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June 15, 2016

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Visit www.aacap.org/AnnualMeeting/2016
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Cover Photo: The picture titled “Mexico” is from 2009, taken in the city of León, in central Mexico. My wife and I were visiting friends of her family, and we found ourselves in a house bustling with three generations of extended family. The three girls are cousins (several other children were playing around us). The beaming woman in the background is the mother of the girl on the left. The stern-looking man in the corner is their grandfather, who later confided to my wife that his children and grandchildren are very precious to him. ~Marc Sandrolini, MD
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership
December 2014

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

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Systems of Care

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President’s Message

Working on Workforce

At the recent AACAP Legislative Conference in Washington, D.C., (April 14 and 15, 2016), 250 AACAP members, patients, and families fanned out on Capitol Hill to lobby for children’s mental health. Each year this event gets bigger and better, but you can guarantee that one persistent topic, sure to be high on our priority list, is the nationwide shortage of child and adolescent psychiatrists. Although the reduction in stigma and wider recognition of the effectiveness of psychiatric treatment have changed the conversation some, our numbers remain far too small to approach meeting the need for child and adolescent psychiatry services. The length of training required to become a child and adolescent psychiatrist, the increasing debt burden that most medical students graduate with, and the small number of “stretched-to-their-limit” academic child and adolescent psychiatrists appear to conspire, along with other variables, to keep our numbers low. What we as workforce advocates have needed is a tool that instantly dramatizes the shortage of child and adolescent psychiatrists on a very local level. At the Legislative Conference, this new resource proved to be extremely helpful in engaging and educating legislators and their staffers about the workforce shortage issues facing child and adolescent psychiatry.

The new maps provide a much clearer, more defined view of the child and adolescent psychiatry workforce shortage than did previous editions. Journalists, legislators, and families had provided feedback to improve the comprehensibility of the data; asking, for example, how we defined degrees of the shortage and what the source for such definitions were. Highlighted changes include:

- User-friendly, interactive maps of the entire nation by county
- Demarcated areas of “no child psychiatrists,” “extreme shortage” and “serious shortage”
- References used for the shortage calculations
- An easy-to-read, downloadable state snapshot

Some of these features are illustrated in the above graphic.

Remarkably, these maps were produced entirely “in house” at AACAP using publicly available statistics from the American Medical Association, which—like the maps themselves—are constantly updated as physicians start practice, move, retire, etc. I would like to provide special thanks to AACAP’s Research and Training Education Department, especially Mona Noroozi, Lisell Perez-Rogers, and Carmen Head for their leadership, management, and coordination of this project, as well as Wun Jung Kim, MD, for serving as AACAP’s workforce expert and consultant. My deep appreciation also goes to AACAP’s Government Affairs Department—Michael Linskey, Ronald Szahat, Zachary Kahan, and Emily Rohlffs—and to AACAP’s IT Department, especially Don Kenneally and Peter Plourd. Creating these maps was a team effort by a very dedicated and talented group of AACAP staffers.

It is my hope that these maps will be used in future years to evaluate, educate, and advocate on the need for greater pediatric mental health services nationwide and the need for integrated care. I strongly encourage AACAP members to go the AACAP website to view and download your own state map to share with local policy leaders and colleagues—or even for personal use as you consider future career moves. At the very least, have some fun exploring these interactive maps to see how your own practice area stacks up.

Gregory K. Fritz, MD
Becoming a Statewide Collaborative Care PAL (Partnership Access Line)

Child psychiatrists are a rare commodity, such that if we all only worked in traditional models of care then most community mental health care needs would go unaddressed. AACAP describes this eloquently within the advocacy section of aacap.org, for instance pointing out that about 80 percent of children with a mental illness do not currently receive treatment in the existing care system.

A collaborative care goal would be to leverage child and adolescent psychiatrist’s expertise to support other care providers and positively impact the lives of whole populations of children. Specifically how this collaboration should best occur is still being investigated. “Collaborative care” might currently describe referral support, screening programs, telephone consult access programs, face-to-face patient consultations, care coordination, co-location, educational support, care reviews, electronic medical record integration, and fully integrated mental/behavioral health services.

In Washington State, our Medicaid division, almost a decade ago, created two different consult service programs that are now operated together as a single collaborative-care support service. The first of these programs was doctor to doctor mandatory second opinion medication reviews for state defined “outlier” prescribing, such as doses over twice the adult Federal Drug Administration (FDA) max or more than five concurrent psychotropic medications. These mandatory reviews were initially unpopular with the prescribing community, and started out focused just on authorization versus denial recommendations rather than on providing a forum for care collaboration. Over time however we learned to do a second opinion review while metaphorically sitting side-by-side with the prescriber, focusing our attention on helping them with the care of their most challenging cases rather than just playing the role of authorizer. This might seem like a subtle distinction, but it makes a huge difference in the provider reported value of the program. For instance, last year’s mandatory second opinion review feedback from prescribers rated their reviewers as a mean of 6.0 on a seven point scale regarding the statement, “The consultant offered appropriate and helpful treatment suggestions for my patient.”

The second program that we created was for all primary care providers to be able to receive elective, on-demand, telephone-based consultations with a child and adolescent psychiatrist. This Partnership Access Line (PAL) is staffed in such a way that primary care providers can expect to nearly always get directly connected to a child and adolescent psychiatrist when they call. They also receive access to a social worker helping with care coordination, access to televideo patient consultations, locally hosted continuing medical education education events, and a treatment guide designed for primary care mental health services. Provider feedback for this service has consistently been overwhelmingly positive. This collaborative care support service was made available by both Washington State and Wyoming Medicaid for all of the primary care providers in those states, and was created because primary care providers kept asking for a support like this. More details of the PAL elective primary care consultation service have been described elsewhere (Hilt et al. 2009, 2013, and 2015), and at palforkids.org and wyomingpal.org.

Early on in the PAL program development process, we learned that we needed to functionally combine the elective PAL consultation and mandatory secondary opinion review consultation programs into a single service. Doing this provided for greater staffing flexibility (difficult to always have a child and adolescent psychiatrist “available”) and helped us to ensure fidelity of message regardless of the door of entry for collaboration assistance. The consultants work as a team, discuss challenging scenarios to reach a best consensus approach, and formally audit the consultations provide for consistency of best practice messaging. System outcomes have been notable. For instance, in just the first three years of combined PAL/Second Opinion consult services Washington’s pre-existing rapid increase in child antipsychotic use reversed course, and then decreased by 17%.

Collaborative care systems need to be explicitly tailored to local needs. In working with Wyoming Medicaid we learned that children in their foster care system had particular challenges with getting timely access to child psychiatric assessments, and this lack of access negatively impacted overall treatment planning. So we created a path for rapid access and in depth system collaboration televideo patient consultations for their foster care system. An analysis of the whole package of Wyoming collaborative care (PAL, medication second opinion, and foster care consults) found there were desirable outcomes beyond positive provider feedback. There were 42% fewer children under five years of age receiving psychotropic medications, 52% fewer children receiving >150% of the adult FDA maximum dose psychotropics, and, by reducing clinically inappropriate residential care placements, the collaborative care system saved money with a 1.8 to 1 return on investment. (Hilt et al. 2015)

Based on all of these experiences, I encourage others to consider working with one of the many types of developing collaborative care systems in their own areas, as it can be highly rewarding work.

References


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CLINICAL VIGNETTES

Hanging in There

Teddy, a 6-year-old male, was handed off to me by a graduating fellow. He was being treated for attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder, and parent-child relational problems. He had a history of witnessing frequent physical altercations between his parents. When the patient presented to me, he had already failed an extended course of trauma-based cognitive behavioral therapy, reportedly because “he wouldn’t say anything,” and a course of parent-child interactional therapy, because he and his mother “wouldn’t stop yelling at each other when they played Connect Four.” His mother’s primary complaints to me focused on oppositional behavior, aggression, and sleep issues.

Consistent with previous reports, Teddy refused to answer any questions about his history, symptoms, or feelings. It was not that he was being overly oppositional; rather, it was as if my questions passively floated over him like clouds—like he did not hear the questions at all. “How was your week?” “What do you do for fun?” “Tell me about your house?” None of my questions appeared to be even subtly acknowledged. However, Teddy was excellent at play, and engaged easily in this form of communication, as I found out on our first meeting when he requested a soccer match. My supervisor would remark that meeting when he requested a soccer communication, as I found out on our first and engaged easily in this form of communication.

At first, the play was aggressive and disorganized. We would kick balls back and forth, throw foam blocks, and jump around. I found myself getting distracted by calculating how much it would cost to replace the large glass window in my office every time a block or toy car would bounce off of it. For a short time, my anxiety surrounding the aggression subsided when the theme changed to cooperatively chasing bad guys, only to return when he began shooting me repeatedly with the toy guns, ramming police cars into my fingers, and sawing off my legs with a toy saw. I wondered if I was going to get hurt. I wondered if I was modeling bad behavior when I pretended blood was spraying out of my various bullet and saw wounds. My supervisor challenged me to consider if the aggression was within the play or if it had traveled beyond what was safe, noting that my fears about getting hurt had not actually happened. Suddenly, it all stopped—all the aggression and violent themes—for no reason that was apparent to me. My supervisor suggested that Teddy had worked through the issue he was dealing with and was ready to move on. So was I.

Next, my anxiety turned to boredom. For six weeks straight, Teddy wanted to play hide-and-seek in my office. After hiding behind the plant, the dry erase board, and finally, the cabinet, the only space left was under my desk. This is where he continued to hide every time, every session, week after week. I was ordered to stand in the corner counting to 10 then 20, then 120 while he repositioned himself—just right. While banished to my corner, I found myself trying to sneak peeks at my phone or position myself to stare out the window. I imagined that I looked like the final victim in the Blare Witch Project, standing there, bored and lifeless. Often, I used those moments in the corner to stretch my toes or rest my head on the cold cement wall. In supervision, I was encouraged to consider that hide-and-seek is often a way to master separation and individuation conflicts. I was also advised that I was making a common beginner’s error of expecting outcomes too quickly. Regardless of the advice, I desperately hoped that Teddy would master the conflict quickly. Personally, I was astounded at how much less tolerable to me the boredom was than my anxiety of the aggression. Then, one day, seemingly out of nowhere, he asked to play with the toys in the sand box. He casually said that he was “bored” with hide-and-seek.

In the sandbox, we had battles with dinosaurs and pirates. His unit of armed soldiers guarded secret treasure against my invading zoo animals. Playing with the toys in the sandbox was certainly more tolerable than being a victim of a handsaw or counting in the corner, but a new sensation arose in me—a nagging sense that nothing was happening—the sense that someone, somewhere, was paying for me to provide skilled babysitting. I recognized this thought as one that had been expressed to me by the previous fellow. It was a significant challenge for me to allow the play to continue to be directed by Teddy. It required my full reserve of patience to avoid the impulse to revert to asking him direct questions about his life.

“It was a significant challenge for me to allow the play to continue to be directed by Teddy. It required my full reserve of patience to avoid the impulse to revert to asking him direct questions about his life.”

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COLUMNS

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your mood?” “Has an adult ever hurt you?” A few times I did ask questions like this. He instantly became guarded and sullenly returned to playing independently. But Teddy was tolerant of my intrusions. He always allowed me back into the play, and kept up his end of the bargain each week by actively participating in his therapy. In supervision, I was assured that the play was progressing.

After many sessions playing in the sandbox, Teddy, much to my surprise, began choosing to play specifically with the dollhouses and people figurines – toys he had expressed explicit disinterest in just a few months before. At first, he played in front of the houses with trucks, army men, and animals, using the people figurines as an audience to watch the play. Next, he started using the people to work directly through issues that sounded familiar to those he had been having at home. To me, this is where the play made a dramatic shift into something that more closely resembled the direct themes I was used to working with in my adult training. The play was becoming less abstract and less displaced. He investigated themes of gender when we made a boy’s house and piled all the girl dolls far away. He was challenged with managing interpersonal relationships as more and more boys moved into our boy’s home. Then, he began to allow girls. First a single mom for all the boys, then more female roles were allowed into the play. Next, he began choosing to play with figures that parallel the makeup of his family. Most recently, he is choosing to play as his parents with me as a child – throwing tantrums. We are redirectly reenacting his home conflicts (as described to me by his mother) with the dolls. Each week, the play picks up exactly in the place it left off the week before. The first thing he says when he comes in is, “I wonder what is going to happen with the family today,” or “lets do the same things as last time.” He is effectively working through conflicts and demonstrating a confidence and mastery I had not witnessed in him before. He is consistently empathetic and demonstrating a strong theory of mind.

Over the six months I have been working with Teddy, the play has evolved from disorganized and aggressive with diffuse displacements, to organized and cooperative, with specific conflict resolution. Throughout, I have been constantly wondering what the hell I am doing and feeling anxious about a therapeutic trajectory I had no experience with—child-directed play. Even with the constant positive assurances and rational interpretations of my supervisor, I had trouble trusting the natural evolution of the process. At present, Teddy and I appear to both be pleased and engaged in the play. Reports from home are that he is improving his ability to tolerate stress, behavioral issues at school have been reduced, and that his broad oppositional behavior has improved. His academic performance has significantly improved across multiple academic domains. However, he still continues to exhibit oppositional behavior toward his mother, and I am interested to see how the tension in this relationship will continue to manifest in the play. I am not sure what the next challenge in our play will be, but if the pattern continues, it will likely be a challenge within me. I can, however, take some comfort in trusting a few principles that have proven their efficacy – supporting a child-directed space, trusting Teddy, checking in with supervision, and simply allowing the process of play to unfold organically.

Dr. Roi is a child and adolescent psychiatry fellow at Louisiana State University in New Orleans, Louisiana. He may be reached at croi@lsuhsc.edu.

2016 AACAP Election
Now Open!

AACAP’s 2016 Election is open! This year’s election positions include two Councilors-at-Large and two Nominating Committee members. All votes must be received by 11:59:59 pm EST on May 31, 2016.

AACAP Members, sign in and check out the candidates online (www.aacap.org/bios.pdf).
It is through the generosity, and the continuing support, of the Klingenstein Third Generation Foundation that AACAP can bring medical students and faculty from medical schools across the United States together to foster student interest in, and understanding of, the field of child and adolescent psychiatry. The number of medical schools involved in this mentorship program has grown over the years to 15. The ongoing activities at these institutions culminate in the annual “Games,” which have been the highlight of this program since 2006. This year, we have the pleasure of looking at the “Games” through the eyes of both a member of the team from the host school and one from a school that accepted the invitation to “compete.” It is a competition where everyone is a winner!

But where are the “Games”?! A Summary of the 2016 Klingenstein Third Generation Foundation Games at the Yale School of Medicine

Corey Horien, BA
Yale School of Medicine

For the past ten years, individuals attending the annual Klingenstein Third Generation Foundation Games, an annual conference for medical students interested in child and adolescent psychiatry generously supported by the Klingenstein Third Generation Foundation, have come to expect a certain number of experiences. These include meaningful conversations with other students, inspiring presentations from child and adolescent psychiatrists concerning their personal journey through medicine, and, last but not least, “The Games” – a mix of spirited, often bizarre contests designed to foster a sense of camaraderie among attendees. Those who travelled to Yale on February 27, 2016, were able to enjoy conversations, lectures, and research. The actual Games, however, were nowhere to be found. What gives? Was the most important part of the conference simply forgotten? Or was this an elaborate scheme devised by the Yale planning committee, intended to ensure The Games trophy remains permanently in New Haven?

The conference started early Saturday with 162 attendees from 15 medical schools gathering in the Donald J. Cohen Auditorium where they listened to John E. Schowalter, MD, (Yale School of Medicine), former president of AACAP, give a moving lecture about how to have an impact in medicine. (Dr. Schowalter also turned heads with his flashy green-and-red checkered trousers). This was followed by six outstanding medical student presentations, with contributions from Emily Olfson (Washington University) on the non-medical use of prescription pain relievers in adolescents, Nikhil Patel (Mayo Clinic) on cannabis and the developing brain, Cordelia Y. Ross (Vermont) on autism and gender identity, Jeannine Rider and Matthew Santos (Brown University) regarding a health outreach program they developed to help incarcerated youth, Danielle Mohabir (University of North Carolina) on structural barriers to mental health in college students, and Ronnye Rutledge (Yale) on the role of cultural spaces in constructing alternative health narratives. To conclude the morning, James Comer, MD, (Yale) spoke about the need for inclusion and a sense of belonging for the mental health of children.

Lunch was next, with plenty of time allowed for mingling among students and faculty. Nevertheless, the allotted 70 minutes for food and conversation seemed too little, as many lively discussions were still occurring as the next activity began (a delightful problem to have for the conference planning committee). Once everyone was reassembled, they were treated to 30 research posters presented by students, with topics ranging from differential methylation sites in genes implicated in eating disorders, to work describing the continued on page 118
use of mobile technologies as a means of large scale mental health interventions to the probable DSM diagnoses of comic book superheroes.

The afternoon session began with engaging presentations from three faculty members, all of whom are leaders in child and adolescent psychiatry. Hanna Stevens, MD, (Iowa) shared how experiences from her time as a student have shaped her work today, studying the molecular and cellular aspects of brain development as it relates to psychiatric disorders. Robert Althoff, MD, (Vermont) discussed his journey as a child psychiatrist, and, through descriptions of his own work, detailed the many exciting challenges awaiting future child and adolescent psychiatrists. Margaret Stuber, MD, (University of California Los Angeles) provided helpful tips about work-life balance and how one can have it all, though not necessarily at the same time. Linda Mayes, MD, chair of the Yale Child Study Center, wrapped up the faculty presentations by detailing her career path, highlighting the history of the Child Study Center, and describing the many ways child and adolescent psychiatry involves a patient’s family.

As the conference drew to a close, attendees had the phenomenal opportunity to hear from a patient and his family about what it is like to live with autism. In poignant detail, Paul, who has grown up with autism and is now in his late 20s, spoke about his experiences with the healthcare system and what he wished people knew about the disorder. His family members also discussed their own experiences and struggles as they watched Paul develop, start a job, and become more independent. The session served as a touching way to end the day’s classroom activities.

To cap the day, Anne Glowinski, MD, and her colleagues from Washington University showed a brief video highlighting the child and adolescent psychiatry department “Wash” and what conference-goers can look forward to next year when Wash U hosts. Attendees then made the short trek to BAR, a New Haven favorite for food and drink. Over mashed potato bacon pizza and a beer, students and faculty alike rehashed the day’s events, explored the finer points of the research posters presented, and made plans to reconnect next year at the conference.

So what about the “Games”? Well, it was apparent to the conference planning committee from Yale that the day was going to be (wonderfully) packed, with all the excellent student presentations, the scores of stimulating posters, and the many faculty members who graciously agreed to share their personal stories. So to allow time for everything, this year we cut the “Games” from The Games – as simple as that. Does this mean The Games as we know them are forever changed? Will there be no more wacky competitions? You’ll have to read Bernie Mulvey’s essay and be in St. Louis next year to find out...

Corey wishes to thank the entire Yale Klingenstein Third Generation Foundation conference planning committee, Dr. Andres Martin and Bernie Mulvey for helpful comments regarding the manuscript, and the Klingenstein Third Generation Foundation for making The Games possible.
Bringing the Games Back
(Or, How I Learned to Stop Worrying and Love the Conference)

Bernie Mulvey, BS
Washington University in St. Louis School of Medicine

Medical students from Washington University (Wash U) in St. Louis made their second visit to the Klingenstein Third Generation Foundation’s Games in February 2016. This young Klingenstein Third Generation Foundation chapter has seen a huge amount of growth since its establishment last year; while sending eight students to the Games—and winning the coveted trophy—at Mayo Clinic in 2015, Wash U sent 15 students to the Games at Yale this spring! Such rapid growth is a testament to the school’s strong reputation in child and adolescent psychiatry as well as to the previously latent interest in the field among Wash U medical students. The posters and brief talks presented by Wash U students at this year’s Games are a microcosm of the strengths in the school’s child and adolescent psychiatry department, and provide a preview of the clinical and research environments Wash U will be sharing with over a dozen other institutions when they host the Games in Spring 2017.

Wash U boasts one of the largest MD-PhD programs in the country, which drives both clinical and laboratory research into disorders of all types. The Klingenstein Third Generation Foundation has been a major hit with students in this program, including two presenters who traveled to Yale. Emily Olfson, a fourth-year medical student in the program—who recently matched to Yale for her residency in psychiatry—gave a brief talk, “Non-Medical Use of Prescription Pain Relievers in Adolescents.” Her talk was quite timely, as the Federal Drug Administration released stronger guidelines on the prescription and use of opioid drugs just a few weeks later. A first-year graduate student in the program, Bernie Mulvey, presented a poster on sexually dimorphic gene expression in the locus coeruleus (LC), the norepinephrine center of the brain. His work with Joe Dougherty, PhD, in Wash U’s psychiatry department indicated that between 60-200 genes are expressed in a sex-specific manner in the LC. Soon after the Games, a mini-grant co-written by Bernie and Dr. Dougherty was accepted for funding.

Joshua Page, first-year medical student, presented a poster demonstrating that quantitative measures of autistic traits are predictive of the presence of genetic risk factors for autism among Hispanic populations. Joshua’s work represents two major areas of focus at Wash U—understanding the biological underpinnings of psychiatric disease, as well as advancing research on—and identification of—psychiatric disorders in underserved and minority populations. Like most clinical research, autism is studied largely in the context of Caucasian populations. Joshua’s work represents a step forward in understanding autism spectrum disorders as a global and ethnically-unbiased phenomenon.

First-year medical students Anna Arnaud, Mary Chavarria, and Erin Klein presented a poster on an exciting new program they have started in their short time at Wash U, in which students travel to nearby juvenile detention facilities to discuss mental health awareness and interpersonal support. The initiative and compassion shown by this group in starting up a service-oriented mental health program so early in their medical careers has been quite impressive to all of us.

Wash U is thrilled about hosting the Games next year. Students and faculty alike will gather to discuss basic science research, clinical practice, and social justice in child and adolescent psychiatry—and we are confident that Wash U’s strengths in this area will give members throughout Klingenstein Third Generation Foundation new ideas to take back to their home institutions, and will help to create new collaborations and friendships with in the child and adolescent psychiatry community.

As for Games that are actually played, there is no question that they will be brought back in grand fashion in 2017. Wash U’s Klingenstein Third Generation Foundation chapter did not mind there not being Games at Yale—as we got to hold onto the trophy for another year by default! While what games will be played is confidential, I will share this much: there will be 15-seater vans involved, and not for reasons of transportation.

Bernie would like to thank Yale’s Klingenstein Third Generation Foundation program for hosting an unprecedented large and intellectually stimulating round of Games; Anne Glowinski, MD, for getting Wash U involved with the Klingenstein Third Generation Foundation program; and Corey Horien (Yale), and Andres Martin, MD (Yale), for their suggestions in writing the presented article.

COMMITTEES
Telepsychiatry Practice: Technological Considerations

Nicole Gloff, MD. and the Telepsychiatry Committee

Programs using telemental health (TMH) to deliver mental health services directly to children and families are developing rapidly. Many institutions are pushing for the use of communications technology in mental health service provision for all ages. Fortunately, there has been a decrease in the cost of video teleconferencing (VTC) systems over the past decade, which allows for greater acceptability and feasibility of such programs (Chou et al. 2015). In this second article, the AACAP Telepsychiatry Committee presents key technological considerations for a telepsychiatry practice.

When implementing a TMH program, an important step is to select the appropriate technology for the services being provided. The chosen technology should be appropriate to the clinical setting and the model of care. Quality of service, reach, and accessibility need to be balanced with the costs of purchasing equipment, training clinicians, and necessary technical support (Chou et al. 2015).

Video Teleconferencing (VTC) Software Applications/Platforms.
There are two basic applications/platforms that are available to use in telepsychiatry. These include standards-based applications and consumer-grade applications.

- Standards-based. Standards-based platforms, sometimes referred to as “legacy hardware,” allow for secure point-to-point transmission of high bandwidth (≥ 1.5 mbps), high-definition video and audio signals using satellite or fiber optic systems. Data are transmitted over digital subscriber lines (DSL). Typical DSL broadband capacities are often small (≤ 12 mbps); however, this speed is guaranteed at all times as these systems use a static IP address, which ensures a stable image (Roth webpage). They provide excellent telepresence. A limitation to standards-based systems is that they are relatively immobile and require technical expertise/IT support to set-up and maintain, thus making them impractical for use in the home and in clinics with few supports (Chou et al. 2015). Additionally they are associated with a higher overall cost, which may be limiting in certain settings.

- Consumer-grade. Consumer-grade platforms allow for VTC over the Internet using software that encrypts the transmission. Subscriptions to these platforms are sold based on the number of users/accounts and the software can be readily loaded onto personal computers, tablets, and smartphones (Chou et al. 2015; Roth webpage). This is also known as cloud-based computing. Accessing the software usually involves downloading an application or utilizing a link to a website to join a session. Major advantages to consumer-grade platforms are that they are easily accessible, adaptable, consumer-friendly, and available at a lower cost. They can be installed wherever broadband is available. Limitations include a highly variable connection speed, which can be affected by factors such as high local Internet traffic, inclement weather, and network failures. This ultimately impacts the quality of streaming audio and video (Roth webpage). Additionally, these systems generally do not allow for the addition of external features such as a remote stethoscope or camera that is operated by the provider site.

Future technological innovations may overcome this limitation in the future. Despite these potential limitations, consumer-grade platforms are considered acceptable for clinical work and widely used.

Network Connection. Bandwidth is the rate at which data is transmitted over an online connection. Video teleconferencing can require large amounts of bandwidth to operate smoothly, without breaks in audio or video transmission (Chou et al., 2015). The general guideline is for a VTC platform to have the ability to operate at a bandwidth of 384 Kbps or higher (Myers, Cain 2008; Yellowlees et al. 2010). Having a seamless network connection allows the telepsychiatrist to observe subtleties in a child’s speech, facial expression, and movements. It also allows the provider to respond fluidly to the child and family during a session. This is important for effective expression of empathy and emotional tone (Glueck 2013).

Video. Display resolution and screen size can impact the telepsychiatrist’s ability to adequately observe a child during a TMH visit. High definition displays allow for transmission of a crisp image as long as the bandwidth is great enough to support this. It is optimal to have a frame rate of 30 frames per second. There is no guideline as to the appropriate size of the display, so the clinician must consider the patient population and resolution to make this determination (Chou et al. 2015).

A camera with pan-tilt-zoom functionality is considered to be the gold standard in TMH (Chou et al. 2015; Glueck 2013; Myers, Cain 2008; Yellowlees et al. 2010). However, this capability may not be possible with consumer-grade applications (Gloff 2015). Pan-tilt-zoom functionality allows for close examination of the child and the ability to follow his or her movements throughout the exam room. Zooming in allows for closer examination of facial expression,
affect, nonverbal cues, subtle movements and dysmorphia. Zooming out allows for observation of the child’s play and gross motor skills while simultaneously talking to the caregiver (Gloff et al. 2015; Glueck 2013).

Audio. Some clinicians consider having crisp seamless audio during a TMH visit to be even more important than a strong video signal, thus it is important to use an appropriate microphone (with the correct placement) during a TMH visit (Chou et al. 2015; Roth webpage) It is generally recommended that TMH visits utilize audio at 7 kHz full duplex with echo cancellation (eliminates room return audio echo) and the ability to mute and adjust volume (Yellowlees et al. 2010).

Privacy. Privacy is an important issue in TMH and decisions regarding the selection of VTC equipment should be made with patient confidentiality, privacy, and security in mind (Chou et al. 2015). Institutions should ensure that their VTC systems and data storage are in compliance with the Health Information Portability and Accountability Act (HIPAA) (Chou et al. 2015; Myers, Cain 2008; Roth webpage; Yellowlees et al. 2010). Encryption alone does not ensure compatibility with the HIPAA. Software vendors with platforms that are HIPAA compliant have signed a Business Associate Agreement (BAA) attesting that they are in compliance with HIPAA. This is particularly important to investigate prior to purchasing a consumer-based platform, as some do not meet HIPAA standards.

Technical support. The level of IT support required to install and maintain a VTC system within an institution largely depends upon the complexity of the system, resources available at both the patient and provider site, and the abilities and availability of existing administrative and technical staff in troubleshooting potential issues. Prompt IT support may reduce the number of TMH sessions that fail to occur or are prematurely terminated due to equipment failures (Chou et al. 2015). In addition to having adequate IT support, it is also useful to have brief provider trainings in order to familiarize clinicians with the VTC equipment and ways to quickly troubleshoot issues. If technical difficulties occur, it is important to have a back-up plan in place, e.g., telephone, in order to complete a session if deemed appropriate (Myers, Cain, 2008). Additionally, when negotiating with a cloud-based vendor, it is important to ask about their typical response time and the services provided by their company to assist with troubleshooting technical difficulties. This can vary widely between vendors.

There are several considerations to be made regarding the purchase, installation, and ongoing maintenance of a VTC system for a TMH practice. Technological advances continue to occur and providers and institutions must stay current. It is important to choose VTC technology that is appropriate to the clinical service, financially sustainable, and matches the available technical support at the patient site. Appropriate technology selection and implementation ensure the quality and security of TMH care for children and their families. ■

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New Mexico Truth: Child Advocacy Campaign Sheds Light on Our National Child Poverty Crisis

New Mexico True (www.newmwcico.org) is a highly successful $2 million campaign created by the state of New Mexico in an effort to generate tourism. The advertisements depict happy families enjoying expansive sunlit skies and snow-topped mountain resorts. In 2015, New Mexico Voices for Children used a virtually identical media platform entitled New Mexico Truth (www.mexicotruth.org) to highlight the very troubling plight of children in the state. New Mexico has the highest rate of child poverty in the country (31%) and ranks 49th for child well-being. Moreover, an astounding 79 percent of children are not proficient in reading by fourth grade and 77 percent of eighth graders are not proficient in math, resulting in low high school graduation rates.

The child poverty mark of 31 percent is especially telling when compared to other rural states such as Utah (13%), Wyoming, (13%) and Idaho (13%) (Annie E. Casey Foundation 2014). However, this issue is not unique to New Mexico. The national child poverty average is a striking 23.1% (by contrast, the Netherlands is at 6.1%), placing the United States at 34 out of 35 developed countries (Adamson 2012).

Child poverty profoundly affects both short- and long-term quality of life (Schickedanz et al. 2015). Children raised in poverty not only endure higher rates of asthma, obesity, developmental delay, failure to thrive, trauma and prematurity (Schickedanz et al. 2015, Kakimani et al. 2014), but are also at increased risk for chronic disease in adulthood (Schickedanz et al. 2015). Food insecurity is associated with higher rates of depression, anxiety, aggressive behavior, inattention, and hyperactivity in children, as well as depression and anxiety in parents (Cook et al. 2013).

Social well-being in children is also significantly impacted by poverty. Child poverty is a strong predictor of all types of child abuse and maltreatment (Lee and George 1999). Low socioeconomic status in youth is associated with decreased school achievement, juvenile justice involvement, early substance abuse initiation, and lower future earnings (Nikulina et al. 2011, Fite et al. 2009). The timing (early development) and duration of poverty can significantly exacerbate these effects.

Child poverty has a profound and pervasive impact on our patients and their families (Brooks-Gunn and Duncan 1997). Child and adolescent psychiatrists need to be at the forefront of advocacy efforts aimed at confronting this problem, as even incremental improvements could result in a substantially greater quality of life for millions of youth across the country. ■

References


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UPDATE ON ADVOCACY COMMITTEE 2016

AACAP Has a New Advocacy Committee Co-chaired by Debra E. Koss, MD, and Karen Pierce, MD

As a national organization, AACAP aims to influence decision within political, economic, and social systems and institution to a much greater degree with the establishment of the AACAP Advocacy Committee. Advocacy long has been a part of AACAP’s mission, and an activity which all child and adolescent psychiatrist need to be a part of—for and with their patients and their patient’s families. As a national organization, AACAP now aims to have greatly influence on decision made within institutions and political, economic, and social systems with the establishment of the AACAP Advocacy Committee. This committee has been formally created to coordinate the grassroots activity of all of AACAP’s regional organizations of child and adolescent psychiatry (ROCAPs), as well as work on issues that are on AACAP’s federal and regulatory agenda. The goal is to mobilize all ROCAPs to designate member each to act as the advocacy liaison in its state or region. Advocacy Liaisons will be child and adolescent psychiatrists acting as the eyes and ears on legislative and regulatory affairs in their ROCAP’s area. Advocacy Liaisons will:

- Participate in monthly calls where they will receive updates on AACAP’s latest federal and state legislative and regulatory priorities, share news from their respective states and regions, and brainstorm about key issues impacting the subspecialty of child and adolescent psychiatry;
- Develop local efforts to recruit, train, and mentor child and adolescent psychiatrists within their respective ROCAPs to become involved in advocacy, using advocacy training materials developed by the AACAP Department of Government Affairs and the AACAP Advocacy Committee;
- Organize grassroots advocacy efforts within their ROCAP with the use of AACAP Advocacy resources (e.g., Voter Voice) and policy resources identified by the AACAP Department of Government Affairs and the new AACAP Advocacy Committee;
- Help engage child and adolescent psychiatrists, including members in training, and local youth and families to participate in the annual AACAP Legislative Conference;
- Find and work jointly with collaborative partners and organizations to advocate for and promote the mental health care of youth in their region;
- Participate in the new AACAP Advocacy Listserv with members of the AACAP Advocacy Committee.

Come join us and keep AACAP updated on what is happening in your state or region! The Advocacy Committee monthly call-in is on the first Monday of each month at 8:00 pm EST. You will unite with other child and adolescent psychiatrists across the country who are working to achieve optimal physical, mental, and social well-being for infants, children, adolescents, and young adults, and to improve the practice of child and adolescent psychiatry. You inform others and learn from your peers. Each of us struggle with new laws and policies impacting child and adolescent psychiatry, as well as the need to create new opportunities for positive change. Past agendas have included psychologist prescribing, foster care and psychotropic medications, and scope of practice. AACAP staff, who are also AACAP’s registered lobbyists in Washington, D.C., support participants in their advocacy efforts by providing information on materials, strategies, and tactics that have been helpful in other states. In addition to the calls, AACAP has membership in Voter Voice, which is a proprietary grassroots advocacy system that helps track what bills and legislation are moving in each respective state.

The committee will spend this year identifying a small number of high profile issues to help to develop and focus corresponding toolkits to advance AACAP’s legislative goals. Currently, child and adolescent psychiatry loan forgiveness and comprehensive mental health reform are at the top of our federal agenda. We also are developing advocacy programming for the AACAP’s 63rd Annual Meeting. Working with AACAP-PAC, the Advocacy Committee is educating members to become active Association members, so they can become active in all phases of legislative activity and the political process. AACAP “Advocacy Updates” are exciting and information filled emails that come to you twice a month.

Come join us—monthly calls are on the first Monday of the month at 8:00 pm EST, and tell us about your state’s issues!

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For more information, please contact Shawn S. Sidhu, MD, president of the New Mexico Council of Child and Adolescent Psychiatry, at shawnsidu@gmail.com.
Transgender Kids Who Are Supported in Their Transition Have Better Mental Health

Transgender children who have socially transitioned to living as their identified gender rather than their natal gender are becoming much more common in society, and correspondingly more common in the child and adolescent psychiatrist’s clinic. Parents who support their children in their social transition to their identified gender often allow children to dress and wear their hair in a way more consistent with their gender identity. Children and parents may choose a new name more consistent with their gender identity and request that others use pronouns consistent with the child’s gender identity.

Previous research found high rates of anxiety and depression among children with gender identity disorder (DSM-IV; now gender dysphoria in DSM-5), though most of these children were typically still living as their natal sex. Past research also suggested that elevated rates of depression, anxiety, suicide, and substance abuse experienced by those with gender dysphoria often resulted from years of prejudice, discrimination, and stigma; conflict between appearance and identity; and general rejection by others, including their families. As societal trends change to allow more transgender children to make the social transition to their identified gender, we find that we really don’t know much about the mental health of transgender children who are supported in living as their identified gender.

As part of the TranYouth Project (https://depts.washington.edu/tran-syp/), researchers at the University of Washington recruited a community-based national sample of transgender, prepubescent children (n=73, aged 3-12 years) along with a control group of 73 cisgender (nontransgender) age- and gender-matched community controls as well as 49 cisgender siblings of the transgender children. The mean age for all of the children was around eight years of age. Parents completed anxiety and depression measures on all the children.

There was no difference among the groups on depressive symptoms. Transgender children had slightly elevated anxiety symptoms compared to controls, though the mean anxiety ratings were not in a clinical or preclinical range.

Notably, these children were mostly white and relatively affluent; more than 70% of each sample was white, 81-90% of the families made more than $75 thousand, and 38-51% made more than $125 thousand. Families who allow or promote the social transition of their transgender prepubescent child may have other unique characteristics as well. Interactions between expression of gender identity, socioeconomic status, and rates of psychopathology will hopefully be explored in future research.

Though important clinical populations, the researchers did not include in this study non-binary gender identities or agender (without a gender) identities, and it is not clear how these children might compare to children with binary gender identities.

Like many scientific studies, this one does not answer all the questions we would like to inform us on how we counsel our patients and families. While transgender identities are becoming more socially accepted, family and even provider acceptance of transgender identities may have some ways to go. However, at least one well-executed study suggests that families of young transgender children will not scar or confuse their children by allowing them to change their name, their pronouns, their haircut, and their wardrobe.


Glutamate-modulating Supplement May Be Helpful for Skin-Picking

N-acetylcysteine (NAC) is most known by medical professionals as Mucomyst, the standard treatment for acetaminophen overdoses in emergency departments. It is also a common supplement sold with claims of antioxidant and liver protecting properties. In addition to its mucolytic or antioxidant properties, NAC is an amino acid prodrug that increases extracellular levels of glutamate in the nucleus accumbens (NA), reducing synaptic release of glutamate. Glutamatergic activity in the NA may be important in many compulsive or habitual behaviors and reward-seeking behaviors. The administration of NAC has been shown to reduce cannabis use in dependent adolescents (Gray 2012).

There are currently no FDA-approved treatments for skin-picking disorders. A few studies in adults suggest mixed results with SSRIs, and a study of lamotrigine did not show benefit over placebo. Skin-picking often presents by itself or comorbid with obsessive-compulsive disorder and other anxiety disorders, and is not so uncommon among children treated with stimulants for attention-deficit/hyperactivity disorder.

A randomized, double-blind trial was conducted at the University of Minnesota and the University of Chicago in 66 adults with skin-picking, with 35 participants randomized to receive NAC and 31 randomized to receive placebo treatment. Fifty-three subjects completed
the study. At the end of the 12-week study, 15 of the 32 (47%) individuals who received NAC were “much” or “very much improved,” compared to only four of the 21 (19%) of those receiving placebo. Of note, 10 of those in the placebo group were lost to follow-up, compared to only three in the NAC group; all those who failed to complete the study did so due to an inability to adhere to the study schedule.

Doses of NAC were started at 1200 mg/day, increased to 2400 mg/day by week three, and increased to 3000 mg/day by week six. The authors stated that they chose these doses because 2400 mg/day had been so well-tolerated in a previous similar study on trichothilomania. In the previously mentioned study of NAC in cannabis-dependent adolescents a dosage of 2400 mg/day (1200 mg twice daily) was used, suggesting this dose might be well-tolerated in adolescents.


Marijuana Use Portends Negative Outcomes in First Episode Psychosis

While research linking marijuana use to an increased risk of developing a psychotic disorder continues to accumulate, not much has been written about the longitudinal clinical course of marijuana-smoking youth who present with first-episode psychosis (FEP). Previous studies that have attempted to ask questions about how marijuana use would affect various longitudinal outcomes in psychosis have been small and inconsistent. Does marijuana use increase rates of relapse? Of hospitalization? Of treatment resistance?

To investigate the effects of marijuana use on FEP, researchers from King’s College London identified 2026 individuals with FEP accepted at an early intervention service in the South London and Maudsley (SLaM) National Health

Service Foundation Trust between 2006 and 2013. SLaM serves a large catchment of around 1.2 million residents in South London. The researchers used Natural Language Processing (NLP) software to scour the anonymized medical records to identify marijuana use. Treatment data were followed for up to five years to look at the course of illness following FEP.

Marijuana use was found in 46.3% of the sample on initial presentation and was particularly common in single males aged 16-25 years. Marijuana use at the time of FEP was associated with a 50% increase in the frequency of hospital admission (incidence rate ratio 1.50, 95% CI 1.25-1.80) and a 55% increase in the likelihood of an involuntary commitment (OR 1.55, 1.16-2.08). Initial marijuana users spent an average of 35 more days in the hospital total over five year follow-up compared to those who did not present with marijuana use at the time of FEP.

Those who used marijuana at the time of FEP were also more likely to have more failed antipsychotic trials and more use of clozapine, suggesting that one way in which marijuana use may mediate these negative outcomes is through interference with the effectiveness of antipsychotic medication.

This was a large retrospective study that was not able to assess how much marijuana was being used at the time of FEP. Information about whether the individual may have stopped or continued to use marijuana following FEP was also not available. Given that these large effects were found even without those important pieces of information, the effect of marijuana on FEP might actually be underestimated. Individuals who smoked very little or who stopped smoking after FEP may have had more favorable clinical courses than those who persistently smoked more, leading to conservative estimates of the hospitalization and treatment data.

This research highlights the likely importance of marijuana use in predicting negative outcomes in early psychosis, particularly increased days in the hospital and increased numbers of antipsychotic trials, a proxy for treatment resistance. Treatment of marijuana use is challenging even in those who do not have comorbid psychotic disorders, with few evidence-based psychosocial treatments and even fewer psychopharmacologic approaches. Developing further treatment for this comorbidity might have a substantial effect on the treatment course of early psychosis.


Another Study of Attention-Deficit/Hyperactivity Disorder Finds Higher Rates of Diagnosis in the Youngest Children in Their Grade

Over the past several years, researchers studying children in a variety of countries, including Iceland, Canada, Spain, Israel, Sweden, and now Taiwan, have found that the younger a child is compared to his peers in his grade, the more likely he will receive a diagnosis of, and be treated for, Attention-Deficit/Hyperactivity Disorder (ADHD). The one exception has been a study in Denmark, a country where the age of entry to school is more flexible than in many other countries. In Taiwan, the cut-off birthdate for entry to school is August 31, such that children born in August are typically the youngest in their grades.

Using longitudinal data from the large National Health Insurance database, nearly 400,000 children aged 4-17 years were followed from the time of entry into the study up until their 18th birthday or the end of the study period. Among those diagnosed with ADHD, the diagnosis was given at least twice by board-certified psychiatrists during the follow-up. Use of methylphenidate and atomoxetine were recorded, and variables around level of urbanization and income of the family were used as confounders.

The initial diagnosis of ADHD was made most often in grade school (60.3%), followed by preschool (22.7%) and the

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teenage years (17.0%). The prevalence of subjects receiving an ADHD diagnosis or being treated with medication steadily increased with each birth month from September (1.8% had the diagnosis, 1.2% received medication) to August (2.9% and 2.1%, respectively). The trends were similar in boys and girls, though boys (September 2.8%, 1.9%; August 4.5%, 3.3%) were more likely to be diagnosed and treated than girls (September 0.7%, 0.5%, August 1.2%, 0.8%). This effect was true in preschool and grade school children, but disappeared by the teenage years.

The main reason for covering this study in the AACAP News is not that the results are somehow surprising; they are not. More significant, however, is the way these studies are often presented in popular media. In the best-case scenario, popular media presents these studies as evidence that psychiatrists and pediatricians diagnosing ADHD are really bad at distinguishing pathology from immaturity. At worst, the news coverage can imply that the diagnosis of ADHD is a myth, and the ADHD diagnosis itself is just evidence of a medical establishment intent on pathologizing and medicating normal childhood behavior. I have heard other child and adolescent psychiatrists, otherwise smart, thoughtful doctors, inadvertently imply these exact same things.

What these analyses ignore is the fact that psychiatric diagnoses are conditions of dysfunction. The fact that the environment affects the development and presentation of a psychiatric condition is not a bug in the system. It is a feature. Childhood psychiatric conditions are often descriptions of developmental delays that result in difficulties accomplishing the tasks that others think you should be able to do. Oppositional defiant disorder (ODD) is basically a condition of difficulty with flexibility, transitioning, and mood regulation. ADHD is basically a condition of difficulty with being able to direct attention and control impulses. Whether a child can do these things is not a yes or no question. The question is whether the child is able to do these things as well as the environment demands that they do them. It should not be surprising that a younger child may not be as good at these tasks as an older child, regardless of an ADHD diagnosis or not. It also should not be that surprising that more of the younger children will not be able to meet the demands of the environment in which they find themselves and that they will be referred for an ADHD evaluation and meet criteria that are designed to capture this particular dysfunction. It should not be surprising that an evidence-based treatment would be offered to treat the disorder.

Depending on the study you read, some children “grow out” of ADHD, and others maintain clinically significant levels of symptomatology throughout adulthood. We do not say that the former group was misdiagnosed and just immature because eventually their executive functioning “caught up” with the demands of their environments. The question about ADHD is not whether it is real or not real, but what we are going to do about it. We can change the environment, we can teach skills and implement psychosocial interventions, or we can prescribe medications. Only two of those three things can happen in a psychiatrist’s office. If children are going to have demands placed on them that are not individualized and scaled to their abilities, it is inevitable that some will have dysfunction. And what is a psychiatric diagnosis other than an attempt to describe dysfunction?

Poetry

Madeline

By John Pruett, MD

My heart’s entwined with Madeline
Baby angel, eyes of blue
A cherub and an imp combined
Her face lights up with all that’s new

Again, Again she shouts for more,
And throws herself without a care
From my shoulders to the floor
Knowing that my arms are there

Unconsciously she flirts with me
A soft caress, a touch that lingers
Knowing how instinctively
To wrap me round her little fingers

She claims her place curled at my side
Arm and head upon my chest
Relaxed she signs a double sigh
Now all is well and she can rest

Commitment

By Daisy Bassen, MD

He has smashed everything,
Torn the corners from squares,
Broken the world the best he could.
He reached to wrest the moon
Her cheek turned to him,
But he was too late. He’d succeeded
In making poison from cure
And he died and died and died
Until they distilled his blood
Into a simple syrup, its gloss
Obscured in the tubing.

The following week, they want to rescue him.
They are afraid it will be worse.
They hope it will be worse, perhaps
This was not annihilation.

Dr. Pruett is associate professor and director of Child and Adolescent Psychiatry at the University of Mississippi Medical Center. He may be reached at jpruett@umc.edu.

Dr. Bassen is a child and adolescent psychiatrist in Providence, Rhode Island, and is associated with Butler Hospital. She may be reached at dgbassen@gmail.com.
To the Editor of AACAP News

April 13, 2016

I thought the article by Dr. Shrier and Dr. Pope about jobs in the March/April 2016 issue of AACAP News was quite interesting. It did not mention the option of jobs in the Public Health Service, particularly the Indian Health Service (IHS). I spent two years in the IHS in Zuni, New Mexico, after my internal medicine internship, as a Family Doctor, it was a great experience. The IHS also employs child and adult psychiatrists and provides either a short-term or a career experience. I believe that there was a recruiter at the AACAP Annual Meeting in San Antonio last fall. There are also careers in branches of the armed forces.

I think they compare favorably with those in the private sector, especially for clinicians who do not want to be in business management, and they provide special insights and service opportunities.

Kim J. Masters, MD

We always look forward to hearing from members! Letters to the Editor of 250 words or less may be submitted through the National Office to Rob Grant, director of Communication and Member Services at rgant@aacap.org.

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 General 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!
CONSUMER ISSUES COMMITTEE

Child and Adolescent Psychiatry: Can We Provide Comprehensive Care in a Changing Health Care Environment?

Henry Gault, MD, and Jennifer Yen, MD

AACAP's Consumer Issues Committee provides personal insights into the evolution of and the changing role of child and adolescent psychiatry today.

The Classic Career Path

Like most of us, I had several wonderful mentors during my psychiatry training. They were also role models for different career options. I enjoyed my experiences with teaching, consulting to schools and community agencies, doing pediatric liaison, and, especially, seeing patients, i.e., working with individuals, families, and couples. At that time, my therapeutic tools were almost exclusively the talking therapies and behavior modification. I was fortunate to have many consultation experiences including spending a day a week in school consultation as a second year fellow.

Medications played a minor role in child and adolescent psychiatry in the late 1970’s. There were the antipsychotics and stimulants. Antidepressants and anti-anxiety agents were of limited help. Upon completing training, my initial desire was to have a half-time academic position and spend half time in private practice. That was frequently done and seemed ideal. My chair told me he would love to have me join the faculty, but only full time. I took a position at a local university affiliated hospital and started a private practice on the side. I worked on a multidisciplinary team doing diagnostic work, saw patients in ongoing therapy, did pediatric liaison, and lectured and taught pediatric residents. I enjoyed my hospital work, and my private practice quickly grew. Over the next three years the hospital administration pushed me to see more and more patients and do less teaching. I spoke with my chair, who told me he would love for me to teach more, but he would pay me less. After a frank discussion, I decided to leave and go into full-time private practice. At that time, many people could afford private practice fees as insurance frequently would pay up to 50 percent of fees up to 50 sessions per year.

My practice today is what many describe as an “old fashioned” psychiatric practice. One of my pediatrician friends describes me as a “dinosaur.” Currently, I see about 35 patients per week, all for 45 minutes each. About a third are children and adolescents and the rest are adults. Almost 100 percent are ongoing psychotherapy patients who I treat with medications, as indicated. For my child and adolescent patients, I work closely with family members and school personnel as needed, sometimes doing parent management. I will frequently make school visits for which I am reimbursed, through insurance or private pay. I also have a cancellation policy to protect my time from last minute cancellations. I do almost no “medication management,” except for former therapy patients or when psychotherapy was not indicated initially.

The rest of my time I consult to schools, special education programs, and community agencies. I feel it balances what I do by allowing me to work with a socioeconomically disadvantaged population. My private practice is a fee-for-service practice where I submit a statement to my patients who pay me directly and then submit it to their insurance company for whatever reimbursement they provide. I am not on any insurance panels. I realize this model would need to be modified in most areas of the country and could not work in a less affluent area. It does, however, allow me to utilize all the skills I was trained in and follow the path that led me into psychiatry in the first place. (Henry Gault, MD)

The Early Career Path

As with many passionate psychiatry residents completing their training, I had a mental image of what kind of a child and adolescent psychiatrist I would like to be. I felt as though my general and child and adolescent psychiatry residency programs prepared me for all aspects of the job, including preparing the formulation of a biopsychosocial model for treatment, experience with various psychotherapy modalities, and a good foundation on pharmacological treatment.

Unfortunately, it was not long after graduation that I became aware of several issues that changed my understanding of the practice of psychiatric medicine today. First, I had to come to grips with the fact that unlike all the years before, my choice of the type of practice I wanted would have to take into account multiple factors. This included financial considerations, such as buy-in costs and overhead (for private or group practice), loan repayment, paid leave, benefits, automatic administrative support, pay potential, scheduling, and staff requirements for training or supervision (for academics). Second, my duties and

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Can We Provide Comprehensive Care continued from page 129

responsibilities would be to some degree dictated by the managed care systems that my patients are a part of.

These factors played an increasingly prominent part in my decision to transition to a 50/50 private practice and academic position. The private practice offered me the financial growth that I would need as time goes on, along with flexibility in schedule and patient population. The academic position covered much of my professional expenses, such as liability insurance, medical dues, and benefits, as well as offering paid leave. I did my best to balance medication visits with brief psychotherapy, where I could, carried a few weekly or biweekly therapy patients, and reached out regularly to therapists, school teachers, and school counselors. Despite running into some barriers, including patients (or parents) requesting fewer visits to avoid time off from work or school, difficulty collaborating with other providers due to scheduling, and changes in insurance coverage for care and medication, I managed to be fairly successful in my endeavor to provide comprehensive care.

In the recent months, however, I was surprised to find myself heading toward an unexpected outcome. After spending four years working within the current structure of managed care, I made a life-changing decision. I have joined a group of psychiatrists who have transitioned to a fee-for-service practice. Although my choice was difficult and I still struggle with the guilt of leaving some patients behind, it allowed me the chance to improve my ability to provide quality patient care. Despite my initial reservations and worries, so far my patients have responded warmly and positively to the change. My stress level has decreased significantly, and I feel more confident that the care my patients are receiving is the best that I can provide. I am hopeful that as time passes, I will find the personal and professional satisfaction that I seek. (Jennifer Yen, MD)

Future Concerns for Child and Adolescent Psychiatry and Its Practice

Many of us chose to become psychiatrists and ultimately to specialize in child and adolescent psychiatry primarily due to the appeal of being able to treat the whole patient. That would include a thorough evaluation of the genetic, physical, psychological, and environmental factors affecting each patient. With children and adolescents, that includes work with the individual child, family, school, other professionals, or outside agencies.

Unfortunately, the role of child and adolescent psychiatrists today is becoming increasingly narrow, with the result that for many child and adolescent psychiatrists, their involvement is marginalized while psychologists and social workers are the primary providers. Many psychiatrists, especially those recently trained, are focusing more on evaluations and medication management and less on ongoing regular therapy with patients and families. Much of the transition has been dictated by financial concerns and restrictions on psychiatric practice based upon policies of the insurance industry. Individual practitioners have little power against a now well-entrenched system. Many questions arise as to whether or not these changes are in the best interest of patients and the impact it will have on psychiatry as a specialty.

How do we cope with the challenge of providing good psychopharmacological treatment to the many in need without giving up on the advantages of a psychiatrist doing both kinds of treatment? Some specific concerns are:

1. Increased focus on medication to the neglect of other therapies that may be needed alone or in conjunction with medical treatment.
2. Minimization of individual and family dynamics as major factors in a child's problems, and more focus on biological factors with medication as the primary treatment modality.
3. Loss of the learning acquired from long-term interactions with patients and families, and the deficiency of knowledge that could result from only providing brief and problem-focused treatment.
4. Emergence of 15-20 minute patient interviews as the norm due to insurance reimbursement policies and its negative impact on effective patient communication to obtain vital information (such as life changes or psychosocial stressors) before making treatment decisions.
5. The great variability in communication between the psychiatrist prescribing medications and the therapist providing the ongoing therapy.
6. The ever increasing view by patients and families that psychiatrists are solely medication specialists without experience in use of non-pharmacological modalities or understanding of the multiple psychosocial factors that impact mental health.
8. Training future generations of psychiatrists to provide comprehensive assessments, including the family, genetic, physical, psychological, social and environmental factors as well as to provide effective psychotherapy.
9. The possibility that child and adolescent psychiatry may become less relevant because of the narrowness of our roles and a diminution in the breadth of our knowledge.

Child and adolescent psychiatrists are historically experts in development, and are trained in talking therapies, including family therapy and behavior therapy, medications, individual and family psychodynamics, and managing a treatment team. Patients have the advantage of working with a well-trained professional that provided well-rounded care. With the new challenges that are faced by child and adolescent psychiatrists today, it will be important to consider all of these concerns in order to produce solutions that will allow for the continuation of quality patient care.

Jennifer Yen, MD, is on AACAP’s Consumer Issues Committee and can be reached via email at jyenmd@gmail.com.

Henry J. Gault, MD, is an AACAP Distinguished Life Fellow and can be reached via email at henrygault@att.net.
Motherhood, Medicine and Mentoring

Desiree Shapiro, MD

At 4:05 AM on January 11, 2016, my little bundle of joy entered the world. My life changed instantly, and I was surprisingly shocked at the transition. Despite past pediatric rotations, being an aunt, being a current child and adolescent psychiatry fellow, and spending the past few months making preparations and completing the nursery, I felt scared, excited, clueless, and humbled. My family and friends reassured me that I simply had to use my common sense and follow my motherly instinct—all of which was only minimally reassuring when trying to master the car seat, feedings, and inconsolable meltdowns.

My idealistic expectations of how life would be after birth did not exactly equate to the reality of taking care of my newborn home. I imagined I would be well prepared for sleepless nights given the many “on calls” I had conquered; however, I soon realized that taking care of a newborn did not come with the glorious and rejuvenating post call, uninterrupted, deep sleep. I imagined my husband and I would take long walks, cook delicious meals, and watch movies while our bundle of joy slept like an angel. However, after diapering, feeding, soothing, swinging, singing, shushing, and swaddling, there was no thought of walks, meals, or movies.

I imagined I would become an arts and crafts mom (no history of these skills) and create decorative albums of the first days of my sweet girl’s life. I promised to write one memory down each day in a baby book, but the blank entries outnumbered the completed ones. Each day I missed I thought, “I will never forget today, I will catch up later,” but of course the whirlwind of the following days faded those seemingly unforgettable memories away.

Looking back, nothing could have prepared me for the magnificent adventure that becoming a new mother brought. I am not in any way claiming to simplify the experience of parenthood for readers; rather I am humbly sharing my story and what I learned to be helpful to me along the way.

Even after carrying my baby for months, it was not until the moment I held my newborn that I sincerely felt like a mother, guardian, and caretaker. I added a new role to my many other roles including wife, sister, daughter, friend, and child psychiatry trainee. I was now a parent. In this new position, I learned many tasks of basic caretaking and I experienced feelings of all-consuming love and a desire to protect. This gave me an overwhelming sense of appreciation for my parents who had given so much of themselves to love, nurture, and protect me. Thomas Berry Brazelton, MD, said it best: “A grandchild is a miracle, but a renewed relationship with your own children is even a greater one.”

As a parent, I also experienced a wide range of emotions in response to my newborn. When I heard my baby crying, my heart sunk and I would do anything to soothe her. I wondered what was going on in my brain and in my body to generate such a strong response. I had heard babies cry before, but this sensation was different. When I witnessed my little one smiling, I was joyous and ecstatic. In sync, we stared at one another lovingly with sparkling eyes. It was those magical moments that immediately cured me of any sleep deprivation or concerns about the overflowing dishes, my inability to leave the house because of my girl’s intense car seat aversion, and my endless to-do list. I had read about oxytocin, complicated neurohormonal systems, the neurobiology of mothering, reward processing, psychoanalytic theories of early attachment, brain activation sites involved in this attachment, empathy, and emotional bonding, and now all of these articles took on a new meaning as my baby stared back at me. This was real. I had become a mother, but how was I going to continue on at the same pace in medicine? Thankfully, I looked to my mentors for guidance.

10 Tips to surviving parenthood in residency or fellowship:

➤ Embrace every extraordinary moment with your baby. These seconds go by fast!
➤ Be kind to yourself.
➤ It is okay to put family first.
➤ Appreciate the lessons your newborn is teaching you about development, compassionate care, and parenting.
➤ Consult with mentors on navigating and balancing difficulties of being a trainee and a parent.
➤ Reach out to your colleagues for support.
➤ Schedule time with your partner each day to check-in.
➤ Each family has a different story and a different journey. Make decisions best for you and your family.
➤ It will get easier.
➤ Laugh, play, and be present.

OPINIONS

continued on page 132
Mentoring has always been incredibly important and valuable to me, but it was not until I became a mother that I fully appreciated the preciousness of my mentors and supervisors. While at the AACAP Annual Meeting in October 2016, members of all ages generously shared their advice and stories about being a mother or a father. I benefited from the experiences of mentors at my institution and those from various professional organizations across the country. The two most common pieces of information I received included: 1) Time would pass much too fast (This I found to be extremely true as I sadly look at those newborn outfits that no longer fit); and 2) Family is most important. Hearing the emphasis on family life from my professional organization was heartwarming and motivational. I knew I had chosen the right career for myself.

Dorothy Stubbe, MD, offered a statement, profoundly resonating with my experience: “newborns are the most wonderful, joyous, terrifying, and overwhelming creatures alive.” I felt understood! Others had been terrified and overwhelmed as well! This comment was unbelievably therapeutic. Laura Dunn, MD, from Stanford University provided immense support while I struggled with balancing work and family. She told me about raising her own little “koala” (as I am writing these thoughts, my baby is wrapped around me like a little koala leaving my hands free to type) and gave me reassurance and hope.

In addition to my mentors, fellow AACAP trainees who are new parents and soon-to-be parents provided a network of support and encouragement that I appreciate greatly. Knowing that others in the field welcomed my questions and understood my situation was priceless for my survival in those first few weeks. I heard the powerful stories of those who had done this before me. I listened to the challenges and the beauty of being a mother in medicine, and how attitudes and expectations had evolved over time. I learned from mothers who had stopped working, worked part time, and worked full time—each making her decision fit for her family. These stories inspired me, notwithstanding my own doubt and uncertainty. It can be easy to compartmentalize mentoring as solely clinical in nature: patient management, psychopharmacology, and psychotherapy; however, mentoring may be the most beneficial when you are struggling with a personal transition such as parenthood. Navigating this journey in motherhood and medicine, I will continue to look to wise mentors who have survived and thrived as parents and psychiatrists. I encourage others to reach out and seek insight and knowledge from their mentors as well!

Dr. Shapiro is the executive chief fellow for the University of California, San Diego, Child and Adolescent Psychiatry Fellowship Program. She serves on the AACAP Adolescent Committee. She may be reached at dlshapiro@ucsd.edu.

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Stay involved. Stay connected to all Life Members activities, programs, and photos by reading the Life Members Owl eNewsletter.

2016 Owl Pin. Remember, if you donate $450 or more to the Life Members Fund by October 31, 2016, you will receive a limited edition 63rd Anniversary OWL PIN!
AACAP: Your One Stop for MOC Resources

www.aacap.org/moc

Lifelong Learning Modules
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AACAP members can download these tools at www.aacap.org/pip.

Questions? Contact Elizabeth Hughes, Assistant Director of Education and Recertification, at ehughes@aacap.org, or Quentin Bernhard III, CME Manager, at qbernhard@aacap.org.

Live Meetings (www.aacap.org/cme)
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One article per month is selected to offer 1 CME credit. Simply read the article, complete the short post-test and evaluation, and earn your CME credit. Up to 12 CME credits are available at any given time.
Visit www.jaacap.com/cme/home for more information.
AACAP’s 63rd Annual Meeting is just five months away, and we’re excited! Whether you’re 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/2016.

Attendee To-Do List

- **June 15** – Review the Annual Meeting programs online
- **June 15** – Make your hotel reservation
- **August 1** – Members Only Registration opens for the Annual Meeting
- **August 8** – Registration opens to nonmembers
- **September 15** – Early Bird Registration Deadline
- **October 3** – Last day AACAP room rate guaranteed at hotels
- **October 24** – First day of AACAP’s 63rd Annual Meeting
- **October 29** – Last day of AACAP’s 63rd Annual Meeting
- **November 4** – Look for the General Evaluation Survey in your email inbox. CME certificate available upon completion of survey.
Hotels

New York Hilton Midtown
1335 Avenue of the Americas
New York, NY 10019
Phone: 212.586.7000
Rate: $375 single/double per night
Check-in is at 3:00 pm and check-out is at 12:00 pm.

Sheraton New York Times Square
811 7th Avenue 53rd St.
New York, NY 10019
Phone: 212.581.1000
www.sheratonnewyork.com (for detailed hotel information)
www.aacap.org/AnnualMeeting/2016/hotel (to reserve your hotel room)
Rate: $375 single/double per night.
Early Bird Rate (limited quantities): $345 single/double per night, but must be pre-paid in full with a non-refundable deposit. Check-in is at 3:00 pm and check-out is at 12:00 pm.

When making your reservation, ask for the AACAP ANNUAL MEETING GROUP RATE to qualify for the reduced rate.

Both the New York Hilton Midtown and the Sheraton New York Times Square will host scientific sessions for AACAP’s Annual Meeting. Located directly across the street from each other, both hotels sit in heart of non-stop excitement in midtown Manhattan. After attending AACAP’s stellar educational offerings, you will be steps from Times Square, Broadway, Radio City Music Hall, Central Park, the Museum of Modern Art, and hundreds of restaurants with cuisines ranging from Austrian to West African and everything in between!

Travel

Plane
New York City is served by three airports, the John F. Kennedy International Airport (JFK), LaGuardia Airport (LGA), and Newark Liberty International Airport (EWR). For more information about the airlines serving these airports, flight schedules, and ground transportation options, visit www.panynj.gov.

Train
New York City is served by two main rail stations: Grand Central Terminal and Penn Station. Both are served by numerous bus and subway lines, including Metro-North Commuter Railroad, Long Island Railroad (LIRR), Amtrak, New Jersey Transit, and PATH (Port Authority Trans Hudson).

Don’t miss this opportunity to save money!

AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount on their 63rd Annual Meeting registration. All referrals must be first time AACAP exhibitors and must purchase a booth for AACAP’s 63rd Annual Meeting.

Exhibitors can connect with more than 5,000 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/2016.

Questions? Contact Exhibits@aacap.org or 202.966.9574

Show your support for AACAP and save today!
What to Do in New York!

Central Park is a visual masterpiece created by landscape designer Frederick Law Olmsted and architect Calvert Vaux. It has gone through major developments and restoration over time to carry on its initial purpose as an open-air oasis for a metropolitan city. No matter the season or reason for your visit, this national historic landmark is a setting for enjoying many pursuits. For more information, visit www.centralpark.com.

Forever at the forefront, the Museum of Modern Art (MoMA) is not only devoted to presenting the best in contemporary art, but also to promoting the understanding of modern art and expanding the definition of what is considered “art” in the first place. Whether it is showing you something you have never seen before, or showing you how to see something familiar in a new way, the MoMA is always an eye- and mind-opening experience. For more information, visit www.moma.org.

New York City has an abundance of concert halls, but none is quite so storied as Carnegie Hall. Musicians of all walks and genres have entertained crowds in the venerable space; indeed, playing the venue looms as something of an unspoken benchmark in many artists’ careers. The Italian Renaissance-style building—with a brick-and-terra-cotta facade and, in its main auditorium, plush red seats, impeccable acoustics and open design (there’s no curtain, for a start)—has also hosted politicians, authors, comedians, and religious leaders for more than a century. For more information, visit www.carnegiehall.org.

There’s no better place to experience the excitement of New York than Times Square. Surrounded by neon lights, giant billboards, Broadway theaters, electronic ticker tape, and television studios. Times Square is truly the heart of Midtown. The TKTS Discount Booth (where theater tickets are sold at up to 50% off face value) is topped with a giant red staircase, open to visitors daily until 1:00 am. Walk to the top of the steps and you will be rewarded with a sweeping view of the area, including the site of the annual New Year’s Eve Ball Drop. Elsewhere in Times Square, the City has created several new pedestrian-only zones furnished with tables and chairs, perfect for people-watching. The neighborhood is central to Midtown West, located near the Theatre District and Broadway shows. For more information, visit www.timessquarenyc.org.

For more information about other New York City attractions, please visit: www.nycgo.com.
Why I ♥ NY!

Scott M. Palyo, MD: I ♥ NY because New York is a fantastic city, and its diversity makes it appealing to everyone. Whatever your interests – food, parks, theatre, music, art, shopping, people watching – New York has it all. Our subway system (as well as the easy access to cabs and Uber drivers) makes our meeting site easy to go wherever you want to go. Besides the newer sites such as One World Trade Center, New Museum, and the Highline, there is also much to see in the other boroughs. Feel free to explore; there is always something to see wherever you end up.

Melvin D. Oatis, MD: I ♥ NY for the opportunity of adventure just by walking down the street. Sans your distracting devices, you will be afforded the possibility of taking in culture by listening to the multitude of languages, the rhythm and fashion of Gotham by watching the residents walk the runway of our pedestrian friendly city streets and the aesthetic beauty of the historical buildings surrounding you. Times Square, Central Park, the fashion district, several museums, Columbus Circle, Rockefeller Center, and Radio Center Music hall are all within walking distance of AACAP’s Annual Meeting.

New Research Call For Papers

AACAP’s 63rd Annual Meeting takes place October 24-29, 2016, in New York, NY. 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 16, 2016, and are no longer accepted. Abstract proposals for (late) New Research Posters must be received by Wednesday, June 15, 2016. All Call for Papers applications must be submitted online. The online Call for Papers submission form is available at www.aacap.org/AnnualMeeting/2016 in mid-April 2016. Questions? Contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
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For more information about the Monitor Program, visit www.aacap.org/AnnualMeeting/2016/Monitors.
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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.

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Errata: In the March/April 2016 issue of AACAP News, the Media Page review of the movie “Inside Out” and Dr. Mina Dulcan’s book “Dulcan’s Textbook of Child and Adolescent Psychiatry: Second Edition” were incorrectly credited to Erek Lorras, MD. It was in fact the last Media Page written by Harmony Abejuela, MD, as outgoing resident editor.

We would like to amend the attribution of the March/April cover from Alvin Rosenfeld, MD, to Kathryn Massie. The photo features the granddaughter of Henry Massie, MD, (on left) and her friend (on right). Thank you Dr. Massie for contributing the great picture and following up on the correct acknowledgement.
FOR YOUR INFORMATION

100% CLUB Photos

We’re incredibly proud of our 100% Club members!

All of your efforts and enthusiasm in your involvement with AACAP are much appreciated, and we want to give you the recognition you deserve. Plus, it’s always great for our community to see our future leaders.

If your program is in the 100% Club, thinks it is, or wants to be, please contact memberservices@aacap.org.

A big thank you to the 100% Clubs pictured here for sharing your photos!

Institute of Living-Hartford Hospital
University of Tennessee
Yale Child Study Center
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FOR YOUR INFORMATION

Ponce Health Sciences University

Palmetto Health-USC SoM Child Psychiatry

Ann & Robert H. Lurie Hospital of Chicago-McGaw Medical Center of Northwestern University

Tripler
Welcome New AACAP Members

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Joseph Aloj, Omaha, NE
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Thank You for Supporting AACAP!

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

Gifts Received February 1, 2016 to March 31, 2016

$100,000 – $249,999
James C. Harris, MD Developmental Neuropsychiatry Forum
James C. Harris, MD and Catherine DeAngelis, MD, MPH

$1,000 – $2,499
Break the Cycle
The Empathy Fund, in honor of Andres Martin

$500 – $999
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Nancy Collins, MD

$100 to $499

For Your Information

MAY/JUNE 2016 143
AACAP Policy Statement

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY
WWW.AACAP.ORG

Transgender Youth in Juvenile Justice and Other Correctional Systems

Approved by Council on March 16, 2016

Research demonstrates that transgender youth are at increased risk for being bullied, harassed and physically assaulted. They also have a higher incidence of suicide attempts. For these reasons, transgender youth face particular challenges in juvenile justice and other correctional systems.

The American Academy of Child and Adolescent Psychiatry opposes all discrimination based on gender identity. Consistent with this position, AACAP recommends that detention and corrections staff classify and house all youth consistent with their gender identity, as the youth defines it. Based on individualized risk assessments, facilities should take the necessary precautions to ensure the safety of every youth in their custody, including transgender youth.

AACAP further recommends that transgender youth should be referred to by their preferred pronoun and name. AACAP also believes that transgender youth must have access to all educational and recreational programs and services available to the general youth population. Absent serious short term safety concerns, it is inappropriate, discriminatory and dangerous for transgender youth to be segregated, isolated or placed in solitary confinement due to resource limitations or the absence of an appropriate setting. Finally, AACAP believes that transgender youth in correctional systems are entitled to access to comprehensive psychiatric and other medical care consistent with prevailing national standards and guidelines.


World Professional Association for Transgender Health (WPATH) (2012). Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People (Version 7).


For more information or to review AACAP’s Policy Statements visit www.aacap.org.
POLICY STATEMENTS

AACAP Policy Statement Requirements

Policies should:
1) be a statement regarding an important policy issue,
2) be a well-written statement, as brief as possible,
3) identify the target audience,
4) have the potential of having some specific impact, and
5) include ideas for distribution.

Platitudinous statements supporting “Apple Pie and Motherhood” or condemning the multitude of actions, behaviors, social events, or cultural patterns which may have some negative effect on children and families are not likely to serve the AACAP well and may, ultimately, undermine the credibility of AACAP efforts in other areas.

The final draft policy statement should be submitted by the author(s) or body (e.g., component or Assembly) to the Policy Statement Advisory Committee via the National Office. In formulating the policy statement, the authors should keep in mind the criteria as stated above. Statement must include ideas for distribution. If the author(s) wishes to have the statement reviewed by the next Executive Committee or Council, they must have the draft statement to the National Office eight weeks in advance.

Policy Statement Procedures

» Once a final draft policy statement is submitted by an individual author(s) or body (e.g., component or Assembly) to the Policy Statement Advisory Group (PSAG) via the National Office, the Policy Statement Advisory Group Chair directs that:
  • the author(s) is told what major revisions or minor edits are necessary. After the author(s) has revised the statement, they may resubmit to the PSAG;

  OR

  • The author(s) is informed that the statement does not meet the criteria for a policy statement.

» If the PSAG recommends it, the Executive Committee reviews the statement to decide whether it should be eailed to Council or placed on Council’s meeting agenda. If the Executive Committee decides not to advance the statement, the author(s) may be contacted to resolve the issue(s).

» If emailed, Council members have a two-week discussion period in which to convey concerns and ask questions. After this period, a one-week voting period begins.

» If Council approves the statement, the author(s) is notified. The statement is printed in AACAP News and distributed to the recommended sources then placed on the AACAP website.

» If Council does not approve the statement, the author(s) may be requested to rewrite and resubmit to the PSAG with an explanation of what changed.

» Every two years, the PSAG reviews all policy statements for necessary revisions or updates. Revisions are made by the original author(s), if available, or by known specialists in that area of expertise. The revising author(s) is given a 3-month period to make changes and resubmit to the PSAG for final approval.

» Annually, committee chairs are asked to review policy statements online and update if necessary.

*revised 10/2012
Make a **Donation. Make **Hope. Make an **Impact.

Child mental illness is a complex issue that needs urgent attention, long-term vision, and new financial resources. When you become an American Academy of Child & Adolescent Psychiatry **Hope Maker with a monthly donation, you are helping us to tackle this issue head on.

**Please consider a Monthly Hope Maker Gift**

- You will be investing in the next generation of child psychiatrists, who will lead in innovative research, training, and treatment.

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It's easy to sign up; just visit [www.aacap.org/donate](http://www.aacap.org/donate) or give us a call at 202-966-7300 ext. 140.
CLASSIFIEDS

CALIFORNIA

FULL-TIME AND PART-TIME CHILD AND ADOLESCENT PSYCHIATRIST
Malibu, CA

Paradigm Malibu is currently seeking a part- and full-time Board Certified Child and Adolescent Psychiatrist to join our compassionate and expert clinical staff at Paradigm Malibu. We offer a warm and inviting team atmosphere, a highly competitive salary and excellent benefits package. Please submit questions or your curriculum vitae/resume and we provide a timely response.

Job Requirements:
- Board certified child and adolescent psychiatrist
- Ability to see client in Malibu, California

ILLINOIS

INPATIENT (WITH OPTIONAL OUTPATIENT) CHILD AND ADOLESCENT PSYCHIATRIST
Suburban Chicago

Advocate Childrens Medical Group at Advocate Childrens Hospital in Park Ridge, Illinois seeks a full time flexible BE/BC Child and Adolescent Psychiatrist with excellent interpersonal skills and a passion for improving the lives of children. Come join an outstanding multidisciplinary team to provide care for and an opportunity to lead one of the few and truly unique child and adolescent inpatient psychiatry units in the Chicagoland area!

This would be primarily an inpatient role providing services to patients in the 12-bed C/A inpatient psychiatric unit, partial hospitalization program, and patients on the general medical floors through consultative work. (Outpatient work would be optional.) Assist in being part of an extraordinary and nationally renowned hospital network focused on development of its child behavioral health services. There are opportunities for growth and leadership and additional responsibilities may include hospital staff education, community education and partnerships, and assisting in the supervision and teaching of a wonderful group of dedicated psychiatry and pediatric residents.

A devoted team of clinicians, support and administrative staff are there to assist in any way to ensure a comfortable, respected and balanced work/life environment. On Call Schedule: ER phone call 5-6 days with 1 weekend per month. No in-house call, coverage by phone. Patient population is a wonderful payor-mix blend. 1-2 average patient admissions per call.

Please forward CV and detailed cover Letter to: Nancy Mathieu. Mathieu@advocatehealth.com


CHILD AND ADOLESCENT PSYCHIATRIST
Chicago, IL

Northwestern Medicine Central Dupage Hospital and Northwestern Medicine Delnor Hospital is seeking a BE/BC Child and Adolescent Psychiatrist. This position would be based primarily at Central Dupage Hospital, outpatient clinic and potentially a mix of inpatient consults and partial hospitalization program. This is an outstanding opportunity for a new or experienced psychiatrist to build your career with the premier health provider in the western suburbs of Chicago.

- Employed position with Northwestern Medicine Regional Medical Group.
- Full-time Opportunity.
- Competitive compensation and outstanding benefits.
- EPIC electronic health system.
- Outstanding 24/7 nursing support staff.
- Great Location – Western Suburbs of Chicago, easy access by Metra/expressway.

Job Requirements:
- BE/BC in Child and Adolescent Psychiatry
- Illinois licensure in good standing

LOUISIANA

CHILD AND ADOLESCENT PSYCHIATRIST
New Orleans, LA

OCHSNER HEALTH SYSTEM is seeking a BC/BE CHILD AND ADOLESCENT PSYCHIATRIST to practice at OCHSNER MEDICAL CENTER in NEW ORLEANS. Our Child and Adolescent Psychiatry Section offer outpatient consultation, evaluation, testing and treatment for children and adolescents with problems related to behavior, feelings, emotions, thinking and learning. The approach involves teams of social workers, psychologists and psychiatrists, in close collaboration with educational specialists, primary care pediatricians and pediatric specialists. Opportunities exist for teaching through our combined Ochsner-LSU psychiatry residency program. Salary offered will be competitive and commensurate with experience and training.

Ochsner Health System is Louisiana’s largest non-profit, academic, healthcare system. Driven by a mission to Serve, Heal, Lead, Educate and Innovate, coordinated clinical and hospital patient care is provided across the region by Ochsner’s 28 owned, managed and affiliated hospitals and more than 60 health centers. Ochsner is the only Louisiana hospital recognized by U.S. News & World Report as a “Best Hospital” across six specialty categories caring for patients from all 50 states and more than 99 countries worldwide each year. Our medical school, the Ochsner Clinical School, in partnership with the University of Queensland in Australia, enrolls 130 medical students each year. We also have the largest graduate medical educational (GME) program in the state. Ochsner employs more than 1,000 physicians in over 90 medical specialties and subspecialties and conducts more than 900 clinical research studies. For more information, please visit www.ochsner.org. New Orleans is one of the most exciting and vibrant cities in America. Amenities include multiple universities, academic centers, professional sports teams, world-class dining, cultural interests, renowned live entertainment and music.
Please e-mail CV to profrecruiting@ochsner.org or call 800-488-2240 for more information. Reference # CAPSYC-5.

Sorry, no opportunities for J1 applications.

Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law.

NEW JERSEY

ACADEMIC CHILD AND ADOLESCENT PSYCHIATRIST – ASSISTANT/ASSOCIATE PROFESSOR
New Brunswick, NJ

Rutgers Robert Wood Johnson Medical School Cancer Institute of New Jersey The Division of Child and Adolescent Psychiatry at Rutgers Robert Wood Johnson Medical School (RWJMS) has an opening for a full time CA Psychiatrist to work both with patients with cancer at Cancer Institute of New Jersey (CINJ), and with outpatients in one of our general child and adolescent clinics at University Behavioral Health Care (UBHC). The position is at the Assistant/Associate Professor level and includes protected teaching time. Responsibilities include direct patient care as well as teaching medical students and residents from multiple services and CAP Fellows. Teaching is an integral part of the service and time is protected for formal didactic teaching. Research is encouraged and the successful candidates will be expected to develop an area of scholarly focus. Fellowship training in child and adolescent psychiatry is required. The Division of Child and Adolescent Psychiatry is based at Robert Wood Johnson Medical School in the Department of Psychiatry which offers a range of training programs, including a fellowship in CAP, as well as clinical services and multiple research opportunities. The Rutgers Robert Wood Johnson Medical School (RWJMS) is a vibrant medical school located on the campus of Rutgers University in New Brunswick, New Jersey – midway between New York City and Philadelphia. This is a great opportunity for someone interested in psychosomatic medicine and an academic career. Please email your CV and cover letter to: Wun Jung Kim, MD, MPH wunjung.kim@rutgers.edu

Job Requirements: Fellowship training in child and adolescent psychiatry is required.

OHIO

CHILD AND ADOLESCENT PSYCHIATRIST
Akron, OH

Ohio based Akron Children’s Hospital seeks a Weekend Child and Adolescent Psychiatrist to join its mental health team. Akron Children’s Hospital is the largest pediatric healthcare system in Northeast Ohio and was recently named by Modern Healthcare as the fastest growing children’s hospital in the nation! Akron Children’s Hospital is nationally ranked by US News and World Report in seven pediatric specialties and is an integrated healthcare delivery system that includes: Two free-standing pediatric hospitals 700 providers, who manage over 850,000 patient visits annually A network of 80 primary and specialty care locations Robust research and innovation endeavors Over 5,000 employees, nurses and healthcare professionals The successful candidate will join a well-established team of 10 Child and Adolescent Psychiatrists and 5 Advanced Practice Nurses, who provide comprehensive mental health services. Inpatient care is provided in a 14 bed inpatient which will be expanded to a 24 bed unit by the end of 2016. Outpatients are treated in the 20 bed partial hospitalization unit and through intense outpatient service programs. In addition, the Psychiatric Intake Response Center, co-located in the Emergency Department at Akron Children’s Hospital provides access to behavioral health services 24 hours a day, 7 days per week. This position offers opportunities for: Weekend only responsibilities affording exceptional work-life balance Partnership with an established team of child and adolescent psychiatrists Active involvement in medical student, resident and fellowship education; academic appointment at Northeast Ohio Medical University is available and commensurate with experience Research and innovation available through the Rebecca D. Considine Research Institute and partnerships with NEOMED and local university-based scientists with a variety of interests and expertise in clinical and translational research A predictable and stable compensation plan as well as bonus compensation A comprehensive benefit package Akron Children’s Hospital is set in the beautiful Cuyahoga Valley, just minutes south of Cleveland. From major league attractions to small-town appeal, the greater Akron area has something for everyone. The area is rich in history and cultural diversity, and provides a stimulating blend of outstanding educational, cultural and recreational resources. This four-season community will have outdoor enthusiasts thrilled with over 40,000 acres of Metro Parks for year round enjoyment. Northeast Ohio has become a premiere destination to work, live, play, shop and dine! Interested candidates may submit their CV to Jane Hensley, via e-mail to jhensley@chmca.org. To learn more, visit our website at www.akronchildrens.org or call 330-543-3015.

Job Requirements: Requirements include MD or DO degree, board eligibility/certification in Child and Adolescent Psychiatry and the ability to obtain an active medical license in the state of Ohio.

DIRECTOR OF CHILD AND ADOLESCENT PSYCHIATRY
Dayton, OH

The Psychiatry Department at WRIGHT STATE’S Boonshoft School of Medicine is seeking a proven academic and research leader to become the Director of Child and Adolescent Psychiatry (CAP). The CAP Director is one of the key faculty members involved in growing and maintaining the academic, research and clinical presence of the entire department by delivering effective administration, leadership and mentorship. All faculty members enjoy the opportunity for clinical contract and private practice through the auspices of WRIGHT STATE PHYSICIANS. Candidates should be board eligible or certified in Psychiatry.

Job Requirements:
• MD or DO degree
• Board Certification (ABPN)
• Ohio Medical License or eligible.
• 2-5+ years combined academic, research and/or medical administration experience.

Assistant Professor level candidates must fulfill all the requirements listed above. Associate Professor level candidates must fulfill all the requirements of
• Proven knowledge of grant writing, preferred qualifications:
  • Proven leadership and ability to function in a professional, collaborative manner with community stakeholders, faculty peers, medical students and psychiatry residents and fellows. Excellent human relations skills, independent judgment, initiative, planning capability and ability to serve as a model for excellent research and clinical care. Track record of research and other scholarly activities. Knowledge of relevant clinical skills applicable to research or practice settings.

Essential Functions and Percentage of Time

Division Direction – Direct, strategize and organize the activities of the division. Formulate current and long-term program plans with related policies. Participate in departmental strategic planning. Prepare and present information in facilitating these interactions for decision making. Direct the revision of rules, regulations, and procedures to meet changes in law, policy or accreditation. Participate in the hiring of relevant faculty and staff. Maintain records, prepares reports and composes correspondence relative to the division and its activities. Direct the overall program of clinical activities. Mentor division members. Supervise and participates in residency recruitment efforts.

Research & Scholarly – Investigate and facilitate funding opportunities for the program and/or related research. Expected to publish regularly on program and project related topics.

Teaching – Teach and supervise fellows, psychiatry residents and medical students. Collaboration with the training directors is essential.

Administer current division relationships, support, grants and funding.

CMHC, clinical contracts and office hours – Patient care. (or more time attributed to grants, scholarly and teaching)

Serve as liaison between the Chair, WSU Boonshoft School of Medicine and other community and state agencies.

Pennsylvania

Child and Adolescent Psychiatrist

York, PA

Child and Adolescent Psychiatrist Take Advantage of Our Educational Loan Repayment Plan! WellSpan Health, a progressive medical community in York, PA, is seeking a successful candidate who will provide Child and Adolescent outpatient behavior health care. This is an opportunity to join a large Behavioral Health department with strong support from leadership. WellSpan Health is a top-rated, integrated health system with a focus on a high-quality patient care. About the Practice Join a team of 6 fellowship-trained child and adolescent psychiatrists Excellent daily schedule with no weekend appointments Typically manage 15 patients per shift Call is limited Must have PA medical license and be a BC/BE Psychiatrist Must be a graduate of accredited school of medicine with Doctor of Medicine degree plus completion of residency training program in Psychiatry Be a member of our large Behavioral Health Department with over 20 Psychiatrists and 60 licensed therapists Benefits Competitive salary, sign on bonus and educational loan repayment Health, life and disability insurance Retirement savings plan with employer automatic contribution and employer match Medical malpractice insurance and tail coverage Continuing Medical Education time off and stipend Relocation Physician-led medical group Lifestyle Conveniently located 45 minutes north of Baltimore and 90 minutes west of Philadelphia Abundant outdoor and cultural activities including restaurants, theatre, golf courses, hiking, water sports, farmers markets and downtown access to a 42-mile recreation trail Family oriented community, with excellent schools, low cost of living and low crime rates.

Qatar

Division Chief – Child and Adolescent Psychiatry

Sidra, Qatar

Reporting to the Chair of Psychiatry, the Division Chief provides clinical, education, research and executive management leadership in Child and Adolescent Psychiatry. The Division Chief is a clinical and managerial leader working with the Sidra executive team to develop and deliver strategy and business plans and is accountable for resources and performance in Child and Adolescent Psychiatry and integrates research and education priorities into a program of excellent clinical service delivery. It is anticipated that the Division Chief will be able to continue with personal clinical, educational and research activities albeit in a reduced and modified manner, and will have a full-time appointment with Weill Cornell Medical College – Qatar and hold the position of Vice Chair in the Department of Psychiatry at Sidra.

Key Role Accountabilities:

• Identifies and articulates the vision, strategic direction, and growth of the Division of Child and Adolescent Psychiatry and collaborates on the implementation of strategies to achieve them.

• Leads clinical service planning, service development and capacity planning for the clinical activities of Child and Adolescent Psychiatry services.

• Promotes leadership and direction for the development of strategies to promote the recruitment, retention, and direct mission of excellence for the medical staff, and collaborates with the Division Chiefs to execute the strategies.

• Recommends clinical privileges, appointment, reappointment and corrective action for each member of the Division of Child and Adolescent Psychiatry as well as promoting
mentorship and academic career development for these staff members.

- Responsible for all administrative related activities of the Child and Adolescent Psychiatry Division unless otherwise provided for by the hospital, and serves on all requested committees including medical executive committee, and appointing such committees as necessary to conduct the function of the department.
- Develops and implements policies and procedures that guide support provision of services to the Child and Adolescent Psychiatry Clinic services.
- Continues surveillance of the professional performance of all individuals in the Child and Adolescent Psychiatry Division who have delineated clinical privileges, including performance, and ongoing and focused professional practice evaluations (OPPE and FPPE).
- Continues surveillance of patient care and the professional performance of all individuals in the Child and Adolescent Psychiatry Division who have defined clinical privileges.
- Ensures that the staff of the Child and Adolescent Psychiatry Division provides services that are in compliance with all applicable standards and requirements of the Joint Commission International, Qatar Supreme Council of Health, and all other applicable regulatory bodies.
- Accountable for the financial performance and management of all budgets within the Child and Adolescent Psychiatry Division.
- Implements the clinical service strategies and business plan for the Child and Adolescent Psychiatry Division.
- Makes recommendations for the purchase of capital and other equipment and participates in the evaluation of products for use by different members of the Child and Adolescent Psychiatry Division to ensure their safety and efficacy.
- Sets and achieves targets to drive continuous assessment and improvement of the quality of care and services provided and initiates actions for necessary improvements according to Sidra Board initiatives.
- Works with the Service Chief to establish and update the work week standards for all physicians on staff and assures that there is appropriate clinical coverage for all patients requiring medical care from the Child and Adolescent Psychiatry Division (including emergency care).
- Ensures all members of the Child and Adolescent Psychiatry Division optimize the use of electronic medical records.
- Sets and achieves targets for programs and procedures for confidentiality of all patient information in accordance with hospital policy and the privacy laws of the State of Qatar.
- In conjunction with the Service Chief, ensures the implementation of robust clinical governance structures and processes to ensure patient safety.
- In conjunction with the Chief Research officer and division heads of research, ensures a program of clinical and translational research is developed and promoted and delivered within the Child and Adolescent Psychiatry Division.
- In conjunction with the Dean of Weill Cornell Medical College – Qatar ensures there is an active and continuous program of undergraduate teaching within the Child and Adolescent Psychiatry Division to ensure an effective learning environment for students, residents, and medical staff.
- Is actively involved in research, graduate teaching, and publication in higher impact journals, advising of students and participation in academic services.
- Ensures effective communication with and involvement of all staff within the Child and Adolescent Psychiatry Division in regards to key decisions and initiatives.
- Works collaboratively with other service chiefs, chief officers, and executive directors to achieve broad Sidra objectives.
- Conducts other duties as may be directed by the Clinical Service Chief of Psychiatry, Chief Medical Officer and / or Chief Executive Officer.
- Initiates, implements and oversees programs designed to foster positive relations between Child and Adolescent Psychiatry physicians and other Child and Adolescent Psychiatry Division staff, and the hospital operations and administration.
- Assists with marketing strategies to inform physicians and their staff of Sidra’s clinical diagnostic and treatment procedures, services and resources.
- Promotes and evaluates physician community outreach programs as appropriate.
- Develops, manages and supports physician and community relationships, coordinating and disseminating information to all stakeholders to solicit ongoing support from the State of Qatar for Child and Adolescent Psychiatry.
- Promotes outreach and communications with non-Sidra to providers of Child and Adolescent Psychiatry care to help Sidra function as the premier regional Child and Adolescent Psychiatry Center of the Gulf Region.
- Identifies and coordinates resolution of problems to improve physician utilization and patient satisfaction.
- Develops and maintains appropriate systems of communication between Sidra and other providers of primary and advanced Child and Adolescent Psychiatry services in Qatar for the purpose of individual patient care and systemic safety and quality improvement.
- Supports the development of Sidra as a world class regional center.
- Adheres to Sidra’s standards as they appear in the Code of Conduct and Conflict of Interest policies.

Scope of clinical responsibilities for Division Child and Adolescent Psychiatry:

- Screening consultations for diagnostic and therapeutic procedures as indicated.
- Coordination of care for complicated Child and Adolescent Psychiatry cases.
- Coordinates appropriate referrals and transfers under standard and emergency situations.

Sites of practice:

- Outpatient clinic building at Sidra and Sidra hospital building.
- Telemedicine consultation when developed and appropriate.
- Procedure rooms in the clinic suites (and in hospital when needed and appropriate)
- Site visits to referring and affiliated hospitals and clinics when requested and appropriate.
FOR YOUR INFORMATION

SELECTION CRITERIA:

Education:
- MD degree (or equivalent)
- Residency Training in Psychiatry (or equivalent)
- Subspecialty Fellowship in Child and Adolescent Psychiatry (or equivalent training or certification)

Experience:
- 10+ years post-residency clinical experience in the relevant field from a North American Academic/Health care Institution or equivalent in UK, Republic of Ireland, Australia or New Zealand.
- 5+ Plus years in academic leadership in child and adolescent psychiatry
- Expertise in Child and Adolescent Psychiatry
- Presentations at National / International level (Preferred)
- Peer Reviewed publications (Preferred)

Certification and Licensure:
- Active license to practice medicine in home country (or equivalent certifications)

Professional Membership:
- American Academy of Child And Adolescent Psychiatry or Similar

TEXAS

ACADEMIC CHILD AND ADOLESCENT PSYCHIATRIST
Lubbock, TX

Texas made the 2015 list on the best states for physicians. Why? No state income tax. Fewer malpractice lawsuits. Excellent medical community. The Texas Tech University Health Sciences Center School of Medicine is seeking a BE/BC psychiatrist to join busy academic practice. We are open to all levels of experience including 2016/2017 fellows. Clinical opportunities abound throughout the community including: Outpatient Service – TTUHSC Psychiatry Clinic Consultation/Liaison Service University Medical Center [https://www.umchealthsystem.com/], Covenant Medical Center – Lakeside [http://www.covenanthealth.org/view/default] Child-Adolescent Psychiatry Service TTUHSC Psychiatry Clinic Lubbock Independent School District Community Psychiatry Student Wellness Center at Texas Tech University The Department of Psychiatry’s residency program is fully accredited by the Accreditation Council for Graduate Medical Education. It is a four year program and currently has 15 residents. Emphasis is on general psychiatry supported by departmental and community resources in specialized care areas. Residents participate in a progression of experiences which blend inpatient and outpatient care responsibilities with a series of didactic seminars. Research activities are encouraged through opportunities in ongoing clinical and basic science studies. Junior and senior medical students rotate through the department and resident have an opportunity to participate in their education. The Texas Tech University Health Sciences Center has been a leader in education and patient care in the West Texas area for over 40 years. Since 1969, the organization has grown into a seven-school university. Lubbock is a family friendly community offering a mild climate, low cost of living, and high-quality public and private schools. Lubbock and the surrounding communities comprise a population of over a quarter of a million year round residents plus patients from New Mexico. With multiple universities and professional schools, there are diverse entertainment and leisure opportunities to accommodate any tastes. Qualified candidate will enjoy a very competitive compensation package including production incentives after first year, sign on bonus, minimal call, relocation expenses up to $10K, CME/Professional Development, exceptional benefits package, i.e. vacation and sick leave, retirement, malpractice insurance.

Interested applicants should apply online through Texas Tech Jobs [http://jobs.ttuhsc.edu/child-adolescent-psychiatry-dept-lbk-genl/job/5542046] or contact sarah.harris@ttuhsc.edu for questions!

Job Requirements:
MD/DO BE/BC Fellowship Trained

VIRGINIA

CHILD AND ADOLESCENT PSYCHIATRIST – PART TIME
Staunton, VA

The Commonwealth Center for Children and Adolescents (CCCA) invites you to consider a child and adolescent psychiatry position in the beautiful Shenandoah Valley. CCCA is Virginia’s only public acute psychiatric hospital for children and adolescents. CCCA serves youngsters with a variety of serious psychiatric and behavioral difficulties from across the Commonwealth. Treatment is provided in a relationship-based, collaborative, trauma-informed treatment model of care. The mission of CCCA is to provide high quality acute psychiatric evaluation, crisis stabilization, and intensive short-term treatment that empowers children and their families to make developmentally appropriate choices and that strengthens children’s hope, resilience and self esteem.

As psychiatrist, you will be responsible for providing high quality psychiatric evaluations and treatment services to assigned child and adolescent clients and their families. You will function as a member of a collaborative, multi-disciplinary team providing diagnostic evaluations, medication management, and individual therapy for children and adolescents with significant psychiatric, emotional, behavioral, and environmental challenges.

For further requirements and to apply, please visit the Virginia Jobs at [https://virginiajobs.peopleadmin.com].
MAY IS MENTAL HEALTH AWARENESS MONTH