Section III
GOALS & RECOMMENDATIONS (THE “ROADMAP”) FOR THE COMING DECADE 2013-2023

Vision Statement
The Back to Project Future Presidential Initiative will develop prioritized recommendations that define and promote high quality preventive and clinical services, education and training, research, and advocacy in child and adolescent psychiatry across the coming decade (2013-2023). These recommendations will be used to guide AACAP in

• promoting mentally healthy children, adolescents and families;
• defining the professionalism, ethics, training and skills of child and adolescent psychiatrists;
• promoting the development of broadly effective interventions and treatments for children and adolescents;
• supporting child and adolescent psychiatrists’ practice in systems of care and other child serving systems.

Core Values and Principles
All elements of the BPF “framework” (i.e., goals, recommendations, rationales, and action steps) support the following values and principles:

• Represent innovative and forward thinking concepts and projections for the coming decade.
• Incorporate emerging technologies.
• Capture a new core professional identity and role of child and adolescent psychiatrists.
• Project a new public image of child and adolescent psychiatrists.
• Promote high morale and interest for trainees (medical students and residents) and child and adolescent psychiatrists in practice.
• Reflect the move toward an international/global perspective on child and adolescent psychiatry.
• Address the changing population demographics and characteristics for children, adolescents and families in the United States across the coming decade.
Master Goal List (2013-2023)

Goal 1 (Core knowledge and skills) – As providers of quality clinical care to children, adolescents, and families, child and adolescent psychiatrists will develop and maintain competence and lifelong learning throughout their careers in a core knowledge base and skills that incorporates research findings and advances in the field.

Goal 2 (Unique role and advocacy) – Child and adolescent psychiatrists, as physician specialists in both mental health and mental illness in children, adolescents, and families, should articulate, promote, and preserve their unique role, skills, and expertise in healthcare and advocate for the mental health rights and needs of children, adolescents, and families.

Goal 3 (New healthcare systems and models) – As experts in pediatric mental health, child and adolescent psychiatrists must be prepared to both practice child and adolescent psychiatry and provide leadership in new and emerging healthcare systems and models of healthcare delivery.

Goal 4 (Expanded access to care) – Child and adolescent psychiatrists and AACAP should support the development of new models of practice that improve access to quality psychiatric care for all children, adolescents, and their families.

Goal 5 (Role as educators and collaborators) – Child and adolescent psychiatrists should be trained and supported throughout their careers to be educators and to collaborate with child serving systems of care.

Goal 6 (Research) – AACAP will promote the full range of research to improve the prevention and treatment of psychiatric disorders throughout childhood, adolescence, and early adulthood.

Goal 7 (Recruitment and shortages) – AACAP will continue to promote increased recruitment into child and adolescent psychiatry and develop additional strategies to address the critical shortages and maldistribution of child and adolescent psychiatrists.

Goal 8 (Technological advances) – Evolving technological advances must be incorporated into the training, teaching methodology, and clinical practice of child and adolescent psychiatry.

Goal 9 (Global perspective) – AACAP and child psychiatrists should increasingly promote the international and global perspective to meet the mental health needs of children, adolescents, and families around the world.

Goal 10 (Diversity and culture) – Child and adolescent psychiatrists should enhance their cultural competency and awareness to meet the needs of our nation’s changing demographics.

Goal 11 (Ethics) – Child and adolescent psychiatrists will incorporate and adhere to the AACAP’s ethical and professional standards (Code of Ethics, AACAP 2009) in clinical practice, training, and research.
Goals, Recommendations & Action Steps (The “Roadmap”)

Introduction

This section is organized as a comprehensive resource document that can be studied and referred to by the AACAP leadership, members, and staff. The following pages contain the detailed recommendations and action steps for each “Goal” identified in the Plan for the Coming Decade. The collective goals, recommendations, and action steps constitute the “roadmap” developed by the Back to Project Future (BPF) Steering Committee and Subgroups. This section presents many possible options, choices, and “routes” on the “roadmap” as AACAP moves forward into the coming decade. The number and extent of specific recommendations and action steps reflects the careful and systematic work of the BPF Subgroups and BPF Steering Committee.

Recommendations and action steps that have been prioritized for implementation during 2013–2015 are identified. Broad topics/issues of interest in child and adolescent psychiatry can be located using the report’s “Table of Contents” and the “Master Goal List.” Each goal statement has a brief “descriptor” in parentheses to identify the broad content(scope) of the goal. Readers can also find specific topics or issues using the topical “Index of Recommendations” in the Appendix.

Goal 1 (Core knowledge and skills) – As providers of quality clinical care to children, adolescents, and families, child and adolescent psychiatrists will develop and maintain competence and lifelong learning throughout their careers in a core knowledge base and skills that incorporates research findings and advances in the field.

GOAL 1 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: Historically, child and adolescent psychiatrists (CAPs) have been well trained across a broad array of theories and techniques focused on understanding the complex and multidimensional aspects of child development and psychopathology. This knowledge base, which combines the most established practices of medicine, neurobiology, and psychosocial sciences, provides a foundation for CAPs to be uniquely qualified to understand the complexities of genetic and epigenetic aspects of development and psychiatric disease. We must preserve this foundation while providing the means to efficiently integrate advances within these areas into training and into the practices of mid career and senior career CAPs. There is also concern that economic forces (e.g., insurance payors, pharmaceutical industry, etc.) are influencing practice decision-making by selectively reinforcing biologic therapies. This trend works to the detriment of the child and to the profession of CAP.

(2013–2015 Priority) Recommendation 1.1 – AACAP will support the integration of evidenced-based treatments and advances in both neurobiology and psychosocial sciences into members’ practices.

Rationale: Advances within the medical and neurosciences fields are occurring at a dramatic rate. This new and exciting information must be translated to CAPs in a timely and organized manner so that it can be used in practice. Unfortunately, there can be a disconnect in CAP between those engaged in “research” and those engaged in “practice.” This divide needs to be bridged through active cooperation and collaboration between clinicians and researchers—focused on the effective translation of science advances into clinical practice.

Action step 1.1.1 – Create an AACAP Task Force (e.g., representatives from JAACAP, AACAP Program Committee, Quality Issues Committee, senior clinicians, etc.) focused on establishing a working relationship between CAP researchers and practitioners to facilitate the translation of science advances into clinical practice.

Action step 1.1.2 – Create a Web-based portal for members on evidence-based practices and translational research.

Action step 1.1.3 – Ensure that all AACAP Clinical Practice Guidelines (formerly AACAP Practice Parameters) are updated and revised in accord with Institute of Medicine (IOM) standards.
Action step 1.1.4 – Consider broadening the membership of the AACAP Program Committee to include more CAPs in clinical practice and, also, consider establishing an advisory group to the JAACAP Editors composed of CAPs in clinical practice.

Action step 1.1.5 – Ensure adequate representation of psychosocial sciences and treatments at AACAP’s Annual Meeting and continuing medical education (CME) programs.

Recommendation 1.2 – Complex issues surrounding ‘off-label’ use of psychiatric medications and polypharmacy (multi-drug regimens) with children and adolescents need to be examined and best practices defined and disseminated.

Rationale: Over the last two decades there has been a marked increase in the use of multiple psychotropic medications in children and adolescents. Some of this is clearly related to the development of more effective medication and a greater awareness of their potential benefits. Often times, however, the increased use appears to have been among vulnerable populations of children who might not have access to a full array of psychosocial treatments or whose presentation is complicated by multiple comorbid biological and psychosocial issues. Given the potential risks, and our relative lack of knowledge regarding the benefits of these practices, there is concern regarding patient safety and the public’s perception of CAPs.

Action step 1.2.1 – AACAP needs to advocate for research on the safety and effectiveness of polypharmacy (multi-drug regimens).

Action step 1.2.2 – AACAP should develop a policy statement and guidelines on the use of polypharmacy (multi-drug regimens) in children and adolescents.

Action step 1.2.3 – AACAP should develop CME and other educational programs for members on polypharmacy (multi-drug regimens) and medication monitoring with children and adolescents.

Action step 1.2.4 – AACAP should consider developing an evidence-based medication monitoring system that represents best practice in CAP.

Recommendation 1.3 – A fundamental skill of CAPs must include the understanding and provision of multiple models of psychotherapy.

Rationale: Given changes in payment and the increased use of medication, the provision of psychotherapy by CAPs has been decreasing. This trend is concerning given our understanding of the importance of environmental influences on a child’s development and on the development of psychopathology. There is also ample evidence that psychotherapies can also be effective in the treatment of most psychiatric diagnoses. Psychosocial therapies need to be a core skill of CAP’s throughout their careers. CAPs must receive appropriate payment for providing those therapies.

Action step 1.3.1 – CAPs need to promote health care systems that conceptualize the recipient of treatment as part of a family system. Effective treatment focuses on and includes the family.

Action step 1.3.2 – AACAP should advocate for studies to demonstrate that treatment of children and adolescents with the combination of medication and psychotherapy is cost effective.

Action step 1.3.3 – ACCAP should explore collaboration with executives from healthcare companies, insurance companies, and health care systems to promote and advocate for effective mental health care and coverage for children and adolescents.

Recommendation 1.4 - CAPs need to integrate outcome and quality improvement initiatives in every practice setting.

Rationale: One of the bigger changes in the delivery of healthcare that is predicted to occur over the next decade is the increasing use of quality indicators and quality improvement techniques across are treatment settings. This is a fundamental part of the Affordable Care Act (ACA)—an effort to improve the quality of care provided while
containing costs. While the core concepts involved are more easily integrated into primary care settings, it is widely expected that specialty practices will need to adopt such strategies in the near future.

**Action step 1.4.1** – AACAP will provide leadership in developing appropriate quality and outcome measures and tools related to the mental health care of children and adolescents.

**Action step 1.4.2** – CAPs need to adopt outcome and quality measures and use the tools that have been developed across all practice settings.

**Action step 1.4.3** – AACAP should promote development of systems to collect outcome data on psychopharmacologic treatment of disorders using standardized protocols (e.g. similar to the PDQ database for pediatric cancer).

**Recommendation 1.5** – CAPs need expertise in prevention and treatment of substance use disorders (SUD).

**GOAL 1 – TRAINING AND WORKFORCE RECOMMENDATIONS:**

**Rationale:** Essential knowledge and skills of CAPs include the ability to: provide quality psychiatric assessment and treatment to children, adolescents, and families with a range of psychopathology, from diverse populations, and served by various types of institutions/ systems; learn and incorporate new information and skills systematically and continuously; and teach others relevant information and skills.

*(2013-2015 Priority)* **Recommendation 1.6** – AACAP will promote the creation of outcomes-based data on the efficacy and effectiveness of psychiatric treatments for children and adolescent.

**Action step 1.6.1** – Develop, implement, and maintain an information center/clearinghouse on psychiatric treatment outcomes that covers the spectrum of care (e.g., psychotherapy, psychopharmacology, environmental interventions, consultation):

- Provide data searchable by various criteria (e.g., patient age, disorder, etc.)
- Collaborate with clinicians to obtain information on clinical practices and results (e.g., solicit information on certain types of therapy based on certain criteria; provide incentives for contributors’ participation)
- Collaborate with researchers to design collection practices/criteria, analyze data, and summarize conclusions
- Provide outcomes data with treatment recommendations

**Action step 1.6.2** – Promote the education of CAPs to use evidence supported treatment interventions, participate in the collection of data, and develop models to monitor and systematize clinical practice:

- Verbal and written educational material (e.g., meetings, website, *JAACAP*) for members
- Training for members throughout the lifespan
- Training the trainers (e.g., program directors)
- Ongoing educational requirement for membership
- Educational programs on using Performance in Practice (PIP) modules and other quality assurance monitoring

**Recommendation 1.7** – CAPs will need to be trained in community engagement and public health and population management strategies, including primary and secondary prevention, to influence social determinants of children’s and families’ mental health.

**Action step 1.7.1** – CAP training should include understanding and assessing social determinants of mental health within communities and society.
Action step 1.7.2 – CAP training should include understanding and practicing public health and population management strategies, including primary and secondary prevention, that influence social determinants of children’s and families’ mental health.

Action step 1.7.3 – CAP training should include understanding and assessing capacities and strengths within children, families, communities, and society.

Action step 1.7.4 – CAP training should include engagement strategies for linking with community organizations and local and state governments. AACAP will promote and support CAPs involvement in community engagement through developing and collecting training and educational resources and common funding and development strategies.

Recommendation 1.8 – AACAP will promote development of resources for members to support maintenance of certification (MOC) and lifelong learning beginning in training and continuing throughout their careers.

Rationale: Throughout their career, CAPs should maintain competence in core knowledge, as well as develop skills to support their practice and enhance the field. Skill development may occur in a wide variety of areas, such as transition to practice, business, advocacy, leadership, education, and administration, along with clinical practice. CAPs often have multiple roles and responsibilities therefore requiring new skill sets throughout their career. AACAP should support CAPs in the development of knowledge and skills. Additionally, AACAP should help support members achieving and maintaining both licensure and certification. AACAP will use innovative technology to support lifelong learning.

Action step 1.8.1 – Develop improved Internet technology (IT) systems for teaching, learning, and credentialing at all developmental levels of knowledge and skills for healthcare providers.

Action step 1.8.2 – AACAP should invest in a Learning Management System or other IT supports that allow for online delivery of course materials, testing, evaluation, and certificate generation.

Action step 1.8.3 – AACAP should form a workgroup consisting of continuing medical education (CME) staff, IT staff, and AACAP members from the CME Committee, Maintenance of Certification (MOC) Committee, and Program Committee to evaluate proposals to build a Learning Management System.

Action step 1.8.4 – AACAP should develop more interactive methods of delivering CME to better engage learners and facilitate change in participants’ practice.

Action step 1.8.5 – AACAP should consider developing activities that span longer periods of time (i.e., not a one-time institute), including those that ask participants to measure their own work, identify problems, design a personal improvement plan, and conduct follow up assessments. Consider developing a new format at the AACAP Annual Meeting to support self-assessment and practice based improvement.

Recommendation 1.9 – AACAP should continue to support quality CME programs (for members and non-members) to provide self-assessment, improve clinicians’ knowledge/skills, and assist with maintenance of certification/licensure.

Action step 1.9.1 – Continue to offer high quality CME at the Annual Meeting and other meetings throughout the year.

Action step 1.9.2 – Continue to develop high quality materials (webinars) and JAACAP CME offerings.

Action step 1.9.3 – Develop products or activities delivering a minimum of eight hours of self-assessment credit per year in accordance with Part 2 of American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC). Activities should provide evaluation with peer comparison.

Action step 1.9.4 – Continue to develop materials that support ABPN’s MOC such as Performance in Practice (PIP) tools in accordance with Part 4 of the ABPN Maintenance of Certification.
Recommendation 1.10 – AACAP will assess educational needs in the changing healthcare environment, identify gaps, and develop new educational content to promote evidence-based practice.

Action step 1.10.1 – AACAP should collaborate with ABPN to ensure activities and products for MOC meet ABPN requirements.

Recommendation 1.11 – AACAP should support AACAP committees and regional organizations in designing and implementing CME activities.

Action step 1.11.1 – AACAP should evaluate ways in which CME accreditation of activities might be expanded to certify educational activities of committees and regional organizations with attention to the additional cost and manpower needed to accomplish these tasks.

Recommendation 1.12 – AACAP should expand CME offerings focused on transition to practice skills, financial and business training, leadership, work-life balance, and personal/professional growth.

GOAL 1 – RESEARCH RECOMMENDATIONS:

Rationale: Knowledge from research without dissemination is of no value. There are a number of critical constituencies, and effective dissemination of research requires thoughtful market segmentation. Target groups will include but are not limited to: the many diverse groups of CAPs in practice, education, administration, and research; youth with psychiatric disorders and their families; federal and non-federal agencies that fund research or make policy; child health advocacy organizations; and the educational and judicial systems.

Recommendation 1.13 – Review, clarify and expand, as needed, AACAP’s research dissemination efforts.

Action step: 1.13.1 – Evaluate the efficiency, accountability and effectiveness of JAACAP, AACAP’s website, and AACAP’s Government Affairs Department regarding dissemination of research information.

Action step: 1.13.2 – Develop and test best practices for dissemination of research information using market segmentation (i.e., identifying the best approaches for fellows, early career psychiatrists, psychiatrists in hospital practices, psychiatrists working in the community).

Recommendation 1.14 – Expand dissemination of research findings in partnerships with other organizations (e.g., American Academy of Pediatrics, American Academy of Family Physicians).

Rationale: There are other important organizations and constituencies with strongly overlapping goals in this area. By collaboration we increase our influence.

Action step 1.14.1 – Continue and expand dissemination of research-based AACAP Clinical Practice Guidelines.

Action step 1.14.2 – Encourage development of new AACAP Clinical Practice Guidelines (formerly AACAP Practice Parameters) that cover the full range of treatment modalities and methodologies – including some that may have a limited research base at the present time (e.g., integrative medicine).

Recommendation 1.15 – Increase AACAP’s efforts to “make the case for research” to government agencies, foundations, hospitals, medical schools, and the public.

Action step 1.15.1 – Disseminate research findings showing that investment in child and adolescent mental health research efforts pay off in improvements in prevention, treatment, and service delivery. Specifically, communicating the message that CAPs help youth with psychiatric disorders and that research in CAP is an important investment in and contribution to the nation’s health.

Action step 1.15.2 – Expand media training (e.g., Annual Meeting, web-based programs, and modules) for AACAP members to increase CAPs effectiveness in communicating research findings with the media and general public.
Goal 2 (Unique role and advocacy) – Child and adolescent psychiatrists (CAPs), as physician specialists in both mental health and mental illness in children, adolescents, and families, should articulate, promote, and preserve their unique role, skills, and expertise in healthcare and advocate for the mental health rights and needs of children, adolescents, and families.

GOAL 2 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: Payment structures, employer demands, training gaps, and public perception are converging to constrict the professional identity of CAPs primarily to prescribers of medications. These dynamics and forces fail to consider the CAPs unique expertise in differential diagnosis, clinical formulation, evidence-based treatment planning, evidence-based treatment services, and evidence-based preventive interventions. Other disciplines and providers are beginning to fill the service gaps; resulting in a general perception across both private and public sectors that CAPs involvement (whether direct or in an oversight capacity) is not needed for these critical services. Also, since these other providers are less costly, the systems can accrue cost savings. As a result, both the identity of CAPs as holistic clinicians and the quality of care provided to youth are being eroded. Practicing clinicians, AACAP, training programs, and lifelong learning programs have a critical obligation to engage in activities that both preserve and promote the unique role, skills, and expertise of CAPs.

Recommendation 2.1 – AACAP, training programs and continuing medical education (CME) and lifelong learning programs will promote and preserve the unique role, skills, and expertise of CAPs.

Action step 2.1.1 – CAPs must acquire and maintain a core knowledge base with an emphasis on normal/abnormal child development and child/adolescent psychopathology; epigenetics; evidence-based assessment and treatment of psychopathology in children and adolescents; evidence-based mental illness prevention and mental health promotion; pediatric psychosomatic medicine; systems of mental health care for children and adolescents; and basic scientific knowledge such as genetics, pharmacology, etc.

Action step 2.1.2 – CAPs should be fully trained in the core knowledge base and translate this information into clinical practice.

Action step 2.1.3 – CAPs should maintain their expertise throughout their careers by continual self-evaluation and lifelong learning.

Recommendation 2.2 – CAPs need to understand and participate in the full range of preventive interventions for children and adolescents.

Rationale: The care of children and adolescents, in all areas of medicine, begins with an understanding of those factors that increase the risk of illness. AACAP and its members should work to address these factors and collaborate with providers and educators to minimize their impact. This includes the development of early intervention and treatment programs by professionals in education and mental health. Primary care for children and adolescents should include interventions that prevent the occurrence and recurrence of psychiatric disorder. The role of the CAP will focus on minimizing risk factors as well as the assessment and treatment of mental health problems.

Action step 2.2.1 – AACAP should be a clearinghouse for information on the prevention of mental illness (e.g., advances in practice, early interventions, benefits of systems based care).

Recommendation 2.3 – CAPs should understand and collaborate with population-based screening efforts.

Rationale: In population-based models the practice of CAP will be guided by outcome data collected from multiple settings. Diagnoses and treatments will be tested and protocols changed based on the results of these reviews.

Action step 2.3.1 – CAPs should be familiar with the use of rating scales and the integration of population-based data.
**Action step 2.3.2** – CAPs should advocate that tools be used to screen for prevention and early intervention with broad populations.

**Action step 2.3.3** – CAPs should consider using AACAP’s Early Childhood Service Intensity Instrument (ECSII) and the Child and Adolescent Service Intensity Instrument (CASII) in their practice.

**Action step 2.3.4** – CAP training programs should insure that trainees are introduced to population-based tools and screening measures.

**Action step 2.3.5** – CAPs should collaborate with child welfare, juvenile justice, and educational professionals on prevention and early intervention by providing timely access to practical and understandable advice about the screening and assessment of mental health problems in children and adolescents.

**Recommendation 2.4** – CAPs should be informed and supported to act on major advocacy issues in CAP.

**Rationale:** The mental health difficulties and needs of most children and adolescents go untreated. In addition, there are small numbers of CAPs compared to the large numbers of families and individuals needing help. CAPs throughout their careers (training through retirement) should be an active and assertive voice for high quality and adequate treatment of those children with mental illness and for the healthy emotional development of all children. While the need for broad-based advocacy is apparent, only a small percentage of AACAP members participate in advocacy events. AACAP needs to more actively engage members in advocacy work as a professional responsibility, beginning in training and lasting throughout their careers. AACAP needs to encourage 100 percent of its members to be involved in advocacy efforts at local, state, and national levels.

**Action step 2.4.1** – AACAP should study the advocacy efforts of other organizations (e.g., professional, family, advocate) to market AACAP’s advocacy programs and efforts as a vital member benefit, and to develop a plan to increase member involvement in advocacy.

**Action step 2.4.2** – AACAP, in partnership with other appropriate consumer and professional groups, needs to develop a strategic agenda for advocacy efforts at both state and federal levels.

**Action step 2.4.3** – AACAP should expand the Advocacy Liaison Program and encourage each Regional Organization Child and Adolescent Psychiatry to identify an “advocacy liaison” to coordinate advocacy efforts at the local level.

**GOAL 2 – TRAINING AND WORKFORCE RECOMMENDATIONS:**

**Recommendation 2.5** – Define the diverse roles for CAPs within various healthcare delivery systems in the coming decade.

**Rationale:** Multiple forces (managed care, CAP shortage, etc.) are converging to reduce and fragment the role of the CAP in the health care delivery system. Without assertive action, other organizations and systems may redefine and restrict the role of CAP, for example, CAPs becoming solely psychopharmacological consultants with inadequate time to fully assess the child and family, thus relegating therapy to other health care providers. AACAP needs to proactively define and promote the unique role of CAP, and clearly communicate what we have to offer. An integrated model of training ensures that a fully trained CAP can provide a variety of therapies. Our ability to work with children and adolescents within the context of their families, schools, and communities, and to provide continuity of care using multimodal approaches, allows us to effectively tailor our treatments to best fit the patient’s needs. For example, rather than allowing market forces to define us as doctors who overprescribe without really getting to know the patients, we can make it clear that our ability to prescribe medication in the context of providing therapy and working within the child’s system of care allows us to carefully assess and titrate the need for medication. We are uniquely positioned to provide the best and most effective treatment. We must clearly define our skill set and effectively communicate it to others, in order to reduce stigma, secure reimbursement and funding, improve clinical care, and improve recruitment into the field.
Action step 2.5.1 – AACAP committees (e.g., Training and Education, Systems of Care) should collaborate and carefully review the multiple roles that CAPs may have within a broader system of care, and how to provide training in these diverse healthcare delivery roles.

Action step 2.5.2 – Continue periodic assessments of members’ work practices to identify career development needs.

Action step 2.5.3 – Create descriptions of CAP roles and responsibilities in various systems and various approaches to career development and practices; domestic and international; include information on finances: how to approach developing, implementing, maintaining and managing the economic/business aspects of work.

Action step 2.5.4 – Develop information and resources on multiple types of CAP careers. This could be organized by type of work (e.g., clinical, research, administrative) or type of structure/institution (e.g., self-employed, contractor, non-profit agency, for profit agency, academic, military).

Recommendation 2.6 – AACAP should strengthen the role of CAPs as advocates by providing advocacy education and advanced curricula on political/mental health policy for CAPs and families.

Action step 2.6.1 – Conduct periodic assessment of membership regarding needs in advocacy knowledge, skills, and priorities.

Action step 2.6.2 – Develop and distribute advocacy tools (e.g., “How to be an Advocate”) and promote effective advocacy strategies, programs, and initiatives for CAPs.

Action step 2.6.3 – Develop and provide advocacy curricula for trainees (e.g., basic and more advanced, didactic and experiential) that are longitudinal (medical school through CAP fellowship) and incorporates advocacy as an essential and integral aspect of practice.

Action step 2.6.4 – Maintain a resource database on federal and state initiatives (e.g., facts sheets, position statements, data cards). Use various formats and methods to disseminate this information to members (e.g., section on website, webinars, annual meeting presentations).

Action step 2.6.5 – Develop and provide a range of information and resources on advocacy issues (e.g., general or specific topics, local, state or national).

Action step 2.6.6 – Provide funding/awards for political and other types of advocacy to residents and members for various types of advocacy opportunities, national and local, of varying lengths and intensity.

Recommendation 2.7 – CAPs should improve the understanding of social determinants in communities (e.g., poverty, hunger, discrimination, violence, trauma) that influence the mental health of children and families.

Rationale: CAPs training must include competencies in engaging diverse children and families from a broad range of cultures and including race, ethnicity, class, geography, language, sexuality, and gender. CAPs must also be aware of and engaged with community organizations, including civic, religious, and service groups.

Action step 2.7.1 – CAPs will be able to assess social determinants of mental health within their communities and society.

Action step 2.7.2 – CAPs will be able to assess capacities and strengths within children, families, communities, and society.

Recommendation 2.8 – AACAP educator leaders will participate actively in the development and ongoing evolution of the ACGME Milestones that will include competencies relevant to changing healthcare environment.
Recommendation 2.9 – AACAP, in partnership with other organizations, will continue strong efforts to educate insurance companies, other agents, and payors about CAPs’ skills and expertise to ensure appropriate payment for all services.

Recommendation 2.10 – Improve the public image of CAPs through public education.

Action step 2.10.1 – AACAP should promote media training for CAPs throughout their careers to help them more effectively engage advocacy organizations and news organizations, educate the public on mental health problems facing the country’s youth, and promote evidence-based solutions.

Recommendation 2.11 – Improve education of the public about normal development, normal variation, problems, and disorders in children, adolescents, and families.

Action step 2.11.1 – Provide curricula for parents and children regarding normal development and identification and accessing services if there are concerns about a child’s emotional and behavioral development.

Action step 2.11.2 – Provide information to patients and families regarding: patient advocacy organizations, appropriate and effective treatments, and risks and benefits of treatment versus no treatment when participating in clinical research.

Goal 3 (New healthcare systems and models) – As experts in pediatric mental health, child and adolescent psychiatrists (CAPs) must be prepared to both practice child and adolescent psychiatry and provide leadership in new and emerging healthcare systems and models of healthcare delivery.

GOAL 3 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: As a result of the Affordable Care Act (ACA) the next decade has the potential to bring enormous changes in the delivery of healthcare and mental health care within the United States. The transition to team-based, integrated models of care has already begun in large healthcare systems and is predicted to filter its way through all aspects of public and private healthcare systems. Another consequence of the ACA is the expansion of health insurance coverage to millions of previously uninsured adults, children, and adolescents. Given the long standing shortage of CAPs and other child mental health professionals, increasing demands for access to mental health services will be made upon a system that is largely viewed as fragmented and inefficient.

CAPs, as physicians trained in medicine, public health, child development, and the diagnosis and treatment of developmental and psychiatric illness in children and adolescents, are uniquely suited to lead in the design, development, and implementation of systems of care that will have the potential to address the mental health needs of our nation’s children and adolescents.

Recommendation 3.1 – CAPs need the skills to address the mental health issues within complex systems of care and population-based medicine practices.

Rationale: Many aspects of CAP training have historically contained many of the components needed for effective leadership within team-based care delivery models. For instance, aspects of school and hospital consultation/liaison training, knowledge of systems theory, development, and group dynamics all lend themselves towards effective team-based care. In addition to these core skills, evolving models of healthcare delivery will require understanding of modern leadership and management theories. Systems of care in both public and private sectors are likely to be increasingly complex with a reliance on population-based surveillance and interventions as a means of increasing access to care without dramatically increasing costs.

Action step 3.1.1 – Through the collaboration of AACAP committees (e.g., Healthcare Access and Economics, Training and Education, Schools, Systems of Care), core competencies in leadership principles related to integrated delivery systems should be developed.
**Action step 3.1.2** – Continuing medical education (CME) programs (e.g., Annual Meeting track) in leadership principles should be developed to support members’ roles in these new systems and models.

**Action step 3.1.3** – AACAP committees (e.g., Healthcare Access, Systems of Care, and Collaboration with Medical Professional) should develop educational models to assist members with understanding and implementing new models of healthcare delivery within integrated systems.

**Action step 3.1.4** – AACAP will sponsor and encourage education about the evolving need for population-based medicine strategies—for screening, risk assessment, and interventions.

**Recommendation 3.2** – AACAP needs to develop educational materials for CAPs on issues related to complexity of financing models that will be an increasingly integral part of healthcare reform.

**Rationale:** The evolution of the financing of healthcare within our country has a complex history. As a result of the ACA financing models will become increasingly complex as models begin to include partial capitalization, bundled payments, shared savings, and other interventions aimed at reducing overall healthcare costs. Added to this will be the introduction of payment systems based on meeting specific parameters for efficiency and quality of delivered care. Initially, the greatest impact of these changes will be on those CAPs working within larger systems of care, however, eventually many of these innovations will affect CAPs working in private practice as well.

**Action step 3.2.1** – AACAP will need to educate its members (using the Annual Meeting, webinars, and JAACAP articles) and develop programs and materials about system finance models, service design, and physician compensation/reimbursement.

**Action step 3.2.2** – AACAP will need to educate its members about benefit design features in order to advocate assertively for essential benefit design at the state and systems level (e.g., Annual Meeting programs and other educational materials).

**(2013-2015 Priority)** **Recommendation 3.3** – CAPs need to be familiar and able to work in evolving models of healthcare delivery systems, including the Accountable Care Organization (ACO) and medical home models.

**Rationale:** The ACA has incentivized the use of the “medical home” and “Accountable Care Organization” models to target areas such as quality improvement and cost containment within healthcare delivery models. AACAP members will need to be familiar with these and other evolving models of care delivery. In addition, CAPs should be participating and leading the design of integrated models of mental healthcare delivery.

**Action step 3.3.1** – In the short term, AACAP will need to actively educate its members about the impact of healthcare reform (e.g., Annual Meeting presentations, AACAP News and JAACAP articles, and webinars developed by the various AACAP committees).

**Action step 3.3.2** – AACAP needs to inform and support its members by developing educational materials related to innovations in efficient mental healthcare delivery.

**Recommendation 3.4** – AACAP and CAPs need to proactively address the increase in the number of patients seeking mental health services that comes from the expansion of health insurance.

**Rationale:** During 2013-2015, as a result of the expansion of insured populations, there will be a dramatic increase in insured individuals seeking treatment. Given our historically fragmented and underserved service models this will stress an already overloaded and outdated system of care. AACAP members need to anticipate this trend and be prepared to advocate at local, state, and federal levels for appropriately designed and funded systems of care.

**Action step 3.4.1** – AACAP needs to develop materials to assist members to be leaders in advocating locally for models of care that will address this dramatically increased service need.
**Action step 3.4.2** – AACAP needs to provide leadership in organizing and facilitating meetings with other stakeholders (e.g., consumer and allied professional organizations and federal policy directors) to address ways to improve the care system for children’s mental health.

**Recommendation 3.5** – AACAP should provide leadership in assessing market forces on the field and practice of CAP.

**GOAL 3 - TRAINING AND WORKFORCE RECOMMENDATIONS:**

**Rationale:** Healthcare systems are preparing for a new reality that will likely involve more individuals who are insured, but lower reimbursements for each of those individuals. This will likely exacerbate the issues caused by the shortage of CAPS. New systems of treatment, such as functioning in a consultation role to other mental health and somatic health providers, will be key for adequately treating the general population as well as preserving the relevance of CAP. Continuing to strengthen the consultation training that is in residency programs is critical. The new era of healthcare will likely mean that healthcare organizations will be responsible for the treatment of populations rather than individuals. This will mean that psychiatrists and other mental health professionals will be required to focus more on prevention rather than treatment. CAPs will need to be better equipped to work in traditional consulting relationships such as school, juvenile justice, and social service settings. They will also need to develop additional skills in less traditional settings such as community health clinics, pediatric offices, and in governmental agencies. Population health and public health treatment paradigms will need to be addressed in residency programs. As healthcare systems become more financially complex and challenged, physicians (including psychiatrists) will need additional financial and business training to be able to adequately protect current services and expand future services. Basic financial literacy will need to be provided for all psychiatrists, with the option of additional training depending on the career goals of the individual psychiatrists. It will be critical that we train enough CAPs as administrators and policymakers so that we can have a future impact in health systems.

**Recommendation 3.6** – Expand consultation and collaborative care training in CAP residency programs.

**Recommendation 3.7** – Population health and public health treatment paradigms should be included in CAP residency programs.

**Recommendation 3.8** – Teaching/training will be done by teams in settings that integrate CAP and pediatric health.

**Action step 3.8.1** – Develop a joint set of training recommendations regarding integrated CAP and pediatric health between the training committees of AACAP and the American Academy of Pediatrics (AAP) and other national training organizations. Recommendations could focus on collaboration on school-based health services, childcare consultation, child welfare (foster care), infant mental health, and screening/assessment in primary care.

**Action step 3.8.2** – Develop workshops and Web-based education modules on “Models of Teaching Collaborative and Consultative Child and Adolescent Psychiatry.” The programs would train CAPs how to integrate their care into a Patient-Centered Medical Home, and could include case management and consultation/collaboration with primary care providers and other medical and mental health professionals.

**Action step 3.8.3** – Develop model curricula for resident training on collaboration with primary care through dialog between AACAP, the Model Curriculum Committee of AADPRT and AAP.

**Action step 3.8.4** – Develop a web based clearinghouse for grants (e.g., SAMHSA, NIMH) to support collaborative care.

**Action step 3.8.5** – Establish dialog with the ACGME about recognizing need for training in collaborative care while taking into account the realities of limited training time, variable faculty expertise, and opportunity.
Action step 3.8.6 – Identify AACAP expert mentors to serve as “mentors” to members interested in program development in collaborative care.

Action step 3.8.7 – Explore opportunities with other organizations (e.g., AAP, AAFP) to develop needs assessment of their members for training and education in CAP.

Recommendation 3.9 – As healthcare systems become financially complex and more challenging, physicians (including child and adolescent psychiatrists) will need additional financial and business training.

Recommendation 3.10 – Increase training and mentoring of CAPs as administrators and policymakers to increase the impact of CAP in health systems.

Goal 4 (Expanded access to care) – Child and adolescent psychiatrists (CAPs) and AACAP should support the development of new models of practice that improve access to quality psychiatric care for all children, adolescents, and their families.

GOAL 4 – SERVICE/ClinICAL PRACTICE RECOMMENDATIONS:

Rationale – Changes in healthcare delivery at the national and state level will increase access to mental health services for children and adolescents while monitoring both cost and quality. CAPs should expand their clinical service reach by: enhancing the capabilities of other professionals to provide mental health care, working collaboratively to make services available to a broader population of patients, including those on Medicaid, and working to meet the mental health needs in both rural and urban areas.

Recommendation 4.1 – CAPs should participate in the education and training of other child-trained mental health professionals (e.g., child-trained psychologists, social workers, mental health counselors, Advanced Practice Registered Nurses [APRNs]) in normal development, mental health, and mental illness in children and adolescents.

Rationale: A variety of mental health professionals are providing services to children and adolescents that include psychotherapies as well as psychotropic medications. There are insufficient numbers of CAPs to meet the growing mental health needs of the population. CAPs can enhance the treatment and assessment of these patients by participating in the training and standards of practice for these other professionals.

Action step 4.1.1 – CAPs should enhance the capacity of other child-trained mental health professionals to promote mental health and prevent mental health problems in children and adolescents.

Action step 4.1.2 – CAPs should enhance the capacity of other child-trained mental health professionals to provide assessment, differential diagnosis, and clinical formulations for psychiatric disorders in children and adolescents.

Action step 4.1.3 – CAPs should enhance the expertise of other child-trained mental health professionals in evidence-based psychological and family therapies and contextual interventions for psychiatric disorders in children and adolescents.

Action step 4.1.4 – CAPs should collaborate with mid-level practitioners, including advance practice nurses (APRNs), in the provision of psychiatric care for children and adolescents, including the safe and effect use of psychotropic medications.

Action step 4.1.5 – CAPs should enhance the capacity of other child-trained mental health professionals to know when consultation and referral to CAP specialty services is indicated.

Action step 4.1.6 – AACAP should collaborate in the creation of educational tools that will guide the practice of other mental health professionals in the assessment and care of mental health and mental illness in children and adolescents, and identify standards of care.
**Action step 4.1.7** – AACAP should provide guidelines for CAPs on collaboration with other health, mental health professionals, and mid-level practitioners.

**Action step 4.1.8** – AACAP should participate in efforts to create standards of specialization and certification amongst other child and adolescent mental health professionals.

**Recommendation 4.2** – AACAP and its members need to form collaborative relationships with ancillary provider organizations.

**Rationale:** Organizations that represent mental health professionals will begin to set standards for the care of children and adolescents and create initiatives to meet the need. This process will occur with or without the involvement of CAP and it is, therefore, important that CAPs participate. If CAPs are involved, their level of expertise will be appreciated, their recommendations will be incorporated into the ancillary providers practice, and they will establish a role for the CAP in a system of care.

**Action step 4.2.1** – AACAP leadership should explore opportunities for collaboration and consultation with the leadership from social work, psychology, and other allied children’s mental health organizations at the state and national levels, with the goal of improving the mental healthcare delivery system and integrating mental health services into care treatment models.

**Action step 4.2.2** – CAP trainees should have experience working collaboratively with other mental health providers throughout their training.

**Recommendation 4.3** – CAP practices should incorporate mid-level/advance practice providers as partners.

**Rationale:** CAP is an area of growth for APRNs. Standards of practice and certification are being developed. CAPs and AACAP must participate in these processes to define the working relationship between CAPs and APRNs, particularly in the area of psychopharmacology.

**Action step 4.3.1** – AACAP should collaborate on a national level with relevant professional organizations to define the role of mid-level and advance practice providers in child and adolescent psychiatric care.

**Action step 4.3.2** – CAPs should participate in and coordinate training in child and adolescent mental health with mid-level/advance practice providers.

**Action step 4.3.3** – AACAP should work with the national organizations of APRNs to develop qualifications for certification in child and adolescent mental health.

**Recommendation 4.4** – CAPs should be knowledgeable about the development of new population-based models of healthcare delivery, including Accountable Care Organizations (ACO) and the medical home, and be ready to assume multiple roles in these practices.

**Rationale:** The Affordable Care Act (ACA) supports the development of population-based models of care as opportunities to deliver services to more patients with less cost and an emphasis on quality. Mental health care for children will be shared among multiple professionals and the roles of CAPs will include those of educator, consultant, collaborator, and specialist in the assessment and treatment of serious psychiatric disorders.

**Action step 4.4.1** – CAPs should engage in preventive services by enhancing the knowledge of clinicians regarding screening tools and other mental health educational resources.

**Action step 4.4.2** – CAPs should engage in early intervention by providing readily accessible ‘curb-side’ and timely ‘in-person’ consultations to clinicians regarding the evaluation and management of mental health problems.
Action step 4.4.3 – CAPs should engage in specialty consultation/coordination by collaborating with clinicians to develop a “family mental health care plan” that can be implemented in their practice.

Action step 4.4.4 – CAPs should engage in specialty intensive services by providing assessment, differential diagnosis, formulation, and treatment of psychopathology in children and adolescents, while working collaboratively with clinicians for return of care to their practice when appropriate.


Rationale: Care for children and adolescents will be organized around the primary care specialist or pediatrician who provides most of the patient’s care. Referrals to tertiary care specialists will be based on collaborative relationships that emphasize education, consultation, and access in a broader system of care. CAP must be part of this process to ensure access to patients and to ensure participation in the reimbursement models.

Action step 4.5.1 – CAPs should work with primary care and pediatric subspecialty physicians to clearly define their respective roles in patient and family mental health care coordination.

Action step 4.5.2 – AACAP should encourage CAP training programs to increase training in collaboration with primary care and examine new models of education (e.g., primary care pediatric practice rotations).

Action step 4.5.3 – AACAP should advocate that CAP function as a subspecialty of both pediatrics and psychiatry when considering policy and system planning.

Recommendation 4.6 – CAPs should be willing to participate in Medicaid and insurance networks to provide care to the increased insured population resulting from implementation of the Affordable Care Act (ACA).

Rationale: The ACA offers coverage to larger numbers of patients and families through the expansion of Medicaid and the creation of insurance networks. More children and adolescents will have access to mental health services, but the nature and quality of those services is not yet known. CAPs and AACAP can lead in this area if they participate in developing payment systems and make a commitment to care for these populations.

Action step 4.6.1 – AACAP and CAPs, in partnership with other appropriate organizations, should advocate locally and nationally to ensure fair payment for services.

Action step 4.6.2 – AACAP should partner with the American Psychiatric Association (APA) to collect data on payment structure (e.g., CPT codes) and advocate for fair payment. This information should be shared with insurance providers and state agencies.

Action step 4.6.3 – AACAP should help organizations work with the new exchange structures that are feasible for CAPs.

Action step 4.6.4 – AACAP should define outcome data for CAPs and describe the benefits that derive from the use of outcome measures.

Action step 4.6.5 – CAPs should understand the emergence of insurance exchanges and their impact on the provision of child and adolescent psychiatry services.

Action step 4.6.6 – AACAP should introduce the role of the CAP as a leader and entrepreneur in the development, management and coordination of services.

Action step 4.6.7 – AACAP should promote residency training and continuing education for CAPs in business models of integrated care delivery that identify CAPs as business leaders and entrepreneurs.
**Action step 4.6.8** – AACAP should work with its members to increase their participation with insurance networks and Medicaid.

**Action step 4.6.9** – AACAP should study future reimbursement models for CAP (e.g., development of ACOs with business partnerships between CAPs and other professionals).

**Recommendation 4.7** – New models for CAP practice should be developed that go beyond fee for service and include population- and outcome-based programs in organized healthcare systems.

**Rationale:** Child and adolescent psychiatrists, along with most pediatric subspecialists, are moving to larger group practices that can incorporate population- and outcome-based programming encouraged by the ACA. The CAP will assume multiple roles depending on the changing needs of the referral sources in the system. Many CAPs will be moving to larger organized healthcare systems in order to meet future clinical and administrative demands. There will always be a place for the solo practitioner in CAP, most likely in fee for service arrangements.

**Action step 4.7.1** – AACAP should develop career webinars and CME programs to educate members on new practice models.

**Action step 4.7.2** – AACAP should compile and disseminate information on the multiple new roles for child and adolescent psychiatrists in team based medicine.

**GOAL 4 - TRAINING AND WORKFORCE RECOMMENDATIONS:**

**Rationale:** Persisting shortages in the child and adolescent psychiatry workforce combined with health care reform have stimulated and mandated the development of new models to provide psychiatric care to children living in underserved communities. A decade ago, the Surgeon General called for the use of telecommunications technologies to address disparities in children's access to mental health care. Recent technological advances have answered this call. Telepsychiatry or the use of video-teleconferencing (VTC) to provide care that is usually rendered in person is now a viable alternative for youth who cannot access traditional in-person psychiatric care.

To realize this potential, a new generation of CAPS is needed to explore new venues for practice with experienced psychiatrists and examine ways to develop flexible practice models to fit lifestyles of early career psychiatrists (ECPs). Many barriers still exist to making telepsychiatry a fluid and natural choice in psychiatric practice.

**Recommendation 4.8** – All states should mandate that health insurers pay for telemedicine, including telepsychiatry. These payments should include both staffing and technology costs at the patient site.

**Rationale:** Only twelve (12) states currently mandate that health insurers/payors cover direct care delivered through VTC or telemedicine.

**Action step 4.8.1** – AACAP will advocate for parity in payment for telepsychiatry services.

**Action step 4.8.2** – AACAP, in partnership with health plans and other stakeholders, will advocate for legislation mandating that payors/health insurers (including Medicaid) cover telepsychiatry.

**Action step 4.8.3** – AACAP will promote the development of “toolkits” for regional councils to use for advocating telepsychiatry payment at the state level.

**Recommendation 4.9** – AACAP should promote the development of user-friendly, easily accessible telepsychiatry materials that provide a “road map” for establishing a patient base, selecting appropriate technologies, and implementing a business plan.

**Rationale:** Practicing CAPs (potential telepsychiatrists), particularly those in private practices, need guidance in approaches to developing a sustainable practice of telepsychiatry.

**Action step 4.9.1** – AACAP will empower a Telepsychiatry Task Force consisting of members from the Private Practice Committee, Systems of Care Committee, Early Career Psychiatrist Committee, Juvenile Justice Reform
Committee, Lifelong Learning Committee, Training and Education Committee, Workforce Issues Committee, and the Telepsychiatry Committee to develop webinars, websites, and “toolkits” to guide psychiatrists in developing their own “How to Do It” road map to establishing a telepsychiatry practice.

Recommendation 4.10 – AACAP should develop easily accessible materials describing telepsychiatry as a viable option in providing quality mental health care to children.

**Rationale:** Information on telepsychiatry should be widely distributed to stakeholders in underserved areas who are charged with children’s welfare.

**Action step 4.10.1** – The AACAP Telepsychiatry Task Force will develop strategies for disseminating knowledge about the benefits and challenges of telepsychiatry and assist in connecting telepsychiatrists with potential telepsychiatry service sites.

Recommendation 4.11 – Develop Integrated Care Models using telepsychiatry/VTC to bring psychiatric care to children, adolescents and, primary care providers.

**Rationale:** Evolving Integrated Care Models will require CAPs to expand their usual models of consultation and liaison with primary care. Practice sites that are distant and/or under-served will need telepsychiatry involved in such models.

**Action step 4.11.1** – AACAP should support a collaboration with the American Academy of Pediatrics (AAP) and the AACAP’s Committee on Collaboration with Medical Professionals, Community-based Systems of Care Committee, Physically Ill Child Committee, and the Telepsychiatry Committee to adapt current models (e.g., Unutzer’s Collaborative Care Model and Dobbins’ Consultation Conference) using VTC and telepsychiatry to improve pediatric and adolescent mental health care in primary care.

Recommendation 4.12 – CAPs should be prepared to assist in natural and man-made disasters using telepsychiatry.

**Action step 4.12.1** – AACAP should explore developing educational, networking, and interventional materials to support a “virtual disaster response team” that can collaborate with other agencies using telepsychiatry during the acute crisis and post-trauma recovery stage of disaster response.

**Action step 4.12.2** – AACAP should consider creating a special task force consisting of members from the Disaster and Trauma Issues Committee, Military Issues Committee, Media Committee, International Relations Committee, and the Telepsychiatry Committee to develop guidelines on using telepsychiatry during disaster relief, nationally and internationally.

Recommendation 4.13 – AACAP will promote training in the use of technologies and other approaches to expand the reach of CAPs to underserved areas (i.e., telepsychiatry and other developing e-health technologies).

Goal 5 (Role as educators and collaborators) – Child and adolescent psychiatrists (CAPs) should be trained and supported throughout their careers to be educators and to collaborate with child serving systems of care.

**GOAL 5 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:**

**Rationale:** Psychiatric care for children and adolescents may be provided in settings that offer direct and consistent access to patients in ways that go beyond traditional clinical models. Mental health services are provided in schools, through the juvenile justice system, in programs for young clients with developmental disabilities, and in partnership with child welfare agencies. CAPs should actively participate in the creation and operation of these systems in order to enhance the knowledge and clinical skills of the providers.
Recommendation 5.1 – CAP practices should be integrated with other child-serving systems of care including education, child welfare, and juvenile justice.

**Rationale:** The psychiatric care of children and adolescents begins with access. For large segments of the population, routine contact with patients is more easily attained in schools, child welfare agencies, and the courts. Non-CAP mental health professionals provide much of the care in these systems and are seeking consultation from and access to CAP.

**Action step 5.1.1** – AACAP should advocate for each community mental health system to have a CAP involved in its leadership.

**Action step 5.1.2** – CAPs should be available to provide child welfare, juvenile justice, and education professionals with timely access to practical and understandable advice about the screening, assessment, and management of mental health problems in children and adolescents.

**Action step 5.1.3** – CAPs should be available to provide child welfare, juvenile justice, and educational professionals with timely access to assessment and treatment for psychiatric disorders in children and adolescents.

**Action step 5.1.4** – CAPs should reach agreement with child welfare, juvenile justice, and educational professionals on the extent the role of each team member will have in patient and family mental health care coordination.

**Action step 5.1.5** – ACCAP should advocate for communication between the pediatric medical home and community based systems of care to ensure appropriate access for vulnerable children and adolescents.

**Action step 5.1.6** – Training in child and adolescent psychiatry should include exposure to diverse community-based systems of care.

**Action step 5.1.7** – AACAP should advocate with federal, state and local authorities for the integration of CAPs in child serving systems of care.

Recommendation 5.2 – CAPs need to be trained in the supervision and delivery of school-based mental health care.

**Rationale:** A child’s performance in the classroom, his ability to get along with peers, and his response to the direction of teachers are among the most sensitive indicators of psychosocial functioning. Schools present a unique opportunity to identify those children in need of services and to impact those who are struggling. School personnel and ancillary mental health staff, under the guidance and direction of CAPs, can provide the services necessary to make a difference for these children.

**Action step 5.2.1** – Training in school-based mental health care should include program design, service delivery, screening and models of care.

**Action step 5.2.2** – CAPs should work in partnerships with school-based counselors, social workers, nurses, psychologists, special educators, and school administrators.

**Action step 5.2.3** – CAPs and the AACAP should advocate for universal mental health screening in schools.

**Action step 5.2.4** – AACAP should develop school-based mental health continuing medical education (CME) and educational resources for members (e.g., Annual Meeting programs, webinars).

Recommendation 5.3 – CAPs should understand the complex and evolving systems of funding and use of resources within public systems of care.

**Action step 5.3.1** – AACAP will provide continuing education to assist members in understanding the integration of public and private service delivery models, as well as new and developing payment models.
Action step 5.3.2 – AACAP should advocate for blended funding models to support integration of CAPs into child serving systems of care.

Recommendation 5.4 – CAPs should participate in the changes occurring in forensic psychiatry and juvenile justice.

Action step 5.4.1 – AACAP should support the translation of neurodevelopmental research findings to the courtroom, assist in adjudication of youth offenders and develop guidelines around sentencing, treatment, and rehabilitation of children and adolescents.

GOAL 5 – TRAINING AND WORKFORCE RECOMMENDATIONS:

Rationale: During their training, most CAP residents are expected to provide training to medical students and residents. It is essential that they learn how to teach effectively and receive feedback on their teaching. Necessary skills include supervision, creating active learning environments in small and large group settings, providing formal educational activities that actively engage students, learning effective use of technology, understanding adult learning theory, learning how to assess skills, and knowing how to provide formative and summative feedback. The entire field of graduate medical education (GME) is changing with the advent of the ACGME’s Next Accreditation System (NAS). The establishment of Milestones, developmental benchmarks for knowledge, skills and attitudes at each stage of professional development will require CAP educators to understand educational methods for each level of student, resident, fellow, or peer. In addition, new methods of valid and reliable assessment of outcomes will increasingly be developed and implemented for use in medical education, residency training, Maintenance of Certification (MOC), hospital credentialing, and potentially medical licensure. Faculty development will be required to teach particular milestones and use advanced information technology to provide real-time assessments of student and physician performance and outcomes. The role of CAP as educator also extends to working with families, school personnel, and communities. CAPs act as consultants to other specialties and need to be able to provide in-service education to other health professionals. Given the shortage of CAPs, they need to be able to educate primary care providers about common CAP disorders. CAPs also need to educate the general public to reduce stigma and help inform parents and youth about mental health, illness and resilience. The importance of a well-educated public is critical to well-coordinated care. CAPs must also learn to be effective advocates for child mental health.

Recommendation 5.5 – AACAP will develop the AACAP Alliance for Learning and Innovation (AALI) – a community of educators across training levels and including AACAP members from diverse practice environments (academic, private practice, community) to promote superior education and training.

Action step 5.5.1 – Recruit diverse members and perform a needs assessment to identify training gaps in current teaching skills.

Action step 5.5.2 – Develop programming to target the training gaps identified by the needs assessment. This could include both online programming and live programming.

Action step 5.5.3 – Recognize outstanding educators at the Resident, Early Career Psychiatrist, and Master Teacher level through awards given by the Alliance for Learning and Innovation (AALI) and AACAP’s other venues.

Recommendation 5.6 – CAPs should learn how to teach effectively using technology and new learning techniques and methods.

Recommendation 5.7 – CAPs will be able to teach a wide range of learners including allied health professionals, non-health professionals, and the general public.

Recommendation 5.8 – AACAP will promote increased training in assessment and treatment of CAP disorders for all physicians, mid-level practitioners and advance practice providers.
**Action step 5.8.1** – AACAP’s committees will explore opportunities for increased CAP training with the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and organizations representing psychiatric nurse practitioners and physician assistant training programs.

**Action step 5.8.2** – Explore with AADPRT, and ACGME opportunities for increasing requirements for CAP in general psychiatry training.

**Action step 5.8.3** – Advocate for inclusion of sufficient education in child mental health for all physicians, mid-level practitioner and advance practice provider training programs.

**Action step 5.8.4** – Collaborate with other groups/organizations (e.g., AAP, NIH), nationally and internationally, to support the acquisition and sharing of data on treatment outcomes in support of collaborative training:

- Meetings: Joint meetings; overlapping annual meetings
- Funding/Awards: Continue to provide funding/awards to regional organizations to collaborate with pediatrics to disseminate information on evidence/outcomes
- Other Support: Scholarships/support to have representatives from other organizations present to membership; support AACAP representatives to attend/participate in other organizations' activities

**Action step 5.8.5** – Develop infrastructure/support to collaborate with experts in relevant disciplines (e.g., business, law, economics); medical specialties (e.g., pediatrics, family medicine); and relevant organizations (e.g., children's hospitals, community mental health, patient advocacy).

**Recommendation 5.9** – AACAP will provide career development assistance and mentorship for members.

**Action step 5.9.1** – Maintain a group of diverse mentors (career type/location) for interested CAPs at any stage of career, and develop and maintain system/resources to educate and support mentors.

**Action step 5.9.2** – Expand the AACAP mentorship matching program that currently provides mentors to CAPs in training.

**Goal 6 (Research)** – AACAP will promote the full range of research to improve the prevention and treatment of psychiatric disorders throughout childhood, adolescence, and early adulthood.

**(2013–2015 Priority)** **Recommendation 6.1** – Develop and disseminate a clear, broad-based research agenda that covers the breadth of child and adolescent psychiatric (CAP) disorders, with particular emphasis on those disorders that are the most common, have the greatest morbidity and mortality, are in areas where prior research provides the most promising opportunities, and have the greatest public health and societal costs, especially those occurring in understudied or underserved populations.

**Rationale:** Research is critical to preventing and treating psychiatric disorders in youth. A wide range of basic, translational, clinical, and services research is critically needed to improve our nation's ability and capacity to prevent, diagnose, and effectively treat psychiatric disorders in children and adolescents. Research areas include but are not limited to: basic developmental neuroscience; genetics, imaging, and other biomarkers; epidemiology; developmental psychopathology; treatment development including psychosocial treatments, pharmacological treatments, and other novel treatment approaches; implementation and dissemination; national quality measure development; cost-effectiveness; and national child health policy research. Each area is distinctly important, as are translational studies that link several research domains. Within and across domains, a deeper understanding of the developmental processes underpinning each of these areas is necessary to fit specific treatment approaches to each specific developmental period.

**Action step 6.1.1** – Develop and implement an approach to guide the prioritization of research agendas, explicitly communicate the rationale, and integrate transparent mechanisms for refining priorities in response to scientific advances. This process should include members who are representative of the AACAP membership and include opportunities for all members to provide comments (i.e., email updates and surveys).
Rationale: CAPs in research, clinical care, administration, and in all other aspects of the field have valuable insights regarding priority areas for research. Groups of AACAP members have more wisdom in aggregate than do individuals acting on their own.

Action step 6.1.2 – Develop a transparent process to develop and maintain a current list of research priorities that is responsive to all of AACAP’s membership. The process to develop and maintain this prioritized list would be inclusive of the full range of AACAP members.

Rationale: The list of research priorities would be updated on a regular basis, perhaps every two years. The prioritization does not need to provide a complete sorting of all prioritized items, but rather might be most useful if it separates recommended research areas into different levels of priority (e.g., “extremely timely and of potentially enormous impact,” “timely and important”). AACAP should report only the higher levels—there is little or no advantage to the field for the AACAP to report on a wide range of less promising areas of research. In developing the list, AACAP needs to consider overall funding availability—in times of limited funding it may be more strategic to emphasize fewer areas that represent the greatest opportunity.

Possible research studies and priority areas:

1. Treatment approaches targeting the progression of psychiatric disorders to more severe forms or disorders (e.g., Do antipsychotics given very early prevent progression of psychotic disorders? Does treatment of anxiety prevent progression to Major Depression?)

2. Usefulness of specific biomarkers and other risk factors in predicting disease course and optimizing individualized treatment.

3. Treatment approaches in severely refractory cases. Research in adults and in neurological conditions uses relatively invasive methods that act directly on brain circuitry. Clearly, some of these treatments will not be appropriate for children for many years. Others may be appropriate but only for children who are treatment refractory. Work is needed to define the situations where such invasive treatments are justified, and research needs to evaluate their efficacy.

4. Development of quality improvement interventions using emerging technologies to more rapidly disseminate and sustain evidence based practices in community-based settings.

5. Development and demonstration of effectiveness of short-term/brief psychotherapy modules addressing specific symptoms and problems that may be combined in optimum ways for our patients.

6. Psychotherapy dissemination and effectiveness research.

7. The impact of the new DSM-5. Research will be needed to understand the impact of the changes in DSM-5 diagnostic categories, especially in the area of autism and the carving out of Disruptive Mood Dysregulation Disorder from Bipolar Disorder.

Action step 6.1.3 – Disseminate AACAP’s prioritized list of research opportunities to all members, the National Institutes of Health, other governmental agencies, Congress, clinical and research training programs, allied professional organizations, and others to build a consensus of support.

Action step 6.1.4 – Promote collaboration between AACAP and other stakeholders (e.g., consumer organizations, other professional organizations) to jointly advocate for more funding and targeted research in priority areas.

Recommendation 6.2 – Build capacity in the CAP workforce to: conduct research; use research to inform decisions about the prevention, early detection, treatment, and delivery of child mental health care; and guide health policy decisions to enable, promote, and sustain high quality child mental health care.
PLAN FOR THE COMING DECADE

Rationale: CAPs have roles in many diverse treatment settings and contexts (e.g., academic health centers, public mental health programs, collaborative primary care, schools, child welfare, and juvenile justice). CAPs have a unique perspective on: the implications of health policies, access and quality of child mental health care, and the costs (direct and indirect) of providing high quality care to children with psychiatric disorders and their families. A trained work force of CAP researchers is critical to ensuring that researchers with the necessary skills are available to carry out our research agenda.

Action step 6.2.1 – Increase the number of CAPs trained in critical areas of research and promote research literacy in all CAPs.

Rationale: Expert clinicians need solid research literacy to use scientific advances in their practices. CAPs need to be leaders in studies that use basic science knowledge to improve clinical treatments and preventative interventions. Interdisciplinary approaches are critical to solving the problems of the coming decade.

Action step 6.2.2 – Promote increased research literacy in all CAPs by targeting different segments of CAPs. For example, residents and fellows could be targeted through training directors whereas early-career, mid-career, and later career psychiatrists may be targeted through AACAP’s continuing medical education (CME) programs – including Web-based modules and programs.

Action step 6.2.3 – Increase opportunities for collaborative work with scientists from other disciplines and expertise in training programs for residents, CAP post-doctoral research fellows and early career psychiatrists (ECPs) involved in research.

Action step 6.2.4 – Encourage training programs to develop training in research that spans several domains with the potential to translate work from more basic levels to prevention and/or treatment.

Action step 6.2.5 – Explore new models to prepare CAP residents and ECPs and adolescent psychiatrists for careers in research.

Rationale: While some “research powerhouse” programs have consistently trained successful CAP researchers, most programs have neither a sufficiently large base of CAP researchers nor the infrastructure to succeed despite having residents and early faculty who might be interested in and promising for such a career. We have a shortage of trained CAP researchers, so it is critical to explore new and broader approaches.

Action step 6.2.6 – Explore developing collaboration models between the “research powerhouse” programs and training programs with strong adult psychiatry researchers or strong research departments in allied fields, including basic neuroscience, public health, psychology, etc., to provide a combination of local mentoring and distant televideo mentoring by CAP researchers.

Action step 6.2.7 – Develop a model “Research in Child and Adolescent Psychiatry Track” for medical students that includes research and post doctoral (PhD) opportunities to help launch the student’s research career while in medical school. AACAP could partner with the Association of Directors for Medical School Education in Psychiatry (ADMSEP) and the Association for Academic Psychiatry (AAP) to disseminate this model.

Action step 6.2.8 – Encourage combined MD-PhD programs in medical schools to emphasize as a productive field of research.

Action step 6.2.9 – Identify “Training Programs of Excellence” that provide integrated models that have embedded education in research methods, protected research time, include research mentorship, and have the ability to incorporate trainees into labs to help promote early research productivity and on-site learning. Publish and disseminate information about successful methods shared among these programs to all medical schools in the United States.

Action step 6.2.10 – Increase mentorship in research by facilitating CAP researcher attendance and presentation at local, regional, and national meetings where medical students with research interests can be informed about
CAP research careers, such as large MD-PhD programs and meetings of American Physician Scientists Association (APSA) and Society for Neuroscience (SfN), etc. Encourage and collaborate with funding agencies to provide financial support for early career researchers to attend scientific meetings and to fund pilot research projects (medical school through post-doctoral).

Action step 6.2.11 – Develop a CAP research training curriculum in collaboration with strong research institutions. This could be modeled after current extremely promising efforts of Stanford, MIT, Harvard, and other universities to put advanced college courses on the web.

Recommendation 6.3 – CAPs should participate in research that examines the effectiveness and financial implications of collaborative care models for psychiatric patients.

Rationale: The Affordable Health Care Act (ACA) will have a large impact on CAP service delivery systems and will affect all AACAP members and their patients. Without scientific understanding and research into how the new law actually changes systems CAPs cannot advocate for changes and approaches that will best serve children and families. This services research is critical to inform policy makers, health systems, clinicians, and families.

Although new care models are beginning to be disseminated in primary care practices, there is a paucity of research to guide the use of these models for children with psychiatric illnesses, or to identify how these partnerships affect patient outcomes, the cost-effectiveness of these models, and satisfaction with these care models across clinicians, patients, and parents.

Action step 6.3.1 – CAPs should study the effect of CAPs partnering with other health and mental health professionals in delivering more efficient care.

Action step 6.3.2 – CAPs should study the quality and effectiveness of care in practice networks, groups, and Accountable Care Organizations (ACOs).

Action step 6.3.3 – CAPs should develop and evaluate quality indicators for psychiatric care.

Recommendation 6.4 – CAPs should engage in research that develops and disseminates equitable psychiatric care.

Rationale: Disparities in mental health and mental health care have been documented, and there is a need to develop effective assessments and treatments for underserved groups, especially as health care becomes more available to populations of children previously untreated or undertreated.

Action step 6.4.1 – CAPs should engage in research that seeks to improve the patient-centeredness of psychiatric care for children and families, by improving culturally and linguistically appropriate care.

Action step 6.4.2 – CAPs should investigate and study novel ways to engage underserved populations in psychiatric care.

Recommendation 6.5 – Promote studies of effective community dissemination of evidence-based psychiatric treatments.

Rationale: As the ACA is implemented, a larger number of patients are expected to be accessing health and mental health care. CAPs will be needed to provide more service and consultation within child-serving systems of care. It will be increasingly important for CAPs to study mechanisms for disseminating evidence-based treatments in these community settings.

Action step 6.5.1 – CAPs should study the effectiveness and cost-effectiveness of telepsychiatry in children and the use of new technologies to enhance dissemination of psychiatric treatments.
**Action step 6.5.2** – CAPs should study the implementation and dissemination of prevention, early intervention, and psychosocial and psychopharmacological treatments, especially effective treatments in a broad range of child serving systems of care.

**Recommendation 6.6** – AACAP should provide leadership in preparing and training CAPs to understand and interpret research advances throughout their careers (i.e., research literacy).

**Goal 7 (Recruitment and shortages)** – AACAP will continue to promote increased recruitment into child and adolescent psychiatry (CAP) and develop additional strategies to address the critical shortages and maldistribution of CAPs.

**Rationale:** The numbers of CAPs in the United States are insufficient to meet the public health needs of children and families with mental health needs. All projections of need over the past 30 years have concluded that the number of CAPs is woefully inadequate for the 20 percent of the pediatric population with mental health problems. Although the numbers of graduating CAPs has increased over the past 10 years, it has fallen further behind projected needs. In addition, practitioners are maldistributed so that urban core and rural areas are especially lacking in access to CAPs. Given these realities, as well as current primacy placed on the medical home, other primary care health professionals will increasingly be looked to for child mental health assistance. CAPs will need to extend their impact by collaborating effectively with pediatricians, family physicians, nurse practitioners, physician assistants, and others who are on the front lines of pediatric care as well as in other systems of care. Further, CAPs should have a key role in the education and training of these health care professionals

**(2013–2015 Priority)** **Recommendation 7.1** – AACAP will provide leadership by advocating for the unique role of CAPs and expanded funding to target the critical CAP workforce shortage and maldistribution.

**Action step 7.1.1** – AACAP will partner with appropriate national organizations, regulatory agencies, and key stakeholders to obtain and maintain funding for key roles and functions of CAP. Examples include but are not limited to graduate medical education (GME) funding, undergraduate medical education funding, and funding to support practitioner activities.

**Action step 7.1.2** – Advocate with HRSA and SAMSHA to promote and support CAPs repayment of loans and work in FQHCs in underserved areas.

**Action step 7.1.3** – AACAP will support expansion and development of primary care consultation models to target CAP maldistribution (e.g., Massachusetts Child Psychiatry Access Project).

**Action step 7.1.4** – AACAP will advocate to remove the cap on the number of GME positions or to allow exceptions for shortage specialties including CAP.

**Action step 7.1.5** – AACAP will advocate for developing incentives for medical students to pursue careers in child and adolescent psychiatry (e.g., differential payments from Medicare and Medicaid).

**Action step 7.1.6** – AACAP will establish a clearinghouse for loan repayment and funding methods to address the shortage and maldistribution of CAPs. AACAP will explore possible funding for CAPs through National Health Service Corps and also develop a loan repayment model for states to target CAP practice in rural areas.

**Action step 7.1.7** – AACAP will advocate for credits and/or funding for providing CAP training experiences in non-traditional GME sites (e.g. schools, correctional facilities, or community settings).

**Action step 7.1.8** – AACAP will advocate for incentives for medical colleges to offer innovative GME training programs in CAP (e.g., integrated programs, post pediatric portal programs).

**Action step 7.1.9** – AACAP will advocate for states to classify CAP as a primary care specialty in order for general psychiatry residents to extend J-1 Visa waivers into CAP training.
Recommendation 7.2 – AACAP, in partnership with other national organizations (e.g., SPCAP, AADPRT, ADMSEP, APA), will expand efforts to recruit talented medical students and residents into CAP.

Action step 7.2.1 – AACAP, in partnership with other national organizations, will examine and promote the development of flexible training models in CAP.

Action step 7.2.2 – AACAP will conduct a needs assessment on competencies obtained in other residency programs that are required to practice CAP.

Action step 7.2.3 – AACAP, in partnership with other national organizations, will provide a clearinghouse of training resources and curricula for CAP training programs.

Action step 7.2.4 – AACAP, in partnership with other national organizations, will work to ensure that funding continues for CAP training - including exploring innovative ways to fund CAP training and experiences.

Action step 7.2.5 – Promote increased exposure to CAP for undergraduate students (e.g., psychology majors) and medical students. Students in rural areas should be encouraged to consider practicing in their home states.

Action step 7.2.6 – AACAP will actively support the development and implementation of undergraduate college programs in child and adolescent mental health to encourage interest in CAP during formative academic years.

Action step 7.2.7 – AACAP will increase efforts to recruit high quality osteopathic medical students into CAP.

Action step 7.2.8 – AACAP will increase efforts to recruit high-quality International Medical Graduate (IMG) applicants into the field.

Action step 7.2.9 – AACAP will support and encourage Regional Organizations of CAP and American Psychiatric Association District Branches to do more outreach to medical students and residents.

Action step 7.2.10 – AACAP will strengthen efforts to recruit general psychiatry residents into CAP.

Action step 7.2.11 – AACAP will support expansion of alternative training programs such as Post- Pediatric Portal Program (PPPP) or Triple Board.

Action step 7.2.12 – AACAP will expand and support mentorship programs for medical students and residents.

Action step 7.2.13 – AACAP, in partnership with other appropriate national organizations, will work to fund research opportunities for medical students and residents. Funding must include faculty positions to support these programs.

Recommendation 7.3 – AACAP, in partnership with other appropriate national organizations (e.g. SPCAP, AADPRT, ADMSEP, APA), will continue working to destigmatize psychiatry and CAP within the medical community.

Goal 8 (Technological advances) – Evolving technological advances must be incorporated into the training, teaching methodology, and clinical practice of child and adolescent psychiatry (CAP).

GOAL 8 – SERVICE/CLINICAL PRACTICE RECOMMENDATIONS:

Rationale: Technological innovations have and will continue to revolutionize the way that medical care is delivered in the United States and mental health care is no exception. Advances in areas such as electronic medical records, telepsychiatry, and other health information technology are changing the way that CAPs interact with patients and their families. Understanding the use of these technologies, as well as the ethical issues surrounding the use of these technologies, is critical in the training of future CAPs. It is also important for mid- and senior career CAP’s to understand and use these technologies.
Recommendation 8.1 – Actively educate child and adolescent psychiatrists about the use of health information technology in clinical practice.

**Rationale:** No expansion or reconfiguration of the workforce will ever meet the overall needs of youth with mental health treatment needs. Future young people will expect that technology be part of their treatment. New technologies should be explored for their therapeutic potential and to assist practitioners in meeting the mandates of health care reform.

**Action step 8.1.1** – AACAP should expand efforts to gather information and educate members about evolving technology advances (e.g., electronic medical records (EMRs), Web-based tools and therapies).

**Action step 8.1.2** – AACAP will disseminate information on the current and future use of mobile apps and online interventions that can be used by youth and families to augment care.

**Action step 8.1.3** – AACAP will investigate and disseminate information on the use of Web-based and mobile screening and treatment tools.

Recommendation 8.2 – The use of EMRs needs to be integrated into the practice of all CAPs.

**Rationale:** EMRs that function well and are integrated have the potential for improving the quality and efficiency of care—especially in the areas of screening, adhering to standard practices of care, and reducing medication errors.

**Action step 8.2.1** – AACAP, in partnership with appropriate organizations (e.g., American Academy of Pediatrics, American Psychiatric Association), will work to develop EMR standards that support best practices for documentation of CAP treatment and adherence to mental health confidentiality standards.

**Action step 8.2.2** – AACAP will work with multiple EMR vendors to develop products with pricing and functionality that is attractive and meets the needs of members' practices.

Recommendation 8.3 – E-prescribing needs to be integrated into the practice of CAP to improve safety and facilitate monitoring and tracking of side effects.

**Rationale:** E-prescribing is being adopted across medicine due to its inherent efficiency. It also can reduce prescribing errors and complications related to the use of multiple medication regimens. Given the potential benefits with regard to safety, and the ability to track side effects and outcomes, all AACAP members should be encouraged to integrate E-prescribing in their practices. A major barrier to CAPs routinely using E-prescribing is the slow adoption of capacity to prescribe Drug Enforcement Administration (EDA) controlled substances—especially stimulants.

**Action step 8.3.1** – AACAP will educate members about the benefits of safety and treatment adherence with E-prescribing.

**Action step 8.3.2** – AACAP will work with electronic prescribing networks and EMR vendors to collect and analyze data to improve the quality of care.

**Action step 8.3.3** – AACAP will work with electronic prescribing networks and EMR vendors to develop programs that would support E-prescribing of all medications—including stimulants.

Recommendation 8.4 – CAPs need to understand the impact on children and families of social media and information available through the Internet.

**Rationale:** Patients and their families have never before had access to such a large amount of variable quality information regarding all aspects of mental healthcare and child development. CAPs need to be aware of the types of different information that is available and to be prepared to help patients and families understand it and use appropriate Web-based information and tools.

**Action step 8.4.1** – AACAP will educate members on collaborating with patients and families to assist them in gathering and understanding health information from the Internet.
GOAL 8 – TRAINING AND WORKFORCE RECOMMENDATIONS:

Rationale: The projected continued shortage of academic CAP challenges us to explore teaching methodology that will effectively reach larger numbers of learners, while still continuing to provide personal supervision and mentoring whenever possible. We need to ensure that the CAP residency curriculum uses effective teaching methodology and incorporates active learning techniques such as case-based or problem-based learning, audience response systems, effective stimulus video, and interactive multimedia modules highlighting child and adolescent psychiatric syndromes. Our trainees should also learn how to teach effectively using technology. Many of our graduates will also be teaching in the community, providing in-service training to allied health care professionals, or training other specialists such as primary care providers. As curricula are developed, care should be taken to consider their adaptability to various training needs and levels, and to include assessment methodology and a way to regularly update the material.

(2013–2015 Priority) Recommendation 8.5 – Promote innovative models for training and practice that include e-health (e.g., telepsychiatry, Internet, communication technology) and multidisciplinary collaboration that expands the reach of CAPs to underserved areas.

Action step 8.5.1 – Develop a curricular needs assessment and gather innovative training models for medical student and CAP residents regarding telepsychiatry.

Action step 8.5.2 – Develop a curricular needs assessment and gather innovative training models for medical students and CAP residents regarding multi-disciplinary collaboration.

Action step 8.5.3 – Develop Web-based multidisciplinary case conferences with edited content and commentary for CAP trainees and practitioners.

Goal 9 (Global perspective) – AACAP and child and adolescent psychiatrists (CAPs) should increasingly promote the international and global perspective to meet the mental health needs of children, adolescents, and families around the world.

Rationale: In a global world, we can no longer focus exclusively on the mental health of only our nation's children. As the largest children's mental health organization, and with an increasing number of international members, AACAP needs to provide leadership in addressing developmental and psychiatric illness in children and adolescents throughout the world. The Academy's size and strength can be used to assist CAPs in other countries around the globe.

AACAP is uniquely positioned to provide leadership and to collaborate on common themes with all child and adolescent mental health (CAMH) organizations around the world. Forging such partnerships and relationships with CAMH organizations will be the focus of AACAP President Paramjit Joshi, M.D.’s 2013–2015 Presidential Initiative “Partnering for the World’s Children.” The focus of Dr. Joshi’s initiative will strengthen AACAP’s relationship with other CAMH organizations around the world and strategically position AACAP as a global organization.

Each CAMH organization (e.g., International Association of Child and Adolescent Psychiatry and Allied Professions [IACAPAP], World Psychiatric Association [WPA]) has its own members, publications, websites, resources, meetings, etc. As President, Dr. Joshi intends to reach out to other CAMH organizations with the goal of supporting each other, sharing resources, and jointly promoting various efforts. No one organization can do it all and each organization should not have to “reinvent the wheel.” For example, AACAP could develop a list of resources on its website that would link to all the other global CAMH organizations and their resources. Each of the CAMH organizations (e.g., IACAPAP, WPA) has developed informative, valuable materials that should be shared with AACAP members.

During the coming decade, the global landscape for CAP and CAMH organizations will be undergoing substantial change. There is a real need for CAP from around the world to unite and work together on behalf of children, adolescents, and families. More than ever, collaboration is essential to maximize the impact and efforts of CAPs to improve child mental health.
Recommendation 9.1 – AACAP should enhance communication and collaboration with international CAPs and share contrasting approaches to the assessment and treatment of psychopathology in children and adolescents.

Action step 9.1.1 – CAPs should collaborate with international colleagues in developing and sharing mental health resources that increase the quality of mental health care around the world.

Action step 9.1.2 – AACAP should encourage international membership and participation in AACAP’s Annual Meetings, CME activities, and scholarly publications.

Action step 9.1.3 – AACAP should facilitate international communication and resource-sharing among organizations through its website.

Action step 9.1.4 – AACAP should collaborate with other child international health organizations (e.g., IACAPAP, WPA, UNICEF, WHO) to promote mental health for children and adolescents around the world.

Goal 10 (Diversity and culture) – Child and adolescent psychiatrists (CAPs) should enhance their cultural competency and awareness to meet the needs of our nation’s changing demographics.

Rationale: Children and adolescents are entitled to the best possible mental health care regardless of their ethnic and cultural backgrounds. The population of the United States is becoming more diverse. CAPs should provide care that is sensitive to and consistent with the patient and family’s cultural health beliefs and practices. Families must be actively involved in treatment and decision making to ensure alignment of the patient’s and family’s treatment goals with those of the CAP. AACAP’s membership should also reflect the demographics and diversity of the United States.

Recommendation 10.1 – CAPs must be sensitive to and capable of working with children, adolescents, and families from diverse cultural and ethnic backgrounds.

Rationale: Cultural competency is an expectation of physicians caring for patients and families in a social environment that is more diverse. CAPs should recognize the importance of history, traditions, values, belief systems, acculturation, and migration patterns; the reasons for immigration, dialects, and languages; and the stressors and traumas that preceded and accompanied immigration. CAPs must be aware of different culture bound syndromes and differing presentation and expression of symptoms in patients and families.

Action step 10.1.1 – CAPs should consider using the national standards on Culturally and Linguistically Appropriate Services (CLAS) developed by the U.S. Department of Health and Human Services to make their practices more culturally and linguistically accessible within the communities they serve.

Action step 10.1.2 – AACAP should use the CLAS standards to ensure that the principles and activities of AACAP are culturally and linguistically appropriate and accessible.

Action step 10.1.3 – CAP residency training should incorporate elements of cultural competence training using the Substance Abuse and Mental Health Services Administration (SAMHSA) standards.

Action step 10.1.4 – AACAP should consider developing a portal that addresses the impact of cultural issues on the mental health of children and adolescents in various populations.

Action step 10.1.5 – AACAP will expand learning opportunities for members regarding culture and diversity. These opportunities could include Web-based educational resources, Annual Meeting programs, and dissemination of AACAP’s Clinical Practice Guideline on “Cultural Competency in Child and Adolescent Psychiatric Practice” (AACAP 2013).

Recommendation 10.2 – CAPs need to be trained in the use of formal and informal interpreters for both assessment and treatment with diverse groups of non-English speaking families.
**Rationale:** The use of interpreters in the clinical setting involves an inclusive approach that discloses all interactions during the session to all participants. The interpreter should be transparent to everyone involved and should allow the patient and the psychiatrist to communicate directly as if no language barrier existed. The interpreter’s goal is to ensure accurate and objective communication between the patient, family, and CAP.

**Action step 10.2.1** – CAP resident training should include the use of interpreters.

**Action step 10.2.2** – AACAP should offer members educational programs and continuing medical education (CME) on the use of interpreters.

**Recommendation 10.3** – CAPs need to understand and implement youth and family driven models of healthcare.

**Rationale:** Patients and families should be actively involved in all aspects of care. When consumers are empowered and have more control over what happens in treatment, compliance, and outcomes are improved.

**Action step 10.3.1** – CAPs should provide patient and family choice and voice in assessment, decision making and the development of the treatment plan.

**Action step 10.3.2** – AACAP should encourage and seek out parent and youth participation in AACAP programs and presentations (e.g., AACAP’s Advocacy Day).

**Action step 10.3.3** – AACAP’s “youth advisory group” should prepare materials to educate CAPs on issues important to youth.

**Recommendation 10.4** – CAPs should understand the use of peer counselors as a possible adjunct to standard treatments.

**Rationale:** Patients and families experiencing the distress of mental illness often look for advice and direction from someone with whom they can identify. Peer counselors serve this role, representing both the patients who suffer with a psychiatric disorder and the families who struggle to support and care for youngsters with emotional and behavioral problems.

**Action step 10.4.1** – CAPs, in partnership with the National Alliance for the Mentally Ill (NAMI) and other local and national organizations, should work to develop mental health services that use peer counselors as part of assessment and treatment.

**Action step 10.4.2** – CAPs, in partnership with NAMI and other local and national organizations, should work to develop appropriate training for peer counselors in the psychiatric care of children and adolescents.

**Recommendation 10.5** – CAPs should be trained to understand and engage children and families from a broad range of cultures, in areas including race, ethnicity, class, religion, geography, language, sexuality, and gender.

**Action step 10.5.1** – CAPs will appreciate commonalities and differences in experience across a broad range of patient and family populations, and be able to work with families whose cultural and societal beliefs are incongruous with the CAPs’ principles and knowledge.

**Goal 11 (Ethics)** – Child and adolescent psychiatrists (CAPs) will incorporate and adhere to the AACAP’s ethical and professional standards (*Code of Ethics*, AACAP 2009) in clinical practice, training, and research.

**Rationale:** Ethical dilemmas in CAP are broad and complex – including but not limited to: clinical boundary crossings, conflicts of interest affecting patient care and public perception, risk management, privacy, beneficence, non-maleficence, autonomy, confidentiality, consent, use of media, managed care, juvenile justice, and social justice. Practicing clinicians,
AACAP, training programs, and lifelong learning programs have a critical obligation to engage in activities that maintain the CAPs’ ethical compass in a world of unethical opportunity.

CAPs should be familiar with AACAP’s Code of Ethics, know the expected ethical and professional behaviors, and practice them. CAPs should have a systematic approach to ethical and professional issues.

Recommendation 11.1 – CAPs should have peer supervision and/or mentorship to help develop and maintain a framework for consideration of ethical and professional issues.

Recommendation 11.2 – CAPs should have a working understanding of the ethical and professional framework and expectations of any allied professionals with whom they practice.

Recommendation 11.3 – All clinical practice, training, and research must be carried out with the highest ethical standards.

Action step 11.3.1 – The AACAP should continue to focus attention on ethical issues arising in all aspects of research, including continued attention to ethical issues related to research at AACAP meetings, in training, in pilot research grants, and in JAACAP.