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Call for Papers Deadline: February 14, 2019
New Research Poster Deadline: June 4, 2019
Preliminary Program / Hotel Reservations: June 14, 2019

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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

Child and adolescent psychiatrists are the leading physician authority on children’s mental health. For more information, please visit www.aacap.org.

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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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At 3:00 am, as I lay in the dark chief’s office between two inpatient rooms, an astounding ringing woke me up from a sweet dream where I was playing with my one-year-old daughter. I had not seen her for a week. A chief resident in China is required to work in the hospital 24 hours a day, six days a week, for six months during the PGY-4 year. The emergency room (ER) attending requested an urgent consultation for a suicidal patient. There was no crisis worker in the ER, so I was responsible for all urgent consultations. I jumped out of bed and rushed to the ER, which was 1.2 kilometers away from my office. Hospital policy required the psychiatry chief resident to see any emergent consult within 15 minutes after receiving a phone call; otherwise the chief resident was responsible for any outcome, including the patient’s death. A former chief resident told me the story of a patient on the internal medicine unit who jumped off the tenth floor two minutes before she arrived. Despite the sad and unfortunate outcome, the resident was not held responsible because she arrived at the inpatient unit 14 minutes after receiving the consultation request. Being the chief resident for six months was the most stressful time of my psychiatry residency in China - not just because of the long clinical hours, but because of the separation from my family. I was either working or sleeping for 24 hours, six days per week in the hospital, with very limited time to take a break. Every resident in every specialty in the hospital had to survive this grueling training before becoming an attending. Unfortunately, there was no house officer association protecting the residents or negotiating on our behalf. However, this experience improved my competency dramatically because of the large volume of patients encountered and the level of responsibility I had for those patients.

**Brief Overview of the Child and Adolescent Psychiatry (CAP) Training in China**

There was no CAP fellowship available in China in 2008, so I worked in the CAP inpatient unit during the first six months of my PGY4 year and as chief resident during the second six months. There are fewer than 500 qualified child psychiatrists in China. CAP services are only available in the capital cities and the populous municipalities. China began standardized psychiatry residency training in 2014. The West China Hospital at Sichuan University is the largest single-site hospital in China with more than 4,800 inpatient beds and 7,800 medical staff. Established in 1938, the Mental Health Center (MHC) in the Hospital is the first mental health institute in western China and one of four key mental health centers in mainland China. Although my residency experience is not generalizable to other residencies, it is a good example of how most psychiatry residencies in China’s big teaching hospitals work. Because I have always been extremely interested in CAP, I chose to work in the inpatient CAP unit as a junior attending, interviewing new patients and creating the treatment plans. I provided psychotherapy for several patients. I did research on social anxiety disorder for young adults and successfully published several manuscripts. I worked on an outpatient service two afternoons per week from PGY2 to PGY4. Each resident had a 4-hour long outpatient clinic per half day, capped by 20 outpatients. Most of the afternoons, I saw six to ten patients.

Because of the shortage of CAPs in China, I decided to come to the United States to learn more about research and clinical practice in child and adolescent psychiatry. Now I am a first year attending in the outpatient clinic at the University of Utah. I wanted to compare my training experience in China and the United States with the hope to improve the understanding of training on both sides, and to build collaboration between the two countries.

**Comparison of the Training Experiences in the Two Countries**

The United States has well-established requirements for both general psychiatry residency and CAP fellowship. My first-year fellowship consists of four months of consult-liaison, three months of inpatient service, and five months of residential treatment center rotations. The second-year fellowship consists of a large variety of outpatient services, including specialized populations.

Programs in China and the United States gave me high quality training in psychiatry but through very different approaches. West China Hospital at Sichuan University offered many research opportunities which included funding from the hospital and government. The training also involved a tremendous patient workload. China began the process of modeling general psychiatry residency training programs after the United States in 2003, and psychiatric training with similarities to Western medicine have become more and more popular. It may take a while for China to develop subspecialty

*continued on page 6*
A Comparison of a Fellows Life in China and United States continued from page 5

Table 1: Comparison of general psychiatry residency in China and CAP fellowship in United States

<table>
<thead>
<tr>
<th></th>
<th>University of Utah (from 2013 to 2018)</th>
<th>MHC in China (from 2013 to 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual income</td>
<td>$52,000 to $65,000</td>
<td>¥60,000 (flat rate for all residents from PGY1 to PGY4) (about $9,000)</td>
</tr>
<tr>
<td>Housing (Rent)</td>
<td>$800 per month for a 2-bedroom apartment (about 14.8% to 18.5% of the monthly income)</td>
<td>¥2500 per month for a 2-bedroom apartment (about $375; 50% of the monthly income)</td>
</tr>
<tr>
<td>Retirement account</td>
<td>Available but optional</td>
<td>Not available</td>
</tr>
<tr>
<td>Disability insurance</td>
<td>Included</td>
<td>Not available</td>
</tr>
<tr>
<td>Malpractice insurance</td>
<td>Included</td>
<td>Not available</td>
</tr>
<tr>
<td>Medical insurance</td>
<td>Residents pay part of the premium. Residents pay more to include dependents and spouse.</td>
<td>Hospital pays all the insurance premium, which is not able to include dependents and spouse. Residents need to buy public or private insurance for dependents and spouse.</td>
</tr>
<tr>
<td>Future job</td>
<td>Residents have local and national opportunities.</td>
<td>Most residents stay in the same hospital where they trained.</td>
</tr>
<tr>
<td>Inpatient workload</td>
<td>Capped by 8 patients/fellow</td>
<td>No cap, ranging from 6 to 10 patients</td>
</tr>
<tr>
<td>Outpatient workload</td>
<td>8 hours/day, 2 days/week</td>
<td>4 hours/half day, two half days/week</td>
</tr>
<tr>
<td>Electronic Medical Record (EMR)</td>
<td>Available</td>
<td>Not available</td>
</tr>
<tr>
<td>Attending’s income</td>
<td>Tripled or quadrupled</td>
<td>Doubled or tripled</td>
</tr>
</tbody>
</table>

fellowships because of financial stress experienced by trainees, due to very limited income, the uncertainty regarding their future, and the higher work demand on Chinese physicians compared to U.S. residents. This is outlined in Table 1.

Social and Cultural Influences on Child and Adolescent Psychiatry Practice

It is important to mention several cultural and social influences in China which impact CAP. First, Buddhism and Daoism are the most popular religions and influence culture. Therefore, Chinese patients may feel their mental suffering results from retributions of sins from their previous or current lives. Family members’ support and religious rituals are extremely important for people’s mental health. Second, the one-child policy from 1979 to 2015 has had a tremendous influence on family dynamics, education, and social resources. It caused an unbalanced sex ratio because of the cultural preference of male over female. Spoiled by four grandparents and two parents, the only child has less empathy and social skills but more responsibilities to take care of the aging grandparents. Third, the growing migration of workers from rural to urban areas in China has resulted in many children being left behind to be raised by their grandparents or relatives. Fourth, most government and private insurances only cover inpatient treatment. Therefore, patients use outpatient services more often than inpatient services in order to reduce costs. One aspect where I believe China provides better services than the United States is in accessible and affordable psychiatric outpatient services; it costs ¥5 to see a psychiatry resident and ¥20 to see an attending. Although the patient has to self-pay for the outpatient visit, the intake assessment and the follow up appointment charge the same amount of money for a 30-minute appointment. (Note: ¥1 = $0.15. A single person’s monthly cost in Chengdu, China, was ¥3,254.16 ($488.12) without rent in 2018.) Psychiatry is growing fast in China, and growing pains are expected. Its growth has been impressive due to the hard work and devotion of many mental health professionals. Collaborations between the United States and China can be mutually rewarding for American psychiatrists interested in global health, as well as Chinese psychiatrists looking to incorporate the best of Western and Eastern mental health treatments.

References


Dr. Xiao, Assistant Professor (Clinical), received her medical degree at West China School of Medicine, Sichuan University and finished her first psychiatry residency there from 2004 to 2008. She earned her PhD at the School of Social Work, University of Southern California from 2008 to 2013. She received training from the University Hospital at University of Utah as a general psychiatry resident, a child and adolescent psychiatry fellow, and a chief resident from 2013 to 2018. She may be reached at rong.xiao@hsc.utah.edu.

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Strategies for the Inpatient Adolescent Unit

One Sheep, Two Sheep, When Teens Get No Sleep: Strategies for the Inpatient Adolescent Unit

Case

Sarah is a 17-year-old female who is hospitalized with passive suicidal ideation in the context of anxiety about finals. She endorsed poor concentration, constant worries about her grades, feeling tense, irritable, and worsening sleep. Sleep initiation has been particularly troublesome with “racing thoughts” about her academic progress and then being “exhausted and irritable” in the morning since she has to get up early for school after only five to six hours of sleep. She is on Lexapro for generalized anxiety and has tried trazodone, Benadryl, and melatonin in the past, but she reports these trials have either been ineffective, without lasting results, or made her feel groggy. She asks for non-pharmacologic treatment options and hopes there is something that “I can do on my own without meds.”

Sleep is an essential part of physical and emotional health and balance, and sleep issues are significantly associated with psychiatric disorders and emotional and behavior problems. Children and adolescents need at least nine hours of sleep per night. Yet the majority of teens, 53-70%, are getting less than eight hours on school nights, and approximately 30-36% endorse insomnia symptoms. The issues of sleep during adolescence are unique and Crowley et. al describes this period as a “Perfect Storm” – a time where both intrinsic (sleep homeostasis and circadian physiology) and extrinsic factors (societal and cultural pressures) collide leaving youth sleep deprived.

Insufficient sleep has implications for academic performance, interpersonal relationships, emotional and behavioral regulation, and cognitive adverse outcomes. Further, some studies suggest that sleep problems are associated with suicidal ideation and attempts, and precede the development of anxiety and depression in adolescents.

It is well established that cognitive behavioral therapies for insomnia (CBT-I) and mindfulness based sleep interventions, light therapy, and chronotherapy are effective treatments for adult sleep disorders. Several meta-analyses of CBT-I for chronic insomnia have demonstrated medium-to-large effect sizes for sustainably improving various sleep parameters (sleep efficiency, sleep onset latency, wake after sleep onset, and sleep quality) in adults. This improvement has been demonstrated for primary insomnia as well as for insomnia that exists alongside comorbid medical and psychiatric disorders. The American College of Physicians (ACP), in a 2016 practice guideline, recommended that all adults with chronic insomnia receive CBT-I as first line treatment. Conversely, the adolescent literature remains limited, and general psychoeducational sleep hygiene programs geared toward the general student population have not improved sleep behaviors or mental health outcomes. However, Blake et. al. found that a CBT-I and mindfulness based sleep intervention was effective in at-risk adolescents, those already experiencing subclinical and clinical symptoms of anxiety and depression. Additionally, there is a randomized controlled trial (RCT) that found CBT-I effective and another RCT that found CBT-I plus bright light therapy improved self-reported and objective sleep as well as functional (anxiety and depression) outcomes in adolescents with a primary sleep disorder.

Beyond the general adolescent population, the youth admitted to an inpatient psychiatric unit overwhelmingly report symptoms of sleep disorders. While there are limited studies and protocols to systematically target sleep complaints within an acute care context, the structured hospital setting offers a rich forum to both collect objective sleep data and begin treatment and psychoeducation to address sleep related issues. The inpatient milieu is organized with consistent rules and routines which schedule wake/bedtime and meals, control light variables, permit/prohibit screen time, objectively record amount/time of sleep (15 minute checks), and facilitate a variety of therapeutic groups and activities which can be targeted toward sleep related issues. The five core CBT-I components consist of sleep hygiene education and instruction, stimulus control, sleep restriction, relaxation training, and cognitive therapy. While not all core concepts may be addressed, many of these CBI-I techniques can be incorporated within the frame of an inpatient hospitalization.

Sleep diaries can be important tools in sleep interventions. Sleep logs offer valuable information about an individual’s timing, quality, and patterns of sleep. In a hospital setting, the data from a patient’s sleep diary can be compared to the objective information documented by staff who log sleep/awake activity every 15 minutes throughout the night. Accurate patterns of sleep can be identified and discrepancies explored to help inform treatment goals.

continued on page 8
One Sheep, Two Sheep continued from page 7

Sleep Hygiene
Specific routines and instructions are provided to patients on an inpatient unit, including consistent wake BED times and predictable pre-sleep as well as wake-up routines. Promoting evening “wind down” activities with low light levels and soothing music encourages sleep readiness. While mornings are structured to maximize light from windows, scheduled coffee and breakfast times as well as staff offerings of additional hygiene products aim to stimulate wakefulness. Psychoeducation is provided in multiple ways, ranging from direct individual instruction to written literature and group/activity modalities. Given that adolescents often benefit from more active engagement and participation, groups can be created to incorporate discussion with worksheets, videos, and games. For example, Sleep Hygiene Bingo Group incorporates a Bingo board (picture 1) which covers broad sleep hygiene topics (e.g., chocolate, exercise, temperature, etc.), and as the game progresses each topic is processed within the group and typically spurs a lively discussion.

Stimulus Control
Picture 1: Sleep Hygiene Bingo

Promote sleep. When there is an in vivo opportunity, the staff provide in-the-moment direct feedback to patients to avoid naps or do non-sleep activities out of bed. Thus, all rooms are furnished with a window and dimmers to regulate light, and a desk and chair to offer an alternative space for non-sleep activities.

Sleep Restriction
On the inpatient unit, it may be difficult to incorporate sleep restriction within a hospital milieu schedule. The goal of sleep restriction technique is to promote homeostatic drive to achieve 85% or greater sleep efficiency (defined as the ratio of the total time spent asleep at night compared to the total time spent in bed). It is plausible to incorporate this technique if patients have a single room or otherwise do not disrupt the therapeutic milieu; however, thoughtful and cautious consideration of comorbidities and adverse outcomes of restricting sleep is vital.

Relaxation
A variety of relaxation techniques can be taught, practiced, and utilized to reduce cognitive and physiologic arousal and promote sleep. Many inpatient units already have relaxation groups. Our unit offers a daily afternoon group called “Sensory Modulation and Relaxation Group” which encompasses a variety of activities including yoga, meditation, seven senses, progressive muscle relaxation, guided imagery, and deep breathing skills.

Cognitive Therapy
Within CBT-I, cognitive therapy aims to explore negative thought processes and negative beliefs about sleep by focusing on ruminations and worries that occur at bedtime. It assists in identifying and then challenging negative thoughts about sleep, unrealistic expectations of sleep, and catastrophic thinking and fears about missing out on sleep. The skills learned from inpatient CBT groups can be generalized and practiced to target specific issues with sleep.

Conclusion
As in any intervention, the firm foundation of psychoeducation is a beginning point. In an acute care setting, psychoeducation can be provided in a group or individual format and should not be limited to sleep hygiene; adolescents are curious about their development, biology, and physiology. Motivational interviewing can be incorporated to improve engagement. Identifying areas of investment such as improving academic performance, interpersonal relationships (via better emotion and behavioral regulation), improving stress management, and physical/health benefits (e.g., acne, obesity) may be areas to promote greater treatment investment. The inpatient setting offers a captive audience of both patients and families, who serve as a powerful ally in helping adolescents.

Sleep is a common and important adolescent problem associated with many mental illnesses, an issue further exacerbated by normal adolescent physiologic changes, emotional development, technological pressures, and societal changes (e.g., early school times). At the acute level of inpatient care, sleep difficulty is one of the most common symptoms and complaints. The structured hospital setting offers an ideal environment to collect accurate sleep data as well as engage patients to actively take part in their treatment. While a hospital admission is brief, it offers a powerful opportunity to reset internal circadian rhythm, provide valuable education, and teach and practice skills to promote balanced and healthy sleep habits. It is important to note that while an inpatient hospitalization is a unique and potentially valuable starting point to begin psychoeducation and intervention for insomnia, it is in no way comprehensive, and coordination of care with outpatient providers is imperative to ongoing treatment.

References


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**CALL FOR NOMINATIONS**

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

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

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

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

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

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AACAP’s 2019 Legislative Conference and Assembly Meeting will take place in Washington, DC, from May 2–4, 2019. Join us for both events to advocate for children’s mental health.

**AACAP Legislative Conference**

On May 2–4, AACAP’s Government Affairs team will teach you about the legislative process, provide you with advocacy materials to help you develop and deliver the most impactful messages, and schedule your meetings with legislators on Capitol Hill. Join us as we advocate for children’s mental health, and make your voice heard!

Visit [www.aacap.org/LegislativeConference](http://www.aacap.org/LegislativeConference) for more information or contact Harry deCabo, Advocacy & PAC Manager, at hdecabo@aacap.org or 202.587.9669.

**AACAP Assembly Meeting**

On May 4, AACAP’s Assembly of Regional Organizations will meet to discuss the issues facing your state and region. The Assembly consists of AACAP member representatives from across the nation and is always looking for more voices and advocates like you to join the discussion.

Visit [www.aacap.org/Assembly](http://www.aacap.org/Assembly) for more information or contact Megan Levy, Executive Office Manager, at mlevy@aacap.org or 202.966.1994.
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How to Treat Unaccompanied Minors Separated at the Border

The zero-tolerance policy that forcibly separated migrant children from their parents at the border earlier this year was short-lived, but the traumatic effect it has on the children may last a lifetime. More than 2,600 children, classified as unaccompanied minors, were torn from their parents and transferred to the custody of the U.S. government. A federal judge has ordered the children be reunited with their parents, but as of late August, more than 500 children remained separated from their parents.1

As psychiatrists, we are exceedingly concerned about the impact of the separation on the children and their families. Several leading psychiatric and medical associations — including the American Academy of Child Adolescent Psychiatry (AACAP), the American Psychiatric Association (APA Psychiatric), the American Academy of Pediatrics (AAP), the American Medical Association (AMA), and the American Psychological Association (APA Psychological) — issued strong statements condemning the policy and calling for its end.

“When children experience sudden separation from one or both parents, especially under frightening, unpredictable, and/or chaotic circumstances, they are at heightened risk for developing posttraumatic stress disorder (PTSD), anxiety, depression, and other trauma-related reactions that may last for the rest of their lives,” AACAP’s statement read.2

AACAP officials highlighted the undue harm the separation placed on children who are already vulnerable. The families crossing the U.S.-Mexico border often are fleeing war and violence in their home countries and, even before they reach the United States, must cope with the related effects of stress and trauma. Highly stressful experiences, like family separation, can cause irreparable harm, which can disrupt children’s brain architecture and affect their development, AAP officials emphasized. This type of prolonged exposure to serious stress — known as toxic stress — can carry lifelong consequences for children.

During the 2018 AMA Annual Meeting, delegates discussed how the zero-tolerance policy can cause great harm to children and their families, who are compelled to make a dangerous and uncertain journey largely out of concerns of safety for their children. In a letter to federal officials, the AMA’s CEO wrote that childhood trauma and adverse experiences “created by inhumane treatment often create negative health impacts that can last an individual’s entire lifespan.”3 Similarly, the president of the APA said the policy threatened the mental and physical health of the children and their caregivers. “The longer that children and parents are separated, the greater the reported symptoms of anxiety and depression for the children,” she wrote. That leads to negative outcomes including psychological distress, academic difficulties, and developmental disruptions.

If the children are not already in the care of a mental health professional, they may soon be. Psychiatrists and mental health professionals need to apply a cultural lens when treating them, making sure we are aware of the child’s cultural beliefs and values. Employing a culturally-sensitive approach during treatment promotes the child’s culture while bridging their understanding of their illness with ours. Even in 2018, we cannot discount the power of stigma in keeping children from seeking mental health care. We must combat that at every turn. In addition, this population — which is already marginalized — may fear that seeing a mental health professional could isolate them further and even jeopardize their immigration case. This may affect the child’s willingness to seek or remain engaged in treatment.

These children likely are already suffering from immigration-related loss or trauma. They endured overwhelming stress during the pre-migration, migration, and post migration periods, from violence in their home countries to separation upon arrival. The uncertainty of the future only exacerbates that issue, as does the sense of limbo they face waiting to know if they will be deported. Specifically, these children are at a higher risk for depression, anxiety, posttraumatic stress disorder, conduct disorder, and substance abuse disorder. However, they may express their symptoms through somatic patterns or other indirect means — something psychiatrists should watch for.

The use of DSM-5’s Cultural Formulation and Cultural Formulation Interview may prove useful in these cases. AACAP’s Practice Parameter for Cultural Competence in Children and Adolescents3 is a tool every psychiatrist should have in their toolkit. Among the recommendations is enlisting an interpreter outside of the family if the child’s primary language is not English. Connecting the family with an agency that can help with transportation to and from appointments can go a long way in encouraging consistent participation in treatment. When available, the children often prefer clinics located within their ethnic community or clinics within school and community buildings, as opposed to hospitals.

Checking our own implicit biases is essential, albeit difficult. We need to engage with our patients and listen to their individual stories. It’s easy to assume that we may know what they experienced based on articles we have read.
read about children crossing the border or even previous patients we have seen. We should resist that urge and leave our preconceptions at the door. It is also good to remember that these children typically come from collectivist cultures, so involving the extended family in treatment could improve treatment outcomes. With that, however, we must emphasize confidentiality. Many young people, especially teenagers, may not feel comfortable sharing information with a psychiatrist if they think it will get back to their parents or other relatives. Some of those family members may be dealing with their own stressors, so we need to be aware of acculturation stress and intergenerational acculturation conflict. Documenting the trauma, whether the child experienced it before or after arriving to the United States, also is important. Report suspected abuse or neglect to child protective services, even if it occurred in the child’s home country. Unaccompanied minors are especially vulnerable to human trafficking.

The challenges facing the children who were separated from their families do not end once they are released from the government’s custody. In addition to treating those children who walk through our doors, we can make our voices heard. Contacting our elected officials and media outlets raises awareness about the issue. It also educates the public about the damage the separation caused and the continued struggles these children will face. Psychiatrists and mental health professionals should consider signing up for asylum evaluation. As the situation continues to evolve, our goal of aiding these children in recovering from the harm they experienced remains the same.

References

Dr. Adam is a child and adolescent psychiatrist and clinical associate professor of Psychiatry at the University of Missouri-Columbia. She may be reached at adamb@health.missouri.edu.
ESTLED in the tranquil mountains of Washington, less than an hour away from Seattle, one finds the facility aptly called reSTART: Serenity Mountain. A first of its kind residential treatment facility for internet and video game addiction for teens in the United States, it is a short drive from its sister facility for young adults. “Connecting people with what matters most – Life” reads their mission statement, and it is not hard to see why after a personal tour given by one of their founders, Dr. Hilarie Cash, and admissions coordinator, Mr. Johnny Tock. Video game addiction is still not recognized as an official disorder in the United States, and the financial cost, which is not reimbursed by insurance, places this kind of treatment out of reach for many patients. However, demand is so great that reSTART has a waitlist for patients. There was no waiting though for our group of 13 AACAP Media Committee and Substance Abuse Committee members who took a detour from AACAP’s Annual Meeting in Seattle to visit the reSTART personal tour arranged by Paul Weigle, MD.

The tour started off with meeting in one of the two residential houses. We sat in a large living room, surrounded by guitars and other instruments scattered across the room that were left behind by the patients. It is hard to imagine what gatherings resemble for under-socialized teens who have been glued to screens since the age of three. Social anxiety from deficits in skills and time spent with peers is quite evident in this population. The multidisciplinary staff gave us a detailed description of their admission process, nature, and course of treatment and outcomes.

With the lack of motivation for independence, paralyzing fear of failure, poor work ethic, and personality traits of dependency, avoidance, schizotypal, narcissism, antisocial, and melancholia, most of the adolescents admitted to reSTART are coerced by parents into signing consent for treatment. Washington state allows children 12 years and older to sign in voluntarily. During an initial detox period that lasts an average of three weeks, withdrawal symptoms, including emotional lability and aggression, are commonly experienced. Thereafter, the teens are able to start improving themselves and reversing the impact of chronic insomnia, unhealthy diet, and social isolation.
Video game addiction is still not recognized as an official disorder in the United States, and the financial cost, which is not reimbursed by insurance, places this kind of treatment out of reach for many patients.

While CBT has been a recognized mode of treatment for this population group, reSTART counsellors tailor a combination of therapies to meet patients’ specific needs in order to adopt a recovery mindset, understanding, and acceptance of their gaming problems. All patients participate in daily individual, group, and family therapy. A visiting psychiatrist prescribes medication to address comorbid ADHD, depression, and anxiety symptoms. Residents attend six hours of school every day, where they are slowly reintroduced to productive use of screen media. The average length of stay is 12 to 16 weeks, after which a gradual transition back into society is enacted.

Given the considerable cost of treatment (roughly $16,000 per month), there is a lack of socioeconomic diversity amongst residents of this for-profit facility. Typical patients come from higher income households, with well-educated parents who have high expectations. During treatment, an emphasis is placed on learning and maintaining personal hygiene and learning to schedule and prioritize school work. Treatment also focuses on building relationships with their parents and other family members.

As our tour goes on, we witness breathtaking views of the mountain from the dorm-style rooms, hiking trails, swimming pool, gymnasium, rooms dedicated to art and play therapy, and well-supplied greenhouse, which together create a seemingly ideal environment for recovery. The generous staff-to-patient ratio, adequate space, and structured schedule also support quality care.

Patients are assessed for their readiness for discharge based on their stability on psychiatric medication as well as their ability to maintain school work, socialize with peers, practice coping skills, and communicate productively with parents. The staff report that immense changes in the residents’ behaviors and self-confidence are typical.

According to Dr. Cash, the brain requires two years to recover from the deleterious effects of video game addiction, so following discharge she recommends youth abstain from video games for at least two years. Thereafter, she recommends a continued avoidance of high-intensity games and the games that were a part of their former addictive habit.

As we see a rise in excessive video game play in youth, and the accompanying prevalence of related behavioral problems and addictive habits, it will be invaluable for clinicians to have data on the effectiveness of interventions of this nature. Dr. Cash is currently conducting a post-treatment survey and reports promising initial results. As ICD 11 officially incorporates gaming disorder, lessons learned from this groundbreaking program could potentially be replicated by other treatment facilities and used in designing effective treatment at other levels of care.

For more information about reSTART, visit netaddictionrecovery.com.

Dr. Kaliamurthy is currently a fellow in Child and Adolescent Psychiatry at the Institute of Living in Hartford, Connecticut. He completed his medical training at the Rajah Muthiah Medical College, India prior to general psychiatry residency training at the Institute of Living. His areas of interests include addiction psychiatry and the interface of psychiatry and technology. He may be reached at sivabalaji.kmurthy@gmail.com.

Dr. Weigle is associate medical director at Natchaug Hospital of Hartford Healthcare and teaches at UConn School of Medicine and Quinnipiac Medical School. He serves as co-chair of AACAP’s Media Committee and on the National Scientific Advisory Board for the Institute of Digital Media and Child Development. He may be reached at pweigle@sbcglobal.net.
Call for Papers and Children’s Artwork

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

Special Call for Papers on Depression

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

Call for Cover Artwork

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

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

Read the updated Guide for Authors to learn more at www.jaacap.org
AACAP’s Douglas B. Hansen, MD, 44th Annual Review Course emphasizes the most recent material relevant to the general practice of child and adolescent psychiatry and serves as an up-to-date review of child and adolescent psychiatry as well as addresses important clinical research. The course is designed to update practitioners on state-of-the-art standards of diagnosis and treatment.

www.aacap.org/ReviewCourse-2019

QUESTIONS? Email meetings@aacap.org
The Opioid Epidemic and Youth: A Clinical Update for Child Psychiatrists

Amy Yule, MD

Background

Opioid misuse has captured the attention of providers in all clinical disciplines because opioid misuse and opioid use disorders (OUD) are associated with substantial morbidity and mortality. Between 1999 and 2016, 632,331 individuals died of a drug overdose in the United States, and the majority of these deaths involved opioids. Young people have also been affected; in 2016 alone, 4,070 young people ages 15 to 24 years died from an opioid related overdose. Since substance use disorders (SUD) start in late adolescence, and childhood psychiatric disorders such as attention-deficit/hyperactivity disorder, conduct disorder, and depression increase a young person’s risk of developing a SUD, child psychiatrists can play an important role in changing the trajectory of the opioid epidemic.

Assessment

Most adolescents with a SUD do not view their substance use as a problem and do not volunteer this information unless asked specifically. It is therefore important for providers to routinely screen all adolescents for substance use. The National Institute on Drug Abuse recently made two validated, free adolescent substance screening instruments available online (www.drugabuse.gov/adolescent-substance-use-screening-tools). Screening to Brief Intervention (SBII) and the Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD) are patient or clinician administered and assess substance use in the past year. Both instruments ask first about tobacco, alcohol, and cannabis use. If an adolescent has not used any of these substances, no further questions are required. If an adolescent has used one of these substances, the clinician is prompted to ask about five other substances, including “prescription drugs that were not prescribed for them,” “illegal drugs,” “inhalants,” and “herbs or synthetic drugs.”

If an adolescent endorses any opioid use, it is important to assess further details including the type of opioid used since opioids vary considerably in potency. Since prescription opioids have become less available for misuse recently, many individuals misusing opioids are using heroin and fentanyl. If someone intended to use heroin and took a “dose” that they thought was safe based on the potency of heroin, but the substance was fentanyl which is approximately 50 times stronger, they are at high risk for an unintentional overdose and death.

When an adolescent is misusing opioids, other important variables to assess include the frequency of use, method of use [oral, intranasal, smoked, or intravenous (IV)], and the 11 DSM-5 SUD criteria. Withdrawal symptoms are important to monitor when starting medication to treat an OUD. They can be formally quantified with the Clinical Opioid Withdrawal Scale and commonly include insomnia, anxiety, irritability, mydriasis, diaphoresis, pain, or gastrointestinal upset. Knowing how the opioid was used is also critical since IV use has the highest risk of transmitting infectious diseases such as hepatitis C. and HIV. The prevalence of acute hepatitis C has increased in parallel with the number of opioid overdoses, and the highest incidence is among 20 to 29 year olds. Likewise, a thorough assessment for co-occurring psychiatric disorders – especially depressed mood and suicidality – is important for adolescents with OUD since the prevalence of co-occurring psychiatric disorders is high.

Treatment

If an adolescent meets criteria for an OUD, medication – which decreases risk for overdose and death – should be discussed. Currently, three medications are FDA approved to treat OUD in adults: buprenorphine/naloxone, methadone, and naltrexone extended release. Each has 1) a different mechanism of action at the opioid receptor, 2) evidence base for use in adolescents, 3) different route of administration, and 4) challenges with medication access.

With regard to mechanism of action, buprenorphine is a partial opioid receptor agonist, methadone a full agonist, and naltrexone an antagonist. Clinically, opioid agonists decrease urges and cravings to use opioids, prevent opioid withdrawal, and prevent the experience of pleasure if an opioid is taken when the agonist is active in their system. Since buprenorphine is a partial agonist, an individual needs to have some symptoms of opioid withdrawal before starting the medication as they will experience sudden opioid withdrawal if they go from having an opioid receptor fully activated by an opioid to having an opioid receptor only partially activated by buprenorphine. Since methadone is a full agonist, an individual can start this medication when they still have

“When an adolescent is misusing opioids, other important variables to assess include the frequency of use, method of use [oral, intranasal, smoked, or intravenous (IV)], and the 11 DSM-5 SUD criteria. Withdrawal symptoms are important to monitor when starting medication to treat an OUD.”
opiates in their system. As an antagonist, naltrexone blocks activity at the opioid receptor and prevents an individual from experiencing pleasure if they use an opioid. To start naltrexone, a patient must be off opioids for several days since they would experience symptoms of opioid withdrawal if they started an antagonist medication when opioids were still activating the opioid receptor.

Buprenorphine/naloxone has the largest evidence base for use with adolescents with OUD. It is a daily sublingual medication that a provider who obtained an X license from the DEA can prescribe in the outpatient setting. Three randomized controlled trials demonstrated that buprenorphine is safe and effective in adolescents 16 years and older who have a moderate or severe opioid use disorder. Naltrexone extended release is a once monthly intramuscular gluteal injection that often requires prior authorization. Methadone is a daily oral solution that can only be obtained through highly structured methadone maintenance programs which often do not serve people under 18. Adolescents who have misused opioids and their families should be educated on signs of an opioid overdose – including sedation, decreased level of consciousness, slowed breathing, and cyanosis – and encouraged to get naloxone. When an individual stops breathing, overdoses become fatal. Naloxone is a short-acting opioid receptor antagonist that can be administered intranasally, intramuscularly, or intravenously to temporarily reverse an opioid overdose. It is available by prescription in most states and has been increasingly made available for family members or other potential bystanders. The “Opioid Overdose Prevention Toolkit” is a resource for providers, patients, families, and communities available through SAMHSA (store.samhsa.gov/product/opioid-overdose-prevention-toolkit/SMA18-4742).

In addition to medication, evidence-based therapy – such as motivational enhancement therapy with cognitive behavioral therapy (MET/ CBT) – can help adolescents with SUD especially when their family is involved. MET/ CBT engages youth in treatment by first building their motivation to change and then helping them build skills to help them be effective in making changes. When a young person is reluctant to come to treatment, providers can work with families to incentivize engagement in care with rewards and consequences. The community reinforcement and family training protocol is a manualized treatment targeted to parents to help their child engage in SUD care.

Summary
Although integrating buprenorphine/naloxone and naltrexone extended release into your practice may feel challenging, society needs more providers trained to work with youth with OUD and their families. Provider training and support for treating OUD can be accessed for free from a SAMHSA funded project, the Provider Clinical Support System (PCSS) (www.pcssnow.org). PCSS can connect a provider with live waiver trainings and free webinars for CME credit on treating OUD and psychiatric and medical co-morbidity associated with SUD. PCSS has short videos where providers model how to discuss medication with patients. PCSS also offers free one-on-one mentoring with experts. A different SAMSHA project, the State Targeted Response-Technical Assistance Consortium, provides states and communities with help expanding OUD treatment into systems and practices (www.getSTR-TA.org).

References

Dr. Yule is a psychiatrist at the Massachusetts General Hospital and an Assistant Professor of Psychiatry at Harvard Medical School. She is currently part of AACAP’s Physician Scientist Program in Substance Abuse funded by NIDA (K12DA000357-17). She may be reached at ayule@partners.org.

Disclosure: Dr. Yule currently receives funding from NIDA through AACAP’s Physician Scientist Program in Substance Abuse (5K12DA000357-17). She is also on the PCSS Steering Committee as the AACAP representative.

I’m Going to See a Child and Adolescent Psychiatrist: Now What?
The comics on the next page (and available at www.aacap.org) were created in 2017-2018 through a collaboration between child and adolescent psychiatrists and AACAP’s Youth Connection (AYC), a group of youth with lived mental health experience. They are available to be printed out and placed in your waiting room so that young patients can read them as they wait for their appointment.

The comics are a hypothetical depiction of a first visit to a child and adolescent psychiatrist and represent just some of things a young patient may experience. The intent of the comics is not only to educate, but to let children and adolescents know that there is nothing wrong with seeing a psychiatrist or getting help.

AACAP greatly appreciates the contributions of Francesca Pileggi, Rachel Shim, Wilton Johnson, and Vanesty Lozada, along with Chinenu Varma, MD, MPH, and Otema Adade, MD, in bringing these to life.

continued on page 20
How long am I going to be here? What am I supposed to say? What if I don't have enough stuff to say? What if I say something wrong?

I wonder what this doctor is going to look like? Will she understand where I'm coming from? What if I don't like talking to her?

I really hope I don't see anyone I know here. What's going to happen when I'm in her office? I wonder if I'll have to lie down on a big couch. That would be SO awkward. Is she just going to keep asking "how do you feel" over and over? I'm not sure if I feel like talking. It might just make things worse.

It's going to be so weird to open up to a total stranger. If I tell her I've had bad thoughts, will I get locked up in a mental hospital? Can I get in trouble if I did something I shouldn't have done?

What if she thinks I'm a freak? Or talks to her friends and family about me? What if she thinks I'm doing it for attention? My life isn't that bad so what if she tells me I just need to get over it? Will she even believe me...

Will my mom be in the whole session with me? I can't say anything around her. The doctor might just tell my mom everything after the appointment anyway.

Ugh and will I have to take medicine? I don't want to feel like a zombie. Or worse... what if I get addicted?

Is this doctor just seeing me because my mom is paying her to talk to me? Will she actually care?
Hey, are you okay?

I'm freaking out. This is my first time here.

It's okay, I was nervous at my first visit too. What are you worried about?

Is the doctor nice? What if I don't like her? What am I supposed to even talk about? Do I HAVE TO LIE ON A COUCH?!!

Haha, no you don't have to lie on a couch. I'm not sure which doctor you're seeing but all of the doctors here are nice and cool. They get it. You just talk.

Talk about what?

You can talk about whatever. She'll ask you questions too so that will help if you don't know what to say.

How will talking change the fact that my life sucks?

I can't explain it, but letting it out helps. It helped me to see things differently.

Uhh... I don't know.

Is she just going to tell my parents everything I say?

No, not really. You guys will talk more about what she can and can't share when you get in there.

Getting help is one of the bravest things you can do. It takes a lot of courage. If nobody knows what's going on, nobody can help you.

At first I thought my doctor was going to freak out when I told her stuff. But I was able to to be honest and she really helped me.

I don't know. I'm not even sure I need to be here.

Just remember, it's okay. Lots of us go through hard times. I finally decided I wasn't going to lie anymore or act like everything's fine when it isn't. With my doctor's help, I finally feel like myself again. I hope you'll feel the same way too.

I guess that makes sense.

Just remember, it's okay. Lots of us go through hard times. I finally decided I wasn't going to lie anymore or act like everything's fine when it isn't. With my doctor's help, I finally feel like myself again. I hope you'll feel the same way too.

Hey, thanks.

No problem! Just don't overthink it. You've got this!

Okay.
Hi, Matt and Mrs. Smith. My name is Dr. Cap. I am a child and adolescent psychiatrist. It's nice to meet you both. Matt, would you and your mom like to come back to my office now?

Um, Sure.

Please sit wherever you like and I'll explain what will happen today.

Matt you and I will spend the majority of the hour together talking about what brought you in today. Then I'll spend a few minutes with your Mom to see if she has any concerns. At the end, we'll all come back together to discuss next steps. Do you have any questions about anything I just said?

I don't think so.

No, not at the moment.

Okay, but if any questions come up, please feel free to stop me to ask.

Okay.

Okay Mrs. Smith if you can return to the waiting room, I'll come and get you when it is time for us to talk.

Before I start asking you questions, do you have any questions for me?

So what exactly are you allowed to tell my mom?

What about like... drinking and stuff?

That depends. If you engage in life-threatening activities while drinking or using drugs, that is something I'd want your Mom to know. If you used a long time ago, but it's not causing problems right now, that's not something I have to tell. Does that make sense?

Yeah, okay.

Okay, well can you tell me more about yourself?

Um, well I'm 15 and I'm a sophomore at Northeast High School. I live with my mom and my little sister. I play soccer.

Okay cool, what position do you play?

I'm a midfielder.

That's great. I played defense when I was in college.

Really?

Yes, I love soccer too. I still play whenever I can and I love watching the world cup.
I love watching the US team play. One of my dreams is to actually go to the championship game someday.

That would be so awesome!

I agree. I’m glad to be around another soccer enthusiast.

So you’re in 10th grade, you like soccer, and you live with your mom and sister. That’s a good start. Can you tell me about what brought you here to see me today?

Well this was more of my mom’s idea but I don’t know… I haven’t been feeling like myself lately. I’ve been feeling… weird. Like everything is ten times harder than it should be.

That sound like it must be tough for you.

Yeah it is. Even with soccer… Sometimes I come up with excuses so I don’t have to go. When I do go, it takes all the energy I have to make it through practice or a game.

Some time later...

I just notice everything and get so annoyed. I don’t mean to yell at my mom or sister, but I just get so annoyed with some of the things they do and say to me. I feel bad after I yell, but I can’t stop it in the moment...

How so?

Matt, thank you for sharing what’s been going on with you. I really appreciate your courage and honesty. Sounds like you have been having a tough time. I’m really hopeful that you will start to feel better as we work together.

Yeah me too.

Now I’d like to invite your Mom back in to talk with her. Sometimes it’s helpful so she doesn’t have a million questions for you when you guys get in the car to drive home.

Yeah, it would be great if she didn’t interrogate me in the car, she likes to do that.

Well, I can’t make any promises, but this should help. After I talk to her, we’ll all meet together to discuss my recommendations for treatment. Does that sound okay?

Yeah it does, thanks.

That wasn’t so bad.
Poetry

By Khalid I. Afzal, MD, The University of Chicago

ERASER

A few grams, maybe an ounce
of something
as inconspicuous as a colorless and tasteless gel
or not even
but serving as a harbinger of the end
an end that is so painful
and yet it is not

As the gel
like an old eraser
with some edges still remembering to do
what the eraser did the best
to erase
but also having sides
as shiny as the surface of a hard-boiled egg
that instead of erasing
painlessly skid over the lines
leaving streaks of grayish black lead
distorting and disfiguring the alphabets
like tall ghostly trees
in dying sunlight
when their shadows become alive
and their leaves
frantically rustle
to communicate their plight
facing the engulfing night

A few grams, maybe an ounce
of something
as inconspicuous as a colorless and tasteless gel
erases
the paths, the trails, the tracks
that one traverses in a lifetime
but not at once
just like a virus
infecting a computer
and making its software run slow
losing a pixel here
distorting a message there
little by little, bit by bit
but not shutting it down completely
yet

A few grams, maybe an ounce
of something
as inconspicuous as a colorless and tasteless gel
slowly but surely
completes the task with diligence
staying majestically accurate till the end
leaving nothing behind
so painful
and yet not!

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the Resident/ECP Editor, Amna Aziz, MD, 816 Broadway St., Indianapolis, IN 46202, or by email to aziza@iu.edu.
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.

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**Life Members Reach 200!**

No, not 200 years old. But, **over 200 lives you have impacted.**

**Impact.**

Since 2010, AACAP’s Life Members Fund has made an investment in awards for over 200 medical students and residents. This includes 17 residents and 13 students in 2018. If you attended the Life Members Dinner at AACAP’s Annual Meeting, you got to meet these young superstar future owls!

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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.

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**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.
Thank you Dr. Seligman for once again donating your time and expertise to AACAP and for capturing these meaningful moments of the Annual Meeting!
AACAP’S 65TH ANNUAL MEETING RECAP

[Images of various individuals at the meeting]

AACAP NEWS

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AACAP’S 65TH ANNUAL MEETING RECAP
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The Importance of Trauma and Adversity in the Treatment of Child Psychiatric Disorders

Steven Berkowitz, MD, and Lisa Amaya-Jackson, MD, MPH

According to the 2012 National Survey of Children’s Health, approximately 50% of children in the United States experienced one or more types of serious childhood trauma, and almost 33% of youth 12-17 experienced two or more adversities.1 Data collected from 2009 to 2016 by the Substance Abuse Mental Health Services Administration’s (SAMHSA) System of Care grantees found that 82% of youth aged 0-21 with a DSM psychiatric disorder had at least one traumatic experience (TE) before entering treatment.2

Childhood trauma and adversity are either causal or a key contributor to many psychiatric disorders throughout the lifespan. Strong correlations have been found with depression, attention-deficit/hyperactivity disorder, and oppositional defiant disorder. Research supports that childhood trauma is involved in the development of bipolar and psychotic disorders, or at the very least, increases the risk for a more severe and refractory course of illness. While most child and adolescent psychiatrists (CAPs) are aware that their patients have and are being exposed to potentially traumatic events (PTEs), adversity, and chronic stress, it is less clear that trauma and stress histories and symptoms are obtained or incorporated into treatment. The Clinical Perspective, The Importance of Trauma and Adversity in the Treatment of Child Psychiatric Disorders, provided the rationale for making trauma and stress central to the practice of child and adolescent psychiatry.

Lisa Amaya-Jackson, MD, MPH, Professor of Psychiatry at Duke University and Deputy Director of the National Child Traumatic Stress Network (NCTSN), presented Psychiatric Disorders in Youth Exposed to Trauma: Complexity and Synergy. She reported on key findings from the NCTSN Core Data Set (CDS). The NCTSN CDS collected information between 2004 and 2016 from over 14,000 youth referred for treatment with histories of PTEs. 47% of youth reported exposure to four or more PTEs. The most common diagnoses or clinical problems (in descending order) were PTSD, General Behavioral Problems, and Generalized Anxiety Disorder. Over 60% of youth presented with behavior problems and over 50% experienced academic problems, demonstrating the wide range of issues associated with childhood PTEs. Both the NCTSN CDS and the National Comorbidity Study demonstrated a positive correlation between the number of PTEs and the number of comorbid diagnoses. In the NCTSN CDS, 93% of the sample was exposed before eight years of age with 50% demonstrating impairment in multiple areas, such as affect regulation, attention, and concentration, by age 11.

Dr. Amaya-Jackson and colleagues used data from the Adverse Childhood Experiences (ACE) Study and the National Comorbidity Study to demonstrate that certain combinations of ACEs confer a greater effect than the sum of their individual effects. For example, for females, the single most potent ACE is sexual abuse. When combined with domestic violence, the risk of developing psychopathology increases more than the individual risks of the two ACEs combined. For males, poverty is the most potent ACE and a multiplicative effect exists when combined with parental substance abuse. Dr. Amaya-Jackson concluded that childhood trauma is probably the single most predictable (and preventable) contributor to mental illness.

Brooks R. Keeshin, MD, presented Pediatric Trauma: Practical Approaches to the Assessment of Experiences and Symptoms in which he described a protocol, The Process Care Model (CPM), to assess for traumatic experiences and traumatic stress symptoms. CPM is a proposed treatment algorithm for pediatric ambulatory care practices. Dr. Keeshin is an assistant professor in the Division of Child Protection and Family Health at the University of Utah and Safe and Healthy Families. He is both a child abuse pediatrician and a CAP. While specifically designed for pediatrics, his model is clearly applicable to child and adolescent psychiatry. Dr. Keeshin described the rationale for targeting childhood traumatic stress by comparing risk of medical illness due to toxins versus the risk of developing psychiatric illnesses after traumatic experiences. For example, tobacco smokers have an 8% chance of developing lung cancer. In comparison, youth exposed to four or more ACEs have a 50% chance of developing depression, while those exposed to a single potentially traumatic event have a 5-30% chance of developing PTSD. Moreover, traumatic stress is co-morbid with many psychiatric disorders.

CPM is a decision support tool that helps providers follow standard/best practice. The overall “road map” begins with the identification of a PTE either in the past or recent. If positive, the Assessment for Safety, Symptoms, and Protective Factors is conducted in three steps: 1) an assessment of whether a referral to child protective services is necessary, 2) a suicidality assessment using the PHQ-9 as the initial screener, 3) a treatment decision tree of trauma specific therapies.
Dr. Keeshin provided a number of clinical samples to demonstrate the utility of the CPM and how it provides an expedient protocol for providers, including algorithms for prescribing medications. Dr. Keeshin addressed the importance of identifying and treating trauma related sleep disturbances as they may be a key contributor to poor functioning. The presentation ended with an initial finding of trauma screening in a general pediatric outpatient clinic and a child abuse clinic that illustrated the commonality of trauma related issues; 25% of youth in the primary care clinic and 100% in the child abuse clinic had at least one previous PTE. In these two groups, 10% vs. 46% had suicidal ideation and 22% vs. 46% had significant traumatic stress symptoms, respectively.

Steven Berkowitz, MD, presented Naming Names: Incorporating Childhood Trauma and Adversity Into Practice. He reviewed the complexity and poor specificity of nomenclature regarding trauma and stressor related disorders and presented research that demonstrated the correlation of early life stress (as illustrated by low socioeconomic status) in the development of childhood disorders such as ADHD, depression, anxiety, and disruptive behaviors. Neuroimaging work of Martin Teicher, MD, PhD, and colleagues demonstrates the wide range of neurodevelopmental and brain changes associated with child maltreatment, including findings involving the hippocampus, anterior cingulate cortex, and the ventromedial and dorsomedial cortices. Furthermore, maltreatment impacts key fiber tracts such as the corpus callosum, superior longitudinal fasciculus, uncinate fasciculus, and cingulum bundle. Interestingly, the presence or absence of maltreatment in individuals with the same diagnoses predicts different structural brain alterations. Since single incident and chronic exposures may impact brain functioning, an injury model may be the best explanatory approach for understanding trauma and stressor related disorders. It is consistent with the findings that chronic stress causes or contributes to multiple disorders and also with the observations that symptoms are often transitory and diminish over time, similar to many physical injuries. Dr. Berkowitz offered a definition of trauma that attempts to be consistent with the research: Trauma is the deleterious change in function caused by an experience/experiences.

Victor G. Carrion, MD, provided a discussion in which he described the large number of effective psychotherapies for traumatized youth now available and the importance of traumatic reminders or cues in understanding behaviors and symptoms seen in traumatized youth. Given that treatment is effective, it is imperative that symptomatic children are evaluated for histories of trauma and stress. He provided a number of clinical examples to demonstrate how frequently child psychiatric patients have been exposed to stressful and traumatic experiences and how this knowledge should influence practice.

In summary, this Clinical Perspectives demonstrated that traumatized children present with a wide variety of symptoms and psychiatric disorders and that traumatized children represent a majority of patients seen by mental health professionals. Incorporating a trauma-informed approach to assessment and treatment should improve outcomes and decrease untoward medication effects. A barrier to optimizing our assessment and treatments is the complicated trauma nomenclature. An injury model of psychological trauma may abrogate these difficulties.

References


Dr. Berkowitz is a Visiting Professor in Psychiatry at the University of Colorado, School of Medicine and the Director of the Stress, Trauma and Adversity Research and Treatment (START) Center. He may be reached at steven.berkowitz@ucdenver.edu.

Dr. Amaya-Jackson is a child psychiatrist and the Associate Director of the UCLA-Duke National Center for Child Traumatic Stress (NCCTS). She is also the Associate Director (and Training Director) of the Center for Child & Family Health – a tri-university (Duke University, University of North Carolina-Chapel Hill, North Carolina Central University) research, prevention, treatment, and training center for children at risk or exposed to child maltreatment. She may be reached at amaya001@mc.duke.edu.
Marijuana Clinical Perspectives Review

Shane Shucheng Wong, MD, and Timothy E. Wilens, MD

A majority of the states in the United States have now legalized access to medical marijuana. The many issues raised by the increasing access to medical marijuana among children and adolescents was the focus of the Clinical Perspective, Medical Marijuana: A Potpourri of the Evidence Base, Clinical, Neurodevelopmental, Legal, Ethical, and Research Issues. The forum was a collaboration among the following AACAP committees: Complementary & Integrative Medicine, Ethics, Psychopharmacology, and Substance Use.

Gail A. Edelsohn, MD, MSPH, from Community Care Behavioral Health Organization, chaired the Clinical Perspectives, and presented the historical perspective on the legal and ethical status of marijuana. The early history of marijuana includes the era of prohibition in the 1930s, when the Federal Bureau of Narcotics condemned it as leading to “homicidal mania” and the Treasury Department levied prohibitive taxes. In 1970, marijuana was classified as a Schedule I drug, which prohibited use for any purpose. Since then, the passing of more permissive state laws have led to increasing tension with the restrictive federal laws. Within this legal landscape, there may be professional risks for physicians recommending marijuana. The ethical principles that inform clinical guidelines include establishing a patient-physician relationship, completing a thorough patient evaluation, balancing the principles of beneficence and maleficence, promoting informed and shared decision-making, maintaining fidelity, protecting confidentiality, and ensuring informed consent and assent.

Timothy E. Wilens, MD, from Massachusetts General Hospital, summarized the evidence base for medical marijuana. He highlighted chemotherapy-induced nausea and vomiting and treatment-refractory epilepsy as the two major conditions for which there is research support. Studies for seizures used cannabidiol (CBD) up to 50 mg/kg/day, with sedation as the most common adverse event. Studies targeting chemotherapy-induced nausea and vomiting used tetrahydrocannabinol (THC), with typical doses ranging from 0.5 mg to 2.5 mg scheduled or as needed every 6-12 hours. Based on a systematic review published in Pediatrics, there currently remains very limited, and overall insufficient, evidence to support the use of medical marijuana for pediatric psychiatric disorders, including post-traumatic stress disorder, Tourette disorder, and psychiatric symptoms of Fragile X. Different constituents of marijuana, specifically THC and CBD, were highlighted as chemicals with distinct dose-dependent effects of overdose. There are many distinct dose-dependent effects of over 80 unique cannabinoids in marijuana. One important clinical consideration is the lack of standardization of marijuana preparations from dispensaries, leading to variations in dose, potency, and chemical constituency. Furthermore, labeling is often inaccurate. Risks demonstrated by current research range from acute intoxication such as impaired driving and decision-making, to risks from chronic repeated use such as addiction, worsening course of psychiatric illness, negative impact of emotion and cognitive development, and poor academic achievement. Clinical discussions of medical marijuana should include the evidence of therapeutic efficacy, safety concerns, and alternatives that may have a more favorable efficacy and safety profile. Discussions of marijuana policy changes are also complicated, as options extend beyond prohibition or legalization, and decriminalization, medicalization, and commercialization. Engaging in an open dialogue with families is critical to maintaining rapport when addressing a polarized and challenging topic.
Albert J. Allen, MD, PhD, from Eli Lilly, presented the complicated regulatory issues involved in research in children and adolescents. He reviewed the Federal Drug Administration programs relevant to pediatric medical marijuana research, including the Investigational New Drug application, the Pediatric Research Equity Act provisions, and the Botanical Drug Development guidance for drug labelling. Additionally, there are specific FDA regulations relevant to pediatric research, including the principle of scientific necessity and the prospect of direct benefit (PDB) concept. A significant barrier to research is marijuana’s classification as a schedule I controlled substance under the Controlled Substances Act, which is overseen by the U.S. Department of Justice’s Drug Enforcement Agency.

Due to the federal regulations that can be enforced by the Department of Justice, there are potential risks for subjects and investigators enrolled in medical marijuana clinical trials which can be mitigated by Certificates of Confidentiality. Federal banking laws also prohibit involvement with marijuana, limiting sources of sponsorship for clinical trials.

Finally, Catherine A. Martin, MD, from the University of Kentucky College of Medicine, as the discussant, summarized the presentations. She shared a clinical case that illustrated the complexity and challenges of addressing adolescent marijuana use, especially in the context of a shifting legislative policy landscape and limited scientific research.

Reference

Dr. Wong is a child and adolescent psychiatrist at Kaiser Permanente Santa Cruz County, and a former fellow at Massachusetts General Hospital. He may be reached at shane-shucheng.x.wong@kp.org.

Dr. Wilens is the chief of the Division of Child and Adolescent Psychiatry and co-director of the Center for Addiction Medicine at Massachusetts General Hospital. He may be reached at twilens@mgh.harvard.edu.
Coordinated Specialty Care for First Episode Psychosis

Oladunni Oluwoye, PhD, CHES, and Jon M. McClellan, MD

Approximately 115,000 young people annually develop a psychotic illness in the United States. Despite significant research and clinical efforts, affected individuals often suffer substantial long-term morbidity and impairment. To address this important public health need, there has been an increase in the development and implementation of coordinated specialty care programs, modeled after the National Institute of Mental Health initiative Recovery After An Initial Schizophrenia Episode – Early Treatment Program (NAVIGATE). At this year’s AACAP Annual Meeting, the symposium Coordinated Specialty Care for First Episode Psychosis addressed various components and outcomes of coordinated specialty care programs for first-episode psychosis.

Maria Monroe-DeVita, PhD, an associate professor at the University of Washington, reviewed the implementation of Washington State’s coordinated specialty care program for first episode psychosis, named New Journeys. Dr. Monroe-DeVita highlighted that the New Journeys treatment model was based on a combination of approaches developed by the Early Assessment and Support Alliance (EASA) and NAVIGATE. To date, New Journeys, funded through a mental health block grant, has been implemented in five community mental health agencies throughout Washington State. A diverse array of clients receive services from New Journeys, including a large (43%) Hispanic population. At the beginning of the six-month evaluation period, almost half of participants reported moderate or higher levels of depression and anxiety. After six months of treatment, there were significant reductions in psychotic symptoms, depression, and anxiety among clients. No reductions in substance use were observed. Dr. Monroe-DeVita concluded by highlighting additional areas of clinical need that the University of Washington’s developing first-episode psychosis program will address, including addressing substance use disorders and incorporating whole person care, centralized screenings, and mHealth (medical and public health services supported by mobile phones and other wireless technology).

Oladunni Oluwoye, PhD, CHES, a research assistant professor at Washington State University, addressed the issues of racial and ethnic disparities in treatment outcomes for those experiencing first-episode psychosis. Using data from the RAISE-ETP, a large randomized trial that assessed the effectiveness of NAVIGATE, Dr. Oluwoye examined whether there were racial and ethnic differences in psychiatric symptoms and service utilization in those receiving treatment as usual, versus the coordinated specialty care provided by NAVIGATE. When compared to non-Hispanic whites, non-Hispanic blacks and other minorities receiving routine treatment in community settings had significantly higher psychiatric symptoms and lower rates of service utilization. In the NAVIGATE group, there were no ethnic or racial differences in psychiatric symptoms. The only disparity in service utilization was that families of non-Hispanic black participants were less likely than non-Hispanic white families to receive family psychoeducation. Coordinated specialty care programs such as NAVIGATE appear to reduce racial and ethnic disparities found in usual community mental health care.

Dr. Oluwoye highlighted the importance of including family members, particularly racial and ethnic minorities, in treatment planning. When treating first-episode psychosis, family involvement and psychoeducation are associated with improved outcomes.

Dr. Oluwoye also discussed a secondary data analysis that she and her colleagues conducted using data from the RAISE-ETP study regarding substance use. The study examined the impact of tobacco, alcohol, and cannabis use on treatment outcomes. The overall data found that at intake, roughly 50% of participants reported recent tobacco use and up to 30% reported alcohol or cannabis use. Participants reporting alcohol use at intake were more likely to not adhere to medication regimens. Cannabis users had higher levels of illness severity during treatment compared to non-users. Patients using tobacco had higher levels of illness severity, a higher number of missed pills, higher ratings of psychiatric symptoms, and lower quality of life during treatment relative to non-smokers. Thus, although much of the research has focused on cannabis use, tobacco smoking was associated with more negative clinical outcomes than the other two substances. Of course, individuals using one substance often use another, so these findings overlap. The development of effective treatments for substance abuse remains a vital clinical need.

Krystal Ozanick, MD, a child psychiatrist at Kaiser Permanente (formerly at Seattle Children’s Hospital), discussed her experience in developing an outpatient clinic for adolescents with first-episode psychosis. She described in detail individual resiliency training (IRT), one of the major pillars of the NAVIGATE model. IRT promotes wellness and recovery by identifying client strength and resiliency factors, improving illness self-management, and teaching skills to enhance functional recovery. IRT has seven standard modules, plus additional modules that can be taught based on the client’s needs. For Dr. Ozanick, the NAVIGATE IRT training provided the necessary skills and knowledge to use IRT with clients.
She also addressed challenges in the implementation of a clinic specializing in first-episode psychosis, including coverage issues related to other clinical demands and the need for multiple team members to fulfill all the roles of the NAVIGATE treatment model. Dr. Ozanick left AACAP members with some advice. Even if your organization does not have the capacity to fully implement the NAVIGATE model, using IRT, including the patient handouts/worksheets that are free and available online, greatly enhances the treatment of youth with first-episode psychosis.

Jon M. McClellan, MD, professor at the University of Washington, provided an overview of coordinated specialty care, highlighting points from each presentation. Per the World Health Organization, schizophrenia affects approximately 23 million people worldwide, and confers a substantial amount of social and illness burden. The lifespan of affected individuals is cut short on average by approximately two decades, given the high rate of comorbid medical problems, including diabetes, cardiovascular disease, and suicide. Unfortunately, the efficacy of medication treatments has not advanced much in the past several decades. Individuals often go months before the illness is recognized, and longer durations of untreated psychosis are associated with worse outcomes. Thus, the goal of first-episode psychosis programs is to promote early identification and effective comprehensive treatment. Collectively, coordinated specialty care programs all involve multidisciplinary teams that provide evidence-based pharmacology, individual and family-based educational and psychotherapeutic services, occupational and educational supports, and assertive community outreach and case management. Research assessing the effectiveness of these programs demonstrates improvements in clinical symptoms, functional outcomes, treatment adherence, and rates of hospitalization. The next hurdle is the wide dissemination of these models of treatment across communities and states, such that all affected individuals have access to high quality coordinated care.

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More Annual Meeting Photos
Violent Video Exposure and Its Impact on Youth of Color

If you have never played one of the popular violent video games, it is hard to understand the embedded levels of violence, racism, and misogyny. Youth, particularly youth of color, are increasingly interacting with video games. This Clinical Perspectives, a joint presentation by the Diversity and Culture Committee and the Media Committee, had three objectives: 1) examine associations between youth’s race/ethnicity and their violent video game playing habits; 2) highlight the data from some of the larger and more recent national surveys, paying particular attention to the gaming patterns of adolescents; and 3) provide recommendations to child and adolescent psychiatrists about how to educate patients and their parents about violent video games and their impact on youth.

As Chair, Wanjiku Njoroge, MD, of the University of Pennsylvania, shared data from a Commonsense Media survey of viewing practices. Tweens (ages 8-12 years) endorsed playing video games 52% of the time, and teens (13-18 years) endorsed playing video games 42% of the time. Overall, 12% of tweens and 17% of teens reported spending over two hours every day interacting with video games. The data reflected that 68% of video games involved some depiction of violence. Research has shown that in some of the most popular games there are 2.3 violent interactions per every minute of play!

Lee Carlisle, MD, of the University of Washington, presented data reflecting the ubiquity of racial and stereotypic portrayals of characters in violent video games. White protagonists remain over-represented in popular video games, whereas Latinx and African-American characters are simultaneously underrepresented and typically cast in a stereotypical manner. Dr. Carlisle shared data indicating that violent video games have a discernable negative effect on youth of color secondary to rampant racism and sexism, and on non-Hispanic white players using avatars of color.

Paul Weigle, MD, of Hartford Healthcare, reviewed both positive and negative impacts of gaming habits on youth. He noted that 61% of children and adolescents age 8-18 years are playing video games on any given day, for an average of two hours and 13 minutes. He cited a relative overuse of gaming by African American boys, who play more video games than their peers. Dr. Weigle highlighted that violent video game play is increasingly commonplace among youth, as game ratings are typically unheeded. He reviewed the data around the potential harms of increased playing of violent games, including increased aggressive thoughts. Dr. Weigle ended his presentation by encouraging providers to educate youth and their families about the risks of excessive gaming and violent game exposure.

Mawuena Agbonyitor, MD, MSC, of Mercy Care in Atlanta, GA, focused on the intersection of race and gender in video game culture, highlighting the diversity of the gaming community. She discussed the lack of diversity of characters in lead roles and that present diverse characters often display racial stereotypes. Female characters are often overly sexualized. Dr. Agbonyitor shared data showing exposure to such games can promote formation of prejudices and reinforce gendered behaviors amongst video game players in real life. She also discussed the harassment experienced by female gamers, as well as racialized hate speech experienced by gamers of color while playing with others. She highlighted how some gamers have created safe spaces targeted towards women and girls of color to play video games with less fear of facing prejudiced behaviors from other players.

As discussant, Nicholas Carson, MD, of Harvard Medical School, began by discussing the immense popularity of the video game industry, noting its current worth at $130 billion. Dr. Carson detailed the data from Commonsense Media’s national survey, “Social Media, Social Life,” showing that youth exposure to hate speech in media has increased from 2012 to 2016. He suggested that gaming has “captured the hearts and minds of our patients,” noting the important role for mental health professionals to attend more closely to the gaming habits of patients. He further suggested that online video gaming forums that allow player anonymity can be an important source of racist, sexist, homophobic, and anti-religious trolling. Dr. Carson highlighted innovative strategies that are being used to enhance prosocial attitudes in gaming. The most effective efforts occurred when positive messages were presented subtly during a meaningful, immersive gaming experience. Dr. Carson ended the panel by highlighting that the number of hours per week youth spend playing video games, and the meanings that patients ascribe.
to these games, are public health and clinical concerns.

The panelists recommended that child and adolescent psychiatrists should be vigilant not only to the time patients spend with video games, but also to the types of games and the impacts these games may have on development. They outlined concrete guidelines and resources to assist child and adolescent psychiatrists in understanding the gaming culture.

While the panelists highlighted with concern the amount of time youth spend interacting with violent video games, they also shared the literature reflecting benefits from prosocial gaming. The presenters noted that video game developers are diversifying their field to combat the racism, violence, and misogyny currently seen in many of the most popular games. Further, adolescents are responding to the bullying and misogyny by banding together to play with one another in “safe spaces.” By the end of the session, participants gained the tools needed to be able to discuss violent video games with their adolescent patients, to recognize when gaming may be negatively impacting teens, and to provide options for prosocial games with positive messages. ■

Dr. Njoroge is an assistant professor of psychiatry at University of Pennsylvania and is the program director for the child and adolescent psychiatry fellowship at the Children’s Hospital of Philadelphia (CHOP). She is also the director of the Young Child Clinic at CHOP. She is a member of AACAP’s Diversity and Culture Committee. She may be reached at wanjiku.njoroge@yale.edu.

Dr. Carlisle is an associate professor of psychiatry at University of Washington with a focus on childhood trauma and cultural competence and is attending on preadolescent unit at Child Study and Treatment Center (Children’s Long-term Psychiatry Inpatient Program). She is a member of AACAP’s Diversity and Culture Committee. She may be reached at carlill@dshs.wa.gov.

Dr. Weigle is associate medical director at Natchaug Hospital of Hartford Healthcare and teaches on the clinical staff at UConn School of Medicine and Quinnipiac Medical School. He is also co-chair of AACAP’s Media Committee and serves on the National Scientific Advisory Board for the Institute of Digital Media and Child Development. He may be reached at pweigle@sbcglobal.net.

Dr. Agbonyitor is lead child and adolescent psychiatrist at Mercy Care in Atlanta, GA. She also works as an adult psychiatrist at Mercy Care clinics and on its street medicine team. She may be reached at mawuena@gmail.com.

Dr. Carson is the medical director for child and adolescent outpatient psychiatry services at the Cambridge Health Alliance (CHA). He is also a clinical research associate at the CHA Health Equity Research Lab and an assistant professor in psychiatry at Harvard Medical School. He is a member of AACAP’s Media Committee and often presents on topics related to mental health assessment of digital media effects on child development. He may be reached at nicholascarson@gmail.com.

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Member Services: Making Effective Change in This Unpredictable World: A Panel Discussion With Elected Officials

Avanti Bergquist, MD, MS

If the recent midterm election voter turnout is a measure of political engagement, then our country is more engaged than it has been for the last 50 years. As the Annual Meeting was held just two weeks prior to this election, the timing could not have been better for a Member Services Forum focused on political advocacy. Making Effective Change in This Unpredictable World: A Panel Discussion With Elected Officials featured a discussion with three legislators from the Washington State House of Representatives along with the only known AACAP member currently holding a publicly elected office. Members learned directly from this bipartisan and nonpartisan group of elected officials about how to speak to officials to be better advocates; how state and local governments work and the most opportune times for input into the policy-making process; how our expertise as child and adolescent psychiatrists is valuable to effect positive change; how to identify avenues for increased influence in policy that affect ourselves and our patients, including running for office ourselves; and much more.

The presenters began with introductions into their backgrounds, why they ran for elected office, and how they impact children's mental health policy. Avanti Bergquist, MD, MS, from Eating Recovery Center and Seattle Children's Hospital, works full-time as a child and adolescent psychiatrist while also being an elected member of the Renton School District Board of Directors. She is married to another presenter, Steve Bergquist, who was elected to the Washington State House of Representatives in 2012. Representative Bergquist was recently honored with the inaugural Washington State Psychiatric Association Legislator of the Year award for his efforts to improve the state's climate for mental and physical health care. Tana Senn and Tom Dent, members of the Washington State House of Representatives since 2013 and 2015 respectively, also participated. Representatives Senn and Dent have worked tirelessly to improve Washington State policies to increase access to, and the quality of, children's mental health care in the state. For their efforts, they each received the 2017 National Child Health Advocate Award from the American Academy of Pediatrics.

The panel explored the experience of the audience in child advocacy. The attendees spanned the spectrum, from novice to seasoned political advocates. All attendees agreed that they frequently advocate for their patients, and many, but not all, had experience in directly contacting elected officials. A surprisingly large number had traveled to Washington, DC, to advocate, perhaps indicating the success of AACAP's Legislative Conference. Many had also been to their state capitol to advocate. A majority of attendees indicated that they knew that officials want to hear from their constituents, but a majority also wondered if their advocacy efforts made a difference. The presenters used these audience participation questions to advise attendees how to further develop their advocacy skills. They described how they as elected officials experience the advocacy efforts of their constituents. Some of the helpful tips that were shared included:

1. Developing a working relationship with officials is the most important foundation for advocacy efforts. They are much more likely to want to help you with a specific legislative “ask” if they already know you and trust your judgment.

2. To develop a relationship, meet with them in the off-session without a specific ask. Invite them to your clinic to see how you are helping their constituents. Ask them for coffee to discuss your interests and offer yourself as a resource for information about children’s mental health in the future.

3. Remember that they ran for office to make a positive difference in their communities. Compliments and expressing your appreciation goes a long way. Send them a thank you note after the meeting and follow up to keep your message on their minds.

4. Learn about them beforehand to better craft your message. For instance, Representative Dent was a foster and then adopted parent to a son with significant mental health difficulties, which influences his desire to help other young people with similar struggles. Representative Senn shared how her children’s school staff used social and emotional learning skills to support her children when there were a series of deaths in the family.

5. Elected officials want to meet with their constituents, and also will meet with you if you do not live in their district but are caring for their constituents in your practice. For example, there are many counties in Washington State without a child and adolescent psychiatrist. It would be even more impactful to bring a child and family that are their constituents.

6. They prefer in-person meetings or phone calls, but if you send a form email, be sure to change the subject and the first two lines. Otherwise it gets batched with all of the other emails that are the same, and they are unlikely to read it specifically.

7. Dr. Bergquist advised that more local government positions such as school board may be different, but for the legislators, meeting with constituents...
is their job. Representative Senn stated that if a legislator will not meet with you as a constituent, “run against them!”

Dr. and Representative Bergquist went on to describe their entry into political life as a potential road map for our members or other friends of medicine to consider a run for office. Some of their advice:

1. It was incredibly valuable to attend the AMA PAC’s candidate training school which focused specifically on teaching physicians and friends of medicine to run for office. They learned that running for office takes a strong commitment not just from the candidate, but also from their family and community. There are also multiple other candidate training programs that could be helpful.

2. Representative Bergquist utilized his deep roots in their community to gather support and win an election with far less funds than his opponents (one opponent raised six times as much money). He made personal connections with voters by knocking on 12,000 doors himself (and losing about 30 lbs. that he really could not afford to lose), plus an additional 8,000 doors visited by his supporters.

3. Dr. Bergquist saw the positive effects Representative Bergquist and his colleagues made in office and was inspired to get more involved in policy-making. She started with committees and boards that influenced mental health care improvements, and organically made connections that led to more and more opportunity to effect positive change.

4. Seeing these positive changes resolved any burnout issues Dr. Bergquist was experiencing, and she emphasized that when we talk about solving physician burnout, we should always include the positive impact of successful advocacy efforts.

5. The organic connections and positive policy changes led Dr. Bergquist to run for office herself on the school board in her hometown. She was already active in the community and had shown the value of her interest in children’s issues, which likely contributed to no one running against her.

6. The Bergquists encourage AACAP members to contact them if they are interested in running for office.

Attendees had the opportunity to ask questions and interact with the presenters. It was a lively and engaged group, and the presenters expressed their gratitude for being asked to share their experiences.

Dr. Bergquist is a child, adolescent, and adult psychiatrist at Eating Recovery Center in Bellevue, WA, and Seattle Children’s Hospital in Seattle. She is a member of the Advocacy Committee, the Inpatient, Residential, and Partial Hospitalization Committee, and is the current president of the Washington State ROCAP. She may be reached at avanti@alumni.duke.edu.

More Annual Meeting Photos
Biological Roots of Child Psychiatry and Health: Neuroscience, Transgenerational Effects, and Social Factors

Douglass A. Kramer, MD, MS, chair of the Symposium, Biological Roots of Child Psychiatry and Health: Neuroscience, Transgenerational Effects, and Social Factors, posed the question, “If we were asked to invent psychiatry today, knowing what we now know, what would be the minimal unit of research, prevention, and treatment?”

This provocation framed the research and recommendations of all four presenters at the symposium. Echoing David A. Brent, MD’s advocacy at the Karl Menninger, MD, Plenary, the presenters offered their emerging research while also encouraging implementation of interventions incorporating what we have learned. Like Dr. Brent, their research findings direct child and adolescent psychiatry to act more systemically and upstream. In this Biological Roots symposium, the roots revealed themselves to be interdependent diverse systems that cannot be adequately understood with reductionist inquiry.

Stacy Drury, MD, PhD, is engaged in the tangled work of specifying biological markers of the impact of social determinants of health during the initial stages of child development. She discussed evidence from The Infant Development Study that placental telomere length may be both a marker for cumulative stress as well as a predictor of disease. High maternal Adverse Childhood Experiences (ACEs) are highly associated with shortened telomeres in placental villi cells, suggesting an impact of pre-existing maternal allostatic load on fetal cells. Thus, the work of Dr. Drury and colleagues is mapping out the avenues by which social determinants begin to impact the development and health of children as early as prenatally.

Dr. Drury and colleagues also link these biological models of allostatic load to clinically relevant behavioral and emotional systems.1 They found sex differences to cumulative maternal stress in infant stress response system reactivity. At four months of age, infants of mothers with high prenatal stress had alterations in sympathetic tone compared to infants of mothers with low prenatal stress. Girls of mothers with high prenatal stress had less recovery of sympathetic tone than girls of mothers with low prenatal stress, whereas boys of mothers with high prenatal stress had higher baseline sympathetic tone and no relative reactivity. This suggests very early establishment of sex differences in infant stress response associated with maternal prenatal stress. Dr. Drury asserted, “Boys and girls are forever different.”

Furthering the links between biologic markers, pathophysiology, and opportunities for directed interventions, accelerated telomere loss in toddlers enhanced the association between maternal ACE score and externalizing behaviors at 18 months of age. Dr. Drury is developing a model of the development of the child stress response system across developmental time periods linked with the influence of maternal early life and perinatal experiences, as well as the child’s relational environment, and ultimately related to both premature telomere aging with its resultant socio-emotional and physical impacts.

Ryan Herrina, MD, PhD, envisions a time when treatments might be tailored to their impact on individual neurocircuity rather than on symptom clusters. He discussed data from his longitudinal study of brain development of youth with post-traumatic stress disorder (PTSD), compared to youth without psychiatric symptoms. Dr. Herrina and colleagues found decreased resting-state coupling between the ventromedial prefrontal cortex and both the amygdala and the hippocampus, as well as between the dorsolateral prefrontal cortex and the hippocampus, in youth with PTSD in comparison to youth without psychiatric symptoms.2 This decrease in coupling occurs despite reductions in symptoms of PTSD, anxiety, and depression, suggesting that symptom improvement does not always correlate with expected neurological findings. They also found sustained reductions in prefrontal cortex grey matter over time, among youth with PTSD. He raises questions about the eventual possibility of determining which brain networks are predictive of recovery from, versus persistence of, PTSD symptoms. With such information, theoretically, therapies can be tailored to strengthening the recovery-associated networks.

Dylan G. Gee, PhD, provided an example of how relational interaction can influence the development of endogenous anxiety regulatory mechanisms. She described a normative switch from childhood to adolescence involving

“In this Biological Roots symposium, the roots revealed themselves to be interdependent diverse systems that cannot be adequately understood with reductionist inquiry.”
the regulation of amygdala reactivity to a fear stimulus. Children primarily rely upon a caregiver’s presence to facilitate regulation of their fear reaction. By adolescence, fronto-amygdala connectivity is mature and allows greater internal fear regulation.1 However, young children who have experienced parental deprivation during their first three years of life, e.g., being raised in an orphanage, tend to not absorb biologically the reassurance of external caregivers when afraid, even after an extended period of time with a stable adoptive family. Similar to the work of Dr. Drury, Dr. Gee is mapping out mechanisms of how life experience can impact developmental trajectories. In summary, an insufficient amount of relationship-mediated regulation during the early developmental period, or excessive reliance upon relationship-mediated regulation during the period of fronto-amygdala maturation in a child with separation anxiety, can result in persistent separation anxiety, and disruptions to the maturation of fronto-amygdala coupling.

John P. Capitanio, PhD, began by stating, “Our sociality is embedded in our biology in a fundamental way.” In fact, there is extensive sympathetic nervous system innervation of the lymphatic system. He and colleagues at the California National Primate Research Center found that among rhesus monkeys inoculated with simian immunodeficiency virus (SIV), those living in unstable social groups had a much shorter duration of survival than those living in stable social groups.4 Socially stressed monkeys showed increases in the density of catecholaminergic varicosities in their lymph nodes. SIV replicates preferentially in proximity to such varicosities. These animals also manifested blunted antibody production compared to socially unstressed individuals.

Dr. Capitanio and colleagues also studied the underlying biology of loneliness in humans and rhesus monkeys. Loneliness is associated with reduced glucocorticoid receptor functional activity, upregulation of proinflammatory genes, downregulation of interferon (viral) responses, and downregulation of antibody responses. Separation from our social connection disrupts our biology as it disrupts our emotional experience. In a concluding statement, he said, “The idea of interactions, and particularly the dynamics involved in systems-type thinking, is being considered more these days . . . reductionism has value, but it will never explain more than a piece of reality, since reality is mostly a set of embedded systems at all levels, ranging from the molecular to the planetary.”

In his summary, James J. Hudziak, MD, the discussant, encouraged us to broaden our conception of treatment beyond medication and traditional psychotherapy. He described the benefit of mindfulness and meditation on both regulating glucocorticoid and sympathetic nervous system mediated stress responses. He identified the findings of aerobic exercise promoting hippocampal volume. Finally, he outlined the impact of family-focused psychiatry on supporting health-promoting relationships.5

This symposium followed the call to action by Dr. Brent during his plenary address, for child and adolescent psychiatrists to: 1) provide family-focused psychiatry in the context of collaborative care in primary care clinics, 2) strengthen basic well-being, and 3) engage in prevention efforts. All of the speakers in the Biological Roots of Child Psychiatry symposium advocated for the importance of reinforcing attuned, responsive relationships between caregivers and children. Thus, while there is no such thing as a baby, there is also no such thing as a child. Our social nature and our biology require family and relationally oriented psychiatry as both treatment and nourishment of the roots of child psychological development.6

References

Dr. Cary is a member of AACAP’s Family Committee, the child and adolescent psychiatrist for Washington State’s King County Behavioral Health and Recovery Division and Best Starts for Kids Initiative, and she maintains a clinical practice with a reservation-based community. She may be reached at mcury@kingcounty.gov.

Dr. Kramer is a member of AACAP’s Life Members Committee, Emeritus Clinical Professor of Psychiatry, University of Wisconsin School of Medicine and Public Health, and Medical Director, Catholic Charities of Dane County Addiction Services. He may be reached at dakrame1@wisc.edu.
Applications of Transcranial Magnetic Stimulation to Understand and Treat Adolescents With Depressive Disorders and Autism Spectrum Disorder

Rana Emaghraby, MD, and Kathryn R. Cullen, MD

Transcranial magnetic stimulation (TMS) is a novel technology capable of revealing new information about brain functioning and cortical plasticity, including potential biomarkers for disease and treatment response. When applied repeatedly, it can also be used as an intervention for conditions such as depression and autism spectrum disorders (ASD). While TMS has been studied extensively in adults, research in children and adolescents is more nascent. This symposium brought together researchers from four different institutions in North America to present cutting-edge data on the application of TMS in pediatric populations, both as a technique to reveal new information about brain functioning in the context of pediatric depression and ASD, and to share new results of clinical trials using TMS as a treatment for these disorders in young people.

First, Paul E. Croarkin, DO, MS, provided an overview of TMS applications as a neurophysiological probe and a therapeutic intervention for psychiatric disorders. He reviewed safety data from pediatric TMS studies to date, and explained the different types of stimulation protocols that are currently available for these applications. Dr. Croarkin reviewed past pioneering work conducted by himself and others at the Mayo Clinic in repetitive TMS for the treatment of depression in adolescents. A recent re-analysis of these studies suggested that TMS treatment was capable of reducing suicidal ideation in youth. He also reviewed promising findings utilizing TMS and magnetic resonance scanning technology to identify biomarkers of suicidality in adolescents.

Dr. Croarkin discussed the promise of recent innovations in TMS methodology, including theta-burst stimulation, which may be capable of achieving similar efficacy in depression treatment with shorter protocols, and synchronized TMS, which delivers lower-energy stimulation that is tailored to the patient’s own brain oscillations. Finally, Dr. Croarkin presented the design of a multi-site, sham-controlled study funded by NeuroStar that was designed in pursuit of FDA approval for repetitive TMS as a treatment for adolescent depression. The study has completed enrollment, and the data are currently under analysis.

Second, Kathryn R. Cullen, MD, presented her results on a small trial of “deep” TMS in adolescents with depression using the H1 coil. Compared to the standard butterfly TMS coil, the H1 coil was designed to achieve deeper brain penetration. This has appeal for the treatment of depression which involves limbic brain structures located deep in the brain. Dr. Cullen shared her original study protocol, a sham-controlled clinical trial that applied the same TMS parameters FDA-approved for the deep TMS device in the treatment of depression in adults (including a stimulation intensity 120% of motor threshold, stimulation frequency 10 hertz). However, as she reported in 2016, the first adolescent in the protocol had a grand-mal seizure following the first active treatment given at the target stimulation intensity of 120% of motor threshold. Dr. Cullen reviewed changes made to the adolescent deep TMS protocol in order to enhance safety (decreasing both stimulation intensity [80% of motor threshold for three subjects and then 100% of motor threshold for another three subjects] and stimulation frequency to 10 hertz). She described clinical and safety observations from six adolescents who have undergone deep TMS treatment with the revised protocol. While no significant adverse events have occurred, the response rate has been low (one out of six). Next steps include increasing the stimulation intensity back to 120% of motor threshold while keeping the frequency at 10 hertz.

Third, Stephanie Hope Ameis, MD, presented her work on the use of TMS to improve cognitive functioning in adolescents with ASD. She commented on the heterogeneity of ASD as a barrier to developing innovative treatments. She also noted that higher executive functioning is a predictor of greater response to interventions, and presented an argument for targeting executive functioning with TMS. In her study of 42 young adults with ASD who were randomized to four weeks of repetitive TMS or sham, the rate of adverse effects was equal across groups. Both TMS and sham were well tolerated. Both groups showed significant improvements in executive functioning after the intervention, with no significant differences between groups. However, a post-hoc analysis revealed that a subgroup of patients defined by low adaptive scores on the Vineland II assessment showed a significant treatment effect. Active TMS was associated with improvement in performance compared to sham in those with low adaptive functioning. This group difference was not found in those with high adaptive scores.

Fourth, Ernesto Pedapati, MD, MS, discussed the clinical overlap between ASD and ADHD, and presented his
findings using TMS as a probe to understand brain function in these populations and to differentiate the clinical groups. Dr. Pedapati reviewed the dramatically increased prevalence of ASD in the last decade, and pointed out that comorbid ADHD is quite common in the ASD population. This comorbidity is a major challenge for treatment optimization. Dr. Pedapati reviewed his prior research showing reduced intracortical excitability in youth with ASD compared to controls. He also noted significant variability in the results, which motivated a subsequent study of 49 people with ASD: 20 patients without comorbid ADHD (ASD-) and 20 patients with comorbid ADHD (ASD+). He found that ASD+ had lower intracortical facilitation (ICF) than both ASD- and controls. ICF was associated with executive function and inattention in ASD. Dr. Pedapati offered that changes in ICF may suggest aberrant subcortical contributions to ASD+ patients. His future work will examine the impact of methylphenidate treatment on ICF in ASD+ and ASD-.

Finally, as the discussant, Graham J. Emslie, MD, provided a synthesis of the presentations and led a discussion with the audience and panel. He reviewed findings from the STAR*D study and TORDIA, highlighting the need for new treatments of adolescent depression. He discussed the importance of exploring the use of neuromodulation tools to advance the understanding and the treatment of neurodevelopmental disorders such as depression, ASD, and ADHD. Dr. Emslie highlighted the pioneering work of Dr. Croarkin in examining neural biomarkers of suicidality in adolescents. He commented on the pitfalls discussed in Dr. Cullen’s presentation, the challenges that come with this type of work, and also the importance of this research even in the context of small samples. He commended the approach taken by Dr. Ameis in focusing on executive functioning with TMS, since this domain is relevant to so many other psychiatric conditions. He also underscored the importance of her findings in identifying a subgroup of youth with autism that showed an improvement in executive functioning after TMS. This type of research is needed to allow the development of personalization strategies. Dr. Emslie also highlighted the potential impact of Dr. Pedapati’s work toward understanding variability, and how identifying biological signatures that distinguish subgroups can provide important clues suggesting pathological mechanisms and pave the way for novel treatment development.

Dr. Elmaghraby is a third-year resident in the Department of Psychiatry at the University of Minnesota. She has special interest in mood disorders in the child and adolescent population. She may be reached at rana@umn.edu.

Dr. Cullen is an associate professor and Division Director of Child and Adolescent Psychiatry at the University of Minnesota. Her research focuses on understanding the neurobiology of, and advancing the treatment for, adolescents with depression and self-injurious behaviors. She may be reached at rega0026@umn.edu.
AACAP’s 66th Annual Meeting takes place October 14-19, 2019, at the Hyatt Regency Chicago, in Chicago, Illinois. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

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High Medical Care Costs Revealed for Children with Co-Existing Mental Health and Substance Use Disorders

More and more youth experience chronic health conditions. The new study published in *Academic Pediatrics* examines a sample of 6.6 million children and adolescents ages 0-26 years and 5.8 million of their parents with commercial health insurance. In this group, patients with a chronic medical condition and co-occurring mental health or substance use disorders had annual insurance payments 2.4 times larger than those with a chronic medical condition only. Most of the increase in health care claims reflected medical services rather than mental or behavioral health services. This difference translated to a greater estimated annual expenditure of $8.8 billion. Parents of these children also had total insurance payments 59% higher than parents whose children had only a chronic medical condition.

Integrated or collaborative care, in which mental health problems are diagnosed and treated within the medical setting in collaboration with medical professionals, is widely seen as a way to increase access to mental health services and to intervene earlier before problems become more serious. The degree to which integrated care is adopted across the country depends significantly on financial factors, including whether it saves money, on a per capita basis, compared to the current compartmentalized system. These new data help support the notion of collaborative care as a strategy to improve health care costs. Integrated care approaches may be one of the strategies to prevent or reduce the impact of mental health and substance use disorders in children with chronic medical conditions and their parents.

This project is notable as the first time these five child-serving professional organizations have pooled their resources and expertise on a project of mutual interest.

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• Indicates a memorial donation
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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.
AACAP Policy Statement

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

Adolescent Pregnancy Prevention

Approved by Council January 2009; Revised October 2018

The American Academy of Child and Adolescent Psychiatry (AACAP) is committed to improving interventions to address the important public health issue of adolescent pregnancy in the United States.

Background

An estimated 1 in 4 girls will become pregnant at least once by age 20. Pregnancy carries with it negative physical, psychological, emotional, economic, and social sequelae for teen mothers and their children.\(^1\) The increased risks for mental health issues in pregnant adolescents include depression and increased suicidal thoughts.\(^2\) In addition, adolescent pregnancy results in enormous costs to society (an estimated $9.4 billion in 2010).\(^1,2\) Adolescent pregnancy disproportionately affects minority racial/ethnic groups and adolescents from households where parents or guardians are of low education and/or low income.\(^1\) Pregnancy and childbirth contribute to high school dropout rates and carry a higher risk of repeat teen pregnancy.\(^1,2\)

Practical and Concrete Implications

Despite a decrease in recent years, the rate of teenage pregnancy in the U.S. continues to be higher than that in other western industrialized countries,\(^1\) underscoring the need for continued prevention efforts. The decline has been attributed to increased access to educational materials and reproductive health care (including contraception), through programmatic development and implementation. This has contributed to a reduction in the proportion of teenagers who are sexually active and an increased proportion of those sexually active teenagers using contraception.\(^1\) The most effective programs provide information about the risks of unprotected intercourse and ways to avoid unintended pregnancy, as well as modeling and practice of communication, negotiation, and refusal skills among peers and with parents.\(^3\) Full service health centers in schools where access to health care, including contraception, and education/options counseling are available have proven efficacy.\(^4\)

Recommendations

Based on these data, AACAP:

- Endorses the development and teaching of curricula on pregnancy, parenting, and sex education throughout the U.S. school system.
- Recommends that school systems collaborate with local and state health and education agencies to establish medically accurate and high quality comprehensive education that teaches about psychological and physical human growth and development and relationships, and encourages adolescents to make informed, responsible, and safe choices regarding sexual activity.
- Recommends accessible health clinic programs that provide a full range of services, including confidential counseling and information regarding sexual activity and reproductive health.
Although AACAP supports parental involvement in adolescent decision-making, AACAP recognizes that many adolescents may be less likely to seek necessary health services if required to inform their parents. Therefore, laws that empower adolescents to obtain certain basic health care on their own, make decisions regarding reproductive health care, and ensure confidentiality are very important, as they improve access to critical health care services.

References:
1. https://www.cdc.gov/teenpregnancy/about/

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

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

POLICY STATEMENTS

AACAP Policy Statement Requirements

Policies should:

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

Format for Policy Statements:

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

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

Procedures for Developing AACAP Policy Statements

1. An individual AACAP member or body interested in creating a policy statement submits to the Executive Committee a “letter of intent” to create a policy prior to developing a draft policy statement. (This allows Executive Committee input of the desirability, appropriateness, etc. of the policy – without constituting any form of approval prior to the substantial work of creating a final draft policy statement.)
2. A final draft policy statement is submitted to the Policy Statement Advisory Group (PSAG) (to ensure that the language, tone, format, etc. conform to AACAP policy standards).
3. The author responds to the suggestions made by the PSAG and resubmits the edited draft until PSAG approval is achieved.
4. The Executive Committee receives the PSAG-approved policy statement and decides whether or not to forward it to Council. Feedback on this decision is given to the author, and resolution of problematic issues is undertaken.
5. The Executive Committee-approved policy is emailed to Council members, who have a two-week discussion period to convey concerns and ask questions followed by a one-week voting period to approve or disapprove the policy. (A simple majority determines the outcome).
6. A policy draft that is disapproved by Council vote may be re-written and resubmitted to the PSAG, with an explanation of what was changed; The process begins again with steps 2-5.
7. Upon Council approval, the new policy is printed in *AACAP News*, distributed/publicized as recommended, and placed on the AACAP website.
8. The expectation is for policy statements to be reviewed as needed, but no longer than 5 years, with the decision to renew, update, or sunset. Updated policy statements will be sent to the PSAG, Executive Committee, and Council for approval.
9. Committees are encouraged to collaborate with and get feedback from other relevant committees when drafting or updating a policy statement.
The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to introduce a new and improved JobSource, an advertising and recruiting tool to assist AACAP members and related experts looking for new career opportunities, and to help employers find the most qualified child and adolescent psychiatrists.

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

With questions, please contact Samantha Phillips, Communications Manager, at sphillips@aacap.org.
Residents and Junior Faculty

AACAP Pilot Research Awards
APPLICATION DEADLINE: APRIL 1, 2019
Provides $15,000 to members with a career interest in child and adolescent mental health research.
- AACAP Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows
  (Supported by AACAP)
- AACAP Research Award for Attention Disorders and/or Learning Disabilities
  • for child and adolescent psychiatry fellows and junior faculty (Supported by AACAP’s Elaine Schlosser Lewis Fund)
- AACAP Pilot Research Award for General Psychiatry Residents
  (Funded by Industry Supporters)

AACAP Educational Outreach Programs (EOP)
APPLICATION DEADLINE: JULY 12, 2019
Provides the opportunity for residents to travel to AACAP’s Annual Meeting.
- AACAP EOP for Child and Adolescent Psychiatry Residents
  (Supported by AACAP’s Campaign for America’s Kids (CFAK), Endowment Fund, John E. Schowalter, MD Endowment Fund, and Life Members Fund)
- AACAP EOP for General Psychiatry Residents
  (Supported by AACAP’s Endowment Fund)

AACAP Systems of Care Special Program
APPLICATION DEADLINE: JULY 5, 2019
Provides support of $1000 to present a poster on a Systems of Care related topic during the “Systems of Care Special Program” at the AACAP’s Annual Meeting.
- Clinical Projects Scholarship
  (Co-Sponsored by SAMHSA’s Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee)

AACAP Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award
APPLICATION DEADLINE: APRIL 15, 2019
Provides up to $8,000 in funding for a qualified child and adolescent psychiatry resident, fellow, or an early career psychiatrist (ECP) with demonstrated interest in the fields of child welfare, foster care, and/or child maltreatment prevention/intervention. With the collaboration of a mentor, award recipients design a project to raise awareness in these subject area(s).
(Supported by K. Lisa Yang, MBA, in honor of Marilyn B. Benoit, MD)

AACAP Psychodynamic Faculty Training and Mentorship Initiative
APPLICATION DEADLINE: MAY 1, 2019
Provides a stipend of $350 to cover travel expenses to AACAP’s Annual Meeting and an opportunity for residents to design a psychodynamic training project within their child and adolescent psychiatry division with the assistance of a mentor through the subsequent year.
(Supported by the Samuel and Lucille B. Ritvo Charitable Fund)

AACAP Junior Investigator Award
APPLICATION DEADLINE: MARCH 18, 2019
Provides $30,000 a year for two years to a psychiatry junior faculty with a career interest in child and adolescent psychiatry.
(Funded by AACAP and Industry Supporters)

Medical Students

AACAP Life Members Mentorship Grants – APPLICATION DEADLINE: JULY 12, 2019
Provides a grant of $1,000 to travel to AACAP’s Annual Meeting. (Supported by AACAP’s Endowment Fund)
• for medical students interested in networking with leaders in the field.

AACAP Medical Student Fellowships – APPLICATION DEADLINE: MARCH 4, 2019
Provides $3,500 to $4,000 stipend for 12 weeks of research training and covers travel to AACAP’s Annual Meeting.
- AACAP Jeanne Spurlock, MD, Research Fellowship in Substance Abuse and Addiction for Minority Medical Students
  (Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign for America’s Kids (CFAK))
  • for medical students focusing on substance abuse and addiction
- AACAP Summer Medical Student Fellowship Program
  (Supported by AACAP’s Endowment Fund)
Distinguished Member Awards
APPLICATION DEADLINE: MAY 1, 2019

AACAP Cancro Academic Leadership Award
Recognizes, in odd-numbered years, a currently serving or retired master teacher, which may include an associate or full professor, chair, dean, or equivalent level through teaching, mentorship, scholarship, and leadership to the field of child and adolescent psychiatry education.

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

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

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

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

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

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

International Scholar Awards
APPLICATION DEADLINE: MAY 1, 2019

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

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

Academic Paper Award
APPLICATION DEADLINE: MAY 1, 2019

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

www.baca.org

ADULT & CHILD PSYCHIATRISTS – INPATIENT PSYCHIATRIST – GERIATRIC PSYCHIATRIST Southern California

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 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. For consideration or to apply, please visit our website at http://scpmgphysician-careers.com. For additional information about these opportunities, contact Jolanta Buschini at Jolanta.U.Buschini@kp.org or call (877) 298-1128. We are an AAP/EEO employer. The Answer to Health Care in America.

Company: Spin Recruitment Advertising
Job ID: 11702867
http://jobs.source.aacap.org/jobs/11702867
live and raise a family. Safe Harbor Behavioral Health

**Job Requirements:**
Requirements Board-eligible/board-certified in child psychiatry. A strong interest in community mental health and serious mental illness.

**Company:** Safe Harbor Behavioral Health at UPMC Hamot (1119149)
**Job ID:** 11479969
[http://jobsource.aacap.org/jobs/11479969](http://jobsource.aacap.org/jobs/11479969)

**NATIONWIDE**

InnovaTel

**CHILD AND ADOLESCENT PSYCHIATRIST – WORK FROM HOME**

**Job Description:**
InnovaTel is looking for passionate professionals who are dedicated to the provision of quality psychiatric care to under-served and at risk populations. Join a team of highly qualified professionals and enjoy the ongoing support of the professional and administrative staff. We offer competitive salary and excellent benefit package. Essential Functions: Provides a full range of psychiatric services utilizing a video technology. The services include initial evaluations and medication management including prescribing of medication, ordering psychological tests and laboratory tests and evaluating results. Develops treatment plans by determining nature and extent of cognitive, emotional, developmental, social, and behavioral disorders; establishing treatment goals and methodologies. Treats patients by utilizing psychotherapeutic methods and medications; discussing progress toward goals with patients; providing instructions; monitoring effect of medications; supervising staff provision of services. Becomes an active member of the treatment team by reviewing treatment plans and progress; consulting and collaborating with primary care physicians, mental health therapists, nurses, and other health care providers. Assures quality and safe service for patients and staff by following policies, procedures, standards, rules, and legal regulations; participating in utilization reviews. Provides training and participates in discussions with staff on topics relating to diagnoses, psychosocial and physiological problems, psychotropic medications, crisis intervention, and other issues. Documents all encounters in the EMR/EHRs. Updates job knowledge by participating in continuing medical educational opportunities. Competencies: Ability to engage with patients and work collaboratively with staff, Documentation Skills, Analyzing Information, Decision Making, Listening, Verbal Communication, Comfort with technology.

**Job Requirements:**
Unrestricted license to practice medicine DEA registration Board certified or board eligible. Reside within the United States

**Company:** innovaTel Telepsychiatry (1130913)
**Job ID:** 11728566
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