August 2012

SCSCAP Newsletter

Southern California Society
of Child and Adolescent Psychiatry

President's Column by Marcy Forgey, M.D., M.P.H.

While attending the SCSCAP Child and Adolescent Psychiatry Networking Event in Riverside, an attendee asked me to describe the value of an AACAP membership. This is not the first time this question has come up, especially in the context of a difficult economy and the transition from resident dues to general member dues. Here are some of the benefits described by our members in attendance:

Networking:

Members have the opportunity to network with other child psychiatrists at both regional, statewide and national meetings. This can be particularly helpful for members to feel connected to others in the field, to advertise their practice, to solicit new employment opportunities, and to obtain mentorship. It is also an opportunity to commiserate about some of the difficulties in our field such as systemic barriers to good care and to hear how others have managed these.

Advocacy:

This is one of the most important roles we have. As the only organization representing the interest of child and adolescent psychiatrists, we have an important role to: (1) insure that state and national laws and policies which are enacted are beneficial to our patients and their families, and, of course, to child and adolescent psychiatrists and (2) prevent the passage of potentially harmful legislation. Some important examples of successful advocacy include AACAP's support of federal mental health parity, funding for the State Children's Health Insurance Program, and the creation of a loan repayment program for child and adolescent mental health professionals serving in underserved areas. Examples of successful advocacy by Cal ACAP in the past year include the passage of legislation to support children who are incarcerated, children in foster care, and children who are victims of cyberbullying.

Resources:

The AACAP website (www.aacap.org) is full of useful resources such as practice parameters, Facts for Families, advocacy materials, job search information, lifelong learning modules, and continuing medical education materials. In addition, membership includes a subscription to the Journal of the American Academy of Child and Adolescent Psychiatry, helping our members to stay current on the child psychiatric literature as well as a subscription to AACAP News.

Discounts:

Members receive discounts on the multiple meetings AACAP sponsors each year. For example, members receive a $225 discount on the cost of attending the AACAP Annual Meeting. They also receive preferential rates through AACAP sponsored malpractice and liability insurance as well as publications. Another question that often comes up is where do the dues go? General member dues are divided up into national dues of $400 and regional dues of $230 ($150 toward Cal ACAP and $80 toward SCSCAP).

The national dues support AACAP's infrastructure, annual meeting, psychopharmacology meeting, lifelong learning institutes, advocacy efforts, and the vast array of member resources as described above.

Cal ACAP dues support our state advocacy efforts, which have expanded dramatically over the last few years due to the efforts of the Cal ACAP legislative advocate, Paul Yoder and its Government Affairs and Advocacy Committee. Cal ACAP has also been working to develop relationships with other organizations that support children and families to increase its advocacy efforts including the National Alliance on Mental Illness, United Advocates for Children and Families, and LETS (Let's Erase the Stigma) and has strong working relationships with the Child Committee of the California Psychiatric Association. *(continued on page 2)*

President's Column *(continued from page 1)*

Cal ACAP also hosts an annual advocacy conference to strengthen our advocacy coalition; train members, residents, and fellows in successful advocacy strategies; and to honor a legislator who has made a significant contribution to children and families. This year's advocacy conference was hosted here in Marina del Rey (see separate article by Dr. Brenda Robertson) and honored Assembly Member Bonnie Lowenthal and former president of Cal ACAP member, Dr. Joseph Mawhinney.

SCSCAP has already organized 5 member meetings this year alone, including our Annual Brunch, our Annual Speaker Meeting with special guest speaker Dr. James McCracken, a joint meeting with the Southern California Psychiatric Society with special guest speakers Dr. Joan Asarnow and Dr. Tim Fong, and two regional networking events in Orange County and Inland Empire. In addition to joining Cal ACAP in its advocacy efforts and working on local advocacy issues, SCSCAP is in the process of developing a new website and Facebook page for our members. SCSCAP also supports the development of members-in-training through participation on our Executive Council and by nominating members to serve important roles in Cal ACAP.

We will continue to need the support of you and all child and adolescent psychiatrists in order to pursue our agenda. Please contact me if you want to get more actively involved at scscap@gmail.com.

2011—2012 SCSCAP Executive Council

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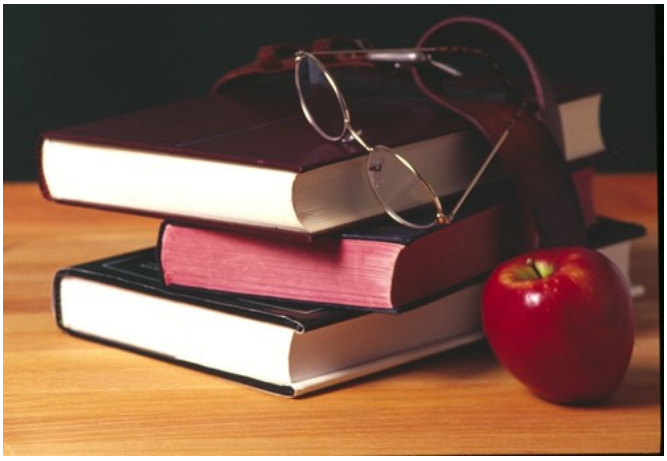
SCSCAP & SCPS Educational and Social Event by Nora Papasian, M.D.

In June 2011, the Southern California Society for Child and Adolescent Psychiatry (SCSCAP) and the Southern California Psychiatric Society (SCPS) jointly hosted an educational on Schizophrenia along with a light dinner. The presentation took place in Sherman Oaks, where Dr. William Arroyo graciously offered his home for the gathering. Our guest speakers were Dr. Rochelle Caplan, Professor Emeritus of Psychiatry and Biobehavioral Sciences at the UCLA Semel Institute, and Dr. Stephen Marder, Professor of Psychiatry and Biobehavioral Sciences at the UCLA/ West LA VA Healthcare System. Drs. Caplan and Marder presented on Schizophrenia through the ages, with an emphasis on understanding current diagnostic nosology and strategies toward improving functional outcomes.



The discussion began with an historical look at the evolution of the diagnosis of schizophrenia as well as current consideration in the diagnosis of psychotic disorders. Conditions that are not included in the DSM nomenclature were discussed. These included *Multidimensionally Impaired Disorder* (MDI) and *Multiple Complex Developmental Disorder* (McDD), which were compared with the well-known DSM-IV diagnoses of Schizophrenia, Schizophreniform, Psychosis NOS, Brief Psychotic Disorder, Personality Disorders (Schizotypal, Schizoid, Borderline) and Autism Spectrum Disorders. Dr. Caplan urged the attendees to consider various clusterings of symptoms, with an emphasis on the presence or absence of a formal thought disorder, psychotic symptoms (hallucinations and delusions), deficits in cognition and executive functioning, impairments in social relatedness, affective dysregulation, and other negative symptoms.

Multidimensionally Impaired Disorder (MDI) was characterized by fantasy, magical thinking, poor reality testing and intermittent hallucinations and delusions (brief, often stress-induced) without a formal thought disorder; impaired attention and impulse control; poor affect regulation; impaired interpersonal skills despite a desire to be social; and premorbid or transient autistic symptoms. MDI has been compared to early onset (even very early onset) schizophrenia, but 2-8 year data show the predominant diagnosis is psychosis NOS, often with a mood disorder.

Multiple Complex Developmental Disorder (McDD), formulated in the Netherlands, has been used as a clinical diagnosis there for some years. McDD describes a syndrome starting in childhood with features combining both autism spectrum disorder and childhood schizophrenia. The diagnosis is characterized by impaired affect regulation (anxiety, panic, unusual fears or aggression), a formal thought disorder (poor reality testing), impaired social relationships, ambivalent attachments to caregivers, and rigid behaviors.

The presentation then transitioned to treatment strategies aimed at improving functioning, looking specifically at cognitive functioning and negative symptoms, which typically are minimally responsive to traditional treatments. Cognitive symptoms are prevalent in 100% of patients with schizophrenia, and approximately 50-60% of patients also have negative symptoms (particularly adults). Because these symptoms are very difficult to treat, the goal in older patients is usually to relieve suffering from positive symptoms. In younger patients, however, functioning can sometimes be restored. Current research has looked at stopping or postponing the cognitive impairments, including loss of IQ, frequently seen at the onset of the disorder. Recent research has examined the early onset of progressive loss of brain tissue volume, particularly in the mesotemporal and frontal lobes and in the thalamus. Contrapositive evidence comes from studies showing that cannabis abuse may trigger earlier onset of schizophrenia by as much as 1.5 years.

An NIMH initiative to develop cognition enhancing medications has spurred a number of studies. Targets of interest include neuronal nicotinic receptor agonists, for example, alpha-7-nicotinic receptor agonists (DMXBA, studied in Alzheimer's disease, which has had some positive results). *(continued on page 8)*

Highlights of Assembly Meeting of October 18, 2011 in Toronto, Canada

by William Arroyo, M.D.

The Assembly Speaker, Michael Houston, of the American Academy of Child and Adolescent Psychiatry (AACAP) reported that the formation of a political action committee or PAC was approved by AACAP Council. Robert Hendren (CA), as chair, and Warren Ng (NY), as co-chair, will direct its development.

AACAP By-Laws changes will be implemented during the next year. Strategic efforts will be developed to retain those members who up until now have not had to be members of both the AACAP and their local regional organization such as the Southern California Society for Child and Adolescent Psychiatry (SCSCAP). Those members who were "grandfathered" and allowed to choose whether or not to belong to only their regional organization will no longer be provided this option.

The 2013 Annual Conference will be in Orlando.

The recent dues increase has allowed AACAP to have a balanced budget this year. There is a proposed $50 increase in dues for 2012. The income provide by the pharmaceutical industry at the annual meeting has continued to decrease during the last three consecutive years. Revenue form investments has decreased due to the economy. There is a healthy AACAP reserve fund of $3.1 million.

The anticipated registration of 4000 is higher than all other previous annual meetings except for the recent meeting in New York city.

AACAP Council approved $175,000 to upgrade the website.

AACAP delegates to the AMA are David Fassler, Louis Kraus, Kayla Pope (as Early Career Psychiatrist) and Anita Shue (as resident representative).

The draft position statement of "Solitary Confinement of Juvenile Offenders" was discussed and reviewed by the Assembly. It will be sent to AACAP Council for possible review and approval in 2012.

Regional organizations will be able to provide updates to the AACAP online very soon.

Maintenance of certification continues to be an area of much debate. One of the primary concerns is the requirement to request feedback from patients.

A strategic plan was developed by the Regional Organization Infrastructure Task Force Report. Various regional organizations continue to struggle with their infrastructure. These regional organizations will be systematically contacted in order to determine the support they require in order to remain viable organizations. These include those of Alaska, Arkansas, Mississippi, Big Sky (Montana), Nebraska, Nevada, NY Capital, N. Dakota, Northwest Ohio, Oklahoma, and S. Dakota.
Andres Martin, editor of the Journal of the AACAP Editor, reported that various search engines have enhanced the "discoverability" of the journal to levels not previously anticipated. The Netherlands provides more co-authors of papers than any other country. It's the 50th anniversary of the JAACAP; there will be a special presentation at this annual meeting on the fifty years of the journal.

The newly elected Assembly officers are: Wayne Baxter (Hawaii) for Secretary; Warren Ng (Vice Chair); and Louis Kraus (Chair).

AACAP new membership has increased by more than 200 which exceeds the projected number. 42 training programs have full membership (100% club). List of members who now are dual members of both the AACAP and their local ROCAP are included in Assembly pkt. SCSCAP has the second largest number, 40, after the New York Council of new dual members, approximately 60. In 2010 there were 600 resident members and in 2011 there are 910. There may be a change in Assembly representation with the addition of these new members.
(continued on page 5)

Highlights of Assembly Meeting of October 18, 2011 in Toronto, Canada *(continued from page 4)*

Two recently published U.S. Government Accountability Office (GAO) Reports include: (1) fraud and abuse in the SSDI program with a special focus on children with ADHD and (2) fraud and abuse in the foster care system with a special focus on polypharmacy and the use of psychotropic agents in the birth – 5 year old population.

Gary Blau, Chief of the Child, Adolescent and Family Branch of SAMHSA reported on the proposed decrease in the budget of the Child Mental Health Initiative program. His branch now has two child fellows who work with this program on a weekly basis. A tip sheet on how to improve communication with youth was developed by AACAP in consultation with a youth organization.

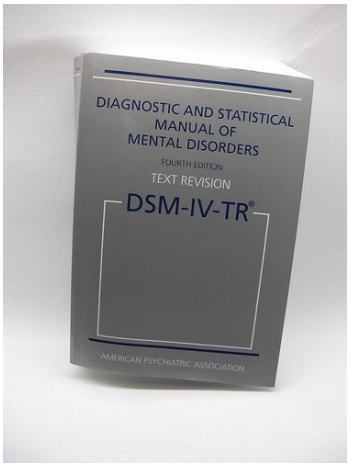
AACAP funded efforts to outreach to early career psychiatrists were highlighted; Southern California Society of Child and Adolescent Psychiatry was a recipient of an award (see article by Matthew Khory, M.D. in this issue).

In an "open microphone" session, various issues of concern were raised by representatives of their respective regional organizations. One issue that was common among many was the recent shortage of stimulants. AACAP has pursued this with FDA. It is apparently due to a confluence of several factors. Another issue that was frequently addressed was that the recent position paper issued by the California Medical Association in which recommendations related to the legalization of marijuana were made.

New Pediatric Bipolar Label: Disruptive Mood Dysregulation Disorder

by Preetpal Sandhu, M.D. , M.B.A.

On the heels of our well-attended talk by Dr. Gabrielle Carlson last January, the tumult surrounding the diagnosis and treatment of pediatric mood disorders continues to flourish. Since that time, the DSM 5 Task Force has been refining and re-working the definition of a disorder designed to more accurately portray children with behavioral disturbances which some feel were being inaccurately characterized at Pediatric Bipolar Disorder. A large impetus for further investigation of this diagnostic category involved the <50% chance of children with these symptoms progressing into an adult diagnosis of Bipolar Disorder. During this process, the name for this diagnosis has changed from initially being called Temper Dysregulation Disorder to what is now referred to as Disruptive Mood Dysregulation Disorder. The discussion regarding how these criteria will or will not be incorporated into DSM 5 has not yet been finalized but, the draft criteria below has been published. *(continued on page 14)*



Statewide Advocacy Conference

by Brenda Robertson, M.D. (CAP Fellow—Harbor-UCLA)

Child and adolescent psychiatrists from across the state met with members from the National Alliance on Mental Illness-California (NAMI) and the United Advocates for Children and Families (UACF) at the 3rd annual conference sponsored by California Academy of Child and Adolescent Psychiatry (Cal ACAP), NAMI-California, and UACF. It was held at the Marina del Rey Marriott on November 5, 2011. General psychiatry residents and child and adolescent fellows from training programs statewide were, also, in attendance. The conference started by highlighting the advocacy activities of the collaborating organizations. Past President Stewart Teal from Cal-ACAP spoke about advocacy concerns from a professional standpoint. The Vice President of NAMI, Mark Gale, poignantly spoke about the impact of the loss of AB 3632 on families by sharing his own personal experience and NAMI's efforts to support children and families. Mark Gale has an adult child who became psychotic during his teenage years; Mr. Gale's family were repeatedly challenged by the fragmented mental health system available to his son. The Executive Director of UACF, Oscar Wright, spoke about his organization's grass roots efforts to help local parents navigate systems issues and also highlighted ways that psychiatrists could collaborate in these endeavors. Mr. Wright spoke lovingly and frankly about the obstacles that he and his family faced to address the needs of his adolescent daughter who had schizophrenia.

The Cal ACAP "Children's Hero Award" was presented to Dr. Joseph Mawhinney, Past President of Cal ACAP, for his lifetime achievements in child mental health advocacy. He discussed how advocacy needs have changed over the scope of his career and the direction the advocacy efforts will take in the future. California State Assemblymember Bonnie Lowenthal of Long Beach also received the "Children's Hero Award" for her strong commitment to suicide prevention programs in schools. Assemblymember Lowenthal discussed current state level issues related to mental health with attendees, and took some extra time to meet with residents and fellows to discuss their specific concerns.

The third component of the conference focused on advocacy training. Paul Yoder, Cal ACAP legislative advocate, gave a detailed presentation educating attendees about recent and pending legislative issues in California. Next, SCSAP President Dr. Marcy Forgey and Paul Yoder, gave an informative and useful step-by-step tutorial on how psychiatrists can make their concerns known and then work with their local, state, and federal representatives.

Photo: Assembly Member Bonnie Lowenthal discusses current issues with UCLA resident, Dr. Roya Ijadi-Maghsoodi

Are you interested in advocating for improvements in mental health care for children and families? Next fall's 4th annual Advocacy and Collaboration Conference, which will again be by a generous AACAP Advocacy and Collaboration Grant, will take place on Saturday, October 13 at the Presidio Golf Club in San Francisco. The conference will include new collaboration partner Let's Erase the Stigma, an advocacy organization that focuses on stigma reduction in schools along with NAMI and UACF. The conference will highlight current local, state, and national legislation and systems issues pertaining to the delivery of children's mental health. For more information on next fall's Advocacy and Collaboration Conference, contact Marcy Forgey, M.D., at scscap@gmail.com.

State Update by William Arroyo, M.D. (Delegate to CAL-ACAP)

The California Academy of Child and Adolescent Psychiatry has recently had its eye on numerous pending bills and policies at the state level that may have implications for all child and adolescent psychiatrists and our patients and their families.

The governor is still consolidating and juggling state agencies. The State Department of Mental Health has essentially been bifurcated into two agencies. Several functions, especially those pertaining to federal funding for childrens mental health services, has been transferred to the Department of Healthcare Services (DHCS). On some level this makes perfect sense since the administrative functions related to federal funding for healthcare services for children are part of DHCS. However, DHCS has not been able to successfully appoint a deputy director of mental health during the last nine months, thus leaving a gap in leadership at the state level. A plan to establish a state agency that manages all State hospitals is virtually completed; there are no longer hospital beds for children and youth (as of a few years ago), except for those with developmental disabilities. The administrative function related to "involuntary holds" (5150's and 5585's) has been farmed out to the CA Department of Social Services which has not had this responsibility; the lack of experience by this Department in this arena may reverberate during this initial transition period. Other functions of the former State Department of Mental Health have been peeled off and assigned to, yet, other state agencies. The decision not to consolidate the State Alcohol and Drug Program with DHCS is, frankly, befuddling, but the state legislature decided to wait at least a year; this state agency does provide some funding for drug treatment/rehabilitation services for youth.

Another major change that took place during the last week of state budget negotiations is the transfer of the "Healthy Families" program, a federal initiative entitled, States' Children's Health Insurance Program, which includes a mental health benefit, serves children below age 19 from its current state agency to DHCS so that it is consolidated with the Medi-Cal program. There are nearly 900,000 children currently enrolled in the Healthy Families program; the transition will encounter many bumps in the road.

The work of the Insurance Health Exchange (IHE), a component of the federal Patient Protection and the Affordable Care Act (PPACA) (or Obamacare as its known in political rhetoric), has been ongoing and now is full steam ahead as the US Supreme Court did not invalidate the PPACA. Thus far, there has been very minimal, at best, attention to the mental health benefit for children and adolescents both nationally and in CA. Without a doubt, California is much further along in implementing PPACA than any other state. Cal-ACAP will need to interject in all discussion related to a mental health benefit for children in the new insurances to be offered by the IHE. Also, it will be important to see how mental health parity in incorporated into the new insurances; the proposed models for insurance plans under the IHE do NOT include mental health parity. Obviously, there is a lot of more work to accomplish. Related to this is that the state mental health parity bill introduced by Assemblyman James Beall has all but failed to pass during the final week of the legislative session.

The transition year of "AB3632" (a county mandate which technically no longer exists) has been rocky at best. This mental health service mandate now rests with school districts, most of whom have not provided any mental health service and still do not. In FY 11/12, the state appropriated money to county mental health departments to assist with the transition; use of the money required agreements between school districts and county mental health departments. In many counties, such agreements were either never completed or not initiated at all. In FY 12/13, school districts are solely responsible for ensuring that those children who are determined in an IEP process as needing mental health services.

Through its legislative advocacy firm, Cal-ACAP has been involved in several bills this past year. These include bills related child welfare, juvenile justice, tarasoff warnings, and, oddly enough, what is commonly known as Reparative Therapy, therapeutic interventions to change a young person's sexual orientation. *(continued on page 8)*

State Update *(continued from page 7)*

The bill pertaining to Reparative Therapy was introduced by Senator Ted Lieu of Torrance; if passed, such practice referred to as "sexual orientation change efforts" with patients under age eighteen would be considered unprofessional conduct by any therapist, including psychiatrists, and subject to discipline by their licensing agency.

Virtually all professional organizations attempted to assist the author with the bill despite the fact that all of the organizations opined that it is unwise to legislate which practices are unprofessional and which are not. The author would not budge on this notion.

The fear is that, if passed, there may be a chilling effect on therapists such that they may be reluctant to discuss sexual orientation with youth.

The legislative two year cycle is all but over; those bills which were introduced in 2011 or earlier this year and have not moved through the two houses are essentially doomed (as some should be).

Clearly with healthcare reform on its way, we should anticipate that we be practicing somewhat differently in the near future; we will need to be actively involved in

SCSCAP & SCPS Educational and Social Event *(continued from page 3)*

Alpha-7-nicotinic receptor agonists have also shown some improvements in apathy and avolition. Studies with varenicline, a partial agonist at alpha 4, beta 2 nicotinic acetylcholine receptors, have shown some cognitive enhancement but worsening of psychotic symptoms.

Studies in the area of neuroprotection have looked at a number of candidates, including omega-3-fatty acids and minocycline. Some studies of omega-3-fatty acids have shown significant differences in people with prodromal symptoms. There has also been evidence that minocycline has neuroprotective effects, and may improve both cognition and negative symptoms, possibly by decreasing or delaying inflammation and apoptosis. Studies looking at oxytocin show it may increase a person's response to social information.

Other strategies to improve "brain fitness" include using Cognitive Remediation Therapy, usually in the form of computer programs or cognitively stimulating games. There is some evidence that these strategies may be associated with increased levels of Brain Derived Neurotropic Factor (BDNF), suggesting increased neural plasticity. Other studies of cognitive training have demonstrated increased grey matter volume relative to controls. Psychosocial treatments for negative symptoms include Aaron Beck's work looking at negative symptoms associated with a "defeatist attitudes." There is evidence that patients with schizophrenia may respond to CBT techniques.

Despite the myriad of ongoing efforts to understand and improve functioning in patients with psychotic disorders, it is important to reflect on some practical considerations. First, most treatments postpone but do not prevent symptom progression. Second, many patients engage in behaviors that undermine treatment. Poor treatment adherence and substance abuse are prevalent examples. Thus, while promising research continues to improve our understanding of psychosis and offer new options for treatment, it remains our imperative as psychiatrists to also continue robust efforts in patient education, advocacy, and improved social supports that, along with pharmacologic treatments and psychotherapies, are cornerstones of care for all patients.

Pharmacotherapy for ADHD

by Shivani Chopra, M.D. (CAP Fellow—UC Irvine)

Attention Deficit Hyperactivity Disorder (ADHD) is a childhood mental disorder characterized by inattention, hyperactivity, and/or impulsivity. Estimates of prevalence range from 5-8%, with a male to female predominance of 3 -4:1. Treatment of ADHD, or rather the necessity of treatment, has been quite a controversial topic in psychiatric literature. Because of this, many studies have been conducted to evaluate the efficacy of pharmacotherapy as a treatment modality. One such study is the ADHD landmark study, Multimodal Treatment Study of ADHD (MTA), which divided 597 participants diagnosed with ADHD, combined type into 1 of 4 groups: intensive medication management alone (methylphenidate); intensive behavioral treatment alone; a combination of both; and routine community care. Results of the MTA study indicate that the children, ages 7-9 years, who were part of the medication group and combination treatment group, had a significant reduction in ADHD symptoms when compared to those in the behavior treatment and community care groups. In this manner, MTA supported the use of stimulants in the treatment of ADHD.

The use of stimulants, which affect dopamine and norepinephrine, are the first line of treatment for ADHD in children. There are three sub-categories within the stimulant class of medications: methylphenidate (trade names of Concerta, Ritalin, Methylin, Metadate, Focalin, Daytrana); dextroamphetamine (trade names of Dexedrine, Vyvanse); and mixed amphetamine salts (trade names of Adderall XR, Adderall). Common side effects include insomnia/sleep disturbances, appetite suppression/weight loss, stomachache, headache, mood lability/irritability, social withdrawal, increased heart rate and blood pressure. It is also important to be cautious about using stimulants in patients who have any history of psychosis, bipolar disorder, and/or tic disorder, as these pharmacologic agents may exacerbate psychotic symptoms, mania, and/or tics. Lastly, it is crucial to screen for a family history of cardiac disease prior to initiating therapy (arrhythmias, sudden death, syncope, etc.); however, it is not necessary to obtain a baseline EKG.

In addition to the stimulants, there are several non-stimulant medications that can be used to treat ADHD in children. One such includes atomoxetine (trade name of Strattera), a selective norepinephrine reuptake inhibitor. Important side effects of atomoxetine include: gastrointestinal distress, sedation, decreased appetite, suicidal thinking, liver injury, worsening of tics, and cardiovascular events. Other non-stimulant medication classes used to treat ADHD involve tri-cyclic antidepressants (TCA's) and buproprion. TCAs are known to have adverse cardiac and anticholinergic effects, while buproprion can lower the seizure threshold and exacerbate tics. Finally, alpha-adrenergic agonists, such as guanfacine and clonidine, are FDA approved to treat ADHD in children. With these medications, it is important to monitor for hypotension, rebound hypertension, sedation, bradycardia, headache, and abdominal pain.

As with all childhood disorders, the choice of agent for treatment should be made on a case-by-case basis, only after a comprehensive evaluation has been completed, which takes into consideration factors such as patient/parent/teacher reports, rating scales, medical history, family history, previous psychiatric history, medication allergies, psychosocial history, substance use, and developmental history.

Annual Speaker Forum by Michael Enenbach, M.D.

The Southern California Society of Child and Adolescent Psychiatry (SCSCAP) Annual Speaker Forum was held on January 29th, 2012 at the California Yacht Club in beautiful Marina Del Rey. It was a wonderful summer-like day in southern California at a spectacular venue. It was a real pleasure to mingle with our colleagues and enjoy a wonderful seaside brunch (side note: the bacon was delicious for anyone who was not calorie or particularly health conscious!).

Our featured speaker was Dr. James McCracken, Joseph Campbell Professor of Child and Adolescent Psychiatry and Director of the Division of Child and Adolescent Psychiatry at the David Geffen School of Medicine at UCLA, who gave a presentation entitled, "An Update on Drug Therapy for Autism Spectrum Disorders (ASD's)." During his presentation, Dr. McCracken highlighted the latest research on the treatment of the various psychiatric symptoms of those diagnosed with Autism, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (PDD NOS).

Some of the highlights of his presentation included:

- Specific symptoms associated with the disorder such as sleep disturbance, aggression, mood and anxiety disorders, sensory sensitivity, hyperactivity and self-injury should be targeted when using psychotropic agents.

- There has recently been a marked increase in the use of psychotropic medications in children with ASDs; antidepressants, followed by neuroleptics and then antiepileptics are the most commonly prescribed medications.

- Both risperidone and aripiprazole are FDA approved for the treatment of ASD-related symptoms. In trials, risperi done showed a significant decrease in aggression, irritability and repetitive behaviors, and aripiprazole demonstrated a marked reduction in irritability. Lower doses proved effective and minimized the risk of extrapyramidal symptoms. Both medications resulted in significant weight gain, and all neuroleptic use should include regular monitoring of CBCs, liver function, cholesterol, blood glucose, weight and extrapyramidal symptoms.

- Ziprasidone and clozapine use should be accompanied by regular EKG monitoring.

- Stimulants can be useful medications in the treatment of hyperactivity and impulsivity often seen in ASDs. The 2005 Research Units on Pediatric Psychopharmacology (RUPP) Autism Network study showed that methylphenidate was superior to placebo on the primary outcome measure, the teacher-rated hyperactivity subscale of the Aberrant Behavior Checklist. As always, adverse events should be monitored closely, as 20% of the participants had intolerable side effects.

- Alpha-agonists and atomoxetine have also been shown to be effective in limited trials. Guanfacine, up to 2.5mg/day, have shown positive results, more so with hyperactivity than inattention, and clonidine has also shown to be effective.

- Selective Serotonin Reuptake Inhibitors (SSRIs) have mixed data on efficacy. Low dose fluoxetine was effective in a small study on repetitive behaviors, whereas citalopram did not differentiate from placebo in a larger study from 2009. Fluoxetine and fluvoxamine have shown fairly positive results in studies on adults with ASDs, but more studies in children would be helpful. *(continued on page 13)*

2012 Early Career Psychiatrist Connect Program

by Matthew Koury, M.D., M.P.H.; Michael Enenbach, M.D., Marcy Forgey, M.D., M.P.H.

Southern California Society of Child and Adolescent Psychiatry (SCSCAP) is one of the largest Regional Organizations in the country. Our membership spans across Los Angeles County, Orange County, San Bernardino County, Kern County, and Ventura County. Given the large geographical area, our members frequently bring to our attention that it is challenging for them to maintain active relationships with other members and to attend the educational meetings organized by SCSCAP. As a result, one of the ongoing goals of our organization is to reach out to the physicians living and practicing in the more peripheral areas of the Southern California ROCAP.

Another, equally important, goal of the SCSCAP is to assist the current and freshly graduated trainees in child and adolescent psychiatry in establishing professional connections in Southern California. As of today, Southern California ROCAP is home to five child and adolescent psychiatry fellowship programs.

Photo: Orange County ECP Connect Brunch

In an effort to meet both of the above described goals, SCSCAP decided to apply for the Early Career Psychiatrist Connect Program to organize a series of networking events aimed at facilitating communication between the early career psychiatrists with the more seasoned physicians. Our goal was to reach out to the members located in Orange County and the Inland Empire (area within San Bernardino County), two of our farthest regions.

The first event took place on February 26, 2012 in Laguna Hills in Orange County. As mentioned earlier, the event was organized to help foster the interaction between trainees/early career psychiatrists and more established members of the professional community.

Photo: Inland Empire ECP Connect Brunch

The group met for brunch, engaged in conversations relevant to their careers, exchanged contact information and provided guidance to those who requested such at a beautiful venue called 'the Deck' just steps from the beach and overlooking the ocean. About eighteen local SCSCAP members turned out and enjoyed each other's company. Several fellows from the University of California Irvine program, the majority of the Executive Council, and many other private clinicians attended to make this a great start in our attempt to broaden our efforts of reaching out to our overall membership. The members spoke openly about the logistical difficulties of commuting in traffic to the West Los Angeles area to attend SCSCAP activities. The Council emphasized its interest in hosting more events in the Orange County in order to more proactively involve this large base of members.

On April 29, 2012 another ECP Connect networking event took place in the Inland Empire. This event, like the previously successful event in Orange County, was organized to help foster the interaction between trainees/early career psychiatrists and more established members of our professional community. *(continued on page 12)*

2012 ECP Connect Program *(continued from page 11)*

The group met for a wonderful brunch at the Mission Inn Hotel in beautiful downtown Riverside. About thirteen local SCSCAP members turned out and enjoyed each other's company on a beautiful, sunny afternoon. The patio location and the fabulous food, combined with the equally fabulous company, made for a wonderful Sunday afternoon networking event. The majority of the SCSCAP Executive Council, several trainees from the Loma Linda residency program and many local academic and private clinicians were present.

Photo: CAP Fellow Summer Brunch

Since the Orange County and Inland Empire events were so successful, and there was a small amount of grant money left over, the SCSCAP Executive Council decided to host a third Early Career Psychiatrist networking event targeting new child psychiatry fellows, continuing child psychiatry fellows, and recent graduates of the Los Angeles-based training programs.

We were delighted to have representation from all five training programs in the Los Angeles area (USC, UCLA Semel Institute, Harbor UCLA, Kern County, and UC Irvine), with a total of twelve in attendance. The intimate setting allowed space and time for all attendees to introduce themselves, discuss their experiences, and areas of interest. The fellows benefited from the experience of other recent grads and early career psychiatrists who shared their experiences in the transition from training to practice.

The fellows also learned a great deal more about SCSCAP and AACAP, benefits of membership, and several committed to sign up afterward and even join the Executive Council as MIT representatives. Dr. Forgey discussed with attendees the advocacy opportunities available and several expressed interest in attending upcoming advocacy and membership events. Overall, the group enjoyed the delicious food and the opportunity to learn from each other and build relationships.

The SCSCAP Executive Council and attendees are so thankful for the grant funding which supported the development of the ECP network events. The Council is optimistic that the events will also assist in not only linking ECPs with the larger child psychiatry community, reducing isolation, but also to recruit and retain members to the organization, whose dues will sustain future events.

SCSCAP Membership

Have you renewed your SCSCAP Membership?

You can do it on line by visiting the AACAP website (www.aacap.org)

or by contacting the AACAP Membership Department:

Phone: 202-966-7300
E-mail: membership-mail@aacap.org

Remembering David A. Coffey

by J. Zeb Little, M.D., Ph.D.

I first met David in 2005 when I joined the UCLA Psychiatric Clinical Faculty Association where we were both members of the Executive Board. My first impression of David was that he was an outspoken and dynamic personality with nearly limitless energy. Over the next seven years, I came to appreciate David's tireless advocacy for residents and fellows and his self-effacing but driven personality. Unknown to most of his professional associates David was also a polymath, with expertise in such diverse areas as music, computer programming, foreign film and photography.

Of all his interests, he devoted himself most to the field of psychiatry. His activities and accomplishments in this area were broad and deep. In addition to a large and successful private practice, he also published articles on issues in child psychiatry and was often pursued as a lecturer by organizations such as the National Alliance for the Mentally Ill. He dedicated himself to psychoanalytic training at the New Center for Psychoanalysis where he was Treasurer of the Institute. He also chaired and co-chaired a number of successful courses including an ongoing course on Psychoanalysis and Film. David was very involved in the UCLA-based volunteer organization, the Psychiatric Clinical Faculty Association, where he was or had been involved in every facet of the organization from organizing the very successful Distinguished Psychiatrist Seminar Series to serving as its Treasurer and most recently being elected to serve as its next President.

David was born on April 8th 1959 and passed away on January 17th 2012. He is survived by his daughter Olivia, parents Dr. Charles and Barbara Coffey, sisters Jennifer and Sybil, and a large extended family. He also leaves behind his loving companion, Judy Gitterman, and many close friends and colleagues whose lives he profoundly enriched; he will be deeply missed.

Annual Speaker Forum *(continued from page 10)*

- Sleep disturbance is a common complaint in children with ASDs. Melatonin, up to 6mg/ day, dosed two hours before sleep initiation has shown to be helpful. Alpha-agonists and trazodone can also be effective. While many parents inquire about novel treatments for ASDs, it is important to know how to educate families. Several treatments have not been established as evidence-based, effective therapies. These include hyperbaric oxygen therapy, chelation, gluten and casein-free diets, secretin, vitamin B12, digestive enzymes, inositol and iron.

- Current and future research in ASD psychopharmacology focuses on various novel treatments, such as oxytocin, memantine, Omega-3s, carnitine, BH4, cholinesterase inhibitors and anti-inflammatory agents. A recent open-label study showed promise for Arbaclofen both reducing irritability and increasing social functioning. Another focus is the theory of Glutamate-GABA imbalance and how it may contribute to ASD symptoms. Hopes are that future treatments can be individualized to the patient's unique presentation.

We hope everyone who attended the Annual Speaker Meeting had a wonderful and educational experience, and we hope to see all and more of you in 2013.

New Pediatric Bipolar Label: Disruptive Mood Dysregulation Disorder *(continued from page 5)*

Disruptive Mood Dysregulation Disorder (per DSM5.org)

A. The disorder is characterized by severe recurrent *temper outbursts* in response to common stressors.

1. The temper outbursts are manifest verbally and/or behaviorally, such as in the form of verbal rages, or physical aggression towards people or property.
2. The reaction is grossly out of proportion in intensity or duration to the situation or provocation.
3. The responses are inconsistent with developmental level.

B. *Frequency*: The temper outbursts occur, on average, three or more times per week.

C. *Mood between temper outbursts:*

1. Nearly every day, the mood between temper outbursts is persistently negative (irritable, angry, and/or sad).
2. The negative mood is observable by others (e.g., parents, teachers, peers).

D. *Duration*: Criteria A-C have been present for at least 12 months. Throughout that time, the person has never been without the symptoms of Criteria A-C for more than 3 months at a time.

E. The temper outbursts and/or negative mood are present in at least two settings (at home, at school, or with peers) and must be severe in at least in one setting.

F. Chronological age is at least 6 years (or equivalent developmental level).

G. The onset is before age 10 years.

H. In the past year, there has never been a distinct period lasting more than one day during which abnormally elevated or expansive mood was present most of the day for most days, and the abnormally elevated or expansive mood was accompanied by the onset, or worsening, of three of the "B" criteria of mania (i.e., grandiosity or inflated self esteem, decreased need for sleep, pressured speech, flight of ideas, distractibility, increase in goal directed activity, or excessive involvement in activities with a high potential for painful consequences; see pp. XX). Abnormally elevated mood should be differentiated from developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation.

I. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder (e.g., Major Depressive Disorder, Dysthymic Disorder, Bipolar Disorder) and are not better accounted for by another mental disorder (e.g., Pervasive Developmental Disorder, post-traumatic stress disorder, separation anxiety disorder). (Note: This diagnosis can co-exist with Oppositional Defiant Disorder, ADHD, Conduct Disorder, and Substance Use Disorders.) The symptoms are not due to the direct physiological effects of a drug of abuse, or to a general medical or neurological condition.

We are hopeful that this new diagnostic label will help further inform the treatment and prognosis of the patients we see every day. Stay tuned for further developments over the course of the next year prior to final version of DSM-5.

2012 AACAP Assembly
(45th Assembly of Regional Organizations)
by William Arroyo, M.D.

AACAP President, Marty Drell, M.D., made his first public appearance since his accident and subsequent surgery last year at the May, 2012, Assembly meeting. He addressed several key issues including the ongoing search for a new Executive Director, as Ginger Anthony had previously announced her retirement. He, also, indicated that a systematic five year review of the Journal of the AACAP was still underway. He, also, spoke briefly about the "Back to Project Future" (Presidential Initiative) for which there will be a corresponding forum at the upcoming annual meeting in San Francisco.

The AACAP fiscal outlook was presented by the Treasurer, Steven Cuffe, M.D. who indicated that the AACAP was making ends meet despite the obvious economic challenges across the country. Despite being in the red in 2010 by approximately $21,000, in 2011 the AACAP was in the black by $58,000. If things go as projected, AACAP will have a budget surplus of nearly $175,000 in 2012. The annual meeting in New York City in 2010 was quite fiscally advantageous. Reliance on pharmaceutical support has leveled off to about 8% during the past three years. The investments of the AACAP this year appear to be resulting in additional earnings.

Warren Ng, the Assembly Vice Chair, reported on the issuance of new Advocacy and Collaboration Grants of which two are in CA incl. Cal-ACAP involving UACF, NAMI California and Let's Erase the Stigma of Mental Illness (LETS). He, also, encouraged the regional organizations to submit one of their articles to AACAP News for publication. The development of the Political Action Committee is underway by Task Force.

The Speaker of the Assembly, Louis Kraus, MD, announced that Jeremy Lazarus, MD, a psychiatrist from Colorado will soon assume the presidency of AMA later this year. Also, he mentioned that the American Academy of Pediatrics has a resolution of autism that is being deliberated. Wisconsin has a resolution on same sex marriage. Medication shortages remain a concern among AMA delegates.

Assembly Secretary, Wayne Batzer, MD, announced that D&O insurance is available to all regional organizations and that the mechanism for ensuring that regional organizations can apply will be launched shortly.

Sherry Barron-Seabrook, M.D., has been actively involved in the development and revision of CPT Codes. Preliminary evidence indicates that 90862 will be eliminated; 90801 may, also, be eliminated. Apparently, psychologists have been working to get CPT codes for prescribing. Current family therapy codes of 90846, 90847 will likely remain. She advised for all to anticipate new coding related to E/M (Evaluation and Management) along with "add-ons" and "modifiers" to be released toward the end of 2012. Child and adolescent psychiatrists will still be able to use codes for exclusive psychotherapy. Regional organizations were encouraged to work with their respective States to ensure that 3rd party carriers understand the new codes. They will be come effective January 2013. A webinar on coding will be sponsored by AACAP. (APA is also sponsoring a web on new procedural coding.)

Warren Ng, M.D., who is heading the Task Force on Regional Organization Infrastructure, indicated that a summary report of the work of the task force is available on the AACAP website. The efforts of the Task Force have targeted those regional organizations with less than 50 members or those without an executive council. There are 12 such RO's incl. Alaska, Arkansas, Central Pennsylvania, Mississippi, Montana, Nevada, North Dakota, South Dakota, Nebraska and three others. Iowa does not have a regional organization. *(continued on page 16)*

2012 AACAP Assembly *(continued from page 15)*

The mentorship program continues to be developed by Nadia Charguia, MD and Melissa Lorang, MD; mentors are still being solicited.

Search Committee for new Executive Director to replace Virgina Anthony is led by Richard Sarles, MD. It was clarified that this is not a medical director position; physicians are eligible to apply just the same. 60 applications for the position have been received thus far. There is no definitive hard deadline for recruitment of the position.

AACAP Membership Drive Update: Rao Gogenini, MD and Rob Grant, Director, Comm & Mbr Services. Last year was best membership to date. The membership of AACAP continues into this year. From October to April 2012, there were 320 new members. Goals are to recruit 90% of all CAP residents, 50 programs in 100% club, 30 New Distinguished Fellows and raising awareness of benefits of AACAP.

Andres Martin, MD, who is in his fifth year as Editor of JAACAP, indicated that the five year annual review of the Journal was underway. Preliminary feedback is that there is broad satisfaction with the content of the Journal. Many members have clamored for more clinically related articles. A new addition to the Journal is an increasing number of editorials by a ten fold increase during the past 6 or 7 years. Podcasts interviews are increasingly more available. The Book Forum is also garnering very good reviews. The CME component is, also, a very popular component which required a lot of restructuring of the JAACAP infrastructure. He indicated that review articles and special series should be anticipated in upcoming issues. Manuscripts in special areas are being solicited eg, autism among others. A series of dissemination of evidence based practices are being considered. A series of longitudinal studies will also be forthcoming. A small number of psychopharmacological studies have been published; an increased effort is underway to solicit more of these. A new feature is "Translations" in which new studies are being discussed in ways that are applicable in the trenches of practicing child and adolescent psychiatry has been added. A new "Perspectives" issue will soon be included; the first issue will be by a former foster parent of an infant who is also a child and adolescent psychiatric trainee.

Bryan Samuels, Commissioner, Administration of Children, Youth and Families; Administration for Children and Families, US DHHS spoke with the Assembly. He is in charge of those services related to States' child welfare programs for both out-of-home placement and those whom remain in home. He was previously director of child welfare for the state of Illinois. He commented on a new focus of his agency, "Psychotropic Medication Use among Children Known to Child Welfare" of which he shared data from the National Survey of Child and Adolescent Well-Being II (NCASW II). He indicates that States are now required to submit their plan to oversee the prescription of psychotropic medications to children in the child welfare. He provided data related to prevalence of trauma symptoms among children in the child welfare system. I shared the experience we have had in California in working with the State child welfare agency about the new requirement for States regarding the safe use of psychotropics in children in the foster care system.

Three States' Medicaid agencies have new restrictions on the use of psychotropic medications among children, each requesting treatment authorization requests; they are CA, PA and MD. Although these restriction are narrow in nature, they are quite disconcerting.

During the "open forum" period, many regional organizations shared their successes and ongoing challenges.