CHILD AND ADOLESCENT PSYCHIATRIC SOCIETY OF GREATER WASHINGTON

CAPSGW

Winter 2012

Inside this issue:

President's Message

Brent Anderson, MD

On Tuesday, October 18, 2011, **Michael Houston, Jeanne Holzgrefe**, and **Brent Anderson** represented CAPSGW at the AACAP Assembly in Toronto. **Michael Houston** served as Chair of the Assembly and was recognized for upgrading the AACAP computer platform that will now allow online assembly registration and roll call submission. **Jeanne Holzgrefe** spoke along with other Assembly Representatives about the ethics and patient confidentiality issues in the ABPN MOC Performance in Practice. Please see her article on page two for more details on this very important topic.

During the open forum time at the Assembly, discussion took place regarding a variety of reimbursement and financial issues. A delegate from Florida stated that, on November 30th, 2011, Blue Cross Blue Shield would be terminating mental health contracts with those psychiatrists who are not part of large medical groups. Also, psychotherapy CPT codes are being discouraged, favoring less costly medication management codes. This is concerning because the effect is to limit the choice of providers as well as the type of treatment for those patients who must go to in-network providers.

The potential federal budget cuts of 1.2 trillion dollars over ten years were presented. In addition to impacting NIMH, Medicare and Medicaid, these cuts would also impact graduate medical education. According to the ACGME survey of residency programs published in October 2011, most residency training programs indicated that they would reduce the number of positions if faced with a 33% funding reduction. Even more concerning is the finding that if faced with a 50% cut, over one in five sponsors would close *all* subspecialty training programs.

I believe that our field faces significant challenges and that all of us together can be more active in addressing these issues. First, we should all contact our Senators and Representatives in Congress to advocate for maintaining federal funding of GME to facilitate the training of the next generation of child psychiatrists. Second, CAPSGW will be sponsoring a CME dinner program on January 18th that will focus on advocacy, financial reimbursement, healthcare reform, and the impact on child psychiatrists. Third, all of us should consider participating in AACAP Advocacy Day on Capitol Hill on May 11th, 2012 to make our voices heard. ■

CAPSGW Annual Spring Symposium

Updates in Autism Spectrum Disorders: From Cutting Edge Science to Clinical Medicine

Saturday, March 3 at Suburban Hospital

8:00 am—4:30 pm

Speakers and Panelists Including:

Robin Allen, Ph.D.
Xavier Castellanos, M.D.
Lance Clawson, M.D.
Sabra Gelfond, M.A./CCP SLP
CT Gordon, M.D.
Roy Richard Grinker, Ph.D.
Steven Kane, Ph.D.
Dan Shapiro, M.D.
Monica Adler Werner

Watch your email for a detailed agenda and registration in the coming weeks and register early for a discount. ■

AACAP Council Passes Motions Requesting ABPN Review/Revisit Performance in Practice and Endorsing Key Components of APA Referendum on Maintenance of Certification

Jeanne G. Holzgrefe, M.D. Ph.D.

The AACAP Council approved a motion encouraging it to request that the American Board of Psychiatry and Neurology (ABPN) review/revisit the current Performance in Practice (PIP) requirements for Maintenance of Certification (MOC) at the Annual Meeting in Toronto, Canada, on October 22, 2011. The Council also endorsed the two key points in a recent American Psychiatric Association (APA) Referendum on MOC: "1) the patient feedback requirements for the purpose of reporting to the Board is unacceptable, as it creates ethical conflicts, and has the potential to damage treatment, and 2) the requirements other than a cognitive knowledge examination once in 10 years, regular participation in continuing medical education, and maintenance of licensure pose undue and unnecessary burden[s] on psychiatrists."

In addition to endorsing the APA Referendum, the AACAP Council also passed a motion that the AACAP President would arrange a meeting between AACAP leadership and the ABPN and include a representation from the Assembly. The APA Referendum finding the patient feedback requirement unacceptable for MOC and essentially eliminating PIP had previously been supported by approximately 80% of APA members voting in an election last spring. However, because less than 40% of the membership voted, the referendum did not carry power. It was therefore not passed by the APA.

The Council's actions shift focus from merely implementing MOC to opening up discussions about the underlying rationale for the new MOC requirements, whether they have proven benefit, and whether they are worth the added costs and burdens. Moreover, the Council's actions raise the possibility that certain new MOC requirements, in particular, PIP, may be changed. MOC requirements apply to physicians who received time-limited specialty certification, which became effective on October 1, 1994 and include: (1) professional standing (licensure); (2) CME and self-assessment activities (which will also be expanded in 2013); and (3) cognitive expertise (proctored recertification exam). Starting in 2013, physicians seeking recertification also will be required to complete a fourth requirement, PIP.

According to the ABPN website, each PIP unit consists "of both a Clinical Module (chart review) and a Feedback Module (Patient/Peer second-party external review)." "Clinical modules require that diplomats collect data from at least five patient cases in a specific category … obtained from the diplomate's personal practice over the previous 3-year period.

Each diplomate must then compare data from the five patient cases with published best practices, or practice guidelines or peer-based standards of care…, and develop a plan to improve effectiveness or efficiency of his/her clinical activities. Within 24 months, each diplomate must collect the same data from at least another five clinical cases in the same specific category, to see if improvements in practice have occurred." "Feedback Modules (Patient/Peer Second Party External Review)… require each diplomate to solicit personal performance feedback from at least five peers and five patients concerning the diplomate's clinical activity over the previous three years. Each diplomate must then identify opportunities for improvement in the effectiveness and/or efficiency in their performance as related to the core competencies and take steps to implement suggested improvements. Within 24 months, each diplomate is required to solicit feedback from at least another five peers and five patients to see if improvements in performance have occurred." (ABPN Website) Over a 10 year period, diplomats will be required to complete 3 PIP units.

For specific rules on PIP units, see the ABPN website at http://abpn.com/moc_10yrmoc.html.

Prior to the Council passing the above-mentioned motions on MOC, the Working Group on MOC Review discussed these important issues. The following is a summary of some of the discussions of the Working Group on MOC Review. Unlike the motions passed by the Council, this summary does not represent official AACAP Policy.

The Working Group began with reviewing the purpose of MOC and whether MOC achieves its stated goals. The purpose of MOC, as noted in the ABPN website (neurology) is the following:

"With so much attention on medical errors and liability issues, as well as spiraling health care costs, the public is demanding that their physicians demonstrate expertise and competence. The ABMS [American Board of Medical Specialties] established the MOC program as a professional response to the need for public accountability and transparency."

The purpose of MOC raises several questions: To what extent has quality of care deteriorated? What are the best, most cost-effective ways of ensuring physician expertise and competence that are valid, reliable, and have proven benefit? To what extent is the demand for public accountability and transparency due to frustrations with spiraling health care costs or other problems with the health care system rather than to deficits in the expertise and competence of physicians? The larger issues related to spiraling healthcare costs and other systemic issues regarding the health care system are generally outside of the scope of Medical Licensing and Certifying Boards.

(Continued on page 3)

Research Studies on the Treatment of Depression, Bipolar I Disorder, Schizophrenia and ADHD.

Principal Investigator: Adelaide S. Robb, M.D., Associate Professor of Psychiatry and Pediatrics

Dr. Robb and a team of psychiatrists and psychologists are conducting research studies with adolescents. All study-related treatments and evaluation are FREE. Patient privacy and confidentiality is assured, and families may receive compensation for time and travel while participating.

See below for our current list of studies with age ranges. Please have patients contact Helen Burton or Holly Semble at (202) 476-6067.

Depression: one study seeking children between the ages of 7-11

Bipolar I Disorder: two studies seeking children and adolescents between the ages of 7 and 17

Schizophrenia: two studies seeking adolescents between the ages of 12 and 17

Autism: one study seeking children and adolescents between the ages of 6 and 17 with autistic disorder

ADHD: one study seeking children and adolescents between the ages of 6 and 12 with ADHD

Certification *(Continued from page 2)*

Ways of ensuring physician competence and quality of care include passing periodic cognitive knowledge exams and completing CME activities, including self-assessment activities. Without clear evidence that these ways of ensuring quality are not effective, physicians will now also be required to implement certain PIP procedures for MOC. These procedures have not been adequately tested to ascertain whether they have proven benefit, that they are not onerous or time-consuming, do not undermine professionalism, and do not increase health care costs.

Other PIP requirements include obtaining **patient and peer feedback for MOC**. The requirement for patient feedback for MOC creates ethical conflicts, is detrimental to the psychiatric relationship, and should be eliminated from MOC requirements. Peer feedback for MOC is of questionable benefit, may be detrimental in this context, and should be eliminated from MOC. Among the list of peers who could evaluate psychiatrists for their specialty certification or licensure include psychologists, social workers, counselors, and nurses, especially problematic in light of current issues regarding the role of psychiatrists in providing/receiving reimbursement for a comprehensive array of psychiatric services and the role of non-psychiatrists in prescribing psychotropic medications.

MOC requirements also change the fundamental landscape of licensing and certifying boards from ensuring that physicians provide care that ***meets*** acceptable standards to adding the goal of ***improving*** medical care. Requiring that physicians pass periodic cognitive exams ensures that physicians keep current with advances in medical care, and in this way MOC already improves medical care. However, broader interpretations of improving medical care under PIP requirements introduce confusion about the adequacy of providing care that meets acceptable standards. It creates medical liability issues with problems of unintended consequences, particularly with regard to discoverability of deficiencies in court.

In summary, psychiatrists need to be aware of these major changes in board certification procedures, to evaluate their rationale, and to determine which of these changes advance our field and which do not. Sharing information about MOC and providing feedback to our professional organizations can help psychiatrists have a voice in matters crucial to our profession. They can also help determine whether the new recertification procedures will be changed. For additional information and to find out how you can help, email Dr. Jeanne Holzgrefe at jholzgrefe@msn.com.

The full Report of the Working Group, is available upon request. Dr. Holzgrefe is a member of AACAP Assembly Working Group on MOC Review and has no disclosures of conflict of interest. ■

Building Resilience in Children and Adolescents

Mary Karapetian Alvord, Ph.D.

Liz is a 31-year old Caucasian female who was born to a drug-addicted mother and a father who was imprisoned for dealing drugs. Her parents continued to abuse drugs throughout her childhood, and used their welfare checks to buy enough food for Liz and her sister to last about a week per month. Despite living in abject poverty and despair, Liz's parents showed their love for her and her sister. Although she rarely attended school, Liz was still able to pass her exams at the end of each year. But she eventually lost interest in school and, at age 17, had earned only one high-school credit. After her mother moved away and her father was placed in a homeless shelter, she became homeless. When her mother died of complications from AIDS Liz realized that she was completely on her own and she resolved to complete high school. She applied to an alternative school in New York City. While there, she met adults who helped her to achieve her goals. Officials in the school system were not aware that she was homeless during the two years that it took her to complete her high school degree. She wrote an essay about her life, won a *New York Times* scholarship, and ultimately graduated from Harvard. This story, taken from the memoir written by Liz Murray called 'Breaking Night', describes an authentic example of *resilience*.

What is resilience?

In 1984, Garmezy, Masten, & Tellegen, defined resilience as "manifestations of competence in children despite exposure to stressful events." In 2001, Masten described resilience as "ordinary magic." Resilience occurs through ordinary rather than extraordinary processes. This helps shift the focus to a more hopeful, strength-based approach instead of a deficit model. In an article Judy Grados and I wrote for *Professional Psychology: Research and Practice* (2005), we offered a further definition of resilience as "those skills, attributes, and abilities that enable individuals to adapt to hardships, difficulties, and challenges." This broadens the definition to include not only people who face such traumas as abuse, war, earthquakes, and poverty, but also those who face difficulties and challenges, such as mood disorders, learning disabilities and/or ADHD.

Understanding resilience as a set of competencies that can be learned and strengthened provides a positive framework within which to assess and treat patients. A growing body of literature recognizes that the level of a person's resilience depends on a complex interplay between risk factors and various characteristics and supports, known as protective factors, that enable a person to better withstand hardships. Despite not being able to control everything, a person can nevertheless influence and, to some extent, regulate much of what happens in his or her life. While some personal difficulties and attributes may have a biological basis and may be difficult to overcome, most resilience skills can be developed.

What are "Protective Factors"?

Protective factors are "influences that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome" (Rutter, 1985). They may arise from within the child, or from the family, caretakers, and/or the community at large. Internal protective factors include, for example, a child's ability to solve problems, his or her motivation or drive to make friends, and his or her capacity to self-regulate behavior. External protective factors include: caring and effective parents, friendships, and supportive educational systems. Protective factors may vary in importance depending on a person's culture and/or on an individual's developmental stage. The American Psychological Association's Task Force on Resilience and Strength in Black Children and Adolescents (2008) indicated, for example, that positive racial and gender identity operate as strong protective factors.

From a review of the resilience literature, and from our own clinical experience, Alvord et al. categorized six protective factors (Alvord and Grados, 2005; Alvord, Zucker & Grados, 2011) as: (1) Being Proactive, (2) Self-Regulation, (3) Connections and Attachments, (4) Achievements, (5) Community, and (6) Proactive Parenting. These six categories are not mutually exclusive; components in one category interrelate with components in another. For example, a child who can moderate his mood is more apt to make friends. A child who experiences academic success is likely to have higher self-esteem. The presence of several factors seems to enhance performance in multiple areas.

The Resilience Builder Program ®

Alvord, Baker & Associates, LLC has been conducting group therapy sessions aimed at developing resilience in children and adolescents since 1992, based on a Cognitive Behavioral therapy model we designed known as the Resilience Builder Program® (Alvord, Zucker, & Grados, 2011). This program's therapeutic aim is to improve children's and teens' social competence and emotional well-being by teaching and practicing specific foundational skills under the rubric of resilience: self-regulation, reciprocity, proactive social problem solving, and adaptability/flexibility. The program, which can also be implemented in individual therapy, is framed by six broad categories of protective factors noted above. Thirty session topics include, for example, proactivity rather than reactivity or passivity, optimistic thinking, distorted thinking, stress management, anxiety and anger management, conversation skills, leadership, game etiquette (using a Wii or other game system), and verbal and nonverbal communication. Every session emphasizes self-regulation strategies such as calm breathing and self-talk. The Resilience Builder Program® targets skill generalization by providing multiple opportunities for practice in a variety of settings, through homework assignments, role-play and free-play activities, and by asking

(Continued on page 5)

Update from Children's National Medical Center (CNMC): Breaking News about the 'Bears'

Richa Bhatia, M.D. and Ash Miller, M.D.

At CNMC, we welcomed the holiday season with inroads into neuropsychiatric and autism research, creation of an advocacy task force, and collaboration with the adolescent medicine clinic. In addition, we welcomed a great group of new fellows.

The second year fellows have been quite busy. Co-Chief **Ashley Miller, M.D.** has helped develop a collaborative clinic with the adolescent medicine department at CNMC for greater integration and coordination of care of adolescents with both medical and psychiatric needs as well as doing work with the American Psychiatric Association as a Diversity Leadership Fellow. Co-Chief **Erin Fallucca M.D.** had an article published from research completed during her General Psychiatry Residency at Wayne State on 'Distinguishing between Major depressive disorder and Obsessive Compulsive Disorder in children by measuring Regional Cortical Thickness' in *The Archives of Psychiatry* (May, 2011) and is working on autism research at CNMC's Center for Autism Spectrum Disorders in Rockville, MD. **Nana Dadson, M.D.** is working at enhancing the interface between neurological and psychiatric disorders. **Richa Bhatia, M.D**. is developing an advocacy project to spread awareness about key psychiatric themes that surround children and adolescents in our society.

Our first year class of fellows includes six wonderful fellows: 1) **David Driver, M.D.** (combined CNMC/National Institute of Health fellow) from Georgetown University; 2) **Margarita Somova M.D.** from Eastern Virginia Medical School in Norfolk, VA; 3) **Merima Jurici, M.D.** from Maimonides Medical Center in Brooklyn, NY; 4) **Kory Stotesbery, D.O.** from Thomas Jefferson Univerity in Philadelphia, PA, **Tahani Alqassem, M.D.** from St. Elizabeth's Medical Center in Boston (sponsored by the Government of Saudi Arabia) and **Tracy Meyer, M.D.** from The George Washington University School of Medicine.

We would also like to note that our long-time coordinator Grace Callis has retired. While we miss her, we have a wonderful new coordinator named Abby Ralph. Finally and sadly, our leader, **Adair Parr, M.D., J.D**. will be stepping down as training director of our program to work in private practice. We will be left in the very capable hands of our current Consult-Liaison Director, **Sandra Rackley, M.D**. We look forward to a productive and fun rest of the academic year! ■

Resilience *(Continued from page 4)*

parents to reinforce the learned skills at home.

Since the Fall of 2009, Alvord, Baker & Associates, LLC, has been involved in a collaborative research effort to assess the effectiveness of the Resilience Builder Program with Dr. Brendan Rich, Assistant Professor in the Department of Psychology of the Catholic University of America. Our ongoing studies are focused on youth 7-12 years old with psychological and social skill deficits. Preliminary results find significant improvement in multiple domains even after only 12 sessions. For example, youth with ADHD and/or anxiety experienced significant changes in problem behavior and improved social and emotional functioning. These changes were reported not just by parents and children, but by the children's teachers, too. Thus, a resilience-based intervention that has been successfully implemented in a private clinical setting for almost 20 years, is now offering promising empirical evidence. ■

References and Resources:

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Masten, A. S. (2001). Ordinary magic: Resilience processes in development. American Psychologist, 56, 227–238.
Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. British Journal of Psychiatry, 147, 598–611.

AACAP 2011 Annual Conference Clinical Perspectives: *A Link between FASD and Juvenile Antisocial Behavior – From Science to Treatment and Prevention*

Building on a symposium at AACAP's 2009 annual meeting, "Fetal Alcohol Spectrum Disorder (FASD): A Paradigm for Neurodevelopmental Formulation and Multidisciplinary Treatment," Susan D. Rich, MD, MPH (CAPSGW Maryland Representative) chaired a Clinical Perspectives program at the 2011 AACAP conference in Toronto.

The purpose of the program was to underscore the important role that knowledgeable child/adolescent psychiatrists can play in prevention of juvenile violence and antisocial behavior by better diagnosis and treatment of individuals with FASD. Shonagh O'Leary-Moore, PhD from the University of North Carolina provided an overview of the science behind alcohol-related neuroteratogenicity, highlighting the vulnerability in alcohol use in pregnancy even as early as the first eight weeks of pregnancy. Kieran O'Malley, MD Child & Adolescent Psychiatrist, from Charlemont Clinic at Our Lady's Children's Hospital in Crumlin, Dublin, Ireland discussed the global epidemic impact of FASD and reviewed the current diagnostic framework and multidisciplinary approach to FASD diagnosis. Dr. Rich, who is in private practice and serves on the Board of Directors for the National Organization on Fetal Alcohol Syndrome provided a comprehensive overview of the link between FASD and antisocial behavior and the importance of child/adolescent psychiatrists in early diagnosis, intervention, treatment and primary prevention. William Edwards, JD from the Los Angeles County Office of the Public Defender provided a riveting case presentation of a death row inmate with FAS, capturing the cognitive and neurodevelopmental deficits that leave individuals vulnerable to antisocial tendencies.

Dr. Rich received a Junior Scholars Award and Mr. Edwards received a Senior Scholars Award from AACAP's Campaign for America's Children toward travel expenses and conference registration fees. ■

Georgetown Child and Adolescent Psychiatry Fellowship Update

Lisa Cullins, M.D.

We are off to another great start! This year we welcomed two new first year fellows. Dr. Hassan Bokhari completed his General Psychiatry Residency at the University of Medicine and Dentistry of New Jersey. Dr. Katherine Mallory completed her General Psychiatry Residency at The Mount Sinai Hospital in New York. We are delighted to have Drs. Bokhari and Mallory on board; they have already demonstrated that they are wonderful assets to our program. Drs. Banks and McGee are now second year fellows and are thoroughly enjoying their last year of training. Each one is pursuing a very interesting research project this year: Dr. Banks was selected to participate in the SAMHSA Systems of Care Fellowship Program working under the leadership of Dr. Gary Blau and Dr. McGee is pursuing her interest in infant feeding disorders by working with Dr. Irene Chatoor at Children's National Medical Center. We are thrilled to have our full complement of fellows this year! This would not be possible without the talent and dedication of our core and volunteer faculty at Georgetown! Thank you! ■

Update from the National Capital Consortium, Child and Adolescent Psychiatry Fellowship, based at Walter Reed Army Medical Center (WRAMC), Washington, DC

Colonel Nancy Black, M.D.

The fellowship welcomed two new First Year Fellows on July 1, 2011: Colonel Rosangela Parsons, M.D., from Landstuhl, Germany. She is a senior medical officer with operational experience and fond memories of Vicenza, Italy and Landstuhl. Captain Sylvia Johnson, M.D. joined from the General Psychiatry Residency at Tripler Army Medical Center in Honolulu. Dr. Johnson is a graduate of Howard University. Our Second Year Fellows, Captain Ryan Smith, M.D. and Captain Keith Penska, M.D. will be promoted to Major in May 2012. They are now both ABPN certified in adult psychiatry.

The legislated Base Realignment and Closure (BRAC) has been demanding. Officially, the National Naval Medical Center also closed and the two facilities consolidated into the Walter Reed National Military Medical Center, in Bethesda (WRNMMC, B). The Dedication Ceremony for WRNNMC, B took place on November 10, 2011. We salute our community-based faculty who have had an enormous amount of work to do to accomplish the necessary administrative requirements to make this move with us. Thank you to all of them! Please note that our new front desk number is 301-295-0576.

Captain Smith presented at the AACAP again this year in October 2011. Captain Penska will again be presenting at the APA in May 2012.

On a sad, closing note: we learned on Monday October 31, that a 2004 graduate of the Department of Social Work, Child and Family Practice Fellowship, Lieutenant Colonel David Cabrera, Ph.D., was killed in Kabul on Saturday October 29, 2011. Our Fellowships have worked jointly in didactics and training for years. We mourn his loss and have reached out to his wife and children. ■

In Need of a Referral or Know Someone Who Is?

As child and adolescent psychiatrists, many of us are often called upon for a referral, both locally and other areas of the country. Remember to take full advantage of AACAP's referral database. It is easy, free and one does not need to be an AACAP member to use it. To locate a fellow AACAP member by name, location or specialty see:

http://www.aacap.org/cs/forFamilies#gettinghelp

CHILD AND ADOLESCENT PSYCHIATRIC SOCIETY OF GREATER WASHINGTON

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Calendar of Events

2012 Psychopharmacology Update Institute: Child and Adolescent Psychopharmacology: Integrating Current Data into Clinical Practice
January 20-21, 2012
Sheraton New York Hotel and Towers - New York, NY

CAPSGW Annual Symposium
Saturday, March 3, 2012
Suburban Hospital
Bethesda, Maryland

AACAP Advocacy Days
May 10-11, 2012

MEMBERS IN THE NEWS!

Congratulations to **Paramjit Joshi,** who was elected as President-Elect of AACAP.

Congratulations to **Michael Houston**, who finished his term as AACAP General Assembly Leader at the October 2011 AACAP meeting.

Marilyn Benoit received the Jeanne Spurlock Award from AACAP for Diversity & Culture at the Toronto AACAP meeting and delivered an Honors lecture on that topic. Marilyn also delivered the opening address to the Systems of Care conference at AACAP, entitled "Child Welfare and Mental Health: A Historical Perspective."

Congratulations to **Christopher Lange**. Dr. Lange was selected as the Chief of the Child and Adolescent Psychiatry Service at Walter Reed National Military Medical Center. As Chief, he oversees the operation of the nation's largest military child and family child psychiatry service. Its services include a robust outpatient care clinic, overseeing a adolescent partial hospitalization service, and a consultation service specializing in the care of families of wounded service members.

Zeus by Kent R.

Kent Ravenscroft is living in Paris half-time and started sculpting in clay at a studio last spring. Kent reports that he is having "great fun" sculpting. In addition, he wrote a psychiatric thriller, *Body Sharing* (BodySharingTheNovel.com) and two non-fiction books. Kent says that these are "all the things I looked forward to as I entered retirement."

Another artist among us!
This is *Grissie*,
painted by **Sheila Sontag.**

We would like our membership to know what other members are up to! Have you been active in the community (speaking at community organizations or schools), given a Grand Rounds, published an article/book, received an award or been quoted in an interview or in print? Then we want to hear from you! In addition, anyone who has written a poem or has original artwork or photography they produced and would like to include in the newsletter, please forward and we will do our best to include it in the next publication. Please send emails Adair Parr at adairparr@earthlink.net.