IPS MIND MATTERS

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Official Publication of the Illinois Psychiatric Society

IN THIS ISSUE

Visit the *new* and *improved* IPS website: **illinois.psychiatry.org**

Be sure to check out the new Career Center.

President's Message

Joshua Nathan, MD, FAPA

As many of our members are aware, physicians' high suicide rate is of major concern for APA and IPS. In an effort to address this issue, IPS has assembled a small task force to create an awareness campaign, the Physician Suicide Prevention Project. The project is aimed at destigmatizing mental illness among physicians and promote mental health by providing easier access to mental health resources for physicians. I am excited to share with our members the progress on this project. IPS applied for and received a grant from the APA to further develop this campaign. We will use the funds to design a postcard and poster for physicians, distribute them to hospitals and medical practices, and build a website that will have educational content, self-assessment tools, and treatment resources. We intend to have links from the postcards directly to the online content, making access to the content very quick and simple.

By raising public awareness of physician depression, burnout, and suicide, we hope to lower the cultural stigma that acts as a barrier to seeking treatment for mental illness. Through highly visible publicity, we hope to bring these issues out of the darkness and into the light, and to socialize physicians seeking help as the expectation rather than the exception. While there are many barriers impeding access to mental health care for physicians, this project aims at tackling them.

Now that the funding has been secured, the next steps will be to start implementation.

The Physician Suicide Prevention Project is building on the success we have had addressing another barrier, the physician licensure application process (discussed later in this issue). Now that a well-treated mental health problem is no longer a concern in licensure in Illinois, we can be clear in the message to our physician friends and colleagues: Get treatment before you work yourself to death.

Members interested in volunteering to work on this project can contact Meryl Sosa (msosa@ilpsych.org). I would like to thank the team members currently working on this vital project. I would also like to express my gratitude to all of our members who provide care to other Illinois physicians. Colleagues like you inspire and support our efforts to enhance physician well-being and mental health in Illinois.

SAVE THE DATE!

IPS ANNUAL MEETING

COLLABORATIVE CARE TRAINING

Saturday, February 2, 2019

More Information Coming Soon!

Amendment to the Illinois Controlled Substances Act

By Hossam Mahmoud, MD MPH

As part of a larger strategy to combat the opioid crisis and improve prescribing practices in Illinois, the legislature passed Senate Bill 2777 earlier in 2018. The Bill, which amends the Illinois Controlled Substance Act by adding a section on Opioid Education for Prescribers, became law after Governor Bruce Rauner signed it in August.

Effective January 1, 2019, the amendment requires all Illinois prescribers with controlled substance licenses to complete the equivalent of three hours of continuing education during their pre-renewal periods, focusing on safe prescribing practices of opioids. The Bill does not specify the educational modules nor their required components; rather it leaves it up to the prescribers to choose educational modules accredited or offered by a state government agency, a federal government agency, or a professional association.

What IPS members need to know:

- As of January 1, 2019, three continuing medical education (CME) credits will be required prior to renewing Illinois medical licenses.
- CME activities that would meet the new requirement include those offered by APA and other professional bodies, as well as those offered by state medical boards, state medical societies, and federal and state agencies or regulatory bodies.
- Such CME credits can also be used to meet the criteria for licensure in other jurisdictions.
- CME credits on the safe prescribing of opioids completed for licensure in a jurisdiction other than Illinois or for professional certification would count towards the new requirement under the Illinois Controlled Substances Act
- The Illinois State Medical Society (ISMS) will be providing CME programs focused on this topic.

The language of the Bill is included for reference:

"The Illinois Controlled Substances Act is amended by adding Section 315.5 as follows:

(720 ILCS 570/315.5 new) Sec. 315.5. Opioid education for prescribers. Every prescriber who is licensed to prescribe controlled substances shall, during the pre-renewal period, complete 3 hours of continuing education on safe opioid prescribing practices offered or accredited by a professional association, State government agency, or federal government agency. Notwithstanding any individual licensing Act or administrative rule, a prescriber may count these 3 hours toward the total continuing education hours required for renewal of a professional license. Continuing education on safe opioid prescribing practices applied to meet any other State licensure requirement or professional accreditation or certification requirement may be used toward the requirement under this Section. The Department of Financial and Professional Regulation may adopt rules for the administration of this Section."

More information on SB2777 can be found on the Illinois General Assembly website or following the link: http://www.ilga.gov/legislation/publicacts/100/PDF/100-1106.pdf

Involuntary administration of psychotropic medication

By Meryl Sosa, Esq.

Recently, the Illinois Appellate Court, Third District, published the decision In re Wilma T, 2018 IL App (3d) 170155, which addressed involuntary commitment and involuntary administration of psychotropic medication.

The respondent in the case was a voluntary patient in an inpatient unit. The respondent would not sign a request for discharge but a request was signed by three nurses who said that the respondent had requested discharge but refused to sign the form. A petition for involuntary commitment and involuntary administration of psychiatric medication were filed because the respondent refused to take medication while he was in the in-patient unit.

The Court made the following rulings:

1. Section 3-403 of the Mental Health and Developmental Disabilities Code (the Code) requires a written notice of a respondent's desire to be discharged in order for an involuntary commitment petition to be filed against a voluntarily admitted patient. An oral request is insufficient.
2. Section 2-102 of the Code requires that the recipient of psychotropic medication to be notified in writing of the alternatives to the proposed treatment. This requirement cannot be satisfied by verbal advice. In addition, the Court held that strict compliance with this rule is required. Thus, "the State cannot establish that a respondent lacks the capacity to make a reasoned decision without the respondent receiving prior written notice."

Gun Violence and the Mental Illness Invocation

By Scott Gershan, MD

In the aftermath of the shooting at Marjory Stoneman Douglas High School, February 2018, the chorus of opinions has re-emerged from its dormancy since the mass shooting in October 2017 in Las Vegas. Our President's initial response focused on tackling "the difficult issue of mental health."

Mr. Trump continued to opine through tweets that the Florida shooter was "mentally disturbed" and a "sicko", an impulsive indictment. In the wake of these tragic events, mental illness consistently elicits powerful language and earns a front row seat in our ongoing debate. We should ask ourselves "why?" and "is it honest?"

The American Psychiatric Association, along with four other professional organizations representing 450,000 physicians, also responded to the massacre, labeling our nation's gun violence a public health epidemic. They further pleaded for our leaders and lawmakers to take an evidence-based approach to understand this epidemic and create a preventive road map. An epidemic calls for an unemotional, scientific analysis including statutory, environmental and cultural factors.

Epidemiological statistics help contextualize our epidemic. Prevalence rates of severe mental illness, including schizophrenia and bipolar disorder, are consistent across national and ethnic boundaries. Other advanced, industrial countries vastly differ in the quantity of mass shootings compared to the United States. Mental illness is everywhere, but gun violence is not. If we adjust for population, the numbers don't add up.

Rubber stamping gun violence as a mental health problem does nothing to advocate for the severely mentally ill; rather, it distorts perceptions into crude caricatures. After all, as we know, mental illness is not as unusual as people may think. Research suggests that nearly half the population experience some symptoms of mental illness over the course of their lifetimes. Only a small percentage may be deemed severely mentally ill, and perhaps more prone to violent acts, but even in this cohort, the vast majority are not violent. When our society reflexively labels mass shooters mentally ill, we slide down a slippery slope that has powerful stigmatizing ramifications on an already vulnerable population. Beyond an unfair misrepresentation, it is a de-emphasis on the plausible environmental factors related to mass shootings.

Why then do so many, including our President and many policy makers, jump to mental health following mass

shootings? It is viscerally instinctive to think that such acts can only be perpetrated by the mentally ill. Criminality, no matter how heinous or violent the act, is not tantamount to mental illness. And psychiatric conditions are not diagnosed through gut instincts or shock value, but rather through a well-defined set of validated criteria that clinicians are trained to recognize.

Beyond a general psychiatric assessment, a forensic trained clinician is best equipped to assess the causal points between criminality and mental illness. The severely mentally ill can be complicit to crime completely irrespective of a psychiatric diagnosis. Statistically, it is quite rare for a court to accept a causal relationship between a criminal act and disease. Known as the insanity defense, it is a strictly defined legal standard.

Perhaps it is societal naiveté that so readily invokes mental health in the aftermath of violence. Perhaps it is a more strategic undertaking, whose sponsors peddle an agenda to turn mental illness into an easy scapegoat. The notion that spree killings are the by-products of mental defect is at best grossly over-simplified and at worst politically opportunistic – a tactic that pivots the focus away from firearm accessibility, gun law reform and a dire need for societal introspection. The tweeted rhetoric targeting disturbed "sickos" is disingenuous and damaging.

IPS Resident Rooftop Happy Hour

The IPS Resident Rooftop Event took place on July 19 in downtown Chicago. There were about 40 residents who attended this event and enjoyed food, drinks and good networking. A big thank you goes to Professional Risk Management Services (PRMS) for sponsoring this event and providing 10, $100 gift certificates to the APPI Bookstore that were raffled off to the event attendees.

From Left: Dr. Ishaq Lachin, Dr. Bianca Pullen, Dr. Victor Patron

A group of Residents from all over the state of Illinois enjoying the roof top event.

Residents listening to a short talk given by Dr. James Mackenzie.

From Left: Dr. Krushen Pillay, Dr. Ahmed Maki, Dr. Indu Nagra, Dr. Deepa Nadella, Dr. Nishaan Nagarakanti

IPS Member Survey 2017: Resources, Priorities and Future Directions

By Caroline Morrison, MD and Hossam Mahmoud, MD MPH

CORRECTION

IPS would like to make a correction to a figure that appeared in Mind Matters Issue 39 under the article IPS Member Survey 2017: Resources, Priorities and Future Directions.

The table published on Page 7 of Issue 39 mentioned that 85% of respondents disagreed with the statement "IPS promotes opportunities to network with colleagues." The accurate figure is 8%. Below is the table reprinted with the accurate figure:

Please indicate your level of agreement with the following statements	Strongly Agree	Agree	Somewhat Agree	Disagree	Stronly Disagree
IPS is a voice for psychiatry in Illinois.	49%	34%	16%	1%	0%
IPS is a voice for patients in Illinois.	35%	35%	27%	4%	0%
IPS is effective in legislative efforts.	33%	45%	18%	4%	0%
IPS effectively informs me about laws and regulations.	40%	40%	15%	5%	0%
IPS promotes opportunities to network with colleagues.	25%	43%	23%	8%	1%
IPS promotes opportunities to meet with legislators and civic leaders.	27%	39%	28%	5%	0%
IPS provides educational opportunities.	21%	44%	20%	15%	0%
IPS adequately connects me with APA initiatives.	31%	32%	24%	11%	3%

The National Partnership to Improve Dementia Care Looks at Antipsychotics in Long Term Care

By Sandra Swantek, MD

Many psychiatrists who prescribe in Illinois nursing homes will soon experience increased encouragement to review antipsychotic prescriptions for their long-term care (LTC) patients. The Centers for Medicare and Medicaid Services (CMS) Antipsychotic Medication Use Data Report (October 2017) identified Illinois as 49th out of 50 states, plus D.C., in the use of antipsychotic medications in long term care. In Illinois, 19.1% of LTC residents are receiving antipsychotic medication while the national average is 15.73%. These numbers *exclude* patients with a diagnosis of schizophrenia, Huntington's disease or Tourette's syndrome. LTC antipsychotic use statistics are reported to the public via the CMS Nursing Home Compare website at https://www.medicare.gov/nursinghomecompare

The National Partnership to Improve Dementia Care in Nursing Homes (NPIDCNH) had achieved the 2012 goal of reducing the national prevalence of antipsychotic use in long-stay nursing home residents by 30% by the end of 2016. It has now announced a new goal for the end of 2019, to decrease by 15% the antipsychotic use for long-stay residents in LTC facilities that did not meet the original goal.

Currently, there are 93 nursing homes in Illinois encouraged to immediately review their use of antipsychotic medications. Facilities are encouraged to initiate person-centered, comprehensive interdisciplinary behavioral plans prior to tapering and discontinuing antipsychotic medications, which aligns with the 2017 Requirements of Participation (ROP). (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)

The American Psychiatric Association Practice Guideline on Use of Antipsychotics to Treat Agitation or Psychosis in Patients is a key resource for psychiatrists seeking guidance on the appropriate use of antipsychotic medications in the older adult population (https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426807). Another resource is IA-ADAPT, a program produced by the Iowa Geriatric Education Center, University of Iowa and funded by the Agency for Healthcare Research and Quality. IA-ADAPT is a free resource found at https://igec.uiowa.edu/ia-adapt. This website provides an overview of an evidence-based approach and evaluation of problem behaviors, non-drug management, and an antipsychotic prescribing guide. There is also an algorithm for behavioral and psychological symptoms of dementia.

Under the direction of CMS, Telligen prepared an antipsychotic reduction prioritization tool for nursing homes implementing antipsychotic reduction plans (https://www.hsag.com/contentassets/a94cac2292914df2bef9611b42c1f177/antipsychotic-reduction-tool_508pubbed.pdf) This tool was designed by a pharmacologist for the purpose of identifying and prioritizing patients who may be appropriate for antipsychotic medication reduction. Other resources available to aide facilities in improving behavioral plans may be found on the National Partnership Resource Repository website.

The NPIDCNH was launched by CMS in 2012 with a commitment to improve the quality of care for individuals with dementia living in nursing homes. The NPIDCNH promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance. The Illinois Psychiatric Society is a state association participant.

For more information and resources, direct questions to ***ildementiacoalition@IHCA.com***

Advocacy Day

IPS Advocacy Day took place on April 18. About 50 people headed down to Springfield, IL for a day of advocacy work, meeting with legislators and discussing issues that are important to mental health, IPS members and their patients. A reception was held in the evening where IPS members could network with legislators. Thank you to Wexford Health for sponsoring the evening reception.

IPS Residents and Attendings with State State Representative Will Guzzardi

IPS members attending the IPS Advocacy Day Reception sponsored by Wexford Health

IPS Residents and Attendings with State Senator Julie Morrison

IPS and Equip for Equality Join Forces to Improve Illinois Physician Licensure Applications

By Joshua Nathan, MD

Over the past year, IPS has worked together with Equip for Equality (EFE) to bring a major change to the Illinois applications for physician licensure. This change pertains to the question for determining an applicant's fitness and ability to practice. This question used to ask applicants whether they have ever had a disease or condition that limited their ability to practice, with additional emphasis on mental illness or substance abuse. As of June 2018, on all physician license applications — including initial applications, renewal applications, and temporary applications for residents — this question asks only about an applicant's current illness that impairs practicing as a physician. Additional details and a guide to answering these questions is available in the official announcement included below. This change came about through concerted efforts and ongoing communication with the Illinois Department of Financial and Professional Regulation (IDFPR). IPS is hopeful that the changes will have profound positive impact on the health and well-being of all Illinois physicians.

Through the efforts of Rachel Weisberg at EFE, IDFPR changed the wording in initial applications in 2016. In June 2017, however, then-President-Elect Joshua Nathan noticed during the license renewal process that the IDFPR application continued to ask about current and past medical illness, including mental illness and substance abuse. IPS had concerns about this question being a possible violation of mental health parity. Additionally, IPS had received input from residents applying for their initial license that the wording was unclear, and the response from IDFPR to "yes" response was quite onerous. If an applicant indicated they had a current or past mental illness, IDFPR would not issue a full license until the applicant had entered into treatment, and shared quarterly letters on progress from the treating physician. Upon further review IPS and EFE discovered that the language change in the initial application had been inconsistent — changed in one part but not another. Ms. Weisberg was able to get IDFPR to correct that, and to ensure that the changes were made in the renewal and temporary applications as well, including the paper and online applications. Thus, as of this past June, all applications for medical licensure ask only about current medical illness, including mental illness and substance abuse.

The significance of this change cannot be overstated. With a minor wording change, a major obstacle to physician mental health is significantly reduced.[1] Past mental illness is irrelevant to licensure. Similarly, licensure is not affected by a current mental illness that is managed by treatment or that does not interfere. This change means that Illinois physicians can address their own mental illness without fearing an impact on their careers. We have significantly reduced one component of institutional stigma.

After a sigh of relief, we cannot rest on our laurels. There is still more to do. First, we must remain vigilant to make sure that the changes that IDFPR agreed to are fully implemented. Second, despite these advances, it seems likely that the application still does not fully comply with the Americans with Disabilities Act. The applications still ask about current medical illness, including mental illness and substance abuse, and at least a couple of published opinions suggest that request of any information about an applicant's medical history is illegal. In 2014, the United States of America reached a settlement with the Louisiana Supreme Court[2] that provides guidance on appropriate questions for licensure. The American Bar Association has issued a resolution[3] that led many states to remove questions about mental illness from attorneys' license applications. Ideally, our medical license applications

Continued on next page...

Changes to IDFPR licensing regarding applicants' mental health and substance use disorders

By Joshua Nathan, MD

The Illinois Department of Financial and Professional Regulation (IDFPR) regulates many professions in Illinois, including physicians. Applicants seeking a professional license are required to complete a licensing application, which includes a number of questions intended to help IDFPR determine an applicant's fitness and ability to practice in his or her desired profession.

For many years, the IDFPR licensing application asked applicants whether they have ever had a disease or condition that limited their ability to practice in their chosen profession. In 2016, however, IDFPR significantly narrowed the scope of this question and now asks only about *current* conditions and *present* limitations.

The question asks: "Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) a mental or emotional disease or condition; (2) alcohol or other substance abuse; and (3) physical disease or condition. *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment."*

This question asks only about an applicant's *current* limitations. There is no reason to disclose a past condition or even a current condition that does not cause any current limitations.

For example:

- John has been diagnosed with bipolar disorder. Before his diagnosis, he would have had difficulty practicing medicine. However, as a result of his current treatment regimen, he does not have any limitations in his ability to practice medicine. ***John can answer no.***
- Maria has a history of substance abuse. She does not currently use or abuse substances, and her history of using substances has no negative impact on her current ability to practice medicine. ***Maria can answer no.***
- Brian has depression. He has days when he is unable to function and expects that when he practices medicine, he will need to find a position where he can work a flexible schedule given the unpredictability of his condition. ***Brian probably needs to answer yes.***

If you have questions about your application, you can contact Meryl Camin Sosa at msosa@ilpsych.org. The Illinois Psychiatric Society thanks Rachel Weisberg of Equip for Equality for her help with making the changes to the licensure applications.

Disclaimer: The material for informational purposes only and does not constitute legal advice to any individual or group. Questions concerning how this material applies to any person's own situation should be discussed with that person's attorney.

Continued from previous page...

would not ask about our medical histories at all, but rather inquire only about our current capacity to function in the role of physician without causing harm to patients. Lastly, the Illinois Medical Practice Act seems to allow for, and may even require, questions about mental health and substance abuse in the IDFPR applications for a medical license. Therefore, statutory change may be needed in Illinois to eliminate any mention of medical illness, much less mental illness and substance abuse in our licensing process.

We owe a special thank you to Rachel Weisberg and EFE for the wonderful and powerful advocacy work that has benefited all Illinois physicians. And we must now spread the word far and wide, to all of our medical colleagues: If you are suffering from a mental illness, do not be afraid to get treatment.

References:

1. LN Dyrbye, CP West, et al. Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. Mayo Clinic Proceedings. Vol. 92, Is. 10, Oct. 2017, pp 1486-1493.
2. http://www.ada.gov/louisiana-supreme-court_sa.htm
3. American Bar Association Resolution 102 (2015)

Staying Informed on MOC

By Hossam Mahmoud, MD MPH

The American Board of Psychiatry and Neurology (ABPN) is initiating an optional pilot program for Maintenance of Certification (MOC) Part III. Scheduled to start in 2019, this project is described as an optional "journal article-based assessment activity" that would serve as an alternative to the 10-year MOC examination. Being an optional program, diplomates were given a deadline of May 1, 2018 to opt to participate in the project or to continue to take the current MOC exam. More details on ABPN's MOC Part III Pilot Project are available through the following links:

https://www.psychiatry.org/psychiatrists/education/certification-and-licensure/moc-part-3-pilot-project

https://www.abpn.com/maintain-certification/moc-part-iii-pilot-project/

In addition, the American Board of Medical Specialties (ABMS) started a process to collect feedback on MOC Requirements, using an online survey. The aim of the survey as described by ABMS is to "identify key concerns regarding MOC and inform the work of ABMS's new Vision for the Future Commission, which aims to use the data in a comprehensive assessment of continuous board certification." While open to all specialties under ABMS, the survey has represented an opportunity for APA members to express their concerns regarding MOC. The ABMS online MOC survey was made available through the following link:

https://www.surveymonkey.com/r/S5YLCN7

Residents' Corner

Patricia Ann S. Calimlim, MD | Chief Resident of Academics
Department of Psychiatry and Behavioral Sciences
Chicago Medical School,
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Physician burnout is like the final sizzle of a career finishing its insidious course of combustion. In a way, we are similar to candles, made of wicks, waxes, and flame. Each component is a construct of our professional identity. For some, the waxy foundation was first formed with childhood "when I grow up" fantasies or from the thrill of frog dissection in biology class. Years of science courses, volunteerism, research, and other experiences further shaped the pillar, solid and strong around the wick of determination to become physicians. We are ignited in medical school, an optimistic light, happily flickering by the breeze of our short white coats. The wax heats and melts, feeding the flame, and at times, the challenges of exams, missed birthdays and holidays, and other dissatisfactions splash the wax away. By residency, we are at varying tapers, our wicks exposed and upright. But we are still lit, and we are finally doctors with our embroidered long white coats and personal pagers. Decisions to pursue leadership roles, posters and journal publications, and fellowships burn us brighter. We are roaring torches, inextinguishable.

As chief resident of academics, I planned the first lecture last year to focus on cases and activities for "Recognizing and Preventing Burn-Out." It was bold for the first didactic day, as if I was preparing everyone to brace themselves for a challenging year ahead. I did not expect my own candle to burn with such intensity, as I encouraged my colleagues to join IPS activities, organized faculty-resident dinners, and coordinated team-building activities on top of planning the already demanding academic curriculum. Successes also came with challenges. It felt as if each administrative roadblock, schedule change, or issue in my outpatient clinic was demanding part of my flame like using one candle to light an entire birthday cake in one attempt. By mid-year, I was scrambling to cloche my candle, which was barely a glowing speck.

In late March 2018, coincidentally on National Doctor's Day, the Journal of the American Medical Association (JAMA) published an article by authors of the Collaborative for Healing and Renewal in Medicine, "Charter on Physician Well-Being." The hope is to share responsibility across health care players, which would benefit physician-patient connections and improve overall health care system performance.

The charter describes societal, organizational, and individual commitments to improve the culture in medicine and address physician well-being:

Societal Commitments involve fostering a supportive culture in medicine, in which individuals and leaders are called to promote community, express compassion to colleagues and educate others by utilizing this in practice. Furthermore, physicians would be encouraged to seek mental health care without fear of licensing penalty.

Organizational Commitments include supportive systems such as adequate practice resources and staffing, manageable workload, and decreased administrative work which would increase time for direct patient care.

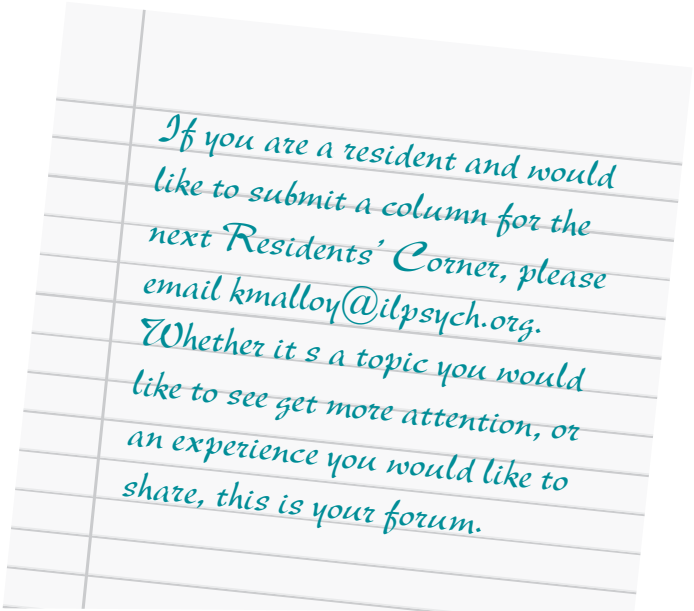
Leadership in organizations including medical school, residencies, hospitals, and healthcare systems would prioritize well-being initiatives and foster shared decision making. This would further be achieved by team-based training, optimizing interprofessional relationships, and other collaborations to disperse workload.

Interpersonal and Individual Commitments promote self-care and protected time for physicians to enrich their own well-being, incentivizing healthy lifestyle practices and improving access to healthy food or exercise facilities near their workplaces. They also prioritize mental health by increasing access to confidential services and openly encouraging physicians to seek help. And finally, to integrate regular coping strategies into training and continuing education, and encourage regular open communication for adverse events at work.

The change in focus to "encourage physician well-being," rather than "prevent physician burn-out," promotes a more proactive and supportive approach to improve the culture in medicine. We would no longer be alluded to candles or to needing re-ignition. We are physicians – people – and in summary, the authors of The Charter on Physician Well-being "intended to inspire collaborative efforts among individuals, organizations, health systems, and the profession of medicine to honor the collective commitment of physicians to patients and to each other."

The full text of the Charter on Physician Well-being can be found on the JAMA website:

https://jamanetwork.com/journals/jama/article-abstract/2677478



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Announcements

The following IPS members were recognized at the Association for Academic Psychiatry (AAP) Annual Meeting in September 2018, for their work and contribution to the field of academic psychiatry:

- Karen Broquet, MD, Associate Dean for Graduate Medical Education, Southern Illinois University School of Medicine – AAP 2018 Lifetime Achievement Award
- Melissa Wagner-Schuman, MD, PhD, Director of Women's Mental Health, University of Illinois College of Medicine – AAP 2018 Early Career Development Award
- Daniel Lee, MD, Rosenstone Fellow in Behavioral Neurology, Northwestern University – AAP 2018 Resident Psychiatric Educator Award