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New Research Poster Submission Deadline: June 17, 2013
Book Hotel and View Preliminary Program: June 17, 2013
AACAP Member Registration Opens Online: August 1, 2013
General Registration Opens Online: August 8, 2013

AACAP’s 60th Annual Meeting
October 22–27, 2013 • Orlando, FL
Walt Disney World Dolphin Hotel

Gabrielle A. Carlson, M.D.
Program Chair
Robert L. Hendren, D.O.
60th Anniversary Committee Chairs
Marilyn B. Benoit, M.D.

Visit www.aacap.org/cs/annualmeeting/2013 for the latest annual meeting information!
While visiting rural villages in Guizhou, China, I was struck by how happy, robust, and independent the children appeared. In a rural market I met this toddler clutching one of the two chickens his mother had just bought as if it was a natural plaything for him. –Robin G. Berglund, M.D., M.B.A.
MISSION STATEMENT
Mission of 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.
- Liases with other physicians and health care providers and collaborates with others who share common goals.

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Our Priority Is Not to Be Listless!

As I entered the second year of my presidency, I wanted to set forth what I thought were the top priorities for action in 2013. After coming up with my list, I discussed it with AACAP Executive Director, Heidi Fordi, and the Executive Committee. A final list was created, which was then discussed with the Council. Having reached consensus on the list, Ms. Fordi met with her staff and came up with a grid for each priority that included the goals for the coming year, the components of AACAP (committees, taskforces, AACAP News, JAACAP, W.E.B., staff, etc.) that would need to be involved and the action steps to move towards the stated goals. This grid will serve as the template for actions in the upcoming year.

The priorities are:

1. **Back to Project Future**, my major presidential initiative, which will hopefully assist AACAP in its planning and actions for the next decade.
2. Education of members regarding DSM-5.
3. Education of members about Healthcare Reform, including medical/health records.
4. Education of members on new CPT Codes. This project is well underway and is apparently quite a success with members and non-members judging by the fact that we have had over 68,000 hits for our educational efforts online.
5. Evaluation of the revised process for creating AACAP Practice Parameters, which have been made to come into compliance with the new Institute of Medicine Guidelines for Parameters.
6. Implementation of 501(c)(6) that will allow for the creation of a PAC (Political Action Committee).
8. Implementation of a Pharmaceutical Task Force that will incorporate guidelines of the new Federal "Sunshine Laws" as to reporting of financial interchanges between pharmaceutical firms, their agents, and physicians.
9. K-12 Renewal Award that will continue our successful NIDA (National Institute on Drug Abuse) grant to develop new research.
10. Planning for the 60th anniversary meeting in Orlando, Florida. Stay tuned for ongoing stories about our upcoming annual meeting and birthday party.
11. Psychotropic Monitoring and Foster Care Developments.
12. Review and revision of AACAP Bylaws.
13. Review of the JAACAP publication contract.
15. AACAP International: Partnering for the world’s children. This is the major initiative of our next president, Paramjit Joshi.

These 15 priorities that began with my major presidential initiative and end with the next president’s major initiative are guaranteed to keep AACAP and its staff busy in the coming months. I thank all who will be involved in moving things forward. If you have any questions or comments, please let me know.

**Slow and Steady Wins the Race**

Speaking of moving forward, our numerous previous efforts at advocacy seem to be paying off. These efforts, that remain ongoing priorities that transcend the yearly priority list that I have listed above.

In the past weeks, AACAP has seen itself invited to the President’s Conference on Gun Control and Mental Health, with reference to many of our main proposals mentioned in Vice President Joseph Biden’s speeches. In addition, we are being asked for our input on mental health issues on an increasing basis; our media contacts and our website “hits” continue. And, we were successful at placing a letter to the editor titled “Treatment of A.D.H.D.” signed by yours truly in the February 4, 2013, issue of The New York Times. All these things do not occur magically. They are the end products of years of hard work by AACAP members and staff. To celebrate these successes, which are the “tip of an iceberg” of hard and steady work, I have asked Kristin Kroeger Ptakowski, AACAP’s senior deputy executive director and director of Government Affairs and Clinical Practice, to discuss all the efforts that have gone on for years “just below the surface.” (See page 106). I thank Kristin, the staff, and the AACAP members who work with her in advocating for AACAP and the children it seeks to assist in leading healthy and happy lives.

**Martin J. Drell, M.D.**

Dr. Drell is head of the Division of Infant, Child, and Adolescent Psychiatry at the Louisiana State University Medical School in New Orleans, Louisiana. He may be reached at MDrell@lsuhsc.edu.
It's a Marathon Not a Sprint!

Kristin Kroeger Ptakowski
AACAP Senior Deputy Executive Director and Director of Government Affairs and Clinical Practice

As those who have participated in AACAP advocacy trainings have heard me say time and time again, policy change does not happen overnight. It is a marathon, not a sprint. AACAP’s members and staff have been consistently advocating for children’s mental health for decades and it can be easy to lose sight of the impact we are having. But in my short 20 years of advocating for kids, I have witnessed significant advances for children with mental illness. I have noticed the stigma slowly fading away, and policymakers and the public finally realizing that we need to treat the whole child, rather than the brain and body separately. Years ago, when I walked into a Congressional office, the reception was not always supportive. They wanted to hear quickly what I had to say and move me along. They did not want to talk about mental illness. But slowly over the years, more and more Congressional staff began to open up about their own mental illnesses or those of family members and friends. As the stigma surrounding mental illness started to fade, we have seen improved access to children’s mental health services through the passage of parity legislation, improved community-based services through increased funding for the Children’s Services Program, and recognition of child and adolescent psychiatry as a shortage specialty through the passage of workforce provisions in the Affordable Care Act (ACA).

These are all significant accomplishments in which AACAP played a big part. These successes are due to three essential elements of advocacy: 1) public education, 2) collaboration, and 3) relationships and involvement.

Public Education
AACAP’s public education—through our website, the media, and letters to the editor—has increased significantly with the recognition of the challenges faced by children with mental illnesses. While very unfortunate, recent tragedies have also presented additional opportunities to educate the public about children’s mental health, and AACAP members are increasingly speaking out to the media through their local papers and on national news programs. For example, in the wake of the shootings in Newtown, Connecticut, AACAP members were part of more than 100 stories in media outlets nationwide. Our advocacy materials provide members with talking points and other resources to prepare them for these opportunities.

Collaboration
Since no one organization can do it alone, we consistently work with our allied consumer and professional organizations. AACAP began the first children’s mental health consortium in the 1980s and continues to participate in this and other coalitions. Our partnerships with parent organizations such as National Alliance on Mental Illness (NAMI), Mental Health America, Children and Adolescents with Attention-Deficit/Hyperactivity Disorder (CHADD), the Balanced Mind Foundation, Autism Society of America, and the Federation of Families for Children’s Mental Health, have been strengthened with biannual meetings, started in 2006, between our organization’s leadership and joint participation in our Advocacy Days. Many AACAP members also partner with the local chapters of the parent organizations in state-level advocacy coalitions and meetings. These partnerships have resulted in numerous wins, both guarding against damaging legislation and protecting state funds for children’s mental health. Finally, with children and adolescents with mental illnesses increasingly being treated by pediatricians, and the changes in the healthcare delivery system resulting from the ACA, our collaboration with the American Academy of Pediatrics has never been stronger. Most recently, our coordinated advocacy by leadership and staff resulted in successes around workforce and medication shortage legislation.

Relationships and Involvement
If you want to participate in policy change, you have to find a spot at the table. AACAP has earned our spot by building relationships in key Congressional offices and federal agencies. These relationships have grown year after year and continue to be essential to our advocacy efforts.

Historically, AACAP has consistently been at the table when kids’ mental health policy decisions are being made. From the early years of the first White House Conference on Mental Health and the New Freedom Commission on Mental Health, we were there to ensure that kids were not left out of the discussion. During the health care reform debate, we were invited to participate in Senator Dodd’s weekly meetings about...
the children’s health provisions within the legislation. As the ONLY mental health organization represented, I knew that we were there to ensure that mental health was included in the legislation. We continue to be at the table as the Administration discusses mental health parity, advocating that the mental health party regulations include a continuum of care for kids. On January 10, 2013, AACAP was at the White House with 14 other national mental health organizations discussing solutions to improve early identification, prevention, and services for children with mental illness with Vice President, Joe Biden.

This year we are holding our 9th annual Advocacy Day, when AACAP members partner with trainees, parents, and youth to promote children’s mental health on Capitol Hill. Each year, our attendance continues to grow. Coming to Washington, D.C., every year to advocate is essential to building relationships and to being invited to the table. For example, many participants have become advisors to their Representatives’ or Senators’ offices as a result of the connections they made at Advocacy Day. As those of you who have participated know, the excitement at Advocacy Day is electric and AACAP members bring this momentum back home to their communities where they meet locally with their legislators and strengthen connections to their parent and youth partners.

We would not be successful in our advocacy efforts if it were not for the commitment and passion of many AACAP members. Whether it is coming to Advocacy Day, responding to our advocacy alerts, organizing at the state level to fight damaging legislation, writing a letter to the editor, advocating with insurance companies for appropriate coverage, or organizing a policy briefing, it is a coordinated effort between our Government Affairs and Clinical Practice team at the national office and our grassroots. I applaud our membership for their commitment to advocacy and hope you will encourage others to get involved.

Ms. Ptakowski may be reached at kkroeger@aacap.org.

June’s Donations Matter . . . in the life of a child.

When you read this, we’ll be six-months into 2013.

While we’ve seen your amazing generosity from 2012 continue into the first half of 2013, more than ever, this is the time when we must accelerate our momentum.

Children’s mental health has become a national focus.

Child psychiatrists know best how long this focus has been needed. It is essential that this focus lead to more than just endless discussion—it must lead to action! The time is now to change the future for children with mental illness.

Be a catalyst for change!

You can help us to invest more in children’s mental health research, push harder for mental health advocacy on Capitol Hill, and to inspire more students and residents to choose child psychiatry as their career.

Please Donate Now.
Support Campaign for America’s Kids.
Transitions and Thanks

Looking Backward, Looking Forward –

JERRY M. WIENER RESIDENT MEMBER TO COUNCIL

In July, hundreds of child and adolescent psychiatry fellows will become attendings. Residents will start their fellowships. Medical students will begin their residencies. This transition is a time to think ahead to new challenges, and to reflect upon the journey so far.

For those leaving training, you can utilize these last few months to help prepare yourself to transition. This may mean going through the credentialing process to get on local insurance panels. If you are moving to a new state, perhaps you are applying for a new state medical license. You will make sure your Drug Enforcement Administration (DEA) registration is up-to-date. You may plan ahead to take your board exams or create your own plan around Maintenance of Certification. This is also a good opportunity to understand your insurance options (e.g., malpractice, disability, life). This may also mean a broader reexamination of your financial situation. Will the salary change allow you to consider a different living situation? What will happen to your student loan payments? Will you want, or need, to adjust your financial philosophy?

One key point: know that you are not alone out there! Whether you are starting a private practice, working in the public sector, or joining an academic department, your AACAP is here for you! Sign up for the Early Career Psychiatrists Committee’s ECP Xtra e-mail newsletter. Check out the AACAP ECP page (www.aacap.org/cs/early_career_psychiatrists) for information on learning about billing and coding, career-planning, and work/life balance. Perhaps, even more so than in training, it will be key to stay connected to AACAP and other members by attending meetings of your Regional Organizations, the Annual Meeting, Advocacy Day, and other training and events. Stay connected!

For those getting ready to begin fellowship, I imagine you are excited and perhaps just a bit apprehensive. Transitioning to working primarily with children and families can be challenging at times, but the opportunities to make significant impact, observe developmental progression, and grow as a clinician will far outweigh those. For some of you, fellowship will mean a physical move and all that entails. For others, you will be making more of a developmental move within your institution. Whether you are revisiting past units or starting work on a new service, remember that you are a Fellow now! Whether it feels like it or not at the beginning, you know more now and can do a great deal more now. You will have greater responsibilities, but will be able to rely upon your previous years of experience in psychiatry to guide you. You will also be able to rely upon even more specialized supervision and resources.

In terms of logistics, depending on your program, you may want to look into applying for a DEA license if you have not already done so. Hold off on buying books until you are a few months in and have a sense of how you are likely to use educational resources. The best investment may now be a subscription to a child pharmacotherapy newsletter or online access to a community with specialized resources for children dealing with trauma.

For those of you starting your psychiatry residency (and hopefully tracking into or planning on applying to a CAP fellowship!), welcome to an exciting and dynamic field! You will learn so much in the next few years that will prepare you to help children, adolescents and adults living with mental illness. Do try to remember that while most programs front-load training with inpatient and high acuity experiences, there are a broad range of levels of care and types of careers within the field. Keep an open mind to different experiences. Read and learn about your patients. Engage with your community and colleagues to stay connected and up-to-date. Most importantly, take good care of yourself so that you can take good care of others.

These transitions are also wonderful opportunities to look back on our experiences and recognize those that have helped us immeasurably along the way.

We can thank our program directors, psychiatrists who have set aside other ambitions and chosen to shepherd along a new flock, year after year. Their dedication to our development is reflected in the amazing work you do in communities across the country (and globe!).

We can thank our program coordinators, those individuals who organize us in our training. Faced with increasing regulatory burdens, each is often at the heart of a residency or fellowship program. They “keep the trains running.”

We can thank the allied professionals, from nurses and social workers to psychologists and administrators that work with us to help the children and families.

“One key point: know that you are not alone out there! Whether you are starting a private practice, working in the public sector, or joining an academic department, your Academy is here for you!”
we serve. They have so much to teach us and so much to offer our patients.

We can thank the staff that help every organization, hospital, or building that we work in function smoothly. Administrative assistants and custodial staff and food service workers all help to ensure that our organizations have the life force to impact the lives of others.

We can thank our teachers. Very few attendings have time set aside to teach. Most volunteer to do it because they care intensely about the training of new psychiatrists. Perhaps some of us can return the favor in teaching others in the next stages of our careers.

We can thank our mentors, those who have been more invested in our own development than their own. They have given of their time and energy, invested in us, and watched us grow.

“We can thank our patients – children, families, communities – who have entrusted their hurts and passions and dreams to us.”

Looking back, we have learned so much, impacted others’ lives, and developed connections to last our careers. Looking forward, we will utilize these experiences to meet the challenges to come. This is an exciting time to be a child and adolescent psychiatrist. There is a great deal to be done. Here we go…

Dr. Sengupta is a graduate of Duke University and Tufts University School of Medicine, and is a child and adolescent psychiatry fellow at the Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center. In July, he will be joining the faculty at the University at Buffalo. Dr. Sengupta is the AACAP’s Jerry M. Wiener Resident Member to Council. He may be reached at sourav.sengupta@alumni.duke.edu.
Alone, Together: The Loneliness of the Long Distance Therapist

Jennifer Harris, M.D.

I frequently remind my supervisees how solitary the work of a psychiatrist can be. While we may work with colleagues, fundamentally, our work involves sitting in a room alone with patients and trying to be helpful. Rarely does one see our work directly, and even when it happens it captures only a small fraction of all the work we have done. We have the incredible privilege of being let into our patients’ lives, and often helping them in a profound and meaningful way, that brings countless rewards to us as providers. But things do not always go so well, and it is at those moments that the responsibility and the loneliness of the work can weigh heavy.

As I write this, I have just found out that a long-term patient of mine took an overdose of acetaminophen, landing herself for the night in an ICU. I have been seeing her for years in what has been, in many ways, a very successful treatment. I had successfully tapered her off antipsychotics through individual and family work. She had been stable and functioning well for a few years, or so it seemed. But looking back at this moment, I can see many mistakes I have made. I have missed signs that she was trying to give me about how deeply she was suffering. During our session, she was upset, saying, “You just don’t understand.” In retrospect, I failed to push harder about some sexual content that was disturbing her. I did not take seriously enough some signs of a thought disturbance. And, I was not in touch with her parents as often, or as deeply, as I should have been.

On a deeper level, though, I am struck with how profoundly solitary this work can be. I am capable of reassuring myself, of understanding my errors in a productive way, of getting consultation and moving forward. But underneath it all, I still have to live with the feeling that I hold people’s lives in my hands, or at least in my head. I carry around their stories and their pain, and when they suffer it feels on some level my fault. If only I had paid more attention, responded differently, asked the right question.

I do not think that there is a way around this dilemma. To be caring and available to patients, we must make ourselves vulnerable to these feelings. To get better as therapists, we must be willing to see our mistakes and acknowledge them. To help our patients, we must do long-term work; and with long-term work can come complacency and mistakes. And as physicians, we carry more responsibility, both practically and ethically, whether we would choose to or not.

Thoughtful researchers have studied the phenomenon of being depleted by the challenges of care-giving work. Studies on physician burnout and compassion fatigue point to many factors: personality traits including perfectionism, the need to be in control, high achieving “type A” personality and the associated

“In a deeper level, though, I am struck with how profoundly solitary this work can be.”
guilt); lifestyle causes including working too much, too little down-time, not getting enough sleep, not having control over your schedule; and work-related causes like lack of recognition or rewards for good work, working in a chaotic or high-pressure environment, have all been implicated. Suggestions are plentiful and helpful: do not take work home, join groups, diversify your work, get therapy yourself, set good boundaries, develop outside interests, do not take on too many cases.

I agree with all of these suggestions, and do my best to implement many. I know that for me, good therapy and supervision have been extremely helpful. Good self-care, including enough time to rest, to be with my family, and to do some creative activities that do not remind me of work helps. I also try to be as kind to myself at these moments as I strive to be with my patients when they tell me of their errors and missteps. I reach out to friends and colleagues (and especially friends who are colleagues) to remind myself that this experience is not unique to me. And that ultimately, we are together in our aloneness.

Perhaps most importantly, it helps me to remember that it is inherent in the nature of the work. Just as being in our “real relationships” with loved ones inevitably involves making ourselves vulnerable to being hurt (by unrequited love, by absences, by empathic pain), so too does being emotionally available to our patients. While I do not like how badly I feel when I wish I had done better, I must accept that these feelings are a part of the work itself. I remind myself that this is the price I pay for having a career that I love.

Dr. Harris is a clinical instructor at Harvard Medical School and teaches at Cambridge Hospital. She also has a private practice in Arlington, Massachusetts. She may be reached at jennifer_harris@hms.harvard.edu.

AACAP Achieves CME Milestone

Committee and Continuing Medical Education Committee that we were able to achieve this status.

Special recognition goes to Bennett Leventhal, M.D., Jeff Bostic, M.D., and Tristan Gorrindo, M.D., for their countless hours dedicated to developing and enforcing policies and procedures that support our programs.

Elizabeth Hughes
Assistant Director of Education and Recertification

AACAP underwent a rigorous reaccreditation process in 2012 with the Accreditation Council for Continuing Medical Education (ACCME) to continue AACAP’s ability to be a provider of continuing medical education.

The ACCME announced its decision in April 2013, awarding AACAP with Accreditation with Commendation, which results in a six year accreditation term.

This decision confirms the strength of AACAP’s CME program. It is through the work of our outstanding Program

Jef Bostic, M.D., Bennett Leventhal, M.D., Tristan Gorrindo, M.D., Heidi Büttner Fordi, and Quentin Bernhard III.
YOUTH CULTURE

Kids, Guns, and Violence

Susan Swick, M.D.

A child is shot approximately every 31 minutes in the United States. Adolescents between the ages of 15 and 19 years are more than 40 times more likely to be killed by gunfire in the United States than in all of the other industrialized nations of the world combined. Eighty-seven percent of the children under 15 who are killed by gunfire worldwide live in the United States. In both 2008 and 2009, twice as many U.S. preschoolers were killed by gunfire as were U.S. law enforcement officers killed by gunfire in the line of duty. Since 2005, gunfire has been inching up towards the top of the list of leading causes of death of American children and teens. By 2010, gunfire was second only to motor vehicle accidents among the leading causes of death of children and adolescents in the United States (CDC 2010; FBI 2010). And 2012 may be the year in which gunfire became the leading cause of death of children in the United States.

These numbers are jarring, but despite my interest in the mental health of American children and my identity as a parent of four young children, I was only vaguely aware of them. It took the slaughter of 20 first grade students and their teachers in their classrooms on a sunny Friday morning close to Christmas to turn me towards the horrors of this deadly epidemic. On that day, I spent several hours speaking to news outlets about how parents might speak to their own children who had heard about the event – asking kids what they had seen, responding with honest yet age-appropriate information. I urged parents to offer reassurance: “The adults in our town, elected leaders, teachers, doctors, parents and policemen are doing everything they can to make sure that nothing like this ever happens again.”

But are we?

Since that horrible day, I have been actively following the public conversation about how we as a country should address this crisis. Reassuringly, many voices have been participating: the president and vice president, grieving parents, policemen, mayors of cities ravaged by gun violence, faith leaders, and public health researchers. Of course, one of the loudest voices is that of Wayne LaPierre and the National Rifle Association, claiming to speak for four million gun owners. The key question for us is what role child and adolescent psychiatry can, and should, play in this debate.

To be sure, our patients are listening to the debate. Whether they are facing the perils and grief of living on Chicago’s South Side or are newly vigilant in a suburban school they thought was safe, they are listening. Those families with children in treatment, whether for ADHD, bipolar disorder, or Asperger’s, are listening. Those families whose children should be in treatment also are listening. And our patients themselves, perhaps struggling with secrecy and stigma, violent impulses or fantasies, or addiction to video games, are listening.

What they have heard so far about mental illness and violence has been mostly misleading and stigmatizing. When Mr. LaPierre suggested that there should be “a national database of these lunatics,” to prevent mass shootings (presumably with the background checks he now opposes), it seems best not to honor his suggestion with any more discussion. When the director of the Gun Owners of America suggested on CNN that the true cause of the American epidemic of school violence was “the fact . . . that 90 percent of these school shooters are on antidepressant medications,” it may sound like sadly familiar scapegoating and backwards reasoning (NBC News 2012). But our patients are listening.

I expect those who have billions of dollars in gun sales at stake to be looking for scapegoats, and of course video games and mental illness are their preferred targets. But the role of mental illness in mass shootings, such as those at Virginia Tech, Tucson, Aurora, and now Sandy Hook, does raise understandable questions for the public and for policymakers alike. While there is an increased risk of violence in patients suffering from certain psychiatric conditions, most acts of violence are not committed by people with mental illness (Monahan 2005). The mentally ill are more likely to be victimized by violence than to commit it. And of course, it would be unethical (and foolhardy) to theorize about the nature of any diagnosable psychiatric problem in the Newtown shooter, Adam Lanza. But when this is all we have to say about mass shootings, we as a profession look hapless and miss an opportunity.

Psychiatrists, and child and adolescent psychiatrists in particular, should be at the center of this discussion. Some things we do know and should say. We know about the forces that might drive children, teenagers, and young adults to use guns to manage conflicts and grievances: the importance of adult...
mentors and social supports; the role of normal adolescent impulsivity; the links between substance abuse and untreated mental illness and violence, both self- and other-directed (Swanson et al. 1990); the dramatic increase in risk of death from a gunshot in every family member when a gun is in their home (Kellermann et al. 1993). We also know the exquisite difficulties already faced by families trying to get treatment for a child with mental illness, even without the heightened stigma and social isolation caused by discussions of mentally disturbed mass shooters.

We know that violence like that in Newtown cannot be explained by video games: few data support the notion that virtual violence directly increases the risk for violent behavior (Anderson et al. 2001). But we also know that playing violent video games can increase aggression and diminish empathy for victims; that some young people are at risk to develop addictive patterns of playing violent video games; and that some young people substitute violent video game play for actual social networks (Gentile et al. 2010; Walkup, Rubin 2012). We know even highly skilled forensic clinicians can predict violence with a success rate not much better than chance.

Perhaps child and adolescent psychiatrists hesitate to speak out because so much of what we do is subtle, nuanced, and even uncertain. These are not qualities that make for easily packaged soundbites. What can we say? Here is a start:

- Untreated mental illness in American children creates an enormous burden of suffering for patients, families, and communities.
- Untreated mental illness can increase an individual’s risk for violence, both suicide and homicide.
- Psychiatric treatment works.
- Families wrestling with psychiatric illness in a child need and deserve our understanding and support, not social isolation and shame.

Families facing psychiatric illness in a child need and deserve a health care system that delivers high-quality, effective treatment in a timely way, just as if their child had broken a leg or developed leukemia.

Families need to be aware that the presence of a gun in their home increases the risk of death by that gun of each person in the home.

How should we deliver this message? In letters to the editor of community newspapers; in op-ed pieces; in school forums and community debates; to our congressmen; on professional blogs; to our professional colleagues in pediatrics and education. And in collaboration between AACAP and the American Psychiatric Association, to enhance the reach and authority of our message.

The time to speak up is now. Our patients and their families are listening.

References


NBC News (2012). Wayne LaPierre on Meet the Press with David Gregory, December 23


Dr. Swick is the acting chief of Child and Adolescent Psychiatry at Newton Wellesley Hospital, where she is also the director of the PACT (Parenting At a Challenging Time) program at the hospital’s Vernon Cancer Center. She is an attending psychiatrist at Massachusetts General Hospital’s Division of Child and Adolescent Psychiatry and is an instructor in Psychiatry at Harvard Medical School. She may be reached at sswick@partners.org.
Have you met Molly, Matthew, Cammie or Chance? Their stories are among the case vignettes available to you on-line through your AACAP membership. For over a decade, the AACAP Psychotherapy Committee has heard from residents and faculty that they need cases to read that model clinical reasoning, therapeutic techniques, and the process of change in psychotherapy. The committee created an annotated bibliography of classic or favorite psychotherapy articles (www.aacap.org/cs/root/member_information/practice_information/psychodynamic_readings_for_residents_or_fellows), but in the era of instant online access, many of these articles are frustratingly hard to find online, often requiring access to the Psychoanalytic Electronic Publishing (PEP-Web) database available through some, but not all, university libraries.

As a benefit of AACAP membership, you have online access to AACAP News, JAACAP, and to the Child and Adolescent Psychiatric Clinics of North America. All three publications offer readings that can be used to teach psychotherapy and clinical reasoning through case presentations. I will share some of my favorites and urge readers to provide “supervisory comments.”

A wonderful aspect of masterful clinical writing is that it ages well. Research articles are soon outdated. One rarely turns back ten years to read research articles in JAACAP. But the clinical articles, despite being relatively few and far between, still demonstrate core skills, core developmental processes, and typical psychopathological formations. “Wild Child”: How Three Principals of Healing Organized 12 Years of Psychotherapy appeared in the orange journal in 2003 (Terr 2003). Lenore Terr, M.D., an exceptionally gifted writer of case material, takes the reader through her work with severely traumatized “Cammie.” Stella Chess, in 2004, called Dr. Terr’s article “a splendid example of good teaching” for its presentation of multiple theoretical view points (including common sense), its therapeutic eclecticism, demonstration of developmental optimism, and recognition of the unique features of the foster parents in this case. The twelve-year duration of treatment allows trainees to see beyond the time limits of their own training experience. The use of play and the creation of narratives are vividly demonstrated. In 2009, “Cammie,” whose real name is Mia, spoke with CBS News reporter John Blackstone in a video, Mia’s Story, which can be viewed on YouTube to further enliven class discussion.

For those teaching techniques of dyadic, parent-child psychotherapy, the intergenerational transmission of psychopathology or reflective function, the Rieger Award-winning 2009 paper in JAACAP by Daniel Schechter, M.D., and Erica Willheim, “When Parenting Becomes Unthinkable: Intervening With Traumatized Parents and Their Toddlers” (Schechter and Willheim 2009) is a five-page gem. Particularly touching is

“As a benefit of AACAP membership, you have online access to AACAP News, JAACAP, and to the Child and Adolescent Psychiatric Clinics of North America. All three publications offer readings that can be used to teach psychotherapy and clinical reasoning through case presentations.”

Rachel Z. Ritvo, M.D.
the moment when the mother, Carol, is crying in the bathroom with her two children, Chance and Monty, wailing outside the door. The next day, Carol describes to her therapist how she called him up in her mind and, using what she imagined he would have said, she was able to leave the bathroom and comfort her daughters with a meaningful explanation of what had happened to scare them all.

The clinical reasoning of three master child and adolescent psychiatrists, Martin Drell, M.D., Henrietta Leonard, M.D. (deceased), and John F. McDermott, M.D., is presented over the course of three articles in “The Case of Matthew” that appeared in JAACAP in 2002 (Nurcombe et al. 2002). Barry Nurcombe presents the case material and the three experts open their minds to the reader. For those of us who knew Henrietta Leonard, it is wonderful to have the teaching she loved continue despite her untimely death. Despite the push toward a biomedical view of child psychiatry that DSM-III and IV gave us, and our uncertainty regarding where DSM-5 will take us, “The Case of Matthew” gives a wonderful tool to those who want to teach a biopsychosocial, developmentally-informed approach. Matthew is a child whose functioning is deteriorating at school and at home. The reader observes how three clinicians hear the clinical data, organize it in their thinking, generate hunches, and check and revise these hunches as more information becomes available. Additionally, Nurcombe’s descriptions of the clinical encounters offer the material directly to the reader to model the interview technique and to draw one’s own opinions of the data.

Did you know you can access the Child and Adolescent Psychiatric Clinics of North America directly from the JAACAP website? Scroll down the JAACAP homepage to find the link in the lower left hand column to a box marked “More Periodicals.” October 2011 saw the publication of “Cognitive-Behavioral Therapy (CBT) in Youth” with fourteen articles covering the state of the art of CBT treatment for many child psychiatric conditions. Particularly helpful to those teaching introductory child psychotherapy and clinical reasoning, “Core Principles in Cognitive Therapy with Youth” by Friedberg and Brelsford emphasizes case conceptualization and the modular format for treatment (Friedberg, Brelsford 2011). Additionally, the value of collaboration, guided discovery, therapeutic alliance formation, “empiricism,” clinical transparency, and “bringing the head and the heart to consensus” are explained. Unfortunately, the CBT volume presents few clinical vignettes.

Schuyler W. Henderson, M.D., M.P.H., and I have edited two issues on psychodynamic psychotherapy for the 2013 Child and Adolescent Psychiatric Clinics of North America with a total of fifteen articles. The motivation for these volumes was to provide child and adolescent psychiatrists, particularly those teaching in our training programs, with easily accessible, up-to-date psychodynamic articles that would be free of psychoanalytic jargon and outdated psychoanalytic controversies. We requested that the authors create clinical illustrations to make the theories and techniques experience near for the readers.

For example, Judy Yanof’s article in the April 2013 issue “Play Technique in Psychodynamic Psychotherapy” – distills dynamic play technique as it has developed over half a century including co-construction and therapist enactments in the play (Yanof 2013). Yanof’s clinical illustrations make technical terms meaningful and easy to learn; and brings the child very much alive. The movement in the therapist’s mind from “getting” the meaning of a play metaphor to making a comment or enacting a play response is clearly demonstrated. In “Psychodynamic Psychotherapy as Treatment for Depression in Adolescence” (Midgley, et al. 2013) present Josie, a depressed 15-year-old with a recent overdose, from intake through the course of Short-term Psychodynamic Psychotherapy (STPP), a 28-session therapy. Here the reader has the opportunity to follow the progression of the treatment, the patient’s comments, and the nature of the clinician’s thoughts throughout the course although there is relatively little verbatim presentation of the clinician’s comments.

Do you have a favorite psychotherapy teaching article readily available online? Let me know.

References


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The Turkish Association for Child and Adolescent Psychiatry was established in 1991. The Board has seven members including a president, vice president, treasurer, and general secretary. The Association has always been the core working body for the advocacy of child and adolescent mental health and also for the development of child and adolescent psychiatry (CAP) as a separate branch in medicine (officially accepted in 1996).

There are 16 committees within the association working on various subjects like infant and adolescent mental health, consultation-liaison, ADHD and learning disorders, autism and other pervasive developmental disorders, mood disorders, inpatient psychiatry, disabilities, ethics, trauma, psychopharmacology, children’s rights, international affairs, public education and forensic psychiatry. Development of research projects, increasing public awareness for child and adolescent mental health, publishing books and booklets for professionals and the public, organizing meetings and training courses, and establishing a Code of Ethics are some of the activities carried on by these committees.

A Board for Training in CAP, established within the Association, coordinates the training programs, works on standardization in affiliation with the Union of European Medical Specialties (UEMS), prepares the board exams for qualification, and establishes continuing medical education (CME) programs. The CAP training program is four years long.

Young medical doctors enter the program by a central medical examination. CAP is currently one of the most highly rated specialties in the country. The training program consists of theoretical, clinical, and research components run in an integrative way. Both biological and psychodynamic sides of CAP are covered in the curriculum; and basic psychotherapy courses are also provided. Since some of the CAP departments have small numbers of academic staff, the Turkish Association establishes complementary courses three times a year.

The Association organizes the National Child and Adolescent Psychiatry Congress and an Adolescent Psychiatry Symposium annually. The Turkish Journal of Child and Adolescent Psychiatry, published quarterly, is the official journal of the Association. During the previous years, six books were published, one being a textbook of CAP, and the other, a handbook.

The Association had been the group responsible for preparing the Child and Adolescent Mental Health Section of the National Mental Health Policy Program in 2003. This led to the establishment of the Child and Adolescent Mental Health Division under the Department of Mental Health within the Ministry of Health, and since then has been serving as the Advisory Council for this Division, which is primarily responsible for policy development.

Though the members of the Association are working very hard to carry on the aims of our profession, there are, of course, some obstacles that we have to struggle with. One of the important issues in Turkey is the small number (around 400 total) of child and adolescent psychiatrists per population under 18 years of age (1 for 60,000). Some measures to improve this are being recently taken by the long-term efforts of policy-makers.

There are also difficulties in the implementation of prevention programs, which is the result of not only politics but also resources. There is a need for more psychologists, social workers, counselors, and other mental health professionals working in the field, as well as child and adolescent psychiatrists. We are working in collaboration with other professional organizations to increase these numbers. Financial resources to run projects can be obtained rather easily nowadays from international institutes or nongovernmental organizations (NGOs), like the European Union, UNICEF, and others, but sustainability of the programs is still a problem.

Currently, most of the CAP services are provided by the university departments. There are 40 university clinics and 35 state hospital clinics. However, only six of the CAP clinics have inpatient units, and most CAP patients have to be admitted to either pediatric medicine or adult psychiatric wards. This is an issue that each child psychiatry department has to act on at a local hospital level because of the lack of implementation of the national policy projects.

More epidemiological studies need to be done to determine the number of children suffering from mental problems.

“One of the important issues in Turkey is the small number (around 400 total) of child and adolescent psychiatrists per population under 18 years of age (1 for 60,000).”
The most frequently seen psychiatric problems among children and adolescents are the anxiety disorders. Depressive disorders are second with substance use and personality disorders infrequently diagnosed.

We are a small group facing many difficulties but are highly motivated to work for the mental health needs of children, adolescents, and families and very much devoted to do as much as we can for further development of our field both nationally and internationally. The Association is enthusiastic about international collaborations as well: it is a member of the Economic and Social Commission for Asia and the Pacific (ESCAP) and the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP); and had been the local organizing party of the 18th World Congress of IACAPAP in 2008. The Adolescent Committee within the Association has been developing an annual symposium since 1996, and next year we will be hosting the Regional Congress of the International Society for Adolescent Psychiatry and Psychology in Ankara. Turkish colleagues are attending the AACAP Annual Meetings in increasing numbers every year. We will be happy to collaborate with AACAP for future work and studies.

Professor Çuhadaroğlu is professor of Child and Adolescent Psychiatry at Hacettepe University Faculty of Medicine in Ankara, Turkey; chief of Outpatient Adolescent Psychiatry Clinic at İhsan Doğramacı Children’s Hospital; serves as president of the Turkish Association, and has leadership positions with the ISAPP, ESCAP, and IACAPAP. She may be reached at fusun.cetin@gmail.com.

Ayesha Mian, M.D. is the coordinator for the Child Psychiatry Around the Globe column and is soliciting articles for this column. If you are interested but have not been contacted directly, she may be reached at mian@bcm.tmc.edu.

Attention Life Members!

Stay connected to all Life Member activities, programs and photos by reading the Life Member eNewsletter distributed quarterly via e-mail. Did you receive the latest Life Member eNewsletter in December?

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Since 2010, the Life Members Fund, which you started and funded, has made an investment in 22 residents and 17 medical students through its two grant awards: Education Outreach for Child and Adolescent Psychiatry Residents and Mentorship Grants for Medical Students. You impacted the lives of 39 young people who are, or will become, the next generation of child and adolescent psychiatrists.

While this achievement is remarkable, it’s our option to double, triple, even quadruple this number in the next two years. We’re at a time of health care change when our skills have never been more important, but the deficit of available child and adolescent psychiatrists is growing. Who better than Life Members to be the leaders in solving this deficit?

To donate, visit www.aacap.org/cs/life_members/life_members_fund_update.
Synthetic cannabinoids are a new class of compounds confronting child and adolescent psychiatrists. Many clinicians are unfamiliar with the substances, but their widespread prevalence and enduring popularity suggest that all of us will be encountering their effects in our clinical practice. With little research data and rapid acceptance of synthetics by teens, it is important that we share our clinical knowledge.

Synthetic cannabinoids are compounds designed to be full agonists at the type 1 cannabinoid receptor (CB1), effectively mimicking the psychoactive properties of tetrahydrocannabinol (THC) (Fattore and Fratta 2011). They have been used in research to investigate the brain’s endocannabinoid system, including rodent studies of addiction, where synthetic cannabinoids are more effective for self-administration paradigms than THC. Typically, small packets are sold legally in ‘head shops,’ gas stations, independent grocers, and over the Internet, marketed under trademarks such as “Spice” and “K2.” These compounds are often sprayed onto plant matter designed to mimic the smell of burning cannabis, but some are designed to have a more benign appeal, with pleasant fruity smells and packaging—perhaps attracting younger and/or more cautious users. The products’ purported use as incense, and often sarcastically phrased prohibition against smoking the products, protects the producers from litigation for the many adverse events associated with their use. The warning “not for human consumption” appears on the label, even as the product stands on head shop shelves next to devices designed to smoke it.

Synthetic cannabinoids pose new regulatory challenges. The federal government made an initial attempt at regulating synthetic cannabinoids in 2011. It banned the five most prevalent compounds found in synthetic cannabinoid products through emergency Drug Enforcement Administration scheduling, but unfortunately left an easily exploited loophole in the system. The prohibited active ingredients were chemically modified making them chemically distinct from the five regulated compounds. The time between the law’s announcement and its date of enforcement was long enough for manufacturers to substitute these compounds, preventing a lag in supply. The substituted compounds were again widely accepted by users, and sales quickly returned to previous levels.

Responding to deficiencies of initial federal actions, a sophisticated piece of legislation called Food and Drug Administration Safety and Innovation Act was passed in 2012. The Act attempted to anticipate the adaptations of molecules chemists and producers by banning chemicals based on chemical structure and the ability to activate the CB1 receptor. However, because the act did not ban all CB1 agonists, only those within five specified chemical classes, more novel chemicals were able to escape the ban. Internet sales of synthetic cannabinoids continue to this day, making them more convenient to obtain than most substances of abuse.

While the literature on these compounds is in its infancy, it has already yielded valuable information on the effects of synthetic cannabinoids. Subjective experiences of users strongly suggest that the quality of their ‘high’ is similar to cannabis, with a common complaint being that synthetics are too likely to cause anxiety. A recent study (Vandrey et al. 2012) showed that most individuals reported a pleasant high from using, but 54% of individuals reported at least sometimes feeling paranoid from synthetic cannabinoids, 54% felt nervous or anxious, and 28% reported hallucinations. These effects are not categorically distinct from those seen with cannabis use (diForti et al. 2009), and, as with cannabis, tachycardia (Gorelic, Heishman 2006) and dry mouth are both common. Adverse effects are often insufficient to dissuade individuals from continuing use. Reasons cited for popularity include potent psychoactivity, legality, ready availability, and non-detection in standard drug testing (Vandrey et al. 2012). These factors are driving their appeal to youth.

The Monitoring the Future study showed that 11.3% of 12th graders used synthetic cannabinoids (Johnston et al. 2012) in the past year; a rate that barely changed from 11.6% in 2011, despite the federal

“The financial success of synthetic cannabinoids virtually ensures that tomorrow’s youth will be faced with more choices of synthetic chemicals, targeting a greater array of receptors, and mimicking a wider array of illegal drugs.”
ban. The drugs’ rapid emergence into common use among American teens is remarkable, as they were only first detected here in 2008. Synthetics perceived similarity to cannabis may also enhance initiation by youth, as the percentage of teens perceiving great risk in using cannabis has continued to fall (Johnston et al. 2012).

Case 1: An intelligent 15-year-old male, with a family history of substance dependence and a personal history of ADHD (without conduct disorder), used synthetic cannabinoids several times per week. He obtained the drug from the local head shop, whose stated policy was to not sell to those under 18 years of age, but this was customarily disregarded if the buyer was known to the employees. After smoking synthetic cannabinoids, he was admitted to the inpatient unit for anxiety, agitation, and auditory hallucinations leading to suicidal ideation. He was frightened by the incident and decided to cease using synthetic cannabinoids. However, instead of discarding them, he put his supply inside of a box and wrapped it several times around with duct tape, making it difficult to access the contents. He initially reported that he did this because it would discourage his mother from inspecting the content, as he was contemplating the best way to dispose of them. One week after discharge, he experienced an interpersonal stressor, then came home, cut the box open, and began using the synthetics again. A recurrence of panic and agitation caused another trip to the emergency department, and he was discharged with an admonishment to cease use, but without substance use follow-up. At his next outpatient appointment, he was referred to an outpatient substance program, to which his mother reluctantly assented after considerable discussion. He confessed craving, and admitted that his attachment to the synthetics influenced his decision not to discard them earlier.

Child and adolescent psychiatrists must be aware of synthetic cannabinoids and associated clinical presentations, amid unprecedented availability of highly potent compounds. Federal and state regulation of these substances has struggled to keep pace with the emerging landscape. Sales through legal retailers and internet distribution bring these substances into every community, while globalization and difficulties policing emerging economies make supply chains difficult to disrupt. The financial success of synthetic cannabinoids virtually ensures that tomorrow’s youth will be faced with more choices of synthetic chemicals, targeting a greater array of receptors, and mimicking a wider array of illegal drugs. The hesitation of young users to use a substance that could be illegal makes synthetics an attractive option for experimentation. Clinical identification of users of synthetics and counseling of the risks—in light of the perceived benefits of the drugs—is increasingly important.

References

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CONSUMER ISSUES COMMITTEE

Staying Strong Together: Fostering Resiliency in Military-Connected Families

Carlene M. MacMillan, M.D.

“S”he’d be good at special ops herself! My girl can keep a secret!” declares Rosa, concerned that her reserved 13-year-old daughter Bettina is not expressing her feelings about her father’s repeated deployments. A brief animated video depicting Bettina and her family provides further details about this military family’s challenges. Paula Rauch, M.D., a child and adolescent psychiatrist and AACAP member, then comes on the screen to discuss common issues raised by the case. This is one of multiple animated vignettes presented on a new website devoted to providing parent guidance to military-connected families and to helping educators who have military-connected students. The website, www.StayingStrong.org, is one of many emerging online resources for these military-connected families and the educators and professionals who care for them.

There is a great need for these resources as there are now roughly two million children in the United States with active-duty military parents (Lester 2012). Multiple recent studies suggest there is heightened risk for emotional and behavioral symptoms for children who are part of military-connected families (Lester 2010; Mansfield 2011). As veterans return to communities across America, the medical and psychological care of their family members will be provided by civilian clinicians, many of whom have little or no familiarity with the challenges associated with military life. A number of online resources are now available to educate providers and enrich the psychiatric care we provide to military-connected children. Innovative partnerships between academic or government institutions and the private sector have been initiated to serve those who have served our nation.

StayingStrong.org, an initiative of the Red Sox Foundation and Massachusetts General Hospital’s Home Base Program (www.homebaseprogram.org), is one example of an innovative partnership. The Home Base Program serves Iraq and Afghanistan veterans and families through clinical care, community education, and research. Staying Strong takes a proactive, preventative stance and builds upon the experiences of Dr. Rauch and her colleagues, providing parent guidance and support as part of Massachusetts General Hospital Cancer Center’s Parenting at a Challenging Time Program (PACT: www.mghpact.org). While the PACT program addresses the challenges and needs of parents with cancer and other life-threatening illnesses, many of the same principles apply to the challenges facing military families living with repeated deployments and facing reintegration to civilian life. Both are based on an appreciation that resilience is not a special quality found within certain children, but is the responsibility of the caring adults in each child’s life. These programs emphasize that challenges facing families, whether it be critical illness in a parent, a military deployment, or any other major stressor, are experienced within the context of each child’s developmental phase. Children in elementary, middle, and high schools will have different ways of processing what is going on for their family and, therefore, parent guidance should be tailored to each child’s temperament and developmental stage. From a shy preschooler who is having

“There is a great need for these resources as there are now roughly two million children in the United States with active-duty military parents.”
Further Resources from the Consumer Issues Committee:


Visit AACAP’s Military Families Resource Center at www.aacap.org/cs/MilitaryFamilies.ResourceCenter

References


Dr. MacMillan is a first-year child and adolescent psychiatry fellow at Massachusetts General Hospital and McLean Hospital. Dr. Rauch is one of her supervisors, whom she thanks for guidance in preparing this article. Dr. MacMillan is a member of the Consumer Issues Committee. She can be reached at cmacmillan@partners.org.
According to the 2010 U.S. Census, ethnic and racial minorities already comprise 36.3 percent of the overall U.S. population and this percentage is anticipated to increase over the next few decades.

In his 2001 report, then-United States Surgeon General, Tommy G. Thompson, highlighted racial and ethnic disparities in health care. He described how cultural factors influence various facets of mental illness, including symptom presentation, coping mechanisms, availability of family and community supports, and treatment adherence. In addition, the cultures of the treating clinician and the service system can influence diagnosis, treatment, and service delivery. The report concludes with a call for culturally competent services which “incorporate respect for, and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems.”

For adolescent patients from an ethnic minority background, the role of cultural factors in symptom presentation and treatment outcomes is particularly relevant. The process of identity formation can be challenging for youth from an ethnic minority background as they struggle to integrate the values of two different cultures in creating their own cultural identity. Factors such as language, family structure, religion, societal, and familial expectations all contribute to a sense of cultural identity.

At a period when peer acceptance is paramount and when youths seek to assert their independence, the process of cultural identity development can create individual stress and intrapersonal conflict as adolescents and families may find themselves caught between two cultural paradigms. Adolescents may abandon certain values of their natal culture in an attempt to assimilate, while parents may seek to preserve those values. For immigrant populations, differences between the acculturative stance of the parents and that of the children can increase the level of acculturative stress experienced as individuals and as a family (Farver et al. 2002). Various factors associated with the processes of immigration and acculturation have been linked to an increased incidence of behavioral and psychiatric disorders amongst second-generation immigrants (Rothe et al. 2010). A study of 579 adolescents from diverse backgrounds found that those youths who endorsed a strong sense of ethnic identity had greater self-esteem, more positive academic attitudes, and more adaptive daily wellbeing (Kiang and Fuligni 2010).

Understanding the cultural framework of a particular patient and his or her family is integral to a clinician’s success in conceptualizing the child’s illness, establishing an alliance with the patient and the family, and improving treatment outcomes.

The following case of an adolescent illustrates how appreciation of her cultural milieu aided treatment progress.

Priya is a 16-year-old, East Indian girl with ADHD and anorexia who first presented to psychiatric treatment because of anxiety and oppositional behavior at home. Conflict with her parents overtly centered on her restrictive eating practices. However, what became apparent over the course of treatment was her profound cognitive dissonance with her ethnic heritage. She disliked her family’s Indian cuisine, was unhappy that she was “dark-skinned,” and had abandoned her Indian friends in pursuit of non-Indian friends. She desperately longed to fit in with her non-Indian peer group and openly rejected the culture and values of her parents.

“In order to effectively address cultural factors, child and adolescent psychiatrists need to expand their knowledge base about their patient’s cultural backgrounds, maintain an attitude of respect, avoid stereotyping, and assist the family in making treatment decisions.”
Nonetheless, she had internalized her parents’ work ethic and worried about being academically successful. Her parents complained that she was disrespectful at home and adopting “American” values. Priya’s therapist, who came from a different cultural background, struggled to understand the parents’ concerns. Through consultation with an Indian colleague, she was able to better understand traditional Indian culture and the vantage point of the parents.

Priya’s parents had come from poor, rural families in India and had, through their hard work and natural aptitude, become highly successful professionals. They were outwardly assimilated into American culture, but, at home, retained traditional Indian values. However, Priya attended a high school with predominantly white, American-born students, and she sought desperately to fit in with her peers. Her family’s traditional values clashed with those of her host culture and she did not have Indian peers who could help her reconcile the two cultural paradigms. Her restrictive eating habits represented her internal struggle against her parents’ values and expectations.

As the clinician facilitated open dialogue within the family about the underlying cultural issues and helped the parents appreciate Priya’s bicultural identity, the eating disordered behavior improved. As per the therapist’s suggestion, Priya was able to express the American aspects of her identity by cooking non-Indian cuisine for the entire family. The therapist sympathized with the parents’ concerns in raising a bicultural teen and empowered them to enforce age-appropriate behavioral expectations for Priya that were consistent with their own traditional Indian values.

In working with families and adolescents from an ethnic minority background, clinicians should utilize the following principles:

1. Maintain an atmosphere of open inquiry, a nonjudgmental attitude, and an appreciation for both the parents’ and the adolescent’s point of view.
2. Elicit details of the parents’ immigration story. What stressors have marked the process and how have they handled those? How have they adjusted to, and how do they perceive, the host culture? What was their culture of origin and how they define their own cultural identity? Assess their understanding of normal adolescent development and their expectations of behavior from their adolescent.
3. Explore the adolescent’s experience of cultural identity. Has the adolescent thought about cultural influences? How does the adolescent perceive himself/herself or self-identify?
4. Assess the cultural context of the home environment and that of the external environment, looking at cuisine, language, familial structure, gender roles, as well as modes and styles of communication. Is the external environment vastly different from that of the host environment? Is there a high degree of conflict between the parental values and those of the adolescent’s peer group?
5. Utilize community, religious, and cultural resources that may facilitate treatment progress and help to bridge the acculturative family distancing.
6. Maintain awareness of one’s own cultural background and biases.

Child and adolescent psychiatry is a field that is inextricably intertwined with the social and cultural context of a child and family. In order to effectively address cultural factors, child and adolescent psychiatrists need to expand their knowledge base about their patients’ cultural backgrounds, maintain an attitude of respect, avoid stereotyping, and assist families in making treatment decisions (Pumariega et al. 2009).

References


“United States Census Bureau American Fact Finder”. Available at: factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDPI&prodType=table. Accessed 2/7/13

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“Trix Are for Kids!”

Kristopher Kaliebe, M.D., and Sonia Krishna, M.D.

“The food you eat can be either the safest and most powerful form of medicine or the slowest form of poison.”

— Ann Wigmore

Recently, AACAP cosigned a letter from the Center for Science in the Public Interest to convince Nickelodeon, the popular children’s television network, to implement strong nutrition standards in its food marketing to children. AACAP’s advocacy position here has reflected concern over the overall socialization and education of modern children, along with questions regarding the role of our professional organization in addressing media choices and nutritional issues.

There is now a significant evidence-base supporting links between media exposure, obesity, and declining mental health. Before assessing some mental health research, let us examine data on changes in the American diet. The 2008 U.S. Department of Agriculture study tracks a quarter century of increases in refined grains, fats, and sweeteners (Well, Buzby 2008). Specifically, from 1970 to 2005, the yearly per capita total grain consumption rose to 192 pounds from 137 pounds; added oils and fats reached 68 pounds versus 53 pounds; and added sugars and sweeteners totaled 142 pounds compared to 119 pounds. These trends are consistent with other data that show the obesity epidemic has been driven, in large part, due to over-consumption of hyper-caloric food. The authors noted that processed “food products” meant to be eaten between meals or away from the home were significant drivers of this increased consumption.

Despite the increase in processed components with dubious health effects, food products have been promoted, labeled, and packaged in the manner most likely to give the appearance of a wholesome healthy product—regardless of nutritional value! A poignant example is the breakfast cereal industry. Any glance down this aisle in the grocery exemplifies successful marketing to children with likable cartoon characters encouraging consumption of high sugar content, vitamin injected, artificially processed, and brightly colored grains. At this point, Trix really are for kids, because that is the type of food most of today’s youth choose to, and, in fact, do eat.

Television advertising has been the primary means of “educating” children and adolescents about these targeted food products. Children’s massive exposure to television and other media has helped make these advertising campaigns so successful. Total media viewing now averages over seven hours daily for 8 to 18-year-olds (Rideout et al. 2010). Shockingly, media consumption is over 16 hours daily for 21 percent of that group! In addition to what they watch directly, new research shows that average U.S. children are exposed to over 230 minutes of background television on a typical day (Lapierre 2012). While these trends have helped corporate bottom lines, the resultant unhealthy lifestyles have had a pernicious effect on children’s health. The damage may go beyond measurable waistlines or symptoms. A new article specifically demonstrates that exposure to advertising lowers children’s life satisfaction (Opree et al. 2012).

Furthermore, the connection between modern diets and mental health outcomes has grown dramatically in the last decade. One example, the evidence-base is quite large linking unhealthy diets and worsening ADHD symptoms. Increased rates of this disorder have paralleled the dietary changes tracked above, and have specifically been found in those who consumed Western style diets (Howard et al. 2011). Also, food additives have been shown to contribute to ADHD symptoms (Nigg et al. 2012). In contrast, a recent meta-analysis of essential fatty acids shows a positive effect (Bloch and Qawasmi 2011), and

“…the combination of large amounts of screen time and the nutrient poor hyper-caloric diets of our youth create a public health dilemma and are contributors to psychiatric illness.”
Studies show similar benefits with elimination diets (Nigg et al. 2011).

The totality of these many lines of evidence further the case that restricting media with food advertising, or better yet a complete “media fast,” might be a first line of treatment to address the dysfunctional lifestyles and psychiatric disorders so commonly comorbid in today’s children and adolescents.

Relative to our ancestors, we clearly have more comfortable lives, plentiful food, wonderful leisure opportunities, and amazing ways to connect. Yet the combination of large amounts of screen time and the nutrient-poor, hyper-caloric diets of our youth create a public health dilemma and are contributors to psychiatric illness. Child and adolescent psychiatrists need to be mindful of new research on these subjects so we can understand the ecology our patients and their families inhabit, and use interventions that work to address these biopsychosocial challenges. If we were to do so, it would be Magically Delicious!

Tips on basic health practices: www.rcpsych.ac.uk/expertadvice/problems/nutrition.aspx

References:

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Dr. Krishna is a second year Child and Adolescent Psychiatry Fellow at the UCLA Semel Institute of Neuroscience and Human Behavior. She has been awarded the AACAP EOP Travel Award and the AACAP Life Members Travel Award to attend the annual conferences. She currently serves as the appointed Resident Committee Member on the Complementary and Integrative Medicine Committee of AACAP.

Residents: Attend the AACAP Annual Meeting and Get Involved!

The American Academy of Child and Adolescent Psychiatry (AACAP) offers numerous award programs and opportunities for residents to get involved and attend AACAP meetings. Some of the current opportunities are listed below.

Educational Outreach Program – Award Deadline: July 12, 2013

The Educational Outreach Program (EOP) for both child and adolescent psychiatry residents and general psychiatry residents provides funding support for residents to attend the AACAP 60th Annual Meeting, October 22-27, 2013 in Orlando, Florida. The Annual Meeting provides residents with exposure to the field of child and adolescent psychiatry, including research and networking opportunities. More information regarding the EOP program can be found on the AACAP website at www.aacap.org/cs/residents/opportunities or by contacting the Training and Education Department at training@aacap.org.

Systems of Care Special Program Scholarship – Award Deadline: July 12, 2013

Child and adolescent psychiatry residents are encouraged to apply for the 2013 Systems of Care Special Program Scholarship. The scholarship includes $1,000 plus shared funding from a training program or regional organization for travel expenses to the AACAP 60th Annual Meeting, October 22-27, 2013 in Orlando, Florida. Residents may apply to both the Special Program Scholarship and the Educational Outreach Program (EOP); however, individuals cannot receive both awards at the same time. For more information, please visit www.aacap.org/cs/residents/opportunities or contact the Clinical Practice Department at clinical@aacap.org

Serving on Committees

Resident members can get involved with national initiatives by serving on one of AACAP’s committees. Serving on a committee is a great way to network with senior members and experience how AACAP members work together to address issues of national concern. AACAP is now accepting applications for residents to serve on committees. Below is a list of committees with open resident member positions. To apply, send an email with a statement of interest for your top three committee choices and a copy of your CV to executive@aacap.org by July 12, 2013. (Note: Residents are only permitted to serve on one committee.)

Open Committees:

For a complete description of all AACAP Committees, visit www.aacap.org/cs/members_only/committees.

References:

What makes for a good mentor? I believe that it’s the mentor’s ability to see you, the mentee, for who you are, and more importantly, for the person you can become.

My first mentorship experience was with my dear Russian-Jewish parents. In all their best intentions, they had it all figured out for me. They were quite focused on who they would have liked me to become. I just needed to follow their directions. I had another mentorship experience with some of my Soviet school teachers. They brought to me their pre-packaged lessons, and, whatever they were, I could either take them or leave them.

Since then, I have had many other mentors, and this is what I came to believe as an early career psychiatrist (ECP). I feel that a good mentor is:

1) **Someone who wants to help you grow, but does not determine the direction of the path.**
2) **Someone who wants to discover with you the lessons you need to learn.**

As I am writing these words, yet another 2013 snowstorm is dropping its soft snowflakes outside my window in Massachusetts. “This could be the last snowstorm of this winter,” I think with excitement. “Soon, it will be time to buy the seeds and seedlings for a new crop of berries, vegetables, and flowers!”

I imagine reading the labels on each packet of seeds—this one needs lots of sun, while this one needs shade; lots of support required for the vines of tomatoes, while sunflowers will do fine without support; plant less than three inches deep versus at least one foot.

The job of a gardener is not simple: a gardener must follow specific directions, precisely for the plant to have a chance to blossom into a magnificent specimen. What about the job of a mentor? How do mentors manage to help new generations of mentees blossom?

Mentees do not come with instructions on how to handle them for best results. But, mentees are able to provide clear feedback to their mentor—“I need more support on this side, and less on that.” And mentors can be direct in their communication with the mentee—“I am good at growing excellent tomatoes, but if you want to grow into a fine rose, I can refer you to my colleague who would be a much better fit.”

Unfortunately, most mentors and mentees tend not to communicate enough. As an aspiring gardener and educator, I would like to share some thoughts on what may be helpful for both mentors and mentees to think about during development of their mentor-mentee relationship.

As a mentee, consider asking yourself these questions.

- What are my strengths?
- What are my mentor's strengths?
- What are my career goals?
- What are my mentor's career goals?
- How do my and my mentor's strengths and goals overlap?

Is this a conversation that I and my mentor could have openly on a regular basis?

Humans are born with several innate needs: to connect with others, to learn, and to grow as individuals. The role of a mentor is to facilitate this growth or at least not get in its way.

During my fellowship, one of my child and adolescent psychiatry mentors gave me a chance to coauthor an academic paper at my own pace, but with specific guidance that I asked of him. He taught me that a good mentor can be both most available and directive, and, at the same time, as hands-off as possible. He gave me an assignment that was far above what I could do comfortably, but he made sure that I was interested in this assignment and that he gave me

“What a miracle it is when a collegial or supervisory relationship can produce the fruits of true mentoring—Connection, Learning, and Personal Growth!!”
crystal-clear directions when I asked for help. He also taught me that an effective mentor did not need to be regularly or frequently present. Like a good diamond cutter, making the right cut at the right time is what matters. Knowing the diamond’s potential, and then helping it come out of the rough stone is the art of mentoring.

On graduation from fellowship, another one of my mentors encouraged me to obtain the job at a program that has since proven to be the best fit between my strengths and my career goals. He taught me that a mentor is someone who helps open the door to the next stage of your life. Many stars must align for this magical door to open—the door must be there, you must be trying and ready to open it, and the mentor must be able to see your potential, the door, and the way to help you step through this door.

Two years after starting my first job, another mentor recognized that my strengths would be better used in a different position. She helped me transition there smoothly, and I am approaching a happy third year there.

Throughout my development as a child and adolescent psychiatrist, numerous mentors at AACAP have given me opportunities to take on exciting projects in which my roles gradually evolved from highly supported to leadership.

Mentorship matters. It is part of our drive to connect, to learn, and to develop. Our mentors help us become who we are. Mentorship is the bridge between the real world and the one of imagination and spirit.

I have been fortunate to have connected with many wonderful mentors. As I travel on my professional journey, I continue to discover new mentors. I have now become a mentor to others. What a miracle it is when a collegial or supervisory relationship can produce the fruits of true mentoring—connection, learning, and personal growth!!

Dr. Lorberg is assistant professor, Division of Child and Adolescent Psychiatry, UMass Medical School, Worcester, Massachusetts. He is the co-chair of the Early Career Psychiatrist Committee. He may be reached at boris.lorberg@umassmed.edu.

New York Council of Child and Adolescent Psychiatry

Elizabeth Hughes

On March 13, 2013, I had the pleasure of meeting with the New York Council of Child and Adolescent Psychiatry to discuss maintenance of certification (MOC). Sponsored by the Early Career Psychiatry (ECP) Committee of the New York Council, the meeting focused on the four-part ABPN requirements as part of a process of improvement and reevaluation of performance measures that will ultimately lead to improved care for one’s patients.

It is always great to meet with our members face-to-face and try to address misperceptions and frustration that often accompany MOC. We realize that upon first glance it can seem complex and burdensome, but with a little guidance, and the help of our AACAP-developed, ABPN-approved tools, we aim to make the process as simple and stress free as possible.

Thank you to Angel Caraballo, M.D., and Vera Feuer, M.D., co-chairs of the ECP Committee of the New York Council, for organizing a great event.

For more information on MOC, please visit our website at www.aacap.org/cs/maintenance_of_certification.

Rachel Mandel, M.D., Jose Vito, M.D., William Yu, M.D., Vera Feuer, M.D., Elizabeth Hughes, Angel Caraballo, M.D., Scott Palyo, M.D., Tata Alejandra Valencia, M.D., Paula Marie Smith, M.D., and Adrianna Rego, M.D.
AACAP Mentorship Network

Be part of a network of enthusiastic AACAP members committed to mentoring medical students, residents & early career psychiatrists.

The Mentorship Network aims to:

- Identify, recruit & provide quality mentors to medical students, residents & early career psychiatrists interested in child and adolescent psychiatry;
- Introduce mentors & mentees;
- Recruit medical students & residents into child and adolescent psychiatry; and
- Enhance careers & build relationships between mentors and mentees.

Make a difference in the careers of medical students, residents or early career psychiatrists by serving as a mentor.

Contact:
AACAP Research, Training, and Education Department
(202) 966-7300 • training@aacap.org
Early Career Psychiatrist Committee
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SRS-2
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The second edition of this highly regarded autism assessment offers the convenience of a screener and the power of a diagnostic tool. Completed in just 15 to 20 minutes, the SRS-2 identifies social impairment associated with autism spectrum disorders (ASDs) and quantifies its severity. It's sensitive enough to detect even subtle symptoms, yet specific enough to differentiate clinical groups, both within the autism spectrum and between ASD and other disorders.

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ADHD Revisited: More Challenging News

ADHD is the most common neurodevelopmental disorder. As child and adolescent psychiatrists, we are fully aware of the risks and challenges that having this disorder presents. In recent News Updates, we have reported on a series of epidemiologic studies on the long-term impact of having this disorder. While these studies have clearly demonstrated multiple adverse outcomes, they have generally been subject to the limitations associated with self-reports, retrospective examinations, or identifying subjects in specialty clinics. Published online in March in Pediatrics, Barbaresi and his colleagues report on a prospective cohort of over 360 participants followed for 17 years drawn from the Rochester, Minnesota (Mayo Clinic) area. In this study, under agreement with the local school district, they examined the school records of every child in the Rochester school district from January 1, 1976, through December 31, 1982. This included 41 public and private schools. They identified 379 children who met ADHD criteria based on either: 1) documented findings within the school record, 2) documented positive ADHD questionnaire results, or 3) documented medical diagnosis of ADHD. 367 subjects consented to be followed, with a mean age at the start of the study of 10.4 years. Of this group, about 63% were available for long-term follow-up with a mean age of 27. Follow-up included searches through legal and death records as well as the as the the Mini International Neuropsychiatric Interview (M.I.N.I.). The M.I.N.I. is a structured interview yielding DSM-IV-TR diagnoses. Because there are no agreed-upon, norm-referenced diagnostic criteria for adult ADHD, the authors “constructed a distribution of the number of symptoms of inattention and hyperactivity/impulsivity endorsed by non-ADHD controls. A childhood ADHD incident case was classified as having persistent, adult ADHD if the number of symptoms exceeded 2 SDs above the mean number of current inattentive (ie, 4 symptoms) and/or hyperactive/impulsive symptoms (ie, 4 symptoms) endorsed by the non-ADHD controls. Our adult ADHD case definition also required endorsement of the M.I.N.I. statement that ADHD symptoms were having a significant adverse impact in 2 or more settings.”

The authors found that 29% of both the men and women who had been diagnosed as having ADHD in childhood persisted into adulthood. For those subjects who no longer had ADHD, the odds ratio of having one or more psychiatric disorders, compared to the comparison group, was 2.8, with 57% having an adult psychiatric diagnosis. The distribution of these disorders was “alcohol dependence/abuse (26.3%), antisocial personality disorder (16.8%), other substance dependence/abuse (16.4%), current or past history of hypomanic episode (15.1%), generalized anxiety disorder (14.2%), and current major depressive episode (12.9%).” For those with persistent ADHD, the adjusted odds ratio was far worse at 4.8 versus the comparison group. Standard mortality ratios (SMR) were also calculated, and the adverse outcomes for subjects with childhood ADHD also extended into death (1.9), accidental death (1.7), and suicide (4.8).

The authors concluded “These findings have important implications for the effectiveness of care provided to children with ADHD and the system of care to meet the needs of individuals with ADHD across the lifespan. It is concerning that only a minority of children with ADHD reaches adulthood without suffering serious adverse outcomes, suggesting that the care of childhood ADHD is far from optimal. Our results also indicate that clinicians, insurers, and health care systems must be prepared to provide appropriate care for adults with ADHD.”

For clinicians, there is increasingly clear data on the long-term prognosis for childhood ADHD. The positive news is that approximately 70% of childhood ADHD will not persist into adulthood. The more disconcerting news is that the neurodevelopmental vulnerability to other adult disorders continues regardless of whether the primary disorder continues, including real vulnerability to early death, especially by suicide. Since this cohort was only followed to the mean age of 27 years, even longer-term vulnerability remains to be clarified.


Bullied or Bullies: Both Suffer

Continuing with the theme of the long-term outcomes for at-risk youngsters, Copeland et al., in a JAMA Psychiatry online publication, report on the long-term impact of being bullied, or being a bully, or both. The authors assessed 1,420 children as part of the Great Smoky Mountain epidemiologic study on an annual basis from ages 9-16 and then re-assessed 1,273 of them as adults at age 26. The 1,273 were divided into 4 groups: bullies (100), bully/victims (79), victims (305), and neither (789). Boys and girls were equally likely to be bullied and there was twice the rate of bullying from ages 9-13 (23.2% of the whole sample) as there was 14-16 (10.2%).

In their follow up, using multivariate analysis, the authors looked at whether “the adverse long-term psychiatric outcomes observed were direct effects or better accounted for by childhood psychiatric and family hardships.” After correcting for psychiatric and family factors, victims continued to be at risk for anxiety disorders. The odds ratio (OR) ranged from generalized anxiety (OR =
Cook & Polivy

2.7) to panic (OR = 3.1) to agoraphobia (OR = 4.6) within the anxiety disorders. Interestingly, the bully/victim group was at a far greater overall risk. The risk for both men and women in this group were markedly elevated with depression (OR = 4.8) and panic disorders (OR = 14.8) in both sexes. This group also had sex-specific findings, with males at an 18-fold risk for suicidality and females 27 times more likely to have agoraphobia. Men and women in the bullying alone group were at increased risk for antisocial personality disorders (OR = 4.1), but not other disorders.

From this careful follow-up study, it is clear that childhood bullying/victimization is an independent risk factor for future psychopathology. Bullies and bully/victims appear to be at risk for internalizing disorders and the bully-alone group for externalizing disorders. This suggests some possible stress-mediated mechanisms (cortisol levels, telomere erosion) for the group that includes some elements of victimization. For clinicians, parents and educators, the imperative to stop bullying continues to grow. Primary prevention, early and active intervention, and long-term follow-up are all badly needed.


Adolescents With ADHD at Elevated Risk for Substance Use Regardless of Treatment

When making the decision to treat ADHD pharmacologically, one rationale that we as clinicians frequently share with parents is our concern about a myriad of negative outcomes that are associated with ADHD. By treating, we hope to be able to mitigate or delay some of this risk. Childhood ADHD has been well established as a risk factor for later substance use disorders in adolescents and young adulthood. Stimulants, our most common and possibly most effective intervention for childhood ADHD, decrease ADHD symptoms, and generally, persistence of ADHD symptoms has correlated in studies with later substance use. Other studies have suggested that stimulants themselves might even increase risk for substance use. The longitudinal follow-up of the children in the Multimodal Treatment Study (MTA) of ADHD has allowed researchers to address many of the questions we as clinicians have about the extended course of childhood ADHD. In a previous report, follow-up of MTA subjects at three years demonstrated no protective or predisposing associations between substance use and early exposure to medication. However, many of these children were not yet at the age of highest risk for substance use.

Molina et al. report in the Journal of American Academy of Child and Adolescent Psychiatry (JAACAP) the results of an 8-year follow-up of 436 of these subjects involving children who were randomized to stimulant treatment after 14 months of initial follow-up to investigate whether stimulant use correlates in any way with substance use and substance use disorders compared to their non-ADHD classmates. The investigators found that treatment with stimulants did not seem to have any effect whatsoever on substance use or the development of substance use disorders. Children with ADHD, regardless of treatment, were at greatly increased risk for SUD.

The good news is that stimulants are not increasing risk for substance use disorders as some have suggested. The bad news is that our treatment does not seem to be doing much of anything to address the elevated risk for substance use disorders in this vulnerable population, despite the fact that stimulants provide dramatic improvement in ADHD symptoms for 80% of the children to whom they are prescribed. While disappointing, these results will hopefully inspire us as clinicians and researchers to develop new ways, psychosocial or pharmacologic, to intervene with children with ADHD to try to decrease and prevent the onset of substance use disorders.


Preschool ADHD Diagnosis Stable into Later Childhood

In a second follow-up report of a major longitudinal ADHD study, Riddle et al. published the six-year follow-up to the Preschool Attention-Deficit/Hyperactivity Treatment Study (PATS) in the March issue of JAACAP. Never is ADHD a more controversial diagnosis than in the youngest children who, despite their age, can present with severe impairment in functioning. Stigma against families with low-functioning young children increases barriers to psychosocial and pharmacologic treatments which have been shown to be effective and safe across several well-executed studies over the past ten years. While separating normal development from pathologic behaviors is not a simple affair, ADHD clearly exists in preschoolers.

This report describes the follow-up of 207 participants of the original PATS study (when they were aged 3-5) six years later (at ages 9-11). 75% of the subjects were male. All participants met criteria for ADHD upon study entry. Generally speaking, the severity of symptoms did decrease from the time of entry to the time of follow-up but remained in the moderate-to-severe clinical range. Girls showed greater improvements. At year six, 89% of the subjects continued to meet criteria and impairment for ADHD. Comorbid ODD or conduct disorder increased the risk of persistence of ADHD by about 30%.

Preschoolers with ADHD are quite ill during some of the most important years of development of impulse control and emotional regulation. Knowing that preschoolers with ADHD will mostly continue to be fairly ill throughout childhood gives clinicians more confidence to accurately diagnose and treat impaired young children, and further bolsters the notion that ADHD in young children is a “real” disorder worth of our clinical attention.

Affordable Care Act and the Physician Payment Sunshine Act – What it Means for You

Elizabeth Hughes and Kristin Kroeger Ptakowski

Beginning in 2007, Congress began to look into concerns over financial relationships between physicians and device and pharmaceutical companies. Senator Grassley (R-IA) introduced the Physician Payment Sunshine Act to require reporting of all payments to physicians or their employers from pharmaceutical or medical device companies. AACAP supported the legislation, stating that the bill will "reinforce the public’s trust in the medical profession and promote transparency to allow patients, researchers, physicians, and others to obtain accurate and complete information on the nature of interactions between industry and physicians.” During the same period, AACAP leadership convened consensus panels to develop conflicts of interest guidelines for child and adolescent psychiatrists working in both clinical and research settings.

Due to the increasing congressional concerns about transparency, and concerns over waste and fraud in the healthcare system, the Physician Payment Sunshine Act was included in the Affordable Care Act. In February 2012, AACAP provided comments to the Centers for Medicare and Medicaid Services (CMS), on their interim regulatory rule, concerned that if implemented without modifications, it could result in the publication of misleading information and impose costly and burdensome paperwork requirements on physicians (See AACAP’s full comments on the Advocacy section of AACAP’s website).

In February, CMS announced a final rule that will increase public awareness of financial relationships between drug and device manufacturers and certain health care providers. The rule finalizes provisions that require manufacturers of drugs, devices, biological, and medical supplies to report to CMS payments or other transfers of value of $10 or more to physicians and teaching hospitals. Payments mean food, entertainment, gifts, consulting fees, honoraria, and other items or services of value. CMS will post that data on a public website. The increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationship with manufacturers.

Continuing medical education (CME) activities have been excluded from the Sunshine Rule. Speaking at CME conferences is not included in the Sunshine Act if certain conditions are met that are consistent with the Accreditation Council for Continuing Medical Education’s (ACCME) Standards for Commercial Support. The Standards state that accredited providers must make all the decisions regarding CME, including faculty selection that is independent of industry influence. All commercial support must be paid directly to the CME provider, not to the speakers. As an accredited provider of CME, AACAP meets the criteria for commercial support. AACAP recognizes the importance of safeguarding independence of accredited continuing medical education. In addition, attendees of accredited continuing education events that are supported by pharmaceutical or medical device companies are not included in the rule.

Other items of interest from the Physician Payment Sunshine Act:

- Payments or other transfers of value to residents are not required to be reported.
- Payments or other transfers of value being provided to a specific physician through a group practice should not necessarily be attributed to all physicians in that group. CMS has specific examples of what should be reported and attributed to the individual vs. group practice.
- If a recipient does not receive payment personally, but rather directs the payment be transferred to charity or other entity, the manufacturer must still report the payment.
- Research funding must be reported, but does not have to be disclosed publicly for four years or until the product under development is approved, whichever comes first.

Here is a quick reference on the key reporting details:

Who reports:
- Applicable manufacturers of pharmaceuticals or medical devices and applicable group purchasing organizations (GPO).

Covered recipient:
- Physicians who are legally authorized to practice medicine.
- Applies regardless of whether the physician is enrolled in Medicare.
- Does not include medical residents or medical students.

What is reported:
- Applicable manufacturer or GPO’s name.
- Covered recipient name, specialty, address, NPI number, state professional license number.

continued on page 133
Task Force on Health Information Technology Report: The Promises and Perils of Health Information Technology in Child and Adolescent Psychiatry

Barry Sarvet, M.D.

Products of the inevitable march of human innovation, these amazing and beguiling machines we call computers, have infiltrated practically every corner of our personal and professional lives. They are in front of us and in our pockets throughout the day, on our nightstands as we sleep. We are told that in the not-so-distant future, we will be wearing them on our wrists and in front of our eyes, and perhaps someday they will interface directly with our brains. By exchanging and processing information, networked computers may enlighten us, empower us, help us to answer questions, solve problems, entertain us, and connect us with others. On the other hand, in commanding our attention so powerfully, computers also distract us from direct experience of the world with at times lethal consequences (consider traffic accidents resulting from texting or fiddling with a GPS device). Relying too heavily on computer information processing, we may underutilize the dramatically more powerful information processing of our human brains. Networked computers also carry the potential to endanger our privacy. The real challenge is this: learning how to harness the enormous benefits of information technology to enhance, rather than take over, our lives and our work.

It should not be a surprise that information technology would be applied to healthcare. What medical student has not experienced the growing realization that his/her brain is “full” in the middle of a long night of memorizing detailed anatomical information, enzyme cascades, obscure genetic syndromes, and the like? The enormous amount of data needing to be processed in order to provide high quality medical care is staggering and computers have come to the rescue. Multi-volume, sloppy, and disorganized medical charts are increasingly being replaced by neatly organized electronic medical record (EMR) systems. The best systems allow a physician to alternate between viewing a high level graphical analysis of trends in data over time and diving into the microscopic details of health information at a moment in time. Automated drug interaction checking is a standard feature within most EMR systems. Groups, clinics, hospitals, and entire health systems

Affordable Care Act and the Physician Payment Sunshine Act continued from page 132

- Amount of payment or other transfer of value.
- Date and form of the payment or transfer of value.
- Nature of the payment.
- Name of entity that received the payment if not provided to the physician directly.
- Payments or transfers of value to physician owners or investors.

Nature of payment:
- Consulting fee.
- Compensation for services other than consulting, including serving as faculty or a speaker at an event other than a continuing education program.
- Honoraria.
- Gift.
- Food and beverage.
- Entertainment.
- Travel and lodging.
- Education.
- Research.
- Charitable contribution.
- Royalty or license.
- Current or prospective ownership or investment interest.
- Grant.
- Space rental or facility fees (teaching hospital only).
- Ownership or investment interest.

Data collection begins on August 1, 2013. Manufacturers and physicians have 45 days to review, dispute, and correct their reported information before it is posted on a publicly available website. CMS will notify the recipient when the reported information is ready for review. Recipients will be notified using an online posting and through notifications on CMS’s listserves. Any dispute will be resolved directly between the covered recipient and the relevant manufacturer or GPO. Applicable manufacturers will report data for August through December 2013 to CMS by March 31, 2014. CMS will release data on a public website by September 30, 2014.

The CMS regulation information can be found at [federalregister.gov/a/2013-02572](http://federalregister.gov/a/2013-02572). Be sure to visit AACAP’s Advocacy information on the website at [www.aacap.org/cs/advocacy](http://www.aacap.org/cs/advocacy) to stay up-to-date on how health care reform impacts you.

Ms. Hughes is AACAP assistant director of Education and Recertification.

Ms. Ptakowski is AACAP senior deputy executive director and director of Government Affairs and Clinical Practice.
with multi-user, networked EMRs allow providers to collaborate in building and utilizing a comprehensive medical record in order to coordinate all components of patients’ healthcare.

Strongly stimulated by federal policies, the adoption of health information technology in healthcare has progressed very rapidly. The purpose of the federal policy is to improve the quality, safety, and efficiency of healthcare. Understandably, it is not yet apparent that EMR systems have fulfilled this purpose. The technology itself needs further evolution to improve the quality of the user interface and to solve problems associated with the exchange of information between systems. On the side of the users, there is a lot for physicians to learn in order to optimally and efficiently incorporate the technology into clinical practice.

What, you may ask, about computers in the practice of child and adolescent psychiatry? AACAP’s Task Force on Health Information Technology was recently established to address this question. Providing high quality healthcare is a team effort. There is a growing recognition that child and adolescent psychiatrists are an essential part of the team and, consequently, our work must be coordinated with our pediatric colleagues. This coordination is a fundamental aspect of healthcare reform and requires efficient communication of clinical information. Properly implemented EMR systems and coming health information exchange (HIE) programs enable this communication, allowing information to be exchanged between systems in a compatible format. Computerized records and electronic prescribing also have the potential to help us track outcomes, reduce medical errors, and to promote the use of clinical practice guidelines in child psychiatry.

At the same time, there are significant risks associated with health information technology in the practice of child and adolescent psychiatry. For example, the privacy of psychiatric treatment may be jeopardized as systems rush to implement methods of sharing information in the spirit of collaborative treatment. Child and adolescent psychiatrists may cling to their manila folders in the desk drawer as they contemplate the vulnerabilities of computer systems to bugs, security breaches, data losses, and down-times.

Many child and adolescent psychiatrists, particularly those who work in clinics and hospitals, are already using electronic medical records, prescribing, billing, accounting, scheduling, and secure messaging systems. Yet according to a recent AACAP member survey, approximately half of our members have not yet adopted these technologies and would like the organization to provide various forms of assistance and support for this transition in their practices. There is also widespread recognition that the robust information sharing features of EMRs could erode the standards of confidentiality associated with child and adolescent psychiatry records. Clearly, there is a need for our organization to: 1) develop resources to address members’ needs in relation to HIT; 2) help our members to be well-informed regarding the evolution of the technology; and 3) to effectively advocate for emerging standards and policies regarding EMR technology to address the unique aspects of child and adolescent psychiatry practice.

In fact, our AACAP Task Force on Health Information Technology is charged with these precise tasks and has been busy at work. Our Policy Statement on Confidentiality in Health Information Technology was recently approved by Council and provides guidelines that will be utilized in joint advocacy efforts with the American Psychiatric Association and the American Academy of Pediatrics. A variety of articles written by Task Force members and annotated links to selected internet resources are posted in a new Health Information Technology section of the AACAP website located at www.aacap.org/cs/business_of_practice/electronic_medical_records. These include pieces explaining the characteristics and features of electronic medical record systems, and resources to assist members in choosing an EMR system for their practices.

The members of the Task Force are:

Barry Sarvet, M.D. (chair), Sherry Barron-Seabrook, M.D., John Dunne, M.D., Anthony Jackson, M.D., Jeremy Kendrick, M.D., Todd Peters, M.D., Jenna Saul, M.D., and Jennifer Medicus (AACAP Staff).

The work of the group continues and is currently focused on developing a protected online forum for members to share their experiences, both positive and negative, with specific EMR systems and vendors. We are also preparing to compile and publish member-submitted templates to promote these practices. As we go forward, we welcome your input and ideas! Members of the Task Force can be reached through Jennifer Medicus at jmedicus@aacap.org.

Dr. Sarvet may be reached at Barry.Savet@baystatehealth.org.
Dressed for Both the DSM-5 and Spaghetti Towers: The 9th Annual Klingenstein Third Generation Foundation (KTGF) Games at Harvard Medical School

Erin West, B.S., and Matthew Baum, D.Phil.

“Are there actually games at this conference? I’m not sure I dressed for that!” We were a bit surprised when the activity at last year’s KTGF Games at Brown University transitioned from an academic presentation about residential treatment in child and adolescent psychiatry to throwing squishy, toy brains and racing, three-legged style. Since Harvard Medical School was newly reinducted last year to the Klingenstein Medical School Fellowship Program, this was our first introduction to the informal, exciting day of scholarship and actual games that forms a solid tradition rooted in the KTGF program’s core values of collaboration, mentorship, fun, and creativity. We soon recognized, moreover, that it is precisely this sort of symbiosis of seriously intellectual and joyous child-like worlds that makes a good child and adolescent psychiatrist.

Thanks to the KTGF Medical Student Fellowship Program, medical students at eleven schools, throughout the country, have access to meaningful mentorship and the opportunity to explore their interests early in their career paths; a combination that is crucial to inspire careers in this exciting field. The program at Harvard Medical School, directed by Robert Kitts, M.D., has provided a tremendously popular and exciting opportunity for Harvard students to connect with child and adolescent psychiatrists for mentorship, research experience, clinical exposure, and informal dialogue. Through events like ‘meet and greet’ dinners with child and adolescent psychiatry faculty and residents and psych cinema with guided discussions, Harvard medical students are able to explore child and adolescent psychiatry in a tailored, yet flexible, manner.

This year, it was our turn to host the ninth annual KTGF Games at Harvard. Energized and ready, our planning committee piled into Dr. Kitts’ office for the first of several meetings where we conceived, incubated, and hatched a combination of events we believed would ensure success. As a newly appointed co-medical student leader of the Klingenstein Medical School Fellowship Program at Harvard Medical School (Erin), and a mentored participant in the program (Matt), we joined forces with fellow medical students Christina Cruz (co-medical student leader), Helen Yu, and Noor Beckwith and our faculty support, Jon Alpert, M.D., Ph.D., and Dr. Kitts.

On February 2, 2013, over 60 medical students, residents, fellows, and faculty from ten schools across the country gathered at Harvard Medical School for the 9th Annual KTGF Games. The evening prior to the Games, attendees joined together at a Harvard medical student lounge for a night of food, drink, conversation, and, of course, games. In a psychiatry-themed game of Pictionary, teams battled to depict concepts like id, consult liaison, and Freud. The creativity and ability to interpret rapidly scribbled drawings were impressive. There was ample time for fellows from each school to get to know each other through discussions ranging from the usual introductions to impassioned debates about the definition of mental disorder.

The next morning, attendees enjoyed breakfast followed by introductions from Drs. Alpert and Kitts. In the spirit of the Games and fostering collaboration, we started the day with a team-building activity called the Marshmallow Challenge. Teams raced to build the tallest freestanding structure made of spaghetti, string, and tape that could hold a marshmallow on top. During a debriefing session, we learned that successful teams display open communication, creative designs, and prototype their structures, checking along the way to see if it could hold the marshmallow. In fact, experience conducting this challenge among many age groups has demonstrated that kindergarteners consistently perform the best because they display all these strategies!

The remainder of the morning was dedicated to academic presentations in an effort to promote research and continued on page 134
encourage students to think critically about the field of child and adolescent psychiatry. First, medical students Brooke Rosen and Keith Miller (Mayo) presented on juvenile bipolar disorder followed by Amanda Wallace (Yale) on the neural circuitry of suicidality in adolescents with bipolar disorder. Next, medical students Quincy Nang and Jessica Saw (Mayo) taught the audience about ‘third culture kids’ and the importance of recognizing the mental consequences of rootlessness.

The keynote speech, given by Paula Rauch, M.D., an accomplished child and adolescent psychiatrist at Massachusetts General Hospital, then captivated the audience as she spoke passionately about her career including her role as director of the Marjorie E. Koff Parenting at a Challenging Time (PACT) Model. The audience was brought to tears during a video about the “Home Base” program, in which Dr. Rauch and other skilled clinicians help military families cope with the stresses of deployment and reintegration.

Lunch was held during an informal poster presentation session, when eight medical students presented interesting research in the field of child and adolescent psychiatry. One of the presenters, Linda Drozdowicz, then showcased the subject of her poster on therapeutic music, her ukulele talents, with a beautiful rendition of “I’m Yours” by Jason Mraz.

With these dulcet tones still hanging in the air, the afternoon activities began with a few more student talks. First, Erin Li (Mount Sinai) gave an interactive talk on the Autism Mental Status Examination. Second, UNC Chapel Hill residents and medical students including Annie Kelly, M.D., and Megan Wilson gave a presentation on an innovative program at their institution that connects medical students with patients with eating disorders through ‘snack passes.’

Afterwards, the atmosphere erupted in the friendly competition and camaraderie of actual games! First, teams battled in a bean bag toss. Second came a breathless relay that included hula-hooping and a modified three-legged race; one of us (Matt) discovered during the hula-hooping that his body motion seems limited to a first harmonic, a spectacle which greatly entertained the rest of the participants. The next game, the Focus Ring, tested participants’ communication, patience, and hand-eye coordination. A metal ring with eight, six-foot long strings attached was used to suspend a tennis ball along a path to its resting place on a pedestal.

By points, Mayo and UCLA tied for first. The final event of the day, “The Innovation Challenge,” served as the tiebreaker and encouraged participants to collaborate on a fun, yet meaningful proposal for how big data or social media could help to solve a problem within child and adolescent psychiatry. From YouTube video contests for young people to create a short about an issue in Global Mental Health, to twitter-based tools to address bullying in schools, the creativity, humor, and range of proposals was astounding.

As everyone’s competitive spirits calmed, the winner was announced and awarded the official KTGF trophy. It was Mayo’s enthusiasm, creativity, academic contributions, impressive attendance and hula-hooping skills that led them to victory! To wrap up the event, attendees mingled amidst wine and cheese while ‘speed-networking’ with near-by guests.
We hope that this year’s Games left attendees feeling energized, fostered new collaborations, and inspired individuals to go on to be leaders within the field of child and adolescent psychiatry. It all starts with mentorship and we are ever grateful to the KTGF for making events like this possible. The Games may be over, but the correspondence kindled between attendees, the interest in child and adolescent psychiatry sparked among students, and the passion renewed among faculty remain strong. We all look forward to playing more games, learning, and collaborating at the 2014 KTGF Games hosted by the University of North Carolina.

Erin West is a fourth year medical student at Harvard and one of the co-medical student leaders of the KTGF Medical Student Fellowship Program at Harvard Medical School. She holds a Bachelor of Science from Fordham University. With her strong interest in both pediatrics and child and adolescent psychiatry, she hopes to work toward the integration of mental health into primary care pediatrics and within school-based health programs.

Matt Baum is a first year M.D., Ph.D., student at Harvard and MIT, and served on the planning committee for the 2013 KTGF Games. He holds a Bachelor of Science and Master of Science from Yale University, a Master of Science from Trinity College Dublin, and a Doctor of Philosophy from the University of Oxford. He became interested in child and adolescent psychiatry through the emerging research supporting psychiatric illness as a neurodevelopmental process and hopes to pursue an integrated path in psychiatry through the combination of clinical practice, translational molecular research, and neuroethics.

Acknowledgments

We would like to thank Jennifer Smialek for her outstanding assistance in the organization of the 2013 Games, Dr. Alpert for his leadership, review, and comments on this article, and Dr. Kitts for his astonishing dedication to mentorship of medical students.

Share Your Photo Talents with AACAP News

The Editorial Board of AACAP News is soliciting photographs from AACAP members to be published on its front page, inside standing alone, or accompanying relevant articles or stories. The published photographs should—in some artistic way—illustrate themes pertaining to children, childhood, parents and children, parenting, or families. All AACAP members are invited to submit up to two photographs every two months for consideration.

A committee of five experienced photographers who are AACAP members—David Corwin, M.D., James Harris, M.D., Fred Seligman, M.D., Ludwig Szymanski, M.D., and Alvin Rosenfield, M.D.—will select the photos to be used. Photos not selected will be included in the voting for the subsequent two issues, along with all newly submitted photos. Unused photos will be retained by the AACAP to be used if and when a story they might illustrate is to be published. The AACAP News may edit photos to enhance them or make them suitable for publication. If you would like your photo(s) considered, please send a high-resolution version to Dr. Rosenfield, the AACAP News photo editor, at ARosen45@aol.com. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
Poetry

Everlasting Love, Sara’s Poem

Love is Boundless,
Twisting the Plane of that
Which is Physical.

Young Love Survives
Prognosis and Traverses
The Hardships.

Strong, Understanding, Limitless,
Filled with Hope of Uniting
And Reuniting.

Young Love Blossoms in
The Pain of Illness.
Death cannot end this Love.

The Joy, the Pain, Equally
Soulful and Intense,
Each Moment Akin to
The Beat of the Lover’s Heart.

Love Lives on in Both,
The One Who Leaves and
The One Who Stays.

Time is Fluid, but Deceivingly
Appears Finite.

Love Must Suffer
Alone the Grief and Anger.

Look Beyond what can be Seen,
Love Continues,
Shared, and Ever-changing

Love Never ends.

Love gives Strength and takes Strength.

Love Changes, but Never Dies.

All are Loved, but Those
Who do not Love are the
Greatest Suffers.

One Lover, the Spiritual Lover,
Burned into Memory
Living in the Heart of
The One Loved,
Provides the Strength
To Grieve, to Anger,
To Transform.

For they will never Know
The Beauty, the Power
The Sorrow, the Passion.

The One Left Behind will find Sorrow,
But eventual Peace in Knowing
That they have been
Blessed with the Greatest
Gift Life can Give.
If Only Briefly.

Nor May they Know the
Grief of Lost Love or
The Beauty of the Love
They will never Lose
As they did not Open their Heart
Which Grief is more Painful?
Which Loss is more Powerful?

The One Left Behind
The Joy in Knowing
How to Love.
For they Learned From
One Who Loved so Purely,
So Unselfishly to Defy
Death Repeatedly for
Their Love.
Succumbing when Released
To Join in the
Most Ultimate Love of the Divine

The Beat of the Lover’s Heart.

This, Divine Love, the Only Love that
Surpasses the Earthly
Young Lovers.

Joni Orazio, M.D., is an A ACAP Life Fellow
from Louisiana.

Individuals interested in submitting poetry should e-mail Poetry Coordinator Charles Joy, M.D., at crjoy1@gmail.com.
Training in College Student Mental Health: A Compelling Argument

Jennifer Derenne, M.D., and Adele Martel, M.D., Ph.D.

Many child and adolescent psychiatrists (CAPs) provide mental health care to college-aged patients in private outpatient practices, community mental health centers, emergency rooms, and hospital inpatient units. Some practitioners actually work as consultants or staff to university counseling and/or health centers. Despite the lack of formal training in college student mental health (CSMH), the emphasis in child and adolescent psychiatry (CAP) training on normal development, developmental psychopathology, and systems of care (educational, family, community) provides a solid foundation for CAPs to work with transitioning college-aged young people.

In 2011, AACAP formally acknowledged the role of CAPs in caring for college-age students through the formation of the College Student Mental Health (CSMH) Committee. It has become apparent to the committee that CAPs are facing many challenges in day-to-day practice with this special population and are interested in learning more about the “nits and bolts” of working with this complex group and expanding their knowledge and skills beyond those typically taught in CAP residency training. At the AACAP Annual Meeting, for example, the CSMH Special Interest Study Group is consistently sold out and increasing numbers of members attend presentations on various aspects of CSMH. The number of AACAP members attending the open CSMH Committee meeting doubled the size of the actual committee.

The natural question that arises is whether CAP training programs should provide experience in CSMH to trainees. It is fairly common for programs to provide elective experiences in CSMH, but far less common for Accreditation Council for Graduate Medical Education (ACGME)-accredited programs to provide core rotations in college settings. A number of factors (including proximity to an appropriate university, financial support, and space in the curriculum) influence a program’s ability to provide experience in CSMH. We would like to advocate for CAP programs to seriously consider adding didactic and clinical experiences in CSMH to their curricula. One of the authors (Derenne) had the experience of adding a CSMH rotation while serving as the program director of an ACGME-accredited CAP residency training program (Medical College of Wisconsin).

A sample “Goals and Objectives” for such a rotation is included below. Initially, trainees were somewhat resistant to the idea, as many of them believed that they had adequate experience working with “adult” patients during general psychiatry training, and should focus their efforts on patients under the age of eighteen. However, as the year progressed, it was clear that they were learning more than they had anticipated about models of care available in university settings. Without exception, each trainee commented that the experience had influenced the way he/she approached the care of adolescents who were still in high school. They found themselves inquiring early on about post-secondary plans, encouraging families to identify treatment providers well in advance of matriculation, and gently yet firmly advocating that teens take more responsibility for scheduling their own appointments, filling their own prescriptions, and administering their own medications when appropriate. They noted the importance of communication with former providers and well-thought-out contingency plans in relapse prevention during this complex developmental transition. They also commented that they were surprised by the number of young adults that they were seeing who were seeking care and support for diagnoses such as ADHD or Asperger’s syndrome, which are arguably firmly within the bailiwick of child and adolescent psychiatry.

We encourage CAP program directors to initiate discussions with local colleges and universities about the possibility of having CAP residents rotate through college counseling centers. Many counseling centers provide clinical educational rotations for psychology practicum students, interns and post-doctoral fellows, so the concept of a training experience is likely to be familiar. Most colleges and universities are very committed to supporting adequate mental health resources for their students, and are particularly receptive to having clinicians available on campus who are able to prescribe medications. Offering to develop an evidence-based ADHD clinic with a focus on accurate diagnosis and preventing stimulant diversion may be one very effective way for CAP programs to get their “foot in the door.”

Obviously, there is much to learn in the field of child and adolescent psychiatry, and we recognize that it may not be feasible for every program to offer a core clinical rotation or elective experience in CSMH. However, within the framework of required didactics and clinical experiences, small enhancements can be made to facilitate knowledge, skills, and awareness in this area. For example, programs can add 1) a lecture on the developmental tasks of transitioning late adolescents/young adults to the required course in normal development; 2) a lecture on the systems of care.

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Training in College Student Mental Health  continued from page 137

and models of mental health service delivery found at institutions of higher education to a course on systems-based care; 3) a lecture or focused discussion on stimulant diversion and cognitive enhancement in a psychopharmacology course; and 4) a lecture on legal and ethical principles which are particularly relevant to this age group to a course on professionalism and patient advocacy.

Given that most CAPs will at least have some patients transitioning to college over the course of their career, we recommend that programs provide trainees with at least a background in the basics of transition. The ACGME Common Program Requirements and Specialty Specific Program Requirements in CAP, emphasize the importance of “structured hand-over processes to facilitate both continuity of care and patient safety” (the intended focus is on transitions of care between trainees and levels of care but arguably this applies to transitions of care to new providers external to the training system). CAP trainees have required clinical experiences in the provision of outpatient care to adolescents; within this clinical venue, trainees and outpatient supervisors (including individual and family therapy supervisors) should add transition goals and objectives to the treatment plan for all high school patients who expect to pursue some form of post-secondary education.

CAPs who feel comfortable working with this special population based on clinical experience and continuing education activities, and have a firm grasp of the laws and systems issues at play, can provide this training using live didactic lectures, group discussion, and focused supervision. Web-based instruction may be more accessible to multiple programs and may provide a more standardized approach. Alternatively, programs may choose to invite directors of local college counseling centers or chiefs of campus psychiatry services, some of whom are CAPs, to discuss different models of care available in the university setting, and to have them identify the issues that they would most like providers to address during transition. Universities may welcome the opportunity to get to know local providers that they can add to their list of community referrals for students who need longer term or intensive care beyond what the college counseling center can provide. Clinical work with college-age students is well within the purview of child and adolescent psychiatry. The CSMH committee, in collaboration with other AACAP committees, is committed to 1) providing avenues for CAPs to strengthen their knowledge and skill sets through various educational activities at the Annual Meeting and 2) advocating for trainees to have adequate experience with this population. We welcome opportunities to work with our colleagues in the American Psychiatric Association and the American Association of Directors of Psychiatry Residency Training on this very important issue.

References
ACGME Psychiatry Program Requirements acgme.org/acgmeweb/Portals/0/PAAssets/ProgramRequirements/405pr07012007.pdf accessed 3/15/13
Kay J, Schwartz V, eds (2010). Mental Health Care in the College Community. John West Sussex, United Kingdom: Wiley & Sons

Dr. Derenne is clinical associate professor of Psychiatry and Behavioral Sciences at Stanford University School of Medicine, a child and adolescent psychiatrist specializing in the treatment of eating disorders. She was previously the program director of the Medical College of Wisconsin Child and Adolescent Psychiatry Training Program. She may be reached at jderenne@stanford.edu.

Dr. Martel is an attending at Lurie Children’s Hospital of Chicago and associate professor of Psychiatry, Clinical Scholar Track, at Northwestern’s Feinberg School of Medicine. She is the chair of the College Student Mental Health Committee. Dr. Martel can be reached at amartel@luriechildrens.org.
Example of “Goals and Objectives” for College Mental Health Rotation

**Rotation:** College Mental Health  
**Residents:** Second year residents in Child and Adolescent Psychiatry  
**Place:** XX University Counseling Center  
**Time:** 3 months, one day/week  
**Supervisor:** XX  

**Content/Activities:** Second year residents will participate in evaluation and treatment of college students seeking psychiatric care in a college-based mental health center. They will also provide consultation to medical providers in the student health center. Activities will be supervised by Dr. XX.

**KNOWLEDGE**

- Understand the normal developmental tasks in older adolescents (separation and individuation, creating stable identity, achieving and maintaining more mature relationships with peers).
- Describe mental health privacy and education laws and how these affect mental health treatment in the college setting.
- Understand the various system components on campus with which students interact (Academic Deans, Residential Life, Disability Services, etc.).
- Appreciate the models of mental health service delivery commonly available on college campuses.
- Identify steps CAP can take to prepare patients and families for a more successful transition to the college setting.

**SKILLS**

- Increased facility in diagnosing and treating conditions commonly found in college populations (substance abuse, eating disorders, learning disabilities, ADHD, autism spectrum disorders, mood and anxiety disorders).
- Increased ability to collaborate and communicate effectively with other members of a multidisciplinary team.
- Increased ability to act as a consultant to therapists, faculty, administrators and other medical providers.
- Increased autonomy in patient care (brief psychotherapy, consultation, medication evaluation and management).
- Improved ability to establish rapport with late adolescents and young adults.
- Ability to adapt the informed consent process in the absence of parents and in the context of college student lifestyle.
- Ability to utilize the medical literature to inform evidence-based care.

**ATTITUDE**

- Appreciate the utility of collaborating with other treatment providers.
- Appreciate the differences in treating college-aged students as compared to younger adolescents.
- Recognize the importance of culturally competent and diversity sensitive care with the college student population.
- Recognize pertinent ethical dilemmas in working with college students.
- Recognize that transition planning for patients going on to post-secondary education is an important prevention practice.

**ASSESSMENT**

The primary supervisor will evaluate the knowledge, skills and attitudes of the resident in relation to the six ACGME core competencies using the online evaluation system at the end of the rotation. In addition, the supervisor will provide a mid-term review and “in-the-moment” feedback at various points in the rotation. The resident will be encouraged to provide feedback “in-the-moment” and will also evaluate the rotation and supervisor at the conclusion of the rotation using the online evaluation system.
Attending social events, participating in policy decisions, and learning about AACAP’s strategic direction are all important components of AACAP’s Annual Meeting, but at its core, the Annual Meeting is a carefully crafted and orchestrated educational event. This task has become increasingly complicated over the last few years as AACAP and the field of post-graduate medical education seeks to ensure clinicians are learning knowledge and skills that will improve care for patients and address each member’s individual educational needs. Ensuring this pedagogic quality of the Annual Meeting is entrusted to the members of the Continuing Medical Education (CME) Committee, a group of experienced CME and Graduate Medical Education (GME) educators committed to upholding the educational integrity of AACAP’s Annual Meeting.

Who sets the guidelines to which continuing medical education must adhere?

As an accredited provider of CME, AACAP follows the educational policies of the Accreditation Council for Continuing Medical Education (ACCME). The ACCME has a lengthy list of guidelines and requirements which build the scaffolding for meaningful, bias-free, and audience-centered education. In recent years, they have placed an increasing emphasis on:

- making sure that attendees are aware of potential speaker bias or conflict of interest;
- ensuring that educational programming can be tied to well identified and documented educational needs (called a “needs assessment”);
- examining the difference between the needs assessment and ideal practice (called a “practice gap”);
- forming measurable learning objectives which are tied to the practice gaps; and
- measuring changes in knowledge, attitudes, and performance as a result of the education.

The sequential and iterative chain from needs assessment to practice gaps to learning objectives to measurable outcomes provides a framework for ensuring that talks and educational activities are relevant and impactful.

Why should I care about accreditation?

Much like the Good Housekeeping Seal of Approval, accredited education has been certified to meet ACCME and American Medical Association (AMA) criteria for quality education. As an accreditor, AACAP has been given authority by the ACCME to provide continuing medical education for physicians and grant AMA PRA Category 1 Credits™. Category 1 CME is needed by providers in all 50 states to maintain licensure and is also required by most hospitals for maintaining clinical privileges. The American Board of Psychiatry and Neurology (ABPN) over the past few years has created a number of additional educational requirements to maintain certification in child and adolescent psychiatry, some of which are related to category 1 CME and some of which are not. The AACAP CME and Lifelong Learning Committees are committed to helping members navigate this jungle of educational requirements.

When applying to give a talk at this year’s meeting, I had to provide a practice gap. Is this new? I don’t remember it being this complicated.

As postgraduate education has evolved over the last decade, AACAP has asked more of its potential speakers and presenters during the submission process. The CME and Program Committees hope that in asking speakers to document a practice gap, the submission process itself will help presenters focus their ideas on well-understood educational voids. These practice gaps also help the Program Committee prioritize submissions in the context of the needs of the membership and ensure that AACAP is in compliance with ACCME requirements during audits.

Why is everyone always disclosing so much? Do I really need to know at a clinical consultation breakfast that the person who is presenting has no disclosures to report?

In short, yes. The AACAP CME Committee believes that transparency is a key component of educational integrity. During AACAP’s last accreditation cycle in 2006, the AACAP earned commendation because of its commitment to and innovation in ensuring speaker transparency. The CME Committee addresses every report of potential bias and contacts speakers who fail to...
make disclosures in every educational setting (even the consultation breakfasts!) because we feel that empowering attendees with knowledge about all potential bias in every setting is key to ensuring educational integrity.

Do I have to fill out the evaluations?

There are two types of evaluations which occur at the Annual Meeting: the general evaluation (which comes at the end of the meeting) and the session evaluations which occur after each session. In order to claim CME credit for the meeting, attendees MUST complete the general evaluation. While members are not required to complete session evaluations for every session attended, it is strongly encouraged. Speakers value feedback from attendees and have shared stories with us about how they have improved their talks based on feedback from evaluations. Session evaluations also help the Program Committee identify hot topics and influential speakers when they create the agenda for future Annual Meetings.

It seems like CME has really changed. What’s next?

AACAP will increasingly look to developing tools that help members create individual education plans. Through the use of self-assessment tools, AACAP wants to arm members with specific knowledge about their strengths and weaknesses so that when they attend annual meetings or participate in other CME activities, they have some knowledge of what they need to work on. At the same time, AACAP is also seeking to harmonize these educational activities with ABPN requirements for self-study.

Why are there monitors at sessions handing out evaluations? Can’t I just do everything on the AACAP app?

Monitors play an important part in ensuring the educational integrity of the Annual Meeting. In addition to ensuring that everyone has access to the evaluations, monitors also complete a checklist at each presentation which documents that speakers provided disclosures and adhered to conflict of interest policies. Their data are important for ACCME audits and also help the CME Committee identify speakers that may need additional education about disclosure and conflict of interest policies. But, yes, you can complete all of the session evaluations on the Annual Meeting app and we strongly encourage you to do so.

Why do I need to do pre- and post-test questions for some of the Institutes?

The AACAP CME Committee uses pre-, post-, and longitudinal follow-up questions as an objective measure of learning. CME Committee members work in teams to write these questions in the hope that they will be meaningful measures that reflect practice. Although this falls short of a true performance improvement (PI-CME) program, where providers would be collecting data from within their own practice, these longitudinal measures give us some framework as to how effective these Institutes are as educational activities. In the coming years, look for more of this type of higher order educational outcome, as well as a new opportunity to earn CME approved Maintenance of Certification Self-Assessment credit at the 2013 Annual Meeting.
Orlando Preview

AACAP’s 60th Annual Meeting is just 6 months away and we’re excited! Whether you’re bringing the kids, laser-focused on our high-quality programs, or somewhere in between, we have scoped out the best that our destination has to offer and have highlighted some important information here! For complete details about the Annual Meeting, visit http://www.aacap.org/cs/AnnualMeeting/2013.

Attendee To-Do List

- **June 17** – Reserve your hotel room
- **June 17** – Review the Annual Meeting programs online
- **August 1** – Members Only Registration opens for the Annual Meeting
- **August 8** – Registration opens to nonmembers
- **September 16** – Early Bird Registration Deadline
- **October 1** – Last day AACAP room rate guaranteed at hotel
- **October 21** – Pre-meeting scientific session: Systems of Care Special Program
- **October 22** – First day of AACAP’s 60th Annual Meeting
- **October 27** – Last day of AACAP’s 60th Annual Meeting
- **November 1** – Look for the General Evaluation Survey in your e-mail inbox. CME certificate available upon completion of survey.
Hotels

**Walt Disney World Dolphin Hotel**
1500 Epcot Resorts Boulevard
Lake Buena Vista, FL 32830
Phone: 888.828.8850
Website: www.swandolphin.com
Rate: $229 single/double per night, plus $10 resort fee per night

The Walt Disney World Dolphin Hotel is the headquarter hotel for the Annual Meeting and all educational events will take place there. Located in the heart of the Walt Disney World® Resort, the award-winning Walt Disney World Swan and Dolphin Resort is a deluxe Disney hotel and your gateway to Central Florida’s illustrious theme parks and attractions. The Disney resort is located in between Epcot® and Disney’s Hollywood Studios™ and close to Disney’s Animal Kingdom® Theme Park and Magic Kingdom® Park.

You’ll find the Walt Disney World Dolphin Hotel has magical surroundings, superior service, luxurious facilities, and redesigned guest rooms featuring the Heavenly Bed®. Enjoy the Mandara Spa, 17 spectacular restaurants and lounges, five pools, a white sand beach, two health clubs, tennis, nearby golf, and many special Disney benefits, including free transportation to all Disney Parks and attractions.

We will also have a small block of rooms at the Walt Disney World Swan Hotel, the Dolphin’s sister property. To reserve a room at the Swan, please call 888.828.8850. The room rate and hotel polices at the Swan are the same as the Dolphin.

Hotel Policies:
- All hotel rooms will be charged a Resort Service Package fee of $10 + tax, per day. This fee includes:
  - Up to 60 minutes free local telephone calls, toll free and credit card access calls (10 cents per minute after 60 minutes)
  - 20 minutes of domestic long distance per day
  - Unlimited access to the resort’s health club facilities
  - In room high-speed Internet access – both wired and wireless
  - 2 bottles of water daily
- When making your reservation, ask for the AACAP ANNUAL MEETING GROUP RATE to qualify for the reduced rate.
- This rate is available until October 1, or until the group block sells out, whichever comes first. We recommend making your reservation early to secure your room.
- A deposit equal to one night’s stay is required to hold each individual’s reservation. Such deposit shall serve to confirm the reservation for the date(s) indicated and, upon check-in, shall be applied to the first night of the reserved stay. This deposit is refundable if notice is received at least 7 days prior to arrival and a cancellation number is obtained. All deposits shall be charged at the time the reservation is made.
- All rooms are charged sales tax of 12.5%.
- Check-in is at 3:00 p.m. and check-out is at 11:00 a.m.

Travel

Orlando is served by the Orlando International Airport (MCO). For more information about the airlines serving this airport, flight schedules, and ground transportation options, visit www.orlandoairports.net.

What to Do in Orlando!

Are you looking to submerge yourself in Disney, or do you want to get off the beaten path? Good news, we have found something for everyone!

**DISNEY**

If you’re ready to get the total Disney experience, look no further! Walt Disney World has one-of-a-kind restaurants, thrilling rides, cultural exhibits, and fantastic shopping to say the least! This family-friendly resort has something for everyone. The only problem you might have is deciding where to start (after you’ve attended all of the scientific sessions, of course)!
Disney’s Animal Kingdom® Park
Encounter exotic animals and exciting adventures at Disney’s Animal Kingdom Park, the largest animal theme park in the world. Home to more than 1,700 animals across 250 species, the park reflects Walt Disney’s dedication to conservation and is committed to animal care, education and research.

Disney’s BoardWalk
Experience the timeless charm of Disney’s BoardWalk, a quarter-mile promenade of exquisite dining, unique shops and exciting nightlife. Stroll along the water’s edge, play afternoon midway games and discover evening street performers. The Boardwalk is just a 5 minute walk from the Dolphin; plan to stop there for lunch in between sessions.

Disney’s Hollywood Studios®
Movie magic comes to life at Disney’s Hollywood Studios, awash in the glitz and glamour of Hollywood’s Golden Age. Step into the action with attractions based on blockbuster movies and top TV shows, and delight in exciting entertainment that puts you center stage.

Downtown Disney®
World-class restaurants, dazzling entertainment, and unique shops line the waterfront at Downtown Disney. Shop in the world’s largest Disney store, dine amid life-size prehistoric creatures, bowl a game at the 30-lane alley and more.

Epcot®
Discover exciting attractions, enchanting international pavilions and award-winning fireworks. Celebrating the human spirit, Epcot has 2 distinct realms: Future World, which features technological innovations, and World Showcase, which shares with Guests the culture and cuisine of 11 countries. Epcot is the park closest to the Walt Disney World Dolphin hotel, just a 10 minute walk.

Magic Kingdom® Park
Fairytale dreams come true for children of all ages at Magic Kingdom park. Delight in classic attractions, enchanting fireworks, musical parades and beloved Disney Characters across 6 whimsical lands.

Shops
Disney has over 200 stores where you’ll find all the Mickey Ears, Disney apparel, and accessories you need! Don’t forget, Disney also has stores with fine food, spirits, art, and collectibles as well!

Spas & Fitness Centers
With 10 different spas and fitness centers, you’ll be able to pump up, work out, and relax!

As an Annual Meeting attendee, Disney offers special rates for Park admission. Visit http://www.mydisneymeetings.com/aacap/ to purchase Disney tickets for you and your family.

Other Orlando Attractions
If you’re ready to see the other amazing experiences that Orlando has to offer, hop in your rental car and check out more restaurants, shopping, and theme parks just 20 minutes away!

Convention Area
A diverse selection of restaurants and nearly endless options means there’s something here for everyone. You’ll find familiar haunts like the Improv Comedy Club and The Oceanaire Seafood Room, as well as local favorites like the Funk Monkey Wine Club. (Approx. 20 minutes from Walt Disney World Dolphin Hotel)

Downtown Orlando
With a sizable skyline, downtown Orlando is both a vibrant entertainment district and a collection of trendy neighborhoods. (Approx. 25 minutes from Walt Disney World Dolphin Hotel)

Restaurant Row
This stretch of Sand Lake Road serves up some of the finest fare Orlando has to offer at more than two dozen upscale and casual restaurants. From Polynesian-fusion to dry-aged steak
Show your Support for AACAP
And save $$ today!

Exhibitors can connect with more than 4,000 child and adolescent psychiatrists and other medical professionals or advertise in several Annual Meeting publications. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. To review an Exhibitor Prospectus with more details on these opportunities as well as forms to sign up, please visit www.aacap.org/cs/AnnualMeeting/2013. Questions? Contact exhibits@aacap.org or 202.966.7300, ext. 155.

Members:
Refer a new Annual Meeting exhibitor and receive a $100 discount on your 60th Annual Meeting registration*

Universal Orlando® Resort
By day, you'll experience more than 25 amazing rides and attractions, including Harry Potter and the Forbidden Journey™, The Amazing Adventures of Spider-Man®, and Despicable Me Minion Mayhem! By night, the CityWalk® entertainment complex at Universal offers an electrifying selection of dining and nightlife experiences for every palate and level of excitement. (Approx. 20 minutes from Walt Disney World Dolphin Hotel)

SeaWorld Orlando
Think that you'll just be seeing Shamu at SeaWorld? Think again! Not only are there animal exhibits, but rides, shows, and other exclusive park experiences like behind-the-scenes tours and up-close experiences. (Approx. 15 minutes from Walt Disney World Dolphin Hotel)

Winter Park
New-world sophistication meets old-world charm in Winter Park, a picturesque city where arts and culture are part of everyday life. You'll enjoy chic bistros, fine dining, gastropubs, trendy wine rooms, museums, art galleries, and specialty boutiques. (Approx. 40 minutes from Walt Disney World Dolphin Hotel)

Don't miss this opportunity to save on your annual meeting registration!

*All referrals must be first time AACAP exhibitors and must purchase a booth for AACAP's 60th Annual Meeting.
New Research Poster Call for Papers

AACAP’s 60th Annual Meeting takes place October 22-27, 2013, at the Walt Disney World Dolphin Hotel in Orlando, Florida. Abstract proposals are prerequisites for acceptance of all presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

Verbal presentation submissions were due by Friday, February 15, 2013, and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by Monday, June 17, 2013. All Call for Papers applications must be submitted online at www.aacap.org starting in April. Questions? Contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or e-mail meetings@aacap.org.

Serve as a MONITOR for one full day of the meeting to receive free registration and half-price on most ticketed events.

For more information about the Monitor Program, visit the AACAP website at:


Registration opens August 1 for AACAP members and August 8 for nonmembers. Become a member TODAY to get priority monitor scheduling!
Staying on Course and on Time!

James C. MacIntyre, II, M.D.
Chair, Back to Project Future

Back to Project Future (BPF) is moving forward with increasing momentum to complete the final report for Martin Drell, M.D., by September 1, 2013. The BPF Steering Committee and three subgroups (Service/Clinical Practice, Research, and Training/Workforce) have held their final meetings and continue to have conference calls to further refine and finalize the project’s report.

Who We Have Heard From
The project leadership group and Steering Committee have received written input and ideas from numerous AACAP Committees, Regional Organizations, parent and advocacy organizations, and other medical organizations. Many thanks to the following groups for their input:

Regional Organizations: Colorado RO; Northern California RO

AACAP Committees: Art Committee; Culture and Diversity Committee; Medical Student and Resident Committee; Psychotherapy Committee; Training and Education Committee

Parent and Advocacy Organizations: National Alliance for the Mentally Ill; Mental Health America

Medical Organizations: American Academy of Pediatrics; American Association of Directors of Psychiatric Residency Training; Society of Professors of Child & Adolescent Psychiatry

This input is being considered and integrated into the final report of Back to Project Future.

The Final BPF Report
The BPF Steering Committee and subgroups are working diligently to complete and finalize the project’s report. The report will present a 10-year action plan (2013-2023) for AACAP and the field of child and adolescent psychiatry. The three major sections of the report (Service/Clinical Practice; Research; Training & Workforce) will each contain an “overview of the coming decade” (see sidebar) in addition to prioritized goals, recommendations, and action steps. The BPF leadership group will use the BPF Distinguished Consultants for additional review, comment, and input as the draft report nears completion. When completed and submitted to Dr. Drell, the report can help guide AACAP’s leadership and members as they face many changing clinical, training, research, and social/economic realities in the coming decade.

Stay Informed
You can stay informed about Back to Project Future by going to our webpage on the “Members only” side of the AACAP website. Keep watching for “all member e-mails” from AACAP with information about BPF. Please do not hesitate to contact any of the BPF leadership group directly: James MacIntyre, II, M.D., chairperson of BPF; David Pruitt, M.D., Training and Workforce subgroup; Neal Ryan, M.D., Research subgroup; and Rich Martini, M.D., and Michael Houston, M.D., Service/Clinical Practice subgroup. You can also send questions and ideas to our special e-mail address: bpfquest@aacap.org.

Dr. MacIntyre is chairperson of the Steering Committee for Back to Project Future. He has been secretary and treasurer for AACAP and served on Council and in the Assembly as an officer and delegate. He was also chairperson of the AACAP Consumer Issues Work Group. Dr. MacIntyre works full-time as an attending child and adolescent psychiatrist for Carolinas HealthCare System (a non-profit system) in Charlotte, North Carolina.

BPF Final Report – “Overview of the Coming Decade”
(Service/Clinical Practice; Research; Training & Workforce)

- Summarizes what is coming/facing our field
- Describes the key issues or trends
- Discusses some of the key challenges and controversies facing CAPs
- Explains how the issues, challenges, and controversies are addressed in the written plan
DONOR PROFILE
Owen Lewis, M.D., and the ESL Fund: An Inspiration and Legacy

How did the idea come to you to start a fund for ADHD research?
The idea didn’t actually start with a fund. The idea began with the father of a patient of mine remarking, after successful initial intervention, how interesting he found the idea of ADHD and asking if he thought there was something he could do. At the time, there were a number of journal prizes, but none for ADHD research, so in consultation with the then AACAP Executive Director Virginia Anthony, we proposed the idea of a prize for an article published in the Journal of the American Academy of Child and Adolescent Psychiatry.

Of course, I suggested it be named for the donor. He wanted it named after me. We were at logger-heads. Ms. Anthony suggested naming it in honor of my mother, who had recently passed away. She had been a special education teacher and an early advocate in our community for educating pediatricians, psychiatrists, and educators that inattention was often something other than how they conceptualized it.

The idea of the fund was proposed by the donor. A month or so after the first prize was awarded, he said to me, “Whatever is worth doing is worth doing well.” On top of his initial donation of $5,000, which covered the prize, he gave an additional $5,000 and told me to start an endowment. He continued this yearly donation, which formed the basis of the Elaine Schlosser Lewis (ESL) Fund.

What did you hope to accomplish?
I hoped that the prize would raise the profile of the researchers on whose work clinical practice is built. Also, it immediately had the unexpected impact of increasing top-notch submissions to the Journal in the area of ADHD research. I was very pleased with this because it meant the prize (and Fund) were serving to get the latest research into the hands of the most number of practitioners.

The ESL Fund has raised more than $885K in 18 years. To what do you attribute this success?
The success of the Fund is attributable to the commitment of parents of children with ADHD and their desire to improve the scientific understanding of the disorder, and to AACAP which would steward the Journal prize and the Fund in a way that is scientifically rigorous and promotes communication with parents.

The ESL Fund has invested more than $334K in 35 child psychiatrists and their research initiatives. Has the ESL Fund exceeded your expectations?
That is an understatement. I never expected to reach a level of endowment of the Journal prize, and then once we began the pilot research awards, to endow those. We are now almost at the point where the second pilot research award is endowed. These funds belong to AACAP and ensure that this work will be able to be continued indefinitely.

What are the top three benefits of the ESL Fund?
The top three benefits: 1) honoring the top researchers, 2) supporting the emergence of new researchers, and 3) promoting access to the emerging science, both to physicians and parents.

What do you envision for the future of the ESL Fund?
If the fund continues to grow as it has to date, the Fund may embark on further dissemination of information to parents (the Fund actually supported a revision of the Facts for Families), as well as an increase in advocacy. At some point, I would like the fund to be able to better investigate the resistance to medication in minority communities and either research or develop better access to child psychiatric care in ethnic-minority communities, particularly looping in schools, parents, and community providers.

If the ESL Fund could raise an additional $2M, what impact would this have on ADHD research?
The Fund could then support not only small pilot research grants, but more major research efforts. As I indicated, research on barriers to care and access to care is, to my mind, as important as the development of the science. That said, I look forward to the day when ADHD is understood as a collection of disorders—understood in terms of neurophysiology, pharmacology, and in educational methods to improve learning in afflicted children.

What are you most proud of in the 18 years of the ESL Fund?
I am most proud of our ability to support young researchers and to have had a role in the early careers of these child psychiatrists who had great “hunches” and who have since been able to parlay success with their pilot grants into larger grants and careers dedicated to research.
The Power of a Bequest: 
Your Legacy, Their Future.

A bequest may be the most important charitable investment you ever make.

For so many people, it is their single largest donation. To the beneficiary organization, it is the source of capital that may be the difference between achieving its stated purpose or not.

For AACAP, that means changing the future for today's children affected by psychiatric illnesses and searching for cures for tomorrow's children. And, as child and adolescent psychiatrists, you are the solution to achieving this future for children.

You have an opportunity to change the world for the next generation of child and adolescent psychiatrists with a bequest in your will. Your decision to include AACAP as a gift in your will is an investment in that future, today.

How it Works
To make a charitable bequest, you need a current will.

Then, in your will, you stipulate that AACAP will receive either a specific dollar amount, a percentage of your estate, or a contingent bequest. It is that simple.

How You Benefit
Your assets remain in your control during your lifetime.

We understand your personal circumstances may change. You can change your gift at any time.

Under current tax law, there is no upper limit on the estate tax deduction for your charitable bequests.

Tell Us
Other people have made a bequest to AACAP without telling us. We like surprises, but, if you are willing to inform us of your decision, we would love to say thank you and, with your permission, acknowledge it to others. You may inspire others to make a similar bequest to AACAP.

Plus, knowing of your bequest helps us think and plan differently for the future and the impact we can have for children with psychiatric illnesses.

Of course, if you choose not to tell us, we respect and honor your wish to remain anonymous.

What Is Next?
Please consult with your attorney, but we encourage you to speak with us if you are interested in making a bequest gift or if we can provide you with additional information.

You can e-mail us at development@aacap.org, or call us at 202-966-7300 x140.

We are grateful and touched that you will consider entrusting us with such a personal and important donation. It is a contribution that will enrich and make permanent your legacy for children with psychiatric illnesses.

This article is a tribute to you. What are three things you would like people to know about you that they may not find in a Google search?

Isn’t everything available on Google search? Seriously, though, not a week goes by in which I don’t derive profound inspiration from the efforts of parents to help their children and the children who find ways to persevere. I am forever grateful to have a role in their lives.

The ESL Fund has actually been a successful business model at raising money for research for AACAP. Many of the donors are parents who have been grateful for the difference you made in their children’s lives. What advice would you give as to how this model can be best replicated to raise money for research into other psychiatric disorders in children?

Many grateful parents tell us in so many ways that they want to do something to contribute to the field. We should listen to them and help them find ways to support the effort they understand only too well.

How would AACAP work with other child and adolescent psychiatrists in other cities to set up a model like this?

AACAP could help local districts identify projects related to ADHD research or research in other areas of psychiatric disorders in nearby hospitals or new models of service delivery and advocate for these.

Are there people you would like to acknowledge?

First, I’d like to acknowledge Bernard Mendik, the inspiration and original donor of the ESL Fund, and his family who have continued to support the Fund in his memory. Other major donors over the years have included The Sy Syms Foundation; my brother, Arthur Lewis and his help with Oppenheimer Miracle Day support; Joe Sangimino; and Claire Edersheim. I’d also like to acknowledge the effort of AACAP’s former executive director, Ms. Anthony, who supported the efforts over the years, as well as the AACAP staff and the parents who have contributed over the years.
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 February 15 to March 31, 2013

$1,000 to $9,999

**Campaign for America’s Kids**
Ledro R. Justice, M.D.

**Elaine Schlosser Lewis Fund**
Suzanne Golden

**Virginia Q. Anthony Fund**
Matthew Brams, M.D.
Douglas B. Hansen, M.D.

Virginia Q. Anthony Fund
Nancy B. Black, M.D.
David Fassler, M.D.
John Glazer, M.D.
David Hamburg, M.D. and Betty Hamburg, M.D.
Quinton C. James, M.D.
Robert Jay Reichler, M.D.

$500 to $999

**Virginia Q. Anthony Fund**
Ledro R. Justice, M.D.

**Elaine Schlosser Lewis Fund**
Suzanne Golden

**Campaign for America’s Kids**
Mark Chenven, M.D.
David C. Hall, M.D.
Bruce Henry, M.D.*
IFC Consulting Group, Inc.*
Melvin P. Melnick, M.D.
Joan Ster. Narad, M.D.
Diane Rankin-Miller, M.D.
Carol M. Rockhill, M.D., Ph.D., MPH
Ariane Schnek, M.D.*
Morris Stambler, M.D.
Marie-Josephe Viard, M.D.
Charles Zeanah, Jr. M.D.

Life Member Fund
Lois T. Flaherty, M.D.
Joel S. Ganz, M.D.
Kent Raverscroft, M.D.
Meyer Sonis, M.D.

$100 to $499

**Campaign for America’s Kids**
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David C. Hall, M.D.
Bruce Henry, M.D.*
IFC Consulting Group, Inc.*
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Joan Ster. Narad, M.D.
Diane Rankin-Miller, M.D.
Carol M. Rockhill, M.D., Ph.D., MPH
Ariane Schnek, M.D.*
Morris Stambler, M.D.
Marie-Josephe Viard, M.D.
Charles Zeanah, Jr. M.D.

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at smajor@aacap.org or 202.966.7300 ext. 140. Donations that did not get in at press time will be included in the next issue of AACAP News.
Is Renewing Stressing You Out?

AACAP offers flexible payment solutions to meet your needs.

- Make life easier. Take advantage of our monthly installment payment program. Contact Member Services at 202.966.7300 ext. 2004 to discuss your personalized payment plan options.

- Give yourself one less thing to think about. Select the Automatic Dues Renewal option on your 2013 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 reminders for next year.

AACAP in Istanbul!

Rob Grant, director of Communications and Member Services, enjoying lunch in Istanbul with AACAP members Murat Coksun, M.D., and Tuba Mutluer, M.D.

100% Club

AACAP’s 100% Club recognizes programs that recruit all their residents. Your involvement in the 100% Club not only helps strengthen our organization, it helps better prepare our specialty for the future.

The perks:

- Recognition in the Annual Meeting Honors Book and in AACAP News
- A free ticket to the Program Director’s Luncheon at the Annual Meeting
- The latest MOC notebook for your program

Contact AACAP’s Member Services at membership@aacap.org or 202.966.7300 ext. 2004.
Welcome New AACAP Members

Carolina Acosta, Bogota, NY
Shahzad Ali, M.D., Winston Salem, NC
Allan Andersen, M.D., Baltimore, MD
David Atwood, M.D., Kansas City, MO
Rozy Aurora, M.D., Valhalla, NY
Kelly Aylsworth, Houston, TX
Manjunath Balaram, M.D., Sioux Falls, SD
Sharmistha Barai, M.D., Durham, NC
Kristin Becker, Arvada, CO
Daniel Bender, Greensburg, PA
Jerry Benzl, Chicago, IL
Jacob Bishop, Ridgeland, MS
Jose Bogantes, M.D., Greenville, NC
Ann Bowden, M.D., Sioux Falls, SD
Jacqueline Brom, Wheaton, IL
Khatija Bukhari, M.D., Hartsdale, NY
David Call, M.D., Washington, DC
Angela Cano-Garcia, Chicago, IL
Ali Canton, M.D., Oklahoma City, OK
Lauren Cashon, M.D., Annapolis, MD
Ariya Chau, Sacramento, CA
Courtney Chelliew, M.D., Lebanon, NJ
Humera Chowdhary, M.D., Plano, TX
Kelsey Christofel, Minneapolis, MN
Jaclyn Congress, Washington, DC
Patrick Conway, West Buxton, ME
Daniel Crain, New Orleans, LA
Audrita Crawford, Newark, NJ
James Curry, Downers Grove, IL
Rebecca Dago, Chicago, IL
Francisco De La Pena, M.D., Mexico, Mexico
Eunice Dixon, New Orleans, LA
Ayeshia Dua, M.D., Chicago, IL
Shivam Dubey, M.D.,
Rasha Elkady, M.D., Columbia, MO
Hadi Farah, Royal Oak, MI
Rachel Faust, Omaha, NE
William Felkel, M.D., Winston Salem, NC
Jaime Fong, Sacramento, CA
Erin Fosnaugh, Omaha, NE
Liberty Fritzler, M.D., Livonia, MI
Elizabeth Garcia-Janis, M.D., Hill City, SD
Wil Germain, M.D., Central Islip, NY
Hilary Gerten, Des Moines, IA
Kurt Gilbert, Johnson City, TN
Gurkiran Gill, M.D., Solon, OH
Kathleen Goble, Worcester, MA
Scott Goldberg, Chicago, IL
Ross Goodwin, Charlottesville, VA
Vikram Gopal, D.O., Brookfield, WI
Alison Greenfelder, Miami, FL
Rosalind Griffin, M.D., Farmington, MI
Paula Griffin, Salt Lake City, UT
Nghiem Ha, West Sacramento, CA
Bernadette Hanley, Co. Limerick, Ireland
Gemmy Hanns, Sacramento, CA
Sara Harmon, Charlottesville, VA
Karah Harvey, M.D., Canal Winchester, OH
Steffi Hernandez, San Antonio, TX
Matthew Hicks, M.D., Ph.D., Calgary, AB, Canada*
Thomas Holley, M.D., Albuquerque, NM
Jessica Holliday, Miami, FL
Krithika Iyer, M.D., Hollywood, FL
Ericka Jaramillo, New York, NY
Young Jeon, Sacramento, CA
Edward Jones, New Orleans, LA
Seth Judd, Chandler, AZ
Shuchi Kapoor, Champaign, IL
Martha Karlstad, M.D., Charleston, SC
Sonya Kaveh, M.D., Charleston, WV
Omar Khan, New York, NY
Edwin Kim, Brooklyn, NY
Juthamas Kositsawat, Corona, CA
Amrita Krishnamurthy, Sacramento, CA
Jeremy Kruger, Chicago, IL
Daniel Kupersmit, Denver, CO
Jacob Laskey, Buffalo, NY
Katherine Legare, New York, NY
Annette Li, Katy, TX
John Lindo, M.D., Kalamazoo, MI
Colleen Manak, Montclair, NJ
Eleni Maneta, M.D., Jamaica Plain, MA
Yolanda Marin, Bronx, NY
Allison Marshall, M.D., Houston, TX
Narjeh Martin, Charleston, SC
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Alexa Mieses, New York, NY
Katherine Miller, Kent, OH
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Karen Mu, M.D., Ph.D., San Francisco, CA
Stephen Mullins, M.D., Pittsburgh, PA
Sagarika Nag, N. Caldwell, NJ
Georgia Nagel, M.D., Houston, TX
Rachel Neuha, M.D., Miami, FL
Stephanie Ng, Houston, TX
Claire Nguyen, Kansas City, MO
Tram Nguyen, Sacramento, CA
Ayodele Oke, Country Club Hills, IL
Erika Olson, Lombard, IL
Fareedat Oluyadi, New York, NY
Kenan Osmanovic, M.D., Somerset, NJ
Rita Ouseph, Denver, CO
Saira Pasha, Baldwin, NY
Jaymin Patel, Davis, CA
Prem Pathak, M.D., Baltimore, MD
Brittany Peters, M.D., Nashville, TN
Christopher Peters, M.D., Louisville, KY
Tai Pham, Sacramento, CA
Brittany Raffa, Norwich, VT
Zelma Rahim, M.D., West Springfield, MA
Ijaz Rasul, M.D., Winston Salem, NC
Pandeeswari Raveendran, M.D., Natick, MA
Elyse Reamer, Ann Arbor, MI
Sabrina Reed, Chicago, IL
Stephen Remolina, M.D., Tucson, AZ
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Timothy Yovankin, Evanston, IL
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Maryam Zulfiquar, Lahore, Pakistan

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Child and adolescent psychiatrists can extend their reach and educate a wide audience by working with the news media. 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.

Additionally, if you do work with the media, please share your work for publication in this section of AACAP News. The following is a snapshot of AACAP members’ recent work with the news media.

- **Michael Scheeringa, M.D., M.P.H.**, was interviewed by Parents.com about recognizing PTSD in children. The article, “Posttraumatic Stress Disorder,” was posted in December 2012. Dr. Scheeringa also spoke with a reporter from the Pediatric News Digital Network about the new diagnostic criteria for PTSD in preschool children in the upcoming DSM-5. The story, “DSM-5 likely to improve identification of preschoolers with PTSD” was posted February 12, 2013.

- **Michael Brody, M.D.**, was interviewed by a reporter with Yahoo News for a story on toy guns. The article, “ANALYSIS: Disciplining children over fake guns may be wrong lesson,” was posted on January 30, 2013.


- **Niranjan Karnik, M.D.**, was interviewed by the Associated Press for a story about the boy held hostage in a bunker. The article, “Experts Warn of Long Recovery for Boy in Bunker,” was posted on February 7, 2013.

- **Jess P. Shatkin, M.D.**, was interviewed by The New York Times about children and toy guns. The article, “Not Always Fun and Games,” was posted on February 8, 2013.


- **Judith Cohen, M.D.**, was interviewed by the Pittsburgh Post-Gazette about child trauma. The article, “Does science know how to treat traumatized children?” appeared on February 24, 2013.

- **Melissa Nishawala, M.D.**, was interviewed by a reporter for HealthDay News about children with autism. The article, “Can Therapy Dogs Help Kids With Autism?” was posted on February 26, 2013.


- **Nancy Rappaport, M.D.**, wrote an article for Education Week on ADHD medications. The article, “ADHD Medication Can Help Kids, But It Can’t Fix Schools,” was published in March, 2013.

- **John T. Walkup, M.D.**, was interviewed by Forbes for an article on ADHD. The article, “Time to Pay Attention: What the Newest ADHD Research Is Telling Us,” appeared on March 5, 2013.

- **T. Atilla Ceranoglu, M.D.**, was part of a panel for WGBH Radio. The panel, “Gun Violence in Media and Electronic Games,” took place on March 18, 2013.
FOR YOUR INFORMATION

CALLING ALL AUTHORS!

Would you like to write an article for AACAP News?

All AACAP members may and are encouraged to submit articles for publication, as well as photographs, poems, cartoons, and drawings. Instructions to Authors is available upon request or at aacap.org.

Categories for submission and consideration are:

- Opinion pieces, including debates 800-1500 words
- Letters to the Editor of 250 words or less
- Articles approved by and coming from Committees 600-1200 words
- Newsworthy items
  - Fully developed News Articles 800-1500 words
  - Kudos (highlighting member achievements) 250 words for less
  - Regional Organizations of Child and Adolescent 250 words or less
  - Committee activity reports or updates 250 words or less
- Features 600-1200 words
  - Interviews
  - Discussions of movies or literature
  - Creative Arts (limit 1 page)

If you are interested in writing a Column for Forensics, Ethics, Youth Culture, or Diversity and Culture, we will put you in touch with the appropriate Column Coordinator.

For more information and to obtain a copy of Instruction to Authors please e-mail your request to pjutz@aacap.org.

Time for Twitter

Caitlyn Camacho, Communications and Marketing Coordinator

It started as “the text messaging of the internet” and grew so powerful it ignited a revolution throughout the Middle East. Celebrities use it to update fans and news services use it to inform the public – and it’s free!

Are you on Twitter?

What is Twitter? It’s a way to share your thoughts and opinions with the Twitterverse – all in 140 characters or less. When you tweet, you send a message to everyone who “follows” you. They in turn can tweet back at you with their response, re-tweet your same message, or add their own thought before re-tweeting. It is quick and straight to the point – there is no fluff here! Remember, you only have 140 characters to get your point across.

Why is AACAP on Twitter?

It is the quickest and best way to communicate with similar organizations (SAMHSA, NAMI, CHADD—the list goes on), others interested in child and adolescent psychiatry, and most importantly – you. You will stay up-to-date on what is going on in the AACAP National Office, with pictures, videos, and, of course, tweets! We live-tweet from events like Advocacy Day and the Annual Meeting; and when we are not on the move we will keep you posted on what is newsworthy in your professional community.

Twitter is all about building new relationships and strengthening existing ones. This is your opportunity to get to know us if you do not, and get to know us even better if you do!

There is no better way to continue the conversation than on Twitter.


For questions contact Caitlyn Camacho, Communications and Marketing coordinator via email at ccamacho@aacap.org or by phone at 202.966.7300, ext.154.
Research has demonstrated that brain development continues throughout adolescence and into early adulthood. The frontal lobes, responsible for mature thought, reasoning and judgment, develop last. Adolescents use their brains in a fundamentally different manner than adults. They are more likely to act on impulse, without fully considering the consequences of their decisions or actions.

The Supreme Court has recognized these biological and developmental differences in their recent decisions on the juvenile death penalty, juvenile life without parole and the interrogations of juvenile suspects. In particular, the Supreme Court has recognized that there is a heightened risk that juvenile suspects will falsely confess when pressured by police during the interrogation process. Research also demonstrates that when in police custody, many juveniles do not fully understand or appreciate their rights, options or alternatives. Accordingly, the American Academy of Child and Adolescent Psychiatry believes that juveniles should have an attorney present during questioning by police or other law enforcement agencies. While the Academy believes that juveniles should have a right to consult with parents prior to and during questioning, parental presence alone may not be sufficient to protect juvenile suspects. Moreover, many parents may not be competent to advise their children on whether to speak to the police and may also be persuaded that cooperation with the police will bring leniency. There are numerous cases of juveniles who have falsely confessed with their parents present during questioning.

Furthermore, the Academy recommends that when interviewing juvenile suspects, police should use terms and concepts appropriate to the individual's developmental level. Any written material should also be geared to the person's grade level and cognitive capacity. In general, it is not sufficient to simply read or recite information to a juvenile. Ensuring meaningful understanding will usually require asking the individual to explain the information conveyed in his or her own words.

When administering Miranda warnings, many jurisdictions use the version and forms developed for adult suspects. Research demonstrates that these warnings are often too complex and advanced for most juveniles. For this reason, the Academy recommends that police and other law enforcement authorities should utilize simplified Miranda warnings developed specifically for use with juvenile suspects. Ideally, an attorney should be present when Miranda Warnings are administered to juvenile suspects.

Finally, the Academy recommends that all interviews of juvenile suspects should be video recorded. The ability to review such a permanent record is integral to the subsequent assessment of the juvenile, his or her comprehension of the Miranda warnings, and the nature, setting and circumstances of the interrogation.

References
Alabama

Child/Adolescent Psychiatrist

The Department of Psychiatry and Behavioral Neurobiology at the University of Alabama at Birmingham (UAB) is offering full-time faculty position for an academically-oriented BC/BE child and adolescent psychiatrist in the Division of Child/Adolescent Psychiatry. Rank, tenure status and salary commensurate with experience and qualifications. This position provides an excellent opportunity for a clinician teacher who enjoys collaborative work and enjoys interdisciplinary training of residents, fellows, medical students and other professionals. Primary responsibilities include clinical services in the Division of Child and Adolescent Psychiatry and participation in the teaching and supervision of child and adolescent psychiatry residents, general psychiatry residents, and medical students. Involvement in research activities is encouraged. UAB is a major regional medical center with excellent resources and benefits. The University is committed to building a culturally diverse educational environment.

A pre-employment background investigation is performed on candidates selected for employment. UAB is an Equal Opportunity/Affirmative Action Employer committed to fostering a diverse, equitable and family-friendly environment in which all faculty and staff can excel and achieve work/life balance irrespective of ethnicity, gender, faith, gender identity and expression as well as sexual orientation. UAB also encourages applications from individuals with disabilities and veterans.

Submit Applications To:
Lee I Ascherman, M.D., Division Director, Child/Adolescent Psychiatry, UAB Department of Psychiatry, Mail: 1720 University Blvd, Birmingham, AL 39294-0009 E-mail: cguyton@uab.edu

Massachusetts

BC/BE Child Psychiatrists Needed in Our Affiliated Community Mental Health Centers

Both full- and part-time physician leadership and staff physician opportunities are currently available in our community mental health center in Central Massachusetts.

Community Healthlink (CHL) is a dynamic, multi-service organization committed to establishing, maintaining and restoring the dignity, well being and overall mental health of individuals and families in Central Massachusetts. It provides a wide range of services to individuals suffering from mental illness, developmental disabilities and substance abuse issues, including youth and family services, residential services, adult outpatient services, and homeless and inpatient services. CHL is staffed by a mission oriented, multi-disciplinary team of psychiatrists, psychologists, nurses, social workers and other dedicated health care providers all committed to providing comprehensive, high quality care. Come join the dedicated team of professionals at CHL and help make a difference in the lives of some of Central Massachusetts’ most challenged individuals and families.

CHL psychiatrists receive competitive salaries and comprehensive benefits packages. Faculty appointments, commensurate with training and experience, are available as well, as is the opportunity to teach University of Massachusetts medical students, residents, and fellows.

For additional information about CHL, please visit our website: www.communityhealthlink.org

Interested candidates are encouraged to submit their CVs and letters of interest to: David DeLuca at: psychiatryrecruitment@umassmemorial.org

New Jersey

Full-Time Psychiatrist

CFG Health Marlton, New Jersey

This full time position will allow the psychiatrist to become a member and lead psychiatrist of the multi-disciplinary treatment team. Primary duties will consist of providing a full range of psychiatric services to assigned patients. Services provided include direct care of patients in the clinical setting including: assessment, screening, diagnosis, and treatment of patients and determining the degree of disabilities in patients. Psychiatrist will prescribe medication to patients as deemed necessary and will conduct medication management.

Additionally, the physician will provide clinical leadership for a treatment team of experienced nurses, clinicians and social workers. Treatment will include initial admissions evaluations, daily follow up care and discharge planning. The ability and willingness to work with System Care and other providers is an important component of the position. The ideal candidate will be board certified in adult psychiatry and or child psychiatry with a New Jersey Medical License, DEA and CDS.

Submit Applications To:
Frank Zura
E-mail: fzura@cfgpc.com
Phone: 609-304-7504
Mail: 765 East Route 70
Marlton, NJ 08053
Fax: 856-797-4779
Website Address: www.cfghealthnetwork.com
Upcoming EVENTS

May 9-10, 2013
Advocacy Day
Washington, D.C.

May 11, 2013
AACAP Assembly of Regional Organizations of Child and Adolescent Psychiatry
Washington, D.C.
emagee@aacap.org

May 9-11, 2013
Society of Professors of Child and Adolescent Psychiatry
Washington, D.C.
emagee@aacap.org

May 16-18, 2013
Society of Biological Psychiatry
San Francisco, CA
www.sobp.org

May 18-22, 2013
American Psychiatric Association Annual Meeting
San Francisco, CA
www.psych.org

June 6-9, 2013
4th World Congress on ADHD
Milan, Italy
www.adhd-congress.org

June 12-15, 2013
International Society for Research in Child and Adolescent Psychopathology
University of Leuven, Brussels
www.isrcap.org

September 25-28, 2013
7th International Congress of the Asian Society for Child and Adolescent Psychiatry and Allied Professions
New Delhi, India
www.ascapapindia2013.com

October 22-27, 2013
AACAP 60th Annual Meeting
Walt Disney World Dolphin Hotel
Orlando, FL
www.aacap.org

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Substance Abuse and Mental Health Services Administration

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