiatrist” by Joshua Gordon, MD, PhD, current Director of the National Institute of Mental Health (NIMH), psychiatrists are uniquely trained—from medical school, through residency/fellowship, and beyond—to integrate information from blades of grass (e.g., information about dendritic spines on neurons, methylation of DNA, etc.) to 30,000 feet in the sky (e.g., information about a patient’s social context, relationships, and work environment). That extensive training can improve our diagnostic formulation about a patient and thus our treatment. Being a “Circuit Psychiatrist” is not easy, as it requires courage to make “life-long learning” not just a slogan, but a regular occurrence.

Currently, studies are testing how neuroimaging might ultimately augment our approach to patient care. For example, studies are evaluating how structural, functional activity, and connectivity alterations observed in MRI
“We desperately need such mechanism-driven biomarkers in child psychiatry. Without them, suicide has become the second leading killer in the United States starting at age 10, all the way to age 33 years old, whereas cancer is not even in the top three.”

Neuroimaging is setting the stage for mechanism-guided treatments. Having neuroimaging—a fact highlighted by an ongoing studies. Together, we can do for our specialty what has been done for ALL.

References

Dr. Dickstein is Director of Pediatric Mood, Imaging, & NeuroDevelopment (PediMIND) Program, Bradley Hospital/Brown University. He may be reached at Daniel_Dickstein@Brown.edu.

Acknowledgment: Dr. Dickstein has received funding from the NIH/NIMH, NARSAD/Brain Behavior Foundation, and the American Foundation for Suicide Prevention. He has not received any pharmaceutical industry support.
Poetry

Yellow notes

By Mali Mann, MD

Wait and watch
Watch and wait
Change creeps in
Unexpectedly as always
Like an uninvited guest

Phone message
Brings the tense
Rushing words
I thought you
Were coming home
Being here this evening
To have dinner at our home
So, where are you?

You asked the one
Who gave care
Incessantly
Where is she
Why she is not here why
Why is she not coming yet

Her word
Reaches inside
She will come
Tomorrow
Early in the dawn
Worry not
You will see
I promise

There I am,
15 long flight hours
Away in the other half
On the Southern hemisphere
Me in the winter
You in the summer

Shy crooked
Inky letters
Timidly lined up
On sticky yellow
colored notes

She will come
All around the house
Repeatedly repeated
On the mirror
On the counter
On the calendar
And on the walls
She would come
Next to the four
Lettered name
Sitting there
One smiley face
Promises
Estimated early arrival

Immigrant blues

By Llewellyn W. Joseph, MD, Toronto, Canada

Man without country
Man without home
Over the wide world
Wistfully roam
Yearning for welcome
A place to belong

Blank mask-like faces
Eyes flashing fire
Tempting half smiles
That fade with desire
Tentative motions
Ambivalent pulls
Half hearted commitments
And passion that dulls

Blazing hot summers
Cold winter chills
Searching for good times
And pleasure that fills

Restlessly searching
Mind ill at ease
No clime is friendly
No ground is firm
For man without country
Man without home.
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
Join Us at AACAP’s 65th Annual Meeting!

On behalf of the entire Program Committee and AACAP Staff, we’re looking forward to seeing all of you at AACAP’s 65th Annual Meeting, October 22-27, at the Washington State Convention Center in vibrant Seattle, Washington!

We have an impressive lineup of educational and innovative sessions to offer this year. As always, the large majority of our sessions are accredited for continuing medical education (CME) credit; therefore, attendees can receive up to 50 CME credits by attending the entire meeting.

As expected each year, we will continue to offer:

✦ Complimentary wireless internet throughout the meeting space at the Washington State Convention Center and in the guest rooms at the Sheraton Seattle, Grand Hyatt Seattle, Hyatt at Olive 8, and The Paramount Hotel.
✦ The AACAP App! The App allows you to fully navigate the meeting without paper (including electronic session evaluations) and gives you access to other valuable AACAP information (like AACAP’s Twitter feed and a member directory) as well.
✦ Online tools to access a variety of meeting-related documents and to plan your schedule while at the meeting.
✦ Wellness Activities. Make sure to take advantage of the twice daily yoga and mindfulness meditation classes, as well as exercise in and around Seattle.

We are also pleased to welcome your families to Seattle and to the beautiful Evergreen State! Please visit the AACAP Annual Meeting website (www.aacap.org/annualmeeting-2018) for information on fun Seattle activities for children and adults alike.

NEW this year, we will be offering:

✦ New scientific session length! At our attendees’ request from previous meeting feedback, we’ve shortened the length for the scientific programming to 2.5 hours for Clinical Perspectives and Symposia, and 2.0 hours for Clinical Case Conferences.
✦ CME tracking through Pathways. Track your AACAP, as well as other organization’s CME credits, all in one place through our new online learning portal, Pathways!
✦ Programming on Depression, tying into Dr. Wagner’s Presidential Initiative. View the online program schedule to find the listing of depression-related programming (www.aacap.org/annualmeeting-2018).
✦ Member Services Fora, including one titled Safe to Return to School? Threat Assessment in Children and Adolescents, sponsored by AACAP’s Program Committee, assisting members in responding to school shootings.

With important ongoing changes in the field regarding depression screening, excessive use of electronics, gun violence, school shootings, new challenges with children of illegal immigrants, and updated research in complementary medicine and psychopharmacology, mental healthcare professionals can’t afford to miss this year’s Annual Meeting in Seattle. Please visit www.aacap.org/AnnualMeeting-2018 for more information!

See you in Seattle,

Boris Birmaher, MD, AACAP Program Committee Chair, and
James J. McGough, MD, AACAP Deputy Program Committee Chair
SYSTEMS OF CARE SPECIAL PROGRAM
Improving Care for Youth With ASD and Intellectual Disabilities
Monday, October 22
8:00 am–4:30 pm (ticket)

Chairs: Lisa R. Fortuna, MD, MPH, Kathleen A. Koth, DO, Kelly McGuire, MD, MPA, Robert L. Klaehn, MD

Speakers: Karen Dineen Wagner, MD, PhD, Kathleen Koth, DO, Gary Blau, PhD, Bryan H. King, MD, Roma A. Vasa, MD, Jill Hinton, PhD, David O’Neal, MS, Kamilah Jackson, MD, MPH, Lindsay Shea, DrPH, MS, Antonio Hardan, MD, Gary A. Stobbe, MD, Elizabeth Griffin, Nathalia Lorella, Katrina Davis, James Mancini, MS, Ivys Fernandez-Pastrina, JD, Eric Boelter, PhD, Marilyn Augustyn, MD, Jeremy Veenstra-VanderWeele, MD, Sandy Trinh, MS

The special program offers opportunities for didactic learning, discussions with experts in the field, and poster presentations regarding the system of care that serves children and adolescents with Autism Spectrum Disorder and/or Intellectual Developmental Disorder (AID). As the role of child and adolescent psychiatrists (CAPs) increasingly includes the care of children with AID, CAPs must be aware of the complex systems of care and the emerging advances for serving these youth. In this day long program, we present innovative approaches to mental health needs, educational planning, cultural barriers, and transition to adulthood in addition to the evidence-based practices that are unique to this population. Participants learn about the system of care that youth with AID and their families must navigate and how collaboration among mental health providers, developmental disability service systems, and other medical providers can best meet the needs of youth with AID and their families. This special program highlights existing resources that can be directly applied by CAPs for treating those with AID and for addressing the existing system gaps. Whether a clinician, policy maker, administrator, or researcher, a CAP is well-served by participating in this special program.

Sponsored by AACAP’s Community-Based Systems of Care Committee and Autism and Intellectual Disability Committee

RESEARCH SYMPOSIUM
OPIOIDS FROM THE RECEPTOR TO THE CLINIC
Tuesday, October 23
7:00 pm–9:00 pm (open)
Chair: Leslie Hulvershorn, MD

Sponsored by AACAP’s Research Committee

Molecular Pharmacology of Opioids: Chronic Stress and Developmental Exposures
Speaker: Charles Chavkin, PhD, Department of Pharmacology, University of Washington, Seattle, WA

Dr. Chavkin is the Allan and Phyllis Treuer Chair of Pain Research and Professor of Pharmacology at the University of Washington. He is the Director of the University of Washington Center for Drug Addiction Research and a fellow of the American College of Neuropsychopharmacology. He received a PhD in pharmacology from Stanford University, and conducted postdoctoral work at Salk Institute and Scripps Clinic in neurophysiology. Throughout his career, Dr. Chavkin’s research program has been focused on understanding the functioning of the endogenous dynorphin opioid neuropeptides and their kappa opioid receptors. Dr. Chavkin’s research effort in his laboratory continues to be focused on 1) the mechanisms regulating synaptic transmission in the mammalian brain; 2) the molecular mechanisms regulating opioid receptor functioning; and 3) the role of the endogenous dynorphin opioids in the regulation of mood and drug addiction risk. They use a combination of electrophysiological, anatomical, and molecular approaches to understand the role of opioid neuropeptides as neurotransmitters in the brain with the ultimate goal of gaining a better understanding of the molecular basis of drug addiction, a malleable form of motivated behavior.

Opioid Use Disorders in Youth: NIDA Research Advances and Implications
Speaker: Geetha Subramaniam, MD, National Institute on Drug Abuse, Washington, DC

Dr. Subramaniam is the Deputy Director of the Center for Clinical Trials Network, at the National Institute on Drug Abuse (NIDA). In this role, she has been instrumental in developing research projects in a variety of topic areas, including addressing prevention of substance abuse in adolescents, and prevention

continued on page 238
Program Highlights continued from page 237

and intervention of prescription stimulant misuse in youth. Previously, she was a full-time faculty member in the Division of Child Psychiatry at Johns Hopkins School of Medicine and the Associate Medical Director of Mountain Manor Treatment Center, Baltimore, MD, where she led clinical trials with adolescents with substance use disorder and served as a preceptor to residents and fellows. She distinguished herself as a clinical and research expert in the assessment and treatment of adolescents and young adults with opioid use disorders. She is certified by the American Board of Psychiatry and Neurology in General, Child and Adolescent, and Addiction Psychiatry and a Distinguished Fellow of both the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. Dr. Subramaniam received a MBBS from Government Medical College in Ballary, Karnataka, completed her residency in general psychiatry at University of Missouri, and completed her fellowship in child psychiatry at the Johns Hopkins University School of Medicine. She is also a past scholar of the K12 career development award, the AACAP Physician Scientist Program in Substance Abuse, supported by NIDA.

NOSHPITZ CLINE HISTORY LECTURE
What Has Happened to Fifty Years of Child Abuse Reporting Laws? The One-Hundred-Forty Million Dollar Mistake
Wednesday, October 24
11:15 am–12:45 pm (open)
Chair: David W. Cline, MD
Speaker: Lenore C. Terr, MD

Lenore C. Terr, MD, practices child, adolescent, and adult psychiatry in San Francisco and serves on the clinical faculty of the University of California at San Francisco. For many years, she has taught part-time in the law schools of Case Western Reserve University, University of California, Berkeley, and University of California, Davis. Her practice and research career has focused on defining, characterizing, treating, and intervention of prescription stimulant misuse in youth. Previously, she was a full-time faculty member in the Division of Child Psychiatry at Johns Hopkins School of Medicine and the Associate Medical Director of Mountain Manor Treatment Center, Baltimore, MD, where she led clinical trials with adolescents with substance use disorder and served as a preceptor to residents and fellows. She distinguished herself as a clinical and research expert in the assessment and treatment of adolescents and young adults with opioid use disorders. She is certified by the American Board of Psychiatry and Neurology in General, Child and Adolescent, and Addiction Psychiatry and a Distinguished Fellow of both the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. Dr. Subramaniam received a MBBS from Government Medical College in Ballary, Karnataka, completed her residency in general psychiatry at University of Missouri, and completed her fellowship in child psychiatry at the Johns Hopkins University School of Medicine. She is also a past scholar of the K12 career development award, the AACAP Physician Scientist Program in Substance Abuse, supported by NIDA.

Fifty years before this talk, every state in the U.S. had legislated a child abuse act. The federal government had also enacted a reporting program. As the years went by, not only were doctors and mental health professionals required to turn in cases of suspected abuse to their local crime and child-protective authorities, but all educational, babysitting, photo-developing, camp counseling, church-related, and nursery school personnel were mandated to do the same. There could be no lawsuits in retaliation for a report. And a report was to be immediate, not after “investigation.”

In Los Angeles, officials at Miramonte School had heard of a number of strange incidents, largely involving Hispanic-American 8- and 9-year-olds. The children did not know what was happening to them at the hands of their male third-grade teacher. When it became apparent that over many years the school had failed to report abusive behavior and that the school system had destroyed their files, Dr. Terr was asked to interview three girls as representative examples. In this talk, she explains how trauma presents in people too naïve to know at the time that they are being traumatized, and why failing to take 50 years of legislation into account became a 140-million-dollar mistake.

Sponsored by AACAP’s History and Archives Committee and supported by David W. Cline, MD

KARL MENNINGER, MD, PLENARY
Saving Holden Caulfield
Wednesday, October 24
4:15 pm-5:45 pm (open)
Chair: Karen Dineen Wagner, MD, PhD, AACAP President, presiding
Speaker: David A. Brent, MD

David A. Brent, MD, is the Academic Chief of Child and Adolescent Psychiatry and holds an endowed chair in Suicide Studies at the University of Pittsburgh School of Medicine, where he also directs Services for Teens at Risk (STAR), a clinical and research program for the treatment of depressed and suicidal adolescents. Dr. Brent has been active as a clinician and researcher focusing on adolescent depression and suicidal behavior for more than three decades, and his work has helped to establish standards of care for these vulnerable youth. He is a member of the National Academy of Medicine and has been recognized for his research by the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, the American Foundation for Suicide Prevention,
the International Association for Suicide Research, the Institute of Living, and the Brain and Behavior Research Foundation.

The adolescent suicide rate has increased over the past decade. While further research on how to prevent adolescent suicide is still needed, there are strategies that, if widely implemented, could result in a reversal in this disturbing trend, which will be addressed in this plenary speech. The title of the classic novel about adolescent angst, The Catcher in the Rye, comes from a passage in which the protagonist, Holden Caulfield, describes a wish to catch kids who are playing in a field of rye before they fall off a cliff. Holden’s predicament is not dissimilar to mental health professionals who are struggling to come up with a coherent plan to reverse the rise in adolescent suicide. Instead of standing by the cliff, when it is too late to effectively intervene, we should: lead kids away from the cliff (prevention); embed ourselves in the field (improve access to care); put a fence around the cliff (restrict access to lethal agents); and change the rules of the game in the field (systemic quality improvement to reduce the risk of suicide in mental health patients). Each of these strategies has evidence-based interventions that are currently not fully utilized. If we have the will to direct resources to these strategies, we can achieve reduction in the adolescent suicide rate now, even as we are awaiting future research advances.

The Karl Menninger, MD, Plenary is supported by Ronald K. Filippi, MD, in honor of his mentor, Karl Menninger, MD.

JAMES C. HARRIS, MD, DEVELOPMENTAL NEUROPSYCHIATRY FORUM

Pediatric Mild Traumatic Brain Injury: Understanding Neuropsychiatric Outcomes and Psychotherapeutic Treatments

Thursday, October 25
8:30 am–11:00 am (open)

Chairs: Roma A. Vasa, MD, Natasha Marrus, MD, PhD

Speakers: Jeffrey E. Max, MD, and Brian Brooks, PhD

In this Forum, two leaders in the field of developmental neuropsychiatry of pediatric Traumatic Brain Injury (TBI) present their findings on mTBI or concussion. The first speaker, Jeffrey E. Max, MD, is a child and adolescent psychiatrist and leader in developmental neuropsychiatry research on pediatric TBI. He is a Professor in the Department of Psychiatry at the University of California, San Diego and Director, Neuropsychiatric Research at Rady Children’s Hospital. His work includes prospective studies of psychiatric outcomes in children and adolescents with mild to severe TBI. The thrust of Dr. Max’s research is to identify brain imaging characteristics including microstructural white matter integrity, magnetoencephalography detection of brain injury, and lesion location as well as psychosocial (e.g., family function, family psychiatric history, child’s pre-injury function) predictors of varied psychiatric disorders that develop after brain injury. Dr. Max leads a 5-year National Institutes of Health study “Magnetoencephalography and Neurobehavioral Outcome of Pediatric Traumatic Brain Injury”. He has received an award from the Big Blue Sky Foundation to study the long-term outcome of pediatric traumatic brain injury.

The second speaker, Brian Brooks, PhD, is a clinician-scientist studying concussion in children and adolescents. He is a pediatric neuropsychologist at the Alberta Children’s Hospital (Calgary, Alberta, Canada), an adjunct faculty member with the Departments of Pediatrics, Clinical Neurosciences, and Psychology at the University of Calgary, a full member with the Alberta Children’s Hospital Research Institute (ACHRI), and an associate member of the Hotchkiss Brain Institute (HBI). His research focuses on neuropsychological outcomes from concussion, including early diagnosis, prognostication of outcome, potential treatment options, and long-term effects. He has more than 200 journal publications, book chapters, and presentations in the field of neuropsychology. He has been recognized with several distinctions from the National Academy of Neuropsychology, including twice receiving the Nelson Butters award for best publication, receiving the early career award in 2014, and being elected a fellow in 2015. He is currently supported by a four-year CIHR Embedded Clinician Researcher award that focuses on neuropsychological outcomes from pediatric concussion.

Dr. Max places biopsychosocial risk for psychiatric and behavioral complications of TBI in a historical and clinical context. He acknowledges the methodological model of studying TBI introduced by Sir Michael Rutter and his group in the 1970’s. He attempts to identify and demystify the phenomenology and treatment of psychiatric syndromes that may be complications of TBI. He presents a selection of his findings on mTBI that underscore not only brain variables but also psychosocial variables. This sets the stage for Dr. Brooks, and his presentation of a psychological treatment for sleep disruption in pediatric mTBI. He presents the newest findings from his studies on sleep disruption and focuses on results of his randomized controlled trial investigating the use of CBT-i in adolescents with refractory symptoms following concussion.

The James C. Harris, MD, Developmental Neuropsychiatry Forum is an annual event thanks to a generous donation from AACAP Distinguished Fellow James C. Harris, MD, and his wife Catherine DeAngelis, MD, MPH. The Forum provides the opportunity for Annual Meeting attendees to learn about cutting-edge science in this evolving subspecialty area of child and adolescent psychiatry.

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TOWN MEETING
The Crisis in Child and Adolescent Psychiatry Residency Recruitment
Thursday, October 25
11:45 am–1:15 pm (open to all AACAP members)
Chair: Lisa M. Cullins, MD
AACAP President, presiding
Speakers: Victor Fornari, MD, MS, James J. Hudziak, MD, Paramjit T. Joshi, MD

An increasing shortage of child and adolescent psychiatrists is occurring as demand for services increase. The national shortage of child and adolescent psychiatrists has prompted efforts not only to address concerns about how we, as a specialty, help with recruitment efforts but how AACAP can help improve access to treatment.

Child and adolescent psychiatrists are essential because of our medical training and our ability and expertise in treating patients. Yet, child and adolescent psychiatry residency slots remained unfilled.

The Town Meeting is the perfect opportunity to highlight the workforce shortage, provide a dialogue from different perspectives on the concerns surrounding recruitment efforts, and explore next steps in addressing this critical topic.

LAWRENCE A. STONE, MD, PLENARY
Building Mental Wellness in Our Children: New Roles for Child Psychiatry and Pediatrics
Friday, October 26
11:45 am–1:15 pm (open)
Chair: Karen Dineen Wagner, MD, PhD, AACAP President, presiding
Speaker: Colleen A. Kraft, MD, MBA

Colleen A. Kraft, MD, MBA, FAAP, is president of the American Academy of Pediatrics. Her background includes work in primary care pediatrics, pediatric education, and health care financing. Dr. Kraft received her undergraduate degree at Virginia Tech and her MD from Virginia Commonwealth University. She completed her residency in Pediatrics at Virginia Commonwealth University.

Dr. Kraft’s presentation outlines current and future strategies that align child psychiatry and pediatrics in building mental wellness. Advances in developmental science and understanding of stress modulators in early childhood have led to targeted efforts toward actions that can build mental wellness and prevent toxic stress. The American Academy of Pediatrics, through its Agenda for Children priority of Early Brain and Child Development, have brought the understanding of toxic stress to pediatricians and the general public. Interventions including home visiting, maternal depression screening and treatment, and partnerships between child psychiatrists and pediatricians can effectively change the paradigm to implement strategies that build mental wellness in our children, adolescents, and families.

PRESIDENTIAL INTERVIEW
Karen Dineen Wagner, MD, PhD, Interviews Joan Luby, MD
Saturday, October 27
11:45 am–1:15 pm (open)

Joan Luby, MD, is the Samuel and Mae S. Ludwig Professor of Psychiatry (Child) at Washington University School of Medicine in St. Louis. She is the founder and director of the Washington University School of Medicine Early Emotional Development Program (EEDP). Dr. Luby’s research has focused on the characterization of early childhood psychopathology, early behavioral and biological markers of risk, and associated alterations in brain and emotional development in early childhood. In addition, her program of research has informed the influence of the psychosocial environment on brain development, sensitive periods for these effects, and implications for risk and early intervention for mental disorders. Dr. Luby’s contributions include establishing the criteria for identification, validation, and early intervention in depressive syndromes in the preschool age group, as well as studies in humans showing the effect of parental nurturance and early experiences of poverty on brain development. She has also developed and tested an early psychotherapeutic intervention for preschool depression. Among her honors are the NARSAD Gerald Klearman award for outstanding research and the AACAP Irving Philips award for prevention. Dr. Luby has published extensively in general and child psychiatric journals and serves on a number of editorial boards.
Focus On…

I’m baaaaccckkk!!! As president-elect and former Program Chair, I get to share with you some of the exciting programs for AACAP’s 65th Annual Meeting which takes place in Seattle, Washington, on October 22-27, 2018.

Your evaluation feedback from 2017 stated that the most requested topics were: pharmacotherapy, autism spectrum disorder, aggression and violence; and that the biggest problem in child psychiatry is workforce issues. I highlight a few submissions in those areas but can testify that the topics of the Annual Meeting program will be wide-ranging and that formats will be educational, interesting, and fun. I look forward to seeing you there!

Gabrielle A. Carlson, MD, AACAP President-Elect

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PHARMACOTHERAPY PROGRAMS
Besides the great annual Advanced Psychopharmacology Institute all day Tuesday and Workshop 25 (self-assessment in psychopharmacology) on Friday morning, there are some new submissions worth considering:

**Clinical Case Conference 7: Withdrawal Mania and Punding in a 12-Year-Old Boy With ADHD (open)**
Thursday, October 25
8:30 am–10:30 am
Sponsored by AACAP’s Psychopharmacology Committee

**Symposium 15: Animal Models for Child Psychiatry (open)**
Thursday, October 25
8:30 am–11:00 am

**Clinical Perspectives 59: Managing Adverse Effects of Psychotropics in Children (open)**
Friday, October 26
1:30 pm–4:00 pm
Sponsored by AACAP’s Psychopharmacology Committee

**Clinical Perspectives 69: One Size Does Not Fit All: Programs Supporting Best Practices in Psychotropic Prescribing (open)**
Saturday, October 27
8:30 am–11:00 am
Sponsored by AACAP’s Community Based Systems of Care Committee and Psychopharmacology Committee

**Clinical Perspectives 76: Pharmacogenomics 2018: A Closer Look at Relevant Genes and Current Guidelines (open)**
Saturday, October 27
1:30 pm–4:00 pm
Sponsored by Sponsored by AACAP’s Triple Board and Post Pediatric Portal Programs Committee, Adolescent Psychiatry Committee, and Physically Ill Child Committee

AUTISM SPECTRUM DISORDER PROGRAMS

**Systems of Care Special Program: Improving Care for Youth With ASD and Intellectual Disabilities (ticket)**
Monday, October 22
8:00 am–4:30 pm
Sponsored by AACAP’s Community Based Systems of Care Committee and Autism and Intellectual Disability Committee

**Clinical Practicum: Seattle Children’s Autism Center and Alyssa Burnett Adult Life Center (ticket)**
Tuesday, October 23
8:00 am–4:30 pm
Sponsored by AACAP’s Local Arrangements Committee

**Symposium 3: Mental Health Crisis in Youth With ASD (open)**
Tuesday, October 23
9:00 am–11:30 am
Sponsored by AACAP’s Autism and Intellectual Disability Committee

**James C. Harris, MD, Developmental Neuropsychiatry Forum: Pediatric Mild Traumatic Brain Injury: Understanding Neuropsychiatric Outcomes and Psychotherapeutic Treatments (open)**
Thursday, October 25
8:30 am–11:00 am
Sponsored by AACAP’s Autism and Intellectual Disability Committee

**Symposium 17: ASD and ADHD: Overlapping Symptoms and Shared Biology (open)**
Thursday, October 25
8:30 am–11:00 am

**Clinical Case Conference 13: Diagnostic Challenges and Treatment Considerations of Catatonia in Patients With ASD (open)**
Friday, October 26
1:30 pm–3:30 pm
Sponsored by AACAP’s Autism and Intellectual Disability Committee
Clinical Perspectives 58: Global Perspectives and Challenges in Treating Children With ASD (open)
Friday, October 26
1:30 pm–4:00 pm
Sponsored by AACAP’s International Relations Committee

Institute 8: ASD and Associated Psychopathology: An Update on Screening, Diagnosis, and Management (ticket)
Saturday, October 27
8:00 am–5:15 pm
Sponsored by AACAP’s Autism and Intellectual Disability Committee

AGGRESSION AND VIOLENCE PROGRAMS
Clinical Perspectives 26: Violent Video Exposure and Its Impact on Youth of Color (open)
Wednesday, October 24
8:30 am–11:00 am
Sponsored by AACAP’s Diversity and Culture Committee and Media Committee

Clinical Perspectives 37: Risk Assessment: From the Clinic to the Courtroom (open)
Thursday, October 25
8:30 am–11:00 am
Sponsored by AACAP’s Adolescent Psychiatry Committee

Member Services Forum 7: Safe to Return to School? Threat Assessment in Children and Adolescents (open to all AACAP members)
Thursday, October 25
1:30 pm–3:30 pm

Clinical Consultation Breakfast 11: Serious, Scary, or Insignificant? Critical Issues in School Threat Assessment (ticket)
Friday, October 26
7:00 am–8:30 am
Sponsored by AACAP’s Schools Committee

Clinical Perspectives 49: Aggression, Translationally Considered (open)
Friday, October 26
8:30 am–11:00 am
Sponsored by AACAP’s Psychopharmacology Committee

Clinical Perspectives 55: Struggles and Strife: Treating American Muslim Youth in 2018 (open)
Friday, October 26
8:30 am–11:00 am
Sponsored by AACAP’s Diversity and Culture Committee

WORKFORCE ISSUES
Town Meeting: The Crisis in Child and Adolescent Psychiatry Residency Recruitment (open to all AACAP members)
Thursday, October 25
11:45 am–1:15 pm

Institute 6: Innovative Interventions in Child and Adolescent Psychiatry: Extending our Reach (ticket)
Friday, October 26
8:15 am–4:30 pm

2018 Annual Meeting Self-Assessment Exam

Registration for the Annual Meeting allows you to take advantage of this ABPN-approved self-assessment activity for FREE. Complete the 100-question exam and earn 8 AMA PRA Category 1 Credits that count toward the CME and self-assessment requirements of MOC. Feedback from the exam can then be used to guide your selection of programs at this year’s Annual Meeting. This exam will be available until November 5.

Not Attending the Annual Meeting?
You can purchase access to the 2018 AACAP Annual Meeting Self-Assessment Exam online at www.aacap.org/annualmeeting-2018.
Guide to Exhibits

Make plans to visit the Exhibit Hall where you can discover new products and services, network with colleagues, and access numerous resources. The Exhibit Hall offers opportunities for attendees to access up-to-date information on products and services affiliated with child and adolescent psychiatry.

Plan your trip to the Exhibit Hall before the meeting by viewing an interactive exhibit hall floor plan on AACAP’s website at: www.aacap.org/exhibits-2018.

Download the Annual Meeting App (sponsored by American Professional Agency, Inc.) for your iPhone, iPad, and Android phone or tablet. Both the interactive floor plan and the App have exhibitor descriptions and contact information, so you can map out your route and make sure you don’t miss any booths. Each attendee also receives a copy of the Exhibits Guide onsite with the floor plan and all of the exhibitor information.

The Exhibit Hall 4B is located on Level Four of the Washington State Convention Center, the same floor with Registration, and adjacent to the New Research Posters.

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 in early October. 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).

To order Module 15:

Online: Purchase via our online publication store at www.aacap.org.

By Fax/Mail: Download and print a publication order from www.aacap.org/moc.

By Phone: Call 202.587.9675 to place your order over the phone.

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.

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.)

For questions about Module 15 or maintenance of certification, please contact cme@aacap.org.
Clinical Handbook of Psychotropic Drugs for Children and Adolescents
New edition out October 2018
Quick, independent, comprehensive, up-to-date

New in this edition:
• Drugs for ADHD thoroughly revised and updated
• Antipsychotics with many changes and additions, including fully revised lab tests/monitoring
• Antidepressants fully revised
• Hypnotics completely revised
• Mood stabilizers fully revised and a new toxicity comparison table added
• Drugs of abuse and treatment of substance use disorders comprehensively revised
• New unapproved treatments with significant updates, including: anti-inflammatories and NMDA agents in anxiety/OCD, cannabis use disorder, and irritability of autism
• New agents include: Third generation antipsychotics brexipiprazole and cariprazine, orexin receptor antagonist suvorexant, selective melatonin agonist tasimelteon, serotonin modulator and stimulator vortioxetine
• More than 30 new formulations and trade names

Denise E. Wilfley / Tyler R. Black / Ian R. McGrane / Ric M. Procysyhn (Editors)
Clinical Handbook of Psychotropic Drugs for Children and Adolescents
Pre-order before Oct. 31 and save 25% – discounted price US $74.85 instead of US $99.80!

“A ‘must-have’ for those prescribing psychotropic medications in children and adolescents.”
Pieter Joost van Wattum, MD, MA, in Journal of Clinical Psychiatry, Vol. 70, p. 301

Also out now

Denise E. Wilfley / John R. Best / Jodi Cahill Holland / Dorothy J. Van Buren
Childhood Obesity
Advances in Psychotherapy – Evidence-Based Practice, vol. 39
US $29.80

Christine Wekerle / David A. Wolfe / Judith A. Cohen / Daniel S. Bromberg / Laura Murray
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Jan Faust
Reunification Family Therapy
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US $59.00
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Meet the editor at AACAP 2018 in Seattle Booth #112

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With questions, please contact Samantha Phillips, Communications Manager, at sphillips@aacap.org.
Missing the Mark in the Face of School Shootings: Rolling Back Reforms to Reduce the School to Prison Pipeline Aims at Wrong Target

Nicole Sussman, MD, and Eraka Bath, MD

Since the devastating school shooting at the Marjory Stoneman Douglas High School in Parkland, Florida, on February 14, 2018, renewed attention has been brought to the Obama-era legislative reforms, known as “Rethink Discipline.” These legislative reforms focused efforts on reducing the school to prison pipeline which disproportionately impacts racial and ethnic minority students by targeting overly punitive school disciplinary practices through increased contact with law enforcement. On March 5, 2018, U.S. Senator Marco Rubio (R-FL) wrote a letter addressed to Attorney General Jeff Sessions and U.S. Department of Education Secretary Betsy DeVos linking Obama’s federal reforms to the actions of Nikolas Cruz, who has confessed to the Parkland school shooting. Rubio claimed that the federal pressure to reduce racial disparities in disciplining students and keeping schools safe through fair disciplinary policies are not mutually exclusive.

Conflating the Parkland school shooting with important reforms on zero tolerance provides an alternative facts-based narrative that distorts the true issues at hand. The school to prison pipeline has been identified as one of the primary entry points of the mass incarceration epidemic, which predominantly affects African-American and Latino youth. Thirty six percent of youth who are expelled from school each year are Black. Students suspended or expelled from school are nearly three times more likely to be in contact with the juvenile justice system the following year. To address these disparities, many of which have lifelong adverse sequelae in 2014 under former President Obama, the federal government created guidelines for schools to improve efforts to offer fair and equal disciplinary actions to all students. This legislation remains a necessary pillar of equal protection in response to unfair treatment of students of color. A school shooting, regardless of the race of the shooter, is not grounds to dismantle efforts to treat all students fairly.

While systemic changes are in order, we must not lose sight of seeing individuals as unique and tailoring treatments for each situation and family. While there have been successful efforts to move from “zero tolerance” policies to those that curate sanctions and treatments based on individual students’ needs, gaps persist in these policies despite increasing efforts to identify students with serious mental health problems and connect them with mental health treatment. Ensuring follow-through of recommendations and connecting families with social services, when appropriate, must also be a priority.

Assessing the risk of an individual for school violence, however, is an ongoing and imprecise endeavor, and it can be difficult to discern whether a person warrants help or hospitalization. Nikolas Cruz reportedly struggled with mental illness and had exhibited warning signs before his deadly actions but was never formally reported to law enforcement officials by his school. If an individual as concerning as he evaded this referral process, then surely something is amiss. It would be prudent to evaluate the circumstances of his case and why no such referral was made so that future gaps in policies created to help students do not occur again. In 2016, the American Bar Association Joint Take Force on Reducing the School to Prison Pipeline made recommendations for implicit bias trainings, which included trainings for school resource officers, restorative justice practices, and specific guidelines for when to contact law enforcement.

Overall, the shared goals of safe schools and equal protection from excessive punitive policies for all youth are not out of reach as long as conscious efforts are made to uphold both of these priorities. Through continuously examining systemic disparities, schools can tailor procedures to ensure all youth are treated fairly. Ongoing individual assessments of students’ educational and emotional wellbeing will be the backbone of identifying youth with learning disabilities, mental illnesses, and other
risks factors for violence. Though schools and law enforcement inherently have different missions, a shared priority of safety still unites them. Efforts to maintain safety in schools must be sensitive enough to identify dangerous students without interfering with individual civil liberties.

References

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

Dr. Sussman is a second year child and adolescent psychiatry fellow at Cambridge Health Alliance in Cambridge, Massachusetts. She co-authored this piece as the trainee member of AACAP’s Children and the Law Committee. After completing her CAP Fellowship training she will be starting a forensic psychiatry fellowship at The Medical University of South Carolina, in Charleston, SC. She may be reached at nicole.sussman@gmail.com.

Dr. Bath is a forensically trained child psychiatrist specializing in forensic psychiatric consultation and juvenile justice research exploring the themes of intersectionality, health disparities, substance use, and trauma. She is interested in determining if mobile technologies and digital health can be applied to justice-involved populations to improve their access and engagement to care. She works with justice-involved youth who are commercially sexually exploited and other at risk youth in specialty court settings. She may be reached at ebath@mednet.ucla.edu.
I Don’t Want to Die: The Case of a Migrant Child

Sarah Berkson, MD, and Iliyan Ivanov, MD

“No quiero morir!” As I entered the Emergency Department (ED), I immediately heard this message screamed repeatedly in Spanish: “I don’t want to die!” As the child psychiatry fellow on call, I received the consult: “Juan Morales is an eight-year-old Central American boy, separated from his mother at the Mexican border a few days ago and sent to a local foster agency, who has now sent him here for fits of acute distress, paranoia, and attempts to run away.”

His episodes of inconsolable crying had increased in duration to hours at a time. He had repeatedly tried to flee. He had flung himself on the sidewalk, refusing to get up. He had talked to a door addressing it as his uncle and called an umbrella his aunt. He said that other children holding pencils had machetes.

“No quiero morir! No quiero morir!” The boy’s pleas were pierced by rhythmic wails, “Mami!” We knew the mother’s name. The agency estimated it would take at least a week and a half to learn her detention site. Then they would need to coordinate with U.S. Immigration and Customs Enforcement (ICE) to gain the ability to speak with her.

On interview, Juan did not answer any questions even by native Spanish speakers. No matter what we said, he repeated his screams. We offered cookies and juice, but he did not even turn to look. He stood, pumping his sneakered feet in an agitated bounce. He trembled. His face was tense, brows drawn together and mouth agape and—like the Greek mask of tragedy—fixed and inconsolable. He clung to a seated police officer who had escorted him to the ED. Rather than leaving soon upon arrival as usual, the officer stayed for hours trying to comfort the boy. When the officer eventually left, Juan protested, “Policia! Policía! No quiero morir!” Soon, Juan similarly clung to the woman providing him one-to-one observation.

His counselor from the agency pleaded for admission. “He’s psychotic! We can’t manage him!” The agency had started a process of seeking to place the child in a more secure facility to address his elopement risk but did not know how long the placement process would take. With similar children, the process had taken anywhere from three days to several weeks.

My supervising attending said that since April 2018, multiple migrant children were brought in distress to our ED. One presented with flashbacks of prior domestic violence. Another in acute distress believed her parents were or would be killed. We evaluated these migrant children weeks before our mayor even knew they were in the city.

“So,” I asked, “what should we do with this kid?”

Should we release him and risk him getting hurt running away to let him serve as a martyr, a spectacle to stain the social conscience? Or should we offer the best crude approximation of a safe home that a psychiatric unit could provide? When we confront social systems that make us sick, must we choose between complicity with the mental illness and complicity with the social ill? How to proceed?

Let us first assess the problem. Public officials separated this family under the color of the law. It inflicted severe trauma to this likely already traumatized child. The government is morally obligated to eliminate family separation and institute safe guards to forbid this practice from ever resuming.

We must build effective collaborations to care for these children and advocate for speedy family re-unification and justice for these young trauma victims. Four main ways we can help are through treatment, research, forensic evaluations, and advocacy.

**Treatment**

- Assessment should begin with determining whether the child’s basic needs are met, like the needs for family re-unification, legal representation for immigration proceedings, housing, and food security, among other things.

- Children should be evaluated by pediatricians for possible medical consequences of common refugee experiences like injury, malnutrition, and sexual abuse.

- As child psychiatrists, our comprehensive psychiatric evaluations should include assessing how much the child can now depend on an emotionally available attachment figure.

- In addition to minding AACAP’s Practice Parameters, we should develop culturally tailored evaluation and treatment methods in collaboration with people from the same countries and ethnic groups as our patients. We could recruit immigrants who have social service experience like teachers and train them to collaborate with us as bicultural workers. A bicultural worker serves not only as a language interpreter but also collaborates with the clinical team in developing and delivering culturally tailored assessment and treatment.
Research

- Researchers should also develop validated psychological instruments for the assessment of migrant children in Spanish and in the indigenous languages of Central America.
- Research should investigate best practices in caring for these migrant children.

Forensic Evaluations

- We can help children fleeing from persecution by conducting forensic evaluations for asylum affidavits.
- We can do these evaluations through organizations like Physicians for Human Rights and human rights clinics based at medical schools. These organizations offer training on conducting psychological evaluations for asylum affidavits.
- Human rights clinics based at medical schools provide trainees who assist with writing the affidavit. Collaborating with trainees lessens the time burden of this work and offers opportunities to teach and to recruit into child psychiatry.

Advocacy

- As individuals and through organizations like AACAP, we can educate the public and advocate for specific public policies.
- We can continue to educate the public on the traumatic effects of family separation to help build widespread support for humane policies for migrant children.
- We can advocate for faster family re-unification, sound immigration policy, and justice for those victimized while in detention, as well as financial and administrative support to ensure that these children's needs are met.

All such efforts will doubtlessly meet numerous obstacles. We should develop forums where we give each other practical and emotional support in facing these obstacles.

Every day as child psychiatrists, we develop partnerships in caring and advocating for children. It is our practice to meet the challenge of these dual roles.

Disclaimer: Since we were unable to obtain parental consent, names are fictional, and alterations were made to identifying characteristics in order to protect patient identity.

Dr. Berkson is a child and adolescent psychiatry fellow at Mount Sinai Hospital. She has conducted research with the Harvard Program in Refugee Trauma and published their findings in the TORTURE Journal: Journal on Rehabilitation of Torture Victims and Prevention of Torture. She may be reached at sarah.berkson@mountsinai.org.

Dr. Ivanov is an associate professor in the division of child and adolescent psychiatry at Mount Sinai Hospital. He may be reached at ilian.ivanov2@mountsinai.org.

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AACAP Announces New Resident/ECP Editor to AACAP News

AACAP is pleased to announce Amna Aziz, MD, as the new Resident/ECP Editor to AACAP News! Dr. Aziz’s term officially starts with the November/December 2018 issue.

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

The AACAP News Editorial Board is looking forward to working with Dr. Aziz for the next two years!

There’s an eerie Underground Tour that takes visitors along the sidewalks and storefronts that existed before the Great Fire. It begins and ends, thankfully, in a refurbished saloon.
Welcome New AACAP Members

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FOR YOUR INFORMATION

SEPTEMBER/OCTOBER 2018 251
AACAP Announces the Recipients of AACAP’s Psychodynamic Faculty Training and Mentorship Initiative

The program chairs of AACAP’s Psychodynamic Faculty Training and Mentorship Initiative, Martin Drell, MD, and Rachel Ritvo, MD, are pleased to announce the 2018 awardees and their assigned AACAP mentors:

Dalia Balsamo, MD  
University of California, Riverside  
Mentor: Sandra Sexson, MD  
Medical College of Georgia at Augusta University

Sindhu Idicula, MD  
Baylor College of Medicine  
Mentor: Tim Dugan, MD  
Cambridge Health Alliance, Lexington, MA

Suzie Nelson, MD  
Wright State University  
Mentor: Ayame Takahashi, MD  
Southern Illinois University

Magdalena Romanowicz, MD  
Mayo Clinic, Rochester, MN  
Mentor: Mary Lynn Dell, MD  
Ohio State University and Nationwide Children’s Hospital, Columbus

Ravi Shankar, MD  
University of Missouri  
Mentor: Sergio Delgado, MD  
Cincinnati Children’s Hospital Cincinnati Psychoanalytic Institute

Michael Shapiro, MD  
University of Florida  
Mentor: David Kaye, MD  
University at Buffalo

Funded through a generous donation by the Samuel and Lucille B. Ritvo Charitable Fund, AACAP’s Psychodynamic Faculty Training and Mentorship Initiative was established in 2018 to support and advance psychodynamic psychotherapy training in child and adolescent psychiatry residency programs through faculty development.

Under guidance of an AACAP mentor, six award recipients identify a problem or area in need of improvement in their child and adolescent psychiatry fellowship program’s teaching of psychodynamic psychotherapy, and design a project to address the need during a day-long project planning session at AACAP’s Annual Meeting. Following the meeting, recipients work through the year toward project completion with their assigned mentor, while gaining access to a network of leaders in the specialty.

The program recipients will be recognized during the Karl Menninger, MD, Plenary: Saving Holden Caulfield and the Training and Education lunch. They will also receive financial assistance in the amount of $350 to attend a day-long project planning session, along with a networking event during the week of the meeting.

The initiative is administered through AACAP’s Department of Research, Grants & Workforce. To learn more about AACAP’s Psychodynamic Faculty Training and Mentorship Initiative, see the psychotherapy news article written by Cecil R. Webster, Jr., MD, in the March/April 2018 issue of AACAP News. You may also visit the program’s webpage at www.aacap.org/PFTMI or contact Anneke Archer, AACAP’s Training & Education Manager, at training@aacap.org or 202.587.9663.
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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org.
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.
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Newest Facts for Families
1. What is a Psychiatric Emergency?
2. Chores and Children
3. Physical Symptoms of Emotional Distress: Somatic Symptoms and Related Disorders
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5. Transgender and Gender Diverse Youth
Chores and Children

Chores are routine but necessary tasks, such as washing the dishes or folding laundry. Research suggests there are benefits to including chores in a child’s routine as early as age 3. Children who do chores may exhibit higher self-esteem, be more responsible, and be better equipped to deal with frustration, adversity, and delayed gratification. These skills can lead to greater success in school, work, and relationships.

Attitudes toward chores vary considerably. Some children are eager to help, while others are not. However, there are many benefits from involving your child in age appropriate chores including:

- Learning time management skills
- Developing organizational skills
- Accepting responsibility in the family
- Providing an opportunity for success (especially for a child struggling in other ways)
- Learning to balance work and play from a young age
- Setting a good foundation for functioning independently

Here are some tips to help you start introducing chores to your child:

- Set clear and reasonable expectations. Let your child know exactly what needs to be done. For example, “please take out the trash from the kitchen after breakfast.”
- Establish regular routines. For example, “Clean up before dinner.”
- Be consistent. Changing rules and expectations can create confusion and frustration.
- For younger children, focus on small, manageable tasks. Make longer jobs fun and cooperative. Use songs or games if you can.
- Set up a star chart or reward system with specific goals to monitor progress and encourage good behavior.
- Be a good role model. Children will more easily learn to pick things up and keep their rooms neat if they see others in the family doing the same.
- Don’t forget to give positive feedback and reinforcement and join in a child’s pride when a chore is done. For example, “Great job on the toys!”
- Pick your battles. At the end of the day, a messy room is not the end of the world.

Remember these are skills and may require a learning process. It may seem faster to do the chores yourself, however, helping your child to learn these will be helpful in the long run. If you need to loop back to help them complete a task correctly, it may mean they are still learning. Picking a chore that is appropriate for your child will increase likelihood of success.

Suggestions by age include:

- 2 to 3-year-olds can put toys and groceries away and dress themselves with help.
- 4 to 5-year-olds can help feed pets, make their beds (maybe not perfectly), and help clear the table after dinner.
- 6 to 7-year-olds can wipe tables and counters, put laundry away, and sweep floors.
- 7 to 9-year-olds can load and unload the dishwasher, help with meal preparation, and pack their own lunch for school.
- 10 to 11-year-olds can change their sheets, clean the kitchen or bathrooms, and do yard work.
● Those 12 and above can wash the car and help out with younger siblings. Teens can help with grocery shopping and running errands.

● Sometimes it can be challenging to get your child to do chores. If your child is unable or unwilling to do chores, it can be frustrating. Try to understand the reasons why. If struggles continue or get worse, it may be a sign of other conflicts or issues that need attention. Talk to your pediatrician or family physician. Ask for a referral to a qualified mental health professional.

# # #

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

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

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What is a Psychiatric Emergency?

Most families know when to call an ambulance or bring their child to the emergency room when they seem physically ill. Families may have a hard time identifying a psychiatric or mental health emergency. A psychiatric emergency is a dangerous or life-threatening situation in which a child needs immediate attention.

If you are reading this because your child has overdosed on medication or drugs, swallowed something dangerous, or attempted suicide, this is an emergency. Immediately call 911 or your local emergency number.

Reasons to bring your child for an emergency mental health evaluation include:

Risk of harm to self, such as:

- Saying in person or online that they want to kill themselves
- Searching online about how to kill themselves
- Taking steps to kill themselves like stockpiling pills, making a noose, or getting a gun or other weapons
- Writing a suicide note
- Giving away favorite belongings or making a will
- Cutting or hurting themselves in order to die or not talking about why

Risk of harm to others, such as:

- Saying in person or online that they plan to kill a person or large groups of people
- Becoming more violent towards others
- Starting fires, destroying property, or harming animals
- Threatening a person with a weapon

Changes in behavior or thinking, such as:

- Acting strangely or not making sense
- Losing touch with reality
- Seeing or hearing things that are not there
- Becoming paranoid

In these cases, an emergency evaluation may be required. Contact your child’s doctor or mental health provider to find out the best way to get help. If your child is in immediate danger, call 911 or your local emergency number, or head straight to the nearest emergency room. If you’re not sure you can transport your child safely, call an ambulance.

If available, bring the following to the emergency room, but only if it does not delay getting there:

- A suicide note or social media post that your child has written
- Medication bottles if your child may have taken an overdose
- Current medications prescribed to your child
- Contact information for the pediatrician and mental health providers
Some issues are concerning but are not psychiatric emergencies and can be handled by a pediatrician or mental health provider during regular business hours. These include:

- Routine medication changes or non-urgent medication refills
- Non-emergent full diagnostic evaluations
- Chronic or longstanding problems that are not dangerous or life threatening, such as anxiety, trouble sleeping, defiant behaviors, or tantrums.

Psychiatric emergencies are life-threatening events that require immediate attention. They can be frightening, but medical staff can help keep your child safe and make sure they get the help they need.

For more information, please visit AACAP’s Suicide Resource Center.

# # #

If you find Facts for Families® helpful and would like to make good mental health a reality, consider donating to the Campaign for America’s Kids. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

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

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

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If you need immediate assistance, please dial 911.

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AACAP Policy Statement

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

Delivery of Child and Adolescent Psychiatry Services Through Telepsychiatry

Approved by Council June 2017

The American Academy of Child and Adolescent Psychiatry (AACAP) is a professional organization dedicated to representing the welfare and mental health needs of children and adolescents. AACAP recognizes that due to health care reform, more youth have become eligible for mental health services. However, the ratio of eligible youth to available child and adolescent psychiatrists, as well as other child-trained therapists, continues to increase and most states experience severe shortages of child and adolescent psychiatrists. This gap between the demand for mental health services and the supply of qualified providers is projected to increase into the foreseeable future. Youth with mental health conditions will be unable to obtain needed evidence-based mental health services, raising their risk of poor outcomes such as suicidality, violence, and school failure. While youth living in small towns and rural areas are the most underserved, there is growing concern for youth living in urban and suburban areas. New models of care and service delivery are needed to meet the needs of the nation’s youth.

Telemedicine refers to the use of interactive, real-time videoconferencing to deliver health care that is usually delivered in person. When that care involves psychiatric, mental health, or behavioral health services, the term telepsychiatry is commonly used. Telepsychiatry is not a new treatment but a venue for the delivery of evidence-based psychiatric care. It has the potential to increase access to quality mental health services in at least three major ways. First, it allows psychiatrists to deliver care directly to youth and their families over geographic distance and settings. Second, it improves the quality of care by disseminating psychiatric expertise for specific disorders. Third, telepsychiatry offers collaboration with primary care physicians to support their skills in providing mental health care, particularly in evolving integrated care models such as the pediatric medical home.

Telepsychiatry has been used with patients across diverse groups and in multiple settings including primary care, schools, correctional settings, and the home. An evolving evidence-base has established that telepsychiatry is feasible, acceptable, and as effective as care delivered in person. It may be superior to mental healthcare provided in the primary care setting for selected populations such as children with attention-deficit hyperactivity disorder or for children with developmental disabilities who do not tolerate the clinic setting well. Psychotherapy, behavior training, and pharmacotherapy services have all been provided successfully using telepsychiatry. The Centers for Medicare and Medicaid Services have expanded their criteria for telemedicine coverage and individual states are increasingly allowing and reimbursing services delivered through telemedicine.

In view of these facts, AACAP recommends that each State pass legislation allowing the delivery of psychiatric services through videoconferencing by child and adolescent psychiatrists and other physicians licensed in the state in which a patient is receiving care. AACAP further recommends that each State mandates third-party payers to reimburse telepsychiatry services on par with psychiatric services delivered in person.
References:

For more information or to review AACAP’s Policy Statements visit www.aacap.org.
AACAP Policy Statement

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

Policy Statement on Psychologists Prescribing

Approved by Council September 2017

AACAP opposes any legislation or regulation at the state or federal level that would grant psychologists prescribing privileges.

Mental illness and psychotropic medications affect not only the developing brain but all organ systems. Child and adolescent psychiatrists obtain a four-year medical education with a focus on anatomy, physiology and pharmacology. During the subsequent five years of residency training, child and adolescent psychiatrists receive extensive clinical supervision in evidence-based treatments and management of medications and side effects. We oppose psychologists prescribing medication because psychologists do not have a medical education that is essential for the appropriate and safe prescription of medications.

For more information or to review AACAP’s Policy Statements visit www.aacap.org.
POLICY STATEMENTS

AACAP Policy Statement Requirements

Updated June 2018

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.
AACAP Resource Centers contain consumer-friendly definitions, answers to FAQ, clinical resources, expert videos, and abstracts from JAACAP, Scientific Proceedings, and relevant Facts for Families.

Visit www.aacap.org to harness the power of our resources today!

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Oppositional Defiant Disorder
Substance Use
Suicide

There’s strength in numbers, so share what you know!
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 would 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.

**ADULT & CHILD PSYCHIATRISTS – INPATIENT PSYCHIATRIST – GERIATRIC PSYCHIATRIST**

(Southern CA)

**Job Description:**
I am a PERMANENTE PHYSICIAN. A dedicated doctor who believes in pursuing dreams, creating hope and driving progress. Southern California Permanente Medical Group is a physician-led, partnership organization with a patient-centered and evidence-based medicine approach. SCPMG is an organization with strong values who provides our physicians with the resources and support systems to ensure our physicians can focus on practicing medicine, connect with one another and provide the best possible care to our patients. ADULT & CHILD PSYCHIATRISTS Openings in Southern California INPATIENT PSYCHIATRIST Los Angeles, California GERIATRIC PSYCHIATRIST West Covina, California At SCPMG, you’ll enjoy the amazing recreational activities, spectacular natural scenery and exceptional climate our area is known for, along with stability in today’s rapidly changing health care environment. SCPMG is proud to offer its physicians: 4 1/2 day work week (8-10 hours) * Flexible schedules Education time (1/2 day a week) * 1 hour for initial evaluations and 30 minutes for follow-ups Multi-disciplinary team consisting of Nurses, LCSWs, Psychologists and MAs Medical, Dental, Vision, Life & Supplemental Comprehensive Insurance Robust retirement plans: Pension Plan, 401K and Keogh Excellent salary and compensation package (bonuses offered) Partnership eligibility after 3 years * Not available for the Inpatient Psychiatrist opportunity. We invite you to make a difference in the community we serve.

**Job Requirements:**
POSITION QUALIFICATIONS BC/BE in Psychiatry required BC/BE in Child & Adolescent Psychiatry preferred

Company: Pacific Permanente Group
Job ID: 11281989
http://jobsource.aacap.org/jobs/11281989

**HAWAII**

PSYCHIATRY IN MAUI, HAWAII

**Job Description:**
The Pacific Permanente Group, LLC is seeking a BC/BE Psychiatrist for its Inpatient Psychiatric Unit at Maui Memorial Medical Center in Wailuku, Maui, Hawaii. POSITION HIGHLIGHTS 12 bed Inpatient Adult Psychiatric Unit managed by 3 Psychiatrists Consultants in ED and on hospital floors Partial Hospitalization Program 3 half days outpatient practice per week Psychologist and Psych APRN on staff Average 3 new patients per day, Average LOS in unit 5-7 days Weekly Grand Rounds Call 1:3 Excellent work/life balance in a beautiful tropical island setting.

**Job Requirements:**
POSITION QUALIFICATIONS BC/BE in Psychiatry required BC/BE in Child & Adolescent Psychiatry preferred

Company: Pacific Permanente Group
Job ID: 1109887
http://jobsource.aacap.org/jobs/1109887

FOR YOUR INFORMATION

**CLASSIFIEDS**

**CALIFORNIA**

CHILD AND ADOLESCENT PSYCHIATRIST
(San Francisco Bay Area, CA)

**Company:** Spin Recruitment Advertising
**Job ID:** 11389940
http://jobsource.aacap.org/jobs/11389940

**HAWAII**

PSYCHIATRY IN MAUI, HAWAII

**Company:** Pacific Permanente Group
Job ID: 11281989
http://jobsource.aacap.org/jobs/11281989

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centers. Teaching responsibilities would include the teaching of medical students, general residents, child/pediatric psychology residents, and child and adolescent psychiatry residents. Leadership opportunities exist for the motivated candidate in the areas of pediatric mental health integration and telepsychiatry. The Division has been a leader in training child psychiatrists, psychologists and other child mental health professionals while delivering high quality child and family mental health services via the Bingham Clinic since 1913. Research/scholarship is encouraged. The faculty have a broad range of academic interests including autism spectrum disorders, epidemiology, family treatment, chronic pediatric illness and pain, and integrated mental health in primary and pediatric subspecialty care. The division has a rich tradition of contributions to child and adolescent psychiatry, psychology and mental health at the national level. The establishment of the division within the Department of Pediatrics has led to a number of new initiatives, including expanded telepsychiatry offerings and integrated care opportunities.

Interested individuals should send CV and cover letter to Jennifer Le, MD, at jennifer.le@louisville.edu

AA/EOE

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.
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- AACAP members and nonprofit entities receive a 15% discount.
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For any/all questions regarding advertising in AACAP News, contact communications@aacap.org.