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– Approved by AACAP Membership December 2014

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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
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2. Education regarding child and adolescent psychiatry.
3. Recording the history of AACAP.
4. Artistic and creative expression of AACAP members.
5. Provide information regarding upcoming AACAP events.
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PRESIDENT’S MESSAGE

AACAP’s International Membership is a Reality!

Paramjit T. Joshi, MD, AACAP President

I am very proud to announce that AACAP’s International Membership is now live!!

This is a major accomplishment of my Presidential Initiative Partnering for the World’s Children – and it would not not be a reality without the efforts and help of the Assembly of Regional Organization of Child and Adolescent Psychiatry, International Relations Committee, Membership Committee, Presidential Steering Committee, and the Web Editorial Board for their help and input.

The new International Membership category allows psychiatrists from across the world, who share in AACAP’s values, goals, and mission, to join AACAP. By creating a dues structure that is sensitive to varying economic conditions around the world, we hope to facilitate the recruitment and active involvement of international members in an economically equitable manner. No longer is geography a hindrance to membership.

I am very excited to welcome international members, many of whom have wanted to join our family for some time. The creation of the International Membership category was in response to the many requests AACAP receives from psychiatrists around the world looking to become part of our growing community. It is my hope that the sharing of global ideas will serve AACAP and our field well as we work together to navigate our ever-changing specialty.

Moving forward, the Member Services team, working in conjunction with both the Membership Committee and International Relations Committee, is putting together a complete and strategic marketing campaign for both building awareness and recruiting international members. In the very near future you will hear – and see – much more about international membership.

Our latest achievement serves as a testament to not only AACAP’s global reach, but the importance and need for services and treatment for children all over the world. We are moving in the right direction, building and strengthening our international collaborations and fostering these relationships while making sure we are keeping the AACAP moving forward and on mission.

The last few months have been a whirlwind of activity. I look forward to what the future brings!

Very sincerely,

Paramjit T. Joshi, MD
President, AACAP

International Membership is available to licensed physicians who live, and are trained, outside the United States and Canada who completed acceptable training in general psychiatry and adolescent psychiatry, and graduated from an international medical school listed in the World Health Organization Directory.

For more information on International Membership check out AACAP’s International page – www.aacap.org.
When is Enough Just Right? Navigating the New EMR World from a Trainee’s Perspective

COLUMNS

ETHICS COLUMN

Justine Wittenauer, MD

A child and adolescent psychiatry fellow is working on a discharge summary for an 11-year-old girl being discharged from the inpatient psychiatric unit. The fellow will be continuing to care for the patient in the hospital’s outpatient psychopharmacology clinic. A trauma narrative was created during the girl’s admission that includes specific details of sexual abuse by a relative. To support a diagnosis of post-traumatic stress disorder (PTSD), the fellow documents key details of the traumatic event in the summary. After the parents give consent for the patient’s records to be shared with other providers, the attending responsible for the case removes the details of the trauma prior to cosigning the discharge summary. The patient has been seen for six months in the outpatient clinic when the fellow’s psychopharmacology preceptor performs a retrospective chart review of the entire treatment. After the parents give consent for the patient’s records to be shared with other providers, the attending responsible for the case removes the details of the trauma prior to cosigning the discharge summary. The patient has been seen for six months in the outpatient clinic when the fellow’s psychopharmacology preceptor performs a retrospective chart review of the entire treatment. The preceptor believes that the chart meets institutional requirements, but worries that historical events surrounding the trauma have been omitted unnecessarily. Since this patient is now going to be transferred to another trainee, the preceptor requests that the fellow document the details in the transfer note that were removed from the record by the inpatient attending.

Proponents of electronic medical records (EMRs) have argued that the use of a digital health medium will improve access to information and make communication between providers more efficient. Not unexpectedly, EMRs have also created additional ethical and legal dilemmas regarding privacy and confidentiality. Although the intent of the Health Insurance Portability and Accountability Act (HIPAA) is to protect medical records, it may be difficult to truly anticipate who would read the record and in what context the information would be used. In the field of mental health, safeguarding medical records is especially important due to the sensitive nature of the material shared in confidence with a clinician, and is explicitly discussed within the ethical principle of confidentiality (autonomy/fidelity) in the AACAP Code of Ethics. Recognition of the importance of maintaining privacy and confidentiality is reflected in some states’ legislation by offering mental health and substance use treatment records a higher level of legal protection. However, once this information is in an EMR, the potential readership may now include people and entities that the patient never intended to have access.

Numerous external factors impact how documentation is completed. These factors include providing adequate information to inform and guide ongoing treatment, adherence to institutional documentation guidelines, compliance with third-party payer requirements, efforts to maximize communication between professionals, as well as deference in honoring individual patient requests that specific material be left out of the record. Trainees may experience even more confusion regarding documentation due to differing expectations by various clinical and administrative supervisors. These seemingly contradictory expectations may reflect the diversity of supervisors’ experience with clinical documentation, perspectives on what constitutes an adequate note and the lack of clearly established guidelines that encompass different types of clinical documentation.

Trainees are often left to their own devices to find and manage an appropriate balance between supervisor expectations, clinical usefulness, compliance requirements, and risk-management; and often struggle to set reasonable limits on the amount of time they spend documenting. Many training programs provide instruction on medical liability and how to document safety risk. However, there often is less teaching on issues related to communication among providers, risk management, and ethics that arise in documentation. There are also specific documentation challenges that present more frequently in residency programs given the transfer of care between residents and clinics, the adoption of new clinical practice guidelines that were not incorporated in previous treatment notes, and different roles that clinical and administrative supervisors can have with regard to documentation.

“Explicit instruction on the ethical issues underlying documentation and how to approach and manage these issues should be included in every training program.”

Supervisory Dilemmas

Trainees have the responsibility to document in the service of best clinical practice, while also knowing that
their supervisors are evaluating their documentation. Notes often require co-signatures; thereby placing additional stress on trainees to ensure that documentation covers all aspects of potential liability. A resident may experience “do as I say, not as I do” as supervisors may expect more thorough and extensive documentation than they would typically produce on their own behalf. As the above case highlights, within child and adolescent mental health it is not an uncommon practice to provide a copy of the discharge summary to a patient’s guardians, school, and outpatient providers for review of the treatment and recommendations. In most training systems, this discharge summary requires a supervisory co-signature if written by a trainee. The ethical dilemma for the trainee includes providing enough information to describe the treatment in sufficient detail to demonstrate his/her medical expertise, while not disclosing too many specifics regarding the private life of the family system. Adequate risk assessment must also be included in the document. Without clear guidelines as to the format of the document or documents, additional time and energy may be spent in the creation of the note, as well as potential revisions.

Notes that include information disclosed in therapy sessions can contain particularly sensitive material. While some supervisors recommend minimal information from sessions to be documented, others are more liberal in their disclosure of details. The level of detail and specific content in a note disclosure may be related to the documentation of a safety assessment, clinical service to ensure receipt of third party reimbursement, provision of information for ongoing care, or the enhancement of coordination when there is a transfer of care to other trainees. Supervisors, like residents, can benefit from education and guidance on what type of documentation is required under different circumstances.

**Institutional Expectations**

Trainees often rotate through multiple sites during their residency or fellowship. Depending on the site, standards for documentation may vary greatly. These standards are likely influenced by broader requirements, such as documentation that supports medical necessity criteria guidelines from third party payers, as well as requirements from state oversight and accreditation bodies. Additionally, different EMRs exist, each requiring varying specific notations. For example, one site may request that particulars of therapy be kept in sequestered psychotherapy notes, with minimal reference to specific details in the regular progress note. Other hospital systems may require additional supporting evidence for each diagnosis, as well as discussion topics from each session. Some institutions have the option to make electronic notes “sensitive,” i.e., only accessible to mental health providers, and others have a “one size fits all” system. While considerable planning may have occurred prior to the integration and implementation of the new note templates into an EMR, trainees may not have had the benefit of an adequate orientation and ongoing support in the selection of different types of documentation templates. Sharing clinical information within the context of informed consent, release of information, maintaining confidentiality, and the specifics regarding protected health information as defined within the HIPPA Privacy Rule certainly can advance the quality of care. However, disclosed information may have unintended and detrimental consequences for the patient, family and guardians, other providers, and child service systems.

**Recommendations**

As the advent of EMRs has rapidly revolutionized medical practice, trainees on the front lines of clinical care are often left to puzzle through many operational details. Trainees and supervisors should be clearly trained in institutional and other compliance standards to enhance uniform documentation styles and reduce trainee confusion. Each residency-affiliated institution should provide its own orientation to the facility, as well as documenting expectations. Guidelines for documentation based on the purpose of, and how the document will be used, should be provided. For example, one approach to providing discharge documentation to different parties is to separate the materials. A discharge management plan for the family may include any diagnoses, follow-up care appointments, prescribed medications with instructions, and a crisis plan. A document tailored for school would include educational recommendations and accommodations, and medications, especially if administered at school. Clinicians that are continuing outpatient care require a more detailed clinical account that can be contained in the formal discharge summary. Small group sessions with trainees and supervisors on especially challenging scenarios may enhance education for both parties. Departmentally, one specific solution is to develop a clear and concise note type that can be accessed within the EMR. Guidelines for how to use these notes should be provided not only to trainees, but their supervisors as well on a regular, ongoing schedule.

Explicit instruction on the ethical issues underlying documentation and how to approach and manage these issues should be included in every training program. Supervisors can be helpful in finding ways for trainees to adequately communicate information in the EMR when notes are non-sensitive. Even without standardized notes, a more open discussion regarding both supervisory and institutional expectations for trainee documentation may reduce uncertainty and increase overall efficiency of patient care. ■

Note: I would like to thank Sandra DeJong, MD, for her assistance in editing this article.

Dr. Wittenauer is a second year child and adolescent psychiatry fellow at Cambridge Health Alliance, a Harvard Medical School affiliate. Upon graduation, she will be starting an additional fellowship in addiction psychiatry through the Partners HealthCare Addiction Psychiatry Fellowship, a Harvard Medical School affiliate. She may be reached at jwittenauer@challiance.org.
Gender Nonconforming Youth and the Juvenile Justice System: Time for a Policy Change?

■ Dalia N. Balsamo, MD

Last year, a 16-year-old transgender girl was incarcerated at a female adult prison in Connecticut without any formal charges against her. Her story gathered a lot of media attention and ignited discussions about the current state of the juvenile justice system and its treatment of gender nonconforming youth. This article aims to provide a more comprehensive picture of her case, while bringing into awareness the various challenges faced by transgender youth in the legal system.

Jane Doe (named as such in courts due to her age) has an extensive history of childhood trauma. She reportedly has had various psychiatric placements starting at the age of nine, including acute hospitalizations, residential facilities, and detention centers. What complicates her presentation is her history of assaultive and threatening behavior towards peers and staff. According to court documents (in Re Doe, 2014), she pleaded guilty to assault of an officer on November 21, 2013, and was committed delinquent to the Department of Children and Families (DCF) for a period not to exceed 18 months. She was subsequently placed at the Meadowbridge Academy in Swansea, Massachusetts. The academy is owned and operated by the Justice Resource Institute and provides trauma-informed care.

On February 4, 2014, pursuant to General Statutes § 17a-12, DCF made a motion to transfer Jane to the male-populated Manson Youth Institution. This institution is run by the Department of Corrections (DOC) and houses male inmates between the ages of 14 to 21 years old. These juvenile offenders usually have either pending or sentenced adult charges. While § 17a-12 states that the “best interests” of the child should be considered in the decision to transfer in addition to safety concerns for other juveniles, the court focused mostly on her “dangerousness.” While the initial proposal was to transfer her to a male facility and it was mentioned that the DOC typically classifies inmates by “biological gender,” the court took into consideration the Prison Rape Elimination Act (PREA) and consequently transferred her to the female prison in Niantic, Connecticut.

While in female prison, she wrote of her conditions there, lamenting not having anybody her age to communicate with and not receiving proper care to process her history of trauma (Rabe 2014). Many child advocates and civil rights activists expressed their indignation over her treatment. Celebrities wrote letters to her and rallies were held (Mock 2014, Valencia 2014). She was subsequently transferred in June to the Pueblo unit at the Albert J. Solnit Children’s Psychiatric Center, where she had originally petitioned to be placed. This is a locked door unit for delinquent girls. It has 10 regular beds and 2 emergency beds. The other state facility with such characteristics is Journey House in Mansfield, Connecticut. Jane’s stay at the Solnit Center only lasted 19 days. She was transferred to CJTS upon allegations of assault towards a staff member and another youth. From CJTS, she was transferred to a treatment facility at the Institute of Living in Hartford, but escaped on her first day there (Kovner 2014). This led to her being transferred back, yet again, to CJTS. She has since publicly decried her treatment at CJTS, saying that while she is receiving hormonal treatment, she is referred to as male, not allowed to wear wigs or makeup, and addressed by a male name (The Guardian 2014).

The purpose of this article is not to point fingers nor take sides. Jane Doe’s history of exhibiting violent behavior and her caregivers’ safety concerns are not being disputed here. What is being discussed is the inconsistent treatment she has received in regards to her gender.
identity. While DCF has recognized her as being female, she has been placed at a male juvenile facility on several occasions. Transgender individuals have historically faced challenges in regards to the department of corrections recognizing their affirmed gender identities (Coffey 2004). One jurisdiction in the state of New York allows juvenile offenders to be placed in accordance with their gender identities, but it is in the minority (Faithful 2009). Many of us are also familiar with the case of Michelle Kosilek, an adult trans-gender woman who had to fight the justice system for 20 years in order to receive sexual reassignment surgery (Kosilek v Spencer 2014).

As child and adolescent psychiatrists, we are all aware of the debilitating effects of a consistently invalidating environment. Denying someone’s sense of his or her own gender is a particularly invalidating experience as it is a direct negation of one’s identity. All youths need a nurturing environment where they feel protected and understood. They need mentalizing caregivers and authority figures who allow them to grow as individuals, even if their paths may not conform to established standards. Mentalization refers to our ability to understand the mental state of self and others. It helps us acknowledge and validate subjective experiences different from our own and appreciate other perspectives. It is unfair for gender-variant youth to be punished and receive inconsistent treatment because of a systems failure to recognize the complexities of gender. It is my hope that Jane Doe’s case will serve as a wake-up call for us to reconsider the make-up of our juvenile justice system.

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Dr. Balsamo is a second year child and adolescent psychiatry fellow at the Yale Child Study Center. She will be pursuing a fellowship in forensic psychiatry at the Yale Law and Psychiatry Division next year. She would like to thank Dr. Howard Zonana for his guidance regarding this article. She may be reached at dalia.balsamo@yale.edu.
International medical graduates (IMGs) are a diverse group of physicians who play an important role in the field of child and adolescent psychiatry. By some estimates, IMGs make up 25 percent of all physicians in the United States (Traverso and McMahon 2012). For IMGs to get accepted into psychiatry training or practice, they must first overcome a number of hurdles (Gogineni et al. 2010).

One of the biggest obstacles faced is visa status. Delays in obtaining the appropriate visa can negatively affect an IMG’s ability to find work and render him/her less appealing to the training program. Hospitals and universities can find themselves in a dilemma when they are confronted with pitting qualifications against legal status. The visa situation can become so dire that some IMGs may relinquish child and adolescent psychiatry fellowship training in order to take a general psychiatry job should that employer offer to rectify their visa conundrum. This is of great concern, as it can adversely impact the current shortage of child and adolescent psychiatrists in the United States.

Typically, IMGs beginning their residency enter the United States on J-1 or H-1B visas (ECFMG, USMLE). Other applicable visa types include the F-1 student visa, which allows students to work in the United States under the Option Practice Training (OPT) visa upon graduation. Once the OPT visa has been consumed, IMGs may choose to change their status to H-1B upon finding a sponsoring employer. A third option, albeit rare, is the Diversity “lottery for green cards” (DV-1).

A chosen few IMGs with extraordinary ability, such as outstanding professors or researchers, may obtain EB-1 or EB-2 visas through their employer. For IMGs of “outstanding caliber,” O-1 visas are offered to claimants who have received national or international endorsement in medicine.

This article focuses on the two major visas offered to IMGs, the J-1 and H-1B. Hopefuls for these particular visas, must have graduated from a recognized medical school and successfully completed mandated assessments, such as the United States Medical Licensing Examination (USMLE). All IMGs must also gain certification from the Educational Commission for Foreign Medical Graduates (ECFMG), which sponsors the J-1 non-immigrant visa. It is important to remember that while the visa process is federal, the actual medical license is state based, so IMGs also need to be aware of any state-specific requirements.

For J-1 visa holders, their stay in the United States cannot exceed seven years. Upon completion of the medical training, the physician must return to his/her home country for two years before obtaining H-1B status or getting a “green card.” IMGs who find employment in the United States can qualify for a waiver that would allow them to forgo the two-year trip home. There are some fellowship programs that accept IMGs on J-1 status, but those IMGs cannot moonlight.

A few training programs are willing to sponsor an H-1B visa, which is used for temporary “special occupation” workers or trainees. However, that can prove very costly to the employer, making these sponsorships competitive. The
H-1B visa is limited to six years (unless the green card process is underway). Unlike the J-1 visa, it is not subject to the two-year home resident requirement and H-1B holders are allowed to moonlight.

Once IMGs have finished their training, many look to practice in the United States, but it takes more than talent and hard work (Meghani and Rajput 2011). Navigating the intricacies of the immigration system while simultaneously acclimating to a new lifestyle can be difficult, but it is a challenge many IMGs have overcome (Sockalingam et al. 2012).

The J-1 visa holders who return to their home country for the two-year hiatus can complete the permanent U.S. residency process while there. Those who are able to obtain a waiver from that return requirement can do so under the state-sponsored Conrad 30 program, a Federal Interested Government Agency (IGA), or through a hardship or persecution waiver. They typically work for at least three years in a Medically Underserved Area (MUA) or a Health Professional Shortage Area (HPSA) in an H-1B status. They can obtain permanent U.S. residency through the Program Electronic Review Management (PERM) process for Labor Certification, a National Interest Waiver, or sometimes through marriage to a U.S. citizen. The Veterans Administration (VA) is an example of a government agency that sponsors a J-waiver.

If the physician chooses the research track, he or she can seek assistance though federal research programs that can recommend a waiver based on the importance of the work being pursued as long as the IMG is an essential contributor. The visa applicant may then apply to change his/her status to H-1B or directly pursue permanent residency.

The challenges do not stop after the IMGs has successfully obtained the legal right to work. Conditions of engagement and contract stipulations can be interpreted differently by the IMG and the employer. Some IMGs have said this leads them to feel like they have to work harder than others in their clinical practice and are not adequately compensated financially. They may also be diverted from the population they intended to serve. There are instances where IMGs reported feeling mistreated by their employers: exploited due to their desperate desire for a job in the United States.

Many IMGs are reluctant to complain however. They feel the need to be grateful to their employers and worry about how a grievance could affect their immigration status. There seems to be little enforcement by government agencies in this area. Moreover, the IMGs may be at the mercy of the attorney who represents the employer. Just like all other physicians, IMGs have rights. If they feel they are being mistreated, they should document the problem and address it with their supervisor.

During the last three AACAP annual meetings, IMGs voiced frustration about visa hurdles, employment options, and treatment after finishing residency. Even finding a Medically Underserved Area or a Health Professional Shortage Area was challenging for some. These discussions paved the way for further conversations with AACAP leaders to ensure that IMGs have the support they need for the future of the physician, the patients and families they serve, and the profession as a whole. Following are suggestions that evolved from these discourses to help IMGs co-navigate the residency and legal systems.

**Recommendations**

1. Start early. Keep in mind the process takes time. You cannot control delays caused by immigration services and labor certification; so it is always better to be prepared.

2. Make a strategic plan with self-imposed deadlines, and make sure to follow through.

3. Have your employer advocate for you.

4. Get a good immigration lawyer who has worked with and understands the needs of IMGs. This does not necessarily need to be one that works for your employer—you can retain your own counsel.

5. Do not be out of status. Nothing can unravel your plans faster.

6. Step back, and look at the whole picture. Consider how each decision will affect you, your family and your future.

7. Do not hesitate to ask for help from other IMGs (especially those who have completed the process) or AACAP members and leaders.

8. Carefully read your contract before signing it. Your immigration lawyer may assist in identifying areas that can be misleading.

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Formation of the Singapore Section of Child and Adolescent Psychiatry

Ong Say How, MD

Background

Child and adolescent psychiatry in Singapore officially began in 1970 when the Ministry of Health opened the Child Guidance Clinic at the Outram Road General Hospital (presently known as the Singapore General Hospital). Since then, it has grown from an ad hoc, part-time service to a full department with 12 consultants, 6 medical officers, 6 clinical psychologists and 3 medical social workers with a full complement of nurses and administrative staff. From seeing 550 children and families in 1980, the clinic has grown to see over 2,500 new cases per year. In the last ten years, with the increasing demand for child mental health services in the public sector, child and adolescent consultation-liaison psychiatric services have also taken root in two other restructured hospitals—National University Hospital Systems and Kedang Kerbau Women’s and Children’s Hospital.

The local psychiatry fraternity believes that the future of child and adolescent psychiatry lies within the integration of child mental health services from both public and private sectors, and strengthening the links within community agencies to enhance mental healthcare for the young in Singapore. Collaboration with several key players such as the social services and the education ministry is particularly crucial, as all these organizations have a common interest in helping children and youths but due to their different backgrounds and working frameworks, close collaboration sometimes cannot be organized effectively. In the hospitals, there is also a greater need for collaboration in research among various medical disciplines and professionals both locally and internationally.

Improving existing medical education and cultivating the younger generation of doctors and psychiatrists has also been the mission of the teaching faculty. With the recent addition of a third medical school, Lee Kong Chian School of Medicine, in 2013 and the implementation of the National Psychiatry Residency Program in 2010, the medical education landscape is set to change. Currently, different hospital systems have their own separate child and adolescent psychiatry residency programs and private psychiatrists have a very limited role in training future psychiatrists. Much could be achieved in child and adolescent psychiatry training if there were more synergy and collaboration.

On November 26, 2014, the first Section of Child and Adolescent Psychiatry was formed under the auspices of the College of Psychiatry, Academy of Medicine Singapore. It comprises 19 active academy members. Together with non-members, the number of child and adolescent psychiatrists in Singapore would total 35. Fellows and members must have completed an approved training program equivalent to a Certificate of Advanced Training in Child and Adolescent Psychiatry, or have had formal training in the local Advanced Specialist Training, or be accredited in a post-graduate education and fellowship program such as the ACGME-I Residency 5th year Elective in Child and Adolescent Psychiatry. Members, especially those in non-institutional practice, must also be actively involved (more than or equal to 50% of their existing caseload) in the assessment and management of children and adolescents with documentary evidence of such work for the last three years. The

“The child and adolescent psychiatry in Singapore has seen rapid changes in recent years. With over 30 child and adolescent psychiatrists now practicing in both the public and private sectors, it is time for us to bring the sub-specialty of child and adolescent psychiatry to the next level.”
broader admission criteria were intended to ensure better representation and inclusion of eligible psychiatrists into the Section. The office bearers of the section include the chairman, vice-chairman, secretary, and four other members. As the Section does not hold any financial assets or responsibilities, the committee does not have a treasurer.

In addition to aligning and executing priorities in accordance with the College’s strategic plan, the goals and objectives of the Section comprise the following:

- Promote awareness of child and adolescent mental health in Singapore to reduce stigma in children, adolescents, and their families seeking psychiatric treatment.
- Develop and coordinate training programs in child and adolescent psychiatry, together with appropriate educational organizations, as part of professional development for psychiatrists and trainee psychiatrists.
- Facilitate professional networking and collaboration with other professionals in the fields of health, education, legal system and social welfare.
- Promote a high standard of clinical practice in child and adolescent psychiatry.
- Promote research and keep up-to-date current advances in child and adolescent psychiatry.
- Be an advocate in child and adolescent mental health issues, and an authority in public and administrative policies.

Child and adolescent psychiatry in Singapore has seen rapid changes in recent years, especially in the form of mental health policy changes, improvements in medical education, intensification in research collaborations, and development of new clinical services. With over 30 child and adolescent psychiatrists now practicing in both the public and private sectors, it is time for us to bring the sub-specialty of child and adolescent psychiatry to the next level, and contribute to the greater good of the children and youth of today.

Dr. Ong Say How is chair of the Singapore Section of Child and Adolescent Psychiatry of the Institute of Mental Health. He may be reached at say_how_ong@imh.com.sg.

**AACAP’s Bylaws Are Online!**

Be sure to check out AACAP’s Bylaws online. You can get the Bylaws online at [www.aacap.org](http://www.aacap.org).

*The Bylaws were revised at the end of 2014*
AALI program
(AACAP Alliance for Learning and Innovation)

The AALI program, created by AACAP’s Training and Education Committee, is a virtual teaching academy to engage members in exciting educational initiatives.

The goals of the AALI program:

- Serve AACAP in the development of innovative educational resources in partnership with its members;
- Ensure that the educational resources are made available to members at the annual meetings and on the web;
- Provide an inclusive community for all educators to allow for support, recognition, and innovation.

AALI is open to all AACAP members with an interest in education.

For more information or to be a part of AALI, contact training@aacap.org or (202) 587-9663.
The Child and Adolescent Service Intensity Instrument

The Child and Adolescent Service Intensity Instrument (CASII) is an empirically supported tool developed by the Committee on Community Systems of Care in 2000 that guides treatment planning and monitors outcomes for children and adolescents ages 6 through 18 years-of-age that have mental health challenges (AACAP 2000). The Committee was awarded the Catchers in the Rye Award in 2001 for its work on the CASII.

The CASII takes into account comorbid physical health, developmental and substance use conditions, and is rooted in the System of Care approach to behavioral health that has guided Federal and State services for the past 25 years. The CASII manual has recently been extensively revised and updated to relate the instrument to emerging concepts in health care reform including the recognition to emerging concepts in health based service intensity rather than the bricks and mortar concept of “level of care.” It incorporates holistic information on the child, the child’s family, and social ecology while assessing across six dimensions: risk of harm (trauma), functional status, co-occurring conditions, recovery environment, resiliency/response to services, and involvement in services. The CASII embraces individualized service planning; the use of child and family “wraparound” teams to promote coordination of care for children with complex needs; and a broad service array that includes such home and community based services as family partners and natural supports.

The CASII links the results of a guided clinical assessment across the six dimensions to one of seven levels of service intensity ranging from Basic, or universal services, to Secure, 24-hour Services with Psychiatric Management, using a clinically-derived and empirically-tested algorithm. The CASII is culturally informed and supports active participation by the child and family. It is designed for use in all child-serving systems (behavioral health, physical health, education, child welfare, juvenile justice, etc.). The CASII differs from the Child and Adolescent Needs and Strengths (CANS) assessment tool by providing more than just an inventory of strengths and needs. By relating clinical history to the six dimensions of concern using an algorithm with demonstrated validity and reliability, it supports specificity with respect to the overall level of service intensity needed and the specific dimension(s) in which care planning and monitoring are most critical. The CASII is complemented by the Early Childhood Service Intensity Instrument (ECSII), created in 2009, which provides similar support for the care of children ages 0- through 5-years-of-age (AACAP 2009).

Several research studies support psychometric properties of the CASII. The validity and reliability of the CASII was originally established by a national field study sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services through the American Institute for Research with four study sites in Pennsylvania, Oregon, Hawaii, and North Carolina (AACAP 2014). When compared with the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Global Assessment Scale (CGAS), the CASII showed excellent external validity. The initial study also demonstrated excellent inter-rater reliability that was even higher among lesser-trained clinicians that has held up in all subsequent studies.

One study analyzed data from the use of the CASII in the child welfare population in the state of Hawaii and showed that the CASII had strong concurrent validity when compared with the CAFAS and significant predictive validity for restrictiveness and cost of services (Daleiden 2004). Two other studies evaluating the use of the CASII among the child welfare population in Hawaii demonstrated overall improvement in outcomes for the youth (Daleiden 2006; Toman 2008). An evaluation of the use of the CASII in the child and adolescent mental health system in the state of Minnesota showed a significant decrease in CASII scores from the initial evaluation to six-month and also twelve-month follow-up (MMHAG 2008).

Pumariega and colleagues recently published a study that evaluated the use of the CASII in the juvenile justice system via data from the review by the Tennessee Child Program Outcome Review Team (CPORT) (Pumariega continued on page 124)
The Child and Adolescent Service Intensity Instrument continued from page 123

2014). This review is conducted on an annual basis by the Tennessee Commission on Children and Youth, the state’s quality assurance agency for children and youth in state custody, including those in the child welfare and juvenile justice systems. In the study, the CASII was compared to the Child and Adolescent Functional Assessment Scale (CAFAS), Child Behavior Checklist (CBCL), Youth Self Report (YSR), and Teacher Report Form (TRF). The CASII Total Score and indicated Service Intensity Level showed a high correlation with the CBCL, YSR and TRF total scores and sub-scales. There was significant correlation between the subscales of the CASII and the CAFAS total scores. When compared with the CPORT Child and Family Indicators, a measure of child outcomes, the CASII showed a strong correlation to these outcomes. However, the actual level of care, or service intensity received by these youth was not infrequently found to be significantly different than that recommended by the CASII. In most of these cases, the CASII recommendation was for a lower service intensity level than was currently in place although it also demonstrated that some youth needed an increase in services.

The CASII has been implemented in 25 states and District of Columbia in the United States. The Hawaii Child and Adolescent Mental Health Division has been using the CASII since 2001. The CASII is used outside the United States in Canada, Japan, Belgium, and the Netherlands. The CASII has been used by wraparound service planning Child and Family Teams in Arizona, with great consumer family acceptability (Klaehn 2015).

In the context of health care reform and the emergence of the electronic health record (EHR), AACAP, in conjunction with a software developer, is developing a digital version that can be integrated into the user’s EHR. In addition, Web-based training has been developed in the past year and facilitates training that previously had to be done in person, significantly increasing training ease and capacity. In addition to its widespread use in public settings supported by Medicaid insurance, the CASII is now licensed to Anthem (BCBS) in Connecticut for Anthem reviewers to establish eligibility for behavioral health benefits. Marketing is progressing to other commercial and public insurers, with 3 additional licensing contracts pending at present. Healthcare reform puts a priority on monitoring outcomes and the CASII is unique in its ability to provide an empirically established algorithm to measure treatment outcomes. Other initiatives underway involve outreach to multiple public and private providers and insurers of behavioral health care and primary pediatric care to support treatment planning, benefit eligibility determination, and monitoring of outcomes. Use of the CASII and its related instrument, the ECSII, significantly enhances the quality of care afforded to children and adolescents with behavioral, substance abuse, developmental, and/or physical health care needs by enhancing care coordination, treatment planning, and monitoring of outcomes within the framework of a System of Care approach.

References


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Dr. Metz is clinical professor of Psychiatry and Pediatrics at University of Massachusetts Medical School, director of community child psychiatry, and emeritus child psychiatry division director, and residency training director. He has been a member of the AACAP Community Systems of Care Committee since 2004. He may be reached at peter.metz@umassmed.edu.

Dr. Varma is a second year child and adolescent psychiatry fellow, one of four chief fellows at the New York Presbyterian Hospital Child and Adolescent Psychiatry Residency Training Program of Columbia and Cornell Universities. She is resident member of the Systems of Care Committee. She may be reached at chinedu.onyedike@gmail.com.
MEDICAL STUDENTS AND RESIDENTS COMMITTEE: MENTORSHIP MATTERS

Winter is Coming: The 11th Annual Klingenstein Third Generation Foundation (KTGF) Medical Student Conference at Mayo Clinic

Even before the last Krispy Kreme had cooled at the 2014 Klingenstein Third Generation Foundation (KTGF) Games at the University of North Carolina, Chapel Hill, the Mayo Clinic contingent of Nikhil (Sunny) Patel, Keith Miller, Jessica Saw, Kristin Nguyen, and Scott Schmidt, MD, began planning to bring the Games to the Midwest in 2015. Unaccustomed to a 50 degree day in February, Mayo’s reign as defending champion was cut short by our victorious colleagues from Harvard. Determined to win again, we decided that a little home-field advantage was exactly what we needed to return to the top. Thus, we lobbied to bring the Games to Mayo for a 2015 Games to remember!

The KTGF program focuses on mentorship and exposing the next generation of physicians to child and adolescent psychiatry. Its Medical Student Fellowship Program has a presence at many participating schools and emphasizes core values of mentorship, scholarship, and, most of all, fun! It helps connect students with mentors in child and adolescent psychiatry as early as their first year in medical school, which helps them explore this amazing field. At Mayo Medical School, our KTGF fellowship is called the Jane Watson Duncan Medical School Training Program. It gives students the opportunity to attend lunch talks from experts, meet with faculty and fellows and with patients hospitalized on the child and adolescent psychiatry inpatient ward. Medical students learn from both academic mentors and their patients, equally incredible teachers with invaluable perspectives.

The Annual KTGF Games is a venue where medical students interested in child and adolescent psychiatry from across the country can come together and share experiences in a fun and supportive atmosphere. In line with an increased emphasis on mentorship and scholarship, this year the KTGF Games was re-named the KTGF Annual Medical Student Conference. On February 7, 2015, over 75 medical students, residents, fellows and faculty from 11 medical schools met in snowy Rochester, Minnesota, at the Mayo Clinic. This included a group from Washington University in St. Louis, which was making its inaugural appearance at a KTGF Medical Student Conference! In addition to this record-setting crowd, we were also incredibly pleased to welcome Andrew D. Klingenstein, president of the Board of Trustees of the KTGF.

The next morning, the conference began with the keynote speaker, Dr. Wells. Drawing on his years of experience, he gave a spirited talk about mentorship, empiricism in the science, and the mastery of the art of psychiatry. While Harvard thought that they had the last participant standing, Mount Sinai swooped in to emerge victorious! Ridwa Abdi, of University of California Davis spoke on mindfulness practice for children and adolescents, while Jessica Becker of Yale talked about the critical appraisal of clinical trial data. Jessie Duncan of University of Illinois at Chicago lectured on an exploration of Parent Management Training, while Leah Schmelkin, Lily Chan, and Kristen Nguyen of Mayo Medical School continued on page 126
wrapped up the morning with a talk discussing the relationship between gastrointestinal symptoms and anxiety.

After lunch, participants received a Mayo Clinic tour including Mayo’s Nobel Prize (presented to Drs. Kendell and Hench for the discovery of cortisol), sculpture by Rodin, glasswork by Chihuly, and paintings by Warhol.

In addition to recreational games, participants transitioned to the more serious intellectual pursuits of the annual poster session.

The poster session included Suman Baddam and colleagues’ neurophysiology work describing differential neural responses to exclusion and inclusion events among childhood friends and strangers. Tiffany Chambers and colleagues described an innovative medical student wellness program inspired by live-action gaming. In all, there was a fascinating hour-long poster session with 13 individuals describing their innovative work.

The day ended with a networking session to learn some more about the faculty and students that we met throughout the weekend. Not only were we able to learn more about residency programs around the country but research ideas were exchanged and collaborations made! In an increasingly digitized world, where our conversations are through the words of a quick e-mail, the genuine interactions fostered and relationships built at the Games are lasting ones.

By the time the games concluded, it was Washington University in St. Louis that took home the cup! Not bad for their initial trip to the KTGF Annual Medical Student Conference! We filled the cup with potatoes, as we heard that they had a six-hour drive ahead of them.

Under the guidance of James Leckman, MD, Andres Martin, MD, and Michael Bloch, MD, the next KTGF games will be held at Yale School of Medicine in New Haven, Connecticut. We are excited to see the spirit of mentorship, scholarship and fun continued at the 12th Klingenstein Third Generation Foundation Annual Medical Student Conference.

Mr. Miller is a fourth year medical student at Mayo Medical School. He headed the medical student planning committee for the 2015 KTGF Annual Conference and is co-medical student leader of the KTGF Medical Student Fellowship Program. He hopes to one day combine his love of comic books with that of psychiatry by using superheroes to educate patients and the public about mental health. He may be reached at miller.keith@mayo.edu.

Mr. Patel is a fourth year medical student at Mayo Medical School and a masters of public health student at the Harvard TH Chan School of Public Health. He served on the planning committee for the 2015 KTGF Annual Conference. As a child and adolescent psychiatrist, he hopes to contribute to the nascent global mental health movement by working on delivery systems of care for children and adolescents suffering from mental illness locally and globally. He may be reached at patel.nikhil@mayo.edu.
Residents

Educational Outreach Program
Award Deadline: July 13, 2015

The Educational Outreach Program (EOP) for both child and adolescent psychiatry residents and general psychiatry residents provides funding support for residents to attend the 62nd AACAP Annual Meeting in San Antonio, TX, October 26 – October 31, 2015. The Annual Meeting provides residents with exposure to the field of child and adolescent psychiatry, including research and networking opportunities. For more information regarding the EOP program, visit the AACAP website at http://www.aacap.org/AACAP/Awards/Home.aspx or contact the Training and Education Department at training@aacap.org.

Systems of Care Clinical Projects
Award Deadline: July 13, 2015

Child and adolescent psychiatry residents are encouraged to apply for the 2015 Systems of Care Clinical Projects, which were created to give residents and fellows the opportunity to learn about the Systems of Care philosophy and framework to treat children with mental health challenges. Those selected to participate in the Clinical Projects receive $1,000 plus shared funding from a training program or regional organization to be part of a learning community led by members of the Systems of Care Committee. One of the requirements of the award includes attendance at the 2015 Systems of Care Special Program taking place on Monday, October 26 at AACAP’s 62nd Annual Meeting in San Antonio, TX. Residents may apply to both the Special Program Clinical Projects and the Educational Outreach Program (EOP); however, individuals cannot receive both awards at the same time. For more information, please visit: http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/Awards_RECP_Home.aspx or contact the Clinical Practice Department at clinical@aacap.org.

Medical Students

Life Members Mentorship Grants for Medical Students
Award Deadline: July 13, 2015

The Life Members Mentorship Grants for Medical Students provides medical students with the opportunity to attend the 62nd AACAP Annual Meeting in San Antonio, TX, October 26 - October 31, 2015. Partnered with the Mentorship Program, this program provides participants with networking opportunities, exposure to varying specialties, and interaction with Life Members. For more information, visit the AACAP website at http://www.aacap.org/AACAP/Awards/Home.aspx or contact the Training and Education Department at training@aacap.org.

*All AACAP Awards are contingent upon available funding.*
Where You Live Matters when Talking about Youth Suicide

As of 2010, suicide was the third leading cause of death in youth aged 10-24 years. Only unintentional injuries and homicide claim more victims. Males account for 81% of the suicide deaths in this age group, and risk increases with age. Of suicide deaths, 6% are under age 15, 34% fall between the ages of 15 and 19, and 60% occur in young adults aged 20-24 years. While increased rates of homicide are generally associated with urban areas, those living in urban areas are actually at higher risk for dying by suicide, at least in adults. Fontanella and colleagues examined these trends over time in adolescents and young adults in their recent study published in JAMA Pediatrics.

The investigators analyzed county-level mortality data of all deaths by suicide in youth aged 10-24 from 1996 to 2010. The data were linked to a rural-urban continuum measure classifying all 3,141 counties in the United States. Over 66 thousand suicides were identified across the selected time period. Measured in suicides per 100,000 youth, suicidal rates were nearly double in rural areas compared to urban areas for both males (19.9 vs. 10.3) and females (4.4 vs 2.4).

This differential appeared to increase over the course of the study. Suicide by firearms actually decreased overall during the study period, though rates of suicide by hanging or suffocation increased for both males and females. However, in males, rates of suicide by firearm or hanging/suffocation increased over the time period, and the differential between rural and urban areas increased even further. Paradoxically, the overall rate of suicide in males in this same time period decreased in urban areas and remained relatively constant in rural areas.

The authors explored several possible explanations for these disparities, especially in rates of suicide by firearm use, which in the most recent years was nearly three times higher for both males and females in rural compared to urban areas. Rural areas tend to have limited availability and accessibility of mental health services. There were some attempts in the analysis to control for this, but the authors still felt this could be a significant issue. More than 85% of areas designated as experiencing a shortage of mental health professionals are rural areas. More than half of all rural counties in the United States do not have a single practicing psychiatrist, psychologist, or social worker, and these shortages are even worse for pediatric specialists. Primary care physicians try to pick up some of the slack, whether they feel comfortable doing this or not.

Rural residents may have to travel much further for care and have longer wait periods for appointments, meaning they do not receive care until later after the start of their symptoms, possibly leading to increased severity. Rural residents are less likely to have health insurance. They tend to have lower incomes. Stigma against seeking treatment for mental health concerns appear to be even greater in rural areas than in many urban areas, with many rural residents tending more heavily toward cultural values of self-reliance and individualism. Rural residents, living in lower population density areas, may find themselves more isolated than urban residents. In youth particularly, those who are left behind by their peers moving to urban environments for economic opportunities may be isolated in any number of ways.

The clinical significance of such data mostly speaks for itself in informing lethality assessments and safety planning. On a policy-level, the study appears to validate the importance of both incentivizing and funding mental health treatment in more rural areas as well as developing interventions targeting those at highest risk for attempting suicide by the most lethal means.


ADHD May Be More of a Life or Death Illness than Many Think

Many mental health conditions are associated with a shortened life expectancy, though attention-deficit/hyperactivity disorder (ADHD) is not necessarily a diagnosis that might come to mind when thinking about illnesses that may lead to a shorter life. ADHD is associated with unintentional injury in youth, and adults with ADHD are at increased risk for serious traffic accidents. ADHD is also associated with a variety of difficulties that might be associated with a shortened life, such as substance use disorders, criminality, and more severe psychiatric comorbidities.
While some of this bears out logically, very little research has actually explored the relationship between ADHD and dying earlier.

A group of researchers in Denmark used a Danish national register to follow 1.92 million individuals, including over 32,000 with ADHD, from their first birthday until the year 2013. Adjusting for calendar year, age, sex, family history of psychiatric illness, age of parents, and various socioeconomic factors, the researchers compared mortality in individuals both with and without ADHD.

Over the follow-up period of 24.9 million person-years (number of people followed times the number of years they were followed), more than 5,000 individuals died. Individuals with ADHD died at a rate of 5.9 per 10,000 person-years compared to 2.2 per 10,000 in the non-ADHD group. Accidents were the most common cause of death. The greatest differences were actually observed in adults, with the relative risk of dying in the ADHD group in adults was four times greater than the non-ADHD group. In comparison, youth with ADHD were only 1.9 (younger than 6) or 1.6 (aged 6-17 years) times more likely to die than their non-ADHD counterparts.

Even after excluding comorbid oppositional defiant disorder, conduct disorder and substance use, the mortality rate was still about 50% greater in the ADHD group. Perhaps most (or least) surprising, these controlled effects were dramatically higher in women, whose relative risk for death of 2.9 (95% CI 1.6-4.7) dwarfed that of boys and men (1.3, 95% CI 0.9-1.8). The latter may be due to the fact that women diagnosed with ADHD tend to have much more severe symptoms than men with ADHD, at least at younger ages, given biases in ADHD criteria that focus on symptoms most commonly noticeable in boys. Girls simply have to be sicker to be referred for treatment than boys do.

The value of this study is not in giving clinicians fuel to scare our patients into taking their medications, it certainly highlights the degree to which impulsivity can get both children and adults with ADHD into trouble, and should inform the psychoeducation we provide, especially to girls and women with ADHD. The study does not make much of ADHD subtypes and cannot parse whether or if hyperactivity, impulsivity or inattention specifically seem to contribute to this all-cause increase in mortality highlighted by increased risk of accidental injury. It is not clear to what degree participation in treatment could reduce this risk of mortality; helping patients understand that the ramifications of their ADHD may go far past just their level of functioning probably will not hurt.


**On a Less Serious Note, Youth with More ADHD Symptoms also May Drink a Lot More Energy Drinks**

At least in New Haven Public Schools, they do.

Researchers at the Yale School of Public Health selected 12 schools randomly from 27 in the New Haven Public School system, identifying 1,649 middle school students to complete health behavior surveys. Among other things, students reported information about the sweetened beverages they drank in the past 24 hours and completed the Hyperactivity/Inattention subscale of the Strengths and Difficulties Questionnaire.

Boys drank more sweetened beverages than girls, and black and Hispanic students drank more than white students. Each additional sweetened beverage consumed by a student was associated with a 14% increase in risk for hyperactivity and inattention, even after adjusting for age, race, sex, socioeconomic status, family structure, and sugary food consumption. Students reporting drinking energy drinks were 66% more likely to be at risk for hyperactivity and inattention symptoms after adjusting for the number of drinks, other kinds of drinks consumed, and other potential confounders.

This study does not address the question of directionality. We could argue very plausibly that sugary energy drinks, through the direct metabolic effects of sugar, caffeine, or other chemical causes, could cause more hyperactivity and inattention symptoms, and it would not be a stretch to suggest that middle school students with more hyperactivity and inattention symptoms might be more likely to drink sweetened energy drinks because of higher impulsivity, poorer decision making, changes in reward processing, or some sort of self-medication process. As youth with ADHD are at higher risk for obesity than their non-ADHD counterparts, counseling our patients to decrease or avoid sweetened energy drinks makes good sense regardless of the direction of causality.


**Asenapine Antipsychotic Approved for Use in Bipolar Disorder in Youth**

Joining the ranks of risperidone, aripiprazole, quetiapine, and olanzapine, asenapine (Saphris), manufactured by Merck and marketed by Actavis, was recently approved by the FDA for the treatment of acute mania and mixed episodes in youth aged 10-17 years with bipolar disorder Type 1.

The approval was based on a 21-day monotherapy trial of 403 patients aged 10-17 years. 302 were randomized to receive twice daily dosing of 2.5 mg, 5 mg, or 10 mg of asenapine. Per various media reports, all three doses were associated with improvement in both mania and overall disease severity. Details about the trial, funded by Merck, are available on the clinicaltrials.gov website, and publication of the study in a peer-reviewed journal is pending.

Efficacy and Safety of Asenapine Treatment for Pediatric Bipolar Disorder. clinicaltrials.gov Identifier: NCT01244815.

Full prescribing information is available on the Actavis website.

continued on page 130
Further Updates from CAMS: SSRI s Both Useful and Safe in Pediatric Anxiety

The Child/Adolescent Anxiety Multimodal Study (CAMS) is a large, multi-site National Institute of Mental Health funded clinical trial designed similarly to the Treatment of Adolescent Depression Study (TADS) for adolescent depression; though CAMS aims to explore clinical aspects of treating pediatric anxiety disorders (social phobia, GAD, or separation anxiety) with cognitive-behavioral therapy, sertraline, bia, GAD, or separation anxiety) with cognitive-behavioral therapy, sertraline, or both. Unlike TADS, there is a placebo arm, and 74% of the participants were 12-years-old or younger. The most recent report from CAMS, published in the Journal of the American Academy of Child and Adolescent Psychiatry, carefully probes each of the four treatment arms for adverse events of treatment. To review from previous publications, the response rate for each group in treating pediatric anxiety disorders was 81% for the combination group, 60% for the cognitive behavioral therapy (CBT) alone group, 55% for the sertraline-alone group, and 24% for the placebo group after 12 weeks of treatment.

When comparing adverse events across the treatment arms, there were no differences in physical or psychiatric adverse events between the sertraline group and the placebo group. Interestingly, when compared to the CBT group and the combination group, the sertraline-alone group had higher rates of total physical adverse events. The total rate of psychiatric adverse events were higher in children aged 12 years or under across all treatment arms (32% vs 23%). The rate of adverse events decreased over time in all groups as well.

Additionally of note, there were no differences in suicidal or homicidal thoughts between sertraline and placebo. Subjects in the sertraline group were more likely to report insomnia, fatigue, and restlessness in comparison to CBT. New physical adverse events, such as stomach pain, difficulty breathing, and numbness or tingling, were actually more likely to be reported in the placebo group than in the sertraline group.

Overall, the results of CAMS suggests that sertraline is very well tolerated in pediatric anxiety and is no worse than simply taking placebo, although those receiving CBT alone do seem to report fewer adverse events. The study could not really compare the sertraline group and the combination group due to methodological issues, but it seems likely that the CBT improves these physical symptoms by decreasing anxiety, whereas similarly effective sertraline appears to decrease anxiety but not necessarily the rates of adverse events compared to placebo. Importantly, these results did not appear to show an increased risk of suicidality with sertraline. Whether this is a finding specific to this study, to anxiety disorders, or to sertraline itself is not entirely clear, but it does suggest that use of SSRIs in children may not increase risk for suicidal thinking across the board in every circumstance. Young children are at the highest risk for side effects to medications, and should thus be monitored even more closely than older children. However, the study does not say much about the long-term use of the medications.

LETTER TO THE EDITOR

“The ADHD Diagnosis: An International De-Construction and Re-Construction”

Dr. Donson’s psychotherapy column in the Jan/Feb 2015 AACAP News is stunning in its detail and its promotion of ideals in the evaluation, diagnosis, and treatment of overly active children.

The recommendations may be reasonable for children in affluent families. A major, if not the top, problem for our AACAP organization is its limited membership. Relative to the population we could be serving, this issue is huge.

The average [child and adolescent psychiatrist] CAP on the front line must demonstrate efficiency and financial restraint. If the average CAP performed, as recommended in this article, on just their overly active patients, it would impair our limited forces.

After forty years of practice to report never having seen a “pure” case of ADHD is like reporting I have never seen a unique child in forty years of practice. All of our patients, with or without over activity, have additional aspects that make them more complex than a single diagnosis.

The author’s omission of the long known fact that ADHD is significantly genetic troubles me. To also omit the findings of visible differences in the MRI findings of children with this diagnosis adds to my concern.

Psychoanalysis has and will continue to contribute to our knowledge of human development. My concern is the excessive time used to treat children with relatively minimal emotional issues. That continues to unnecessarily reduce the professional hours that could be available for more of our children.

R. Larry Schmitt, MD
San Diego, CA

SHARE YOUR PHOTO TALENTS
WITH AACAP NEWS

Several members have asked me about how photos are selected for the News cover. All submitted photos are given a number (no photographer’s name.) When a new cover is needed, all the available numbered photos—up to three by one photographer—are sent to six judges who select their top three choices. The winner goes on the cover, but we do try to have any individual artist appear on the cover no more than once a year.

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

On the whole we try to make the News by members for members but some members have submitted a spouse or child’s photo; on rare occasion we considered those or a photo by a prominent psychiatrist who is a friend of our field. However, we can use a lot more terrific images by AACAP members so please do not be shy; submit your wonderful photos or images of your paintings. We would love to see your work in the News.

If you would like your photo(s) considered, please send a high-resolution version to Dr. Rosenfeld directly via email at ARosen45@aol.com. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.

Alvin Rosenfeld, MD
Photo Editor, AACAP News
arosen45@aol.com
Seizing the Day: An Intergenerational Structure for Higher-Impact Prevention in Child and Adolescent Psychiatry

John N. Constantino, MD

There is a growing body of knowledge that indicates the origins of a majority of life-course, persistent mental disorders are traceable to childhood and adolescence, including schizophrenia, bipolar disorder, major depressive disorder, substance dependence, and personality disorder. But knowing that a psychiatric condition has its origins in childhood/adolescence and having the ability to intervene preventively to alter the course of subsequent development are two different matters.

The past two decades of behavioral genetic research have both damped and raised hopes for preventive interventions for early-onset psychiatric conditions. The overwhelming conclusion from studies of twins, families, and adoptees is that serious adverse behavioral outcomes are highly inherited. However, in most instances, the inherited influences are complex (heterogeneous and often polygenic) rather than Mendelian (single-gene) patterns, with the exception of rare metabolic disorders such as Phenylketonuria, rare developmental disorders such as Fragile X Syndrome, and Niemann Pick Disease, or neurodegenerative disorders such as Rett Syndrome and Huntington’s disease.

Polygenic inheritance makes the prospects for the interruption of causal mechanisms more complicated and makes it essential to focus on other preventable causal factors when they are at play. A formidable environmental cause of child and adolescent psychopathology, with perhaps the highest prospect for successful preventive intervention, is child maltreatment. Other compelling and preventable environmental risk factors include family conflict (including domestic violence), victimization and bullying by peers, early exposure to drugs and alcohol, and neighborhood/community factors such as gang culture. To date, few programs definitively address more than one risk factor, and few programs address the multiplicity of factors that predispose many children and adolescents to these environmental hazards sequentially over the course of life.

We know that mitigation of any of these environmental risks has direct short-term benefits for children and adolescents, and that those programs that do address multiple factors are more likely to lead to enduring improvements in behavior and adaptation throughout life. At the extreme, competent foster care and adoption have led to demonstrable long-term benefits for children and substantiate the hope that environmental support, comprehensively delivered over years, can effect lasting change.

We know that infants in specific adverse environments with demonstrated profiles of familial liability to mental illness or substance abuse are at markedly increased risk for reported maltreatment and they develop psychiatric syndromes at rates up to an order of magnitude higher than what occurs in the general population. While universal prevention can be prohibitively expensive, targeted preventive intervention strategies (for those children with combined environmental and inherited liability for child psychiatric syndromes) are well within reach, especially given the precision with which marked elevation in risk can now be ascertained.

The principles that have emerged from evidence-informed preventive intervention approaches are remarkably convergent in that they emphasize the promotion of secure early social relationships (the “village”) and cultivation of children’s capacity for emotional self-regulation and cooperation (individual competencies that mediate successful social adaptation). These are supported via: 1) ensuring a safe, engaging, and responsive caregiving environment, including the promotion of healthy family and social relationships; 2) moderating the use of discipline so that its primary goals are to educate and reinforce appropriate interpersonal boundaries rather than to punish; 3) maintaining reasonable expectations; and 4) taking care of oneself as a parent. These are also principles of successful clinical interventions for youth with early-onset psychiatric conditions. Innovative hybrids of preventive and therapeutic interventions are being developed for young children at risk for psychopathology in order to apply the relevant therapeutic supports before the conditions develop. Knowledge about the appropriate implementation of a scaled continuum of evidence-based preventive interventions of increasing intensity (based on need) should become part and parcel of the training and “armamentarium” of child and adolescent psychiatrists—currently this would include understanding the indications for (and local access to) modalities such as parenting education home visitation, early childhood education, parent-child interactional therapy, proactive cognitive-behavioral interventions (for children, parents, or dyads), as well as the clinical mental health care of parents, and implementation of appropriate psychiatric interventions for the earliest signs of psychiatric illness in children and adolescents.

In the Division of Child Psychiatry at the Washington University School of Medicine in St. Louis, Missouri, a distinct focus of clinicians and scientists, is on the implementation and refinement...
of these methods, often in collaboration with faculty of the George Warren Brown School of Social Work. One targeted preventive intervention effort known as the SYNCHRONY Project is modeled after a long-standing Tulane University program to incorporate child psychiatric expertise and care into the child welfare system’s support for infants and young children in foster care. The goal is to prevent child maltreatment recidivism, especially given the hopeful epidemiologic evidence that a child who has been officially reported for abuse or neglect once—but never again—has nearly as positive an outcome, on average, as children in the general population. Thus, a comprehensive effort to educate parents, implement secondary preventive intervention, and address any unmet mental health needs of the family is implemented following the first episode.

Funded by a grant from the Children’s Service Fund of St. Louis County, the SYNCHRONY Project is a collaborative effort among Washington University, the St. Louis County Family Court, and the Children’s Division of the Missouri Department of Social Services. Washington University psychiatrists and psychologists with special interest/expertise in infant and family development, along with child psychiatry fellows and trained social service personnel conduct comprehensive evaluation and intervention planning that includes participation by the physical custodian/foster parent, biological parent(s), other related family members, Children’s Division worker and Family Court representatives. The evaluation includes direct observation of the parent-child relationship. The goal is to determine the array of supports necessary to ensure safety, to allow the child to thrive and grow emotionally, and to prepare parents to manage their children’s care safely and competently on a daily basis.

Once the assessments are completed, the SYNCHRONY Project teams communicate their medical/intervention recommendations to the Court. Each strategy attempts to capitalize on the family’s strengths and encompasses specific social, medical, therapeutic, or interventional supports to aid children’s emotional and cognitive development. Goals for the children are always established and a follow-up plan is devised especially regarding surveillance over each child’s and family’s developmental progress, and the capacity of birth parents to interact with their children in a safe and supportive way. If the goals are not met, the intervention plan can be revised in concert with the Court and the Department of Social Services. All parents are afforded the opportunity (including transportation) to attend evidence-based parenting education, which combines hands-on “experiential” education with training parents to promote the social and emotional health of their young children. To date, more than 300 children have been served by the program. Their conditions are improving on standardized ratings, maltreatment recidivism rates are reduced in comparison to a comparable historic control group, and objective ratings of the parents’ caregiving behavior are improving as a function of completion of parent training.

In child and adolescent psychiatry, there is rarely such a thing as a one-time inoculation against psychopathology. Behavior is complex, adaptive and highly evolved (with many checks and balances). Often when things go awry, the causes are multifactorial. For those children whose development is potentially compromised by an array of modifiable known risks, it is important that efforts to minimize those risks are sustained, comprehensive, and organized around the needs of individual families, not bureaucracies.

Although promising effects have been identified in randomized controlled trials for an exciting set of novel preventive interventions, they are often short-term, highly focused, almost never systematically implemented or sustained, and rarely address issues of neighborhood context or parental mental health/substance use impairment that are real-world correlates of serious combined genetic and environmental risk. The current generation of specialists in child and adolescent mental health—clinicians and researchers alike—need to be trained in these methods and to be integral proponents of the advancing frontier of preventive intervention. In the next phase of development in our field, concerted efforts to elucidate which interventions dovetail with what other interventions, when in the child’s development, targeted towards whom, sustained at what dosage and for what duration, will bring about cost-effective improvements in major public mental health outcomes. Embedding such intervention efforts in genetically- and/ or developmentally-informative sampling designs with robust outcome measurements will ensure that the agenda of separating “baby from bathwater” in preventive intervention will itself contribute to the steady advancement of behavioral neuroscience.

Dr. Constantino is Blanche F. Ittleson Professor of Psychiatry and Pediatrics and director of the William Greenleaf Eliot Division of Child Psychiatry at Washington University School of Medicine in St. Louis, Missouri. He may be reached at constantino@wusti.edu.
Media Page
Harmony Raylen Abejuela, MD, Resident Editor

1-2-3 Magic
Effective Discipline for Children 2-12
5th Edition

By: Thomas W. Phelan, Ph.D.

Parent Magic Inc., 2014
228 pages – $14.95

Dr. Phelan has updated this latest edition of his book with stories based on real-life experiences that illustrate topics previously not addressed, such as counting obnoxious behaviors, sibling rivalry, challenges of getting children to sleep, and learning how to listen sympathetically. This book captures the common difficulties parents encounter when attempting to discipline and raise their children, particularly those aged 2 to 12 years old. In addition to exploring these parenting challenges, Dr. Phelan discusses methods to effectively address them. The easy-to-read and easy-to-follow format may help parents and clinicians who work with children and families. Readers will appreciate the cleverly drawn and captivating cartoons that are interspersed throughout the book as well as Dr. Phelan’s quick tips, tables, chapter summaries, and a section devoted entirely to frequently asked questions centering mostly on “What if” situations and scenarios commonly encountered when dealing with children. Learning how to effectively deal with children’s whining, lying, bedtime struggles, temper tantrums, testing limits, manipulating, and picky eating are discussed, as is how to encourage good behaviors like cleaning up, doing chores, and doing homework.

The techniques this book discusses are applicable to both typically developing children and children with attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder, learning disabilities, mood disorders like depression, and even children with autism spectrum disorders who have a mental age of 2 years old or greater. Also available in DVD, this book succeeds in providing effective ways to control obnoxious behaviors, encourage good behaviors, and strengthen parental relationships with children. It is helpful for clinicians to recommend to parents.

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the Resident Editor, Harmony Raylen Abejuela, MD, at Harmony.Abejuela@childrens.harvard.edu.
San Antonio Preview

AACAP’s 62nd Annual Meeting is just 5 months away and we are excited! Whether you are bringing the family, 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 important information here! For complete details about the Annual Meeting, visit www.aacap.org/AnnualMeeting/2015.

Attende To-Do List

June 15 – Review the Annual Meeting programs online

August 3 – Members Only Registration opens for the Annual Meeting

August 10 – Registration opens to nonmembers

September 15 – Early Bird Registration Deadline

October 5 – Last day AACAP room rate guaranteed at hotel

October 26 – First day of AACAP’s 62nd Annual Meeting

October 31 – Last day of AACAP’s 62nd Annual Meeting

November 6 – Look for the General Evaluation Survey in your email inbox. CME certificate available upon completion of survey

Convention Center

Henry B. Gonzalez Convention Center
200 East Market St.
San Antonio,
Texas 78205
Phone: 210.207.8500

The Henry B. Gonzalez Convention Center is the where the majority of educational events will take place for AACAP’s Annual Meeting. Right outside the Convention Center doors, you can breathe in the scent of huevos rancheros, listen to the joyous music of the mariachis, and watch as barges float down the San Antonio River. Discover an array of attractions and things to do; almost everything in the area is accessible by foot or via river taxi or trolley.

Hotels

Grand Hyatt San Antonio
600 East Market St.
San Antonio, Texas 78205
Phone: 210.224.1234
grandsanantonio.hyatt.com
(for detailed hotel information)
www.aacap.org/AnnualMeeting/2015/hotel
(to reserve your hotel room)

Rate: $226 single/double per night
Check-in is at 4:00 p.m. and check-out is at 11:00 a.m.

The Grand Hyatt San Antonio is the main hotel for the Annual Meeting with some educational events taking place there as well. To reserve a room at the Hyatt, please call 1.888.421.1442. The Grand Hyatt is located directly next door to the Convention Center. Cancel your hotel room 48 hours prior to arrival to avoid any cancellation fees.
San Antonio Marriott Riverwalk
889 East Market St.
San Antonio, Texas 78205
Phone: 210.224.4555
www.marriott.com/hotels/travel/satdt-san-antonio-marriott-riverwalk
(for detailed hotel information)
www.aacap.org/AnnualMeeting/2015/hotel
(to reserve your hotel room)
Rate: $226 single/double per night
Check-in is at 4:00 p.m. and check-out is at 12:00 p.m.

We will also have a small block of rooms at the San Antonio Marriott Riverwalk, located directly across the street from the Grand Hyatt. To reserve a room at the Marriott, please call 1.800.648.4462. All reservations must be accompanied by a first night room deposit or guaranteed with a major credit card. Cancel your hotel room by 6:00 p.m. on the date of arrival to avoid any cancellation fees.

Hotel Policies for the Hyatt and Marriott:
When making your reservation, ask for the AACAP ANNUAL MEETING GROUP RATE to qualify for the reduced rate.

This rate is available until October 5, or until the group block sells out, whichever comes first. We recommend making your reservation early to secure your room.

What to Do in San Antonio!
The San Antonio River Walk is a verdant oasis of cypress-lined paved paths, arched stone bridges, and lush landscapes. It gently winds through the city center, providing millions of visitors each year with easy access to the city’s cultural hot spots, historic sites, and other attractions. The River Walk is the largest urban ecosystem in the nation. Tucked quietly below street level and only steps from the Alamo, it provides a serene and pleasant way to navigate the city. Ride a river cruiser, rent a bicycle, or take your time seeing the sights on foot. With 15 miles of sidewalks and paths, the River Walk provides access to museums, the King William Historic District, 300-year-old Spanish missions, hotels, shops, restaurants, and a new adventure around every turn.

The Alamo (Mission San Antonio de Valero) was founded in 1718 as the first mission in San Antonio, serving as a way station between east Texas and Mexico. In 1836, decades after the mission had closed, the Alamo became an inspiration and a motivation for liberty during the Texas Revolution. For more detailed information, visit www.thealamo.org.

Travel
San Antonio is served by the San Antonio International Airport (SAT). For more information about the airlines serving this airport, flight schedules, and ground transportation options, visit www.sanantonio.gov/sat. The airport is just a 10 minute drive from the Grand Hyatt and Marriott and the average price for a taxi is $12-$15.
San Antonio is perched on the southern edge of the Texas Hill Country. Picturesque small towns and a variety of outdoor adventures are just a short distance from here. Floating down cool rivers, strolling quaint main streets in search of unique bargains, or hiking and biking through rolling, scenic terrain—all this and more await you in about a 90-minute drive. Storybook farms and ranches dot the countryside, and you may still hear older folks speaking German in Fredericksburg, Boerne, and New Braunfels. You will also find some of the best barbecue in Texas, antique shops on old-fashioned main streets, and celebrations with roots in the Old World, like Wurstfest (a sausage festival) and Weihnachten (a Christmas festival).

Art and architecture thrive in the King William Historic District and Southtown. The King William Historic District is a restored neighborhood with a variety of architectural styles—Greek Revival, Italianate, and Victorian. Once farmland for the Alamo mission, it grew into a German neighborhood. The area fell into disrepair, but in the 1960s, its beauty was rediscovered and restoration began. Three homes are open to the public, the Guenther House, Steves Homestead, and Villa Finale. The Guenther House was built in 1860, and includes a restaurant, store, and museum. The 1870s era Steves Homestead is now a museum of historic homes. Villa Finale’s Visitor Center is home to a museum and exhibitions focusing on the history of the beautiful King William neighborhood including Villa Finale, the first National Trust Historic Site in Texas.

For more information about other San Antonio attractions, please visit: [www.visitsanantonio.com](http://www.visitsanantonio.com).
Don’t Miss the Opportunity to Save Money!

AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount on their 62nd Annual Meeting registration. All referrals must be first time AACAP exhibitors and must purchase a booth for AACAP’s 62nd Annual Meeting.

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 Invitation to Exhibit with more details on these opportunities as well as forms to sign up, please visit www.aacap.org/exhibits/2015.

Questions? Exhibits@aacap.org or 202.966.9518

Show your support for AACAP and SAVE TODAY!

Residents, Trainees, and Medical Students

ATTEND THE AACAP ANNUAL MEETING FOR FREE!

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

October 26-31, 2015
Henry B. Gonzalez Convention Center and Grand Hyatt San Antonio
San Antonio, TX

For more information about the Monitor Program, visit www.aacap.org/AnnualMeeting/2015/Monitors.
Registration opens August 3 for AACAP members and August 10 for nonmembers.
Become a member TODAY to get priority monitor scheduling!
AAPC’s 62nd Annual Meeting takes place October 26-31, 2015, in San Antonio, Texas. Abstract proposals are prerequisites for acceptance of all presentations given at the meeting. Topics may include any aspect of child and adolescent psychiatry including clinical treatment, research, training, development, service delivery, or administration.

Verbal presentation submissions were due February 17, 2015, and are no longer accepted. Abstract proposals for (late) New Research Posters must be received by Monday, June 15, 2015. All Call for Papers applications must be submitted online. To see step-by-step instructions and for access to the online submission system, please visit www.aacap.org/AnnualMeeting/2015. If you have questions regarding this process, please call 202.966.7300, ext. 2006 or e-mail meetings@aacap.org.

Life Members Reach! 100

No, not 100 years old.
But, 100 lives you have impacted.

Impact. In 2014, we approved 32 new grants, 17 residents and 15 medical students. Which means that, since 2010, the Life Members Fund has made an investment in 54 residents and 46 medical students. That’s potentially 100 next generation child and adolescent psychiatrists. And, future Owls!

More Impact. 20 of the current 31 medical students awarded travel grants have graduated. All 20 or 100% have matched in either psychiatry or pediatrics!

Donate. This achievement is remarkable. We are 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. Life Members can, and are, closing this gap. Let’s keep it up!

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

Stay involved. Stay connected to all Life Members activities, programs, and photos by reading the Life Members eNewsletter distributed quarterly online. Did you receive the latest Life Member eNewsletter in January?

NEW: There is another way you can donate and do more to close the gap. Learn about the 1953 Society. It is a tomorrow investment, made today.

Visit www.aacap.org/1953_Society to learn more.

2015 Owl Pin. Remember, if you donate $450 or more to the Life Members Fund by October 31, 2015, you will receive a limited edition 62nd Anniversary OWL PIN!
AACAP Facts for Families

Not all children grow from infancy through their adolescent years without experiencing some bumps along the way. While every child is unique and special, sometimes they encounter emotions, feelings, or behaviors that cause problems in their lives and the lives of those around them. Families often worry when their child or teenager has difficulty coping with things, feels sad, can't sleep, gets involved with drugs, or can't get along with family or friends.

AACAP Facts for Families are fact sheets that provide concise and up-to-date information on issues that affect children, teenagers, and their families. AACAP currently has 115 fact sheets that are a great resource for doctors, patients, parents, schools, clinics – anyone!

Find AACAP Facts for Families online and in PDF format to download at www.aacap.org.

AACAP Resource Centers

AACAP Resource Centers empower consumers through patient education. Each AACAP Resource Center contains consumer-friendly definitions, answers to frequently asked questions, clinical resources, expert videos, and abstracts from the JAACAP, Scientific Proceedings, and Facts for Families relevant to each disorder.

Find AACAP Resource Centers online at www.aacap.org.
Interview with Gordon and Sharon Smith — 2014 AACAP Humanitarian Award Recipient

Alan Mark Ezagui, MHCA
Deputy Director of Development

Gordon and Sharon Smith were presented the American Academy of Child and Adolescent Psychiatry’s Catchers in the Rye 2014 Humanitarian Award. They were the 22nd recipient of AACAP’s highest honor, given to those who have made significant contributions to society through support of child and adolescent mental health.

As a parent of two children, I cannot imagine a deeper loss than the death of your child, perhaps even improbable to bear when the loss is by suicide. I’m not even sure how your heart can ever survive such a loss. As Senator Smith said in his book, Remembering Garrett, “There’s nothing like burying your child to acquaint you with grief. It’s sort of a chapter that never ends. There’s a hole in your heart that never closes.”

During his time serving in the U.S. Senate in September 2003, Gordon Smith and his wife Sharon received the tragic news that their son had died by suicide. The death of their son Garrett, then a 21-year-old college student, propelled Gordon and Sharon to embark on a mission to improve mental health programs and to combat the epidemic of youth suicide.

They hope that encouraging conversation about mental illness helps keep other families from suffering the loss of a loved one through suicide. The Smiths have been at the forefront of advancing suicide prevention as a national priority, championing early identification, expanding access to mental health and suicide prevention treatment, and working to strongly advocate for the reduction of suicide in the U.S.—issues that AACAP supports and relentlessly fights for.

If you attended the Karl Menninger, MD Plenary on Wednesday evening, October 22, 2014, in San Diego, you heard them share their story. We were all profoundly touched. We asked the Smiths if they would share their story with all our AACAP News readers. The following is a question and answer exchange with Gordon and Sharon Smith.

AACAP: You turned a personal tragedy into powerful advocacy, creating a legacy of hope in Garrett’s name. Can you share with us what you went through in deciding to make mental health your mission?

Gordon and Sharon: The cause of mental health is not one that we found, it found us. When we lost our son, Garrett, to mental illness we realized that there was much we needed to learn because there was much we had the power to do.

AACAP: In Garrett’s memory, the Garrett Lee Smith Memorial Act was enacted into law in October, 2004. What has this meant to you?

Gordon and Sharon: It has been largely definitional of service in the United States Senate. But, more importantly than what it has meant to us is what it has meant to others. The Act was funded, it has saved many lives, and it was the catalyst to the passage of a great deal of additional mental health legislation.

AACAP: What encourages you about the future of mental healthcare in our country, and perhaps even globally?

Gordon and Sharon: Understanding is increasing, stigma is declining, and funding is included in the Affordable Care Act. Affordability and accessibility of mental health services is on the near horizon for America.

AACAP: Do you think we will see in our lifetime, that day when we can finally end the stigma of mental illness?

Gordon and Sharon: Hope springs eternal, so “yes!”

AACAP: We’ve had some very distinguished people receive AACAP’s Humanitarian Award since 1994. I heard from so many of our members tell me your remarks were the most emotional and compelling ever...many in the audience were moved to tears. What did it mean to you to receive AACAP’s Humanitarian Award in San Diego?

Gordon and Sharon: It was, of course, a great honor to receive the Humanitarian Award, but also a personal challenge to stay engaged in the cause of mental health so that others may not suffer as Garrett did and as the Smith family still suffers.

AACAP: What do you envision for the future of children’s mental health, and specifically these two areas: stigma and research?

Gordon and Sharon: As education, understanding, resources and practitioners increase, stigma will decrease proportionately. As for research, I believe we will see great breakthroughs in coming years from research.

AACAP: How do you feel other philanthropists can be motivated or inspired to prioritize their philanthropy to support and invest in children’s mental health?

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Interview with Gordon and Sharon Smith  
continued from page 141

Gordon and Sharon: The breakdown in mental health touches most everyone either directly or indirectly, through family or friends. It does not register Republican or Democrat, it registers human. We all have a stake in the cause of mental health.

AACAP: You have been at the forefront of advancing suicide prevention as a national priority, working to strongly advocate for the reduction of suicide in the U.S. Has enough been done, and what can we do over the next 12 months to create deeper, more profound change?

Gordon and Sharon: Money means access to and affordability of mental health services. All society has a stake in this, whether fully realized or not. So, as courts and lawmakers consider reforms to the ACA, speak up for the necessity of mental health in a basic health care package.

AACAP: Your strength and courage has been remarkable, and admired by so many. What message would you like to share with other parents who have suffered the loss of a loved one through suicide?

Gordon and Sharon: Time helps, but never fully closes the hole in your heart. But advocacy for the mentally ill is therapeutic for survivors. And always be grateful for the time you’ve had on earth with a loved one lost. Gratitude is the best antidote for grief.

AACAP: Do you have any final thoughts you would like to share?

Gordon and Sharon: While now we see through a glass darkly, faith, hope and charity are choices we can make for ourselves. Together they provide us power to see tomorrow’s sunrise joyfully.

AACAP Distinguished Fellowship
It’s Time That You’re Recognized for Your Efforts!

Distinguished Fellow status is the highest membership honor AACAP bestows upon members. It’s a symbol of your dedication, enthusiasm, and passion for our specialty. It also serves as a reflection of your commitment to the Academy.

The criteria for eligibility include:
1. Board certified in child psychiatry
2. AACAP member for at least 5 consecutive years
3. Made (continue to make) outstanding and sustained contributions in any 3 of the 5 areas noted below:
   - Scholarly publications
   - Outstanding teaching
   - 5 years of significant and continuing contribution to patient care
   - Organizational or social policy leadership at community, state, or national levels
   - Significant contributions to AACAP for at least 5 years in one or more of the following:
     ✦ AACAP Committee/Component
     ✦ AACAP Assembly of Regional Organizations
     ✦ An AACAP Regional Organization

Distinguished Fellowship Nomination Package Requirements:
- Current copy of Curriculum Vitae
- Copy of Child Psychiatry board certificate
- 3 recommendation letters written by AACAP Distinguished Fellows

If you have any questions, or would like more information, please contact Nicole Creek, Supervisor, Member Services directly via email at ncreek@aacap.org or by phone at 202.966.7300, ext. #134.

We’re here to help!
Congratulations to Graduating Residents and Medical Students

When planning your graduation ceremony and after-party, be sure to include AACAP! Please provide us with your updated contact and address information so you can put your AACAP member benefits to use for the next phase of your professional career.

Update your information online at www.aacap.org.

Time is running out! Renew for 2015!

You can pay your dues in three easy ways: online at www.aacap.org, by fax, or by mail. Contact AACAP Member Services if you have any questions regarding your benefits or renewing your membership. Renew today and keep your AACAP News coming!

Is Renewing Stressing You Out?

AACAP offers flexible payment solutions to meet your needs.

Take advantage of our monthly installment payment program. Contact Member Services at 202.966.7300, ext. 2004, or email us at dues@aacap.org to discuss your personalized payment plan options.

Upcoming Events

May 16-20, 2015
American Psychiatric Association
Toronto, Canada
http://annualmeeting.psychiatry.org/

May 28-31, 2015
5th World Congress on ADHD
Glasgow, Scotland
www.adhd-federation.org/congress2015/

June 3-6, 2015
17th Annual Conference of the International Society for Bipolar Disorders
Toronto, Canada
www.isbd2015.com

June 24-27, 2015
World Psychiatric Association
2015 Bucharest Congress
Bucharest, Romania
www.wpa2015bucharest.org
Get Involved in AACAP Committees!

As AACAP President-Elect, I invite you to become active in one of AACAP’s many committees. It is our dedicated members serving on committees that enable AACAP to accomplish its goals. To learn more about our committees including charges, most recent annual reports and rosters, please visit www.aacap.org/cs/members_only/members_only.

To be considered for appointment to an AACAP committee, please send an email of interest along with your CV to gfritz@aacap.org or by mail to AACAP, 3615 Wisconsin Avenue, NW, Washington, DC 20016, ATTN: Genifer Goldsmith. If you have questions regarding this process, please contact Genifer at ggoldsmith@aacap.org. Appointments are made in the summer based on available openings. I encourage any member interested to reach out to committee chairs to get involved AND attend committee meetings at the AACAP Annual Meeting, this year being held in San Antonio, October 26-31.

Best regards,
Greg Fritz, MD
AACAP President-Elect

Time for Twitter!

Mona Noroozi, Communications
& Marketing Coordinator

It started as “the text messaging of the internet” and grew so powerful it ignited a cultural revolution. Why does Twitter matter? Because it delivers all that is relevant of the times to you in firehose fashion.

What is Twitter and Why do You Need It?

Twitter is the best cocktail party in town, attended by the world’s brightest and most interesting intellectuals, leaders, and contrarians—and you are the host of that party. You create your invitation list, you choose who you want to listen to, and every day you have the advantage of gaining the shared knowledge of these bright minds, at your convenience and at no cost.

So, what exactly is Twitter? It is today’s way of sharing your thoughts and opinions with the world—all in 140 characters or less. When you tweet, you send a message to everyone who “follows” you. In this way, you become the curator of your own newshouse, sharing the stories you believe matter with straight to the point commentary as to why it matters. Your followers 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. Add cultural titans, inspirational celebrities, top academics to your own list of followed groups and engage directly with the world’s greatest thought leaders.

Why is AACAP on Twitter?

AACAP uses Twitter as a curated news-gathering source on all things related to children’s mental health. 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 the latest national news in children’s mental health, and also the AACAP National Office, through pictures, videos, and of course tweets! We live-tweet from events like Legislative Conference 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 quickly get connected to the rapid changes in children’s mental health.

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

Need a Twitter account? Sign up at www.twitter.com. Already have an account? Follow us at www.twitter.com/aacap. For questions contact Mona Noroozi, Communications and Marketing coordinator via e-mail at mnoroozi@aacap.org or by phone at 202.966.7300, ext.154.
Want to change a child’s life?

Become a **Hope Maker**.

When you make a *monthly donation* to AACAP, you automatically join our new giving program.

**Make a Donation. Give Hope. Make an Impact.**

... for children with mental illnesses.

You can direct your **Hope Maker** donation to support:

- Medical Student Fellowships
- Research
- International Travel Scholarships & Observerships
- **and more!**

To learn more and to join, please visit: [www.aacap.org/HopeMaker](http://www.aacap.org/HopeMaker)

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**January/February Cover**

**Credit:** Alan Sandler, MD

**Description:** “I submitted the photo to the newsletter after returning from a trip to Tanzania in October 2014. This beautiful little guy, posed for me in a classroom we visited while touring a fishing village on the south shore of Lake Victoria. He’s a Democrat, by the way, as you can tell from the back of his shirt. He *made sure* I noted when he was done posing.”
Interview with Patricia McKnight, MD — 1953 Society Member

Alan Mark Ezagui, MHCA
Deputy Director of Development

In July 2014, Dr. Patricia McKnight informed the Development Office of her plans to include AACAP in her will. By acknowledging her intent, Dr. McKnight joined AACAP’s 1953 Society as one of its Founding Members.

Dr. McKnight attended the first annual 1953 Society Reception at the 2014 Annual Meeting in San Diego. Following the Annual Meeting, she sent an email saying how much she enjoyed meeting everyone – Dr. Paramjit Joshi, AACAP President, who hosted the Reception, as well as other 1953 Society Founding Members.

“I am really proud of AACAP. If you ever need anyone to encourage more contributions, I am your person,” said Dr. McKnight. “I have always kept my trust up to date and one constant for many years has been a contribution to AACAP.”

I reached out to Dr. McKnight and asked if we could tell her story. She was delighted to do so. Thus, here’s her story, and as importantly, why she feels leaving a gift in her will to AACAP is so important to ensure the future of AACAP and the children with mental illness whose lives you, our members, change.

Alan: What motivated you to become a child psychiatrist?

Patricia: I always wanted to be a physician, and when I was in college I learned more about child psychiatry, reading Bruno Bettelheim, which was very interesting. I went to medical school really looking more toward psychiatric training. I followed through with that, completing my training, then, eventually completing my fellowship. I read Bettelheim and saw how he was able to help some of the most disturbed children. It appealed to me that children could be helped to have more productive lives. It informed me about that whole area of interest, so I followed through with that.

Alan: I’m certain over the course of your career many children’s lives have been changed because you came into their life professionally to help them.

Patricia: You hope so. Sometimes you get follow up from your patients and sometimes you don’t. Sometimes, someone comes back as an adult and says thank you for helping me and you see, that a child you once thought “I just don’t know”. . . it turns out they become quite impressive adults. That’s a joy to see.

Alan: What was it you loved about your work?

Patricia: I loved being able to see children on a regular basis and work with them and their families in therapy. I also enjoyed running my own practice and keeping my own business going. Being in private practice is a business and you have to be able to manage that. Keeping your business in a settled situation allows you to spend more time with your patients. I enjoyed the connection with my patients and watching that connection grow over time so that they were able to be more productive outside of therapy over time. Some children I would see long term, they would come for two, three, and four years. And, over that time you could really see a lot of change... both in them and in their families. . . change that would make them happier.

Alan: Is there something in your life that defines your philanthropic spirit?

Patricia: For one thing, my father was very generous, and he was very careful to take care of his children financially and to share his wealth with his children. He did that on a very routine basis. I saw him give us fairly substantial gifts all through my life, and in turn I passed some of those gifts on to others in my family. So within my family, that’s something that we do. The other thing that has motivated me has to do with my husband’s family, because his mother was an immigrant and his family did not have the kind of financial means that my family had. There were ways that they all had help. They had a military background, thus, they were able to go to college because of the GI bill. And, everyone in his family has a college education, which I think is quite remarkable considering where they came from. Therefore, when I look at my husband’s family and their needs, this also makes me want to help people who could make use of the giving I can share.

Alan: What is it you hope to achieve with your philanthropy?

Patricia: Well, hopefully my gift will go in some way to assist children through education of child psychiatrists or directly toward education of families. I trust AACAP to decide where the money could go. There are other organizations you could give to, but you might not really know where the money went. I’ve seen that happen. AACAP is such a positive organization you know the money you give will go to something worthwhile.

Alan: Do you recall your decision to include AACAP in your will and why you made it?

Patricia: It was a choice, when you draft your will you think, “There’s this much money here, what’s going to happen to it?” When I think of organizations that are important to me, AACAP is the most special. If you can start with children, and assist them at whatever level they need, then hopefully you’re giving in an area that will pay off over time. If you can give
children a better start, shelter them, feed them, give them parents who can help them, then you’ll have healthier adults. Hopefully over time you’ll have adults who can make better decisions.

Alan: What is it you hope your 1953 Society gift will help accomplish?

Patricia: I would like us to help keep child fellows involved, to get them hooked into the organization. One thing that made a difference to me is that my training director really thought it was important that we have an organization to identify with, and he made every effort to get us involved and get us into the organization quite early. This really made a difference for me. I didn’t have access to grants or any other way to subsidize travel money, but we did go to the meetings as fellows. I think it’s really important to get young people involved early and keep them involved. What I also really like at AACAP are the Facts for Families. I always had them in my office and would make copies, then send them out to people on the different topics. Often I would go into the waiting room of my practice and parents would be reading them. I think the Facts for Families are very good educational tools, and I would like to see AACAP expand them. These two things come to mind at least.

Alan: What difference do you hope AACAP will have made for children when you look 25 or more years into the future?

Patricia: Well, hopefully, they’ll keep children in the forefront and the focus of the organization’s purpose so that society will not neglect these children. I think far too often, children are ignored, and hopefully organizations like AACAP will keep people more aware of the needs of children with mental illness. The world is so big, and there are so many issues that affect us, but you have to keep trying, right? It’s hard enough to be a child in the best of families, in the best of situations, but, being a child and growing up is hard. We’ve got to keep them in mind and help them through that.

Alan: Why should other AACAP members or even nonmembers consider leaving a gift to AACAP in their will?

Patricia: To support the organization, ensure its future, to keep it going, so they can continue to work hard for children. That’s the main thing. I’ve seen too many organizations lose their purpose. I don’t see this happening with AACAP. I think they’re a pretty powerful organization and they need to stay that way.

Alan: Are there any provisions in your will that tell the Academy how you would like your donation to be used?

Patricia: No, I did not want to restrict it. I want you to decide how to use it, to make the most impact for children. I didn’t want to restrict it, because I feel AACAP knows better than I do how to best use it.

Alan: If you were having a discussion with someone who was considering leaving a gift in their will, what would you say to them?

Patricia: I would say, do this. AACAP has provided me with the knowledge and support I needed to continue this difficult work. I trust them to use my gift for a positive end and to assist children. Help your organization. Keep it going. There isn’t a better place where your gift could help the most.

Alan: Is there any advice you would give AACAP as we plan our future?

Patricia: I see the organization as innovative and forward thinking, and things will evolve and change, so what you might think of today won’t be applicable tomorrow or next year, or in three years. It’s important not to stand still, to make changes quickly, and as they need to happen. We all know change is difficult, but you’ve got to be ready to change quickly and adopt new ideas.

Alan: Anything else you would like to add that we haven’t touched on?

Patricia: I think it’s been really nice the way you all have been so responsive to my gift. I made the gift in my will just as a matter of course, not thinking much about it, and you’ve been kind and very helpful to me in my retirement. It’s made me feel like, well, I guess I might still have some importance somewhere. I want to thank you and the Academy for having the 1953 Society for members and others who want to consider leaving a gift in their Will for AACAP. Although I’m now retired, I still feel that I have a support system in the 1953 Society, that provides a camaraderie among my colleagues who share a strong interest in the future of medicine. That has been a surprise for me and a really nice thing that I appreciate. I hope I can be an example to others.

1953 SOCIETY

Your Legacy. Our Future.

Will You Join?
Make a gift to AACAP in your Will.
Ensure AACAP’s Future!
Visit www.aacap.org/1953_society to learn more!
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It costs $15,000 to launch one child psychiatry resident’s research career.

WHERE MOST NEEDED
A donation “Where Most Needed” supports all of AACAP’s initiatives, and gives you the greatest flexibility to direct your contribution where it will have the biggest impact.

THE PARAMJIT T. JOSHI, MD INTERNATIONAL SCHOLARS AWARD
This award, founded by AACAP President Paramjit T. Joshi, will recognize a member of the international medical community who has contributed significantly to best practices in effectively treating children with mental illnesses.

It costs $2,500 to sponsor a travel scholarship for one international Child and Adolescent Psychiatrist or physician to attend the Annual Meeting.

RESEARCH
It’s estimated that just 1% of child psychiatrists are researchers. We know that’s not nearly enough if we are going to accelerate innovation and best-practice gains. Without new researchers, we are facing the very real possibility of not reaching our potential for new medicines and treatments that will have lasting benefits to children with mental illness. Your donation will help us make more investments in promising new researchers.

It costs $15,000 to launch one child psychiatry resident’s research career.

E. JAMES ANTHONY FUND
Created in memory of former AACAP President E. James Anthony, MD (1916-2014), the E. James Anthony IACAPAP Presidential Travel Award provides travel expenses for the sitting president of The International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) to attend AACAP’s Annual Meeting, where his/her attendance will help foster greater international collaboration between child and adolescent psychiatrists.

It costs $2,500 to award the E. James Anthony IACAPAP Presidential Travel Award each year.

LIFE MEMBERS FUND
The Life Members Fund supports medical students and residents interested in a career as child and adolescent psychiatrists with travel scholarships to AACAP’s Annual Meeting. At the meeting, they are mentored by Life Members, our most senior members. Since 2010, 100 medical students and residents have been supported by your donations.

It costs $1,325 to sponsor a travel grant to the Annual Meeting for CAP Medical Students and Residents.

THE ÜLKÜ ÜLGÜR, MD INTERNATIONAL SCHOLAR AWARD
This award, founded by AACAP member Ülkü Ülgür, recognizes a child and adolescent psychiatrist or a physician in the international community who has made significant contributions to the enhancement of mental health services for children and adolescents.

It costs $2,500 to sponsor a travel scholarship for one international Child and Adolescent Psychiatrist or physician to attend the Annual Meeting.

WORKFORCE DEVELOPMENT
The average wait for a child to see a child and adolescent psychiatrist is seven and a half weeks; compared with two weeks for an adult to see a general psychiatrist. This deficit in our workforce has a devastating impact on children in need of treatment. The AACAP Medical Student Fellowship program helps eliminate the CAP deficit by encouraging the best and brightest young medical minds to pursue careers in child and adolescent psychiatry.

It costs $3,500 to sponsor one medical student in a 12-week fellowship.

GENERAL INTERNATIONAL FUND
The international medical community has contributed significantly to best practices in effectively treating children with mental illnesses. By recognizing and investing in the work of our international colleagues, your donation to the General International Fund will help us tackle the biggest barrier to access to services: a global shortage of child psychiatrists.

It costs $2,500 to sponsor a travel scholarship for one international student or resident to attend the Annual Meeting and be mentored by an AACAP member.

ELAINE SCHLOSSER LEWIS FUND
The Elaine Schlosser Lewis (ESL) Fund encourages innovative research in the areas of Attention Deficit Disorder/Attention Deficit Hyperactive Disorder and learning disabilities. It is through this research that physicians and mental health experts can improve the current diagnostic tools and treatment options for ADHD.

It costs $15,000 to sponsor one ESL Pilot Research Award.

CAMPAIGN FOR AMERICA’S KIDS (CFAK)
CFAK funds projects that promote and support innovative initiatives in education and research that improve access to mental health treatments for all children.

It costs $3,500 to sponsor one medical student in a 12-week fellowship.

VIRGINIA Q. ANTHONY FUND
Created to honor the service of AACAP’s retired Executive Director, the Virginia Q. Anthony Fund underwrites the annual Virginia Q. Anthony Outstanding Woman Leader Award, which celebrates the achievements of female CAPs who have had a profound impact on their field.

It costs $2,000 to sponsor a Virginia Q. Anthony Outstanding Woman Leader Award.

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A gift to the AACAP Endowment is a permanent financial investment in the future and stability of AACAP. The AACAP Endowment funds important programs that support AACAP’s mission for current and future generations.

Visit AACAP.org and direct your donation to any of the causes and funds listed above, and enjoy the freedom of targeting your gift exactly where you want it. To learn more about AACAP’s impact funds: Please contact the Office of Development at 202.966.7300 ext. 140 or development@aacap.org.
Opportunity responsibilities and highlights:

- Partner with the Department leadership
- Preferred experience in clinical administra-tional, behavioral, and social work, including direct support to the medical and clinical directors for a variety of programs, participation in resident and fellow education, and pursuit of academic endeavors appropriate for promotion. These clinical programs are staffed by over 50 psychology and psychiatry faculty as well as over 250 nurses, social workers, behavioral health clinicians, and mental health clinicians.

Opportunity responsibilities and highlights:

- Based at the Anschutz Medical and Research Campus, the Division of Pediatric Psychiatry benefits from affiliation with world class interdisci-plinary professional education, research programs and clinical services
- Preferred experience in clinical administration in a child and adolescent psychiatric setting including inpatient
- Partner with the Department leadership to assure that patients receive quality care, that services are provided in a cost-effective manner, and that these services are in compliance with Federal, State and Institution requirements
- Represent the Department on Hospital committees

- Division consists of 19-Pediatric Psychiatrists, 20-Psychologists, and 12-Fellows
- 28-bed Inpatient Unit, 63-bed Day Hospital, 14,000 outpatient visits in 2014

About Children's Hospital Colorado (CHC): Affiliated with the University of Colorado School of Medicine, CHC is consistently ranked by U.S. News & World Report as one of the top ten best children's hospitals in the country. The free standing hospital is licensed to operate 314-beds and annually performs on average over 17,000 surgeries, logs over 400,000 outpatient visits, and delivers over 81,000 days of inpatient care. CHC is home to nationally and internationally recognized clinical and research programs with the Department of Pediatrics consistently ranking as a top academic department for pediatric research funding from the NIH. The Anschutz Medical Campus includes over 5 million square feet of research, educational, and clinical space on 227 acres.

Even better than visiting the Mile High City is calling Denver home. There is no doubt that Denver residents come full circle with a “Mountain West” lifestyle that links them to the great outdoors, where they can enjoy the area’s numerous recreational opportunities, or just sit outside and enjoy the spectacular Rocky Mountain Views. Mix in a sunny climate (the arid conditions bring only 8 to 15 inches of annual precipitation and locals wake up to more than 300 days of sunshine a year) affordable and affordable and diverse housing options, moderate cost of living, multitude of education options, a host of cultural venues, professional sports teams, world class shopping and dining options, and you have one of the country's best places to live and work.

We would appreciate the opportunity to confidentially discuss this position with you and share in greater detail why we feel it to be among the top positions available nationally. Please contact Marcel Barby at (817) 707-9034 or via email at: marcel@millicansolutions.com for more information. All inquiries will remain confidential without your prior approval.

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MD or DO: Must be board certified in Child & Adolescent Psychiatry

DISTRIBUTION OF COLUMBIA

PSYCHIATRIST

Latin American Youth Center (LAYC)
The Psychiatrist provides psychiatrist services to children and/or youth admitted into the LAYC’s mental health program.

ESSENTIAL RESPONSIBILITIES:

- Conducts on-site psychiatric evaluation.
- Conducts sessions regarding education on medications.
- Prescribes medication to clients as needed.
- Reviews diagnostic assessments and treatment plans.
- Provides crisis intervention.
- Documents interventions with client using progress notes and billing forms.
- Enter information into ICAMS electronic record-keeping system.
- Be available for case consultation around crisis intervention as needed.
- Participate in monthly quality improvement committee meetings.
- Meets Director to discuss and review compliance issues.
- Provides input with regard to staff training.
- Reports on time, unless a legitimate excuse is provided;
- Improves professional skills by attending workshops, seminars, and training sessions as allowed by the time and funding constraints;
- Performs other activities specifically assigned by the Director.
- Adheres to all LAYC personnel policies.

POSITION REQUIREMENTS:

- MD and current professional licensure in the District of Columbia.
- At least three year-experience working with adolescents within a culturally diverse population
- Complete FBI and local police medical evaluation and child abuse and neglect clearance
- Knowledge of services and resources in the areas of mental health, substance abuse, prevention, treatment and rehabilitation.
- Ability to evaluate youth’s emotional, behavioral and social
needs and determine the optimal treatment strategies;
• Excellent communication and organizational skills;
• Ability to relate to culturally diverse population;
• Fluency in English and Spanish preferred
• Computer proficiency.

PHYSICAL REQUIREMENTS:
This is largely a sedentary position that requires the ability to speak, hear, see, and lift small objects up to 10 lbs. May require the ability to travel locally and/or regionally.

The above statements are intended to describe the general nature and level of work being performed by the individual(s) assigned to this position. They are not intended to be an exhaustive list of all duties, responsibilities, and skills required. Management reserves the right to modify, add, or remove duties and to assign other duties as necessary. In addition, reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of this position.

Contact: Carlos Vera carlos@layc-dc.org

MARYLAND

CHILD AND ADOLESCENT PSYCHIATRIST

Baltimore, MD

Join a Leader in Integrated Healthcare Delivery - Kaiser Permanente! When you join the Mid-Atlantic Permanente Medical Group (MAPMG), you’ll be able to get more out of your life and your career. As a Physician-owned and managed multi-specialty group with 1100 Physicians serving 580,000 patients, we know firsthand what it takes to advance professionally and thrive personally. That’s why we provide what it takes to advance professionally and thrive personally. That’s why we provide

• Reasonable, predictable schedules
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Requirements: BE/BC in Child Psychiatry. Must have keyboarding skills for electronic medical record. We are an Equal Opportunity Employer.

Contact: Cooper Drangmeister Email: cooper.j.drangmeister@kp.org

MASSACHUSETTS

ASSOCIATE PSYCHIATRIST-IN-CHIEF

Boston Children’s Hospital

Boston Children’s Hospital is seeking a gifted mid-career child and adolescent psychiatrist interested in helping build new clinical capacities in the Department of Psychiatry. This newly created position will be responsible for overseeing all current patient care operations and for developing new clinical programming in collaboration with other BCH departments and outside agencies. Areas of focus will include broadening the existing continuum of care and the integration of behavioral health in the pediatric home.

With over 140 faculty members, the Department has active and diverse clinical services, educational programming, and innovative research efforts that encompass all aspects of the field of child and adolescent psychiatry. The Department’s clinical programs provide over 14,000 outpatient visits, 800 medical consultations, 1,000 emergency room consultations, 200 inpatient admissions, and 3,000 school-based contacts each year. The Department offers highly sought after training programs in child psychiatry, psychology, and social work. The Department has a robust research program as well as a team of professionals dedicated to measuring and improving quality.

We envision hiring an Associate Psychiatrist-in-Chief who has a track record of excellence in administrative leadership, clinical innovation, training mentorship and scholarly productivity. A strong collaborative nature will be required to sustain and build partnerships both within and outside the hospital setting. The candidate for this position must be board certified in child and adolescent psychiatry. The proposed position will include an appointment at Harvard Medical School.

MEDICAL DIRECTOR FOR EMERGENCY SERVICES AND COMMUNITY BASED ACUTE TREATMENT UNIT

Boston Children’s Hospital

We are expanding our clinical capacities in the Boston’s Children’s Hospital’s Department of Psychiatry. It is an exciting time for us as we respond to the Hospital’s call for us to create a new roadmap to the emerging behavioral healthcare landscape. We are aiming to fill the following two new positions.

1) This new, fulltime position is for individuals interested in providing consultation and assessment of children and adolescents in acute psychiatric crisis. The successful candidate will join an established Psychiatry Emergency Service team and will be responsible for overseeing patient care operations and for developing enhanced educational services for trainees and staff. We envision this position being 60% onsite in the emergency room and 40% based in our Outpatient Psychiatry Service (with a focus on urgent care cases). A strong collaborative nature will be required to sustain partnerships within and outside the hospital setting. This position is also for the clinician who aspires to be an educator of child psychiatry fellows and medical students.

2) This second fulltime position is for individuals interested in providing assessment and treatment service for children and adolescents requiring intensive psychiatric services. We will be opening a new 12-bed Intensive Community Based Acute Treatment unit (ICB-T) in January, 2016. The patients will be highly diverse and challenging, including youngsters facing co-occurring emotional and physical disorders. A strong collaborative nature will be required to sustain and build partnerships within and outside the hospital setting. This is an excellent position for the aspiring clinician teacher who will have the rare opportunity to develop and implement a new intensive treatment program.

The successful candidates will have board eligibility or certification in Child and Adolescent Psychiatry. This position will include an appointment at Harvard Medical School. Boston Children’s Hospital is an Affirmative Action/Equal Opportunity Employer.

Applicants are encouraged to submit their application electronically – including CV and brief statement detailing relevant experience to: David R. DeMaso, MD, Psychiatrist-in-Chief, Department of Psychiatry, Boston Children’s Hospital
MINNESOTA
PSYCHIATRISTS

Greenville Health System is an equal opportunity employer which proudly values diversity. Candidates of all backgrounds are encouraged to apply.

Rapidly Expanding System Seeks Psychiatrists

PrairieCare, a private psychiatric healthcare system in the Minneapolis/St. Paul metropolitan area, is recruiting talented and compassionate child and adolescent psychiatrists to treat patients at its Brooklyn Park, Chaska, Edina, Maple Grove and Rochester sites beginning September, 2015. Clinical duties vary by site and may include evaluating and treating children and adolescents in inpatient, partial hospital, intensive outpatient, residential and clinic settings. Academic appointment on the faculty of the University of Minnesota Medical School and training of child/adolescent psychiatry fellows and medical students possible. Reports to Chief Medical Officer. Requires BC/BE in Child & Adolescent Psychiatry and unrestricted license to practice medicine in Minnesota.

PrairieCare is a physician-owned and operated psychiatric healthcare system enjoying rapid growth in Minnesota. With multiple sites in the state, PrairieCare has one of the largest child/adolescent psychiatry group practices in the upper Midwest. The Twin Cities has approximately 3.5 million people, over thirty institutions of higher learning, an outstanding K-12 school system, multiple professional sports teams and a thriving fine arts community.


Send CV and letter of interest to:
Kait Semon, Medical Staff Coordinator; PrairieCare; 12918 63rd Ave N; Maple Grove, MN 55369 or via email to ksemon@prairie-care.com.

NEW JERSEY
CHAIR, DEPARTMENT OF PSYCHIATRY

Monmouth Medical Center Long Branch, New Jersey

The Barnabas Health Behavioral Health Network is seeking to a board-certified psychiatrist to provide clinical and administrative leadership as Chair of the Department of Psychiatry at Monmouth Medical Center located in Long Branch, New Jersey. The position includes oversight and management of the Department’s five units including inpatient and outpatient units for both adult and child/adolescent patients, and the Psychiatric Emergency Screening Services (PESS) Unit. The Chair position is 75% clinical and 25% administrative. Clinical time may include either inpatient or outpatient responsibilities – with the opportunity for child/adolescent psychiatric work. The Chair would also work closely with the Behavioral Health Chief Medical Officer to provide leadership and direction on system-wide quality measures and clinical pathways.

Monmouth Medical Center, a 527 bed facility, is one of New Jersey’s largest academic medical centers and has been a teaching affiliate of Philadelphia’s Drexel University College of Medicine for more than 40 years.

As the largest integrated health system in New Jersey, Barnabas Health offers competitive compensation to physicians as well as robust benefits package including health, life, disability, and malpractice insurance, 401k/retirement, plus paid time off and added time off for CME.

Located along the Jersey shore, the area around Monmouth Medical Center is full of beautiful suburban neighborhoods with access to top-notch schools, plus plenty of places to see and things to do including restaurants, theaters and other amenities. What’s more the hospital is just over an hour from New York City, Philadelphia, and Atlantic City.

For more information about this and other psychiatrist positions with Barnabas Health, please contact Annelise Catanzaro, Manager of Physician Development at acatanzaro@barnabashealth.org or (973) 322-4364

Physicians must be board-certified in Adult Psychiatry and/or Child/Adolescent Psychiatry.

Candidates must have previous administrative experience:

NEW YORK
BOARD CERTIFIED/ELIGIBLE CHILD & ADOLESCENT PSYCHIATRIST

If you are a Board Certified/Eligible Child & Adolescent Psychiatrist who would enjoy growing in a flourishing Multidisciplinary practice not dependent on managed care, we have a Part/Full time position open. Psychiatric evaluations, medication management, and Psychotherapy. Provide quality services for an affluent suburban community thirty miles from New York City. Benefit package available.

If interested, please send a message to sanderson@bartkyhealth.com

SOUTH CAROLINA
INPATIENT CHILD AND ADOLESCENT PSYCHIATRIST

Greenville, South Carolina

Greenville Health System (GHS), the largest healthcare provider in South Carolina, is currently seeking a board certified/board eligible Inpatient Child Psychiatrist to join our collegial group of 14 psychiatrists.

The ideal candidate will have an interest in teaching medical students, residents, and child and adolescent fellows at the University of South Carolina School of Medicine-Greenville, located on GHS’ Greenville Memorial Medical Campus. The psychiatrist would have a faculty appointment at the University of South Carolina commensurate with experience.

This position comes with an excellent compensation package, paid malpractice insurance, paid interview and relocation costs plus a host of other wonderful benefits.

GHS has over 12,000 employees including 800+ physicians. The system includes excellent clinical facilities with 1,662 beds on 7 campuses. We offer 15 residency and fellowship programs, as well as one of the nation’s newest 4-year medical school: University of South Carolina School of Medicine–Greenville, located on GHS’ Greenville Memorial Medical Campus. We are a designated Level I Emergency Trauma Center and also have a separate research facility.
Greenville, South Carolina, is a beautiful place to live and work and the GHS catchment area is 1.3 million people. Greenville is located on the I-85 corridor between Atlanta and Charlotte, and is one of the fastest growing areas in the country. We are ideally situated near beautiful mountains, beaches and lakes. You are able to enjoy a diverse and thriving economy, excellent quality of life and wonderful cultural and educational opportunities.

Please submit letter of interest and current CV to:
Caroline Bates, cbates@ghs.org
Phone: 877-360-5579

TEKS
BC/BE CHILD PSYCHIATRIST
The University of Texas Southwestern Medical Center, Department of Psychiatry, Division of Child and Adolescent Psychiatry is seeking a board certified/board eligible child psychiatrist to provide support to three clinical services: the Eating Disorders Program, the Suicide Prevention Intensive Outpatient Program, and the Consult Liaison Service at Children’s Medical Center. Faculty rank is open and will be commensurate with experience.

The Eating Disorders Program offers a full continuum of care for children and adolescents, girls and boys with eating disorders and other eating-related illnesses. The program includes 12 inpatient beds, a partial hospitalization program, an intensive outpatient program and outpatient care.

The Suicide Prevention Intensive Outpatient Program provides care for patients stepping down from the inpatient and partial levels of care, and patients seen in the emergency room that require rapid access to an intensive outpatient treatment program. The program has been incorporated into the existing outpatient service line and structure.

The Consult/Liaison Service provides integrated clinical services at Children’s Medical Center. Consultations are provided to all pediatric inpatient services, including general pediatric inpatient services, pediatric intensive care unit, pediatric neurology and other subspecialty services as well as ambulatory clinics and the emergency department.

The candidate’s background should include experience with psychiatric assessment and treatment of children and adolescents. This includes the treatment of medical patients with cognitive, behavioral, and emotional needs, and medication management. Candidate must be able to provide supervision and teaching of child psychiatry fellows, general psychiatry residents, medical students and other allied health students.

UT Southwestern Medical Center was founded in 1943 and is now one of the leading medical schools in Education, Research and Patient Care in the country. The Department of Psychiatry is the third largest department on campus.

Children’s Medical Center is a private, not-for-profit health system and is the eighth largest pediatric healthcare provider in the country with over 550 licensed beds, two full-service campuses and 10 outpatient sites.

Applicant must have or be able to obtain a Texas medical license and be board certified or board eligible in Child and Adolescent Psychiatry. Interested applicants should forward curriculum vitae and letter of interest to:
Graham J. Emslie, MD, Director
Division of Child and Adolescent Psychiatry
UT Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas, Texas 75390-8589
ATTN: Jackie Gransberry

UT Southwestern Medical Center is an Affirmative Action/Equal Opportunity Employer. Women, minorities, veterans and individuals with disabilities are encouraged to apply.
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Questions? Contact Elizabeth Hughes, Assistant Director of Education and Recertification, at ehughes@aacap.org, or Quentin Bernhard III, CME Coordinator, at qbernhard@aacap.org.