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– Approved by AACAP Membership December 2014

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The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy

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■ Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.
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Kicking Off Children’s Mental Health Week and Mental Health Awareness Month!

In early May, as a rock-solid kickoff to Children’s Mental Health Week – and Mental Health Awareness Month – I joined Rep. Grace Napolitano (D-CA), Rep. John Katko (R-NY), and others for a briefing on Capitol Hill titled The Benefits of Collaborative Care for Children’s Mental Health. The panel was sponsored by Congresswoman Grace Napolitano (D-CA) and Congressman John Kato (R-NY).

In addition to the panel featured Dr. Lee Beers, the head of the Washington DC Collaborative for Mental Health in Pediatric Primary Care, and Phoebe Lisle, a 17-year-old youth from the DC area with bipolar disorder who has benefited from the benefits of collaborative care.

We focused on ways to increase collaborative care amongst child and adolescent psychiatrists and primary care providers and the benefits that this provides patients. Rep. John Katko highlighted a report from his youth Mental Health Task Force that identified gaps in youth mental health services in central New York, and Rep. Grace Napolitano announced that she will be re-introducing her landmark legislation The Mental Health in Schools Act in the coming weeks.

To follow all the events and happenings during Mental Health Awareness Month, be sure to follow @AACAP and #HeroesofHope.
Collaborative Office Rounds

Rebecca Edelson, MD

In much of the country, primary care doctors manage complex psychiatric issues without the collaboration of a child psychiatrist. Even in my community where we have a large number of pediatricians and a significant number of child and adolescent psychiatrists, there is still a lack of child psychiatric services available. Many local outpatient child and adolescent psychiatrists maintain fee for service practices and often fill their schedules quickly. Moreover, families seeking services via insurance often have difficulty finding a provider. It can also take months to get an appointment with a child and adolescent psychiatrist.

As a recent graduate of a triple board program (pediatrics, adult psychiatry, and child psychiatry) when I arrived in the DC metropolitan area in 2005, I was struck by how little collaboration or communication occurred between psychiatrists and primary care providers, two groups who care for the developmental and psychosocial needs of children.

In January, 2007, I became the Maryland representative to our regional council of AACAP, the Child and Adolescent Psychiatric Society of Greater Washington (CAPSGW). As part of the Executive Committee, I learned about the Virginia Access Project in Northern Virginia. There, they had developed a model where pediatric practices paired up with an individual child psychiatrist who would be available for phone advice and consultation. It sounded like a great idea, but for the most part, it had not worked. It seemed that because the pediatricians and child psychiatrists did not know each other, the pediatricians did not feel comfortable calling for consultation. In April, 2007, I traveled to Richmond, Virginia, for a one day symposium on collaborating with primary care. During that meeting, the presenters talked about the need for pediatricians and child psychiatrists to establish a personal connection in order for collaboration to work. Presenters from Richmond and elsewhere spoke about starting local “Collaborative Office Rounds.”

Collaborative Office Rounds (COR) were first written about in 1988 after the Maternal and Child Health Bureau (MCHB) held a meeting of pediatricians and child psychiatrists “to consider how to enhance collaboration in education.” The meeting led to a recommendation for the establishment of COR (Fishman et al. 1997). The main mission of COR is to “foster joint pediatric-child psychiatry communication and continuing education in the psychosocial-developmental aspects of child health” (Thomasgard, Collins 1998). Some of the reasons pediatricians and child psychiatrists might want to join COR include to study complex clinical problems, collaborate with peers, and to learn about local mental health resources. The meetings also provide a place to discuss job stress and dissatisfaction (Shields, 1985).

Thanks to AACAP, in 2007 CAPSGW received an Advocacy and Collaboration Grant of $4,000 to fund collaborative rounds. That year, I started recruiting participants. CAPSGW member Caroline Sehon, MD, volunteered to co-direct the project with me and Naveena Hemanth, MD, and Shira Rubinstein, MD, volunteered to participate as well. Recruiting pediatricians proved to be more difficult. Fliers were sent out to approximately 230 pediatricians in Montgomery County and a listing was placed in a local hospital’s quarterly newsletter inviting pediatricians to join the rounds. Personal emails were sent to local psychiatrists and pediatricians and a listing was placed on the CAPSGW list serve. Nine pediatricians responded. CAPSGW received another collaboration Grant in 2008 and a few more pediatricians were recruited.

Although these rounds can be organized in different ways, our initial plan was to have a small group of committed pediatricians and child psychiatrists who would meet monthly for 1.5 hours. The goal was to recruit pediatricians who could commit to regular attendance at the meetings in order to create a group identity and group continuity. The first 30 minutes would be a didactic portion focusing on the wide range of psychosocial and developmental problems primary care doctors see in their offices. The following hour would be case-based presentations by the group members with time set aside for discussion. The plan was for the group to meet at a local community hospital from 7:00-8:30 am. It was important to find a time that did not interfere with patient care hours. The chair of the pediatrics department at the local hospital initially donated a conference room and breakfast for the meetings. Although we looked into offering CME, it was not possible. At our first meeting back in 2007, everyone received a copy of the textbook, Bright Futures in Practice: Mental Health, Volumes One and Two. They also received the CAPSGW Membership Directory and the AACAP Facts for Families handouts. Following the second grant, the group received a copy of Helping Your Anxious Child: A Step by Step Guide for Parents by Rapee et al.

Since 2008, Hector Parada, MD, Dr. Hemanth, and myself, along with intermittent attendance of other CAPSGW members and between 7-10 local pediatricians meet monthly between September and May. Most of the group members have attended since 2008 and most have been in practice for more than 15 years. At this point, the group receives no outside funding and no CME is offered. The hospital no longer
supplies breakfast so members rotate bringing coffee each month. Often, outside speakers join to discuss different mental health topics relevant to our group. We will intermittently discuss cases. The group benefits from being located across the street from NIH, from which presenters often come. The small group size allows for rich discussion and learning. The areas of interest are wide ranging. Examples of topics we have discussed are listed below.

COR need to be designed to fit the particular need of the community. For the first few years of our project, an evaluation was provided after each meeting. It asked the members if the meeting met their goals, if it would change their office practice, and if they had recommendations for future meetings. Over the years, the group has consistently reported that they benefit from the meetings. When asked why they return every year, one pediatrician wrote, “I have learned so much practical information that I apply daily to my practice and improve the care of my patients.” Another wrote, “the small group size and expert speakers provide a unique opportunity for back and forth questioning and discussion.” And another wrote, “From a logistical standpoint, by having the meetings early in the morning, it is easier to fit them into a busy schedule.” The informal connections that have developed between members have added to an environment of collegiality and comfort. As the main organizer of the group, I have benefited from the relationships I have developed with my pediatric and psychiatry colleagues and the benefit of learning in a small group atmosphere. ■

References

Dr. Edelson is a child and adolescent psychiatrist at JLG-RICA, a public residential and day treatment program in Rockville, Maryland. She also consults to the National Center for Children and Families, providing clinical services to youth in several of their programs. She also served as president of the Child and Adolescent Psychiatric Society of Greater Washington (CAPSGW) from 2013-4. She may be reached at rgedelson@gmail.com.

EXAMPLES OF TOPICS DISCUSSED

Problems and Disorders:
- Autism: Evaluation, Co-morbidities, and Treatment
- PANDAS
- Learning Disabilities
- Bipolar Disorder
- Dysrhythmic Mood Dysregulation Disorder
- Disruptive Behavior Disorders
- Sensory Challenges in Children
- POST
- Pediatric Epilepsy
- ADHD
- Anxiety Disorders
- Bullying
- Eating Disorders
- Teenage Substance Use
- Suicide Screening in Primary Care
- Tic Disorders
- School Violence

Clinical Management:
- Dialectical Behavior Therapy
- Cognitive Behavior Therapy
- Psychological Testing
- Pharmacogenetics
- Pediatric Obesity
- Maryland Behavioral Health Integration with Primary Care Program
- Collaborative Care Models
- Psychiatric Management of Women of Childbearing Age
- Mindfulness and Meditation

Family and Community:
- The IEP Process
- Divorce and Special Needs Families
- Child Custody Issues
- Legal Aspects: Child Protection
- Couples Therapy

Health Supervision:
- Pediatric Sleep Issues
- Children and Video Games
- Behavioral Management in Young Children
- Adolescent Health
- Children and Social Media

Pediatric Integrated Care Resource Center
Integratedcareforkids.org is designed to promote the integration of medical and behavioral/mental health services for children, adolescents, and their families by providing easy access to needed resources to interested professionals in different disciplines who are working in a variety of settings.
Family Therapy Training and Focus on the Patient – A CAP Fellow Experience

Anand Patel, MD, and Mariam Rahmani, MD

CAP fellows learn to treat families when they treat children. Despite recognizing its importance, CAP fellows report limited supervised experience in family therapy, and rate their family therapy training experience in fellowship to be lower than their overall clinical training experience (Rait 2012). Even for senior CAP fellows like myself, the thought of meeting some families and confronting parents, especially those who are separated, divorced or dislike each other, can seem very daunting. Absorbing parent’s feelings of angst and emotional instability can heighten a provider’s already elevated level of anxiety and stress that comes from feeling the responsibility to “fix the situation” (Heru and Drury 2007). One strategy that has personally helped me in these situations is to focus on the patient rather than my own anxiety. My first encounter with leading a Family Therapy Session on the inpatient psychiatric unit illustrates this.

Sarah, the 12-year-old daughter of divorced parents, who was struggling with symptoms of major depression and generalized anxiety disorder was admitted for worsening (more frequent and intense) suicidal ideation with urges to cut herself. At the time of admission, she was in her father’s care. As soon as her mother, who lived out of state, found out about her daughter’s admission, she immediately got in her car and started driving to see the patient.

Sarah has a challenging and somewhat complex psychosocial history. Her biological parents have been divorced since she was five years old, they live in different states 500 miles away from each other, and both are now re-married. Her father obtained primary custody of the children (Sarah and her brother) a few years ago after it was discovered that the mother’s now ex-boyfriend sexually abused Sarah. When I was conducting Sarah’s initial evaluation, she mentioned spending the summer with her mother, an environment she prefers much more than living with her father. She attributed her feelings of depression, fear, and anxiety to the strict environment at her father’s house, where she spends a majority of the year. She felt that her father “will never change.” Her thoughts of having to go back there exacerbated fear and, hence, led to thoughts of suicide and worsening depression. Sarah had found individual therapy minimally helpful.

On initially speaking with the patient’s biological mother via telephone, she confirmed the patient’s concerns and that she also believed that the father’s strict temperament needed to change. I had not spoken to the father yet. My anxiety had already kicked in. Given that family therapy is more effective than individual therapy for maintaining post-treatment improvement in child/adolescent depression (Starke 2012), our psychiatric hospital offers at least one family therapy session during every patient’s hospitalization. Our social worker, who is usually in charge of the family meetings, was on leave, so I volunteered to lead this family session, although I was dreading scheduling it.

I finally dialed the father’s telephone number. Consistent with previous reports, the father seemed aggressive on the phone and expressed his disdain for the hospitalization and consideration of medication management. He admitted to being a disciplinarian, explaining he came from a military background. He continued on to externalize blame for Sarah’s hospitalization toward Sarah and Sarah’s biological mother. Both parents agreed to schedule a family meeting together, which continued to exacerbate my feelings of intimidation.

“In my frenzied anxiety state during Sarah’s hospitalization, I had almost forgotten my most important job, which was to support the patient!”

I expressed my anxiety about this case, and especially my anxiety about this father, to my supervisors on the inpatient unit. Given that I had two days before the family meeting, I was encouraged to direct my attention away from the father for the time being and turn my attention instead toward the patient. The patient needed to be heard, and my tensions surrounding the family meeting were getting in the way of developing rapport with the patient.

I took their advice and focused on Sarah instead of her parents. Initially, Sarah was guarded. She made it clear that her feelings would never change because her father would never change and the only way she could ever feel better was to live with her mother (which she knew could not happen from a legal standpoint). She spoke about fear of saying anything to him. She expressed frustration that he does not listen to anybody, but was reluctant to go into further detail. She was aware of the scheduled family meeting where both parents
would be present simultaneously, and she expressed fear and hesitancy about this. I felt the tension inside me growing once again: How can I fix this? What if the father gets upset and does not listen? What can I say to the parents to help them understand what their daughter is feeling? How can I get the patient to trust me? I found myself becoming frustrated with the patient’s guardedness, as my usually successful strategies of interviewing were not working. I finally had an idea. I told her to write a letter to each parent about her feelings. I made it clear that this was not something she was required to read to the parents, but instead, this assignment was more for her, presented as a way of processing her emotions. She agreed to put full effort into this assignment, which I took as a minor victory.

The next day, there was an unexpected change during the morning rounds. Instead of being ambivalent about writing to her parents, Sarah asked to read her letter in front of the entire treatment team. She voiced her frustration with her father’s strict disciplinarian style, their (Sarah and her brother’s) fear of him, and how this is affecting their relationship. She went on to voice what the family needs from him to function better, but expressed significant doubt that anything will change. At the end of the rounds, she expressed her love for her father and began to cry. After a few seconds of silence, she stated, “I am tired of feeling this way,” and voiced the need to let her parents, especially her father, to be aware about how exactly she was feeling through her letter. Her one request was that I would be present while she read her letter to her parents during the family meeting. This is when I informed her that I would actually be leading the family meeting. It was evident to me at this point that she was starting to trust me more and more, which also seemed to help ease her elevated anxiety levels. Later in the day, she even called me aside and requested I listen to her while she practiced reading her letter.

The following day was the family meeting. Prior to the meeting, my supervisors emphasized three important points to the meeting (Heru and Drury 2007): (1) “lead” the meeting instead of “fixing” the situation, (2) encourage the parents to listen and realize that everyone is on the same team (despite tension and differences between parents), and (3) set boundaries and expectations for effective communication between Sarah and her parents.

I took a deep breath before I met with Sarah’s parents. I thanked them for coming, especially from so far away. I acknowledged that this must be a difficult situation for both parents, encouraged effective listening and communication, and reminded them that we all had the same goal, which was to help Sarah. To my surprise, both parents agreed to listen, allow Sarah to express her feelings to them without interruption, and interact respectfully and civilly toward each other. It was now time to bring Sarah in. She appeared nervous and worried. I found myself feeling anxious for her. We did three deep breaths together. I validated her anxiety and encouraged her to be open at the same time, all while reminding her that I was there to support her if any conflict were to arise. She nodded her head in agreement and was ready to go in. Both parents showed affection toward her, all three became tearful, and then Sarah sat down. I asked her if she was ready to read her letters. She said “yes,” and she did it! After a few moments of silence, there was an awkward sense of discomfort. Then, just like that, the tension in the room eased as it became evident how impactful Sarah’s words were to her parents. The father expressed sorrow and regret as he was unaware of these feelings, and he apologized. Mother showed empathy and support for Sarah, validated her feelings, and vowed to work with her father. Finally, all parties were able to express appreciation for each other and they all realized that better communication was the key to understanding and respecting each other.

My tension did not ease until the session was over. When it was over, I felt an enormous weight lifted off my shoulders. Many realizations hit me shortly afterward when I had some time to process the meeting. In my frenzied anxiety state during Sarah’s hospitalization, I had almost forgotten my most important job, which was to support the patient! I realized she needed me to listen to her, she needed me to support her, she needed me to guide her, to give her the confidence to feel that she had a voice, and that her voice mattered. I needed her to show me that my job was not to fix everything, but that my job was to be there for her. When I shifted my focus to the patient instead of my own anxiety, that is when the plan of action became clearer and, eventually, led to a successful family meeting.

My experience also made me want to help future CAP fellows at my program with their family therapy experiences, and so I made family therapy training a focus of my quality improvement project. As part of this project, I recommended that my program purchase a book that I had frequently referred to, “working with families of psychiatric inpatients,” as well as to share my experience in the form of this column, in hopes that other CAP fellows may benefit from it.

References

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A Visit to India Created a Lasting Relationship

Peter M. Ferren, MD, MPH

In 2007 as a young faculty member at the University of California, San Francisco, I sent an unsolicited email to Dr. Paul Russell, Professor of Child and Adolescent Psychiatry at the Christian Medical College (CMC) in Vellore, India, asking if I could visit his service. Within 24 hours, he replied, “When can you come!” A decade later our friendship and collaboration has evolved into the “UCSF-CMC Partnership in Child and Adolescent Psychiatry Training,” which has supported a bilateral exchange of visiting faculty between our departments and enabled CMC to establish the first officially recognized training program in India for child and adolescent psychiatry.

Paul is truly one of those special child and adolescent psychiatrists who seizes upon opportunities to make things happen. Coming from a nation that continues to supply the rest of the world with medical specialists, he is committed to raising the standard of child and adolescent psychiatry and access to services from the Southern tip of his nation, Tamil Nadu, to more than one billion citizens, not only of India but from neighboring countries including Bangladesh and Nepal.

On my first visit, walking through the quiet CMC campus that hosts both the adult and child and adolescent psychiatry units twenty minutes away from the bustling downtown hospital, I passed a tree filled with fruit bats and wondered how different child and adolescent psychiatry services would be in India. I quickly learned that children and families are the same everywhere and the commonalities far outweigh the cultural differences. I learned that the strengths of Paul’s service included a multidisciplinary team to evaluate and treat children with autism and intellectual disability, and I marveled naively at Hindu, Muslim, and Christian parents working together to learn strategies to maximize their own child’s level of functioning. I learned that entire families accompany a child patient for a three-month intensive hospitalization as they may travel hundreds of miles and take time away from daily responsibilities to live together as treatment proceeds. Paul emphasized that no one is turned away for an inability to pay for care, as there is no health insurance in India. I was similarly fascinated that in one small room, four psychotic adolescents—boys and girls—and their parents would stand for traditional walk rounds as Paul’s service also specializes in early presentations of schizophrenia, bipolar disorder, and major depressive disorder with psychotic features that the adult psychiatrists were too afraid to treat.

“What areas of child psychiatry are we not providing at CMC?” Paul asked. “What are you doing in schools?” I replied. The answer in 2007 was nothing because politically the schools did not want mental health involvement. When I returned for a subsequent visit, the tone had changed. A suicide in the school had led to a phone call to Paul, and his response was to initiate a statewide school intervention to train school personnel to identify mental health issues, provide basic interventions, and facilitate the referral of children with severe psychopathology to CMC. The tide had turned.

Indian schools struggle with the same viciousness of bullying, excessive academic pressures, and provision of the most nutritious meals that a child may have in a day as the American schools that I know. If an Indian child does not stay in school, he or she may not eat; therefore, addressing child psychopathology as basic as ADHD is essential for a child’s survival.

During my most recent visit in April 2016, Paul’s junior colleague, Dr. Sherab Tsheringla, introduced me to the school where he has been consulting for the past year after a six-month, intensive exposure to child and adolescent psychiatry services with an emphasis on trauma-informed systems of care at UCSF in 2015. The consultation meeting with the staff exactly mirrored the ones I have in San Francisco with the same concerns and needs, and the staff gushed at the impact the CMC school consultation program has had on their ability to educate India’s youth.

The lessons from this international partnership are succinct and powerful: 1) asking a simple question can have a major impact, 2) our commonalities across cultures are greater than our differences, and 3) saying “yes” to an unsolicited email can change a career and lead to a lasting professional relationship.

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The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to introduce a new and improved JobSource, an advertising and recruiting tool to assist AACAP members and related experts looking for new career opportunities, and to help employers find the most qualified child and adolescent psychiatrists.

The new JobSource is simple and easier to use. Get to everything you need with just a few clicks. Visit us online at www.aacap.org and find JobSource under Quick Links or Member Resources.

With questions, please contact Samantha Phillips, Membership & Communications Coordinator, at sphillips@aacap.org.
Pharmacogenomic Testing in Psychiatry

Dr. Carlson: Clinicians understandably would like a way to prescribe the right medication at the right dose without having to use trial and error. Jon McClellan, MD, a professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington, has outlined important background information about pharmacogenetic testing. I have asked him, and two other experts in the area, Stacy Drury, MD, PhD, from Tulane’s Department of Psychiatry and Laura Ramsey, PhD, from Cincinnati Children’s Hospital Medical Center to address specific questions that have arisen in AACAP’s Psychopharmacology Institutes.

An 8-year-old child hospitalized for severe, explosive outbursts has a fuse so short that there is no time to intervene between whatever her trigger is and the subsequent rage. Therapy, stimulants, alpha agonists, numerous SSRIs, second, and now first generation neuroleptics have been directed toward her “irritability” unsuccessfully. Would pharmacogenetic testing add to her care?

Drs. McClellan, Drury, and Ramsey: The choice of a psychotropic medication is complex and influenced by age (which effects things like hepatic metabolism), family history, and illness characteristics, e.g., co-morbidities, severity, and illness duration and medication compliance (a drug cannot work if it is not taken). Pharmacologically, drug level, onset of action, cumulative drug exposure and drug interactions influence response. The information one gets from pharmacogenetic testing does not address all these factors.

Currently, available genetic testing provides a significant amount of data but with varying utility. Many of the current genetic testing companies include both established cytochrome p450 and other drug metabolizing enzymes and genetic variants whose influence on medication response and side effects have yet to be established and their combination in terms of basic biological pathways and mechanisms of action of psychotropic medications is unknown.

Also, studies validating the utility of genetic testing beyond “treatment as usual” are mostly limited to treatment-resistant patients, almost entirely with major depression and in mostly adult Caucasian samples. The Clinical Pharmacogenetics Implementation Consortium (CPIC) provides guidelines for adjusting tricyclic antidepressants and SSRIs based on CYP2D6 and CYP2C19. They provide a strength of recommendation for each genotype and provide references for all recommendations, but do not provide guidance on when to test. However, the French National Network of Pharmacogenetics recommends CYP2D6 and CYP2C19 genotyping before initiating an antidepressant treatment, especially in patients with a high risk of toxicity. The FDA provides recommendations for maximum doses in poor metabolizers for some psychotropic medications (e.g., citalopram).

The issue is this. Given that blood levels of psychotropic medications are not very predictive of treatment response, even when CYP enzymes accurately predict the patient’s metabolizer status, knowing how quickly or slowly the drug in question will be metabolized, does not tell you whether the drug will be helpful. Nor will the testing tell you how much drug the person will tolerate, even if you increase the dose slowly. Finally, few pediatric studies are available and none yet with the commercially available tests. Unfortunately, a significant number of the studies that have been done were written and conducted by employees of the genetic testing companies.

So, the bottom line is this: while some clinicians use pharmacogenetic testing after medication failures or after the onset of serious side effects, the genetic testing results for the child described above will not add meaningfully to her care. Genetics do matter for drug response and medication tolerability, and drug-metabolizing enzymes may be to blame. The problem is that the variants currently being tested do not inform clinical prescribing the way we would like them to. Companies test more than just these enzymes and base their guidance on the larger panel with less available evidence. Testing panels will miss rare variants that matter and the complexity about how all the variations interact is well beyond the interpretation of the tests at this time.

Dr. Carlson: Do the pharmacogenetic tests help make diagnoses?

Drs. McClellan, Drury, and Ramsey: The short answer is “no.” Presently, any genetic test that states it can predict common psychiatric disorders (including ADHD), treatment response, or side effects in pediatric populations does not have sufficient, reliable data. Studies of treatment response have failed to include complexities that we face as child and adolescent psychiatrists regularly: developmental age, race, family history, and context. Genetic testing has use in rare disorders (e.g., fragile X in autism) but for
most of our DSM disorders, there is not yet enough data to suggest that genetic testing will advance our ability beyond the use of careful diagnostic evaluation.

**Dr. Carlson:** What do the green, yellow, and red markers mean?

**Drs. McClellan, Drury, and Ramsey:** The algorithms that are used to bin medications on commercially available tests into “use with caution” or “use as directed” are proprietary, cannot be validated by external cohorts, and seldom include a strength of recommendation or evidence to back up the binning. Medications in the green “use as directed” bin may not have any genetic associations that influence them, but that does not automatically make them the best treatment for that patient — there may be a higher risk of side effects or lower efficacy of those medications compared to some in the yellow or red bins. They also may not be approved for use for the patient’s indication or age. Medications in the yellow or red bins may be safer and more effective than those in the green bin when dosed appropriately based on genotype.

While accuracy of variants tested is regulated, interpretations of genetic variants to metabolizer status is not and varies, as do interpretations of variants/metabolizer status that effect medication. Additionally, variants tested for in each panel are different, and since the presence of the “normal” allele, *1, is indicated by the lack of other alleles, the number of alleles tested affects the prediction of the normal allele. One thing to remember when looking at the reports available from pharmacogenetic tests is that just because a drug is a substrate for an enzyme does not mean that genetic variants in that gene influence response/toxicity.

To date it is unclear about exactly how the modeling was done and how these studies account for any racial, sex or developmental differences. Nor do the studies account for concurrent medication use, dietary factors (Brussel sprouts, grapefruit juice, vitamins, supplements), and other medical conditions that likely directly interact with the end metabolic processes controlling these medications.

In summary:

1) Genetic testing for drug metabolizing enzymes is not supported as first line approach in terms of cost effectiveness, particularly in pediatric populations. Testing for specific drug metabolizing enzymes may have some utility for individuals with abnormal side effect profiles and treatment-resistant conditions, although more study is needed.

2) Inclusion of genetic variants with insufficient or unsupported relevance to drug effectiveness is a current limitation of commercially available genetic testing panels and limits their utility.

3) We should begin to think about creating data sets that are representative of our clinical populations in terms of ancestry, race, sex, genographic distribution and life histories that are clearly relevant in terms of prognostic responses, metabolic processes, and ideally the strength of our ability to effectively utilize and implement the best quality of personalized medicine.


**Dr. Carlson:** Well, then, to quote H.L. Mencken: “There is always a well-known solution to every human problem — neat, plausible, and wrong.” This seems especially true for pharmacogenetic testing at this time.

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Pharmacogenomic Testing: Not Yet Ready for Routine Care

Pharmacogenomic tests are being aggressively marketed for psychiatric clinical practice, with claims of tailored prescribing, improved outcomes and reduced costs. Genetic variation undoubtedly influences drug metabolism and response, and genetic testing has demonstrated utility for other fields of medicine, e.g., cancer chemotherapy (Aminckeng et al. 2016). However, the genetic markers typically assessed for psychiatric treatment have yet to be established as clinically useful. Current evidence does not support routine pharmacogenomic testing to guide the prescribing of antidepressants for major depressive disorder (GENDEP Investigators et al. 2013), antipsychotic medications for schizophrenia (Zhang et al. 2013), and medication treatments for ADHD (Patel and Barzman 2013).

Most commercial tests target two broad categories: genes associated with drug metabolism (e.g., cytochrome P450 system), and genes hypothesized to be involved with the pathogenicity of a disorder and/or mechanisms underlying the therapeutic/adverse event profile of a drug. The human genome has 57 functional cytochrome P450 genes, several of which code for hepatic proteins responsible for the biotransformation of most drugs (Zanger et al. 2014). The cytochrome P450 gene family is characterized by immense variation. Each of these genes harbors thousands of common and rare variants, coding and noncoding. Copy number variation is common, so individuals may carry more or less than two copies of the same gene. Thus, an enormous number of genetic permutations can potentially influence drug metabolism. Non-genetic factors, such as medications, also influence the activity of individual cytochrome P450 enzymes. Given the degree of genetic variation and variability in enzyme activity over time, each person essentially has her/his own unique cytochrome profile.

Commercial tests typically focus on a few dozen common polymorphisms that influence the functional activity and expression of individual enzymes important for drug metabolism (e.g., CYP2D6, CYP2C19, CYP2C9, CYP3A4, CYP2B6, CYP1A2). Based on these results, an individual’s metabolizer status is classified as ultra-rapid, extensive, intermediate, or slow. Genotypes associated with being an extensive metabolizer are generally the most common. Reported allele frequencies are based on studies of individuals from European, and to a lesser degree, Asian ancestry. African populations, which are highly diverse, are underrepresented in this research.

An individual’s profile of common cytochrome P450 alleles is predictive, but not an absolute indicator, of metabolizer status. Other undetected mutations in the same gene, including rare variants, can impact gene function. For example, in CYP2B6, low activity alleles operate in a recessive fashion, so individuals with only one copy of the low activity CYP2B6*6 allele (i.e., heterozygotes) are not characterized as slow metabolizers. However, individuals that carry the CYP2B6*6 allele, which is quite common in some African populations, may also carry a different gene-disrupting variant that is not detected by standard testing. In this situation, the person is a compound heterozygote for low activity alleles, and will be a slow metabolizer, contrary to the test results (Zanger et al. 2013).

More importantly, blood levels are generally not predictive of treatment response to psychotropic agents. So even if the test accurately predicts the individual’s metabolizer status, evidence that the information predicts medication response is lacking (Malhotra et al. 2012).

Commercial pharmacogenomics tests also typically assess common variants in genes speculated to play a role in psychiatric illnesses, e.g., serotonin transporter (SLC6A4) serotonin receptor type 2A (HRT2A), methylenetetrahydrofolate reductase (MTHFR), catechol-O-methyltransferase (COMT) and adrenoceptor alpha 2A (ADRA2A). Unfortunately, the clinical and biological relevance of these and other common genetic risk variants touted to be important in psychiatry are notoriously limited by small effect sizes, variable replication, and questionable biological relevance.

For example, common alleles in the serotonin transporter gene (SLC6A4) have been widely studied in psychiatry, with highly variable findings. In a meta-analytic review of 34 studies examining the impact of the serotonin transporter promoter polymorphism on antidepressant efficacy (Porcelli et al. 2012), 10 studies found no association, while the remainder found efficacy to be variably associated with either one or two copies of the long allele (n = 19) or the short allele (n = 5).

Why are the findings so discrepant? The likelihood of carrying the short or long allele varies markedly across and between different human subpopulations, a phenomenon known as population stratification. In the meta-analytic review, the frequency of the long allele varied from .14 to .79 in different study cohorts, regardless of case status. Given such marked variation, any differences in ancestry between cases and controls can generate false positive findings.

Population stratification is a significant methodological limitation in genetic association studies and often responsible for false positive findings (McClellan and King 2010). To address population stratification, genetic association studies typically control by race. However, the human genome is characterized by
marked heterogeneity, with enormous variation within and between groups of individuals defined by race. For example, there are tens of thousands of common single nucleotide polymorphisms (SNPs) that vary significantly in allele frequency in individuals from different regions of Europe (Moskvina et al. 2010). Most human evolution occurred in small pockets of humans defined by local geography, not by race. Differences in allele frequency across subpopulations are the basis for tests that characterize a person’s ancestry (e.g., 23andMe®). However, in studies of disease, even subtle differences in ancestry between cases and controls may generate false positive findings, especially when examining for very small effect sizes.

In summary, there is currently insufficient evidence to justify routine pharmacogenomic testing for psychiatric care. Cytochrome profiling may be clinically indicated for some individuals with extreme sensitivity to medications, especially when examining for very small effect sizes.

However, for most patients, test results add little beyond the standard axiom of start low and go slow. The future success of pharmacogenomic testing will depend upon more extensive sequencing strategies, and the characterization of rare mutations with definitive biological impact on treatment response, adverse events and disease.

References


Dr. McClellan is a professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington in Seattle, Washington, and medical director of the Child Study and Treatment Center. His research addresses the diagnosis and treatment of early-onset psychotic illnesses and the genetics of complex neuropsychiatric disorders. He may be reached at drjack@uw.edu.
Lights, Camera, Action: Practical Answers to Common Questions About Telepsychiatry

So I hear you do a lot of telepsychiatry. How do you make it feel real to you and the patient?

It’s about intentionally adapting your bedside manner to the limits and strengths of this technical venue. You can easily recreate an authentic clinical experience in a telehealth videoconference. Although there are many important factors, we’ll focus on just a few pieces of the ‘action’ during a telepsychiatry session.

So you think the kids like telehealth visits?

Absolutely, most kids love the experience and novelty. Many kids are less distracted during the telehealth session because they find the video so engaging. Most adolescents are already comfortable using video chats socially. Studies have demonstrated that many adolescents feel more comfortable with a telehealth session vs. a traditional clinic session and offer up more information than they would in other settings (see references). A great rapport builder is to comment if the child is making faces at the camera and watching their own image. Similarly, if you notice details such as the kid’s toy or clothing make a comment to demonstrate you can really see them.

Do you greet your patients differently than you do in a clinic room?

Yes, I have added a new line to my normal greeting as I begin a session. After introducing myself, I ask, “How are you? Can you hear me ok?” This engages the patient in the technical aspect of the videoconference before the clinical work begins. It gives both of us a chance to adjust our camera, microphone, speakers, and lighting to ensure we look and sound lifelike and that the session feels authentic. It is really easy for physicians and patients to be distracted by the imperfections in what we see or hear. It is important to minimize or at least acknowledge the imperfections at the beginning of the session. One time I was meeting with an angry teenager and we bonded over the distracting sounds of the nearby train. What could have been a distraction, turned into an asset. It also gives the patient some sense of control and makes the interaction feel more bilateral and collaborative. Many child and adolescent patients are still mastering Industry vs. Inferiority. Learning how to setup and run their side of the videoconference can add to their sense of capacity and industry. The telepsychiatrist can use this as an opportunity to praise the child’s industry and model delivering real-life positive praise.

How do you build and maintain rapport during a telehealth visit? Does the session seem distant and disconnected? Is it hard to relate to a person’s picture on a phone or tablet?

You may need to revisit the basic tenets of good bedside manner as you adapt to this new patient care venue. You should intentionally communicate more often with congruent facial expressions, gestures, eye contact and tone of voice. The camera and microphone visually and emotionally has a flattening effect. TV newscasters and actors talk about the need to exaggerate tone somewhat to sound normal.

How do I show interest, concern and empathy on camera?

Asking about their physical comfort in the space including privacy, temperature, and lighting also helps overcome the physical gap between you and your patient(s) and build empathy. You can replicate the typical movements towards a patient with a movement towards the camera. Sometimes just opening your body towards them and leaning forward instead of being slightly turned away, slouching or leaning back in your chair, can indicate this concern. Obviously, you can not reach out and touch someone or offer them a tissue, but you can pause, maintain eye contact and let your concern show on your face. In many ways, this technology forces us to be a better listener because we have to take turns speaking and our pauses become more dramatic and encouraging.

‘shaka wave’. It is important to keep the gestures within your shoulders so they stay within the camera frame. It looks weird when your hands are cut off or you move outside the frame.

—David Roth, MD, and Ujjwal Ramtekka, MD, MPE, MBA
Do I have to sound like a newscaster to be a good telepsychiatrist?

You do not want to sound like an announcer or a stylized reporter, but you do need to adjust your voice to accommodate for the transmission delays and occasional lack of clarity. The most important adjustments are to speak more slowly, and clearly. You should also use longer pauses to invite responses. One way to be certain you are doing this well is to record a session or a practice session with a friend and play it back. Amateur telepsychiatrists often sound monotonous, nervous, or unnatural. With practice, most of us naturally adapt to include these necessary changes to our voice. Even a brief signal delay, can complicate turn-taking and you will find yourself talking over your patient. Taking longer pauses after you finish a thought is necessary to allow your patient a chance to respond. Although it seems artificial at first, these longer and more frequent pauses will become a key means of fostering good reciprocal communication during your telepsychiatry session. You can make these pauses even more effective by combining them with other nonverbal communication strategies like gestures, facial expressions, and distance changes which signal your reaction to the patient and encourage them to share more of their thoughts and feelings rather than speaking.

Since we are not trained actors or newscasters, do we need special training to be telepsychiatrists?

No, but it sure helps to have had experience in the theater or on TV. Theater training is a great way to understand how to respond to a patient in a traditional face-to-face visit and do it better in telehealth. It forces you to be more in the moment and mindful of how others perceive you as you interact with them. Your gestures and expressions provide your patient with a window into your intentions and feelings. Trained telepsychiatrists are better at monitoring their own gestures and facial expressions and especially how they use them to respond to the patient. A good telepsychiatrist will employ clear and congruent nonverbal communication like gestures and tone of voice to convey emotion and emphasis.

All this self-monitoring seems complicated and I do not think I can do it all the time. Is there one gesture I can do that will make my telehealth session better?

Yes. Whenever it is appropriate, nod and smile. You can do this when listening to a patient, when you are documenting, looking something up on Medscape, or lost in thought. It will also encourage you to do the second most important thing, which is to maintain eye contact with your camera. When you position the patient’s image near your camera, you will appear to be looking at them when you look at their image. This replicates good eye contact without the need to stare uncomfortably into your camera. Good eye contact is very important because it shows sincerity, trustworthiness, engagement, and your emotions. With good eye contact, patients begin to feel comfortable with the telepsychiatrist. When you consistently look towards from the camera is it calming, helps the patient maintain their focus on your image, and helps you convey your interest, empathy, and attention. Doing this well strengthens the therapeutic relationship, promotes patient retention, and makes your telepsychiatry program sustainable.

How should I setup my camera and lights to make it seem real?

There are several things to consider, which will be covered in a later article—so stay tuned.

References


Dr. Roth maintains a private practice in Honolulu, Hawaii and has been practicing telepsychiatry with patients across the state, California, and Illinois since 2009. This includes a statewide school-based telepsychiatry program for youth with developmental disabilities and/or severe mental illness in Hawaii. He may be reached at droth@mind-bodyworks.com.

Dr. Ramtekkar is currently a physician director in the specialty clinic and telehealth at Compass Health Network and adjunct assistant professor at the University of Missouri School of Medicine, Columbia. He may be reached at drujiwal@yahoo.com.
The Women of ’66: Changing the Face of Medicine
Edited by Diane Schetky
North Wind Publishing
2016
Paperback: 138 pages

The Women of ’66: Changing the Face of Medicine celebrates the 50th medical school reunion of thirteen pioneering women who entered Western Reserve University School of Medicine in 1962. The book opens with a brief history of women in medicine, providing a context for the remarkable stories and accomplishments of the thirteen trailblazers. Ten first person accounts present each individual’s origins, motivations, challenges, and successes during and after their medical education. Those who passed away before the publishing of the book are remembered by their colleagues in touching tributes. The Women of ’66 is a touching, nostalgic collection of history and personal accounts that celebrate the bravery, commitment, and triumphs of pioneering women in medicine. To celebrate the generosity that allowed many of the women of ’66 to complete medical education, proceeds of the sale of this book go to the Dean Caughey Scholarship fund endowed by the class of ’66.

Psyciatric Interview of Children and Adolescents
Claudio Cepeda and Lucille Gotanco
American Psychiatric Association Publishing
2017
Paperback: 514 pages – $79.00

Building on 2010’s Clinical Manual for Psychiatric Interview of Children and Adolescents, Psychiatric Interview of Children and Adolescents is a new, practical, and comprehensive guide for trainees and seasoned clinicians. The book is well-organized into 16 chapters and an appendix. Instructional aims are expanded by the use of helpful tables, images, clinical vignettes, and key point summaries at the end of each chapter. The book opens with a consideration of the factors key to successful therapeutic engagement. General principles of interviewing and utilizing special skills, such as role reversal, role enactment, double chair, play, and drawing techniques are presented. The importance of family involvement in assessment is explored with chapters on family engagement and providing post-evaluation feedback to families. A new chapter on the psychiatric evaluation of preschoolers and very young children has been added and elaborates on the “multiples” model. Sections on bullying have been expanded to include cyberbullying and other concepts related to social media use. Documentation, internalizing symptoms, externalizing symptoms, and neuropsychiatric assessments are also explored in their own chapters. The book concludes with consideration of psychiatric formulation, resistance, and countertransference. Psychiatric Interview of Children and Adolescents is a wonderful resource to help clinicians master the skills needed to assess and treat young patients.

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the Resident Editor, Erik Loraas, MD, 3811 O’Hara Street, Pittsburgh, PA 15213, or by e-mail to loraasek@upmc.edu.
POETRY

My son, John Stone, gave me this beautiful poem for my 87th birthday. As the poem touches on therapeutic process and other themes resonant in our profession, I wanted to share it with our readers.— Clarice Kestenbaum, MD

The Listening Queen

In this room, time is not measured out in coffee spoons (like the poet said), but 50-minute hours, stretching like notebooks piled one atop another in a corner or contracting and unfurling as an accordion, sounding half-forgotten, half-remembered tunes in a darkened closet with the toys.

In this room, more like a kingdom, there is a king who is actually a queen, a royal physician, no, a wise magician, or is she an orator, who is actually a listener, who is actually just a mother?

In this room, with books as far as the eye can see, the listener, and often her cat, sit and calmly welcome all the subjects of the land, the very well-to-do and the very not-well-to-do, who come and present their problems. No one really knows just how the magician heals these multitudes — is it with her dollhouse, or puppets, her pads of paper and markers, a laying on of hands — or perhaps something about her cat assistant infusing them with feline curatives delivered between purrs and yawns?

The legend goes like this: the majestic listener listens, and she takes in all the stories from her stream of nervous visitors, and she tells them stories too until each one feels a little less, and then a lot less, nervous.

Stories fill the air in that room, and settle with the dust on the books, they commune with each other deep in the night and the decades, and they make a web of voices that say together: It’s OK, I’ve felt that too, that must be difficult for you, You’re not alone, I’m here with you, even when I’m not, and even when you leave this room.

Sometimes, the queen of this sad land, grows sad too, and weary of the listening, and having to heal so many. Then she turns to another, smaller chair where childhood sits invisibly, for the children, yes, but also for the grown-ups.

The queen soaks in the voices and no one ever truly grows old in this room.

- John Stone, 1/16/16
A Message From Mexico

Saul Stepensky, MD

Hello my friends!

I call you friends because I have so many friends from the AACAP and the Mexican Association of Child Psychiatry (AMPI). I joined both around the same time 30 years ago. They have given me a sense of belonging, professionally and socially. Attending the AACAP Annual Meeting regularly and being part of its Assembly of Regional Organization for years, while also being part of the AMPI’s Council and serving as its President, has given me the opportunity to meet other professionals and to make good friends in both.

Meeting with colleagues from different areas in our own country and around the world, gives us a great opportunity to learn from the work they do, keeping in mind the idiosyncrasies we confront every day in our communities and our patients. Those from other countries also had the opportunity to hear what the Mexican mental health professionals do, which can enrich their work back home. We have unique challenges with our multicultural population and numerous folk cultures and remedies we must accommodate to. Mexican patients, even college educated ones, often consult with doctors as well as psychiatrists and general practitioners. I always tell my patients and their parents that I am surrounded by mental illnesses that are not well understood by the general population, doctors, or teachers. Many times, mental illnesses are not taken as real illnesses, that is why many times people with those disorders are not treated, or intervention by a psychiatrist is delayed.

There are many differences between a developed country, such as the United States of America, and a third world country such as Mexico. Nevertheless, doctors and mental health professionals are trained with very similar parameters, and even in the same settings in some places. Mexican child and adolescent psychiatrists face unique challenges treating patients that most American doctors do not. For example, we cannot hospitalize children with psychiatric problems in public pediatric hospital wards. We only have one public psychiatric hospital for children and adolescents in the whole country. This makes it hard to reach psychiatrically ill children in the general population. Despite having fewer economic, technical and professional resources, we have learned to treat patients successfully, working as interdisciplinary teams.

We also practice in a country whose typical family structure is quite different than the one in the United States. Mexican children usually stay at home with their parents until they finish their studies, including college and medical school. What might look like separation difficulties in the United States to us it means that Mexican families take care of and support their family members much longer than the typical family in the United States. For instance, one of my children left home only when it was time to do his Master’s degree; another child left to get married, and the other one left when she got a job in another city. My three children were typical of educated Mexican kids. If, for some reason, a child has to study in a different city than the one his/her family lives in, youngsters—who often know each other from their neighborhoods—live together or within a family setting. Despite having close families, Mexican child and adolescent psychiatrists unfortunately also have to deal with child abuse and broken homes as well.

Though Mexico’s population is over 120 million, the AMPI has only 350 members. Our professional staff is composed of one person—yes one—a secretary. Members are therefore in charge of the day-to-day work of planning, preparing, developing, and carrying out all our scientific and social events. Perhaps because there are so few of us, we often become members of the committees earlier in our professional careers than you at AACAP. Due to a small membership, our bi-annual meetings include teachers, therapists, and psychiatry students. The meetings are very inclusive: Everybody is invited to all activities. The AMPI’s current president is regularly a guest, which has given me and my Mexican colleagues their friendship, and of course more relationships when we participate in your meetings.

Our groups are inter-related. We always invite AACAP members to give talks at AMPI’s bi-annual meeting in Mexico. You might be interested in a few details of our last Mexican meeting in Puebla, Mexico in November, 2016. Gregory K. Fritz, MD, and his lovely wife joined us as did our very good friends Dr. Efrain Bleiberg, Dr. Benjamin Goldstein from Canada, and Dr. Laura Viola from Uruguay. Each gave a talk which the audience really enjoyed. We did not just learn; we also had a good time. Our foreign friends had the opportunity to visit the lovely city of Puebla, which has great history, museums, and of course, extremely great Mexican food and very friendly people.

There can be a magic to a small organization: Some years ago, when our association was even smaller, we used to take our families to our annual meetings that had cultural and social activities for families to share. But we Mexican child and adolescent psychiatrists have learned a lot from our American colleagues. I trust that they have also learned valuable lessons from us. In my case, I have had to adapt lessons from scientific talks into my Mexican reality; otherwise I would leave frustrated, and my patients would suffer because of it.

I hope that the friendship we have for so many years nourished between AMPI...
and AACAP continues to grow. Let’s continue our professional and social bonding; let’s learn from each other and for the sake of us and our young patients. And let me formally invite all AACAP members to join us at our AMPI meeting February 1-5, 2018, at the Mérida Yucatán, a beautiful city in southeast Mexico.

Gracias amigos!

Dr. Stepensky graduated from Universidad Autonomy de Mexico and trained in general and child and adolescent psychiatry at the London University Hospital and the Institute of Psychiatry in London. He founded a private child guidance clinic in 1985 where he practices today. He joined the Mexican Academy of Child Psychiatry (AMPI) 30 years ago, and has served as president. That was the same year he joined AACAP and has served on numerous committees and as a member of the Regional Assembly of Child and Adolescent Psychiatrist for 20 years. He may be reached at sastep51@gmail.com.

The lovely city of Puebla, Mexico, at night.

Gregory K. Fritz, MD, and AMPI leadership.
Residents, Trainees, and Medical Students

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CALL FOR PAPERS

AACAP’s 64th Annual Meeting takes place October 23-28, 2017, at the Washington Marriott Wardman Park and the Omni Shoreham Hotel in Washington, DC. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, administration, etc. AACAP encourages submissions on neurodevelopmental interventions (helping children grow healthy brains), translational research, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and violence prevention.

Verbal presentation submissions were due February 15, 2017, and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by Thursday, June 15, 2017, and the online submission site will open in early April. All Call for Papers applications must be submitted online at www.aacap.org. If you have questions or would like assistance with your submission, please contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

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AACAP’s 64th Annual Meeting
Washington, DC Preview

AACAP’s 64th Annual Meeting is just 5 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/2017.

Attendee To-Do List

- **June 15** – Review the Annual Meeting programs online
- **August 1** – Members Only Registration opens for the Annual Meeting
- **August 8** – Registration opens to nonmembers
- **September 15** – Early Bird Registration Deadline
- **September 29** – Last day AACAP room rate guaranteed at hotels
- **October 23** – First day of AACAP’s 64th Annual Meeting
- **October 28** – Last day of AACAP’s 64th Annual Meeting
- **November 3** – Look for the General Evaluation Survey in your email inbox. CME certificate available upon completion of survey.
Hotels


Washington Marriott Wardman Park
2660 Woodley Rd. NW
Washington, DC 20008
Phone: 202.328.2000
Rate: $272 single/double per night
(Special Early Bird rate of $266/night if reservation is booked by July 31!)
Check-in is at 3:00 pm and check-out is at 12:00 pm

Omni Shoreham Hotel
2500 Calvert St. NW
Washington, DC 20008
Phone: 202.234.0700
Rate: $274 single/double per night
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 Washington Marriott Wardman Park and the Omni Shoreham Hotel will host scientific sessions for AACAP’s Annual Meeting. Located directly across the street from each other, both hotels sit in a charming neighborhood in the heart of Washington, DC, filled with amazing restaurants and quaint shops. After attending AACAP’s stellar educational offerings, you’ll be just a few steps away, you’ll discover the funky stores and ethnic cuisine of Adams Morgan or the exciting night life of Dupont Circle. Head north to hear the sounds of animals coming from the National Zoo. Or venture into the hotels’ natural surroundings to enjoy a quiet hike or invigorating run through Rock Creek Park. With a Metro stop just outside the doors and area airports close by, it’s a premier city destination just two Metro stops from everything DC has to offer.

Travel

Plane

Washington, DC, is served by three airports, the Ronald Regan National Airport (DCA), Washington Dulles International Airport (IAD), and Baltimore/Washington International Thurgood Marshall Airport (BWI). For more information about the airlines serving these airports, flight schedules, and ground transportation options, visit washington.org/DC-guide-to/washington-dc-airports.

Train

Washington, DC, is served by one main rail station: Union Station. Union Station is served by numerous bus and Metro lines, including Amtrak, Maryland Rail Commuter Service (MARC), and Virginia Railway Express (VRE).
What to Do in Washington, DC!

Approximately 2,000 animals call the 163-acre National Zoo home, from Asian elephants to great apes to sea lions. While here, don’t miss your chance to meet the zoo’s most popular residents, the giant pandas! Also, be sure to look up every now and then as you stroll beneath the Orangutan Transport System (called the O Line): Chances are you’ll spot orangutans swinging along cables between eight steel towers. Or, if you’re more intrigued by the exotic animals native to South America, head over the the to the 15,000-square-foot Amazonia exhibit, home to creatures like titi monkeys and silver-beaked tanagers. To learn more about the National Zoo and what it has to offer, visit nationalzoo.si.edu.

Arguably the most magnificent building in Washington, the U.S. Capitol Building is where visitors go to witness politics in action. Inside, members of both houses of Congress debate and create national policy and law, while visitors explore the building’s north and south wings and circular centerpiece: the Rotunda. This iconic hall houses paintings, frescoes and sculptures depicting famous scenes from American history, not to mention a 150-year-old cast iron dome. To learn more about touring the Capitol, visit www.visitthecapitol.gov.

Neighboring the Washington Monument (which is unfortunately closed to visitors until spring of 2019 due to renovations) to the north is the White House. Home to every U.S. president since John Adams in 1801, the White House is America’s most famous homestead. If you opt to tour the building, you’ll have the opportunity to visit the State Floor, which includes the East Room, the Green Room and the Blue Room. In order to participate in a tour, you’ll need to contact the office of your senator or House representative at least 21 days in advance to ensure your entry, and bear in mind that tours can be canceled last minute. To plan your visit, please go to www.whitehouse.gov/participate/tours-and-events.

Attracting somewhere around 9 million people each year, the National Air and Space Museum contains a trove of celebrated aircraft, including Amelia Earhart’s Lockheed Vega 5B, Charles Lindbergh’s Spirit of St. Louis and Wilbur Wright’s Wright 1903 Flyer, among others. Exhibits include a flight simulator, and IMAX Theater and a planetarium. To plan your visit, go to airandspace.si.edu.

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You need to be in the right frame of mind to visit this sobering museum, focused on the atrocities of the Holocaust during World War II. Upon entering the United States Holocaust Memorial Museum, you’ll be given an identification card with the name and personal information of an actual person who experienced the Holocaust; as you move through the exhibits—Hitler’s rise to power, anti-Semitic propaganda, the horrors of the Final Solution—you’ll be given updates on your person’s well-being. Many travelers find the museum to be powerful and deeply moving. Please visit the museum website at www.ushmm.org.

For more information about the many, many other amazing Washington, DC attractions and must-sees, please visit: washington.org.
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AACAP’s Lifelong Learning Committee has developed a series of ABPN-approved checklists and surveys to help fulfill the PIP component of your MOC requirements. Choose from over 20 clinical module forms and patient and peer feedback module forms. Patient forms also available in Spanish.

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

Questions? Contact Elizabeth Hughes, Deputy 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)
Pediatric Psychopharmacology Institute — Up to 12.5 CME Credits
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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.
Congratulations to Graduating Residents and Medical Students

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

Update your information online at www.aacap.org.

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AACAP offers flexible payment solutions to meet your needs.

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Search: AACAP

Simplify your life

NEWS CLIPS

We’ll send you an email every M, W, F with the need-to-know child psychiatry news; all you have to do is sign up!

Email Samantha Phillips, AACAP Communications Coordinator, at sphilips@aacap.org today.
The New Kid in Town – What the AACAP Association Means For You

Zachary L. Kahan
Advocacy and PAC Manager

As many of you have seen at recent meetings such as the Legislative Conference or Annual Meeting, AACAP has formed a new closely affiliated Association. It’s called the American Association of Child and Adolescent Psychiatry. This is not a typo, nor a mistake. The Association was established in late 2013 to house AACAP’s advocacy activities and as a way for CAPs to increase our advocacy efforts. Forming the Association allowed us to consider and approve a separate segregated fund for AACAP-PAC. AACAP-PAC is not funded by dues dollars. Advocacy activities include increased federal lobbying and expanded grassroots activities.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

One way to view the Association, which houses all of AACAP’s advocacy programs, is that it is like a three-legged stool. For a stool to be sturdy, all three legs must be equally strong. These three legs of the association are lobbying through activities like the Legislative Conference, grassroots advocacy through the burgeoning Advocacy Liaison program, and AACAP-PAC’s united voice for all CAPs. When we created the Association in 2013, it allowed us to create a separate segregated fund for individual and voluntary donations to fund AACAP-PAC. Please note that under federal law your dues dollars cannot be used by AACAP-PAC to support political candidates. PAC contributions are separate and completely voluntary.

The Association serves as an affiliated organization of the Academy and is a broader vehicle for CAPs to increase our advocacy efforts. These increased advocacy efforts of the Association are already paying dividends. Since 2013, we have advanced children’s mental health reform at the federal level, increased our grassroots activities, and begun the successful startup of AACAP-PAC. In AACAP-PAC’s first two-year election cycle, we raised over $100,000 and educated dozens of members of Congress about children’s mental health. AACAP-PAC supported 13 pro-child and adolescent psychiatry candidates for Congress in the 2016 election, with 12 winning their respective election. This is a fantastic start for a new political action committee!

The good news is that the vast majority of Academy members are already Association members. While it is each member’s individual choice to be an Association member or to voluntarily opt out via your dues statement, it is important to note that your dues remain the same whether you choose to be an Association member or not. By not opting out of the Association on your dues statement, a portion of your dues will go toward our advocacy efforts. Regardless of your decision, your dues dollars will remain the same, and your dues dollars will never go to supporting political candidates.

The Association will continue to use all three-legs of our stool to advocate for child and adolescent psychiatrists and children’s mental health needs in the rapidly evolving federal and state policy and political landscape. It is imperative for AACAP’s members to understand these important differences and how to get involved. If you have any questions, do not hesitate to contact AACAP’s Government Affairs Department at gov@aacap.org.

Life Members Reach 170!

No, not 170 years old. But, 170 lives you have impacted.

Impact.

Since 2010, the Life Members Fund has made an investment in 92 residents and 78 medical students. This includes 17 residents and 13 students in 2016! If you attended the Life Members dinner in NYC, you got to meet these young superstar future Owls!

Donate.

Your donations have made this achievement possible. We are in the midst of a mental health crisis, which comes at a time when our skills have never been more important. Yet, the deficit of available child and adolescent psychiatrists is widening. Life Members are closing this gap. Let’s keep it up.

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

Stay involved. Stay connected to all Life Members activities, programs, and photos by reading the Life Members Owl eNewsletter.
ACADEMY & ASSOCIATION 101

What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP’s Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at gov@aacap.org.
Welcome New AACAP Members

Taryn Abrams, MD, Atlanta, GA
Aus Aburshed, MD, Tulsa, OK
Alexander Adelsberger, DO, Philadelphia, PA
Elizabeth Ahn, Lawrenceville, GA
Samara Albahzaz, Des Plaines, IL
Camila Albuquerque, MD, Brooklyn, NY
Zenita Aldina, MD, Toronto, ON, Canada
Naomi Ambalou, DO, Morgantown, WV
Evangelia-Lila Amirali, MD, Montreal, QC
Seeba Anam, MD, Chicago, IL
Onaiza Anees, MD, Flushing, NY
Joalex Antoniorgi, MD, Bayamon, PR
Kara Arnold Applegate, Midvale, UT
David N. Araiza, Sacramento, CA
Shadi Aramesh, MD, New York, NY
Mitchell Arnovitz, Syracuse, NY
Gurvinder Arora, MD, Lexington, MA
Julian Artunduaga, Pittsburgh, PA
Kenneth C. Asogwa, MD, ON, Canada
Gurvinder Arora, MD, Columbus, OH
Aronica Cotton, MD, Baltimore, MD
Mitchell Crawford, MD, Quincy, MA
Daniel Cubberly, Chicago, IL
Amy Curtis, MD, Chicago, IL
Deekhita Damidi, Pompano Beach, FL
Mahtab M. D. Danai, Cupertino, CA
Jasmin Daniels, MD, Durham, NC
Jessica Diehl, Pittsburgh, PA
Lindsay Diemer, DO, Indianapolis, IN
Karen Ding, Houston, TX
Karen Dionesotes, Baltimore, MD
Estelle L. Dolan, Sacramento, CA
Alexandra Dyer, Madison, WI
Stacy Eagle, MD, Port Jefferson Station, NY
Sreenath Jagannathan, NJ
Albert Elliott, MD, Los Angeles, CA
Sarah Elliott, Los Angeles, CA
Albert Elumn, Berkeley, CA
Caitlin Engelhard, MD, Baltimore, MD
Sarah Grayce, MD, Nashville, TN
Mark David Elliott, MD, Savannah, GA
Sarah Elliott, Los Angeles, CA
Albert Elumn, Berkeley, CA
Caitlin Engelhard, MD, Baltimore, MD
Michael Enich, Piscataway, NJ
Matthew Epelman, East Lansing, MI
Katrina Escuro, MD, Beltsville, MD
Sylvia Exum, MD, Nashville, TN
Travis Fahrenkamp, MD, Saint Paul, MN
Miesha Faramhmand, Sacramento, CA
Cristina Farrell, MD, Morristown, NJ
Fernando Felix, Jr., MD, Aguascalientes City, Mexico
Olivia Fietsam, MD, London, United Kingdom
Thomas E. Fluent, MD, Ann Arbor, MI
Adam Fogel, DO, Mineola, NY
Tamsin Ford, MRC Psych, PhD, Exeter, Devon, United Kingdom
Talia Foster, MD, Philadelphia, PA
Henry Fourcade, MD, Coram, NY
Stephen Frabitore, Greenville, NC
Iuliana Frank, MD, Towson, MD
Kathleen D. Friend, MD, Tucson, AZ
Claire Garber, DO, Minneapolis, MN
Melanie Garcia, Lubbock, TX
Johanna Garcia, Okemos, MI
Sophie Gerber, MD, Indianapolis, IN
Sabrina Ghim, New York, NY
Amy Glick, MD, New York, NY
Sundar Gnanavel, MD, Tyne and Wear
Newcastle, United Kingdom
Marissa Goldberg, DO, Philadelphia, PA
Eric Luria Goldwaser, Jersey City, NJ
Evelin Gonzalez, Woodland, CA
Ross Goodwin, MD, Takoma Park, MD
Khris K. Gosai, MD, White River Junction, VT
Jennifer J. Gould, MD, Gulfport, FL
Sarah Grayce, MD, Nashville, TN
Emily Green, Forest Park, IL
Sneha Gupta, Manipal, Udupi, India
Joan Han, Jackson, MI
Arun Handa, MD, Philadelphia, PA
Kenneth Handelman, MD, Oakland, ON, Canada
Rashad Hardaway, MD, Seattle, WA
Meredith Harewood, MD, Long Beach, CA
Nayla Hariz, MD, Brooklyn, NY
Jewel Harvey, Shreveport, LA
Salman Hashim, McAllen, TX
Luis Hernandez Bocacetti, MD, Guatemala City, Guatemala
DeeAnna Hess, Apex, NC
Tara Holter, MD, Rochester, NY
John Horton, San Diego, CA
Reza Hosseini Ghomi, MD, Seattle, WA
Maya Hubert, MD, New York, NY
Abigail Huertas Paton, MD, Madrid, Spain
Cynthia Hunt, MD, Monteray, CA
Anum Hussain, River Forest, IL
Gina Kim In, MD, Beaumont, TX
Jennifer Ingersoll, MD, Greenville, NC
Akinyele Iyiola, FRCP, FAPA, Medicine Hat, Alberta,
Tina Jackson, MD, Mobile, Canada
Sreenath Jagannathan, Erie, PA
Shirley (Yun Qi) Jiang, Foster City, CA
Sarah Johnson, MD, Honolulu, HI
Anna B. Jolliffe, DO, Silver Spring, MD
Judith Joseph, MD, New York, NY
Nadimire Jules-Dole, MD, Lutherville Timonium, MD
Surabhi Kasera, Salt Lake City, UT
Elizabeth Mary Kelly, MD, Co. Dublin, Ireland
Mikaela Kelly, Los Angeles, CA
Shahbaz Amir Khan, MD, San Jose, CA
Jeremy Kidd, MD, New York, NY
Ingrid Kiehl, Maywood, IL

(continued on page 132)
Welcome New Members! continued from page 131

Duygu Kinay, MD, Fatih, Istanbul, Turkey
Ana Kleinman, MD, Sao Paulo, Brazil
Stephanie Kua, MD, Buena Park, CA
Tracy Kuniega-Pietrzyk, MD, Baltimore, MD
Susan Kuschnir, MD, Cincinnati, OH
Eric J. Kutscher, New York, NY
Tricia J. Kwiatkowski, MD, Franklin, TN
Mang-Tak Kwok, Toledo, OH
Barbara Lam, Los Angeles, CA
Keng Lam, Sacramento, CA
Kristyn Lao, Stamford, CT
Lauren LaRose, MD, Metairie, LA
Catherine Larson, MD, Austin, TX
Laura Ledvora, Milwaukee, WI
Peffin Lee, DO, Northville, MI
James Lee, Rochester, MN
Emily Lelchuk, Chicago, IL
Eric M. Li, Hershey, PA
Katherine Li, Worcester, MA
Morgan Liddell, MD, Philomath, OR
Megan Lin, Great Neck, NY
Emma Rose Livne, Jamaica Plain, MA
Mastan R. Lokireddy, MD, Brooklyn, NY
Jeffrey Lurie, MD, Chicago, IL
Adrienne Maguire, Sacramento, CA
Priya Maillacheruvu, Omaha, NE
Erin Malley, MD, Champion, PA
Rabeea Mansoor, MD, Strongsville, OH
Pradeep Durgacharan Marballi, MD, Port Richey, FL
John E. Marcellus, MD, Missouri City, TX
Sundus Mari, MD, Boston, MA
Mollie Marr, Portland, OR
Alexis Martinez, Laredo, TX
Stephan Mateka, MD, Pensauken, NJ
Sheila Maria Maurer, MD, Winston Salem, NC
Jessica Mayer, MD, Indianapolis, IN
Paula Augusta Vieira Medeiros, MD, Lisboa, Portugal
Crystal Mehta, MD, Indianapolis, IN
Avni Mehta, Ann Arbor, MI
Carlos Melendez Garcia, Villalba, PR
Megan Ann Mendoza, MD, New York, NY
Michael Mensah, San Francisco, CA
Philip Merideth, MD, Jackson, MS
Christy Meyer, Sacramento, CA
Matthew Meyers, Chicago, IL
Laura Jane Miller, MD, Decatur, GA
Raina Milne, MD, Mansfield, MA
Sulman A. Mirza, MD, Baltimore, MD
Jani Modip Avari, MD, White Plains, NY
Leena Mohan, MD, Woodbury, NY
Douna Montazeralghaem, MD, Brooklyn, NY
Ashley Moreno, Chicago, IL
Daniel Moreno De Luca, MD, MSc, Providence, RI
Aris Mosley, MD, Mesa, AZ
Syed Mustafa, MD, PhD, Bothell, WA
Bettina Mutter, MD, Walnut Creek, CA
Farid Nader, MD, Newbury Park, CA
Lauren Nagy, Pisacatway, NJ
Reena Nandihalli, DO, Portland, OR
Anjali Narayan, Port Washington, NY
Lauren Narcisse, Chicago, IL
Tiffany Quyen Y. Nguyen, Sacramento, CA
Van Nguyen, Houston, TX
David Nguyen, Bowling Green, KY
Sohail Amar Nibras, MD, Ballwin, MO
Yunan Nie, New York, NY
Katherine Oberhelman, New Orleans, LA
Toritsejai Okoroedu, Hollywood, FL
Garth Olango, MD, Bakersfield, CA
Elizabeth Olsen, Staten Island, NY
Orlando Ortiz, MD, Albuquerque, NM
Francine Ouellet, MD, MSc, FRCP, Quebec, Canada
Padma Palvai, MD, Gachibowli, Telangana Hyderabad, India
Yajaira Paparone, MD, Jamesville, NY
Chitra Parab, FRACP, MPh, Woonona, Australia
Priyanka Patil, MD, Jamesville, NY
Suravi Patra, MD, Bhubaneswar, Odisha, India
Analise Peleggi, Albany, NY
Hannibal Person, MD, New York, NY
Tuong Pham, Sacramento, CA
Lisa Piazza, MD, New York, NY
Leslie Pillow, Columbus, OH
Ashley Pirozzi, MD, San Francisco, CA
David Pollard, Austin, TX
Catherine Pourdavoud, Sacramento, CA
Thomas Pyo, Houston, TX
Sarah Quaratella, Barrington, RI
Naseem Rad, Oakland, CA
Stephanie Redemeyer, Tucson, AZ
Jace Reed, Lubbock, TX
Jehoshaphat Reich, Williamsport, PA
Lucia Ricardo, Hialeah, FL
Jeannine Rider, Providence, RI
Tracie Rivera, MD, Eureka, CA
Brian Rodyssil, Rochester, MN
Daniel Rohlf, MD, Iowa City, IA
Max Rosen, MD, Saint Louis, MO
Audrey Rossowski, DO, Allentown, PA
Nichole Roxas, Franklin Lakes, NJ
Thais Salan, MD, Sao Paulo, Brazil
Kaitlyn Salter, Jackson, MS
Audrey Sivasothy, MD, Santa Monica, CA
Priyanka Sinha, MD, New York, NY
Sajeev Sinha, MD, Detroit, MI
Erika Sims, Columbus, OH
Venkateshram Singa, Atlanta, GA
Daljinder Singh, MD, Las Vegas, NV
Mauran Sivananthan, DO, Ann Arbor, MI
Margaret Skoch, Oak Park, IL
Hina Smith, MD, Gainesville, FL
Sameep Solanki, San Jose, CA
Jared Solomon, MD, Reno, NV
Adetoun Soeyemi, MD, Abeokuta, Ogun, Nigeria
A. Benjamin Srivastava, MD, Saint Louis, MO
Hirsch Srivastava, Columbia, MO
Brian Stockhouse, New Haven, CT
Phillip L. Stoll, MD, Morton, IL
Johnathan Stathopoulos, Cayce, SC
Anu Stephen, Elk Grove, CA
Zachary J. Sullivan, DO, Tomball, TX
Michael E. Sutton, MD, Roden, Netherlands
Paula Tabares, MD, Yonkers, NY
Jaspinder Tahim, DO, MPH, Bakersfield, CA
Timothy Tawa, MD, Cerritos, CA
Matthew Taylor, MD, Baltimore, MD
George Taylor, Burlington, VT
Gustavo H. Teixeira, MD, Sao Jose Do Rio Preto, SP, Brazil
Steven Tessler, Brooklyn, NY
Jessica Thai, Omaha, NE
Rejini Thomas, MD, Brooklyn, NY
Lynn C. Thomas, MD, Little Rock, AR
Maria Del Carmen Torres, Ponce, PR
Ali Evren Tufan, MD, Bolu, Turkey
Tali Tuvia, MD, New York, NY
Hiren Umrania, MD, Brooklyn, NY
Tom Vadakara, MD, Burr Ridge, IL
Frank Valdez, Sacramento, CA
Arvind Vaz, MD, Nashville, TN
Katherine Venegas, Chicago, IL
Scott Vicenzi, Fort Worth, TX
Ksenia Voronina, MD, Seattle, WA
Haiyan Wang, MD, New York, NY
Matthew Wasser, MD, Glen Oaks, NY
Warnie L. Webster, MD, Acton, MA
Krstin Weinschenk, MD, Atlanta, GA
Nils Westfall, MD, Miami, FL
Mack Whitehead, Spanish Fork, UT
Tjhin Wiguna, MD, PhD, DKI Jacarta, Indonesia
Nolan Williams, MD, Albuquerque, NM
Francois Williams, Atlanta, GA
Alexander Wittenberg, Brooklyn, NY
Alyssa Wood, MD, Coralville, IA
Charles Wulf, MD, Providence, RI
Clare Wyman, Erie, PA
Junko Yamaoka, MBBS, Mount Waverley, VIC, Australia
Shinji Yasugi, MD
Junko Yamaoka, MBBS
Claire Wyman
Saba Zaman, Schaumburg, IL
Giovanni Zelada, Sacramento, CA
Saúl Zelán, MD, Reno, NV
Christopher Zimmerman, Novato, CA
It Does Not Hurt To Ask

Samantha Phillips, Membership and Communications Coordinator

People are often hesitant to ask their friends and family for donations. They may think it’s off-putting or tough to persuade someone to part with their money. However, after years of experience fundraising as an individual on behalf of a variety of causes and several different non-profits, I disagree and have come to believe that it never hurts to simply ask.

Fundraising is about sharing your interests with the people in your life. Furthermore, you’re doing it for a good cause, and you’re not putting the person in a difficult position. You’re presenting them with an opportunity, which they can choose to turn down if they’re not interested. However, here are some tips to help you get them to say yes when you ask.

Passion is Contagious

You are asking for a donation because you care about the cause; you’re not doing this because you’re required or someone is forcing you. You’re a volunteer that is inspired – share that inspiration! Communicating your connection to the cause, including how and why you got involved, will help your potential donor understand why it matters. Even if the individual does not have a direct tie to the cause, they have one to you. Show the person who cares about you how much you care about the effort you’re fundraising for, and you will convince them to support what you support.

Know Where the Money is Going

People often want to know the details of what their donation is supporting. Is the organization a non-profit and the donation going to their cause? Does the organization have multiple missions? Which is the donation directly supporting? Will the donation be earmarked for a particular fund? You want to know the basics of where the money is going when someone asks in order to be able to prove the validity of your cause. The organization should have a page explaining this information, so simply share it if someone wants to learn more. You’ll come across as the expert you are on this cause.

Make Your Request Clear and Easy

You’ve explained what the person would be supporting and why you think they should. Now comes the actual ask. Be straightforward with it. Are you hoping for them to donate, fundraise, post on social media, or get involved in another way? The option you present will depend on the person, the conversation you have with them, and your own goals. Regardless, the object is to avoid overwhelming them with too many options. Make it clear what you’re asking from them, and then make it easy for them to do it. Provide them with a direct link to the donation site or with instructions with how to become a fellow fundraiser. That way they’ll be even more likely to follow through!

I hope you’ll use these tips to go out and fundraise amongst your friends and family. As you are part of my AACAP family, I would like to share with you a cause that I fully support – Break the Cycle – as an example.

Andrés Martín, MD, MPH, a child and adolescent psychiatrist and prominent AACAP member, is leading this cross-country bike ride from Washington State to Washington, DC, from August to October, to raise awareness of the challenges faced by children with mental illnesses.

Happy fundraising!

Samantha Phillips, Membership and Communications Coordinator, AACAP, sphillips@aacap.org

Passion is Contagious

As you know, children’s mental illnesses are real, common, and treatable. Yet today in the United States, this vulnerable population is caught in a vicious cycle of limited access to care, delayed treatment, and worsening illnesses.

Children with mental illnesses deserve to be protected and assisted, rather than stigmatized. Dr. Martín’s doing his part with his ride to raise awareness and support. I intend to do my part by spreading the word, which is why I’m sharing this worthy endeavor with you today. I hope you’ll consider doing your own part to help Break the Cycle of children’s mental illnesses. You are the solution!

Know Where the Money is Going

Your donation to Break the Cycle directly supports AACAP’s Campaign for America’s Kids (CFAK). CFAK’s mission is to support innovative initiatives in advocacy, education, and research that improve access to mental health treatments for all children.

Your donation will:

- Fund innovative research initiatives
  - Launch research careers that promote quality mental health services and treatment for children.

- Increase the number of child and adolescent psychiatrists
  - By educating, encouraging, and providing the tools for students to join the field, AACAP tackles the current shortage of child psychiatrists, which impacts access to mental health services for children and families.

- Help ensure that children suffering in silence get the treatment they need
  - Stigma and the shortage of child psychiatrists means many children are currently unable to access mental health care. Help give a voice to those who can not stand up for themselves.

Make Your Request Clear and Easy

Visit breakthecycle.aacap.org/donate today to donate or learn how you can be a fundraiser for Break the Cycle! You’ll find additional fundraising tools and other ways to get involved online.
13% of youth ages 8-15 have a mental illness severe enough to cause significant impairment in day-to-day living.

79% of children ages 6-17 with mental illnesses do not receive treatment.

Nearly 50% of students age 14+ with mental illness drop out of high school (the highest rate of any disability group).

More than 4,600 youth die by suicide annually, yet experts believe nearly 80% are preventable.

Studies indicate on average the delay between first onset of symptoms and treatment is 8 to 10 years.

50% of all lifetime cases of mental illness are diagnosed by age 14.

JOIN US

ON OUR BIKE RIDE ACROSS THE NATION AND HELP US BREAK THE CYCLE OF CHILDREN'S MENTAL ILLNESSES

Children's mental illnesses are REAL, COMMON, and TREATABLE. Yet today in the United States, this vulnerable population is caught in a vicious cycle of limited access to care, delayed treatment, and worsening illnesses.

Join us on our ride to Break the Cycle, raising awareness and support to (1) fund new research initiatives, (2) increase the number of child and adolescent psychiatrists, and (3) help ensure that children suffering in silence get the treatment they need.

Visit BREAKTHECYCLE.AACAP.ORG and make a donation, take the pledge, or sign up to be a rider.
Thank You for Supporting AACAP!

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

Gifts Received March 1, 2017 to April 30, 2017

**$1,000 to $2,499**

**Where Most Needed**

*General Contribution*

Bruce Bank*, in honor of Andrés Martin, MD
Sandi Kazura, MD
Saul Wasserman, MD

**$500 to $999**

**Break the Cycle**

Devanand Manoli, MD, PhD°

**Campaign for America’s Kids**
Karen Freidus*

**$100 to $499**

**Break the Cycle**

Boris Birmaher, MD°
Justin Joffe*
Streamline Consulting*

**Campaign for America’s Kids**

Gabrielle A. Carlson, MD°
Martin J. Drell, MD♥

**Life Members Fund**

Allan H. Rabin, MD, DLFAACAP
Joan S. Narad, MD
Nirmalam Nagulendran, MD

**AACAP Research Initiative**

Boris Birmaher, MD°

**Where Most Needed**

*General Contribution*

Mary Diamond, DO
Matthew N. Koury, MD, MPH♥
Nancy A. Brown, in honor of Robert O. Brown

**Up to $99**

**Break the Cycle**

Basil Bernstein, MD*♥

**Campaign for America’s Kids**

Abigail B. Schlesinger, MD
Abigail Huertas Paton, MD* Adele R. Pressman, MD
Annie Li, MD
Ashley Angert, DO* April Fields, MD*

Brigitte Bailey, MD
Brigitte Hristea, MD
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Sandra L. Fritsch, MD
Christopher Fox, DO*
Dana S. Rubin, MD, MSW
Denys E. Arrieta, MD
Elizabeth Homan, MD
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Gloria M. Carrera, MD
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Jeffrey Rowe, MD
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Jennifer L. Edwards, MD
Jieun Kim, MD
John A. Allen, MD*
Jonathan T. Megerian, MD, PhD*
Karen A. Goldberg, MG
Kathleen Hughes-Kuda, MD
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Maria Valena, MD
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Nerissa Galang-Feather, MD
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Patricia A. Toups, MD
Rajneesh Mahajan, MD
Ranjay Halder, MD*
Rheanna Platt, MD
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Robert B. Devney, MD*
Robert P. Holloway, MD
Segundo Sergio S. Robert-Ibarra, MD*
Thomas P. Williams, MD, PhD
Welby Nielsen, DO*
William C. Wood, MD
Zhanna Verkh, MD*

Virginia Q. Anthony Fund
Alice R. Mao, MD♥

AACAP Research Initiative
Stephen P. Cuffe, MD♥

**Where Most Needed**

*General Contribution*

David VanBushkirk, MD*
John Hertzer, MD
Leandro Neto*
Lisa Zbaraschuk, MD
Marion Joffe*
Mini Tandon, DO♥
Ryan Herringa, MD, PhD♥
Stephen J. Cozza, MD♥

**1953 Society Members**

Anonymous (5)
Steve and Babette Cufée
James C. Harris, MD and Catherine DeAngelis, MD, MPH
Paramjit T. Joshi, MD
Joan E. Kinlan, MD
Dr. Michael Maloney and Dr. Marta Pisarska
Jack and Sally McDermott (Dr. Jack McDermott, in memoriam)
Patricia A. McKnight, MD
Scott M. Falyo, MD
The Roberto Family
Diane H. Schetky, MD
Gabrielle L. Shapiro, MD
Diane K. Shrier, MD and Adam Louis Shrier, D.Eng., JD

* Indicates a first-time donor to AACAP
° Indicates an honorarium donation
♥ Indicates a Hope Maker recurring monthly donation

ERRATA from March/April issue of AACAP News:

Ledro Justice, MD, made a donation to where most needed, general contributions in the $1,000 to $2,499 range.

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org or 202.966.7300 ext. 140.
CLASSIFIEDS

CALIFORNIA

ACADEMIC PSYCHIATRIST

FACULTY POSITIONS – UCLA

Job Description:

UCLA’s Department of Psychiatry and Biobehavioral Sciences, in conjunction with the Center for Autism Research and Treatment (CART) and the Intellectual/Developmental Disabilities Research Center (IDDRC) within the Semel Institute for Neuroscience and Human Behavior, seeks full-time entry- or mid-level academic psychiatrists to participate in child and adult autism and neurodevelopmental disorder related translational research and clinical programs. Responsibilities will combine independent and collaborative research, teaching and supervising duties, and direct clinical care in outpatient clinical programs for children and adults. The faculty appointment will be in the academic in-residence series with rank dependent on the experience of the individual. Prior clinical and research accomplishments including postdoctoral training; expertise in Autism Spectrum Disorder and neurodevelopmental disorder (eg. schizophrenia, neurogenetic syndromes) diagnosis and treatment; research interest in phenotyping, biomarker investigation, or treatment; or other specialized research or clinical skills will be considered added qualifications. Candidates must possess an MD or MD/PhD degree. Must be board-certified or board-eligible in either general or child and adolescent psychiatry. Must possess or be eligible for a permanent California medical license.

Job Requirements:

Must possess an MD or MD/PhD degree. Must be board-certified or board-eligible in either general or child and adolescent psychiatry. Must possess or be eligible for a permanent California medical license.

Company: UCLA - Department of Psychiatry and Biobehavioral Sciences

Job ID: (1033420)

http://jobs.source.aacap.org/jobs/8955131

CHILD AND ADOLESCENT PSYCHIATRIST – LONG ISLAND

Job Description:

Island Psychiatry is seeking a Child and Adolescent Psychiatrist to join our expanding multidisciplinary Mental Health Practice located in Port Jefferson Station on Long Island. This person will serve as a key member of our leadership team. Island Psychiatry, PC was founded with the aim of providing a broad range of high quality mental health services. We are looking for talented, caring, and highly motivated professionals who will advance our ability to deliver comprehensive care. We offer competitive and incentivized compensation, excellent benefits and an opportunity to grow professionally among clinical professionals of a variety of disciplines. Responsibilities: Overseer and deliver comprehensive psychiatric care to children and adolescents Complete psychiatric screenings and evaluations Conduct examinations and consultations Obtain and review lab work and evaluate other medical conditions and documentation Make clinical recommendations Prescribe and monitor medications Consult with Workers, Behavioral Health nurses and other clinicians specializing in mental health. Highly effective programs, treating close to 10,000 patients a year. Competitive compensation and benefits package, including productivity option and relocation Berkshire Medical Center, BHS’s 302-bed community teaching hospital and Trauma Center, is a major teaching affiliate of the University of Massachusetts Medical School. With the latest technology and a system-wide electronic health record, BHS is the region’s leading provider of comprehensive healthcare services. This is a great opportunity to practice in a beautiful and culturally rich area while being affiliated with a health system with award winning programs, nationally recognized physicians, and world class technology.

Company: Berkshire Health Systems

Job ID: 8955131

http://jobsource.aacap.org/jobs/8955131

NEW YORK

CHILD AND ADOLESCENT PSYCHIATRIST – BERKSHIRSES

Job Description:

We understand the importance of balancing work with a healthy personal lifestyle. Berkshires, a 4-season resort community Endless cultural opportunities world renowned music, art, theater, and museums Year round recreational activities from skiing to kayaking. Excellent public and private schools make this an ideal family location Just 2 ½ hours from both Boston and New York City. Berkshire Health Systems Opportunity BE/BC Child/Adolescent Psychiatrist Collaboration with Clinical Psychologists, Neuropsychologists, Clinical Nurse Specialists, Social
interdisciplinary treatment teams Utilize an EMR to complete progress notes and e-prescribe. Qualifications: Board eligible with the expectation of becoming Board Certified Experience and comfortability with EHR systems. To apply, please email nadine@islandpsychiatry.com. *Applicants only please, no recruiters.

Company: Island Psychiatry (1030367)
Job ID: 8907887
http://jobsource.aacap.org/jobs/8907887

MISSOURI AND LOUISIANA

CHILD AND ADOLESCENT PSYCHIATRISTS – ST. LOUIS, MO, AND NEW ORLEANS, LA

Job Description: Come grow with Mercy Kids. Child and Adolescent Psychiatrists Positions in Missouri and New Orleans SIGN ON BONUS and FELLOWSHIP STIPEND AVAILABLE. Mercy Clinic is seeking full-time BE/BC Child and Adolescent Psychiatrists to join our established group practices located at Mercy Children’s Hospital in St. Louis, Mercy Hospital Jefferson in Festus, Missouri and Mercy Family Center in New Orleans. Opportunities: Mercy Children’s Hospital St. Louis is seeking a Child and Adolescent Psychiatrist to join a practice with five Board-Certified Child and Adolescent Psychiatrists delivering inpatient and outpatient services. Mercy Hospital is the largest child and adolescent psychiatry group in Missouri with 175 pediatric providers on staff with over 80 fellowship-trained pediatric specialists Mercy Hospital Jefferson in Festus, Missouri is a 251-bed acute care facility and is 30 minutes south of St. Louis. Primary responsibilities will be to set up clinic services – both outpatient practice and IOP program. Mercy Family Center in New Orleans is seeking a Child and Adolescent Psychiatrist to join an established group practice located at our Metairie clinic. Mercy Family Center is a multi-disciplinary outpatient behavioral health clinic comprised of 20 full time employees serving nearly 3,000 families. This Position Offers: Integrated health system with a competitive income guarantee. Comprehensive benefits including health, dental, vision and CME. Relocation assistance and professional liability coverage. System-wide EPIC EMR. Sponsorship of H1B Visa.

For more information, please contact: Lisa Hauck, MBA, Senior Physician Recruiter 314-364-3840 fax: 314-364-2597 lisa.hauck@mercy.net mercyfamilycenter.com EOEA/Minorities/Females/Disabled/ Veterans Employer

Company: Mercy (883968)
Job ID: 8570582
http://jobsource.aacap.org/jobs/8570582

MINNESOTA

CHILD AND ADOLESCENT PSYCHIATRIST AND ADOLESCENT BEHAVIORAL HEALTH SERVICES – WILLMAR

Job Description: We have a great opportunity for the right person to lead a group of dedicated staff committed to delivering exceptional care to a complex pediatric population. Our multidisciplinary healthcare employees bring a wealth of education and experience to the task of mental health service; their efforts are invaluable to the ongoing mission of the organization. Our Child and Adolescent Behavioral Health Services provides person centered mental health services to those between the ages of 6 and 18 who have a serious emotional disturbance and whose needs may exceed the resource capacities of their families and local communities. The average length of stay is in the range of 25 to 45 days. We have excellent support staff and collegial working environment. Job Description: Provide clinical oversight and direction to 6 to 8 youth. Provide daily consultation at rounds and report. Why join our team? Our system is devoted to providing high-quality care for those who most need it. Opportunity for a University of Minnesota clinical faculty appointment in Psychiatry No third party billing issues Flexible work schedule More earning possible via voluntary on-call Strong team structure Time off for continued education Loan reimbursement incentive Some relocation reimbursement Low-cost health and dental insurance Defined pension plan Earn up to 29 paid vacation days per year 11 paid holidays Earn 13 sick days per year Minnesota has a long tradition of leadership in innovative health care delivery systems. As health care reform unfolds, and states are also faced with the “Olmstead” challenges of better community integration, Minnesota is an exciting place where psychiatrists can be part of bigger changes as well as doing quality clinical work with excellent supports. Our psychiatrists enjoy a collegial relationship with each other and with medical leadership. Teaching opportunities are abundant, and Weekly Case Conferences provide learning consultation, support, and CME’s. Our medical directors are clinicians first, and are strong advocates for quality of care. CABHS is a good environment for finding that elusive work/life balance. Location: Willmar is surrounded by a multitude of recreational lakes, recreational trails, and provides a growing housing and job market. Willmar has been dubbed the 19th most livable metropolitan city in the nation in Life in America’s Small Cities, and made Demographics Daily’s “dream town” list. It offers the metropolitan conveniences while maintaining a small-town feel. Benefits: In addition to a competitive salary, the State of Minnesota offers excellent employee benefits including a defined benefit pension (increasingly rare!), deferred compensation plan, low-cost health and dental insurance, and affordable dependent coverage. Reimbursement may also be available for some relocation expenses. Other benefits include: Up to 29 paid vacation days 13 paid sick days 11 paid holidays Life insurance (optional family) Ongoing educational opportunities Short-term disability Long-term disability Health care savings plan Pre-tax benefits Credit union membership available I’m available to answer any questions you may have about this or other career opportunities. Contact me for more information or submit your resume/CV by email: Lena Garcia Physician/Clinical Recruitment Specialist Phone: 651-431-3672 Email: lena.garcia@state.mn.us.

Job Requirements: BE or BC Child and Adolescent Psychiatrist

Company: Minnesota Department of Human Services (980150)
Job ID: 8894809
http://jobsource.aacap.org/jobs/8894809

continued on page 138
SOUTH CAROLINA
EMERGENCY PSYCHIATRIST
– GREENVILLE

Job Description:
Greenville Health System (GHS) seeks an Emergency Psychiatrist as faculty in the Department of Emergency Medicine, Division of Emergency Psychiatry. Successful candidates should be prepared to shape the future of Emergency Psychiatry at GHS and contribute to the academic output of the department. GHS is the largest healthcare provider in South Carolina and serves as the tertiary referral center for the entire Upstate region. As an integral system component, the Department of Emergency Medicine provides care in 6 Emergency Departments and 5 urgent care centers. Our program offers: Division leadership that is dual trained in Emergency Medicine and Psychiatry; Dedicated Psychiatric Area within the ED; Team of psychiatric social workers and advanced practice providers with mental health training; Inpatient child and adult psychiatric units located on campus; Five Community Hospital Emergency Departments; Level I Trauma Center; Dedicated Pediatric Emergency Department within the Children’s Hospital; Accredited 3-year Emergency Medicine Residency Program and 4-year Psychiatry Residency The campus hosts 15 residency and fellowship programs and one of the nation’s newest allopathic medical schools – University of South Carolina School of Medicine Greenville. Faculty within the newly developed Emergency Psychiatry Division within the Department of Emergency Medicine enjoy a flexible work schedule, highly competitive salary, generous benefits, and additional incentives based on clinical, operational and academic productivity. Greenville, South Carolina is a beautiful place to live and work. It is one of the fastest growing areas in the country, and is ideally situated near beautiful mountains, beaches and lakes. We enjoy a diverse and thriving economy, excellent quality of life, and wonderful cultural and educational opportunities. *Public Service Loan Forgiveness (PSLF) Program Qualified Employer* Qualified candidates should submit a letter of interest and CV to: Kendra Hall, Sr. Physician Recruiter, kbhall@ghs.org, ph: 800-772-6987. GHS does not offer sponsorship at this time. EOE

Company: Greenville Health System
Job ID: 8990660
http://jobsource.aacap.org/jobs/8990660
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