SCSCAP Newsletter 2017

The Southern California Society of Child & Adolescent Psychiatry

PRESIDENT'S LETTER

by Shivani Chopra, M.D.

In my private practice, I recently had a 14-year-old adolescent female present with classic symptoms of Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD). When it came time to discuss treatment options after discussing my holistic approach to treatment and as soon as I mentioned SSRIs (which was just a part of this approach), I was abruptly stopped by mom. "Oh no, we aren't interested in medications. I know a lot of what you guys do is probably push for meds, but we're looking for alternative treatments." I remember initially feeling taken aback by this mother's comments, as she grouped me with "you guys" who were "medication pushers." As I glanced over to my patient, tears flowing down her cheeks and a total look of desperation, I felt so sad that she was listening to a lot of the invalidating comments that her mother was saying. I found myself spending a significant portion of time during this appointment educating both the mother and my patient about psychopathology, disease processes, psychotherapy, medications, evidence based practices, etc.

As I reflect on this experience, I am reminded that while the stigma against mental health and psychotropic medications has definitely decreased, it still exists. In 2010, Moses conducted a study to look at stigma experiences among adolescents with mental disorders. He found that "the greatest number of participants experienced stigmatization in relationships with peers (62%), which often led to friendship losses and transitions. Participants reporting no peer stigmatization often reported socializing with others "in the same boat" or concealing problems--methods of avoiding potentially stigmatizing interactions. Close to half (46%) described experiencing stigmatization by family members, which often took the form of unwarranted assumptions, distrust, avoidance, pity, and gossip. About one third (35%) of participants reported stigma perpetrated by school staff, who expressed fear, dislike, avoidance, and under-estimation of their abilities. Fortunately, 22% reported "different" treatment by school staff, but this treatment was interpreted as positive and supportive."

In This Issue:

So, what is our role as child and adolescent psychiatrists to help combat the negative perceptions about mental health and psychotropic medications? Education, education, education! I truly think that it is important in our day-to-day life to educate our patients, families, staff, colleagues about mental illness, evidence based practices, the roles of medications/psychotherapy in treatment, etc. On a larger scale, I think it's important that this education be spread to legislators, advocates, institutions/organizations and the general public so that we can effectively advocate for bills/laws that promote appropriate mental healthcare for our youth.

I am not by any means saying that medications are appropriate in every situation, or that they should be used as a sole form of treatment. However, when they are indicated and could be an important part of a comprehensive treatment plan, it's imperative that patients are able to make a truly informed decision, and that child and adolescent psychiatrists are able to comfortably incorporate medications as part of a treatment plan, without the concern for any backlash. Perhaps the need for education regarding psychotropic medications is most relevant in the current situation involving foster care youth and psychotropic medication use. As many of you may be aware, SB 1174, which codifies a pre-existing Data Use Agreement among the state agencies of Department of Social Services, Department of Healthcare Services and the Medical Board of California for the purpose of reviewing data and identifying physicians who engage in "repeated patterns of clearly excessive prescribing of psychotropic medication to a minor" just went into effect on January 1, 2017.

I can't help but wonder if a law such as this would have come to fruition if legislators were more educated about mental health care, including the appropriate use/effects of psychotropic medications.

My hope is that as our field continues to develop, and as we continue to train more and more child and adolescent psychiatrists, the need for psychoeducation is consistently emphasized and provided. As such, hopefully, there will be fewer patients such as my 14-year-old adolescent female with MDD and GAD who are denied appropriate mental health care and more patients who are recipients of a complete mental healthcare treatment plan.

Dr. Chopra presents award of appreciation to past president, Brooke Spanos, M.D. at the SCSCAP Annual Brunch - August 2016

Bathrooms and Beyond: Challenges Facing Trans Youth

by Natalie Ramos, M.D., M.P.H.

Hardly a day passes without a story about transgender rights in the media. Recent national coverage has revolved primarily around bathroom rights in post-election America. On this issue, an era of renewed interest in gender equity and LGBTQ+ rights under the Obama administration has quickly regressed into a confusing backslide under conservative state legislatures and, at the federal level, President Trump.

North Carolina's infamous House Bill 2 (HB2), which mandated that people at government-run facilities use the bathroom corresponding with the gender specified on their birth certificates, was repealed at the end of March, only to be replaced by a new bill (HB142) that restricts local government within the state from enacting its own nondiscrimination policies based on gender. In response, California banned state-sponsored and state-funded travel to North Carolina (as well as Mississippi, Tennessee, and Kansas, other states with anti-LGBTQ legislation) through Assembly Bill 1887, which went into effect on January 1.

At the national level, one of Trump's first official (and highly publicized) acts as president was to revoke the Obama administration's protections for transgender students at public schools. The Obama administration had issued guidelines declaring its position that transgender students have the right to use the bathroom of their choice under Title IX, a federal law prohibiting sex discrimination in schools. The Trump administration publicly stated that it will not uphold this standard.

As a direct result, the Supreme Court subsequently declined to hear the case of Gavin Grimm, a transgender high school student who sued his school district in Virginia over the right to use the bathroom corresponding with his gender identity. Mr. Grimm's school had initially allowed him to use the boys' bathroom, but changed course after some parents complained. The school has argued that allowing Mr. Grimm to use the boys' bathroom would endanger the privacy rights of other students. Mr. Grimm won his case in the U.S. Court of Appeals for the Fourth Circuit, under the auspices of President Obama's guidelines for transgender students. On the school district's appeal, the Supreme Court put a hold on the ruling, but ultimately decided not to hear the case on the grounds that the Title IX guidelines underpinning the Fourth Circuit's opinion had just been revoked. The case was returned to the Fourth Circuit, where a petition to expedite oral arguments to this academic year was declined. Mr. Grimm graduates from high school in June.

At the end of the day, the so-called "bathroom debate" is not really about bathrooms, but a microcosm for the daily struggles facing transgender individuals trying simply to exist in public spaces. All too frequently these struggles translate to poor health outcomes. Indeed, existing research suggests

the presence of longstanding, widespread disparities in both mental and physical health outcomes for transgender individuals. Gender non-conforming youth experience elevated levels of violence, victimization, and harassment, as well as high levels of discrimination (IOM, 2011). In a recent national survey of transgender adults, 40% reported at least one suicide attempt in their lifetime, with 92% reporting the attempt(s) occurred prior to age 25 (James et al, 2016).

Some public policy and population researchers contextualize the debate over bathroom access within a minority stress model, which explains the deleterious effects of both major stressors (i.e. the loss of a relationship) and daily stressors (routine interactions, comments, and experiences) on mental well-being. This model is helpful in understanding the cumulative effects of stress, ranging from overt discrimination to institutionalized prejudice—such as the forced (and often unsafe) use of bathrooms mis-matching one's gender identity and expression—on internalized mood and anxiety symptoms.

As child and adolescent psychiatrists, it is prudent to stay informed about legal and political developments in this area, as they frequently contribute to stress experienced by our patients.

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Herman, J.L. Gendered Restrooms and Minority Stress: The Public Regulation of Gender and its Impact on Transgender People's Lives. Journal of Public Management & Social Policy 19 (1), 65.

Institute of Medicine. (2011). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: The National Academies Press.

James, S. E., Herman, J.L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

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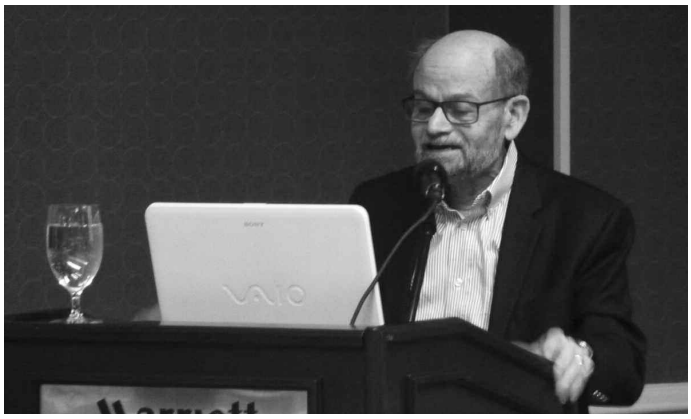
The SCSCAP Annual Brunch will be held in West Los Angeles on Sunday, August 20th, 2017
Save the Date!

SCSCAP ANNUAL SPEAKER EVENT

Presentation by Stephen Marder, M.D.
First Episode and Early Onset Psychosis

By Brooke Spanos, M.D.
On March 12th, SCSCAP held our Annual Speaker Meeting at the beautiful Marriott Hotel in Marina del Rey. Our meeting opened with our Cal–ACAP legislative advocate, Chris Castrillo, who had flown down from Sacramento to update us on the current legislation affecting child and adolescent mental health. His talk sparked a lively discussion and SCSCAP encouraged attendance of Cal–ACAP Advocacy Day on May 1st. (For details regarding Cal–ACAP updates, please see the addendum on Page 7.)



Dr. Stephen Marder, a world–renown expert in psychosis and schizophrenia, generously agreed to speak on the topic of first break and early onset psychosis. In clinical practice, my personal experience has been that when an adolescent initially presents with psychosis, the diagnosis is never clear. Are the symptoms related to drug use? Is this presentation part of an emerging affective disorder? Is there a developmental disorder at baseline contributing to symptoms? Dr. Marder reflected on all of these questions and confirmed that diagnostic uncertainty is almost always part of the process.

Dr. Marder launched into a discussion of some developmental variants that are associated with the onset of psychosis. In my training, they were sometimes referred to as "soft neurological signs." Either way, mild nuances in development, or even overt neurodevelopmental disorders, can often be seen as antecedents to psychotic breaks. Cognitive decline before a first episode is common, often manifested by significant drops in school functioning. One study has shown that IQ tends to deteriorate 17 points below what was expected in a cohort of adolescents (Reichenberg et al). The core features of cognitive decline in schizophrenia include decreases in working memory, remote memory, attention, and executive functioning. It can particularly affect reading ability, and patients with early psychotic symptoms may often present saying, "It's hard for me to read."

Marijuana is a hot topic these days, especially in California. I'm sure many of us have seen the combination of cannabis use and psychotic symptoms in our clinical practice. Dr. Marder presented data showing that patients who were cannabis users and had psychotic symptoms tended to have more severe symptoms of psychosis and overall lower GAF scores (Seddon et al.). He was of the opinion that most cannabis users who develop psychotic symptoms likely have an underlying genetic predisposition to psychosis. Despite that, he strongly believes the use of cannabis can lead not only to the onset of psychosis, but also negatively alters the course of the psychotic disorder, result–

ing in a poorer prognosis. This certainly has implications regarding the recent legalization of marijuana, and reminded me to continually counsel teens in my practice about the risks.

Studies have not shown benefit from "pre-treating" suspected prodromal schizophrenia. However, once a first break has occurred, swift and early treatment has been shown to be of benefit. In fact, a delay in treatment of psychosis for longer than 26 weeks (about 6.5 months) leads to a poorer prognosis (Friis, et al.). Thus, first episode psychosis patients should be followed very carefully in the first few months. Most first episode psychosis patients respond quite well to initial treatment. If, however, they do not remit within the first few months to a year of treatment, prognosis tends to be poor.

One of the questions Dr. Marder is often asked by his first break patients is, "Will I have to take medications all of my life?" His answer is always, "I don't know. It's too early to say." In his practice, about 30–40% can eventually be stable off medications. That number sounds surprisingly high, although he clarified that it tends to happen more frequently in an outpatient private practice population, as opposed to settings that see more high risk patients.

Dr. Marder emphasized that the best treatment responders tend to be young people who receive medications in addition to psychosocial interventions. He gave great examples of Elyn Saks (USC Professor of Law) vs Nathaniel Ayers (the symphony bassist and, often, homeless individual). Elyn received extraordinary care early on in her illness, while Nathaniel was provided rather poor quality in the early stages. Elyn has gone on to be a renowned lawyer, marry, and write about her experience. Nathaniel, on the other hand, has refused treatment and has often ended up in locked residential facilities with LPS mandated treatment against his will. Therapies such as CBT for psychosis ca be quite effective, providing support, insight, and reflection into their reality distortions. Other comprehensive programs such as the UCLA Aftercare Research Program, NAVIGATE (navigateconsultants.org), or RAISE intervention sites (an NIMH funded project) include resources such as family psychoeducation, case management, and resiliency therapy. Of note, referring first break patients to settings that serve chronically mentally ill are often met with trepidation and resistance. One can imagine how scary it must be, and how it could easily evoke feelings of fear and denial. Thus, we as child and adolescent psychiatrists can play a pivotal role in directing the patient down a more helpful path that can positively change the course of their illness.

We thank Dr. Marder for his wonderful lecture and we are appreciative of his expertise and insights on such an important topic.

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Reichenberg A, Weiser M, Rapp MA, Rabinowitz J, Caspi A, Schmeidler J, Knobler HY, Lubin G, Nahon D, Harvey PD, Davidson M. Elaboration on Premorbid Intellectual Performance in Schizophrenia Premorbid Intellectual Decline and Risk for Schizophrenia. *Arch Gen Psychiatry*. 2005;62(12):1297–1304.

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First-Episode Psychosis: A Report from the UK National EDEN Study. *Schizophr Bull.* 2016 May;42(3):619–25

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ADDENDUM:

Current Issues in Child and Adolescent Mental Health in California, as reported by Chris Castrillo, Cal-ACAP legislative advocate.

Take-away points:
-Democrats have regained a supermajority in the California Assembly and Senate.
-Cal-ACAP endorsed Prop 56 (Tobacco tax) and Prop 57 (criminal justice reform), both of which were approved by voters.
-A number of bills went into effect starting July 1, 2016:

SB 238 (Mitchell) – newly updated JV-220 forms for foster youth
SB 319 (Beall) – Foster Care Public Health Nurses
SB 484 (Beall) – Group home data collection
SB 1174 (McGuire) update:
-California medical board is to review pharmacy claims data for the purpose of identifying prescribing physicians who engage in "repeated patterns of excessive prescribing of psychotropic medication to a minor."
-foster children who have been on three or more psychotropic medications for 90 days or more will be flagged for record review.
-It was signed into law and went into effect January 1, 2017

-The governor's budget proposal includes a **$17 million** reversion **cut** to the General Fund for Children's **Mental Health Crisis Services Grants.**
-On the federal level: The US House Republicans plan to end the Medicaid expansion which would result in an **$8 BILLION dollar cut to Medi-Cal.**

Questions or concerns about any of this legislation? We encourage your participation in advocacy at any level!

Contact your representatives and join our advocacy days that occur on the local, state, and national levels.

For further information, contact SCSCAP at scscap@gmail.com or Chris Castrillo at chris@shawyoderantwih.com

Chris Castrillo addresses attendees at the SCSCAP Annual Speaker Meeting on March 12th, 2017.

Finding The Pot of Gold: Work-Life Balance

by Misty Richards, M.D.

If you look at my bedside stand, you can guess an important theme in my life: work–life balance. There are three books, two research articles, an alarm clock, and a notebook. All of these objects are illuminated by my trusty lamp that has worked tirelessly so that I may do the same. The books range in topic from how to nurture a child's developing mind, to potty training, to how successful women make the most of their time. I can always rationalize that I read these books to help patients and parents, but the truth is I read these books to help myself too. The research articles are the latest and greatest from the orange journal, reflecting my attempt to keep up with literature in child and adolescent psychiatry. They often sit there untouched for weeks as a nagging reminder to stay current. The notebook is for furiously scribbling pearls that I want to protect from the natural lapses in memory that accompany late night reading. And the alarm clock? The alarm clock is something I haven't needed for two years since the birth of my son.

What do most physicians have in common? Fearless attempts to find that mysterious pot of gold called the work–life balance. The tricky thing is that this entity is dynamic and different for all physicians. Work is the easy part. We study, we learn, we apply our knowledge to patient care/research/teaching, and we walk the line. The 'life' part is the reason small fortunes have been made with self–help books and highly–trafficked blogs. Whether you have a family, pets, fitness goals, hobbies, or obligations outside of traditional work duties, these things make up the broad definition of 'life.' For most of us, especially as we grow in our chosen professions, the 'life' part gradually demands more nourishment. How do we attend to this new developmental milestone?

1. Be present: During a track meet in high school, my dad sat down next to me in the freshly cut grass. I was worried about my upcoming event, running the 300m hurdles. He put his arm around me, told me to take a deep breath, smell the grass, and listen to the sounds of the people cheering in the stands. He told me that moments like these would be the greatest memories of my life (they are) and that my goal was simply to finish the race (I did). I think about this moment from time to time during the hustle and bustle of life, realizing that the message is so pure and true: be present. The more present you are, the more effective you can be. The more effective you are, the more efficient you can be. The more efficient you can be, the more protected time you can create.

2. Unplug: Turn off your i–phone. Turn off your computer. Get off of Facebook, Instagram, email. Do not respond to non–urgent messages within 2.5 seconds, as this reinforces the illusion that you are available 24–7. The more you can unplug, the more you can experience life.

3. Schedule everything: Transform your to–do list into a schedule. Rather than make a laundry list of things you need to accomplish (which can end up being tremendously bur–

densome), put each item in your planner during a time you are free to do it. Not only does this hold you accountable, it allows you to visualize the time you have in your day. Do this with activities revolving around both work and play so you can set clear priorities. This has been the single most valuable tool utilized during my quest for that pot of gold.

4. Recover: Practicing medicine is like training for a marathon: it takes diligence, perseverance, practice, and recovery. For physicians, this means you must sleep. In order to think clearly and respond appropriately, you need to feel rested and somewhat rejuvenated to accomplish the challenging tasks you have before you. As child and adolescent psychiatrists, it is especially important that we model patience, compassion, and thoughtfulness to not only our patients, but to their often overburdened parents. If you find it challenging to rationalize rest solely for your benefit, realize that it is for the benefit of the families you treat as well.

5. Let go of perfectionism: The very definition of balance means that elements are equal or in correct proportions. Perfect is not synonymous with balance and instead suggests a polarized state that is extreme and impossible to maintain. The sooner you relinquish the desire to be perfect, the sooner you will find the rainbow that leads to the pot of gold. Become comfortable with good enough.

6. Boundaries: "Learn to say 'no' so your 'yes' has more oomph", said Kristin Armstrong, three-time Olympic gold medalist in cycling. There is a reason this quote hangs in the center of my refrigerator. It is a reminder to protect your time so you can preserve it for activities you love. Do not feel obligated to respond to requests right away and instead tell the person you will get back to them soon. Be intentional. If someone is gobbling up a great deal of your "free" time with conversation, politely excuse yourself and move on. Ten seconds of discomfort may be worth an hour of productive/relaxation time. Know your limits.

The above six suggestions were (no joke) scribbled in my little notebook of pearls on my nightstand. These are points distilled from three books I have read over the past six months about work-life balance. While we each have our own idea of what balance looks like between our personal and professional lives, the basic concept stays the same: The goal is to feel content or, dare I say it, even happy. And who wouldn't feel good finding a pot of gold at the end of a beautiful rainbow?

Our speakers, Catherine Mogil, Psy.D. and Emily Dossett, M.D. at the SCPS/SCSCAP Joint Meeting - ***Promoting Mental Health in Pregnancy and the Postpartum*** *- November 2016*

The iPad Bogeyman

by Patrick G. Wiita, M.D.

On a Saturday morning in May 2014, three twelve-year-old girls were playing hide-and-seek in a forested park in Waukesha, Wisconsin. By the afternoon, one of the girls would be fighting for her life after having been stabbed 19 times allegedly by her two playmates. Those two girls were arrested the same day, carrying a bloody kitchen knife, on their way to find the mansion of "The Slender Man," a fictional character invented on the Internet in 2009. They believed the sacrifice of their friend would cement their fealty to the Slender Man and also protect their own families from his wrath. The girls were charged with first-degree attempted murder.

The so-called "Slender Man Stabbing" has garnered national media attention. The faceless Slender Man is purposefully vague, serving as a bogeyman by proxy onto which the reader can project whatever terrifies them most. He is a crowd-sourced monster spawned in the Internet's "creepypasta" community, a forum for the creation of digital folklore (http://creepypasta.wikia.com). In the absence of easy explanations for this monstrous crime, the Internet became a convenient bogeyman. The father of one of the accused girls lamented the purchase of an iPad, the supposed portal through which she learned about Slender Man. Parents wondered how this could have happened, if their kids were into Slender Man, and even if something like this could happen to (or because of) their kids. The knee-jerk was to blame unfettered Internet access or lack of parental supervision.

I spoke recently at a national conference for forensic scientists, using this case to facilitate a discussion of what we do know about children's cognitive development, specifically how they discern the difference between reality and fantasy. Researchers such as Jacqueline Woolley, Ph.D. at the University of Texas, Austin (https://labs.la.utexas.edu/woolley/), and her peers in the field have been helping to push our understanding well beyond the theoretical constructs of Piaget we have all learned during training.

Reality-fantasy differentiation, for most kids, is already happening around the age of three, when they begin to use conversational cues to determine the reality status of ideas. Between the ages of four and six kids are using different types of evidence to judge reality status. It is during this period that adults can actually shape a child's belief in what is real and what is fantasy. Kids give weight to verbal testimony (especially from parents), physical evidence (like money left by the Tooth Fairy), and situational context (e.g. learning something at school or church) when deciding whether something is real. Interestingly, younger kids are less likely to accept as real ideas or events that made them angry or frightened, regardless of whether the event described was plausible or had, in fact, actually happened.

Though the forces that drove these girls to believe in a fantasy so strongly that it may

have influenced their decision to kill are as indecipherable as Slender Man himself, parents can be reassured that they are not completely at the mercy of ghost stories and the darker corners of the Internet. Parents can use their young children's evidence-evaluation abilities to reinforce important realities and abolish distressing fantasies. Present and inquisitive parents that are aware of what their kids are exposed to in media can help with the development of a healthy relationship with reality. The ubiquitous iPad, despite all the parental supervision it truly warrants, is ultimately nothing but a bogeyman.

AACAP
64th Annual Meeting
October 23-28, 2017
Washington, D.C.

The Annual Meeting Preliminary Schedule, including the full list of speakers, will be available online on June 15th, 2017.

Online Registration for the 64th Annual Meeting opens August 7th, 2017 for AACAP members and August 14, 2017 for non-members.
Be sure to register early to attend all of your preferred events.

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GOVERNMENT AFFAIRS UPDATE

By William Arroyo, M.D.

SCSCAP has been very involved once again with government affairs through its work with the California Academy of Child and Adolescent Psychiatry (CALACAP). In addition, CALACAP had been closely monitoring government affairs on the national level. In particular, CALACAP monitored the introduction of the "repeal and replace" effort of the Affordable Care Act by Congress, namely the House of Representatives, and the Trump administration. When it became known that the proposed bill would eliminate health coverage for 15 million people during the first year of its implementation, CALACAP decided to formally oppose the bill by way of sending a letter to all members of the California delegation to Congress prior to the date when the House of Representatives were supposed to cast their votes. The vote, of course, was postponed one day and, subsequently, the bill was withdrawn from consideration when it became evident, despite the arm twisting and threatening comments by the President, that there were not enough votes to pass the bill. An amended form of this effort was passed by the House of Representatives (HR) on May 4, 2017. It would increase the number of uninsured by 13 million according to a recent report issued by the bipartisan Congressional Budget Office and which was not reviewed by the HR prior to its vote. This amended version clearly favors the wealthy, young and health segments of the U.S. population. The Senate will now decide if it will use the HR to develop its bill or if it shall start anew.

On the state front, CA is anticipating less revenue than in the prior two years and therefore legislation with substantial price tags will likely not succeed. However, there are many new bills which may not have a high price tag and may, indeed, effect the practice of psychiatry. The new group of bills of note include: AB 223 (Eggman) on commercial sexual exploitation of youth; AB 244 (Cervantes) on maternal mental health; AB 254 (Thurmond) and SB (191 (Beall) on expansion of mental health/substance use treatment services in schools; AB 340 (Arambula) on trauma screening for all children funded by Medi-Cal; AB 175 (Chau), AB 350 (Salas), AB 1606 (Cooper) and SB 663 (Nielsen) on marijuana and increasing safeguards for children; AB 501 (Ridley-Thomas) on creation of crisis residential services for children; AB 689 (Obernolte) on competency standards for youth in juvenile court; AB 1261 (Berman) an attempt to limit zero tolerance policies re: intoxication on high school campuses; SB283 (Wilk) on traumatic brain injury; SB 755 (Beall) which would limit psychological testing of an abused child to three hours; among others.

CALACAP continues to monitor the implementation of SB 1174 from last year in which a psychiatrist could be investigated by the Medical Board of California (MBC) for questionable prescribing practices for youth in the foster care system based on data supplied to the Board from two other State agencies. Although the MBC has hired a physician to do these reviews, challenges remain.

These include the release of medical records because there is a complex set of laws and regulations which govern authority for such release to the MBC.

As anticipated on a national front, new efforts to provide prescriptive authority to psychologists have been launched. Idaho has a new law since early April which allows psychologists to prescribe; prescriptions for youth and elderly are not permitted. Oregon legislature has a new bill introduced this month patterned after the law in Illinois. The Nebraska legislature has launched an "exploratory" review regarding possible psychologists prescribing.

On May 1, 2017, CALACAP hosted an Advocacy Day in Sacramento along with United Advocates for Children and Families and NAMI (California). There were approximately fifty advocates in attendance. Chris Castrillo from the legal advocacy firm, Antwih, Yoder and Shaw, Inc. in Sacramento, organized office visits at the State Capitol. The AACAP hosted its own Advocacy Day in Washington, D.C. on May 11 and 12; a large contingent of child and adolescent psychiatrists were in attendance. The AACAP advocates focused on workforce shortage issues; the maintenance of "essential health benefits" which includes mental and substance use treatment benefits; re-authorization of the federal law, State Childrens Health Insurance Plan which includes a mental health benefit and which is set to expire in September; and a bill that would provide loan debt relief to those child and adolescents who work in federally designated shortage areas.

William Arroyo, M.D. at our Annual Speaker Meeting in March.

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