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October 22–27, 2018
Seattle, WA
Washington State Convention Center

Call for Papers Deadline:
February 15, 2018

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June 15, 2018

Preliminary Program Available:
June 15, 2018

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Visit www.aacap.org/AnnualMeeting-2018 for the latest information!
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**Cover Photo:** This picture happened at the Annual Meeting when I bumped into the second-year child psychiatry fellows/residents from the NYP Columbia/Cornell program. I wanted to take a picture of all of them in front of the AACAP Sign to celebrate their AACAP experience and send to the program directors. They were all having a great time. Then, Fred Seligman, MD, came by with his camera and stated that I should get into the picture. So, without thinking, I jumped into the photo and assumed a “Zen pose,” because our fellows celebrate “Wellness in Training.” I thought that it would embody their collective spirit of being happy child psychiatrists! – Warren Ng, MD

The names of the trainees: Michael Hoffnung, DO, Colby Tyson, MD, Alison Lenet, MD, Jessica Simberlund, MD, Alice Caesar, MD, Sherry Yao, Liza Mishan, MD, Duncan Cheng, MD, and Pantea Farahmand, MD
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

FUNCTION AND ROLES OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy

■ Establishes and supports the highest ethical and professional standards of clinical practice.

■ Advocates for the mental health and public health needs of children, adolescents, and families.

■ Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.

■ Liases with other physicians and health care providers and collaborates with others who share common goals.

AACAP NEWS
The mission of AACAP News includes:

1. Communication among AACAP members, components, and leadership.
2. Education regarding child and adolescent psychiatry.
3. Recording the history of AACAP.
4. Artistic and creative expression of AACAP members.
5. Provide information regarding upcoming AACAP events.
6. Provide a recruitment tool.

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PRESIDENT’S COLUMN

Presidential Address: Depression Awareness and Screening in Children and Adolescents

Karen Dineen Wagner, MD, PhD

I am honored to highlight my presidential initiative at the opening plenary of the 64th Annual Meeting of the American Academy of Child and Adolescent Psychiatry (AACAP). As you know, my career focus has centered on mood disorders in children and adolescents, particularly major depression. My presidential initiative is to increase awareness of and screening for depression in children and adolescents.

The prevalence rates of depression have been increasing in youth, with reported rates of 11% in adolescents.1 As child and adolescent psychiatrists, we know the devastating impact of depression on children’s emotional, social, and cognitive development. Friendships are lost, family conflict ensues, and academic failures occur when children and adolescents are depressed. We have witnessed their despair; for example, the depressed 9-year-old who says, “No one could ever love me,” and the depressed 14-year-old who looks at you with dull eyes and says, “I am too empty to live.” We know that the typical duration of an episode of depression is 9 months, which is an entire school year. Of grave concern is the risk of suicide for youth with depression. As reported by the Centers for Disease Control and Prevention, suicide rates have increased steadily in the past decade, with the greatest increase for girls 10 to 14 years old.2

Youth with depression are at risk for recurrent episodes of depression, comorbid psychiatric disorders, and medical conditions. Approximately 50% of teenagers with depression are likely to have a recurrence of depression. Youth with depression often have comorbid psychiatric disorders such as anxiety disorders, attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, eating disorders, and substance use disorders, which complicate the course and treatment of depression. The American Heart Association issued a scientific statement that major depression in youth is a moderate risk condition for accelerated atherosclerosis and early cardiovascular disease.3

Although we, as child and adolescent psychiatrists, are all too familiar with the outcome of untreated depression, it is important for the public to be more informed about depression in youth. We have a responsibility as the leading organization in children’s mental health to increase awareness of and screening for depression in children and adolescents.

The US Preventive Services Task Force (USPSTF) reviewed the evidence on the benefits and harms of depression screening in children and adolescents and the accuracy of screening tests administered in primary care settings.4 Based on their review, the USPSTF recommends screening for major depressive disorder in adolescents 12 to 18 years old. The USPSTF further recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The Patient Health Questionnaire (PHQ-A) was found to have the highest positive predictive value as a screening instrument.5 The PHQ-A has a reported sensitivity of 73% and specificity of 94%. Treatment of major depressive disorder that was detected through screening in adolescents was associated with moderate benefits, such as improvements in depression severity, depression symptoms, or global functioning scores. The USPSTF found no direct evidence of harms of screening for major depressive disorder in adolescents.

The USPSTF found that current evidence is insufficient to assess the balance of benefits and harms of screening for major depressive disorder in children 11 years or younger. It was noted that data on the accuracy of major depressive disorder screening instruments in children are limited.

With regard to depression screening intervals, the USPSTF found no evidence on appropriate or recommended screening intervals. However, repeated screening can be most useful for adolescents with risk factors for major depressive disorder.

This presidential initiative on depression awareness and screening in children and adolescents will have a multipronged approach including education, expansion of the Depression Resource Center, and collaboration with professional organizations and government agencies.

Education

Education about the prevalence, symptoms, and course of depression in children and adolescents is an essential component of this initiative. Parents and their children are often unaware of the symptoms of depression. It is readily understandable why parents might not recognize the symptoms of depression in their children. Unlike some other illnesses, the symptoms of depression...
tend to evolve over time. Also, parents often view their children’s moodiness as a normal phase of development, which it could be. If a teenager is irritable and has less interest in doing previous activities, then the parent might think it is typical teenage behavior. If further symptoms develop, such as sleep problems and low self-esteem, then parents might have some concerns but hope that the symptoms will pass with time. When the teenager’s irritability disrupts family functioning, school grades decline significantly, or the teenager begins cutting or mentions suicidal thoughts, then parents tend to seek help for their teenager. In my experience, the time from symptom onset of depression to clinical evaluation is approximately 2 years. If parents were educated about the symptoms of depression in children and adolescents, then intervention could be earlier to decrease the likelihood of impairment for their children.

When children appear physically ill, parents routinely ask their children if they feel sick. Parents should be encouraged to ask their children how they feel when their children’s mood seems different than usual. Parents also should be educated about risk factors for depression in their children such as a family history of depression, bullying, substance abuse, and child abuse.

Teenagers often do not recognize the symptoms of depression or might not use the term “depression” to describe their mood. “Stressed out,” “bored,” and “nothing feels right” are common expressions used by teenagers with depression. If teenagers feel irritable, they tend to blame their irritability on the people around them, that is, other people are trying to annoy them. Teenagers often are not cognizant of the effects of their irritability on their interactions with other people. Depression symptoms such as sleep difficulties, feeling tired, and poor concentration can be attributed by teenagers to the demands of school work and activities. When teenagers reach the point of not wanting to do anything or start to think about suicide, then they are more likely to recognize that there is a problem with their mood. Teenagers need to know that they can talk to their parents, school counselor, or other responsible adult about their mood.

**Depression Resource Center**

I envision the AACAP online Depression Resource Center as the go-to place for clinicians, parents, youth, and organizations to obtain up-to-date evidence-based information about depression in children and adolescents. All information on the existing Depression Resource Center will be reviewed, updated, and expanded. The Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders (last updated 2007)6 will be replaced by a planned Clinical Practice Guideline on the Assessment and Treatment of Depression in Children and Adolescents. Similarly, the Parents Medication Guide on the Use of Medication in Treating Childhood and Adolescent Depression: Information for Patients and Families (last updated 2010)7 will be revised and updated.

The Depression Resource Center will have sections related to depression in children and adolescents as follows: Facts for Families; Frequently Asked Questions; Parent Medication Guide on Depression in Children and Adolescents; Clinical Practice Guideline on Assessment and Treatment of Depression in Children and Adolescents; Screening Instruments for Depression; Clinical Rating Scales for Depression; Major Studies and Publications on Depression in Youth; and links to other professional organizations and resources.

In addition, I would like a section to be developed for teenagers to help increase their understanding of depression, treatment, and resources for help. Development of a Facts for Teenagers on Depression and Frequently Asked Questions by Teenagers such as “What should I do if I’m feeling down?” will be components of this section.

**Collaboration**

To promote depression awareness and screening in children and adolescents, it will be important to collaborate with other national organizations and agencies that deal with children’s mental health issues. As part of this initiative, AACAP will initiate engagement with organizations such as the American Psychiatric Association, American Academy of Pediatrics, American Academy of Family Physicians, American Psychological Association, American Foundation for Suicide Prevention, National Alliance on Mental Illness, Depression and Bipolar Support Alliance, National Institute of Mental Health, and Substance Abuse and Mental Health Services Administration, among others. With the support of these organizations, it is more likely we will achieve the goal of depression screening as routine health assessment for youth.

I have appointed a Presidential Task Force to work with me on this initiative. There is wide representation from AACAP committees including Healthcare Access and Economics, Consumer Issues, Advocacy, Quality Issues, Research, Psychopharmacology, Health Prevention and Promotion, Program, and Web Editorial Board. This initiative will further evolve with input from the Task Force members.

I invite you, as Academy members, to join me in the effort to raise public awareness of depression in children and adolescents and to promote routine screening for depression in youth.

**References**


Dr. Wagner is Professor and Chair, Department of Psychiatry and Behavioral Sciences, University of Texas Medical Branch, Galveston, and is president of the American Academy of Child and Adolescent Psychiatry, 2018 to 2020.

A version of this Presidential Address was delivered on October 25, 2017, at AACAP’s 64th Annual Meeting in Washington, DC.

Disclosure: Dr. Wagner has served as councilor and AACAP delegate to the Texas Society of Child and Adolescent Psychiatry, on the Scientific Advisory Board of the Anxiety Disorders Association of America, and on the Scientific Council of the Brain and Behavior Research Foundation (no financial compensation was received). She has received honoraria from the AACAP, the American Psychiatric Association, the American Society of Clinical Psychopharmacology, the Nevada Psychiatric Association, UBM Medica US, and CME Outfitters.

AACAP Catchers in the Rye Humanitarian Award

Deadline: March 20, 2018

Nominations are now being accepted for the American Academy of Child and Adolescent Psychiatry (AACAP)’s Catchers in the Rye Humanitarian Award. This award honors a non-AACAP-member who has made significant contributions to the field of children’s mental health. Contributions may include but are not limited to philanthropy, research, entrepreneurship, advocacy, increasing awareness, acts of bravery and kindness.

The AACAP Catcher’s in the Rye Humanitarian Award recipient will be recognized for their impact on children’s mental health at the 65th Annual Meeting, October 22-27, 2018, Seattle, Washington. Recipients are required to attend the awards ceremony at the Annual Meeting.

All nominations must be submitted to the AACAP Development Office via email at development@aacap.org. Nominations must be in a Word document or PDF. Please write “AACAP 2018 Humanitarian Award Nomination” in the subject line of the email.

Humanitarian Award Nominees:
- Only AACAP members may submit nominations
- Only non-AACAP-members are eligible to receive the award

Please submit the following information with the nomination:
- Name and contact information, including email, phone number, and mailing address, of nominator
- Name and contact information, including email, phone number, and mailing address, of the nominee
- 2-3 paragraph biography or C.V. of the nominee
- 250-500 word explanation of why the nominee deserves the award
- If available, supporting information that would be helpful to inform the selection committee, such as a website, book, magazine or journal profile

If you have questions about the award the award process, please contact Development Office via email at development@aacap.org.
The Psychiatry and Behavioral Medicine Unit (PBMU) at Seattle Children's Hospital is a 41-bed, acute crisis stabilization unit that serves a diverse population of children and adolescents. We treat patients from ages 3 to 18 years old with all types of psychiatric disorders, and with various degrees of medical complexity, intellectual disabilities, and/or developmental delays, while maintaining a seclusion- and restraint-free environment.

Over the past three years, our unit expanded from 20 beds to 41 beds. We now occupy parts of two different floors within the main hospital building of Seattle Children's. This expansion involved a significant renovation and redesign with a focus on supporting our restraint- and seclusion-free philosophy while being more family-centered and inclusive.

Towards this family focus, some specific changes were made, including giving caregivers access badges and keys to navigate the unit, and building a parent/caregiver bed into each patient bedroom. The access badge allows parents to walk around the unit, including between floors and into various spaces, which are separated by locking doors. The key allows them to unlock their child’s bedroom and bathroom. Each patient has a private bedroom; patients share bathrooms except for cases of specific treatment needs or infection-prevention scenarios, such as Methicillin-resistant Staphylococcus aureus (MRSA) colonization. The keys and access badge do not allow parents to exit the unit.

Before making this change, there was moderate anxiety about giving parents means to wander around our acute inpatient unit. Would they accidentally walk into an agitated patient’s space and get hurt? Would they inadvertently let other patients go into areas that are not appropriate for them? Would mass chaos ensue?

Several years later, we can report that there has not been mass chaos. In fact, there have been no significant safety events related to misuse of keys or badges. Parents have formally commented positively about this feature in our Family Experience Surveys, and informally in discussions about their experiences on the inpatient unit. In particular, parents who had a child hospitalized on our unit prior to our renovations have stated that they feel more included and welcome in our therapeutic environment since this change was made.

Another change was the inclusion of a parent bed in every patient room. Every patient hospitalized on our unit has a private bedroom with two twin beds, one for the patient and one for a caregiver. Below one bed is a locking drawer for parents to safely store belongings. Some parents, especially those who live far away, choose to stay with their child throughout hospitalization. Some stay the first night, and then when they are more comfortable with our environment, return home for the rest of their child’s hospital stay. Some parents spend the night on the day prior to discharge so that they are ready to take their child home as early as possible the next morning. Even though the second bed is not always used, caregivers have reported that they appreciate the option to staying with their child. Parental sleeping arrangements are offered in most other rooms in the hospital; consistency in features like this may be a small step towards reducing the stigma of psychiatric hospitalization.

A few other interventions aim to support caregivers in being active participants in our treatment program. A parent-only lounge on our unit has lockers, a refrigerator and microwave, coffee, sofas, a television, and a few computers. On most days, we offer parent discussion groups focused on specific topics that are pertinent to acute crisis stabilization, such as safety planning in the home and understanding the escalation cycle. Patients and families discharge from our unit with copies of the discharge summary in-hand, so that they can review it themselves and/or share it with outpatient providers.

Our hope is that these interventions continue to help families feel supported and included during the challenging experience of acute inpatient hospitalization for their child.

Dr. Simmons is medical director, assistant training director for Inpatient Psychiatry, and attending psychiatrist in the Psychiatry and Behavioral Medicine Unit at Seattle Children's Hospital; and assistant professor in the Department of Psychiatry and Behavioral Science at the University of Washington. She may be reached at shannon.simmons@seattlechildrens.org.
DIVERSITY AND CULTURE

Muslim Youth

Allan Chrisman, MD

On February 10, 2015, I awakened to the news that Deah Shaddy Barakat, Yusor Mohammad Abu-Salha, and Razan Mohammad Abu-Salha were killed in their home at Finley Forest Condominiums on Summerwalk Circle in Chapel Hill, North Carolina. The shock that these murders had happened in my town and that this is two miles from my house left me feeling worried about the safety of my neighborhood.

Then came the email from the executive director of the North Carolina Psychiatric Association stating the father of the two young women is a colleague, Mohammed Abu-Salha, MD, who practices in the Raleigh area. In that email, there was a request to me as chair of the North Carolina Psychiatric Association Disaster Committee for advice on how to help the staff at their office deal with the trauma of these murders. As I quickly responded to that email, I realized how widespread and overwhelming this news must be for our local and state communities.

The need to reach out to the Muslim community in Chapel Hill and the greater Raleigh metropolitan area also was urgently felt by a friend and colleague, Andrew Short, PhD, who is chair of the Disaster Response Network of North Carolina. Almost immediately, we called each other and reviewed our understanding of the impact. As we began to contact and interview various local officials and colleagues, we realized that our knowledge of the Muslim community was limited. As I talked with other mental health colleagues practicing in the area, I was also struck by how little we knew about Islam and the cultural issues that we needed to understand if we were going to provide appropriate support.

I went to AACAP’s website to find a publication that would provide guidance on treating Muslim youth but did not find one. I then decided to reach out to the chair of AACAP’s Diversity and Culture Committee, Andres Pumariega, MD, for advice and was referred to a member of the committee, Balkozar Adam, MD. Concurrently, I also contacted Farha Abbasi, MD, who is a faculty member of the Muslim Studies Program at Michigan State. Together on a conference call, we discussed the need for a more concise compilation of information about Muslim Youth Issues to provide advice to mental health practitioners. I found out that I was not alone with this view, and we quickly agreed to work together on such a document. To facilitate this effort, and to follow suit with other efforts at AACAP for culturally competent care, we settled on the use of the format used for another resource document, Issues to Consider When Engaging Asian American and Pacific Islander (AAPI) Youth in Psychiatric Care.

When Dr. Chrisman contacted the Diversity and Culture Committee leaders, asking for collaboration with a committee member who is expert in dealing with this population, I was more than happy to answer the call.

We hope the document, Issues to Consider When Engaging Muslim Youth in Psychiatric Care (https://goo.gl/5yzxna), will be of help to child and adolescent psychiatrists across the United States in their work with Muslim youth.

Balkozar Adam, MD

When Allan Chrisman, MD, contacted me, I was reminded of the several Muslim patients and families who complained to me that they feel misunderstood by their doctors. They did not feel “in sync” with their provider. They felt that what was important to them was not valued by their doctors. And, some of the issues their doctors thought were critical for their care did not make sense to them. This led some of them to quit asking for help, especially if they or their loved ones were struggling with emotional issues. I had physicians and treatment team members asking me for help in understanding their patient’s cultural and religious practices.

I remember a patient from early in my training who was admitted for the first time to a psychiatric hospital for treatment of a psychosis. Every time the nurses made the rounds, they found him lying down on the floor at an angle. Later, I realized that he thought he was dying and needed to face the North East, which was the direction of Mecca. I have treated many Muslim patients and have had the privilege to consult on many cases, I also have presented at national conferences on providing culturally sensitive care to the Muslim patients. Being a member of AACAP’s Diversity and Culture Committee has provided me with tools that I was able to share with my colleagues when they were working with Muslim patients. One of the valuable approaches developed by the Diversity and Culture Committee is the Practice Parameters for Cultural Competence in Child and Adolescent Psychiatry Practice. I found it to be very useful when dealing with diverse patients and families. Another valuable approach is the use of the DSM-5 “Cultural Formulation” interview.

When the news broke of the three young individuals who were killed in North Carolina, I realized that there was a further need for me to share my experience and views with my colleagues in order to help provide the best care for the Muslim youth and their families. When Dr. Chrisman contacted the Diversity and Culture Committee leaders, asking for collaboration with a committee member who is expert in dealing with this population, I was more than happy to answer the call.

We hope the document, Issues to Consider When Engaging Muslim Youth in Psychiatric Care (https://goo.gl/5yzxna), will be of help to child and adolescent psychiatrists across the United States in their work with Muslim youth.

Dr. Adam is a child and adolescent psychiatrist and clinical associate professor of Psychiatry at the University of Missouri-Columbia. She may be reached at adamb@health.missouri.edu.

Dr. Chrisman is program training director for Duke University Hospital Child and Adolescent Psychiatry Residency Program and medical director of Duke ADHD Program. He is co-chair of AACAP Disaster and Trauma Issues Committee. He may be reached at allan.chrisman@dm.duke.com.
AACAP’s Legislative Conference and Assembly Meeting
April 8-9, 2018

AACAP’s Legislative Conference and Assembly Meeting will take place in Washington, DC, from April 8-9, 2018. Join us for both events to advocate for children’s mental health.

AACAP Legislative Conference

On April 8 and 9, 2018, learn about the legislative process and public policy issues impacting child and adolescent psychiatry. AACAP’s Government Affairs team will provide you with advocacy materials to help develop and deliver the most effective message. Once again, family advocates will be invited to join AACAP members on Capitol Hill. Join us and make your voice heard as we advocate for children’s mental health.

Visit www.aacap.org/LegislativeConference for more information or contact Michael Linskey, Deputy Director of Congressional & Political Affairs, at mlinskey@aacap.org or 202.587.9667.

AACAP Assembly Meeting

On April 8, AACAP’s Assembly of Regional Organizations will meet to discuss the issues facing your state and region. The Assembly consists of AACAP member representatives from across the nation and is always looking for more voices and advocates like you to join the discussion.

Visit www.aacap.org/Assembly for more information or contact Megan Levy, Executive Office Manager, at mlevy@aacap.org or 202.966.1994.
ADVOCACY COMMITTEE

Advocacy vs. Lobbying: Knowing The Difference

Randall Gurak, MD, and AACAP Government Affairs

“I spend half my time comforting the afflicted, and the other half afflicting the comfortable.”

—Wess Stafford, PhD

Part of our role as a child and adolescent psychiatrist is to be an advocate: We advocate for our patients in terms of the right school or appropriate class, proper parenting, as well as the right medications, nutrition, or health care. In contrast, I was not always comfortable with my expanded role as an advocate for my patients at the local, state, or national level. It also means helping policymakers and elected or appointed officials find specific solutions. Most nonprofits can and do engage in as much advocacy as possible to achieve their goals.

Lobbying... involves activities that are in direct support of, or opposition to, a specific piece of introduced or proposed legislation. Lobbying is usually a small portion of all the typical advocacy activities.

Therefore, all lobbying is advocacy, but not all advocacy is lobbying.

Advocacy can involve explaining to a lawmaker the policy effects on child and adolescent psychiatry; providing technical assistance or advice to a legislative body or committee in response to a written request; making available nonpartisan analysis, study, or research; hosting discussions or analysis of broad issues impacting child and adolescent psychiatry; and updating our members on the status of legislation without a request to take particular action. In contrast, “grassroots lobbying” can be accomplished through answering a particular “Call to Action,” to contact your lawmaker regarding a specific piece of proposed or introduced legislation. Merely educating a lawmaker about an issue or sharing our expertise in response to a question is likely considered advocacy and not necessarily lobbying.

According to AACAP:

Advocacy is the process of stakeholders making their voices heard on issues that affect their lives and the lives of others at the local, state, and national level. It also means helping policymakers and elected or appointed officials find specific solutions. Most nonprofits can and do engage in as much advocacy as possible to achieve their goals.

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Advocacy can involve explaining to a lawmaker the policy effects on child and adolescent psychiatry; providing technical assistance or advice to a legislative body or committee in response to a written request; making available nonpartisan analysis, study, or research; hosting discussions or analysis of broad issues impacting child and adolescent psychiatry; and updating our members on the status of legislation without a request to take particular action. In contrast, “grassroots lobbying” can be accomplished through answering a particular “Call to Action,” to contact your lawmaker regarding a specific piece of proposed or introduced legislation. Merely educating a lawmaker about an issue or sharing our expertise in response to a question is likely considered advocacy and not necessarily lobbying.

Other examples of grassroots lobbying include writing to state lawmakers requesting an increase in funding for mental health services in the annual state budget, a request about a specific bill, or circulating a “Call to Action” to members of your ROCAP asking they contact their representative to support a specific bill, as well as preparing issue briefs on a bill or organizing events, including a physician lobbying event at your state capitol in support of or opposition to specific legislation.

ROCAPs may operate under several different tax-exempt status structures, namely as 501(c)(3) “charities,” 503(c)(4) “social welfare organizations,” or 501(c)(6) “trade associations.” Determining your ROCAP’s tax-exempt status will determine what lobbying restrictions may or may not apply, and sometimes state law also differs from any Federal requirements. Remember that not all advocacy is considered lobbying, and typically restrictions only apply, if at all, to your particular ROCAP or its officers, and not individual grassroots members.

Here is the what you should also remember: a 501(c)(3) organization is the most limited in the amount of permissible lobbying, yet it is still allowed, so long as it does not constitute a “substantial” amount of all ROCAP activities, which can also be measured based on how much money and time is spent on lobbying by a paid employee. Under such measure, a 501(c)(3) ROCAP cannot exceed 20 percent of its annual budget on direct lobbying, and no partisan activities nor direct support or endorsement of a political candidate is allowed. As above, individual ROCAP members, other than officers, can usually act on their own without limitations. For any ROCAP with a tax-exempt status other than a 501(c)(3), there are no limits to the amount of direct lobbying in which a ROCAP can engage. Keep in mind that regardless of a ROCAP’s tax-exempt
“Politics is a contest among people of diverse backgrounds and philosophies, advocating different solutions to common problems. The system only works when principled, energetic people participate.”

~Bob Ehrlich, former Maryland Governor

Advocacy vs. Lobbying continued from page 11

AACAP advises consulting with a professional to understand any additional local or state limits on lobbying not described here, as well as any possible lobbying registration requirements. This article does not intend to provide specific tax advice nor other legal guidance.

In 2013, a 501(c)(6) affiliate organization of AACAP, the American Association of Child and Adolescent Psychiatry, was formed to increase lawful advocacy activities beyond what the Academy could pursue on its own. The Association conducts our annual Legislative Conference and is involved in federal lobbying through our registered lobbyists, grassroots activism, and state advocacy with willing ROCAPs. It also allows for the wholly separate American Association of Child and Adolescent Psychiatry-Political Action Committee (AACAP-PAC) to solicit voluntary contributions from members of the Association. No AACAP dues money flows to candidates through our PAC. AACAP-PAC is independent and bipartisan, and political contributions are made to candidates solely based on their support for advancing children’s mental health and issues important to child and adolescent psychiatry, as determined by a separate AACAP-PAC Board.

As you can see, there are various ways to get involved in both advocacy and lobbying. Our unique experience and training make us the experts on how proposed policy and legislative changes will impact children’s mental health. Lawmakers and government agencies will listen to our input, if we give it. We can produce the change needed for our patients and our profession. Please become involved!

For any further questions, please contact the Government Affairs Team at govaffairs@aacap.org.

CALL FOR NOMINATIONS

AACAP’s Nominating Committee is presently soliciting names for nominations for two Councilor-at-Large positions. The deadline for nominations is February 1, 2018. Nominations should be sent directly to executive@aacap.org.

You must be an AACAP voting member to nominate an individual. If you wish to recommend someone for this position, please send the following to executive@aacap.org:

1. A letter of interest from the candidate
2. The candidate’s current CV
3. The candidate’s Disclosure of Affiliations Statement

If you wish to recommend yourself, please send the following to executive@aacap.org:

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The job description for a Councilor-at-Large can be found on AACAP’s website.

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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 govaffairs@aacap.org.
MEDIA PAGE

■ Erik Loraas, MD
Resident Editor

Edited by Molly McVoy, MD, and Robert L. Findling, MD, MBA
American Psychiatric Association Publishing 2017
Paperback: 545 pages – $82.00

The third edition of Clinical Manual of Child and Adolescent Psychopharmacology, edited by Molly McVoy and Robert L. Findling, contains contributions from leaders in the field. The clinical manual opens with a review of key developmental aspects of pediatric psychopharmacology and provides an up-to-date review of this rapidly growing field, including pharmacokinetics. Following a discussion of pharmacodynamics, efficacy, safety, ethics, and regulatory aspects, the book is organized around nine key diagnostic domains: attention-deficit hyperactivity disorder, disruptive behavior disorders and aggression, anxiety disorders, major depressive disorder, bipolar disorders, autism spectrum disorder, tic disorders, early-onset schizophrenia, psychotic illnesses, and for the first time, eating disorders. Where applicable, DSM-5 criteria and the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are integrated and discussed. Sections are well-organized with clear headings and subsections, allowing for quick and convenient reference. Valuable tables distill existing data and key findings from studies allowing the reader to review current evidence. Each chapter concludes with helpful clinical pearls and a list of references. Providers are sure to find the Clinical Manual of Child and Adolescent Psychopharmacology, Third edition a tremendous resource for up-to-date and evidence-based psychopharmacological treatments.

Mina K. Dulcan, MD, Rachel R. Ballard, MD, Poonam Jha, MD, Julie M. Sadhu, MD
American Psychiatric Association Publishing 2018
Paperback: 478 pages – $58.00

The Fifth Edition of Concise Guide to Child & Adolescent Psychiatry, the first in the DSM-5 era, builds on the 2012 edition. The guide provides a broad introduction to mental health care of children and adolescents. Intended as a primer for students and a brief update to practicing providers, each of its 18 high-yield chapters includes helpful tables that distill and emphasize key concepts and critical information. Reference lists direct readers to additional resources for more comprehensive reviews of topics. Chapter one provides an introduction to the new edition and the use of DSM-5 in child and adolescent psychiatry. Chapter two outlines a helpful approach to evaluation and treatment planning. Thirteen chapters cover the key diagnostic domains of the DSM-5 relevant to child and adolescent psychiatry. Clinical description, epidemiology, etiology, course and prognosis, evaluation and differential diagnosis, often including DSM-5 diagnostic criteria, and treatment are covered for each major disorder. Following the key diagnostic domains, chapter 16 explores special clinical circumstances in child and adolescent psychiatry, including emergencies, family transitions, cultural factors, adolescent pregnancy, obesity, physically ill children and adolescents, and children and adolescents of physically ill parents. The final two chapters focus on psychopharmacological and psychosocial treatments. An appendix lists Internet and print resources for parents and families. Concise Guide to Child & Adolescent Psychiatry, Fifth Edition is a valuable resource that is well-suited for child and adolescent mental health students and practitioners.

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 email to loraasek@upmc.edu.
AACAP’s Newest Lifelong Learning Module Now Available

AACAP is proud to announce the release of Lifelong Learning Module 14: Relevant Clinical Updates for Child and Adolescent Psychiatrists. With the purchase of this module you will have the opportunity to earn 38 AMA PRA Category 1 Credits™ (8 of which will count towards the ABPN’s self-assessment requirement).

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Call for Papers

AACAP’s 65th Annual Meeting takes place October 22-27, 2018, at the Washington State Convention Center in Seattle, Washington. 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, or administration.

Abstract proposals must be received at AACAP by February 15, 2018, or by June 15, 2018, for (late) New Research Posters. The online Call for Papers submission form is available at www.aacap.org, and all submissions must be made online.

Questions? Contact AACAP Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
Thank you Fred, for once again donating your time and expertise in helping bring the Annual Meeting to life! Thanks for capturing the essence of what AACAP is all about!
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Biological Embedding of Childhood Adversity

Ryan Herringa, MD, PhD

Childhood adversity, including maltreatment, is one of the most potent risk factors known for developing psychiatric disorders in childhood and beyond. For example, childhood adversity accounts for up to 40% of the risk for developing affective disorders in childhood. Any clinician will tell you the link is clear in their patients, but what are the biological mechanisms linking childhood adversity to psychiatric illness? In the Symposium Childhood Adversity and Psychiatric Disorders: Advances in Neurobiological Research, a series of four talks explored biological mechanisms that potentially lead youth down paths of resilience or vulnerability to the effects of childhood trauma.

First, Eamon McCrory, PhD, PsyD, professor of Developmental Neuroscience and Psychopathology at the University College of London, presented findings linking maltreatment exposure to differences in autobiographical memory (ABM). He began by highlighting a model of latent vulnerability, in which biological and cognitive processes are affected by maltreatment exposure prior to the development of psychopathology. In essence, if we can identify latent risk markers for psychiatric illness, then perhaps we could use these markers for appropriate and timely intervention before illness occurs. Dr. McCrory revealed evidence that maltreated but otherwise healthy youth have overgeneralized ABM; that is, a failure to recall more specific details of emotional events. Overgeneralized ABM was also associated with abnormal hippocampus and amygdala activation during a memory recall task. He theorized that overgeneralized ABM impairs the ability to use past experiences to adapt to the present, which leads to a more pessimistic and ruminative style that may place kids at greater risk for mental illness.

Second, W. Dustin Albert, PhD, assistant professor of Psychology at Bryn Mawr College, presented findings linking harsh parenting to the development of antisocial behavior in a community sample of healthy youth. In a longitudinal study of youth aged 10-16 years, Dr. Albert showed that harsh parenting does, indeed, increase risk for antisocial behaviors. Furthermore, he showed that amygdala reactivity during threat processing at least partly mediates this relationship. In other words, harsh parenting was associated with greater amygdala reactivity to threat, which in turn was associated with more antisocial behavior. Similar to Dr. McCrory’s model, greater amygdala reactivity may represent a latent vulnerability factor that confers risk for developmental psychopathology, though further longitudinal follow-up is needed to clarify this relationship.

Third, Tanja Jovanovic, PhD, assistant professor of Psychiatry and Behavioral Sciences at Emory University, presented data on the relationship of violence exposure in healthy youth to the development of fear regulatory circuits. As expected, in an inner city sample of youth from Atlanta, Georgia, she showed that violence exposure was associated with greater amygdala reactivity to threat, which was found to be associated with more antisocial behavior. Similar to Dr. McCrory’s model, greater amygdala reactivity may represent a latent vulnerability factor that confers risk for developmental psychopathology, though further longitudinal follow-up is needed to clarify this relationship.

Finally, I presented findings on potential epigenetic mechanisms underlying brain abnormalities observed in pediatric PTSD. I first reviewed data in our cohort showing age-related (cross-sectional) neurodevelopmental abnormalities in pediatric PTSD. Importantly, these previously published findings suggest that neural patterns in pediatric PTSD are not simply a recapitulation of adult PTSD findings. In particular, youth with PTSD showed decreased hippocampal volume, increased amygdala reactivity, and decreased amygdala-prefrontal coupling with age. I then highlighted new data in this cohort looking at epigenetic abnormalities and their relationship to brain abnormalities. I focused on DNA methylation, which is an experience-dependent process by which gene regulation can be altered. I highlighted three genes, including the glucocorticoid receptor, which showed hypermethylation in pediatric PTSD, and which were also related to abnormal neurodevelopment. These data suggest potential molecular genetic mechanisms by which trauma exposure may contribute to abnormal fear circuit development, and thus, the maintenance or worsening of PTSD in youth.

The discussion was led by Daniel S. Pine, MD, chief, Section on Development and Affective Neuroscience at the National Institute of Mental Health. Dr. Pine highlighted the innovative approaches of the speakers in examining neurobiological substrates of childhood adversity, and how these markers may mechanistically be linked to later mental illness. He also cautioned, however, that current findings will not be ready for clinical use in the near future. There was a vibrant discussion with the audience exploring questions of how to truly measure trauma and adversity, incorporating parent-child interactions and relationships as moderators and mediators of risk following trauma, and how biomarkers might be used to enhance prevention and treatment, and educate the public and our patients. Clearly, much work remains to be done, in particular by using longitudinal study designs to better detail biological and cognitive mechanisms linking adversity to the effects of childhood trauma.
Not Fake News: Gun Violence is a Serious Public Health Issue

Dr. Sood presented data on homicide and suicide rates related to firearm violence in youth younger than 12 years of age from Richmond, Virginia. Deaths from firearms, including accidental deaths, are higher between ages one and nine, rather than nine to 12 years, suggesting that these fatal events are unrelated to gang violence but due to children being around firearms that are not stored safely. This is a public health issue affecting very young children and an economic drain for our health system (17.4 billion dollars). There is a scarcity of data on effective interventions to stop firearm violence due to the prohibition of funding to U.S. public health agencies to study this issue. Research funded mostly through private foundations provides promising information on understanding risk and suggesting direction for policy. Collaborating with organizations that do not advocate gun control, but have an investment in reducing morbidity and mortality, may lead to solutions and policy changes. Advocating for the release of funding for federal research into firearm violence, improving safety features of guns, reducing access to guns in vulnerable and at-risk populations, and framing gun violence as a public health issue were discussed.

Edward Mulvey, PhD, presented data on a study that he and his colleagues conducted on gun violence related to crime in adolescents. The study was a seven-year look at serious adolescent offenders ranging in age from 14 to 18 years of age who were interviewed at three points: entry into the justice system, at an interval point during their stay, and at the time of discharge. The overall data showed that (based on recall) gun possession peaked at age 18 years, reported by 20% of these youth, and gradually decreased to about 4% of the youth by the age of 25 years. How many of the adolescents recall using the guns they were carrying? The data does not show any specific trend but a higher percentage of the younger adolescents, ages 14 through 16 years, are more likely to have used their guns. The perception of gun availability, substance abuse history, and exposure to violence appear to have a powerful effect on the incidence of gun violence in youth. Adolescents engaged in criminal activities often use illegal handguns. Dr. Mulvey’s presentation suggests these data should be used to identify youth at risk for gun violence in order to develop prevention strategies.

Jeffrey Swanson, PhD, addressed the question of whether states should prohibit adults with juvenile crime records from purchasing firearms, and until what age. He described a tension between the juvenile justice policy goal of granting civil rights to youthful offenders when they become adults and the public safety goal of limiting access to firearms for people at risk of harming themselves or others. State laws vary widely in the minimum age for legal gun sales to former juvenile offenders, and there has been little research on the effectiveness of different standards in reducing gun violence. Dr. Swanson’s longitudinal study from Florida finds that persons with mental illness who were convicted of at least one violent crime both before and after becoming an adult were significantly more likely than other young adults to engage in additional violent criminal activity, including gun-involved crime. Youthful offenders with mental illness who desisted from crime in the early years of adulthood still carried a significantly elevated risk of violent crime, compared to those without any record of serious crime, but posed a far lower risk than repeat violent offenders. Persons who were disqualified from firearms on the basis of mental health adjudication alone were found to be of relatively low risk of violent crime. Dr. Swanson concluded that state laws delaying the minimum age of firearm purchase for young adults with juvenile crime records could potentially save many lives, but that much more research evidence is needed to determine the most effective parameters.

David A. Brent, MD, presented his work on the correlation of access to firearms and safe storage of guns with suicide in adolescents. He summarized three decades of data on the demographics of risk factors predicting suicide by firearms in this age group. Increases in firearm manufacture, gun ownership and the availability of guns were correlated to an increase in suicides in which a gun was used. Although the rates of firearm suicide deaths have been decreasing in the past decade, the case fatality rate for suicide from firearms far exceeds those of other methods (e.g., 82.5 % versus 34.4% for jumping from a high place). Surveys show that 29% of adolescents in the US live in a home with firearms, and of these, 41% have easy access to firearms; they tended to be older, white and living in rural areas, and have higher rates of alcohol and drug abuse. Case-control studies show that the rate of suicide in teens who have access to firearms within their home is 66 - 80% versus 6 – 23% when a gun is not in the home. Gun-related suicide is highest in those with access to loaded guns and 25% of homes store guns unsafely.
Dr. Brent reviewed studies that operated on an “Injury Control” approach, examining the role of safety guidance to parents/caregivers by primary care physicians about 1) gun ownership and presence of guns within the home, and 2) use of gun safety locks or safe storage of guns. In one study, Dr. Brent and colleagues found that 75% of parents who were asked to remove guns from the home did not do so. Those who did remove guns from the home were more likely to be single parents, suggesting that it is important to speak directly with the gun owner. In addition, surveys of primary care practices show that while parents are willing to listen to physicians who recommend safer storage of guns, they are reluctant to remove them. Therefore, asking parents to remove guns without the option of improving safe storage is unlikely to be effective. Several studies in primary care have shown that brief counseling by the primary care physician, along with the provision of a safety device (such as a trigger lock) can greatly improve the rate of safe storage. This is important because safe storage has been shown to protect against firearm deaths and injuries.

The take away points from this symposium: 1) gun violence is a public health issue, costing major health care dollars and medical resources; 2) youth suicides are connected to easy firearm access, especially if the guns are stored loaded; and 3) the lack of federal funding for research to reduce risk from gun violence has been counterbalanced by funding through other sources. Only 4% of those with serious mental illness account for violence: antisocial behavior as a child confers a higher risk for firearm violence. Increasing the qualifying age of youth to acquire a gun if they have a history of violent behavior and taking a developmental perspective could reduce the risk of firearm violence.

Dr. Sood is professor of Psychiatry and Pediatrics and senior professor of Child Mental Health Policy at Virginia Commonwealth University in Richmond, Virginia. She may be reached at bela.sood@vcuhealth.org.
Borderline personality disorder (BPD) remains a controversial disorder to assess, diagnose, and treat in adolescents. The Symposium Scientific Update on Borderline Personality Disorder in Adolescents: Assessment, Comorbidities, and Treatments had four aims: 1) present data on the validity and usefulness of DSM-based assessment instruments for adolescence; 2) present data from a functional magnetic resonance imaging (fMRI) study regarding regional brain differences between youth with and without BPD in relation to non-suicidal self injury (NSSI); 3) review challenges in differentiating youth with BPD from youth with bipolar disorder (BP); and the possibilities of comorbid BPD and BP; and 4) review a promising open source of a psychoeducational program for families with adolescents who suffer from BPD that may assist in reducing family burden and improve functional outcomes.

Salome Vanwoerden, MA, from the University of Houston, reviewed evidence demonstrating that the two main youth-based instruments: the Childhood Interview for Borderline Personality Disorder (CIPD) and the Borderline Personality Features Scale for Children (BPFS-C), mirror the content and meaning covered in adult-based instruments for BPD. The CIPD and BPFS-C have adequate psychometric properties and expected relations with other measures of BPD and psychopathology in general. Additionally, data were reviewed regarding whether or not teens are able to comprehend the DSM criteria for BPD, particularly because some of these criteria are abstract in nature (e.g., identity disturbance and emptiness). By qualitatively analyzing narrative responses to each DSM criteria on the CIPD and further comparing responses by teens with BPD to teens without BPD who suffer from psychiatric problems, the data indicate that teens can indeed understand, relate to, and elaborate on the DSM criteria for BPD. Importantly, there does appear to be qualitative differences in the ways in which teens with BPD report on their experiences as compared to other inpatient teens without BPD. Finally, the presentation reviewed data examining the invariance of BPD across developmental epochs. Findings from these studies suggest that while interpersonal criteria (e.g., identity disturbance, emptiness, paranoia) have greater discriminative properties in teens compared to adults, these criteria are relatively underdiagnosed when compared to the criteria representing emotional and behavioral dysregulation (e.g., anger and suicidal behavior), which have lower discriminating power in teens. An important point for clinicians may be to use caution in relying solely on emotional and behavioral dysregulation for diagnosing BPD in youth, and instead to closely ascertain symptoms related to the interpersonal criteria.

Rebecca C. Brown, MSc, from the University Hospital Ulm, focused on NSSI and BPD. NSSI often occurs independently of BPD and cannot always be relied upon for accurate diagnosis of BPD. In both NSSI and BPD, however, perception of social situations seems to play an important role. Altered neural processing of social exclusion has been shown in adolescents with NSSI, while adults with BPD also show altered processing of per se positive social situations (i.e., social inclusion).

This presentation reviewed new data from a study investigating direct differences in neural processing of social inclusion and exclusion between adolescents with NSSI and young adults with BPD and NSSI. Using fMRI, neural processing of social inclusion and exclusion (paradigm: ‘Cyberball’) was explored. Cyberball is a task that has been used in numerous (fMRI) studies to investigate effects of social exclusion. In the task, participants initially are included (inclusion condition), by receiving 1/3 of all ball-tosses. After approximately two minutes, they no longer receive the ball (exclusion condition).

Participants in this study were 14 adolescents with NSSI, but without BPD (Mage=15.4; SD=1.9); 15 adults with BPD and NSSI (Mage=23.3; SD=4.1); as well as 15 healthy adolescents (Mage=14.5; SD=1.7) and 16 healthy adults (Mage=23.2; SD=4.4). Behavioral results showed enhanced feelings of social exclusion in both patient groups compared to healthy controls, which were significantly higher in the BPD group than the NSSI group. Both patient groups showed enhanced activation during social exclusion in the ventral prefrontal cortex compared to clinical
controls, while there was no mutual enhanced activation in both patient groups during social inclusion. Enhanced activation during social inclusion, compared to a passive watching condition, was mainly observed in the BPD group in the dorsolateral and dorsomedial prefrontal cortex, and the anterior insula. Therefore, while both patient groups showed enhanced reactivity to social exclusion, only BPD patients also showed increased neural activity in a per se positive social situation. These results might point towards a higher responsiveness to social exclusion in adolescents with NSSI, which might then develop into a generalized increased sensitivity to all kinds of social situations in adults with BPD.

Kirti Saxena, MD, of Baylor College of Medicine, reviewed the challenges in differentiating BD from BPD in a pediatric mood disorder clinic. As described above, emotional dysregulation alone cannot be relied upon to discriminate BPD from BD. Many individuals with a BD are also diagnosed with comorbid BPD. However, the fact that all individuals diagnosed with a BD do not meet BPD criteria suggests that both conditions possess unique and related facets. Identifying related and unrelated items between BD and BPD should improve diagnostic accuracy, which is key to customizing optimal treatment recommendations.

Thirty participants that carried a diagnosis of BP, aged 7-17 years, were assessed using a battery of validated measures, including the 24-item self-report BPFS to obtain cross-sectional data from participants and their primary caregiver(s). Higher BPFS-child scores positively correlated with more severe depression, self-injurious behaviors, and increased impulsive aggression. The significance of these findings lies in assisting clinicians in recognizing which youth with a BD diagnosis may be on the trajectory to developing BPD. This, in turn, can aid clinicians in implementing specific psychotherapeutic interventions that might improve outcomes. Further research examining longitudinal data with larger samples is needed to validate these findings.

In the final presentation, Luciana Payne, MA, from the University of Nevada – Reno, reviewed data from the National Education Alliance for Borderline Personality Disorder structured program, Family Connections (FC). The program was initially structured to include 12 sessions with three main goals: psychoeducation, skills, and social support. The program can be provided by either a trained mental health professional or by family members who receive training on the model. The presentation focused on research outcomes from a system that utilized an intensive residential Dialectical Behavior Therapy model of care. Families were randomized via a waitlist control design to ascertain if additional benefits were found for families who participated versus those who declined (n = 111 adolescents, and n=94 parents). Across all measures of individual symptoms (emotion regulation and depression) and parental communication (validation/invalidation and emotional availability), families that participated in the FC program had significant improvement in both individual symptoms and parental communication.

In conclusion, this Symposium brought a deeper understanding to the methods by which a clinician can reliably assess for BPD in adolescence. Research highlighting what brain regions appear most involved in the dysfunction for BPD, as well as better delineation of comorbidities seen in BPD, may assist in detection and development of targeted models of care. Finally, an intervention that can be available at low cost and could be provided by non-mental health trained providers was reviewed, showing promise in helping young people with BPD and their families find a hopeful path forward in health with meaningful connections.

Dr. Williams is chief of Psychiatry at Texas Children’s Hospital, Child and Adolescent training director and associate professor in the Menninger Department of Psychiatry and Behavioral Sciences at the Baylor College of Medicine. She may be reached at laurel@bcm.edu.

Ms. Vanwoerden is a doctoral candidate in Clinical Psychology at the University of Houston. She works under the mentorship of Dr. Carla Sharp conducting research on the social-cognitive basis of personality disorder development. She may be reached at salomevanwoerden@gmail.com.

Dr. Brown is a post-doctoral researcher, clinical psychologist, and child and adolescent behavioral therapist at the Department of Child and Adolescent Psychiatry and Psychotherapy at the University of Ulm, Germany. She is deputy editor of the journal Child and Adolescent Psychiatry and Mental Health. She may be reached at Rebecca.Brown@uniklinik-ulm.de.

Dr. Saxena is associate professor Psychiatry Baylor College of Medicine and director of the Pediatric Bipolar Disorders Program at Texas Children’s Hospital in Houston, Texas. She may be reached at kxsaxen1@texaschildrens.org.

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to childhood psychopathology. This research will need to examine multiple levels of function, from family/community systems down to genetic and cellular processes. Hopefully, with this kind of information, we will one day be able to identify youth most at risk following adversity, prescribe the most effective treatments based on social-biological profiles, and promote the well-being of traumatized youth and their families. ■

Dr. Herringa is an assistant professor in the Department of Psychiatry at the University of Wisconsin School of Medicine and Public Health. He is a child and adolescent psychiatrist and neuroscientist whose work explores the neural substrates of childhood traumatic stress and PTSD. He directs the BRAVE Youth Lab (Building Resilience after Adversity in Youth). He may be reached at herring@wisc.edu.
Clinical Perspectives: The Opioid Epidemic

Amy Yule, MD

In 2007, drug overdoses surpassed motor vehicle accidents as the leading cause of unintentional injury and death in the United States. These deaths have continued to rise. In 2016, an estimated 64,000 individuals died of a drug overdose. Opioids have been involved in most overdose deaths. The White House formally declared the opioid crisis a public health emergency during The American Academy of Child and Adolescent Psychiatry's (AACAP) Annual Meeting.

The opioid crisis was addressed in several presentations during the meeting and was the focus of the Clinical Perspective Interventions for Child Psychiatrists to Support Children, Adolescents, and Their Families in the Midst of the Opioid Epidemic.

Timothy E. Wilens, MD, from Massachusetts General Hospital, provided an overview of the use of opioids in the United States and the current opioid epidemic. Opioids have been used in the United States since the 1800s to treat conditions ranging from dysentery to cough, pain, and insomnia. At one time, opioids were marketed as “Soothing Syrup” for mothers to quiet children with discomfort. In the early 2000s, a steady increase in prescriptions for opioids followed the Joint Commission on Accreditation of Healthcare Organization's emphasis on the importance of pain assessment (“The 5th vital sign”). A parallel rise in admissions for treatment of opioid use disorders and drug overdoses followed the increase in narcotic prescriptions.

Childhood psychopathology increases the risk for substance use disorders. Youth who misuse prescription medication generally view prescription medication misuse as less dangerous, less addictive, and less stigmatizing compared to other illicit drugs. Most individuals with opioid use disorders initiated opioid use with misuse of prescription opioids and transitioned to heroin use over time. Heroin, which is often adulterated with more potent synthetic opioids such as fentanyl or carfentanil, is believed to be driving the continued increase in overdose deaths since 2010.

Amy Yule, MD, from Massachusetts General Hospital, focused on medications used to treat opioid use disorders, which are associated with a significant decrease in overdose risk. These medications are categorized by whether they are an opioid receptor antagonist, partial-agonist, or agonist. Naltrexone extended release is an opioid receptor antagonist that blocks the euphoric effects of opioids. Since naltrexone is an antagonist medication, an individual needs to be off opioids for several days prior to starting the medication. Individuals given naltrexone, when they have opioids in their system, experience opioid withdrawal. Buprenorphine/naloxone and methadone are opioid receptor agonists that block the euphoric effects of opioids, prevent or minimize withdrawal symptoms, and decrease cravings. Since buprenorphine is a partial agonist, an individual needs to have symptoms of opioid withdrawal or be off opioids when the medication is started. An individual given buprenorphine when there have been opioids in their system may experience opioid withdrawal since buprenorphine is a partial agonist that displaces the opioid, fully activating the opioid receptor. Methadone is a full opioid receptor agonist that can be started when an individual has opioids in his/her system. Most of the research, to date, on the use of medication to treat opioid use disorders in youth has been conducted with buprenorphine/naloxone.

Davida M. Schiff, MD, of Massachusetts General Hospital, discussed the treatment of opioid use disorders in pregnancy, the postpartum period, and care of newborns exposed to opioids in utero. Women now use heroin at similar rates to men. Pregnancy presents an opportunity to engage women with an opioid use disorder in treatment, yet several barriers exist for pregnant women seeking care. There are only a limited number of programs that offer specialized support for pregnant and parenting women, and several states prosecute women for substance use during pregnancy. Despite these challenges, collaborative treatment programs that provide both obstetrical and addiction care are associated with improved maternal and fetal outcomes. Since opioid detoxification is associated with high rates of relapse, standard of care for women in pregnancy includes opioid agonist treatment with either methadone or buprenorphine.

Infants exposed to opioids during pregnancy are at risk for withdrawal symptoms. It is important to be thoughtful regarding the language used when describing these infants. They are not “addicted” or “hooked” on opioids as frequently described in the popular press. They developed a physiologic dependence to opioids that can be treated. Traditionally infants with symptoms of neonatal opioid withdrawal symptoms have been treated with medication, including morphine. Recently there has been increased emphasis on adjunctive non-pharmacologic interventions to support infants, including rooming-in with parents, breastfeeding, skin-to-skin contact, and swaddling/cuddling.

Catherine A. Martin, MD, from the University of Kentucky College of Medicine, reviewed principles of safe medication storage. Adolescents who misuse prescription opioids primarily access prescription opioids for free from a friend or family member. Dr. Martin encouraged providers to counsel families to be as vigilant with opioids as they are when securing poisons from toddlers. For example, locked bags and boxes can be used to safely store medication. Many communities have drop-off locations at pharmacies, police stations, or hospitals for disposal of expired or unwanted medication. If this is not available in your community, the FDA provides...
guidance on safe medication disposal on their website.

Dr. Martin discussed the use naloxone to reverse an opioid overdose. Naloxone can be administered by friends, family, or emergency responders through a nasal spray or intramuscular injection. Several states with high rates of opioid overdoses have standing orders for naloxone to be supplied at pharmacies, with pharmacists trained to educate individuals on how to recognize and respond to an opioid overdose. Dr. Martin has had success in motivating people to get a naloxone prescription by referring to those trained with naloxone as a “trained rescuer.”

The discussant, Geetha Subramaniam, MD, from the National Institute on Drug Abuse, highlighted key epidemiologic and treatment points. Opioid use often starts in adolescence, with youth admitted for treatment of an opioid use disorder reporting first use of opioids between ages 15 and 17 years. Dr. Subramaniam reviewed details from the landmark study on buprenorphine treatment for youth with opioid use disorders published by Woody and colleagues in 2008. She also reviewed the drug enforcement agency requirements for specific training to obtain a waiver to prescribe buprenorphine. Waiver trainings are available through the Provider Clinical Support System (PCSS), the American Academy of Pediatrics (AAP), and the American Society of Addiction Medicine (ASAM). Dr. Subramaniam directed participants to free online screening tools for adolescent substance use (Brief Screener for Tobacco, Alcohol, and Drugs as well as Screening to Brief Intervention) and an interactive tool to improve motivational interviewing skills with adolescents (tinyurl.com/AdolescentMI).

Several other presentations at the AACAP Annual Meeting also addressed the opioid crisis. Drs. Martin, Subramaniam, and Yule provided an overview of the opioid epidemic to the Assembly of Regional Organizations. Dr. Subramaniam and David A. Brent, MD, from Western Psychiatric Institute, presented Perspectives From Child and Adolescent Psychiatry on Adolescent Suicide and Opioid Misuse. Patrice Malone, MD, from Columbia University, presented Dealing with the Opioid Epidemic in College Students as part of a clinical perspective on problematic substance use in college-aged youth. Dr. Yule presented on The Opioid Epidemic and Child Psychiatry as part of the TED Talks Meets Perspectives program.

In summary, there is an urgent need for providers who have experience working with youth and families, such as child psychiatrists, to incorporate the treatment of opioid use disorders into their practice. In addition to waiver trainings through PCSS, AAP, and ASAM, providers can access free webinars and one-on-one mentoring with experts who treat opioid disorders through the PCSS program. PCSS is a program through the Substance Abuse and Mental Health Service Administration that is administered through the American Academy of Addiction Psychiatry. Dr. Yule is a clinician scientist at Massachusetts General Hospital. Her research is currently funded through the AACAP Physician Scientist Program in Substance Abuse from NIDA. She may be reached at ayule@partners.org.

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Containing Contagion: Perspectives on 13 Reasons Why

Sansea L. Jacobson, MD

Recently I evaluated a teen who was referred shortly after a suicide attempt. She had watched the controversial Netflix mini-series, *13 Reasons Why* (*13RW*) prior to cutting her wrists. In her words, the show “made suicide look easy.” This was not my first such patient.

If you are not familiar with *13RW*, you need to be. It was based on a best-selling novel written by Jay Asher a decade ago. The series, which graphically depicts a teen suicide, was named the “Most Tweeted Show of 2017.” Research suggests that the release of *13RW* possibly contributed to an upsurge in google searches with the term “suicide,” including a 26% increase in searches for “how to commit suicide,” and an increase in pediatric psychiatric emergency room visits. Opponents voice concern that the show irresponsibly places susceptible individuals at risk by not following standard guidelines for safe and responsible media. Others argue that *13RW* opens a dialogue on all-too-important topics teens crave to, and need to, understand. But at what cost to vulnerable youth? The discussion could not be more timely, as Netflix intends to release a second season of *13RW* in 2018, and the trailer already has over 3 million views!

Sansea L. Jacobson, MD, of the University of Pittsburgh, set the stage for the presentation by allowing the *13RW* protagonist, Hannah Baker, to introduce herself through a haunting post-mortem audio clip. As a child and adolescent psychiatrist who spent the past decade treating suicidal teens, Dr. Jacobson described her concerns as detailed in her op-ed piece “Thirteen Reasons to be Concerned About 13 Reasons Why” (available on the AACAP website), and then presented Hannah Baker as a fictional case study and platform for the other experts to explore youth suicidality, bullying, sexual trauma, school, and the media.

David A. Brent, MD, from the University of Pittsburgh, described how graphic depiction of suicide on screen has been shown to increase subsequent risk of suicide attempts and completions, usually within the first two weeks of exposure. This risk of suicide contagion is further heightened when there is an absence of mental health information. Youth most likely to be affected tend to identify with the decedent, and are more likely to have pre-existing vulnerability to suicide. Dr. Brent described best practices in identifying patients at risk and developing safety plans as a preventative measure. He also advised that parental monitoring and limit-setting of media and social media exposure is an important component of mitigating negative impacts, especially the impact of cyberbullying.

Ruth Gerson, MD, from New York University, underscored how bullying and cyberbullying are real and frequent triggers for suicidality. She noted that bullying victimization was one of the biggest predictors of suicidal thoughts among youth presenting to emergency departments. Dr. Gerson provided encouragement that there is much we can do to help. Research shows that bullied youth who feel cared for and connected to at least one adult or peer at school are less likely to feel suicidal than those who do not feel such connection. She urged us to allow time and space to listen to youth who are bullied, and cautioned against “mediation” tactics during which a student is placed in the same room as the perpetrator. Instead, she recommends creating individualized, practical plans that prepare a child to know: how to respond, how to get out of the situation, what they can tell themselves, who their safe person is, and where they can go for support.

Judith A. Cohen, MD, of Allegheny General Hospital, provided an eloquent perspective on sexual assault. Adolescent sexual assault is common but underreported for many reasons, including: stigma, shame, fear, and trauma avoidance. Dr. Cohen advises that clinicians ask teens directly about sexual assault in the context of conversations about sexual health. When a teen discloses sexual assault, our first instinct must be to provide support, validation, safety, and appropriate referrals (e.g., medical, victims advocacy, police, and evidence-based treatment.) Dr. Cohen discussed how graphically explicit media depictions of sexual assault model unhealthy sexuality and may traumatize vulnerable youth. She advises that adults encourage open conversations about and provide guidance around positive sexual health. For guidance, she recommends [www.ncatsn.org](http://www.ncatsn.org) and a video (with >3 million views on YouTube) – “Consent and a Cup of Tea.” While humorous, this animation is a perfect example of how even short, playful media can deliver serious and important messages. I strongly recommend you check it out!

Jeff Q. Bostic, MD, EdD, from Georgetown University, then gave a rousing finale during which he discussed school and the media. Dr. Bostic facilely walked the audience through the missteps made by the *13RW* school administrators, from allowing Hannah’s locker to become a mini-shrine (which could be internalized by vulnerable youth as a means to gain recognition) to the problematic portrayal of the school counselor (who was not only ineffectual, but violated various common-sense practices, like turning your cell phone off when in a session). Dr. Bostic reminded us that screenwriters and producers often take dramatic license to tell a compelling story, heightening the emotionality to engage viewership. By portraying adults as inept, it assures that the fictional teens must find resolution to problems on their own. In reality, there are caring adults available to help struggling youth, who ultimately are an essential part of the solution. In the context of a narrative dealing with a suicidal teen, one wonders if it is simply too dangerous to suggest otherwise.

Carl Kurlander from Steeltown Entertainment joined the panel as our special Hollywood expert. Mr. Kurlander
was the screenwriter of the 1980s hit film *St. Elmo's Fire* and writer/producer of the teen sitcom *Saved by the Bell*. We played a clip from his most recent show, *The ReelTeens*, which stars teens exploring the topic of mental health stigma. Like Fred Rogers did with the iconic *Mister Rogers' Neighborhood*, Mr. Kurlander is interested in using media to make “good” attractive – and perhaps putting child and adolescent psychiatrists in a room with media producers is a way to rekindle that flame.

During the panel discussion, one audience member described how *13RW* hit her hospital “like a virus.” The panel built upon this analogy and brainstormed about how we might “inoculate” our nation’s youth in time for Season 2 of *13RW*. While we can attempt to enlist the producers of *13RW* and Netflix in a constructive dialogue, we cannot resolve that the industry goals are different. Editorial input may not be enough. Thus, as essential as it is to “safety plan” with depressed patients, it is critical that we construct a media strategy. The timing is opportune, especially given AACAP President Karen Wagner, MD’s Presidential Initiative to “increase awareness of and screening for depression in children and adolescents.” One practical first-step would be for AACAP to publish recommendations on how parents and schools should approach the *13RW* sequel. It is ultimately our responsibility to be proactive, educate and advocate for the safety of our nation’s most vulnerable youth. If we wait to react, it will be too late.

**More Annual Meeting Photos!**

**Dr. Jacobson is the director of the Child and Adolescent Psychiatry Fellowship and Triple Board Program at the University of Pittsburgh. She works with suicidal teens at the Services for Teens at Risk (STAR) Clinic and is the co-chair of the AACAP Training and Education Committee. She may be reached at jacobsonsl@upmc.edu.**
From Prodrome to Psychosis: Prevention and Evidence-Based Treatment

Approximately, 100,000 adolescents and young adults in the United States experience a first episode psychosis (FEP) every year, with peak onset between 15 and 25 years of age. Psychosis can be severely disabling and difficult to treat, but earlier detection and treatment can lead to better outcomes. In this symposium, chaired by Liwei Hua, MD, PhD, experts presented on evidence-based practices (EBP) for screening, detection and treatment, and the broad application of these EBP.

Jason Schiffman, PhD, started off with “Symptomatic and Neurocognitive Predictors of Psychosis During the Clinical High-Risk (Prodromal) Phase of Illness.” More than 50% of people who develop schizophrenia as adults report psychotic symptoms as adolescents. Currently, the average duration of untreated psychosis (DUP), or time from onset of psychosis to treatment, is two years. Longer DUP can result in worse prognosis, more intensive services, and increased costs to the system. Studies demonstrate that early intervention lowers conversion rates.

The Structured Interview for Psychosis-Risk Syndromes (SIPS) is the most commonly used rating scale for early identification. It is a clinician-rated scale consisting of questions for positive symptoms: unusual thought content/delusional ideas, suspiciousness or persecutory ideas, grandiose ideas, perceptual abnormalities/hallucinations, and disorganized communication. Conditions of psychotic risk state and psychosis are often differentiated by severity of symptoms; degree of conviction; and doubt and insight.

The North American Prodrome Longitudinal Study (NAPLS), a National Institute of Mental Health (NIMH) funded study, that effectively put early identification “on the map,” showed that the mean age of first attenuated psychotic symptoms was 16.3 years old, with mean days of conversion being 288.3 days. The group developed an “individualized risk calculator” based on unusual thought content, suspiciousness, processing speed, verbal learning and memory, social functioning, stressful life events/childhood traumas, and family history of psychotic disorder in a first-degree relative. The accuracy of this calculator is similar to that of cardiovascular risk calculators. Although prediction is helpful, practitioners in the community must become more familiar with screening for, and assessment of, symptoms and risk states, especially in adolescents. Clinical sensitivity is key, as context matters.

Delbert G. Robinson, MD, presented results from the Recovery After Initial Schizophrenia Episode (RAISE) study. RAISE is a NIMH-funded study promoting symptomatic recovery, with the goals of minimizing disability and maximizing social, educational, and vocational functioning, using intervention strategies delivered in real-world settings, utilizing current funding mechanisms. In this NAVIGATE treatment model of coordinated specialty care (CSC), first-episode patients were treated at their local community center. Components of NAVIGATE include Individual Resiliency Training, Family Treatment, supported employment/education, and pharmacologic treatment. The RAISE medication guidelines used COMPASS, a computerized decision support system.

In a randomized controlled trial, NAVIGATE was compared with community care treatment as usual. There was cluster/site randomization of 34 sites in 21 states for a two-year treatment period. Inclusion criteria were ages 15-40 years, first episode psychosis, and no more than six months of antipsychotic medication treatment. Mean age in both groups was approximately 23 years. Although both groups improved, NAVIGATE outcomes showed differential improvement in quality of life, positive and negative symptoms, and depression. NAVIGATE participants had more medication visits and were more likely to be prescribed an appropriate antipsychotic; and they were also less likely to be prescribed an antidepressant. Overall, participants with shorter drug use profile (DUP) gained more from NAVIGATE treatment. In the 14% of NAVIGATE patients <18 years old, median DUP was 48 weeks. There was a significant treatment effect favoring NAVIGATE for this group. In summary, community facilities can successfully establish CSC programs. Although standard care alone is helpful, treatment in CSC programs seems to offer additional improvement.

Next, Lisa B. Dixon, MD, MPH, discussed broad application of CSC programming in New York State with OnTrackNY. Key service elements included case management, supported employment/education, psychotherapy, family education and support, pharmacotherapy, and primary care coordination. The core services processes consisted of team-based approach, specialized training, community outreach, client/family engagement, mobile outreach/crisis intervention services, and shared decision-making.

Subjects eligible for the study were between 16-30 years, had a primary psychotic disorder diagnosis with duration of psychosis between one week and two years, and were a New York State resident. Of 2,800 referrals, the majority from inpatient psychiatric units and outpatient mental health providers, 22% met eligibility criteria. The mean age was 21 years; 13% were younger than 18 years. Average time since onset of psychosis was 7.4 months. Greater baseline symptoms predicted hospitalization. Approximately 78% of clients were prescribed medications at 15-month...
follow-up. Those with suicidal ideation or attempt decreased from approximately 30% at baseline to about 12% at last follow-up. Approximately 68% remained in treatment after 18 months. Results demonstrate the feasibility and usefulness of EBPs applied broadly.

Steven Adelsheim, MD, who was involved in the Early Detection and Intervention for Prevention of Psychosis (EDIPPP) study and RAISE (site PI in New Mexico), stressed the need for early intervention and a continuum of care for mental health in youth in the US. Findings from EDIPPP demonstrated a 20.6% increase in school and/or work functioning in the clinical high risk (CHR) and early FEP groups with intervention. Outreach targeted primary/secondary school/community college/university personnel, medical/mental health providers, law enforcement/juvenile justice, and parent student groups for referrals. In the University of New Mexico NAVIGATE site versus RAISE overall, the sample was younger (mean age was 18.5 versus 23 years) and had a shorter DUP (26 weeks versus 74 weeks for RAISE). The findings imply that earlier screening and referrals, especially in adolescents, decrease DUP.

School-based mental health is one way to increase referrals/supports. Dr. Adelsheim described the headspace program in Australia, offering health checks, health information, pregnancy information and assistance, mental health, and referral pathways. These recovery-focused programs offer a more flexible approach to service provision and community awareness, and have been linked to CHR and FEP programs as “one continuum of early identification and intervention”. In the US, initial funds from Santa Clara County will soon start two headspace sites there.

To facilitate communication and collaboration of US programs providing services to CHR and FEP, the Prodrome and Early Psychosis Program NETwork (PEPPNET) has been developed. Child and Adolescent psychiatrists are especially encouraged to become more involved in this endeavor, as education, detection, and treatment of psychosis needs to begin early. Sign up for PEPPNET at: https://www.surveymonkey.com/r/3RD6DN7.

Discussant Gary M. Blau, PhD, from SAMHSA, ended the symposium with positive findings and funding updates. Findings show that youth with early onset psychosis do make improvements with better behavioral/emotional and clinical functioning, reduction in suicidal ideation and attempts, and increased school attendance. There are multiple Children’s Mental Health Initiatives (CMHI) addressing prodrome and FEP across the United States. The SAMHSA fiscal year 2018 request for CMHI is $119 billion, with a plan to set aside 10% to focus on youth and young adults identified as high-risk for developing FEP. The allocated funds offer increased funding opportunities with a goal of examining how EBPs for CHR youth can be scaled up to mitigate and delay the progression of mental illness, reduce disability, and/or maximize recovery. Future considerations include outreach to community partners to identify CHR, training of mental health providers, understanding the clinical heterogeneity of CHR, considering the same array of CSC services for CHR versus FEP but at “lower dosages,” and emphasis on the importance of accurate screening (CHR from other diagnoses and from FEP).

In a nutshell, the take-home points from this symposium are:

- Long DUP = bad
- Early screening and detection = good
- CAPs must “come to the table”
- Early intervention EBPs can be scaled up broadly
- Increased awareness of early psychosis screening and treatment is leading to increased funding opportunities

Dr. Hua is a child and adolescent psychiatrist working in outpatient community mental health with Baltimore Catholic Charities. She is also the co-chair of the AACAP Adolescent Psychiatry Committee and AACAP liaison to the American Academy of Pediatrics Committee on Adolescence. She can be reached at lhua@cc-md.org.

More Annual Meeting Photos!
The Child Psychiatrist as an Advocate for LGBT Youth: The Intersection of Policy, Law, and Clinical Practice When Optimizing the Health of LGBT Youth

Brandon Johnson, MD, and Scott Leibowitz, MD

Imagine yourself an adolescent boy growing up in a community where the only message you have heard about being gay is that it is perverted and sinful. When you start to recognize that you are having same-sex attractions, you are terrified and keep it to yourself, leading to feelings of depression and isolation. You do everything in your power to fight the urges. You are then brought to a therapist, and eventually gently test the waters by asking, “Is it normal for a boy to feel attracted to another boy?” In response, you detect slight facial disdain in the provider, who then proceeds to say, “Well, if that boy wants to eliminate those feelings, it is possible.” You experience an internal sigh of relief that it is, in fact, possible to change, however, shame intensifies for having those feelings in the first place.

Now, imagine yourself as a transgender youth who spent years trying to convince yourself that you are a girl because you were born with “girl parts.” After years of treatment for depression, you “come out” to disbelieving parents as your authentic male self. After some time, your parents finally allow you to move forward with testosterone treatment for gender dysphoria. You start to develop facial stubble, and your voice pitch starts to lower and you are elated. Despite the bullying in school by some youth who tell you that you are not a real male, strangers begin to address you as sir. For the first time in your life, you feel confident that others are starting to see you in the way you see yourself. Then, one day, a law is introduced in your state that prevents you from using the male bathroom, something you have been waiting years to do without getting noticed.

How could you envision finding your place in a society with so much rejection, ignorance, and stigma simply because of your sexual orientation and/or gender identity? Many lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth wrestle with this question every day and do not feel safe in their schools, communities, families, or, sometimes, even in the offices of their mental health providers. Some LGBTQ youth cannot envision a place for themselves in this world at all, and sadly take their own lives.

Indeed, the rate of mental illness and suicide among LGBTQ youth far exceeds that of their peers, and research shows time and time again that this is related to the stigma they face. Some alarming statistics include:

- A majority of LGB (>67%) and T (>60%) youth are not “out” to their medical providers.
- LGBTQ youth, rejected by their families, have a nine times higher likelihood of engaging in suicidal behavior compared to those with accepting families.
- Only 15 states and Washington, DC, have laws preventing discrimination in education for LGBTQ youth.
- Ten states have specific laws that restrict the inclusion of LGBTQ topics in schools.

Child and adolescent psychiatrists have the responsibility of bearing witness to, and addressing, the pain and struggles of all youth, including those who are either outwardly LGBTQ or suffering internally with these aspects of identity. While doing the difficult daily work is important, it can feel like an uphill battle supporting these youth in such challenging environments. As such, it is becoming increasingly important for us to be advocates with the hopes of reducing stigma and making the world a safer place for them.

This is why the Sexual Orientation and Gender Identity Issues Committee (SOGIIC) teamed up with the DC-based Human Rights Campaign (HRC) to develop a Member Services Forum on advocacy for LGBTQ youth that culminated in visits to Capitol Hill to lobby for the HRC. The HRC is the leading advocacy group for the LGBTQ community in the United States. The organization promotes equality for LGBTQ people in homes, schools, and communities; and educates lawmakers on the struggles that the LGBTQ community faces. They also encourage the passage of laws that promote inclusiveness and equal protections for LGBTQ people.

The Member Services Forum provided AACAP members a clinical overview of the unique issues faced by LGBTQ youth and a legal perspective on the policies and laws that impact their lives. Sponsored jointly by SOGIIC and the Children and the Law Committee, this forum put the intersection of clinical work and policy into the forefront of providers’ minds. The clinical talks were given by SOGIIC co-chairs Sarah Herbert, MD, MSW, and Scott Leibowitz, MD, and members Brandon Johnson, MD, and Shervin Shadianloo, MD. Members received an overview of current terminology related to gender and sexuality, learned more about the harms of conversion therapies, and the important roles of families, communities, and schools in promoting healthy
psychological and emotional outcomes for these youth.

Subsequently, invited speakers from HRC gave AACAP members the opportunity to hear about the laws and policies affecting LGBTQ youth. Ellen Kahn, MSS, the director of the Children, Youth, and Families Program, gave a compelling presentation about the elevated risks LGBTQ youth face in various aspects of their environments. The increased rates of depression, school avoidance, suicide attempts, incarceration, and homelessness are just some of the many inequities to which LGBTQ youth are subjected. Then Sarah Warbelow, JD, legal director of HRC, discussed the federal arguments for LGBTQ rights, which included the protections under Title IX of the Educational Amendments Act of 1972 and the Equal Protection Clause of the 14th Amendment.

Following the member forum, attendees traveled to HRC headquarters to hear about current legislation proposed to protect LGBTQ individuals. Four bills were presented: the Equality Act (protections for employment, housing, education, public spaces, and so on), the Therapeutic Fraud Prevention Act (protection against “conversion therapies”), the Safe Schools Improvement Act (LGBTQ enumeration in anti-bullying laws), and the Tyler Clementi Higher Education Anti-Harassment Act (protection against mistreatment in higher education). Attendees learned how to effectively lobby government representatives to support these bills.

Synthesizing all that had been conveyed throughout the day, teams of child and adolescent psychiatrists from each state descended upon the offices of their respective Senators for pre-arranged meetings organized by HRC. Approximately, 50 members from 20 states and Washington, DC, participated in this first-ever collaborative initiative between AACAP and HRC. We put our lobbying skills to the test by sharing the impact of the injustices experienced by our LGBTQ patients, and asked the lawmakers to co-sponsor these vital bills that could truly make a difference in our patients’ lives.

We returned to the HRC headquarters for a reception to celebrate the successes of the day. The consensus was that our message was well received overall, and we felt that our expertise and clinical experiences connected on a human level with Democrats and Republicans alike. While many of our LGBTQ patients do not have the voice or venue to promote a safe and inclusive environment for themselves, we who have power and privilege must step up and speak for them. Perhaps the LGBTQ youth of tomorrow will not have to ponder where they fit in, but rather will emerge into a world where they are embraced not in spite of who they are, but because of it.

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Dr. Leibowitz is medical director of Behavioral Health for the THRIVE gender and sex development program at Nationwide Children’s Hospital in Columbus, Ohio. He is also an associate professor of psychiatry at The Ohio State University College of Medicine. He is co-chair of the AACAP Sexual Orientation and Gender Identity Issues Committee. He may be reached at Scott.Leibowitz@nationwidechildrens.org.
Public Health Interventions in Schools for Child and Adolescent Psychiatrists

After AACAP’s Annual Meeting, we inevitably find ourselves in a state of reflection regarding our own clinical practice, as well as pondering new ideas, obstacles, and solutions to address the many issues faced by our field. One of these issues, the practice of child psychiatry within schools, was addressed in the symposium: Public Health Interventions in Schools for Child and Adolescent Psychiatrists. A panel of child and adolescent psychiatrists discussed innovative programs that deliver mental health interventions in school settings, across diverse communities, both urban and rural. These programs reach youth who would otherwise not access care in a traditional mental health setting. This panel demonstrated how child and adolescent psychiatrists in the school setting can help address societal demands for care, while also providing evolving communities ways to flourish through psychiatric interventions and providing child and adolescent psychiatrists a new venue of practice.

Kristie Ladegard, MD, of Denver Health and University of Colorado, reviewed how mental health conditions among children are of the utmost concern and a public health emergency. Approximately, 21% of children and adolescents between the ages of 9 and 17 years in the United States have a diagnosable mental health or addictive disorder. Nearly 80% of children and adolescents who benefit from mental health interventions are not able to access care, especially minority and uninsured populations. Dr. Ladegard reviewed the effectiveness of mental health interventions obtained at school-based clinics in Denver Public Schools. Outcomes were measured using the Ohio Youth Problem Functioning and Satisfaction Scale. Significant decreases in suicidal thoughts (88% reduction in score from baseline to 3 month assessment), youth reporting ever hurting oneself, (90% reduction in score from baseline to 3 month assessment), and youth ever feeling sad or depressed (82% reduction in score from baseline to 3 month assessment) were demonstrated. For youth with severe symptoms (a problem severity scale score >30), the proportion reporting ever hurting one’s self decreased significantly from baseline to 3 month assessment, as did the proportion reporting ever talking or thinking about death, ever feeling anxious or fearful, or ever feeling sad or depressed. This illustrates that the most impaired youth exhibited noteworthy improvement in several areas. Youth with high levels of severe symptoms also reported a significant improvement in attending school and getting passing grades from 29% at baseline to 49% at 3 months.

Christian Thurstone, MD, of Denver Health Hospital Authority and University of Colorado, discussed how changes in marijuana policies in Colorado raised concerns in several inner city schools in Denver. Even though substance use is prevalent in adolescents, only 6% receive treatment. Co-locating treatment programs in schools may be one way to improve access to care. Dr. Thurstone has collaborated directly with school administrators to develop substance use treatment programs in school-based clinics. Of the 17 school-based health centers in Denver, 6 of these clinics offer substance use treatment directly on school grounds. In this program, 41 youth (12-18 yrs.) were consecutively admitted to treatment in 3 school-based health centers. These youth have significant co-occurring psychiatric disorders and social problems; 44% had comorbid posttraumatic stress disorder, and 41% had comorbid major depressive disorder. Treatment consisted of 12 weeks of individual motivational interviewing and acceptance commitment therapy, contingency management, case management, and medication management. Overall, 61% of youth achieved a week of abstinence by self-report and 56% achieved a clean urine drug screen with treatment. Mean scores on School Engagement scales increased, illustrating that participants felt more connected to school. Finally, behavioral incidents in school decreased significantly as youth progressed through substance use treatment. Dr. Thurstone worked with school staff, including administrators, to develop policies that helped reduce drug-related suspensions and expulsions in schools that provided substance use treatment. His program illustrates that child and adolescent psychiatrists can play an important role in collaborating with schools to create programs that positively impact youth.

Elizabeth Erickson, DO, also from Denver Health Authority and University of Colorado, discussed her work in a pregnant and parenting teen clinic in Denver Public Schools and how she utilizes a “two generational approach” as an intervention for this population. Dr. Erickson employs an integrated care model, working side-by-side with pediatricians and obstetricians, to address psychiatric and developmental needs of adolescent mothers and their children. In treating the psychiatric needs of these two generations, intervention becomes not only one of psychiatric care, but also a public health model that aides in breaking cycles of poverty, enhancing the ability of these young mothers to continue to engage in their academic pursuits, and to be competent in an ever evolving and competitive work force. Dr.
Erickson evaluated the Two Generational model’s strengths and weaknesses when employed by CAPs and discussed barriers and obstacles of care. Through utilizing an approach that treats teen mothers and their children, child and adolescent psychiatrists have the unique ability to treat two or more generations and promote healthy outcomes in this population.

Erika Ryst, MD, from the University of Nevada-Reno, discussed a broader role that child and adolescent psychiatrists can have in addressing school mental health on a statewide level by working with state agencies such as the Department of Education to develop new programs and policies. After the Newtown school shooting, the Substance Abuse and Mental Health Services Administration (SAMHSA) allocated grant funding to 20 states to create a program Project AWARE (Advancing Wellness and Resilience Education). Project AWARE increases awareness of mental health issues among school age youth, trains school personnel and other adults to detect and respond to mental health issues, and connects children, youth, and families who may experience behavioral health issues to appropriate services. After the Newtown school shooting, the Substance Abuse and Mental Health Services Administration (SAMHSA) allocated grant funding to 20 states to create a program Project AWARE (Advancing Wellness and Resilience Education). Project AWARE increases awareness of mental health issues among school age youth, trains school personnel and other adults to detect and respond to mental health issues, and connects children, youth, and families who may experience behavioral health issues to appropriate services. Dr. Ryst has been involved in Nevada’s Project AWARE, which is piloting the program in three rural and underserved county school districts. Across all three counties, the Nevada Project AWARE showed an increase in the percentage of school-to-community mental health referrals, and an increase in the actual number of youth receiving community mental health services during the second implementation year of the grants. A survey of 407 teachers, school district administrators, mental health providers, and community members indicated that 49.4% felt that AWARE had improved access. Project AWARE promotes collaboration between school districts and communities to design an integrated continuum of care, including school-based and community-based models of mental health service delivery. These new collaborative models of care provide unique opportunities for child psychiatrists to promote and support youth mental health.

Sheryl Kataoka, MD, of the University of California at Los Angeles, served as discussant for the panel and explored how child and adolescent psychiatrists can maneuver an evolving healthcare landscape and prodigious demand for services. Child and adolescent psychiatrists have the opportunity to take the lead in creating innovative approaches and venues to provide care, promote healthy children and families, and in doing so, make significant public health gains. Our field must rely on inventive strategies to meet the societal need, while promoting our own evolution. Schools offer a unique and exciting venue to do so.

References


2. Center for Behavioral Health Statistics and Quality (2016), Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (HHS Publication No. SMA 16-4984, NSDUH Series H-51)

Dr. Ladegard is assistant professor of Psychiatry at the University of Colorado Department of Psychiatry and serves as a child and adolescent psychiatrist at Denver Health and Hospital Authority. She can be reached at Kristie.Ladegard@dhha.org.

Dr. Erickson is associate professor of Psychiatry at the University of Colorado Department of Psychiatry and serves as a child and adolescent psychiatrist at Denver Health and Hospital Authority. She can be reached at Elizabeth.Erickson@dhha.org.
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ABPN Announces New Pilot Project as an Alternative to the 10-Year MOC Exam

Elizabeth Hughes, Deputy Director of Education and Recertification, AACAP

Maintenance of certification (MOC) can be a tricky thing to navigate. I have spoken to many of you, especially at AACAP’s recent Annual Meeting, about the requirements needed to recertify and the resources AACAP has to assist in fulfilling those requirements. Most recently, questions I receive pertain to the American Board of Psychiatry and Neurology’s (ABPN) announcement in September 2017 of a pilot project to address an alternative to the 10-year MOC exam.

The ABPN Pilot Project is a journal article-based, open book assessment activity designed as an optional alternative to the exam. The Pilot Project will run for three years beginning in 2019.

Eligible diplomates were sent an email by the ABPN in December 2017 inviting them to participate in the pilot project. Eligibility consists of:

A. Diplomates whose third Continuous MOC (C-MOC) block begins in 2019, 2020, or 2021 (these diplomates will have a certificate expiring in 2019-2021).

Eligibility Period: Diplomates in this group must successfully complete 30 journal article mini-tests by December 15 of their certificate expiration year. All other MOC Program requirements (CME, SA, PIP) must be attested to by September 1 of their certificate expiration year.

Those eligible must elect to participate by March 2018. One may choose to take the 10-year exam rather than participate in the pilot project. All other MOC requirements remain the same — CME, Self-Assessment, and Improvement in Medical Practice (PIP).

The pilot project design includes reading a minimum of 30 journal articles and a maximum of 40 articles and completing a mini-test per article. Each article has 5 questions, and one must achieve 4 out of 5 questions correct for the article to count. The 30 articles and mini-tests can be completed any time during the eligibility period.

Access to the journal articles will be up to the individual to obtain. The ABPN will provide a list of articles with links; however, there may be fees associated to gain access to the article. The ABPN expects to have some articles that are free access.

The usual MOC fee structure will be in place for the pilot project. Those in C-MOC will not be required to pay an additional fee to participate. Those in the 10-year MOC cycle will pay a fee equal to the amount of the 10-year exam. There is no “combined exam” so those wishing to recertify in both Psychiatry and Child and Adolescent Psychiatry will need to complete 30 articles for each specialty and subspecialty, as well as pay a fee equal to the combined MOC exam.

B. Diplomates in the 10-Year MOC Program who need to take an MOC examination in 2019, 2020, or 2021 (these diplomates will have a certificate expiring in 2019-2021).

Eligibility Period: Diplomates in this group must successfully complete 30 journal article mini-tests by December 15 of their certificate expiration year. All other MOC Program requirements (CME, SA, PIP) must be attested to by September 1 of their certificate expiration year.

The American Board of Medical Specialties (ABMS) will review the results of the pilot project at the end of its three years in 2021, and if the pilot project is then approved by the ABMS, it will become available for all diplomates in 2022.

AACAP is encouraged that the ABPN is looking into flexible options for its members.

We have dedicated staff to answer any questions you may have regarding MOC or the pilot project. You may always contact me at ehughes@aacap.org or 202.966.1944, or my colleague Quentin Bernhard III, CME Manager, at qbernahrd@aacap.org or 202.587.9675. More information can also be found on the ABPN website at www.abpn.com.
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Campus Access for Central Delaware, PA
Robert Salminger
David A. Sasso, MD, MPH
Susan M. Scherer, MD
Robert L. Schmitt, MD
Scott Shannon, MD
Jess P. Shatkin, MD, MPH
Joseph A. Shrand, MD
Josh Spieler
William J. Swift, III, MD
Sarabjit Tokhie, MD
Kimberly C. Walker, MD
Sharon R. Weinstein, MD
Lyman Wible
Cynthia Wilson, MD
Liz Woods

Campaign for America’s Kids
Sherry Barron-Seabrook, MD
Donald W. Bechtold, MD
Patricia Mary Butler
Martin J. Drell, MD
Teresa Frausto, MD
Theodore John Gaensbauer, MD
Gordon R. Hodas, MD
Jujamcyn Theaters
Helen Krell, MD
Marcia E. Leikin, MD
Cathy Lore, MD
Kirk C. Lum, MD
Ardis C. Martin
Carolyn B. Robinsonowitz, MD
Robert A. Root, MD
David C. Ruck, MD
Amy S. Smith, MD
Richard M. Spiegel, MD
Laine E. Taylor, DO
Sonja B. Ybarra, MD

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Thank You for Supporting AACAO continued from page 47

Elaine Schlosser Lewis
Journal Award for Research on ADD
Stephanie Hamarman, MD

Life Members Fund
Thomas F. Anders, MD
L. Eugene Arnold, MD
Perry B. Bach, MD
Sherry Barron-Seabrook, MD
Eileen Bazelon, M.D.
William H. Beute, MD
Chandrakant Bhata
Stephen Wood Churchill, MD
Louise Desgranges, MD
Lois T. Flaherty, MD
Theodore John Gaensbauer, MD

Barbara Rosenfeld
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Gregoria Marrero, MD
Bennett L. Leventhal, MD
Ayesha S. Lall, MD
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J. Kipling Jones, MD
Margery R. Johnson, MD
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Giuliana G. Gage, MD
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Louise Desgranges, MD
Stephen Wood Churchill, MD
Chandrakant Bhatia
William H. Beute, MD
Eileen Bazelon, MD
Sherry Barron-Seabrook, MD
Perry B. Bach, MD
L. Eugene Arnold, MD
Life Members Fund
Stephanie Hamarman, MD

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.
AACAP Award Opportunities
FOR MEDICAL STUDENTS, RESIDENTS, AND EARLY CAREER PSYCHIATRISTS

RESIDENTS AND JUNIOR FACULTY

**AACAP Pilot Awards**
Application Deadline: March 30, 2018
Provides $15,000 to members with a career interest in child and adolescent mental health research

Research Award for Child and Adolescent Psychiatry Residents and Junior Faculty, Supported by AACAP
Research Award for Child Psychiatry Residents and Junior Faculty focusing on Attention Disorders and/or Learning Disabilities, Supported by AACAP’s Elaine Schlosser Lewis Fund
Research Award for General Psychiatry Residents, Supported by Industry Supporters

**AACAP Educational Outreach Programs (EOP)**
Application Deadline: July 13, 2018
Provides travel support of up to $1,000 for Residents and CAP Fellows to travel to AACAP’s Annual Meeting and network with leaders in the specialty

EOP for Child and Adolescent Psychiatry Residents, Supported by AACAP’s Endowment Fund, AACAP’s John E. Schowalter, MD, Endowment Fund, and AACAP’s Life Members Fund
EOP for General Psychiatry Residents, Supported by AACAP’s Endowment Fund

**AACAP Systems of Care Special Program Clinical Projects Scholarship,**
Co-sponsored by SAMHSA’s Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee
Application Deadline: July 13, 2018
Provides support of $750 to attend AACAP’s Annual Meeting and present a poster on a systems-of-care-related topic

**AACAP Junior Investigator Award,** Supported by AACAP
Application Deadline: March 15, 2018
Provides $30,000 a year for two years for one child and adolescent psychiatry junior faculty

MEDICAL STUDENTS

**Medical Student Fellowships**
Application Deadline: March 2, 2018
Provides a $3,500 to $4,000 stipend for 12 weeks of research training and covers travel expenses for AACAP’s Annual Meeting

AACAP Jeanne Spurlock Minority Medical Student Research Fellowships in Substance Abuse and Addiction, Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign for America’s Kids (CFAK)
AACAP Summer Medical Student Fellowship Program, Supported by AACAP’s CFAK

**AACAP Life Members Mentorship Grants for Medical Students**
Application Deadline: July 13, 2018
Provides travel support of up to $1,000 for medical students to travel to AACAP’s Annual Meeting and network with leaders in the specialty

*All awards contingent upon available funding.*

For more information, visit www.aacap.org/awards.
AACAP Cancro Academic Leadership Award recognizes, in even-numbered years, a currently serving General Psychiatry Training Director, Medical School Dean, CEO of a Training Institution, Chair of a Department of Pediatrics, or Chair of a Department of Psychiatry for his or her contributions to the promotion of child and adolescent psychiatry.

AACAP George Tarjan, MD, Award for Contributions in Developmental Disabilities recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with intellectual and developmental disabilities.

AACAP Irving Philips Award for Prevention recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents.

AACAP Jeanne Spurlock Lecture and Award on Diversity and Culture recognizes individuals who have made outstanding contributions to the advancement of the understanding of diversity and culture in children’s mental health, and who contribute to the recruitment into child and adolescent psychiatry from all cultures.

AACAP Norbert and Charlotte Rieger Service Program Award for Excellence recognizes innovative programs led by AACAP members that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents, and serve as model programs to the community.

AACAP Sidney Berman Award for the School-Based Study and Treatment for Learning Disorders and Mental Illness recognizes an individual or program that has shown outstanding achievement in the school-based study or delivery of intervention for learning disorders and mental illness.

AACAP Simon Wile Leadership in Consultation Award, supported by the Child Psychiatry Service at Massachusetts General Hospital, acknowledges outstanding leadership and continuous contributions in the field of consultation-liaison child and adolescent psychiatry.

For details about all awards, eligibility requirements, and for access to applications and nomination information, visit www.aacap.org/awards.
CLASSIFIEDS

CALIFORNIA
ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS
(San Bernardino County, CA)

Job Description:
I am a PERMANENTE PHYSICIAN. A dedicated doctor who believes in pursuing dreams, creating hope and driving progress. While every physician at the Southern California Permanente Medical Group has their own personal and professional ambitions, they all share a common vision: to transform the practice of medicine. Every day, they work hand in hand—with each other and their patients—to achieve outcomes that elevate the level of care across our organization and, ultimately, our nation. ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS San Bernardino County location offers spectacular natural scenery and an exceptional climate. Ideally situated near Big Bear and Lake Arrowhead, you're just a short trip away from amazing recreational activities such as hiking, skiing and watersports. We also provide an excellent salary/benefits package and stability in today's rapidly changing health care environment. Our physicians enjoy: 4 1/2 day work week (8-10 hours) Options for flexible schedules Education time (1/2 day) Academic teaching opportunity available through our Adult Residency Program Bonuses offered Research opportunities Team model - MA, LCSW, Psychologists Child and Adolescent Fellowship opened in the summer of 2017 In clinic consult model available in the Chino/Grand facility (embedded in Primary Care) If you believe in pursuing dreams, creating hope and driving progress, then you're the very definition of a Permanente Physician. For consideration or to apply, please visit our website at http://scpmgphysiciancareers.com. For questions or additional information, please contact Kathy Uchida at (877) 259-1128 or Kathy.C.Uchida@kp.org. The Answer to Health Care in America.

Company: Spin Recruitment Advertising
Job ID: 10523151
http://jobsources.aacap.org/jobs/10523151

ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS
(Southern California)

Job Description:
I am a PERMANENTE PHYSICIAN. Building a future for my career, my family and my community. At the Southern California Permanente Medical Group (SCPMG), we believe in giving every member of our community the opportunity to live a happy, healthy life. From the physicians we employ to the patients we serve, our mission is to provide a level of care and support that enables each of us to achieve our best. ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS Openings throughout Southern California At SCPMG, you’ll enjoy the amazing recreational activities, spectacular natural scenery and exceptional climate our area is known for, along with stability in today’s rapidly changing health care environment. Kaiser SCPMG is proud to offer its physicians: An organization that has served the communities of Southern California for more than 60 years A physician-led practice that equally emphasizes professional autonomy and cross-specialty collaboration Comprehensive administrative support An environment that promotes excellent service to patients A fully implemented electronic medical record system An excellent salary, comprehensive benefits and partnership eligibility after 3 years If you believe in pursuing dreams, creating hope and driving progress, then you're the very definition of a Permanente Physician. For consideration or to apply, please visit our website at http://scpmgphysiciancareers.com. For questions or additional information, please contact Kathy Uchida at (877) 259-1128 or Kathy.C.Uchida@kp.org. The Answer to Health Care in America.

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CHILD AND ADOLESCENT PSYCHIATRISTS AND ADULT PSYCHIATRISTS
(Riverside, CA)

Job Description:
I am a PERMANENTE PHYSICIAN. A skilled practitioner who seeks to create high-quality outcomes through integrated care. At the Southern California Permanente Medical Group (SCPMG), we believe in giving every member of our community the opportunity to live a happy, healthy life. From the physicians we employ to the patients we serve, our mission is to provide a level of care and support that enables each of us to achieve our best. ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS Openings in Riverside, California Riverside is an area rich in recreational opportunities. Here, you can enjoy world class golf and tennis facilities, Lake Matthews, the Box Springs Mountain and the Mount Rubidoux Trail. You’ll also enjoy our many cultural attractions, including the Riverside Metropolitan Museum, Mission Inn, Fox Performing Arts Center, Coachella Valley Music and Arts Festival and more. And our location is ideal, as just about 2 hours can take you from Palm Springs to San Diego to the beach. At SCPMG, you’ll enjoy the amazing recreational activities, spectacular natural scenery and exceptional climate our area is known for, along with stability in today’s rapidly changing health care environment. Kaiser SCPMG is proud to offer its physicians: An organization that has served the communities of Southern California for more than 60 years A physician-led practice that equally emphasizes professional autonomy and cross-specialty collaboration Comprehensive administrative support An environment that promotes excellent service to patients A fully implemented electronic medical record system An excellent salary, comprehensive benefits

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and partnership eligibility after 3 years. If you believe in pursuing dreams, creating hope and driving progress, then you’re the very definition of a Permanente Physician. For consideration or to apply, please visit our website at http://scpmgphysiciancareers.com. For questions or additional information, please contact Kathy Uchida at (877) 259-1128 or Kathy.C.Uchida@kp.org. The Answer to Health Care in America.

Company: Spin Recruitment Advertising
Job ID: 10523420
http://jobs.source.aacap.org/jobs/10523420

CHILD AND ADOLESCENT PSYCHIATRISTS
(Southern California)

Job Description:
I am a PERMANENTE PHYSICIAN. A true innovator who leverages the latest tools, resources and technologies to deliver high-quality outcomes. Every physician who is part of the Southern California Permanente Medical Group shares a passion for advancing the practice of medicine. We fuel that passion by creating a culture of innovation and collaboration—one where the quality of care we deliver is elevated by the accelerated resources we provide. ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS Openings in Antelope Valley, California Our Antelope Valley location offers spectacular natural scenery and offers four distinct seasons. Ideally located a 1-2 hour drive from beaches, skiing, Hollywood and Downtown LA, you’re also just a short trip away from amazing recreational activities such as hiking, skiing and watersports. We also provide an excellent salary/benefits package and stability in today’s rapidly changing health care environment. Our Psychiatry Department is medium-sized offering all of us an opportunity to get to know each other very well. It also allows for individuals to take their own initiative and start new programs or create solutions, and provides for greater flexibility of schedules. Our physicians enjoy: 4 1/2 day work week (8-10 hours) Options for flexible schedules Education and training Time in patient and consult/liaison settings. Nemours is a nationally recognized large pediatric multi-specialty provider with locations in Florida (Jacksonville, Orlando, Pensacola) and in Delaware. In Jacksonville we provide services in 3 outpatient settings in the greater Jacksonville area, as well as at our affiliated children’s hospital Wolfson Children’s Hospital. We also have strong ties to major academic sites and responsibilities include the supervision and education of trainees from University of Florida (pediatric, psychiatry and child psychiatry trainees), Mayo-Jacksonville (pediatric neurology fellows), among others. We are seeking 2 child and adolescent BC/BE trained psychiatrists interested in working a mixture of inpatient and outpatient practice, depending upon service demands and provider interests. Graduates trained in both pediatrics and child and adolescent psychiatry (e.g. Triple Board trained) are especially sought after, but not necessary for consideration. Although having a Florida license is a requirement prior to starting employment and providers with...
an active Florida license will have priority consideration, this is not a requirement for consideration during the application process. NSCS is located in Jacksonville, a cozy city nestled between the St Johns River and 30 min. from the Atlantic coast brimming with restaurants, shopping, arts, entertainment, golf courses including the famous TPC, and home of the NFL Jacksonville Jaguars. Our clinics and hospital-based settings are esthetically pleasing child friendly work environments. Nemours offers a competitive comprehensive compensation package including medical, dental, vision, retirement, and a large number of other benefits including expenses related to practicing including malpractice insurance, CME and membership stipends, among others. Support is available for providers interested in research. Salaries include a base salary set at the 25-75% of MGMA standards depending upon experience and additional qualifications. Following the first year of employment providers are eligible for additional bonus compensation with potential for total compensation into the upper quartiles of the MGMA salary range. Sign on bonus and moving expense stipends may be considered in the negotiation process.

Job Requirements:
ABPN board certified or board eligible in child and adolescent psychiatry Florida license required for employment, but not necessary during application process

Company: Nemours Children’s Specialty Care (1073697)
Job ID: 10522589
http://jobsource.aacap.org/jobs/10522589

PENNSYLVANIA
ASSOCIATE MEDICAL DIRECTOR – COMMUNITY CARE BEHAVIORAL HEALTH

Job Description:
Community Care Behavioral Healthcare Organization (CCBHO) is seeking a qualified individual to fulfill the role of Associate Regional Medical Director and offer administrative services involving 7 counties in Northeast Pennsylvania including the Pocono region. This individual would report to the Senior Medical Director of CCBHO and offer clinical and medical supervision to the care management and quality clinician staff in 2 of our offices, Moosic (near Scranton) and Tobyhanna (near Mount Pocono), Pennsylvania. Though many of the duties can be provided on a remote basis, there would be a need for being on site approximately or a minimum of once per month. More information on position location will be discussed at time of interview. CCBHO is part of the UPMC healthcare system and compensation and benefits are highly competitive and is based on part on attaining 1 or more board certification status. Duties could be individualized and be offered within a weekly time frame of 28 to 40 of usual working hours. There are no requirements for on-call, weekend or evening hours. The Associate Regional Medical Director would join a highly educated and motivated team of physician advisors at CCBHO who advocate well for the recovery from mental health and substance use disorders for nearly a million individuals across Pennsylvania. He or she would have the opportunity to be involved in many new initiatives some of which lend towards research and journal inclusion.

Job Requirements:
Board Certification in Psychiatry required Minimum 8 years clinical experience required. Experience in Behavioral Health treatment and program development. At least 5 years of management experience preferred. Experience in managed care setting preferred. Doctor of Medicine or Doctor of Osteopathy from an accredited school. Ability to obtain an Unrestricted License in Pennsylvania. Post residency clinical experience. Ability to implement medical policies, and to enforce those policies through appropriate action. Ability to maintain effective professional liaison with all levels of executive and medical staff, including professional and institutional providers of care. Ability to implement programs of quality care analysis, peer review, and professional education.

Company: UPMC Health Plan (1073523)
Job ID: 10519022
http://jobsource.aacap.org/jobs/10519022

SOUTH CAROLINA
EMERGENCY PSYCHIATRIST – Greenville, SC

Job Description:
Emergency Psychiatrist Greenville, SC 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 1 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.

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ph: 800-772-6987. GHS does not offer sponsorship at this time. EOE.

Company: Greenville Health System (928051)
Job ID: 10587982
http://jobsource.aacap.org/jobs/10587982

WISCONSIN

CHILD AND ADOLESCENT PSYCHIATRY ON THE BEAUTIFUL SHORES OF LAKE MICHIGAN

Racine, WI

Job Description:
Wheaton Franciscan Healthcare, a part of Ascension Wisconsin is currently seeking a highly motivated and energetic full time Child/Adolescent Psychiatrist to join our collegial group at our hospital in Racine, WI.

Opportunity: Practice opportunity is flexible, with either a mix of inpatient and outpatient or just outpatient. Join a well-established team of: 1 Adult Psychiatrist, 3 Child Psychiatrists, and 2 Advanced Practice Clinicians. Excellent ancillary support staff EHR-Epic Call Week day, Clinicians take call for their own patients Weekend 1:2, but goes through answering service first. Flexible scheduling Monday through Friday, 36 patient contact hours. Candidates must be Board Eligible or Board Certified in Child and Adolescent Psychiatry. Competitive Compensation Package Generous Benefits, including a great retirement plan. FACILITIES: All Saints Mental Health and Addiction Care is a large provider of mental health and addiction services in Southeastern WI that offers a variety of treatment programs: Adult Services: 22 beds for inpatient, Partial hospitalization, Program Intensive outpatient programs: Mental Health and Addiction Outpatient Medication and Psychiatric Clinic, Individual and Family counseling in 9 locations. Child and Adolescent Services. 7 child and 10 adolescent beds. Partial hospital programs

Get in the News!

All AACAP Members are encouraged to submit articles and news items for publication, as well as photographs, poems, cartoons, and drawings.

Categories for submission and consideration are:

- **Letters to the Editor**, of 250 words or less, submitted in response to an article published in the AACAP News should be submitted directly to the Editor at urao@mmc.edu or through the National Office to Managing Editor Rob Grant at rgrant@aacap.org. Please include your name and contact information.

- **Photographs** to be published on the front page, inside standing alone, or accompanying relevant articles or stories. Photographs should—in an artistic way—illustrate themes pertaining to children, childhood, parents and children, parenting, or families. Members are invited to submit up to two photographs every two months for consideration. Please send a high-resolution version to communications@aacap.org with a description of 50 words or less.

- **Opinion pieces**, including debates, 800-1500 words

- **Articles** approved by and coming from Committees, 600-1200 words

- For a list of column coordinators for Diversity and Culture, Ethics, Acute Care, Clinical Case Reports and Vignettes, Systems of Care, Psychotherapy, and International Relations email pjjutz@mac.com.

- **Newsworthy items**
  - Fully developed News Articles, 800-1500 words
  - Kudos, highlighting member achievements 250 words or less

- **Regional Organization of Child and Adolescent Psychiatry, 250 words or less**

- **Committee activity reports or updates, 250 words or less**

- **Features**, 600-1200 words

  - Interviews
  - Discussions of movies or literature
  - Creative Arts, e.g. poems, cartoons, drawings (limited to 1 page)
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www.aacap.org/ReviewCourse-2018

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