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www.aacap.org/UpdateCourse-2020

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MISSION OF AACAP NEWS

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

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Welcome to Chicago!

Karen Dineen Wagner, MD, PhD
AACAP President

It is my pleasure to welcome you to our 66th Annual Meeting. We are excited to be hosting this year’s meeting in Chicago, along the beautiful shores of Lake Michigan. While you may choose to enjoy one of the iconic foods Chicago is known for – deep dish pizza and popcorn – you are participating in a meeting that delivers the best in continuing education with child and adolescent psychiatrists gathered from around the globe. The goal of the meeting is to help advance AACAP’s mission 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.”

This year’s Annual Meeting offers something of value for every child and adolescent psychiatrist and highlights many key issues. To align with my Presidential Initiative on Depression Screening and Awareness in Children and Adolescents, a wealth of programming on this topic is infused throughout the entire meeting and featured in several Clinical Perspectives, Workshops, Symposia, and other special Annual Meeting sessions. Be sure to attend the Lawrence A. Stone, MD, Plenary on Friday, October 18, for a presentation by Joshua A. Gordon, MD, PhD, Director of the National Institute of Mental Health, entitled, “Progress and Priorities in Child and Adolescent Mental Health Research.” On Saturday, October 19, I interview Neal Ryan, MD, Professor of Child and Adolescent Psychiatry at the University of Pittsburgh. Dr. Ryan is a resounding leader in research on depression and anxiety and machine learning techniques in psychiatry. Don’t miss the Karl Menninger, MD, Plenary on Wednesday, October 16. In this session, AACAP President-Elect, Gabrielle A. Carlson, MD, introduces her Presidential Initiative in an address entitled “Emotion Regulation in Children–Coming Together to Treat the Sickest Kids.”

I applaud and thank AACAP’s Program Committee, chaired by James J. McGough, MD, who is assisted by the members of the Committee, Deputy Program Chair Tami D. Benton, MD, and staff, led by Jill Braddock, CMP, MTA, Director of Meetings and Continuing Medical Education, and Lucinda Flowers, CMP, Assistant Director of Meetings. Their job is an interesting, complex, and delicate one that includes creating the call for papers, carefully reviewing every submission (a record 595 this year), making sure that key areas are addressed and the program is balanced. They have done tremendous work in developing the program schedule and fitting all sessions and other events into the available meeting rooms and attractive venues. The rigors, care, and time that goes into every program is truly impressive. The attendees experience the best part – enjoying the meeting as well as the city of Chicago. Much of the local events have been knowledgeably planned and orchestrated by the Local Arrangements Committee, chaired this year by Margery R. Johnson, MD.

I look forward to an enjoyable and productive meeting in Chicago, and I hope you do, too. It’s always a high point of my year, as it provides hope for the future with our collective commitment to improving the mental health of children.

Sincerely yours,
Resources on Depression for Parents, Youth, and Clinicians

Check out AACAP’s expanded Depression Resource Center, with up-to-date resources on depression helpful to parents, youth, and clinicians, including FAQs, fact sheets, treatment resources, books, apps, videos, websites, articles, and more!

www.aacap.org/depressionrc

Plus, with your member access to Child and Adolescent Psychiatric Clinics of North America, read the issue on Depression in Special Populations!

This special issue starts with a preface by Karen Dineen Wagner, MD, PhD, President, AACAP, and Warren Y.K. Ng, MD, and include 18 articles on depression written by a collection of 18 AACAP members!

The release of these important resources coincides with the current Presidential Initiative on Depression Awareness and Screening in Children and Adolescents of Karen Dineen Wagner, MD, PhD.

Thank you to AACAP’s Presidential Task Force, Consumer Issues Committee, and Web Editorial Board for the expertise they contributed in these projects!

You can access the special issue on www.aacap.org.
“Is it because I’m Black, Dr. Webster?”: Racial Identity Development in Child and Adolescent Psychotherapy

Cross developmental ages, this is not an unusual question from many of the children I see for psychotherapy. Impossible questions are a welcome inevitability in my office as is the case in many of yours. Impossible questions regarding race present particular challenges for both the psychiatrist as well as the patient where psychotherapy and burgeoning racial identity development collide.

Our relative lack of racial identity exploration with kids may allow the clinician to under-appreciate, under-utilize, and inadvertently constrict an important developmental trajectory, involving racial identity. Our intensive news cycles confront us with abrasive discourse on race in America. These messages surround children often before children develop the capacity to make sense of their own experiences and those of their families and peers. Contrastingly, family history, language, culture, and other ways that we may be similar or different from one another may serve as a source of resilience. Race and its meaningful discussion, particularly with children, is often fraught and if not avoided even with in our clinical spaces.

Why is it so difficult to talk about race? This discomfort may have a number of historical, personal, and training origins. Psychoanalytically informed thinking provides a number of useful frameworks from which to examine the ‘racial enactment’. Racial enactments are unplanned ways in which we engage with one another based on our attitudes toward race or racial differences. Contemporary psychoanalyst Kimberlyn Leary, PhD, postulates that America’s most significant racial enactment has been our relative silence about race as compared to its central place in our history and culture. Other psychoanalysts posit that as clinicians, we are of society and not separate from it. Therefore we may unwittingly and unconsciously subject our patients to the same culturally-informed racial slights and oversights they face outside of the office. In addition, our avoidance may arise from our own internal discomfort. Some clinicians may worry that questions regarding race may be seen as imposing or rude by child or adolescent patients or by their family. Contrastingly, others may become preoccupied in observing an intractable system. Clinically vital curiosity about the lived cultural lives of our patients may collapse as a result.

“Is it because I’m Black?” is not only a question for children receiving care but also for those learning to treat them.

This area of deficit in clinical discussion is also reflected historically. Freud and other early thinkers asserted that race and culture were matters outside of the purview of a psychoanalysis. Some thinkers reason that this approach resulted from an effort to gain broader intellectual acceptance (not surprisingly during a racially calamitous and violent period in Europe). As a result, in early clinical formulations, an individual’s psyche was viewed separately from their culture. It was a critical omission not to name or acknowledge the social world of patients to include marginalization or persecution. Presently we risk extracting our patients and families from the social worlds they inhabit and the impact of these environmental interactions on their inner lives. Fortunately, contemporary dynamic psychotherapies lean heavily on race and other areas of personhood of both the patient and the therapist as useful instruments to evoke clinical themes, areas of resilience, and strengths.

Nonetheless, whether a result of history or internal discomfort, whenever our defensive avoidance of cultural inquiries results in obscuring or restricting a line of major childhood development, we do our patients a disservice.

Defensive avoidance is revealed in child and adolescent psychiatry training as well. As an example, at a recent gathering of Black psychiatrists and trainees, some attendees lamented a number of common experiences. Some outlined the relative hesitance of psychotherapy supervisors and colleagues to spontaneously engage in questions about a child’s race and culture. Others noted quick one-liners about patients (without racial descriptions) were often assumed to be white. Trainees of color quietly queried what was behind their clinic assigning them to comparatively more children of color. In short, not only had individuals noticed an inhibited capacity for racial/ethnic curiosity about patients on an institutional level, but they also noticed this limited capacity to engage with their race/ethnicity and its implications in drawing out the inner world of children.

“What is it because I’m Black?” is not only a question for children receiving care but also for those learning to treat them.

How might this impact children? From a developmental perspective, latency-age children seek to adapt to and master prevailing social norms and rules.
They learn that it is okay to yell in the schoolyard but not so during spelling class. They learn to file into lines before assemblies, to raise a hand to have a question recognized, and to wait for a turn at the water fountain. Notably, these norms include our relative lack of discussion about race and racial differences. In the classroom, this may be borne out as standards of ‘color-blindness’ or a less race-centered position in general. In evaluative settings, it may manifest as a child’s reluctance to bring racial themes into the clinical space. One may consider how this presents a number of developmental dilemmas.

For many children, regardless of race, the need to abide by these ‘color-blind’ ideals conflicts with the need to make sense of the racialized experiences and messages they receive through media, within their own lives, and through the experiences of others. This conflict is especially distressing for children of color, who need to discuss and explore racialized experiences with others (including the clinician) for healthy racial identity development and yet need to adhere to social norms that ignore or suppress this awareness. Children may lag, languish, or limit their embrace of racial identity to accommodate this American social norm. Alternatively, children may disregard this societal standard in favor of the norms of ethnic communities that openly discuss race with their children.

The child and adolescent psychiatrist, if not purposefully attentive to the myriad of lived racial experiences and identities of their patients, may unintentionally imply to children that aspects of their developing identities create apprehension in the clinician or are associated with shame in general. In a different vein, a lack of questions around race and identity may convey that the clinician is indifferent to or lacks the capacity for observing major parts of the patient’s world view. This may be especially true for the white child and adolescent psychiatrist. Given the past experiences of societal norms in our patients, they may assume clinician neutrality as a clinician’s discomfort at best, or disdain at worst. An astute clinician may observe this broad discomfort with these themes and directly ask families about how aspects of their race and culture affect their relationship with schools, family, the larger community, and the psychiatrist. In addition, as adolescence is a time of exploration and integration of identities, it may be wise to not presume the centrality of racial identities, and instead expect their evolution.

Understanding the cultural perspectives of families may provide a solid base to assess relative strengths and risk-mitigating supports. Statements matched to the developmental level of the child are critical. Asking questions such as, “Which identities matter most for you?” or “What messages do you get about your identity from your family or media?” may be appropriate for children and adolescents that have the developmental capacity to notice differences between themselves and others. It may be tempting to formulate lists of important cultural questions, but acknowledging discomfort in ourselves and in our society and not allowing our clinical curiosity to narrow may ultimately prove most efficacious.

References

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

Refugee children and youth are exposed to multiple traumas and stressors before, during, and after migration. They have witnessed and sometimes are forced to fight in wars. They are victims of persecution, discrimination and harsh economic conditions. All of this puts them at high risk for mental illnesses including PTSD, depression, and anxiety.

Once they have arrived in the US, they begin the resettlement phase. In this phase, their priority is to survive the challenges of a new country and a new life. They must learn a new language, understand a different culture, start a new school, and somehow navigate a healthcare system most Americans don’t even fully comprehend. If they are struggling with mental illness, they may not know it or have time to address it. Mental health often takes a backseat to surviving the new stressors. In addition, the way mental illness is viewed in their country of origin may keep them from recognizing the extent of their mental health issues. The fear of double discrimination—being refugees and mentally ill—may prevent them from seeking treatment.

AACAP and the American Academy of Pediatrics (AAP) have long recognized the effects of refugees’ experiences on their mental health and physical well-being. The impact the experiences have on refugees’ critical development in the areas of physical, social, intellectual, and emotional development is well acknowledged.

The Greater St. Louis ROCAP was awarded one of the 2018 Advocacy and Collaboration grants sponsored by the AACAP Assembly of Regional Organizations of Child and Adolescent Psychiatry. The Greater St. Louis ROCAP, in collaboration with the Missouri Chapter of AAP, worked to develop a video promoting refugee mental health and encouraging them to seek treatment. In 2017, the University of Missouri and the Interagency Council on Immigrant Health (ICIH) started down this path by developing a video addressing the medical health needs of refugees, which was well-received by refugees and advocates alike. That video was the model for developing the 2018 Promoting Refugees’ Mental Health video.

For the mental health video, the St. Louis ROCAP representative and the ICIH, led by Dr. Kristin Sohl, associate professor of pediatrics and president-elect of the Missouri Chapter of the AAP, worked together with other clinicians, educators, a health literacy expert, and the filmmaker. The group held several meetings and agreed on the videos’ goals: increase refugees’ awareness of mental illness, combat the stigma of mental illness, and identify mental health resources in Mid-Missouri. The team also agreed on the best way to produce the video to ensure it addressed the identified goals. They discussed the progress at meetings over the phone and in person over the course of nine months. Following the videos’ completion and approval by representatives from St. Louis ROCAP and AAP, it was translated into six languages. The intended audiences were refugees and those who work closely with them. The video was then shared with the St. Louis ROCAP and the Missouri Chapter of the AAP. It was also distributed to various Mid-Missouri organizations that work closely with refugees, as well as other organizations inside and outside Missouri. In addition, it was posted on various social media outlets, including the APA’s Twitter account. The hope is that this video will be a resource for refugees and the clinicians who work with them.

Links to the video are included here:

English – https://vimeo.com/306502562/6748a91354
Spanish – https://vimeo.com/306502434/f4d49f21b0
Swahili – https://vimeo.com/306502562/6748a91354
Kinyarwanda – https://vimeo.com/306502434/f4d49f21b0

Please feel free to share with others!

The St. Louis ROCAP appreciates the support of the Assembly of Regional Organizations of Child and Adolescent Psychiatry. Without the Advocacy and Collaboration Grant from the Assembly, the production of this video would not have been possible.
Advocacy at Work: Overview of the 2019 Legislative Conference and Spring Assembly

In the first week of May 2019, over 200 child psychiatrists, residents physicians, medical students, patients, and their families, as well as AACAP leaders, attended the Legislative Conference and Spring Assembly in Washington, DC. The meeting’s location—walking distance from Capitol Hill—could not have been more convenient. One of the main purposes of the conference was to meet with legislators to discuss childhood depression and pending bills with the potential hope of impacting patient care and psychiatric practice. An additional goal was to familiarize attendees with the legislative process and the intricacies of working with their local legislators. The organizers of the conference and the assembly devoted extra care toward planning the event to ensure it would benefit the participants, which in turn would benefit our patients and their families.

The legislative conference kicked off on May 2nd, 2019. Essential training was provided to attendees, and they were given information and tools to prepare for talking to the legislators. Ronald Szabat, Michael Linskey, Emily Rohlffs, and the Advocacy Committee played an important role in educating and preparing the Capitol Hill visits. A folder prepared by the American Association of Child & Adolescent Psychiatry included a brochure addressing key issues, as well as helpful handouts which were included for the legislators. Maps showing the workforce distribution of CAPs by state and county were also included.

Before visiting Capitol Hill on May 3rd, there was another review and Q&A session to assure that the delegates were ready and comfortable to advocate and discuss the topics at hand. Information on childhood depression and the need for screening was discussed with a fact sheet. Three priority issues were identified: First, the psychiatric workforce shortage and the need to increase access to child and adolescent psychiatrists. It was clear that every state has a CAP shortage, and most US counties have no CAPs at all. This information was very surprising to the legislators. It was eye-opening for the legislators to know that there are fewer than 8,000 CAPs practicing nationally while estimates place US needs at over 30,000. A statistic indicating that less than half of over 3 million adolescents experiencing depression received treatment was also discussed. The serious consequences of delayed care were shared with the legislators. The legislators were asked to support the Mental Health Professionals Workforce Shortage Loan Relief Act of 2019 (H.R. 2431).

The second bill lobbied for support was the Mental Health Services for Students Act of 2019 (H.R.119 or S.1122). Participants emphasized how getting mental health services into local schools to address unmet needs and reduce stigma is crucial for students’ well-being and success. We helped legislators understand that students spend a third of their time at school, and mental illness will impact 20 percent of students. Many schools are woefully ill-equipped to meet student mental health needs.

Expanding SAMHSA pilot school programs would increase on-site mental health services for students, grades K-12. Therefore, including a local child and adolescent psychiatrist is necessary to help students.

The third issue discussed was keeping migrant children and families together. We asked legislators for support on two bills. The Dream Act of 2019 (S. 874) and The American Dream and Promise Act of 2019 (H.R.6). As CAPs, promoting family unity and avoiding separating migrant children and families is an issue near and dear to our hearts. Deferred Action for Childhood Arrivals (DACA), currently under court review, allows 700,000 immigrants to reside and work in the US. Granting conditional permanent resident status, under specific requirements, would mitigate negative impacts of trauma and support healing and recovery.

The 2019 AACAP Spring Assembly was well attended with 117 CAPs signed up and representatives from almost every state. The program started with the Regional Organizations Information Support breakfast, followed by a welcome from Assembly Chair and AACAP President Dr. Karen D. Wagner. Dr. Wagner reported on the progress and current initiatives taken by AACAP. Various topics were shared with the CAPs including an update on the assembly policies, advocacy and collaboration grants, award opportunities, resource groups on gun violence, physician wellness and the critical needs of children and their families at the US border. The assembly election was also completed. Morning and afternoon open forums were provided to assure the Assembly addressed the questions and/or concerns from the CAPs.

Joining the legislative conference and the Spring Assembly Meetings was very helpful. It was a way to take an active part and advocate for our patients and their families. We believe our voices were heard loud and clear by the legislators. It was also clear that there is still
a lot of work to be done. As CAPs, we have a mission and responsibility to our patients and their families. Attending these two meetings was the first step to increase awareness of CAPs on current pending legislative issues and enlist the legislator’s support. We encourage our fellow AACAP members to continue their work with their local legislators and encourage the CAPs to plan on attending the 2020 Legislative Conference and Spring Assembly.

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.

Dr. Karen Pierce is a psychiatrist in Chicago, Illinois, and is affiliated with multiple hospitals in the area, including Ann and Robert H. Lurie Children’s Hospital of Chicago and Northwestern Memorial Hospital. She received her medical degree from University of Illinois College of Medicine and has been in practice for more than 20 years. karenpierc@gmail.com

In 1893, the first open heart surgery in the United States was performed in Chicago.
Telepsychiatry has entered the mainstream of mental health care. A recent summary of the status of and best practices in child and adolescent telepsychiatry helps aspiring telepsychiatrists to appreciate the benefits of this evolving service delivery model (American Academy of Child and Adolescent Psychiatry [AACAP] Committee on Telepsychiatry and AACAP Committee on Quality Issues, 2017). Now we have a toolkit to complement the Clinical Update and further guide aspiring telepsychiatrists.

Through videoteleconferencing, telepsychiatry addresses the ongoing and projected deficit in the needed numbers of child and adolescent psychiatrists and their consolidation in major urban and coastal areas (American Academy of Child and Adolescent Psychiatry, ND). This situation is exacerbated by the implementation of federal and state mental health parity laws that have made more children eligible for services and mental health parity laws that have made more children eligible for services. It helps increase access to care, build capacity in communities, and improve primary providers’ skills in caring for youths’ psychiatric needs. Telepsychiatry also benefits its practitioners. By including telepsychiatry in their practices, child and adolescent psychiatrists diversify their patient populations and revenue streams whether by reaching out to under-served communities or to local families experiencing other barriers to care, such as work schedules, extra-curricular activities, or transportation difficulties. Yet, it is difficult for child and adolescent psychiatrists to obtain training in telepsychiatry.

The charge of AACAP’s Telepsychiatry Committee is to educate the membership on the use of telepsychiatry to improve the care and outcomes for children and adolescents. To this end The Committee developed the Telepsychiatry Webpage that includes the video-based Child and Adolescent Telepsychiatry Toolkit (https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/toolkit_videos.aspx). The toolkit is the product of a unique collaboration between AACAP and the American Psychiatric Association (APA). This collaboration optimized efficiency and resources in developing a toolkit and increases visibility in disseminating the toolkit across providers. This AACAP Telepsychiatry Committee Toolkit provides 18 video presentations on issues specific to child and adolescent telepsychiatry. Each video presentation is complemented by timely references to comprise a comprehensive resource for aspiring and established child and adolescent telepsychiatrists. As well, members can link to the APA’s Telepsychiatry Toolkit (https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit) to view brief videos regarding the general practice of telepsychiatry. The APA Telepsychiatry Toolkit includes a section with the AACAP Telepsychiatry Toolkit so that general psychiatrists who treat youth can readily access relevant information.

The Telepsychiatry Committee’s Toolkit and Webpage are evolving resources. As new information emerges, the Telepsychiatry Committee will provide the membership relevant resources. Please visit the toolkit to determine how Telepsychiatry may be helpful to your practice.

The Child and Adolescent Telepsychiatry Toolkit was funded by AACAP’s Abramson Fund which actively supports the development and implementation of mental health services for children and adolescents.

References

Dr. Pruitt is a Professor in the Department of Psychiatry, Division Director of Child and Adolescent Psychiatry, and Division Director of Telemental Health at the University of Maryland in Baltimore Maryland.

Dr. Myers is Professor of Psychiatry and Behavioral Sciences at the University of Washington and Director of Telemental Health at Seattle Children’s Hospital in Seattle Washington.

Drs. Myers and Pruitt co-chair AACAP’s Telepsychiatry Committee.
**AUTISM COMMITTEE**

Promoting Autism/Intellectual Disability Capacity in Training Programs and Clinical Practice

The prevalence of autism spectrum disorder (ASD) continues to grow at an unprecedented rate. Whereas prior reports from the CDC indicated that 1 in 59 children was diagnosed with ASD by age eight, two new separate studies utilized data from the National Survey of Children’s Health of 2016 to estimate that 1 in 40 children has ASD.1,2

Children and adolescents with ASD are at greater risk for mental health problems compared to children without ASD, although providers with expertise in this area are seriously lacking. In population-derived cohorts, 70% of children with ASD are reported to have at least one psychiatric disorder and 40% have two psychiatric disorders.3 The prevalence is even higher in clinic-based samples in which 95% of children with ASD had three or more psychiatric disorders.4 Importantly, recent data show that in comparison with parents of children without ASD, parents of children with ASD were 46% more likely to report that their children were not receiving adequate mental health care, and were 44% more likely to report difficulties accessing mental health care.3 According to the Americans with Disabilities act of 1990, it is illegal and a form of discrimination to refuse to serve these individuals. Yet many such individuals of all ages are often turned away from psychiatric clinics and inpatient units, with clinicians citing a lack of expertise and resources to adequately serve this population.5

A 2014 survey of all general and child and adolescent psychiatry (CAP) training programs in the United States performed by the AACAP committee on ASD and Intellectual Disability (ID) found shortages within most programs of both didactics and clinical training in ASD/ID.6 On average, approximately four hours of lectures on ASD and three on ID were offered in an entire year, and CAP trainees reportedly treated only one to five patients with ASD each year in the inpatient setting, or as outpatients for medication management. Preliminary findings from a repeat survey five years later found no significant increase in ASD/ID didactics during CAP training, and overall the case numbers appear similar. On a positive note, 43 percent of psychiatry training directors expressed an interest in receiving resources to strengthen training in this area, indicating a willingness to address this training gap (personal communication, Dr. Marrus).

Treating individuals with ASD and/or ID and mental health conditions can pose unique challenges. Often, co-morbid psychiatric disorders can manifest with atypical presentations that do not neatly conform to DSM-5 criteria. While clinicians can likely successfully treat individuals with developmental disabilities who are cognitively and verbally capable, children with more severe disabilities (such as those who are minimally verbal, or those with greater comorbidity) require special considerations.6

“While clinicians can likely successfully treat individuals with developmental disabilities who are cognitively and verbally capable, children with more severe disabilities (such as those who are minimally verbal, or those with greater comorbidity) require special considerations.”

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Jessica Hellings, MD, McLeod Gwynette, MD, Roma Vasa, MD, Natasha Marrus, MD, Kathleen Koth, DO, Rebecca Muhle, MD, PhD, and William David Lohr, MD

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To develop these videos, the Training Workgroup met monthly for the past two years to discuss in depth what topics would be most important and clinically relevant to the subject of children with ASD/ID. Each member developed a lecture on a specific topic and each lecture was reviewed and edited by the workgroup. Once reviewed, lectures were submitted for external review by other experts in the field for additional feedback. Lastly, the videos were professionally recorded at the 2018 AACAP Annual Meeting in Seattle. The recordings were funded by the AACAP Abramson grant, which was awarded to Dr. Vasa. The final videos and teaching materials will be posted on the AACAP website and will be available to training program directors and website users in the near future.

Several noteworthy components of the videos deserve mention. First, the workgroup decided to focus on the most clinically relevant material that psychiatry trainees could immediately learn and generalize in their practice. Some of these topics included assessment of ASD/ID, genetic testing, co-occurring psychopathology, psychopharmacology, the IEP process, and transition planning. Second, a variety of clinical cases were presented throughout the lectures to illustrate the heterogeneous presentations of children with developmental disabilities and emphasize important clinical points. Finally, the end of each video includes a ten-minute segment called “Application Questions,” where two workgroup members discuss key teaching points of each lecture and their direct application to clinical practice.

Through these nine peer-reviewed videos, it is the group’s intent that psychiatry trainees become more confident and interested in treating individuals with ASD/ID during training and develop that knowledge further in ongoing practice. This is an important step towards increasing our work force to decrease the service gap for these individuals and thereby improve care for the growing number of people of all ages with ASD/ID.

References


Jessica Hellings, MD, is a psychiatrist in Kansas City, Missouri, and is affiliated with multiple hospitals in the area, including Nationwide Children’s Hospital and Ohio State University Wexner Medical Center. She received her medical degree from University of the Witwatersrand and has been in practice for more than 20 years.

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Roma Vasa, MD, is the Co-Chair of the Autism and Intellectual Disability Committee, and an Associate Professor of Psychiatry at the Johns Hopkins University School of Medicine. She is also the Director of Psychiatry Services at the Kennedy Krieger Institute Center for Autism and Related Disorders. vasa@kennedykrieger.org

Natasha Marrus, MD, PhD, is a child and adolescent psychiatrist and behavioral neuroscience researcher at Washington University in St. Louis. Her clinical practice primarily focuses on school consultations in children and adolescents with ASD. Her research focuses on developmental and neural mechanisms of social development, in particular social motivation, in ASD. natasha@wustl.edu

Kathleen A. Koth, DO, is an associate professor and the director of neurodevelopmental disabilities for the child and adolescent psychiatry division at the Medical College of Wisconsin where she was recently the training director for the child and adolescent psychiatry fellowship program. KKoth@mcw.edu

Rebecca Muhle, MD, PhD, has a focus in caring for people with neurodevelopmental conditions such as autism spectrum disorder, and has a special interest in molecular genetic diagnoses associated with neurodevelopmental disorders. Her current research projects use animal and cellular models to uncover the biological changes that occur when genes associated with autism spectrum disorder are genetically disrupted. She currently sees patients and conducts her research at the Yale Child Study Center. rebecca.muhle@yale.edu

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Get in the News!

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

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

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

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

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

Production Schedule

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

Citations and References

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

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HIPAA Final Rule Highlights

Moira Wertheimer, Esq., RN, CPHRM, FASHRM, Vice President, Risk Management Group

In 2013, the Department of Health and Human Services (HHS) published the HIPAA Omnibus Rule (Final Rule) designed to strengthen the HIPAA Privacy and Security Rules. The Final Rule became effective March 26, 2013 and covered entities (CE) and business associates (BA) had until September 23, 2013 to comply with most provisions. A brief summary of the Final Rule modifications relevant to the practice of psychiatry is listed below.

Updates to Notice of Privacy Practices (NPP):

1) All CEs “Notice of Privacy Practices” must now, among other things:
   - Inform patients that they have a right to be notified following a breach of unsecured protected health information (PHI)
   - Inform patients that they now have the right to limit particular releases of PHI to a health plan if the patient pays the CE out of pocket in full.

2) CEs that maintain psychotherapy notes:
   - The NPPs must contain a statement specifying that most uses and disclosures of psychotherapy notes will be made only with permission from the patient, as well as a statement informing the patient that they may revoke a prior authorization;
   - A description of the CEs record-keeping practices regarding psychotherapy notes is NOT required to be included in the NPP (a description may be included if the CE chooses)
   - CEs who do not keep psychotherapy notes are not required to include this statement regarding uses and disclosures of psychotherapy notes in their NPPs.

Business Associates and Subcontractors Now Directly Liable for HIPAA Violations:

- BAs and their subcontractors are now directly liable for HIPAA violations and must follow HIPAA rules in the same way as CEs. Under the Final Rule, however, CEs will remain responsible for their BAs actions, and therefore must ensure that they acquire satisfactory assurances of HIPAA compliance through their BA agreements. In turn, BAs must receive the same HIPAA compliance assurances from their subcontractors.

Modifications to Breach Notification Rule:

- As of the 2013 Final Rule update, HIPAA’s breach notification standard is now a “presumption of breach” standard
- Under the Final Rule’s “presumption of breach” standard, an “impermissible use or disclosure of PHI is presumed to be a breach unless the CE or BA demonstrates that there is a low probability that the protected health information has been compromised”
- Under the new “presumption of breach” standard, the Final Rule requires CEs/BAs to assess the probability that the PHI has been compromised using a documented risk assessment which takes into account at least the following four factors:
  1. The nature and extent of PHI involved, including the types of identifiers and the likelihood of re-identification
  2. The unauthorized individual who used the PHI, or to whom the PHI may have been disclosed
  3. Whether that PHI was actually acquired or viewed
  4. The extent to which the risk to the PHI has been lessened (for example, guarantees that information has been destroyed or will not be further used or disclosed).

- The completed risk assessment for all potential breaches should be documented in your records
- The Final Rule now establishes a financial penalty structure for breaches, with fines ranging from $100 to $50,000 per violation. In addition, there is a $1.5 million cap on violations of an identical type occurring within the same calendar year.

Uses and Disclosures of PHI When the Individual is Deceased:

- The Final Rule now allows (but does not require) CEs to disclose a deceased patient’s PHI to family members and others “who were involved in the individual’s care or payment for health care prior to the individual’s death,” unless doing so is inconsistent with any prior statement by the patient, that is known to the CE. Note: some states may have a more restrictive rule on privacy. Please check your state’s specific regulations regarding disclosure to deceased patient’s family members. Further, there may be regulations on whether a specific family member has the legal right to access information or if that right belongs to another individual within or outside of the family. Consider consulting an attorney if you have questions.

50-year HIPAA Privacy Rule Protection for a Deceased Patient’s PHI:

- The Final Rule now provides that CEs must comply with HIPAA regarding a patient’s PHI for 50 years following the patient’s death.
- HHS commentary further clarified that the 50 year period of protection for deceased PHI does not supersede state laws or ethical
continued on page 230
HIPAA Final Rule Highlights continued from page 229

According to HHS, “the 50-year period of protection is not a record retention requirement.”

Note: Record retention laws vary from state to state, and CEs should continue to comply with their jurisdiction’s record retention law.

Additional Final Rule Modifications:
- CEs must provide properly requested medical records in the format requested within 30 days.
- If the CE cannot provide the medical records in the format requested, the patient and CE must now reach a mutually agreeable solution.
- A patient’s right to receive their PHI takes precedence over HIPAA’s Security Rule.

If a patient requests PHI be sent via email, the PHI may be sent as long as the patient is informed of the risks associated with sending PHI via email. The patient’s request and informed consent should be documented in the patient’s medical record.

Final Rule prohibits the sale of a patient’s PHI without their permission.

CEs may not send 3rd party marketing materials to patients if the materials are paid for by a 3rd party and promotes the 3rd party’s products and services.

Conclusion:
The Final Rule’s modifications implemented widespread changes to HIPAA and provides patients with increased privacy protections and control of their PHI. Moreover, these changes are designed to help protect patient’s PHI in the rapidly evolving digital age. CEs are encouraged to review the Final Rule in its entirety in order to fully comprehend the impact on the practice of psychiatry.

Resources
3. AACAP, Practice Forms, HIPAA/Disclaimers, https://www.aacap.org/aacap/clinicalpracticecenter/BusinessofPractice/PracticeFormsHIPAADisclosures.aspx

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Join Us at AACAP’s 66th Annual Meeting!

On behalf of the entire Program Committee and AACAP Staff, we’re looking forward to seeing all of you at AACAP’s 66th Annual Meeting, October 14-19, at the Hyatt Regency Chicago in Chicago, Illinois.

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

We look forward to providing attendees with:

- **Complimentary wireless internet** throughout the meeting space and guest rooms at the Hyatt Regency Chicago as well as in the guest rooms at the Radisson Blu Aqua Hotel.

- **The Newly Updated AACAP App!** The App allows you to fully navigate the meeting without paper (including electronic session evaluations) and gives you access to other valuable AACAP information (like AACAP’s Twitter feed and a member directory) as well.

- **Online tools** to access a variety of meeting-related documents and to plan your schedule while at the meeting.

- **Wellness Activities.** Make sure to take advantage of the twice daily yoga and mindfulness meditation classes, as well as exercise in and around Chicago.

- **CME tracking through Pathways.** Track your AACAP as well as other organization’s CME credits all in one place through our online learning portal, Pathways!

- **Programming on Depression,** tying into Dr. Wagner’s Presidential Initiative. View the online program schedule to find the listing of depression-related programming at www.aacap.org/AnnualMeeting-2019.

We are also pleased to welcome your families to exciting Chicago! Please visit the AACAP Annual Meeting website for information on fun Chicago activities for children and adults alike.

With important ongoing changes in the field regarding depression screening, excessive use of electronics, gun violence, school shootings, AACAP’s desire to address the tremendous unmet mental health needs of migrant children and families at the border, and updated research in complementary medicine and psychopharmacology, mental healthcare professionals can’t afford to miss this year’s Annual Meeting in Chicago. Please visit www.aacap.org/AnnualMeeting-2019 for more information!

Not registered yet? Registration opens at 4:00 pm on Monday, October 14 in the Grand Ballroom Foyer, Ballroom Level, East Tower, of the Hyatt Regency Chicago.

Look forward to seeing you in Chicago,

James J. McGough, MD
Program Chair

Tami Benton, MD
Deputy Program Chair
Program Highlights

SYSTEMS OF CARE SPECIAL PROGRAM
The Opioid Epidemic, Parents With Substance Use and Abuse, and the Child Welfare System: Creating Responsive Systems of Care
Monday, October 14
8:00 am–4:30 pm (ticket)
Chairs: Lisa R. Fortuna, MD, MPH, Justine Larson, MD
Speakers: Justine Larson, MD, Debra Waldron, MD, Allen Joseph Brenzel, MD, MBA, Henrietta Bada, MD, Beverly Bryant, MD, Nancy Byatt, DO, MBA, MS, Eileen Costello, MD, Gary Blau, PhD

This special session focuses on the impact of parental substance use and the opioid epidemic on children and child-serving systems of care, including the child welfare system, which has been experiencing rising caseloads since 2012 after more than a decade of decline. We consider the role of child welfare agencies, substance use disorder treatment programs, family courts, pediatric health services, public health, and other community partners in addressing the needs of children and families affected by addictions. Presenters highlight the ways child and adolescent psychiatry can participate in addressing the complex needs of families struggling with substance use, challenges, opportunities, and ethical questions in working with parents in recovery, and the response required of child-serving and family-serving systems of care.

Sponsored by AACAP’s Community-Based Systems of Care Committee, Adoption and Foster Care Committee, and Substance Use Committee

RESEARCH SYMPOSIUM
Advances in the Genetics of Neurodevelopmental Disorders: Translating Findings to the Clinic
Tuesday, October 15
6:30 pm–8:30 pm (open)
Chairs: Ellen J. Hoffman, MD, PhD, David Cochran, MD, PhD

Sponsored by AACAP’s Research Committee

The Revolution Has Begun: Autism, Genomics, and the Advancing Science of Neurodevelopmental Disorders
Speaker: Matthew State, MD, PhD, University of California, San Francisco

Matthew State, MD, PhD

Dr. State is the Oberndorf Family Distinguished Professor of Psychiatry, Chair of the Department of Psychiatry, President of the Langley Porter Psychiatric Institute, and member of the Weill Institute for Neurosciences at the University of California, San Francisco. He is a board-certified child and adolescent psychiatrist and human geneticist. Over the past 15 years, his laboratory has played a leading role in elaborating the contribution of rare and de novo mutations to the etiology of autism spectrum and Tourette’s disorders. He has been the recipient of numerous awards, including the AACAP George Tarjan, MD, Award for Contributions in Developmental Disabilities, the Ruane Prize from the Brain and Behavior Research Foundation, and the Sarnat International Prize in Mental Health from the US National Academy of Medicine. He was elected to membership in the National Academy of Medicine (NAM) in 2013.

Harnessing an Autism Genomic Revolution in the Here and Now: Personalized Medicine, Risk-Based Counseling, and What to Do About Polygenic Risk
Speaker: John N. Constantino, MD, Washington University in St. Louis

John N. Constantino, MD

Dr. Constantino is the Blanche F. Ittleson Professor of Psychiatry and Pediatrics at Washington University in St. Louis, where he directs the William Greenleaf Eliot Division of Child Psychiatry, co-directs an NICHD Intellectual and Developmental Disabilities Research Center, and serves as Psychiatrist-In-Chief of St. Louis Children’s Hospital. He completed a triple board residency (pediatrics, psychiatry, and child psychiatry) at Bronx Municipal Hospital in New York and the Albert Einstein College of Medicine. His work has focused on understanding genetic and environmental influences on disorders of social development in childhood, and their implications for preventive intervention. He and his scientific team developed and advanced methods for measuring autistic symptoms as quantitative traits, allowing patterns of transmission of inherited susceptibility to be traced in families and large populations. These methods are now in standard use in laboratories around the world, and their findings have helped elucidate the genetic structure of autism spectrum disorders.

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KARL MENNINGER, MD, PLENARY

Emotion Dysregulation in Children and Adolescents

Wednesday, October 16
8:00 am–9:45 am (open)

Chair: Karen Dineen Wagner, MD, PhD, AACAP President, presiding

Speaker: Gabrielle A. Carlson, MD, AACAP President-Elect

Dr. Carlson has been Professor of Psychiatry and Pediatrics at Stony Brook University School of Medicine since 1985. She founded and directed the Division of Child and Adolescent Psychiatry until 2013. She trained at Cornell, Washington University-St. Louis, National Institute of Mental Health, and UCLA’s Division of Child and Adolescent Psychiatry, and has written over 250 papers and chapters on mood disorders in children. She has been awarded APA’s Blanche F. Ittleson Award for research, Agnes Purcell McGavin Award for Prevention, and AACAP’s Virginia Q. Anthony Outstanding Woman Leader Award.

Dr. Carlson specializes in childhood psychopathology and psychopharmacology in general, and the subjects of childhood and adolescent depression, bipolar disorder, and suicide ideation.

Emotion dysregulation is too much emotion, too fast, for too long. For a problem that brings children to emergency rooms, inpatient units, residential and foster care, and special education, we have no agreed upon term for the behavior. Are the children irritable? Aggressive? Having a mood swing? A meltdown?

Children with these symptoms are sometimes diagnosed with bipolar disorder, but emotion dysregulation is a component of many disorders, and none provide a satisfying diagnostic home. Without an agreed-upon term for the behaviors, we lack a treatment target. This in turn impacts how children are treated and how funding and regulatory agencies such as the US Food and Drug Administration pursue research into treatment options. Existing policies, although well-intended, often focus on what not to do; there is limited guidance for what should be done.

Children with emotion dysregulation require the best diagnostic acumen. Management requires an understanding of the child’s development, temperament, family and social dynamics, and coordination of systems of care. Dr. Carlson plans to bring together the best minds in our field to begin to address some of these issues and improve treatment outcomes for children and their families.

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

CATCHERS IN THE RYE HUMANITARIAN AWARD

Justice Anne M. Burke is the recipient of the 2019 AACAP Catchers in the Rye Humanitarian Award. Illinois Supreme Court Justice Burke is a remarkable humanitarian who has been “brave in the attempt” to overcome her disabilities and win, while doing so much for children in Illinois and around the world.

Anne M. Burke, JD

Justice Burke is a member of the Illinois Supreme Court’s First Judicial District. She was appointed to the Supreme Court on July 6, 2006, was elected in 2008, and was retained in November 2018. Prior to joining the Supreme Court, Justice Burke was appointed to the Appellate Court in 1995 and was elected the following year to the Appellate bench where she served until July 5, 2006. Her judicial career began earlier, in 1987, with an appointment to the Illinois Court of Claims by Governor Jim Thompson. She was later reappointed by Governor Jim Edgar. Before serving on the Illinois Appellate Court, Justice Burke provided in-depth leadership in reshaping and improving the Illinois juvenile justice system. Governor Jim Edgar appointed her Special Counsel for Child Welfare Services and made her a member of his Legislative Committee on Juvenile Justice.

Prior to her judicial career, Justice Burke was a physical education teacher with the Chicago Park District where she worked with children with learning disabilities. Having recognized the positive impact that sports competition had on her students, she championed the idea of a city-wide competition. This ultimately led to the creation of the Chicago Special Olympics in 1968, and grew to become the International Special Olympics, reaching tens of millions in 172 nations across the globe. She later served as a Director of the International Special Olympics and remains involved with the Chicago Special Olympics to this day. Justice Burke will become the Chief Justice of the Illinois Supreme Court effective October 26, 2019.

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NOSHPITZ CLINE HISTORY LECTURE

The Emerging Genetics and Neurobiology of Mental Disorders: Interdisciplinary Challenges for Child Psychiatry

Wednesday, October 16
1:15 pm–2:45 pm (open)

Chair: David W. Cline, MD

Speaker: Steven E. Hyman, MD

Steven E. Hyman, MD, Distinguished Service Professor of Stem Cell and Regenerative Biology at Harvard University, is a Core Member of the Broad Institute of Massachusetts Institute of Technology and Harvard University, and director of the Stanley Center for Psychiatric Research at the Broad. From 2001 to 2011, Hyman served as provost of Harvard University, the university’s chief academic officer. As provost, he had a special focus on establishment of collaborative initiatives in the sciences and engineering spanning multiple disciplines and institutions. From 1996 to 2001, he served as director of the U.S. National Institute of Mental Health (NIMH), where he emphasized investment in neuroscience and emerging genetic technologies and also initiated a series of large practical clinical trials that were a forerunner of comparative efficacy studies.

Dr. Hyman is president of the American College of Neuropsychopharmacology (2018–present), past president of the Society for Neuroscience (2015), the leading global association of neuroscientists, was founding president of the International Neuroethics Society (2008–2014) and served as editor of the Annual Review of Neuroscience (2002–2016). He is a member of the U.S. National Academy of Medicine where he served on the governing Council (2012–2018). For the National Academies of Sciences, Engineering, and Medicine (NASEM), he has chaired the Forum on Neuroscience and Nervous System Disorders (2012–2018), which brings together industry, government, academia, foundations, and patient groups, and serves on the Governing Board of the National Research Council, the operating arm of NASEM. In 2016, he was awarded the Rhoda and Bernard Sarnat International Prize in Mental Health by the National Academy of Medicine. He received his BA, summa cum laude, from Yale College, an MA from the University of Cambridge, and an MD, cum laude, from Harvard Medical School.

In this lecture, Dr. Hyman describes the first decade of modern psychiatric genetics, which has yielded important findings that are wending their way toward clinical relevance. Above all, it has revealed that psychiatric disorders are remarkably polygenic and thus etiologically highly heterogeneous. Nonetheless, aggregate signals, such as polygenic risk scores, can be extracted from genotyping data. Polygenic scores are biomarkers that while probabilistic and partial, can aid in stratification of cohorts for epidemiology and clinical studies. Moreover, the analyses based on polygenic scores have confirmed overlapping genetic risk among psychiatric (but not neurologic) disorders, helping explain developmental trajectories of symptom appearance and co-morbidity. Most importantly, genetics is beginning to reveal biological mechanisms leading to testable hypotheses concerning disease mechanisms, such as a potential neurodevelopmental mechanism for schizophrenia that is discussed.

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

DEBATE

Should Cannabis Be Legalized? An Exchange of Views on Legalization of Cannabis in America

Thursday, October 17
11:45 am–1:15 pm (open)

Chair: Edwin Williamson, MD

Speakers: Kara Bagot, MD, Sherika Hill, PhD, Ray C. Hsiao, MD, David C. Rettew, MD, Paula Riggs, MD, Amy Yule, MD

The legal state of cannabis in the United States is shifting rapidly. Twenty years ago, California became the first state to legalize “medical” cannabis, and currently 33 states have some legal status for the use of cannabis. The effect of increasing legal access to cannabis is not well understood by child and adolescent psychiatrists in the United States. This debate between experts in the field brings a balanced, entertaining format to AACAP to help explain the nuances of legalization, decriminalization, and prohibition of cannabis in the United States and their effects on children and adolescents.

Sponsored by AACAP’s Substance Use Committee, Health Promotion and Prevention Committee, and Training and Education Committee

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JAMES C. HARRIS, MD, DEVELOPMENTAL NEUROPSYCHIATRY FORUM
Fetal Alcohol Spectrum Disorders: Research Advances in Assessment, Diagnosis, and Treatment
Friday, October 18
9:00 am–11:30 am (open)

Chair: Roma A. Vasa, MD, and Natasha Marrus, MD, PhD
Speakers: Claire D. Coles, PhD, Heather C. Olson, PhD

Claire D. Coles, PhD, and Heather Carmichael Olson, PhD

In this Forum, two leaders in the field of developmental psychopathology of fetal alcohol spectrum disorders (FASD) provide an overview of advances in the diagnosis and screening of FASD, research findings related to the neurobiological effects of gestational alcohol exposure, and the growing evidence base for interventions targeting educational and behavioral outcomes in FASD.

The first speaker, Claire D. Coles, PhD, is a developmental and clinical psychologist, Professor of Psychiatry and Behavioral Sciences, and Director of the Maternal Substance Abuse and Child Development Laboratory at Emory University School of Medicine. Dr. Coles has studied the behavioral teratogenic effects of prenatal alcohol and drug exposure both nationally and internationally since 1981. She has been instrumental in conducting longitudinal studies of families and children affected by FASD. Through her research, she has examined outcomes related to gestational alcohol exposure over the lifespan, identified key neurobehavioral features of FASD, developed evidence-based treatment models, and implemented a variety of community prevention activities. Dr. Coles is a member of the NIAAA-sponsored Collaborative Initiative on Fetal Alcohol Spectrum Disorders (CIFASD) and, as part of this effort, has investigated the neurobehavioral signature of FASD in clinically referred individuals as well as the benefits of nutritional supplementation during pregnancy.

The second speaker, Heather Carmichael Olson, PhD, is a developmental and clinical psychologist, and a Clinical Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine. Dr. Carmichael Olson is also a research scientist at the Seattle Children’s Research Institute. There she directs a team that created and tested the Families Moving Forward Program, a tailored, family-focused behavioral consultation intervention with promising outcomes. Dr. Olson has authored research publications on the impact of parental substance abuse, brain-behavior relationships among youth with FASD, and outcomes such as sleep difficulties and parenting stress in this clinical population. Dr. Carmichael Olson is a practicing clinician, with 30 years of experience in assessment and treatment of birth, foster, and adoptive families raising individuals with FASD. She was a key member of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect (NTFFASFAE) that included successful submission of a proposed condition to DSM-5.

Dr. Coles describes the epidemiology, neurobiology, and neurobehavioral outcomes related to FASD, as well as current advocacy efforts to advance policies supporting evidence-based educational interventions for FASD. This sets the stage for the second speaker, Dr. Carmichael Olson, and her presentation of evidence-based and expert consensus guidelines for the assessment and treatment of FASD. Dr. Carmichael Olson specifically covers approaches to diagnostic and clinical evaluation, and current perspectives on management of this condition.

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

LAWRENCE A. STONE, MD, PLENARY
Progress and Priorities in Child and Adolescent Mental Health Research
Friday, October 18
11:45 am–1:15 pm (open)

Chair: Karen Dineen Wagner, MD, PhD, AACAP President, presiding
Speaker: Joshua A. Gordon, MD, PhD

Joshua A. Gordon, MD, PhD, Director of the National Institute of Mental Health, provides an overview of progress and priorities in child and adolescent mental health research. Dr. Gordon discusses emerging approaches and future directions for this diverse field. In a time marked by increased interest in the developmental foundations of mental illnesses, Dr. Gordon highlights the importance of cross-disciplinary, integrative approaches to address the vast
complexities associated with mental illnesses as we move closer to our goal of finding effective treatments and therapies for children and adolescents.

Dr. Gordon received his MD/PhD degrees at the University of California, San Francisco and completed his psychiatry residency and research fellowship at Columbia University. He joined the Columbia faculty in 2004, as an assistant professor in the Department of Psychiatry where he conducted research, taught residents, and maintained a general psychiatry practice. In September of 2016, he became the Director of the National Institute of Mental Health.

Dr. Gordon’s research focuses on the analysis of neural activity in mice carrying mutations of relevance to psychiatric disease. His lab studies genetic models of these diseases from an integrative neuroscience perspective, focused on understanding how a given disease mutation leads to a behavioral phenotype across multiple levels of analysis. To this end, he employs a range of systems neuroscience techniques, including in vivo anesthetized and awake behaving recordings and optogenetics, which is the use of light to control neural activity. His work has direct relevance to schizophrenia, anxiety disorders, and depression.

Dr. Gordon’s work has been recognized by several prestigious awards, including The Brain and Behavior Research Foundation—NARSAD Young Investigator Award, the Rising Star Award from the International Mental Health Research Organization, the A.E. Bennett Research Award from the Society of Biological Psychiatry, and the Daniel H. Efron Research Award from the American College of Neuropsychopharmacology.

The Lawrence A. Stone, MD, Plenary is named in honor of AACAP Past President and Life Fellow, Lawrence A. Stone, MD. It recognizes his leadership, vision, and passion to the mission of AACAP. Mrs. Marnette Stone endowed this plenary in loving tribute to her husband.

PRESIDENTIAL INTERVIEW
Karen Dineen Wagner, MD, PhD, Interviews Neal D. Ryan, MD
Saturday, October 19
11:45 am–1:15 pm (open)

Karen Dineen Wagner, MD, PhD, and Neal D. Ryan, MD

Neal D. Ryan, MD, is the Joaquim Puig-Antich Professor in Child and Adolescent Psychiatry at the University of Pittsburgh. He has led a number of large NIMH-funded studies of depression and anxiety in youth looking at course, psychobiology, and treatment, and resulting in over 300 publications. These studies were some of the first to explore the role of child and adolescent development in affective disorders. More recently he has expanded research efforts to explore the use of machine learning techniques in psychiatry.

Dr. Ryan currently works with Community Care Behavioral Health looking at machine learning approaches to predictive analytics with particular interest in questions related to the interaction of medical and psychiatric disorders in the Medicaid population.

In addition to his research work, for the past two decades Dr. Ryan has served as the Director of Education for the Department of Psychiatry, and for over a decade, he has led the “Child Intervention, Prevention, and Services Summer Research Institute,” an NIMH-funded institute for early career researchers.
Focus On…

Gabrielle A. Carlson, MD,
AACAP President-Elect

The Annual Meeting is like a huge buffet at a very fancy resort! Everything looks delicious but the plates are small, and there is only so much one can eat. You can approach it by seeing how much food you can get on the plate but then, some of it falls off, it all gets jumbled up, some of it looked better than it tasted, but you don’t know because it was difficult to tell it apart.

A better approach to buffets is to decide whether you want to eat what you know you’ll like, you want to try things that look good that you’ve never had, or maybe some of each. If it is possible to go back for “seconds”, then you can do both—be adventuresome and eat what you know is good.

As AACAP expands its educational options, it is possible to go to the buffet more than once, so to speak. First, topics are covered different ways at the Annual Meeting. For those who really want to test everything, the Conference Enrichment Package allows you to learn about topics in the comfort of your own home. Finally, there are now online options to learn about important topics. So fill your educational plate with a few things you need to know, a few things you are curious about, and a few things you know absolutely nothing about.

A couple of particularly interesting features:

1) Instead of the Town Meeting, we will be having a debate on legalizing marijuana on Thursday, October 17. This is a well-orchestrated event with each speaker being given a limited amount of time. But there is time at the end for audience participation.

2) Some of the posters this year will have a new format. You will be able to get the gestalt almost instantly and decide if you want to hear more or not. We hope you’ll let us know what you think about that!

Aggression is one of the top three requested areas about which members want to hear more. I expect that refers to explosive/impulsive/reactive aggression that characterizes many children referred to emergency rooms, inpatient, and residential programs and are overrepresented in foster care. It also encompasses mood dysregulation. Some of the programs addressing these issues include:

Clinical Perspectives 24: Outpatient Management of Irritability, Impulsive Aggression, and Other Severe Behaviors in Youth With ASD (open) Wednesday, October 16 3:00 pm–5:30 pm
Sponsored by AACAP’s Autism and Intellectual Disability Committee

Clinical Perspectives 39: Management of Aggressive Behavior in Inpatient Units (open) Thursday, October 17 1:30 pm–4:00 pm
Sponsored by AACAP’s Inpatient, Residential, and Partial Hospitalization Committee

Clinical Perspectives 44: Bad Boys (and Girls): Addressing School Violence (open) Friday, October 18 9:00 am–11:30 am

Symposium 40: No Reason to Get Irritable: Standardizing the Approach to Agitation and Aggression in Youth in Emergent and Inpatient Settings and the Pediatric Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) Consensus Guidelines (open) Saturday, October 19 9:00 am–11:30 am
Sponsored by AACAP’s Physically Ill Child Committee and Emergency Child Psychiatry Committee

Related Mood Disorders:

Symposium 24: Understanding How to Treat and Prevent Pediatric Bipolar Disorder (open) Thursday, October 17 9:00 am–11:30 am

Symposium 28: Predicting the Onset of Mood Disorders (open) Thursday, October 17 1:30 pm–4:00 pm

Symposium 31: Interpreting the Multiple Facets of Pediatric Bipolar Spectrum Disorders: Clinical and Biological Models (open) Friday, October 18 9:00 am–11:30 am

Member Services Forum 14: The Aggressive Child: Teaching Practical Skills to Fix Big Problems (open) Friday, October 18 1:30 pm–3:30 pm
Sponsored by AACAP’s Training and Education Committee

Symposium 35: DMDD and Borderline Personality Disorder: In Search of the Missing Link (open) Friday, October 18 1:30 pm–4:00 pm
The increasing suicide rate among children and adolescents is a topic about which we need more information; programming includes:

- **Workshop 8: Therapeutic Assessment for Adolescents Presenting With Suicide Attempts or Nonsuicidal Self-Injury (ticket)**
  - Tuesday, October 15
  - 1:30 pm–4:30 pm
  - Sponsored by AACAP’s Community-Based Systems of Care Committee

- **Symposium 14: Federal Efforts to Improve Mental Health and Substance Use Outcomes for Youth (open)**
  - Wednesday, October 16
  - 10:00 am–12:30 pm
  - Sponsored by AACAP’s Collaborative and Integrated Care Committee, Physically Ill Child Committee, and Emergency Child Psychiatry Committee

- **Clinical Perspectives 17: Rural Mental Health for Children and Adolescents: Challenges and Opportunities (open)**
  - Wednesday, October 16
  - 10:00 am–12:30 pm

- **Clinical Perspectives 27: Improving Emergency Care for Youth at Risk for Suicide (open)**
  - Thursday, October 17
  - 9:00 am–11:30 am
  - Sponsored by AACAP’s Collaborative and Integrated Care Committee, Physically Ill Child Committee, and Emergency Child Psychiatry Committee

- **Clinical Perspectives 31: The Truth About Suicide Revisited: Prevention and Postvention in High School, College, and Transitional-Age Youth (TAY) (open)**
  - Thursday, October 17
  - 9:00 am–11:30 am
  - Sponsored by AACAP’s Transitional Age Youth and College Student Mental Health Committee

- **Member Services Forum 12: Minimizing Liability Exposures When Treating Patients Experiencing Suicidal/Homicidal Ideation**
  - Friday, October 18
  - 9:00 am–10:30 am

- **Cutting edge presentations:**
  - **Symposium 11: Research Symposium: Advances in the Genetics of Neurodevelopmental Disorders: Translating Findings to the Clinic (open)**
    - Tuesday, October 15
    - 6:30 pm–8:30 pm
    - Sponsored by AACAP’s Research Committee
  - **Previews From the Pipeline: A Data Blitz Featuring Early Career Investigators (open)**
    - Thursday, October 17
    - 9:00 am–10:30 am
  - **Other Programs: Rapid Fire Cases: 10-Minute Intriguing Cases and Clinical Dilemmas Presented by Trainees (open)**
    - Thursday, October 17
    - 1:30 pm–4:30 pm

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**2019 Annual Meeting Self-Assessment Exam**

Registration for the Annual Meeting allows you to take advantage of this ABPN-approved self-assessment activity for FREE. Complete the 100-question exam and earn 8 AMA PRA Category 1 Credits that count toward the CME and self-assessment requirements of MOC. Feedback from the exam can then be used to guide your selection of programs at this year’s Annual Meeting. This exam will be available until November 30.

**Not Attending the Annual Meeting?**

You can purchase access to the 2019 AACAP Annual Meeting Self-Assessment Exam online at [www.aacap.org/AnnualMeeting-2019](http://www.aacap.org/AnnualMeeting-2019).
Guide to Exhibits

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

Plan your trip to the Exhibit Hall before the meeting by viewing an interactive exhibit hall floor plan on AACAP’s website at: www.aacap.org/exhibits-2019.

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

The Exhibit Hall is located on the Exhibit Level (East Tower) of the Hyatt Regency Chicago, adjacent to the New Research Posters. The Exhibit Hall will be open Wednesday, October 16 (10:00 am-5:00 pm), Thursday, October 17 (10:00 am-4:00 pm), and Friday, October 18 (9:00 am-12:30 pm).

AACAP’s Newest Lifelong Learning Module

AACAP is proud to announce the release of Lifelong Learning Module 16: Relevant Clinical Updates for Child and Adolescent Psychiatrists. With the purchase of this module you will have the opportunity to earn 38 AMA PRA Category 1 Credits™ (8 of which will count towards the ABPN’s self-assessment requirement).

You can order either version of Module 16 online via our publication store at www.aacap.org.

SPECIAL PROMOTION

Order Module 16 when you pay your 2020 membership dues by January 31, 2020 and SAVE $60! Look on your dues renewal form for more information.

For questions about Module 16, please contact Quentin Bernhard III, CME Manager, at 202.587.9675 or at cme@aacap.org.

Module 16 is now available electronically. You can choose to purchase an electronic-only version of Module 16 or still opt to receive the printed version. (Please note that those who purchase the printed version will also have access to the electronic version.)
Current Topics in Pediatric Psychopharmacology

Watch top-rated AACAP speakers provide clinically relevant, evidence-based pediatric psychopharmacology updates. This course, co-chaired by Timothy E. Wilens, MD, and Barbara J. Coffey, MD, MS, includes lectures on autism spectrum disorder, attention-deficit hyperactivity disorder, pediatric bipolar disorder, and many more.

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Is Advocacy an Ethical Obligation in Child and Adolescent Psychiatry?

William Arroyo, MD, and Adam J. Sagot, DO

The practice of child and adolescent psychiatry in the US often includes the concept of “doing whatever is in the best interest of the child”. Such ethical guidance permeates public policy, the legal field, as well as the medical field. While the intent of this concept is reasonable on its face, substantial debate is still evident among medical ethicists (and further discussion is beyond the scope of this article). Such a concept becomes muddier when a more contemporary model of medical decision making—so-called shared decision making—is applied to children. This challenge increases as children, especially young children or children on life support, can hardly contribute anything to such decision-making discussions about the child’s personal medical condition and proposed interventions. And yet, more physicians appear to be better versed in these types of medical ethical decision-making circles than, for example, public policy circles where many medical related policies are being made on a routine basis. For example, President Trump has repeatedly directed the various branches of the federal government, most recently in March of this year, to completely dismantle the increasingly popular Affordable Care Act. Enactment of such policies could potentially strip health coverage from nearly 20 million people; other health policy pundits suggest estimates of up to 100 million individuals.

The guidance provided to child and adolescent psychiatrists (CAP) on a national basis as to what to do in a situation such as the proposed policy to dismantle the Affordable Care Act is limited at best. We would argue that if the health, including mental health, of a CAP’s patient was at great risk, a CAP would likely know how to advocate for that patient. This advocacy, which we will refer to as “individual patient advocacy”, would be almost immediately pursued in order to ensure that the right health care intervention be mobilized. As CAPs, we have learned this moral obligation since our earliest days in medical school, if not before. Formal instruction of such ethical concepts are not standard components of residency curricula. A very recent review (Sagot 2018), which was awarded the best paper by a single author resident by the New Jersey Psychiatric Association, of medical residency curricula concluded that advocacy was minimally referenced within the published criteria from the Accreditation Council of Graduate Medical Education (ACGME) and most specialty curricula with the exception of pediatrics. The requirements for pediatric residency (Lichtenstein, et.al.) included both language for modular learning in child advocacy and milestones specific to advocacy. As health policy rapidly approaches another period of marked change, child and adolescent psychiatry trainees must be prepared to meet the demand for effective advocacy for their patients and care delivery systems. Training residents/fellows in effective advocacy strategy with modular learning would be a crucial step forward in our journey for improved mental health care policy advocacy efforts.

The American Academy of Child and Adolescent Psychiatry (AACAP) published a Code of Ethics (2014), which is intended to guide all of its members. The AACAP Code of Ethics has provisions rooted in basic medical ethics and many more that are specific to the practice of child and adolescent psychiatry including statements related to developmental relevance which makes it unique in the field of medical ethics. However, a gap of guidance remains insofar as provisions directly related to advocacy targeting the different branches of government including the executive, legislative, and judicial branches of federal government; along with the local, state and national agencies which have authority to implement and monitor health programs and services. This omission is very significant in that laws which directly impact medical practice including the practice of child and adolescent psychiatry are introduced, amended, and executed by these bodies of decision-makers. The critical absence of medical knowledge and medical leadership, especially as it relates to child and adolescent psychiatry, should compel CAP’s to fill this significant gap.

In May 2019, the Executive Committee (EC) reviewed the Advocacy Committee’s request to add language to AACAP’s Code of Ethics that would specifically highlight the importance for child and adolescent psychiatrists to advocate with executive, legislative, and judicial branches of government at local, state and national levels.

Although the EC recognizes and appreciates the importance of advocacy, it agreed this language was too prescriptive. The EC is concerned that adding this language could imply that those who do not engage in advocacy are not following AACAP’s Code of Ethics.

The EC thanks the Advocacy Committee for its work and continued dedication to the field.
The seventh principle of medical ethics, found in the Code of Medical Ethics of the American Medical Association addresses this type of advocacy: “A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.”

The annotations to the AMA’s code which were developed by the American Psychiatric Association further elaborate: “…psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judicial branches of government…”

AACAP has increasingly supported targeted advocacy relevant to the aforementioned gap in expertise among government bodies through the American Association of Child and Adolescent Psychiatry; the Advocacy Committee; sponsorship of the Legislative Conference and Advocacy Day on capitol hill; the establishment of the Advocacy Liaison Network; annual meeting presentations; support of Amicus briefs; the offering of a one month resident rotation in AACAP government affairs through the Resident Scholar Program; and through the development of various advocacy tools found on the AACAP website. It is evidently clear to AACAP leadership and staff involved in policy work that such advocacy is fundamental to promoting the AACAP policy agenda. However, the concept of an ethical (or moral) obligation for CAPs has not yet been distinctly nor strategically promoted as such by AACAP.

Such promotion would strengthen and possibly expand advocacy among its membership. Therefore, we strongly urge AACAP to include in the next revision of the AACAP Code of Ethics the following statement: “Child and adolescent psychiatrists are strongly encouraged to directly advocate with executive, legislative, and judicial branches of government at local, state and national levels and with government agencies which manage health programs for children and their families in order to improve the welfare of children and families.”

Resources
American Medical Association (AMA) (2001). Code of Medical Ethics; AMA.
American Psychiatric Association (2013). The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry; APA.
Membership CORNER

ERRATA & FIXES

Mortal Kombat 11: Evaluating Violent Video Game Use Among Youth – an incorrect photo was used for Mathew Fadus, MD. Below is the correct photo. Thank you Dr. Fadus for your patience and understanding.

Matthew Fadus, MD, and Atilla Ceranoglu, MD

If you have essays written by children, adolescents, or parents about their experiences with their mental health and their experiences with child and adolescent psychiatry that you think will be helpful for our members, please consider submitting them to AACAP News. As with all submissions, they will be reviewed for consideration by the AACAP News Editorial Board. Please send all submission to communications@aacap.org.

Renew Early for 2020

Don’t procrastinate! Make the effort and get it out of the way! AACAP 2020 dues invoices drop in early October.

Renew today at www.aacap.org!
Welcome New AACAP Members

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Neil Sina Abidi, DO, Los Angeles, CA
Lara Addesso, MD, Bayville, NJ
Claire E. Andersen, MD, Poway, CA
Nathaniel Aquino, Blountville, TN
Nathalia Badilla, MD, Santiago, Chile
Jesse Bangs, El Paso, TX
Brooke Becker, Birmingham, AL
Jamon Blood, DO, Irving, TX
Maria Carvajal, MD, Port Chester, NY
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Tyler Curry, MD, Omaha, NE
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Nattawat Ngamsamut, MD, Muang Samut Prakan, Thailand
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Thomas James Zimmer, MD, Ann Arbor, MI
AACAP Policy Statement

American Academy of Child and Adolescent Psychiatry

Policy Statement on Depression Screening

Approved by Council June 2019

Background

Depression is a leading cause of disability and morbidity with an estimate of more than 300 million people suffering from the disorder worldwide. Depressive disorders are now known to arise in early childhood with marked increases in prevalence with onset of puberty in girls. There are several brief and developmentally specific screeners that can be used in children/adolescent from age 3-18. Children/adolescents with depression suffer from social, emotional and educational impairments. Childhood/adolescent depression are also associated with an increased risk of suicide as well as risk for developing other psychiatric disorders and substance abuse. Over 50% of youth (children/adolescents) with depression will have a recurrence of depression in adulthood. Studies suggest that less than 50% of depressed children/adolescents receive mental health care, thus there is a clear need for screening for depression across health care settings.

The American Academy of Child and Adolescent Psychiatry recommends:

- Routine screening for depression in children/adolescents age 8 and older across health care settings, including primary care as well as mental health care setting.
- Assessing for symptoms of depression in children/adolescents 3 and older referred for emotional and behavioral problems.
- If a child/adolescent has depressive symptoms, the primary care provider or the mental health clinician should conduct a clinical interview with the child/adolescent and parent(s) to assess for a possible diagnosis of depression.
- Once the diagnosis of depression has been established, the child/adolescent and family should be educated about depression in youth, and the child should be treated or referred for treatment.
- Improving education of health professionals, teachers, and the general public about the signs and symptoms of depression and its treatment in youth.

#

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.
AACAP Policy Statement

American Academy of 
Child & Adolescent Psychiatry

WWW.AACAP.ORG

Policy Statement on Suicide Prevention

Approved by Council June 2019

Background

Rates of completed suicide in the United States have risen consistently over the last two decades, with significant increases occurring in 44 states. Suicide is the second leading cause of death in children and adolescents between ages 10 and 19. In addition to deaths from suicide, experiences of suicidal thoughts and suicide attempts are common among children, adolescents, and young adults: approximately 157,000 youth are treated in emergency rooms annually for self-inflicted injuries, and 8% of American high school students report a suicide attempt in the previous year. Untreated or ineffectively treated mental illness is a crucial risk factor for suicide, and yet many individuals at risk for suicide are not being identified for mental health intervention. In addition to history of mental illness, additional risk factors among children and youth include exposure to violence, experience of abuse and neglect, peer rejection, lack of social support connections, and emotion dysregulation. Observable signs of risk for suicide include seeking means to kill oneself; thinking, talking about, or threatening suicide; thoughts and feelings of hopelessness, purposelessness, not belonging; withdrawing from people and activities; non-suicidal self-injury; substance abuse; and expressions of unusual anger, mood changes, and recklessness. In addition, seeking out Internet sites that provide information about suicide and self-harm is now considered a significant warning sign of suicide intent.

The American Academy of Child and Adolescent Psychiatry recommends:

- The urgent identification of and clinical intervention for children and youth at risk for suicide.
- Key components of a comprehensive, cross-sector approach to reduce rates of suicide should include:
  - Improved education of health care providers, educators and the general public about risk factors for suicide, as well as observable signs of risk for suicidal thoughts and behaviors;
  - Screening for suicide risk across physical and mental health care settings;
  - Greater utilization of evidence-based treatments of mental health conditions for affected individuals; and
  - Reduced access to firearms and other lethal means for at-risk individuals.

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.
AACAP Policy Statement

American Academy of Child & Adolescent Psychiatry

Policy Statement on Mental Health Screening in Primary Care

Approved by Council July 2019

Background

Primary care providers serve as the first-line providers in pediatric health maintenance, disease prevention, assessment and management. Approximately 13-20% of youth and 19% of adults in the United States have a mental disorder. In the past 20 years, primary care clinics have experienced a significant increase in patients presenting for mental health concerns. Early detection of emotional and behavioral problems is an important step in preventing future mental health illnesses. Primary care providers are well positioned to identify, assess, and manage mental health concerns in youth; the need for this role is emphasized by limited mental health resources. Research supports the benefit of utilizing brief mental health screening tools to foster communication between parents, children and physicians, and to identify a subgroup of higher risk patients who need additional psychiatric evaluation. Potential barriers such as limited mental health knowledge and clinical skills, insufficient resources and referral mechanisms, and inadequate payment for the time and effort spent may challenge mental health screening in primary care.

The American Academy of Child & Adolescent Psychiatry recommends:

- Routine mental health screening in primary care to increase awareness, early recognition and early intervention for mental health problems in children and youth.
- Comprehensive mental health education, resources and services be made available to patients, families, and clinicians.
- Innovative collaboration between primary care and mental health clinicians to improve access to mental health services.

#

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.
DON'T MISS A THING
Check out AACAP’s Social Media

American Academy of Child & Adolescent Psychiatry

AACAP NEWS CLIPS
We'll send you an email every Monday, Wednesday, and Friday with the need-to-know on child psychiatry news.

Email Reilly Polka, AACAP Communications Manager, at rpolka@aacap.org with questions.
Thank You for Supporting AACAP!

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

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- Helen R. Beiser, MD Trust

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  - Linda and Rusty Quillin
    - (in memory of Norbert Enzer, MD)

**Up to $99**

- Campaign for America’s Kids
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**Virginia Q. Anthony Fund**
- Alice R. Mao, MD

**Where Most Needed**
- Amazon Smile Foundation
- Mini Tandon, DO

**Workforce Development**
- Paula Marie Smith, MD

**Correction:** AACAP would like to acknowledge the following AACAP members who donated royalties from the book *Lewis’s Child and Adolescent Psychiatry: A Comprehensive Textbook 5th Edition* to AACAP’s Campaign for America’s Kids. Each individual contribution totaled $2837.00

- Michael Bloch, MD
- Andrés Martin, MD
- Fred Volkmar, MD

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: Get Involved! Get Connected Stay Connected

Learn more about the products and services AACAP has to offer our members at all career stages! We particularly recommend that training directors make use of this resource as an introductory guide to AACAP for their trainees. Visit www.aacap.org to download the PowerPoint.

Thank you to the Consumer Issues Committee for their work on this useful product!
AACAP AWARD SPOTLIGHT:
Eraka Bath, MD

2016—2020
AACAP PHYSICIAN SCIENTIST PROGRAM IN SUBSTANCE ABUSE, SUPPORTED BY NIDA

Project Title: Commercially Sexually Exploited Youth in Specialty Courts: Examining Substance Use and Mental Health Problems and Adapting Emergent Technologies to Increase Engagement

The NIDA-AACAP K12 award is funding my research project which aims to better understand the processes that affect engagement and retention of judicially-involved youth with histories of commercial sexual exploitation in drug and mental health treatment; to determine the acceptability and feasibility of mobile health text-messaging to facilitate engagement in court-referred programming (mental health and substance use treatment); and to understand judicially involved youth with histories of commercial sexual exploitation perspectives of facilitators and barriers to engagement in health services and explore their receptivity and preferences for mobile health interventions to improve engagement in court recommended care. AACAP has been an amazing and welcoming home base and has helped me further my research career, enormously.

My professional identity as a forensic child and adolescent psychiatrist can be isolating, particularly since my home is in the juvenile courts. Serving on AACAP’s Children and the Law Committee enables me to meet and mentor trainees, as well as colleagues who are interested in forensics. Bi-directional mentoring has also been beneficial. Mentoring others and receiving mentoring from senior faculty has been extremely rewarding. Moreover, I enjoy being able to “crash” other committees including Diversity and Culture, Adoption and Foster Care, as well as Child Maltreatment and Violence. AACAP has a commitment to diversity and there has been an effort to have better representation in the area of equity diversity and inclusion in programming and leadership.

COMMITTEE WORK
Children and the Law Committee (formerly Juvenile Justice Committee)

WORKFORCE IMPACT
I have mentored numerous award candidates, junior faculty, and multi-disciplinary trainees in need of career and professional development advice. Now, as I am solidly in the mid-career zone, most of my time at the AACAP Annual Meeting is spent huddled in various corners, mentoring a cadre of trainees and junior faculty. I love it!

ABOUT DR. BATH
JOINED AACAP: MARCH 2005
WORKS AT: UCLA DEPARTMENT OF PSYCHIATRY, DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
POSITIONS:
ASSOCIATE PROFESSOR
ASSOCIATE CHAIR OF EQUITY, DIVERSITY AND INCLUSION
DIRECTOR, CHILD FORENSIC SERVICES
SPECIALTIES:
JUVENILE JUSTICE
CHILD WELFARE
FORENSIC PSYCHIATRY
COMMERCIAL SEXUAL EXPLOITATION OF YOUTH
EXPERT TESTIMONY
DISPARITIES
EQUITY, DIVERSITY, AND INCLUSION

AACAP AFFILIATION:
CHILDREN AND THE LAW COMMITTEE
MENTORING:
2017 JEANNE SPURLOCK, MD, RESEARCH FELLOWSHIP IN SUBSTANCE USE AND ADDICTION MENTOR
AACAP SYSTEMS OF CARE MENTOR
Pathways is AACAP’s new online learning portal, which allows you to access top rated courses to earn CME credit on your schedule. Pathways serves as your continuing medical education home, giving you access to a variety of online courses and activities, including:

✦ Clinical Essentials on Autism
✦ Clinical Essentials on Depression
✦ Clinical Essentials on Substance Use Disorder
✦ Current Topics in Pediatric Psychopharmacology: An Online Advanced Course
✦ Free JAACAP CME
✦ Lifelong Learning Module 15

To learn more about these exciting CME opportunities, contact the CME department at CME@aacap.org or visit www.aacap.org/onlinecme.

Share Your Photo Talents With AACAP News

Members are invited to submit up to two photographs every two months for consideration. We look for pictures—paintings included—that tell a story about children, family, school, or childhood situation. Landscape-oriented photos (horizontal) are far easier to use than portrait (vertical) ones. Some photos that are not selected for the cover are used to illustrate articles in the News. We would love to do this more often rather than using stock images. Others are published freestanding as member’s artistic work.

We can use a lot more terrific images by AACAP members so please do not be shy; submit your wonderful photos or images of your paintings. We would love to see your work in the News.

If you would like your photo(s) considered, please send a high-resolution version directly via email to communications@aacap.org. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
You’re ready for the next career step.

We’re ready to help you leverage your membership to get there.

AACAP members have a distinct advantage over the typical job seeker. Your member benefits include access to a free online job board, JobSource.

Employers from across the country look to JobSource to seek out the most qualified child and adolescent psychiatrists.

You want your profile and resume to be there when they look. Visit jobsource.aacap.org today to get started.

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American Academy of Child & Adolescent Psychiatry

www.aacap.org
ACADEMIC CHILD & ADOLESCENT PSYCHIATRIST
Tucson, AZ

Job Description:
Join Top Rated Academic Medical Center in Tucson, AZ Academic Child and Adolescent Psychiatry Faculty Position. Join our collegial academic child and adolescent psychiatry faculty in beautiful Tucson Arizona. We are a growing department supporting an ACGME approved child and adolescent fellowship program looking for an additional team member to help support the academic mission of teaching and clinical care in the Banner-University of Arizona health system. Duties include outpatient supervision, consult/liaison, and didactic teaching. Opportunities to expand duties based on interests are welcome. Qualifications, schedule and scope include: Graduate of an ACGME accredited psychiatry residency program Graduate of an accredited CAP fellowship Position is open to experienced physicians and new grads Experience in Autism and Developmental Disorders, Addictions preferred Work Schedule: M-F Shared call (can be taken from home) Average Patient Volumes: 10-15/ day Ability to access a variety of behavioral health patients Ability to work in a collaborative, team environment; one that thrives in a highly integrated and innovative setting; and above all a desire to focus on patient excellence BUMC-S, formerly University of Arizona Medical Center – South Campus, is a comprehensive medical center with an Emergency department, a state-designated trauma center and a Behavioral Health Pavilion. It is a state-accredited Cardiac Receiving Center and is designated a senior-friendly hospital by Nurses Improving Care for Health System Elders. Banner Health and University of Arizona Health Network have come together to form Banner – University Medicine, a health system anchored in Phoenix and Tucson that makes the highest level of care accessible to Arizona residents. Banner Health is one of the largest non-profit health care systems in the country with twenty-eight hospitals, six long term care centers and an array of other services, including family clinics, home care services and home medical equipment, in six Western states. Banner Health offers a competitive salary plus incentives along with an industry leading benefits package that provides security for you and your family. Please submit your CV and cover letter, to: doctors@bannerhealth.com. For questions, please call Tiffany Lewis, Sourcing Strategist, at: 602-747-4578. Visit our website at: www.bannerdocs.com As an equal opportunity and affirmative action employer, Banner University Medical Group (BUMG) recognizes the power of a diverse community and encourages applications from individuals with varied experiences and backgrounds. BUMG is an EEO/AA – M/W/D/V Employer

Company: Banner Health (1035441)
Job ID: 12746495
http://jobsource.aacap.org/
jobs/12746495

CALIFORNIA

CHILD & ADOLESCENT PSYCHIATRIST: PART-TIME OUTPATIENT-ONLY OPPORTUNITY
Near Los Angeles, CA

Job Description:
Our practice in an incredible location along the West Coast is seeking a board-certified or board-eligible child and adolescent psychiatrist to join our team. This is an outpatient-only role, though our organization offers a full spectrum of services, including a residential treatment center, a group home, an aftercare program, shelter care, foster care, adoption services, family preservation, family reunification, wraparound services, and mental health services. As an integral member of our practice, you’ll benefit from the following: A permanent part-time opportunity with no call responsibility A flexible schedule—to 3 days per week, 8 to 12 total hours A treatment team approach—psychiatrist, therapist, case manager, parent partner, and rehab specialist Opportunity to take on key responsibilities—initial assessments, follow-ups, and medicine management Located just south of Los Angeles, our practice is part of a remarkable beachside community filled with incredible opportunities and activities throughout the entire year. You’ll also have the option to work at our second location, more inland to the southeast of Los Angeles. As part of our community, you’ll also enjoy the following: Easy access to the beach, unique shopping and dining venues, professional sporting events, and LAX, Long Beach, and Santa Ana airports Incredible public and private school options Consistent sunshine and an abundance of outdoor activities, including surfing, hiking, biking, fishing, and paddle boarding U.S. News ranks California #4 in Best States for Economy and #7 in Best States for Healthcare For immediate consideration please inquire with an updated copy of your CV so we can discuss the position by phone. Also, inform me of your best available times to speak. I look forward to your reply and thank you for your review. Please do not delay as we anticipate a significant response. Please contact Amy Pannell at medcareers@merritthawkins.com or at (866) 406-0269 and reference CPSY-105443

Company: Merritt Hawkins (1096672)
Job ID: 12758900
http://jobsource.aacap.org/
jobs/12758900

ADULT & CHILD PSYCHIATRISTS
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. GERIATRIC PSYCHIATRIST West Covina, California. At SCPMG, you’ll enjoy the amazing recreational activities, spectacular natural scenery

continued on page 256
and exceptional climate our area is known for, along with stability in today’s rapidly changing health care environment. SCPMG is proud to offer its physicians: 4 1/2 day work week (8-10 hours) * Flexible schedules Education time (1/2 day a week) * 1 hour for initial evaluations and 30 minutes for follow-ups Multi-disciplinary team consisting of Nurses, LCSWs, Psychologists and MAs Medical, Dental, Vision, Life & Supplemental Comprehensive Insurance Robust retirement plans: Pension Plan, 401K and Keogh Excellent salary and compensation package (bonuses offered) Partnership eligibility after 3 years * Not available for the Inpatient Psychiatrist opportunity. We invite you to make a difference in the community we serve. 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) 259-1128. We are an AAP/EEO employer. The Answer to Health Care in America.

Company: Spin Recruitment Advertising (876472)
Job ID: 12698812
http://jobsource.aacap.org/
jobs/12698812

COLORADO
MEDICAL DIRECTOR - OFFICE OF CHILDREN, YOUTH AND FAMILIES Colorado

Job Description: The Colorado Department of Human Services welcomes your interest in the Medical Director position. This position oversees the medical, behavioral health and dental needs of children in the child welfare and youth services systems, including the Department’s 24-hour, seven (7) day-a-week (24/7) facilities in the Division of Youth Services. The facilities operated by the Department provide health care via complex systems and are governed by many state and federal laws and regulations requiring close coordination and partnerships with private or non-profit providers, academic research and policy organizations and publicly funded clinics and hospitals. There is consistent pressure on the facilities/programs to stretch fixed budgets, provide innovative services and continually provide higher quality care. This position serves as an internal consultant to OCYF for medical and behavioral health oversight. Knowledge: The OCYF Medical Director will have thorough knowledge of medication management, human development, psychiatric diagnosis, and intervention modalities with children, adolescents, and adults. Knowledge of and adherence to American Psychiatric Association ethical standards. Understanding of varying management techniques, working with budgets, planning and development of health care systems. A solid knowledge of The Joint Commission and the Continuing Quality Improvement concepts and processes. The Medical Director will: Provide medical and behavioral health (including psychiatric) consultation for individual cases, including development and planning for comprehensive care reviews involving medical complexity, polypharmacy, and other concerns in order to ensure appropriate medical and behavioral health care; Consolidate and align pertinent policies, protocols, rules and regulations to incorporate best practices in the standards of care for each population served by the Division; Review vendor policies, procedures and practices related to medical and/or behavioral health care and oversight, identifying and correcting deficiencies, misalignments and inconsistencies; Establish continuous quality improvement systems for the quality of care provided by state facilities, including reviewing health, medical and behavioral health audits, surveys and reviews across the OCYF 24/7 facilities, identifying common deficiencies and developing strategies to unify policy and practice where appropriate; Serve as an advisor to the OCYF leadership on medical or behavioral health issues; Work with appointing authorities for facility medical directors, medical officers, nurse officers, and other clinical staff as requested by programs, or clinical/medical contractors to set practice-appropriate performance standards and develop plans to ensure health care oversight and coordination of care among clinical and medical staff; Develop and manage any new initiatives related to health care provided by OCYF; Develop and present solutions to complex problems, which typically involve merging unique state or federal law. What might seem like a logical and simple solution to a problem may not be allowed by state or federal rules, requiring this position to develop alternatives, or develop and draft new policy or legislation. This position, directly and through the work of others, bridges differences of policy and opinion and finds workable solutions; Demonstrate ability to distinguish between alcohol and other drug-related symptoms and other pre-existing physical problems or pathologic behaviors; Make independent decisions, working knowledge/familiarity with computers and electronic medical record keeping and to verbally communicate with patients and staff and document communications effectively.

Job Requirements:
Minimum Qualifications, Substitutions, Conditions of Employment & Appeal Rights: Minimum Qualifications: M.D./D.O. degree in Pediatrics, Psychiatry, Family Practice or related field Current, unencumbered license to practice medicine and to prescribe medications in the State of Colorado Minimum of two years of previous experience in the supervision of other professional staff Knowledgeable with current psychotropic medications and side effects Demonstrated ability to develop treatment plans and summaries based on patient needs Ability to cooperatively work as part of a multidisciplinary treatment team Understanding of varying management techniques, working with budgets, planning and development of health care systems Experienced user of EHRs – Electronic Health Records Preferred Qualifications: Preference will be given to candidates with greater depth and breadth of experience than listed in the minimum qualifications. Other preferred qualifications or experience desired may include: Certification by the American Board of Psychiatry and Neurology Specialty training in child and adolescent psychiatry or Developmental Pediatrics Two years of documented experience in the treatment of children, adolescents, or patients
with developmental disabilities in either inpatient or outpatient psychiatric treatment settings. Experience with juvenile justice, foster care, and developmentally disabled populations. Able to demonstrate competence in gathering and interpreting information about mental disorders and chemical dependencies including the biopsychosocial influences and effects of each. Experience advising a Government, State or Local agency or other legislative/Advisory Board.

Management experience coordinating and managing systems/organizations in a complex environment. Conditions of Employment: The successful candidate in this position must be willing and available to submit to the following conditions: The successful candidate in this position will be willing to submit to and able to successfully pass a criminal background check. The successful candidate in this position will independently travel throughout Colorado using personal transportation or a state vehicle to conduct customer visits.

**Company:** Department of Human Services - State of Colorado (1176027)

**Job ID:** 12679855

http://jobsource.aacap.org/jobs/12679855

**MAINE**

**PSYCHIATRY FACULTY, DIVISION OF CHILD & ADOLESCENT PSYCHIATRY EARLY PSYCHOSIS LEAD**

**Portland, ME**

**Job Description:**

Maine Medical Center (MMC) is seeking a part time BC/BE Adult, Child & Adolescent Psychiatrist clinician-educator to join the Department of Psychiatry. Successful candidates will be gifted clinicians or investigators committed to improving the lives of youth through patient care, education, research, and advocacy. The primary role will be physician leader of the Child & Adolescent Psychiatry Division’s Portland Identification and Early Referral (PIER) program team, a nationally known family-focused center for research and treatment of adolescents and young adults, in the first years of a psychotic spectrum disorder. This role involves not only patient care but leadership in program development, state-wide and national teaching, consultation, advocacy, and research. The position also involves outpatient care in our child and adolescent psychiatry outpatient clinic. Special consideration will be given to candidates with prior experience in specialized care for emerging psychosis. The Child Psychiatry Division offers comprehensive evaluation and treatment for those under 21 with mood, anxiety, behavior, psychotic, substance use, trauma-related, learning, and developmental disorders. Evaluations offered include assessment of autism and other developmental disorders. Our clinical staff includes child and adolescent psychiatrists, clinical social workers, and psychologists. The Child Psychiatry Division is part of a larger clinical network that includes Spring Harbor Hospital and Maine Behavioral Healthcare, a region wide comprehensive mental health system. The division is an active teaching program for child & adolescent psychiatry fellows, psychiatry residents, medical students, social work interns, and trainees in other disciplines. Maine Medical Center has 637 licensed beds and is the state’s leading tertiary hospital and Level One Trauma Center, with a full complement of residencies and fellowships and an integral part of the Tufts University Medical School. The position involves teaching and mentoring Psychiatry residents, Child & Adolescent Psychiatry fellows, and medical students from the Maine Medical Center-Tufts University School of Medicine Program. The successful candidate would have an academic appointment at Tufts University School of Medicine commensurate with medical school criteria.

Maine Medical Partners is an organization within Maine Medical Center, and is Maine’s largest multi-specialty medical group serving the healthcare needs of patients locally and throughout northern New England. This high quality team of more than 500 physicians and 200 advanced practice providers provides a wide range of hospital-based, primary, specialty and sub-specialty care delivered through a network of more than 30 locations in and near Greater Portland. Situated on the Maine coast, Portland offers the best of urban sophistication combined with small-town friendliness. The area provides four season recreational opportunities, such as skiing, hiking, sailing, and miles of beautiful beaches. Just two hours north of Boston, this is an exceptionally diverse and vibrant community. For more information please contact Gina Mallozzi, Physician Recruiter at (207) 661-2092 or gmallozzi@mainehealth.org.

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MASSACHUSETTS  
HOSPITALIST AND OUTPATIENT CHILD PSYCHIATRISTS  
Boston, MA  

Job Description:  
Here at Boston Children’s Hospital’s Department of Psychiatry, we are offering exciting opportunities for the child and adolescent psychiatrist who is interested ensuring the provision of highest quality evidence-based family-centered psychiatric care across our care continuum. While we continue to welcome inquiries from anyone who might be interested in joining the Department, we are currently interested in filling the following two positions.  

HOSPITALIST CHILD PSYCHIATRIST  
We are seeking a full-time child and adolescent psychiatrist to work with other child psychiatry attendings and a robust multidisciplinary team of social work, psychology and nursing staff, to provide intensive hospitalist services to youth facing a wide range of challenging psychiatric disorders including those facing co-occurring emotional and physical illnesses. Our innovative services include a 16-bed inpatient psychiatry unit and a 12-bed community-based acute residential treatment unit, both located within our pediatric hospital. The position evolves ensuring highest quality teaching and education of our child and adolescent psychiatry fellows, general psychiatry residents and medical students. Support will be provided for involvement in quality improvement initiatives pertaining to the inpatient service.  

OUTPATIENT CHILD PSYCHIATRIST  
We are seeking a full-time child and adolescent psychiatrist interested in providing diagnostic consultation and management services in our Outpatient Psychiatry Service. Part time positions (half-time or more) will be considered. We have particular interest in the psychiatrist with interest and/or expertise in working with neurodevelopmental disorders, particularly autism spectrum disorders and/or intellectual disabilities. The position involves collaboration with pediatric neurologists and developmental-behavioral pediatricians within our multidisciplinary autism spectrum center as well as providing high quality teaching and education of psychiatry and pediatric trainees. Support will be provided for involvement in quality improvement initiatives pertaining to the care of patients with neurodevelopmental disorders.  

Job Requirements:  
We are looking for collaborative physicians who can build working partnerships both within and outside our Department. Candidates for these positions must be board eligible/certified in general and child/adolescent psychiatry. All positions will include an appointment at Harvard Medical School. For each of these positions academic rank and salary will depend on experience and qualifications. Women and minorities are encouraged to apply. Boston Children’s Hospital is an Affirmative Action/Equal Opportunity Employer. Applicants should submit electronically their CV and a brief statement of interest detailing relevant experience to Patricia Ibeziako, MD, Associate Chief for Clinical Services, Department of Psychiatry, Boston Children’s Hospital, at patricia.ibeziako@childrens.harvard.edu.  

Company: Boston Children’s Hospital  
(881542)  
Job ID: 12741266  
http://jobsource.aacap.org/  
jobs/12741266  

PSYCHIATRIST - CHILDREN AND ADOLESCENTS  
Boston, MA  

Job Description:  
This Child and Adolescent Psychiatrist will provide direct outpatient psychiatric services for children and adolescents through comprehensive evaluation, diagnosis, treatment planning, counseling, and psychopharmacological treatment of assigned patients. Basic responsibilities: Provides psychiatric evaluations, ongoing psychiatric assessments and treatments, and counseling to assigned patients. 

Analyzes patient data and test or examination findings in the diagnosis of mental disorders of assigned patients. Data acquisition/coordination of treatment: Gathers and maintains patient information and records, including social, medical, and substance use history obtained from patients, relatives and significant others, and other sources. Also collaborates with physicians, psychologists, social workers, and other professionals to obtain client history and to discuss treatment plans and progress. Treatments: Develops individualized care plans involving evidence-based psychotherapeutic and/or medication treatments to assigned clients, when indicated. Monitors patient responses to these treatments (including adverse effects for medications) and makes necessary adjustments or recommendations. Foci on and screens for patient safety and harm-reduction with each patient meeting and with all forms of treatment. 

Documentation: Completes and submits billing sheets and progress notes within seven (7) days of providing service. Supervision: Participates in periodic supervision by the Medical Director and integrates recommendations and other feedback into clinical work performance. May provide ongoing, periodic supervision to psychiatric nurse practitioners, as directed by the Medical Director. Adherence to regulations: Adheres to HIPAA and other pertinent regulations and laws. 

Job Requirements:  
Must have current licensure as physician in the State of Massachusetts, current licences with the DEA and State of Massachusetts for controlled substances (Buprenorphine licensure not mandatory), and must be Board Eligible or Board Certified in Child & Adolescent Psychiatry. Please apply to Matt Hubbell, Physician Recruiter at matthew.hubbell@lahey.org  

Company: Beth Israel Lahey Health  
(1175063)  
Job ID: 12649215  
http://jobsource.aacap.org/  
jobs/12649215  

Gathers and maintains patient information and records, including social, medical, and substance use history obtained from patients, relatives and significant others, and other sources. Also collaborates with physicians, psychologists, social workers, and other professionals to obtain client history and to discuss treatment plans and progress. Treatments: Develops individualized care plans involving evidence-based psychotherapeutic and/or medication treatments to assigned clients, when indicated. Monitors patient responses to these treatments (including adverse effects for medications) and makes necessary adjustments or recommendations. Foci on and screens for patient safety and harm-reduction with each patient meeting and with all forms of treatment. 

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Company: Beth Israel Lahey Health  
(1175063)  
Job ID: 12649215  
http://jobsource.aacap.org/  
jobs/12649215  

Gathers and maintains patient information and records, including social, medical, and substance use history obtained from patients, relatives and significant others, and other sources. Also collaborates with physicians, psychologists, social workers, and other professionals to obtain client history and to discuss treatment plans and progress. Treatments: Develops individualized care plans involving evidence-based psychotherapeutic and/or medication treatments to assigned clients, when indicated. Monitors patient responses to these treatments (including adverse effects for medications) and makes necessary adjustments or recommendations. Foci on and screens for patient safety and harm-reduction with each patient meeting and with all forms of treatment. 

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Company: Beth Israel Lahey Health  
(1175063)  
Job ID: 12649215  
http://jobsource.aacap.org/  
jobs/12649215
CHILD AND ADOLESCENT PSYCHIATRIST OPPORTUNITIES IN OUTPATIENT AND INTEGRATED CARE
Boston, MA

Job Description:
Cambridge Health Alliance (CHA), a well-respected, nationally recognized and award-winning public healthcare system, is seeking full-time/part-time Child and Adolescent Psychiatrists. CHA is a teaching affiliate of Harvard Medical School (HMS) and Tufts University School of Medicine. Our system is comprised of three hospital campuses and an integrated network of both primary and specialty outpatient care practices in Cambridge, Somerville and Boston’s Metro North Region. Full-time or half-time opportunities within our outpatient clinic in Revere Half-time opportunity in child integrated care providing team-based, short term consultation to outpatient primary care practices. Work closely with multidisciplinary staff; including psychologists, social workers, primary care providers, nurses and administrative support. Work in a collaborative practice environment with an innovative clinical model allowing our providers to focus on patient care and contribute to population health efforts. Fully integrated electronic medical record (Epic). Academic appointments are available commensurate with medical school criteria. Opportunities for scholarship in community mental health and supervision of Harvard-affiliated trainees. Ideal candidates will be board eligible or board certified in Child and Adolescent Psychiatry and possess a strong commitment to and passion for our multicultural, underserved patient population. Please visit www.CHAProviders.org to learn more and apply through our secure candidate portal. CVs may be sent directly to Melissa Kelley, CHA Provider Recruiter via email at ProviderRecruitment@challiance.org. CHA's Department of Provider Recruitment may be reached by phone at (617) 665-3555 or by fax at (617) 665-3553.

Company: BCambridge Health Alliance (1177750)
Job ID: 12729251
http://jobsource.aacap.org/jobs/12729251

MINNESOTA
CHILD PSYCHIATRIST
Minneapolis and St. Paul, MN

Job Description:
At Children's Minnesota, we don’t simply care for kids. We care for the most amazing people on earth. For more than 90 years, we have proudly served our community as an independent and not-for-profit system dedicated to providing health care exclusively to children, from before birth to young adulthood. With two hospitals, 12 primary and specialty care clinics, and six rehabilitation sites, and representing more than 60 pediatric specialties, Children’s Minnesota has the largest and broadest team of pediatric experts in the region. An award-winning health system, Children’s received Magnet® recognition from The American Nurses Credentialing Center (ANCC) in 2018 and is regularly ranked by U.S. News & World Report as a top children's hospital. We’re looking for individuals who are driven to join us in our mission to champion the special health needs of children and their families. Who want to be part of something bigger. Who want to grow, innovate and improve. Who want to make Children’s Minnesota an even better place tomorrow.

Department Overview
The Psychiatric and Psychological departments provide services on both the Minneapolis and St. Paul campuses, with limited services at Woodwinds in Woodbury and Children’s West in Minnetonka. Specific services include individual and family therapy, psychological assessment, neuropsychological assessment, and psychiatric evaluation and medication management. (Available to children who are already patients of Children’s mental health, pediatric, or subspecialty clinics.).

Position Summary: To provide a broad array of psychiatric services to Child and Family Services outpatient population. Services provided will include consultation to staff regarding diagnostic and medication issues; direct service (including consultation, evaluation, and medication follow-up) to children and their families; collaboration and consultation with nurse practitioners.

Qualifications
Medical Doctor. Licensed Physician in Minnesota. Board Certified Child Psychiatrist. Five Years Clinical Experience. Please submit your cover letter and CV to Ryan Berreth at Ryan.Berreth@childrensmn.org

Company: Children’s Hospitals and Clinics of Minnesota (943330)
Job ID: 12741212
http://jobsource.aacap.org/jobs/12741212

NORTH CAROLINA
CHILD AND ADOLESCENT PSYCHIATRIST
Charlotte, NC

Job Description:
Join a team on the cutting edge - building the behavioral health system of the future. Atrium Health - where we say ‘Patients first, Always’ - is seeking BC/BE Child and Adolescent Psychiatrist in the following areas: BE/BC Child and Adolescent Psychiatrist for outpatient clinic at main Behavioral Health location in Charlotte as well as the consultation liaison service with award-winning Levine Children’s Hospital. Clinical duties include a week of call every 8 to 9 weeks and opportunities for work on the child inpatient unit and partial hospitalization program. Atrium Health is the largest healthcare system and most comprehensive provider of mental health and addictions services in the region. We continue to grow our psychiatric medical staff (now over 70) as we invest and expand behavioral health – this last year adding the new hospital, launching projects in primary care integration, virtual BH teams for EDs, and Mental Health First Aid; while expanding tele psychiatry to over 400 visits a month. Excellent compensation and benefits including: CME dollars Malpractice insurance with tail coverage Health insurance and life insurance Short and long-term disability, 401K, 457B and pension plan Vacation Behavioral Health Centers (BHC), a vital part of Atrium Health, is the largest regional provider of mental health and substance abuse services in the Carolinas. They provide the most advanced care in psychiatric and substance abuse services and offers treatment options for adults, adolescents and children through a comprehensive,

continued on page 260
integrated system of inpatient and outpatient programs.

**Job Requirements:**
BE/BC Child and Adolescent Psychiatrist

**Company:** Atrium Health (1151680)
**Job ID:** 12733773
http://jobsource.aacap.org/jobs/12733773

**MEDICAL DOCTOR (MD) - DOCTOR OF OSTEOPATHY (DO)**
University of North Carolina

**Job Description:**
Summary UNC Physicians Network is seeking a full-time, outpatient only, Triangle-based Child and Adolescent Psychiatrist to join a network that has fully operational support in place including nurse, pediatricians, and licensed clinical social workers. High-quality health care begins with high-caliber people. Our steadfast commitment to the health of our community begins within. If you seek an environment that promotes excellence, leadership and autonomy in clinical practice, then a career with UNCPN may be for you. Job Duties and Responsibilities Unique opportunity for a well-qualified licensed and board eligible or board certified prescriber to join a successful outpatient practice of Psychiatrists, Pediatricians, Advanced Practice Providers and a full array of support staff. Requirements Board Certified or Board Eligible Psychiatrist Successful completion of Child/Adolescent Psychiatry fellowship North Carolina MD or DO license to be obtained by start date Benefits Include Competitive MGMA salary Paid CME days & fund reimbursement, and paid annual leave (vacation) Matching 401(k) and malpractice insurance 403(b) & 457(b) retirement plans To inquire about this opportunity, email Amber Williams at Amber.Williams1@unchealth.unc.edu

**NORTH DAKOTA**

**BC/BE CHILD PSYCHIATRIST**
Fargo, ND

**Job Description:**
Sanford Health is currently seeking a BC/BE Child Psychiatrist to join the region’s leading team of Child Behavioral Health Specialists in Fargo, North Dakota. At Sanford Health, our reputation of excellence is founded on our talented team of dedicated providers, and we believe they are the cornerstone of healthcare. PRACTICE DETAILS: •Our experienced team is comprised of 6 Psychiatrists, 7 Psychologists, 1 Masters Level Therapists, and 3 Integrated Health Therapists. •Sanford’s Behavioral Health Services offers a full spectrum of office based specialists providing PCIT (Parent Child Interactive Therapy), TF-CBT (Trauma Focused Cognitive Behavioral Therapy), testing, group therapy, and short and long term therapy services. •Sanford also has a team of Behavioral Health specialists that is fully integrated into Pediatrics, providing both clinic services and consult services to the 60-bed Children’s Hospital housed within Sanford’s general hospital. •Partial Hospitalization Program •Light Call responsibilities Sanford Health offers a guaranteed salary for the first two years. Comprehensive benefits are offered along with paid malpractice insurance, relocation allowance and much more. To learn more about Sanford Health and this excellent practice opportunity contact: Patty Absey, Manager-Physician Recruitment Office PO Box 2010 Fargo ND 58122-2181 Phone: (701) 234-6539 Email: patricia.absey@sanfordhealth.org

**Company:** Sanford Health (936056)
**Job ID:** 12645416
http://jobsource.aacap.org/jobs/12645416

**OHIO**

**INPATIENT STAFF RN - BEHAVIORAL HEALTH PAVILION**
Ohio

**Job Description:**
At Nationwide Children’s, we’ve made behavioral health a major focus. Our goal is to develop a system of pediatric behavioral health care for our region that will serve as a national model for other health care systems. The Big Lots Behavioral Health Pavilion, a state-of-the-art facility opening in 2020, will be the cornerstone in our effort to improve the behavioral health of youth in the region. The nine-story Behavioral Health Pavilion at Nationwide Children’s Hospital is expected to be the largest facility on a pediatric campus devoted to children and adolescent mental health in the country.

**Job Requirements:**
Neuro Behavioral Unit (NBU): The Neuro Behavioral Unit is a 12 bed unit serving patients ranging from 3-17 years old that have an intellectual and or developmental disability. [https://external-nationwidechildrens.icims.com/jobs/18811/staff-rn--neuro-behavioral-unit/job](https://external-nationwidechildrens.icims.com/jobs/18811/staff-rn--neuro-behavioral-unit/job)

**Company:** Nationwide Children’s Hospital (1179224)
**Job ID:** 12768573
http://jobsource.aacap.org/jobs/12768573

**SOUTH CAROLINA**

**ASSISTANT PROFESSOR/CLINICIAN EDUCATOR**
South Carolina

**Job Description:**
Seeking a Board Eligible or Board Certified Child and Adolescent Psychiatrist for clinician-educator faculty positions in the child and Adolescent Psychiatry Division. Candidate will be involved with clinical services in a variety of settings, including outpatient, day treatment, in patient and residential programs. Direct patient encounters and
Remote telepsychiatry services will be included. Desire to work with medical students, residents, and child fellows preferred.

**Job Requirements:**
BC/BE in Child Psychiatry. If BE plans to be certified within the next calendar year.

**Company:** Medical University of South Carolina (1176380)
**Job ID:** 12725215
**http://jobsource.aacap.org/jobs/12725215**

**TEXAS**

**PSYCHIATRIST**
Austin, TX

**Job Description:**
Integral Care, the premier provider of psychiatric services in Austin—live music capital of the world—seeks to add another BC/BE child psychiatrist to our growing staff. Integral Care conducts more than forty innovative, community-based programs, including a new child and family crisis response team. Job description: 30 hours per week in outpatient settings, working alongside a multi-disciplinary team of psychiatrists, therapists, and nurse practitioners. Job salary and benefits: $96.82-$124.01 an hour depending on licensed experience.

**Company:** Integral Care (1178667)
**Job ID:** 12758661
**http://jobsource.aacap.org/jobs/12758661**

**UTAH**

**CHILD AND ADOLESCENT INPATIENT PSYCHIATRIST, RANK DOQ**
University of Utah Health (UNI)

**Job Description:**
Academic Child/Adolescent Inpatient Psychiatrist, Rank DOQ University of Utah Health (UNI) - School of Medicine - Psychiatry The Child Psychiatry Division in the Department of Psychiatry at the University of Utah School of Medicine is looking for dedicated and motivated full-time Child and Adolescent Inpatient Psychiatrists to join its faculty. We are looking for qualified professionals to help us meet the challenges of providing high-quality psychiatric services in a market with growing mental health care needs. University of Utah Health is relied upon by our local and regional communities to improve overall health and quality of life. We do this by maintaining a commitment to outstanding patient care, the highest standard of training for medical students and residents, and continued expansion of our pioneering research programs. Successful candidates will have a faculty appointment in the Department of Psychiatry with rank based on academic experience. Faculty members provide clinical services for the University of Utah’s Neuropsychiatric Institute (UNI). The University of Utah is located in the capital city, Salt Lake City - one of the most beautiful cities in the world, surrounded by mountains, with world-class skiing, hiking, backpacking, rock climbing, and mountain biking. The city also enjoys the Sundance Film Festival, a lively music scene, excellent restaurants, one of the largest LGBT communities in the country, the Utah Symphony/Utah Opera, professional basketball, baseball, and soccer teams, Ballet West (one of the premiere ballet companies in the country), a vibrant art community, and many other cultural attractions. Qualifications: Applicants should hold a current, unrestricted license to practice medicine in the State of Utah (or eligible) and have expertise in child and adolescent inpatient psychiatry. Completion of a residency in Psychiatry and a Triple Board residency or a Child and Adolescent Psychiatry fellowship is required. The candidate must be board certified or board eligible in Psychiatry and Child and Adolescent Psychiatry. Obtaining board certifications is a requirement for retention. Responsibilities: Clinical care: Use excellent clinical skills in psychiatry to serve the mental health needs of inpatient clientele; Show a strong commitment to clinical care as well as demonstrated clinical aptitude; Call is an expected clinical responsibility for all faculty members. Provide cross coverage for vacations and meetings. Specific assignments will be coordinated through the Division Chief of Child Psychiatry. Investigation: Engage in scholarly activities; Show effectiveness in academic career Education: Engage in patient care activities with learners. (Learners include residents, medical students, and fellows); Serve as medical student and resident mentor; Teaching/supervising medical students, residents and fellows in psychiatric clinical rotations Administration: Administrative duties associated with clinical care provided; Administrative service to the Department of Psychiatry, the Medical school and the hospital, including peer review and participation on committees, may be requested in order to attain academic promotion The percentage of effort spent in education, investigation, and administrative activities will be negotiated annually. Specific assignments will be coordinated through the Child Division Chief of the Psychiatry department. Candidates should apply on-line by sending a letter of interest and curriculum vitae to: http://utah.peopledmin.com/postings/96304 Inquiries may be directed to: Philip Baese, MD, Child Psychiatry Division Chief philip.baese@hsc.utah.edu Department of Psychiatry University of Utah School of Medicine 501 Chipeta Way Salt Lake City, UT 84108 The University of Utah Health (U of U Health) is a patient focused center distinguished by collaboration, excellence, leadership, and respect. The U of U Health values candidates who are committed to fostering and furthering the culture of compassion, collaboration, innovation, accountability, diversity, integrity, quality, and trust that is integral to our mission. The University of Utah is an Affirmative Action/Equal Opportunity employer and does not discriminate based upon race, national origin, color, religion, sex, age, sexual orientation, gender identity/ expression, status as a person with a disability, genetic information, or Protected Veteran status. Individuals from historically underrepresented groups, such as minorities, women, qualified persons with disabilities and protected veterans are encouraged to apply. Veterans’ preference is extended to qualified applicants, upon request and consistent with University policy and Utah state law. Upon request, reasonable accommodations in the application process will be provided to individuals with disabilities. To inquire about the University’s nondiscrimination or affirmative action policies or to request disability accommodation, please contact: Director, Office of Equal Opportunity and Affirmative Action, 201 S. Presidents Circle, Rm 135, (801) 581-8365. The University of Utah

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values candidates who have experience working in settings with students from diverse backgrounds, and possess a strong commitment to improving access to higher education for historically underrepresented students.

**Job Requirements:**
Applicants should hold a current, unrestricted license to practice medicine in the State of Utah (or eligible) and have expertise in child and adolescent inpatient psychiatry. Completion of a residency in Psychiatry and a Triple Board residency or a Child and Adolescent Psychiatry fellowship is required. The candidate must be board certified or board eligible in Psychiatry and Child and Adolescent Psychiatry. Obtaining board certifications is a requirement for retention.

**Company:** The University of Utah Department of Psychiatry (956175)
**Job ID:** 12674419
[http://jobsource.aacap.org/jobs/12674419](http://jobsource.aacap.org/jobs/12674419)

**WASHINGTON**

**NURSE PRACTITIONER - PEDIATRIC PSYCHIATRY**
Tacoma, WA

**Job Description:**
Nurse Practitioner – Pediatric Psychiatry MultiCare Health System – Mary Bridge Children’s Hospital Tacoma, WA
Founded in 1955, Mary Bridge Children’s provides our region’s most advanced care for children. We are focused on what we can do in the future. Our new Pediatric Nurse Practitioner will play a key role in that future. You will be a trusted provider and a part of our MultiCare values of Respect, Integrity, Stewardship, Excellence, Kindness and Collaboration. A bit about us... Mary Bridge Children’s Hospital & Health Network is more than just a place for children to heal. It’s a place for them to grow and thrive. A place for families to come for solutions and support. A place where medical expertise and a passion for children and families work together in perfect balance. Key statistics from 2017 include: 3,655 medical and surgical inpatient admissions 675 pediatric intensive care unit admissions 6,268 OR cases 157,674 outpatient clinic visits (76,917 primary care & 80,757 specialty care visits) As part of MultiCare Health System, you’ll enjoy the benefits of a financially stable, technologically advanced health system with more than 18,000 employees. You’ll also be supported by an active foundation committed to our mission of “Partnering for Healing and a Healthy Future”. Job Description: In total, the medical practices within Woodcreek Pediatrics currently manage the primary care of over 43,000 pediatric patients in east Pierce County. Our Providers come in contact with children in need of behavioral health resources daily and we believe that an integrated collaborative care model that places behavioral health resources in our clinic settings will have significant positive impact on the health of our communities. Woodcreek Pediatrics serves children and adolescents with considerable behavioral health needs and we firmly believe that to treat them to the best of our ability, we need behavioral health resources in our clinics that can collaborate with our primary care providers and help guide our treatment plans. We are seeking a dynamics in population health based, collaborative care model of practice. This full-time ARNP position is focused on consultative care and case review to facilitate management of patients with ADD/ADHD, mood disorders, anxiety, OCD & ODD, and other behavioral health challenges. This practitioner will join 2 other psychiatry nurse practitioners who are embedded within our primary care network and will assist in the future expansion of embedded behavioral health services. There will be ongoing opportunities for face to face and virtual consultations with other embedded team members as well as a psychiatrist. Competitive salary, a full array of benefits, a healthy work/life balance, and a great location makes this an ideal choice for the provider who is looking to experience the best of Northwest living: from big-city amenities to the pristine beauty and recreational opportunities of the great outdoors. Apply: Please visit our website to apply for position # 65068 online at [multicare-jobs.org](http://multicare-jobs.org).

**Job Requirements:**
Graduate of a Pediatric – Mental Health Nurse Practitioner program Training and/or experience in Child and Adolescent Psychiatry Licensed in the state of WA as an ARNP by the time of employment Board certified as a psychiatric mental health nurse practitioner by the time of employment ARNPs are also required to maintain valid RN license and have “prescriptive authority” Current BLS for Healthcare Providers certification by the American Heart Association

**Company:** Buyer Advertising (1059546)
**Job ID:** 12758266
[http://jobsource.aacap.org/jobs/12758266](http://jobssource.aacap.org/jobs/12758266)

**DEVELOPMENTAL BEHAVIORAL PEDIATRIC PHYSICIAN**
Tacoma, WA

**Job Description:**
Pediatric Developmental Behavioral Physician MultiCare Health Systems Tacoma, WA. Based in Tacoma, WA (near Seattle), MultiCare Health System is a leading-edge, integrated not-for-profit healthcare organization. MultiCare Mary Bridge Children’s Hospital is an advanced regional care and referral center for Southwest Washington serving more than 13 referring hospitals over 9 counties and backed by fully staffed services 24/7. Mary Bridge supports a level IV NICU. The Pediatric Urgent Care service is another great option for our community, which has excellent support through fully staffed busy ED service, PICU, trauma service, IPS and a full complement of pediatric subspecialties. Mary Bridge Children’s Hospital and Health Network was one of 13 Children’s Hospitals named a top performing children’s hospital for 2018. The Leap Frog Top Hospital award is tied to achievements in patient safety and quality and is widely acknowledged as one of the most competitive honors American hospitals can receive. Job Description: Our dynamic multi-specialty group is seeking a Pediatric Developmental-Behavioral Physician to work in our growing Pediatric Neurobehavioral program. The ideal candidate will complete evaluation and treatment of pediatric patients with autism, developmental delays, genetic
syndromes, and other conditions that affect his or her developmental behavior. The Physician provides clinical support services for pediatric medical programs across MultiCare Health System. Collaboration is key with Mary Bridge Providers and Staff. Work situations are of a routine nature yet require analysis, good judgment, decision making, and diplomacy. Competitive salary, a full array of benefits, a healthy work/life balance, and a great location makes this an ideal choice for the provider who is looking to experience the best of Northwest living: from big-city amenities to the pristine beauty and recreational opportunities of the great outdoors.

Apply: Please visit our website to apply for position #69859 online at: jobs.multicare.org/dbh

About us: MultiCare Health System is a not-for-profit health care organization committed to our mission of “partnering for healing and a healthy future”. Our 18,000 team members (employees, providers and volunteers) are united by MultiCare’s values of respect, integrity, stewardship, excellence, collaboration and kindness. Our roots date back more than a century to the founding of Tacoma’s first hospital. Since then, we’ve grown to become Washington State’s largest community-based, locally governed health care system with numerous primary care, urgent care and specialty services — including Immediate Clinic, MultiCare Indigo Urgent Care, Pulse Heart Institute and MultiCare Rockwood Clinic. Our system of care also includes eight hospitals: Allenmore Hospital (Tacoma) Auburn Medical Center (Auburn) Covington Medical Center (Covington) Deaconess Hospital (Spokane) Good Samaritan Hospital (Puyallup) Mary Bridge Children’s Hospital (Tacoma) Tacoma General Hospital (Tacoma) Valley Hospital (Spokane) MultiCare is also proud of our commitment to workforce diversity and culturally competent care. This commitment is led by our CEO and supported through employee education and community outreach. Please visit our website to apply for position #69859 online at jobs.multicare.org. Or email kaquinn@multicare.org. MultiCare is an equal opportunity employer. Hiring decisions are made without regard to race, color, religion, national origin, sexual orientation, gender identity, disability, veteran status or age.

Job Requirements:
Requirements: Fellowship in Developmental-Behavioral Pediatrics or Neurodevelopmental Pediatrics Board Certified or Board Eligible in Developmental-Behavioral Pediatrics or Neurodevelopmental Pediatrics Licensed in the state of WA by the time of employment DEA, NPI & prescriptive authority Current BLS for Healthcare Providers certification by the American Heart Association Administration of the Autism Diagnostic Observation Scales (ADOS) (Preferred)

Company: Buyer Advertising (1059546)
Job ID: 12755544
http://jobsource.aacap.org/jobs/12755544

WEST VIRGINIA
WEST VIRGINIA CHILD PSYCHIATRY
West Virginia

Job Description:
Join one of the best health care providers and teaching hospital in the state Child Psychiatry * Competitive base salary with wRVU bonus potential plus comprehensive benefits* Occurrence malpractice; No tail coverage required* $20,000 sign-on bonus* Potential for leadership position with stipend for medical director duties for actual hours worked* Nationally recognized 88 bed Residential Treatment Center* Well established and tenured support staff* Accredited Charter School* Integrated approach and Continuum of Care ranging from Sub-Acute Residential to Community Based Programs* Clinical Emphasis on Assessment, Treatment Planning, Discharge and After Care Planning * 2020 graduates encouraged to apply Wild and wonderful . . . almost heaven * The cultural, recreational, and business capital of the Appalachian Mountains* Excellent Public and Private Schools* NCAA Division I Intercollegiate Sports Teams* Driving distance for skiing, water sports, hiking, etc.* Bike friendly community with a network of trails* Art walks, downtown street festivals and brown bag concert series* Come play - multiple family friendly venues and activities Timothy Stanley Direct: 404-591-4224800-492-7771

tstanleyweb@phg.com Fax: 404-591-4237Cell / Text: 770-265-2001

Job Requirements:
Minimum Requirements:MD or DO Medical DegreeEligible to be state licensed in the United StatesUnited States Residency and / or Fellowship training

Company: Pinnacle Health Group (1114165)
Job ID: 12653792
http://jobsource.aacap.org/jobs/12653792

The term “jazz” was coined in Chicago in 1914.
Pediatric Psychopharmacology Update Institute

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www.aacap.org/psychopharm-2020
A novel, once-daily treatment option for patients with ADHD 6 years and older

**Now Available**

![Jornay PM](image)

**methylphenidate HCl**

extended-release capsules

20mg 40mg 60mg 80mg 100mg

The first and only ADHD stimulant
dosed in the evening

Help patients wake up ready
for the day

When dosed in the evening, the delayed-release and extended-release technology of JORNAY PM enables the drug to be delivered in the early morning—and it lasts throughout the day

Visit booth #133 and JORNAYpm-pro.com to learn more about JORNAY PM

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**Indication and Important Safety Information**

**INDICATION**

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

**IMPORTANT SAFETY INFORMATION**

**WARNING: ABUSE AND DEPENDENCE**

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

**CONTRAINDICATIONS**

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

**WARNINGS AND PRECAUTIONS**

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

**ADVERSE REACTIONS**

- Based on accumulated data from other methylphenidate products, the most common (≥5% and twice the rate of placebo) adverse reactions for pediatric patients and adults are: appetite decreased, insomnia, nausea, vomiting, dyspepsia, abdominal pain, weight decreased, anxiety, dizziness, irritability, affect lability, tachycardia, and blood pressure increased.

**PREGNANCY AND LACTATION**

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

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

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

DOSE AND ADMINISTRATION
JORNAY PM should be taken only in the evening. Adjust the timing of administration between 6:30 pm and 9:30 pm to optimize the tolerability and efficacy the next morning treatment without the need to adjust dosing. The recommended starting dose for patients 6 years and above is 20 mg daily in the evening. Dosage may be increased weekly in increments of 20 mg per day up to a maximum daily dose of 100 mg. Capsules may be swallowed whole or opened and the entire contents sprinkled onto applesauce.

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

CONCURRENT TREATMENT
Concomitant treatment with monoamine oxidase (MAO) inhibitors, or within 14 days of discontinuation of sums, may exacerbate symptoms of behavior disturbance and thought disorder.

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

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

ADVERSE REACTIONS
Clinical Trial Experience Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared with rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice. Clinical Trials Experience with JORNAY PM in Pediatric Patients (6 to 12 years) with ADHD The safety of JORNAY PM was evaluated in 280 patients (6 to 12 years of age) who participated in two randomized, double-blind studies of CNS stimulants with methylphenidate in children with ADHD. Study 1, conducted in pediatric patients 6 to 12 years of age, was comprised of a 6-week open-label dose-optimization phase in which all patients received JORNAY PM (n=125; mean dose 52 mg), followed by a 1-week, double-blind controlled phase in which patients were randomized to continue JORNAY PM (n=65) or switch to placebo (n=54). During the open-label JORNAY PM treatment phase, adverse reactions reported in >5% of patients included: any insomnia (41%), decreased appetite (27%), affect lability (22%), headache (19%), upper respiratory tract infection (17%), upper abdominal pain (9%), nausea or vomiting (9%), increased diastolic blood pressure (8%), tachycardia (3%), and irritability (3%). Three patients discontinued treatment because of affect lability, panic attacks, and agitation and methamphetamine. Because of the trial design (6-week open-label active treatment phase followed by a 1-week, randomized, double-blind, placebo-controlled withdrawal), the adverse reaction rates described in the double-blind phase are lower than expected in clinical practice. No difference occurred in the incidence of adverse reactions between JORNAY PM and placebo during the 1-week, double-blind, placebo-controlled phase. Study 2 was a 3-week, placebo-controlled study of JORNAY PM (n=81; mean dose 32 mg) in pediatric patients 6 to 12 years. Most Common Adverse Reactions (incidence of ≥5% and at a rate at least twice placebo in one or both treatment groups).

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

<table>
<thead>
<tr>
<th>Body Organ System</th>
<th>JORNAY PM (N=81)</th>
<th>Placebo (N=80)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric disorders</td>
<td>Any insomnia</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Initial insomnia</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Middle insomnia</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Terminal insomnia</td>
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</tr>
<tr>
<td></td>
<td>Insomnia, not specified</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Affect lability/Mood swings</td>
<td>6%</td>
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<td>19%</td>
</tr>
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<td>Headache</td>
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</tr>
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<td></td>
<td>Psychomotor hyperactivity</td>
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</tr>
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<td>Cardiovascular</td>
<td>Blood pressure diastolic increased</td>
<td>7%</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>Vomiting</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Nausea</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Constipation</td>
<td>2%</td>
</tr>
</tbody>
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Other Methylphenidate Products in Children, Adolescents, and Adults with ADHD Commonly reported (≥2% of the methylphenidate group and at least twice the rate of the placebo group) adverse reactions from placebo-controlled trials of methylphenidate products include: appetite decreased, weight decreased, acne, abdominal pain, dryness, dry mouth, vomiting, insomnia, anxiety, nervousness, restlessness, affect lability, agitation, irritability, dizziness, vertigo, tremor, blurred vision, blood pressure increased, heart rate increased, tachycardia, palpitations, hyperactivity, and pyrexia. Clinical Trials Experience with JORNAY PM in Pediatric Patients (6 to 12 years) with ADHD The safety of JORNAY PM was evaluated in 280 patients (6 to 12 years of age) who participated in two randomized, double-blind studies of CNS stimulants with methylphenidate in children with ADHD. Study 1, conducted in pediatric patients 6 to 12 years of age, was comprised of a 6-week open-label dose-optimization phase in which all patients received JORNAY PM (n=125; mean dose 52 mg), followed by a 1-week, double-blind controlled phase in which patients were randomized to continue JORNAY PM (n=65) or switch to placebo (n=54). During the open-label JORNAY PM treatment phase, adverse reactions reported in >5% of patients included: any insomnia (41%), decreased appetite (27%), affect lability (22%), headache (19%), upper respiratory tract infection (17%), upper abdominal pain (9%), nausea or vomiting (9%), increased diastolic blood pressure (8%), tachycardia (3%), and irritability (3%). Three patients discontinued treatment because of affect lability, panic attacks, and agitation and methamphetamine. Because of the trial design (6-week open-label active treatment phase followed by a 1-week, randomized, double-blind, placebo-controlled withdrawal), the adverse reaction rates described in the double-blind phase are lower than expected in clinical practice. No difference occurred in the incidence of adverse reactions between JORNAY PM and placebo during the 1-week, double-blind, placebo-controlled phase. Study 2 was a 3-week, placebo-controlled study of JORNAY PM (n=81; mean dose 32 mg) in pediatric patients 6 to 12 years. Most Common Adverse Reactions (incidence of ≥5% and at a rate at least twice placebo in one or both treatment groups).

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Postmarketing Experience  The following adverse reactions have been identified during postapproval use of methylphenidate products. Because these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate the frequency with which such reactions occur or if a causal relationship to drug exposure exists.

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

DRUG INTERACTIONS

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

USE IN SPECIFIC POPULATIONS

Pregnancy  Risk Summary  Published studies and postmarketing reports on methylphenidate use during pregnancy are insufficient to inform a drug-associated risk of adverse pregnancy-related outcomes. No teratogenic effects were observed in pre- and post-natal development studies with oral administration of methylphenidate to pregnant rats and rabbits during organogenesis at doses up to 2 and 9 times the maximum recommended human dose (MRHD) of 100 mg/day given to adolescents on a mg/m² basis, respectively. However, spina bifida was observed in rabbits at a dose 31 times the MRHD given to adolescents. A decrease in pup body weight was observed in a pre- and post-natal development study with oral administration of methylphenidate to rats throughout pregnancy and lactation at doses 3.5 times the MRHD given to adolescents. The background risk of major birth defects and miscarriage for the indicated population is unknown. However, the background risk in the U.S. general population of major birth defects is 2% to 4% and of miscarriage is 15% to 20% of clinically recognized pregnancies.

Clinical Considerations  Fetal/Neonatal-Adverse Reactions CNS stimulant medications, such as JORNAY PM, can cause vasoconstriction and thereby decrease placental perfusion. No fetal and/or neonatal adverse reactions have been reported with the use of therapeutic doses of methylphenidate during pregnancy; however, premature delivery and low birth weight infants have been reported in amphetamine-dependent mothers. Data Human Data A limited number of pregnancies have been reported in published observational studies and postmarketing reports describing methylphenidate use during pregnancy. Due to the small number of exposed pregnancies with known outcomes, these data cannot definitively establish or exclude any drug-associated risk during pregnancy.

Animal Data In studies conducted in rats and rabbits, methylphenidate was administered orally at doses of up to 75 and 200 mg/kg/day, respectively, during the period of organogenesis. Teratogenic effects (increased incidence of fetal spina bifida) were observed in rabbits at the highest dose, which is approximately 31 times the MRHD of 100 mg/day given to adolescents on a mg/m² basis. The no effect level for embryo-fetal development in rabbits was 60 mg/kg/day (9 times the MRHD given to adolescents on a mg/m² basis). There was no evidence of specific teratogenic activity in rats, although increased incidences of fetal skeletal variations were seen at the highest dose level (6 times the MRHD given to adolescents on a mg/m² basis, which is also maternally toxic). The no effect level for embryo-fetal development in rats was 25 mg/kg/day (2 times the MRHD given to adolescents on a mg/m² basis).

Lactation  Risk Summary  Limited published literature, based on breast milk sampling from five mothers, reports that methylphenidate is present in human milk, which resulted in calculated maternal milk:plasma ratios of 0.7% to 10.0% of the maternal weight-adjusted dosage and a milk:plasma ratio between 1.1 and 2.7. There are no reports of adverse effects on the breastfed infant and no effects on milk production. However, long-term effects on infants from CNS stimulant exposure are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for JORNAY PM and any potential adverse effects on the breastfed infant from JORNAY PM or from the underlying maternal condition. Clinical Considerations Monitor breastfeeding infants for adverse reactions, such as agitation, insomnia, anorexia, and reduced weight gain.

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

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

DRUG ABUSE AND DEPENDENCE

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

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

Dependence  Tolerance Tolerance (a state of adaptation in which exposure to a drug results in a reduction of the drug's desired and/or undesired effects over time) can occur during chronic therapy with CNS stimulants including JORNAY PM.

Dependence Physical dependence (a state of adaptation manifested by a withdrawal syndrome produced by abrupt cessation, rapid dose reduction, or administration of an antagonist) can occur in patients treated with CNS stimulants, including JORNAY PM. Withdrawal symptoms after abrupt cessation following prolonged high-dose administration of CNS stimulants include: dysphoric mood; depression; fatigue; vivid, unpleasant dreams; insomnia or hypersonia; increased appetite; and psychomotor retardation or agitation.

OVERDOSE

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

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

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