To PAC or Not to PAC? That is the Question

Christopher Varley, M.D. Opinions Section Editor

In this issue of AACAP News, we learn more regarding the AACAP’s consideration of establishing a Political Action Committee (PAC). Formation of a PAC would result in the capacity to raise money to make political contributions to candidates for public office that support its issues. An article in the January/February 2011 issue of AACAP News by Warren Ng, M.D., and Kristin Kroeger Ptakowski laid out some of the opportunities and challenges with regard to the formation of a PAC. In this issue, opposing views are presented by Louis Kraus, M.D., and Fred Seligman, M.D. They identify important pros and cons regarding this complex issue.

Members are encouraged to express their opinions through Letters to the Editor of AACAP News or to Kristin Kroeger Ptakowski, who is actively involved in this issue as AACAP’s senior deputy executive director and director of Government Affairs and Clinical Practice, at kkroeger@aacap.org.

The Next Level of Advocacy: Establishing an AACAP Political Action Committee

Louis Kraus, M.D.

I have been involved in AACAP for 18 years and been an advocate for child and adolescent psychiatry and children with mental illness, starting with my work with the American Medical Association, for the past 16 years. For the past 20 years, since working as a psychiatrist at the maximum security youth center in Joliet, Illinois, I have had a significant interest in working with children and adolescents involved in the juvenile justice system. The relative lack of services available to these kids was a significant concern to me. This is one of the early reasons that I became involved with the AACAP advocacy programs and began going to Capitol Hill with AACAP.

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AACAP Should Not Compromise Its Integrity

Fred Seligman, M.D., C.M., M.P.H.

Should AACAP decide to have a Political Action Committee (PAC), our unique leadership as an unbiased voice for the mental health of children and for the highest standards of pediatric psychiatric care will be severely compromised. Should we, as AACAP members, go that route we will head down the path of the deterioration in moral and ethical perspective that the lay public and elected representatives have regarding many segments of the medical community. The closest example to us is the “educational consultation” payments made by pharmas to the psychiatric community. The ethical deterioration in our field is becoming so pervasive that even academic departments of psychiatry have been recently tarnished at the finest institutions such as Harvard, Stanford, and the University of Minnesota.

continued on page 91
Assessing Youth Anger Inside and Out.

The Anger Regulation and Expression Scale (ARES) is a comprehensive, self-report measure of angry thoughts, emotions, and behaviors in youth aged 10 to 17 years. Derived from the Anger Disorder Scale (ADS™), the ARES assesses tendencies towards inward and outward expressions of anger, along with the range and duration of anger experiences.

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Authored by Dr. Raymond DiGiuseppe & Dr. Raymond Chip Tafrate
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MISSION STATEMENT
Mission of the AACAP: Promote the healthy development of children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

Amended and Approved by Council, June 27, 2010

FUNCTION AND ROLES OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy
■ Establishes and supports the highest ethical and professional standards of clinical practice.
■ Advocates for the mental health and public health needs of children, adolescents, and families.
■ Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.
■ Liaisons with other physicians and health care providers and collaborates with others who share common goals.
RESIDENT MEMBER TO COUNCIL

When Hospitals Close: The Saint Vincent’s Child Psychiatry Training Program Experience

“Maintaining open communication with the residents was what mattered most and being allowed to stay open for a full academic year also made a significant difference. I’m glad we were able to place all first year fellows and incoming trainees in other programs. It helped to have great fellows, who despite the tremendous stress placed upon them, were collaborators, who kept their cool and supported each other, while also fulfilling their clinical roles.”

Karim Mailutha, M.D., M.P.H.
Jerry M. Wiener Resident Member

When a hospital closes down, ripple effects are felt throughout the surrounding community and by the hospital staff. It causes a lasting impact upon the neighborhood residents who have historically looked to their local medical institution for treatment. Not just a tragedy for the local residents, the loss is also experienced by employees who built careers and friendships over several years of working in a hospital system. Residency training programs and departments are disassembled, leaving faculty, staff, and trainees with the task of identifying a new institution for clinical practice and learning. The following captures the experiences of a child psychiatry training program in the New York City area who, during the spring of 2010, weathered the closure of Saint Vincent’s Hospital, located in the Greenwich Village section of Manhattan.

Beginning in the winter of 2009–10, every newspaper in the New York City area began publishing articles about the financial problems and possible closure of Saint Vincent’s Hospital. As the city’s last Catholic general hospital, Saint Vincent’s was founded in 1849 by the Sisters of Charity to serve the residents of the Westside neighborhood of Manhattan. The hospital carried an impressive reputation and a 160-year tradition of caring for indigent and homeless populations through several community-based programs. To most outside observers, the hospital’s closure happened unexpectedly and rapidly over a six-month period. St. Vincent’s weathered a bankruptcy in 2007 and was reportedly doing well. However, according to New York state statistics they were accruing monthly losses of $5 to $10 million dollars during 2009 and 2010.

The Department of Psychiatry and Behavioral Health was one of the few clinical services with financial viability in the hospital network. A. Reese Abright, M.D., was the chief of Child Psychiatry and the child and adolescent psychiatry (CAP) training director. In reflecting upon the closure, he states: “Maintaining open communication with the residents throughout this process was crucial. The hospital’s decision to stay open to allow psychiatry residents to complete the academic year made a significant difference. We were fortunate to place all first year fellows and incoming trainees in other programs. It helped to have great trainees who, despite the tremendous stress placed upon them, were collaborators, who kept their cool and supported each other, while also fulfilling their clinical roles.”

Scott Palyo, M.D., graduated from the St. Vincent’s child and adolescent psychiatry training program in June 2010 and is currently the AACAP Congressional Fellow in Washington, D.C., with Senator Debbie Stabenow of Michigan. He entered his first year of general adult psychiatry training at St. Vincent’s when the hospital was declaring bankruptcy in 2007; a year when...
“there was a hopeful atmosphere...The problems had been worked through and positive changes were occurring.” He recalls the initial talk of closure in January 2010 came as a shock to him and several of his co-fellows because they were unaware of the severity of the financial problems facing the hospital. By February 2010, Dr. Palyo recalls finding out that the Neurology, Medicine, and Surgery residencies had been instructed to close their training programs. He felt that child and adolescent psychiatry trainees were kept well informed by Dr. Abright and he appreciated that he was able to complete his second year CAP training.

Anthony Conciatori, D.O., is now a first year CAP resident at Long Island Jewish Hospital. He completed three years of adult psychiatry at St. Vincent’s and recalls his excitement after receiving the match results of his acceptance to continue his training as a CAP resident. He was happy that two of his co-residents from the St. Vincent’s adult psychiatry program had also matched for child training at St. Vincent’s. He describes the closing as “shocking and quick, unfolding over a three-month period.”

Dr. Conciatori and his two co-residents began calling other CAP programs in the New York City area to inquire about open positions and interviews. He uniformly found training directors at other institutions welcoming. They responded to his calls and e-mails immediately. However the interview process was inevitably awkward. He states: “The three of us were friends. We often went for interviews on the same day; each of us knowing that only one spot was available and just one of us would get it.”

Dr. Conciatori has been very happy at his current training location, his preferred choice, which is close to his family home and the hospital where he completed his core rotations as a medical student. When asked to reflect upon the experience, he states: “It was hard, it was strenuous, especially for a resident just entering training. Watching the hospital fall apart so rapidly was surreal. Then being faced with competing for just a handful of remaining training spots. But if I had to do adult residency again, knowing the hospital was going to close, I would still have chosen St. Vincent’s. It was a special place, with a family feel and great clinicians who cared about patients and about psychiatry.”

When asked what made the experience manageable, Dr. Palyo highlighted the critical role played by his training director, Dr. Abright, whom Dr. Palyo states was supportive, “He kept everyone informed, and had a lot of one-to-one conversations with each trainee to discuss their options and how to help them stay in the New York City area if that was the preference, or to move to a more distant program for those who wanted to go out of town.” In describing the atmosphere in the department at the time, Dr. Palyo states: “There was a general feeling of anxiety, of wondering where everyone, both patients and colleagues, were going next. There were no major disasters for most trainees I know. But it seemed much harder for attending psychiatrists who trained, taught, and worked at St. Vincent’s since the 1980s. They put a lot of time, energy, and emotion into the hospital’s mission. Many got excellent jobs afterwards. I think on some level, trainees are prepared for transitions. There is a determined date, on which your training will end and you have to be prepared to move on.” He notes that since the closure, he has missed having his home-base, the institution where he trained. Residents, faculty and support staff stayed in touch through social networking sites and have gathered together for seasonal activities during the summer, fall, and at major holidays since the closure.

Regarding lessons learned from the experience, Dr. Conciatori focused on the importance of better protection for trainees entering the residency match who end up ranking a hospital that unbeknownst to them is experiencing severe financial difficulties. Dr. Palyo highlighted the need for more advocacy efforts and a policy statement not just within AACAP, but also within ACGME addressing financial implications for residents who fall into “orphan status,” meaning their training program has closed and they need to obtain a new CAP training position to complete their training. In today’s economic and political climate, increasing funding for medical training is a challenge. Direct and indirect GME funding for residency training positions comes from Medicare dollars, and vary based upon the trainee’s post-graduate year. This is a very relevant issue for PGY4 to PGY6 year residents with orphan status who are in search of a training program placement. Their non-primary status and upper level post-graduate training level means they receive less financial government subsidy, and they require greater institutional support from the new training program absorbing them after dissolution of their original training program. It is important to continue advocacy by the AACAP and other professional organizations on behalf of residents who experience unexpected and anxiety-provoking disruptions in their training due to hospital closures and it is important to develop a structured protocol on how to guide residents through this experience.

Dr. Mailutha is a 2nd year child and adolescent psychiatry resident at New York Presbyterian Hospital at Cornell and Columbia Universities. She completed medical school at Harvard University, her Masters in Public Health at Johns Hopkins University, and her adult psychiatry training at Columbia University. Dr. Mailutha may be reached at kam9064@nyp.org. She gives her thanks to Drs. Abright, Palyo, and Conciatori for being available for interviews and contributing to this article.
Martin J. Drell, M.D.

Session #1 with Molly: My Sister Is Way, Way More Upset Than I Am

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ick and Jenny asked to meet with me to see if their 7-year-old daughter, Molly, was dealing well with their divorce. They noted in our initial session with them that Molly had become more perfectionistic, bossier, and picked on her younger sister. They were especially upset that she had begun to tell them that she hated them and that they did not love her. Other history showed that whatever was going on had not affected her school work. “Her teachers love her!” said the mom. “It is, however, harder to get her to do her homework.” After obtaining more history, I had an extended psychoeducational discussion with the parents on the impact of divorce on children. This included a brief reassurance that I had heard little that led me to believe there were massive problems and general suggestions on how they might deal with Molly. I told them to see how things went and that I would be happy to see Molly should their concerns continue. They called several weeks later to say that things were a little better, but that they did not love her. Other history showed that Molly was uncomfortable talking about her angry feelings and that she was acting out through her behaviors.

Molly was hesitant to separate from her mother in the waiting room until I made a face at her. She responded in kind and proceeded to my office and commenced immediately to talk. “I’m very frustrated. I get mad a lot, but I don’t know why. My baby sister (n.b. age 3 years) annoys me. I never have fun. Mom’s always on the phone or working or cleaning the house. That’s when I get annoyed. My sister annoys me. My dog scratches me. And I have to play with the hamster!”

“You have to?” I responded with drama equal to hers.

“If I don’t, the hamster will grow up to be mean and crabby… I don’t get to play outside that much… and I have to do things.”

“I note that you have Velcro shoes on today. Doesn’t that solve the problem?”

“So everyone is frustrated and annoyed,” I summarized.

“When is that?”

“When I have parties. And they won’t buy me toys, and if they do and I don’t play with them they give them away to my sister or charity.”

“If you don’t play with the toys, then what’s the difference?” I asked.

“I would play with them if I didn’t have so much to do, like long, long, long, long, long, long, long, long baths.”

“So you want to play, but there’s never enough time.” I echoed.

“That’s positively, absolutely correct! I have to be on time for school. I have to be on time or I get scolded. I usually have troubles getting dressed in the morning. There’re so many choices, and I can’t tie my shoes yet. I’m supposed to triple knot them.”

“I hate making my bed, but I do it or I’ll be late. I have to wear more clothes. That makes me late. I want to do girly stuff, but mom says no.”

“What’s girly stuff?”

“Like making my bed or doing homework. Each and every time! And I have to brush my teeth five times!”

“No,” she said in exasperation. “I only have 2 pairs of shoes at Dad’s that fit. I get very frustrated on the holidays. It’s very hard dyeing Easter eggs the way I want them. Drawing on the eggs with crayons is hard. It is frustrating. My sister got so frustrated that she broke the crayons. She was annoyed.”

“Like what?” I asked.

“Like what?”

“Like making my bed or doing homework. Each and every time! And I have to brush my teeth five times!”

“Five times!” I wondered aloud. “That’s once after breakfast, once after lunch, once after dinner, and before bedtime!”

“What’s the fifth time?” I asked.

After a pause, she responded “It seems like five. And I sometimes get upset when I have to take a bath. Dad makes me take baths twice a day when it’s a sweaty day. And mom makes me take long, long, long, long, long, long, long, long baths.”

MARCH/APRIL 2011
"Painting my nails, dressing up, having parties, make-up, wearing high heels, making beautiful pictures. All I get to do is paint my nails."

"So you want to do more and you aren't allowed to?"

"Yah!"

"Have you always been frustrated?"

"No!"

"When did it start?"

"Two to three weeks after the divorce. Mom says it's because I have lots on my mind. Dad says that I'm frustrated because of the divorce."

"Those two could fit together," I suggested.

"I don't know how?" she answered.

"How would that go together?"

"Well, maybe there are other theories," I offered.

"Like what?"

"Like things have changed because you now live in two houses, and you have separate clothes in each house, and maybe your Mom and Dad aren't the same. Maybe they're more emotional and have lots on their minds."

"No, it doesn't seem like that's it," she said with equal emphasis. "My mom is working 3 jobs.

At this point, I was puzzled as to her insistence that she was not upset or changed by the divorce. What was this about? I determined to gently continue looking for differences that I knew were there. In keeping with this strategy, I asked her if her mother had always worked.

"My mom has trouble saying no."

"Has mom changed since the divorce?" I asked more specifically.

"Sort of."

"How."

"I don't know."

"And has Dad changed?"

"No."

"So he's the same guy?"

"No, he's taller."

"So the divorce has made him taller?"

"No, but he's grown taller over the last 2 years. He used to be very short. And my sister's going through a phase. She's tired and whiny and wants to do everything herself and gets upset if she doesn't get her way."

And you don't think this might have something to do with the divorce?"

"Yes, she's way, way, way, way, way, way, way, way changed since the divorce."

"It sounds like she needs to be weighed," I joked.

When she didn't respond, I asked if she got the joke.

"Yah, I did, but I never laugh at any jokes. I fake laugh or don't laugh at all."

"How do you decide which of the two to do?"

"I fake laugh for special people because I don't want to hurt their feelings."

My instantaneous thought at hearing this was to be upset at not being "special." I wanted to say: "So, I'm not special?" I noted my response and did not act on it. Rather, I suspected that we were dealing with a little girl who was not feeling very special. After a brief pause, I returned to talking about the sister and her "way, way, way problems. "So she's changed and you haven't?"

"No. Well sorta, I changed after 2-3 weeks. It's terrifying!"

"What's terrifying?"

"That I've changed. Now I'm bad!"

"That must not feel good."

"No."

"So you're very sensitive?"

"Yes, especially to my mom. I don't want to hurt her."

"Like you with your fake laugh?"

"Yes."

"So you're upset about being upset and upset that you're hurting others' feelings."

As she nodded, she drew her legs towards her head so that she looked like a pretzel and made hyperventilating noises.

"The feelings make you feel tied up like a pretzel?" I asked.

"I really like jokes. I love them, but some I don't understand."

"I know. Do you know that lots of kids don't understand their feelings either sometimes?"

"I try to be good," she answered.

"I know. You have feelings and feelings about your feelings and sometimes you don't understand them. You think we should work on trying to understand them?"

She mouthed saying the word "yes." I immediately picked up on her pantomime and responded to her without talking. We had a "fake" conversation for a while. As the time was about to end, I repeated, in spoken words, my offer to help her understand about her feelings.

"Do you have any questions?" I asked.

"Yes. Who made God? When did God get made?"

I smiled and said that was a difficult question, more difficult than helping her with her feelings.

"By the way," I interjected. "Do you ever talk to your parents about your feelings since the divorce?"

"I did. I talked to my mom and she said I should talk to the feelings doctor about it."

"That's great, but I'd like you to know that part of my job will also be to help your parents be able to talk to you about your feelings. Would that be good?"

She answered by nodding yes and making faces at me.

"I think that we should see each other again. Is that ok?"

"Yes."

We made faces and had a pantomime conversation as we walked back to the waiting room. ■

Dr. Drell is president-elect of the AACAP and head of the Division of Infant, Child, and Adolescent Psychiatry at the Louisiana State University Medical School in New Orleans, Louisiana. Dr. Drell may be reached at MDrell@lsuhsc.edu.
The establishment of a therapeutic alliance with an adolescent and their parents or guardian helps both to be as forthcoming as possible in telling the history and voicing concerns. This holds true for any new evaluation or ongoing treatment relationship. Outside of circumstances pertaining to safety, the child and adolescent psychiatrist is often challenged to balance the adolescent’s need for privacy and the parents’ wish to know. While this tension exists in any treatment relationship, it is especially alive when the adolescent is engaged in an ongoing psychotherapy process.

A recommendation for individual psychotherapy usually reflects an appreciation that disturbance in the child’s internal world (whether conceptualized as thoughts, feelings, or both) carries its own momentum despite biologic and environmental interventions, and that these disturbances threaten to distort the trajectory of further development. Protecting the adolescent’s confidence in their privacy is essential when the child and adolescent psychiatrist is conducting psychotherapy. The ethical obligation is to respect and maintain the integrity of the therapeutic frame, including the protection of the adolescent’s privacy. However, given that a respectful relationship with parents or guardians is essential and interface with them is likely and often necessary to maintain the therapeutic process, an understandable tension regarding the protection of the adolescent’s privacy is inevitable.

The adolescent who perceives their therapist as too open a conduit of information to their parents is likely to withhold essential information from the process, rendering it compromised, if effective at all. Given this reality, it is important to be clear about the frame for the psychotherapy process and the child’s privacy, and the rationale for this frame, at the beginning of the treatment relationship. There are reasonable ways to do this. The challenges faced in balancing the child’s need for reasonable privacy against the parents’ need for reasonable information can be shared candidly with parents or guardians. The clinician can explain to parents that their child’s confidence in the relative privacy of the process can be critical to its success, but that their need for information is respected. They can also be reassured that information suggesting imminent danger would not be withheld from them. The parents’ comfort with their child’s privacy can be enhanced by emphasizing that improvement in their child’s relationship with them can be a consequence of the psychotherapy.

The structure of the psychotherapeutic frame should also be reviewed with the adolescent. The rationale for periodic contact with parents or guardians can be discussed, highlighting that these contacts in no way release the child and adolescent psychiatrist’s responsibility to protect their privacy. The adolescent should be informed in advance of the frequency of sessions with parents or guardians, and should be invited to discuss what he or she would like communicated before such sessions. Together, the child and adolescent psychiatrist can anticipate what may arise in discussions with the parents. The clinician also can provide the adolescent with an example of how one might frame an issue for the parents, inviting feedback as to whether this example is respectful of their privacy. Communication of broader themes that avoid details that the adolescent would deem too personal is advised, e.g., “Johnny is working at how he can gain independence while still maintaining important ties to you as his parents.”

One common challenge to any adolescent’s confidence in their privacy is with a parent’s appeal to have time with the child and adolescent psychiatrist at the beginning or end of their child’s scheduled time. It is not unusual for a parent to want to report on what a child has done, with the implicit or explicit message that the child and adolescent psychiatrist address the issue in the upcoming session. Sometimes a parent will attempt to have this discussion in the waiting room. These types of communication challenge the confidence that an adolescent has in the autonomy of his or her process or privacy. It also disrespects the boundary of the adolescent’s time.
and therapeutic space. Fulfilling the parent’s appeal for time at the beginning or end of the adolescent’s session, whether the child remains in the room or not, inevitably distorts the adolescent’s freedom to begin the session with his or her agenda, confusing for the adolescent whether the psychiatrist is the guardian of the therapeutic space or just an extension of the parent. Meeting with a parent during the latter part of the adolescent’s scheduled time or immediately after, may collude with the adolescent’s fantasy that the psychiatrist is reporting to their parent, constricting their confidence that they really have privacy in sessions. Discussing issues with a parent in a waiting area is an obvious violation of the adolescent’s privacy. The solution to the challenge of providing sufficient time for the parent or guardian without violating the adolescent’s therapeutic space is to structure a parent session separate from the adolescent’s time, as regularly as is indicated.

References


Dr. Ascherman is the child and adolescent psychiatry division chief and residency director at the University of Alabama at Birmingham.

Dr. Rubin is an associate professor on the child and adolescent psychiatry faculty at the University of Alabama at Birmingham.
Three years earlier, on a Friday morning in January, Odgren had stabbed to death 15-year-old James F. Alenson in the bathroom at Lincoln-Sudbury Regional High School in Massachusetts. The two boys did not know each other but Odgren had reportedly become obsessed with the number 19. The number is prominently featured in Stephen King's, The Dark Tower, a series of books in which a protagonist violently battles enemies. Three expert witnesses for the defense made the case that his obsession with The Dark Tower and the number 19 had inspired paranoia in Mr. Odgren and, as a result, he had gone to school with a knife on that day, January 19th, to defend himself. Odgren, who was born on 9/1/90, was reportedly obsessed with the number in his own daily life. All three witnesses testified that the number made him fear something was going to happen.

Soon after Alenson was stabbed, Odgren was seen holding himself against a wall, crying out, “Oh God, what have I done?” and asking for another classmate to get help.

During the course of the trial it emerged that Odgren, who had been the target of bullying, had carried diagnoses of Bipolar Disorder and ADHD in the past, and also had been assessed as suicidal at times going back to the age of nine. The case was made by the defense that Mr. Odgren had significant social and emotional difficulties. Up for debate was whether psychiatric factors significantly contributed to his crime. Regardless of the verdict on the latter point, what was ultimately decided was that Mr. Odgren was not amenable to rehabilitative efforts. Therefore, punitive measures were applied.

The juvenile justice system in the United States has seen several recent changes. In the mid-1990s, the political “bumper sticker” read, “Adult time for adult crime,” as Grisso (2007) describes. This followed a more than doubling in homicides and aggravated assaults committed by adolescents since the late 1980s. The longstanding convention of approaching juvenile justice with a rehabilitative intent had shifted. However, several years later (2000), the U.S. Surgeon General declared a “mental health crisis” among youths entering the juvenile justice system, and the pendulum began to swing back. Despite increasing juvenile offenses at the time, and the resulting political movement towards punishment and away from rehabilitation, there was a concurrent effort to conceptualize and measure mental disorders within the context of adolescence as a developmental period. Regarding youth aggressive behavior, Grisso (2007) states, “The image of the delinquent as super-predator has been replaced by the troubled delinquent—a youth who meets criteria for one or more mental disorders and who is in need of treatment.” These competing images clearly played a role during those 12 hours of deliberation on April 29, 2010, and will remain central to the debate on how we approach juvenile justice going forward.

During my tenure as a trainee in child and adolescent psychiatry, I have been consistently drawn to the interplay between medicine and law, and between science and ethics. As the technological complexity of our society continues to increase, there will be a growing demand for child and adolescent psychiatrists trained in forensic psychiatry. A recent spate of cases involving adverse events related to “cyberbullying” provides an example of how the expanding “virtual world” is likely to provide increasing need for the child and adolescent forensic psychiatrist. In addition, as we continue to better understand the biological bases of decision making, impulse inhibition, and perhaps even morality, the role of the child and adolescent forensic psychiatrist will likely be further expanded. Forensically trained child and adolescent psychiatrists will be in a unique position to bridge the gap between medicine and law, particularly as it applies to the child and adolescent psychiatric population.

Although the utility of a debate on free will versus biological or perhaps biopsychosocial determinism is likely to be minimal in the courtroom setting, it is a debate which is intrinsic to the interface between psychiatry and criminal law, and one that must have featured prominently as Mr. Odgren’s fate was deliberated. However laden with complexity this debate may be in adult forensic psychiatry, it is that much more complicated in child and adolescent forensic psychiatry where one must carefully weigh the impact of cognitive and emotional faculties that are still developing. It is the intrigue and importance of this challenge that propels the next generation of child and adolescent forensic psychiatrists and inspires this author to enter this still emerging field.

Reference


Dr. Raub completed a general psychiatry residency at the New York-Presbyterian Hospital/Weill Cornell Medical Center and is now a second year fellow in child and adolescent psychiatry at the Cambridge Health Alliance. He will be starting a fellowship in Forensic Psychiatry at the University of Rochester this summer, training in the Child and Adolescent Forensic Psychiatry Track. He may be reached at jraub@challiance.org.
Avoiding Mal-Release

Lee H. Haller, M.D.

As a practitioner, you may be called upon to release information about minor patients you are currently treating or have treated previously. Several factors are involved in determining how to do so properly. To do otherwise is to commit what I have termed “mal-release.” This term encompasses both releasing information improperly, as well as failing to release mandated information. Either of these can be grounds for a malpractice action against you, the provider. Alternatively, the child’s parent or legal guardian could file a complaint against you with the state medical board. This column and subsequent columns are designed to refresh your knowledge regarding how to respond to requests for the release of medical records. However, please remember that this information is general in nature and should not be construed as legal advice.

As a guiding principle, when releasing information to third parties, keep in mind that “one size does not fit all.” In other words, there are a variety of situations where release of your medical records may be warranted. They should not all be handled the same way. Additionally, the laws and regulations related to individual states and situations are diverse. For example, you may receive a request for your records from: 1) another health care provider; 2) the child’s school; 3) a life insurance company; 4) one or both parents; 5) the police; or 6) an attorney. Another request for releasing records could be in response to a subpoena.

Finally, you may find yourself in the position where you need to initiate the release of treatment information due to an abuse/neglect situation or a Tarasoff-type predicament. The request for information in each of these situations can be and must be dealt with differently. What information you are required to divulge will be governed by one or more of the following: privilege, confidentiality, federal law (such as HIPAA or HITECH), state law, medical ethics, and whether a medical emergency exists.

Let me address the last of these first. In a true medical emergency, you should release information which might be necessary to save the life of the child. For example, if an EMT or hospital emergency room physician contacts you to say that your patient is comatose and the person needs to know what medications you have prescribed, or what illegal drugs you know the child takes, give the person that information, even in the absence of authorization to do so from the legal guardian. Providing this information may be life saving, whereas to delay doing so until an authorization is obtained could be life threatening. However, the information given must be limited to that which may be needed to save the child’s life. Do not provide information about the patient’s psychodynamics, family issues, or other non-emergent data. To do so would constitute an unnecessary breach of the patient’s privileged information.

In subsequent columns, I will discuss how one should respond to each of the other requests for information, what information must be given to you in order to have a valid authorization, and how you determine what information, if any, should be released. In the meantime, and as a general rule, remember you can always contact an attorney through your malpractice carrier who will help you decide how to respond to the request to release information.

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Risk Management by Lee Haller, M.D. is supported by Allied World National Assurance Company, the professional liability carrier endorsed by AACAP. The company compensates Dr. Haller for writing the Risk Management column.
Making a Career in Psychotherapy Research: An Interview with Judith Cohen, M.D.

“I walked on the unit pregnant, maybe three or four months pregnant, with my first child. Before I even got to the nurses’ station a ten-year-old kid ran up to me, punches me in my abdomen and ran off.”

Judith Cohen, M.D.

How does a child and adolescent psychiatrist become a psychotherapy researcher? I asked Judith Cohen, M.D., whose treatment for traumatized and abused children, Trauma Focused-CBT (TF-CBT), has been taught to more than 70,000 people in 60 countries as far flung as Sri Lanka, Pakistan, and Uganda. Her answer: encouragement from residency directors and mentors, a residency program that supports research, motivating personal experiences, and collaborators from allied disciplines. One more essential to developing an effective psychotherapy: treating a couple thousand patients while observing carefully “what works best and what doesn’t work so well.”

Innovation is stimulated by unmet needs at a particular moment in history. When Dr. Cohen trained as a pediatric intern in 1978, her residency director, Dr. Chabon, was an M.D. and J.D., who was very alert to the hidden epidemic of child maltreatment. He trained her to look for child abuse. During her first year of a combined adult residency/child fellowship in psychiatry at Western Psychiatric Institute in Pittsburgh, Dr. Cohen discovered she was expected to present grand rounds on “something I was interested in.” Looking to see who was on the faculty and what they were doing, she discovered Ellen Frank was researching the treatment of rape victims. Dr. Cohen knocked on Dr. Frank’s door where she received a warm welcome. Dr. Frank needed a child and adolescent psychiatrist for the teenage subjects in her study. Many of these teens were victims of sexual abuse by fathers or family members. Dr. Frank invited Judith to join her research team. Around this same time she met Anthony Mannarino, Ph.D., who was then the associate director of the Pittsburgh Child Guidance Center and with whom she has worked collaboratively to this day. Tony had collected data on hundreds of traumatized kids trying to figure out “what they looked like and what would work for them.” In the early 1980s, this was pioneering work.

Another formative experience occurred as Dr. Cohen began her first rotation on the child inpatient unit. “I walked on the unit pregnant, maybe three or four months pregnant, with my first child. Before I even got to the nurses’ station a ten-year-old kid ran up to me, punches me in my abdomen and ran off. ‘I am not in pediatrics anymore!’ was my first thought. ‘What was that?’ I asked. The nurse said, ‘That’s your new patient. Read the chart.’” It was a horrific story. This boy had been severely injured by his mother during her attempt to kill her child and herself. When the nurses learned that Dr. Cohen intended to talk to this patient about what had happened they tried to dissuade her, arguing that “he was not ready.” She said, “No, we are not doing this. We are not making this unspeakable.” She was not deterred and found that the boy was very ready to talk about his experience.

Dr. Cohen’s determination to find psychologically sound ways to make unspeakable childhood traumas “speakable” has its roots in her own experience. When she was in first grade her baby sister became ill and died suddenly. Even into her adulthood, her family found it impossible to speak about this terrible loss. When she entered the child unit as a resident, she already knew firsthand the struggle of a child trying to comprehend a tragedy that adults are afraid to discuss. “I was twenty before I really talked to someone about it. When I started repeating my beliefs about my sister’s death I understood that ‘wait a minute, that doesn’t really make sense.’ I have seen that with so many kids that I have treated in therapy. Their beliefs are stuck back when the experience happened and they have gone on in their trajectory of life. I believed I should have been able to save my sister. That is an omnipotent six-year-old kind of belief. No one had ever said, ‘Do you know what a six-year-old is like?’ Six-year-olds can barely tie their shoes. They cannot cross the street alone. They did not even have CPR back then. What were you supposed to do?”

TF-CBT is a therapy that, through its carefully sequenced component parts, prepares a child or adolescent and their...
caregiver to develop a trauma narrative. Through this process of narrative development the reappraisal of the trauma occurs. This involves metacognition, the ability to think about and evaluate one’s own thoughts and experiences. Dr. Cohen says from her own experience, “Metacognition is tough. It is hard to be objective about your own thoughts. When you have held them most of your life, they just seem natural and normal and that is the only way to think.” Through therapy a person finds new ways to think.

Reflecting on the ten-year-old boy on the inpatient unit, Judith Cohen says, “My thought was, this kid must be pretty angry at his mother, but all he ever said the whole time on the unit was, ‘When can I see my mother?’ This taught me a very important lesson in child psychiatry, the power of attachment. That is why in TF-CBT we include the parents. It is all about attunement and helping parents understand their children, improving parental support, and resolving parental distress so they can be there for the child.” Dealing with parental distress requires therapists to have broad psychotherapeutic skills and creativity. In her book, Treating Trauma and Traumatic Grief in Children and Adolescents, she describes a therapist faced with a mother who struggled to implement the therapist’s suggestions at every step of the child’s treatment after a traffic accident. “My thought was, this kid must be pretty angry at his mother, but all he ever said the whole time on the unit was, ‘When can I see my mother?’ This taught me a very important lesson in child psychiatry, the power of attachment. That is why in TF-CBT we include the parents. It is all about attunement and helping parents understand their children, improving parental support, and resolving parental distress so they can be there for the child.” Dealing with parental distress requires therapists to have broad psychotherapeutic skills and creativity. 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In her book, Treating Trauma and Traumatic Grief in Children and Adolescents, she describes a therapist faced with a mother who struggled to implement the therapist’s suggestions at every step of the child’s treatment after a traffic accident. “When can I see my mother?” This learned that children had placed on the traumatic experience. “We were absolutely addressing meaning. We developed a game for this, the Who Made It Happen Game, to help very young children understand causation. With a three-year-old if it is not fun you are not going to be doing it.” Applying to do research on preschoolers was not just the happenstance of working in a clinic for young children. “It was also pragmatic. I thought we had a better chance of getting funding,” says Dr. Cohen. Fast forward past the careful development of the TF-CBT components and the equally careful manualization, the many late nights (after putting her three children to bed) that Dr. Cohen was up writing grant applications, past the eight different randomized control trials, to the challenge of disseminating an evidence-based psychotherapy. Once again Dr. Cohen pioneers. Though the SAMHSA funded National Child Traumatic Stress Network (NCTSN), a collection of trauma treatment programs across the United States, she connected with colleagues from the Medical University of South Carolina who were developing Web based training programs. TF-CBT [www.musc.edu/tfcbt] has reached more people than any other single product developed for the Web training site.

Judith Cohen concluded our interview with a heartfelt offer to readers who wish to contact her for research mentoring. “I answer every e-mail I get. I would love to hear from residents interested in research. I mentor about twelve people at a distance. I am happy to talk to anyone about their ideas, their research, whatever!”

Dr. Cohen is professor of psychiatry at MCP-Hahnemann University School of Medicine, Drexel University College of Medicine; adjunct consulting assistant professor of pediatrics at Children’s Hospital of Pittsburgh; and adjunct assistant professor of psychiatry at the University of Pittsburgh School of Medicine. ■

Reference

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Tantrums and Language Delays: Understanding the Connection and Exploring Treatment Options

Research findings have documented the co-morbidity of speech delays and behavior problems. Cantwell, Baker, and Mattison (1981) studied 200 children with communication disorders. They found that 50 percent of them had psychiatric disorders, the most common were behavioral disorders (N=51). Gillberg (2010) noted that children coming to the attention of health care providers for general development required assessments in multiple domains including communication and language problems. The results revealed a receptive language delay of one and a half years, predictable end without abandonment. As a result of this experience, I began using this receptive language screen on children up to age seven who were referred to me for behavior disorders, particularly tantrums leading to physical restraints. I found in most of these assessments receptive language delays of two years or more. After reviewing the AACAP News discussion of the pros and cons of using restraints to set limits with children, I wondered if the children who provoked these restraints could also have language delays.

Language Delays and Anger

Thirty years ago, I was asked to consult about an aggressive 3½ year-old boy staying at the Hillcrest Receiving Home, a social services crisis facility in San Diego, California. I was unable to get his attention and ended up following him around the room fruitlessly asking unanswered questions. The next day, I returned with a copy of the Peabody Picture Vocabulary Test Receptive Language Screen. It is a series of plates, each with four pictures showing an activity. The child is asked to select one in response to a descriptive word, for example, ‘towing’ or ‘carpenter.’ To my surprise, the boy was eager to participate. The results revealed a receptive language delay of one and a half years, meaning that he understood speech in a fashion similar to a two-year-old. I thought, no wonder he ran away when I asked him questions, he could not understand them!

As a result of this experience, I began using this receptive language screen on children up to age seven who were referred to me for behavior disorders, particularly tantrums leading to physical restraints. I found in most of these assessments receptive language delays of two years or more. After reviewing the AACAP News discussion of the pros and cons of using restraints to set limits with children, I wondered if the children who provoked these restraints could also have language delays.

Some Speculation

It may be that both impulsivity and hyperactivity decrease a child’s ability to process verbal communication at odds with his or her current behavior. For example, consider a five-year-old child with a two-year receptive language delay who, while playing with a toy, is told to go bed. This child understands bedtime as a 3-year-old, imagining night as prolonged time without a parent. He would have difficulty expressing these thoughts or understanding verbal comforting encouragement. Parents also would have difficulty addressing these concerns because of having expectations that the child would respond to them as a 5-year-old, including night times that predictably end without abandonment. Lenore Terr, M.D., (1988) has demonstrated that early memories in children four-years-old and younger are stored and retrieved as pictures. When these pictorial remembrances are traumatic and combined with language delays, there may be a lack of collaborative verbal interchange during memory triggered aggressive outbursts. For example, a 9-year-old child with a marked receptive language delay was sent to our residential treatment facility to treat rage episodes. During rages he would act like a ninja warrior kicking and jabbing at staff as if fighting off deadly enemies, all the while refusing to talk. These episodes lasted 20 to 30 minutes during which he would use only ninja expressions and not listen to anyone. Between the ages of three and five, after episodes of being abused with a belt, he developed a schema of an avenging ninja attacking everyone, both peers and adults, ‘to protect’ himself from imagined abuse. Minimal stressors such as being told to clean up his room, share a toy, get dressed, or move away from another patient activated this non-verbal persona.

Treatment approaches with language delays

Once specific language impairment is suspected, it should be evaluated by a speech pathologist for confirmation and to plan for remediation. Currently, there are two general explanations for this condition: delayed ‘neuro processing,’ (Poldrack et al. 2001); and “poor speech perception creating underspecified lexical and phonological representations with poor verbal short term memory,” described by Studdert-Kennedy (Turner and Pearson. 1999). Tallal’s Fast ForWord Program claims some success with remediating these delays by enhancing auditory processing skills using computer based feedback programs (Fast ForWord Web site). I have seen the program in action. Used at age five, with one of my children who had severe receptive language delay, it enabled him to begin to read. Now, 12 years later, history is his best subject. Other approaches emphasizing inference training and mental imagery are described in a recent review (Duff and Clark 2011).
Supplementary Treatment Options

In tandem with these assessments, using sensorimotor and verbal assists with these children may also be helpful. For example, in the case cited above, we replaced our patient’s ninja clothing with age appropriate dress - jeans, tee shirts and sweat shirts; we role-played exposure to stressors that evoked his rages, and then practiced alternative verbal de-escalation strategies.

Other helpful strategies we have employed with aggression prone language delayed patients include:

1) Repetition of staff statements and instructions. Often these children stop listening when the adults speak the first few words of a direction and assume the worst. Repetition clarifies these statements, often de-escalating a hostile exchange; 2) Role playing anger triggering conflicts with puppets; 3) Creating a song that can be sung as a calming strategy; and 4) Teaching negotiation to school age children through a Plan B Passport workbook. (A free copy as a Word document is available via e-mail from Dr. Masters).

In summary, behavior problems in children are often complicated by language delays that make verbal management difficult. Assessing and treating them when present may help prevent tantrums and avoid restraints.

References


Dr. Masters is medical director at Three Rivers Behavioral Health Services Midlands Campus Residential Treatment Center and adjunct professor in the physician’s assistant program at the Medical University of South Carolina. Dr. Masters was the lead author on the “AACAP Practice Parameter on the Prevention of Aggressive Behavior in Child and Adolescent Psychiatric Institutions with Special Reference to Seclusion and Restraint.”

Twelve million children and teenagers in America have a psychiatric disorder. Left untreated, emotional and mental disorders shatter lives, families, and dreams.

The mission of the Campaign for America’s Kids (CFAK) is to continually improve the lives of children affected by mental illnesses and their families through improved treatments and access to quality mental healthcare. Mental illnesses in children are real, common, and treatable.

In 2010 CFAK supported projects such as the Early Career Psychiatrist Connect Program and the New Jersey Forum on Children’s Health.
The New Jersey Council of Child and Adolescent Psychiatry (NJCCAP) held the second annual “Forum on Children’s Health” on November 17, 2010. This Forum, funded by a generous grant from AACAP’s Campaign for America’s Kids, continued to strengthen the collaborative relationships between stakeholders in the state’s children’s health care initiatives, with the goal of improving access to children’s mental health care.

The Forum was sponsored by the AACAP/New Jersey Council of Child and Adolescent Psychiatry, New Jersey Psychiatric Association, American Academy of Pediatrics – New Jersey Chapter/Pediatric Center on Research and Education, the Medical Society of New Jersey, the National Alliance on Mental Illness, Children and Adults with Attention Deficit Hyperactivity Disorder, and the New Jersey Council of Children’s Hospitals. Representatives from each of these organizations engaged in advocacy and outreach to raise awareness about the event and develop the format for the program. AACAP staff, Elizabeth DiLauro, grassroots advocacy manager, and Kristin Kroeger Ptakowski, senior deputy executive director and director of Government Affairs and Clinical Practice, provided resources and technical assistance.

The objectives for this program were to improve participants’ awareness of mental health services available to children and families in New Jersey; identify strategies to facilitate access to these services and to support the ongoing development of a sustainable and integrated model of children’s health care. To meet these objectives, members of the planning committee worked closely with the New Jersey Children’s System of Care to provide participants with resource materials for use within their own communities.

The planning committee also worked closely with the New Jersey Primary Care Child Psychiatry Collaborative Task Force, a statewide coalition created by the New Jersey Psychiatric Association in September 2010, to formally present a proposal for a pilot collaborative care program. This Task Force is currently exploring models of collaborative care as one effort to address the child psychiatric workforce shortage and access to care issues, as described by AACAP’s Committee on Collaboration with Medical Professionals (AACAP 2010). The New Jersey model will build on the work of Massachusetts, Washington, Minnesota, and most recently Ohio, which have implemented systems of consultation between primary care physicians and child psychiatrists with promising results.

Panel discussions led by experts effectively addressed access to care issues at this forum. Panelists at the forum included Alicia Stevenson, the NAMI Basics New Jersey program coordinator and national trainer; Nadia Cayce-Gibson, executive director of New Jersey Family Support Organizations; Mary Bierne, M.D., chief child and adolescent psychiatrist with the New Jersey Department of Children and Families; Steven Kairys, M.D., chairman of Pediatrics at Jersey Shore Medical Center and medical director for the Pediatric Council for Research and Education; Jeff Guenzel, director of the New Jersey Division of Child Behavioral Health Services; and Kevin Martone, deputy commissioner for the New Jersey Department of Human Services.

Ms. Stevenson highlighted some of the obstacles to accessing care, including lack of awareness of the Children’s System of Care and inconsistencies in the types of services available across counties. It was also noted that services needed for pre-school children and transitioning youth were overlooked.

Ms. Cayce-Gibson spoke of the importance of peer support services for youth and families as they entered the system of care, the need for ongoing cultural competence training, and the need for outcome data to direct the ongoing development of the current system of care. Dr. Bierne described the role of the child and adolescent psychiatrist within systems of care, as well as the importance of early identification and intervention for at-risk children. Dr. Kairys reviewed data from a pilot program in Monmouth County, New Jersey, that provided educational support to primary care physicians who were utilizing the Child Behavior Checklist as a screening tool during well-visits. He then presented the Task Force’s proposal. Mr. Guenzel affirmed that collaboration was central to the Children’s System of Care and acknowledged that improved integration of services was required. Finally, Mr. Martone discussed the impact of health care reform on children’s mental health services, highlighting issues of workforce development and the medical home model.

The audience consisted of a diverse group of individuals addressing children’s health issues in a variety of capacities, including primary care, mental health, education, juvenile justice, and as parent advocates.

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Complementary and Alternative Medicine
Interest Continues to Build

Scott Shannon, M.D., Co-chair
Wayne B. Batzer, M.D., Co-chair

Over the last two decades, the public interest and utilization of complementary and alternative medicine (CAM) has continued to build. David Eisenberg of Harvard triggered significant attention to this trend when he published his survey results in the *Journal of the American Medical Association* in 1993. Eisenberg repeated his survey six years later and found that visits to CAM providers now exceeded visits to primary care physicians in the United States (634 million versus 454 million) and continued to grow rapidly (Eisenberg 1998). He documented that the American public spent almost $20 billion dollars on CAM products and services, most of it out of pocket, during 1997. He also discovered that out of pocket spending for CAM surpassed out of pocket spending for hospital care in the United States and equaled out of pocket spending for physician services. The explosive growth of the 1990s has slowed slightly, but CAM remains one of the fastest growing components of health care spending.

CAM has evolved in the academic arena as well. It is now referred to as Integrative Medicine (IM), a term popularized by Andrew Weil, M.D., of the University of Arizona. IM centers have sprung up in almost 50 medical schools across the United States, resulting in the creation of the Consortium of Academic Health Centers in Integrative Medicine (CAHCIM). Last year CAHCIM sponsored an international conference on research in IM and drew over 700 people from around the world to Minneapolis, Minnesota. Over 100 medical schools now include CAM curriculum as part of basic medical education. Lead by the University of Arizona, ten CAHCIM schools now offer fellowship training programs in IM. Family Medicine was the first residency program to include tracts focused on additional education in IM. Piloted in eight residency programs across the country, this program has become a recruiting tool in the competitive market for quality residents. The American Board of Integrative Holistic Medicine (ABIMH) has certified over 1400 physicians and 450 physicians attended their 11th annual review course in San Diego, California. The University of Arizona sponsored the 1st International Conference on Integrative Mental Health in Phoenix, Arizona, in April 2010 and drawing over 700 professionals, selling out two months prior to the event.

IM has generated considerable interest among the psychiatric community as well. According to the latest National Health Interview Survey (NHIS-2008) over 38 percent of Americans routinely use CAM in some way. If you include the use of vitamins and prayer, this number is dramatically higher. Three of the top ten reasons for CAM use lie in the purview of psychiatry: depression, anxiety, and insomnia. CAM use becomes much higher in chronically ill populations. For example, over 50 percent of chronically ill children are given CAM treatments of some kind (Ball 2005; McCann 2006). In one survey, over 74 percent of parents with an autistic child employ some type of CAM treatment (Hanson 2007). Sinha (2005) surveyed parents of children diagnosed with ADHD and found utilization of CAM modalities to be over 67 percent.

The data in this area strongly suggests that the public, not the medical profession, drives the phenomenon of CAM use. In one survey (NHIS 2008), only 26 percent of patients used CAM secondary to a professional’s direction. Eisenberg documented in his studies that well under half ever discussed their CAM use with a physician. The pattern of disclosure may be even worse in Child Psychiatry: Cala (2003) found that 7 percent of parents with children being treated for ADHD or depression did not disclose their CAM use. This creates a “don’t ask, don’t tell” situation of poor communication, increased medical risk, and impaired rapport. Patients do not share this information with their physicians secondary to concerns about lack of interest, lack of knowledge, and fear of criticism. As child and adolescent psychiatrists, most of us are operating in a knowledge gap that should be addressed. It should come as no surprise that for the past two years CAM offerings have ranked among the top three events to sell out first for AACAP’s Annual Meeting.

In response to this growing interest, AACAP has established the committee on Complementary and Integrative Medicine (CIMED), supporting broader education for our membership about current clinical practice and research on CAM/IM to close that knowledge gap. The first CIMED committee meeting was held at the New York AACAP Annual Meeting and was attended by a large and very enthusiastic group. The committee has already established liaison relationships with many AACAP components and is eager to work with all
interested AACAP members. This year’s AACAP dues questionnaire includes two CIMED questions: 1) How often do parents/patients ask you about complementary treatments (e.g. acupuncture, chiropractic, nutritional, herbal, non-traditional therapies, etc.)? and 2) For what percentage of your child/adolescent patients do you recommend nutritional supplements? We look forward to presenting the membership response to these questions. As part of our effort to foster CAM education, CIMED will offer regular articles and columns in AACAP News, as well as increasing submissions to the Annual Meeting on CAM topics.

References


Dr. Shannon is the co-chair of the Complementary and Integrative Medicine Committee and is an assistant clinical professor at the University of Colorado’s Children’s Hospital in Denver. He has been involved with CAM for over thirty years and works at Wholeness Center in Fort Collins, Colorado. He can be reached at scott@wholeness.com.

Dr. Batzer, also the co-chair of the Committee, is a clinical associate professor at the University of Hawaii’s John A. Burns School of Medicine. He works with military children and families at Schofield Barracks, Hawaii. He may be reached at wbatzer@mac.com.

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Child and adolescent psychiatrists from neighboring Regional Organizations of Child and Adolescent Psychiatry (ROCAP) in New York and Eastern Pennsylvania expressed their interest in developing similar programs in their states. Additionally, child psychiatrists and primary-care physicians explored opportunities for collaboration within their local communities and parent advocates described feeling empowered by the opportunity to speak with state policymakers.

The second annual Forum on Children’s Health proved to be an informative and inspiring evening for all in attendance. NJCCAP is grateful to AACAP’s Campaign for America’s Kids and members of AACAP’s Government Affairs and Clinical Practice Department for their support and guidance. Our grassroots efforts will continue well beyond the scope of the Forum as we continue to address access to care issues for children with mental illness. Collaboration between child and adolescent psychiatrists and pediatric health care providers is fundamental to an integrated model of health and vitally important given the workforce shortage issues. I encourage all ROCAPs to identify opportunities for collaboration and share the results of your experiences so that we may continue to identify effective strategies.

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Mentorship Matters: Pearls of Wisdom from AACAP Mentorship Program

Victoria Pham, D.O.

I entered general adult psychiatry residency at the University of Pittsburgh Medical Center in July of 2008. With rewarding experiences while working with children and adolescents during my residency, I applied to the Child and Adolescent Psychiatry Fellowship this year. Wanting to learn more about child psychiatry, I attended the AACAP 57th Annual Meeting for the first time. The Annual Meeting was held at the Hilton New York, on 53rd Street and 6th Avenue, which was within walking distance to Rockefeller Center, the Museum of Modern Art, Central Park, and chic stores on Fifth Avenue. In an attempt to save money on lodging, I commuted daily from Philadelphia to New York City and even stayed at a colleague’s home the night before a few early (7:30am) events. Even with four hours of daily commute, I truly felt that the Annual Meeting was a worthwhile experience! By the end, I was affirmed of and enthused by my decision to enter the field of child and adolescent psychiatry. One thing that caught me by surprise was the deep level of involvement and dedication that AACAP endows in its mentorship and services to medical students, residents, and fellows.

As part of the Mentorship Program, medical students, residents, and fellows came together to network and to have discussions with mentors for three consecutive afternoon sessions. Each mentorship table had two to four mentors and seven to eight mentees that were pre-assigned. At my table, we had three mentors, Sharon Hirsch, M.D., chief of Child and Adolescent Psychiatry at the University of Chicago; Bonnie Zima, M.D., a researcher from the University of California Los Angeles; and Jeffrey Hunt, M.D., director of Triple Board Training Program at Brown University. As for the mentees, we had first and second year fellows, residents, and medical students. With a diverse group of mentees, our questions guided the discussions. As questions came up about life after training, Dr. Hirsch explained how women are often paid less than men, in part because women do not often negotiate. She mentioned, in negotiating for a job, it is not just salary that needs to be discussed, but vacation days, office space, and health benefits. She highlighted the importance of talking to the person who previously held the job in order to get a better sense of the environment. Because many resident and fellows have family and children during their training, Dr. Zima addressed the issues of balancing clinical work, research, and family. She emphasized the importance of prioritizing aspects of one’s life and always working as a team, both at home and at work. Dr. Hunt shared tips on applications for residency and fellowship because he is knowledgeable on issues pertaining to Accreditation Council for Graduate Medical Education (ACGME) and training requirements.

Not only did I learn from these mentors, but I was deeply touched by the stories that my colleagues shared. While we discussed balancing life and work, a third-year, female resident from Louisiana talked about how she had to take time off from training in order to care for her dying mother. Despite this personal loss and set back, she became more determined to finish her residency and to eventually obtain a M.P.H. I came back to the Mentorship Program sessions each day because those pearls of wisdom cannot be easily found.

Midway through the Annual Meeting, trainees and medical student came together for the Medical Student and Resident Breakfast. This event was subsidized by AACAP, therefore trainees and students paid a meager $15 to attend. One of the great things about the Breakfast was that the speakers talked about their challenges, career highlights, and personal lives. The three invited speakers were Deborah Deas, M.D., M.P.H., professor and senior associate dean for Diversity at the Medical University of South Carolina; Glenn Kashurba, M.D., clinical professor at Drexel University School of Medicine; and Jess Shatkin, M.D., assistant professor and director of Education and Training, at the NYU Child Study Center. They each shared personal stories and pearls of wisdom that led to their successful careers.

I liked Dr. Deas’ talk because she spoke about the importance of having clear short-term and long-term goals. She encouraged us to develop mentors and mentees as we move through training. She gave personal examples of how she had publications during her training through poster presentations, case reports, and literature reviews of various topics. One take-home message from her was “one can have it all, but it may not be all at once.” Dr. Kashurba’s talk stood out to me because he retold his rescue effort on 9/11, for Flight 93. He reminded us of how the disaster changed lives, but also united people. Lastly, Dr. Shatkin’s charisma and hard work clearly showed through his words. He advised us to engage in career developmental activities that we may not have otherwise taken advantage of, because those activities may lead to fruitful results and opportunities in the future. As he experienced it himself, he emphasized the importance of saying “YES” to opportunities that come our way. As I listened to these speakers, I recognized that they are passionate about their work and want to create positive changes.
In addition to the Medical Student and Resident Breakfast, I also found the Successful Transition to Practice Forum to be helpful because it prepared medical students and trainees for what will come beyond the training years. The forum, successfully organized by Howard Liu, M.D., and Boris Lorberg, M.D., focused on balancing family and work, leadership skills, and negotiation tactics. Trainees rotated between three breakout groups. I first went to the Building Leadership table with Eugene Beresin, M.D., professor at Harvard Medical School and training director at Massachusetts General Hospital, and Alexander Kolevzon, M.D., associate training director at Mount Sinai School of Medicine. Through a real-life problem that a new graduate experienced at her work place, we learned that in order to create changes we need to understand the culture of the institution in which we work, build morale and teamwork, and have the support of its leaders. Next, the discussion table with Harsh Trivedi, M.D., executive medical director of Vanderbilt University School of Medicine, focused on negotiation tactics from both the perspectives of employees and employers. He advised us to focus on our skills and strengths, and to be enthusiastic about medicine and patient care during job interviews. In addition, we should be friendly and approachable, not reveal our previous salary, and attempt to have the employer put the salary bid down first.

The information was priceless, and the wonderful people I met will now become my colleagues, mentors, and friends. The AACAP is investing and empowering future child and adolescent psychiatrists with all the wonderful services and resources, and I remain grateful to AACAP for its commitment. After having more exposure to children and youth, and having been accepted to Columbia/Cornell for the Child Psychiatry Fellowship, I am looking forward to a rewarding career as a child psychiatrist. I will see you in Toronto in 2011.

Author’s Note: I would like to thank Dr. Deborah Deas for her ongoing mentorship and guidance in preparing and editing this article. She has been an inspiration!

Dr. Pham is currently a third-year general adult psychiatry resident at Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center. In July of 2011, she will be a first-year child fellow at New York-Presbyterian Hospital, Columbia and Cornell Universities. Dr. Pham can be reached at phamc@upmc.edu.

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2011 CATCHERS IN THE RYE AWARDS

The AACAP recognizes and promotes advocacy for children. To better recognize outstanding advocacy efforts, the AACAP established three advocacy awards to:

- **Recognize an individual** that advocates for children *(must be an AACAP member)*
- **Recognize an AACAP component** that best advocates for children
- **Recognize a regional organization** of child and adolescent psychiatry whose activities best highlight the contributions of AACAP regional organizations on behalf of children.

The award title was taken from John Schowalter M.D.’s Presidential Address in which he alluded to J.D. Salinger’s book and Holden Caulfield’s response to what he wanted to be when he grew up . . .

“I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody’s around – nobody big, I mean – except me.

And I am standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff.”

Nominations should include a brief paragraph describing the nominee’s work. The Assembly Executive Committee serves as the selection body. Awards will be presented at the Assembly meeting during the AACAP Annual Meeting in October 2011 in Toronto, Ontario, Canada. Please forward your nominations to:

Earl Magee
AACAP, 3615 Wisconsin Avenue, N.W., Washington, DC 20016

or e-mail to emagee@aacap.org

**THE DEADLINE FOR NOMINATIONS IS JUNE 30, 2011.**
Are New CPT Codes Coming?

Editor’s note: This is the first in a series of articles from the Committee on Healthcare Access and Economics discussing the possibility of new CPT codes for child and adolescent psychiatry.

David Berland, M.D., Sherry Barron-Seabrook, M.D. and Benjamin Shain, M.D., Ph.D.

The Basics:
Congress mandates that the Centers for Medicare and Medicaid Services (CMS) use Current Procedural Terminology (CPT) codes and the Relative-Based Resource Value Scale (RBRVS) to pay doctors for their service to Medicare patients. (The American Medical Association [AMA] owns the copyright for CPT codes.) The RBRVS is a scale that ranks all medical procedures in terms of physician work and practice expense needed to provide that service. Services ranging from psychotherapy to appendectomy to heart transplantation are assigned specific values known as relative value units (RVUs).

The Relative-Value Update Committee (RUC) of the American Medical Association, through physician surveys and other methods, develops RVUs for each code and makes recommendations to CMS. CMS considers the recommendation, and then assigns an RVU to each CPT code. At its simplest and without extra calculations for location, etc., physician payment is the product of the RVU multiplied by a Conversion Factor (CF), a number determined by CMS and updated at least annually. For example, if the RVU for 90801 in an office setting is 4.53 and the CF is 33.9764, then the payment is 4.53 x 33.9764 = $153.91 (based on the 2011 CF and RVUs).

The Process to Date:
Recognizing that medicine is dynamic, Congress mandated that CMS review the RBRVS every five years to insure it is current and that there are no anomalies such as one procedure valued lower than another one requiring less work, e.g. 20-30 minutes of psychotherapy being valued higher than 45-50 minutes of psychotherapy.

When CMS and the RUC began the current 5-year review, the AACAP and other mental health organizations took the opportunity to review the psychiatric codes. Through surveys, questions to the AACAP office and other methods of feedback, our members have made it clear that the current psychiatric codes do not accurately reflect the work child and adolescent psychiatrists do for evaluating or performing psychotherapy with children and these concerns were expressed to the RUC. Furthermore, the RUC raised questions whether some codes, like 90801 or 90802, that include possible medical procedures such as ordering and reviewing lab testing are appropriate for use by non-medical providers. Because of some of the RUC concerns, the majority of the psychiatric codes were sent to the CPT Committee of the AMA, which oversees the creation and editing of the CPT codes.

Current Context:
CPT has formed a workgroup consisting of representatives from the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, and the American Nurses Association, which had a short series of conference calls to set parameters for discussion and designated subgroups to prepare ideas regarding the development of new codes to present to a larger Psychological and Psychiatric Services Workgroup, in which the AACAP is a participant.

At this time, it appears that medical providers will have different codes from non-medical providers. There will continue to be a set of codes for office visits and one for facility visits because of differences in practice expenses between the types of sites.

For the sake of discussion, we will refer to 3 current and potential code sets:

1. Diagnostic (currently 90801, 90802)
2. Psychotherapy – outpatient and inpatient (currently 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829)
3. Medical office visit (currently 90862)

Issues we hope will be addressed by the Psychological and Psychiatric Services Workgroup include:

1. Should psychiatry abandon the psychiatric diagnostic and office visit codes in favor of physician office visit codes (9920x, 9921x, also referred to as office evaluation/management codes)? Or should psychiatry define what makes our work different from primary care and other specialties and develop our own codes?
2. Should the psychotherapy codes be stratified into different levels of complexity, based on medical decision making?
3. How can we best describe the value of and bill for the unique work of the child and adolescent psychiatrist?

As discussions progress, other issues will emerge. The first conference calls for the workgroup and the first in-person meeting occurred in January and February, after this article went to press. As we move through the code discussions and development process, we will update the AACAP membership through AACAP News, member emails, and the Advocacy Update from the Department of Government Affairs and Clinical Practice. The coding subcommittee of the Committee on Healthcare Access and Economics welcomes input from our members. Please send your ideas and comments to Jennifer Medicus at jmedicus@aacap.org.

Dr. Berland practices outpatient child and adolescent psychiatry in St. Louis, Missouri. He is the AACAP CPT advisor and current president of the Missouri...
In each issue of AACAP News, I include brief commentary and a link to newsworthy items that the membership might have missed or that merit repeating. If you have suggestions for this column, please send them to me at stuart.goldman@childrens.harvard.edu.

Studies that either confirm or challenge common held beliefs or practices are of great value to practitioners as they strive to make all their clinical actions as evidence based as possible. This edition’s News Updates summarizes some of the more recent findings.

Our field has embraced evidence-based practice and I applauded its efforts. But what exactly does “evidence-based” mean? Is there real “evidence” in the conventional wisdoms that we convey to patients and their families? Do standardized validated measures truly measure what they are purported to? Does statistically sound epidemiologic association prove causality? How do we generate reliable “evidence” when much of what we attempt to do is so complex? As clinicians, we want and need “proof,” but how do and can we ever get to the “beyond a reasonable doubt” standard? These three articles are clustered because each calls into question elements of “evidence” in its own way.

Alcohol, Caffeine, and Driving

Conventional wisdom, especially among adolescents (and even more so many adults), is that caffeine can prevent or undo some of the risks associated with intoxication. “Have a cup of coffee before you take off” has been the advice given countless times, but are there any grounds (no pun intended) for this belief? Howland et al., in February's Addiction, addresses this question. They studied 127 heavy, episodic, young adult (age 21-30 years) drinkers in a randomized, 2x2 study. Groups were given beer or non-alcoholic beer with or without caffeine being added. The caffeine was set at 69mg/12 ounces of beer (4.8% alcohol), which is the same amount of caffeine as a typical 8 ounce cup of instant coffee and the same ratio that the now off the market alcohol/caffeine products contained. The targeted breath alcohol level was 0.12% (states vary but 0.08% is intoxicated in many states). They assessed driving on a driving simulator and looked at attention on the Psychomotor Vigilance Task. Their results were that “across the driving and attention/reaction time we found main effects for alcohol, with alcohol significantly impairing driving and sustained attention/reaction time, with mainly large statistical effects; however, the addition of caffeine had no main or interaction effects on performance.” In other words, while caffeine may help you stay awake, it will not help your driving or attention. Clarification and warning to all of our young adult patients is needed.

ADHD, Conduct Disorder, and Substance Abuse

The association between ADHD and multiple co-morbid disorders and/or subsequent risk for future disorders has been documented numerous times over the past two plus decades. These risks have included: ODD, Conduct Disorder, Anxiety Disorders, Depressive Disorders, and Substance Use Disorders. In January’s JAACAP, Charach, in a meta-analysis, and Wilens, in a concise and thoughtful accompanying editorial, focus on the data to date on the relationship between ADHD and the development of substance abuse disorders; in this series alcohol, cannabis, and nicotine. They present substantial and sobering documentation that “ADHD is a definitely known risk for SUD” (Wilens).

Charach and her colleagues thoughtfully and critically reviewed 13 studies, up through some time in 2008, and described them in clear detail. She concludes that “the meta-analyses reported in this review confirm that children with ADHD are at risk for developing alcohol use disorder (OR = 1.35, 95% CI = 1.11-1.64) by early adulthood and for self-reported nicotine use by middle...
Looking at the role of conduct disorder and following a population longitudinally is exactly what Brook et al’s report explores in October 2010 Archives of Pediatric Adolescent Medicine. Their study looked at just under 500 youth taken from the upstate New York area in 1975. The children were originally identified and assessed in 1975 and then studied from a mean age of 14 years (1983) until just under 37 years (2005-6). Using parental interviews, the Diagnostic Schedule for Children, and self reports (University of Michigan Composite International Diagnostic Interview SUDs measure), they looked at the relationship between childhood ADHD, Conduct Disorder, and adolescent and adult Substance Use Disorders. It is the “first investigation to longitudinally study a sample of adolescents with and without ADHD, CD, and SUDs observed to a later stage of development, namely, their 30s.”

They found that “the percentage of adult SUDs was significantly higher in those who had adolescent ADHD (17.9%) than in those who did not (10.3%) (odds ratio [OR], 1.9; 95% confidence interval [CI], 0.9-4.0). The percentage of adult SUDs was significantly higher in those who had adolescent CD (25.7%) than in those who did not (9.1%) (OR, 3.5; 95% CI, 1.8-6.8). The percentage of adolescent CD was significantly higher in those who had adolescent ADHD (37.5%) than in those who did not (8.6%) (OR, 6.4; 95% CI, 3.4-12.0) ADHD conferred an odds ratio of 1.9 for adult SUDs and that childhood Conduct Disorder conferred an odds ratio of 3.5 for adult SUDs.” However, they found that “the relationship between ADHD in adolescence and later SUDs in adulthood was also no longer significant when controlling for CD at T2 or T3 (adolescence), sex, age, and earlier MDD (adjusted OR, 1.4; 95% CI, 0.6-3.2; P = .22).”

While the authors go over the limitations of the study (the population was disproportionately Caucasian) and that there were some dropouts, they go on to conclude “ADHD is related to CD. Second, CD is highly related to SUDs, even after controlling for ADHD. Third, ADHD is related to SUDs, but this effect is not maintained after controlling for CD. Thus, these findings support a mediational model: the association between ADHD and SUDs is mediated by CD.” By their calculations the meditational effect was 0.6.

Their findings, for clinicians, serve as a critical link in the pressing questions of etiology, mechanisms, risk, and prevention. While they found that both ADHD and CD put one at risk for subsequent SUDs, the effects of ADHD, in this unique study, are mediated by CD. In other words, children with ADHD are at increased risk, but this risk is mediated by CD; and that the sub population of children or adolescents with ADHD and CD merit the most powerful interventions. Additionally, the converse is true; adolescents with ADHD and no history of CD are not clearly at risk.

There are several take home messages. First, it confirms earlier reports that children with ADHD are at risk for SUDs, particularly, those with the co-existence with CD. Second, their findings are potentially anticipated by Charach and Wilens, in their recommendations for future study and clarification. Third, while this is only one study, it calls into question the nature of what we “know” and how confident we can be in that knowledge. Risk is often complex and sorting through the mediating and moderating factors is challenging. Finally, for clinicians, it identifies the most “at-risk” population and helps us target our energies while at the same time potentially reassuring parents of children who have ADHD without CD.


ADHD, School Entry Age, and Teachers

The DSM was created to provide an objective, descriptive set of criteria to aid clinicians in making a “reliable” diagnosis. Many authors have written about the challenges that arise when categorical criteria are applied to dimensional behaviors (where exactly is the cutoff when squirmy and fidgety become “often,” as item number 1 in the DSM hyperactivity criteria demands). Others have taken the DSM to task for its failure to incorporate clear developmental anchor points as a child continues to grow and evolve. With respect to ADHD, the clinicians’ tasks are further complicated by the fact that the diagnosis is most often dependent upon teacher or parental report or questionnaire. For most clinicians, the teacher completed questionnaire (and there are many well validated instruments) is the gold standard. However, Elder, in the September issue of Journal of Health Economics, calls the practice of relying upon teacher reports into question.

In his report, he looked at the data from 11,784 children who began school in the fall of 1998. The Early Childhood Longitudinal Study (ECLS), that his study is grounded in, is a national cohort that has undergone serial evaluations beginning in kindergarten and repeated in grades 1, 3, 5 and beyond. He then stratified the data using birth date and school entry cutoffs and looked for any relationships between the diagnosis of ADHD, usage of medication, and age at entering kindergarten. For example, in schools with a September 1 cutoff, those born in August would be the youngest and those in September the oldest. Similar age dependent calculations were done for each cutoff date.

Overall, they found that the rates of ADHD diagnosis was 6.4% (consistent with many reports); however, if you were born in the youngest month cohort (August with September school cutoffs) your rates of diagnosis were 10% and if you were born in September (the oldest cohort) your rates were 4.5%. That is the youngest cohort was more than twice as likely to be diagnosed when compared to the oldest. The results were pretty much linear with the oldest children having the lowest rates, children born mid-year diagnosed with the middle rates (6.4%) and rates that continued to rise to the 10% rate in the youngest group. The differences in the rates of receiving ADHD medications followed the same pattern, with overall medication rates by 8th grade being 4.5%; however, if you were in the youngest group rates almost doubled to 8.9%. As expected, the oldest groups did have lower rates.

He also compared teacher ratings and parent ratings. Parent ratings varied relatively little based upon their child’s birth month; however, teacher ratings varied dramatically both on behavior and maturity. Elder’s conclusion was that teachers apparently compared the youngest children to the oldest children and then conveyed concern when they lagged behind. This concern then apparently became the grounds for children being identified, diagnosed, and then, eventually, being placed on medication to address the perceived problems.

The author concluded that while the younger students do present some age dependent challenges, that transient, age-based immaturity is leading to inappropriate long-term diagnosis and treatment. The author concludes that these teacher-based misperceptions may mean that upwards of 20% of the children diagnosed with ADHD are being misdiagnosed and are not in need of on going treatment. This translates into approximately 900,000 children on a national level. He ends by lamenting the financial, social, and health related costs and possible harms generated by this misperception.

For clinicians, it should give us pause in thinking about the ADHD diagnosis. How much does the perceived diagnosis hinge upon maturity and, while clearly necessary, how dependable are teacher reports in making a “reliable” diagnosis? For the youngest students the impact appears to be quite substantial.


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Business is Business:

A short history in malpractice insurance for child and adolescent psychiatrists.

1986. AACAP, in an effort to address the needs of a growing membership, first approached the American Psychiatric Association about amending their malpractice insurance program to include risk differential premiums for child psychiatrists. This made sense as child psychiatrists experienced far fewer claims and payouts were significantly lower.

The APA, not seeing the value, balked at the idea, leaving child psychiatrists to deal with high premiums and limited coverage.

1987. AACAP, working closely with dedicated members and staff created, crafted and developed their very own malpractice insurance program. Not only was the program tailor made to the specific needs of child psychiatrists, it was offered at 25% lower premiums.

The very next year the APA offered 25% lower premiums for child psychiatrists.

2000. AACAP, always looking to improve their offerings, programs and services chose the American Professional Agency to manage its malpractice program, eventually being insured by Darwin/Allied World Assurance.

2010. Recently the APA chose the American Professional Agency to manage their insurance program with Darwin/Allied World Assurance as the underwriter. AACAP is the pioneer in providing the best products, programs and services for the child and adolescent psychiatry community. We’ve got the track record to prove it! When looking for the best malpractice insurance program, go with the leader. Go with AACAP – better coverage at reduced rates.

We lead – they follow.

When it comes to malpractice insurance who leads and who follows? Just ask the APA!

Give them a call at 800.421.6694 or online at www.americanprofessional.com.
Media Page

■ Jean Dunham, M.D.

Dulcan’s Textbook of Child and Adolescent Psychiatry

The organization of the original text and the structure of the chapters have been revamped to better communicate the clinical art and wisdom of child psychiatry while remaining grounded in clinical science. Each chapter highlights what we know about evidence-based practices in assessment and treatment, while sections on future research point toward current pressing questions. At the end of each chapter are educational summary take home points. It has been written particularly for child and adolescent residency programs to use as one of the core training textbooks in their educational curriculum.

Special topics include new chapters on bereavement and traumatic grief; ethnic, cultural, and religious issues; aggression and violence; and fundamentals of genetics relevant to child and adolescent psychiatry.

In addition, a new section on consultation provides guidance on interactions with schools, primary care practitioners, and the juvenile justice system. It includes treatments, including psychopharmacology, brain-based innovative treatments, and a spectrum of psychosocial approaches that focus on individual, family, therapeutic milieu, and systemic models of care.

Mina K. Dulcan, M.D. is the Osterman Professor of Child Psychiatry and head of Child and Adolescent Psychiatry at Children’s Memorial Hospital; head of the Warren Wright Adolescent Center at Northwestern Memorial Hospital; and professor of Psychiatry and Behavioral Sciences and Pediatrics at Northwestern University’s Feinberg School of Medicine in Chicago, Illinois. She can be reached at m-dulcan@northwestern.edu.

■ Edited by Mina Dulcan, M.D.

American Psychiatric Publishing, Inc., 2010
1074 pages – $249.00 (hardcover)

Dr. Dulcan’s latest, most comprehensive text offers a fresh look at the field of child mental health. It is useful to trainees and practitioners in a variety of specialties, providing chapters by over 110 contributors who condense their knowledge and expertise into a single authoritative volume.

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to:
Jean A. Dunham, M.D.
PO Box 90656
Austin, TX 78709-0656
or
jeandunham@gmail.com

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A A C A P  N E W S
Home Sweet Home: The Acquisition of the AACAP Building

The dates of the 50th anniversary celebration of the Academy represent, almost to the day, the 20th anniversary of the acquisition of the Academy building. However, behind that search for a permanent home is an interesting history.

For 16 years following its founding, the Academy had no national office. During those intervening years, from 1953 to 1969, the business of the Academy was conducted by the officers at annual, semi-annual, and regional meetings.

In 1969, the elected membership was under 300. That year, because of the illness of Academy President Anne Benjamin, M.D., Sidney Berman, M.D., assumed the presidency and established the first national office of the Academy. With the assistance of Walter Barton, M.D., of the American Psychiatric Association (APA), the Academy was housed rent free in the basement of the APA building on R Street, N.W., in Washington, D.C. Literally, we started on the bottom. That was the same year our Bylaws were changed to make membership in the Academy available by application rather than election.

Then in 1970, the Academy moved to its first rental office space, a two-room apartment at 1800 R Street, N.W., across the street from the APA headquarters. The office remained there until 1975 and by that time, because of the 1969 Bylaws change, our membership had expanded to 1,000 and the staff from one to five. That same year, the Academy moved to 1424 Sixteenth Street, N.W., providing 1,632 square feet of rented space for our staff of six. Rapidly, the Academy membership continued to grow and with it, the accompanying programs, functions, and responsibilities of the central office. As the existing space was being outgrown, hallways became meeting rooms and bathtubs became filing cabinets. Clearly, the time had come for a change.

A study of the long-term space needs of the Academy was undertaken. At a June 1977 meeting, with the advice of the Long Range Financial Planning Committee, the Academy Council agreed that a purchase of a building for the Academy was desirable. In planning for future growth, it was recommended that it have sufficient space available for growth, be cost effective, and be able to undergo change without serious disruption.

Extensive discussions occurred debating the advisability of renting office space vs. purchasing a building. However, renting space would subject the Academy to the vagaries of a tight office space market with escalating rents (then $22 to $25 per square foot), an unpredictable economic future, and a potential compromise in the Academy’s growing activities. In contrast, ownership of a building would permit the Academy to be in control of its future financially and provide the greatest latitude in executing its responsibilities and functions. Ownership would most clearly provide a low-risk, high-gain investment.

Thus, in 1981 one of the most exciting periods in Academy history began with the appointment of a Building Committee whose charge was to find and arrange for the purchase of a building for the Academy in Washington, D.C. The committee members were: William Stark, M.D., Chairman; Sidney Berman, M.D.; William Clotworthy, M.D.; Thomas Haizlip, M.D.; John Meeks, M.D.; Pirooz Sholevar, M.D.; Larry Silver, M.D.; Preston Walker, M.D.; and Jerry Wiener, M.D. On April 29, 1981, the Committee held the first of many meetings. Vital and significant issues investigated by committee members were: outright purchase, optional purchase plans and financing, the buying of land in joint ownership with a builder, limited partnership of Academy members, and legal and tax implications.

Trust departments of banks were consulted to investigate available buildings in their portfolios. Realtors were contacted about suitable properties. Indeed, it was a busy and challenging time. In the spring of 1982, a Building Fund Committee was

William Stark, M.D.
established with the charge of raising funds from donors, members, and other possible contributors for the purchase of an Academy building. Its members were: Lawrence Stone, M.D., Chairman; Myron Belfer, M.D.; Reginald Lourie, M.D.; Jack Martin, M.D.; David Cline, M.D.; Taghi Modaressi, M.D.; Preston Walker, M.D.; and Albert Solnit, M.D.; with consultants J. Sanford Davis, Ph.D., and Sidney Berman, M.D.

With the limited availability of suitable properties in Washington, D.C., the search was extended to Montgomery County, Maryland; Alexandria, Virginia; and Northern Virginia. Innumerable properties were evaluated only to be rejected. From 1981 to 1983, the Academy experienced periods of hope and disappointment. Contracts were submitted on buildings only to have them fall through. But members of the Committee were always willing to examine yet another building, and their enthusiasm, persistence, and support never wavered.

In retrospect, it was fortunate that we had to renew our search. A realtor, whom we had consulted, presented an outstanding property at 3615 Wisconsin Avenue, N.W., superior on many levels to other buildings we had previously reviewed. The property was then 22 years old, of high quality construction, concrete, with an Italian marble and fieldstone façade, two stories with an elevator, and 14,000 square feet of space. Parking space for ten cars was part of the property. The building, in upper northwest D.C., borders the Cleveland Park upscale residential neighborhood and is near the National Cathedral. On one side its windows overlook the prestigious Sidwell Friends School, its students, and playing fields. The building fronts Wisconsin Avenue, one of the major thoroughfares in the city. To quote the old real estate axiom, this building certainly had the three essentials: “Location, location, location.” The size of the building permitted the leasing of space to other child health organizations and housing the National Consortium, thus providing additional income to the Academy. Finally, our search had ended! The Building Committee was unanimously enthusiastic and pleased.

On October 12, 1983, we submitted a contract on the building with a purchase price of $1,050,000 (asking price of $1,350,000), and it was accepted on October 20, 1983. The building was purchased with all cash, two-thirds coming from the Academy’s reserves at the time of purchase – all surplus from 1983 – and the money contributed to the Building Fund. NO MORTGAGE! I recall saying at the time of purchase that I had the unique privilege of spending the funds that were accumulated during my terms as Academy treasurer from 1973 to 1979.

The weather on settlement day in February 1984 was dark and gloomy. In contrast, the mood inside was filled with joy and enthusiasm. Members congratulated each other on the successful completion of the venture. In early March 1984, we moved into our new home. With the purchase of our building, we acquired stability, control of our financial future, adaptability for future growth, identity, image, and a low-risk, high-gain investment.

The building is now 42 years old (in 2003) and has served the Academy well, fulfilling its original expectations. It has increased in value several times over our original costs. This past year, because of the age of the building, the major systems (mechanical, electrical, plumbing) were undergoing major renovations and upgrading in compliance with current building codes.

But buildings, after all, are only bricks and mortar. More importantly, the associations and friendships that I have shared for more than 40 years with Academy members, and the sense of dedication to the Academy in the steady, persistent pursuit of a common goal, have been a continued source of fulfillment and pleasure to me. For that and more, I am most grateful.

Dr. Stark was the chairman of AACAP’s first Building Committee and was the treasurer of AACAP from 1973 to 1979. He is clinical professor emeritus of Psychiatry and Behavioral Science and Pediatrics at the George Washington University School of Medicine. In his retirement, Dr. Stark and his wife, Vivienne Stark, have enjoyed traveling – to Europe, the Middle East, Australia, New Zealand, China, Vietnam, Japan, Africa, South America, and Antarctica. Dr. Stark has continued an active participation in the AACAP having served as chair of the Building and House Committee for 27 years and is still a contributing member of that Committee at the present time.

On Wisdom — In Toronto!

The 2nd Annual Life Members Clinical Perspective at the AACAP/CACAP Joint Annual Meeting in Toronto will focus on Study Groups.

One group, in particular, has been together for 42 years! Learn first-hand of their collective experience including not only challenges and victories, but the fun and laughter shared for over four decades. As Mark Twain said, “It is wiser to find out than suppose.” All study groups are unique, however similar adventures, challenges and hurdles exist. As we continue to prepare for the Annual Meeting, we want to hear from those of you in study groups. We want you to share your anecdotes, experiences and wisdom with us.

Who better to learn from than you? Please email your comments to development@aacap.org.
“When Will They Ever Learn?”

We are once again reeling from yet another tragic day in America: Congresswoman Gabriella Giffords was shot in the head and others were killed and seriously wounded by a deranged gunman.

It was in the nineteen sixties that Peter, Paul, and Mary sang plaintively “When Will They Ever Learn?” and we did not take that message to heart. We did not learn from the murders of John and Robert Kennedy, and of Martin Luther King. We did not learn that inflammatory and hate-filled language in politics and in the media generates roiling unrest in the human psyche and soul.

We did not learn that angry and disturbed people (young men usually) can be provoked by verbal rancor and threats in the emotional climate into explosive violence. We did not learn - perhaps did not wish to learn - that the constantly spewed invective and hate in the social atmosphere is as toxic to our society as carbon-generated pollution.

The Tucson shooter seems to have been psychotic, and certainly his mental illness should have been recognized earlier, treated and even prevented. Those who are emotionally fragile may be particularly vulnerable to the public vitriol, but so are we all.

The current political arena is filled with invective and slurs between candidates. The inflammatory styles of some radio and television pundits have only added to their audiences. Vitiolic political candidates get votes, and nasty media personalities are popular. The sad truth is that many adults eat this stuff up: they seem to get vicarious pleasure from loud negativism and rancor.

Sad to say, we even demonstrate and experience examples of incivility in our everyday lives, which our children witness, learn from, and emulate. They learn from their models and mentors that angry and uncivil behavior is common and acceptable. Disrespectful and demeaning behaviors, insults, and disregard for others have become commonplace. Celebrities, athletes, politicians, and people in the media and in other spheres of public life have demonstrated derisive nastiness towards others.

If their heroes demonstrate disrespect and nastiness towards others, what are the take-away messages for our young people? We cannot take solace that this incivility is limited to the public sphere: Kids observe in their own families ugly feelings and opinions when “others” are referred to. They witness displays of rudeness and incivility from adults in stores, on public or private transportation, and throughout the community. And then we are surprised by school bullying?

We have been preoccupied of late by the legacy of our “Carbon Footprint,” but we have another problem, equally as serious: our negative “Emotional Footprint,” which is the effect we have on others in all our interpersonal encounters. Mutual respect and tolerance engender a more caring environment and society; a positive emotional footprint. Incivility, rudeness, and rancor breed demoralization and aggressiveness.

Brooding individuals who are angry at society for real or imagined wrongs often want to seek retribution and personal salvation. When they are at the same time emotionally fragile, disturbed, and zealous, they hear the “answers” to all their problems in the nasty polemics uttered by vitiolic pundits and politicians. These answers are described using fury-colored language and facile reasoning, and they inflame and incite. And when their answers are facilitated by the remarkable and unconscionable availability of guns in this country, we have the terrible “perfect storm” which we have witnessed on so many sad occasions.

A revised children’s saying should be “sticks and stones will hurt my bones, but ‘names’ can indeed harm me.” Words can be dangerous, of that there is no doubt. By all means, we have to drastically reduce the rhetoric in the public domain. The loud-mouthed invective fulminating from people you and I can easily name must be toned down considerably. But we also have a more fundament problem to deal with, and this is the general incivility which is permeating our society. We need bear in mind the words of the late comic strip character Pogo (Walt Kelly) who intoned, “I have seen the enemy, and he is us.”

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The Next Level of Advocacy: Establishing an AACAP Political Action Committee by Louis Kraus, M.D. (continued from cover)

The AACAP advocacy programs within the Department of Government Affairs have expanded from a one-person office in the 1980s to a four-person office overseeing federal and state legislation and regulatory action. My work with Mary Crosby into the 1990s and into the new millennium, helped solidify my interest in this area. I have watched the program continue to grow and expand under the direction of Kristin Kroeger Ptakowski.

Five years ago, the AACAP held its first Advocacy Day with about 50 members and, in more recent years, we have had over 200 attend. This shows the shared interest among our members in being involved in the political process. I believe most of this has to do with the fact that so many of us are advocates. Perhaps it is related to the change in the political landscape of the past years. Our members have increasingly expressed concern over this and the impact this has had and will likely have on child and adolescent psychiatry in the future. As such, many more members have chosen to become involved with advocacy. The more child and adolescent psychiatrists who become engaged in this process, and the more we intensify our efforts, the better chance our patients will have in the future and the better chance that we will have to treat those in need.

Over recent years, we have seen how government affairs have improved our ability to communicate on the “Hill.” We have had more and more child and adolescent psychiatrists communicate with their members of Congress in a way that likely has had an impact on legislation. As a result of increased advocacy over the years, two of the AACAP’s priorities – mental health parity and incentives for training in child psychiatry – were successful. However, we are not always going to be successful. We are at a turning point in healthcare. Psychiatry, and more specifically child and adolescent psychiatry, is often not at the forefront of more complex healthcare plans. As we progress into the 21st Century, it is extremely important to situate ourselves in a way that we can best communicate with Congress so that we can best advocate for our patients. The way to do this is through a Political Action Committee (PAC).

PACs originated in 1944, progressively becoming important and, at times, an influential part of U.S. politics. There have been concerns from some that there is a negative connotation to a PAC. Essentially, the only negative is not understanding what a PAC does, its oversight, and what it will do to potentially help our organization. The purpose of an AACAP PAC would be to support policy goals important to child and adolescent psychiatrists and the practice of child and adolescent psychiatry through the support of candidates for elective office; to promote better understanding among elected officials of the unique and important role of child and adolescent psychiatry in the delivery of high quality mental health care to patients; and to assist our membership in organizing themselves for effective political action.

A PAC is used by numerous medical societies to better their involvement with members of Congress in a variety of contexts. Some members are concerned that a PAC is “buying a vote.” This is not true. The AACAP has grown from a handful of child psychiatrists that essentially started out as a guild, to a professional society with over 8,000 members. We have changed in many respects, but also in many respects we have not. If we do not begin to change how we work with government, our voice will progressively be lost. Some have expressed concern that if we go to the “Hill”, we will simply be looked at as that guild rather than the organization and advocates that we are. I can assure you that I see myself as advocating for my patients first and foremost. If there is policy that is going to benefit me as a physician; it will likely benefit my patient, either directly or indirectly.

At the present time, we have some access to elected officials through their staff; however, most child and adolescent psychiatrists are tremendously busy and it takes tremendous effort and time to make that connection because of the time pressures and schedules of politicians, as well as our own. PACs offer another way of connecting with elected officials by bringing the power of like-minded people together. PACs can assist as an effective tool for educating legislatures about associations and their issues of greatest concerns. Our government affairs department meets with congressional staff on a regular basis, but with a PAC, AACAP will have more consistent access to the policymakers themselves. This access will provide more personal opportunities to advance our associations political agendas. By having a PAC, we, as members, will also have additional access to elected officials. This will allow us to have more direct one-to-one contact with these officials and for them to be able to spend more time with us to discuss these issues, not just us as individuals, but with larger groups at the AACAP.

Having a PAC will likely increase the members understanding of what is occurring in Congress. Part of having a PAC would be having a PAC board. The PAC board would be made up of AACAP members and the PAC director. It would be responsible for overseeing money given out, (who it goes to and how much) and to develop future goals of the PAC board. The PAC donations will be aligned with AACAP policies and priorities. There are very few negative attributes that I can see from having a PAC. There are concerns that it would decrease funding to the AACAP in other areas. This has not been seen in other medical organizations that have PACs. There is concern as to how this may be perceived by others. The reality is that the PACs have tremendous oversight and for over 60 years have been part of the political community and part of how organizations on different levels are able to help continue their mission through working with Congress in a more effective way.

The pros and cons of the AACAP establishing a PAC were presented to the AACAP Assembly of Regional Organizations of Child and Adolescent Psychiatry in October 2010. Following this, there was a vote within the Assembly as to whether or not we should support a PAC. The majority of the Assembly supported development of a PAC.
In my experience, a PAC within a medical organization increases the role of members and their involvement in this very important agenda. Without a PAC, the AACAP will continue with limitations in their ongoing efforts to help implementation of such important issues as mental health parity and healthcare reform. The AACAP is ready and NEEDS to move to the next level of advocacy. Having a PAC will give all of us a seat at the table in any future debates.

AACAP Should Not Compromise Its Integrity

by Fred Seligman, M.D., C.M., M.P.H. (continued from cover)

On the other hand, I have been so proud to be an AACAP member because we have always stood on the higher ethical ground. The PAC discussion in the AACAP and its support by several members is the first time I recall that we are thinking of taking the lower ethical path. Ethical dilemmas are not new to the AACAP. We have discussed for a long time our position of being cautious in accepting pharma monies. Indeed, when recently the American Psychiatric Association (APA) was singled out by Senator Chuck Grassley’s investigation, the AACAP was never included. I even recall discussions in the ‘old’ days of the 90s of the ethical questions surrounding the excessive psychiatric hospitalizations of children and the problems it created in the child and adolescent psychiatry community. Throughout this controversy, the AACAP pointed our field toward the highest ethical ground.

Be sure about it. I am neither against political contributions nor Congressional advocacy. We all have opportunities to contribute individually and through the PACs of other organizations to which we may belong. What I am saying is that AACAP now has the mechanism to do very effective ‘political’ activism, and in my opinion, a PAC would not make it more effective. Ask yourself the question, have all the significantly increased political contributions resulted in more effective legislation?

We have an exceptional governmental liaison office that has worked most effectively on the Hill. Some would say that adding a PAC component would strengthen this activity. I do not. I have personally met with Congressional leaders as part of the annual “March on the Hill.” I have always felt that this personal lobbying was effective just because I was part of an organization that was not channeling monies to particular Congressional candidates. The fact that I was representing a non-PAC organization motivated me to come to Washington and advocate. I often have explained to non-child and adolescent psychiatry colleagues this wonderful activity on the part of the AACAP and have always been so proud of this. I feel the personal commitment that I and others have to such activity would deteriorate. Why not let the PAC handle it? Make no mistake about it, I personally have a long history of Congressional advocacy, and have been described as ‘politically shrewd and energetic’ (Steiner 1976). It is this experience that forces me to be vocal about this topic, rather than the often-quieter position I have chosen for myself in the AACAP.

In my role as a consultant to a foundation, I have found it easy to sell the mission of the AACAP. It was the fact that the AACAP does not support paid lobbying that strengthened my hand in selling the merits of the AACAP to a foundation. Do not think for one minute that contributions to a particular University would not diminish from donors the moment a University developed a PAC. What about a museum that you may support? Would your support level change if that museum developed a PAC?

The fact that we serve children and youth gives us a leg-up in our advocacy. It is no coincidence that the American Academy of Pediatrics (AAP) does not have a PAC.

There is a delicate balance between the missions of a professional, especially a medical, organization. I see three main missions, namely, 1) member benefits such as improved quality of practice and better economic rewards, 2) professional enrichment such as collegiality and professional education matters, and 3) benefits to those the organization serves, such as better mental health and excellent psychiatric services to children and youth. Professional organizations tend to minimize their trade positions and elaborate on what it does for constituents. The public tends to see professional organizations as especially concerned with self-serving interests. This waxes and wanes over time, but how the public views an organization like the American Medical Association (AMA) over time would be an example of this. I believe that the AACAP has been able, quite genuinely, to maintain a high public commitment to being interested in the welfare of children and their mental health and psychiatric needs. I believe that even our sister organizations have such an opinion of us. I believe that an AACAP PAC would tarnish this image, and over time put us in the same box with the other organizations that have PACs. Try this on your friends and colleagues. Rate the following organizations in terms of self-interest. Include some of the following: AACAP, AMA, APA, American Psychological Association, AAP, American Orthopedic Society, and American Academy of Orthopedic Surgeons. Then correlate that with whether they have a PAC or not.

The AACAP has always taken pride in having international members. We specifically have a reception for international members at our Annual meeting. Currently about 5 percent of our membership are international members, albeit a small number. An AACAP PAC would detract from this focus and probably would not be favored by international...
members. Or perhaps we should use 5 percent of the PAC funds to support political candidates in other countries!

I am not one of our Founding Fathers, but it is my understanding that originally, the AACAP was limited to mostly academic types. In fact, practitioners were originally not allowed to be members. The “Founders” thought it would change the focus too heavily to the interests of practice. What it has, in fact, accomplished, is to enrich this organization to be an extremely rich diversity of talents and interests in our field. While there will always be the concern that we engage in the appropriate balance of self-interest, the art and science of our field, and the benefits of our constituents, I believe that we have the best possible balance now. A PAC will tilt the balance, much as the concern that many in this country share, that politics and the “Washington mentality” have taken over our government. Moreover, the cost benefits of a PAC to AACAP will at best be negligible to minimal and will likely result in a substantial decline in foundation and other philanthropic support. Don’t let that happen to AACAP.

In summary, an AACAP PAC will change the perception of our organization both by its members and by the public. It will join the current bandwagon in American politics of more and more lobbying by funneling more and more money into political campaigns. It will make it much more difficult for us to raise foundation money. It makes us an easier target for the likes of a Senator Grassley and others. Frankly, it brings more Washington politics to an organization that should focus on all the wonderful things it now does.

Reference

Dr. Seligman is a Life Member of the AACAP and serves as the Assembly delegate from the South Florida Regional Council. He is the former division director of Child and Adolescent Psychiatry at the University of Miami Miller School of Medicine. He currently is voluntary professor of Psychiatry at the University of Miami. He may be reached at fredseligman@me.com.

Speak Up for Kids!

AACAP and the Child Mind Institute (CMI), along with Hunter Boot and Parents magazine, encourage you to be a part of Speak Up for Kids during National Children’s Mental Health Awareness Week, May 1-7, 2011.

Extend your advocacy efforts and your voice in helping your community recognize the signs of anxiety, ADHD, depression, trauma as well as the risk factors for suicide.

We’re counting on you!

Our goal is to have hundreds of child and adolescent psychiatrists deliver talks across the country during Children’s Mental Health Awareness Week.

For more information and to register online visit: www.childmind.org/en/events/2011-5-1-speak-up-for-kids

When we reach 500 participating AACAP members, we’ll promote your efforts by placing an ad in The New York Times on May 3, 2011 with the names of all participants.

Speak up for those who need our help the most!
Notes from the “Trenches”:
Coping with My “Handicap” – Partnering with Interpreters when Treating Spanish-speaking Hispanic* Families

Growing up in a small town in Upstate New York in the 1950-60s, I experienced very little cultural and language diversity. I studied French in high school and college. As an intern and resident at the Los Angeles County-U.S.C. Medical Center I first encountered significant numbers of Spanish-speaking Hispanic patients and their families. This was my first experience in working with interpreters and realizing the significant “handicap” I faced as a psychiatrist who does not speak a patient’s primary language.

In my current position with Carolinas HealthCare System in Charlotte, North Carolina, I care for large numbers of Spanish-speaking Hispanic families. In this article, I will focus on my experiences with Hispanic families; however, many of my observations or recommendations can be generalized to any population being treated by a psychiatrist who does not speak the patient/family’s primary language.

Hispanic children are the fastest growing segment of the U.S. population under age 18 years. They are at high risk for psychiatric problems. On the 2006 Youth Risk Behavior Survey (YRBS), Hispanic children self-identified: depression (36%), suicidal thoughts (14.5%) and suicide attempt (11%). Factors associated with increased risk for psychopathology in immigrant children include: immigration (loss of friends/family, feeling alienated); acculturation stress; poverty and unemployment; prejudice and discrimination; segregated environments; decreased support; and cultural background (family roles, communication patterns). Low or limited proficiency in English is also a risk factor and can be associated with poor outcomes (e.g., high rates of school drop-out, academic difficulties, unemployment, poverty, or lower incomes). Any child and adolescent psychiatrist working in a public mental health setting in 2011 is likely to encounter Spanish-speaking Hispanic families. Diagnosing and treating children and teens in these families can be difficult and challenging but it is also rewarding.

Glancing at the parent’s responses on the clinic’s patient questionnaire (Spanish version) as we walk to my office, I realize the challenges ahead for myself and the interpreter in the brief medication appointment:

Javier (age 5) – The boy sat quietly with his mother in the examining room of the psychiatric emergency department. The interpreter told me his mother was very worried because the boy said he wanted to die and had tried to run out into the street in front of a car. He remained mute and stared at me as I attempted to interview him in English. When the interpreter spoke to him in Spanish he continued to stare without responding. His mother told us he was afraid of his father and that he had seen his father physically assault her many times before she had moved out. She also told us the family spoke Spanish and that he was learning English in his kindergarten class. What was going on with this young boy? Was he depressed and experiencing psychotic symptoms? Did he have an expressive or receptive language disorder? Did he have developmental deficits/delays or cognitive and intellectual limitations? Would the interpreter and I be able to get him to open up?

Mario (age 10) – Since his mother had been removed from the family and detained in an immigration center, he had suffered with severe nightmares and generalized anxiety. His father had been deported to Mexico and he had recently developed fears of sirens and police cars. Through the interpreter, his aunt asked me, “What should I tell him about his mother?”

Pedro (age 17) – He had been arrested for “trespassing” and spent 30 days in jail. Diagnosed with paranoid schizophrenia after three inpatient hospital admissions for severe psychotic symptoms and aggressive paranoid behavior, he was taking a complex multi-medication regimen. His mother is worried and upset because he is now facing a deportation hearing to be returned to his Latin American country. Through the interpreter she asks, “What can you do to help him? He can’t get treatment for his illness in our country.”

* Note: The term “Hispanic” as used in this article refers broadly to all Spanish-speaking peoples in both hemispheres. The term “Latino” refers more exclusively to persons or communities of Latin American origin. Neither term refers to a particular race.
En la cita de hoy, Yo quiero que me cambien los medicamentos. (At today’s appointment I want to have medication changed.)

Unless you speak Spanish, you must depend on some form of assistance in translating Spanish to English. Psychiatry, more than most medical specialties, relies almost exclusively on the words used by patients and families. What words are used, how they are used and other nuances become the data for the history, assessment/formulation, diagnosis and outcomes of treatment. The optimal support for a child and adolescent psychiatrist as you evaluate and treat Spanish-speaking Hispanic families is the availability of interpreters to join you in your office. My facility also has a “translation-line” available 24/7 by phone. This service provides real-time translation of many different languages (including Spanish). While it is certainly preferable to have an interpreter physically present with you in the office, the “translation-line” provides coverage when there are gaps in their availability. Tasks for child psychiatrists when working with interpreters or using a translation line include:

- Developing a comfort level, familiarity, and trust with each interpreter’s style – some will provide literal word-for-word translation, others will listen and then repeat or paraphrase. Discuss your preferences or needs with the interpreter.
- Introducing the interpreter and his/her role with the psychiatrist (e.g., “This is Mr./Ms. _____ and s/he is here to help me today.”). Remember – it is a partnership.
- Reassuring the parent/family that everything discussed is confidential.
- Allowing sufficient time during the appointment for the translation process (e.g., Spanish to English, then English back to Spanish).
- Focusing and organizing your questions and information. Be prepared to rephrase a question or statement as needed for clarity.

Engaging the assistance of the interpreter in translating patient education materials and handouts.

In order to provide quality care during the assessment and all phases of treatment with a child in a Hispanic family, the child psychiatrist must consider and be sensitive to the following issues:

- History of immigration for child/teen and for parents/family
- Adaptation to community (acculturation)
- Primary language used in home
- Child’s language competence with Spanish and English
- Parent’s understanding of child/teen’s problems
- Child and parent’s expectations of treatment (past experiences with treatment)
- Child-rearing practices
- Cultural practices, observations and rituals
- Issues/problems for parent(s) and/or child with immigration status/INS.

General tips and suggestions for child psychiatrists working with Spanish-speaking Hispanic families and patients – most of these also apply to any non-English speaking family:

- Be diligent about scheduling interpreters for these appointments.
- Be patient and take adequate time to explain and answer questions. Families want answers to questions such as – What is wrong with my child? What caused their problem(s)? How long do they need to take a medicine?
- Be aware that families often have fears about coming to a mental hospital or mental health center.
- Be sensitive to the fact that families may be ashamed of mental illness in their child.
- Be aware that parents or other family members often don’t believe in taking medicine for behavioral or mental problems.
- Carefully explain medication regimen, dosing, and changes. Discuss any cost concerns and problems in obtaining medication(s).
- Remember - families are looking for reassurance from the doctor.
- Families appreciate any helpful materials translated into Spanish. Utilize patient questionnaires, education handouts and other materials that are translated into Spanish to facilitate communication and maximize efficient use of appointment time. For example, I routinely use Spanish-versions of a letter explaining clinic appointments, as well as “10 Questions for Parents,” and “Medication Do’s and Don’ts.”


In writing this article I spoke with Mr. Alex Zambrano, the lead Spanish interpreter at our Behavioral Health Center (BHC), to reflect on our work together. I have worked with Mr. Zambrano for six years and “Mr. Z.” is my partner in overcoming my “handicap.” I have always been impressed by his responsiveness, his energy and enthusiasm, and his caring and dedication to assist the Hispanic patients and families being treated at the BHC. Each day, when I review my afternoon clinic schedule, I note which appointments are designated “Spanish” beside the patient name. If I find a patient who is not listed on our Spanish interpreter’s daily schedule (he gives me online access), I send him a quick e-mail asking if he can assist me with the patient. Almost immediately, I receive a reply from Mr. Zambrano, “Dr. Mac, I got you covered,” and my anxiety disappears. Mr. Z. takes a highly individualized and personal approach to each patient and family – he refers to them as “my people.” Most of the families call specifically for Mr. Z. when they have questions or concerns between appointments. He is an invaluable member of the treatment team and frequently makes important contributions to the care of the children and families - many of the tips and suggestions listed above come directly from Mr. Z.
This summer, as I drove out of the hospital parking lot after a busy afternoon in the clinic, I recognized my Hispanic patient, his mother, and two younger siblings (one in a stroller) waiting to take the city bus home in the sizzling heat. Their appointment with me had been almost two hours earlier. I realized then the amount of time and hardship facing this mother every time she brings her son to see me for his medication. Seeing her reminded me of the importance of my partnering with an interpreter to communicate with her about her child in her primary language.

Working with Hispanic children and their Spanish-speaking families is a gift – it has been and continues to be challenging, rewarding, and a real learning experience for me. Maybe it is not too late for me to learn Spanish – I can always listen to the Rosetta Stone Spanish language program while I am sleeping!

Dr. MacIntyre is a full-time attending psychiatrist at Carolinas Medical Center’s Behavioral Health Center (CMC-BHC). CMC-BHC provides public mental health services for the residents of Mecklenburg county and Charlotte, North Carolina.

The opinions in this article are solely those of Dr. MacIntyre and do not represent the views of Carolinas HealthCare System (CHS). Dr. MacIntyre has spent more than 35 years working in public mental health settings. He is Secretary of AACAP and was a member of the Work Group on Consumer Issues for 19 years and Chairperson of the WGCI for 11 years. Dr. MacIntyre may be reached at jmacintyre@carolina.rr.com.

All the material presented in this column is based on my clinical experience; vignettes are not based on actual individuals, situations, or circumstances.

NEW RESEARCH POSTER CALL FOR PAPERS

The AACAP/CACAP Joint Annual Meeting is taking place on October 18-23, 2011, at the Sheraton Centre Toronto and Hilton Toronto in Toronto, Ontario, Canada. Abstract proposals are prerequisites for acceptance of all presentations given at the meeting. Topics include any aspect of child and adolescent psychiatry including clinical treatment, research, training, development, service delivery, or administration.

Verbal presentation submissions were due February 15, 2011, and may not be submitted after the deadline. Abstract proposals for (late) New Research Posters must be received at the AACAP by Wednesday, June 15, 2011. All Call for Papers applications must be submitted online at www.aacap.org. Step-by-step instructions for how to use the online submission system are available at www.aacap.org. Also note that there are new requirements this year, so be sure to review the guidelines early. If you have questions regarding this process, please call 202.966.7300, ext. 2006 or email meetings@aacap.org.

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Give yourself one less thing to think about. Select the Automatic Dues Renewal option on your 2011 dues notice and let us handle the rest. Your annual membership fee will be charged automatically to your credit card. Don’t worry – we’ll send you electronic reminders for next year.

**ATTENTION CAP Program Directors!**

Sign up 100% of your CAP residents for membership and join the **100% Club!**

As a member of the 100% Club, you’ll enjoy:

- Free ticket to the Program Director’s Luncheon at this year’s Annual Meeting in Toronto, Canada
- Special recognition in AACAP News and on www.aacap.org
- Personal acknowledgement at the Annual Meeting
  …and much more!

To learn more about joining the **100% Club**, contact Nicole Creek at ncrest@aacap.org or 202.966.7300 ext. 134.

AACAP would like to thank the following members for their tenure and celebrate their **elevation to Life Member:**

- Richard Angell, M.D., Aurora, Oregon
- Marcia Greed, M.D., Portland, Oregon
- Alicia Gavalva, M.D., Brookline, Massachusetts
- Stanley Leiken, M.D., Encino, California
- Michael Reding, M.D., Oakland, California
- Charles E. Cladel, Jr., M.D., Hummelstown, Pennsylvania
- David H. Kaufman, M.D., Poway, California

**Congratulations to Our New AACAP Fellows!**

The following members were nominated to become a Fellow of the AACAP.

- Emmilie Attwell Becker, M.D., Austin, Texas
- Mark B. Carroll, M.D., Clemmons, North Carolina
- Clarence Chou, M.D., Mequon, Wisconsin
- Mohammad Sayadul Islam Mullick, M.D., Ph.D., Dhanmondi, Dhaka, Bangladesh
- James R. Peacey, M.D., Seattle, Washington
- P. Brent Petersen, M.D., Salt Lake City, Utah
- Julia W. Tossell, M.D., Bethesda, Maryland

AACAP bylaws mandate nominations to this esteemed membership category be submitted for comment by the AACAP member community. Members have 30 days to comment on the nomination. If you wish to submit a comment, please e-mail the chair of the Membership Credentials Committee at aacap.membership.chair@gmail.com.

**In Memoriam**

AACAP would like to extend our condolences to the family and friends of:

- Harold Fogelman, M.D., Nanvet, New York
Welcome New AACAP Members

Adam Gunn, M.D., Victoria, British Columbia, Canada
Alaa M. Elrefai, M.D., Birmingham, Alabama
Alexanian Jean Baptiste, Rouen, Haute Normandie, France
Andrew Safron III, M.D., Naples, Florida
Alta Red, M.D., Los Angeles, California
Ashley Weiss, M.D., New Orleans, Louisiana
Barbara Mellman, Toledo, Ohio
Brent Crane, M.D., Derby, Kansas
Bridget M. Smith, M.D., River Ridge, Louisiana
Carmel Anne Flores, M.D., Beavercreek, Ohio
Catherine Schuyler Brennan, Davis, California
Christie Tsimoyianis, Greenwich, Connecticut
Christopher Erickson, M.D., Saint Paul, Minnesota
Colleen O’Rourke, Cambridge, Wisconsin
Dana Rosenfarb, Washington, DC
Daniel Tseng, Columbus, Ohio
Danielle Bradshaw, M.D., Columbia, Missouri
David Danish, M.D., Philadelphia, Missouri
David M. Margulies, M.D., Stony Brook, New York
Davita Burkhead-Weiner, M.D., Ann Arbor, Michigan
Erin McCune, D.O., Portland, Oregon
Evita Limon, Los Angeles, California
Farhad Numan, M.D., Union City, California
Farzana Amin, M.D., San Mateo, California
George Vana, Burlington, Vermont
Giovanni Giaroli, M.D., Ilford, United Kingdom
Gisela Sandoval, M.D., Ph.D., Chicago, Illinois
Harold Bornstein, M.D., Oakland, California
Heather Simpson, M.D., Tampa, Florida
Judith Grimmond, M.D., Columbia, Missouri
Julia Tan, Mobile, Alabama
Julie Sadhu, M.D., Somerville, Massachusetts
Justin Wade, M.D., Cambridge, Maryland
Kavitha Selvaraj, Chicago, Illinois
Kelly Schofield, M.D., Chapel Hill, North Carolina
Kristen Dauss, Smyrna, Georgia
Maricarmen Lopez, Dr., San Juan, Puerto Rico
Mehnaz Hyder, East Meadow, New York
Michael Zeola, M.D., Dayton, Ohio
Michele Nelson, Rochester, New York
Mohammad AbdelHakeem Seleem, M.D., Gharbia, Egypt
Mridula Kamthan, M.D., Goshen, New York
Nisha Fernandes, Minneapolis, Minnesota
Noelia Cabrera, San Antonio, Texas
Ozan Toy, Scranton, Pennsylvania
Paul Fehrenbacher, Chicago, Illinois
Peter Ureste, Chicago, Illinois
Pier Bryden, M.D., Ontario, Canada
Rachel Rebecca, M.D., Seattle, Washington
Ron Steingard, M.D., Milton, Massachusetts
Rudolf Winkler, M.D., Klagenfurt, Austria
Shubhranjan Ghosh, M.D., Anchorage, Alaska
Sitra Tauscher-Wisniewski, M.D., Indianapolis, Indiana
Sogand Ghasemi, Berwyn, Illinois
Sophia Banu, M.D., Houston, Texas
Stella Ndem, M.D., Roanoke, Virginia
Sumit Chauhan, Thane, India
Suneetha Somireddy, M.D., Columbia, Missouri
Sylvia Subia, M.D., Caba, Buenos Aires, Argentina
Tatyana Semenova, Brooklyn, New York
Tong Shen, M.D., Lakewood, Washington
Travis Mickelson, M.D., Salt Lake City, Utah
Troy Hoff, Ph.D., Christiansburg, Virginia
William Mann, D.O., Wilson, North Carolina
Yon Chong, Newark, Ohio
FOR YOUR INFORMATION

Members and the NEWS

The AACAP Communications Office connects journalists with AACAP members. If you would like to work with the news media, please contact the Communications Office with your area of interest at communications@aacap.org

If you work with the media – please let us know!


- **Craig Erickson, M.D.**, participated in a Q&A session about children with autism. The article appeared in the *Indianapolis Star* on November 21, 2010.


- **Eric Arzubi, M.D.**, discussed his unique partnership with a local school to provide mental health care to students. The article, “Serious About Mental Health Of Challenged Children,” appeared on *Courant.com* on November 28, 2010.

- **Andrew Nanton, M.D.**, connected with a *CentralFloridaFuture.com* reporter to discuss whether or not mentally ill prisoners actually suffer from a mental illness. The article, “Prof. Finds Inmate Feign Mental Illness,” appeared November 28, 2010.


- **Victor Fornari, M.D.**, helped a *The Herald* (Monterey County) reporter create tips for parents to use to help their children understand the new TSA regulations. The article, “Scan or Pat-Down? With Kids, It’s Not an Easy Decision,” appeared November 30, 2010.


- **Stephen Xenakis, M.D.**, wrote an article for the *Washington Post* about Omar Khadr’s trial. Dr. Xenakis evaluated Khadr and advised on military procedure during the trial. The article, “Radical Jihadism is not a Mental Disorder,” appeared December 5, 2010.

- **Paula Rauch, M.D.**, discussed how losing a parent at a young age can deeply affect kids. The article, “Elizabeth Edwards’ Death: Children Face Piercing Pain,” appeared on *ABC.com* on December 8, 2010.


Bela Sood, M.D., discussed introducing a new baby to older siblings with a Richmond Times-Dispatch reporter. The article, “In My Shoes: Growing Families Learn about Ways to Welcome a Baby,” appeared December 17, 2010, and included a video clip.


William Hughes, M.D., discussed parenting advice for the new year with a Sacramento Bee reporter. The article, “Mom.me: as 2010 Comes to a Close, Some Parenting Advice is Non-Refundable,” appeared December 28, 2010.


Patricia Lester, M.D., connected with a Military Times reporter to discuss the increased usage of psychiatric medication in military kids. The article, “Military Kids Taking More Psychiatric Drugs,” appeared January 2, 2011.


Judith Cohen, M.D., connected with a Medscape reporter to discuss the effects of violence on children. The article, “Children Exposed to Domestic Violence Benefit from Trauma-Focused Therapy,” appeared January 7, 2011.

Glenn Saxe, M.D., discussed the shooting spree in Tucson, Arizona, with a USA Today reporter. The article, “What Would Cause a Young Person to Snap,” appeared January 9, 2011.

Alan Ravitz, M.D., connected with a PopEater reporter to discuss “Bieber Fever” and its effects on young girls, January 10, 2011.

AACAP is pleased to announce the naming of the Douglas B. Hansen, M.D. Annual Review Course and Training Session for the Oral Exams. Dr. Hansen generously contributed $100,000 to name this meeting in perpetuity. This donation is especially meaningful since Dr. Hansen was the chair of the first Annual Review Course in 1976 in Houston, Texas. The inaugural Douglas B. Hansen, M.D. Annual Review Course and Training Session for the Oral Exams takes place March 9-11, 2011, in Dallas-Ft. Worth. Stay tuned for a full report in the May/June AACAP News.
According to the 57th Annual Meeting evaluations, the highest rated sessions in each presentation category were:

Clinical Case Conference 6: The “Wild Child:” A Work in Progress Chair: Joan Daughton, M.D.

Clinical Consultation Breakfast 7: Clinical and Practical Issues in Rural Child and Adolescent Psychiatry Chair: Stuart A. Copans, M.D.

Clinical Perspectives 31: Culturally Alert Cognitive Behavioral Therapy with Youth Chair: Robert D. Friedberg, Ph.D.

Honors Presentations 11: The Long War and Parental Combat Deployment: Effects on Military Children and Parents Chair: Patricia Lester, M.D.

Institute 8: The New Kids in America: Immigrant Children Chairs: Claudio O. Toppelberg, M.D. and Brian A. Collins, M.A.

Media Theatre 12: Girlhood: A Profile of the Adolescent Female Offender Chair: Kenneth M. Rogers, M.D.

Special Interest Study Group 1: College and Student Mental Health Chair: Adrian Sondheimer, M.D.

Symposium 13: Community-Based Participatory Research and Mental Health Service Delivery in American Indian Communities Chair: John T. Walkup, M.D.


Please note these rankings are determined by average overall ratings on session evaluations. The response rate and enrollment numbers did not influence ranking.

Congratulations to all the presenters!

We would like to acknowledge the first ten sessions to sell-out at the 2010 Annual Meeting. In chronological order based on sell-out date, they are:

Workshop 10: Asperger’s Disorder: Diagnosis, Behavioral Interventions, and Social Competence Training Chair: Martin Lubetsky, M.D.

Workshop 9: Understanding Learning Disabilities: Implications for Psychiatric Practice Chair: Lee I. Ascherman, M.D.

Workshop 8: Normal Development: A Review with Video Examples Chair: Geraldine S. Fox, M.D.

Workshop 5: School Consultation: Special Education and School Mental Health Programs Chair: Richard E. Mattison, M.D.

Clinical Consultation Breakfast 13: Master Clinician David Shaffer, M.D. Chair: David Shaffer, M.D.

Thank you to all of the 57th Annual Meeting speakers for your contribution to the AACAP!
2011 AACAP Award Opportunities

AACAP is once again pleased to offer awards to members who have made significant contributions to the field of child and adolescent psychiatry, to early career psychiatrists, and to residents and medical students interested in child and adolescent psychiatry. Please check the AACAP Web site for a complete listing of award opportunities, updated information, and application deadlines.

For more information, please contact the Department of Research, Training, and Education at 202.966.7300 or visit our website: http://www.aacap.org/cs/awards.

AACAP Distinguished Member and Service Awards
Deadline: April 29, 2011

All Distinguished Member and Service Awards are conferred through a nomination process. Distinguished Member and Service Award recipients will be recognized at the Distinguished Members Awards Luncheon and will give an Honors Presentation regarding their work at the AACAP/Canadian Academy of Child and Adolescent Psychiatry (CACAP) Joint Annual Meeting, October 18 - October 23, 2011, in Toronto, Ontario, Canada.

The AACAP Irving Philips Award for Prevention recognizes a child and adolescent psychiatrist AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents. The award offers $2,500 to the award recipient and a $2,000 donation to a prevention program or center of the recipient’s choice.

The AACAP George Tarjan Award for Contributions in Developmental Disabilities recognizes a child and adolescent psychiatrist AACAP member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with developmental disabilities. The award recipient will receive an honorarium of $1,000.

The AACAP Sidney Berman Award for the School-Based Study and Intervention for Learning Disorders and Mental Illness recognizes an individual or program that has shown outstanding achievement in the school-based study or delivery of intervention for learning disorders and mental illness. The award recipient will receive an honorarium of $4,500.

AACAP Paper Prizes
Deadline: April 29, 2011

All Paper Prizes are conferred through a nomination process.

The AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award recognizes the best published (within 3 years) or unpublished paper, written by an AACAP member, that and continuous contributions in the field of liaison child and adolescent psychiatry. The $500 award is named after Simon Wile, M.D., a renowned pediatrician and a life-long supporter of child and adolescent psychiatry.

The AACAP Robert Cancro Academic Leadership Award recognizes a currently serving General Psychiatry Training Director, Medical School Dean, CEO of a Training Institution, Chair of a Department of Pediatrics, or Chair of a Department of Psychiatry for his or her contributions to the promotion of child and adolescent psychiatry. Named in honor of Robert Cancro, M.D., this award offers an honorarium of $1,500 to the award recipient.

The AACAP Jeanne Spurlock Lecture and Award on Diversity and Culture recognizes individuals who have made outstanding contributions to the advancement of the understanding of diversity and culture in the United States and the world as it pertains to children’s mental health, and who will support the recruitment of child and adolescent psychiatrists from all cultures. The award provides the recipient an honorarium of $2,500.
addresses the use of psychodynamic psychotherapy in clinical practice and fosters development, teaching, and practice of psychodynamic psychotherapy within child and adolescent psychiatry. Authors with papers that express a novel hypothesis, raise questions about existing theory, or integrate new neuroscience and developmental psychotherapy research with psychodynamic principles may be nominated. The recipient will receive a $4,500 honorarium, be recognized at a Distinguished Awards event, and give an Honors Presentation about his or her work during the AACAP/CACAP Joint Annual Meeting, October 18 - October 23, 2011 in Toronto, Ontario, Canada.

The AACAP Robinson-Cunningham Award is given for the best manuscript written by a child and adolescent psychiatrist. The paper must have been started during residency training (Child or General), and involve children, adolescents, or their families. The paper should be published in a professional, peer-reviewed journal within three to five years of graduation from the training program, and the candidate must be the first author. Each paper will be rated for originality and potential impact. The award recipient will receive a $200 honorarium and will be honored at the Young Leaders Awards Luncheon during the AACAP/CACAP Joint Annual Meeting, October 18 - October 23, 2011, in Toronto, Ontario, Canada.

Resident and Junior Faculty Awards
Deadline: April 29, 2011

The AACAP Pilot Research Award, supported by Eli Lilly and Company, encourages junior faculty and child and adolescent psychiatry residents in their research careers by providing up to eight pilot research grants of $15,000. Recipients have the opportunity to submit a poster presentation on their research during AACAP’s 59th Annual Meeting in San Francisco, California, October 23-28, 2012. Each award also includes funding support to attend the AACAP Annual Meeting for five days.

The AACAP Pilot Research Award for Attention Disorders, supported by The Elaine Schlosser Lewis Fund, encourages a junior faculty member or child and adolescent psychiatry resident in his or her research career by supporting one $15,000 pilot research grant on attention disorders. The recipient has the opportunity to submit a poster presentation on their research during AACAP’s 59th Annual Meeting in San Francisco, California, October 23-28, 2012, and present their research at up to two Elaine Schlosser Lewis Luncheons.

The AACAP Pilot Research Award for Learning Disabilities, supported by The Elaine Schlosser Lewis Fund, encourages a junior faculty member or child and adolescent psychiatry resident in his or her research career by supporting one $15,000 pilot research grant on learning disabilities. The recipient has the opportunity to submit a poster presentation on his or her research during AACAP’s 59th Annual Meeting in San Francisco, California, October 23-28, 2012, and present the research at up to two Elaine Schlosser Lewis Luncheons.

Resident Awards
AACAP Educational Outreach Program for Child and Adolescent Psychiatry Residents provides the opportunity for child and adolescent psychiatry residents to fully explore the field of child and adolescent psychiatry and establish relationships with child and adolescent psychiatrists as mentors through the AACAP Annual Meeting. This program includes attendance to several institutes and workshops on cutting-edge research topics, an extensive mentorship program, and the opportunity to network with their peers and distinguished AACAP members. The program provides participants up to $1,500 for travel expenses to the AACAP/CACAP Joint Annual Meeting, October 18 - October 23, 2011, in Toronto, Ontario, Canada. The application deadline is July 11, 2011.

The AACAP Beatrix A. Hamburg Award recognizes the best new research poster presented at the AACAP/CACAP Joint Annual Meeting by a child and adolescent psychiatry resident attending an accredited institution who is also an AACAP member. The recipient will receive $1,000 and will be honored at the Young Leaders Awards Luncheon during the AACAP/CACAP Joint Annual Meeting, October 18 - October 23, 2011, in Toronto, Ontario, Canada. There is no application process for this award. In order for your poster to be considered for this award, please submit a Call for Papers application form for the AACAP/CACAP Joint Annual Meeting. New Research Poster submitters may use the late deadline of June 15, 2011, for submissions.

The distribution of ALL AWARDS is contingent upon the receipt of adequate funding.

AACAP reserves the right to waive liabilities.
Maintenance of Certification: Goals and Accomplishments

Elizabeth Hughes
Assistant Director, Education and Recertification

Child and adolescent psychiatry was established as an American Board of Psychiatry and Neurology (ABPN) subspecialty in 1959. From 1959 to 1994, certification was awarded on a lifetime basis. Beginning in 1995, certification in child and adolescent psychiatry has been awarded for a ten-year period only. At the conclusion of the ten-year certification cycle, child and adolescent psychiatry practitioners must take a recertification examination in order to maintain their certification. The recertification, or maintenance of certification (MOC), movement was initiated by the American Board of Medical Specialties (ABMS) and the major certifying specialty boards as a way of demonstrating to the public that physicians maintain professional statues (e.g. state licensure), documentation of commitment to lifelong learning, and assessment of practice-based performance. This began as a take-home examination, but the ABMS mandated that it become a secure, proctored examination, and the ABPN complied with this mandate. This change was made for accountability to the public. In May 2004, the ABPN gave its first recertification examination in Child and Adolescent Psychiatry.

Since the ABPN outlined the new recertification requirements, AACAP has worked tirelessly to develop a plan and provide a way for its members to comply with the requirements. AACAP established a Work Group on Lifelong Learning, co-chaired by Sandra Sexson, M.D., and Andrew Russell, M.D. The Work Group has clear goals, has accomplished the production of 7 modules, and will soon provide performance in practice tools.

ABPN’s current Child and Adolescent Psychiatry Maintenance of Certification program includes four components: 1) professional standing; 2) self-assessment and CME; 3) cognitive expertise; and 4) performance in practice.

1. Evidence of professional standing – this is simply a current unrestricted license to practice medicine in at least one state, commonwealth, territory, or possession of the United States or a province of Canada.

2. Evidence of self-assessment and CME – diplomates are required to participate in two broad-based self-assessment activities during the 10-year MOC cycle. A total of 300 specialty or sub-specialty, Category 1 CME credits equates to 30 hours per year. At least an average of eight hours of CME credits per year should involve self-assessment.

The Work Group’s goal is to provide members with continuous educational opportunities. The first educational opportunity is a series of lifelong learning modules over a 10-year period on specific disorders. Each module contains relevant literature on targeted topics in child and adolescent psychiatry and seminal articles on the latest research on any aspect affecting child and adolescent psychiatrists in the field. It also includes a self-assessment exam based on the journal articles, and provides 30 hours of CME credit. Additionally, the ABPN uses these modules as one source for writing questions for their recertification exam.

Each module represents a year-long process of soliciting articles from AACAP members, experts in the field, and researching medical journals for pertinent literature. The Work Group reads and evaluates all articles, and selects approximately 30-35 articles for inclusion in the module. The Work Group writes article annotations and CME questions for the pre-and post-tests. All of this effort culminates in a printed, bound book that assists child and adolescent psychiatrists who are recertifying, and keeps those who are “grandfathered” in abreast of the recent issues facing child and adolescent psychiatrists.

In addition to providing one new module a year, AACAP offers a specialized Institute at each Annual Meeting, devoted to the latest module articles and topics. Expert speakers present the material. Another Lifelong Learning Institute is given in the spring each year. These Institutes provide ABPN-approved, specialty-specific Category 1 CME credit, and self-assessment credit.

Further resources can be found on the ABPN’s Web site (www.abpn.com). The American Psychiatry Association (APA) offers products, including their publication FOCUS: The Journal of Lifelong Learning and the FOCUS Self-Assessment Program.

3. Evidence of cognitive expertise – this requirement is the successful passage of the cognitive exam. Exams are given in a Pearson VUE testing center, of which there are over 200 testing centers in the United States. A passing score on the exam extends the renewal date of time-limited certificates to December 31 after the 10th year of the examination. All self-assessment, CME, and performance in practice requirements must be completed before applying to take the recertification exam.

4. Evidence of performance in practice (PIP) – this requirement is scheduled to begin in 2013, and has been the topic of controversy and confusion. PIP is designed to evaluate whether or not physicians have shown improvement in the last ten years. This is done by a clinical module (chart review) and a feedback module (second party external review). Participants will be required to complete three PIP units consisting of both reviews.

The clinical module uses data from at least five patient charts in the diplomate’s practice over the previous three years, in a specific category (e.g., diagnoses, type of treatment, treatment setting). Data from the clinical cases is then compared to best practices or practicing guidelines, such as AACAP’s Practice Parameters. Diplomates develop a plan to improve his/her performance, and reassess data from at least another five cases in the same specific category.
within 24 months of the original assessment. All documentation of the clinical modules is kept by the diplomate and not sent to either AACAP or the ABPN.

The feedback modules are based on feedback from at least five peers and five patients over the previous three years. Peers are not limited to other child and adolescent psychiatrists, but can include pediatricians, psychologists, nurses, social workers, and counselors. Documentation is made to show improvement in the effectiveness and/or efficiency of the diplomate’s practice. Another set of five peers and five patients must provide feedback within 24 months similar to that provided in the original assessment. Again, documentation is kept by the diplomate and not sent to AACAP or ABPN.

The ABPN may audit approximately 5 percent of applicants for recertification, who may be required to explain further their documentation and compliance with the MOC program. Even in this case, no patient data will be sent to the ABPN.

To help AACAP members fulfill the PIP requirement, the Work Group is in its final stage of developing tools and checklists based on the Practice Parameters for ADHD, Anxiety Disorder, Bipolar Disorder, and Depression. In addition, patient forms for the parent to fill out for their child and an adolescent patient form are in development, as well as the peer feedback form. Look for these resources on AACAP’s Web site soon.

AACAP’s Web site is a great source of information. The MOC page has expanded information and a Frequently Asked Questions page provides answers to important questions. Drs. Sexson and Russell invited Dr. Larry Faulkner, president and CEO of ABPN, to participate in a Webinar in November 2010, and the archived Webinar can be found in the Members Only section of the AACAP Web site. Visit www.aacap.org/cs/moc for more information, or contact AACAP’s MOC experts, Elizabeth Hughes and Quentin Bernhard III, at ehughes@aacap.org, qbernard@aacap.org respectively, to ask questions or order modules.

As child and adolescent psychiatrists, staying up-to-date on advances in the field, and fostering good patient care and improved outcomes is essential. AACAP will continue to work closely with the ABPN to ensure that we are meeting these needs.
2011-2012 Mary Crosby Congressional Fellow

The AACAP is delighted to announce that the AACAP’s 2011-2012 Congressional Fellow will be named in honor of AACAP’s former staff member, Mary Crosby.

Mary joined the AACAP staff in 1982 as the director of Government Affairs. For over two decades, Mary led the AACAP’s efforts for legislation to improve outcomes for children and adolescents with mental illnesses as well as the overall health and well-being of children. Mary served as the AACAP’s Deputy Executive Director from 1995 – 2005.

Mary’s expertise was recognized in the many national coalitions that work on mental health issues, including the Mental Health Liaison Group and the Consortium for Citizens for Disabilities (CCD), where she served as chair of CCD’s committee on children.

While the National Consortium for Children’s Mental Health was coordinated through the AACAP, Mary coordinated its activities and chaired the Consortium’s committee on legislative issues.

When the AACAP was accepted into the American Medical Association’s (AMA) House of Delegates in 1986, Mary began her work as staff liaison to that delegation.

Mary’s leadership resulted in positive change among many issues of concern to the AACAP, including: mental health parity; funding for mental health research; the State Children’s Health Insurance program (SCHIP); the Individuals with Disabilities Act; the expansion of Supplemental Security Income (SSI) for children with disabilities; managed care reform; juvenile justice reform; youth violence prevention; foster care; and child and adolescent psychiatry workforce issues including recruitment and support for training programs.

Working with AACAP members, Mary lobbied for the Child and Adolescent Mental Health Services Program (CASSP), which gained initial approval at $1.5 million during the 1980s severe budget cuts, and program reduction. One of the few new programs approved, it eventually touched all 50 states providing assistance for children’s mental health services.

When CASSP ended, it was replaced by a children’s services program that actually funded systems of care for children with mental illnesses and their families. The combination of research and services support kept the issue of mental illnesses before Congress, which contributed to the 1996 parity legislation, the Surgeon General’s Report on Mental Health and on Children’s Mental Health, and the current campaign for full parity laws at the state and local level.

Under Mary’s exceptional leadership, the Department of Government Affairs advocated for policies to address the critical national shortage of child and adolescent psychiatrists, including the need for increased graduate medical education funding to child psychiatry training programs. She also worked to ensure that children who receive mental health services are not denied care due to limitations in their health plan.

Specifically, this ensured that lifetime and annual limits were treated equally, hence creating the pathway for full mental health parity. Mary also fought to prevent budget cuts to children’s mental health services and research and ensured the AACAP’s message was heard by testifying before Congress.

In 2001, Mary received the Catchers in the Rye Advocacy Award and the Council dedicated the Opening Reception to Mary in honor of her achievements for child and adolescent psychiatry, children, and families.

Mary Crosby served as Deputy Director and Director of Government Affairs for 25 years retiring in 2005. She symbolized our fight for better access to better services. She was an indefatigable fighter and director, grooming Kristin Kroeger Ptakowski who seamlessly took on the network and excellent leadership that Congress and our members count on and expect. Little did I know that in retirement Mary Crosby would set new standards as our stealth eighth director. To call her a safety net is too paltry but on several occasions when we needed an interim director, be it in Research, Training and Education, the Journal Editor Search, Development, Membership etc., Mary agreed to take on the mantle of directing these different offices and did it superbly, always leaving the position in better shape than she found it. It is a dream to have a superstar, not an understudy, in the wings should a situation call for a superstar. Thanks Mary for an extraordinary five years of spontaneous leadership and superb capacity for jobs well done.”

Virginia Q. Anthony, AACAP Executive Director
Learn About AACAP’s Endowment!

Melinda Lim, AACAP Development Coordinator

Many of the fantastic programs that AACAP develops and implements are outside our operating budget. Fortunately, the AACAP Endowment exists to fund important programs that support AACAP’s mission. Learn more about how the AACAP Endowment expands on the professional resources to help our membership and promote the healthy development of children, adolescents, and families.

Advocacy and Collaboration Grants

For the past five years, the AACAP Endowment has funded the Advocacy and Collaboration program, which offers grants to projects developed by AACAP regional organizations (ROCAPs) to improve access to mental health resources. ROCAPs partner with community allies to create these projects. In 2010, the AACAP funded five projects created by the California, Georgia, Maryland, Minnesota, and New York ROCAPs. As an example, the Maryland ROCAP partnered with six community mental health organizations to enhance the ability of primary care providers in a low-resource area to detect, treat, and refer children with mental health problems. The project focused on two primary care offices that serve rural populations with high rates of unemployment and who also face geographic barriers to accessing mental health services.

Parent Summit

Another longstanding AACAP Endowment program is the Parent Summit. Twice a year, the board presidents and executive directors of organizations such as the National Alliance on Mental Illness (NAMI), Mental Health America, and Children and Adults with Attention-Deficit Hyperactive Disorder (CHADD) meet at the AACAP headquarters in Washington, D.C., to discuss issues currently affecting the field of children’s mental health. Through this dialogue, the group formulates strategies to work together to advocate for mental health issues. At the most recent meeting, in September 2010, the Parent Summit started an initiative between the AACAP and six other national mental health organizations to combat the growing trend in the media of blaming “bad parenting” as the cause of children’s mental illnesses; targeting bad parenting habits or lack of a discipline structure traditionally set by parents as the reason for over-the-top rebellious behavior or aggression in very young children.

Educational Outreach Program for Child and Adolescent Psychiatry Residents

The AACAP Endowment also funds the Educational Outreach Program, which began over ten years ago and provides child and adolescent psychiatry (CAP) residents matching travel stipends of $750 to attend the AACAP Annual Meeting. CAP residents are required to participate in the mentorship program and attend special events such as the Career Development Program and the Young Leaders Award Luncheon. Administered by the Committee on Medical Student and Residents, the program funded 33 residents to attend the 2010 Annual Meeting in New York, providing those individuals with the opportunity to experience the cutting edge science and network with members and other residents that could eventually become valuable professional contacts.

Congressional Fellow

In the fall of 2009, the AACAP Endowment became the main source of funding for a new AACAP initiative: the Congressional Fellow Program. The 2009 – 2011 program is named after AACAP Past-president Irving N. Berlin, M.D. (1975-77), whose vision was to encourage the AACAP to more formally engage in public policy activities in order to introduce child and adolescent psychiatry into the lexicon of legislative advocacy by creating our Government Affairs department. From the month of September to the following July, the Irving Berlin, M.D. Congressional Fellow works on Capitol Hill with congressmen and legislative staff on mental health issues as they relate to policy decisions. For 11 months, the AACAP funds living and initial moving costs for the fellow as he/she works alongside a congressman and their staff to serve as the in-house expert on issues in the area of children’s health, mental health, and access to care that could affect legislation. This year the AACAP selected Scott Palyo, M.D., to work in Senator Debbie Stabenow’s (D-MI) office. The AACAP looks forward to hearing about his experience and efforts on the Hill as his year comes to a close this July. The AACAP Government Affairs department is currently interviewing for the 2011-2012 Congressional Fellow, which will be named the Mary Crosby Congressional Fellow, after Mary Crosby, AACAP’s former director of Government Affairs.
Thank You for Supporting AACAP

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

Gifts Received November 23, 2010 through January 31, 2011

$100,000 to $149,999
AACAP Douglas B. Hansen, M.D. Annual Review Course and Training Session for the Oral Exams
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Ruth and Peter Metz Family Foundation

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Congressional Fellow Program
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Life Members Fund
Dr. E. James and Virginia Anthony
Richard Gross, M.D.

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Campaign for America’s Kids
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You also can contact the AACAP’s Development Office at 202.966.7300 ext. 130 or email at
development@aacap.org.
Attention Life Members!

Who Are AACAP Life Members?

AACAP Members qualify as Life Members when they reach:

- A mandatory minimum age of 65; and attain
- 30 years as a member.
- Total must add to 95 years of age plus membership

*Each year above age 65 reduces the number of membership years required by one year.*

Benefits:

- Annual AACAP Dues are optional.
- The AACAP Journal is available for $60.
- Participation in many exclusive Life Member Activities!

Fact: Approximately 1,030 of AACAP’s members are Life Members.

*Please contact Amanda Iverson, assistant director of member services to find out if you qualify as a Life Member.*

Visit the Life Members’ Online Community today and share your thoughts and ideas for the group. Discussion topics include mentoring strategies, retirement, and more. Go to http://www.aacap.org/cs/life_members/online_community and log in with your AACAP username and password.

Read the quarterly Life Member e-Newsletter. Did you miss the December issue? If so, contact Melinda Lim, development coordinator, at mlim@aacap.org or 202-966-7300 ext. 140 to ensure you’re on our email list.

Attend Life Member events at the Joint AACAP/CACAP Annual Meeting in Toronto from October 18 – 23, 2011 such as the 4th Annual Life Member Reception and Dinner and learn about how a ‘secret’ study group has existed for 42 years!

Contribute to the Life Members Fund! Support Life Members’ activities, such as funding travel awards to the Annual Meeting for child and adolescent psychiatry residents, and mentorship session at the Joint AACAP/CACAP Annual Meeting in Toronto. Visit http://www.aacap.org/cs/giving to donate or learn more information about Life Members’ programs.

*It’s never been a better time to be a Life Member!*
Save the Date

AACAP/CACAP Joint Annual Meeting
October 18-23, 2011
Sheraton Centre Toronto and Hilton Toronto – Toronto, Ontario, Canada

New Research Poster Submission Deadline: June 15, 2011

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MAINE
CHILD/ADOLESCENT PSYCHIATRISTS
Acadia Hospital
Bangor, Maine

As part of our continued growth and development, Acadia Hospital is recruiting for BE/BC child psychiatrists to join our current team on the child and adolescent inpatient unit and in our outpatient clinic and partial hospital programs. Other opportunities include consultation to the Pediatric Service at Eastern Maine Medical Center and work in a Juvenile Corrections Center.

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Bangor area offers an international airport, a symphony, and the University of Maine flagship campus. As a small city in a rural setting, you will find excellent school systems, very affordable housing and a safe living environment. Four-season outdoor activities include boating, hiking, biking, skiing and golfing. Bangor is located about one hour from both Acadia National Park and Baxter State Park, and is about two hours from New England’s largest ski resorts.

Acadia Hospital offers a highly competitive salary and benefit package, reasonable on-call responsibilities, moving expenses and a loan repayment program.

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Please e-mail resumes to: Nancy Barrows at nbarnows@emh.org or apply online at www.acadiahospital.org – careers

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When added to a stimulant, extended-release Kapvay™ demonstrated statistically significant improvement of ADHD symptoms compared with a stimulant alone at the end of 5 weeks of treatment, as measured by the ADHD RS-IV total score.

Indication

Kapvay™ (clonidine hydrochloride) extended-release tablets are indicated for the treatment of attention deficit/hyperactivity disorder (ADHD) as monotherapy or as adjunctive therapy to stimulant medications in children and adolescents ages 6-17. The efficacy of Kapvay™ is based on the results of 2 clinical trials in children and adolescents.

Kapvay™ is indicated as an integral part of a total treatment program for ADHD that may include other measures (psychological, educational, and social) for patients with this syndrome.

The effectiveness of Kapvay™ for longer-term use (more than 5 weeks) has not been systematically evaluated in controlled trials; therefore, the physician electing to use Kapvay™ for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

Important Safety Information

- Kapvay™ should not be used in patients with known hypersensitivity to clonidine.
- Kapvay™ can cause dose-related decreases in blood pressure and heart rate. Use caution in treating patients who have a history of syncope or may have a condition that predisposes them to syncope, such as hypotension, orthostatic hypotension, bradycardia, or dehydration. Use with caution in patients treated concomitantly with antihypertensives or other drugs that can reduce blood pressure or heart rate or increase the risk of syncope.
- Somnolence/Sedation were commonly reported adverse reactions in clinical studies with Kapvay™. Potential for additive sedative effects with CNS-depressant drugs. Advise patients to avoid use with alcohol. Caution patients against operating heavy equipment or driving until they know how they respond to Kapvay™.
- Patients should be instructed not to discontinue Kapvay™ therapy without consulting their physician due to the potential risk of withdrawal effects. Kapvay™ should be discontinued slowly in decrements of no more than 0.1 mg every 3 to 7 days.
- In patients who have developed localized contact sensitization or other allergic reaction to clonidine in a transdermal system, substitution of oral clonidine hydrochloride therapy may be associated with the development of a generalized skin rash, urticaria, or angioedema. Use cautiously in patients with vascular disease, cardiac conduction disease, or chronic renal failure. Monitor carefully and uptitrate slowly.
- Clonidine may potentiate the CNS-depressive effects of alcohol, barbiturates or other sedating drugs.
- Use caution when Kapvay™ is administered concomitantly with antihypertensive drugs, due to the additive pharmacodynamic effects (e.g., hypotension, syncope).
- Kapvay™ should not be used during pregnancy unless clearly needed. Since clonidine hydrochloride is excreted in human milk, caution should be exercised when Kapvay™ is administered to a nursing woman.
- Caution is warranted in patients receiving clonidine concomitantly with agents known to affect sinoatrial node function or AV nodal conduction (e.g., digitalis, calcium channel blockers and beta-blockers) due to a potential for additive effects, such as bradycardia and AV block.
- Clonidine, the active ingredient in Kapvay™, is also approved as an antihypertensive. Do not use Kapvay™ in patients concomitantly taking other clonidine-containing products, (e.g., Catapres® (clonidine hydrochloride), JENLOGA).
- Common adverse reactions (incidence at least 5% and twice the rate of placebo) include: somnolence, fatigue, upper respiratory tract infection, irritability, throat pain, insomnia, nightmares, emotional disorder, constipation, nasal congestion, increased body temperature, dry mouth, and ear pain.

Kapvay™ is a trademark of Shionogi Pharma, Inc.
Catapres® is a registered trademark of Boehringer Ingelheim.

Please see Brief Summary of full Prescribing Information on the adjacent page.
KAPVAY (clonidine hydrochloride) extended-release tablets, oral, Rx only

INDICATIONS AND USAGE
KAPVAY™ is a centrally acting alpha₂-adrenergic agonist indicated for the treatment of attention deficit hyperactivity disorder (ADHD) as monotherapy or as adjunctive therapy to stimulant medications. (1)

The efficacy of KAPVAY is based on the results of two clinical trials in children and adolescents. (14) Maintenance efficacy has not been systematically evaluated, and patients who are continued on longer-term treatment require periodic reassessment. (1)

This extended-release formulation of clonidine hydrochloride is also approved for the treatment of hypertension under the trade name JENLOGA. (1)

CONTRAINdications
KAPVAY should not be used in patients with known hypersensitivity to clonidine.

WARNINGS AND PRECAUTIONS

Hypotension/Bradycardia
Treatment with KAPVAY can cause dose related decreases in blood pressure and heart rate. In patients that completed 5 weeks of treatment in a controlled, fixed-dose monotherapy study in pediatric patients, during the treatment period the maximum placebo-subtracted mean change in systolic blood pressure was -4.0 mmHg on KAPVAY 0.2 mg/day and -8.8 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in diastolic blood pressure was -4.0 mmHg on KAPVAY 0.2 mg/day and -7.3 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in heart rate was -4.0 beats per minute on KAPVAY 0.2 mg/day and -7.7 beats per minute on KAPVAY 0.4 mg/day.

During the taper period of the fixed-dose monotherapy study the maximum placebo-subtracted mean change in systolic blood pressure was +3.4 mmHg on KAPVAY 0.2 mg/day and -5.6 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in diastolic blood pressure was +3.3 mmHg on KAPVAY 0.2 mg/day and -5.4 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in heart rate was -0.6 beats per minute on KAPVAY 0.2 mg/day and -3.0 beats per minute on KAPVAY 0.4 mg/day.

Measure heart rate and blood pressure prior to initiation of therapy, following dose increases, and periodically while on therapy. Use KAPVAY with caution in patients with a history of hypotension, heart block, bradycardia, or cardiovascular disease, because it can decrease blood pressure and heart rate. Use caution in treating patients who have a history of syncope or may have had syncopal events. Advise patients to avoid becoming dehydrated or overheated.

Sedation and Somnolence
Somnolence and sedation were commonly reported adverse reactions in clinical studies. In patients that completed 5 weeks of therapy in a controlled fixed dose pediatric monotherapy study, 31% of patients treated with the maximum dose of 0.4 mg/day and 38% treated with 0.2 mg/day vs 7% of placebo treated patients reported somnolence as an adverse event. In patients that completed 5 weeks of therapy in a controlled flexible-dose pediatric monotherapy study 19% of patients treated with KAPVAY 0.2 mg/day and 18% treated with placebo. The use of KAPVAY may elicit an allergic reaction (including generalized rash, urticaria, or angioedema). Patients who have developed localized contact sensitization to clonidine transdermal system, continuation of clonidine transdermal system or substitution of oral clonidine hydrochloride therapy may be associated with the development of a generalized skin rash.

Patients with Vascular Disease, Cardiac Conduction Disease, or Renal Failure
Clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, conduction disturbances, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

Other Clonidine-Containing Products
Clonidine, the active ingredient in KAPVAY, is also approved as an antihypertensive. Do not use KAPVAY in patients concomitantly taking other clonidine-containing products, (e.g. Catapres®).

ADVERSE REACTIONS

Clinical Trial Experience
Two KAPVAY ADHD clinical studies evaluated 256 patients who received active therapy, in one of the two placebo-controlled studies (Study 1 and 2) with primary efficacy endpoints at 5-weeks.

Study 1: Fixed-dose KAPVAY Monotherapy
Study 1 was a multi-center, randomized, double-blind, placebo-controlled study with primary efficacy endpoint at 5 weeks, of two fixed doses (0.2 mg/day or 0.4 mg/day) of KAPVAY in children and adolescents (6 to 17 years of age) who met DSM-IV criteria for ADHD hyperactive or combined inattentive/hyperactive subtypes.

Commonly reported adverse reactions (incidence of ≥ 2% in either active treatment group and greater than the rate on placebo) during the treatment period are listed in Table 2.

Table 2 Common Adverse Reactions in the Fixed-Dose Monotherapy Trial- Treatment period (Study 1)

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>KAPVAY 0.4 mg/day N=78</th>
<th>KAPVAY 0.2 mg/day N=76</th>
<th>Placebo (N=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somnolence*</td>
<td>31%</td>
<td>38%</td>
<td>5%</td>
</tr>
<tr>
<td>Headache</td>
<td>19%</td>
<td>29%</td>
<td>18%</td>
</tr>
<tr>
<td>Upper Abdominal Pain</td>
<td>13%</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Fatigue*</td>
<td>13%</td>
<td>16%</td>
<td>1%</td>
</tr>
<tr>
<td>Upper Respiratory Tract Infection</td>
<td>6%</td>
<td>11%</td>
<td>4%</td>
</tr>
<tr>
<td>Irritability</td>
<td>6%</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Nausea</td>
<td>8%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Nightime</td>
<td>9%</td>
<td>3%</td>
<td>0</td>
</tr>
<tr>
<td>Dry Mouth</td>
<td>5%</td>
<td>0</td>
<td>1%</td>
</tr>
<tr>
<td>Nasal Congestion</td>
<td>5%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Body Temperature Increased</td>
<td>1%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Gastrointestinal Viral</td>
<td>0%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>1%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Ear Pain</td>
<td>0</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Skin and Appendage</td>
<td>3%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Headache</td>
<td>19%</td>
<td>29%</td>
<td>18%</td>
</tr>
<tr>
<td>Abdominal Pain Upper</td>
<td>6%</td>
<td>0</td>
<td>3%</td>
</tr>
<tr>
<td>Headache</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Gastrointestinal Viral</td>
<td>5%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Somnolence</td>
<td>3%</td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td>Heart Rate Increased</td>
<td>3%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Urticaria et al.</td>
<td>0</td>
<td>3%</td>
<td>0</td>
</tr>
</tbody>
</table>

1. Somnolence includes the terms "somnolence" and "sedation".
2. Fatigue includes the terms "fatigue" and "lightheadedness".

Commonly observed adverse reactions (incidence of ≥ 2% in either active treatment group and greater than the rate on placebo) during the taper period are listed in Table 3.

Table 3 Common Adverse Reactions in the Fixed-Dose Monotherapy Trial- Taper period (Study 1)

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>KAPVAY 0.4 mg/day N=78</th>
<th>KAPVAY 0.2 mg/day N=76</th>
<th>Placebo (N=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain Upper</td>
<td>6%</td>
<td>0</td>
<td>3%</td>
</tr>
<tr>
<td>Headache</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Gastrointestinal Viral</td>
<td>5%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Somnolence</td>
<td>3%</td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td>Heart Rate Increased</td>
<td>3%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Urticaria et al.</td>
<td>0</td>
<td>3%</td>
<td>0</td>
</tr>
</tbody>
</table>

* Taper Period: 0.2 mg dose; week 6: 0.4 mg dose, weeks 6-8; Placebo dose, weeks 6-8

Study 2: Flexible-dose KAPVAY as Adjunctive Therapy to Psychostimulants
Study 2 was a multi-center, randomized, double-blind, placebo-controlled study, with primary efficacy endpoint at 5 weeks, of a flexible dose of KAPVAY as adjunctive therapy to a psychostimulant in children and adolescents (6 to 17 years of age) who met DSM-IV criteria for ADHD hyperactive or combined inattentive/hyperactive subtypes. KAPVAY was initiated at 0.1 mg/day and titrated up to 0.4 mg/day over a 3-week period. Most KAPVAY treated patients (75.5%) were escalated to the maximum dose of 0.4 mg/day.

Commonly observed adverse reactions (incidence of ≥ 2% in either treatment group and greater than the rate on placebo) during the treatment period are listed in Table 4.
Interactions with Drugs Known to Affect Sinus Node Function or AV Nodal Conduction

If a patient is receiving clonidine hydrochloride and also taking tricyclic antidepressants the hypotensive effects of clonidine may be reduced.

Interactions with Tricyclic Antidepressants

If a patient is receiving clonidine hydrochloride and also taking tricyclic antidepressants the hypotensive effects of clonidine may be reduced.

Interactions with Drugs Known to Affect Sinus Node Function or AV Nodal Conduction

Due to a potential for additive effects such as bradycardia and AV block, caution is warranted in patients receiving clonidine concomitantly with agents known to affect sinus node function or AV nodal conduction (e.g., digitalis, calcium channel blockers and beta-blockers).

Use with other products containing clonidine

Do not use KAPVAY concomitantly with other products containing clonidine (e.g. Catapres®).

Antihypertensive Drugs

Use caution when KAPVAY is administered concomitantly with antihypertensive drugs, due to the potential for additive pharmacodynamic effects (e.g., hypotension, syncope) [see Warnings and Precautions (5.2)].

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Category C: Oral administration of clonidine hydrochloride to pregnant rabbits during the period of embryo/fetal organogenesis at doses of up to 80 mcg/kg/day (approximately 3 times the oral maximum recommended daily dose [MRHD] of 0.4 mg/day on a mg/m² basis) produced no evidence of teratogenic or embryotoxic potential. In pregnant rats, however, doses as low as 15 mcg/kg/day (1/2 the MRHD on a mg/m² basis) were associated with increased resorptions in a study in which dams were treated continuously from 2 months prior to mating and throughout gestation. Increased resorptions were not associated with treatment at the same or at higher dose levels (up to 3 times the MRHD) when treatment of the dams was restricted to gestation days 6-15. Increases in resorptions were observed in both rats and mice at 500 mcg/kg/day (10 and 5 times the MRHD in rats and mice, respectively) or higher when the animals were treated on gestation days 1-14; 500 mcg/kg/day was the lowest dose employed in this study. No adequate and well-controlled studies have been conducted in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should not be used during pregnancy unless clearly needed.

Nursing Mothers

Since clonidine hydrochloride is excreted in human milk, caution should be exercised when KAPVAY is administered to a nursing woman.

Pediatric Use

A study was conducted in which young rats were treated orally with clonidine hydrochloride from day 21 of age to adulthood at doses of up to 300 mcg/kg/day, which is approximately 3 times the maximum recommended human dose (MRHD) of 0.4 mg/day on a mg/m² basis. A slight delay in onset of preputial separation was seen in males treated with the highest dose (with a no-effect dose of 100 mcg/kg/day, which is approximately equal to the MRHD), but there were no drug effects on fertility or on other measures of sexual or neurobehavioral development.

KAPVAY has not been studied in children with ADHD less than 6 years old.

Patients with Renal Impairment

The impact of renal impairment on the pharmacokinetics of clonidine in children has not been assessed. The initial dosage of KAPVAY should be based on degree of impairment. Monitor patients carefully for hypotension and bradycardia, and titrate to higher doses cautiously. Since only a minimal amount of clonidine is removed during routine hemodialysis, there is no need to give supplemental KAPVAY following dialysis.

Adult Use in ADHD

KAPVAY has not been studied in adult patients with ADHD.

DRUG ABUSE AND DEPENDENCE

Controlled Substance

KAPVAY is not a controlled substance and has no known potential for abuse or dependence.

OVERDOSAGE

Symptoms

Clonidine overdose: hypotension may develop early and may be followed by hypotension, bradycardia, respiratory depression, hypothermia, drowsiness, decreased or absent reflexes, weakness, irritability and moxie. The frequency of CNS depression may be higher in children than adults. Large overdoses may result in reversible cardiac conduction defects or dysrhythmias, apnea, coma and seizures. Signs and symptoms of overdose generally occur within 30 minutes to two hours after exposure.

Treatment

Consult with a Certified Poison Control Center for up-to-date guidance and advice.

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