SCSCAP Newsletter 2016

The Southern California Society of Child & Adolescent Psychiatry

PRESIDENT'S LETTER

by Brooke H. Spanos, M.D.

I saw a mom in my practice today. She's successful and highly educated, yet she is struggling. "It wasn't supposed to be this hard. I never thought I would feel like a failure when it comes to parenting." Sound familiar? Yet another example of the isolation, anxiety, and feelings of insecurity that seem to go hand-in-hand with parenting these days. There are a plethora of newspaper articles, blog posts, and even a new reality show about the subject popping up. Do you practice "attachment" parenting? Or maybe you subscribe to "free range" parenting? There is not a right or wrong way to parent, but it is clear that people are searching. Parents feel insecure in their abilities and overwhelmed by their responsibilities. Throwing poverty or violence into the mix complicates the picture even more. Raising a child is difficult for people with resources, not to mention families without means. As child psychiatrists, where do we fit in to this complex societal system?

I find we do a poor job of educating the public about the role and expertise of a child psychiatrist. There is a shortage in our field and demand is high, yet our voice is not always on the forefront. In general, the public is not aware of our knowledge about family dynamics, child development, parenting, medical diseases, emotion regulation, and neurodevelopmental variations, to name a few. When the public is not well informed, it is easy for alternative or misleading narratives about child psychiatrists to develop. A perfect example is the Sacramento Bee articles written last year about foster youth being overmedicated. It is, no doubt, a complex issue. What should have been a discussion about how to fix the broken foster system – by creating legislation to provide increased support, parent training, and behavioral treatments – became a discussion about how to stop psychiatrists from indiscriminately overmedicating children with "dangerous" and "mind-altering" psychotropics. Now there is legislation that will create even more obstacles for treatment.

For the psychiatrist, it means more roadblocks and increased paperwork. For these at-risk and often traumatized youth,

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however, the stakes are higher. They risk destabilization, re-hospitalization, and the potential for yet another break in their sense of long term security and attachment. (I'm not even going to get into how it can lead to skyrocketing healthcare costs and taxpayer burdens…)

Recently I started working part time in an adolescent partial hospital program setting. Again, the bureaucracy hit me like a brick. I find it insane that unless I am starting new meds or increasing current doses of their meds, an insurance company will threaten to discharge the patient. It's a guaranteed time consuming fight with insurance. The purpose of treating children at a higher level of care is to provide structure, improve skill building, educate the family, and maintain safety. It is not to encourage polypharmacy. And yet, polypharmacy is what is rewarded.

At the most basic level, our job is to connect and support. We have to make sure to keep it that way. As child psychiatrists, we need to continue to advocate for emphasizing **prevention** of mental illness with parenting, education, and support for all families. We need to find ways to reinstate the proverbial "village." Moreover, let's ensure we can use medications only as we feel appropriate – not so the insurance company thinks we are "doing something." Otherwise, we might end up feeling like the mom I saw in my office – highly educated but struggling with where we went wrong, all while buried in paperwork and bureaucracy.

Have ideas? Feeling inspired? Need support? I encourage you to reach out to your local child psychiatry village (SCSCAP).

Bullying, Victimization and Delinquency

Shivani Chopra, M.D.

Bullying is defined as an act by an individual(s) that: intends to cause harm or disturb; occurs repeatedly over time; and occurs in a relationship in which there is an imbalance of power or strength, with the more powerful person or group attacking the less powerful one. According to a US nationally representative survey, approximately 30% of school age children report involvement in bullying at school, with 13% being bullies; another 11% are victims, while 6% are deemed to be bully–victims.

Several theories exist to postulate why bullying occurs. These include: control and power, social dominance, social learning theory, school ethos, negative peer persuasion, social cultural theory, and theory of mind.

As indicated above, there are typically four types of bullying participants: bullies, victims, bully–victims (provocative victim), and bystanders. Victims are often characterized into two subtypes: passive–submissive and provocative, or bully–victims. Passive–submissive victims are more common. They are viewed as anxious, quiet and insecure, typically respond by backing down; and they may have difficulty asserting themselves. Many passive–submissive victims have low self esteem, and may struggle with impaired social skills and emotional issues.
On the other hand, bully–victims often engage in bullying behavior as a result of being bullied. Many tend to be quick tempered, and fight back/attack when they are bullied. Bully–victims also tend to have low self esteem, and may also struggle with attention/hyperactivity/ impulsivity issues.

So what are the potential consequences for bully victims? Bullying victimization outcomes can be broadly classified into internalizing outcomes and externalizing outcomes. Internalizing outcomes include: depression, anxiety, poor self esteem, peer rejection, poor physical health, social withdrawal and isolation, irritability, and self blame. Externalizing, or delinquent outcomes, include: aggressive behavior, lying, running away, stealing, deviant peer relationships, substance abuse, poorer school adjustment and functioning, vandalism, weapon–carrying to school, and suicide/homicide.

In 2009 Wong et al., studied the impact of bullying victimization on 10 delinquency outcomes measured over a 6–year period. What they found was that victimization prior to the age of 12 years is significantly predictive of 6 delinquent behaviors: running away from home, selling drugs, vandalism, theft, other property crimes, and assault. Their research also suggested that victimization prior to age 12 years was not significantly predictive for school suspension, carrying a handgun, gang participation, or arrest.

Perhaps one of the most feared externalizing outcomes that involves bullying victimization is school shootings. Many school shooters

may have been bully–victims. Vossekuil et al. looked at 37 incidents of school shootings and attacks involving 41 attackers between 1974–2000. They found that: *"almost three–quarters of the attackers felt persecuted, bul–lied, threatened, attacked or injured by others prior to the incident…"* Many attackers expe–rienced severe, longstanding bullying, and in more than half of the cases, revenge played a significant role in the attacker's decision to engage in violence. In more than 75% of these incidents, at least one person had infor–mation indicating that the attacker was plan–ning the school attack. Many school shooters indicated their plans through direct threats or by implications in drawings, diaries, or school essays. Information known by other students or friends was rarely communicated to adults. For these reasons, and many others, most states in the US now have strict anti–bullying programs implemented in schools. Of course, the long term goal is to recognize, respond, and treat issues that arise from bullying as early and effectively as possible.

SCSCAP Election of
New Officers
will take place in June.
Stay tuned for complete details!

AACAP ASSEMBLY MEETING, San Antonio October 27, 2015

By Michael Enenbach, M.D.

The Assembly of Regional Organizations was held in San Antonio on October 27th, 2015. SCSCAP was represented by William Arroyo, MD; Michael Enenbach, MD; Brooke Spanos, MD; Ara Anspikian, MD; Patrick Kelly, MD; Roya Ijadi–Maghsoodi, MD. The day–long meeting covered several important topics relevant to regional organizations and AACAP in general.

Dr. Paramjit Joshi, MD gave the President's report on behalf of the Executive Commit–tee. She noted that 23% of members regis–tered for this annual meeting. The Ad Hoc committee is searching for a new JAACAP Editor, and the final decision will be made at the June 2016 Council Meeting. A new Ad–vocacy Committee chaired by Drs. Karen Pierce and Deb Koss has been created and will be part of the Association. This is the fifth year in a row that AACAP has increased its membership and the first time AACAP has crossed the $10 million mark in reserves. There were 44 new distinguished fellows this year. AACAP has a new Triple Board and post Pediatric Portal Programs Committee to include the 5 programs in the United States. Dr. Joshi finished by recapping her Presiden–tial initiative, Partnering for the World's Chil–dren, and discussed the two international awards established during her presidency, the Ulku Ulgur, MD, International Scholar Award and the Paramjit Joshi, MD, Interna–tional Scholar Award.

The Task Force on School Violence reported on their efforts to prevent school violence

and have engaged national experts in their different focus areas. Despite philosophical differences among members, they have worked on developing a common lens through which to look at school violence. The task force issued a document called "What Every CAP needs to Know About HIPAA/FERPA," as an essential tool for crisis situations. There is also a working Resource Library consisting of over 40+ documents, tools and other website links.

Dr. Warren Ng, Assembly Chair, discussed some of the problems with recertification, namely that many psychiatrists are retiring early so that they do not have to go through the process. Almost all delegates agreed that part IV should be removed, though Dr. Sandra Sexton voiced disagreement. Some members felt that even if they were not in support of part IV of MOC, it was important to set standards for CAPs.

The Journal Editor's Report was given by Dr. Andres Martin. Study 329 was again discussed (and was also discussed during Dr. Joshi's presentation). The impact factor of the Journal is at an all–time high of 7.26 and is still the #1 ranked journal in pediatrics.

Election results were as follows (2015–2017): Mark Borer, MD as Assembly Chair, Debra Koss, MD as Assembly Vice–Chair and Melvin Otis, MD as Assembly Secretary/Treasurer. The next Assembly meeting will be June 2015.

The AMA gave a report announcing that they will be coming out with a comprehensive paper on juvenile delinquency and the needs of these children and encouraged doctors to submit ideas for resolutions to them. Finally, Dr. Ng introduced a motion by Jeanne Holzgrefe, MD for AACAP on gun safety and public health approach, which was passed and will be brought to full council. It reads as follows:

AACAP Assembly endorses and recommends that Council endorse and actively work to initiate and support within AACAP a public health campaign to promote gun safety through public health educational approaches which may include collaboration with various other professional associations and groups including APA, AAP, AMA, and other groups working toward the public health and safety of children, adolescents and adults, and endorses achieving these ends by working through existing task forces and committees of AACAP at the national and grass roots levels.

The full minutes from the Academy Assembly Meeting can be found at the following website:

http://www.aacap.org/App_Themes/AACAP/docs/member_resources/assembly/minutes/assembly_minutes_20151027.pdf

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SCSCAP ANNUAL SPEAKERS' EVENT

By Andrea Carter, M.D.

The SCSCAP Annual Speakers' Meeting was held Sunday, March 16th 2016 at the Marina del Rey Marriott. Approximately 40 attendees enjoyed breakfast and learned about 'New Trends in Adolescent Substance Abuse.'

In his talk, "Rounding up the Weeds," Dr. Ara Anspikian, Assistant Professor and Medical Director of Outpatient Youth Services at Loma Linda University Medical Center, discussed adolescent substance abuse screening and reviewed the wide variety of currently available marijuana formulations.

SCSCAP Secretary, Ara Anspikain M.D. speaks on cannibis use disorder

Escalating marijuana use appears to be largely driving a rise in adolescent substance use. Standardized self-report measures indicate that clinical interviews alone may overlook as much as 50% of substance use behavior. The Car, Relax, Alone, Forget, Family/Friends Trouble (CRAFFT) questionnaire and the Problem Oriented Screening Instrument for Teenagers (POSIT) tools are free, standardized adolescent substance abuse screens. The Cannabis Abuse Screening Test (CAST), the Cannabis Use Problems Identification Test (CUPIT), and the Cannabis Use Disorders Identification Test (CUDIT) are cannabis specific measures.

Marijuana, as distributed today, contains approximately 20–40% tetrahydrocannabinol (THC) which is one of the numerous psychoactive components of marijuana; the content of THC was approximately 2–4% THC in marijuana available in the 1980s and 1990s. By comparison, the percent of cannabidiol (CBD), which is conjectured to have anti-psychotic properties, in marijuana has remained relatively stable over this period. *Cannabis sativa* is a marijuana strain marketed for promoting alertness, while *cannabis indica* may contain more CBD and is marketed as a more relaxing compound. Synthetic cannabinoids (aka 'spice') have stronger psychoactive effects, contain no CBD, and are not detected on routine urine drug screens. Marijuana concentrates (waxes, dabs, butter, honey, oils) are produced via solvent extraction from plant residue; they contain a higher concentration of THC and CBD. Marijuana edibles are available in a variety of packages that closely resemble real food products, thereby placing children and pets at risk of inadvertent ingestion.

Our second speaker was Dr. Timothy Fong, Associate Clinical Professor of Psychiatry at UCLA Semel, director of the UCLA Addiction Medicine Clinic, and director of the UCLA Addiction Psychiatry Fellowship. Dr. Fong reviewed DSM 5 changes to addiction categories. These include the addition of gambling disorder as a substance-related

Timothy Fong, M.D.

disorder, and the removal of substance abuse / dependence categories in lieu of criteria for substance use disorder (mild, moderate or severe). DSM 5 also includes criteria for substance intoxication, withdrawal, sub¬stance / medication–induced disorders, and unspecified substance–induced disorders. Canna¬bis withdrawal, caffeine withdrawal, and tobacco use disorder are also new.

While nearly a third of Americans meet criteria for alcohol use disorder at some point in their lives, a minority of users seeks treatment; fewer users complete a 12–step program. Electronic cigarettes are increasing in popularity and represent a $7 billion industry annually worldwide. Finally, Dr. Fong emphasized the importance of discussing and documenting instructions to patients regarding proper disposal of old prescription medications. Most prescription medications can be disposed of in the trash after de–identifying, mixing with an unpalatable substance, and sealed. However, federal guidelines recommend flushing controlled medications down the toilet. Medications can also be brought to DEA authorized medication take–back programs.

Additional Resources:
CRAFFT screening tool (http://www.ceasar–boston.org/clinicians/crafft.php)

Problem Oriented Screening Instrument for Teenagers (POSIT, http://www.emcdda.europa.eu/html.cfm/index4439EN.html)

CAST screen [Legleye S, Karila L, Beck F, Reynaud M. Validation of the CAST, a general population Cannabis Abuse Screening Test. J Subst Use. 2007 Aug;12(4):233–242.]

CUDIT screen [Adamson SJ, Sellman JD. A prototype screening instrument for cannabis use disorder: the Cannabis Use Disorders Identification Test (CUDIT) in an alcohol–dependent clinical sample. Drug Alcohol Rev. 2003 Sep;22(3):309–15.]

CUPIT screen [Bashford J, Flett R, Copeland J. The Cannabis Use Problems Identification Test (CUPIT): development, reliability, concurrent and predictive validity among adolescents and adults. Addiction. 2010 Apr;105(4):615–25.]

American Academy of Addiction Medicine (http://www.aaap.org)

American Society of Addiction Medicine (http://www.asam.org)

Drug–Free LA (http://www.drugfreela.com)

DEA Office of Diversion Control (http://www.deadiversion.usdoj.gov/drug_disposal/takeback)

SCPS/SCSCAP Joint Meeting - Transgender Issues

By Jessica Jeffrey, M.D.

The 8th annual Southern California Society of Child and Adolescent Psychiatry (SCSCAP) and Southern California Psychiatric Society (SCPS) joint meeting was held on November 4, 2015 in Sherman Oaks at the beautiful home of Dr. William Arroyo, SCSCAP, Delegate to the California Academy of Child and Adolescent Psychiatry and member of the SCPS Program Planning Committee. Given increasing popularity of transgendered themes in the media, such as the recent release of Amazon's Golden Globe winning television show Transparent, and the complexities involved in the clinical care of transgender individuals, this year the topic of the joint meeting was "A New Frontier: Complex Issues of Diagnosis, Development and Treatment of Transgender Individuals", with renowned speakers in the field Vernon Rosario, MD and Ethan Grumbach, PhD. The event was well received by attendees and engendered both deep reflection and lively discussion about gender variance and the comprehensive treatment of gender dysphoria.

Dr. Vernon Rosario opened the evening with a historical overview of gender variance and the treatment of gender dysphoria. He reviewed the literature on transgender identification and gender dysphoria. The child psychiatrists attending the event were particularly captivated by the discussion of the literature surrounding the persistence and desistence of gender dysphoria in children. Specifically, it was noted research studies have reported a 16–27% persistence rate of gender dysphoria from childhood to adolescence (Steensma and Cohen–Kettenis, 2015;

Our speakers, Vernon Rosario, M.D. and Ethan Grumbach, PH.D.

Steensma et al., 2013). The Dutch Protocol for Pubertal Treatment of Gender Dysphoria (Kreukels, 2011) was discussed as a guideline for consideration of hormonal treatment in adolescents. Please see below for a review of the Dutch Protocol.

The second portion of the evening, led by Dr. Ethan Grumbach, involved a thoughtful and lively discussion of the psychotherapeutic treatment of individuals with gender dysphoria. Dr. Grumbach presented a case study of a patient with gender dysphoria which illustrated the mourning process individuals with gender dysphoria may experience as a result of the disconnect between their internal and external experiences. Dr. Grumbach emphasized the importance of helping the family of an individual with gender dysphoria understand this mourning process.

For more information about gender variance and gender dysphoria, please refer to the following websites: Group for the Advancement of Psychiatry website on LGBT

behavioral health at http://www.aglp.org/gap/ and the World Professional Association for Transgender Health at http://www.wpath.org/.

Dutch Protocol for Pubertal Treatment of Gender Dysphoria (Kreukels, 2011):
• Staged hormonal treatment in patients ≥ 12 years

• Male–to–female transsexuals are given gonadotropin–releasing hormone analogs (GnRHa) first, followed by estrogens at age 16 years or older

• Female–to–male transsexuals are given GnRHa, followed by androgens at age 16 years or older

Eligibility Criteria:
• Age ≥ 12 years
• Pubertal development > Tanner stage 2 or 3
• Clear early–onset (before puberty) of gender identity disorder
• Persisting or increasing gender dysphoria upon entering puberty
• No comorbidities or other circumstances that could interfere with the diagnostic work or treatment
• Support from parents or caregivers
• A good understanding of the effects of the treatment

References:

Kreukels BP, Cohen–Kettenis PT. 2011. Puberty suppression in gender identity disorder: the Amsterdam experience. Nature Reviews Endocrinology, 7, 466–472.

Steensma TD, Cohen–Kettenis PT. 2015. More than two developmental pathways in children with gender dysphoria? J Am Acad Child and Adol Psych 54(2): 147–8.

Steensma TD, McGuire JK, Kreukels BP, Beekman AJ, Cohen–Kettenis PT. 2013. Factors associated with the desistence and persistence of childhood gender dysphoria: a quantitative follow–up study. J Am Acad Child and Adol Psych 52(6): 582–90.

BALLOT INITIATIVES TO CONSIDER IN NOVEMBER 2016

By William Arroyo, M.D.

The following are four ballot initiatives for which we will be casting votes in November. As has been the case recently, there will be plenty of ballot initiatives which can be very confusing. Here is a brief summary of four of them which are pertinent to children and youth.

CHILDRENS EDUCATION AND HEALTH PROTECTION ACT. The sponsor claims that $56 billion have been curtailed from the education (K–12) and health budgets which primarily benefit children. The sponsor also pleads that California will not be able to move forward without having well educated children and children who are healthy; CA ranks 48th among States in healthcare spending on children. The initiative would also support mental health services and substance use prevention and treatment services for children. However, 11% of funds would go to assist community colleges. The primary aim of this initiative will be accomplished by extending a tax on an individual's income of more than $250,000 which expires at the end of 2016; this would extend the tax until 2031. This initiative seems very worthwhile to support.

THE PUBLIC SAFETY AND REHABILITATION ACT. The sponsor primarily aims to abort the trend of sending youth who commit offenses to criminal court where adult cases are adjudicated routinely. The exception would be for those youth who commit violent crimes. In general, the current situation is that district attorneys have a fair amount of authority as to where a juvenile offender will be adjudicated. This initiative would curb that authority to a large extent and place it with the juvenile court judge who would decide as to whether or not a case will remain in the juvenile court. In addition, the judge will need to routinely consider the youth's past mental health problems and the youth's development for making the final determination. In addition, there would be a benefit for State prisoners who could earn credits (shortened incarceration) based on good behavior thereby decreasing duration of incarceration for certain prisoners. This initiative also seems worth supporting insofar as providing youth with an opportunity for rehabilitation as opposed to punishment and decreasing duration of sentences for adults who were not involved in very serious and violent crimes.

UNDER AGE 16, PARENTAL NOTIFICATION, CHILD AND TEEN SAFETY, AND STOP SEXUAL PREDATORS AND SEX TRAFFICKERS ACT. The primary thrust of this initiative is to prevent a youth under the age of sixteen to undergo an abortion anytime within 48 hours after a parent has received a notification about a request for an abortion. The sponsor believes that this measure would eliminate "secret" abortions. There are penalties for misinformation by all parties involved. This initiative shifts substantial burden onto pregnant youth and physicians. In summary, this does not appear to be rational public health policy.

CONTROL, REGULATE, AND TAX ADULT USE OF MARIJUANA ACT. This is an attempt to launch the use of cannabis for the primary purpose of recreation among the adult

population, above the age of 21. In addition, there are provisions for controlling, manufacturing, and regulating its use. There are provisions for funneling tax revenue to universities in California for research and evaluation of the implementation of the initiative. There are other activities supported which include substance use prevention among youth, training of public safety officers, establishing an advisory group to State, penalties for those who may sell to youth, restoring environments where illegal growth has destroyed vegetation among others. The California Medical Association has issued a statement of support of this initiative. On the one hand, this is a laudable attempt to regulate cannabis and to restrict its usage among youth. On the other hand, there are many risks involved for young people and, especially, individuals who may have a mental disorder that may become exacerbated through the use of cannabis. It is this latter concern that should give all of our members pause as they go to the polls.

CAL–ACAP/NAMI/UACF Annual Advocacy and Collaboration Conference

By Marcy Borlik, M.D., MPH and former president of CALACAP

The annual CAL–ACAP, NAMI (National Alliance on Mental Illness), and UACF (United Advocates for Children and Families) took place on Saturday, October 17, 2015 in the California Yacht Club, Marina Del Rey. After a delicious continental breakfast, Dr. Robert Holloway, CAL–ACAP President, welcomed all the members and gave an overview of CAL–ACAP as an organization before introducing Betty Reinhart, representative from NAMI.

Ms. Reinhart discussed NAMI's programs on advocacy education for their local areas and discussed important bills that NAMI supported this year. NAMI's advocacy program focuses on reduction of disparities and stigma. They have a new program called "Mental Health 101" which includes scripts and videos representing consumers of 8 different ethnicities. Regarding NAMI's bills of interest, SB 11 (became law in 2016) and SB 29 (became law in 2016) were two bills requiring more education for law enforcement to enable them to better understand and intervene with persons who have mental illness. SB 614 would certify peer specialists for mental health, allowing California to join 36 other states that have such programs. (SB 614 has been amended substantially and has stalled). SB 82 (which became law in 2015) was designed to expand crisis services statewide and provide 31 grants in 32 counties.

Next, Dr. Holloway introduced Michaele Beebe, the director of public policy for United Advocates for Children and Families. She noted that UACF supports parents and families in the mental health, juvenile justice, and foster care systems. She notes that this year they monitored 18 bills in the legislature. She notes that some of their programs include "parent cafes," which are mini chapters that provide mutual support for parents, meeting from weekly to monthly. They also hold training and education programs for parents around issues of special education, coping with mental illness, grief, and advocacy through self-disclosure. She also described their Parent Partner 101 training for parents employed as family advocates. This program teaches ethics, team training, provider relationship building, appropriate boundaries and inspires hope and courage.

Chris Castrillo, CAL-ACAP legislative advocate, followed with a legislative update. He noted that the legislature had adjourned on September 11 and would be in recess until January 4. 941 bills had been sent to the Governor, and he had vetoed 133 of them. He highlighted a few bills such as climate change legislation, medical marijuana regulation, right to die legislation, and Dr. Richard Pan's SB 277 (became law in 2015) which would require full vaccines for school children. He also described the 3 foster care bills which were eventually signed into law by governor (SB 238, SB 319, SB 484) and touted as among the most progressive in the nation in terms of protections for foster youth. In addition, SB 253 (which has undergone several amendments), opposed by CAL-ACAP, which was designed to limit the use of psychotropic medications in this population, but brought with it so many restrictions that it would likely diminish the quality of care and access to psychiatric care for these youth.

Mr. Castrillo also reviewed the results of the Medi-Cal TAR program, which was designed to restrict antipsychotic prescriptions in youth by requiring scrutiny and justification for their use. He noted that since October 2014, when the TAR system was implemented, requests for antipsychotics were cut in half. He also described some unintended consequences of this system, including increased rates in crisis and emergency visits, destabilization of previously stable patients, and behavioral difficulties at school and home. He also explained that the AB 3632/AB 114 audit results would be released sometime in January. (State audit ultimately concluded that the State Department of Education could not clearly describe how the $400 million plus funding for this program was used.) Senator Jim Beall spearheaded this audit to examine the use of mental health funds and mental health services in schools since the elimination of the AB 3632 program. Finally, he highlighted that more efforts were being put forth to develop pilot programs for early intervention. Looking ahead to 2016, he

stated that he expects more action on foster youth and medication, marijuana legalization initiatives, more issues with the Medi-Cal funding shortfall, and the tobacco tax initiative to provide funding for children's health programs.

Robert Holloway next presented the CAL-ACAP Children's Hero Award to Dr. Richard Pan, California State Senator, representing the Sacramento area. Dr. Pan is a developmental pediatrician and former faculty from UCDavis. He described experience in the Sacramento School district and still practices medicine one day per week. He was elected to the Assembly in 2010 and to the Senate in 2014. Priority areas for him are the vaccination crisis in California and mental health reform. He emphasized that he wants children to have a voice in Medi-Cal. He would like to see the Children's Health Advisory Board for Healthy Families to move to Medi-Cal. This board would look at the fragmentation of health care. He would like to see the state get to a point where care is not restricted, but children are not over-medicalized. He said that he would support the concept of a medical passport for youth to carry from provider to provider so relevant information on their history and treatment is not lost. Dr. Pan asked attendees to help him collect family surveys and to serve as witnesses in the legislature. He expressed a strong desire to raise the tobacco tax to $2 per pack and noted that California has the lowest tax in the country. He would like to see this used to increase payments for Medi-Cal. He would like to see the cost of tobacco-related health issues be reduced from $13 billion to $2 billion per year and would like to see a significant reduction in youth smoking, including e-cigarettes. He emphasized the skyrocketing use among youth. Dr. Pan answered questions and thanked the attendees for their support before departing.

After a scrumptious buffet lunch, attendees were broken into multi-organization breakout groups to identify priority areas for the coalition to work on for the coming year and potentially for the annual advocacy day to be held in May. The groups presented their feedback to the large group, and the following themes emerged: issues with fragmented care and barriers to access, telehealth and use of electronic health records, school based services and screening, stigma, marijuana legalization, lack of provider incentives and mental health integration.

After an Ipod giveaway, Dr. Holloway thanked everyone for attending and wished them safe travels.

AACAP 63rd Annual Meeting
October 24-29, 2016
New York, New York

New York Hilton Midtown +
Sheraton New York Times Square

The Annual Meeting Preliminary Schedule, including the full list of speakers, will be available online on Monday, June 15, 2016.

Online registration for the 63rd Annual Meeting opens Monday, August 1, 2016 for AACAP members and Monday, August 8, 2016 for non-members. Be sure to register early to attend all of your preferred events.

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