



american society for adolescent psychiatry

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Gregory P. Barclay, M.D., Editor

Winter 2012

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2013 Annual Meeting March 23-24, 2013

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FROM THE PRESIDENT GREGORY BUNT, M.D.

Dear ASAP members:

Indeed these are exciting times for the field of Adolescent Psychiatry. Rapidly evolving circumstances and regulations of the delivery of psychiatric services to adolescents underscore the importance of networking with colleagues in the *American Society for Adolescent Psychiatry*. Novel developments in adolescent psychopharmacology as well as updated DSM-5 diagnostic criteria behoove all psychiatrists treating adolescents to access the latest information, participate in educational continuing educational activities and communicate with experts in our field. The newsletter, journal, textbook and continuing educational seminars/conferences of the *American Society for Adolescent Psychiatry* provide the practicing or academic psychiatrist with practical opportunities and incentives to keep abreast of the latest developments in our field. I want to take this opportunity to thank Gregory Barclay, M.D., the editor of our newsletter, and Lois Flaherty, M.D., the editor of our journal, for their unswerving and indefatigable efforts in the oversight of these outstanding publications.



Among the greatest challenges in treating adolescents today are the areas of trauma and addiction. Recent events as the devastating effects of hurricane Sandy in the Northeast, which left thousands of families with adolescents displaced, traumatized and/or homeless, are a grim reminder of the reality of traumatic stress and events in our modern world. The current epidemic of prescription drug abuse with correlate overdoses, many fatal, among adolescents; along with synthetic drug development including K2 and other cannabinoids and stimulants should be of great alarm to the public, policymakers and our profession. The need for psychiatrists treating adolescents to be both informed and involved with these issues is paramount. Expert in the fields of diagnosis and treatment of adolescent trauma and adolescent addictions are in the forefront of our conferences, seminars and publications in the *American Society for Adolescent Psychiatry*.

Other areas of great import to our Society include adolescent cognitive and emotional development, the utilization of EMR in Adolescent Psychiatry, and the international aspects of Adolescent Psychiatry. Now is the time to encourage our colleagues in Psychiatry and Medicine to join as new members of the *American Society for Adolescent Psychiatry*.

I look forward to seeing all of you in Charleston, South Carolina in March during our next exciting annual conference.

Gregory Bunt
ASAP President
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ASAP Web Site: <http://www.adolpsych.org> • e-mail: adpsych@aol.com

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Ads must be received at the ASAP office by the following deadlines: Summer issue – June 30; and Fall issue – December 1st. Copy should be typed and doubled space.

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A preview of our upcoming annual meeting in Charleston, South Carolina, March 23-24, 2013...

The 2013 annual meeting of the American Society for Adolescent Psychiatry will be held March 23-24, 2013 in Charleston, South Carolina. Hosted conjointly by ASAP and the Medical University of South Carolina Department of Psychiatry and Behavioral Sciences, the conference's theme is "Adolescents in Transition: The Health Care Role." Designed to provide practical guidance for the full range of mental health professionals, the meeting will have something for those of varying disciplines.



Topical areas will include strength-based treatment for teens and families, school based services, adolescent participation and associate impact in child custody evaluations, effective responses to sexual abuse, mental illness and behavioral management as they relate to juvenile offending, substance use and sexual risk taking, the adolescent transition to college, findings regarding any differences between adolescents with LGBT parents vs. conventionally-raised adolescents, and discussion of the Roper vs. Simons case. The annual Schonfeld Lecture will address new developments in the understanding and treatment of adolescent marijuana dependence.

This year the ASAP welcome reception and dinner will occur Saturday night aboard the Spirit of Charleston for a private harbor cruise. Hotel options will range from economy fare adjacent to the university campus and thus a stroll down campus sidewalks before arrival at the presentation hall, to ones embodying the local downtown Charleston charm and history, but still close by.

As part of an intentional organizational effort to reach out to all who serve adolescents regardless of practice discipline, this will be the first ASAP conference to offer continuing education credits for clinical psychologists, social workers, marriage and family therapists, and licensed professional counselors, as well as physicians, with speaker representation from each of those disciplines. An argument could be made that of all the mental health specialty areas, the care and treatment of adolescents is the most discipline-diverse. Accordingly, a multi-disciplinary conference approach is long overdue and is consistent with ASAP's recent efforts to expand membership to all mental health disciplines.

In addition to the annual conference's expanded focus, its location will also be a first, as Charleston, SC has been voted a "Top City in the United States" in the Conde Nast Traveler Reader's Choice Awards for two years. A popular destination for tourists year 'round, Charleston has much to offer including a variety of culinary options (to be described in a separate newsletter article), its place in U.S. history beginning with colonial times (several museums, national historical sites, local legends), the wares of local artisans, nationally recognized golf courses, and nearby beach front. There are plantations, gardens, and pirate tours, an aquarium, a naval museum complete with a submarine and an aircraft carrier, extensive shopping options including an outlet mall, and much more, all at a time of the year when Charleston's climate is literally in the

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perfect range with temperatures generally in the 60's-70's most days.

With limited time and a watchful eye on one's expenses, attending conferences doesn't seem to be as popular as in the recent past. As a result, one needs to get much for the outlay of time, money and effort. ASAP provides just that – a conference offering the latest in evidence-based findings in our field presented in many cases by the clinical researchers who discovered or developed them. ASAP does that while providing continuing education credits for topics you will actually put to use in your practices after

returning home, and at a reasonable cost in an inviting setting with attractions beyond the conference content. In addition, you will have the chance to catch-up in-person with friends and make new ones who share your professional interests.

Please join us in March. I look forward to seeing you in Charleston!

Gregg Dwyer, M.D., Ed.D.
2013 ASAP Conference Chair

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Position Statements by the candidates for 2013 APA President-Elect

Editor's note: Each year, ASAP requests that the candidates for the upcoming year's President-Elect position submit position statements, in particular with regard to Adolescent Psychiatry. These are published in our fall newsletter in advance of the APA election. What follows are the position statements supplied by Paul Summergrad, M.D., and Robert Ursano, M.D. Each candidate has also supplied a website address for you to learn more about his candidacy.

Paul Summergrad, MD www.paulsummergrad.com

I am honored to be a candidate for President-elect of the APA and am focused on advancing the interests of our profession and patients. I want to take the opportunity of this brief statement to tell you something about myself, my qualifications for this office and my priorities for Adolescent Psychiatry and the APA.



Time for Leadership

Over the past 30 years, as a psychiatrist also trained as an internist and psychoanalyst, I have cared for patients in academic, public, and private practice settings. In recent times, governmental and financial pressures have intensified, risking the stability of our field and the well being of our patients. Despite our scientific accomplishments and clinical expertise, I have become deeply concerned about our ability to provide integrated and equitable psychiatric and medical care for our patients.

Through my work as chair of the APA Board of Trustees Workgroup on Psychiatry and Healthcare Reform, it has become clear that APA needs vigorous leadership to ensure that reform efforts benefit our patients and practices and sustain the highest quality of psychiatric care, education and research.

APA is a richly diverse organization. We work with both acutely and persistently ill patients, often with co-morbid psychiatric, medical, and substance use illnesses. We care for men and women in personal crisis, children and families, the elderly, veterans and active military, the dispossessed and incarcerated, and many who suffer from stigma, discrimination, and social dislocation. Together we can and must successfully navigate the complex challenges in front of us.

It is essential that APA work with state associations/district branches, other medical and psychiatric specialty groups such as the American Society of Adolescent Psychiatry and our members to actively advocate for our profession and patients.

Priorities for Adolescent Psychiatry and Psychiatry

Adolescent Psychiatry is a critically important field. Adolescence is the onset of major psychiatric and substance use syndromes and a time of great psychological ferment. While there has been increasing research into the diagnosis and treatment of child and adolescent disorders such as the TADS study, more research is needed to answer important treatment questions. The challenges of teen suicide, substance abuse, disparities such as the cradle to prison pipeline and the challenge of transition to adult services especially for youth with serious mental illness needs greater attention.

Psychiatric disorders are increasingly understood as having important psychological and neurobiological developmental trajectories often beginning in early life but manifesting in adolescence. Morbidity and mortality in the adolescent period is highly correlated with psychiatric and substance abuse illness. Likewise the promise of early identification and treatment may alleviate the severity of some of these conditions.

The American Society of Adolescent Psychiatry working closely with APA could have enhanced impact in education and public policy. These efforts could include joint dissemination of practice guidelines and coordinated advocacy of areas of important public health concern such as teen suicide, the transition to adult services for youth with serious

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psychiatric illness and college psychiatric and substance abuse care.

The shortage of child and adolescent psychiatrists warrants both joint advocacy for child and adolescent psychiatry training, and enhanced training of pediatric residents in child and adolescent psychiatry.

Advocacy for parity, payment reform and especially understanding the special uncompensated time demands on child and adolescent psychiatrists are important joint opportunities as well.

My priorities for APA are:

- Ensure APA leadership of healthcare reform efforts - Health care reform efforts are occurring throughout our US healthcare system. These efforts will only intensify but can be disruptive of our field if we do not actively lead. Chairing the APA Board of Trustees Workgroup on Psychiatry and Healthcare Reform has prepared me to lead these efforts.
- Protect the integrity of psychiatric practice - Psychiatric care has been impaired by economic and discriminatory forces. It is essential that we continue vigorous efforts to reverse these trends and enforce parity laws.
- Ensure high quality research and education for our future -- Research allows us to improve the quality of our care and the scientific basis of our field. Training residents and other physicians renews our field and enhances the care of all patients. Both are essential to our future.
- Embrace our diversity as colleagues and caregivers - We have a wonderfully diverse profession. We need to make sure we fully reflect the diversity of our membership and affiliated organizations and can when needed speak with a singular voice to support our field.
- Enhance the value of APA membership - We are losing members particularly early and mid career psychiatrists. We must increase the value of APA to our members and their practices. We need to listen to the voice of our members to better guide our policies. We also have to collaborate more effectively with State Association/District Branches and Psychiatric Specialty Organizations such as the American Society of Adolescent Psychiatry
- Combating Stigma and Discrimination- Stigma has a deep impact on our patients and our profession. I pledge to combat this pernicious discrimination

Please let me know your concerns about psychiatry and how APA can support you at www.paulsummergrad.com

Current Position and Professional Experience

- Chairman and Arkin Professor of Psychiatry at Tufts University School of Medicine and Professor of Medicine.
- Psychiatrist-in-Chief of the Tufts Medical Center
- Chairman of the Tufts Medical Center Physicians Organization.

I graduated from the State University of New York at Buffalo School of Medicine and completed training in internal medicine at Boston City Hospital. I trained in Psychiatry at the Massachusetts General Hospital serving as Chief of Inpatient Psychiatric Services and as a member of the Harvard Medical School faculty. I completed psychoanalytic training at the Boston Psychoanalytic Society and Institute. I have had a long-standing commitment to the study of mood and medical-psychiatric disorders and the training of adult and child psychiatric residents and fellows. I have had deep involvement in the care of psychiatric patients in community public and private practice settings and have had a private practice for over 20 years.

APA and other Leadership Activities:

- Chair of the APA Board of Trustees Workgroup on Psychiatry and Healthcare Reform.
- Member of the DSM-5 Scientific Review Committee.
- Previously served as a member of the Finance and Budget Committee, the Steering Committee on Practice Guidelines, the Assembly and as President of the Massachusetts Psychiatric Society.
- President of the American Association of Chairs Departments of Psychiatry
- Chair-elect of the American Hospital Association Governing Council for Psychiatry and Substance Abuse.

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Personal Background

I was born and raised in and near New York City. My wife of 26 years Randy Glassman MD is a psychiatrist who was Director of the Women's Psychiatry Service at Brigham and Women's Hospital and Harvard Medical School and is currently in full time private practice. We have a daughter and a son.

Primary Professional Activities and Sources of Income

Professional Activities

- 100% Tufts University School of Medicine/Tufts Medical Center
- ✓ 70% Administrative
- ✓ 10% Teaching
- ✓ 10% Research
- ✓ 10% Clinical

Income

- 95% Tufts Medical Center Physicians Organization
- 5% Consulting and honoraria: lectures, royalties, forensics

Robert J. Ursano, M.D.

<http://robertursano.com/>

Thank you for the opportunity to speak to the issues of psychiatry and adolescent psychiatric care in particular. The American Psychiatric Association speaks the challenges and needs of psychiatric care to the nation and the world. This must include all stages of development- importantly adolescence when most psychiatric disorders have their beginnings. The opportunity to intervene early is critical to the future of psychiatry both for prevention and for limiting impairment.

The responsibility of the organized medicine including the APA and the ASAP stems from the patients we represent. Our members provide scientifically based, evidenced informed, compassionate care to millions of those in need. This strength must be maintained in order to provide the best care for our patients and to assist their families.

I have been a member of the APA since residency when I was selected a Falk Fellow. Since that time I have been continuously active in the APA, primarily in the areas of disaster psychiatry, research, education and quality care. Having trained in psychoanalysis I am particularly alert to the importance of development as one trajectory for assessment of disorders and planning interventions, neurobiological, psychotherapeutic and social. Development forms the overarching frame for considering the particularities of stressors, risks, resilience factors and intervention options.

First, in the responsibilities of the APA President, representing the members and their medical care practices, is to ensure the protection, care and future of our patients of all ages, many of whom have no voice in their communities and need our help to obtain the care they need. Adolescents and children of all ages are special groups needing advocates. Extending knowledge of the disorders and interventions for evidenced based care for these groups can better ensure sufficient care resources.

This is even more critical as the nation addresses the needs for health care and its expense. This advocacy requires our support of individual treatment needs, public health care and furthering the opportunity for psychiatry to join collaboratively in primary care. The broad perspective of behavioral risk to health- from alcohol and smoking behaviors, to family violence, depression, schizophrenia and bipolar disorder- all have morbidity and sadly mortality associated with them. The disorders we care for are often complicated comorbid disorders with complex health problems. Suicide, a particular concern for adolescents, is now the leading cause of morbidity from self-injury- surpassing motor vehicle accidents. To address these mental health care tasks – in psychiatric care and primary care- requires addressing important access to care issues for our patients, providing appropriate reimbursement for care to sustain the psychiatric



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workforce and training sufficient numbers of psychiatrists to meet the future needs.

Psychiatry is part of the house of medicine and must maintain its strong ties to medicine, particularly primary care. Further development of our treatment guidelines and guidelines for primary care physicians can help our patients through direct care as well as referral to specialty care. Guidelines need to reflect the developmental needs of each patient. Psychiatric illness is a part of everyday life. Psychiatric disorders span a broad range from medical bruises (a simple adjustment disorder) to the equivalent of broken bones (depression that responds to treatment) to disorders with high morbidity and mortality (schizophrenia, bipolar disorder). The extent of these disorders is important for non-psychiatric physicians and the public to recognize in order to decrease the stigma associated with mental illness and end the assumption that “once ill always ill”.

The future of our field depends on the education of our medical students, residents and fellows. Fostering their early involvement in the APA and awareness of our many special populations across developmental lines is important to the APA’s future and to bringing new knowledge and skills to the APA. Most importantly, the APA needs its assembly, its leaders and its members to be strong and ready to define the future of psychiatric health care.

The Real Southern Belle

By: James Gilfoil, M.D.



Or at least that’s what Charlestonians like to think. They’re fiercely proud of their city and how it has maintained its civility, gentility, and grace without sliding into that primordial sleaze that is the (horrors!) Big Easy. And most of that good press is true. Charleston is a beautiful, small city, and you can do some wonderful walks and tours, especially since ASAP’s annual conference coincides with the start of the home and garden season. Hell, the azaleas may even be in bloom. Charleston has also become somewhat of a foodie destination—surprise, surprise. That, of course, is good news for us, for you’re going to need some places to fuel up for the conferences you’re attending and the tours you’re taking. Here are some of my ideas.

Sean Brock, Sean Brock—I can’t get his name out of my head. He’s everywhere—not only is he Charleston’s most touted chef, but he’s on national TV, he’s a James Beard award winner, an adoring article was written about him in the *New Yorker*, etc., etc. It also happens that he’s at the epicenter of several converging trends in the food world—the “locavore” movement, Southern food being the “it” cuisine for these 15 minutes at least, and the desire to “go back to one’s roots” via food. So, given that he champions all of these trends, and having practically invented that “back to one’s roots thing,” he is the Man! Now, granted that locavore thing can get way to precious and self-righteous. I even looked it up on Wikipedia, and I won’t bore you with a quote, but there’s a lot of blah, blah, blah there, and I’m not sure there’s a there there. Every-

one knows fresher things tend to taste better, I’m all for that, but, if you really like to eat, and I do, what you really want is not self-righteousness on a plate, but something that tastes really good. If it’s something creative and different, that’s great, that adds another dimension of enjoyment to the experience, but there’s a lot to be said for the old standbys, or “comfort food,” if you will. That’s one of the major factors fueling Southern food’s ascendance at this moment. Fried chicken and donuts or waffles anyone? In fact, down-home Southern food was always focused on the local and the fresh. We might have cooked the hell out of it—like those mustard or turnip greens that simmered for 4 or 5 hours on the stove, but they were damn fresh. Brock’s genius is not only that he’s a damn good chef, but that he really cares about his craft, and wants to research all these old ingredients that have fallen out of favor in our increasingly homogenized, corporatized culture. So, he’s bringing back beans and veggies you never heard of, in addition to using artisanal grits and cornmeal—and yes, the artisanal really does taste better. I turned my Louisiana relatives onto some obscure producers in Alabama and South Carolina, and now they’re hooked. But enough philosophizing, how about those restaurants?

Brock’s restaurant of the moment is *Husk*, where he is mining all those trends mentioned above to create some interesting, exciting, but most of all great tasting food. *Husk* was *Bon Appetit*’s best new restaurant of 2011. The

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website says *Husk: A Celebration of Southern Ingredients*, and is it ever! You can have BBQ pork ribs with pork rinds—make me swoon!—fried chicken skins, his take on pimento cheese with cornmeal fried green tomatoes, and on and on. Enough updates of Southern classics to make a grown Southern boy cry. And don't forget his justly famous sides for the table—the sweet potato puree, the Geechie Boy grits, but especially his skillet cornbread with bacon. *Husk* also has a wonderful burger, but that's available only at lunch, so you'll have to eat there at least one lunch and one dinner. Oh well, soldier on.

McCrary's, Brock's first restaurant in Charleston, made him and gave him the freedom to do *Husk*. *McCrary's* provides a quite different experience, since here Brock is doing molecular gastronomy. In fact, if you're a real foodie, this may be the restaurant in Charleston for you. Here's the world of the gourmet, and not the arcane world of Southern ingredients and tastes that may not titillate the Yankee palate. We're in the land of foie gras, Wagyu beef tartare, caramelized mascarpone, with a Southern riff or two, and certainly local ingredients, but, all in all, much more familiar territory to those without Southern "roots." My suggestion—do *McCrary's* too, so that you can experience what one of our great chefs can do. I mean, after all, you wouldn't turn down a chance to see something you hadn't seen from Cezanne, would you?

Are there any other decent restaurants in town, other than those done by Brock? Well, yes, in fact, many Charlestonians consider *FIG* to be the best restaurant in town. By the way, it stands for Food Is Good. Chef Michael Lata has garnered quite a local following with his gourmet take on Low Country cuisine. He's into Wagyu, some Italian influences, and has a suckling pig confit that'll bring you to your knees and possibly have you "oinking" too. Good cocktails, an eclectic wine list featuring areas you may

not have heard of, e.g. the Jura region of France, along with superb service reminiscent of Danny Meyer's *Union Square Café* and no wonder it's such a local favorite. Lata opened a seafood hall called *The Ordinary* after this article went to press, so check that out and put it on your short list.

Other possibilities include one of Sean Brock's favorites—*Two Boroughs Larder* where Heather and Josh Keeler are cooking up serious foodie fare that is wowing people. The space is a little self-consciously hip, but who are we to quibble with self-consciousness. It's a bit of a boutique, a deli, and a restaurant, so you could stay here most of the day tasting various goodies. You also might check out *The MacIntosh*—selected best new restaurant in Charleston—where chef Jeremiah Bacon—no joke—cooks up some mighty good bacon among other delectables. He's definitely into meats with a butcher plate featuring fried head cheese along with a sausage plate, sweetbreads, pork belly, and bacon jam all on the same appetizer list, while his list of sides includes a bone marrow bread pudding. This is a man after my heart, literally. Just have that defibrillator at your side. *The Grocery* is getting good reviews, and *Glazed* has amazing doughnuts. For breakfast *Hominy Grill* is a must, even if it has become a bit touristy. Try a big nasty or the gold standard shrimp and grits.

To wash it all down, try Social a local wine bar, but don't forget cocktails. *Husk* has one of the best bars in town, and most of the restaurants listed above have good cocktail lists. There are two excellent bars with artisanal cocktails and pretty good food—*Gin Joint* and the relatively new *Cocktail Club* which has a rooftop bar. It's a great way to experience the city—just don't get too close to the edge. And don't you do that either while enjoying the many charms this delightful city offers.

From Our Members...

Harvey Horowitz, M.D., (life fellow and ASAP past president, 1991-92) was elected a distinguished life fellow by the APA at its annual meeting this past May. Congratulations, Dr. Horowitz!

Waquar Waheed, M.D. has been elected Chair of the National Association of Program Directors in Child and Adolescent Psychiatry of Canada. Congratulations, Dr. Waheed!

Proposed Changes to the Organization of Councils and Committees



By Dominic Ferro, M.D. Chairperson, Bylaws Committee

The Governing Board has been discussing the structure of ASAP's Councils and Committees. The current ASAP Bylaws call for a number of Councils and standing committees that have been difficult to staff in recent years. Rather than assisting with the business of the organization, the Board has found the present council structure burdensome. As the organization has shrunk, tasks have been more efficiently addressed by small, focused ad hoc committees. The Bylaws empower the President to appoint ad hoc committees. Eliminating the Councils and committees is not so much a change as it is an acknowledgement that they are no longer functioning, and that they are no longer necessary. That structure is a vestige from a time when ASAP was a much larger organization.

Over the years, the ASAP's organization has shifted from a confederation of a number of local societies to an organization centralized on the national level. Because there are fewer constituent societies, the Governing Board now consists of more Members-at-Large. Similarly, the functions of governance have become more centralized with the Governing Board directly overseeing most of them. Members of the Board assist each other in functions on an ad hoc basis.

As a result, the organization of councils and standing committees reporting to the Governing Board has become obsolete. The proposed changes to the Bylaws will call for the dissolution of the Councils on Administration and Organization, Educational and Scientific Affairs, Programs and Meetings and Topical Studies. The only Council that will remain in place is the Council on Certification in Adolescent Psychiatry. This Council was formed when the American Board of Adolescent Psychiatry was absorbed by ASAP, and it remains an independently-functioning council. The function of certifying individual psychiatrists, who may or may not be members of ASAP, should have some measure of independence from the Governing Board, and our Bylaws should recognize that fact.

While the Bylaws should define an autonomous Council on Certification, defining individual committees in the

Bylaws only adds an unnecessary layer of procedures. If the function of committees is defined in the Bylaws, then every change in committee structure, function and membership would require a change of the Bylaws. So, the Bylaws Committee now proposes that the functions of the committees be defined in another document, The American Society for Adolescent Psychiatry Manual of Committees. This will allow the Bylaws to be a more fixed document defining the organization, which is the proper role of Bylaws. At the same time, it will allow the Governing Board to more flexibly mold the function and organization of its committees to ASAP's immediate needs, which is the proper role of committees.

Most of the committees will not change. The Nominating Committee, the Past Presidents Committee, the Program Committee, the Membership Committee and the Bylaws Committee all perform vital functions for the organization. Each will be listed in the Manual with the same descriptions, with the exception that they will all report to the Governing Board, as the Councils will be dissolved.

Article IX of the Bylaws which defines committees now states: "The President shall appoint as many Ad Hoc Committees as are needed to implement the purposes and functions of ASAP. The President and Governing Board, pursuant to these Bylaws, are empowered to appoint, abolish, and/or reorganize the standing Committees." The proposed change will delete the word standing, since all committees will be ad hoc, standing as long as they are needed, and the following sentence will be added, "The definitions and membership of these committees will be recorded in the ASAP Manual of Committees."

Although we will have fewer Council positions, ASAP will still need the time and talents of its members. Our committees will continue to serve our members needs, providing excellent educational programs and networking opportunities, creating a professional home for professionals committed to the care of adolescents with psychiatric disorders.

APA DOINGS...

By
Richard Ratner, MD



Greetings from the Fall Meeting of the Assembly of the APA held, as usual, this November at the JW Marriott Hotel in Washington, DC. As you may recall from previous posts, ASAP is an allied society with the APA and as such is represented on the APA Assembly as a member of the assembly allied organizations liaison (AAOL), along with reps from social psychiatry, group psychotherapy, various analytically oriented organizations, organizational psychiatrists, and numerous others. This past year, the American Academy of Child and Adolescent Psychiatry (AACAP) left the group, claiming that it had adequate representation within the APA in other fore; thus, it felt that the money that AACAP spends on their representative was not money well spent.

Since the Assembly is the legislative branch of the APA, its main task at these meetings is the consideration for passage of various ‘action papers’, which, if passed, are sent up to the Board of Trustees (or a committee made up of both Assembly and Board members) for final action. Also at these meetings, the APA president, secretary and treasurer also give extensive presentations on the state of the group, including its financial status (quite a bit more robust than it was a few years ago, because of, in part, draconian cuts imposed several years ago during the recession). At the same meeting, each of the Areas of the APA (I am, for example, associated with Area 3 – New Jersey, Pennsylvania, Maryland, and the Washington, DC metropolitan area) meet, as does the group of all the AAOL reps, the latter to consider matters of common interest to our various groups. I typically parse out what are the most significant issues that come up at each sub-group meeting, and participate and report accordingly. What follows are the major topics addressed at this assembly’s meeting:

DSM 5

Drs. Kupfer and Regier, editor and co-editor of the upcoming DSM 5 (or I should say 5.0, because the reason for switching to Arabic numerals is so that further revisions may mimic software changes, e.g. 5.1, 5.2, etc.) gave an overview of what is close to the final iteration. Approval of the near-finished product was then required by the Assembly, which it did at this meeting, and by the Board of

Trustees, which is expected to do so in December. It is expected that the new manual will be published and available for purchase in time to coincide with the APA annual meeting in San Francisco in May, 2013. The online draft is available to APA members at www.psychiatry.org/practice/dsm;/dsm-5-and-dsm-iv-criteria, but to access it one must have current APA log-in information.

Among other elements presented in his overview, some of the changes highlighted by Dr. Kupfer included, (1) a diagnosis of Autism Spectrum Disorder (with appropriate qualifiers) replaces the previous conditions: Autism, Asperger’s Disorder, and Pervasive Developmental Disorder; (2) the deletion of the subtypes of Schizophrenia; (3) the elimination of the Bereavement exclusion for Major Depressive Disorder (although there is a place for grief to be added to a MDD diagnosis); (4) the addition of a Disruptive Mood Dysregulation Disorder, severe, non-episodic, as a better fit for many kids that are now diagnosed with pediatric bipolar disorder; (5) added diagnoses of Hoarding Disorder and Binge Eating Disorder (the latter to cut down on the many “NOS” specifiers added to the current eating disorder diagnoses); and (6) an end to the split between substance “abuse” and substance “dependence” disorders: henceforth they will be more like mild, moderate and severe substance overuse disorders.

Finally, for this overview (and perhaps most relieving to many of us), all of the personality disorders from DSM-IV will reappear unscathed! Earlier, an ambitious attempt had been made to overhaul the entire personality disorder category, allowing only certain ones to survive while previous ones would have become cross-cutting features of the surviving ones. Ultimately, the advocates for this notion capitulated; as most of us believed it would be so hard to understand and get accustomed to that it would be a hindrance to the practitioner.

Oh, and did I mention that the multiaxial system is headed for the dustbin? It will be eliminated, and all the diagnoses (formerly found on Axes I, II, and III) will henceforth be listed (as diagnoses are in all other medical reports) in descending order of most seriousness/salience. The GAF will also be eliminated and replaced by a mech-

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anism by which functional impairment and behavioral dyscontrol will be separated, as was previously not done in the former GAF rating.

NEW LEADERSHIP

Dr. Jim Scully will be stepping down from his post as Medical Director and CEO of the APA in 2013, and a search committee is working on identifying his replacement. Their choice is expected to be announced, according to APA President-elect Dr. Jeff Lieberman, in late spring. There is general consensus that Dr. Scully has done a terrific job over the time frame that he has occupied the position, something that cannot be said for some of his predecessors.

CPT CODES ARE A'CHANGIN'

Most of our readers are hopefully aware that some of the CPT codes we have grown to know and love will no longer be honored for services we render after the end of the year. Our old friends, 90801, 90807, and 90862 may be disappearing into the sunset – the 90862 is clearly on the chopping block - and we are henceforth supposed to begin using “E and M” codes that apparently begin with ‘99’ (*Editor’s note: “E and M” codes are “evaluation and management” office visit codes established using different criteria than our 90862 code - 99213 being the code most likely to be compatible with the soon-to-be shelved 90862 code. This is a HIPPA-required change that all HIPPA-compliant providers will have to make. The good news is that we will now be able to use “add-on” psychotherapy codes in addition to the E/M codes, so that we can bill for the psychotherapy “procedure” simultaneous to our office visit, analagous to a general physician billing for a flu shot and an office visit simultaneously!*)

The E and M codes are all listed in the new CPT Handbook, which is available from the AMA (www.amabookstore.com). There are apparently webinars and other resources available on the APA website, and there are staffs of experts on coding at the APA itself (1-800 343-4671) presumably available to answer questions. I have not yet explored any of these resources, as I have not gotten past the ‘deer in the headlights’ feeling that these changes have caused. Nonetheless, all of these changes must be dealt with, and soon.

THE FUTURE OF HEALTH CARE

A modicum of uncertainty was removed by the recent Presidential election, which means that the Affordable Health Care Act is here to stay. Much of what that means remains very unclear. Trends noted by Dr. Paul Summergrad, one of APA’s experts on future developments, in-

clude the increased emphasis on ‘integrated care’, which might mean more psychiatrists practicing in ‘medical home’ settings along with family practitioners. In process are pilot programs focusing on patient-centered care teams, so called measurement-based care, and, of course, evidence-based care. For what it is worth, we were told that there was a 4% reduction in the number of hospital acute inpatient psychiatric units over the past five years.

In addition to changing patterns of practice (which clearly do not favor the private practitioner), some more immediate financial concerns are on the horizon. It is unclear, for example, whether the so-called ‘doc fix’, which Congress has used to pull all Medicare practitioners back from the brink of meat-axed cuts of reimbursement for the last several years, will work again this year. Some people see it as one of the ‘loopholes’ that should be closed to bring down the deficit, which could mean a dramatic cut in reimbursement rates for all of us. In addition, down the road there is the prospect of the Independent Payment Review Commission, which could end up having authority to set and reset provider procedure code rates.

OTHER BUSINESS

MOC (Maintenance of Certification): The older members of the Assembly continued to express their outrage at the ABPN’s actions in this area by submitting two action papers: one, for the APA to set up its own Board for accreditation purposes, which failed, and another, more subtle, to engage experts in medical education to “assess whether the procedures promulgated in the ABPN MOC program meet appropriate educational standards and are relevant to the practice of psychiatry.” This one passed and was forwarded to the APA Board of Trustees.

Older guys not already upset enough by the ABPN realized that for those of us who are lifetime certified and who therefore need not (and usually don’t) engage in the MOC recertification process, we are being placed in a special category the ABPN refers to as “Certified but not meeting MOC Requirements”. The Assembly membership agreed that this language is clearly stigmatizing of lifetime certified diplomates and passed a motion calling on ABPN to modify this language.

POSTSCRIPT

Finally, AAOL reps lost a hard fought battle to have the APA pick up the expenses of those of us who attend these Assembly meetings in November and other associated meetings (such as the twice yearly separate meetings

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of each of our Areas) at the same rate as it pays for district branch representatives (the bulk of the Assembly's membership). This would have been a big break for those organizations that pay representatives to attend these meetings or, as is true for smaller organizations such as ASAP, favorable action would have meant we could send our representative to these meetings without him having to rely on one volunteer who currently covers these expenses himself.

That's it from the fall meeting of the APA Assembly. I will update you after the APA Assembly convenes again in San Francisco just prior to the APA Annual meeting.

(Editor's note: ASAP presently lacks the financial capacity to support representation at the APA assembly. Dr. Ratner attends the semi-annual APA Assembly meetings on our behalf entirely at his own expense. We owe Dr. Ratner a debt of gratitude for his continued service in support of ASAP).

Book Review Corner:

Editor's Note: It is with great pleasure that I am able to offer the following two reviews, completed by Dr. Christopher Fields and Dr. Diana Mullis respectively, both of whom are faculty members at the Medical University of South Carolina, co-host of our upcoming 2013 annual conference.

Talking to Families About Mental Illness-What Clinicians Need to Know

Igor Galynker (W.W. Norton & Company, 2011) \$32.95 hardback, ISBN 978-0-393-70600-0

Reviewed by Christopher S. Fields, M.D., Assistant Professor, Medical University of South Carolina, Institute of Psychiatry, Charleston, SC

In his recent book Talking to Families About Mental Illness- What Clinicians Need to Know, Igor Galynker does a masterful job of imparting to his readers a wealth of clinical pearls from his 20 years of treating psychiatric patients and working with their families in a variety of settings. He offers comprehensive strategies for educating and communicating with families struggling with loved ones' mental illnesses. He utilizes significant references to relate illness specific information and educational points important to family members.

The text is very well organized and divided into four main sections: General Rules and Approaches, Diagnosis and Treatment, Common Disorders, and Real-Life Issues. Each section is further subdivided, so that the book serves as an excellent reference text for the mental health clinician struggling with how to address most mental health dilemmas in the context of the family. Dr. Galynker has a very readable style with the use of clear, concise language. This increases the probability that the book would be read from cover to cover. He provides pragmatic, valuable advice to the practicing clinician. He shares case vignettes and relates specific narratives that prepare clinicians to effectively communicate with families in crisis.

The illustrative examples of conversations with families regarding anything from first break psychotic episodes to suicide attempts or the decision to have children if one's spouse has bipolar illness are addressed using an extremely well-informed, compassionate approach. Difficult subjects such as helping families cope with the diagnosis of a new, potentially chronic psychiatric disorder are discussed. Dr. Galynker's approach serves as a very practical guide to strengthen the alliances among the patient, family, and health care provider.

As a clinician in a teaching hospital surrounded with students and residents I found Dr. Galynker's text to be extremely valuable and informative. The book is particularly helpful for psychiatrists, primary care providers, mental health professionals and trainees. I highly recommend it to my peers, psychiatry residents and medical students.

Suicide by Security Blanket, and Other Stories from the Child Psychiatry Emergency Service: What Happens to Children with Acute Mental Illness.

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Laura M. Prager, M.D. and Abigail Donovan, M.D.: Praeger An Imprint ABC-CLIO/LLC, 2012. 115 pp., \$37, ISBN 978-0-313-39949-7.

Reviewed by Diana Mullis, M.D., Assistant Professor, Medical University of South Carolina, Institute Of Psychiatry, Charleston, South Carolina

Suicide by Security Blanket, and Other Stories from the Child Psychiatry Emergency Service: What Happens to Children with Acute Mental Illness was written by Abigail Donovan, M.D. and Laura M. Prager, M.D. They are both psychiatrists practicing in the field of Emergency Psychiatry at Massachusetts General Hospital (MGH). Dr. Donovan is the associate director of the Acute Psychiatry Service (APS) and Dr. Prager is the director of Child Psychiatry Emergency Service.

I practice in the field of Emergency Psychiatry at an academic medical center and was very interested in reviewing this book. Not only did it provide fascinating patient cases to read, but also gave me an opportunity to compare and contrast our two systems of providing acute psychiatric care.

Dr. Prager wrote the introduction to the book and it gives a broad overview of the complexities and challenges of providing psychiatric care for children. She identified numerous issues related to providing mental health assessment and care for children. Dr. Prager stated that her desire to tell the stories arose from her frustrations with the current mental health care delivery system and her wish to advocate for the children because they cannot advocate for themselves. She talked about the health care delivery systems, problems with payment coverage by insurance companies, and the lack of availability to provide outpatient mental health treatment for children. This often necessitates hospitalizing a child in an inpatient psychiatric unit because there are no outpatient resources available for the child and family to access.

The author of the introduction stated that providing psychiatric care for children is a field “dependent on collateral information and bound by systems of care.” She said that a medical practitioner providing psychiatric evaluation of the child has to rely heavily on information provided by parents or guardians, schools, Child Protective Services, or others who are involved in the child’s life. Although it is apparent that the author has been dedicated to working with children in crisis, she also expressed her frustration with the current mental health systems that consistently fail to meet the needs of children with psychiatric illnesses.

Each chapter in the book tells the story about a child in psychiatric crisis or exhibiting behaviors that others found disturbing. Patient stories about the children and their families were written in such a way as to maintain complete privacy. The cases described in the book were drawn from material from more than one patient’s experience and reconstructed to alter all identifying details. The information is usually complex and fascinating, and the reader is given an opportunity to look into lives of children and their families. After reading the cases in this book, the reader can understand the devastating results of childhood mental illness and the challenges faced by the APS staff and physicians who provide the crisis management for these children.

Each story starts with a description about why the child was brought to the Emergency Department (ED) for evaluation. As the stories unfold, one often finds that the reason for bringing the child to the ED is often more complicated than the initial complaint. The reader watches the process of evaluation and how information is gathered and then utilized to assess the child and determine the appropriate disposition for the patient. The patient issues are not always as initially presented and the story evolves as more information about the child, situations, and the family is revealed. A story usually paints a picture of what it is like to be treated in the ED, including the long wait times, the necessity for security, and sometimes seclusion of the patient for safety of himself and others. There are realistic descriptions of how the doctors and staff approach patient care using an inter-professional team approach. The conversations in the stories express concern, advocacy, compassion, frustrations, and humor that are often unique to working in the ED. What comes through loud and clear is that the doctors and staff are doing the best they can to treat patients within the limitations of a system that does not have the capacity to meet the high demand for mental health care.

Sometimes there is a happy ending to a story, but more often, not. The book contains stories that sadly show how hopeless and truly suicidal a child can become. Children can have severely debilitating mental illnesses that need aggressive and sustained treatment just like the adult mentally ill person. These children’s stories provide windows to

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look into a child's everyday life and the stress that can overwhelm the child to a breaking point, such as being the victim of bullying. Other stories leave the reader wondering if the problem was the child or the parent. One of the more amusing stories was about a child that clearly controlled everything and everyone around her, including the medical providers and security.

In conclusion, this book can be easily enjoyed in an afternoon. For the layperson, the case stories are interesting and informative. For professionals in the mental health field who provide APS, an opportunity is provided to see how MGH has structured a system of resident and attending physicians to meet the patient demands for care. As a practicing psychiatrist in the field of emergency psychiatry, I have experienced many of the same challenges described in the book. I related to the satisfaction as well as frustrations that are part of practicing in this field, and I think that other physicians will connect with the professional challenges described in the book. The issues are not unique to a particular region, but are global. As advocated in this book, we all have to meet the challenges and strive to do our best in the current health care climate.

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June 2012

Report from the Nominating Committee

The Nominating Committee hereby presents the following slate of candidates for the 2013-2014 Governing Board. Per our by-laws, a vote to approve this slate of candidates will be taken at the annual membership meeting held during our annual conference in Charleston, South Carolina, March 23-24, 2013.

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