

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 18MP01C / Exam #32

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Exam must be returned byDecember 31, 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.

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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 XX, January 2018 through June 2018 (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.

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M.J. Powers & Co. Publishers

Phone: (973) 898-1200 Email: cme@alertpubs.com

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M.J. Powers & Co. Continuing Education
CHILD & ADOLESCENT PSYCHIATRY ALERTS

1. In a manufacturer-sponsored, placebo-controlled trial of lurasidone in young patients with bipolar depression, lurasidone was associated with a significantly larger reduction in Children's Depression Rating Scale-Revised total score than placebo.

- A. True
- B. False

1/18, pgs. 1-2

2. Significantly more patients in the lurasidone group than the placebo group met _____ criteria ($p < 0.0001$).

- A. Response
- B. Remission
- C. Both response and remission

1/18, pgs. 1-2

3. In this study, changes observed in body weight and body mass index were:

- A. Greater in the placebo group
- B. Greater in the lurasidone group
- C. Similar in the 2 groups

1/18, pgs. 1-2

4. According to the 2015 National Youth Risk Behavior Survey, lesbian, gay, bisexual, and questioning adolescents were up to _____ times more likely than their heterosexual peers to report suicidal behaviors.

- A. 2
- B. 3
- C. 4
- D. 5

1/18, pgs. 2-3

5. By minority subgroup, risks of each type of suicidal behavior were elevated in _____ adolescents, relative to their heterosexual peers.

- A. Lesbian
- B. Gay and bisexual
- C. Questioning
- D. All of the above

1/18, pgs. 2-3

6. According to the survey, rates of suicide attempt in the past year ranged from about 15% to 23% in subgroups of sexual minority males and from 12% to _____% in subgroups of sexual minority females.

- A. 18
- B. 24
- C. 28
- D. 34

1/18, pgs. 2-3

7. In a population-wide cohort study in young adults in the U.K., frequent cannabis use (at least 2-3 times per week) predicted:

- A. Depression
- B. Psychosis
- C. Hypomanic symptoms
- D. All of the above

1/18, pgs. 3-4

8. Results of a path analysis conducted in this study showed that cannabis use was an independent risk factor for hypomania and also mediated the associations of male gender and _____ with hypomania.

- A. Hazardous alcohol use
- B. Childhood abuse
- C. Family adversity
- D. All of the above

1/18, pgs. 3-4

9. Results of an uncontrolled trial suggest that group metacognitive therapy _____ an effective, acceptable treatment for generalized anxiety disorder in children.

- A. Is
- B. Is not

1/18, pgs. 4-5

10. In this study, treatment effects were significantly inferior to those previously found with cognitive behavioral therapy.

- A. True
- B. False

1/18, pgs. 4-5

11. In a systematic review of 12 randomized trials that reported health-related quality of life (HRQoL) in patients with ADHD, 10 reported improvement in ≥ 1 domain or summary measure, with the largest improvements in domains related to:

- A. Participation and satisfying relationships
- B. Achievement and risk taking
- C. Risk taking only
- D. Participation and functional ability

1/18, pgs. 5–6

12. Function was often measured with the Weiss Functional Impairment Rating Scale–Parent, and children and adolescents showed fairly consistent improvement in the _____ domain(s).

- A. Family
- B. Learning
- C. School
- D. All of the above

1/18, pgs. 6–7

13. The results of this analysis suggest that improving function and quality of life should be an important aim of ADHD treatment.

- A. True
- B. False

1/18, pgs. 6–7

14. Like other eating disorders, avoidant restrictive food intake disorder (ARFID) is driven by body-image distortion and fear of weight gain.

- A. True
- B. False

2/18, pgs. 7–8

15. In an uncontrolled retrospective study of olanzapine in 9 patients with ARFID, the study patients gained a mean of 16 lbs and _____ BMI point(s) at discharge.

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

2/18, pgs. 7–8

16. All of the study patients had a comorbid psychiatric diagnosis on admission. By the time of discharge, patients and their families reported significant improvement in _____ symptoms.

- A. Depressive
- B. Anxiety
- C. Depressive and anxiety

2/18, pgs. 7–8

17. For children with Tourette syndrome who require treatment, _____ is highly effective and should be considered as first-line therapy.

- A. Family-focused therapy
- B. Emotion-focused therapy
- C. Interpersonal therapy
- D. Comprehensive behavioral intervention for tics

2/18, pgs. 8–9

18. According to recommendations based on published research and clinical guidelines from Canada and Europe, _____ are appropriate first-line pharmacotherapy for Tourette syndrome.

- A. Clonidine and guanfacine
- B. Baclofen and risperidone
- C. Aripiprazole and valbenazine
- D. All of the above

2/18, pgs. 8–9

19. Baclofen should be considered second-line pharmacotherapy for children with Tourette's. _____ has/have also shown promising results.

- A. Tetrabenazine
- B. Deutetrabenazine
- C. Both drugs

2/18, pgs. 8–9

20. According to a review of treatment guidelines and the limited research literature, antidepressant treatment, if response is achieved, should be continued for 9–12 months in children and adolescents with depression and for _____ months for those with anxiety disorders.

- A. 3–6
- B. 6–9
- C. 8–10
- D. 9–12

2/18, pgs. 9–10

21. Factors associated with a lower likelihood of response or remission in long-term treatment of depression in children and adolescents include non-response to acute therapy and:

- A. More prior depressive episodes
- B. Residual symptoms after treatment and female gender
- C. Greater family levels of expressed emotion and perceived family conflict
- D. All of the above

2/18, pgs. 9–10

22. There is currently no known evidence suggesting harm from long-term use of SSRIs in the absence of adverse effects.

- A. True
- B. False

2/18, pgs. 9–10

23. In a large randomized trial, multisystemic therapy (MST) showed _____ advantage over usual care in adolescents with antisocial behavior.

- A. No
- B. A moderate
- C. A large

2/18, pgs. 10–11

24. In this study, MST had _____ effect on the rate of out-of-home placements at 18 months.

- A. No
- B. A moderate
- C. A large

2/18, pgs. 10–11

25. According to a medication treatment algorithm for children and adolescents at high risk for bipolar disorder, in patients with unipolar depression and a history of antidepressant-induced mania, first-line treatment should be:

- A. Atomoxetine
- B. Citalopram
- C. Quetiapine
- D. Lamotrigine

2/18, pgs. 11–12

26. According to the algorithm, in patients with bipolar disorder NOS and comorbid ADHD, first-line treatment should be:

- A. Methylphenidate
- B. Mixed amphetamine salts
- C. Either drug

2/18, pgs. 11–12

27. Buspirone is FDA approved for treatment of anxiety in adults, and case reports have suggested it may be effective in younger patients. However, a literature review identified only 2 randomized trials of the agent for pediatric anxiety, and both studies were conducted nearly 2 decades ago. A reanalysis of the data from those studies, which were unpublished, _____ buspirone's efficacy in children and adolescents.

- A. Supported
- B. Did not support
- C. Could neither support nor refute

3/18, pgs. 13–14

28. Adverse events in these 2 studies were minimal, and _____ was the only event significantly elevated relative to placebo.

- A. Lightheadedness
- B. Weight loss
- C. Insomnia
- D. Nausea

3/18, pgs. 13–14

29. Results of a clinical trial in adolescents with manic or mixed-episode bipolar disorder suggest that _____ is the best predictor of response and remission with olanzapine.

- A. Absence of comorbidity
- B. Family support
- C. Socioeconomic status
- D. Early improvement

3/18, pgs. 14–15

30. In this study, statistical calculations identified an optimal cutoff point of a 35.5% reduction in Young Mania Rating Scale score during week _____ as having the greatest accuracy in predicting ultimate response.

- A. 1
- B. 2
- C. 6
- D. 8

3/18, pgs. 14–15

31. These observations suggest that initial treatment of mania with olanzapine should be reevaluated in patients who do not show substantial improvement within the first week.

- A. True
- B. False

3/18, pgs. 14–15

32. In an analysis of clinical trial data of fluoxetine in pediatric depression, children and adolescents whose depression was successfully treated with the drug had an increased risk of relapse if they had comorbid _____ at baseline and higher levels of residual symptoms after acute treatment.

- A. Anxiety
- B. Dysthymia
- C. ADHD
- D. OCD

3/18, pgs. 15–16

33. In this study, gender was a moderator of relapse in fluoxetine-treated patients, with a nearly 9-fold greater risk of relapse in _____ who continued the drug.

- A. Boys
- B. Girls

3/18, pgs. 15–16

34. This study also identified some factors that could help identify patients who would benefit from _____ and treatment tailored to their specific risk factors.

- A. Benzodiazepines
- B. Added aripiprazole
- C. Additional psychoeducation
- D. All of the above

3/18, pgs. 15–16

35. Fasoracetam is an investigational mGluR activator. Copy number variants in the mGluR gene network occur in an estimated 11% of children with _____, about 10 times the frequency in unaffected children.

- A. Executive dysfunction
- B. ADHD
- C. Autism spectrum disorder
- D. Major depression

3/18, pgs. 16–17

36. In a phase I trial, study subjects taking fasoracetam showed clinical improvement on all 4 efficacy measures. When patients were stratified into 3 tiers according to specific mGluR variants, the 2 highest-risk tiers had significantly _____ Clinical Global Impression (CGI) Improvement and Severity responses than the group with less severe mutations.

- A. Larger
- B. Smaller

3/18, pgs. 16–17

37. The new mixed-amphetamine salts formulation, SHP465 (*Mydayis*), contains _____ types of drug-releasing beads that provide immediate and delayed release.

- A. 2
- B. 3
- C. 4
- D. 5

3/18, pgs. 17–18

38. In a clinical trial in children and adolescents with ADHD, SHP465 was:

- A. Effective
- B. Ineffective
- C. Effective but poorly tolerated
- D. Effective and well tolerated

3/18, pgs. 17–18

39. According to the results of a meta-analysis conducted to evaluate the trajectory of antidepressant response in pediatric anxiety disorders and compare the effects of drug class and dose, antidepressant improvement occurs quickly.

- A. True
- B. False

4/18, pgs. 19–20

40. In the analysis, efficacy of SSRIs was found to be _____ to SNRIs beginning at week 2 and continuing to week 12.

- A. Inferior
- B. Similar
- C. Statistically superior

4/18, pgs. 19–20

41. Low doses of SSRIs were no less effective than higher doses overall, but high doses were associated with:

- A. Somnolence
- B. Intolerable adverse effects
- C. An earlier response
- D. All of the above

4/18, pgs. 19–20

42. In a longitudinal cohort study in adolescents and young adults with a diagnosis of deliberate self-harm, risk of suicide was markedly elevated in the year following treatment for an episode of nonsuicidal self-injury. Suicide risk was particularly high in:

- A. Males
- B. American Indians and Alaskan Natives
- C. Individuals who used a violent method of self-harm
- D. All of the above

4/18, pgs. 20–21

43. Suicide risk profiles did not differ substantially between adolescents and young adults.

- A. True
- B. False

4/18, pgs. 20–21

44. Risk of repeat episodes of nonfatal self-harm was also increased during the year of follow-up, with the maximum risk occurring in the _____ after the initial event.

- A. First few days
- B. Month
- C. 6 months
- D. Year

4/18, pgs. 20–21

45. In a population-based cohort study, irritability in childhood _____ predictive of risk of suicidal behaviors in adolescence.

- A. Was
- B. Was not

4/18, pgs. 21–22

46. Patients in the cohort with the highest levels of irritability and depressed/anxious mood in childhood were more likely than others to be:

- A. Male
- B. From a socioeconomically advantaged family
- C. To be raised by a depressive and/or hostile-reactive mother
- D. All of the above

4/18, pgs. 21–22

47. In a community-based cohort study in adolescents and young adults with OCD, _____ of the cohort patients had at least 1 comorbid psychiatric disorder.

- A. A quarter
- B. Nearly half
- C. Two-thirds
- D. Nearly all

4/18, pgs. 22–23

48. After adjustment for age, gender, and other disorders occurring prior to OCD diagnosis, presence of OCD was significantly associated with later development of other psychiatric disorders, particularly bipolar disorder and bulimia, as well as:

- A. Social phobia
- B. Dysthymia
- C. Generalized anxiety disorder
- D. All of the above

4/18, pgs. 22–23

49. Primary treatments for ADHD specifically address time management-related difficulties that interfere with daily routines and social relations.

- A. True
- B. False

4/18, pgs. 23–24

50. In a randomized trial, a multimodal intervention (including advocacy, compensation, and remediation) improved time management skills in children and adolescents with ADHD. Effects sizes for improvement were:

- A. Small
- B. Medium
- C. Large

4/18, pgs. 23–24

51. In a study in adolescents with anxiety or depression, treatment with a standardized saffron extract (*affron*) produced a larger reduction than placebo in youth-reported _____ scores on the Revised Child Anxiety and Depression Scale (RCADS).

- A. Total anxiety
- B. Total internalizing
- C. Total anxiety and total internalizing
- D. Suicidal thoughts

5/18, pgs. 25–26

52. Specifically, the adolescents who received saffron demonstrated significantly larger improvements than the placebo group on the _____ RCADS subscale(s).

- A. Depression
- B. Separation anxiety
- C. Social phobia
- D. All of the above

5/18, pgs. 25–26

53. According to a survey, the number of marijuana-related emergency and urgent-care visits to a Colorado pediatric hospital increased nearly _____-fold following the legalization of medical marijuana in 2009 and then recreational use in 2014. The annual total increased steadily over the years.

- A. 2
- B. 3
- C. 4
- D. 5

5/18, pgs. 26–27

54. Over this time period, the number of behavioral health evaluations also showed a steady increase.

- A. True
- B. False

5/18, pgs. 26–27

55. Recent research shows that the effects of cognitive behavioral therapy for anxiety are much less robust in adolescence than childhood, and the effects may not be lasting.

- A. True
- B. False

5/18, pgs. 27–28

56. The Launching Emerging Adults Program (LEAP) was designed specifically for young adults with anxiety disorders and their families. LEAP targets:

- A. Individual factors that maintain anxiety
- B. Delays in life skills
- C. Deficits in life skills
- D. All of the above

5/18, pgs. 27–28

57. In contrast to many existing anxiety therapies, LEAP directly addresses the patient’s functional status and family framework while providing:

- A. Skill building
- B. Exposure
- C. Both skill building and exposure

5/18, pgs. 27–28

58. The novel antipsychotic asenapine shares the dopamine D₂ and serotonin 5-HT_{2a} receptor affinity of other second-generation antipsychotics, but it also has a complex profile of activity at other receptors. Asenapine was FDA approved for treatment of _____ in children and adolescents, aged 10–17 years.

- A. Schizophrenia
- B. Bipolar I disorder
- C. Generalized anxiety disorder
- D. All of the above

5/18, pgs. 28–29

59. A 3-week placebo-controlled trial and a 50-week open-label extension study showed that serious adverse events were generally related to:

- A. Cardiovascular effects
- B. Worsening of the underlying psychiatric disorder
- C. Extrapyramidal symptoms
- D. Incorrect dosing

5/18, pgs. 28–29

60. Asenapine is only available as a sublingual tablet; bioavailability is _____ if the tablet is swallowed.

- A. Markedly reduced
- B. Increased
- C. Unchanged

5/18, pgs. 28–29

61. In a head-to-head, randomized comparison study of extended-release quetiapine and aripiprazole in children and adolescents with first-episode psychosis, _____ was associated with small but statistically significant increases in the QTc interval.

- A. Aripiprazole
- B. Extended-release quetiapine

5/18, pg. 29

62. The magnitude of change in QTc was not affected by:

- A. Antipsychotic dose
- B. Patient age or body mass index
- C. Patient smoking status
- D. All of the above

5/18, pg. 29

63. In the study, the QT changes with quetiapine were small and likely not clinically significant in otherwise healthy patients, but they may be clinically relevant in patients with significant risk factors for cardiac arrhythmias.

- A. True
- B. False

5/18, pg. 29

64. In a nationwide longitudinal study, adolescents and young adults with ADHD _____ an increased incidence of type 2 diabetes compared with controls.

- A. Had
- B. Did not have

6/18, pgs. 31–32

65. Study subjects with ADHD had an increased prevalence of ADHD-related comorbidities, with hazard ratios ranging from 1.9 to 10.8 for:

- A. Hypertension and dyslipidemia
- B. Obesity and hypertension
- C. Dyslipidemia, obesity, and hypertension

6/18, pgs. 31–32

66. A study of families with boys who had a diagnosis of conduct disorder found that high levels of callous-unemotional (HCU) traits in the child can have a substantial negative impact on family functioning.

- A. True
- B. False

6/18, pgs. 32–33

67. Compared with families of children with lower levels of callous-unemotional (LCU) traits, families that included a child with HCU traits showed poorer levels of:

- A. Affective involvement
- B. General functioning
- C. Role functioning
- D. All of the above

6/18, pgs. 32–33

68. According to a literature review of pharmacotherapy for school refusal in children and adolescents, the limited data indicate that pharmacotherapy can be a useful adjunct to psychological therapy in children with comorbid:

- A. Depression
- B. ADHD
- C. Depression and ADHD
- D. Anxiety or depression

6/18, pgs. 33–34

69. Although data on pharmacotherapy for school refusal are sparse and newer antidepressants do not appear to have been evaluated, the authors suggest that combined pharmacotherapy and psychosocial treatment may be warranted because of the serious nature of school refusal, along with the fact that children with _____ make up a large subset of school refusal patients.

- A. ADHD
- B. Depression
- C. Anxiety
- D. All of the above

6/18, pgs. 33–34

70. A systematic review of recent studies found _____ evidence to provide guidance on use of nonpharmacological interventions for ADHD.

- A. Significant
- B. Little
- C. No

6/18, pg. 34

71. Evidence in this review suggested that in addition to improvements in ADHD symptoms, cognitive behavioral therapy may alleviate:

- A. Anxiety
- B. Depression
- C. Oppositional-defiant and conduct-disorder symptoms
- D. All of the above

6/18, pg. 34

72. In a preliminary study of a brief, parent-only group cognitive behavioral training for children with anxiety disorders, parents in the intervention group reported significant improvement in:

- A. Family functioning
- B. Their child's emotional symptoms
- C. Their own depression
- D. All of the above

6/18, pgs. 34–35

73. Clinicians reported that children whose parents underwent the training showed significant improvement in Child Global Assessment scores, compared with controls. Outcomes did not differ, however, between the groups on child self-report measures.

- A. True
- B. False

6/18, pgs. 34–35

74. In a study in adolescents hospitalized for a psychiatric emergency, an intensive, community-based treatment to integrate them into outside life (supported discharge services [SDS]) was associated with _____ in the following 6 months.

- A. Improved functioning
- B. Increased self-harm
- C. Reduced hospital use
- D. All of the above

6/18, pgs. 35–36

75. SDS was associated with a marked difference in the rate of multiple incidents of self-harm, compared with usual care. Adolescents in the SDS group were _____ likely than the usual-care group to have returned to school at the end of 6 months.

- A. Less
- B. More

6/18, pgs. 35–36

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):

- | | |
|---|---|
| <input type="checkbox"/> Do nothing as the content was not convincing. | <input type="checkbox"/> Change my practice. |
| <input type="checkbox"/> Seek additional information on this topic. | <input type="checkbox"/> Do nothing as current practice reflects program's recommendations. |
| <input type="checkbox"/> Do nothing. Barriers at my institution prevent me from changing my practice. | |

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: 18MP01C Test 32

e-mail address (for credit notification)

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

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

Physicians: I claim ____ *AMA PRA Category 1 Credit(s)*TM 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 December 31, 2019

CME Activity Code: 18MP01C Test 32