M.J. Powers & Co. Continuing Education

CHILD & ADOLESCENT PSYCHIATRY ALERTS

Target Audience
This activity is intended for physicians and other healthcare providers who are involved with or have an interest in the diagnosis and management of child and adolescent psychiatric disorders.

Learning Objectives
- Integrate into clinical practice findings from new diagnostic and therapeutic studies.
- Determine appropriate patient evaluation and treatment selection for child and adolescent psychiatric and behavioral disorders.
- Discuss developmental risk factors and comorbid disorders and how they affect outcomes.
- Plan strategies for early intervention to improve outcomes.
- Appropriately prescribe medications or other therapeutic interventions.
- Recognize and implement new approaches to the treatment of child and adolescent psychiatric and behavioral disorders.

Activity Code 17MP02C / Exam #31

Issues to be included . . . . . July–December 2017

Release date . . . . . February 2018

Exam must be returned by . . . . . June 30, 2019

Upon completing this activity as designed and achieving a passing score of 70% or higher on the post-test examination, participants will receive a letter of credit awarding *AMA PRA Category 1 Credit(s)*™ and the test answer key four (4) weeks after receipt of the post-test and registration/evaluation form.

Accreditation
M.J. Powers & Co. Publishers is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

M.J. Powers & Co. Publishers designates this enduring material for a maximum of 12 *AMA PRA Category 1 Credits*.™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

In order to obtain CME/CEU credit, participants are required to complete all of the following:

1. Read the learning objectives and review ***Child & Adolescent Psychiatry Alerts***, Volume XIX, July 2017 through December 2017 (6 issues), and complete the post-test.
2. Complete the enclosed registration/evaluation form and record your test answers in the boxes using either pen or pencil.
3. Mail the form to **M.J. Powers & Co. Publishers, 45 Carey Ave, Ste 111, Butler, NJ 07405; scan and email it to cme@alertpubs.com; or fax it to 973-898-1201.**

Planning Committee
Trish Elliott, Executive Editor, M.J. Powers & Co. Publishers, Butler, NJ
Tara Hausmann, Associate Editor, M.J. Powers & Co. Publishers, Butler, NJ

Contributing Editors
Bennett Silver, MD, Private Practice, Springfield, NJ
Kate Casano, MSHyg, M.J. Powers & Co. Publishers, Butler, NJ
Donna Foehner, Assistant Editor, M.J. Powers & Co. Publishers, Butler, NJ

Consulting Editor and CME Reviewer
This activity was reviewed for relevance, accuracy of content, and balance of presentation by Theodore A. Petti, MD, MPH, Professor of Psychiatry, Rutgers-Robert Wood Johnson Medical School, Piscataway, NJ.

Disclosure Declarations
Kate Casano has no relevant financial relationships.
Trish Elliott has no relevant financial relationships.
Donna Foehner has no relevant financial relationships.
Tara Hausmann has no relevant financial relationships.
Theodore A. Petti, MD, MPH has no relevant financial relationships.
Bennett Silver, MD has no relevant financial relationships.

M.J. Powers & Co. Publishers is fully independent and accepts no commercial support of any kind.

Off-Label Usage Disclosure
This activity may discuss commercial products unlabeled for use or an investigational use of a product not yet approved by the United States Food and Drug Administration.

For Additional Information or Questions
M.J. Powers & Co. Publishers
Phone: (973) 898-1200 Email: cme@alertpubs.com

CME credit for this activity can be claimed through June 30, 2019.

1. In a randomized trial in children with anxiety symptoms, parent-delivered CBT was superior to solution-focused brief therapy.

A. True
B. False

7/17, pgs. 37–38

2. The overall costs were nearly _____% lower for parent-delivered CBT than for solution-focused brief therapy.

A. 15
B. 25
C. 30
D. 35

7/17, pgs. 37–38

****

3. In an observational study in 264 older adolescents with depression, treatment with SSRIs was associated with:

A. Increased adiposity
B. Decreased adiposity
C. Loss of appetite
D. Binge eating

7/17, pgs. 38–39

4. In an analysis comparing the individual antidepressants used in this study, _____ was/were associated with the largest increases in body composition measures compared with no treatment.

A. Citalopram and escitalopram
B. Escitalopram and sertraline
C. Sertraline and fluoxetine
D. Fluoxetine and fluvoxamine

7/17, pgs. 38–39

****

5. In a 6-week placebo-controlled trial in adolescents with schizophrenia, treatment with lurasidone resulted in significantly better efficacy than placebo beginning after treatment week:

A. 1
B. 2
C. 3
D. 4

7/17, pgs. 39–40

6. Significantly more patients who received treatment with lurasidone achieved remission than those who received placebo.

A. True
B. False

7/17, pgs. 39–40

7. Lurasidone treatment was associated with minimal changes in:

A. Body weight
B. Metabolic parameters
C. Prolactin
D. All of the above

7/17, pgs. 39–40

****

8. In an independently-funded, head-to-head comparative trial in children and adolescents with first-episode psychosis, both quetiapine and aripiprazole had limited efficacy and _____ levels of adverse effects.

A. High
B. Low

7/17, pgs. 40–41

9. At study week 12, patients who received quetiapine had gained at least _____ lbs more than the aripiprazole group.

A. 3
B. 5
C. 7
D. 8

7/17, pgs. 40–41

10. Patients who received aripiprazole experienced more _____ than those who received quetiapine.

A. Extrapyramidal symptoms
B. Weight gain
C. Cognitive improvements
D. All of the above

7/17, pgs. 40–41

****

11. According to a meta-analysis of 32 trials that reported irritability as an adverse effect of stimulant medication, methylphenidate derivatives appear to be associated with _____ risk of irritability.

A. Increased
B. Reduced

7/17, pgs. 41–42

12. In this analysis, amphetamine-derived stimulants were associated with _____ risk of irritability.

A. Increased
B. Reduced

7/17, pgs. 41–42

****

13. A new once-daily triple-bead mixed amphetamine salts formulation (*Mydayis*) has received FDA approval for the treatment of ADHD in adults and adolescents aged ≥13 years. In clinical trials, the agent was shown to significantly improve symptoms for up to _____ hours postdose.

A. 12
B. 16
C. 18
D. 24

8/17, pg. 43

****

14. In a longitudinal study of >25,000 patients given a prescription for methylphenidate, risk of suicide attempt was highest in the 90 days preceding the methylphenidate prescription. Risk remained elevated during _____ of methylphenidate use before returning to near-baseline levels.

A. The first 30 days
B. Days 10–30
C. The first 90 days
D. Days 30–90

8/17, pgs. 43–44

****

15. In a meta-analysis of randomized, controlled trials, methylphenidate was associated with a >3-fold increase in risk of:

A. Reduced appetite
B. Increased appetite
C. Vomiting
D. Diarrhea

8/17, pgs. 44–45

16. Methylphenidate was also associated with decreased weight in parallel-group trials and with _____ in the crossover trials.

A. Vomiting
B. Diarrhea
C. Abdominal pain
D. Dyspepsia

8/17, pgs. 44–45

****

17. The Safe Alternatives for Teens and Youths (SAFETY) program is a 12-week intervention for suicide prevention that includes both the adolescent patient and a parent. The program combines aspects of:

A. CBT
B. Dialectical behavior therapy
C. Family-centered approaches
D. All of the above

8/17, pgs. 45–46

18. In a preliminary, randomized, controlled trial, SAFETY _____ a protective effect against suicide attempts in adolescents with a history of suicide attempt or nonsuicidal self-injury in the past 3 months and 3 or more lifetime episodes of self-harm.

A. Had
B. Did not have

8/17, pgs. 45–46

19. In this study, overall, patients in the SAFETY program had a significantly reduced likelihood of a suicide attempt at 3 months. However, the effects of the program weakened over time, suggesting that it might be enhanced by including:

A. Increases in stimulant dosage
B. Continuation or maintenance strategies
C. A school-based component
D. Sibling participation

8/17, pgs. 45–46

****

20. An individual-level risk calculator was developed to predict onset of bipolar disorder using data from an ongoing longitudinal study of children and adolescents at familial risk. When tested, the risk calculator discriminated between young people who did/did not convert to the disorder with _____% accuracy.

A. 58
B. 62
C. 67
D. 76

8/17, pgs. 46–47

21. _____ was the only variable whose removal uniformly decreased the accuracy of the prediction.

A. Childhood infection
B. A diagnosis of ADHD
C. Parental age at onset
D. Anxiety

8/17, pgs. 46–47

****

22. In a 2-year observational study in 299 children and adolescents with ADHD, lisdexamfetamine _____ throughout the trial.

A. Slowly lost efficacy
B. Showed continued clinical efficacy

8/17, pgs. 47–48

23. In this study, adverse effects of lisdexamfetamine were:

A. Reported by 90% of study patients
B. Mostly mild or moderate
C. Dose-related
D. All of the above

8/17, pgs. 47–48

****

24. An investigational once-daily methylphenidate formulation, HLD200, was designed to address the unmet need for treatment of ADHD-related functional impairment in the evening.

A. True
B. False

9/17, pgs. 49–50

25. In a phase-III trial in children with ADHD, treatment with HLD200 was associated with early morning functional improvements. In the study, sleep-related adverse effects were _____ and resolved with time.

A. Very common but mild
B. Mild but long-lasting
C. Rare and mild
D. Rare but serious

9/17, pgs. 49–50

****

26. At present, there is no consensus definition of problematic social media use. However, according to the biopsychosocial theoretical model, problematic social media use can be determined by these symptoms:

A. Mood modification and salience
B. Tolerance and withdrawal symptoms
C. Interpersonal conflict and relapse after a period of abstinence
D. All of the above

9/17, pgs. 50–51

27. This theoretical model informed the development of the Bergen Social Media Addiction Scale (BSMAS), which had a sensitivity of 83% for detecting individuals at high risk of developing problematic social media use and a specificity of _____%.

A. 78
B. 89
C. 99
D. 100

9/17, pgs. 50–51

28. High-risk users, identified by the BSMAS, made up 4.5% of all social media users in the study sample of >6000 users and were characterized by high scores on the tolerance and _____ items.

A. Sleep disturbance
B. Withdrawal
C. Interpersonal conflict
D. Salience

9/17, pgs. 50–51

****

29. In a large, longitudinal, population-based study of children, internalizing and externalizing behavior problems were associated with:

A. Altered brain development
B. Prenatal exposure to stimulants
C. PTSD
D. All of the above

9/17, pgs. 51–52

30. In the study, higher baseline Child Behavior Checklist (CBCL) externalizing scores were associated with smaller total brain and _____ volumes.

A. Subcortical
B. Cortical gray matter
C. White matter
D. All of the above

9/17, pgs. 51–52

31. The findings of this study suggest that, in addition to the standard model of brain shaping behavior, behavior may also shape the brain.

A. True
B. False

9/17, pgs. 51–52

****

32. Celecoxib is an antiinflammatory drug that can curb levels of proinflammatory cytokines and prostaglandins that may contribute to the etiology of:

A. Ritualistic behavior
B. Depression
C. Anxiety
D. Mania

9/17, pgs. 52–53

33. In a small placebo-controlled trial, treatment with adjunctive celecoxib resulted in reduced symptoms of mania in adolescents with bipolar disorder. Differences in response and remission rates _____ reach statistical significance.

A. Did
B. Did not

9/17, pgs. 52–53

****

34. In a placebo-controlled trial of intranasal oxytocin in children with autism, scores on the Social Responsiveness Scale decreased by a significantly larger margin with oxytocin than with placebo.

A. True
B. False

9/17, pgs. 53–54

35. Patients with the _____ pretreatment plasma levels of oxytocin experienced the greatest improvements in social ability with oxytocin treatment.

A. Highest
B. Lowest

9/17, pgs. 53–54

****

36. In a placebo-controlled trial in children with recent-onset, severe OCD and PANS/PANDAS, treatment with azithromycin resulted in a 22% decrease in CGI-S score, compared with _____% with placebo.

A. 1
B. 5
C. 8
D. 12

10/17, pgs. 55–56

37. In this trial, patients with a higher level of tic severity at baseline were _____ likely to have experienced symptomatic response.

A. More
B. Less

10/17, pgs. 55–56

****

38. In a large cohort of children, internalizing problems were found to be more likely to occur in girls, in children who at age 6–7 years had greater emotional dysregulation and externalizing problems, and in children whose mothers reported poorer mental health and:

A. A history of physical abuse
B. A more angry parenting style
C. Poorer socioeconomic status
D. Suicidality

10/17, pgs. 56–57

39. Also, poorer maternal mental health and peer problems in 4–5 year olds were associated with more internalizing problems 2 years later.

A.True
B. False

10/17, pgs. 56–57

40. These results support the recognized importance of peer interactions and maternal mental health. Attention to social and emotional skill development in children transitioning to school as well as programs to support _____ could be useful in preventing later internalizing problems.

A. Family nutrition
B. Family financial difficulties
C. Maternal mental health
D. All of the above

10/17, pgs. 56–57

****

41. In a longitudinal study that compared within-patient experience, treatment with stimulants or atomoxetine was associated with _____ risk of substance use problems.

A. Increased
B. Lowered

10/17, pgs. 57–58

42. In within-individual models that excluded potentially confounding individual-level factors, ADHD medication was associated with a 35% lower risk of substance-related events in men and a _____% lower risk in women.

A. 31
B. 36
C. 41
D. 44

10/17, pgs. 57–58

43. Accumulating evidence suggests that ADHD medication may protect against not only substance use problems, but related outcomes such as:

A. Injuries and accidents
B. Criminality
C. Depression and suicide
D. All of the above

10/17, pgs. 57–58

****

44. In a systematic review and meta-analysis of all currently recommended treatments for anxiety symptoms in children and adolescents, SSRIs were significantly superior to placebo for _____-rated measures.

A. Child
B. Parent
C. Clinician
D. All of the above

10/17, pgs. 58–59

45. No evidence supported the use of tricyclic antidepressants or benzodiazepines.

A. True
B. False

10/17, pgs. 58–59

46. CBT was found to be effective in treating anxiety symptoms in children and adolescents. In a network meta-analysis, CBT performed as well as any individual medication but not all medications pooled.

A. True
B. False

10/17, pgs. 58–59

****

47. Results of a systematic review and meta-analysis indicate that SSRIs and SNRIs are superior to placebo by a large margin in children and adolescents with common psychiatric disorders.

A. True
B. False

10/17, pgs. 59–60

48. Medication effects were stronger in anxiety disorders and _____ than in depression, largely because the placebo effects in depression were large.

A. PTSD
B. OCD
C. Personality disorders
D. ADHD

10/17, pgs. 59–60

49. An accompanying editorial suggests these results indicate that pharmacotherapy offers similar efficacy to that reported for psychological interventions in common pediatric psychological problems. The large placebo effect in depression suggests that in young people, access to _____ can result in improvement in symptoms.

A. Care
B. Attention
C. Support
D. All of the above

10/17, pgs. 59–60

****

50. Over the course of an 8-week, open-label pilot study of *N*-acteylcysteine (NAC) in adolescents and young adults with nonsuicidal self-injury (NSSI), the mean weekly frequency of NSSI episodes decreased significantly from 0.74 to 0.35. Those with _____ were more likely to show a response.

A. More severe baseline anxiety
B. Lower levels of education
C. Greater lifetime severity of NSSI
D. All of the above

11/17, pgs. 61–62

51. Patients also had significant reductions from baseline in average scores on the Beck Depression Inventory (BDI). Improvements in NSSI _____ correlated with changes in BDI score.

A. Were
B. Were not

11/17, pgs. 61–62

52. With NAC, study subjects also showed declines in:

A. Anxiety and hostility
B. Phobic anxiety and psychoticism
C. Somatization and paranoid ideation
D. All of the above

11/17, pgs. 61–62

****

53. A sample of children from a longitudinal study who had onset of psychotic disorder by age 18 years were found to have _____ at age 11 years, suggesting a possible early biomarker signature for psychosis.

A. Elevated levels of dopamine
B. Higher rates of OCD
C. Lipidomic alterations
D. Lower socioeconomic status

11/17, pgs. 62–63

54. These alterations were indicative of _____ and altered phospholipid metabolism, consistent with what is believed to be the pathophysiology of schizophrenia.

A. Monoamine deficiency
B. Inflammation
C. Serotonin excess

11/17, pgs. 62–63

****

55. In a survey of 180 parents of children with stimulant-treated ADHD, _____% reported household diversion of the stimulant medications.

A. 5
B. 16
C. 18
D. 21

11/17, pgs. 62–63

56. Another _____% of surveyed parents reported being tempted to take their child's stimulant.

A. 6
B. 9
C. 13
D. 16

11/17, pgs. 62–63

****

57. In a population-based study of nearly 120,000 children and adolescents who had started an antidepressant, current use of antidepressants was associated with a nearly 2-fold increase in diabetes risk. Risk was increased with current use of _____ but not with other antidepressants.

A. SSRIs
B. SNRIs
C. Tricyclics
D. All of the above

11/17, pgs. 63–64

58. Increased risk was associated with increasing duration of SSRI or SNRI use and the highest cumulative SSRI/SNRI dose.

A. True
B. False

11/17, pgs. 63–64

****

59. In a randomized trial of dialectical behavior therapy (DBT) in treatment of disruptive mood dysregulation disorder (DMDD), treatment adherence was _____ with DBT than/as with treatment as usual (TAU).

A. The same
B. Significantly worse
C. Significantly better

11/17, pgs. 64–65

60. In this study, treatment response was achieved by 19 of 21 DBT patients, compared with 10 of 22 TAU patients. Nearly _____ as many children in the DBT group as in the TAU group achieved remission.

A. Half
B. Twice
C. Three times
D. Four times

11/17, pgs. 64–65

****

61. In a cross-sectional study, compared with typically developing participants, _____ was the predominant influence affecting development of ADHD.

A. Parental ADHD
B. Maternal smoking
C. Birth weight
D. Socioeconomic status

11/17, pgs. 65–66

62. In comparisons between study patients with ADHD alone and those with comorbid ADHD and oppositional defiant disorder (ODD), which of the following risk factors contributed to the development of ODD?

A. Parental ADHD and adverse life events
B. Socioeconomic status
C. Deviant peer affiliation and parental criticism
D. All of the above

11/17, pgs. 65–66

****

63. According to a review from the NIMH, recognizing irritability as a mood problem, rather than simply a behavioral issue, along with consideration of it in the context of common comorbidities, could improve patient outcomes while reducing unsupported use of antipsychotics.

A. True
B. False

12/17, pgs. 67–68

64. For children with irritability, treatment should first address:

A. Comorbid conditions
B. Problem behaviors
C. Medication options

12/17, pgs. 67–68

65. In parallel with this approach or as a next step, _____ should be considered.

A. Antipsychotics
B. Psychological treatments
C. Lithium
D. ECT

12/17, pgs. 67–68

****

66. In a study examining adverse events reported to Health Canada and the U.S. FDA for generic formulations of extended-release (ER) methylphenidate, reports of therapeutic failure were about _____ times more frequent with generic than branded OROS methylphenidate (*Concerta*).

A. 3
B. 5
C. 7
D. 10

12/17, pgs. 68–69

67. According to the U.S. data, 29% of reports involved loss of efficacy and 40% involved:

A. Social functioning
B. Excessive somnolence
C. Excessive drug exposure
D. Serious GI problems

12/17, pgs. 68–69

****

68. Current extended-release methylphenidate formulations leave an important unmet need for coverage in the hours after awakening. An investigational formulation of methylphenidate, HLD200, was designed to provide symptom control beginning in the early morning and lasting throughout the day, following _____ administration.

A. Evening
B. Midnight
C. Early morning

12/17, pgs. 69–70

69. Pharmacokinetics of HLD200 were similar in adults and children. Following administration, after about an 8-hour delay in drug release, plasma methylphenidate concentrations increased rapidly, peaked at _____ hours post-dose, and then declined slowly.

A. 12–13
B. 15–17
C. 16–18
D. 18–20

12/17, pgs. 69–70

****

70. In a nationwide cohort study, compared with never-users of hormonal contraception, current users had nearly a 2-fold elevation in risk for suicide attempt and a 3-fold increase for:

A. Nonsuicidal self-injury
B. Suicide
C. A major depressive episode
D. Psychosis

12/17, pg. 70

71. Risks were elevated for all types of hormonal contraceptive. _____ contraceptive(s) was/were associated with higher risk than oral combined products.

A. Patch
B. Vaginal ring
C. Progestin-only
D. All of the above

12/17, pg. 70

****

72. In a multinational controlled trial, aripiprazole was a safe and effective treatment for tics in _____ with Tourette's disorder.

A. Children only
B. Adolescents only
C. Children and adolescents
D. Adolescents and adults

12/17, pgs. 70–71

73. Aripiprazole adverse effects were similar to those observed in other pediatric clinical trials and included:

A. Sedation and fatigue
B. Sedation, somnolence, and fatigue
C. Somnolence and nausea/vomiting
D. Fatigue and nausea/vomiting

12/17, pgs. 70–71

****

74. In a population-based study, children whose mothers reported use of acetaminophen during pregnancy had a _____% increase in risk of developing ADHD, depending on the number of trimesters exposed.

A. 5–21
B. 8–26
C. 10–30
D. 17–46

12/17, pgs. 71–72

75. The results of this study suggest that the association of acetaminophen with ADHD in the offspring occurs regardless of parental ADHD symptoms. The results also suggest that indications for maternal use (e.g. fever, infection) _____ a major factor in the association.

A. Are
B. Are not

12/17, pgs. 71–72

****

M.J. Powers & Co. Continuing Education

Child & Adolescent Psychiatry Alerts - Activity Evaluation Form

Please note: Credit letters will be issued upon receipt of this completed evaluation form. The planning and execution of useful and educationally sound continuing education activities are guided in large part by input from participants. To assist us in evaluating the effectiveness of this activity, please complete this evaluation form. Your response will help ensure that future programs are informative and meet the educational needs of all participants. Thank you for your cooperation!

Program Objectives: Having completed this activity, you are better able to:	**Strongly Agree**				**Strongly Disagree**
Integrate into clinical practice findings from new diagnostic and therapeutic studies.	5	4	3	2	1
Determine appropriate patient evaluation and treatment selection for child and adolescent psychiatric and behavioral disorders.	5	4	3	2	1
Discuss developmental risk factors and comorbid disorders and how they affect outcomes.	5	4	3	2	1
Plan strategies for early intervention to improve outcomes.	5	4	3	2	1
Appropriately prescribe medications or other therapeutic interventions.	5	4	3	2	1
Recognize and implement new approaches to the treatment of child and adolescent psychiatric and behavioral disorders.	5	4	3	2	1

Overall Evaluation:	**Strongly Agree**				**Strongly Disagree**
The information presented increased my awareness/understanding of the subject.	5	4	3	2	1
The information presented will influence how I practice.	5	4	3	2	1
The information presented will help me improve patient care.	5	4	3	2	1
The information demonstrated current knowledge of the subject.	5	4	3	2	1
The program was educationally sound and scientifically balanced.	5	4	3	2	1
The program avoided commercial bias or influence.	5	4	3	2	1

Based on information presented in the program, I will (please check one):

- ❑ Do nothing as the content was not convincing.
- ❑ Seek additional information on this topic.
- ❑ Do nothing. Barriers at my institution prevent me from changing my practice.
- ❑ Change my practice.
- ❑ Do nothing as current practice reflects program's recommendations.

If you anticipate changing one or more aspects of your practice as a result of your participation in this activity, please provide us with a brief description of how you plan to do so:_____

_____

_____

Please provide any additional comments pertaining to this activity and suggestions for improvement:_____

_____

_____

Please list any topics that you would like to be addressed in future educational activities:_____

_____

_____

ANSWER SHEET

CHILD & ADOLESCENT PSYCHIATRY ALERTS

45 Carey Ave., Ste 111, Butler, NJ 07405
E-mail: cme@alertpubs.com Fax: 973-898-1201

Activity Code: 17MP02C Test 31

_____
e-mail address (for credit notification)

	A	B	C	D		A	B	C	D		A	B	C	D
1	Ⓐ	Ⓑ	Ⓒ	Ⓓ	26	Ⓐ	Ⓑ	Ⓒ	Ⓓ	51	Ⓐ	Ⓑ	Ⓒ	Ⓓ
2	Ⓐ	Ⓑ	Ⓒ	Ⓓ	27	Ⓐ	Ⓑ	Ⓒ	Ⓓ	52	Ⓐ	Ⓑ	Ⓒ	Ⓓ
3	Ⓐ	Ⓑ	Ⓒ	Ⓓ	28	Ⓐ	Ⓑ	Ⓒ	Ⓓ	53	Ⓐ	Ⓑ	Ⓒ	Ⓓ
4	Ⓐ	Ⓑ	Ⓒ	Ⓓ	29	Ⓐ	Ⓑ	Ⓒ	Ⓓ	54	Ⓐ	Ⓑ	Ⓒ	Ⓓ
5	Ⓐ	Ⓑ	Ⓒ	Ⓓ	30	Ⓐ	Ⓑ	Ⓒ	Ⓓ	55	Ⓐ	Ⓑ	Ⓒ	Ⓓ
6	Ⓐ	Ⓑ	Ⓒ	Ⓓ	31	Ⓐ	Ⓑ	Ⓒ	Ⓓ	56	Ⓐ	Ⓑ	Ⓒ	Ⓓ
7	Ⓐ	Ⓑ	Ⓒ	Ⓓ	32	Ⓐ	Ⓑ	Ⓒ	Ⓓ	57	Ⓐ	Ⓑ	Ⓒ	Ⓓ
8	Ⓐ	Ⓑ	Ⓒ	Ⓓ	33	Ⓐ	Ⓑ	Ⓒ	Ⓓ	58	Ⓐ	Ⓑ	Ⓒ	Ⓓ
9	Ⓐ	Ⓑ	Ⓒ	Ⓓ	34	Ⓐ	Ⓑ	Ⓒ	Ⓓ	59	Ⓐ	Ⓑ	Ⓒ	Ⓓ
10	Ⓐ	Ⓑ	Ⓒ	Ⓓ	35	Ⓐ	Ⓑ	Ⓒ	Ⓓ	60	Ⓐ	Ⓑ	Ⓒ	Ⓓ
11	Ⓐ	Ⓑ	Ⓒ	Ⓓ	36	Ⓐ	Ⓑ	Ⓒ	Ⓓ	61	Ⓐ	Ⓑ	Ⓒ	Ⓓ
12	Ⓐ	Ⓑ	Ⓒ	Ⓓ	37	Ⓐ	Ⓑ	Ⓒ	Ⓓ	62	Ⓐ	Ⓑ	Ⓒ	Ⓓ
13	Ⓐ	Ⓑ	Ⓒ	Ⓓ	38	Ⓐ	Ⓑ	Ⓒ	Ⓓ	63	Ⓐ	Ⓑ	Ⓒ	Ⓓ
14	Ⓐ	Ⓑ	Ⓒ	Ⓓ	39	Ⓐ	Ⓑ	Ⓒ	Ⓓ	64	Ⓐ	Ⓑ	Ⓒ	Ⓓ
15	Ⓐ	Ⓑ	Ⓒ	Ⓓ	40	Ⓐ	Ⓑ	Ⓒ	Ⓓ	65	Ⓐ	Ⓑ	Ⓒ	Ⓓ
16	Ⓐ	Ⓑ	Ⓒ	Ⓓ	41	Ⓐ	Ⓑ	Ⓒ	Ⓓ	66	Ⓐ	Ⓑ	Ⓒ	Ⓓ
17	Ⓐ	Ⓑ	Ⓒ	Ⓓ	42	Ⓐ	Ⓑ	Ⓒ	Ⓓ	67	Ⓐ	Ⓑ	Ⓒ	Ⓓ
18	Ⓐ	Ⓑ	Ⓒ	Ⓓ	43	Ⓐ	Ⓑ	Ⓒ	Ⓓ	68	Ⓐ	Ⓑ	Ⓒ	Ⓓ
19	Ⓐ	Ⓑ	Ⓒ	Ⓓ	44	Ⓐ	Ⓑ	Ⓒ	Ⓓ	69	Ⓐ	Ⓑ	Ⓒ	Ⓓ
20	Ⓐ	Ⓑ	Ⓒ	Ⓓ	45	Ⓐ	Ⓑ	Ⓒ	Ⓓ	70	Ⓐ	Ⓑ	Ⓒ	Ⓓ
21	Ⓐ	Ⓑ	Ⓒ	Ⓓ	46	Ⓐ	Ⓑ	Ⓒ	Ⓓ	71	Ⓐ	Ⓑ	Ⓒ	Ⓓ
22	Ⓐ	Ⓑ	Ⓒ	Ⓓ	47	Ⓐ	Ⓑ	Ⓒ	Ⓓ	72	Ⓐ	Ⓑ	Ⓒ	Ⓓ
23	Ⓐ	Ⓑ	Ⓒ	Ⓓ	48	Ⓐ	Ⓑ	Ⓒ	Ⓓ	73	Ⓐ	Ⓑ	Ⓒ	Ⓓ
24	Ⓐ	Ⓑ	Ⓒ	Ⓓ	49	Ⓐ	Ⓑ	Ⓒ	Ⓓ	74	Ⓐ	Ⓑ	Ⓒ	Ⓓ
25	Ⓐ	Ⓑ	Ⓒ	Ⓓ	50	Ⓐ	Ⓑ	Ⓒ	Ⓓ	75	Ⓐ	Ⓑ	Ⓒ	Ⓓ

I attest that I have completed the Child & Adolescent Psychiatry Alerts activity as designed.

❑ **Physicians:** I claim____ *AMA PRA Category 1 Credit(s)™* for participating in this activity (1 credit for each hour of participation, not to exceed 12 credits).

❑ **Non-Physicians:** I claim (up to 1.2) _____Continuing Education Units (CEUs). One CEU is awarded for 10 contact hours of instruction.

Signature_____**Date**_____

Exam must be returned by June 30, 2019 **CME Activity Code: 17MP02C Test 31**