Special Issue on Advocacy

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Welcome to JAACAP Connect!

What is JAACAP Connect?
All are invited! JAACAP Connect is an online companion to the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), the leading journal focused exclusively on psychiatric research and treatment of children and adolescents. A core mission of JAACAP Connect is to engage trainees and practitioners in the process of lifelong learning via readership, authorship, and publication experiences that emphasize translation of research findings into the clinical practice of child and adolescent psychiatry.

Why do we need JAACAP Connect?
The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. JAACAP Connect engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences.

Who reads JAACAP Connect?
All students, trainees, and clinicians who are interested in child and adolescent mental health will benefit from reading JAACAP Connect, available online at www.jaacap.com/content/connect. AACAP members will receive emails announcing new quarterly issues.

Who writes JAACAP Connect?
You do! We seek highly motivated students, trainees, early career, and seasoned clinicians and researchers from all disciplines with compelling observations about child and adolescent psychiatry. We pair authors with mentors when necessary, and work as a team to create the final manuscripts.

What are the content requirements for JAACAP Connect articles?
JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our first edition, the topic and format can vary widely, from neuroscience to teen music choices.

How can JAACAP Connect help with my educational requirements?
Motivated by the ACGME/ABPN Psychiatry Milestone Project©, JAACAP Connect aims to promote the development of the skillset necessary for translating scientific research into clinical practice. The process of science-based publication creates a vital set of skills that is rarely acquired elsewhere, and models the real-life thought process of translating scientific findings into clinical care. To bring this experience to more trainees and providers, JAACAP Connect aims to enhance mastery of translating scientific findings into clinical reality by encouraging publishing as education.

JAACAP Connect combines education and skill acquisition with mentorship and guidance to offer new experiences in science-based publication. We will work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles. Opportunities for increasing knowledge and skills through publishing as education will be available through continued contributions and direct involvement with the JAACAP Connect editorial team, using an apprenticeship model.

Start Thinking About Authorship With JAACAP Connect
What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate. All are welcome, and you are invited.
Writing Like You’re Running Out of Time: Being a Publishing Advocate

“Why do you write like you’re running out of time? Write day and night like you’re running out of time?”

– Hamilton, the Musical

Sitting down to write my very first introduction to JAACAP Connect as editor, I have to admit it is not a role I would have ever seen myself in. I’ve always considered myself a clinician and an advocate. Like many of you, I went into child and adolescent psychiatry with an interest to help those most often in need. As a child and adolescent psychiatrist, I viewed my role as not only providing therapy and medication management, but also being an advocate against stigma, increasing access to care, increasing community supports, and challenging those that would restrict care. At the time, doing this work meant talking to policy makers, reviewing health policy, or working in the clinical setting. It didn’t seem like using research or scientific writing would be the way for me to accomplish these goals, and it wasn’t until my advocacy rotation that a faculty mentor showed me what I was missing. During her career, she had influenced policies that had real impact on adolescents throughout the state and beyond. She made it clear that if she didn’t study it and publish it, any advocacy work she did didn’t happen. It became clear that scientific study and publishing would be a valuable tool to be a strong advocate.

Like many of you, I have become obsessed with the musical Hamilton and was fortunate enough to see it at The Benedum Center in Pittsburgh, PA. The musical and many of its famous lines have been used in conjunction with advocacy. In fact, it has been so popular to talk about Hamilton in reference to pediatric advocacy that it has the social media hashtag #Ham4Peds. When I was sitting in the theater listening to lyrics of the song “Non-Stop”, the reference that Alexander Hamilton was writing “like he was running out of time” really struck me. Though Hamilton was a great orator, able to debate and give speeches to prove his point, it was his pen he is most famous for as an advocate. He used the written word to educate and influence political leaders and the voting public. As child and adolescent psychiatry advocates there is something to be learned from this. If we can’t share our knowledge and our stories, then we can’t shape change to benefit our patients. This issue illustrates how we can use evidence-based writing to better shape ourselves as advocates and make sure we aren’t throwing away our shot.

In this issue, Dr. and Representative Bergquist discuss how one can run for office as a child and adolescent psychiatrist or help an ally of one get elected. Having more child and adolescent psychiatrists in office allows for the views and policies essential for the patients we serve to receive a consistent voice. But if you don’t have time to run for office, then at the very least, writing an op-ed can make sure politicians and the public can hear the views of a child and adolescent psychiatrist expressed. Drs. Holloway and Copeland walk us through the process shown to be successful when trying to write an op-ed. When doing advocacy work, the national advocacy often gets all the attention, so Drs. Rogers and Fritsch write to reinforce the phrase “all politics is local.” Knowing how to navigate one’s state and local governments can allow for a greater influence than trying to influence national politics. This is even more true when you can build a coalition of like-minded groups to promote an agenda. Drs. Fritsch and Gerwin use the example of coalition building in Maine to walk us through the process of how to do something similar in our own state. Finally, Drs. Sagot, Willing, and Koss summarize the necessary skills to build and grow future physician advocates in the child and adolescent psychiatry world so that we can expand our voice to influence policy.
Hopefully, reading this issue focused on advocacy will get many of you who might have never considered writing or editing for a journal to do it. You might have something to share that colleagues, families, or the public could benefit from hearing, and if you don’t know where to start your journey as a writer, then hopefully JAACAP Connect can help you along the way.

Justin Schreiber, DO, MPH
Editor

References
Save the Dates

Member Registration Opens:  
August 1, 2019

General Registration Opens:  
August 8, 2019

Early Bird Registration Deadline:  
September 5, 2019

Visit www.aacap.org/AnnualMeeting-2019 for the latest information!
Psychiatry trainees and early career practitioners are often confronted with the limits of their knowledge. Whether it be from a patient with a less common disorder, a conference filled with undiscovered topics, or what seems like a completely unintelligible journal article, we are often hit in the face with how much we don’t know as individuals and how much in the fields of psychiatry and neuroscience don’t know overall. This is mainly a good thing – it keeps us humble and hungry to learn more. But these frequent reminders can also hold us back by creating the illusion that our knowledge and skills are so rudimentary and incomplete that we need to delay jumping into the world of advocacy, media, and politics until we reach some poorly defined threshold of expertise.

Humility is certainly important, but we also need to have an appreciation for the fact that child psychiatrists of all levels have knowledge and skillsets that are rare and valuable and can be put to use in ways other than direct patient care. Even if you are a resident or a fellow, you likely know more than you think you do, and advocacy groups devoted to improving the lives of vulnerable and disadvantaged people are eager to put your talents to work. What’s more, engaging the broader community on mental health related issues is a wonderful motivator for ourselves, as it reminds us how what we do impacts so many people outside the world of hospitals, conferences, and research articles.

One of the most attractive things about our field of psychiatry and mental health in my view is how far reaching and relevant it is to so many important social causes today. While AACAP itself is certainly a great place to begin a journey in advocacy, it is hardly our only option for those of us who want to take our experiences and expertise to community organizations. If you care about LGBT rights, preventing domestic violence, fighting stigma, ending hunger and homelessness, quality childcare, gun safety, disaster relief, helping refugees, and so many other worthy causes, then you need to care about mental health.

Many of us choose psychiatry out of fascination with neuroscience and a desire to make a positive impact on others who struggle with emotional-behavioral problems. The further pull specifically to child psychiatry, other than the fact that kids are AWESOME, often comes from the conviction that by getting involved earlier in someone’s life we can have an even larger positive influence. But as rewarding as it can be to work with individual patients and families, advocacy provides a mechanism to take some of that same knowledge and skill towards improving the lives of even more people. The impact may not always be as large as suggested by the lofty motto for the Johns Hopkins Bloomberg School of Public Health “Saving Lives – Millions at a Time,” but even more modest efforts to bring resources to organizations that need them or spread a message that needs to be heard or changing a law or policy that no longer serves the community well can induce beneficial results in groups of people that can then snowball into even bigger effects.

Of course, a column on advocacy would not be complete without acknowledging the reality that there can be a somewhat strained relationship between some mental health advocacy groups and the psychiatry community. This tension can be difficult to navigate and confusing for legislators or other groups that are trying to make decisions and create policy about issues affecting our world. Here, I believe it is important to avoid the temptation to disengage from these groups and automatically view them as the “other side.” Many, although certainly
not all, of the members and leadership of these organizations have a history of interacting with the mental health system either on behalf of themselves or as a family member of loved one struggling with mental illness. Some of these individuals have unfortunately not had good outcomes either due to past procedures and treatment that are no longer considered the standard of care, or from more recent experiences with people in our field that have resulted in conflict and frustration. When encountering what might be called an “anti-psychiatry” perspective from some of these groups, I try to keep this perspective in mind. Over the years, I’ve gained more sympathy for critiques of psychiatry that come from personal experience as opposed to the armchair pundit who can wax poetic about how things should be without any first-hand knowledge of how things really work. This perspective doesn’t mean that we, as psychiatrists, should be passive in the face of misinformation about our field, but it can affect our approach and demeanor in these challenging situations.

Tension and disagreements often continue despite out best efforts, but like lots of circumstances in which groups of people get painted in overly wide brushes that minimize existing diversity and common ground, there can be a lot of value to real engagement that demonstrates in very personal terms psychiatry’s commitment to human well-being and dignity.

Wrapping up, advocacy in its many forms and levels should be a consideration for all psychiatrists at any stage of their career. AACAP itself offers a number of excellent opportunities to get involved in advocacy, but the importance of mental health across so many aspects of our community means that there are countless groups at the local, state, and national level that can benefit from our skills and knowledge. This work can be challenging at times, but it is a rewarding complement to clinical practical that demonstrates our commitment to the broader society in which we serve.

About the Author

David C. Rettew, MD, is an associate professor of psychiatry and pediatrics at the University of Vermont Larner College of Medicine and the Medical Director for the Child Division of the Vermont Department of Mental Health. He is author of the book Child Psychiatry: New Thinking About the Boundary Between Traits and Illness and the “ABCs of Child Psychiatry” blog on the Psychology Today website. You can follow him on Twitter at @PediPsych.

Disclosure: Dr. Rettew has received royalties for his blog for Psychology Today and from Guilford Press.

To Participate in the Lab to Smartphone Column

To suggest a topic for this column or to inquire about co-writing a Lab to Smartphone column with Dr. Rettew or another child psychiatry mentor, please send an email to david.rettew@med.uvm.edu.
AACAP Award Opportunities
for Medical Students, Residents, and Early Career Psychiatrists
For more information, visit www.aacap.org/awards

Residents and Junior Faculty

AACAP Pilot Research Awards
APPLICATION DEADLINE: WEDNESDAY, APRIL 1, 2020
Provides $15,000 to members with a career interest in child and adolescent mental health research.
- AACAP Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows
  (Supported by AACAP)
- AACAP Research Award for Attention Disorders and/or Learning Disabilities
  • for child and adolescent psychiatry fellows and junior faculty
    (Supported by AACAP’s Elaine Schlosser Lewis Fund)
- AACAP Pilot Research Award for General Psychiatry Residents
  (Funded by Industry Supporters)

AACAP Educational Outreach Programs (EOP)
APPLICATION DEADLINE: JULY 12, 2019
Provides the opportunity for residents to travel to AACAP’s Annual Meeting.
- AACAP EOP for Child and Adolescent Psychiatry Residents
  (Supported by AACAP’s Campaign for America’s Kids (CFAK), Endowment Fund, John E. Schowalter, MD Endowment Fund, and Life Members Fund)
- AACAP EOP for General Psychiatry Residents
  (Supported by AACAP’s Endowment Fund)

AACAP Systems of Care Special Program
APPLICATION DEADLINE: JULY 5, 2019
Provides support of $1000 to present a poster on a Systems of Care related topic during the “Systems of Care Special Program” at the AACAP’s Annual Meeting.
- Clinical Projects Scholarship
  (Co-Sponsored by SAMHSA’s Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee)

Medical Students
All awards contingent upon available funding, and funders are subject to change.

AACAP Life Members Mentorship Grants — APPLICATION DEADLINE: JULY 12, 2019
Provides a grant of $1,000 to travel to AACAP’s Annual Meeting.
  • for medical students interested in networking with leaders in the field.

AACAP Medical Student Fellowships — APPLICATION DEADLINE: MONDAY, MARCH 2, 2020
Provides $3,500 to $4,000 stipend for 12 weeks of research training and covers travel to AACAP’s Annual Meeting.
- AACAP Jeanne Spurlock, MD, Research Fellowship in Substance Abuse and Addiction for Minority Medical Students
  (Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign for America’s Kids (CFAK))
  • for medical students focusing on substance abuse and addiction
- AACAP Summer Medical Student Fellowship Program
  (Supported by AACAP’s Endowment Fund)

AACAP Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award
APPLICATION DEADLINE: APRIL 15, 2020
Provides $8,000 in funding to be shared with up to two qualified child and adolescent psychiatry resident, fellow, or an early career psychiatrist (ECP) applicants with demonstrated interest in the fields of child welfare, foster care, and/or child maltreatment prevention/intervention. Award recipients collaborate with a mentor of their choosing to design a project that raises awareness in these subject area(s).
(Supported by K. Lisa Yang, MBA, in honor of Marilyn B. Benoit, MD)

AACAP Psychodynamic Faculty Training and Mentorship Initiative
APPLICATION DEADLINE: FRIDAY, MAY 1, 2020
Provides an opportunity for faculty to design a psychodynamic training project, within their child and adolescent psychiatry division, with the assistance of a mentor through the subsequent year, along with a stipend of $450 to cover travel support for attending the training session during AACAP’s Annual Meeting.
(Supported by the Samuel and Lucille B. Ritvo Charitable Fund)

AACAP Junior Investigator Award
APPLICATION DEADLINE: WEDNESDAY, APRIL 1, 2020
Provides $30,000 a year for two years to a psychiatry junior faculty with a career interest in child and adolescent psychiatry.
(Funded by AACAP and Industry Supporters)
Distinguished Member Awards
APPLICATION DEADLINE: FRIDAY, MAY 1, 2020

**AACAP Cancro Academic Leadership Award**
Recognizes, in odd-numbered years, a currently serving or retired master teacher, which may include an associate or full professor, chair, dean, or equivalent level contributions through teaching, mentorship, scholarship, and leadership to the field of child and adolescent psychiatry education.

**AACAP George Tarjan, MD, Award for Contributions in Developmental Disabilities**
Recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with intellectual and developmental disabilities.

**AACAP Irving Philips, MD, Award for Prevention**
Recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents.

**AACAP Jeanne Spurlock, MD, Lecture and Award on Diversity and Culture**
Recognizes individuals who have made outstanding contributions to the advancement of the understanding of diversity and culture in children’s mental health, and who contribute to the recruitment into child and adolescent psychiatry from all cultures.

**AACAP Norbert and Charlotte Rieger Service Program Award for Excellence**
Recognizes innovative programs led by AACAP members that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents, and serve as model programs to the community.

**AACAP Sidney Berman, MD, Award for the School-Based Study and Treatment for Learning Disorders and Mental Illness**
Recognizes an individual or program that has shown outstanding achievement in the school-based study or delivery of intervention for learning disorders and mental illness.

**AACAP Simon Wile, MD, Leadership in Consultation Award**
Supported by the Child Psychiatry Service at Massachusetts General Hospital, acknowledges outstanding leadership and continuous contributions in the field of consultation-liaison child and adolescent psychiatry.

International Scholar Awards
APPLICATION DEADLINE: FRIDAY, MAY 1, 2020

**AACAP Paramjit Toor Joshi, MD, International Scholar Awards**
Recognize mid-career international physicians who primarily work with children and adolescents providing mental health services outside the United States.

**AACAP Ülkü Ülgür, MD, International Scholar Award**
Recognizes a child and adolescent psychiatrist or a physician in the international community who has made significant contributions to the enhancement of mental health services for children and adolescents.

Academic Paper Award
APPLICATION DEADLINE: FRIDAY, MAY 1, 2020

**AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award**
Recognizes the best published or unpublished paper written by an AACAP member using a psychodynamic psychotherapy framework.
They Didn’t Teach That in Medical School: Running for Office as a Child and Adolescent Psychiatrist

Avanti Bergquist, MD, MS, FAPA, DFAACAP, and Steve Bergquist, MIT

As a child psychiatrist, I could see some improvements in individual patients and families with whom I worked, but frustration with the overall system of mental health was leading to burn out. After my husband, Steve Bergquist, was elected to the Washington State House of Representatives, I met Frank Chopp, the Washington State Speaker of the House, who then recruited me for his mental health task force. As a new graduate from child and adolescent psychiatry fellowship, I was able to overcome my “imposter syndrome” and eventually realized I was qualified to participate in this task force. I started to see how influencing policy-making could create change in the system that had been the cause of frustration for me and most importantly, for my patients and families. As I learned about the impact of policy-making on patient care, and saw my husband create important change in the system, I looked for other ways I could create improvements. I began attending school board meetings to learn more about our school district and community, and contemplated running for a position. When a member unfortunately passed away in 2017, I was appointed to the Renton School Board, Director District 2, and subsequently elected to the position in November 2017 after running unopposed.

My husband’s run for office included far more hurdles. He was in a crowded primary race for the open seat with 3 democrats and one republican. He raised only 10% of the overall money spent on the 5 candidates in the primary election, yet he advanced to the general election with first place in the primary and eventually won the seat. As you will see, his campaign was a good example of the commitment and perseverance it takes to run for office.

A record number of candidates ran for Congress in 2018, and almost twice as many candidates had filed for office in December 2017 as at the same time in 2015. This was the most candidates at that stage of the election season since the Federal Election Commission started keeping records in 1977. In 2018, the largest number of scientists in modern history ran for political office. The midterm elections added 3 new physicians to Congress, but that still equals only 16 physicians in Congress (3 in the Senate and 13 in the House). There is no known record indicating how many physicians hold other state or local public offices, nor how many physician family members hold public office. Within the American Academy of Child and Adolescent Psychiatry (AACAP), I am the only known member in a publicly elected position. In a 2013 survey conducted by the American Medical Association’s Political Action Committee (AMPAC), physicians ranked third highest in terms of being viewed as honest and ethical, only behind nurses and pharmacists, whereas members of Congress were second from the bottom of the survey list. If physicians are viewed so well by the public, why are there so few of us in Congress? Maybe it is due to political advocacy and campaigning being so different from the scientific and analytical tenets that we learn in medical school? Physicians also may be civic-minded and have high regard for public roles, but this does not generally translate to action. However, children’s mental health topics are in great need of strong advocacy work. If child and adolescent psychiatrists are not involved in this work, others with different or less experience will create the policies that affect our patients and ourselves. Can you think of any better way to effect positive change than by creating the positive policies yourself as an elected official? This article will use personal experiences and evidence-based techniques to guide other AACAP members to run for office. If nothing else, advocacy can help to decrease any physician burnout you may be feeling.
As stated, I am a child and adolescent psychiatrist, and my husband, Rep. Steve Bergquist, is a high school social studies teacher and was also a small business owner. Neither of us had any public political experience prior to being elected. To get started, we attended the AMPAC Campaign School in 2012, a program to teach physicians and friends of medicine to run for political office. This intense program teaches the basics of campaigning and makes it clear that campaigning and a political career are a team effort. There are many programs available to teach the basics of becoming a candidate and running for office that are geared towards specific genders, minorities, and other specialized groups. As a physician and a physician spouse, the AMPAC program was invaluable because it teaches the value of physicians and friends of medicine in politics. Through hands on exercises, it taught us the importance of understanding your own background, what you would bring to a political office, and how to amplify those strengths to your voters. There was a focus on the importance of understanding your community and where you can draw support, including the need for and how to do fundraising. Participants learned how to effectively get their vision out through public speaking, and the importance of face-to-face conversation. There are many similar programs to prepare citizens to run for office, but the AMPAC program is the only known program geared specifically towards physicians.

After attending AMPAC Campaign School, Rep. Bergquist’s plan to run was solidified, but how did he win? He knocked on 12,000 voter’s doors in person. He was able to create a connection and have a conversation with more voters at their doors than any other candidate in the race. Up to that point, he had taught about 1,500 students, coached many adults and children in local sports, had connections through owning a small business, and knew numerous community members as a fourth-generation member of his family in the town. He knew that talking with voters would be more important in understanding the community’s needs and not only getting him elected, but also better learning how to support the community if he was elected, rather than spending time on significant fundraising or money on media campaigns.10

I identified the importance of advocacy through my roles on the AACAP Advocacy Committee and as president of the Washington State AACAP Regional Organization. AACAP has been involved in advocacy and policy-making for some time, as evidenced by the talented Government Affairs staff. Over the last several years, AACAP has increased efforts to support our members in advocacy work on a national and state level, including the creation of the Advocacy Committee, revitalization of the Advocacy Liaison position and network, creation of a separate Political Action Committee (AACAP-PAC), and financial support of the AACAP Advocacy and Collaboration Grant. The AACAP-PAC supports candidates for Congress who advocate for child and adolescent psychiatry and children’s mental health. There has been one known child psychiatrist in Congress who has now retired, so while the AACAP-PAC would likely support a child and adolescent psychiatrist to run for Congress, we have not had one run any time recently.

For AACAP members hoping to get into politics, some advice is to start by getting involved in any way that feels comfortable. It is important to begin by getting involved in the community that you hope to represent as an elected official. Perhaps start by joining a community organization that you find interesting, such as one that helps children. Get to know people in your community through these roles. Get involved in AACAP by starting with your AACAP regional organization. You may be surprised by how these small opportunities blossom organically into more opportunities to be involved and build a base of support for when running for office. Meet with your local community leaders and state legislators and learn from their experiences, as well as let them know of your political interest. This communication will help you learn of upcoming opportunities for open seats or positions that need a candidate, and keeping up relationships will be important for creating a base of support. Take a training such as the AMPAC Candidate or Campaign Schools to learn the basic nuts and bolts of running for political office. Specifically for physicians, the AMPAC study found the following factors important for physician candidate success: let voters know why you want to give up a successful medical career for politics, show voters
that you are honest and can get results for constituents, voters want someone to listen to them so showcase your psychiatrist listening talents, be able to relate to voters on a personal level and not just a physician-patient relationship, combat the negative stereotype of politicians by bringing some new ideas that appeal to your community members, be a multidimensional candidate where you emphasize other aspects of your life beyond medicine, and know that being an expert on healthcare is not enough for a physician candidate to be successful.5

Having gone through these processes to become elected officials, Rep. Bergquist and I can attest to feeling a much greater sense of efficacy on behalf of the constituents we serve. This has also led to resolution of any feelings of burnout, since we can now make larger systemic changes that improve people’s lives. Running for public office fits directly with AACAP’s mission to promote the healthy development of children, adolescents, and family along with meeting the professional needs of child and adolescent psychiatrists. Child and adolescent psychiatrists are eminently qualified to run for public office and make positive changes for their patients, their families, and colleagues. With only one child and adolescent psychiatrist currently in office, it is time for more to take up the call to run, or this voice will continue to be overshadowed by those with less expertise or training.

Take Home Summary

Scientists, including physicians, are getting more involved in running for public office. The authors share their experience as a child psychiatrist and a physician spouse in both getting elected to office, in an effort to shed light on how other physicians and friends of medicine may follow suit.

References


About the Authors

Avanti Bergquist, MD, MS, FAPA, DFAACAP, is a child, adolescent, and adult psychiatrist with the Eating Recovery Center in Bellevue, WA. She serves as Past-President of the Washington State AACAP Regional Organization, and as an elected director of the Renton School District Board of Directors.

Steve Bergquist, MIT, is a high school social studies teacher with the State of Washington Renton School District and is an elected member of the Washington State House of Representatives, representing the 11th District.


Follow @AACAP for the latest news on your membership and in child and adolescent psychiatry.

Follow @JAACAP for updates about newly published articles and all things #jaacap.
What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP’s Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at.govaffairs@aacap.org.
Advocacy: Writing Effective Op-Ed Pieces

J. Nathan Copeland, MD, MPH, and Robert Holloway, MD

Abstract

Child and adolescent psychiatrists have extensive experience in direct clinical care and working within health systems. This leads to an expertise that can inform and improve mental health care delivery. Yet physician voices aren’t necessarily sought after or readily heard when making legislative and policy decisions. Writing informative and effective op-eds can amplify your voice, but it requires many elements beyond expertise. An effective op-ed must be engaging enough to be read by a diverse group of readers, informative enough to allow readers to grasp the issues, and should avoid divisive language that could introduce barriers to problem solving.

See the original op-ed by Dr. Copeland below.

Reprinted with permission by The News & Observer.

NC Mental Health System Needs Rebuilding

By John Nathan Copeland

Don’tay Jones lived for months under Wake County’s guardianship in a house east of downtown. A city housing inspector found the building to be substandard and lacking proper heat in November, but the housing case still was unresolved three months later. Jones and his roommate are wards of the county due to mental illness. Portrait photographed Tuesday February 24, 2015. TRAVIS LONG tlong@newsobserver.com.

North Carolina’s mental health system has been in crisis, and despite efforts within and outside the state government, it’s getting worse.

In the past year, WakeMed hospital in Raleigh had to stop accepting new patients because its 60-bed emergency department was filled with over 100 people with mental illness, UNC Hospital’s ED was routinely overwhelmed by those seeking mental health care and Mission Hospital in Asheville often had a quarter of its ED occupied by people needing psychiatric treatment.

This chaos in our emergency departments reflects the growing and unmet mental health needs across the state.

Four of our cities are in the top 20 nationally for opiate abuse, our prisons hold more people with mental illness than treatment facilities, suicides are increasing, the wait time for an urgent admission to a state psychiatric hospital is over five days and in 2012 the United States Department of Justice sued the state for not providing adequate housing for people with mental illness.

The reason for this crisis is simple. North Carolina has massively reduced and misused mental health resources for decades.

Since 1955, through the deinstitutionalization movement, cost-savings measures and a reform effort that began in 2001, North Carolina has reduced its state-psychiatric hospital beds by more than 90 percent. While experts recommend 50 mental health beds per 100,000 people, North Carolina has just 8 state-psychiatric beds per 100,000, a level last seen in the mid-1800s.

“A recent collaboration between UNC, Duke and N.C. State found that the central catchment area of North Carolina must increase its mental health beds by 165 percent to significantly reduce the number of patients with mental illness waiting in emergency departments.”
However, it’s not all about hospitals. Deinstitutionalization meant to transition people out of facilities and back into their communities through outpatient services. But the promise was broken. While the elimination of mental health beds occurred, the money pledged for adequate community services never fully materialized.

Across the nation there has been a 30 percent per capita reduction in mental health spending.

In North Carolina, it’s even worse. In the mid-2000s, the state privatized many of its mental health services and unintentionally allowed dubious agencies to bill more than $400 million for unacceptable care. From 2013-2015, we were one of only three states to reduce mental health funds each year, and over the past few years, North Carolina has decreased support for mental health by hundreds of millions of dollars.

Fortunately, the argument to rebuild the mental health system is easy. Because psychiatric disorders are one of the leading causes of disability in the United States with nearly 50 percent of Americans experiencing a mental illness during their lives, addressing mental health needs has profound impacts. It also saves money.

Already within North Carolina, there are proven and innovative solutions to meet outpatient and inpatient demands.

The emergency department is one of the most costly and ineffective means to serve those with mental health concerns, and stand-alone psychiatric centers such as WakeBrook Campus in Raleigh and Cleveland Crisis and Recovery Center in Shelby have reduced burdens on EDs, delivered expert care, and improved patient satisfaction.

Moore Place in Charlotte, which provides housing and medical/psychiatric services to the homeless under a Housing First model, has saved the city millions while reducing residents’ utilization of EDs, hospitals, and jails by 80 percent.

Integrated Care, which provides psychiatric services in primary care settings, has demonstrated that for every $1 spent there can be a $6.50 return on investment, and groups such as The UNC Center for Excellence in Community Mental Health, Carolinas HealthCare System and Community Care of North Carolina are finding results.

To tackle the opiate epidemic, last week North Carolina’s General Assembly discussed the Strengthen Opioid Misuse Prevention Act which can dramatically improve the state’s capacity to curb opiate misuse and provide treatment and relief for those impacted by opiate addiction.

And the above is just the beginning.

North Carolina has the resources, talent and services to significantly improve the mental health of the state, but we need more.

We must encourage our legislators and Gov. Roy Cooper’s administration to reverse the defunding of mental health, finalize and pass the STOP Act and invest in a dynamic and comprehensive mental health system.

Through this investment, North Carolina can obtain substantial savings, grow a robust and healthy workforce, and ultimately do the right thing for its residents. We can end this crisis, and we can become better.

John Nathan Copeland, MD, MPH, is a child and adolescent psychiatry fellow at the University of North Carolina Hospitals in Chapel Hill.

Read more here: https://www.newsobserver.com/opinion/op-ed/article139744578.html#storylink=cpy

Discussion

When Dr. J. Nathan Copeland entered his General Psychiatry Residency in 2011 at University of North Carolina, Chapel Hill, like most residents, he spent many hours covering the emergency department (ED). Over the next few years, he noticed an alarming trend. The number of people in the ED for mental health reasons was increasing at a rapid pace, and local newspapers were also reporting similar patterns across the state. As he researched the topic, he saw a decades-long story
of reforms that had unintentionally brought the North Carolina mental health system to a crisis. Fortunately, there were also many groups in the state that were providing solutions.

As Dr. Copeland gathered more examples of causes and remedies to the state-wide mental health crisis, he wanted to share his findings. While writing an article for an academic journal would provide him a space to publish, the people he really wanted to communicate with were North Carolina citizens and those that could improve funding and mental health policy, namely state legislators. To meet this objective, Dr. Copeland decided to publish an op-ed in the local paper, The News & Observer.

Fortunately for Dr. Copeland, the article met its objective. The op-ed was shared thousands of times across social media, was retweeted by legislators, and was read by the North Carolina Department of Health and Human Services (NC DHHS) Secretary, Mandy Cohen, MD, MPH. This prompted Secretary Cohen to organize a meeting with Dr. Copeland to further discuss mental health reform. Dr. Copeland’s op-ed started a relationship with legislators who had the power to take action on this issue.

There are many strong writing components in Dr. Copeland’s op-ed. The title and introductory sentences are short, clear, and meaningful. Because many readers won’t read more than the first paragraph, points must be made early and clearly to engage readers and keep them reading. Through stories and statistics, Dr. Copeland is able to illustratively address complicated issues and offer solutions rather than placing the onus of problem solving on others. Through this, he is better able to control the narrative and the take-home points of the reader.

In order to capture the attention of the audience, Dr. Copeland strikes a balance of story-telling and statistical analysis. He’s not writing a journal article full of technical jargon and using passive voice. He’s using language that is understandable for a general readership. Additionally, through relatable stories and events happening across the state, he is able to avoid theories and opinions and can discuss events happening in the reader’s backyard, making it more meaningful to the reader. Dr. Copeland also skillfully addressed a legislative bill about the opioid epidemic that, at the time of his writing, was being discussed state-wide. Through this combination of tangible stories and information, he both increased his likelihood of being published and kept his op-ed topical enough to maintain reader engagement.

The facts listed in this op-ed took extensive research, thereby establishing Dr. Copeland as an expert, but the way facts were presented objectively, avoided introducing opinions that could be polarizing and off-putting to readers. Dr. Copeland was able to document the events that led to expensive and ineffective outcomes without falling into divisiveness. For example, the phrase, “the money pledged for adequate community services never fully materialized,” avoids blame of specific parties while still describing the process. We all have biases and those can easily show up in our writing. However, focusing on blame distracts readers from problem solving, and can cause the knowledge and intent of a piece of writing to be lost. Ultimately, the goal is for 100% of readers to come away from the op-ed feeling respected and with new knowledge, and it was this impartiality that allowed his piece to be shared and discussed without being politically toxic. Although “internet trolls” may jump into a culpability war regardless, this writing is effective in keeping the public focused on solutions rather than fault.

It is also important to ask for help when writing. You may need several people to help review and revise your piece to fit it into a publication’s guidelines. You could ask for help from people who have written non-academic articles, or you could consider hiring a publicist to help review your writing and shop it around to papers. Requesting editing assistance and input from groups such as your state’s psychiatric association, local experts in your topic, and even consumer advocacy groups will ensure that your article maintains a consistent message while identifying blind spots and unintended consequences. Also, have someone who isn’t a
mental health expert read your op-ed to ensure it makes sense to someone who isn’t a specialist, and consider having someone read it out loud so that you can hear if phrases are awkward or could be misconstrued. What we write and what we mean are not always the same, and it is key to have a team ensuring your writing meets your goals while unifying readership.

Finally, in order to complete your objective of informing, be sure to share your piece on social media. Through this, you will be able to further your goal of dissemination to your colleagues and the public.

When we write op-eds, we need to use our knowledge to encourage problem solving rather than just exercising our right to share opinions. We can have powerful voices in building coalitions and improving mental health for everyone but only if we choose our words wisely. With the whole world a Twitter to express opinions, it is critical to write an article that remains kind while identifying a problem, informing, and providing practical solutions. Through this, you will gain readership, maintain integrity to patient care, and build bridges.

When you hear a discussion or know about a topic that affects your field or patient care, and you feel compelled that your community needs to know more, strongly consider writing an op-ed. You can become an effective advocate with a well written piece, and an op-ed allows you to use a topical medium to sway public opinion and influence change.

### Take Home Summary
Effective op-eds are able to succinctly tell a story, inform, avoid divisiveness, and unify the readership. Used skillfully, they are powerful tools to communicate the challenges we see in mental health care while providing solutions that can influence change.

### References

### About the Authors
**J. Nathan Copeland, MD, MPH,** is with the Duke Division of Child and Family Mental Health and Developmental Neuroscience and is an attending physician in the Duke Center for Autism and Brain Development, Durham, NC. Dr. Copeland serves on the Executive Committees of the North Carolina Psychiatric Association and North Carolina Council of Child and Adolescent Psychiatry, and his areas of interest include the impacts of autism and mental health on children and their families, mental health systems and policy, and telepsychiatry.

**Robert P. Holloway, MD,** is a child and adolescent psychiatrist on faculty at Children’s Hospital Los Angeles and Keck USC School of Medicine, Los Angeles, CA. Dr. Holloway serves on the Advocacy Committee of AACAP and on the Executive Committee of the California Academy of Child and Adolescent Psychiatry, and his areas of expertise include chronic pain, transgender health, and mental health advocacy.

**Disclosure:** Drs. Copeland and Holloway report no biomedical financial interests or potential conflicts of interest.
AACAP AWARD SPOTLIGHT:
Leslie Hulvershorn, MD, MSc

The Journal award recognized a paper published in JAACAP entitled, Abnormal Amygdala Functional Connectivity Associated with Emotional Lability in Children with Attention-Deficit/Hyperactivity Disorder. I think I reran the analyses on the data for this paper 50 times, so it was so gratifying that all that hard work paid off.

The NIDA-AACAP Physician Scientist Career Development Award (K12) allowed for substantial amounts of my time to be covered over a five-year period, so I could be mentored in clinical research and develop as an independent investigator. The mentorship and training that occurred during this award was the most influential experience of my career. I wouldn't be doing the work I am today without it and am forever grateful for the opportunity.

The Pilot award funded a project examining how the brains of kids differed in those with and without severe temper outbursts. I was the Principal Investigator on a study for the first time, and I learned a tremendous amount about neuroimaging from my mentors. More importantly, it generated pilot data for a larger grant, which in turn generated pilot data for the next larger grant.

The EOP award allowed me to attend an AACAP meeting for the first time, opening my eyes to the variety of research occurring in the field, and providing an awareness that the AACAP meeting was a great place to showcase that work.

I served as a member of the Research Committee as a fellow and again now as a faculty member. It has been a privilege to interact with prominent researchers. We are very involved in promoting junior investigators by reviewing grant applications and planning events at AACAP’s Annual Meeting. I have really enjoyed working together with colleagues to promote up-and-coming researchers.

ABOUT DR. HULVERSHORN

JOINED AACAP: JULY 2008
WORKS AT: INDIANA UNIVERSITY SCHOOL OF MEDICINE
POSITION: ASSOCIATE PROFESSOR OF PSYCHIATRY
SPECIALTIES: SUBSTANCE USE DISORDERS, MOOD DISORDERS, NEUROIMAGING
AACAP AFFILIATION: RESEARCH COMMITTEE
MENTORING: 2016 SUMMER MEDICAL STUDENT FELLOWSHIP MENTOR
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Course highlights include:
- Presentations by nine top child and adolescent clinicians from past AACAP Psychopharmacology Institutes
- Important topics such as autism spectrum disorder, attention-deficit hyperactivity disorder, pediatric bipolar disorder, and many more
- Up to 8 *AMA PRA Category 1 Credits™* available

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Questions? Contact the CME Department at 202.966.7300 ext. 2007 or cme@aacap.org.
State-Level Advocacy for the Child and Adolescent Psychiatrist: Changing the Rules of the Game

Christopher Rogers, MD, and Sandra Fritsch, MD

Child and adolescent psychiatrists commonly face barriers to treating patients that extend beyond the practice setting. These barriers include lack of available treatment resources and modalities, inadequate support for youth in schools, and paucity of funding or significant stigma in the community. These are all challenges that can be addressed with advocacy efforts. While many practicing child and adolescent psychiatrists may not feel qualified to tackle these social issues, in 2015 the Accreditation Council for Graduate Medical Education (ACGME) set “advocacy competencies” throughout patient care, medical knowledge, and systems-based practice milestones. For those who may not feel proficient in advocacy skills, this article will offer guidance on steps clinicians can take to advocate at the local and state level.

As our professional code of ethics states: “Principle VIII: Advocacy and Equity: Child and adolescent psychiatrists support the principle that competent mental health care and a full array of services should be available for all children, adolescents, and their families, and support efforts to improve access to care at the individual, local community, and national levels.” Advocacy can be many things, but in general it is applying one’s passion and expertise to solve a problem or accomplish a goal. Physicians immersed in clinical care may find the prospect of taking on the work of uncompensated advocacy daunting. State level advocacy can be an effective and achievable tool for child psychiatrists who are looking to improve care beyond their offices. Different forms of advocacy require varying amounts of time and commitment. Activities one can do with minimal commitment can still contribute to lasting change for the families we serve, a reward beyond a paycheck that you can feel proud of for the rest of your career. There are many potential state avenues to advocate for improved mental health outcomes for youth (see Table 1).

Our pediatrician colleagues have been effectively promoting public health prevention measures, environmental safety, greater access to care for kids, and so on for decades. Modern day seatbelt laws, school mandated vaccinations, universal coverage of prenatal care and more were all originally ideas of concerned clinicians, often starting at the community and state level. In Jerome Paulson’s article “Pediatric Advocacy”, pediatricians have shared their experiences, including how to become a more effective advocate. The article details pediatricians’ advocacy contributions to changes of the cultural landscape, as well as concrete steps to improve advocacy skills. Child psychiatrists could use this model to both educate and inspire our actions as advocates.

There are many examples of how state level advocacy has been meaningful for children, teenagers, and families. In 2018, a bill was proposed in Colorado to add autism spectrum disorders to the list of certifying medical conditions to be treated with marijuana products. The debate was intense but, in the end, it was the voice of child and adolescent psychiatrists that led directly to Governor Hickenlooper vetoing this bill despite significant political pressure to sign. Child and adolescent psychiatrists in Colorado had an effective voice by sharing expert testimony during the legislative debate and meeting directly with the Governor Hickenlooper, as he was deciding to sign or veto this bill into becoming law.

This case illustrates the most appropriate adage, “the world is run by those that show up.” State level advocacy is often very much about “showing up.” State advocacy often involves engaging with the legislative process.
While trying to influence the political machine in Washington, DC, is complicated and challenging, this is may not be the case in your state government. Child psychiatrists can impact local or state government in ways that can span from very little time to a significant investment.

Engaging with state legislators\(^7\)\(^8\) is often an effective way to advocate. The child and adolescent psychiatrist, as an expert in mental health, can provide the knowledge to help guide policy decisions, and the only way to have a voice in the debate is to build relationships with state legislators. Setting up time to meet with a legislator to share your thoughts may be as simple as calling or emailing their office. Your local AACAP Regional Organization or American Psychological Association chapter may have a legislative committee that can also help facilitate these personal interactions in your state. Once the meeting has been arranged, be sure to have a clear “ask” for your legislator. Do you hope they will support or vote against a specific bill? Is there an issue within their district that you need help crafting a bill to address? When preparing for this type of meeting, be ready to tell the legislator: What is the cause? Why does it matter? Who does it impact? How can he or she help? Be sure to thank them for their time, ask for follow up regarding your conversation, and leave a business card. Within 3-4 days, send them a follow up email to reinforce talking points and thank them again.

Washington State legislators speaking at the 2018 annual meeting of the American Academy of Child and Adolescent Psychiatry denoted a strong interest in pediatric mental health issues, and guided a discussion on how they welcome input from child psychiatrists.\(^9\) A child and adolescent psychiatrist may be offered an appointment to a state committee or commission.
to provide expertise around children’s mental health. Some workgroups meet for a limited tenure to resolve or investigate a specific issue. Other committees may include ongoing meetings where you represent the voice of the families in your state on a variety of policies. These opportunities are sporadic, so remaining visible in your community and known to your elected officials may result in these sorts of invitations. If a legislator is particularly aligned with your values, offering to volunteer for their election campaign is an opportunity to cement your relationship.

Another valuable experience in state level advocacy is testifying in a state committee hearing. Each state has its own distinct process for a bill becoming law, but all states have a public hearing process when debating if a bill becomes a law. This is an opportunity to provide expert testimony regarding the proposed legislation. Taking the time to testify in committee allows the child mental health provider to give expertise to a larger number of lawmakers at a crucial decision time for the law. When preparing testimony stick with the ABC’s of testifying: be Accurate, Brief, and Clear. Remember that facts make the individual giving testimony credible, but stories make them memorable. Sharing patient stories can be an effective way of illustrating the importance of your testimony, but it is important to honor patient confidentiality and HIPAA laws. When testifying, clearly understand who you are representing: are you representing yourself, your place of employment, or your professional organization? Be sure to clarify if you are advocating as a concerned individual versus representing a larger affiliated group. If representing a group, it is vital to get permission and coordinate with any staff or representatives that may want to have input on what you do or don’t say. If part of a coalition, one may receive guidance to develop testimony.

AACAP has prepared training materials and resources to help guide efforts specific to state level advocacy. One easy way to get involved is to sign up for regional and national grass roots alerts through the AACAP Legislative Action Center’s VoterVoice. Once the individual has signed up for “VoterVoice”, participants will receive “action alerts” via email that allows for contact with legislators on proposed legislation around mental health and healthcare needs of youth and families issues pertinent to AACAP members. Membership in AACAP may also include membership in a Regional Organizations of Child and Adolescent Psychiatry (ROCAP). ROCAPs represent child and adolescent psychiatrists in either a region of or the whole state and may offer resources for issues pertinent to the youth and families in that region. Each ROCAP should have at least one Advocacy Liaison who serves as the representative to guide regional advocacy efforts.

Building alliances with various stakeholders who are interested in the well-being of children and their families is a key component of effective advocacy. A natural avenue for child and adolescent psychiatry advocacy is within local schools. Whether through partnering with a school board to provide guidance on programs across a district or volunteering to speak at career day at a neighborhood school, forming relationships with local schools is a meaningful component of advocacy for the child and adolescent psychiatrist. There are specific trainings available to mentor and certify those interested in educating school faculty around teen mental health issues, such as the APA’s “Typical or Troubled” program. Those interested may want to extend an offer of collaboration to school counselors when consulting on shared patients as one way to build this partnership. Most local school departments have websites outlining policy initiatives, contacts for their board of education, and other potential key contacts. Other community specific advocacy opportunities include partnering with organizations such as the local National Alliance on Mental Illness or Mental Health America chapter by getting involved in a specific event or offering to help out as a resource for families. Rotary Clubs and United Way Foundations often have annual campaign initiatives encompassing child mental health such as early childhood “best start” and prevention campaigns and may be interested in having child psychiatrists speak to their members or in the community. If you work in a hospital or healthcare center, your organization likely
has a legislative affairs department or lobbying group under contract. Involvement and suggesting priorities that are important to your patients is of great benefit and leverages your role within the organization.

In summary, advocacy is a key component of the professional identity of the child and adolescent psychiatrist. We have much to learn from our pediatric colleagues who have often led the way in effective advocacy for the wellbeing of children and teens at the state level. It is time we as child psychiatrists take our own leadership role in stewarding the future of mental health much as pediatricians have done for physical wellness. Becoming involved in advocacy at the local and state level can be an effective tool to lead policy change and effect the mental health of the children, teens and families we treat. In addition, it is rewarding and fun!

Take Home Summary
Advocacy at the state level is an effective and rewarding tool for the child and adolescent psychiatrist to support the families they serve beyond the scope of individual patient interactions. This article describes different advocacy initiatives available at the state and local level.

References

About the Authors
Christopher Rogers, MD, is the Medical Director of Child and Adolescent Services at The Medical Center of Aurora and is an Associate Program Director for the Rocky Vista University Psychiatry Residency program. Professional interests include teaching, advocacy and psychotherapy.

Sandra Fritsch, MD, is the Medical Director of the Pediatric Mental Health Institute, Children’s Hospital Colorado and is an Associate Professor in the Department of Psychiatry at the University of Colorado School of Medicine. Professional interests include advocacy, collaborative care models for pediatric primary care providers, digital technology and the impact on child mental health, and innovations in medical education.

Disclosure: Dr. Rogers has received a teaching stipend from Rocky Vista University. Dr. Fritsch has received grant funding from HRSA (Health Resources & Services Administration) and internal grant funding from the University of Colorado Upper Payment Limit program. Dr. Fritsch has received grant funding from HRSA (Health Resources & Services Administration) and internal grant funding from the University of Colorado Upper Payment Limit program.
AACAP AWARD SPOTLIGHT:
Amy Yule, MD

The NIDA-AACAP Physician Scientist Career Development (K12) award has provided me with four years of funding to execute a study, protected time for learning, and opportunities to build research collaborations with colleagues. AACAP’s K12 award has been an incredible opportunity, providing for close mentorship from my primary mentor, Dr. Timothy Wilens, and my mentor through the award, Dr. Frances Levin. The biannual in-person meetings have also facilitated mentorship from the other mentors involved in the award and critical peer mentorship from the awardees themselves.

The Pilot award funding allowed me to work with mentors at MGH on a secondary analysis of an existing dataset. The opportunity gave me valuable experience with writing a grant proposal, grants management, and the process of working collaboratively with a statistician. I also gained important experience presenting and disseminating our findings through a poster at the 2013 AACAP Annual Meeting and the published manuscript in Drug and Alcohol Dependence. This project helped me establish myself at my institution as a junior faculty member committed to clinical research.

The EOP award supported travel to my first AACAP annual meeting as a 4th year adult psychiatry resident. I distinctly remember the mentorship sessions, and was impressed with the membership’s commitment to trainees. Thank you Schuyler Henderson for leading conversations at our table and your encouragement!

It has been an honor to be a part of the Substance Use Committee. Our monthly calls provide a tremendous opportunity to learn about substance trends and practice settings from colleagues across the country. The committee has also provided me with valuable leadership opportunities and experience reviewing and selecting AACAP awardees. Furthermore, through the committee I have had the opportunity to help increase awareness within the AACAP membership about a population I feel passionate about, young people with opioid use disorders.
Coalitions for Advocacy and Collaboration

Sandra Fritsch, MD, and Roslyn Gerwin, DO

“Necessity is the mother of invention.”

proverb, author unknown, attributed to Plato

The number of practicing child and adolescent psychiatrists (CAP) is roughly 8,500 throughout the United States, with most states having one or more counties with no child and adolescent psychiatrists. States with expansive rural areas have greater numbers of counties with no practicing CAPs (see Figure 1), making them both disproportionately underserved and in need of strong child mental health treatment advocates. Advocacy work at the local and state government level is often most successful with constituents working with their legislator. Advocacy can occur on the individual level, but often one voice is not sufficient enough to effect change. Coalitions have been utilized as a political vehicle to create a more expansive or powerful voice to the issues being debated, response to legislative initiatives, or to create public awareness. This article describes the development of a coalition of stakeholders vested in child mental health in Maine, a rural location. This coalition became a unified call to guide policy formation and to address state legislative and budgetary issues affecting child mental health. Lessons learned from the creation of this coalition are shared and used to guide creation of coalitions in other states.

The Need for a Coalition

In 2013, LD (Legislative Document) 338 became law in Maine “Resolve, Directing the Department of Health and Human Services to Amend its Rules Governing the Use of Certain Antipsychotic Drugs by Children Enrolled in MaineCare.” For patients under 17 years of age this required the prescriber of atypical antipsychotic medication to provide documented justification of use beyond the recommended period. It also required the prescriber perform a timely assessment and ongoing monitoring of metabolic and neurologic variables of the child in accordance with the American Academy of Child and Adolescent Psychiatry’s Practice Parameter. Though well-intentioned, this bill was introduced by a state legislator in a county without a practicing child and adolescent psychiatrist. The same legislator then went on to introduce another bill, LD 716, in 2013: “Resolve, To Review and Make Recommendations on Appropriate Prescribing of Certain Medications for Children with Attention Deficit Hyperactivity Disorder That Are Reimbursed under the MaineCare Program,” also without...
Coalitions for Advocacy and Collaboration

CAP input. In response, Maine Child and Adolescent Psychiatrists (MCCAP) recognized the need to create an effective response with regards to proposed legislative actions. MCCAP is a smaller organization and had no formal relationships with other professional groups, thus leading to the need to form a coalition to develop a more robust advocacy voice.

Developing a Coalition

The experience of the MCCAP can serve as a useful example of coalition building, no matter the state. In many ways, building relationships in a sparsely populated state, such as Maine, is easier to navigate than in densely populated states. Like minded professional organizations have fewer degrees of separation. However, the core principles of building a coalition are universal, regardless of population density.

The creation of the coalition in Maine began with an initial meeting bringing together stakeholder physician professional organizations caring for children and adolescents. In general, when recognizing the need for partnership to address local, state, or national legislative/policy initiatives, it is helpful to determine if there are already established relationships to lend a unified voice. Regional child and adolescent psychiatry organizations (ROCAPS) may already have a formal relationship for advocacy with other state/regional professional organizations, such as local branches of the American Psychiatric Association (APA), American Medical Association (AMA), and American Academy of Pediatrics (AAP).

Some ROCAPS may have established partnerships with state advocacy groups, children’s hospital legislative staff, or have established contacts with lobbyists supporting other regional/state professional organizations. For example, many members of the MCCAP were also members of the Maine Association of Psychiatric Providers (MAPP). MAPP had a formal partnership with the Maine Medical Association (MMA) for support and lobbying around legislation affecting general psychiatry. These previously established relationships were used to guide and support the development of this coalition. The physician groups initially identified to build the coalition were based on the premise that these groups provided primary or psychiatric care for children and adolescents.

Foundational stakeholders should then meet to further define the goals of the coalition. With an identified vision and defined purpose of the coalition, the foundational stakeholders are tasked to identify other potential members of the coalition. In Maine, each attendee had worked on advocacy, policy initiatives, or shared clinical work with the subsequent groups invited to join the coalition. The specifics of this are individual to each coalition, but for Maine, it involved extending invitations to greater than 15 other professional organizations. This included, but was not limited to, the involvement of parent groups, pediatrics, family medicine, and other organizations focusing children’s health and wellness. Further growth of the coalition occurred “organically” as member organizations of the coalition had contact with other potential member groups.

In developing the coalition in Maine, trainees were another important stake holder. When developing a coalition, trainee involvement can be a valued professional development opportunity for the child and adolescent psychiatry fellow and pediatric resident. Involvement of the trainee can be most effective through mentorship and ensuring awareness of the formative meetings. This can be accomplished by reaching out to training directors to invite participation, introducing them to coalition members, and highlighting relevant resources.

The coalition in Maine was named the Maine Coalition for the Advancement of Child & Adolescent Mental Health (MeCACAMH), (see Figure 2). With the breadth of organizations and individuals in attendance representing a variety of roles in the lives of children, the ensuing key factors impacting youth were identified:

- Access to care
- Poverty
- Ineffective state government
- Lack of support for early prevention programs
- Quality of care varied throughout the state
The development of the coalition was financially supported by an AACAP Advocacy and Collaboration Grant, with the focus of the grant centered on building relationships with other professional organizations. Grant funding provided financial support for external consultants, meeting space, and communication. Important operational factors were to establish an executive team to guide the coalition, plan trainings on the essentials of advocacy for members of the coalition, arrange meetings with gubernatorial candidates, and set initial policy efforts. A core tenet established by the coalition was to be politically neutral instead of lobbying for more partisan goals.

**The Work of the Coalition**

In 2014, members of the Coalition met with the legislator who introduced LD 716 to provide education about evidence-based practice and concerns on the negative impact the bill would have for youth in Maine. Due to these efforts, LD 716 was not introduced as legislation. This led to a robust working relationship with the legislator, who sponsored child mental health friendly legislative actions and became co-sponsored legislative breakfasts backed by MeCACAMH.

A critical component of this success was timely communication between Coalition members. To ensure this, an email listserv was created. A listserv was chosen by members collectively endorsing the use of email as they were separated geographically and professionally. An example of early utilization of the listserv was a survey created to prepare to meet with gubernatorial candidates.

The survey sought to:
- agree upon the description of the Coalition
- develop questions members wanted to pose to the candidates
- assign tasks to research and prepare materials for the meeting of the candidates

This lead to the development of a “state of the state” document for the gubernatorial candidates, educating them about the role of the Coalition, workforce shortage challenges, and an overview of the challenges in the state to support children’s mental health. Meetings were arranged by members of the Coalition who had previous connections with the candidates (see Figure 3).

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**Figure 2. Letterhead: Maine Coalition for the Advancement of Child & Adolescent Mental Health**

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**Figure 3. Gubernatorial Meeting of MeCACAMH**

Note: Mike Michaud, Democratic gubernatorial candidate, summer 2014, and members of the MeCACAMH. Published with permission from Sandra L. Fritsch.
In Conclusion

The Coalition has since served to develop bipartisan partners and develop joint efforts for testimony around specific budgetary and legislative initiatives, wrote a policy proposal that became a state workgroup around preschool expulsions, and continues to provide a collective, nonpartisan voice speaking on behalf of the mental health of youth in the state of Maine. Formation of the MeCACAMH created a powerful voice promoting positive change and responding to potential legislative threats. While the field of child and adolescent psychiatry has a relatively small professional and advocacy footprint, coalitions allow that professional footprint to magnify logarithmically. The case study of the Maine coalition should serve as an example for inspiring other child and adolescent psychiatrists to take these steps to start their own coalitions to successfully advocate for children and adolescent mental health in their state (see Table 1).

MeCACAMH Coalition Postscript:

The MeCACAMH remains robust and active in ME as noted by a recent email on the listserv: “As most of you know, OCFS contracted with PGC to conduct an audit of children’s mental health services as part of developing a comprehensive children’s state mental health plan. Attached is a pdf of the final report.

MCCAP remains a member of the advocacy coalition we helped develop with a few AACAP advocacy grants some years ago and we will be providing input to the state with our coalition partners. Please email any thoughts or observations regarding the report. This is our opportunity to help shape children’s mental health services in the years to come.”

Table 1. Lessons Learned From the Formation of the Maine Coalition for the Advancement of Child and Adolescent Mental Health

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<td>1.</td>
<td>Hunger exists for such coalitions, especially in states without any unified voice speaking for youth, and the creation of a Coalition powerfully channels and strengthens the efforts of the individual organization</td>
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<td>2.</td>
<td>Coalitions are most effective if nonpartisan</td>
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<td>3.</td>
<td>Knowledge of state and local government is needed, and that knowledge is available through participant members of the coalition</td>
</tr>
<tr>
<td>4.</td>
<td>Consultation and support from key medical lobbying groups can be helpful</td>
</tr>
<tr>
<td>5.</td>
<td>Know your role and who you are representing; do not represent your employer unless this has been agreed upon at the beginning</td>
</tr>
<tr>
<td>6.</td>
<td>Listservs and electronic technologies are necessary to support communication to members</td>
</tr>
<tr>
<td>7.</td>
<td>All politics is personal (and local), and persistence is key ingredient to change; members of the Coalition will extend the development of the necessary relationships with local and state legislators</td>
</tr>
<tr>
<td>8.</td>
<td>Time to participate can be the greatest challenge</td>
</tr>
<tr>
<td>9.</td>
<td>Plan for leadership changes to ensure stability of the coalition</td>
</tr>
<tr>
<td>10.</td>
<td>AACAP Advocacy &amp; Collaboration Grants can be instrumental to form coalitions</td>
</tr>
</tbody>
</table>

Take Home Summary

This paper describes both the value for child and adolescent psychiatrists to partner with other stakeholders with an interest in serving the mental health needs of youth and how one state, Maine, developed a coalition in response to state legislative efforts undermining the profession of child and adolescent psychiatry.

References


About the Authors

Sandra, Fritsch, MD, is the Medical Director of the Pediatric Mental Health Institute, Children’s Hospital Colorado, Aurora, and is an Associate Professor in the Department of Psychiatry at the University of Colorado School of Medicine, Aurora. Dr. Fritsch’s professional interests include advocacy, collaborative care models for pediatric primary care providers, digital technology and the impact on child mental health, and innovations in medical education.

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Check out AACAP’s expanded Depression Resource Center, with up-to-date resources on depression helpful to parents, youth, and clinicians, including FAQs, fact sheets, treatment resources, books, apps, videos, websites, articles, and more!

[www.aacap.org/depressionrc](http://www.aacap.org/depressionrc)

Plus, with your member access to Child and Adolescent Psychiatric Clinics of North America, read the issue on Depression in Special Populations!

This special issue starts with a preface by Karen Dineen Wagner, MD, PhD, President, AACAP, and Warren Y.K. Ng, MD, and include 18 articles on depression written by a collection of over 50 AACAP members!

The release of these important resources coincides with the current Presidential Initiative on Depression Awareness and Screening in Children and Adolescents of Karen Dineen Wagner, MD, PhD.

Thank you to AACAP’s Presidential Task Force, Consumer Issues Committee, and Web Editorial Board for the expertise they contributed in these projects!

You can access the special issue on [www.aacap.org](http://www.aacap.org).
The Child and Adolescent Psychiatrist as an Advocate: How to Fill the Growing Need Amidst Rapidly Evolving Health Policy Changes and Reform Through Training and Beyond

Adam J. Sagot, DO, Laura M. Willing, MD, Debra E. Koss, MD

There are many roles that child and adolescent psychiatrists are asked to play in the care of patients in their charge. Providing needed services to the vast numbers of child and adolescent populations is a daunting task in-and-of itself, especially considering that the current estimates of practicing providers is approximately 8,000 in the United States. The need for more providers is overwhelming. Published data estimates 20% of US children and adolescents (15 million), ages 9 to 17, have diagnosable psychiatric disorders. Given the limited number of providers and the ever-growing patient population they are asked to serve, the few providers that are specialty-trained are facing an uphill battle. Of the 8,000 practicing providers, many are based in geographic regions with specific metropolitan areas that contain more providers than the entirety of some states, such as Rhode Island or Delaware. This dramatically limits patient access to care. One way to address a resource shortage and lack of access to mental health care is through advocacy. Research has shown that networking, interacting with members of the government, and raising awareness of mental health needs can lead to better training, service delivery, and mental health policy. Due to the shortage of trained child and adolescent psychiatrists, the demand for both quality clinical care and effective advocacy is a responsibility that must be shared by all. Child and adolescent psychiatrists can lend credibility and expertise to advocacy groups seeking to improve access to quality care.

The American Medical Association (AMA) stated in its Declaration of Professional Responsibilities that physicians must “advocate for the social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.” This urgent need has been met in pediatric residencies in the US through the Milestones Initiative Project and the American Academy of Pediatrics (AAP) by including mandated core competencies through the Accreditation Council of Graduate Medical Education (ACGME). Child and adolescent psychiatrists of all levels of experience could benefit from advocacy training. One place to begin is by including advocacy curricula in general psychiatry residencies and psychiatry fellowships. Fellowship programs offer a unique forum to increase training, comfort, and expertise of physician advocates. Advocacy curricula in training programs will better enable graduates to have an effective understanding of health care and policy advocacy, its exigent importance, and their capacity to be agents of change for child and adolescent populations. Additional strategies would include continuing medical education courses, didactic conferences, advocacy conference days, and programs offered by professional organizations.

1) What It Means to be a Physician Advocate as a Mental Health Provider

While there is no consensus definition completely applicable, varying definitions have been offered by different specialties, accreditation bodies, and professional organizations that contain commonalities helpful to discuss and understand what it means to be a physician advocate as a mental health provider. Descriptions of advocacy from both the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) include the elements of education, engaging lawmakers, improving mental health policy and the development of policies that support the population's needs.
health policies, and increasing quality mental health services.\textsuperscript{8,9}

Advocacy in psychiatry is more than just community psychiatry, as it includes promoting psychosocial education, reducing stigma, increasing access to mental health care and seeking additional treatment, research, and education resources. These authors define the role of the physician advocate to encompass purposeful action to affect change, identify social determinants of health adversely impacting individuals and communities, and use expertise to inform decision-makers who may address community and system-level issues through legislative action.\textsuperscript{10} Being a physician advocate in child and adolescent psychiatry means using any of these ways to advocate for patients, reduce stigma, educate the public, and improve access to health care.

In child and adolescent psychiatry, the application and proper understanding of this role is critical. There is current legislative action impacting access to care through parity of mental health services and scope of practice that will impact patients and child and adolescent psychiatrists. As they are not able to vote and their voice is removed from the political and legislative process, children and teenagers are at a disadvantage.\textsuperscript{11} Child and adolescent psychiatrists have the knowledge base to provide a unique vantage point to educate policymakers about the mental health of children, scientific evidence, and clinical experience in an attempt to affect change. By taking an oath to do no harm, it is our duty to use our knowledge to advocate that legislation is in the best interest of children's mental health. As physicians we educate about mental illness, we present the scientific evidence, we translate the science so that the information is accessible to lawmakers, and we offer clinical anecdotes to illustrate impact of policy. In order to do this effectively, it is imperative that child and adolescent psychiatrists learn how to navigate systems of care, develop skills for communicating with legislators, and cultivate a deeper understanding of how federal, state, and local laws impact their patient populations.

\section*{2) Effects From Efforts in Advocacy for Child and Adolescent Populations}

Pediatric physician organizations have been working towards legislative changes since the late 19th century. There are countless examples of these physician-driven efforts impacting the welfare and wellbeing of children. A notable example is the physician-led effort behind passing the Sheppard-Towner Maternity and Infancy Protection Act of 1921, which provided states federal funding specifically allocated to establish programs to inform people about prenatal health and child welfare.\textsuperscript{11} Additionally, the reinstatement of the Children’s Health Insurance Program (CHIP) was heavily influenced by physician advocates. CHIP is a federal program that relies on shared funding from the states to provide health insurance to children in low-income families that earn too much to qualify for Medicaid.

Physicians have continued to address issues impacting the health issues of children over the years. AACAP is one avenue for psychiatrists to engage in ongoing advocacy. AACAP has effectively advocated for protecting the Affordable Care Act, passing the 21st Century Cures Act (which included the Mental Health Reform Act of 2016), delaying CMS billing and coding changes, and increasing the funding for NIH-sponsored research in the appropriations process in the US Congress. The AACAP Government Affairs team relies on child and adolescent psychiatrists to be content experts that drive the advocacy and inform policy recommendations.

\section*{3) Becoming an Effective Advocate}

Education on the strategies to effectively communicate with legislators, how to reach those that can impact the legislators, and identifying health and social determinants that negatively affect patients can help improve the quality of physician driven advocacy and increase the confidence of physician-advocates.\textsuperscript{12}

It is important to understand that there is data on how best to communicate with legislators. A study of nearly 200 former and current Congressional staff reported on their experiences with citizen-driven advocacy efforts.\textsuperscript{13} Several common truisms come to
mind regarding advocacy as discussed by this study. “All politics is local,” is an example described by former Speaker of the House Tip O’Neil and universally applies no matter the advocacy topic. This means that the success of a politician is directly tied to their ability to address and influence the concerns of their constituents. Understanding this will better enable mental health advocates to affect change. “Forming relationships with lawmakers’ staff members is critical,” as these individuals are the gatekeepers to the legislators and must not go unrecognized or undervalued. Influence from local constituents through “in-person” visits were considered to have a positive impact on the legislator by 94% of reporters ($n = 192$).13

4) Building Future Advocates for Child and Adolescent Psychiatry Fellows and Beyond

There are many options for incorporating advocacy training into fellowship curricula: didactics focused on health policy, lectures reviewing current mental health legislation, research electives dedicated to public health or systems level issues, small group projects aimed at affecting change, and electives that use hands-on learning to teach about effective advocacy techniques. Using blocked rotations, small group projects, modular learning, and experiential learning techniques are all successful means to better inform trainings on health systems. One way that residency programs teach advocacy is through exposure to community health rotations. Goldshore et. al found that pediatric residents who were exposed to community health rotations were more likely to anticipate future involvement in community health.14 This indicates that exposure to types of advocacy and community health in training increases the possibility that trainees will continue with advocacy and community health after graduation. Rotations including writing and delivering testimony before a legislative body, taking meetings with legislators, or joining work groups with state Medicaid administrators are all wonderful learning opportunities for a budding advocate.

Furthermore, advocacy education can be helpful for psychiatrists at every stage of their career. There are numerous opportunities for trainees, early career psychiatrists, and more seasoned psychiatrists to begin their advocacy careers that do not rely on a training program. Attending the AACAP Legislative Conference is an ideal starting place. It is held annually each spring in Washington DC, and the general program is free to members. This conference provides excellent opportunities for experiential learning through didactic lectures, forming relationships with other members, and meeting with staff of different Senate and Congressional offices. Expenses are always a concern during training, but both AACAP and the regional organizations offer the Advocacy Ambassador Program and travel grants to defray costs to help trainees attend.

Many training programs allow fellows to create their own electives, including those related to advocacy and health policy. Child and adolescent fellows across the country have created electives involving writing research papers on the state of the mental health care system in their state, partnering with local organized medicine to advocate for improved mental health access in their state, and joining local committees for advising Medicaid administrators and managed care organizations. In addition, AACAP sponsors the Resident Scholar Fellowship, which is awarded to deserving applicants during their Child and Adolescent Psychiatry Fellowship. The Resident Scholar program comprises a four week elective in Washington, DC in which awardees have the opportunity to work closely with the staff from the AACAP Department of Government Affairs. During this elective, fellows will work on legislative issues, attend meetings with coalition partners, and learn to advocate directly with congressional offices. While established psychiatrists will not get elective credit for advocating in these ways, attending psychiatrists may still help further the cause of mental health care for their patients by writing editorials, joining legislative committees, and meeting regularly with their local representatives.

Learning from your local organized medicine association is also a helpful way to begin to advocate, regardless of career stage. Many local branches of the AMA, APA, AACAP, AAP, etc. have legislative committees,
government affairs staff, or even lobbyists who can help guide those first starting out in the world of health policy. Residents and fellows can join these organizations as representatives from their institutions. Early Career Psychiatrists can join as an ECP representative or join committees dedicated to advocacy and furthering systems of care. Organized medicine is not the only way to earn advocacy chops. Patient groups and other advocacy groups (such as National Alliance on Mental Illness, Mental Health America, and Autism Speaks) are also great avenues for volunteer work and learning the advocacy ropes.

Conclusion

Child and adolescent psychiatrists are well positioned to advocate for our patients and provide education and clinical expertise to legislators, administrators, and regulators. As physicians, psychiatrists have an opportunity to influence legislation that directly impacts patient access to mental health care, serve as thoughtful leaders in health care reform, and stand up for evidence-based medicine. All psychiatrists and physicians in general need to be informed of the professional obligation to advocate for their patients and undergo training to be effective agents of change. Given this workforce shortage, we do not have the luxury to rely only on those choosing to involve themselves, or on professional organizations alone to accomplish this task. We need to instill urgency for all child psychiatrists in all stages of their career to participate and become stronger advocates. We must accomplish the ultimate goal: to make “more sustainable and resilient physicians with a sense of agency to affect change.”

References


Take Home Summary

Children and adolescents are at a disadvantage compared to adult patient populations in their ability for agency, organization, and execution of advocacy driven efforts. We must be prepared to do so on their behalf.
About the Authors

Adam J. Sagot, DO, is a child and adolescent psychiatry fellow with Drexel University College of Medicine, Philadelphia, PA, and a volunteer faculty member with Rowan University School of Osteopathic Medicine Department of Psychiatry, Glassboro, NJ. He currently serves as the Pennsylvania Advocacy Chair for the Regional Organization of Child and Adolescent Psychiatrists in Eastern Pennsylvania and Southern New Jersey ROCAP, is a co-chair of the Advocacy Committee for AACAP, and is the Resident Representative to the Assembly of Regional Organizations of AACAP. Dr. Sagot’s focus is on mental health and policy advocacy.

Laura Willing, MD, is an Assistant Professor of Psychiatry and Pediatrics at Children’s National Health system and George Washington University in Washington, DC. She is the Co-Director of the Multidisciplinary Anxiety Program at Children’s National, is a member of the AACAP Advocacy Committee, and serves on the APA Council on Minority Mental Health and Health Disparities. She is the president-elect for the Child and Adolescent Psychiatrists of Greater Washington.

Debra Koss, MD, is a Clinical Assistant Professor with Rutgers-Robert Wood Johnson Medical School, Piscataway, NJ. Dr. Koss has been in private practice for over 20 years. In addition to teaching and clinical responsibilities, she currently serves as Chair of the AACAP Assembly of Regional Organizations and Co-chair of AACAP’s Advocacy Committee. Dr. Koss is also the NJ Psychiatric Association Senior Vice President and Chair of the Council on Advocacy, a member of the American Psychiatric Association Council on Advocacy and Government Relations, a consultant for the American Psychiatric Association Political Action Committee, a member of the NJ Medical Society Council on Legislation, a member of the National Child Traumatic Stress Network Advisory Board, a fellow of the NJ HealthCare Executive Leadership Academy. Her primary area of interest is mental health advocacy.

Disclosure: Dr. Willing’s salary is supported through Children’s National Health System since July, 2017. 0.2 FTE of that salary is supported by a grant from the DC City Government to provide integrated mental health care through DC Mental Health Access in Pediatrics. From August 2016 through May 2017 Dr. Willing received a stipend from the American Psychiatric Association as the Jeanne Spurlock Congressional Fellow. Drs. Sagot and Koss report no biomedical financial interests or potential conflicts of interest.

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**MSR Events Guide**

**AACAP 2019**

**Oct 14-19** Chicago, IL

**Hyatt Regency Chicago**

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**Legend:**
- MSR Signature Event
- MSR Ticketed Event
- MSR: Medical Students and Residents
- MSRF: Medical Students, Residents and Fellows

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**Other Activities**

**Tuesday, October 15**

3:15 - 5:15pm

**Diversity and Culture Roundtable:** Gun Violence and Its Impact on Child and Adolescent Mental Health and Well-Being

**Wedneday, October 16**

10:00am - Noon

**Life After Combined Training:** Perspectives and Mentorship Opportunities for Triple Board and Post-Pediatric Portal Graduates

**10:00am -12:30pm**

**Member Services Forum 6**

From Residency Rags to Riches: A Young Physician’s Guide to Personal Finance, Paying off Debt, and Planning for the Future

**3:00 - 5:30pm**

**Clinical Perspectives 23**

Meeting Children “Where They Are At”: Models for the 21st Century School-Based Mental Health Clinic

**Thursday, October 17**

8:30 - 4:30pm

**Extended Workshop:** The Role of Child and Adolescent Psychiatrists (CAPs) When Disaster Strikes: A Training Course

**Friday, October 18**

9:00 - 11:00am

**Hot Air, Hot Water, Hot Topics:** How to Effectively Influence the Conversation Regarding Child and Adolescent Mental Healths

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**Tuesday, Oct. 15**

9:00 - 11:00am

**Growing Up: An Insider’s Guide to Choosing the Right Job and Transitioning from Training to Practice**

**Tues., Oct. 15**

9:00:00 - Noon

**Stirring the Melting Pot: Introduction of Practice-Based Module to the Cultural Competency Exercise for Child Adolescent Psychiatry Trainees**

**Tues., Oct. 15**

6:00 - 7:00pm

**MSR Networking Hour**

Meet, greet and interact with your peers at Howl at the Moon

26 W Hubbard St, Chicago, IL 60654

**Thurs., Oct. 17**

8:00 - 10:00am

**MSR Breakfast:** Crafting Your Career in Child and Adolescent Psychiatry


**Thurs., Oct. 17**

1:30 - 4:30pm

**Rapid Fire Cases:** 10-Minute Intriguing Cases and Clinical Dilemmas Presented by Trainees

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**Wednesday, Oct. 16**

10:00am - 12:30pm

**Member Services Forum 6**

From Residency Rags to Riches: A Young Physician’s Guide to Personal Finance, Paying off Debt, and Planning for the Future

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**NOTE:** Event dates and times are subject to change.
JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our previous editions, the topic and format can vary widely, from neuroscience to teen music choices. What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate.

Authors are strongly encouraged to submit an initial outline to the editors, so that early feedback and guidance can be provided prior to the development of a full manuscript. An invitation to submit does not ultimately assure acceptance of the manuscript.

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