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Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

inside

PERIODICALS:
TIME-SENSITIVE MATERIALS

"No city invites the heart to come to life like San Francisco does," author William Saroyan once wrote. See for yourself by coming to APA's 2009 annual meeting, which is being held in the City by the Bay from May 16 to 21. Register now and save on fees. See page 2.

Credit: Istockphoto/Klaas Lingbeek-van Kranen

Cardiac Death Risk Rises With Both Antipsychotic Types

One scientist questions the ability of current research to determine the extent to which new and old drugs cause cardiac death and focuses instead on modifiable risk factors associated with coronary heart disease.

BY MARK MORAN

Current users of both first-generation and second-generation antipsychotics appear to have a similar, dose-related increase in sudden cardiac death.

Further, the presumed safety advantage of second-generation antipsychotics (SGAs) over first-generation antipsychotics (FGAs) regarding the adverse effects on cardiac health does not appear to exist, according to results from a retrospective analysis of the incidence of sudden cardiac death among users of FGAs and SGAs and nonusers of antipsychotic medication.

The antipsychotic medications included in the analysis were haloperidol, thioridazine, clozapine, olanzapine, quetiapine, and risperidone.

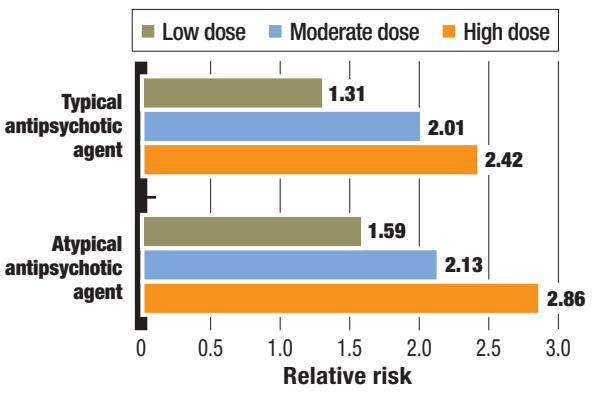
The study, which appeared in the January 15 *New England Journal of Medicine*, was conducted by Wayne Ray, Ph.D., and colleagues at Vanderbilt University School of Medicine.

An association between risk for sudden cardiac death and use of FGAs has long been recognized. This new study appears to extend that association to all antipsychotics and to underscore the need for a comprehensive medical and cardiac history before initiating treatment and for

please see ***Antipsychotics*** *on page 23*

Sudden Cardiac Death Risk Linked to Antipsychotic Dose

The risk of sudden cardiac death among users of either typical or atypical antipsychotics, relative to nonusers, rises with dose. Rates are adjusted to account for confounding factors.



Source: Wayne A. Ray, Ph.D., et al., *New England Journal of Medicine*, January 15, 2009

MH Parity Mandate Added to SCHIP, Giving More Children Access to Care

The new measure replaces long-standing provisions in the children's health insurance program that limited reimbursement for mental health treatment.

BY RICH DALY

President Barack Obama signed legislation last month that expands the State Children's Health Insurance Program (SCHIP) and includes provisions aimed at increasing mental health care, including for substance abuse, for millions of lower-income children.

Under the nearly $33 billion measure (PL-111-3), the number of children eligible for SCHIP will increase from 7 million to 11 million. Moreover, for the first time in its 12-year history, SCHIP will cover treatment for mental illnesses at the same rate and on the same terms as it does for nonpsychiatric disorders. The expansion becomes effective on April 1.

The measure also raises the maximum income of the families whose children can receive full matching funds from 200 percent of the federal poverty level to 300 percent, or $52,800 for a family of three.

The change thrilled mental health advocates.

"The American Psychiatric Association continues to fight for mental health equality, and we are especially pleased that this legislation includes strong language that will strengthen and improve access to mental health services, including substance abuse treatment services for children," said APA President Nada Stotland, M.D. "Children's [good] mental health is essential to their well-being, and access to mental health care will enable children to play, learn, and grow into healthy adults."

The measure eliminated the long-standing SCHIP provision that allowed states—which administer the program—to cover only 75 percent of the cost of mental health care included in benchmark plans that each state designates as models for SCHIP plans. The change requires that all private-sector SCHIP plans comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which

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FDA Allows Drug Reps to Give Articles on Off-Label Use

Industry sales representatives cannot talk about unapproved uses of medications and devices with health professionals, but they can hand out published articles that do so.

BY JUN YAN

Despite objections from vocal opponents, the Food and Drug Administration (FDA) issued official rules in January to allow pharmaceutical and medical-device companies to distribute to health care professionals who prescribe medications reprints of journal articles and reference publications that describe unapproved uses of a drug or product.

Although companies are legally barred from promoting their products for off-label indications, the FDA Modernization Act of 1997 allowed companies to give out reprints of articles published in peer-reviewed medical journals to physicians until 2006, when the law expired. The lack of guidance on this practice during the past few years had created a legal vacuum that prevented this practice.

The new guidelines revive the earlier rule and allow industry reps to again distribute medical and scientific journals and refer to texts that discuss off-label indications. However, company salespersons are still not allowed to directly discuss or promote unapproved use of drugs and medical devices with health care professionals.

The official guidance document defines a medical or scientific journal article as one that is "published by an organization that has an editorial board that uses experts" who "objectively select, reject, or provide comments about proposed articles" and that should be peer reviewed according to established policies. The guidelines do not limit these publications to ones reporting on primary research studies, but apply to reviews, commentaries, and meta-analyses.

Journal supplements and special publications funded in whole or in part by the maker of the product described in the articles do not qualify as permitted reprints for distribution, according to the guidelines. However, if the authors have financial relationships with pharmaceutical or device manufacturers or the study was sponsored by manufacturers, the publication is not disqualified as long as potential conflicts of interest and bias are disclosed.

A reference publication should be something "generally available in bookstores or other independent distribution channels where medical textbooks or periodicals are sold." Moreover, the reference should not be "edited or significantly influenced by a . . . . manufacturer or any individual having a financial relationship with the manufacturer."

The rule also requires that the information distributed in the reprints should not "be false or misleading" and not "pose a significant risk to the public health, if relied upon." In addition, a reprinted article "should not be physically attached to

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Important Annual Meeting Announcements

» Register Now for APA's 2009 Annual Meeting and Take Advantage of Advance Fees!
Meeting and hotel information, including rates and hotel descriptions and course information, can be accessed on APA's Web site at <www.psych.org> by clicking on the 2009 annual meeting logo and then "APA Members" under "Meeting Registration." San Francisco is a popular city for APA members, so you are advised to act quickly and save on fees.

» Look for Annual Meeting Information Online
APA has gone *green!* The Association is trying to do its part in helping save the environment, while also saving money on printing and
mailing costs. Thus, APA is no longer mailing an advance registraton information packet; instead, the information and registration and hotel-reservation forms it had traditionally contained have been posted on APA's Web site. Access information appears above.

More information is available by contacting Vernetta Copeland at (703) 907-7382 or vcopeland@psych.org.

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A Time to Invest in Psychiatric Care

BY NADA STOTLAND, M.D., M.P.H.

Credit: David Hathcox

Aside from the incredible antics of my state governor, which I addressed in my column in the January 16 issue, most questions I receive from the media these days are about the psychiatric impact of the world economic cataclysm. Reporters want to know whether the incidence of mental illnesses has increased; are we seeing more patients? They want to understand how the threat and reality of job and financial loss work to affect our patients. They want to pass on to their readers and listeners any expert advice we can offer to help them weather these abrupt and unanticipated changes in their finances.

Since we don't have any organized central oversight of the health of our population, I don't have data to indicate an increase in psychopathology. I have been told that the number of prescriptions for antidepressants has increased. We have some studies from areas differentially affected by economic hardships in the past. The suicide rate increases. There is evidence that people tolerate hard times better when everybody is in the same boat than when others are doing better than they are.

Tragically, I expect that there is increased need for, but decreased access to, psychiatric services under current circumstances. Employees, whose mental health coverage was often inadequate to begin with, lose their health insurance when they lose their jobs. People who lose their homes and have to move their families in with relatives or to shelters hardly rank mental health care as a top priority. As state and local budgets are stretched, public psychiatric services are overwhelmed or disappear—the city of Chicago is about to close three mental health clinics in an already disadvantaged area. So I tell reporters that I am concerned that we are having a silent epidemic of anxiety and depression and that those symptoms will make it all the more difficult for those affected to face moves, find new jobs, and adapt to new lifestyles.

We have all read about the positive and negative reactions to President Obama's $500,000 ceiling on salaries at companies receiving "bailout" funds. Reporters want to know why some people are profoundly distressed despite the fact that, even with the economic downturn, they should have ample remaining resources to house, feed, and educate their families. People can lose their senses of identity, status, and purpose along with their incomes. Recently regarded as geniuses and heroes, they have suddenly become dupes, villains, or losers. They may have failed a great many other people, who were depending on their advice, and made investments intended to fund their children's college educations, provide a comfortable retirement, or just keep roofs over their heads. In America, people are closely identified with their jobs.

Here is the advice I give reporters to pass on to their readers. This is a time to renew basic values of family, friends, and faith. People have to support their loved ones rather than blaming them for financial decisions that turned out to be unwise. They need to reassure their children. They need to take care of themselves. Healthy meals and regular exercise may seem like indulgences, but they are more important now than ever. People need to keep themselves strong to find new resources and adapt to new circumstances. So this is a time for investments in psychiatric care even when money is tight. When anxiety and depression persistently interfere with sleep, appetite, energy, and concentration and are left untreated, a person enters a downward spiral. It takes more energy, more creativity to think up new ways to earn a living and survive economic loss than just to go to work each day. Sad faces and agitated body movements are not positive attributes in job interviews. People with persistent symptoms need professional consultation.

We don't know where our economy is going or for how long. We are all worried about our own security and about our coworkers, employees, and loved ones. We may have to eliminate the jobs of people we care about and depend on to run our offices and care for our children and elderly parents. APA is making serious cuts in staff and governance to protect the resources we need to serve us and our patients. This is a time for us to pull together and invest in ourselves. Encourage your colleagues to become or remain members of APA. Come to the annual meeting in San Francisco: to refresh, learn, network, enjoy old friends, and be inspired by our brilliant fellow researchers, teachers, and clinicians. ■

FDA

continued from facing page

any promotional material the sales representative uses or delivers during the [physician] office visit," the document says.

These FDA recommendations are guidelines and not legally binding.

A year ago the draft version of the guidelines received much criticism from Rep. Henry Waxman (D-Calif.) and advocacy groups (*Psychiatric News*, March 21, 2008), who felt they would give industry a loophole to promote their products while bypassing the regulatory evaluation and approval process, thus posing safety risks for the public.

"Guidance for Industry: Good Reprint Practices for the Distribution of Medical Journal Articles and Medical or Scientific Reference Publications on Unapproved New Uses of Approved Drugs and Approved or Cleared Medical Devices" is posted at <www.fda.gov/oc/op/goodreprint.html>. ■

Combat Just One Cause Of Army Suicide Crisis

Suicides among U.S. Army soldiers reach a record high in 2008, and military leaders push harder for awareness and prevention programs.

BY AARON LEVIN

Suicides among members of the U.S. Army increased for the fourth straight year in 2008, nearly doubling since 2004, despite the service's efforts at awareness and prevention. The Army also said that as many as 24 service members may have committed suicide in January, more than the number killed in combat in Iraq and Afghanistan that month.

At least 128 suicides occurred among active-duty soldiers in 2008, and 15 cases are still under investigation by the Armed Forces medical examiner. In 2004, 67 soldiers committed suicide.

The 2008 deaths represented a suicide rate of 20.2 per 100,000 active-duty personnel, up from 12.7 in 2005. The comparable, demographically adjusted rate for the overall U.S. population was 19.2 per 100,000 in 2005.

Further, 43 members of the Army Reserve or National Guard not on active duty also killed themselves last year.

Comparison with civilian or national rates is difficult, however, because the military background of persons committing suicide in the general population is not always recorded on death certificates.

"We want the families who have lost loved ones to suicide to understand how deeply we feel their loss and that we are committed to doing everything possible to prevent this tragedy in our Army," said Secretary of the Army Pete Geren in a statement.

According to the Army, 30 percent of suicides occurred during deployment to Iraq or Afghanistan, 35 percent happened after deployment, and 35 percent occurred among troops who had never deployed to a war zone.

The Army figures do not include the suicides by soldiers who have left the service. The Department of Veterans Affairs (VA) reported last year that 254 veterans (of all services) under its care who left the military between September 11, 2001, and the end of 2006 committed suicide.

The rise in those numbers partly reflects the increased number of veterans leaving military service since 2001. Not all discharged military personnel choose to obtain medical care from the VA, so the VA count may underestimate the number of suicides among those who served in the two current conflicts.

Suicide remains a challenge for which military leaders must identify effective prevention initiatives, said Adm. Mike Mullen, chair of the Joint Chiefs of Staff.

"We have got to be able to support those individuals in ways that, in some cases, we haven't quite figured out yet," said Mullen in a February speech at Grove City College in Pennsylvania. "Part of [the problem] has got to be the pressure of these constant deployments into combat, where young individuals . . . whose lives change forever see things and do things they had never imagined."

The Army has developed or expanded programs in recent years to try to decrease the stigma surrounding mental health issues and encourage soldiers to seek help for themselves or for troubled buddies. The "Battlemind" program, originally designed to prepare soldiers psychologically for the stresses of combat, has now been expanded to include spouses and also cover the homecoming from war.

"Battlemind" is part of a new Comprehensive Soldier Fitness strategy intended to give mental resiliency the same status traditionally accorded to physical health. The Army Chaplains Corps provides training for officers and soldiers in suicide risk recognition and prevention. The service has also begun hiring additional psychiatrists, psychologists, social workers, and other mental health care providers to support its troops.

In January the Army ordered commanders throughout the service to hold two to four hours of suicide prevention training between February 15 and March 15, followed by a "chain-teaching" program to reach all members of the service.

The deaths by suicide of four Army recruiters in the Houston area were attributed to "poor command climate, failing personal relationships, and long stressful workdays. . . ." Those conclusions prompted Geren to order a one-day "standdown" on February 13 for all Army and Army Reserve recruiters during which they could receive training in leadership, suicide-prevention, and coping skills.

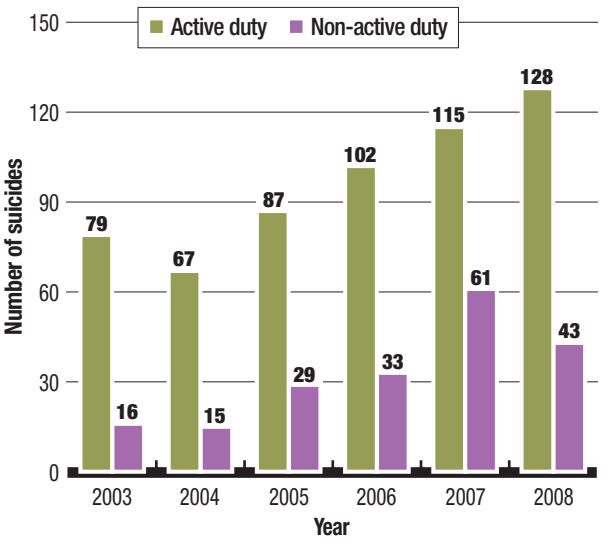
To improve the research base about suicide in the armed forces, the Army also signed a memorandum of understanding with the National Institute of Mental Health last October to study ways to reduce suicide.

The proposed research seeks to evaluate risk and protective factors leading to suicide-related events to influence the development of effective strategies to reduce suicide risk and enhance resilience, according to the NIMH request for applications.

"This study will evaluate selected samples of soldiers across all phases of Army service, both cross-sectionally and longitudinally, including entry-level training and service, predeployment training, deployment and noncombat assignments, postdeployment, and postseparation reintegration to civilian life," according to the Army-NIMH memo. ■

Army Suicides Rise As Wars Continue

Both the number and rate of U.S. Army soldiers committing suicide have risen steadily over the last five years, despite attempts at prevention.



Source: U.S. Army

MH Services on Chopping Block As States Slash Spending

Budget cuts by cash-strapped states are beginning to take their toll on public mental health services across the country.

BY AARON LEVIN

Public mental health systems around the country are cutting or privatizing services as the recession bites deeper into state revenues.

At the end of the year, Massachusetts Gov. Deval Patrick (D) announced $9 million in cuts for the state's Department of Mental Health, including $8 million from adult day services and $1 million from social clubs that support people with mental illness.

Virginia Gov. Tim Kaine (D) proposed closing a mental health facility for children and adolescents in Staunton, an adolescent unit at the Southwestern Virginia Mental Health Institute in Marion, and a training center for the mentally disabled in Chesapeake as part of a plan to close a $2.9 billion state budget shortfall.

In Washington state, the Division of Alcohol and Substance Abuse and state Mental Health Division announced cuts to state-funded mental health and substance abuse services and programs.

"We're in the middle of an economic debacle that will probably continue into 2011," said Michael Fitzpatrick, M.S.W., executive director of the National Alliance on Mental Illness (NAMI) and a former Maine state legislator. "It's not just government money or Medicaid. Philanthropic giving is down, and many clinics depend on lines of credit that have dried up."

More than half of all states' mental health agencies have seen budget cuts in the current fiscal year and many expect them in the next one, according to a report from the National Association of State Mental Health Program Directors (NASMHPD). States are paying more in unemployment compensation while reduced consumer spending and falling real estate values are cutting tax revenues.

The NASMHPD report was based on survey responses from 42 states in November 2008. Ten states reported that they anticipated no cuts. The 32 state mental health agencies facing budget cuts this year reported that those declines would average 4.9 percent for Fiscal 2009, and they anticipated decreases of 8.2 percent in 2010 and 9.4 percent in 2011. Many states expect to face reductions in Medicaid as well.

Asked how they would cope with the budget cuts, the agencies said they would most likely implement hiring freezes, reduce administrative expenses, cut staff or services, or close state hospitals.

NAMI's Fitzpatrick doesn't hold out much hope that Washington will ride to the rescue.

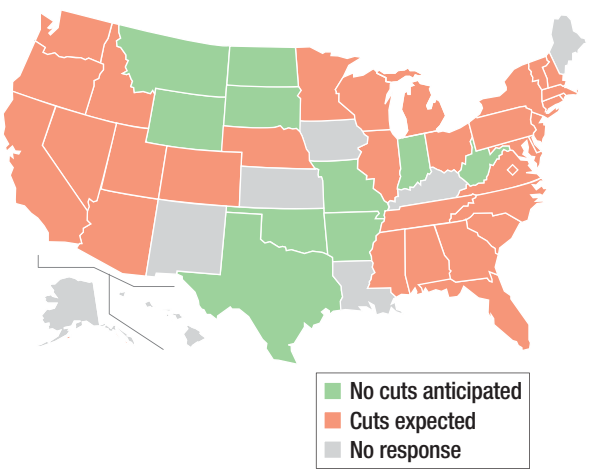
"The economic problems won't be solved by the stimulus package because it won't fix the structural funding problems in the states," he said.

Sometimes the cuts and privatization are driven by more than funding problems. Maryland is planning to shut down the only public inpatient mental health

please see ***MH Services*** *on facing page*

State Mental Health Agencies Tighten Belts

Around the United States, state mental health services face budget cuts over the next two years because the slowdown in the economy has led to reduced tax revenues and increased expenses.



Source: National Association of State Mental Health Program Directors, 2009

Teens Falling Short on Key Health-Improvement Goals

The ability of adolescents to obtain needed mental health care, including for substance use, is limited by lack of insurance, high cost, and privacy concerns, among other factors.

BY RICH DALY

As federal legislators begin to consider expansion and overhaul of the nation's health care system, researchers are highlighting the unmet health needs of many adolescents—an age cohort that is especially likely to depend on emergency rooms for routine medical care or go without any care.

A lack of access to many areas of health care, including mental health and substance use, is a crucial problem among older youth, whose dynamic physical and psychological development can result in quickly developing health problems related to one or both of those areas, according to recent research from the National Research Council (NRC) and the Institute of Medicine (IOM).

Adolescents' "developmental complexities and risky behavior, together with the need to extend their care beyond the usual disease- and injury-focused services, are key considerations in any attempt to reform the nation's chaotic health care system—especially if adolescents are to benefit," said Robert Lawrence, M.D., a professor of medicine at Johns Hopkins University School of Medicine, and colleagues in a report on U.S. adolescent health services by the NRC and IOM.

That study's findings were released in December 2008 and included recommendations to improve health services for adolescents, whom they categorized as youth aged 10 to 19.

The researchers found limited recent progress in improving the overall health of adolescents, as measured by data collected through the Centers for Disease Control and Prevention's (CDC) Healthy People 2010. That initiative has found that since 2000, adolescents' health outcomes have improved in only three of its 21 objectives: behaviors leading to pregnancy, tobacco use, and unintentional injury.

Categories in which the CDC found worsening adolescent health since 2000 included death, suicides, and binge drinking, as well as the ability to access needed mental health treatment.

Among the prominent obstacles to adequate health care for adolescents, the IOM and NRC researchers pointed out, are problems stemming from access to care. For example, more than 5 million adolescents aged 10 to 18 are uninsured, and adolescents are in the age group most likely to depend on emergency departments for routine health care.

The authors found evidence that specialty services in mental health and substance use treatment in particular are not accessible to most adolescents, and the available services in "safety-net settings" frequently fail to address the needs of adolescents who seek care.

"Even when such services are accessible, many adolescents may not find them acceptable because of concerns that confidentiality is not fully ensured, especially in such sensitive domains as substance use or sexual and reproductive health," wrote Lawrence and colleagues.

Even adolescents insured through private health plans frequently face high cost-sharing requirements and a shortage of clinicians and health workers trained to treat them and willing to take their insurance. These limitations are most frequently seen among conditions that require counseling or case management of multiple health problems—conditions such as substance abuse and other mental illnesses, which are "particularly problematic for adolescents," the researchers noted.

How to locate and organize mental health and substance use screening and treatment services in a way that adolescents feel more comfortable has been a leading challenge, according to research by Shay Bilchik, director of the Center for Juvenile Justice Reform at Georgetown University Public Policy Institute and a study author.

"We obviously want high-quality medical care, but there are continuing questions about whether the care we have is reaching a significant number of kids," Bilchik told *Psychiatric News*.

Reform Recommendations Offered

Informing parents that their children may be eligible for public health plans is one of the simpler solutions the authors urged for the undertreatment of health conditions among adolescents. A less demanding, public-insurance enrollment process also might go a long way toward encouraging participation.

More involved changes to public and private health care systems include changing payment approaches so that adolescents' primary care providers are encouraged to make disease prevention, health promotion, and mental health major components of routine health services. The authors called for an approach similar to the "medical home" model urged by some health reform advocates, which designates one clinician to coordinate screening, assessment, health management, and referrals to specialty care.

One health system reform that the authors urged would direct clinicians to "monitor behavior that increases risk in such areas as injury, mental health, oral health, substance use, violence, eating disorders, sexual activity, and exercise."

Consent, Confidentiality Issues Crucial

The authors also called for a review of state laws and regulations concerning the rights of minor adolescents to give their own consent for health services and receive those services on a confidential basis in certain situations.

> **"Training of the part of the health care workforce that regularly works with adolescents really needs attention."**

Especially in mental health, including substance use, the researchers emphasized, a balance is needed between maintaining the confidentiality of information regarding the care of underage adolescents and encouraging involvement of parents and families in that care.

They also called on health-profession regulatory bodies involved in adolescent care to incorporate a minimal set of competencies in such care as part of their licensing, certification, and accreditation requirements.

Comparative questionnaires have found that adolescent patients often felt poorly understood after interactions with health care providers who had rated the same interaction as successful, Bilchik said.

"Training of the part of the health care workforce that regularly works with adolescents really needs attention," Bilchik said.

Federal and state policymakers also were urged to ensure that all adolescents have comprehensive, continuous health insurance coverage. This most expensive recommendation could include assuring access to Medicaid or other forms of health insurance coverage for especially vulnerable or underserved groups of adolescents. The researchers also called for State Children's Health Insurance Program (SCHIP) policies that increase enrollment and retention of eligible but uninsured adolescents.

SCHIP enrollments nationwide could rise in the near future as a result of a SCHIP expansion signed by President Barack Obama in February (see page 1).

"This is far from health care reform, but it is a necessary start," said Rep. Henry Waxman (D-Calif.), chair of the Energy and Commerce Committee, which has primary jurisdiction over SCHIP.

The SCHIP expansion mandates that federal mental health parity coverage provisions enacted in 2008 for private health plans also apply to coverage funded through SCHIP.

The NRC/IOM study "Adolescent Health Services: Missing Opportunities" is posted at <www.iom.edu/CMS/12552/35625/%2060680.aspx>. ■

MH Services

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facility in the city of Baltimore and is trying to decide where to send the patients. While budgetary considerations apparently played some part in the decision, a local mental health official said other factors were involved as well.

The aging Walter P. Carter Center, located in downtown Baltimore near the University of Maryland's medical campus, houses primarily forensic patients, said Jane Plapinger, M.P.H., president and CEO of Baltimore Mental Health Systems, the local mental health authority.

"The Carter Center houses mostly forensic patients, who will be transferred to other state facilities, while the nonforensic patients will go to three general hospitals in the city with psychiatric units or to Sheppard Pratt Hospital," said Plapinger in an interview. "The state will purchase care for them."

Down the road from Baltimore, the District of Columbia announced plans to shift 4,300 clients of its public mental health services to private providers. That process is already underway—spurred by a court-appointed monitor before the budget crisis hit—but the endeavor is expected to save at least $11 million, said Steve Baron, L.C.S.W.-C., director of the District of Columbia Department of Mental Health, in an interview.

"About 2,500 clients will shift to private services by August, while 650 will remain in government-operated care," said Baron. The latter include mainly non-English-speaking, deaf, dual-diagnosis, or court-involved patients. The agency's 16 psychiatrists will remain on staff to oversee and manage care for the patients moved to private care.

The department will create 12 continuity-of-care teams, each consisting of one consumer and one staff person, to follow patients, get them enrolled with private providers, and make sure they keep appointments.

The shift to privatization has some public-sector employees in D.C. and elsewhere worried about their futures, but one psychiatrist at a private, nonprofit clinic doesn't mind.

"I don't think it's a bad thing at all," said Carl Bell, M.D., president and CEO of Community Mental Health Council and Foundation Inc. and a clinical professor of psychiatry and public health at the University of Illinois at Chicago. "City clinics are burdened with unions, patronage, seniority, and fixed-benefit pensions. Private comprehensive mental health centers can be more flexible and innovative and offer more services."

Municipal health departments should be doing public health, not tertiary care, said Bell, who is chair of APA's Council on Social Issues and Public Psychiatry.

Despite the cuts, state mental health agencies will remain an essential part of psychiatric care in the United States, and the entire system will feel the difference if it is seriously diminished, said NAMI's Fitzpatrick.

When states cut staff, the public system loses capacity and cases back up, and untreated mentally ill persons end up in shelters or jails, he said.

"You end up with shells of services," he said. "Our concern is that the economy is hurting this fragile system." ■

Barriers Slow, But Don't Halt March of Collaborative Care

Partnerships between psychiatrists and primary care doctors, which started a third of a century ago in England and then spread to the United States, are expanding their experience.

BY JOAN AREHART-TREICHEL

One of the best ways in which American psychiatrists can extend mental health care to more Americans is to work together with family doctors, Canadian psychiatrist Joel Paris, M.D., argues in his new book, *Prescriptions for the Mind*.

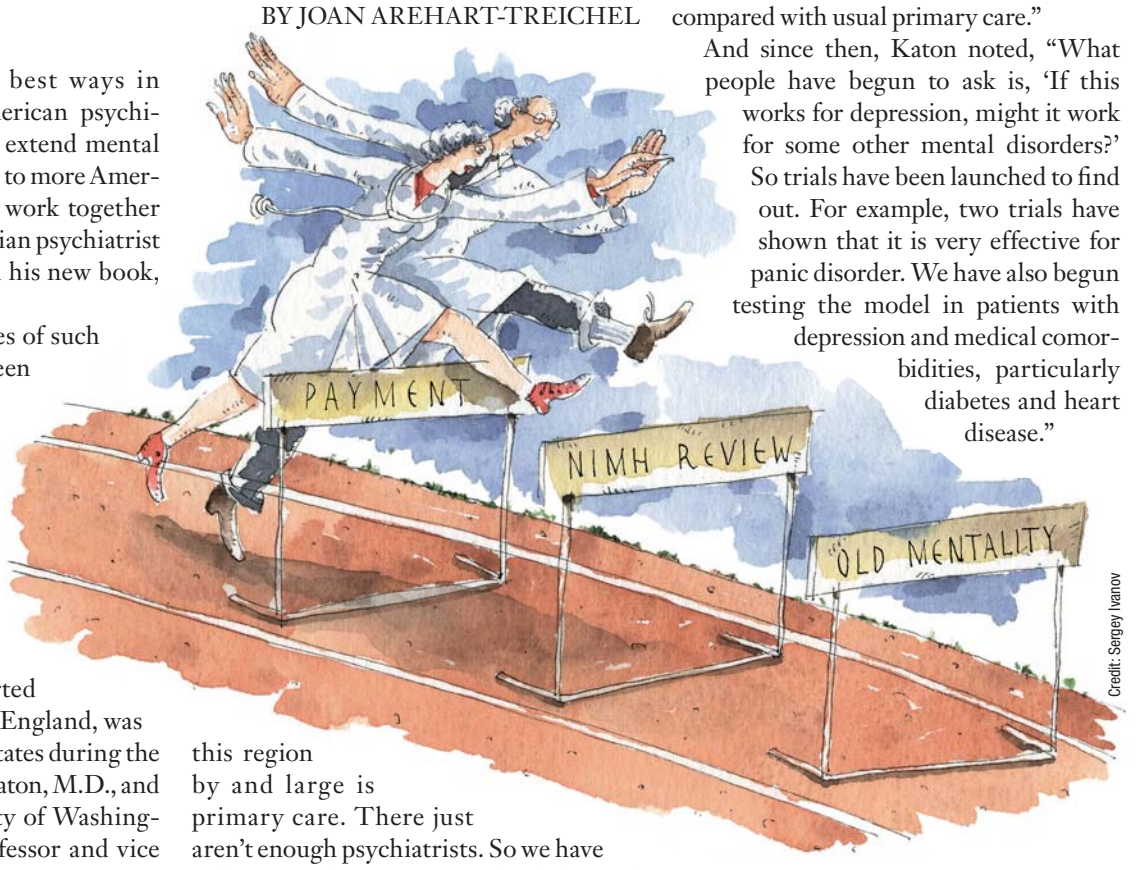
But what are the chances of such "collaborative care" between psychiatrists and family doctors becoming a seismic trend?

Actually quite good, according to U.S. psychiatrists who are pioneering and promoting the practice.

The concept of collaborative care, which started about three decades ago in England, was imported into the United States during the 1990s, notably by Wayne Katon, M.D., and colleagues at the University of Washington. Today Katon is a professor and vice chair of psychiatry at the university.

That collaborative care in the United States debuted in Washington was not by chance, Jurgen Unutzer, M.D., also a professor and vice chair of psychiatry at the University of Washington, told *Psychiatric News*.

"We are the only medical school with a psychiatry training program for a five-state region that makes up a quarter of the land mass of the continental United States. . . . The only care available to people in this region by and large is primary care. There just aren't enough psychiatrists. So we have to leverage what is a tremendously limited resource and assist our colleagues in primary care in caring for patients with some common mental disorders."



Credit: Sergey Ivanov

Early on, Katon and his colleagues applied research principles to the concept of collaborative care to learn whether integrating psychiatrists into a primary care clinic could improve the outcomes of depressed patients. They found that it could. They reported these seminal results in the April 5, 1995, *Journal of the American Medical Association*.

Since then, they and other researchers have found that partnering between psychiatrists and primary care doctors can help depressed patients (*Psychiatric News*, June 3, 2005; January 20, 2006; April 7, 2006). To date, there have been 37 trials, Katon said in an interview. "Overall, the trials have shown a dramatic effectiveness of collaborative care, compared with usual primary care."

And since then, Katon noted, "What people have begun to ask is, 'If this works for depression, might it work for some other mental disorders?' So trials have been launched to find out. For example, two trials have shown that it is very effective for panic disorder. We have also begun testing the model in patients with depression and medical comorbidities, particularly diabetes and heart disease."

Partnering Has Many Profiles

Partnering between psychiatrists and primary care doctors assumes various profiles. For example, Britta Ostermeyer, M.D., an associate professor of psychiatry at Baylor College of Medicine, and colleagues have established a collaborative-care program between psychiatrists and primary care doctors at Harris County Hospital in Houston to care for patients with depression or anxiety disorders (*Psychiatric News*, March 17, 2006).

"We are furthering the scope of what the primary care physicians do," she explained. "We want them to diagnose mental illnesses, make referrals for those patients whom they cannot properly treat or address themselves, and then when a psychiatrist stabilizes those patients and refers them back, they continue the care. So that is one aspect. The other aspect is that there are patients who do not need to be seen by a psychiatrist. . . .The primary care doctor seeks a 'curbside' consultation with the psychiatrist and then goes back and treats the patient."

Such collaboration, initially only research based, is becoming routine clinical practice in several places. Count Ostermeyer's program among these, along with the groundbreaking approach at the University of Washington where psychiatrists practice within most of the university's large primary care clinics.

In California, the large HMO Kaiser Permanente has integrated psychiatric staff into all of its primary care clinics. This means that collaboration between psychiatrists and primary care doctors has become a standard benefit for some 6 million Californians who receive health care through Kaiser. A project at the Department of Veterans Affairs (VA) called the Tides and Waves Project is expanding its partnering between psychiatrists and primary doctors to VA outpatient clinics throughout the country.

Probably the most groundbreaking collaborative-care operation that is moving beyond research into clinical practice is the Diamond Project in Minnesota. It is run by the Institute for Clinical Systems Improvement, which is working to get routine depression screening with the nine-item Patient Health Questionnaire (PHQ-9) established in some 25 large primary-care groups and in some 90 clinics in Minnesota. The institute is also working to get eight health insurance companies to pay for such screening, as well as for the services of psychiatrists, primary care doctors, and case managers who assist in treating the screened patients found to be depressed.

And more is coming. "All sorts of places around the country are looking into doing collaborative care by bringing primary care and psychiatry together at one location," Ostermeyer observed.

Reimbursement Is Major Hurdle

In the rush to transform psychiatrists and primary care doctors into confreres, experts agree that several hurdles need to be overcome.

"I think the biggest challenge is payment," Unutzer said, adding that although some insurance companies are making it easy for primary care clinics to adopt the collaborative-care model (*Psychiatric News*, January 20, 2006), others are not.

A second obstacle is getting collaborative-care models past review sections at the National Institute of Mental Health (NIMH) or the VA. "Most people who sit on review sections at the NIMH or at the VA," Katon said, "tend to be 'splitters' or 'lumpers.' Splitters are people who want you to do something in a very narrow population very well. Lumpers are people" who want you to do something for more people with the resources available.

A third barrier to be overcome is to "change the mentality of primary care physicians, especially some of the older generation," Ostermeyer noted. "Some are not comfortable prescribing psychiatric medications."

"Effectiveness studies have shown that you can improve patient outcomes dramatically by using algorithms to make sure that patients are getting evidence-based care and then to refer them to specialty care if they are not meeting certain criteria," said David Katzelnick, M.D., a clinical professor of psychiatry at the University of Wisconsin. Yet he also noted that getting such algorithms implemented in collaborative-care clinics is tough. In other words, there are two separate challenges. One is convincing primary care doctors that using algorithms is worthwhile. The other is actually getting them to put algorithm information into patients' medical records so that psychiatrists and other health care providers have access to it.

Collaboration Brings Many Rewards

Nonetheless, partnering between psychiatrists and primary doctors has its compensations.

"Our patients are absolutely thrilled that they can walk into their neighborhood primary-care center and get psychiatric

please see ***Collaborative Care*** *on page 8*

Collaboration Also Gains Momentum North of the Border

Collaboration between psychiatrists and primary care doctors, which is becoming increasingly popular in the United States (see article above), is also gaining ground throughout Canada.

"It works well in the Canadian system, playing on its strengths and weaknesses," Randall White, M.D., a clinical assistant professor of psychiatry at St. Paul's Hospital in Vancouver, told *Psychiatric News*. "We have too few psychiatrists, so this approach allows us to use our time effectively by supporting primary care providers."

In Quebec, for example, the government is trying to reorganize the health care system so that less-ill psychiatric patients will be cared for by family doctors, not by psychiatrists, Joel Paris, M.D., a professor of psychiatry at McGill University in Montreal, said during an interview. This means that psychiatrists will see only the sickest patients, either at the family doctors' offices or at the hospital where they work. (Most psychiatrists in Quebec work in hospitals, not in private practice.) "So that's how things have evolved here," he said. "This is pretty typical of Canada."

In Vancouver, White and Rainer Borkenhagen, M.D., a family physician, set up a collaborative-care program whereby psychiatrists would help family physicians provide better mental health care to their patients. They named the program Urbandoc. Today, not just White, but two other psychiatrists at St. Paul's and two psychiatrists at Vancouver General Hospital are participating in the program.

The family physicians and psychiatrists involved in Urbandoc can communicate with each other through a secure Web site. "We accept any referrals the family practitioners send," White said. "I have diagnosed mood disorders, anxiety disorders, addictions, personality disorders, and somatoform disorders." Still another valuable aspect of the program, White explained, is that the public health insurance system in British Columbia has set up special mechanisms to reimburse the family physicians and psychiatrists who participate in the program.

"So I think partnering in Canada is going to increase," Paris anticipates. "Patients will be treated by family doctors unless there is a reason not to."

Is Slowing Health Care Spending A Trend or Anomaly?

The large decrease in the growth of medication spending is being linked to the increased use of generic drugs and a slowing economy.

BY RICH DALY

The growth of the nation's health care spending slowed in 2007 to its lowest rate in nearly a decade, according to recently released data—but the reduction in the growth of spending is likely to be temporary.

Health care spending by both the private and public sectors increased by only 6.1 percent in 2007 and totaled $2.2 trillion (or $7,421 per person), according to a report by the Centers for Medicare and Medicaid Services' (CMS) Office of the Actuary. In the preceding year, the growth rate was 6.7 percent over that of 2005.

The spending estimates are based on an analysis of government data, including Medicare and Medicaid information, health care provider surveys, and private health insurance filings with state insurance commissioners.

The latest government data showed that health care expenditures rose to 16.2 percent of the gross domestic product in 2007, up from 16 percent in 2006.

The slower growth was largely attributed to reduced retail prescription drug spending and slowed government spending on health care. Physician payments also showed slower growth. Most other types of health care services either grew at about the same rate as in 2006 or faster.

More than half of the slowed growth in spending was attributed to decreased spending on prescription drugs, which made up 10 percent of all health care spending in 2007. In that year, retail prescription drug spending grew by just 4.9 percent to $227.5 billion, which was a deceleration from its 8.6 percent growth in 2006. The yearly average growth in spending on medication was 9.4 percent from 2001 to 2006, according to the study, led by Micah Hartman, a statistician for the CMS Office of the Actuary.

Hartman and his coauthors attributed the drop in medication outlays to increased use of lower-cost generic drugs, slower growth of drug prices, and safety concerns that have decreased sales of some medications.

The increased use of typically cheaper generic versions of medications by patients is a behavior that has been encouraged by insurers. Generic drugs cost 30 percent to 80 percent less, on average, than their brand-name counterparts, the authors noted.

Some grocery-store chains and large retailers also have contributed to the lower-spending trend by offering customers generic-drug discount programs. Another factor in drug price reductions may be the loss of patent protection in 2006 by several top-selling brand-name drugs, which allowed generic competitors to enter the market

The increasing role of generics is not likely to become an annual occurrence, said Richard Foster, CMS chief actuary, in a press conference.

"I wouldn't expect the good news to continue," Foster said.

On another front, insurers lowered copayments for certain drugs but raised them for other drugs, some of which companies may want consumers to avoid for safety as well as financial reasons. Consider: the Food and Drug Administration mandated 68 black-box safety warnings on drug labels in 2007, compared with 58 warnings in 2006 and 21 in 2003, according to the CMS report.

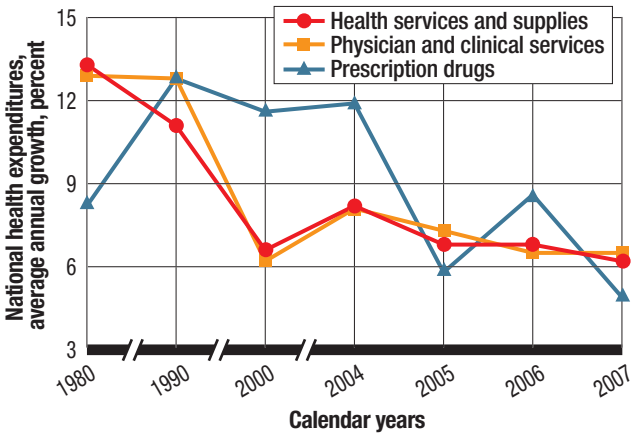
Another area where growth slowed was payment to physicians—representing 18 percent of health care outlays. Payments grew by 5.9 percent, compared with an increase of 6.4 percent in 2006, according to the report. The authors attributed this slowdown, at least in part, to a reduction in physician reimbursements for "imaging services" that went into effect in 2007.

CMS officials welcomed the slower growth in the cost of health care but warned that the relative lull was not expected to continue, as long-term trends

please see ***Spending*** *on page 13*

Spending Growth Slows for M.D. Services, Medications

Declines in the growth of spending on medications and physician services in recent years by both public and private health care systems generally reflected the overall recent decrease in growth by the health care sector.



Source: "National Health Spending In 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," Centers for Medicare and Medicaid Services Office of the Actuary, January 2009

Ethicist-Educator Insists Community Must Be Engaged

The president of the American Association of Chairs of Departments of Psychiatry says that the biggest challenge facing the field today is defining for society psychiatry's special contributions to the care of mentally ill people.

BY MARK MORAN

Laura Roberts, M.D., finished her psychiatry training in the early 1990s just as the ethical challenges of psychiatric research—how to acquire informed consent from individuals with mental illness, the pitfalls and potential of drug "washout" trials, and other questions—were attracting national attention.

As it happened, she emerged from her training with a unique grounding in medical ethics—she had studied with Mark Siegler, M.D., and other prominent thinkers in the field at the University of Chicago, where she went to medical school—and in clinical care with a diverse and underserved rural population served by the University of New Mexico, where she did her residency.

In a field that until then had been traditionally guided by "expert opinion" issuing edicts about an abstract ideal, Roberts brought to medical ethics the new and refreshing perspective of evidence-based research.

"I began writing proposals in this unique area of evidence-based ethics," Roberts told *Psychiatric News*. "I didn't approach these topics from the standpoint of 'What is the expert opinion on this question?' Instead, we went out and really talked with people living in the community with mental illnesses and got their perspective about their own experiences in research.

"The idea was to think more systematically and in a more down-to-earth way about complex ethical questions. Expert opinions do not always help resolve dilemmas, and very, very good people can have very different points of view about controversial topics. We took the approach of listening to the people most deeply affected by ethics policies and trying to understand their perspectives, rather than making assumptions about what their motivations or vulnerabilities were."

So as early as 1996, Roberts (still in her 30s) began publishing evidence-based ethics work on such topics as teaching ethics in psychiatric supervision, attitudes of consultation-liaison psychiatrists toward end-of-life practices, ethical issues around disparities in access to mental health services, and conceptual issues and empirical findings about the ethical bases of psychiatric research.

Her approach to ethics research—focused on real-world problems and their solutions, casting a wide net for maximum input from stakeholders most affected by an issue, and capable of integrating conflicting viewpoints—was one that would serve her well as she rose through the ranks of academic medicine. By 2000 she was named interim chair of the department of psychiatry at the University of New Mexico, where she established the Institute on Ethics, and in 2003 Roberts moved to the Medical College of Wisconsin, where she assumed the chair of the Department of Psychiatry and Behavioral Medicine.

Photo courtesy of Laura Roberts

Laura Roberts, M.D., the first woman president of the AACDP, brings a background in evidence-based ethics and career development.

Last November, Roberts reached a new landmark when she was elected the first woman president of the American Association of Chairs of Departments of Psychiatry (AACDP).

Diversity of all kinds is the future in academic medicine, Roberts commented.

"People with very diverse and distinctive pathways to leadership—that's the emerging pattern. Certainly there are a lot of department chairs who are outstanding physician investigators in the traditional mold, and my own reputation is related to that tradition. But many of my colleagues who are coming up through the ranks today have shown superb leadership in nontraditional areas such as community programs, medical education, or executive and economic issues.

"There is no longer only one path to becoming a chair. Today, it's all about demonstrating leadership capacity in diverse areas."

Psychiatric educators say that in that regard, Roberts is an exemplar.

"I think what the department chairs have recognized in electing [Roberts] is her ability to get people with disparate backgrounds and conflicting priorities to work together," said immediate past APA President Carolyn Robinowitz, M.D., and a past dean of Georgetown University School of Medicine. "She has a very deft touch, which is really important for a department chair who has to be the interface between the work of the department and the goals of the institution.

"Laura is the kind of department chair a dean likes to have. She's a problem solver who focuses on what can be done, rather than saying, 'No, we can't do that.' And she is able to deal with conflicts and resolve them without becoming enmeshed in them herself."

Roberts also has responsibilities within APA. She is chair of the Task Force to Update the Ethics Annotations, a member of the editorial board and board of directors of American Psychiatric Publishing Inc., and a member of the Council on Research.

"We Can't Just Sit Around and Be Smart"

As a department chair, Roberts said she has found a place at the center of research, education, clinical care, community outreach, and professional development where she can put her talents to work. "For me, being an academic chair means you can do it all, all at once," she said. "That is what I love."

As for being the first woman president of the AACDP, Roberts acknowledged that it's a landmark: there are few women chairs of departments throughout medicine, she said, and the number of women who are deans of medical school is growing, but lags proportionately far behind their numbers as physicians.

But Roberts said that she believes a more striking divide in academic medicine is the generational and attitudinal one between physicians trained in previous decades and those rising to leadership positions in academic medicine today.

"The task of leadership now is to preserve the strengths of the past, such as a deep commitment to the therapeutic relationship and patient well-being, and to advance a modern model of medicine that will serve society in the future."

In a "President's Message" on the Web site of the AACDP, Roberts wrote that the mission of academic psychiatry must go beyond the traditional "three-legged stool" of education-research-clinical care to also include what she calls "community engagement" and "professionalism."

"We can't just sit around and be smart," Roberts told *Psychiatric News*. "We have to demonstrate that we can contribute to society and to the health of future generations."

Roberts said that is the biggest challenge facing the field of psychiatry today—showing the larger society "what it is that psychiatrists do as physicians that is an invaluable and unique contribution to the care of people living with all kinds of illnesses. We need to be very clear about why psychiatry can and does improve the lives of people who experience devastating diseases."

At the same time, resources are scarce. "We are undervalued in society, people with mental illness are marginalized, and some in the public doubt even that mental illness exists," she said. So we have to be innovative, creative, and wise stewards of resources."

So what are her goals as AACDP president this year?

Roberts said they are threefold: strengthening the skill set of people who are already department chairs, helping to define the ethical basis of the field for the larger society, and supporting the professional development of future department leaders.

This educator-researcher-clinician-ethicist and mother is not deterred by challenges or obstacles. "People have said to me, 'Oh, you can't be a mother and have an academic career' or 'You can't do evidence-based ethics.' But I've never been discouraged by negative messages in my environment.

"At all times," she said, "I've followed my heart." ■

Collaborative Care

continued from page 6

care," Ostermeyer attested. "It removes the stigma that surrounds walking into a psychiatric clinic."

"Primary care patients really like getting results from the PHQ-9," Katzelnick reported. "The PHQ-9 is also very helpful in communicating with primary care clinicians and in advising them on depression treatment."

"For me, the main reward is that I feel that I am providing better patient care," Unutzer remarked. "I am providing care to whole patients, not just to their minds or emotions. For example, if a patient says, 'I hurt all over,' I can address the depression and then work with a primary doctor to address the arthritis pain."

"Part of the gratification for me," Katon noted, "is that we psychiatrists are able to treat a much wider portion of the population than we would otherwise be able to treat."

The best in the psychiatry-primary care partnership may be yet to come.

"We are seeing a dramatic expansion of it now, and I think that is going to continue because there is going to be more demand from regulators, insurance, and the government to provide evidence-based care," Katon predicted.

"Certainly many large health care settings, like the VA and the large HMOs, but also many federally qualified health centers that serve low-income, uninsured, safety-net populations are moving toward integrating mental health specialists into their clinics," Unutzer observed. "So I think we will see more of this. I think we will start to train psychiatrists to work in these kinds of settings. I also think we are going to see more of the reverse—those of us who practice in mental health specialty settings are going to find ways of inviting our colleagues in [primary care] medicine to help care for our [seriously, persistently ill] patients."

"I hope that collaborative care will become the standard of care within the United States and that reimbursement of clinicians will be restructured to support it," Katzelnick asserted. "I think that is starting to happen. The Diamond Project is an example. . . .If that goes well, it will spread throughout Minnesota, and I know that Wisconsin is also looking at it."

"I think there is a bright future for collaborative care because both primary care and psychiatry realize that they need each other," Ostermeyer said. "For the new generation of primary care doctors, it will be normal and natural for them to treat mental illness, just as they treat cardiac conditions." ■

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Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine.

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Namenda undergoes partial hepatic metabolism, with about 48% of administered dose excreted in urine as unchanged drug or as the sum of parent drug and the N-glucuronide conjugate (74%). No dosage adjustment is needed in patients with mild or moderate hepatic impairment. Namenda should be administered with caution to patients with severe hepatic impairment.

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No dosage adjustment is needed in patients with mild or moderate renal impairment. A dosage reduction is recommended in patients with severe renal impairment (see CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION in Full Prescribing Information).

Drug-Drug Interactions
N-methyl-D-aspartate (NMDA) antagonists: The combined use of Namenda with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution.

Effects of Namenda on substrates of microsomal enzymes: In vitro studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. In addition, *in vitro* studies indicate that at concentrations exceeding those associated with efficacy, memantine does not induce the cytochrome P450 isoenzymes CYP1A2, CYP2C9, CYP2E1, and CYP3A4/5. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected.

Effects of inhibitors and/or substrates of microsomal enzymes on Namenda: Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the metabolism of memantine.

Acetylcholinesterase (AChE) inhibitors: Coadministration of Namenda with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine and donepezil was similar to that of donepezil alone.

Drugs eliminated via renal mechanisms: Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system, including hydrochlorothiazide (HCTZ), triamterene (TA), metformin, cimetidine, ranitidine, quinidine, and nicotine, could potentially result in altered plasma levels of both agents. However, coadministration of Namenda and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%. In addition, coadministration of memantine with the antihyperglycemic drug Glucovance® (glyburide and metformin HCl) did not affect the pharmacokinetics of memantine, metformin, and glyburide. Furthermore, memantine did not modify the serum glucose lowering effect of Glucovance®.

Drugs that make the urine alkaline: The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate), and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions.

Carcinogenesis, Mutagenesis and Impairment of Fertility
There was no evidence of carcinogenicity in a 113-week oral study in mice at doses up to 40 mg/kg/day (10 times the maximum recommended human dose [MRHD] on a mg/m² basis). There was also no evidence of carcinogenicity in rats orally dosed at up to 40 mg/kg/day for 71 weeks followed by 20 mg/kg/day (20 and 10 times the MRHD on a mg/m² basis, respectively) through 128 weeks.

Memantine produced no evidence of genotoxic potential when evaluated in the *in vitro S. typhimurium* or *E. coli* reverse mutation assay, an *in vitro* chromosomal aberration test in human lymphocytes, an *in vivo* cytogenetics assay for chromosome damage in rats, and the *in vivo* mouse micronucleus assay. The results were equivocal in an *in vitro* gene mutation assay using Chinese hamster V79 cells.

No impairment of fertility or reproductive performance was seen in rats administered up to 18 mg/kg/day (9 times the MRHD on a mg/m² basis) orally from 14 days prior to mating through gestation and lactation in females, or for 60 days prior to mating in males.

Pregnancy
Pregnancy Category B: Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 9 and 30 times, respectively, the maximum recommended human dose [MRHD] on a mg/m² basis).

Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the post-partum period. The no-effect dose for these effects was 6 mg/kg, which is 3 times the MRHD on a mg/m² basis.

There are no adequate and well-controlled studies of memantine in pregnant women. Memantine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers
It is not known whether memantine is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother.

Pediatric Use
There are no adequate and well-controlled trials documenting the safety and efficacy of memantine in any illness occurring in children.

ADVERSE REACTIONS
The experience described in this section derives from studies in patients with Alzheimer's disease and vascular dementia.

Adverse Events Leading to Discontinuation: In placebo-controlled trials in which dementia patients received doses of Namenda up to 20 mg/day, the likelihood of discontinuation because of an adverse event was the same in the Namenda group as in the placebo group. No individual adverse event was associated with the discontinuation of treatment in 1% or more of Namenda-treated patients and at a rate greater than placebo.

Adverse Events Reported in Controlled Trials: The reported adverse events in Namenda (memantine hydrochloride) trials reflect experience gained under closely monitored conditions in a highly selected patient population. In actual practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior and the types of patients treated may differ. Table 1 lists treatment-emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled dementia trials and for which the rate of occurrence was greater for patients treated with Namenda than for those treated with placebo. No adverse event occurred at a frequency of at least 5% and twice the placebo rate.

Table 1: Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving Namenda and at a Higher Frequency than Placebo-treated Patients

Body System Adverse Event	Placebo (N = 922) %	Namenda (N = 940) %
Body as a Whole		
Fatigue	[illegible]	2
Pain	[illegible]	3
Cardiovascular System		
Hypertension	2	4
Central and Peripheral Nervous System		
Dizziness	5	7
Headache	3	6
Gastrointestinal System		
Constipation	3	5
Vomiting	2	3
Musculoskeletal System		
Back pain	2	3
Psychiatric Disorders		
Confusion	5	6
Somnolence	2	3
Hallucination	2	3
Respiratory System		
Coughing	3	4
Dyspnea	1	2

Other adverse events occurring with an incidence of at least 2% in Namenda-treated patients but at a greater or equal rate on placebo were agitation, fall, inflicted injury, urinary incontinence, diarrhea, bronchitis, insomnia, urinary tract infection, influenza-like symptoms, abnormal gait, depression, upper respiratory tract infection, anxiety, peripheral edema, nausea, anorexia, and arthralgia.

The overall profile of adverse events and the incidence rates for individual adverse events in the subpopulation of patients with moderate to severe Alzheimer's disease were not different from the profile and incidence rates described above for the overall dementia population.

Vital Sign Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with Namenda. A comparison of supine and standing vital sign measures for Namenda and placebo in elderly normal subjects indicated that Namenda treatment is not associated with orthostatic changes.

Laboratory Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Namenda treatment.

ECG Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with Namenda treatment.

Other Adverse Events Observed During Clinical Trials
Namenda has been administered to approximately 1350 patients with dementia, of whom more than 1200 received the maximum recommended dose of 20 mg/day. Patients received Namenda treatment for periods of up to 884 days, with 862 patients receiving at least 24 weeks of treatment and 387 patients receiving 48 weeks or more of treatment.

Treatment emergent signs and symptoms that occurred during 8 controlled clinical trials and 4 open-label trials were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized categories using WHO terminology, and event frequencies were calculated across all studies.

All adverse events occurring in at least two patients are included, except for those already listed in Table 1, WHO terms too general to be informative, minor symptoms or events unlikely to be drug-caused (e.g., because they are common in the study population). Events are classified by body system and listed using the following definitions: frequent adverse events - those occurring in at least 1/100 patients; infrequent adverse events - those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to Namenda treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies.

Body as a Whole: *Frequent:* syncope. *Infrequent:* hypothermia, allergic reaction.

Cardiovascular System: *Frequent:* cardiac failure. *Infrequent:* angina pectoris, bradycardia, myocardial infarction, thrombophlebitis, atrial fibrillation, hypotension, cardiac arrest, postural hypotension, pulmonary embolism, pulmonary edema.

Central and Peripheral Nervous System: *Frequent:* transient ischemic attack, cerebrovascular accident, vertigo, ataxia, hypokinesia. *Infrequent:* paresthesia, convulsions, extrapyramidal disorder, hypertonia, tremor, aphasia, hypoesthesia, abnormal coordination, hemiplegia, hyperkinesia, involuntary muscle contractions, stupor, cerebral hemorrhage, neuralgia, ptosis, neuropathy.

Gastrointestinal System: *Infrequent:* gastroenteritis, diverticulitis, gastrointestinal hemorrhage, melena, esophageal ulceration.

Hemic and Lymphatic Disorders: *Frequent:* anemia. *Infrequent:* leukopenia.

Metabolic and Nutritional Disorders: *Frequent:* increased alkaline phosphatase, decreased weight. *Infrequent:* dehydration, hyponatremia, aggravated diabetes mellitus.

Psychiatric Disorders: *Frequent:* aggressive reaction. *Infrequent:* delusion, personality disorder, emotional lability, nervousness, sleep disorder, libido increased, psychosis, amnesia, apathy, paranoid reaction, thinking abnormal, crying abnormal, appetite increased, paronia, delirium, depersonalization, necrosis, suicide attempt.

Respiratory System: *Frequent:* pneumonia. *Infrequent:* apnea, asthma, hemoptysis.

Skin and Appendages: *Frequent:* rash. *Infrequent:* skin ulceration, pruritus, cellulitis, eczema, dermatitis, erythematous rash, alopecia, urticaria.

Special Senses: *Frequent:* cataract, conjunctivitis. *Infrequent:* macula lutea degeneration, decreased visual acuity, decreased hearing, tinnitus, blepharitis, blurred vision, corneal opacity, glaucoma, conjunctival hemorrhage, eye pain, retinal hemorrhage, xerophthalmia, diplopia, abnormal lacrimation, myopia, retina detachment.

Urinary System: *Frequent:* frequent micturition. *Infrequent:* dysuria, hematuria, urinary retention.

Events Reported Subsequent to the Marketing of Namenda, both US and Ex-US
Although no causal relationship to memantine treatment has been found, the following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in labeling: aspiration pneumonia, asthenia, atrioventricular block, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, cholelithiasis, claudication, colitis, deep venous thrombosis, depressed level of consciousness (including loss of consciousness and rare reports of coma), dyskinesia, dysphagia, encephalopathy, gastritis, gastroesophageal reflux, grand mal convulsions, intracranial hemorrhage, hepatitis (including increased ALT and AST and hepatic failure), hyperglycemia, hyperlipidemia, hypoglycemia, ileus, increased INR, impotence, lethargy, malaise, myoclonus, neuroleptic malignant syndrome, acute pancreatitis, Parkinsonism, acute renal failure (including increased creatinine and renal insufficiency), prolonged QT interval, restlessness, sepsis, Stevens-Johnson syndrome, suicidal ideation, sudden death, supraventricular tachycardia, tachycardia, tardive dyskinesia, thrombocytopenia, and hallucinations (both visual and auditory).

ANIMAL TOXICOLOGY
Memantine induced neuronal lesions (vacuolation and necrosis) in the multipolar and pyramidal cells in cortical layers III and IV at the posterior cingulate and retrosplenial neocortices in rats similar to those which are known to occur in rodents administered other NMDA receptor antagonists. Lesions were seen after a single dose of memantine. In a study in which rats were given daily oral doses of memantine for 14 days, the no-effect dose for neuronal necrosis was 6 times the maximum recommended human dose on a mg/m² basis. The potential for induction of central neuronal vacuolation and necrosis by NMDA receptor antagonists in humans is unknown.

DRUG ABUSE AND DEPENDENCE
Controlled Substance Class: Memantine HCl is not a controlled substance.

Physical and Psychological Dependence: Memantine HCl is a low to moderate affinity uncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 2,504 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

OVERDOSAGE
Signs and symptoms associated with memantine overdosage in clinical trials and from worldwide marketing experience include agitation, confusion, ECG changes, loss of consciousness, psychosis, restlessness, slowed movement, somnolence, stupor, unsteady gait, visual hallucinations, vertigo, vomiting, and weakness. The largest known ingestion of memantine worldwide was 2.0 grams in a patient who took memantine in conjunction with unspecified antidiabetic medications. The patient experienced coma, diplopia, and agitation, but subsequently recovered.

Because strategies for the management of overdose are continually evolving, it is advisable to contact a poison control center to determine the latest recommendations for the management of an overdose of any drug. As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine.

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Rev. 04/07

Foundation Expands APA's Outreach

The American Psychiatric Foundation funds programs that benefit people with mental illness and aim to reduce stigma. APA members are encouraged to support these efforts through donations and attending the annual gala.

Credit: David Hathcox

The 2008-2009 Board of Directors of the American Psychiatric Foundation

In addition to APA, members have another organization hard at work for them to make a difference in the lives of people with mental illness and enhance the profession of psychiatry: the American Psychiatric Foundation.

The foundation is the philanthropic and charitable arm of APA. Established in 1991, the foundation seeks to advance public understanding of mental illnesses. It promotes awareness of mental illnesses and the effectiveness of treatment, the importance of early intervention, access to care, and the need for high-quality services and treatment through a combination of grants, programs, research funding, and awards.

The foundation negotiates for funds to support research, fellowship grants, and public-education programs for APA, the American Psychiatric Institute for Research and Education (APIRE), and its own programs. As a 501(c)3 not-for-profit entity, it raised $5 million in 2007 through grant requests and negotiations with industry for APA, APIRE, and foundation programs.

The foundation's fundraising on behalf of APA focuses on grants for fellowships and supporterships from pharmaceutical companies, Paul Burke, the foundation's executive director, told *Psychiatric News*. These activities provide revenue to APA as part of the annual meeting and Institute on Psychiatric Services and fellowship experiences to residents that enhance their professional leadership capabilities.

Annual meeting supporterships, like the new Product Theater and the Daily Bulletin, provide funding to support educational activities at the annual meeting and the institute. APA fellowships provide leadership training and career-enhancing opportunities for residents in professional leadership, legislative activities, and leadership in minority mental health issues. These fellowships are supported by restricted grants from a number of pharmaceutical companies such as AstraZeneca, Bristol-Myers Squibb, Janssen, Lilly, Shire, and Wyeth. In 2008 over $380,000 was raised through restricted grant funding by the foundation.

This year, the foundation successfully resurrected the funding for the APA Psychiatric Achievement Awards. (Funding was not available for 2008.) The award recognizes innovators in the field of public mental health. Since 1949 the Achievement Awards have been presented annually to public and community psychiatry programs that offer innovative, outstanding services to people with mental illness and developmental disabilities in both institutional and community settings. Pfizer has provided $82,961 of grant funding for the 2009 awards.

Restricted grants generated by the foundation on behalf of APA have more than tripled since 2000 to approximately $3.5 million a year (note that this is direct support of APA and APIRE and does not include approximately $500,000 in funds received and administered annually by the foundation on behalf of APA and APIRE).

Although the foundation is responsible for the revenue stream associated with grants to fund education and provide meeting funding, it also seeks to build and broaden APA's relationship with key funders, particularly pharmaceutical companies. In doing so, the foundation works to identify areas of mutual concern and foster new ways of collaborating in a positive and appropriate manner. To this end, the Corporate Advisory Council gives the APA leadership and the corporate representatives a forum to discuss issues of mutual interest and concern. As a result, key funders have become more likely to not only provide grant funding to APA but to advertise in APA journals and participate in the APA meetings. The foundation will continue to enhance this unique forum and it value in 2009.

The foundation raised about $2 million for APIRE research projects and fellowships. APIRE research projects are always supported by more than one company. All areas of the research design and faculty selection are made before grants are requested and are controlled by APIRE. Requests for grants are written by APIRE staff in consultation with the foundation and then submitted to potential funders. In 2008 the foundation requested and received $576,000 in funding for APIRE research projects. Support from industry is always acknowledged and appreciated.

APIRE fellowships in research provide industry grants to young researchers to get into their first research project with the guidance of a research mentor and financial support. Studies show that there is a severe shortage of physicians researching severe mental illness. APIRE has four pharmaceutical-funded research fellowships that support more than 25 fellows a year. Many of these fellows go on to a career in research. In 2008 the foundation requested and received $744,000 for fellowships in research.

"I'm most proud of our grants to medical students," said child psychiatrist Richard Harding, M.D., a professor of clinical neuropsychiatry at the University of South Carolina in Columbia, who took over as the foundation's president in January 2007. He is also a former APA president.

These Helping Hands Grants, of up to $5,000, go to students who develop and manage mental health service projects, usually for minorities, said Harding. The foundation recently awarded grants to students from the Morehouse School of Medicine in Atlanta to educate disadvantaged youth about mental health. The program also granted funds to Tulane University School of Medicine in New Orleans to develop a mental health service plan for young people in New Orleans, and to Boston University School of Medicine students to link mental health and educational services.

The program has immediate benefits for the students and for the people they serve, but there is another objective too, said Harding.

"We hope that some of them will go into psychiatry, but even if they don't, their knowledge and ability to deal with psychiatric problems in their patients will be enhanced," he said.

The foundation also backs five public mental health programs. One, "Typical or Troubled?," has provided education about the early warning signs of mental illness in adolescents to 12,000 teachers, counselors, and psychologists in 125 school districts in 27 states in the last five years.

The Partnership for Workplace Mental Health develops alliances with businesses to explain how unrecognized and untreated problems like depression or substance abuse costs billions of dollars in lost work time and productivity.

The foundation is part of the Depression Is Real Coalition, which has produced and distributed print, radio, and television public-service announcements in English and Spanish.

The foundation also supports the Give an Hour program *(Psychiatric News*, March 7, 2008), which enrolls volunteer psychiatrists, psychologists, social workers, and other professionals to provide an hour a week in counseling free of charge for up to a year to military service personnel and their families.

The foundation recently began Community Connections, featuring speakers from APA, local universities, and community organizations who hold town hall–style meetings to educate targeted communities about mental illness. Using nonmedical settings lessens stigma, and events have been held in cooperation with

please see ***Foundation*** *on page 24*

Outstanding DB Newsletters Win Honors From APA

Every year APA recognizes outstanding newsletters produced by its district branches and state asssociations. Each award category is based on the number of members in the district branch or state association. Awards are also presented for individual articles and editorials from the newsletters. Here are the 2008 Newsletter of the Year Award winners:

- **100-200 members**

Winner: *Synapse*, West Hudson Psychiatric Society

- **201-500 members**

Winner: *Wisconsin Psychiatrist*, Wisconsin Psychiatric Association
Continuing Excellence: *Louisiana Psychiatric Medical Association Newsletter*, Louisiana Psychiatric Medical Association

- **501+ members**

Winner: *Insight Matters*, Ohio Psychiatric Physicians Association
Continuing Excellence: *New Jersey Psychiatrist*, New Jersey Psychiatric Association
Honorable Mention: *Pennsylvania Psychiatrist*, Pennsylvania Psychiatric Society

- **Best Editorial**

Winner: Editorial series, "Through the Looking Glass—Reflections," "Questions," "The Data Wars," and "Making the Unconscious Conscious" *Colorado Psychiatric Society Newsletter*, Colorado Psychiatric Society
Honorable Mention: "Education or Slick Advertisement?" *Lousiana Psychiatric Medical Association Newsletter*, Louisiana Psychiatric Medical Association

- **Outstanding Feature Article**

Winner: "Psychiatry and Collaborative Practice: Re-Engineering Primary Care," *New Jersey Psychiatrist*, New Jersey Psychiatric Association
Honorable Mention: "Medical Society Addresses Epidemic of Opiate Addiction" *NCPS News*, North Carolina Psychiatric Society ■

APA Anticipates Future With New CME Opportunities

APA is striving to prepare members for a new paradigm in continuing medical education, whereby physicians in all specialties will be expected to measure their clinical performance against evidence-based guidelines.

BY MARK MORAN

An electronic tool for helping clinicians continually sharpen their clinical acumen, known as eFOCUS, is APA's newest initiative in the brave new world of "lifelong learning."

APA members have begun to receive periodically a clinical vignette and a multiple choice question via e-mail about how to manage the case described in the vignette. There are no wrong answers—this is not a test!—but rather, all of the options represent valid clinical approaches to a complex case.

As members respond to the question, a table and pie chart illustrating the proportion of members who chose each option automatically appear on their screen.

Later, after members have electronically returned their responses, eFOCUS sends an e-mail containing an "expert commentary" on the case by a prominent clinician-researcher in the clinical area being addressed by the case.

"EFOCUS allows a clinician to think about how he or she would assess and care for a patient as described by the vignette and compare and contrast it with expert opinion and with the approach of other colleagues," said Mark Rapaport, M.D., who is co-editor of APA's CME journal *Focus* (along with Deborah Hales, M.D., director of APA's Division of Education).

The new program, an extension of the journal, is edited by Thomas Kramer, M.D., and Carl Chan, M.D.

There have been two editions thus far, with the first edition sent to members last year. Hales says that in time she hopes to have eFOCUS sent to members four times a year.

The first eFOCUS vignette described a patient referred by a primary care physician for depression. The patient is prescribed fluoxetine for depression, but on follow-up a month later the patient reveals a history of obsessive-compulsive symptoms.

Clinicians were then offered a range of options including increasing the dosage of the antidepressant, switching drugs, and adding or switching in combination with other agents and/or with cognitive-behavioral therapy (CBT).

As members chose an answer, the table and pie chart appeared showing how psychiatrists around the country were responding. Ultimately, 44 percent of respondents opted to increase the dose of fluoxetine and initiate CBT, 26 percent said they would switch to another SSRI and initiate CBT, and 16 percent said they would start or refer for CBT. Smaller percentages of respondents said they would increase the dose of fluoxetine or switch to a different SSRI without initiating CBT.

John Greist, M.D., a clinical professor of psychiatry at the University of Wisconsin School of Medicine and Public Health, who has written widely about OCD, offered commentary on the vignette.

Rapaport and Hales emphasized that eFOCUS is one part of an evolving effort by APA to prepare members for what Hales called a "sea change" in the way physicians in all specialties will be expected to demonstrate competency. The model of a one-time or periodic recertification examination and accumulation of continuing medical education credits through attendance at symposia and lectures is on its way out.

In its place is the new buzzphrase "lifelong learning," by which physicians are expected to measure their clinical performance continually against standards of care.

"We want members to understand that APA has taken a very proactive approach to continuing medical education," Rapaport told *Psychiatric News*. "We have created a systematic approach to lifelong learning for APA members to help them stay current and constant with what the American Board of Medical Specialties considers the critical issues in clinical practice. So far we have a paper journal, the electronic journal, eFOCUS, and "Focus Live" at the annual meeting."

Hales described a perfect storm of factors—including the movement toward electronic medical records and concerns about medical errors and the "quality" movement—that are moving American physicians toward a new way of maintaining certification through demonstration of lifelong learning.

For instance, she noted that in 2013 the American Board of Psychiatry and Neurology (ABPN) will require clinicians to complete a performance-in-practice clinical module—essentially a chart review of five or more patients with comparison of the clinician's performance against recommended standards of care.

To help prepare members for this change, a sample performance-in-practice module on major depressive disorder was included in the winter 2008 *Focus*. Members receive five hours of CME credit for completing the module and returning their feedback to APA.

Hales said the feedback on the voluntary module will help APA when performance in practice becomes a requirement for all specialties. A second voluntary sample module on PTSD will appear in the spring *Focus*.

The performance-in-practice requirement is still being developed by the American Board of Medical Specialties and the ABPN, but Hales emphasized that these and similar changes in CME are certainly coming.

"Eventually the way you will show competency is not only by getting CME credits but by showing that your clinical practice follows evidence-based guidelines, facilitated by electronic medical records," Hales said. "Performance in practice will be part four of maintenance of certification and will be a requirement for all specialties."

Further information about eFOCUS, the journal* Focus*, and other continuing education products is available by contacting Miriam Epstein, CME program manager of eFOCUS, by phone at (703) 907-8661 or by e-mail at mepstein@psych.org. ■

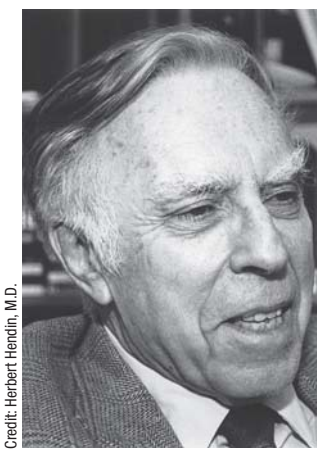
Program Helps Psychiatrists Cope With Patient's Suicide

Psychiatrists who have lost a patient to suicide can sign up for a group teleconference. Such a "meeting of minds" should prove both emotionally supportive and educational.

BY JOAN AREHART-TREICHEL

Herbert Hendin, M.D., CEO and medical director of the not-for-profit Suicide Prevention International (SPI) in New York City, has prepared a Web-based program to help APA members deal with the loss of a patient to suicide.

The program consists of a short audiovisual presentation on the subject by Hendin, who explains that many psychiatrists are not prepared for a patient's suicide. They experience shock, guilt, shame, self-reproach, and other negative emotions, just as do family members and friends of the patient. In addition, they may experience an emotion that family members and friends usually do not—betrayal—as well as fear of a lawsuit by family members or friends of the patient. They may have dreams of inadequacy or punishment. They may be angry or anxious about dealing with other patients. They may avoid taking certain patients who present a risk of suicide. Some even consider abandoning psychiatry altogether, Hendin noted.



Credit: Herbert Hendin, M.D.

Herbert Hendin, M.D.: "Studies have shown that almost half of psychiatrists have lost a patient to suicide, and our work indicates that a third have been severely distressed by the problem, some to the point of giving up the practice of psychiatry."

Toward the end of the audiovisual presentation, Hendin encourages psychiatrists who have lost a patient to suicide to sign up for a "live" small-group teleconference designed to help them deal with their loss. Such teleconferences will be organized by SPI, and "six psychiatric experts in the area will alternate facilitating the conference calls," Hendin explained during an interview.

"This APA Web-based program was created in response to the APA Assembly's request for more support to residents and psychiatrists who have experienced the suicide of a patient," Deborah Hales, M.D., APA's director of the Division of Education, told *Psychiatric News*.

Indeed, Hendin appears to be well suited to provide that support since he has worked in the field of suicide during most of his professional career and since he and his colleagues have been holding, for 15 years now, workshops to help therapists who have lost a patient to suicide. They have written extensively about their work, most notably in an article in the August 2004 *American Journal of Psychiatry* titled "Factors Contributing to Therapists' Distress After the Suicide of a Patient." Six of Hendin's books and 50 of his professional articles have dealt with suicide.

"The psychiatrists who have participated in one of our workshops over the years have indicated that it was a highly valuable experience, not only because it helped them deal with their distress, but because they learned from it," Hendin reported. "One young psychiatrist who had reacted to the loss with strong doubts about his ability to function as a psychiatrist instead went on to a distinguished career as a suicide researcher. He credited his participation in the program with helping him turn what had been a traumatic experience into a constructive one."

An advantage of the workshops, Hendin noted, is that it gives psychiatrists an opportunity to discuss their traumatic experience outside of their own institutions, where they can feel comfortable and not threatened. "We are not in a position to have any influence on their careers," he pointed out.

Hendin will be inviting some of the psychiatrists who participate in the teleconferences to SPI's office in New York City to further discuss their cases in such a workshop. Travel and hotel costs as well as an honorarium will be provided. He stated that participation is especially beneficial to psychiatry residents since "young doctors are particularly sensitive to the loss of a patient to suicide."

The Web-based audiovisual presentation for APA members who have lost a patient to suicide can be accessed at <www.spiorg.org/flash/copingwithlossofpatient.html>. To participate in a "live" teleconference on the subject, click on the link on the presentation's last slide, which will take you to the application form on APA's Web site. Complete the application form, print it out, and mail it to Suicide Prevention International, 1045 Park Avenue, New York, N.Y. 10028. Further information is available via e-mail at info@spiorg.org. ■

legal news

Sex-Offender Commitment Law Ruled Unconstitutional

A federal appellate court rules that the section of the Adam Walsh Child Protection and Safety Act regarding prolonged federal civil commitment of sexual offenders is unconstitutional.

BY RICH DALY

A federal appeals court has struck down a 2006 federal law that allows indefinite civil commitment of "sexually dangerous" inmates beyond the length of their prison terms.

The 4th U.S. Circuit Court of Appeals in Richmond ruled in January in the case *U.S. v. Comstock* that Congress intruded on powers reserved for the states through civil-commitment provisions it included in the Adam Walsh Child Protection and Safety Act of 2006 (PL 109-248). The ruling, which affirmed a lower court ruling in the case, was the first time a federal appeals court addressed the legality of the federal commitment law.

The ruling is binding only in Virginia, North Carolina, South Carolina, West Virginia, and Maryland.

The law allows the U.S. attorney general's office to obtain a stay prolonging federal detention of people convicted of certain sex-related offenses through a certification alleging sexual dangerousness.

The three-judge appeals panel noted that "no evidence or preliminary showing is required" as part of the preliminary certification of sexual dangerousness to automatically remand the inmate for indefinite detention in a federal prison hospital. The law allows a federal court to rule on the petition but the court can use only the standard of "clear and convincing evidence" instead of the higher bar of "beyond a reasonable doubt."

"The Constitution does not empower the federal government to confine a person solely because of asserted 'sexual dangerousness' when the government need not allege (let alone prove) that this 'dangerousness' violates any federal law," Judge Diana Gribbon Motz wrote in the unanimous opinion.

The law defines a "sexually dangerous person" as someone who "has engaged or attempted to engage in sexually violent conduct or child molestation and who is sexually dangerous to others," and who suffers from a severe mental illness to the extent that the person would "have serious difficulty in refraining from sexually violent conduct or child molestation if released."

The ruling noted that the law does not define either "sexually violent conduct" or "child molestation."

Motz wrote that the perceived need for a federal civil-commitment statute did not create the constitutional power for the government to create one, and Congress could seek alternative and constitutional means of achieving the possibly "commendable objectives" of civil commitment.

The ruling by the appeals court upheld much of the 2008 decision by U.S. District Judge W. Earl Britt of Raleigh, N.C., which was similar to a previous ruling by a federal district judge in Minnesota. The appeals court ruling, however, is at odds with the decisions of federal district courts in Hawaii, Oklahoma, and Massachusetts, which have upheld the commitment law.

Federal prosecutors may appeal the ruling to the U.S. Supreme Court or seek a rehearing before the full 4th U.S. Circuit Court of Appeals.

The ruling came on the appeals of five inmates convicted of receiving online child pornography, including Graydon Earl Comstock. All of the inmates have been kept in custody for at least two years beyond the end of their sentences in a North Carolina federal prison hospital.

The ruling is explicitly limited to the federal civil-commitment law and does not affect the legality of state civil-commitment measures. Motz said federal authorities were still free to contact state officials about potentially dangerous inmates about to be released, and state officials could then bring their own civil-commitment proceedings. The federal law specifically directs the U.S. attorney general to make "all reasonable efforts" to transfer responsibility for sexually dangerous offenders to an appropriate state authority at the conclusion of their federal sentences, but until a state assumes that responsibility, inmates are held in federal confinement for as long as they remain "sexually dangerous."

The ruling noted that the civil-commitment power is among the most "severe" wielded at any level of government.

"The Framers, distrustful of such authority, reposed such broad powers in the states, limiting the national government to specific and enumerated powers," Motz wrote.

Also unaffected by the ruling are provisions of federal law that fund state civil-commitment programs. The Adam Walsh law authorizes $10 million each year for state civil-commitment programs through Fiscal 2010.

By March 2007 20 states had enacted laws regarding civil commitment of sexual offenders. Such state laws have been upheld by the U.S. Supreme Court as constitutional in part because their aim is to ensure that inmates receive treatment, not be punished twice for the same crime. Despite this, only a small fraction of committed offenders have ever completed treatment to the point where they could be released without additional mandated oversight.

The federal appeals court ruling will have a limited impact because many such prisoners will simply be transferred to state control, said forensic psychiatrist Paul Appelbaum, M.D., a member of APA's Council on Psychiatry and Law, in an interview with *Psychiatric News*. The only individuals likely to be affected are people held

please see ***Commitment*** *on page 14*

SEE ME FOR WHO I CAN BE

Lisa, 32*
Part-time Caterer
Diagnosis: Bipolar Disorder
Recent Episode: Mixed

*Not an actual patient.

Do you see your patients' full potential?

GEODON is indicated for the treatment of acute manic or mixed episodes associated with bipolar disorder, with or without psychotic symptoms.

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death compared to placebo. GEODON is not approved for the treatment of patients with dementia-related psychosis.

GEODON is contraindicated in patients with a known history of QT prolongation, recent acute myocardial infarction, or uncompensated heart failure, and should not be used with certain other QT-prolonging drugs. **GEODON has been associated with prolongation of the QT_c interval. In some drugs, QT prolongation has been associated with torsade de pointes, a potentially fatal arrhythmia. Patients who are at risk for significant electrolyte disturbances should have baseline measurements performed before initiating GEODON. Patients on diuretics should be monitored.**

As with all antipsychotic medications, a rare and potentially fatal condition known as neuroleptic malignant syndrome (NMS) has been reported with GEODON. NMS can cause hyperpyrexia, muscle rigidity, diaphoresis, tachycardia, irregular pulse or blood pressure, cardiac dysrhythmia, and altered mental status. If signs and symptoms appear, immediate discontinuation, treatment, and monitoring are recommended.

Prescribing should be consistent with the need to minimize tardive dyskinesia (TD), a potentially irreversible dose- and duration-dependent syndrome. If signs and symptoms appear, discontinuation should be considered since TD may remit partially or completely.

Hyperglycemia-related adverse events, sometimes serious, have been reported in patients treated with atypical antipsychotics. There have been few reports of hyperglycemia or diabetes in patients treated with GEODON, and it is not known if GEODON is associated with these events. Patients treated with an atypical antipsychotic should be monitored for symptoms of hyperglycemia.

Precautions include the risk of rash, orthostatic hypotension, and seizures.

The most common adverse events associated with GEODON in bipolar mania were somnolence, extrapyramidal symptoms, dizziness, akathisia, and abnormal vision.

Please see brief summary of prescribing information on adjacent page.

For more information, please visit www.pfizerpro.com/GEODON

GEODON®
(ziprasidone HCl) **Capsules**

BRIEF SUMMARY. See package insert for full prescribing information.

Increased Mortality in Elderly Patients with Dementia-Related Psychosis—Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Geodon (ziprasidone) is not approved for the treatment of patients with Dementia-Related Psychosis (see **WARNINGS**).

INDICATIONS—GEODON Capsules is indicated for the treatment of schizophrenia and acute manic or mixed episodes associated with bipolar disorder with or without psychotic features. **GEODON**® (ziprasidone mesylate) for Injection is indicated for acute agitation in schizophrenic patients.

CONTRAINDICATIONS — ***QT Prolongation:*** Because of GEODON's dose-related prolongation of the QT interval and the known association of fatal arrhythmias with QT prolongation by some other drugs, GEODON is contraindicated in patients with a known history of QT prolongation (including congenital long QT syndrome), with recent acute myocardial infarction or with uncompensated heart failure (see **WARNINGS**). Pharmacokinetic/pharmacodynamic studies between GEODON and other drugs that prolong the QT interval have not been performed. An additive effect of GEODON and other drugs that prolong the QT interval cannot be excluded. Therefore, GEODON should not be given with chlorpromazine, mesoridazine, thioridazine, chlorpromazine, droperidol, pimozide, sparfloxacin, gatifloxacin, moxifloxacin, halofantrine, mefloquine, pentamidine, arsenic trioxide, levomethadyl acetate, dofetilide or ibutilide mesylate, probucol or tacrolimus. GEODON is also contraindicated with drugs that have demonstrated QT prolongation as one of their pharmacodynamic effects and have this effect described in the prescribing information as contraindicated or boxed or bolded warning (see **WARNINGS**). GEODON is contraindicated in individuals with a known hypersensitivity to the product. **WARNINGS** — ***Increased Mortality in Elderly Patients with Dementia-Related Psychosis:*** Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. **GEODON** (ziprasidone) **is not approved for the treatment of patients with dementia-related psychosis (see BOXED WARNING).** ***QT Prolongation and Risk of Sudden Death:*** GEODON use should be avoided in combination with other drugs that are known to prolong the QT_c interval. Additionally, clinicians should be alert to the identification of other drugs that have been consistently observed to prolong the QT_c interval. Such drugs should not be prescribed with GEODON. A study directly comparing the QT/QT_c-prolonging effect of GEODON with several other drugs effective in the treatment of schizophrenia was conducted in patient volunteers. The mean increase in QT_c from baseline for GEODON ranged from approximately 9 to 14 msec greater than for four of the comparator drugs (risperidone, olanzapine, quetiapine, and haloperidol), but was approximately 14 msec less than the prolongation observed for thioridazine. In this study, the effect of GEODON on QT_c length was not augmented by the presence of a metabolic inhibitor (ketoconazole 200 mg bid). In placebo-controlled trials, GEODON increased the QT_c interval compared to placebo by approximately 10 msec at the highest recommended daily dose of 160 mg. In clinical trials the electrocardiograms of 2/2988 (0.06%) GEODON patients and 1/440 (0.23%) placebo patients revealed QT_c intervals exceeding the potentially clinically relevant threshold of 500 msec. In the GEODON patients, neither case suggested a role of GEODON. Some drugs that prolong the QT/QT_c interval have been associated with the occurrence of torsade de pointes and with sudden unexplained death. The relationship of QT prolongation to torsade de pointes is clearest for larger increases (20 msec and greater) but it is possible that smaller QT/QT_c prolongations may also increase risk, or increase it in susceptible individuals, such as those with hypokalemia, hypomagnesemia, or genetic predisposition. Although torsade de pointes has not been observed in association with the use of GEODON at recommended doses in premarketing studies, experience is too limited to rule out an increased risk. A study evaluating the QT/QT_c prolonging effect of intramuscular GEODON, with intramuscular haloperidol as a control, was conducted in patient volunteers. In the trial, ECGs were obtained at the time of maximum plasma concentration following two injections of GEODON (20 mg then 30 mg) or haloperidol (4.5 mg then 10 mg) given four hours apart. Note that a 30 mg dose of intramuscular GEODON is 50% higher than the recommended therapeutic dose. The mean change in QT_c from baseline was calculated for each drug using a sample-based correction that removes the effect of heart rate on the QT interval. The mean increase in QT_c from baseline for GEODON was 4.8 msec following the first injection and 12.8 msec following the second injection. The mean increase in QT_c from baseline for haloperidol was 6.0 msec following the first injection and 14.7 msec following the second injection. In this study, no patient had a QT_c interval exceeding 500 msec. As with other antipsychotic drugs and placebo, sudden unexplained deaths have been reported in patients taking GEODON at recommended doses. The premarketing experience for GEODON did not reveal an excess of mortality for GEODON compared to other antipsychotic drugs or placebo, but the extent of exposure was limited, especially for the drugs used as active controls and placebo. Nevertheless, GEODON's larger prolongation of QT length compared to several other antipsychotic drugs raises the possibility that the risk of sudden death may be greater for GEODON than for other available drugs for treating schizophrenia. This possibility needs to be considered in deciding among alternative drug products. Certain circumstances may increase the risk of the occurrence of torsade de pointes and/or sudden death in association with the use of drugs that prolong the QT_c interval, including (1) bradycardia; (2) hypokalemia or hypomagnesemia; (3) concomitant use of other drugs that prolong the QT_c interval; and (4) presence of congenital prolongation of the QT interval. GEODON should also be avoided in patients with congenital long QT syndrome and in patients with a history of cardiac arrhythmias (see **CONTRAINDICATIONS**, and see ***Drug Interactions*** under **PRECAUTIONS**). It is recommended that patients being considered for GEODON treatment who are at risk for significant electrolyte disturbances, hypokalemia in particular, have baseline serum potassium and magnesium measurements. Hypokalemia (and/or hypomagnesemia) may increase the risk of QT prolongation and arrhythmia. Hypokalemia may result from diuretic therapy, diarrhea, and other causes. Patients with low serum potassium and/or magnesium should be repleted with those electrolytes before proceeding with treatment. It is essential to periodically monitor serum electrolytes in patients for whom diuretic therapy is introduced during GEODON treatment. Persistently prolonged QT_c intervals may also increase the risk of further prolongation and arrhythmia, but it is not clear that routine screening ECG measures are effective in detecting such patients. Rather, GEODON should be avoided in patients with histories of significant cardiovascular illness, e.g., QT prolongation, recent acute myocardial infarction, uncompensated heart failure, or cardiac arrhythmia. **GEODON** should be discontinued in patients who are found to have persistent QT_c measurements >500 msec. ***Neuroleptic Malignant Syndrome (NMS):*** A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with administration of antipsychotic drugs. The management of NMS should include (1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; (2) intensive symptomatic treatment and medical monitoring; and (3) treatment of any concomitant serious medical problems for which specific treatments are available. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored since recurrences of NMS have been reported. ***Tardive Dyskinesia (TD):*** A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients undergoing treatment with antipsychotic drugs. Although the prevalence of TD appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict at the inception of antipsychotic treatment which patients are likely to develop TD. If signs and symptoms of TD appear in a patient on GEODON, drug discontinuation should be considered. ***Hyperglycemia and Diabetes Mellitus:*** Hyperglycemia-related adverse events, sometimes serious, have been reported in patients treated with atypical antipsychotics. There have been few reports of hyperglycemia or diabetes in patients treated with GEODON and it is not known if GEODON is associated with these events. Patients treated with an atypical antipsychotic should be monitored for symptoms of hyperglycemia. **PRECAUTIONS** — ***General:*** Rash. In premarketing trials, about 5% of GEODON patients developed a rash and/or urticaria, with discontinuation of treatment in about one-sixth of these cases. The occurrence of rash was dose related although the dose might also be explained by longer exposure in higher-dose patients. Several cases with rash had signs and symptoms of associated systemic illness, e.g., elevated WBCs. Most patients improved promptly upon treatment with anti-histamines or steroids and/or upon discontinuation of GEODON, and all patients were reported to recover completely. Upon appearance of rash for which an alternative etiology cannot be identified, GEODON should be discontinued. Orthostatic Hypotension: GEODON may induce orthostatic hypotension associated with dizziness, tachycardia, and, in some patients, syncope, especially during the initial dose-titration period, probably reflecting its alpha adrenergic antagonist properties. Syncope was reported in 0.6% of GEODON patients. GEODON should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease or conditions that would predispose patients to hypotension (dehydration, hypovolemia, and treatment with antihypertensive medications). Seizures: In clinical trials, seizures occurred in 0.4% of GEODON patients. There were confounding factors that may have contributed to seizures in many of these cases. As with other antipsychotic drugs, GEODON should be used cautiously in patients with a history of seizures or with conditions that potentially lower the seizure threshold, e.g., Alzheimer's dementia. Conditions that lower the seizure threshold may be more prevalent in a population of 65 years or older. Dysphagia: Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia, and GEODON and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia. **(See also Boxed WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis).** Hyperprolactinemia: As with other drugs that antagonize dopamine D2 receptors, GEODON elevates prolactin levels in humans. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent in vitro, a factor of potential importance if the prescription of these drugs is contemplated in a patient with previously detected breast cancer. No clinical studies or epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive at this time. Potential for Cognitive and Motor Impairment: Somnolence was a commonly reported adverse event in GEODON patients in the 4- and 6-week placebo-controlled trials. Somnolence was reported in 14% of GEODON patients vs 7% of placebo patients. Somnolence led to discontinuation of 0.3% of patients in short-term clinical trials. Since GEODON has the potential to impair judgment, thinking, or motor skills, patients should be cautioned about performing activities requiring mental alertness, such as operating a motor vehicle (including automobiles) or operating hazardous machinery until they are reasonably certain that GEODON therapy does not affect them adversely. Priapism: One case of priapism was reported in the premarketing database. Body Temperature Regulation: Although not reported with GEODON in premarketing trials, disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Suicide: The possibility of a suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. GEODON prescriptions should be written for the smallest quantity of capsules consistent with good patient management to reduce overdose risk. Use in Patients with Concomitant Illness: Clinical experience with GEODON in patients with certain concomitant systemic illnesses is limited. GEODON has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from pre-marketing clinical studies. Because of the risk of QT prolongation and orthostatic hypotension with GEODON, caution should be observed in cardiac patients (see ***QT Prolongation and Risk of Sudden Death*** in **WARNINGS** and Orthostatic Hypotension in **PRECAUTIONS**). ***Information for Patients:*** To ensure safe and effective use of GEODON, the information and instructions in the *Patient Information* section should be discussed with patients. ***Laboratory Tests:*** Patients being considered for GEODON treatment who are at risk of significant electrolyte disturbances should have their serum potassium and magnesium measurements. Low serum potassium and magnesium should be repleted before treatment. Patients who are started on diuretics during GEODON therapy need periodic monitoring of serum potassium and magnesium. Discontinue GEODON in patients who are found to have persistent QT measurements >500 msec (see **WARNINGS**). ***Drug Interactions:*** If GEODON should be used with any drug that prolongs the QT interval (2). Given the primary CNS effects of GEODON, caution should be used when it is taken in combination with other centrally acting drugs. (3) Because of its potential for inducing hypotension, GEODON may enhance the effects of certain antihypertensive agents. (4) GEODON may antagonize the effects of levodopa or dopamine agonists. Effect of Other Drugs on GEODON: Carbamazepine 200 mg bid for 21 days results in a decrease of approximately 35% in the AUC of GEODON. Ketoconazole, a potent inhibitor of CYP3A4, 400 mg qd for 5 days, increases the AUC and C_{max} of GEODON by about 35%–40%. Cimetidine, 800 mg qd for 2 days, did not affect GEODON pharmacokinetics. Dosing with a total of 30 mL of Maalox® did not affect GEODON pharmacokinetics. Population pharmacokinetic analysis of schizophrenic patients in controlled clinical trials has not revealed any clinically significant pharmacokinetic interactions with benztropine, propranolol, or lorazepam. Effect of GEODON on Other Drugs: In vitro studies revealed little potential for GEODON to interfere with the metabolism of drugs cleared primarily by CYP1A2, CYP2C9, CYP2C19, CYP2D6 and CYP3A4, and little potential for drug interactions with GEODON due to displacement. GEODON 40 mg bid administered concomitantly with lithium 450 mg bid for 7 days did not affect the steady-state level or renal clearance of lithium. GEODON 20 mg bid did not affect the pharmacokinetics of concomitantly administered *oral contraceptives*, ethinyl estradiol (0.03 mg) and levonorgestrel (0.15 mg). Consistent with in vitro results, a drug-drug interaction study in healthy volunteers showed that GEODON did not alter the metabolism of *dextromethorphan*, a CYP2D6 model substrate to its major metabolite, dextrorphan. There was no statistically significant change in the urinary dextromethorphan/dextrorphan ratio. ***Carcinogenesis, Mutagenesis, Impairment of Fertility:*** Lifetime carcinogenicity studies were conducted with GEODON in Long Evans rats and CD-1® mice. In male mice, there was no increase in the dose of tumors relative to controls. In female mice there were dose-related increases in the incidences of pituitary gland adenoma and carcinoma, and mammary gland adenocarcinoma at all doses tested. Increases in serum prolactin were observed in a 1-month dietary study in female, but not male, mice. GEODON had no effect on serum prolactin in rats in a 5-week dietary study at the doses that were used in the carcinogenicity study. There is no evidence for human risk of the findings of prolactin-mediated endocrine tumors in rodents is unknown (see Hyperprolactinemia). Mutagenesis: There was a reproducible mutagenic response in the Ames assay in one strain of *S. typhimurium* in the absence of metabolic activation. Positive results were obtained in both the in vitro mammalian cell gene mutation assay and the in vitro chromosomal aberration assay in human lymphocytes. Impairment of Fertility: GEODON increased time to copulation in Sprague-Dawley rats in two fertility and early embryonic development studies at doses of 10 to 160 mg/kg/day (0.5 to 8 times the MRHD of 200 mg/day on a mg/m² basis). Fertility rate was reduced at 160 mg/kg/day (8 times the MRHD on a mg/m² basis). There was no effect on fertility at 40 mg/kg/day (2 times the MRHD on a mg/m² basis). The fertility of female rats was reduced. ***Pregnancy—Pregnancy Category C:*** There are no adequate and well-controlled studies in pregnant women. GEODON should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. ***Labor and Delivery:*** The effects of GEODON on labor and delivery in humans is unknown. ***Nursing Mothers:*** It is not known whether, and to what amount, GEODON or its metabolites are excreted in human milk. It is recommended that women receiving GEODON should not breast feed. ***Pediatric Use:*** The safety and effectiveness of GEODON in pediatric patients have not been established. ***Geriatric Use:*** Of the approximately 4500 patients treated with GEODON in clinical studies, 2.4% (109) were 65 years of age or over. In general, the use is not indicative of any different tolerability for GEODON or of reduced clearance of GEODON in the elderly compared to younger adults. Nevertheless, the presence of multiple factors that might increase the pharmacodynamic response to GEODON, or cause poorer tolerance or orthostasis, should lead to consideration of a lower starting dose, slower titration, and careful monitoring during the initial dosing period for some elderly patients. **ADVERSE REACTIONS** — ***Adverse Findings Observed in Short-term, Placebo-Controlled Trials:*** The following findings are based on the short-term placebo-controlled premarketing trials for schizophrenia (a pool of two 6-week and two 4-week fixed-dose trials) and bipolar mania (a pool of two 3-week flexible-dose trials) in which GEODON was administered in doses ranging from 10 to 200 mg/day. ***Adverse Events Associated with Discontinuation:*** Schizophrenia: Approximately 4.1% (29/702) of GEODON-treated patients in short-term, placebo-controlled studies discontinued treatment due to an adverse event, compared with about 2.2% (6/273) on placebo. The most common event associated with dropout was rash including 7 dropouts for rash among GEODON patients (1%) compared to no placebo patients (see **PRECAUTIONS**). Bipolar Mania: Approximately 6.5% (102/2/9) of GEODON-treated patients in short-term, placebo-controlled studies discontinued treatment due to an adverse event, compared with about 3.7% (5/136) on placebo. The most common events associated with the dropout in the GEODON-treated patients were akathisia, anxiety, depression, dizziness, dystonia, rash, and vomiting with 2 dropouts for each of these events among GEODON patients (1%) compared to one placebo patient each for dystonia and rash (1%) and no placebo patients for the remaining adverse events. ***Adverse Events at an Incidence ≥5% and at Least Twice the Rate of Placebo:*** The most commonly observed adverse events associated with GEODON in schizophrenia trials were somnolence (14%) and respiratory tract infection (8%). The most commonly observed adverse events associated with the use of GEODON in bipolar mania trials were somnolence (31%), extrapyramidal symptoms (31%), dizziness (16%), akathisia (13%), abnormal vision (6%), asthenia (6%), and vomiting (5%). The following list enumerates the treatment-emergent adverse events that occurred during acute therapy, including only those events that occurred in 2% of GEODON patients and at a greater incidence than in placebo. Schizophrenia: Body as a Whole—asthenia, accidental injury, chest pain. Cardiovascular—tachycardia. Digestive—nausea, constipation, dyspepsia, diarrhea, dry mouth, anorexia. Nervous—extrapyramidal symptoms, somnolence, akathisia, buzzing. Respiratory—respiratory tract infection, rhinitis, cough increased. Skin and Appendages—rash, fungal dermatitis. Special Senses—abnormal vision. Bipolar Mania: Body as a Whole—headache, asthenia, accidental injury. Cardiovascular—hypertension. Digestive—nausea, diarrhea, dry mouth, vomiting, increased salivation, tongue edema, dysphagia. Musculoskeletal—myalgia. Nervous—somnolence, extrapyramidal symptoms, dizziness, akathisia, anxiety, hypesthesia, speech disorder. Respiratory—pharyngitis, dyspnea. Skin and Appendages—fungal dermatitis. Special Senses—abnormal vision. ***Dose Dependency:*** An analysis for dose response in the schizophrenia trials revealed an apparent relation of adverse event to dose for the following: asthenia, postural hypotension, amblyopia, dry mouth, increased salivation, arthralgia, anxiety, dizziness, dystonia, hypertonia, somnolence, tremor, rhinitis, rash, and abnormal vision. ***Extrapyramidal Symptoms (EPS):*** The incidence of reported EPS for GEODON patients in the short-term, placebo-controlled schizophrenia trials was 14% vs 8% for placebo. Objectively collected data from those trials on the Simpson-Angus Rating Scale and the Barnes Akathisia Scale do not generally show a difference between GEODON and placebo. ***Dystonia:*** Prolonged abnormal contractions of muscle groups may occur in susceptible individuals during the first few days of treatment. Dystonia may occur at any dose level but with greater frequency and severity with high potency and at higher doses of first-generation antipsychotic drugs. Elevated risk is observed in males and younger age groups. ***Vital Sign Changes:*** GEODON is associated with orthostatic hypotension (see **PRECAUTIONS**). ***Weight Gain:*** In short-term schizophrenia trials, the proportions of patients meeting a weight gain criterion of ≥7% of body weight were compared, revealing a statistically significantly greater incidence of weight gain for GEODON patients (10%) vs placebo patients (4%). A median weight gain of 0.5 kg was observed in GEODON patients vs 0.0 kg in placebo patients. Weight gain was reported as an adverse event in 0.4% of both GEODON and placebo patients. During long-term therapy with GEODON, a categorization of patients at baseline on the basis of body mass index (BMI) showed the greatest mean weight gain and the highest incidence of clinically significant weight gain (≥7% of body weight) in patients with a low BMI (<23) compared to normal (23–27) or in overweight (>27) patients. There was a mean weight gain of 1.4 kg for patients with a "low" baseline BMI (<20 kg/m²) for patients with a "normal" BMI, and a 1.3 kg mean weight loss for patients with a "high" BMI (>27 kg/m²). ***ECG Changes:*** GEODON is associated with an increase in the QT interval (see **WARNINGS**). In schizophrenia trials, GEODON was associated with a mean increase in heart rate of 1.4 beats per minute compared to a 0.2 beats per minute decrease among placebo patients. ***Other Adverse Events Observed During the Premarketing Evaluation of GEODON:*** Frequent adverse events are those occurring in at least 1/100 patients; infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. Schizophrenia: Body as a Whole—*Frequent:* abdominal pain, flu syndrome, fever, accidental fall, face edema, chills, photosensitivity reaction, flank pain, hypothermia, motor vehicle accident. Cardiovascular System—*Frequent:* tachycardia, hypertension, postural hypotension. *Infrequent:* tachycardia, angina pectoris, atrial fibrillation. *Rare:* first-degree AV block, bundle branch block, phlebitis, pulmonary embolus, cardiomegaly, cerebral infarct, cerebrovascular accident, deep thrombophlebitis, myocarditis, thrombophlebitis. Digestive System—*Frequent:* anorexia, vomiting. *Infrequent:* rectal hemorrhage, dysphagia, tongue edema. *Rare:* gum hemorrhage, jaundice, fecal impaction, gamma glutamyl transpeptidase increased, hematemesis, cholestatic jaundice, hepatitis, hepatomegaly, leukoplakia of mouth, fatty liver deposit, melena, tenesmus. *Rare:* hepatocellular necrosis, hepatic failure. Hemic and Lymphatic System—*Infrequent:* anemia, ecchymosis, leukocytosis. *Rare:* leukopenia, eosinophilia, lymphadenopathy. *Rare:* thrombocytopenia, hypochromic anemia, lymphocytosis, monocytosis, basophilia, lymphedema, polycythemia, thrombocythemia. Metabolic and Nutritional Disorders—*Infrequent:* thirst, transaminase increased, peripheral edema, hyperglycemia, creatine phosphokinase increased, alkaline phosphatase increased, hypercholesterolemia, dehydration, lactic dehydrogenase increased, albuminuria, hypokalemia. *Rare:* BUN increased, creatinine increased, hyperlipemia, hypercholesterolemia, hyperkalemia, hypocholesterolemia, hypoglycemia, hyponatremia, hypoproteinemia, glucose tolerance decreased, gout, hypercholremia, hyperuricemia, hypocalcemia, hypoglycemic reaction, hypomagnesemia, ketosis, respiratory alkalosis. Musculoskeletal System—*Frequent:* myalgia. *Infrequent:* tendonitis. *Rare:* myopathy. Nervous System—*Frequent:* agitation, extrapyramidal syndrome, tremor, dystonia, hypertonia, dyskinesia, thought disorder, paresthesia, confusion, vertigo, hypokinesia, hyperkinesia, abnormal gait, oculogyric crisis, hypesthesia, ataxia, amnesia, coordination disorder, rigidity, delirium, hypotonia, akinesia, dysarthria, withdrawal syndrome, buccoglossa syndrome, choreoathetosis, diplopia, incoordination, neuropathy. *Infrequent:* paralysis, *Rare:* myoclonus, nystagmus, torticollis, oculogyric crisis, manic reaction, paresthesia, opisthotonos, reflexes increased, trismus. Respiratory System—*Frequent:* dyspnea. *Infrequent:* pneumonia, epistaxis. *Rare:* hemoptysis, laryngismus. Skin and Appendages—*Infrequent:* maculopapular rash, urticaria, alopecia, eczema, exfoliative dermatitis, contact dermatitis, seborrhea, cutaneous ulcer. Special Senses—*Frequent:* lung disorder, dermatitis. *Infrequent:* conjunctivitis, dry eyes, tinnitus, blepharitis, cataract, photophobia. *Rare:* eye hemorrhage, visual field defect, keratitis, keratoconjunctivitis. Urogenital System—*Infrequent:* impotence, abnormal ejaculation, amenorrhea, hematuria, menorrhagia, female lactation, polyuria, urinary retention, metrorrhagia, male sexual dysfunction, anorgasmia, glycosuria. *Rare:* gynecomastia, vaginal hemorrhage, nocturia, anuria, female sexual dysfunction, uterine hemorrhage. **Adverse Finding Observed in Trials of Intramuscular GEODON:** In these studies, the most commonly observed adverse events associated with the use of intramuscular GEODON (≥5%) and observed at a greater incidence in GEODON than in the other dose groups) at least twice that of the lowest intramuscular GEODON group were headache (13%), nausea (12%), and somnolence (20%). **Adverse Events at an Incidence >1% in Short-Term Fixed-Dose Intramuscular Trials:** The following list enumerates the treatment-emergent adverse events that occurred in ≥1% of GEODON patients in the higher dose groups and at least twice that of the lowest intramuscular GEODON group. Body as a Whole—headache, infection site pain, asthenia, abdominal pain, flu syndrome, back pain. Cardiovascular—postural hypotension, hypertension, bradycardia, vasodilation. Digestive—nausea, rectal hemorrhage, diarrhea, vomiting, dyspepsia, anorexia, constipation, tooth disorder, dry mouth. Nervous—dizziness, anxiety, insomnia, somnolence, akathisia, agitation, extrapyramidal syndrome, hypertonia, coordination disorder, rigidity, paresthesia, personality disorder, dysphoria, speech disorder. Respiratory—rhinitis, sinusitis, coughing. Urogenital—dysmenorrhea, priapism. **DRUG ABUSE AND DEPENDENCE** — ***Controlled Substance Class:*** GEODON is not a controlled substance. **OVERDOSAGE**—In premarketing trials, in over 5400 patients, accidental or intentional overdosage of GEODON was documented in 10 patients. All patients survived without sequelae. In the patient taking the largest confirmed amount (2240 mg), the only symptoms reported were minimal sedation, slurring of speech, and transitory hypertension (SP 200/95).

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Psychiatrist Awarded for Research On Psychoanalytic Therapy

Five years ago, the APsaA decided to raise the profile of science in psychoanalysis by bestowing an annual prize for excellence in psychoanalytic research. Barbara Milrod, M.D., is this year's winner.

BY JOAN AREHART-TREICHEL

If Barbara Milrod, M.D., had appeared on the television program "What's My Line?" back in the 1950s and 1960s, one might have guessed that she was a comedian since she makes wry facial expressions and has a dry sense of humor.

In fact, Milrod is a professor of psychiatry at Weill Cornell Medical College, a psychoanalyst on the faculty of the New York Psychoanalytic Society and Institute and the Columbia Psychoanalytic Center for Treatment and Research. She is an expert on the psychotherapeutic treatment of anxiety disorder, and one of the pioneers trying to demonstrate scientifically that psychoanalysis or psychodynamic psychotherapy works.

Or as she quipped at the January meeting of the American Psychoanalytic Association in New York City: "Panic disorder and psychodynamic psychotherapy are what I study. Analysis is what you guys do."

And to date, the findings that she and her colleagues have made are most encouraging. For this reason, the American Psychoanalytic Association bestowed its Fifth Annual Scientific Paper Prize for Psychoanalytic Research on her at its January meeting.

It all started some 15 years ago, Milrod reported. There was a sense that the clinical syndrome of panic disorder might involve certain psychodynamic conflicts. For example, in her experience and that of some other analysts, panic patients' symptoms often seemed to represent unconscious rage. Panic patients frequently appeared to be furious at someone they loved, and the panic seemed to be a way of expressing their rage while also punishing themselves for feeling it. Panic patients often appeared to have problems with autonomy. Their panic often emerged at times when they felt conflicted about a big event such as college, marriage, or pregnancy. So Milrod and some colleagues decided that they wanted to determine scientifically whether psychodynamic psychotherapy can help panic patients.

They designed a short-term psychodynamic psychotherapy called Panic-Focused Psychoanalytic Psychotherapy (PFPP) to help patients with their panic symptoms. It is a 12-week, 24-session therapy where the therapist discusses the meanings of a patient's panic symptoms as well as why he or she starts to feel better after therapy has commenced.

"The time constraint puts pressure on both patient and therapist to get a lot done quickly," Milrod explained. "Also, termination is a very important aspect of the treatment because of panic patients' problems with autonomy. As a result, the therapist starts talking about termination with the patient long before that time comes."

Once Milrod and her colleagues had developed PFPP, they taught some analytically trained psychiatrists to use it. After that, they conducted an open pilot clinical trial to see whether PFPP might help 21 subjects with *DSM-IV*-diagnosed panic disorder. Sixteen of the 21 responded. Results were published in the October 2001 *Journal of Psychotherapy Practice and Research*.

In the wake of this encouraging outcome, they undertook a randomized controlled trial to explore PFPP's efficacy in treating *DSM-IV*-diagnosed panic disorder. Since there was some evidence that Applied Relaxation Training (ART), which involves progressive muscle relaxation, exposure, and homework, is efficacious for patients with panic disorder, they decided that it would constitute a good comparison psychotherapy condition for PFPP in their randomized, controlled trial. The study was funded by the National Institute of Mental Health.

Out of the 49 subjects who participated in the trial, 26 were randomized to PFPP and 23 to ART. By the study's completion in 2005, both the PFPP group and the ART group had experienced a decrease in panic symptoms as measured by the Panic Disorder Severity Scale, but the former had experienced a significantly greater decrease in such symptoms. The findings were published in the February 2007 *American Journal of Psychiatry*.

Researchers in Germany and Sweden are now attempting to replicate those results, Milrod noted. She and her colleagues, she added, are now planning to compare the efficacy of PFPP with that of cognitive-behavioral therapy on patients with *DSM-IV* panic disorder. Their recruitment goal for this trial is 233 subjects.

All of these research efforts by Milrod and her group demonstrate that psychodynamic psychotherapy and psychoanalysis can be subjected to rigorous scientific-outcome research, said Robert Michels, M.D., a professor of psychiatry at Weill Cornell Medical College, at the meeting. Moreover, a number of analysts have been inspired by their success to conduct similar studies, he said. Michels chaired the session where Milrod discussed the research that she and her team have conducted.

Kenneth Levy, Ph.D., an assistant professor of psychology at Penn State University, a previous winner of the association's Annual Scientific Paper Prize for Psychoanalytic Research, and a session discussant, agreed: "This is big science with a capital 'S.' This is what analysis needs more of if it is going to survive." ■

Don't Rule Out Psychoanalysis In Treating Autistic Children

Can psychoanalysis help move autistic children closer to a normal life, thus turning on its head the notion that these children can never get better?

BY JOAN AREHART-TREICHEL

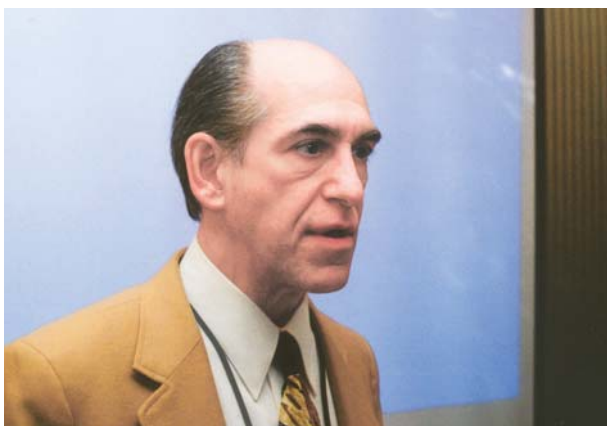
Psychoanalysis may be able to help some children with autism or an autism spectrum disorder make dramatic progress toward normalcy.

So reported psychoanalyst Susan Sherkow, M.D., an associate professor of psychiatry at Albert Einstein College of Medicine, at the January meeting of the American Psychoanalytic Association in New York City.

Moreover, during the meeting, she provided details about one patient to make her case. Later, during a phone interview, she said that she has also used psychoanalysis with five more children who were "flat-out autistic" or "on the spectrum," and that the outcomes in these cases too were quite positive. The six children ranged in age from 2 to 9 when they started analysis, she said.

Credit: Joan Arehart-Treichel

Susan Sherkow, M.D.: "If you start early enough with these kids, you can achieve empathy rather quickly."



Credit: Joan Arehart-Treichel

Emanuel DiCicco-Bloom, M.D.: "We are learning that the brain has an incredible amount of plasticity. So outgrowing a diagnosis of autism? Well, it might be possible."

Autistic children tend to have difficulty communicating verbally, or even if they can talk, it is often difficult to understand them, Sherkow explained to *Psychiatric News*. Nor is it always possible to know whether what they are saying is connected to what they are thinking or feeling. So a major goal of her analysis with each of the six children (five boys and one girl), she said, was to "pay very close attention to the child's behavior" so that the behavior would give her clues to thoughts and emotions. And once she had decided on how to interpret the child's behavior, she would verbalize it in her or his presence. For example, if the child appeared to be upset, she would say, "You're upset." Or if he or she appeared to be angry, she would say, "You must be angry." And if the child gave her a furtive glance after she made such a comment, she would conclude that her interpretation of the behavior was probably correct. So by using such techniques over a period of weeks, she came to understand quite well what the child was thinking and feeling when he or she engaged in various behaviors, she said.

Further, her verbally expressing her interpretations of the child's behaviors in his or her presence served another purpose, she pointed out. The child came to realize that thoughts and feelings were being understood. She was forging a relationship with the child.

Another goal of the analysis was to help the child relinquish stereotypic behaviors for imaginative play, Sherkow reported. "These kids are typically lacking in imaginative play," she said. "Imaginative play comes from having used language and from having identified emotions with language."

Also, the mother of each of the six children was present during her child's analytic sessions, Sherkow noted. There were several reasons why the mother was included, Sherkow said. One was to help the mother recognize what her child was thinking and feeling. Another was to help her and her child communicate verbally with one another. Yet a third goal was to demonstrate to her that her child could be helped.

The six children whom Sherkow analyzed were in analysis anywhere from two to four years, she said.

"All six significantly improved in outcome," Sherkow reported, "but I will clarify that since 'outcome' is a very broad word. . . . By the end of the first year of analysis they had developed empathy. . . . They can socialize with other children and communicate their needs. They can say 'I'm angry,' 'I'm sad,' 'I'm hungry,' or 'I'm tired.' They look like a child without a diagnosis. I would say that they all arrived at that. . . . Some have even gone on to mainstream schools. . . ."

please see ***Psychoanalysis*** *on page 14*

Patients' Violence Risk Tied to Specific Factors

Social factors and aspects of personal history influence the risk of violence among individuals with psychiatric disorders.

BY AARON LEVIN

The relationship between mental illness and violence is complex and unsettled, and it is likely to remain so, even after publication of a new study drawing on nationwide survey data.

Tragedies like recent mass shootings on university campuses, especially when perpetrated by people described as formerly in psychiatric treatment, connect violent acts with mental illness in the public's mind.

Yet Sally Johnson, M.D., a professor of psychiatry at the University of North Carolina (UNC) at Chapel Hill, told *Psychiatric News*, "the issue of dangerousness is more complicated than meets the eye."

A decade ago the MacArthur Violence Risk Assessment study reported that patients discharged from psychiatric facilities were no more likely to commit violent acts than anyone else. Other scholars disagreed, and the published record is divided. Some research concluded that there is a causal connection between some mental illnesses and violent behavior while other studies say that the link appears only when mental illness is accompanied by drug or alcohol abuse, or other risk factors.

Now, Johnson and her colleague Eric Elbogen, Ph.D., an assistant professor of psychiatry at UNC, have contributed a new study to the debate. Drawing on data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), the two researchers, both affiliated with UNC's Forensic Psychiatry Program and Clinic, found that severe mental illness alone did not predict violent behavior.

"[P]eople with mental illness did report [engaging in] violence more often, largely because they showed other factors associated with violence," wrote Elbogen and Johnson in the February *Archives of General Psychiatry*.

They used NESARC data collected by the National Institute on Alcohol Abuse and Alcoholism in two waves from people living in the United States in 2001-2003 and 2004-2005. There were 43,093 respondents in the first wave, and 34,653 who completed the second wave. The sample was weighted to reflect the general population. Respondents were asked if they had lifetime or recent (in the prior 12 months) diagnoses of a major mental disorder or substance dependence, as well as if they had engaged in violence.

The NESARC data allowed researchers to look at respondents at two time points and see if their earlier psychiatric status predicted later violence.

About 10.9 percent of respondents said they had been diagnosed with schizophrenia, bipolar disorder, major depression, or substance abuse disorder alone, while 9.4 percent had co-occurring mental and substance abuse disorders. The researchers also included other factors in their analysis. These included dispositional factors (age, race, gender, education, income), historical factors (parental criminal history), and contextual factors (victimized in past year, divorced or separated, unemployed), as well as clinical factors.

The incidence of violent behavior was significantly higher among persons with severe mental illness only when other factors—particularly substance abuse or dependence—were present, reported Elbogen and Johnson.

"[T]he current results show that if a person has severe mental illness without substance abuse and a history of violence, he or she has the same chances of being violent during the next three years as any other person in the general population," they wrote. "Multivariate analyses confirmed that severe mental illness alone did not significantly predict committing violent acts; rather, historical, dispositional, and contextual factors were associated with future violence."

Overall, this study is fairly consistent with previous reports, said Renée Binder, M.D., a professor of psychiatry at the University of California at San Francisco, who has also studied dangerousness.

"The study is strengthened because it is based upon data from more than 34,000 individuals, but it has severe limitations," she said. Those include the self-report format of the survey, the absence of personality disorder or traumatic brain injury in the original survey, and lack of information on the stage of mental illness during which violent behavior occurred.

"A person diagnosed with schizophrenia may have a greater risk for violence when delusional, but much less when stabilized on medication," said Binder in an interview.

Elbogen agreed, noting that the NESARC survey was primarily designed to gather data about alcohol use and consequences, but its size and the scope of its questions could still be useful.

For one, it allowed Elbogen and Johnson to go beyond previous cross-sectional research and make use of a survey that was both longitudinal and representative.

Binder also said the inclusion of "perceived threats of violence" by a mentally ill person as a factor was valuable, since it went beyond simple paranoia to include elements of the respondent's life that posed genuine threats to safety.

"We started with no preconceptions in the context of the dangerousness debate," said Elbogen. "We're trying to talk to both camps, and we hope it helps clarify the discussion."

Johnson noted that there were potential policy implications to their research, especially in an age when public mental health budgets are dwindling.

"We have to look more closely at how we assume that treating people for mental illness is the only or even the best intervention needed to help them and to lessen the risk of danger," she said. "More broadly based social interventions like job training and placement, family therapy, housing, and so on might also lessen the risk of violence."

"The Intricate Link Between Violence and Mental Disorder" is posted at <http://archpsyc.ama-assn.org/cgi/content/full/66/2/152>. ■

ECT: What's the Latest?

A number of sessions at APA's 2009 annual meeting in San Francisco will provide psychiatrists with the latest information on electroconvulsive therapy as well as invite psychiatrists' input on APA's ECT handbook.

MAY 19 — TUESDAY

9 a.m.-10:30 a.m.

Medical Update: 21st Century ECT: Updating the APA Recommendations on ECT

Room 300, Esplanade Level, Moscone Center

APA's Task Force to Revise the Practice of Electroconvulsive Therapy welcomes attendees to provide feedback on the revisions for the next edition of "The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging."

MAY 20 — WEDNESDAY

8 a.m.-Noon

Course: Practice Update for the General Psychiatrist

Yosemite Ballroom B, Hilton San Francisco

APA's Corresponding Committee on Electroconvulsive Therapy and Other Electromagnetic Therapies is presenting this basic-level course designed to provide general psychiatrists and other health care providers who practice ECT, or refer patients for ECT, an opportunity to update their knowledge of ECT. Please note: This is one of APA's CME courses; advance registration and payment are required.

2 p.m.- 5 p.m.

Symposium: Advances in Electroconvulsive Therapy

Room 304, Esplanade Level, Moscone Center

This session is presented by APA's Corresponding Committee on Electroconvulsive Therapy and Other Electromagnetic Therapies.

Also, the Association for Convulsive Therapy is holding two certificate courses in conjunction with APA's annual meeting. One course is on electroconvulsive therapy, and the other is on transcranial magnetic stimulation. Both include lectures, a hands-on practicum, and examination. Scheduling and fee information may be obtained by sending an e-mail to rnewman@wpahs.org.

Spending

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indicate costs will continue to outstrip the rate of inflation and wage increases far into the future.

"This report—like the reports issued last year on the financial status of Medicare and Medicaid—is a stark reminder that we must redouble our ongoing efforts to reform the delivery of health care services in this country to bring about the goal of affordable, high quality health for all Americans," said Kerry Weems, CMS acting administrator, in a written statement.

Out-of-pocket spending by patients increased by 5.3 percent in 2007 to $268.6 billion, which compared with an increase of 3.3 percent in 2006, the CMS analysts found.

However, the cost of private health insurance premiums rose 6 percent in both 2006 and 2007, which was less than in many previous years such as the 10.7 percent increase in 2002. The auditors linked the slower growth rate to fewer small employers offering health coverage and increasing enrollment in health savings accounts and in high-deductible health plans.

Spending growth continued in other areas of health care, including payments to hospitals. Such spending—31 percent of health care outlays—increased by 7.3 percent in 2007, compared with an increase of 6.9 percent in 2006, the report stated.

Public spending on health care grew faster than spending by employers and other private sources in recent years, according to the report. Local, state, and federal governments paid for a larger portion of the nation's health care in 2007. Such spending comprised 46.2 percent of total health care outlays, an increase from 45.3 percent in 2004.

The federal auditors linked the increase in government health care spending to changes in Medicare, including the rising cost of the Medicare prescription drug benefit. That program's cost rose from $40.5 billion in 2006 to $47.6 billion in 2007.

Medicare spending continued to increase overall by 7.2 percent to $431.2 billion in 2007. That was a smaller increase than the 18.5 percent jump in 2006, which largely was a one-time result of costs associated with implementing the Medicare Part D program.

Medicaid spending in 2007 increased by 6.4 percent to $329.4 billion, the report found. The jump in Medicaid spending followed growth of 1 percent in 2006—due in part to loss of dual-eligible enrollees to Medicare Part D. However, the 2007 increase was credited as the main driver in rising overall state and local health spending that now accounts for about 24 percent of all state and local budgets.

"National Health Spending In 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," is posted at <http://content.healthaffairs.org/cgi/content/abstract/28/1/246>. ■

Large Study Reveals Insights On Suicides in Teens

An NIMH-sponsored clinical trial examines self-injury and suicidal behaviors in adolescents with treatment-resistant depression, a high-risk group often excluded from industry-sponsored clinical trials.

BY JUN YAN

The risk of suicide in adolescents taking antidepressants, especially selective serotonin reuptake inhibitors (SSRIs), has been a subject of intense debate in recent years. A large, government-sponsored clinical trial has provided a wealth of new insights to illuminate this complex issue and clinical guidance on suicide prevention in seriously depressed youths.

The Treatment of SSRI-Resistant Depression in Adolescents (TORDIA) study was a randomized, controlled clinical trial of several treatments for 334 adolescents who were between 12 and 18 years old, had been diagnosed with major depressive disorder, and had failed to respond to an adequate course of SSRI antidepressant. Four treatment options, all given for 12 weeks, were compared for efficacy and safety: an SSRI different from the drug the patient had been taking; venlafaxine, which acts on both serotonin and norepinephrine receptors; the different SSRI plus cognitive-behavioral therapy (CBT); and venlafaxine plus CBT (*Psychiatric News*, March 21, 2008). Not surprisingly, the medication-plus-CBT groups had a significantly greater response than the medication-alone group; another SSRI and venlafaxine were similar in effectiveness.

The new analysis, published online in *AJP in Advance* on February 16, focuses on analyses of the frequencies of reported suicidal thoughts, behaviors, and attempts and associated risk factors in this particularly vulnerable population. The study will appear in print in the April *American Journal of Psychiatry*.

Because depression is the most prominent psychiatric risk factor for suicidal behavior, suicidal ideation and behaviors in children and adolescents often prompt physicians in the community to prescribe antidepressants, noted the team led by David Brent, M.D., a professor of psychiatry at the University of Pittsburgh School of Medicine. However, industry-sponsored clinical trials of antidepressant drugs, intended to gain regulatory approval, routinely exclude patients with a history of suicide attempts or suicidal ideation, making it difficult for clinicians to draw relevant real-life conclusions.

The TORDIA study was funded by the National Institute of Mental Health and conducted at six academic centers across the United States. A valuable feature of the protocol was that patients were not excluded if they had suicidal thoughts at the time of entering the study. Indeed, nearly 60 percent of study participants had suicidal ideation, and over one-third had a history of nonsuicidal self-injury at baseline. Another feature of the study was that the first 181 participants were monitored for suicidal thoughts and behaviors based on patients' spontaneous reports, while the later 153 participants were questioned by the researchers every week using a standardized scale that rated the severity of the suicidal ideation and behaviors on a scale of 0 to 5.

During the 12 weeks of the study, 48 of the 334 patients had at least one suicidal event, defined as a new or worsening suicidal ideation, a suicidal threat, or a suicide attempt. The systematic assessment method identified a 20.8 percent rate of suicidal events in the second half of the study, significantly higher than the 8.8 percent rate identified by spontaneous reporting during the first half of the study.

The study also analyzed nonsuicidal self-injury events, defined as "self-injurious behavior resulting in physical damage with no explicit or implicit intent to die" such as cutting, scratching, and burning. The rate of nonsuicidal self-injuries detected by systematic assessment was 17.6 percent and by spontaneous reporting, 2.2 percent.

Although not as sensitive as systematic assessment in less severe self-injuries, spontaneous reporting was effective in picking up serious events, defined as an event that "led to hospitalization [or] was life-threatening, disabling, or resulted in death." The rates of all serious events detected by both methods did not differ significantly.

The most significant predictors for suicidal events were strong suicidal ideation and more severe depression at baseline, family conflict, and drug use or alcohol use. The median time to the occurrence of a suicidal event was three weeks after the treatment was initiated. A poorer response to treatment was significantly associated with suicidal events but not nonsuicidal self-injuries.

In patients with a higher-than-average baseline suicidal ideation, treatment with venlafaxine was associated with a higher likelihood of suicidal or nonsuicidal self-injury than another SSRI. CBT did not significantly affect the rate of suicidal events, which, the authors explained, may be due to the early onset of most events (on average at three weeks after the start of the study), and CBT takes a longer time to be effective.

"This study is a report full of pearls for psychiatrists and families," said Myrna Weissman, Ph.D., in an interview with *Psychiatric News*. She is a professor of epidemiology and psychiatry at the College of Physicians and Surgeons and the School of Public Health at Columbia University and chief of the Department in Clinical-Genetic Epidemiology at New York State Psychiatric Institute. Her editorial on the study will appear in the April *AJP*. "It is very elegantly designed."

"It's an important paper because it addressed many problems that people have been concerned about in suicidal ideation in adolescents," Weissman said.

She noted the importance of data on nonsuicidal self-injuries. "There have been suggestions that these events may be increasing among adolescents, which is alarming." The findings in the study can be valuable to clinical practice, she said.

"Predictors of Spontaneous and Systematically Assessed Suicidal Adverse Events in the Treatment of SSRI-Resistant Depression in Adolescents (TORDIA) Study" is posted at <http://ajp.psychiatryonline.org/cgi/reprint/appi.ajp.2008.08070976v1>. ■

Commitment

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on federal sex crime charges in states without civil-commitment statutes, he said.

APA's Committee on Persons With Mental Illness in the Criminal Justice System provided a written statement on the court ruling to *Psychiatric News* that described civil commitment for sexual offenders as "incarceration under the guise of treatment."

"The court ruled against indefinite commitment because it determined this to be a states' rights issue and not a power controlled by Congressional statute," said the committee statement. "However, in our opinion the legal tests defining 'sexual dangerousness,' 'severe mental illness,' and 'difficulty from refraining from future sexual violence or child molestation' are difficult to translate into psychiatric decision making."

The committee pointed out that the burden of a societal remedy for sexual violence should not rest with psychiatry. "By obliging psychiatrists to participate in the indefinite detention of individuals, their role as treating clinicians is transformed into that of a jailer," the committee statement said.

Instead, the committee's members suggested that the complex forensic issue of predicting sexually violent dangerousness is better handled through criminal-justice proceedings and sentencing rather than through the psychiatric civil-commitment process.

The ruling is posted at <http://pacer.ca4.uscourts.gov/opinion.pdf/077671.P.pdf>. ■

Psychoanalysis

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How much of these children's impressive outcomes were actually due to analysis?

Sherkow is the first to admit that she is not sure, especially since the children were also receiving speech therapy and occupational therapy and, in some cases, physical therapy. Further, she and the other therapists worked closely together in each case "to make sure that everybody was on the same page." Nonetheless, she has little doubt that the children's remarkable results were due at least in part to analysis. For example, her patient who had started analysis at age 9 had already had speech therapy, and it had done nothing to help him with his grave speech difficulties. But now, after analysis, "he is understandable," she reported. "You can actually have conversations with him."

Sherkow's greatest achievement may have been in making the children empathetic, Emanuel DiCicco-Bloom, M.D., a professor of neuroscience at the Robert Wood Johnson Medical School and an autism scientist, declared at the APsaA meeting. "It is heartwarming, something we don't hear about at our autism meetings," he added.

But perhaps the more sweeping implication of these outcomes, DiCicco-Bloom pointed out, is that they challenge the traditional belief that children with a diagnosis of autism or of an autism spectrum disorder cannot get better. "We are learning that the brain has an incredible amount of plasticity," he declared. "There is far more plasticity than many of us would have imagined even 10 years ago."

Sherkow agreed: "One of the main things we are up against in our work is that there has been a lot of press over the years that you can't lose the diagnosis of autism .... Now we are beginning to see that that is just not true."

Other American analysts are also using analysis to help autistic children, Sherkow noted. So are some European analysts, she added. So does she recommend that children with autism or an autism spectrum disorder receive psychoanalysis? "Absolutely!" she replied. And where might American parents find an analyst to help an autistic child? "They should go to a psychoanalytically trained child psychiatrist or child psychologist who knows how to do this or who would learn how to do it because it is based on how we do child analysis anyway." ■

Applications Sought For Fellowship

Psychiatry residents are invited to apply for APA's Public Psychiatry Fellowship. This important collaborative venture between APA and Bristol-Myers Squibb Co. provides for the selection of 10 residents in psychiatry, based on recommendations from their departments and evidence of a track record of commitment to and accomplishment in public psychiatry.

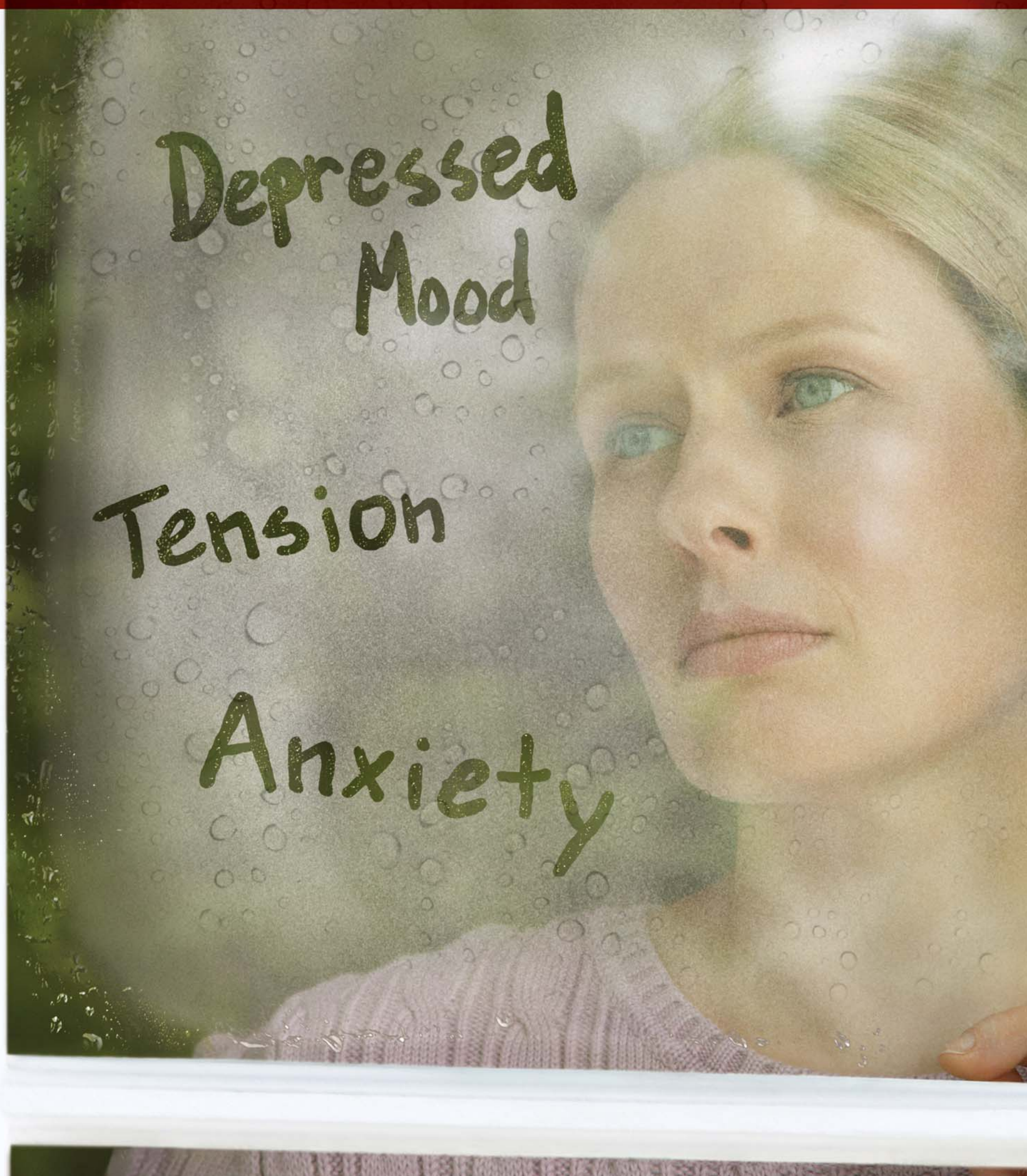
The purposes of this fellowship are to heighten psychiatry residents' awareness of the many activities of psychiatry in the public sector and of the career opportunities in this work, and to provide experiences that will contribute to the professional development of those residents who will play leadership roles within the public sector in future years.

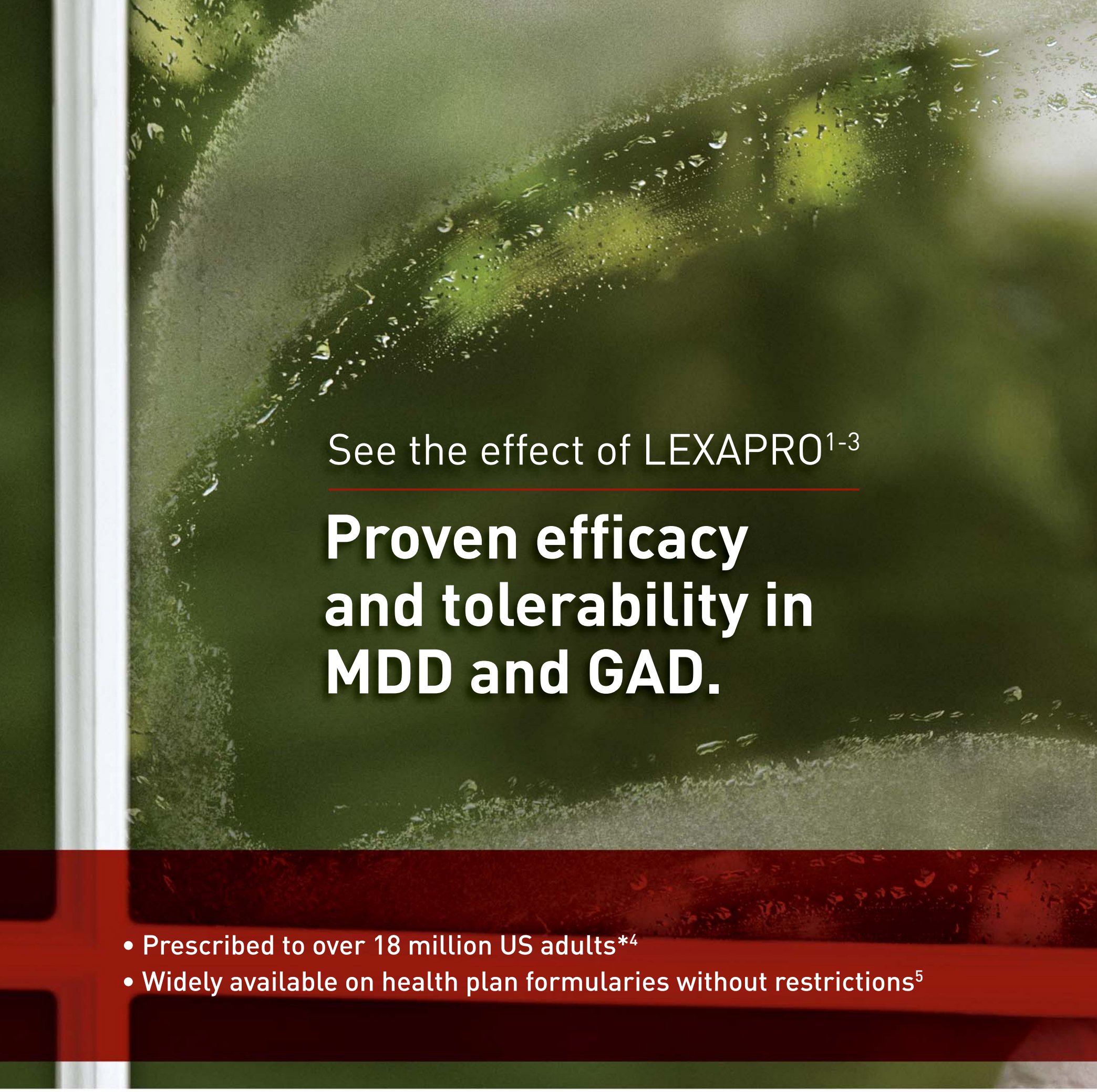
The fellowship is open to PGY-1 through PGY-3 residents. Applicants must be APA members and have approval from their training director or department chair.

The deadline for applications is March 31. Applications and more information are posted at <www.psych.org/publicpsychiatry>. ■

Treat core symptoms[1,2]

of Major Depressive Disorder (MDD) & Generalized Anxiety Disorder (GAD)





*Lexapro Market Overview. Patient level report based on longitudinal analysis of US electronic pharmacy claims submitted for third-party reimbursement. Patients projected based on their activity in retail pharmacies.

IMPORTANT SAFETY INFORMATION – Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Antidepressants increased the risk of suicidality (suicidal thinking and behavior) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of antidepressants in children, adolescents or young adults must balance the risk to clinical need. Patients of all ages started on antidepressant therapy should be closely monitored and observed for clinical worsening, suicidality or unusual changes in behavior, especially at the beginning of therapy or at the time of dose changes. This risk may persist until significant remission occurs. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients.

Lexapro is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs), pimozide (see DRUG INTERACTIONS – Pimozide and Celexa), or in patients with hypersensitivity to escitalopram oxalate. As with other SSRIs, caution is indicated in the coadministration of tricyclic antidepressants (TCAs) with Lexapro. SSRIs and SNRIs (including Lexapro) and other psychotropic drugs that interfere with serotonin reuptake may increase the risk of bleeding events. Concomitant use of aspirin, NSAIDs, warfarin, and other anticoagulants may add to the risk. Patients should be cautioned about these risks. SSRIs and SNRIs have been associated with clinically significant hyponatremia. Elderly patients or patients taking diuretics or who are otherwise volume-depleted appear to be at a greater risk. Discontinuation of Lexapro should be considered in patients with symptomatic hyponatremia, and appropriate medical intervention should be instituted. The most common adverse events with Lexapro versus placebo (approximately 5% or greater and approximately 2x placebo) were nausea, insomnia, ejaculation disorder, somnolence, increased sweating, fatigue, decreased libido, and anorgasmia.

Please see the accompanying brief summary of prescribing information for LEXAPRO.

References: 1. Burke WJ, Gergel I, Bose A. Fixed-dose trial of the single isomer SSRI escitalopram in depressed outpatients. *J Clin Psychiatry.* 2002;63:331-336. **2.** Davidson JRT, Bose A, Korotzer A, Zheng H. Escitalopram in the treatment of generalized anxiety disorder: double-blind, placebo controlled, flexible-dose study. *Depress Anxiety.* 2004;19:234-240. **3.** LEXAPRO [package insert]. St. Louis, Mo: Forest Pharmaceuticals, Inc.; 2008. **4.** Surveillance Data, Inc. (SDI), April 2008. **5.** Data on file, Forest Laboratories, Inc.

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Brief Summary: For complete details, please see full Prescribing Information for Lexapro.

Suicidality and Antidepressant Drugs Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Lexapro or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients. (See WARNINGS: Clinical Worsening and Suicide Risk, PRECAUTIONS: Information for Patients, and PRECAUTIONS: Pediatric Use)

INDICATIONS AND USAGE Major Depressive Disorder Lexapro (escitalopram) is indicated for the treatment of major depressive disorder. The efficacy of Lexapro in the treatment of major depressive disorder was established in three, 8-week, placebo-controlled trials of outpatients whose diagnoses corresponded most closely to the DSM-IV category of major depressive disorder (see **CLINICAL PHARMACOLOGY**). A major depressive episode (DSM-IV) implies a prominent and relatively persistent (nearly every day for at least 2 weeks) depressed or dysphoric mood that usually interferes with daily functioning, and includes at least five of the following nine symptoms: depressed mood, loss of interest in usual activities, significant change in weight and/or appetite, insomnia or hypersomnia, psychomotor agitation or retardation, increased fatigue, feelings of guilt or worthlessness, slowed thinking or impaired concentration, a suicide attempt or suicidal ideation. The efficacy of Lexapro in hospitalized patients with major depressive disorder has not been adequately studied. The efficacy of Lexapro in maintaining a response, in patients with major depressive disorder who responded during an 8-week, acute-treatment phase while taking Lexapro and were then observed for relapse during a period of up to 36 weeks, was demonstrated in a placebo-controlled trial (see **Clinical Efficacy Trials** under **CLINICAL PHARMACOLOGY**). Nevertheless, the physician who elects to use Lexapro for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see **DOSAGE AND ADMINISTRATION**). **Generalized Anxiety Disorder** Lexapro is indicated for the treatment of Generalized Anxiety Disorder (GAD). The efficacy of Lexapro was established in three, 8-week, placebo-controlled trials in patients with GAD (see **CLINICAL PHARMACOLOGY**). Generalized Anxiety Disorder (DSM-IV) is characterized by excessive anxiety and worry (apprehensive expectation) that is persistent for at least 6 months and which the person finds difficult to control. It must be associated with at least 3 of the following symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance. The efficacy of Lexapro in the long-term treatment of GAD, that is, for more than 8 weeks, has not been systematically evaluated in controlled trials. The physician who elects to use Lexapro for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient. **CONTRAINDICATIONS** Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated (see **WARNINGS**). Concomitant use in patients taking pimozide is contraindicated (see **Drug Interactions – Pimozide and Celexa**). Lexapro is contraindicated in patients with a hypersensitivity to escitalopram or citalopram or any of the inactive ingredients in Lexapro. **WARNINGS WARNINGS-Clinical Worsening and Suicide Risk** Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older. The pooled analyses of placebo-controlled trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) are provided in Table 1. **TABLE 1: Age Range and Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated:** Increases Compared to Placebo; <18 (14 additional cases); 18-24 (5 additional cases); Decreases Compared to Placebo; 25-64 (1 fewer case); ≥65 (6 fewer cases). No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide. It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression. **All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.** The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see **PRECAUTIONS and DOSAGE AND ADMINISTRATION—Discontinuation of Treatment with Lexapro**, for a description of the risks of discontinuation of Lexapro). **Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to healthcare providers. Such monitoring should include daily observation by families and caregivers.** Prescriptions for Lexapro should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Screening Patients for Bipolar Disorder:** A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that Lexapro is not approved for use in treating bipolar depression. **Potential for Interaction with Monoamine Oxidase Inhibitors In patients receiving serotonin reuptake inhibitor drugs in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRI treatment and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Furthermore, limited animal data on the effects of combined use of SSRIs and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that Lexapro should not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping Lexapro before starting an MAOI. Serotonin syndrome has been reported in two patients who were concomitantly receiving linezolid, an antibiotic which is a reversible non-selective MAOI.** ***Serotonin Syndrome:*** The development of a potentially life-threatening serotonin syndrome may occur with SNRIs and SSRIs, including Lexapro treatment, particularly with concomitant use of serotonergic drugs (including triptans) and with drugs which impair metabolism of serotonin (including MAOIs). Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). The concomitant use of Lexapro with MAOIs intended to treat depression is contraindicated (see **CONTRAINDICATIONS** and **WARNINGS - Potential for Interaction with Monoamine Oxidase Inhibitors**.) If concomitant treatment of Lexapro with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **PRECAUTIONS - Drug Interactions**). The concomitant use of Lexapro with serotonin precursors (such as tryptophan) is not recommended (see **PRECAUTIONS - Drug Interactions**). **PRECAUTIONS General** Discontinuation of Treatment with Lexapro During marketing of Lexapro and other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with Lexapro. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate (see **DOSAGE AND ADMINISTRATION**). Abnormal Bleeding SSRIs and SNRIs, including Lexapro, may increase the risk of bleeding events. Concomitant use of aspirin, nonsteroidal anti-inflammatory drugs, warfarin, and other anticoagulants may add to the risk. Case reports and epidemiological studies (case-control and cohort design) have demonstrated an association between use of drugs that interfere with serotonin reuptake and the occurrence of gastrointestinal bleeding. Bleeding events related to SSRI and SNRI use have ranged from ecchymoses, hematomas, epistaxis, and petechiae to life-threatening hemorrhages. Patients should be cautioned about the risk of bleeding associated with the concomitant use of Lexapro and NSAIDs, aspirin, or other drugs that affect coagulation. Hyponatremia Hyponatremia may occur as a result of treatment with SSRIs and SNRIs, including Lexapro. In many cases, this hyponatremia appears to be the result of the syndrome of inappropriate antidiuretic hormone secretion (SIADH), and was reversible when Lexapro was discontinued. Cases with serum sodium lower than 110 mmol/L have been reported. Elderly patients may be at greater risk of developing hyponatremia with SSRIs and SNRIs. Also, patients taking diuretics or who are otherwise volume-depleted may be at greater risk (see **Geriatric Use**). Discontinuation of Lexapro should be considered in patients with symptomatic hyponatremia and appropriate medical intervention should be instituted. Signs and symptoms of hyponatremia include headache, difficulty concentrating, memory impairment, confusion, weakness, and unsteadiness, which may lead to falls. Signs and symptoms associated with more severe and/or acute cases have included hallucination, syncope, seizure, coma, respiratory arrest, and death. Activation of Mania/Hypomania In placebo-controlled trials of Lexapro in major depressive disorder, activation of mania/hypomania was reported in one (0.1%) of 715 patients treated with Lexapro and in none of the 592 patients treated with placebo. One additional case of hypomania has been reported in association with Lexapro treatment. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorders treated with racemic citalopram and other marketed drugs effective in the treatment of major depressive disorder. As with all drugs effective in the treatment of major depressive disorder, Lexapro should be used cautiously in patients with a history of mania. Seizures Although anticonvulsant effects of racemic citalopram have been observed in animal studies, Lexapro has not been systematically evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarketing testing. In clinical trials of Lexapro, cases of convulsion have been reported in association with Lexapro treatment. Like other drugs effective in the treatment of major depressive disorder, Lexapro should be introduced with care in patients with a history of seizure disorder. Interference with Cognitive and Motor Performance In a study in normal volunteers, Lexapro 10 mg/day did not produce impairment of intellectual function or psychomotor performance. Because any psychoactive drug may impair judgment, thinking, or motor skills, however, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. Use in Patients with Concomitant Illness Clinical experience with Lexapro in patients with certain concomitant systemic illnesses is limited. Caution is advisable in using Lexapro in patients with diseases or conditions that produce altered metabolism or hemodynamic responses. Lexapro has not been systematically evaluated in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were generally excluded from clinical studies during the product's premarketing testing. In subjects with hepatic impairment, clearance of racemic citalopram was decreased and plasma concentrations were increased. The recommended dose of Lexapro in hepatically impaired patients is 10 mg/day (see **DOSAGE AND ADMINISTRATION**). Because escitalopram is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. Until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with Lexapro, however, it should be used with caution in such patients (see **DOSAGE AND ADMINISTRATION**). **Information for Patients** Physicians are advised to discuss the following issues with patients for whom they prescribe Lexapro. Patients should be cautioned about the risk of serotonin syndrome with the concomitant use of Lexapro and triptans, tramadol or other serotonergic agents. In a study in normal volunteers, Lexapro 10 mg/day did not impair psychomotor performance. The effect of Lexapro on psychomotor coordination, judgment, or thinking has not been systematically examined in controlled studies. Because psychoactive drugs may impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. Patients should be told that, although Lexapro has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of Lexapro and alcohol in depressed patients is not advised. Patients should be made aware that escitalopram is the active isomer of Celexa (citalopram hydrobromide) and that the two medications should not be taken concomitantly. Patients should be advised to inform their physician if they are taking, or plan to take, any prescription or over-the-counter drugs, as there is a potential for interactions. Patients should be cautioned about the concomitant use of Lexapro and NSAIDs, aspirin, warfarin, or other drugs that affect coagulation since combined use of psychotropic drugs that interfere with serotonin reuptake and these agents has been associated with an increased risk of bleeding. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breastfeeding an infant. While patients may notice improvement with Lexapro therapy in 1 to 4 weeks, they should be advised to continue therapy as directed. Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with Lexapro and should counsel them in its appropriate use. A patient Medication Guide about "Antidepressant Medicines, Depression and other Serious Mental Illness, and Suicidal Thoughts or Actions" is available for Lexapro. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. Patients should be advised of the following issues and asked to alert their prescriber if these occur while taking Lexapro. **Clinical Worsening and Suicide Risk:** Patients, their families, and their caregivers should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during antidepressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to look for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication. **Laboratory Tests** There are no specific laboratory tests recommended. **Concomitant Administration with Racemic Citalopram** Citalopram - Since escitalopram is the active isomer of racemic citalopram (Celexa), the two agents should not be coadministered. **Drug Interactions Serotonergic Drugs:** Based on the mechanism of action of SNRIs and SSRIs including Lexapro, and the potential for serotonin syndrome, caution is advised when Lexapro is coadministered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, linezolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, or St. John's Wort (see **WARNINGS-Serotonin Syndrome**). The concomitant use of Lexapro with other SSRIs, SNRIs or tryptophan is not recommended (see **PRECAUTIONS - Drug Interactions**). **Triptans:** There have been rare postmarketing reports of serotonin syndrome with use of an SSRI and a triptan. If concomitant treatment of Lexapro with a triptan is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **WARNINGS - Serotonin Syndrome**). CNS Drugs - Given the primary CNS effects of escitalopram, caution should be used when it is taken in combination with other centrally-acting drugs. Alcohol - Although Lexapro did not potentiate the cognitive and motor effects of alcohol in a clinical trial, as with other psychotropic medications, the use of alcohol by patients taking Lexapro is not recommended. Monoamine Oxidase Inhibitors (MAOIs) - See **CONTRAINDICATIONS** and **WARNINGS**. **Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)** Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin may potentiate the risk of bleeding. Altered anticoagulant effects, including increased bleeding, have been reported when SSRIs and SNRIs are coadministered with warfarin. Patients receiving warfarin therapy should be carefully monitored when Lexapro is initiated or discontinued. Cimetidine - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of 400 mg/day cimetidine for 8 days resulted in an increase in citalopram AUC and C_{max} of 43% and 39%, respectively. The clinical significance of these findings is unknown. Digoxin - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of citalopram and digoxin (single dose of 1 mg) did not significantly affect the pharmacokinetics of either citalopram or digoxin. Lithium - Coadministration of racemic citalopram (40 mg/day for 10 days) and lithium (30 mmol/day for 5 days) had no significant effect on the pharmacokinetics of citalopram or lithium. Nevertheless, plasma lithium levels should be monitored with appropriate adjustment to the lithium dose in accordance with standard clinical practice. Because lithium may enhance the serotonergic effects of escitalopram, caution should be exercised when Lexapro and lithium are coadministered. Pimozide and Celexa - In a controlled study, a single dose of pimozide 2 mg co-administered with racemic citalopram 40 mg given once daily for 11 days was associated with a mean increase in QTc values of approximately 10 msec compared to pimozide given alone. Racemic citalopram did not alter the mean AUC or C_{max} of pimozide. The mechanism of this pharmacodynamic interaction is not known. Sumatriptan - There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of an SSRI and sumatriptan. If concomitant treatment with sumatriptan and an SSRI (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram) is clinically warranted, appropriate observation of the patient is advised. Theophylline - Combined administration of racemic citalopram (40 mg/day for 21 days) and the CYP1A2 substrate theophylline (single dose of 300 mg) did not affect the pharmacokinetics of theophylline. The effect of theophylline on the pharmacokinetics of citalopram was not evaluated. Warfarin - Administration of 40 mg/day racemic citalopram for 21 days did not affect the pharmacokinetics of warfarin, a CYP3A4 substrate. Prothrombin time was increased by 5%, the clinical significance of which is unknown. Carbamazepine - Combined administration of racemic citalopram (40 mg/day for 14 days) and carbamazepine (titrated to 400 mg/day for 35 days) did not significantly affect the pharmacokinetics of carbamazepine, a CYP3A4 substrate. Although trough citalopram plasma levels were unaffected, given the enzyme-inducing properties of carbamazepine, the possibility that carbamazepine might increase the clearance of escitalopram should be considered if the two drugs are coadministered. Triazolam - Combined administration of racemic citalopram (titrated to 40 mg/day for 28 days) and the CYP3A4 substrate triazolam (single dose of 0.25 mg) did not significantly affect the pharmacokinetics of either citalopram or triazolam. Ketoconazole - Combined administration of racemic citalopram (40 mg) and ketoconazole (200 mg), a potent CYP3A4 inhibitor, decreased the C_{max} and AUC of ketoconazole by 21% and 10%, respectively, and did not significantly affect the pharmacokinetics of citalopram. Ritonavir - Combined administration of a single dose of ritonavir (600 mg), both a CYP3A4 substrate and a potent inhibitor of CYP3A4, and escitalopram (20 mg) did not affect the pharmacokinetics of either ritonavir or escitalopram. CYP3A4 and -2C19 Inhibitors - *In vitro* studies indicated that CYP3A4 and -2C19 are the primary enzymes involved in the metabolism of escitalopram. However, coadministration of escitalopram (20 mg) and ritonavir (600 mg), a potent inhibitor of CYP3A4, did not significantly affect the pharmacokinetics of escitalopram. Because escitalopram is metabolized by multiple enzyme systems, inhibition of a single enzyme may not appreciably decrease escitalopram clearance. Drugs Metabolized by Cytochrome P4502D6 - *In vitro* studies did not reveal an inhibitory effect of escitalopram on CYP2D6. In addition, steady state levels of racemic citalopram were not significantly different in poor metabolizers and extensive CYP2D6 metabolizers after multiple-dose administration of citalopram, suggesting that coadministration, with escitalopram, of a drug that inhibits CYP2D6, is unlikely to have clinically significant effects on escitalopram metabolism. However, there are limited *in vivo* data suggesting a modest CYP2D6 inhibitory effect for escitalopram, i.e., coadministration of escitalopram (20 mg/day for 21 days) with the tricyclic antidepressant desipramine (single dose of 50 mg), a substrate for CYP2D6, resulted in a 40% increase in C_{max} and a 100% increase in AUC of desipramine. The clinical significance of this finding is unknown. Nevertheless, caution is indicated in the coadministration of escitalopram and drugs metabolized by CYP2D6. Metoprolol - Administration of 20 mg/day Lexapro for 21 days in healthy volunteers resulted in a 50% increase in C_{max} and 82% increase in AUC of the beta-adrenergic blocker metoprolol (given in a single dose of 100 mg). Increased metoprolol plasma levels have been associated with decreased cardioselectivity. Coadministration of Lexapro and metoprolol had no clinically significant effects on blood pressure or heart rate. Electroconvulsive Therapy (ECT) - There are no clinical studies of the combined use of ECT and escitalopram. **Carcinogenesis, Mutagenesis, Impairment of Fertility** Carcinogenesis Racemic citalopram was administered in the diet to NMRI/BOM strain mice and COBS WI strain rats for 18 and 24 months, respectively. There was no evidence for carcinogenicity of racemic citalopram in mice receiving up to 240 mg/kg/day. There was an increased incidence of small intestine carcinoma in rats receiving 8 or 24 mg/kg/day racemic citalopram. A no-effect dose for this finding was not established. The relevance of these findings to humans is unknown. Mutagenesis Racemic citalopram was mutagenic in the *in vitro* bacterial reverse mutation assay (Ames test) in 2 of 5 bacterial strains (Salmonella TA98 and TA1537) in the absence of metabolic activation. It was clastogenic in the *in vitro* Chinese hamster lung cell assay for chromosomal aberrations in the presence and absence of metabolic activation. Racemic citalopram was not mutagenic in the *in vitro* mammalian forward gene mutation assay (HPRT) in mouse lymphoma cells or in a coupled *in vitro/in vivo* unscheduled DNA synthesis (UDS) assay in rat liver. It was not clastogenic in the *in vitro* chromosomal aberration assay in human lymphocytes or in two *in vivo* mouse micronucleus assays. Impairment of Fertility When racemic citalopram was administered orally to 16 male and 24 female rats prior to and throughout mating and gestation at doses of 32, 48, and 72 mg/kg/day, mating was decreased at all doses, and fertility was decreased at doses ≥32 mg/kg/day. Gestation duration was increased at 48 mg/kg/day. **Pregnancy** Pregnancy Category C In a rat embryo/fetal development study, oral administration of escitalopram (56, 112, or 150 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased fetal body weight and associated delays in ossification at the two higher doses (approximately ≥56 times the maximum recommended human dose [MRHD] of 20 mg/day on a body surface area [mg/m^2] basis). Maternal toxicity (clinical signs and decreased body weight gain and food consumption), mild at 56 mg/kg/day, was present at all dose levels. The developmental no-effect dose of 56 mg/kg/day is approximately 28 times the MRHD on a mg/m^2 basis. No teratogenicity was observed at any of the doses tested (as high as 75 times the MRHD on a mg/m^2 basis). When female rats were treated with escitalopram (6, 12, 24, or 48 mg/kg/day) during pregnancy and through weaning, slightly increased offspring mortality and growth retardation were noted at 48 mg/kg/day which is approximately 24 times the MRHD on a mg/m^2 basis. Slight maternal toxicity (clinical signs and decreased body weight gain and food consumption) was seen at this dose. Slightly increased offspring mortality was seen at 24 mg/kg/day. The no-effect dose was 12 mg/kg/day which is approximately 6 times the MRHD on a mg/m^2 basis. In animal reproduction studies, racemic citalopram has been shown to have adverse effects on embryo/fetal and postnatal development, including teratogenic effects, when administered at doses greater than human therapeutic doses. In two rat embryo/fetal development studies, oral administration of racemic citalopram (32, 56, or 112 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased embryo/fetal growth and survival and an increased incidence of fetal abnormalities (including cardiovascular and skeletal defects) at the high dose. This dose was also associated with maternal toxicity (clinical signs, decreased body weight gain). The developmental no-effect dose was 56 mg/kg/day. In a rabbit study, no adverse effects on embryo/fetal development were observed at doses of racemic citalopram of up to 16 mg/kg/day. Thus, teratogenic effects of racemic citalopram were observed at a maternally toxic dose in the rat and were not observed in the rabbit. When female rats were treated with racemic citalopram (4.8, 12.8, or 32 mg/kg/day) from late gestation through weaning, increased offspring mortality during the first 4 days after birth and persistent offspring growth retardation were observed at the highest dose. The no-effect dose was 12.8 mg/kg/day. Similar effects on offspring mortality and growth were seen when dams were treated throughout gestation and early lactation at doses ≥24 mg/kg/day. A no-effect dose was not determined in that study. There are no adequate and well-controlled studies in pregnant women; therefore, escitalopram should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Pregnancy-Nonteratogenic Effects** Neonates exposed to Lexapro and other SSRIs or SNRIs, late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (see **WARNINGS**). Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1-2 per 1000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective, case-control study of 377 women whose infants were born with PPHN and 836 women whose infants were born healthy, the risk for developing PPHN was approximately six-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. There is currently no corroborative evidence regarding the risk for PPHN following exposure to SSRIs in pregnancy; this is the first study that has investigated the potential risk. The study did not include enough cases with exposure to individual SSRIs to determine if all SSRIs posed similar levels of PPHN risk. When treating a pregnant woman with Lexapro during the third trimester, the physician should carefully consider both the potential risks and benefits of treatment (see **DOSAGE AND ADMINISTRATION**). Physicians should note that in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication. **Labor and Delivery** The effect of Lexapro on labor and delivery in humans is unknown. **Nursing Mothers** Racemic citalopram, like many other drugs, is excreted in human breast milk. There have been two reports of infants experiencing excessive somnolence, decreased feeding, and weight loss in association with breastfeeding from a citalopram-treated mother; in one case, the infant was reported to recover completely upon discontinuation of citalopram by its mother and, in the second case, no follow-up information was available. The decision whether to continue or discontinue either nursing or Lexapro therapy should take into account the risks of citalopram exposure for the infant and the benefits of Lexapro treatment for the mother. **Pediatric Use** Safety and effectiveness in the pediatric population have not been established (see **BOXED WARNING** and **WARNINGS—Clinical Worsening and Suicide Risk**). One placebo-controlled trial in 264 pediatric patients with MDD has been conducted with Lexapro, and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of Lexapro in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use** Approximately 6% of the 1144 patients receiving escitalopram in controlled trials of Lexapro in major depressive disorder and GAD were 60 years of age or older; elderly patients in these trials received daily doses of Lexapro between 10 and 20 mg. The number of elderly patients in these trials was insufficient to adequately assess for possible differential efficacy and safety measures on the basis of age. Nevertheless, greater sensitivity of some elderly individuals to effects of Lexapro cannot be ruled out. SSRIs and SNRIs, including Lexapro, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse event (see **PRECAUTIONS**, Hyponatremia). In two pharmacokinetic studies, escitalopram half-life was increased by approximately 50% in elderly subjects as compared to young subjects and C_{max} was unchanged (see **CLINICAL PHARMACOLOGY**). 10 mg/day is the recommended dose for elderly patients (see **DOSAGE AND ADMINISTRATION**). Of 4422 patients in clinical studies of racemic citalopram, 1357 were 60 and over, 1034 were 65 and over, and 457 were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but again, greater sensitivity of some elderly individuals cannot be ruled out. **ADVERSE REACTIONS** Adverse event information for Lexapro was collected from 715 patients with major depressive disorder who were exposed to escitalopram and from 592 patients who were exposed to placebo in double-blind, placebo-controlled trials. An additional 284 patients with major depressive disorder were newly exposed to escitalopram in open-label trials. The adverse event information for Lexapro in patients with GAD was collected from 429 patients exposed to escitalopram and from 427 patients exposed to placebo in double-blind, placebo-controlled trials. Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and tabulations that follow, standard World Health Organization (WHO) terminology has been used to classify reported adverse events. The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. **Adverse Events Associated with Discontinuation of Treatment Major Depressive Disorder** Among the 715 depressed patients who received Lexapro in placebo-controlled trials, 6% discontinued treatment due to an adverse event, as compared to 2% of 592 patients receiving placebo. In two fixed-dose studies, the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro was not significantly different from the rate of discontinuation for adverse events in patients receiving placebo. The rate of discontinuation for adverse events in patients assigned to a fixed dose of 20 mg/day Lexapro was 10%, which was significantly different from the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro (4%) and placebo (3%). Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice that of placebo, were nausea (2%) and ejaculation disorder (2% of male patients). **Generalized Anxiety Disorder** Among the 429 GAD patients who received Lexapro 10-20 mg/day in placebo-controlled trials, 8% discontinued treatment due to an adverse event, as compared to 4% of 427 patients receiving placebo. Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice the placebo rate, were nausea (2%), insomnia (1%), and fatigue (1%). **Incidence of Adverse Events in Placebo-Controlled Clinical Trials Major Depressive Disorder Table 2** enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred among 715 depressed patients who received Lexapro at doses ranging from 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The prescriber should be aware that these figures cannot be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were insomnia, ejaculation disorder (primarily ejaculatory delay), nausea, sweating increased, fatigue, and somnolence (see **TABLE 2**). **TABLE 2: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Major Depressive Disorder* (Percentage of Patients Reporting Event) Body System/Adverse Event [Lexapro (N=715) and Placebo (N=592)]: Autonomic Nervous System Disorders:** Dry Mouth (6% and 5%); Sweating Increased (5% and 2%). **Central & Peripheral Nervous System Disorders:** Dizziness (5% and 3%). **Gastrointestinal Disorders:** Nausea (15% and 7%); Diarrhea (8% and 5%); Constipation (3% and 1%); Indigestion (3% and 1%); Abdominal Pain (2% and 1%). **General:** Influenza-like Symptoms (5% and 4%); Fatigue (5% and 2%). **Psychiatric Disorders:** Insomnia (9% and 4%); Somnolence (6% and 2%); Appetite Decreased (3% and 1%); Libido Decreased (3% and 1%). **Respiratory System Disorders:** Rhinitis (5% and 4%); Sinusitis (3% and 2%). **Urogenital:** Ejaculation Disorder[1,2] (9% and <1%); Impotence[2] (3% and <1%); Anorgasmia[3] (2% and <1%). *Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo ≥ Lexapro: headache, upper respiratory tract infection, back pain, pharyngitis, inflicted injury, anxiety. [1]Primarily ejaculatory delay. [2]Denominator used was for males only (N=225 Lexapro; N=188 placebo). [3]Denominator used was for females only (N=490 Lexapro; N=404 placebo). **Generalized Anxiety Disorder Table 3** enumerates the incidence, rounded to the nearest percent of treatment-emergent adverse events that occurred among 429 GAD patients who received Lexapro 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were nausea, ejaculation disorder (primarily ejaculatory delay), insomnia, fatigue, decreased libido, and anorgasmia (see **TABLE 3**). **TABLE 3: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Generalized Anxiety Disorder* (Percentage of Patients Reporting Event) Body System/Adverse Event [Lexapro (N=429) and Placebo (N=427)]: Autonomic Nervous System Disorders:** Dry Mouth (9% and 5%); Sweating Increased (4% and 1%). **Central & Peripheral Nervous System Disorders:** Headache (24% and 17%); Paresthesia (2% and 1%). **Gastrointestinal Disorders:** Nausea (18% and 8%); Diarrhea (8% and 6%); Constipation (5% and 4%); Indigestion (3% and 2%); Vomiting (3% and 1%); Abdominal Pain (2% and 1%); Flatulence (2% and 1%); Toothache (2% and 0%). **General:** Fatigue (8% and 2%); Influenza-like symptoms (5% and 4%). **Musculoskeletal:** Neck/Shoulder Pain (3% and 1%). **Psychiatric Disorders:** Somnolence (13% and 7%); Insomnia (12% and 6%); Libido Decreased (7% and 2%); Dreaming Abnormal (3% and 2%); Appetite Decreased (3% and 1%); Lethargy (3% and 1%); Yawning (2% and 1%). **Urogenital:** Ejaculation Disorder[1,2] (14% and 2%); Anorgasmia[3] (6% and <1%); Menstrual Disorder (2% and 1%). *Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo ≥ Lexapro: inflicted injury, dizziness, back pain, upper respiratory tract infection, rhinitis, pharyngitis. [1]Primarily ejaculatory delay. [2]Denominator used was for males only (N=182 Lexapro; N=195 placebo). [3]Denominator used was for females only (N=247 Lexapro; N=232 placebo). **Dose Dependency of Adverse Events** The potential dose dependency of common adverse events (defined as an incidence rate of ≥ 5% in either the 10 mg or 20 mg Lexapro groups) was examined on the basis of the combined incidence of adverse events in two fixed-dose trials. The overall incidence rates of adverse events in 10 mg Lexapro-treated patients (66%) was similar to that of the placebo-treated patients (61%), while the incidence rate in 20 mg/day Lexapro-treated patients was greater (86%). **Table 4** shows common adverse events that occurred in the 20 mg/day Lexapro group with an incidence that was approximately twice that of the 10 mg/day Lexapro group and approximately twice that of the placebo group. **TABLE 4: Incidence of Common Adverse Events* in Patients with Major Depressive Disorder Receiving Placebo (N=311), 10 mg/day Lexapro (N=310), 20 mg/day Lexapro (N=125): Insomnia** (4%, 7%, 14%); **Diarrhea** (5%, 6%, 14%); **Dry Mouth** (3%, 4%, 9%); **Somnolence** (1%, 4%, 9%); **Dizziness** (2%, 4%, 7%); **Sweating Increased** (<1%, 3%, 8%); **Constipation** (1%, 3%, 6%); **Fatigue** (2%, 2%, 6%); **Indigestion** (1%, 2%, 6%).*Adverse events with an incidence rate of at least 5% in either of the Lexapro groups and with an incidence rate in the 20 mg/day Lexapro group that was approximately twice that of the 10 mg/day Lexapro group and the placebo group. **Male and Female Sexual Dysfunction with SSRIs** Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence. **Table 5** shows the incidence rates of sexual side effects in patients with major depressive disorder and GAD in placebo-controlled trials. **TABLE 5: Incidence of Sexual Side Effects in Placebo-Controlled Clinical Trials** [In Males Only: **Adverse Event: Lexapro** (N=407) **and Placebo** (N=383)]: Ejaculation Disorder (primarily ejaculatory delay) (12% and 1%); Libido Decreased (6% and 2%); Impotence (2% and <1%). [In Females Only**: Lexapro** (N=737) **and Placebo** (N=636)]: Libido Decreased (3% and 1%); Anorgasmia (3% and <1%). There are no adequately designed studies examining sexual dysfunction with escitalopram treatment. Priapism has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects. **Vital Sign Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, and diastolic blood pressure) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses did not reveal any clinically important changes in vital signs associated with Lexapro treatment. In addition, a comparison of supine and standing vital sign measures in subjects receiving Lexapro indicated that Lexapro treatment is not associated with orthostatic changes. **Weight Changes** Patients treated with Lexapro in controlled trials did not differ from placebo-treated patients with regard to clinically important change in body weight. **Laboratory Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables, and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Lexapro treatment. **ECG Changes** Electrocardiograms from Lexapro (N=625), racemic citalopram (N=351), and placebo (N=527) groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed (1) a decrease in heart rate of 2.2 bpm for Lexapro and 2.7 bpm for racemic citalopram, compared to an increase of 0.3 bpm for placebo and (2) an increase in QTc interval of 3.9 msec for Lexapro and 3.7 msec for racemic citalopram, compared to 0.5 msec for placebo. Neither Lexapro nor racemic citalopram were associated with the development of clinically significant ECG abnormalities. **Other Events Observed During the Premarketing Evaluation of Lexapro** Following is a list of WHO terms that reflect treatment-emergent adverse events, as defined in the introduction to the **ADVERSE REACTIONS** section, reported by the 1428 patients treated with Lexapro for periods of up to one year in double-blind or open-label clinical trials during its premarketing evaluation. All reported events are included except those already listed in **Tables 2 & 3**, those occurring in only one patient, event terms that are so general as to be uninformative, and those that are unlikely to be drug related. It is important to emphasize that, although the events reported occurred during treatment with Lexapro, they were not necessarily caused by it. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in less than 1/100 patients but at least 1/1000 patients. Cardiovascular - *Frequent:* palpitation, hypertension. *Infrequent:* bradycardia, tachycardia, ECG abnormal, flushing, varicose vein. Central and Peripheral Nervous System Disorders - *Frequent:* light-headed feeling, migraine. *Infrequent:* tremor, vertigo, restless legs, shaking, twitching, dysequilibrium, tics, carpal tunnel syndrome, muscle contractions involuntary, sluggishness, coordination abnormal, faintness, hyperreflexia, muscular tone increased. Gastrointestinal Disorders - *Frequent:* heartburn, abdominal cramp, gastroenteritis. *Infrequent:* gastroesophageal reflux, bloating, abdominal discomfort, dyspepsia, increased stool frequency, belching, gastritis, hemorrhoids, gagging, polyposis gastric, swallowing difficult. General - *Frequent:* allergy, pain in limb, fever, hot flushes, chest pain. *Infrequent:* edema of extremities, chills, tightness of chest, leg pain, asthenia, syncope, malaise, anaphylaxis, fall. Hemic and Lymphatic Disorders - *Infrequent:* bruise, anemia, nosebleed, hematoma, lymphadenopathy cervical. Metabolic and Nutritional Disorders - *Frequent:* increased weight. *Infrequent:* decreased weight, hyperglycemia, thirst, bilirubin increased, hepatic enzymes increased, gout, hypercholesterolemia. Musculoskeletal System Disorders - *Frequent:* arthralgia, myalgia. *Infrequent:* jaw stiffness, muscle cramp, muscle stiffness, arthritis, muscle weakness, back discomfort, arthropathy, jaw pain, joint stiffness. Psychiatric Disorders - *Frequent:* appetite increased, lethargy, irritability, concentration impaired. *Infrequent:* jitteriness, panic reaction, agitation, apathy, forgetfulness, depression aggravated, nervousness, restlessness aggravated, suicide attempt, amnesia, anxiety attack, bruxism, carbohydrate craving, confusion, depersonalization, disorientation, emotional lability, feeling unreal, tremulousness nervous, crying abnormal, depression, excitability, auditory hallucination, suicidal tendency. Reproductive Disorders/Female* - *Frequent:* menstrual cramps, menstrual disorder. *Infrequent:* menorrhagia, breast neoplasm, pelvic inflammation, premenstrual syndrome, spotting between menses. *% based on female subjects only: N=905 Respiratory System Disorders - *Frequent:* bronchitis, sinus congestion, coughing, nasal congestion, sinus headache. *Infrequent:* asthma, breath shortness, laryngitis, pneumonia, tracheitis. Skin and Appendages Disorders - *Frequent:* rash. *Infrequent:* pruritus, acne, alopecia, eczema, dermatitis, dry skin, folliculitis, lipoma, furunculosis, dry lips, skin nodule. Special Senses - *Frequent:* vision blurred, tinnitus. *Infrequent:* taste alteration, earache, conjunctivitis, vision abnormal, dry eyes, eye irritation, visual disturbance, eye infection, pupils dilated, metallic taste. Urinary System Disorders - *Frequent:* urinary frequency, urinary tract infection. *Infrequent:* urinary urgency, kidney stone, dysuria, blood in urine. **Events Reported Subsequent to the Marketing of Escitalopram** - Although no causal relationship to escitalopram treatment has been found, the following adverse events have been reported to have occurred in patients and to be temporally associated with escitalopram treatment during postmarketing spontaneous and clinical trial experience and were not observed during the premarketing evaluation of escitalopram: Blood and Lymphatic System Disorders: hemolytic anemia, leukopenia, thrombocytopenia. Cardiac Disorders: atrial fibrillation, cardiac failure, myocardial infarction, torsade de pointes, ventricular arrhythmia, ventricular tachycardia. Endocrine Disorders: diabetes mellitus, hyperprolactinemia, SIADH. Eye Disorders: diplopia, glaucoma. Gastrointestinal Disorders: gastrointestinal hemorrhage, pancreatitis, rectal hemorrhage. General Disorders and Administration Site Conditions: abnormal gait. Hepatobiliary Disorders: fulminant hepatitis, hepatic failure, hepatic necrosis, hepatitis. Immune System Disorders: allergic reaction. Investigations: electrocardiogram QT prolongation, INR increased, prothrombin decreased. Metabolism and Nutrition Disorders: hypoglycemia, hypokalemia. Musculoskeletal and Connective Tissue Disorders: rhabdomyolysis. Nervous System Disorders: akathisia, choreoathetosis, dysarthria, dyskinesia, dystonia, extrapyramidal disorders, grand mal seizures (or convulsions), hypoaesthesia, myoclonus, neuroleptic malignant syndrome, nystagmus, seizures, serotonin syndrome, tardive dyskinesia. Pregnancy, Puerperium and Perinatal Conditions: spontaneous abortion. Psychiatric Disorders: acute psychosis, aggression, anger, delirium, delusion, nightmare, paranoia, visual hallucinations. Renal and Urinary Disorders: acute renal failure. Reproductive System and Breast Disorders: priapism. Respiratory, Thoracic and Mediastinal Disorders: pulmonary embolism. Skin and Subcutaneous Tissue Disorders: angioedema, ecchymosis, erythema multiforme, photosensitivity reaction, Stevens Johnson Syndrome, toxic epidermal necrolysis, urticaria. Vascular Disorders: deep vein thrombosis, hypotension, orthostatic hypotension, phlebitis, thrombosis.

Self-Destructive Acts Linked To Limited View of Future

Glitches in the brain's ability to see the future may contribute to a variety of self-destructive tendencies including addiction, youth crimes, and risky behaviors.

BY JUN YAN

An excessively shortened view of the future may explain substance abuse and dependence, risk-taking behaviors, youth crimes, and a wide variety of self-destructive behaviors, according to Warren Bickel, Ph.D., and other like-minded researchers in a unique multidisciplinary area.

This research combines the theories, tools, and technologies used in neuroscience, behavioral psychology, and economics to seek the common processes behind these seemingly unrelated human phenomena.

Bickel, a professor of psychiatry, the Wilbur D. Mills Chair of Alcohol Abuse and Drug Prevention, and director of the Center for Addiction Research at Psychiatric Research Institute at the University of Arkansas for Medical Sciences, uses the term "tyranny of small decisions" to describe how a person "can be victimized by the narrowness of the temporal context" in his or her decision-making process. Various self-destructive behaviors, he told *Psychiatric News*, are largely the result of a person's inability to think far into the future.

This inability is directly related to addiction. A hallmark of dependence and abuse is to seek an immediate high despite repeated, clear negative consequences and a person's desire to quit.

"Why do addicts make poor decisions when they clearly face bad consequences that would cost themselves severely?" Bickel attributed the self-destructive tendency, at least in part, to these individuals' inability to evaluate rationally the trade-off between instant gratification and future consequences.

Using Economics to Measure Behavior

Borrowed from behavioral economics, an important tool Bickel uses in his addiction research is temporal discounting, which measures how a person weighs the relative values of immediate and delayed rewards. The test subject is asked to choose between two hypothetical rewards: either receiving $1,000 in a month or a smaller amount now. If the current prize is also $1,000, an average person would choose the prize now. As the current reward is reduced to $950, $900, $850, and so on, while the future prize is held constant, a person will eventually switch from the smaller current prize to the larger future prize. The trade-off amount is a discount against the future constant. The larger the discount due to delay would indicate a greater unwillingness to wait and can be used to measure how impulsive a person is.

Temporal discounting ties addiction to abnormally high impulsivity and a severely narrowed view of the future, Bickel said. The link has been demonstrated in human as well as animal research, which shows that chronic self-administration of certain substances such as amphetamine can alter the extent of discounting. In a review published in the September 2007 *Drug and Alcohol Dependence (Supplement)*, Bickel and colleagues noted that previous studies have found that people with opioid and cocaine dependence, drinking and gambling problems, and a smoking habit discount the future significantly more than nonaddicted controls. In a study they published in the July 2008 *Drug and Alcohol Dependence*, cigarette smokers discounted the hypothetical future, as well as past monetary gains significantly more than nonsmoking controls.

Tug-of-War in Near-Sighted Brain

To understand the physiology of behavioral patterns, scientists use neuroeconomics to uncover the mechanisms underlying how people perceive the cost of their choices and make trade-off decisions in the context of time. A number of new studies have found evidence to support the connection between addiction and impulsivity.

Two systems in the brain compete in the temporal discounting process: the impulsive system that wants the reward immediately and the executive system that evaluates rationally the temporal consequences and restrains the urge of instant gratification, Bickel explained.

Credit: The Psychiatric Institute, UAMS

Warren Bickel, Ph.D., a professor of psychiatry and chair of Alcohol Abuse and Drug Prevention at the University of Arkansas for Medical Sciences, uses tools in neuroimaging and economics to uncover the roots of self-destructive behaviors.

In a study published in the October 15, 2004, *Science*, Samuel McClure and colleagues used functional magnetic resonance imaging scans to demonstrate the two systems involved in the time-discounting decisions. Parts of the limbic system associated with the midbrain dopamine system are activated by immediate rewards. This is consistent with knowledge about dopamine's role in addiction and the overall reward system. However, choosing a delayed reward required greater activities in the lateral prefrontal cortex and posterior parietal cortex, McClure found.

Bickel calls the theory of two systems the "competing neurobehavioral decision systems hypothesis." Impulses are primarily driven by activities in the limbic region, ventral striatum, and nucleus accumbens. The executive system, in contrast, is known to be carried out in the prefrontal cortex and dorsolateral prefrontal cortex, which are central to learning, planning, regulating impulses, and making rational decisions. In other words, the executive system regulates the urges for immediate reward and considers whether a delayed reward is more valuable.

In individuals with addiction, this balance is tipped in the direction of the impulsive system, and a person's reason and future outlook are severely weakened.

Nature Versus Environment

Are individuals with addiction born with a vulnerable executive neurocircuitry that make them more susceptible to substance abuse? Or is substance abuse responsible for damaged brain functions? There is evidence to support both scenarios, and the interaction between innate predisposition and the environment is a plausible explanation.

A recent study, published in the December 31, 2008, *Journal of Neuroscience*, provides a glimpse of one biochemical pathway for risk-taking behavior and addiction. David Zald, Ph.D., and colleagues at Vanderbilt University found that these individuals have lower density of dopamine autoreceptors in the brain than control individuals. These autoreceptors normally "wipe up" the amount of free dopamine after it is initially released. With fewer autoreceptors, these people are more likely to have a greater "rush" after a dopamine-triggering stimulus, leading to greater temptation for seeking the next reward.

In addition, neuroimaging research in recent years undertaken by Nora Volkow, M.D., director of the National Institute on Drug Abuse, and other scientists suggests that long-term abuse of substances is associated with normal neurocircuits being compromised and the cognitive and executive functions being damaged (*Psychiatric News*, July 6, 2007).

The chicken-and-egg question is less important than what can be done to prevent or reverse the nature-environment feedback loop that pushes people into a downward spiral, according to Bickel. He suggested that public policies to promote a long-term view may help children and adolescents to extend their temporal horizon and reduce the discounting of future reward.

Training the Brain to See Farther

Brain-imaging research has shown that adolescence is a period of incomplete development of the executive function accompanied by peak activities in the nucleus accumbens, the brain's center for reward and pleasure. It is no coincidence that the majority of alcohol and substance use as well as smoking begin in teenage years and peak during adolescence and young adulthood, Bickel said. A similar time profile is seen in crime rates and impulsive, risk-taking behaviors such as unsafe sexual practices. "Risk is a biologically normal event among adolescents," said Bickel, because they have a "shortened temporal view of life events and choices."

"It may be important to train executive and cognitive function in children or strengthen their capacity in this area," Bickel said. Early training for children and adolescents specifically to extend their long-term outlook from a young age could make a big difference in preventing addiction and other risky, self-destructive behaviors, he suggested.

Fortifying executive function and restraining impulsivity are possible with active interventions. "The prefrontal cortex is very plastic," Bickel said. It is possible to escape "the tyranny of small decisions" even for victims of addiction whose brain functions have already been eroded, he believes, pointing to the effectiveness of contingency management of addiction and replacement medications in tempering a hyperactive impulsivity and in treating addiction. Future medications may boost a person's hypoactive executive functions.

There is ongoing research into whether cognitive and executive functions can be restored in those with brain damage from traumatic brain injuries or schizophrenia. It remains to be seen whether neurological deficits related to substance use can be similarly reversed. ■

Test Your Knowledge!

FOCUS AN INTERACTIVE SELF-ASSESSMENT SESSION LIVE!

Three Focus Live sessions will be held at APA's 2009 annual meeting during which an audience-response system (ARS) will be used to allow participants to test their knowledge. The 90-minute interactive sessions will cover topics from APA's continuing medical education journal, *Focus: The Journal of Lifelong Learning in Psychiatry.*

During the sessions, experts will lead lively discussions based on multiple-choice questions that the audience answers using the ARS. The ARS instantly projects a histogram on a screen, allowing each participant to compare privately his or her responses with the responses of others in the audience, and offers a new and entertaining way to learn.

Sessions will be moderated by the editors of *Focus*, Deborah Hales, M.D., and Mark Rapaport, M.D., and held in the Moscone Center Gateway Ballroom. The schedule, topics, and presenters are as follows:

MAY 18

MONDAY

9 a.m.-10:30 a.m.
Geriatric Psychiatry
Barry Lebowitz, Ph.D.

11 a.m.-12:30 p.m.
PTSD and Disaster Psychiatry
Anand Pandya, M.D.

2 p.m.-3:30 p.m.
Panic and Social Anxiety Disorder
Mark Pollack, M.D.

BY JUN YAN

ADHD

• Medications used to treat attention-deficit/hyperactivity disorder (ADHD) are associated with a small increase in the risk of psychosis or mania, according to an analysis conducted by Food and Drug Administration (FDA) reviewers and published in the February *Pediatrics*.

From 2005 to 2006, the FDA conducted a comprehensive review of data from 49 randomized, controlled clinical trials that were submitted by manufacturers. The agency reviewers compared the rates of psychiatric adverse events between pediatric ADHD patients who took active drugs and patients who took placebo. The drugs included in the evaluation were various formulations of methylphenidate and dexmethylphenidate, atomoxetine, and modafinil; modafinil was studied, although it is not approved to treat ADHD.

After pooling these trials, the reviewers identified 11 events of psychosis or mania in patients exposed to active drugs during the double-blind treatment periods, compared with no such events in subjects exposed to placebo. The average rate of the adverse event was 1.48 per 100 persons in a year. Spontaneous postmarketing safety surveillance identified 865 case reports of psychosis, mania, or similar events. The most common symptoms of hallucinations related to ADHD drugs in children were "visual and/or tactile sensations of insects, snakes, or worms."

Mosholder AD, et al. Hallucinations and Other Psychotic Symptoms Associated With the Use of Attention-Deficit/Hyperactivity Disorder Drugs in Children. **Pediatrics.** ***2009; 123(2):611-6.***

• Guanfacine extended release was more effective than placebo in treating children and adolescents with ADHD in a randomized, double-blind, controlled trial. A total of 324 ADHD patients aged 6 to 17 were randomly assigned to receive placebo or guanfacine, 1 mg, 2 mg, 3 mg, or 4 mg a day for nine weeks. Patients on active guanfacine saw significant reduction from baseline in ADHD symptoms, which was measured by the ADHD Rating Scale-IV, in all four dose groups. The reduction in each of the guanfacine groups was significantly greater than in the placebo group. Notably, the weight-adjusted dosage correlated with response.

Because guanfacine is an α_{2A} receptor agonist, lowered blood pressure was an expected side effect. The mean systolic blood pressure was reduced by 7.39 mmHg from baseline and the mean diastolic blood pressure by 5.43 mmHg in the guanfacine 4 mg group at weeks 4 to 6. The mean heart rate was reduced by 9.51 beats a minute in the same dose group. The most common adverse effects were drowsiness and sleepiness, headache, fatigue, dizziness, irritability, upper abdominal pain, and nausea.

The study was funded by Shire. Guanfacine extended release has not been officially approved by the FDA to treat ADHD, although the agency issued an approvable letter to Shire in 2007.

Sallee FR, et al. Guanfacine Extended Release in Children and Adolescents With Attention-Deficit/Hyperactivity Disorder: A Placebo-Controlled Trial. **J Am Acad Child Adolesc Psychiatry.** ***2009; 48(2):155-65.***

Dementia

• Known risk factors of Alzheimer's disease (AD) and dementia, such as impaired cognitive function, older age, and carrying the apolipoprotein E (APOE) 4 allele, were found to be associated with particular characteristics on a positron emission tomography (PET) scan of the brain using a radioactive labeling agent known as FDDNP. This agent, which contains a radioactive fluoride isotope, binds to amyloid plaques and tau protein tangles, which accumulate in the brain of patients who develop Alzheimer's.

In this study, 76 healthy volunteers who were aged 47 to 87 and did not have dementia, underwent PET brain scans after receiving intravenous injections of FDDNP. About half of the subjects had mild cognitive impairment, and half were APOE-4 allele carriers. The researchers saw increased binding by FDDNP in the various brain regions of subjects who had cognitive impairment, who were older, and who carried APOE-4.

The study was conducted at the University of California at Los Angeles, which holds the patent on FDDNP. It was funded by grants from the National Institutes of Health, the Department of Energy, the Rotary CART Fund, and several other foundations. Siemens has licensed the molecule and has filed an investigational new drug application with the FDA (*Psychiatric News*, October 5, 2007).

Small GW, et al. Influence of Cognitive Status, Age, and APOE-4 Genetic Risk on Brain FDDNP Positron Emission Tomography Imaging in Persons Without Dementia. **Arch Gen Psychiatry.** ***2009; 66(1):81-7.***

• Galantamine showed efficacy in improving cognitive function in elderly patients with severe Alzheimer's, but did not significantly improve other aspects of overall activities of daily living. In a randomized, double-blind, placebo-controlled study, 207 patients with severe Alzheimer's were given galantamine, and 200 took placebo. Galantamine is approved by the FDA for treating mild and moderate Alzheimer's.

After 26 weeks, the patients' cognitive function, measured by the Severe Impairment Battery scores, improved in the galantamine group, which was significantly different from the deterioration observed in the placebo group. However, the change in mean scores on the minimum data set–activity of daily living scale did not significantly differ between the two groups. The adverse events were similar between the galantamine and placebo groups.

The patients in this study had a mean age of 84 and resided in nursing homes. The study was funded by Janssen-Cilag, the Belgium-based branch of Johnson and Johnson.

Burns A, et al. Safety and Efficacy of Galantamine (Reminyl) in Severe Alzheimer's Disease (The SERAD Study): A Randomized, Placebo-Controlled, Double-Blind Trial. **Lancet Neurol.** ***2009; 8(1):39-47.***

Suicide

• In a meta-analysis, three authors from the World Health Organization's Collaborating Centre for Research and the University of Verona, Italy, found that exposure to selective serotonin reuptake inhibitors (SSRIs) was associated with a decreased likelihood of attempted and completed suicide in adults and the elderly compared with no SSRI exposure. However, SSRI exposure was associated with an increased likelihood of attempted and completed suicide in younger people.

The data were pooled from eight observational cohort or case-control studies that reported suicides and previous SSRI exposure in patients with a diagnosis of major depression who attempted or completed suicide. Five of the studies included children and adolescents aged 2 to 18, seven studies included adults aged 18 to 64 years, and two of the studies included adults 65 years or older. The odds ratio for completed and attempted suicide (not including suicidal thoughts or preparatory acts for suicide) associated with SSRI exposure was 1.92 in the age 6 to 18 group, 0.57 in the adult group, and 0.46 in the elderly group. All three risk ratios were statistically significant.

The study authors and an accompanying editorial both noted that the analysis of studies with naturalistic design has numerous inherent limitations for drawing conclusions. For example, the study did not have enough data to adjust for the severity of depression in adolescents receiving SSRIs, which might be collectively more severe than adults being prescribed SSRIs. The editorial urged that randomized, controlled trials be conducted to answer many remaining questions about the true risk of SSRIs on adolescent suicide.

Barbui C, et al. Selective Serotonin Reuptake Inhibitors and Risk of Suicide: A Systematic Review of Observational Studies. **CMAJ.** ***2009; 180(3):291-7.***

Gibbons R and Mann JJ. Proper Studies of Selective Serotonin Reuptake Inhibitors Are Needed for Youth With Depression. **CMAJ.** ***2009; 180(3):270-1.***

Anxiety Disorders

• A randomized, double-blind, placebo-controlled trial showed that older patients suffering from generalized anxiety disorder (GAD) can obtain some benefits from escitalopram, but the effect is fairly modest compared with placebo. Among the 177 patients with GAD and aged 60 or older, 82 were given 10 mg to 20 mg of escitalopram a day and 92 took placebo. After 12 weeks of treatment, the escitalopram group had a statistically significantly higher cumulative response rate than the placebo group (69 percent versus 51 percent, respectively). The anxiety symptoms and self-reported role functioning were also significantly improved in the escitalopram group compared with the placebo group. However, a more conservative intention-to-treat analysis on the response rates did not reach statistical significance between the groups.

Escitalopram was relatively well tolerated in these older adults. The dropout rate due to adverse effects of the drug was 3 percent. The most common adverse effects reported by patients were fatigue or somnolence, sleep disturbance, and urinary symptoms, which, the authors noted, were different from the risk profiles reported by younger patients or older patients with major depressive disorder taking escitalopram.

The study was funded by grants from the National Institutes of Health, Center for Mental Health Services Research, the Advanced Center for Interventions and Services Research in Late-Life Mood Disorders, the John A. Hartford Center of Excellence in Geriatric Psychiatry, and the University of Pittsburgh Medical Center endowment in geriatric psychiatry. The maker of escitalopram, Forest Laboratories, provided free medication for the study.

Lenze EJ, et al. Escitalopram for Older Adults With Generalized Anxiety Disorder: A Randomized Controlled Trial. **JAMA.** ***2009; 301(3):295-303.***

Personality Disorders

• The effectiveness of 12-week olanzapine treatment did not differ significantly from that of placebo for patients with borderline personality disorder in a randomized, double-blind, placebo-controlled clinical trial funded by Eli Lilly. A total of 314 subjects with borderline personality disorder were randomly assigned to take either olanzapine or placebo. Patients' symptoms, measured by the Zanarini Rating Scale for Borderline Personality Disorder, improved substantially from baseline in both the olanzapine and the placebo group, but the difference was not statistically significant. The mean dose of olanzapine in the treatment period was 7 mg a day.

The olanzapine group had significantly greater average weight gain and a higher rate of abnormally high prolactin levels than the placebo group.

Schulz SC, et al. Olanzapine for the Treatment of Borderline Personality Disorder: Variable Dose 12-Week Randomized Double-Blind Placebo-Controlled Study. **Br J Psych.** ***2008; 193(6):485-92.*** ■

Applications Invited For Spurlock Fellowship

APA and the American Psychiatric Foundation invite nominations for the Jeanne Spurlock Congressional Fellowship.

This fellowship provides all psychiatry residents, fellows, and early career psychiatrists a unique opportunity to work in a congressional office on federal health policy, particularly policy related to child and/or minority issues. This fellowship was established in honor of the late Jeanne Spurlock, M.D., who was deputy medical director of APA's Office of Minority/National Affairs and an advocate for child and minority issues.

The recipient will serve a 10-month fellowship on Capitol Hill in Washington, D.C., starting January 2, 2010. The fellow will be introduced to the structure and development of federal and congressional health policy, with a focus on mental health issues affecting minorities and underserved populations, including children.

Application information is available at <www.psych.org/Resources/OMNA/MFP/jeannespurlockmdcongressionalfellowship.aspx> or from Marilyn King by phone at (703) 907-8653 or e-mail at mking@psych.org. ■

Narratives, Normality, and Diagnostic Neutrality

BY RONALD PIES, M.D.

Let's say Mr. Jones, a 75-year-old retired teacher with no personal or family history of depression, comes to you with a classic picture of major depressive disorder. He tells you that his wife of 50 years died two months ago. Since then, he has experienced profound depression, a 15-pound weight loss, early-morning awakening, and inability to concentrate.

Shouldn't "common sense" tell you that Mr. Jones' depression was "triggered" by his wife's death and that it simply represents a "normal" and "proportionate" response to grievous loss? This, at any rate, is the core of a popular and superficially plausible thesis advanced by Professors Jerome Wakefield and Alan Horwitz.

But as Brandeis University biochemist Douglas Theobald, Ph.D., has observed, "common sense" tells us that the Earth is flat, the sun truly rises and sets, and the Earth is not spinning at more than 1,000 miles per hour. Medical science is not founded on "common sense," but on uncommon investigation: on randomized, controlled studies that try to rule out as many confounding variables as possible.

Psychiatric medicine, too, relies less on common sense than on what the French call *sense clinique*—that ineffable blend of knowledge, experience, and hard-won wisdom that comes from seeing hundreds of patients over the course of one's career. Your *sense clinique* is what leads you to respect Mr. Jones' narrative of bereavement, while also contemplating a medical workup to rule out a covert malignancy as another possible trigger for his depression.

Your clinical sense also tells you that myriad other biopsychosocial factors may be causally related to Mr. Jones' depressive symptoms. Making an early calculation that his depression is, or is not, proportionate to any one putative trigger represents clinical naivete and premature closure.

You may discover several months into psychotherapy that Mr. Jones was not grieving the death of his wife so much as castigating himself for an extramarital affair he had 20 years earlier. Similarly, in severely anxious or traumatized patients, facts may emerge that cast serious doubt on what the psychiatrist first assumed was the precipitant of the patient's acute illness.

It is the psychiatrist's job to maintain respectful and open-minded neutrality regarding the cause or causes of a patient's acute disturbance. As Otto Kernberg has pointed out, therapeutic neutrality is not disgruntled indifference to the patient's felt experience; rather, it refers to the therapist's position of "equidistance" from the powerful emotional forces clashing within the patient.

By analogy, diagnostic neutrality means maintaining a position of equidistance from the biological, psychological, social, and spiritual forces impinging on the patient. Diagnostic neutrality is akin to keeping a sailboat steady in the swirl of shifting cross-winds. Such neutrality is especially important early in the clinical encounter.

As more information emerges in the context of evaluation and treatment, the psychiatrist's *sense clinique* begins to winnow less likely causal factors in the patient's condition. Often, we never discover the ultimate cause, or trigger, of the patient's acute anxiety, depression, or psychosis. But with or without obvious cause, some forms of intense suffering and incapacity represent disease or disorder.

Furthermore, the possibility that bereavement-related major depressive symptoms might remit in a few weeks should not deter us from diagnosing a major depressive disorder, when full criteria for that disorder are met—nor should we be reluctant to provide professional care in such circumstances.

The inherent problem in positing a depressive trigger is that we humans are famous for constructing explanatory narratives, even when the facts of the situation are not clear. Indeed, in her book, *Narrative Gravity*, linguistics professor Rukmini Nair argues that human beings have a genetic drive to fabricate narratives that serve our emotional needs. Furthermore, Dr. A.M. Ergis and colleagues have demonstrated that memory in depressed patients shows a "recall bias" toward recollection of negatively toned material.

But if the foundational notion of a depressive trigger itself is dubious, then any calculation regarding the "proportionality" of the patient's supposed response is necessarily doubtful. Making such calculations is like trying to measure floor boards while standing atop a scaffold of toothpicks.

This certainly doesn't mean we should dismiss what our patients tell us when they try to explain "why" they are depressed or anxious. It does mean that we must use our *sense clinique* in weighing such reports as a part of all the available data. Finally, we should base our judgments regarding disordered mood on observations of the patient's degree and duration of suffering and incapacity—not on calculations of "proportionality" derived from facile causal narratives. ■

Ronald Pies, M.D., is a professor of psychiatry at SUNY Upstate Medical University and a clinical professor of psychiatry at Tufts University School of Medicine. (References used by the author in preparing this column are available via e-mail to ronpies@massmed.org.)

Is There Duty to Report Impaired Drivers?

Q. I'm an early career psychiatrist. I recently read about a physician's being held liable for the harm his patient, who was an impaired driver, caused to a third party. Should I make it a practice to report patients in treatment for substance or alcohol abuse or who are on certain medications? What about elderly drivers?

A. As a general rule, physicians are not held liable for the actions of their patients except in cases of serious, imminent harm to identifiable victims, in which case most states require the physician to take some form of action to warn or otherwise protect the victims. However, with regard to patients who are or may be impaired drivers, the obligation to take action becomes less clear-cut.

In one specific instance, the duty to report is clear. If you see your obviously impaired patient drive away despite your best efforts to make other arrangements for leaving your office, then you may alert the authorities in the interest of public safety. Remember, of course, to disclose only the minimum information.

Most cases, however, are not as straightforward as the above; so the general advice, which is in keeping with risk management's primary and secondary goals of providing appropriate patient care and minimizing liability, is as follows:

C: Clinically address the underlying cause(s) of the impairment.
A: Advise/educate/warn the patient.
R: Report in accordance with your state law.

Unless your state mandates immediate reporting of a specific diagnosis, your first duty as the treating physician is to address any clinical reasons a patient might be impaired. For example, an elderly patient with vision or hearing loss may need referrals to see an appropriate specialist to possibly correct those problems. Furthermore, your clinical judgment may dictate changes in treatment approach, medications, dosages, or some combination thereof. If you have already made a report, you can subsequently continue with the process of addressing the patient's clinical needs.

Next, as an extension of the informed consent process, you are charged with advising, educating, and/or warning the patient regarding his or her impairment and documenting the same. Counseling the patient includes not only warnings about safety and your possible duty to report, but also information about adverse reactions to medication or combinations of medications.

Regardless of your state law, you may still be exposed to claims of breaches of confidentiality should you report a patient as an impaired driver. Therefore, you may need to seek additional guidance from your state medical association, your malpractice liability carrier, or personal counsel when deciding how to improve safety for patients and others and whether reporting is the best option for a given set of circumstances.

Visit the PRMS Booth at Annual Meeting

The Psychiatrists' Program (the Program) will be located at booth #1202 in the Exhibit Hall of the Moscone Center at APA's 2009 annual meeting in San Francisco. PRMS, the manager of the Program, will have risk managers and insurance underwriting specialists present to provide individualized insurance information and risk management advice for psychiatrists. Complimentary risk management articles and information about future seminars will also be available.

As a thank you, Program participants will receive a copy of "My Risk Management Plan," a workbook to help psychiatrists develop their own risk management plan. Participants will also receive a complimentary "For Participants Only" customer resource guide.

PRMS risk management staff will be presenting at the following sessions in the Moscone Center:

- **Malpractice Risks for Psychiatrists Basics and Beyond:** Saturday, May 16, 1 p.m. to 5 p.m., Room 309, Esplanade Level
- **Risk Management Issues in Psychiatric Practice:** Monday, May 18, 9 a.m. to 10:30 a.m., Room 125, Exhibit Level North
- **How to Launch a Successful Private Practice (Part I):** Wednesday, May 20, 9 a.m. to 10:30 a.m., Room 309, Esplanade Level

While at the meeting, be sure to check the meeting schedule for last-minute changes to times or locations.

This column is provided by Professional Risk Management Services, manager of the Psychiatrists' Program, for the benefit of APA members. More information about the Program is available by visiting <www.psychprogram.com>; calling (800) 245-3333, ext. 389; or sending an e-mail to TheProgram@prms.com. ■

Ferry Building, Fisherman's Wharf: Hot Spots, Old Favorites

Ready to embark on several first-rate adventures when you are in San Francisco? Then visit the Embarcadero, which includes the historic Ferry Building and picturesque Fisherman's Wharf.

BY JOAN AREHART-TREICHEL

To truly capture the ambience of San Francisco, you need to stroll along the Embarcadero—a thoroughfare lined with palms that fronts on San Francisco Bay.

The Embarcadero was built as an embankment. It derives from the Spanish word "embarcar," or "place to embark." Formerly it was flanked by an unsightly double-decked freeway. The freeway was damaged in an earthquake in 1989 and subsequently torn down, opening up sweeping views of the Bay and the city.

The Embarcadero begins on the east side of the city at the intersection of Second and King streets near AT&T Park, home of the San Francisco Giants, and travels north, passing under the Oakland Bay Bridge.

Along the Embarcadero are two of San Francisco's most colorful and visited venues—the Ferry Building, located on the Embarcadero at Market Street, and Fisherman's Wharf, located along the Embarcadero west of Pier 39.

Even back during the time of the California Gold Rush in the mid-19th century, the Embarcadero had a wooden ferry house on it. In 1898 the wooden house was replaced with the large steel-framed Ferry Building. It was so well built that it survived the formidable earthquake of 1906. The building was gloriously renovated a few years ago, and its former baggage area is now an enticing marketplace with eateries and shops that encourage visitors to tarry. Its produce shops have such fanciful names as Cowgirl Creamery's Artisan Cheese Shop, Hog Island Oyster Company, and the Kingdom of Herbs.

City Guides, a nonprofit volunteer organization, offers free walking tours of the Ferry Building. From the Ferry Building, you can also catch a ride to various parts of the East Bay or Marin County. Such rides provide spectacular, panoramic views of San Francisco and a chance for inhaling some tangy bay air.

Fisherman's Wharf, in contrast, offers boisterous crowds, street performers, a wax museum, a Ripley's Believe It or Not Museum, an aquarium, a fleet of historic sailing ships, a World War II submarine, and a vast collection of seafood restaurants and souvenir establishments. Barking sea lions add to the rumpus. "Fisherman's Wharf is great for a half-hour daytime stop for fresh sourdough, for which the wharf is famous; seafood; and souvenirs for your friends back home," one visitor reported. "I also loved riding on one of the charter sailboats that leave from the wharf."

Fisherman's Wharf got its start in 1853 thanks to a man named Henry Meiggs, according to the book *Crab Is King: The Colorful Story of Fisherman's Wharf in San Francisco*. Meiggs, the book states, was "a scheming, nefarious, unscrupulous businessman who got run out of town with a vengeful posse nipping at his heels." Fortunately he left his wharf behind. It eventually became a mooring for fishing boats—hence its eventual name, "Fisherman's Wharf." It also became a weekend promenade for sunbathers and swimmers who rented bathhouses. It had a museum in which an "educated" pig played cards, a saltwater tub bathing emporium, and a place where people could try to climb a greased pole and claim a $5 gold piece on top.

The wharf's excesses did not cease with the end of the 19th century. In 1963 one wharf entrepreneur taught penguins to skateboard. Today the wharf's attractions are perhaps more conventional than skateboarding penguins, but nonetheless fun to visit.

In spite of its flamboyance, or perhaps because of it, Fisherman's Wharf has been ranked in some international surveys as the number-one tourist destination in San Francisco, even beating San Francisco's beloved Chinatown and the world-famous Golden Gate Bridge.

Another interesting nearby place to visit is the Embarcadero Center, which features more than 100 retail shops and restaurants, a five-screen cinema, and services to meet visitors' every need.

Information about the Ferry Building and its marketplace is posted at <www.ferrybuildingmarketplace.com>. Information about Fisherman's Wharf is posted at <www.fishermanswharf.org>. ■

Credit: SFCVB photo by Jerry Lee Hayes

In spite of its flamboyance, or perhaps because of it, Fisherman's Wharf has been ranked in some surveys as the number-one tourist destination in San Francisco. It offers barking sea lions, street performers, an aquarium, historic sailing ships, and a World War II submarine, not to mention oodles of restaurants and souvenir shops and a glorious view of the Golden Gate Bridge and Alcatraz.

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REGISTER NOW FOR THE MEETING!

There are three easy ways to register for APA's 2009 annual meeting and courses, and you can save on fees by registering before **April 10.** Forms to register by mail or fax can be printed out from the annual meeting booklet posted at <www.psych.org/MainMenu/EducationCareerDevelopment/Meetings/AdvanceRegistrationInformation.aspx>.

REGISTER ONLINE

Click on the 2009 annual meeting logo on APA's homepage at <www.psych.org> or go directly to <www.psych.org/MainMenu/EducationCareerDevelopment/Meetings.aspx> and then look for "Meeting Registration." "Housing Registration" can also be found here.

FAX REGISTRATION FORM

Fax your completed registration form with credit card information to (703) 907-1097.

MAIL REGISTRATION FORM

Mail your completed registration form and payment by credit card or check made payable to APA to Registration, APA, Suite 1825, Arlington, Va. 22209-3901.

After April 10, you may register online only (on-site fees apply), not by mail or fax.

News From APIRE's Practice Research Network

Come Say "Hello" While at APA's 2009 Annual Meeting!

The Practice Research Network (PRN) of the American Psychiatric Institute for Research and Education is pleased to announce the appointment of Eve Mościcki, M.D., as its new director. After 24 years at the National Institute of Mental Health, Dr. Mościcki joins the PRN at an opportune time. Her interest in the epidemiology of suicide, prevention science, child and adolescent psychopathology, and cross-cultural issues in mental health dovetail nicely with current and future PRN research initiatives outlined below.

Please take a moment during the annual meeting to stop by the PRN booth in the APA Resource Center to welcome Dr. Mościcki and learn more about the network's projects.

- ***Mental Health U.S. 2008:*** This upcoming publication will include a chapter on mental health practitioners and trainees of compiled data from all professional mental health organizations.
- **Walter Reed Army Institute for Research Routine Army Behavioral Health Treatment Study:** This study will lay the groundwork for future research on clinical care by testing methodology used to regularly collect basic clinical and practice-level data in Army behavioral health treatment settings.
- **PTSD: A Comprehensive Approach to Disseminate Evidence-Based Care:** This study will identify and disseminate key evidence-based recommendations to support clinical decision making in the assessment, diagnosis, and treatment of PTSD in military mental health settings.
- **Medicare and Medicaid Psychopharmacologic Treatment Access and Continuity Studies:** These studies are examining the scope and consequences of medication-access problems among Medicaid and Medicare psychiatric patients. Data from these studies are being used by APA and other advocacy groups to help improve Medicare and Medicaid prescription drug policies.
- **National Depression Management Leadership Initiative (NDMLI):** Two new projects were developed in collaboration with the AAFP and ACP as a follow-up to the successful NDMLI. The Sustainability and Spread Follow-Up Study examined the sustainability and spread of key elements of change introduced during the NDMLI following the conclusion of the project in 2006. The Shared Care Initiative will study the effect of systematic use of self-rated assessments on communication between primary care pysicians, psychiatrists, and other mental health providers and on outcomes for patients with depression. This study also aims to promote collaborative education of primary care physicians and psychiatrists regarding the recognition and appropriate management of bipolar and anxiety disorders.

More information on the PRN is available at <www.psych.org/MainMenu/Research/PracticeResearchNetworkandHealthServicesResearch.aspx>.

Antipsychotics

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careful monitoring of patients.

"The study basically provides additional information to our understanding of something we have known for a long time, which is that there is a very low frequency, but still an increased rate, of deaths from sudden cardiac death," said Jeffrey Lieberman, M.D., chair of APA's Council on Research, in an interview. "The study also tells us that there is no safety advantage to second-generation drugs. So what it means is that anyone who is treated needs to be evaluated and monitored for any potential effects the drugs could have on their cardiac function. Our practice guidelines already call for a thorough medical, including cardiac, history and for an annual physical exam as part of a patient's general health."

Lieberman is chair of the Department of Psychiatry at the College of Physicians and Surgeons at Columbia University and director of the New York State Psychiatric Institute.

An APA statement by the Council on Research about the study and its implications for clinicians treating patients with antipsychotic medication is posted on APA's Web site at <www.psych.org/MainMenu/Newsroom/APAMemberDBSAResources/ResearchRecommendations.aspx>.

The statement outlines the methods and results of the *NEJM* study as well as some methodological concerns.

"[C]linicians should continue to observe extant practice guidelines for the workup and management of psychotic patients," the statement reads. "With regard to cardiac safety, these include obtaining a medical and medication history, a thorough physical exam, vital signs, and routine laboratory tests."

The higher rates of early death, metabolic syndrome, and cardiovascular illness among people with serious mental illness are believed to be multifactorial, including socioeconomic status and lifestyle choices involving diet, smoking, and exercise. Antipsychotic drugs, however, are also suspected to contribute to the mix; antipsychotics are believed to block potassium electrical currents in the heart, which may lead to QT-prolongation and the fatal arrhythmia known as torsades de pointes (TdP). The *NEJM* study appears to bolster the belief that the drugs themselves may be contributing to early risk for death.

But at least one prominent researcher believes that interpretation obscures a more obvious issue confronting clinicians treating patients with severe mental illness: the higher mortality associated with coronary heart disease and the established sources of modifiable risk including smoking, obesity, dislipidemia, hyperglycemia, and hypertension.

"These factors are more than sufficient to explain excess deaths in this population without invoking a drug effect on cardiac conduction to explain the mortality," said John Newcomer, M.D., a professor of psychiatry at Washington University School of Medicine in St. Louis, in an interview. Newcomer's research has focused on general medical health—especially cardiometabolic health—and medical monitoring of patients with serious mental illness.

"The only thing we can be sure of here is that patients die early, and most patients are treated—but whether and how the treatment plays a role is uncertain," Newcomer told *Psychiatric News*. "What we do know is that coronary heart disease—with all its modifiable risk factors—is the leading cause of death among the general population and the leading cause of death among patients with serious mental illness."

No Drug Had Higher Risk Than Another

In the study researchers analyzed the adjusted incidence of sudden cardiac death in a retrospective cohort study of Medicaid enrollees in Tennessee. The primary analysis included 44,218 baseline users of a single first-generation antipsychotic, 46,089 users of a single second-generation antipsychotic, and 186,600 matched nonusers of antipsychotic drugs between January 1, 1990, and December 31, 2005.

The cohort included every eligible Medicaid enrollee with at least one qualifying day of use of antipsychotic drugs during the study period; the first day of follow-up was defined as the first qualifying day. The cohort also included two controls for each user of antipsychotic drugs, matched for age, sex, and first day of follow-up, and were randomly selected from qualifying nonusers of antipsychotic drugs on the first day of follow-up.

Follow-up extended from the first qualifying day until the end of the study period, the death of the person, the termination of Medicaid enrollment, or the date on which eligibility criteria for inclusion in the cohort were no longer met.

To try to account for the many confounding factors affecting the risk of sudden cardiac death, Ray and colleagues also performed several "residual confounding analyses" in which they matched users and nonusers according to a "propensity score"—that is, the predicted probability that a person would become a user of antipsychotic medications. This allowed the researchers to achieve cohorts for comparison that were at least roughly balanced with regard to patient characteristics, including psychiatric profile.

They found that current users of both typical and atypical antipsychotic drugs had significantly higher rates of sudden cardiac death than did nonusers of antipsychotic drugs. Of patients treated with any of the first- or second-generation antipsychotics for a total of 166,324 person years, there were 478 sudden cardiac deaths.

That translates to approximately 2.9 events per 1,000 patient years. By comparison, nonusers of antipsychotic medications experienced 1.4 sudden cardiac deaths per 1000 patient years.

There was no statistically significant difference in frequency of death between users of FGAs and SGAs: there were 255 sudden cardiac deaths among patients using FGAs and 223 among those using SGAs. Moreover, no drug had a significantly higher risk for sudden cardiac death than did another.

This risk was dose dependent in both medication classes, with doses equivalent to at least 300 mg of chlorpromazine a day posing the greatest risk, Lieberman explained.

Former users of antipsychotic drugs did not have a significant risk of cardiac death.

An editorial that accompanied the *NEJM* article argued that an electrocardiogram should be obtained for all patients prior to being prescribed antipsychotic drugs—a recommendation that has not generally been considered cost-effective and that could be impossible with some patients.

"This modest effort could enable each patient starting on a high-dose antipsychotic to be screened for existing or emergent prolongation of the QT interval," wrote Sebastian Schneeweiss, M.D., Sc.D., and Jerry Avorn, M.D., in the editorial.

But APA, in its guidance document on the findings, questions the wisdom of the recommendation: "Instituting a policy of routine serial measurement of the QTc interval in all patients initiating treatment with antipsychotic medication may be premature. While some antipsychotics are known to substantially prolong the QTc, others do so to only a modest degree. Furthermore, although prolongation of the QTc is the best available clinical surrogate for the development of TdP, it is an imperfect biomarker. The QTc generally has low specificity for predicting arrhythmias, and for some drugs a dissociation exists between QTc prolongation and TdP."

Teasing Out Effects of Variables Difficult

Ray and colleagues acknowledged in the *NEJM* study the difficulty of controlling for a large number of possibly confounding factors associated with antipsychotic use that may affect risk for cardiac death.

But they state that a "sensitivity analysis found that residual confounding by smoking had at most a minor effect on estimates of relative risk. Although unmeasured behavioral factors may influence the study findings, the absence of a significantly increased risk of sudden death among former users of antipsychotic drugs and the marked dose-response relationship are evidence of a drug effect per se."

Still, Newcomer countered that the prevalence of smoking—and other risk factors for cardiovascular disease—is so high in the population of patients with serious mental illness that the analysis may not be able to disentangle those effects from the effects of the drug alone.

He added, "Dose tends to be a proxy for severity of illness, on top of whatever else it may indicate. We know that patients who are sicker get higher doses and that they also tend to get poorer medical care with respect to primary and secondary prevention."

An abstract of "Atypical Antipsychotics and the Risk of Sudden Cardiac Death" is posted at <http://content.nejm.org/cgi/content/abstract/360/3/225>. ■

SCHIP

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requires parity coverage of psychiatric illness in employer-sponsored plans that offer mental health coverage.

Obama described the expansion of the program for the children of the working poor as the first step in his plan to overhaul the nation's health care system and expand access to insurance.

"Providing health care to more than 10 million children through the [State] Children's Health Insurance Program will serve as a down payment on my commitment to ensure that every American has access to quality, affordable health care," Obama said in a written statement.

Coverage Hard to Find

The impact of the change in SCHIP is significant because research has found that while low-income children have much higher rates of mental illness than those in higher-income families, only about 40 percent of states offer full coverage of necessary services for children with complex psychiatric illnesses. Up to 20 percent of children and young adults may have a psychiatric illness at any given time, according to the Department of Health and Human Services, which estimates that the number of affected youth is between 7.7 million and 12.8 million. The department also estimates that two-thirds of all youth with mental illness are untreated. These children are at higher risk to fail at school, have poor employment prospects, have contact with the juvenile justice system, and are more vulnerable to suicide, according to David Shern, Ph.D., president and CEO of Mental Health America.

"Mental health care is a critical component of the range of services that children need for healthy development," Shern said in a written statement.

Critics Blast Expansion

Opponents of the measure included former President George W. Bush, who twice vetoed nearly identical measures to expand SCHIP in 2007. Bush, like many other opponents, argued that the expansion would bring many privately insured children under the federal program, in part, because it provides federal matching funds for children from families whose income is up to 300 percent of the federal poverty level and are likely already insured. Some estimates have put the number of such children at about 2.4 million.

Many Republicans also complained that the measure expands coverage to include legal immigrant women who are pregnant and up to 600,000 children of legal immigrants. The previous law had set a five-year wait before children of legal immigrants could qualify for SCHIP coverage. Citizen children of illegal immigrants are eligible for SCHIP; however, illegal adult and child immigrants are eligible only for emergency care under Medicaid.

Democratic leaders countered that most Americans support SCHIP expansion and that it has become increasingly important as the economy worsens and more people lose their jobs.

Critics also objected to the expansion being funded by a 62-cent increase in the federal excise tax on cigarettes, which brings the total federal excise tax to $1.01 a pack. Opponents said cigarette taxes should go to smoking-cessation programs, not children's health care.

The federal funding for the program was set to run out on March 31, but the new law extends federal support for five years.

The SCHIP bill can be accessed by searching on HR 2 at <http://thomas.loc.gov>. ■

letters to the editor

Readers are invited to submit letters not more than 500 words long for possible publication. *Psychiatric News* reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be sent by mail to *Psychiatric News*, APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209 or by e-mail to pnews@psych.org. Clinical opinions are not peer reviewed and thus should be independently verified.

Study Methodology Questioned

The article "Some With Depression Able to Get Assisted Suicide" in the December 5, 2008, issue addresses a legitimate concern, but the study being reported on involved a questionable instrument, narrow interpretation, and biased language.

Physician aid-in-dying in Oregon, under the Death With Dignity Act (DWDA), has been closely observed in the decade of its operation. Fears that patients without insurance, with chronic disabilities, or with less education would be pressured into hastening death have proved groundless. The study in the *Psychiatric News* report used an instrument for assessing depression that was neither designed for, nor tested with, terminally ill patients. The conclusion focuses on three of 18 patients who tested as depressed, without distinguishing between clinical depression and competency to decide on end-of-life care. The authors wrote that because a sixth of the patients manifested signs or symptoms of depression, increased psychiatric vigilance was needed.

In Oregon in 2007, 85 prescriptions to hasten death were written by 45 physicians; of the 85 patients, 46 hastened death, 26 died of illness, and 13 were alive at the end of the year. These deaths are not classified as suicide—nor should they be. Assisted suicide is illegal in every state, including Oregon.

Unlike suicidal patients for whom preventive measures are indicated, these patients want to live but face certain death within months or weeks. DWDA provides control and reassurance with psychological benefits: half of those who receive a prescription do not use it.

Oregon has excellent end-of-life care, including high rates of hospice enrollment and death at home—90 percent for DWDA patients. They and their loved ones, realistically accepting the prognosis, take a measure of control to achieve a peaceful, dignified ending, which they urge we not confuse with "assisted suicide." The term "suicide" is inapt and pejorative, denigrating both patient and doctor who, in appropriate circumstance, use a law that is supported by a majority of Americans and several professional organizations: the American Public Health Association, the American Women's Medical Association, and the American Medical Student Association. Last November a DWDA in Washington state won handily in a referendum.

Over a decade, many observers have found that the Oregon law lessens depression by empowering patients and may prevent suicide in patients who have a terminal diagnosis with an unpredictable life expectancy. How else to explain the fact that 15 of 18 in the study sample did not test positive for depression, even though they faced imminent death? I submit that Oregon doctors, two of whom must certify the patient's terminal status and mental competence, are able to evaluate competence and the need for psychiatric consultation. Indeed, psy-

association news

Foundation

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African-American churches in Memphis and a largely white, military community in Columbia, S.C.

Harding said that he would like to see an increase in the number and percentage of members who contribute to the foundation. Only about 1.6 percent of APA members contributed funds in 2007, representing 6 percent of the foundation's revenues.

In a new area of development, the foundation has just signed an agreement with New York public broadcasting station WLIW to expand distribution of a television program on mental health through national syndication across the Public Broadcasting System. The foundation has been working closely with APA member Jeffrey Borenstein, M.D., to collaborate on the production of three episodes of the current "Healthy Minds" season, which Borenstein has hosted for the past two years.

"The agreement represents an innovative collaboration between the foundation, APA's Office of Communications and Public Affairs, and PBS," said Burke. APA leaders may be featured on the program, and the show's Web site will include links to the APA and foundation Web sites. Expansion to the full PBS network could expose the program to up to 39 million viewers.

The "Healthy Minds" collaboration is just one way that the foundation fills its mandate to advance public understanding that mental illnesses are real and can be effectively treated, said Burke. Broadcast of the three episodes was scheduled to begin in late February.

More information about the foundation, including how to make a donation, is posted at <www.psychfoundation.org>. ■

chiatric consultation would, in many cases, constitute a burden and an insult to dying patients and their families. Better studies are needed to weigh the psychiatric benefits along with risks in what is a major innovation in palliative care.

E. JAMES LIEBERMAN, M.D., M.P.H.
Potomac, Md.

Merger of Psychiatry, Neurology

In the November 21, 2008, issue Stuart Yudofsky, M.D., is quoted as proposing that psychiatry and neurology be "combined into one discipline" and stating that "[i]t would obviate the mind-body dualism that is the source of all stigma against mental illness, and against us [as psychiatrists], and it would reestablish psychiatry as a medical specialty." Do psychiatrists really believe this combination of historical amnesia and denial of their long record of human rights abuses?

From its origins more than 300 years ago until well into the 20th century, psychiatry and neurology made up a single discipline, called "mad-doctoring" and "neuropsychiatry." Consider the following:

• 1884: Theodor Meynert (1833-1892), neuropsychiatrist: "The reader will find no other definition of 'Psychiatry' in this book but the one given on the title page: Clinical Treatise on Diseases of the Forebrain. The historical term for psychiatry, i.e., 'treatment of the soul,' implies more than we can accomplish, and transcends the bounds of accurate scientific investigation."

• 1889: Carl Wernicke (1848-1905), neuropsychiatrist: "The medical treatment of mental patients begins with the infringement of their personal freedom."

• Emil Kraepelin (1856-1926), Adolf Meyer (1866-1950), and their colleagues were all neuropsychiatrists, sharing the assumption that mental diseases are brain diseases.

Inasmuch as psychiatry is taught in all medical schools as a medical specialty, Dr. Yudofsky's reference to "reestablish[ing] psychiatry as a medical specialty" seems redundant, to say the least.

Lastly, Dr. Yudofsky ascribes "the source of all stigma against mental illness" and psychiatrists to "the mind-body dualism." I disagree. It lies in the psychiatrist's fundamental legal-social mandate and practices—coercion and excuse making (civil commitment and the insanity defense).

THOMAS SZASZ, M.D.
Syracuse, N.Y.

Nominations Sought For APA's 2009 Achievement Awards

APA is seeking nominees for the 2009 Psychiatric Services Achievement Awards competition. Eligible for the awards are innovative programs that deliver services to people with mental illness or mental disabilities, that have overcome obstacles, and that can serve as models for other programs.

Two Gold Achievement Award winners will be chosen—an academically or institutionally sponsored program and a community-based program. The gold award winners will each receive $10,000. Second- and third-place winners will receive awards of $7,500 and $5,000, respectively.

Funds for the 2009 achievement awards program have been provided by Pfizer Inc. The application deadline is March 31.

More information about the awards and an application form can be accessed online at APA's Web site at <www.psych.org/achievementawards> or by phone at (703) 907-8592. ■

Residents Invited To Submit Papers For AGLP Award

The Association of Gay and Lesbian Psychiatrists (AGLP) is seeking outstanding papers on LGBT mental health written by psychiatry residents.

Papers can be original research papers, case series and detailed case reports, or review articles. The award includes $500; publication in the AGLP's official journal, the *Journal of Gay and Lesbian Mental Health*; and assistance with travel to the AGLP annual meeting to present the resident's work. This meeting is held concurrently with APA's annual meeting.

The deadline to be considered for a 2009 award is April 1. Coauthored papers are eligible as well, but the resident must be the first author.

The award is supported by a generous grant from the William A. Kerr Foundation.

Entries or questions should be sent to Roy Harker at rharker@aglp.org. The AGLP's Web site can be accessed at <www.aglp.org>.

Errata

• It was reported in the January 2 issue that Atul Gawande, M.D., would be the speaker at the Convocation of Fellows at APA's 2009 annual meeting in San Francisco. Unfortunately, he had to cancel the engagement. Another speaker has not yet been chosen. Updated information will appear in a future issue.

• In the January 16 issue a chart for the article "AAMC Issues Alert About Looming Physician Shortage" comparing future physician demand with physician supply was mislabeled. The chart should have reflected the report's findings that rising patient demand for physicians will outstrip the supply and result in a shortage of 124,400 physicians by 2025. ■

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Department of Veterans Affairs

VA SIERRA NEVADA HEALTH CARE SYSTEM
Reno, NV

PSYCHIATRISTS
PTSD Clinical Team and/or Mental Health Clinic
Reno and Minden

VA Sierra Nevada Health Care System (VASNHCS) in Reno, NV is seeking BC/BE psychiatrists, to join our mental health care team. For PTSD Clinical Team, experience working with combat veterans is highly desirable. Recruitment incentive may be available. Must be a U.S. citizen.

The VASNHCS provides primary and secondary care to a large geographical area that includes 20 counties in northern Nevada and northeastern California. Approx 120,000 veterans reside in this region. The Reno campus operates 64 hospital beds and 60 Community Living Center beds in addition to three CBOCs.

Academic affiliations for VASNHCS are the University Of Nevada School Of Medicine and the East Bay Surgical Program at the University of California, San Francisco. Approximately 45 medical, surgical, and psychiatry residents rotate annually through VASNHCS. Located on the eastern slope of the Sierra Nevada mountain range, Reno is minutes away from beautiful Lake Tahoe. Year round recreation, entertainment, arts, and culture abound. Reno also boasts an average of 260 days of sunshine per year. Best of all, Nevada has no state income tax!

A career with the VA offers stable employment and a future that is challenging, satisfying, and rewarding. Our excellent patient care environment includes learning and teaching opportunities, an advanced electronic medical records system, and competitive salaries. We have a generous comprehensive benefits package including education debt reduction program and liability protection.

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EOE

The Southeast Louisiana Veterans Health Care System in New Orleans, LA, is recruiting for the following positions:

PSYCHIATRIST
PTSD Outpatient Program

The incumbent will be assigned to the PTSD Outpatient Program. As a member of the interdisciplinary PTSD treatment team, the employee will provide assessment, medication management and therapeutic services for veterans with PTSD, post-deployment stress, and comorbid disorders.

PSYCHIATRIST

A general mental health position is available at our main clinic site in New Orleans, LA. Some duty time may be spent at our outlying clinics throughout Southeast Louisiana. This staff psychiatrist will provide assessment and medication management to veterans who are experiencing psychosis, anxiety, depression, behavioral problems, medically caused mental status change, and substance abuse issues.

The incumbent will be part of a multi-disciplinary team composed of psychiatrists, psychologists, psychiatric social workers, and nurse practitioners who work collaboratively to provide comprehensive, state-of-the-art outpatient mental health care. The psychiatrist will be a key participant in the implementation of the principles of Advanced Clinic Access in mental health.

Both positions require current, full and unrestricted license to practice medicine in a State, Territory, or Commonwealth of the United States, or in the District of Columbia. Must be proficient in written and spoken English, in accordance with 38 USC 7402(d).

There are also vacancies for psychiatrists in General Mental Health, full-time or part-time, at our Community Based Outpatient Clinics in:

- **Reserve, LA**
- **Hammond, LA**
- **Baton Rouge, LA**
- **Slidell, LA**

Applicants selected for these positions may be eligible to apply for financial reimbursement under the provisions of the Education Debt Reduction Program (EDRP). Recruitment and relocation incentives may also be available.

The Southeast Louisiana Veterans Health Care System is located in downtown New Orleans, a culturally rich city which has rebounded vibrantly since Hurricane Katrina in 2005. There is an abundance of available housing in both the city and surrounding suburbs.

SLVHCS is an AA/EO Employer and is strongly committed to policies of nondiscrimination and affirmative action in employment.

Applications can be mailed to:
Loren Wilkenfeld, PhD,
Chief, Mental Health Service (116),
Southeast Louisiana Veterans
Health Care System, P.O. Box 61011,
New Orleans, LA 70161-1011.

PSYCHIATRISTS

VA Boston Healthcare System

The VA Boston Healthcare System (VABHS) is recruiting academically oriented psychiatrists for a number of key positions in our rapidly growing Mental Health Service, which has strong and longstanding affiliations with Harvard Medical School (HMS) and Boston University School of Medicine (BUSM) and major campuses located in Boston (Jamaica Plain and West Roxbury) and Brockton. VABHS is a New England regional referral center for veterans' health care.

Emergency Services/Outpatient Psychiatrist – West Roxbury campus: VABHS is recruiting a board certified (board eligible if less than 2 years post-residency) psychiatrist with recent experience in an ED setting. Candidate will provide direct outpatient care at West Roxbury and services and clinical supervision of psychiatry residents on evenings and weekends in the Emergency Department. This individual would join an established, highly regarded Psychiatry Consultation-Liaison team that trains residents and fellows from both medical schools. Academic appointment is through HMS and/or BUSM, commensurate with qualifications.

Medical Director, Consultation-Liaison Psychiatry – West Roxbury campus: VABHS is recruiting a Medical Director for the Psychiatry Consultation-Liaison service, West Roxbury campus. We seek a board certified academic psychiatrist with at least 3 years' post-residency experience full time (or equivalent) on an academic C-L service, demonstrated excellence in clinical teaching, strong administrative skills, and the motivation and ability to lead this outstanding clinical teaching service. The C-L service receives more than 1200 consultation requests per year, and is an integral part of a vibrant and exceptional academic environment that features nationally recognized training and research programs, and several VA Clinical Centers of Excellence. Academic appointment is through HMS, commensurate with qualifications. The Medical Director oversees the VA-Brigham Women's Hospital Psychosomatic Fellowship and BUSM and HMS resident and medical student C-L rotations.

Geriatric Psychiatrist – Brockton/Boston campuses: VABHS is recruiting a geriatric psychiatrist to provide clinical services to outpatient geriatric mental health clinics and geriatric extended care bed programs, and to supervise advanced psychiatry residents rotating to these programs. We are seeking an academically oriented individual to participate in our vibrant research programs in geriatrics, neurology, and mental health. This individual would join an established multidisciplinary clinical team with an active and productive research program. Academic appointment is through BUSM and/or HMS, commensurate with qualifications.

Outpatient Psychiatrist/Substance Use Disorders - Jamaica Plain campus: VABHS is recruiting a board-certified (board eligible if less than 2 years post-residency) psychiatrist with an interest and experience in substance use disorders and comorbid mental illnesses. This individual will participate in programming a well-staffed and clinically excellent 18-bed residential substance use disorder rehabilitation program on the Jamaica Plain campus. The individual will also be involved in outpatient treatment of PTSD, depression, and serious mental illnesses. The position includes direct services and clinical supervision of outpatient psychiatry residents. The candidate will have an outstanding academic environment with prominent BUSM and VA substance abuse and PTSD research programs. Academic appointment will be through BUSM and/or HMS

If you are interested in any of these positions, please send a letter of interest, CV, and contact information for three references to: **Gary B. Kaplan, M.D., Director, Mental Health Service, VA Boston Healthcare System, 940 Belmont Street Brockton, MA 02301 • Phone: 774-826-2473 • Email: Gary.Kaplan@va.gov**

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STANFORD SCHOOL OF MEDICINE

INITIATION OF SEARCH
ASSISTANT or ASSOCIATE PROFESSOR (Medical Center Line)
PSYCHIATRY AND BEHAVIORAL SCIENCES / VAPAHCS

The Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine is seeking a full-time Assistant or Associate Professor in the Medical Center Line. This position does not confer tenure. The position will be based at the Veterans Affairs Palo Alto Health Care System.

The chosen candidate will be expected to act as a resource for teaching and clinical research in outpatient or inpatient psychiatry services. Candidates should be knowledgeable about health care issues related to the veteran and the veteran with mental health problems within the Department of Veterans Affairs and be able to work successfully with VA researchers and managers.

The successful candidate is required to have proven clinical, administrative, and clinical research interests in adult inpatient or outpatient psychiatry, in addition to excellence in clinical teaching. In addition, the individual will be expected to take an active role in teaching Stanford psychiatry residents. Experience with Substance Abuse and/or Psychotic Disorders is desired.

Applicants must have a medical degree or equivalent degree, completed training in General Psychiatry, be either board eligible or board-certified in General Psychiatry by July 2009, and possess or be fully eligible for a California medical license.

General criteria for the Medical Center Line (MCL) are:
"The major criteria for appointment, reappointment and promotion for faculty in the MCL shall be excellence in the overall mix of clinical care, clinical teaching, scholarly activity that advances clinical medicine, and institutional service."

Stanford University is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women and members of minority groups, as well as others who would bring additional dimensions to the university's research, teaching and clinical missions. I would appreciate your forwarding this announcement to individuals whom you feel would be particularly suited for this position. Interested candidates should send a copy of their curriculum vitae, a brief letter outlining their interests and the names of three references via e-mail only to:

Trisha Suppes, M.D., Ph.D.
c/o Stacy Moeder
stacy.moeder@va.gov
Psychiatry Service MIRECC/WRIISC (151-Y) • VAPAHCS
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From the mountains to the coast, we employ Psychiatrists at the following Hospitals and Alcohol & Drug Abuse Treatment Centers (ADATC):
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NEUROPSYCHIATRIST

VA Boston Healthcare System
&
Harvard Medical School

The VA Boston Healthcare System and Harvard Medical School are recruiting a neuropsychiatrist to provide clinical services to veterans with a broad range of brain disorders, including traumatic brain injury (TBI) and pain. This individual will be a key member of the new TBI clinical team being assembled to staff a newly forming regional TBI clinical center, and would have a joint appointment with the Brigham & Women's Hospital. We are seeking a board certified clinician-scientist with specialized training and research track record in neuropsychiatry and preferentially TBI to lead this emerging and highly prioritized clinical program to a position of national excellence. Depending on qualifications, this individual would be given protected research times and start-up resources and have the opportunity to collaborate with neuroscientists at VA Boston and BWH, including Dr. David Silbersweig.

This position offers a highly competitive VA salary and a faculty appointment at Harvard Medical School commensurate with experience. Please send a letter of interest, CV, and contact information for three references to:

Gary B. Kaplan, M.D., Director, Mental Health Service
VA Boston Healthcare System
940 Belmont Street
Brockton, MA 02301
Phone: 774-826-2473
Email: Gary.Kaplan@va.gov

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Rush Medical College/Rush University Medical Center

Chair, Department of Psychiatry

Rush Medical College at Rush University Medical Center is seeking outstanding candidates for the position of Endowed Professor and Chair of the Department of Psychiatry. The Department is founded on a long tradition of excellence in clinical care, research and teaching. Currently, there are five endowed chairs in the department. The Department Chair has oversight over the Sections of Adult and Child Psychiatry. Rush is committed to providing outpatient and inpatient psychiatry services, with separate inpatient units for geriatric psychiatry; adult affective disorders, general psychiatry, and child psychiatry. The Chair also has responsibility for fully accredited training programs in Adult Psychiatry and Child Psychiatry.

Candidates must have an outstanding record of commitment to clinical service and research, and substantial administrative experience with an established national reputation as an academic leader. A commitment to advancement of the Department's research mission is also important. In addition, candidates must possess a commitment to innovation in the field and the leadership skills necessary for faculty development and advancement of clinical and academic missions.

Rush Medical College is one of the oldest medical colleges, established in 1837, and one of the largest private academic medical centers in Illinois. The Rush System for Health encompasses an 824 bed hospital serving adults and children, the 110 bed Johnston R. Bowman Center, Rush University, and four affiliate hospitals. **Rush** is a thriving center for basic and clinical research, with a newly built state-of-the-art research facility and over 1,600 active investigations.

In 2004, **Rush University Medical Center** in Chicago initiated its plan for the most comprehensive construction and facilities renovation program in its history. The "Rush Transformation" refers to Rush's plans to invest in new technology and build new facilities. This nine-year project will thoroughly redefine our physical plant and technology, as well as many of the processes we use to deliver patient care safely and efficiently.

We encourage women and minorities to apply. Nominations or letters of interest that include curriculum vitae should be sent to:

Julie Karstrand
Staff Support for Search/Office of the Dean
Rush University Medical Center
600 South Paulina · Chicago, Illinois 60612

Or preferably electronically to: Julie_Karstrand@rush.edu

RUSH UNIVERSITY MEDICAL CENTER

CVs should be submitted no later than April 30, 2009

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We are seeking 3 full time psychiatrists to join our clinical team. The positions are located at the VA outpatient clinics in Coeur d'Alene, ID, Wenatchee, WA, and at the medical center in Spokane.

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Call or send resume in confidence to:

Gregory Winter, MD
Chief, Behavioral Health Service
Spokane VA Medical Center
4815 N. Assembly
Spokane, WA 99205-6197
Telephone: 509-434-7260
Fax: 509-434-7113

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For More Information Please Contact Jessica Meisner at 888-343-4912 or at meisnejj@ihs.org.

BOARD CERTIFIED/BOARD-ELIGIBLE PSYCHIATRISTS

The Portland VA Medical Center (PVAMC) is recruiting board certified/board-eligible Psychiatrists for several full- and part-time positions within the Mental Health Division. The psychiatrist will work in one or more Mental Health Programs located in the Portland metropolitan area or in community based outpatient clinics located in urban and rural areas (including Bend) of Oregon and will carry a caseload and provide consultation to Mental Health and/or other clinical programs.

The physician is an integral part of patient care, teaching and research activities, which are shared with Oregon Health & Sciences University (OHSU); as such, the candidate must be eligible for a faculty appointment at OHSU. The psychiatrist will supervise residents and fellows, engage in leadership activities or develop medical services in the inpatient and/or outpatient arenas.

Salary is commensurate with qualifications and experience and includes a generous benefits package. Recruitment/relocation incentives may be available to high quality candidates.

Applicants must be US citizens and hold a current, active, and unrestricted license to practice medicine in any US state. This position will require Federal security clearance, a pre-employment physical and may require a drug test.

For further information, please send a CV/resume to:
Steven K. Dobscha, MD, Interim Clinical Director and Chief of Psychiatry at **steven.dobscha@med.va.gov** or contact his office by phone at **(503)220-8262 x56490**.

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ADULT PSYCHIATRISTS

Scott & White/Texas A&M College of Medicine
Temple, Texas

Scott & White and Texas A&M College of Medicine is seeking outstanding candidates to join our nationally recognized Department of Psychiatry. Currently, we have openings for Adult Psychiatrists at our main campus in Temple. We are a full service Psychiatric Department with specialty clinics and programs. We have a diverse faculty with a close sense of collegiality.

Scott & White is the largest multi-specialty practice in Texas, with more than 700+ physicians and research scientists who care for patients at Scott & White Memorial Hospital in Temple and within the 20+ regional clinic system networked throughout Central Texas. Led by physicians with a commitment to patient care, education and research, Scott & White is listed among the "Top 100 Hospitals" in America and serves as the clinical educational site for The Texas A&M University College of Medicine. Additionally, the +250,000-member Scott & White Health Plan is the #1 health plan in Texas. For more information on Scott & White, please visit our web site at: **www.sw.org**.

For additional information regarding these positions, please contact: **Jason Culp, Physician Recruiter, Scott & White Clinic, 2401 S. 31st, Temple, TX 76508. (800) 725-3627, jculp@swmail.sw.org**.

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PSYCHIATRIST

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The facility has 172 beds serving adult, geriatric and forensic patients, located on 85 tranquil acres in Marion, Virginia, deep in the heart of the Blue Ridge Mountains. We are not dependent on managed care and on-call duty is not required of our psychiatrists.

Marion is surrounded by beautiful mountains, rich valleys and many outdoor adventures. It offers the comforts of a small community with low cost of living, little traffic, good schools, safe neighborhoods, but is within short driving distance to several metropolitan areas.

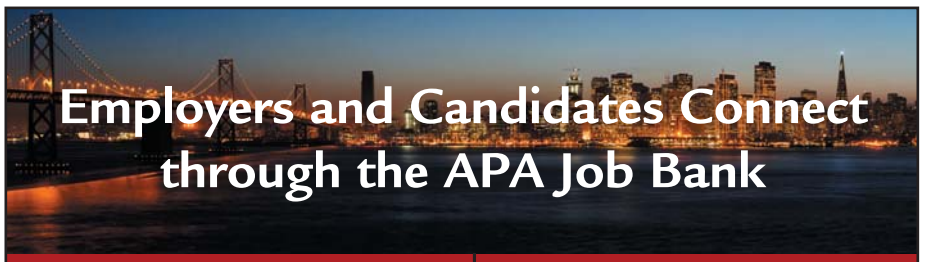
We seek candidates who are BE/BC in psychiatry to work with adult and geriatric patients.

Candidates for this position will possess or be eligible for licensure to practice medicine in Virginia. Candidates may qualify for loan repayment with the Virginia Department of Health.

For additional information, please contact:

Kim Sayers
Human Resources
Southwestern Virginia Mental Health Institute
340 Bagley Circle,
Marion, VA 24354
Phone: 276-783-1204
Fax: 276-783-0844
Website: **www.swvmhi.dmhmrsas.virginia.gov**
Job Application Site: **http://jobs.agencies.virginia.gov**

EOE



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- Post your psychiatric position with the APA Job Bank at **psych.org/jobbank** and reach qualified professionals.
- Use the many resources of the APA Job Bank to make a smart recruitment decision.
- Advertise in the *Psychiatric Services* or *Psychiatric News* classifieds and the APA Job Bank and receive a 10% discount on each.
- Post your psychiatric position with the APA Job Bank before the APA Annual Meeting in San Francisco, May 16-21, and use the Conference Connection to set up interviews with candidates at the meeting.

Candidates

- Search the most comprehensive online listing of psychiatric positions at **psych.org/jobbank**.
- Register to post your resume, receive instant job alerts, use the career tools and more.
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Call 703-907-7330 to post your psychiatric position

STANFORD SCHOOL OF MEDICINE

ASSISTANT PROFESSOR (Medical Center Line)

Division of Child & Adolescent Psychiatry and Child Development Psychiatry and Behaviorial Sciences

The Stanford University Division of Child & Adolescent Psychiatry and Child Development, Department of Psychiatry and Behavioral Sciences is seeking a talented Assistant Professor for its Child and Adolescent Mood Disorders Program. This faculty member will specialize in the neurobiology of mood regulation and mood disorder, working alongside outstanding child psychiatric faculty who are specialized in Depressive Disorders and Bipolar Disorders, in an academic environment with very strong resources and collaborative opportunities in neuro-imaging, neurophysiology, genetics, neuroendocrine/neurohormonal function, psychopharmacology, and biostatistics.

Faculty in the Division are affiliated with the Lucile Packard Children's Hospital, a first rank clinical and teaching hospital. The Stanford University School of Medicine is one of the nation's leading academic and research institutions.

The faculty member will provide expert compassionate clinical care, will teach and supervise Stanford trainees in psychiatry, child psychiatry, clinical psychology, pediatrics, as well as medical students. Major emphasis will be placed on programmatic research in the neurobiology of mood in children and adolescents. This faculty position is in the Medical School's Medical Center Line, which requires excellence in the mix of research, clinical care, and teaching.

Applicants must have a medical degree or equivalent degree, completed training in both General Psychiatry and Child and Adolescent Psychiatry, be either board eligible or board-certified in both areas by July 2009 and possess or be fully eligible for a California medical license. Candidates should have significant research training and a demonstrated track record in empirical research.

Stanford University is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women and members of minority groups, as well as others who would bring additional dimensions to the university's research, teaching and clinical missions.

Interested candidates should send a copy via e-mail only of their curriculum vitae, a brief letter outlining their interests and the names of three references to:

Joachim Hallmayer, M.D.
c/o Ellen Van Stone
E-mail: vanstone@stanford.edu
Division of Child & Adolescent Psychiatry and Child Development Department of Psychiatry & Behavioral Sciences

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All advertising copy, changes and cancellations received after the deadline will be placed in the next available issue. We do not provide proofs of ads before publication.

DEADLINES: All new advertising copy, changes, and cancellations must be received *in writing* by Friday, 2 p.m. (E.T) two weeks prior to publication date. Publication dates are the first and third Fridays of every month. Specific deadline dates for upcoming issues are as follows:

Issue	Deadline (Friday, 2 p.m. E.T.)
April 3	March 20
April 17	April 3

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ALABAMA

Assistant/Associate Professor of Psychiatry

The University of Alabama - College of Community Health Sciences (CCHS) (University of Alabama School of Medicine -Tuscaloosa Campus) offers a unique opportunity for the Psychiatrist, non-tenure earning clinical track, interested in working in a multi-specialty group practice and participate in the education of medical students and family medicine residents, and focusing clinical care in college mental health. The University of Alabama, with an enrollment of over 27,000 offers significant diversity in diagnosis.

CCHS is one of three clinical campuses of the University of Alabama, School of Medicine providing clinical training for third and fourth year medical students. In addition, for over 25 years the College has administered one of the most prestigious and successful Family Practice Residency programs in the Southeast. The College is located on the main campus of the University of Alabama, a comprehensive research institution that offers a wide variety of opportunities for faculty and their families. Located in Tuscaloosa, Alabama, a community of approximately 150,000 there are many exceptional cultural and recreational opportunities. The Campus is located one hour from Birmingham, three hours from Atlanta, and five hours from the Gulf of Mexico.

Salary is commensurate with experience and includes a generous benefits package. Candidates must be Board Certified in General and/or Child & Adolescent Psychiatry, meet requirements for an academic appointment at the UA and be eligible for licensure in the State of Alabama.

Screening is on-going. Applications will be accepted until the position is filled. Interested candidates should submit application and include CV, letter of interest and three letters of recommendation to: http://facultyjobs.ua.edu

For additional information, contact: Susan Arnold, MD, Chair, Search Committee at sarnold1@cchs.ua.edu.

Please see our website at http://cchs.ua.edu/ The University of Alabama is an Equal Opportunity Affirmative Action Employer. Women and minorities are encouraged to apply.

View your ad online for free!

All line classified ads are posted on the *Psychiatric News* web-site:

pn.psychiatryonline.org

ARIZONA

University of Arizona

The University of Arizona's **Psychiatry Department** is recruiting adult and child psychiatrists to join a progressive and growing academic department located in the beautiful Southwest. Candidates must have current credentials to practice medicine in the United States and be Board-certified or -eligible in Psychiatry.

Assistant/Associate Professor, Clinical Psychiatry (NTE) - Inpatient & Women's Mental Health, Job #42184 - The successful candidate will assist in caring for inpatients in an 8 bed unit at the University Medical Center (UMC), and coordinate activities and direct all efforts of the Women's Mental Health program. The Women's Mental Health program is dedicated to improving detection of mental health issues and providing expert care to women across the lifespan. Ongoing responsibilities include the diagnosis and treatment of mental disorders common in women, participation in community forums/presentations to provide education to the community regarding mental health issues in women, supervision of resident care, and performing attending psychiatric evaluations and the care of up to eight inpatients. Other duties may include participation in committees and department services as directed by the Department Head, assistance in reviews and audits of the inpatient unit, and other clinical duties as assigned.

Assistant/Associate Professor, Clinical Psychiatry (NTE) - Outpatient Director, Job #42065 - Successful candidate will take a lead role in planning and developing the new residency outpatient clinic located at the University Physicians Healthcare Hospital - Kino Campus. Ongoing responsibilities include provision of direct outpatient care, supervision of resident care, and the administration of the clinic. Other duties may include participation in committees and department services as directed by the Department Head, providing inpatient psychiatric services, and other clinical duties as assigned.

Child Psychiatrist / Assistant or Associate Professor or Professor, Clinical Psychiatry Job # 39689 - Responsibilities include child and adolescent services for outpatient care and in a correction/residential treatment setting. Other duties include providing a significant contribution to the didactic and supervisory component for training programs. Individuals must be Board-certified or -eligible in Child and Adolescent Psychiatry. Salary: DOE

For additional information and/or to apply visit www.uacareertrack.com and reference specific job # from above. If you have questions, please contact: Ashley Lott, Human Resources, Dept. of Psychiatry, 1501 N. Campbell Avenue, P.O. Box 245002, Tucson, AZ 85724-5002; (520) 626-3819; or aelott@email.arizona.edu. Review of applications is ongoing until positions are filled. The University of Arizona is an EEO/AA Employer-M/W/D/V

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$35 extra for a confidential ***Psychiatric News*** blind box.

Child and Adolescent Consultation-Liaison Psychiatrist
St. Joseph's Hospital and Medical Center/Barrow Neurological Institute (SJHMC/BNI) houses over 700 beds, nearly 1500 medical staff, and 180 residents spanning 12 specialties including Pediatric Neurology and Pediatrics. SJHMC/BNI has also been repeatedly named the best place to work in Phoenix. Responsibilities will include supervision of medical students and residents. This position would include an academic appointment commensurate with experience. Qualified candidate will possess and M.D. or D.O. degree, be board eligible or certified in Child and Adolescent Psychiatry, and be eligible for an Arizona license and credentialing at SJHMC/BNI. We offer a very competitive salary and benefits package including personalized relocation. For immediate consideration, please visit our website at www.stjosephs-phx.org or send your CV to:

Jason P. Caplan, M.D.
Chief of Psychiatry
St. Joseph's Hospital and Medical Center
222 W. Thomas Rd, Suite 110A
Phoenix, AZ 85013
Fax: (602) 798-9956
E-mail: jason.caplan@chw.edu

St. Joseph's Hospital and Medical Center
A member of CHW

The Phoenix VA Health Care System at Phoenix seeks Staff Psychiatrists. Become a part of a tradition of excellence with new and rewarding challenges. Mental Health is currently offering inpatient and outpatient positions concentrating on the readjustment of veterans from the recent conflicts in Afghanistan and Iraq and on the treatment of veterans with posttraumatic stress disorder, and substance abuse care positions concentrating on the treatment of addictions directly related to veteran mental health care. Candidates must be highly motivated, flexible and able to work as part of an integrated team. Previous experience with combat-related posttraumatic stress disorder is a plus. We offer competitive salaries and an excellent benefit plan, including medical coverage, malpractice coverage, retirement plan, and MORE! Psychiatrists may have licensure in any state. Either board certified or board eligible. Please send your curriculum vitae to: Human Resources Management Service (05B1), 650 E. Indian School Road, Phoenix, Arizona 85012, 602-277-5551 ext 3021 or Fax 602-222-6554. The VA is an equal opportunity employer.

PSYCHIATRIST, ADULT INPATIENT SERVICE at Banner Good Samaritan Medical Center, Phoenix, AZ. 600 bed tertiary care teaching hospital with fully accredited Psychiatry Residency and major teaching affiliate for the University of Arizona College of Medicine's Phoenix Campus medical student programs. Other responsibilities include teaching and supervision of residents and medical students, opportunities in consultation-liaison and outpatient settings and shared on-call responsibilities. This full-time faculty position has a competitive salary and excellent benefits. The qualified candidate's title, academic rank and salary will be commensurate with training and experience. Interested individuals should forward his or her curriculum vitae and two letters of reference to James B. McLoone, M.D., Chairman, Department of Psychiatry and Director of Training, Banner Good Samaritan Medical Center, 925 E. McDowell Road, 4th Floor, Phoenix, AZ 85006. Requested information can also be sent via e-mail to Melissa.Hardy@bannerhealth.com Please visit our website at www.bannerhealth.com. EOE. Not a J1 opportunity.

ARKANSAS

General and Child Psychiatrists - several locations throughout state. Inpatient & partial programs. Fulltime or part-time positions offering salary, benefits & more. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

CALIFORNIA

Contract psychiatrists are needed to work 10 hours, 4 days wkly at Coalinga State Hospital, CA, at hrly rate of $180. Call 800-758-7012 or fax CV to 800-758-7013 or e-mail hahacorp@gmail.com if interested. CA license, and insurance needed. We will work with recruiter for a fee.

Part-time Psychiatrist. Private practice. Outpatient setting. Adult population, no on-calls in Riverside, California (Riverside County). Flexible hours. E-mail CV to psychmedical@hotmail.com or fax to 714-972-0477 attn: Elizabeth or you can contact her at 714-972-0040.

California Department of Mental Health

Patton State Hospital — Care and Treatment With Respect and Dignity — Patton, CA

CALIFORNIA
BC/BE STAFF PSYCHIATRIST

Patton State Hospital is recruiting board certified/eligible psychiatrists. Patton is a Joint Commission accredited, 1500 bed, adult forensic psychiatric hospital, with an extremely interesting and challenging patient population. The hospital is nestled below Arrowhead and the San Bernardino Mountains, 65 miles east of Los Angeles; an hour's drive to beaches, Palm Springs, or mountain lakes and skiing. Salary with Board Certification starts at **$15,387 and goes to $21,311, plus $2,085 monthly.** Salary for Board Eligible starts at **$14,979 and goes to $20,711, plus $2,085 monthly.** In addition, Patton offers excellent benefits (health, dental, and vision; license renewal; malpractice insurance; tax-deferred compensation; paid annual leave and 12 holidays (plus one personal holiday), as well as seven days per fiscal year of Continuing Medical Education leave). Voluntary on call duty is compensated on an hourly basis over and above base salary. We provide civil service security and retirement plans (including safety retirement). For confidential consideration, send CV to Wadsworth Murad, D.O., (A) Medical Director, 3102 East Highland Avenue, Patton, California 92369, (909) 425-7326 or Fax (909) 425-6635.

Karl E. Douyon, M.D., Inc.
Psychiatrists are needed as independent contractors for Locum Tenens positions in California. Pay is $175 to $250.00 per hour depending on location. On call pay is extra. Hours are flexible for weekdays and some weekends. Call 805-644-4093. Fax resumes to 805-830-6300. karledouyonmd.com

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PSYCHIATRIST

Immediate opening for Adult Psychiatrist with progressive medical group in Los Angeles area. Psychiatrist duties include inpatient, outpatient and long term patient care. Interest in the development of Telemental Health programs is desirable. Competitive salary, benefits package, and will pay for relocation.
Email: jminor@asanamg.com or pbennett@asanamg.com
Fax: (818) 907-1482. For more information call Janet Minor or Peter Bennett: (818) 907-1480.

GREATER BAY AREA - Modesto, California

General & Child Psychiatrists needed, for unique, stable County Mental Health system in a welcoming community. Serve both public & private sector patients, in both inpatient/outpatient settings that have been benchmarked for their quality. Possibilities for Resident teaching & consultation with a full range of providers. When patients require hospitalization, inpatient & outpatient staff work **TOGETHER** to optimize care. Stanislaus County is located only 1 1/2 hours from both San Francisco and Yosemite, enjoying the best of both worlds.

Excellent salary scale, with steps from $171K to $208K; **PLUS** full benefits; **PLUS** 5% additional for Inpatient, and General Boards or Child Boards; **PLUS** extra for limited On-Call; **PLUS** Union-negotiated increases already set for next few years. Negotiable hourly contract also an option. Fax CV to Uday Mukherjee, MD, 209-525-6291 or call 209-525-6121.

University of California San Francisco — UCSF — Department of Psychiatry

University of California San Francisco
Department of Psychiatry
VA Research Psychiatrist

THE DEPARTMENT OF PSYCHIATRY AT THE UNIVERSITY OF CALIFORNIA SAN FRANCISCO invites applications for a **Research Psychiatrist** position at the San Francisco Veterans Affairs Medical Center. Applicants must have an M.D. and Ph.D.; have a California medical license at time of appointment; have established skills in-and dedication to-both basic and translational research on mental illnesses that are central to the VA mission, especially PTSD and other anxiety disorders; and have demonstrated clinical experience and teaching ability. A strong emphasis in methodologies for use of human subjects including neuroimaging is desirable. An interest in the application of translational research interventions for anxiety disorders including PTSD is also desirable. This is an 8/8 VA position and could begin on July 1, 2010. While applicants at the Assistant Professor level are preferred, the position will be filled at an academic rank commensurate with experience. Eligibility for an appointment in the UCSF Neuroscience Program is necessary. Responsibilities include launching a successful independent program in psychiatric research; clinical responsibilities at the VA; and participating in teaching, supervision or support of educational programs for medical students, residents, psychology interns, postdoctoral fellows, and graduate students in a variety of disciplines. Applicants are encouraged to submit their application electronically-including CV, statement of research interest, three representative journal articles, brief statement of contributions to teaching and/or educational program evaluations, and three letters of reference-to Samuel H. Barondes, M.D., Search Committee Chair, c/o Astrid Prackatzsch at astridp@lppi.ucsf.edu. UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Equal Opportunity/Affirmative Action Employer. The University undertakes affirmative action to assure equal employment opportunity for underrepresented minorities and women, for persons with disabilities, and for covered veterans. All qualified applicants are encouraged to apply, including minorities and women.

PSYCHIATRIST

Immediate opening for Gero-Psychiatrist with progressive medical group in Los Angeles area. Psychiatrist duties include inpatient, outpatient and long term patient care. Interest in the development of Telemental Health programs is desirable. Competitive salary, benefits package, and will pay for relocation.
Email: jminor@asanamg.com or pbennett@asanamg.com
Fax: (818) 907-1482. For more information call Janet Minor or Peter Bennett: (818) 907-1480.

County of Santa Barbara, California

COUNTY OF SANTA BARBARA
Alcohol, Drug, and Mental Health Services

is recruiting for

PSYCHIATRIST
BOARD CERTIFIED
$183,666 - $210,761/YR.

PLUS new hire incentives, excellent benefits, and cash allowances. For detailed information, visit **www.sbcountyjobs.com**

Job location is Santa Maria

Call Ratio:
Only one weekend every three months!

For immediate consideration, contact Dr. Edwin Feliciano, Medical Director, at 805-681-5235, or apply online at **www.sbcountyjobs.com**

The County of Santa Barbara strongly promotes diversity and equality in the workplace.

COLORADO

Denver Health Medical Center is actively seeking a BE/BC general or forensic psychiatrist to join our correctional psychiatry team at the Denver County Jail. The position also includes a faculty position in the Department of Psychiatry, University of Colorado and in the Forensic Psychiatry Fellowship Program. Opportunities exist for teaching medical students, psychiatry residents, and forensic psychiatry fellows. Our team is a multidisciplinary group that provides comprehensive care to psychiatric patients in a correctional setting. We offer a competitive salary, excellent benefits, and reasonable call. Denver Health is a comprehensive, integrated health care organization that is Colorado's primary "safety net" hospital. The lifestyle in Denver and Colorado is not to be missed. Interested applicants should submit a CV and cover letter to: Gregory Kellermeyer, MD, Director of Correctional Psychiatry, Denver Health Medical Center, 1155 Cherokee Street, MC 3440, Denver, CO 80204. Office: (303)-436-3808, gregory.kellermeyer@dhha.org

CONNECTICUT

Inpatient Psychiatry at Yale/CMHC

The Yale University School of Medicine seeks a psychiatrist for a full-time faculty position on the Inpatient Service of the Connecticut Mental Health Center [CMHC] for July 2009 in an academic position as Clinician within the Yale Department of Psychiatry. Outstanding clinical and teaching skills are required for roles in patient care as well as supervision of psychiatry residents and other trainees. Applicants must be board certified or eligible in psychiatry, licensed to practice in CT and be legally employable. Please send a CV and 3 references by May 15th to Jeanne Steiner, D.O., Medical Director CMHC, 34 Park St., New Haven, CT, 06519. Direct inquiries to jeanne.steiner@yale.edu. Yale University is an affirmative action/equal opportunity employer; applications from women and minority group members are specifically invited.

BEAUTIFUL SUBURBAN CT/ 1 ¼ HRS FROM NYC

CT licensed BC/BE Psychiatrist to join a 30 year well established multi-disciplinary practice providing adult psychiatric services. Excellent Compensation. Send CV/cover letter by fax 203-797-0877 or Email: afrymd@yahoo.com. Any questions, contact Sam at 203-792-6060 x15.

St. Vincent's Behavioral Health Services — Hall-Brooke — Ascension Health

St. Vincent's Medical Center, Behavioral Health Service, Fairfield County, CT

Inpatient and Outpatient Opportunities

St. Vincent's Medical Center, Behavioral Health Services is recruiting Psychiatrists to join its expanding clinical service at their Westport and Norwalk campuses.

A Full Time Inpatient Staff Psychiatrist is needed in the Westport, CT campus. Responsibilities include inpatient care of adults with a small percentage of adolescents. Minimal weekend and call requirements. Our 76-bed hospital has adult, geriatric, women's, addiction, and child/adolescent services, and affiliations with St. Vincent's Medical Center in Bridgeport, CT and the University of Connecticut. In addition to the inpatient services in Westport, the St. Vincent's behavioral health service line includes a 16-bed psychiatric unit at the Medical Center in Bridgeport. The combined service offers 92 behavioral health inpatient beds for treating children, adolescent and adults with mental health and substance abuse issues. This makes the inpatient behavioral health service line of St. Vincent's one of the largest in Connecticut serving approximately 2,350 individuals annually. Job responsibilities may be tailored to suit specific skill areas or interests.

A Part Time Outpatient Staff Psychiatrist is needed in our Norwalk, CT campus. This is primarily an IOP based afternoon program with some flexibility of hours. Responsibilities include outpatient care of adolescents. This position is part of a large multidisciplinary treatment team. The outpatient site at Norwalk is also part of this large continuum of Psychiatric care based in Fairfield County. For more information, please contact: Clayton Tebbetts; Physician Recruiter, St. Vincent's Medical Center - 203.576.6204 - ctebbetts@stvincents.org

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OUTPATIENT ADULT PSYCHIATRIST
CENTRAL CONNECTICUT

Flexible options available for BC psychiatrist in adult outpatient mental health and addictions center associated with a community hospital offering a comprehensive mental health continuum that serves over 1600 adult patients annually. This position offers leadership potential for the candidate who can bring their skills and expertise to provide clinical and medical oversight to serve a chronic psychiatric and addictions patient clientele. You'll work with a multidisciplinary team of highly experienced therapists, nurse practitioner and other providers in a fast-paced environment. This is a hospital-based position offering competitive salary and benefits and adaptable hours for the right individual.

Our central Connecticut location offers easy access to all the amenities of the New England region, including first-rate schools and a choice of family-oriented suburban communities. Close proximity to urban living with professional sporting events, concerts, ballet, theatres, easy access to skiing and shoreline. 2 hours to NYC and Boston.

For more information about this opportunity, please contact Christine Bourbeau in the Recruitment Office at 800.892.3846 or fax/email your CV to 860.714.8894.

Email address cdoughti@bristolhospital.org
Visit our website at www.bristolhospital.org

EEO

GENERAL PSYCHIATRY-CT
Busy two-person provider of behavioral healthcare services seeks a BE/BC psychiatrist to join their private practice providing adult psychiatric services. Practice is affiliated with a suburban community hospital offering a full continuum of mental health services. The practice is offering a competitive salary and benefits package and partnership potential.

ATTRACTIVE SOUTHERN NEW ENGLAND LIVING

Our central CT location offers a choice of upscale suburban communities with first-rate schools and is a short distance from professional sporting events, concerts, ballet, gourmet dining, and theatre. The coastal beaches of Long Island Sound are within easy reach and in just two hours, you can enjoy Boston, New York and the ski slopes of Vermont.

To learn more about this opportunity, call toll-free, Christine Bourbeau, Director of Physician Recruitment at 800.892.3846/860.714.1090 or fax/email your resume to 860.714.8894. EOE.

Email address: cbourbeau@brishosp.chime.org

FLORIDA

The Department of Psychiatry at the University of Florida College of Medicine is recruiting for a Psychiatrist to serve as a full-time, non-tenure Clinical Assistant/Clinical Associate/Professor. Responsibilities will include Emergency Room, NPEU, and Consult Services at Shands @ UF. The Psychiatrist should be especially strong in Medical Psychiatry, Evaluation, and Acute Treatment as he or she will be an Attending for the 10 bed Neuropsychiatric Evaluation Unit and active with the consult service at the UF College of Medicine. Teaching of Interns and Residents, working with some of the nation's experts in other branches of medicine and research are all part of this exciting Position. This position also has an important role in housestaff education, fellowship training and prevention activities related to adult medicine. Applicants must have an M.D. degree and be Board Eligible (recent graduates) or Certified in Psychiatry and who are able to obtain a Florida Medical License are encouraged to apply. Faculty rank and salary will be commensurate with experience. Application deadline **April 15, 2009.**

Candidates should send a letter of interest and C.V. to: Herbert Ward, M.D., Associate Professor and Vice Chair, Search Committee Chairperson, University of Florida College of Medicine, Department of Psychiatry P.O. Box 100256 Gainesville, Florida 32610-0256.

An Equal Opportunity Institution

Planning to retire to South Florida? Are you planning to maintain your license active? The Institute for Child and Family Health (ICFH) may be the right match for you. We are a dynamic social service agency that provides pediatric and behavioral health treatment services to the children, adolescents and their families in the Miami-Dade community. ICFH can provide you with the service hours needed to keep your psychiatry license current. Our clinics and schools are conveniently located in South Miami where there is access to a variety of cultural, professional sports and recreational venues as well as other urban amenities. If you would like to supplement your income by providing school-based services, consultations and medical management then please consider this unique and exciting practice opportunity. If you would like more information about Institute for Child and Family Health, please visit www.icfhinc.org. You may apply by faxing your C.V. or Resume to the Recruiter at (305) 685-4208. EOE and DFWP.

DAYTONA - MELBOURNE - ORLANDO - MIAMI - FORT LAUDERDALE - PALM BEACH - OCALA - GAINESVILLE - FORT MYERS - SARASOTA - PENSECOLA - JACKSONVILLE - Psychiatrists needed for rapidly expanding Nursing Home Service. Great support. No call. Average Salary 210K + benefits. Part-time available. Some travel required. Must have FL Medicare & FL Medicaid individual provider #s. No Restrictions (H1B Candidates Considered). Call our administrator, Christy, at 866-936-5250.

Lee Mental Health Center, Inc. (LMH) is the primary provider of mental health services in Lee County, in Southwest Florida. A private non-profit company, the Center provides a continuum of mental health and substance abuse services for adults and children, including crisis stabilization, outpatient and community based services. We are committed to the recovery model of service delivery. Visit us online at www.leementalhealth.org . We are currently seeking dynamic candidates for the following positions:

Chief Medical Officer - This position reports directly to the C.E.O. The successful candidate will provide leadership to all staff as Clinical Director for the agency; manage medical staff as a group practice and set up and provide psychiatric services that reflect the clinical standards of this company in the assessment and treatment of patients. Must be Board certified in General Psychiatry by the ABPN (Board certified in Child & Adolescent Psychiatry preferred). Must possess an active/clear FL medical license and valid DEA. Must be eligible to serve as a provider in Medicaid and Medicare programs. Two years of management experience in a medical setting required. Previous community mental health care experience is a plus!

Child & Adolescent Psychiatrists - PT or FT positions in our Crisis Stabilization and Outpatient departments available. Will be responsible for diagnostic interviews, medication management, consults, second opinions, rotating on-call duty and rounds. Will interface/collaborate with other treatment professionals, as appropriate. Successful candidates will possess an active/clear Florida medical license and a valid DEA. Must be Board certified or eligible in General/Adult or Child psychiatry. Must be eligible to serve as a provider in Medicaid and Medicare programs. Experience in community mental health and substance use disorders a plus.

Compensation/Benefits: Our commitment to you is not only a generous salary but a benefits package for FT employees that includes: Malpractice Insurance, Generous paid time off plan (includes sick, personal leave, and vacation); 10 paid holidays per year, Health, dental and life insurance, Flexible Spending Account (health care), Short Term & Long Term Disability (and other supplemental insurance options) and 403b retirement plan.
Nearby: LMH is located on the vibrant Gulf Coast of southern Florida. Lee and its neighboring counties offer a variety of residential communities with excellent public/private schools, colleges and universities. Residents enjoy easy access to year round recreational and cultural activities and unlimited sunshine. You are encouraged to come and enjoy the diversity and beauty of SW Florida!
Submit both an employment application and CV to: Lee Mental Health Center, Inc. (Attention: HUMAN RESOURCES), 2789 Ortiz Avenue, Fort Myers, FL 33905; or fax: 239-418-0094; or email: resume@leementalhealth.org Please visit www.leementalhealth.org to download an employment application and/or for additional information.
EOE/DFWP

GEORGIA

ATLANTA: General Psychiatrist - Inpatient & partial programs. Fulltime or part-time positions - salary & benefits. Also weekend coverage needs - no call required. **MOULTRIE:** General Psychiatrist for residential & partial programs - psychiatric & addiction. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

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PSYCHIATRISTS

New Horizons Community Service Board in Columbus, Georgia is seeking an Adult psychiatrist for its outpatient and residential programs. This growing community offers a pleasing climate and is situated within a short distance to Atlanta and the Gulf Coast. The qualified applicant will possess or be eligible for a valid physician's license from the State of Georgia and have completed a three-year residency in an accredited facility. Excellent salary with a comprehensive benefits package. Interested parties should fax their curriculum vitae to the attention of Shannon Robertson at 706/317-5004.
No phone calls, please.

Psychiatrist - Metro-Atlanta

Cobb-Douglas Community Services Board, a behavioral healthcare organization in metro Atlanta (Marietta, GA), seeks a full-time or part-time BC/BE Adult Psychiatrist for Community Outpatient Behavioral Health clinic. Please send CV to cholt@cobbcsb.com or fax to Cheryl Holt at 770-948-6147.

ILLINOIS

Academic Child Psychiatrist
Department of Psychiatry and Behavioral Neuroscience
The University of Chicago

The Department of Psychiatry and Behavioral Neuroscience at The University of Chicago is seeking an academic psychiatrist. Clinical activities will be focused on the clinical management of psychiatric patients in the outpatient department and in consultation on the inpatient units of the University of Chicago Medical Center. In addition to involvement in the clinical management of psychiatric patients, academic clinicians are expected to be involved in the clinical and didactic training of medical students, residents and fellows. M.D. required & licensure as a Physician & Surgeon in IL will be required. Must be eligible for required board certifications. Excellent teaching skills required. Academic rank and salary will be commensurate with background and experience. Screening of applications will continue until the position is filled. Initial inquiries should be made by e-mail. Applicants should send curriculum vitae and a list of at least 3 potential references electronically to: Sharon L. Hirsch, M.D., Child and Adolescent Section Chief, Department of Psychiatry and Behavioral Neuroscience at shirsch@yoda.bsd.uchicago.edu. The University of Chicago is an Affirmative Action/Equal Opportunity Employer.

LOUISIANA

The Department of Psychiatry and Neurology at Tulane University School of Medicine is recruiting for a Director of Residency Training in Psychiatry. This is a full-time faculty position with half-time devoted to the residency training program and half-time to other academic pursuits. An associate director is available to assist with program leadership and administration. The person selected for this position must be professionally competent and be board eligible/certified in general psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. This is a fully accredited psychiatry program for up to 39 general residents, 10 triple board trainees, 6 child fellows and 3 forensic fellows. We also offer combined programs in med-psych and in psych-neuro. Salary will be competitive and commensurate with the level of the candidate's academic appointment. We will continue to accept applications for this position until a suitable qualified candidate is identified. Qualified applicants should send email of interest, updated CV and list of references to Daniel K. Winstead, MD, Heath Professor and Chair, at winstead@tulane.edu or letter to Department of Psychiatry and Neurology, Tulane University School of Medicine TB48, 1440 Canal Street, Suite 1000, New Orleans, LA 70112. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.

SEEKING PSYCHIATRIST

Community-based agency in Southeast Louisiana seeks both general and child psychiatrists to serve in the community mental health centers north of New Orleans (with easy access to Gulf Coast). In addition to competitive salary, benefits include health/life/dental insurance, retirement plans, and annual and sick leave. Medical malpractice covered.

For details contact:

FPHSA Administration
11236 Hwy 16 West
Amite, LA 70422
(985) 748-2220
www.fphsa.org

DEPARTMENT OF PSYCHIATRY AND NEUROLOGY, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for several general and forensic psychiatrists (clinical track) for our growing department, at the Assistant/Associate Professor level. Candidates must have completed an approved general psychiatry residency and be board certified/eligible in general psychiatry and forensic psychiatry, respectively. Responsibilities will include direct patient care, teaching of medical students and house officers (including those in our accredited forensic psychiatry fellowship program), and research (clinical and basic science) at various state hospitals, state correctional institutions, and at Tulane University Health Sciences Center. Time allocations will be based upon individual situations. Applicants must be eligible to obtain a Louisiana medical license. Applications will be accepted until suitable qualified candidates are found. Send CV and list of references to John W. Thompson, Jr., M.D., Vice Chair, Adult Psychiatry and Director, Division of Forensic Neuropsychiatry, Tulane University School of Medicine, Department of Psychiatry and Neurology, 1440 Canal Street TB53, New Orleans, LA 70112. For further information onsite, please contact Dan Winstead, MD, Chair of Psychiatry and Neurology, at 504-473-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

CHILD PSYCHIATRISTS - DEPARTMENT OF PSYCHIATRY AND NEUROLOGY, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for BE/BC child psychiatrists at the assistant professor level, salary commensurate with experience. Clinical responsibilities available in the areas of consultation/liaison psychiatry, school based mental health, community based child and adolescent psychiatry and early childhood development. Teaching responsibilities include the supervision of residents, clinical psychology fellows and interns, and medical students rotating through the clinical facilities serviced by this position as well as the presentation of grand rounds and participation in the didactic series in child psychiatry. Clinical research is strongly encouraged. The persons selected must be professionally competent and be board eligible/certified in general psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Applications will be accepted until a suitable qualified candidate is found. Send CV and list of professional/academic references to Charley Zeanah, Jr, MD, Professor and Vice Chair, Child and Adolescent Psychiatry, Tulane University School of Medicine, Department of Psychiatry and Neurology, 1440 Canal Street TB52, New Orleans, LA 70112 (czeanah@tulane.edu). Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

Physicians' Health Foundation of Louisiana Medical Director Position

The Physicians' Health Foundation of Louisiana is seeking an experienced psychiatrist or addictionist to serve as full-time Medical Director. This position requires clinical experience in addictions and board certification in psychiatry or primary care specialty. For primary care candidates, ASAM certification is required. Additional credentials in addiction are preferred for psychiatry candidates. The position entails working with physicians suffering from substance related and other psychiatric disorders. This position also requires leadership, staff supervision, public speaking, advocacy efforts with the state licensure agency and other entities, policy development, outreach, and computer skills. It is an excellent opportunity to work with a statewide program and to further its mission of assisting physicians in the state of Louisiana. The Physicians' Health Foundation of Louisiana offers an excellent salary and benefits package. A typical work week is 37.5 hours with no weekends or call. **Please submit a curriculum vitae and salary requirements to:** Julie Alleman, M.Ed., LPC, LMFT, LAC, Administrative Director, Physicians' Health Foundation of Louisiana, 4303 Bluebonnet Blvd., Baton Rouge, LA 70809, jalleman@phfl.org

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The Department of Psychiatry and Neurology at Tulane University School of Medicine is recruiting a geriatric psychiatrist for a full-time faculty position. The candidate will spend part of their time at the Southeast Louisiana Veterans Health Care System (SLVHCS) and will also be involved in the new initiatives in both clinical geriatric care and special geriatric education programs at Tulane. Responsibilities include patient care as well as contributing to the various teaching and training programs of Tulane University's Department of Psychiatry and Neurology at the SLVHCS. He/she will be provided the opportunity to pursue their research interests. The person selected for this position must be professionally competent and be board eligible/certified in general psychiatry and in geriatric psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Salary will be competitive and commensurate with the level of the candidate's academic appointment. Applications will be accepted until a suitable qualified candidate is found. Applicants should send letter of interest, updated CV and list of references to Daniel K. Winstead, MD, Heath Professor and Chair, Department of Psychiatry and Neurology, Tulane University School of Medicine, 1440 Canal Street TB48, New Orleans, LA 70112. Interested and eligible candidates may obtain further information by contacting Daniel K. Winstead, MD at 504-988-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.

MAINE

Adult IP Psychiatrist - Scenic Central Maine

MaineGeneral Medical Center in Augusta/Waterville, Maine is seeking a BC/BE adult psychiatrist with interests in inpatient psychiatry or outpatient psychiatry/substance abuse. You will be joining a staff of 7 employed physicians who provide multidisciplinary inpatient, outpatient, and consultative services. We have a 30-bed inpatient program at our Thayer Campus in Waterville, 5 Intensive Outpatient Programs in Waterville and Augusta, an ACT Team, and an outpatient program providing psychiatric and substance abuse treatment. We also provide consultative support for our inpatient medical and surgical services. We offer excellent benefits including relocation assistance and competitive salary. MaineGeneral is located in scenic central Maine and is a short drive away from ski resorts, lakes and rivers, award-winning golf courses, abundant hiking trails, and the beautiful Maine coast. We are just an hour north of Portland, Maine's largest city, and three hours from Boston. Send your CV to Lisa Nutter, Physician Recruiter at lisa.nutter@mainegeneral.org or call 1-800-344-6662. For more information, visit www.mainegeneral.org.

Adult and Child/Adolescent Psychiatrists
Nation's 1st Psychiatric Magnet Hospital seeking BC/BE psychiatrists for both our adult and child/adolescent inpatient and outpatient programs. We are a thriving, non-profit, private community-based hospital offering acute psychiatric care for adults and children, as well as chemical dependency programs. One of only two private psychiatric hospitals in Maine. We offer physicians clinical practice in a highly collaborative, multi-disciplinary setting. Competitive salary/benefit package. Send CV to: VP of Medical Affairs, The Acadia Hospital, P.O. Box 422, Bangor, ME 04402-0422.
www.acadiahospital.org

MARYLAND

"THE MARYLAND PLAN" is a nationally acclaimed program in public psychiatry. Positions are available for child and adult psychiatrists. Academic involvement with med. schools in your area of interest is encouraged. Please e-mail CV with area of interest and geographic preference to: GJordanRandolph@dhmh.state.md.us or mail to: Gayle Jordan-Randolph, M.D., Mental Hygiene Administration, Spring Grove Hospital, Dix Building, 55 Wade Avenue, Catonsville, MD 21228.

EHP® BEHAVIORAL SERVICES, LLC

Union Memorial Hospital
Department of Psychiatry
Associate Chief

We are seeking a board-certified psychiatrist that has the ambition and skills to assume a leadership role within our group and advance to the chief position within a 5-year period. Qualified candidates must be able to demonstrate the following:

- Comprehensive, efficient and quality clinical care
- Excellent interpersonal skills with:
  - Executive hospital management
  - Behavioral health professionals in our group
  - Community and hospital-based physicians
  - Hospital administrative and clinical support staff
  - Group administrative and management staff
- Practice management knowledge
- Leadership ability
- Medical administrative management knowledge
- Professional staff recruitment and retention skills

EHP is a multi-discipline, multi-location behavioral health group that provides consultation, crisis intervention services, inpatient, PHP and outpatient services at Union Memorial Hospital in Baltimore, Maryland. The selected individual will be expected to gain experience in all phases of our operation. Primary initial focus will be on consultation service management and inpatient support.

For consideration, please forward your cover letter and CV to: EHP at 3333 N. Calvert Street, Suite 670, Baltimore, MD 21218 via mail, 410-933-9085 via fax or sar@psychbillinc.com via e-mail. Should you have any questions, please feel free to contact Steven A. Rose, RN at 410-933-9000, extension 210.

Springfield Hospital Center is seeking Board-certified or Board-eligible **general psychiatrists** for our 350-bed MHA adult inpatient facility. Salary is negotiable, within MHA guidelines. Our rural, tobacco-free campus is 22 miles west of Baltimore, convenient to the Chesapeake Bay, Washington, and a variety of cultural, historic, sports, and recreational venues. Benefits include 27 paid days off in the first year, subsidized health insurance, free parking, a generous retirement program, and a truly pleasant workplace. A Medical Services physician is always on campus to attend to patients' somatic needs. Staff psychiatrists are not expected to work after hours, but some choose to supplement their salary by providing evening and weekend/holiday coverage under contract. In addition, we offer after-hours coverage contracts to psychiatrists who are not full-time staff members. Please send CV to **Jonathan Book, M.D., Clinical Director, SHC, 6655 Sykesville Road, Sykesville, MD 21784. For questions, call (410)970-7006 or e-mail JBook@dhmh.state.md.us.** EOE

MASSACHUSETTS

The Department of Psychiatry at Mount Auburn Hospital, affiliated with Harvard Medical School, is recruiting for a full-time position in our Outpatient Psychiatry Service. Responsibilities include evaluation and treatment of adult patients with a variety of psychiatric disorders, including dual diagnosis patients, and coordination of care with other psychiatric clinicians and with primary care and specialty physicians. There are opportunities to work with our Dept. of OB/GYN and the women's mental health program. Position includes participating in the teaching activities of the Department. Academic appointment to the clinical faculty at Harvard Medical School is anticipated. Please send letter of interest and cv to: Joseph D'Afflitti, M.D., Chair, Department of Psychiatry, Mount Auburn Hospital, 330 Mount Auburn Street, Cambridge, MA 02138; tel: 617 499-5008; email: jdafflit@mah.harvard.edu.

Starr Psychiatric Center seeks a 20-30 hr psychiatrist for dynamic established psychiatric practice On Boston's South Shore. Medical model, multi-disciplinary staff. Stimulating environment, good pay. Clinic has a reputation for successful care, where others have failed. Email davidzstarr@juno.com or call 508.580.2211.

CHILD AND ADOLESCENT PSYCHIATRIST

St. Ann's Home is seeking a part-time Child and Adolescent Psychiatrist (BE/BC) to provide services to children, ages 5-18, and families in our residential, educational, hospital diversion, and outpatient programs . The Child and Adolescent Psychiatrist will be part of our dynamic multi-disciplinary team. St. Ann's Home is known and respected for our holistic and multifaceted approach to providing psychiatric care.

Contact:

Denis Grandbois
St. Ann's Home and School
100A Haverhill St.
Methuen, MA 01844
dgrandobis@st.annshome.org
Phone: (978)682-5276
FAX: (978)688-4932
www.st.annshome.org

High Point Treatment Center is seeking a 40 hr week psychiatrist for a 16-bed Inpatient Psychiatric Unit located in Plymouth, MA. Salary ranging from $170,000 - $190,000. No weekends, paid holidays and leave time. Health benefits available. If willing to work an additional 1 hr per day salary range would be $200,000 - $215,000. If interested, please contact Jim Horvath at 508-503-2455 or email to jim.horvath@hptc.org.

BOSTON & SUBURBs - Brookline, Jamaica Plain, & Pembroke (Cape Cod area)! Full time & part-time positions for **Child & General Psychiatrists.** Inpatient/partial programs - **NO CALL.** Administrative/clinical positions for qualified candidates. Salary, benefits & incentive plans offered. Week night & weekend call coverage/moonlighting shifts also available. Contact Courtney Williams @ 866-227-5415 or email courtney.williams@uhsinc.com

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UMass Department of Psychiatry is looking for moonlighting BE/BC psychiatrists to assist with our coverage needs at local hospitals. This may involve either overnight or weekend coverage. Excellent reimbursement. Please email psychiatryrecruitment@umassmemorial.org or fax to 508-856-5990. AA/EOE

Central Massachusetts - The University of Massachusetts Department of Psychiatry is seeking BC/BE psychiatrists for part-time to full-time positions in our community mental health centers in Worcester and Leominster. Community HealthLink (CHL) is a dynamic organization providing services to those with mental illness, developmental disabilities and substance abuse (see www.communityhealthlink.org). Work with a dedicated multidisciplinary staff. CHL psychiatrists are part of our UMass faculty with opportunities for teaching and research. Please email psychiatryrecruitment@umassmemorial.org or fax to 508-856-5990. AA/EOE

MARLBOROUGH, MASSACHUSETTS - UMass Department of Psychiatry is seeking candidates for a half-time to three-quarter time psychiatrist at its affiliated general hospital in Marlborough, Massachusetts. The position primarily involves providing treatment and clinical care supervision on the unit's superb partial hospital program and a small amount of inpatient coverage. The hospital is a popular training site for medical students and faculty may participate in other academic activities of the department. Faculty appointment at UMass Medical School commensurate with experience. Applicants should send letter of interest and CV to Alan P. Brown, MD, Vice Chairman of Clinical Services, Department of Psychiatry, UMass Memorial Medical Center, 55 Lake Avenue North, Worcester, MA 01655 or e-mail BrownA01@ummhc.org AA/EOE

Inpatient psychiatrist position with unique group practiceBC/BE inpatient psychiatrist wanted to join an 11 psychiatrist group in Southeastern MA. Southern New England Physicians Associates (SNEPA) provides a collegial work atmosphere in an all physician/physician run group practice environment. Our group prides itself on facilitating members individual interest while providing high quality clinical services. This position will be well compensated and with partnership tract available.
CONTACT: CV to Russell Pet, M.D or Duane Bishop, M.D.101 Page St., New Bedford, MA 02740 Fax (508) 961-5931
Call (508) 961-5930 or email c/o pepina@southcoast.org

Greater Boston—Northeast Hospital Corp is a local nonprofit medical and psychiatric system on Boston's North Shore, named one of the nation's top 100 integrated healthcare systems by Solucient. The Inpatient Behavioral Health division includes BayRidge Hospital, a 62 bed freestanding psychiatric facility in Lynn, an 18 bed inpatient unit at Beverly Hospital, and a 12 bed Senior Adult inpatient unit at Addison Gilbert Hospital in Gloucester, as well as Partial Hospital Programs at each site. Both BayRidge and Beverly Hospitals serve as teaching sites in psychiatry for Boston University School of Medicine. Upcoming opportunities at both the inpatient and partial hospital levels of care are anticipated. No required night call, but participation in a lucrative call system is optional. Competitive salary, and full benefit package includes generous time off as well as reimbursement for malpractice insurance and CME expenses. Contact Barry Ginsberg, M.D., Chief and Administrative Director, NHC Dept. of Psychiatry, 60 Granite Street, Lynn MA 01904. Phone (781) 477-6964, Fax (781) 477-6967, email bginsber@nhs-healthlink.org.

MICHIGAN

Associate Medical Director
Alpena, MI

Horizon Health, in partnership with **Alpena Regional Medical Center** in **Alpena, MI**, seeks an Associate Medical Director for a 15-bed Adult Inpatient Psychiatric Program.

Alpena Regional Medical Center (ARMC) is a 146-bed acute care facility with nearly 100 physicians, over 900 employees and approximately 300 volunteers. Federally-designated as a rural Regional Referral Center for all of Northeastern Michigan.

Alpena overlooks Lake Huron's picturesque Thunder Bay in northern Michigan, and is located on the Sunrise Side Coastal Highway, a 200-mile stretch of US 23 graced with scenic views, undeveloped wild areas, roomy beaches and recreational areas for hiking, biking, cross-country skiing and snowmobiling. Excellent practice and income opportunity.

Contact: Mark Blakeney, Horizon Health, 972-420-7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. EOE.

MONTANA

Medical Director
&
Associate Medical Directors
Helena, MT

Horizon Health, in partnership with **St. Peter's Hospital** in **Helena, MT,** seeks a **Medical Director** and **Associate Medical Directors** for new distinct **Adult** and **Geriatric** Inpatient Psychiatric Units, comprised of **26** total beds.

Nestled beneath the foothills of the Montana Rockies, **Helena,** the Capital of Montana, is a thriving city of 70,000 people known as the "Queen City of the Rockies". Alive with history and culture, this charming, sophisticated, and beautiful Victorian city provides a diverse attraction with many street festivals, theater, museums, symphonies, fairs and rodeos. There is truly something for everyone here!

St. Peter's Hospital in **Helena, MT** is an independent, community-based, 99-bed facility that partners with its patients, community, and medical staff to provide exceptional and compassionate healthcare. **St. Peter's** is accredited by the Joint Commission and is the recipient of numerous national, regional, and state awards.

Excellent practice opportunity with salary ($200K+) and benefits! For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

NEW HAMPSHIRE

Medical Director For Established, Diverse, Cutting Edge Program In Concord, New Hampshire. Competitive compensation package which includes signing bonus and performance bonuses twice a year. Call to obtain complete job description for your clinical and administrative responsibilities. Opportunity for ECT and TMS, if desired. Participate in teaching of NH Dartmouth Family Medicine Residents. EMR. One hour to Boston, the White Mountains, or the Atlantic Coast! No state income tax or sales tax. **Contact Germaine Lorbert at 800-678-7858, x63704 or glorbert@cejkasearch.com ; www.cejkasearch.com .** ID#31624PY.

NEW JERSEY

Southern NJ near Cherry Hill - Geriatric Psychiatrist. Fulltime position - inpatient & partial programs. **No weekend call.** Salary & benefits. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

NEW MEXICO

Presbyterian Healthcare Services (PHS) in New Mexico has openings in general adult and child/adolescent psychiatry. PHS is New Mexico's largest private, non-profit integrated healthcare system. The Behavioral Medicine Program is a full-service psychiatry department covering inpatient and outpatient care, intensive outpatient treatment, emergency and consultative psychiatry and mental health services embedded in primary care. These are full-time employed positions with the 500+ provider Presbyterian Medical Group. PHS provides competitive salary and benefits including malpractice insurance and relocation allowance. Additional information about PHS can be found at www.phs.org.

Contact: Susan Camenisch, Physician Recruiter, PHS
E-mail: scamenisc@phs.org
Phone: 1-866-742-7053

NEW YORK CITY & AREA

FULL-TIME PSYCHIATRIST: EXCELLENT OPPORTUNITY for general & geriatric psychiatrist available at The Long Island College Hospital in brownstone Brooklyn, one step from Manhattan over the Brooklyn Bridge. These BC/BE psychiatrist will be a member of a very active inpatient 39 bed unit. We offer a highly competitive salary/benefit package. We're looking for highly motivated and committed physician. Please fax resume to: THE LONG ISLAND COLLEGE HOSPITAL, DEPARTMENT OF PSYCHIATRY, 339 Hicks Street, FAX: (718) 780-1236.

PSYCHIATRISTS

The City of New York Human Resources Administration's Customized Assistance Services is recruiting Psychiatrists for a unique program providing home-based psychiatric evaluation and crisis-intervention services. In this role, you will utilize a team approach to provide consultative evaluations throughout the City's five boroughs. This will often involve working on geriatric, emergency, and consult/liaison issues.
Psychiatrists must possess a valid license to practice medicine in the State of New York, must have completed an approved residency training program in Psychiatry, and be Board Eligible/Certified.
This position offers regular hours, competitive pay, a collegial atmosphere, a minimum of paperwork, no managed care, and optional on-call duties for additional pay. Fringe benefits include health insurance, 401K, 457, defined benefit pension plans, and paid vacations and sick leave. Physician Loan Forgiveness programs may be available to eligible candidates.
Interested individuals should submit their curriculum vitae and a copy of their New York State Registration(s) to: **Johnny Bon, Director of Personnel Services, NYC Human Resources Administration, Customized Assistance Services, 2 Washington Street - 17th Floor, New York, New York 10004, E-mail: bonj@hra.nyc.gov, Fax: (212) 495-2931.**
HRA/City of New York, an Equal Opportunity Employer

Child and Adolescent Psychiatrist
P/T - 10-15 hours per week (evenings and/or weekends) in a Child and Family Mental Health Center in Brooklyn. Excellent compensation. No call. Fax resume to (718) 553-6769, or email to clinicaldirector@nypcc.org

PSYCHIATRIST

DBMA, the Faculty Practice of Lincoln Medical and Mental Health Center, a major teaching hospital in the Bronx and part of the NYC Health and Hospitals Corporation seeks BC/BE psychiatrists to join staff in In/Out patient, ER services. Successful candidate will provide exec'l clinical care and effective teaching & supv to residents/medical students. Spanish speaking preferred. Academic appt w/ Weill-Cornell Medical College. Send CV w/cltr to Dr. Amy Hoffman, Psychiatry Chair: Fax: 718-579-4910 or Email: somwarub@dbmapc.org AA/EOE M/F

Full Time, Consultation/Liaison & Outpatient Clinic Psychiatrist: excellent opportunity for general psychiatrist available at the Long Island College Hospital in Brownstone Brooklyn. Position has benefits and 403B, also many opportunities for moonlighting. We're looking for a highly motivated and committed physician. Please fax your CV to Camille Munch at 718-780-1236.

Consulting Psychiatrists & Psychologists

BC/BE **Psychiatrists** to provide Consultation-Liaison services and **Psychologists** to provide Psychotherapy and Behavioral Management in Long Term Care settings (NH, SNF).
Facilities Located in NYC Metro area and Westchester, Putnam, Dutchess, Rockland, Orange and Ulster Counties. PT/FT Well above average salaries/benefits, flexible hours.
Recent graduates encouraged to apply.

Please contact: Carlos Rueda, M.D. at Tel: 718-239-0030 or via fax: 718-239-0032
E-mail: crueda@neuropsych-services.com

Medical Director
Bowery Residents' Committee
www.brc.org

Described by *The New York Times* as "one of New York City's most respected charity groups," BRC's mission is: *Helping people reclaim lives lost: we provide hope and dignity by offering opportunities for health and self-sufficiency.* This year, BRC will serve over 8,000 individuals through 25 programs located throughout New York City. Taking a holistic approach to serving a person instead of solving their problems, BRC has been recognized repeatedly for our innovative programs which provide temporary shelter, permanent housing, and a comprehensive array of drug treatment, health, mental health, and employment services. As a result, 2 out of every 3 individuals leaving BRC do so successfully.

We are seeking a board certified/eligible psychiatrist to serve as full-time **Medical Director.** Reporting to the Chief Program Officer, the Medical Director provides leadership and direction regarding agency policy and practice related to medical and psychiatric services; develops quality assurance standards and protocols; works closely with the program management team to ensure compliance with regulatory agencies and standards of care; coordinates and assists in the selection of psychiatric and nursing staff; serves as liaison to outside providers related to medical and psychiatric services; conducts in-service training to staff on related topics. The Medical Director also provides direct psychiatric care to a caseload of patients representing approximately 40% of the position's duties. Preferred candidate will have community psychiatric experience working with homeless mentally ill, chemically addicted individuals in a variety of settings including detoxification centers, shelters and residential treatment programs. Office will be based in Manhattan. Compensation is very competitive and includes a generous benefits package with liberal annual vacation and other leave benefits.

To apply, please submit a letter of interest and CV via email to Careers@BRC.org. Please indicate "Medical Director" in the subject line.

NEW YORK STATE

GLENS FALLS - SARATOGA SPRINGS, NY - Glens Falls Hospital seeks a BC/BE Psychiatrist to join an integrated outpatient psychiatry team consisting of 8 Psychiatrists, and a team of nurses, and social workers. Primary duty is outpatient psychiatry; also provide consults to general medical units and back up to inpatient Behavioral Health Unit. Call is 1:6 with primary ED response by dedicated adjunct staff. Competitive salary and full benefits package. Situated near the Adirondacks, Lake George, and Saratoga, you have access to hiking, boating, skiing, and numerous cultural opportunities year-round. Only 3 hours to NYC, Boston, and Montreal. Send CV to Jennifer Metivier, Physician Recruiter at 518-926-1946 or jmetivier@glensfallshosp.org.

PSYCHIATRIST

An established and progressive private practice located in Albany, NY is seeking a N.Y.S. Certified Psychiatrist for an adolescent and adult outpatient program with flexible hours available. Excellent weekly salary and full administrative services included, in a warm and pleasant ambience. Insurance panel a plus. Please forward your C.V. to: pinbill@nycap.rr.com

Central New York Psychiatric Center, a state-operated, JCAHO Accredited facility, is seeking Psychiatrists for full and part-time positions at its main inpatient facility in Marcy, NY, and at its forensic outpatient units throughout New York State. There are also opportunities to work in an innovative Sex Offender Treatment Program.
- Comprehensive NY State Benefits package available to part-time employees (20 hours and above)
- Outstanding NY State Pension Plan
- Opportunity for Loan Forgiveness Program
- Opportunities exist for additional compensation

Assistant Psychiatrist: $104,192-$115,970
Qualifications: Possession of a NY State Limited Permit AND completion of a training program in psychiatry approved by the American Board of Psychiatry and Neurology for entrance into their certifying examination AND eligibility for full and unconditional participation in Medicaid and Medicare programs.
Psychiatrist 1: $157,623
Qualifications: Possession of a License to practice medicine in NY State OR possession of a Limited Permit and licensure in another state or by written examination in Canada; AND completion of a training program in psychiatry approved by the American Board of Psychiatry and Neurology for entrance into their certifying examination; AND eligibility for full and unconditional participation in Medicaid and Medicare programs.
Psychiatrist 2: $169,707 ($181,777 for Attica)
Qualifications: Possession of a license to practice medicine in NY State OR possession of a Limited Permit and licensure in another state or by written examination in Canada; AND certified in psychiatry by the American Board of Psychiatry and Neurology; AND eligibility for full and unconditional participation in Medicaid and Medicare programs.

Dr. Jonathan Kaplan, Clinical Director
Central New York Psychiatric Center
Box 300 Marcy, NY 13403
Phone: (315) 765-3624 Fax: (315) 765-3629
E-Mail CN00025@OMH.STATE.NY.US

Psychiatrist - $2,500 sign-on bonus, Albany, New York Capital District. Relocation allowance. Excellent pay and Benefits. EOE. Private psychopharmacology practice in Albany, New York. Driving distance to New York City, Montreal, Boston. Enjoy the great Adirondack region for hiking, boating, golfing, site seeing. **Direct Contact Information:** Resume: POB 5324, Albany, NY 12205 or info@psychopharmconsultants.com.

NORTH CAROLINA

Close to Greensboro and Winston-Salem - Due to expansion of psychiatric services in the Thomasville Medical Center, we are seeking another psychiatrist already in practice who wants to add on some inpatient work, or we can offer an income guarantee to help a psychiatrist get their practice going. Great quality of life; great location; and great income potential. Please **call Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

9 to 5 POSITION RIGHT NEAR RALEIGH - Live in Rocky Mount or Raleigh and work in a very impressive general hospital with adult and chemical dependency inpatient/outpatient services. Offering opportunity to join our Medical Director's very successful practice; or salary with benefits if preferred. Contact **Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; terry.good@horizonhealth.com.

Private Practice Opportunities in North Carolina

Carolina Partners in Mental HealthCare, PLLC is seeking BE/BC psychiatrists for our practices in Raleigh, Cary, and Wake Forest, NC. Child/adolescent and/or adult psychiatrists welcome. Private outpatient practices, full partnership from day one - no investment required. FT, PT flexible. Carolina Partners has ten offices in Raleigh, Durham, Cary, Chapel Hill, Pittsboro and Wake Forest, North Carolina. Good opportunity to control your life and clinical practice, while making a good income! Contact Executive Director or send CV to: Carolina Partners in Mental HealthCare, 1502 W. Hwy 54, Suite 103, Durham, NC 27707. Phone 919-967-9567; Fax 919-882-9531; Email carolinapartners@bellsouth.net. Please visit our website located at carolinapartners.com

NORTH DAKOTA

Join Prestigious Upper Midwest Medical Group

MeritCare Health System of Fargo, ND is seeking an Adult Psychiatrist to join its multi-disciplinary Psychiatry Department. Faculty appointment and teaching of psychiatry residents is available through University of North Dakota School of Medicine. MeritCare is an integrated 450-physician, multi-specialty group practice, 583-bed, Level II tertiary/trauma hospital with 27-primary care clinics in two states. Sister cities, Fargo, ND and Moorhead, MN, are a tri-college community of 190,000 located near the heart of Minnesota's lake country. Fargo-Moorhead offers excellent educational systems, recreation and sports activity as well as a variety of entertainment and cultural events. This is an excellent opportunity with a competitive compensation and benefits package being offered. This is not a designated HPSA site. To learn more about this practice opportunity visit our website at www.meritcare.com or contact:

Jean Keller, Physician Recruiter
MeritCare Health System
P O Box MC
Fargo, ND 58122-0385

Phone: 701-280-4853
Fax: 701-280-4136
Email: Jean.Keller@meritcare.com

OHIO

30 Minutes from Dayton Suburbs - easy drive to Indianapolis - Expanding adult and geropsych services in an extremely impressive med/surg hospital (gorgeous brand new facility). Join top-notch medical staff. Services include inpatient, outpatient and IOP. Offering very attractive salary with benefits & bonus plan & possible sign-on bonus. Please call **Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com. EOE

OREGON

Oregon Department of Human Services

The Oregon Department of Human Services (DHS) is looking for Board Certified or Board eligible Psychiatrists with interest and/or experience in adult and forensic programs. You must also be eligible for licensure to practice medicine in Oregon. Salary is very competitive and includes psychiatric differential, certification pay, and opportunities for additional on-call work can increase your income substantially. A generous benefit package includes health and dental insurance and one of the best public employee retirement programs in the country. DHS operates three Psychiatric Hospitals in Salem, Portland, and Pendleton. Please call (503) 945-2817, Fax#: (503) 945-9910; Email: osh.recruitment@state.or.us. Or mail CV to: Human Resources, 2600 Center Street NE, Salem, OR 97301-2682. The Oregon Department of Human Services is committed to affirmative action, equal employment opportunity and workplace diversity.

PENNSYLVANIA

Faculty Openings
Inpatient, Consultation and Liaison

Temple University School of Medicine, Department of Psychiatry and Behavioral Science has faculty openings in Inpatient, Consultation and Liaison. Responsibilities include providing clinical care and teaching residents and medical students. The selected individual will also have the opportunity to participate in research. Candidate must be board-eligible or board-certified (preferred). Rank and salary commensurate with experience.

To apply, submit curriculum vitae to Dr. David Baron, Chair, TUSM Department of Psychiatry and Behavioral Science C/O Scott Caldie, Director, Physician/Faculty Recruitment & Retention, Temple University School of Medicine, 3401 North Broad Street, 6th Floor Parkinson Pavilion, Suite 640, Philadelphia, PA 19140.

Temple University is an affirmative action/equal opportunity employer and strongly encourages applications from women and minorities.

TEMPLE UNIVERSITY®

Horizon Health and St. Vincent Health System
Staff Psychiatrist
Erie, PA

Horizon Health, in partnership with **St. Vincent Health Center (Voted 5th Best Place to work in Pennsylvania!)**, a 436-bed tertiary care hospital in **Erie, PA,** has an exciting opportunity for a **Staff Psychiatrist** for a **32-bed** Adult and Geriatric Inpatient Psychiatric Program.

Opportunities for input and growth, tertiary care, teaching opportunities in FP residency program and LECOM medical school. Excellent compensation package with full benefits.

Located on the shores of **Lake Erie** with 7 miles of beaches, Erie is the **fourth largest city** in Pennsylvania with a metropolitan population of 280,000. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

Medical Director
Ashland, PA

Horizon Health, in partnership with **St. Catherine Medical Center** in Ashland, PA is seeking a **Medical Director** for a brand new, 14-bed Adult inpatient psychiatric unit.

Ashland is located in eastern Pennsylvania in a region that is rich with the history of America's pioneers, and is an outdoor enthusiast's playground. The world famous cheese steaks of Philadelphia and outlets of Reading are less than 90 miles away, and there is easy access to the excitement of Manhattan.

Become a pioneer and get in on this truly unique ground floor opportunity! For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

One Hour From Philadelphia; One and a Half Hours to Baltimore - Seeking Psychiatrist to work on adult inpatient program in an impressive med/surg hospital in a beautiful Lancaster—close to Harrisburg. Plans for future geropsych unit. Can offer salary with benefits, income guarantee, or contract with local practice for part-time Medical Director position. Please call **Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

PHILADELPHIA - Child Psychiatrists for Residential & Inpatient Treatment Center OR Partial Day Program only in Bucks County. **CLARION & SHIPPENSBURG** - General Psychiatrist for Adult services. Positions can be fulltime or part-time (Mon-Fri schedule) - salary & benefits. Contact Joy Lankswert @ 866-227-5415; OR email joy.lankswert@uhsinc.com

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Psychiatrists:

Currently we have exciting full- and part-time positions in a rapidly expanding department. Opportunities include responsibilities in and outside our five-hospital health system. There are immediate openings for child/adolescent, adult and addictions psychiatrists.

In addition, there are private practice options in a traditional psychotherapy model. Evening and weekend positions available. Excellent salaries, no on-call nor rounding responsibilities ever and exceptional benefits package offered. Send CV to Kevin Caputo, M.D., Vice President and Chairman, Department of Psychiatry, Crozer-Keystone Health System, One Medical Center Blvd., Upland, PA 19013 or contact the department manager, Kathy Waring at 610-619-7413

RHODE ISLAND

LIFESPAN PSYCHIATRY
Rhode Island Hospital
Affiliated Hospital of the Warren Alpert Medical School of Brown University

This full-time clinical position is part of an academic medical center program, and eligible through teaching opportunities to be considered for a Clinical Faculty appointment at Brown University. There are possibilities for research participation for applicants with appropriate background and interests, although the position is primarily clinical.

The position consists of half-time inpatient unit attending role along with half-time general outpatient psychiatry.

Applicant must be Board Certified in Psychiatry or Board eligible (within three years of training completion). Salary and benefits commensurate with level of training and experience.

Please send CV's along with a letter of interest to Richard J. Goldberg, M.D., Psychiatrist-in-Chief, APC-9, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903 and/or email: rjgoldberg@lifespan.org.

(1-2-09/eh/hr/ads)

Fulltime position available for board eligible/certified inpatient psychiatrist interested in clinical faculty position at Butler Hospital. This outstanding opportunity offers a collegial academic environment in the major psychiatric teaching facility of the Warren Albert School of Medicine at Brown University, located in Providence, RI. Salary and clinical faculty appointment commensurate with experience. Apply by sending CV to Steven_Rasmussen@brown.edu.

SOUTH CAROLINA

AIKEN - minutes from Augusta GA & Columbia, SC. General Psychiatrist - inpatient & partial programs. Fulltime position - salary & benefits. LOAN REPAYMENT ELIGIBLE. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

TENNESSEE

Board-certified/eligible psychiatrists needed for full time positions in a large Psychiatry Service at Mountain Home VAMC in Johnson City, Tennessee. Primary responsibility will be managing outpatients with a variety of psychiatric disorders. Join staff of 30 prescribers, including 18 psychiatrists at ETSU-affiliated residency training program with medical students, adult and med-psych residencies. Clinical appointment potential and some teaching expected. Research a plus. On-call is backup to residents and shared amongst staff psychiatrists. **NO STATE INCOME TAX, LOW COST OF LIVING, BEAUTIFUL MOUNTAINOUS REGION, LOTS OF PARKS, GOLF COURSES, LAKES, NATIONAL FOREST.** Inquiries: Deborah Burchfield, 423-979-3465, or Deborah.Burchfield@va.gov applications and/or CVs to: James H. Quillen VA Medical Center P.O. Box 4000 (05), Mountain Home, TN 37684 or Fax: (423) 979-3443 or E-mail: mtnhomehrmservice@med.va.gov

TEXAS

AUSTIN GERIATRIC PSYCHIATRY, www.senioradults.net: office, nursing and assisted living facilities, research. Great job with flexible income, hours and benefits. E-mail CV and 3 references to jwinston@austin.rr.com

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AUSTIN: Child Psychiatrist for Residential Treatment Center. Salaried employment & benefits. **WEST TEXAS San Angelo:** Private practice opportunity. Income guarantee & practice start-up support. Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

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PSYCHIATRISTS: Mental Health Mental Retardation Authority of Harris County (MHMRA) in Houston, Texas is one of the largest mental health centers in the United States. Demands have created the need for additional psychiatrists throughout the Agency.

Northwest Outpatient Clinic
Work 8 to 5 Monday through Friday
Perform psychiatric evaluations & treatment in clinic setting
No on call

Harris County Jail
Day shift at 24/7 facility
Perform psychiatric evaluations & medication management
Some on call
Seeking Lead Psychiatrist & Psychiatrist

Texas licensure is required for all positions

MHMRA offers competitive salary plus a generous benefit package. Houston offers excellent quality of life, lower than average cost of living, no state sales tax and exciting cultural, entertainment, sporting and tourists venues. **Contact Charlotte Simmons at (713) 970-7397, or submit your C.V. to charlotte.simmons@mhmraharris.org or fax: 713-970-3386**

VIRGINIA

Virginia Commonwealth University, Department of Psychiatry, School of Medicine, is recruiting a Virginia license-eligible BE/BC psychiatrist for adult attending psychiatry faculty position in the Division of Inpatient Psychiatry. Will work as inpatient/outpatient attending and will be responsible for administration and clinical care as well as teaching and supervision of medical students, residents and fellows. The selected candidate will have community outpatient clinic teaching responsibilities for medical students, psychiatric residents and other trainees. The VCU, Department of Psychiatry employs over 70 fulltime faculty and has well-funded research in genetics, addictions, child and women's mental health and psychopharmacology. VCU is a large urban university with robust health science campus and 750-bed university hospital. Richmond, the State Capital, has moderate climate and rich mix of history with modern facilities, excellent suburban housing, and top public/private schools. The internet provides comparative cost of living. Send CV to Anand Pandurangi, MD, c/o Marie Baker-Roach, Human Resources, Department of Psychiatry, VCU, Box 980710, Richmond, VA 23298. VCU is an Equal Opportunity/Affirmative Action employer. Women, minorities, and persons with disabilities are encouraged to apply.

Richmond, Virginia-An established successful psychiatry group is seeking a BE/C Adult Psychiatrist to join their private practice. This is a partnership track position and includes a combination of outpatient, and consultation. A guaranteed salary, full benefits, paid vacation/CME and assistance with relocation will be provided. Contact Stephen@mdrsearch.com or 800-327-1585 ext 206. Not a J-1 site.

Exciting Opportunity with a large behavioral health company nestled in the heart of Southwest Virginia. Full-time outpatient Psychiatrist needed to work with adult patients in Lee, Scott & Wise Co. Communities. Comprehensive array of services available with Case Workers, Nurse Practitioners and licensed Clinicians. Salaried position with full benefit package. For more information, please contact Andra Savage @ 423.844.5062 or Andra_R_Savage@Wellmont.org.

Newport News - Child Psychiatrist - Residential Treatment with children and adolescents. Fulltime position - salary & benefits. Contact Joy Lankswert @ 866-227-5415 or email joy.lankswert@uhsinc.com

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Come Work & Play in the Mountains

Centra Health, located in Lynchburg, Virginia, is seeking a board certified/eligible general/adult psychiatrist for its expanding mental health programs. Duties include maintaining an outpatient practice, facilitating admissions to our acute inpatient program, and sharing call, 1:7, with our psychiatric team. Centra provides an unrivaled continuum of mental health and substance abuse services.

A not-for-profit healthcare system comprised of Virginia Baptist, Lynchburg General, and Southside Community Hospitals, Centra provides a guaranteed and competitive base salary and incentive bonus along with an excellent benefit package.

Located in Central Virginia on the James River, in the foothills of the Blue Ridge Mountains, the area offers a temperate climate, distinguished schools, a wide variety of activities and amenities, and a high quality of life. For more information, contact Bill Semones, Vice President, Mental Health Services, at 434-200-4514 or bill.semones@centrahealth.com

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PACT PSYCHIATRIST - #682
STAFF PSYCHIATRIST - #694

District 19 Community Services Board, based in Old Towne Petersburg, is recruiting for these two full time positions. The hiring range for each position is $125-$145k. For more information, please visit our website at www.d19csb.com or call (804)862-8062.

VIRGINIA COMMONWEALTH UNIVERSITY, Department of Psychiatry, School of Medicine, is recruiting a **BE/BC psychiatrist for a faculty position to direct the ECT Program** and develop a brain stimulation therapies program. Candidates should have had one year fellowship or hands-on experience in ECT, or 2-5 years experience post-residency and an interest in developing the ECT and other stimulation therapies program at VCU. The selected candidate will have community outpatient or teaching clinic responsibilities and will be expected to teach medical students, psychiatric residents and other trainees. The VCU, Department of Psychiatry employs over 70 fulltime faculty and has well-funded research in genetics, addictions, child and women's mental health and psychopharmacology. VCU is a large urban university with robust health science campus and 750-bed university hospital. Richmond, the State Capital, has moderate climate and rich mix of history with modern facilities, excellent suburban housing, and top public/private schools. The internet provides comparative cost of living. Send CV to the Search Committee Chair, to Anand Pandurangi, MD, c/o Marie Roach, Human Resources, Department of Psychiatry, VCU, Box 980710, Richmond, VA 23298. VCU is an Equal Opportunity, Affirmative Action employer. Women, minorities, and persons with disabilities are encouraged to apply.

VIRGINIA COMMONWEALTH UNIVERSITY, Department of Psychiatry, School of Medicine, is recruiting a **BE/BC psychiatry educator to serve as Chair, Division of Ambulatory Psychiatry.** Duties include development of new programs, ambulatory care research, ambulatory resident and student education, and direction of general and specialty clinics. Significant experience in academic ambulatory care, psychiatric education, administration and clinical research desired. Ambulatory Care Clinics are located at the VCU Medical Campus, and have an estimated 16,000 patient visits/year. Department of Psychiatry employs over 70 fulltime faculty, is financially stable, and is nationally ranked in federally funded research. Richmond, the State Capital, has moderate climate and rich mix of history, a diverse multicultural community, excellent housing and public/private schools. Internet provides comparative cost of living. Send CV to Search Committee Chair, to Joel J. Silverman, MD, c/o Marie Roach at VCU, Department of Psychiatry, PO Box 980710, Richmond VA 23298. Virginia Commonwealth University is an Equal Opportunity/Affirmative Action employer. Women, persons with disabilities, and minorities are encouraged to apply.

VIRGINIA BEACH

Board certified psychiatrist to join 1 psychiatrist and 3 therapists in well-established out-patient practice caring for children adolescents and adults. Opportunity for ownership in several years. Contact Dan Darby, MD at Tel: (757) 425-5050 Fax: (757) 425-1389.

Psychiatrist Virginia

Per Diem - $150/hr
Salaried: $225,000.00/year

Join a team of Internists, Psychologists and Counselors in collaboration with Correctional officers. It is a rewarding experience for a Psychiatrist who is interested in the "continuity of care and positive outcome" of treatment. Work in the safest environment one can imagine at two local prisons. Close to UVA Wise and an hour from historic Abingdon, and enjoy the outdoor activities in SW Virginia. The position requires 20hrs/wk work at each facility. Work is available as of March 1st, 2009. Malpractice coverage is provided.
Salaried position offers 2 weeks' paid vacation and retirement benefits. **Send CV to HCCI, PO Box 5070, Williamsburg, VA 23188 or email at neuro-psych@usa.net**

WASHINGTON

The University of Washington and Harborview Medical Center (HMC) in Seattle, WA is accepting applications for a psychiatrist at the rank of Instructor or Assistant Professor (without tenure). This position is 1.0 FTE and will do a mix of consultation and inpatient psychiatry. Two half days a week will be spent working in psychiatry outpatient service settings. The position requires an MD and includes responsibility for teaching residents and medical students. Please send CV and cover letter to Peter Roy-Byrne, MD, Chief of Psychiatry, HMC 325 9th Ave. Box 359911, Seattle, WA 98104. University of Washington faculty engage in teaching, research, and service. The UW is building a culturally diverse faculty and strongly encourages applications from females and minority candidates. The UW is an EOE/AA employer.

Western Washington State: Adult/Geriatric/Forensic Psychiatrist (BE/BC with a WA state license) applications considered. Western State Hospital is a fully accredited (JCAHO) and certified (CMS) 997 bed hospital serving adult, geriatric and forensic populations. Annual salary up to $158,304 DOQ. Excellent benefits, including hospitalization/medical insurance, retirement and vacation leave, plus optional deferred income plan. Send CV to Leah Muasau, Medical Staff Coordinator; Western State Hospital; 9601 Steilacoom Blvd. SW; Lakewood, WA 98498-7213. E-Mail: MUASALL@DSHS.WA.GOV.

WEST VIRGINIA

Shenandoah Valley-3rd psychiatrist for multidisciplinary behavioral health service 90 minutes from DC/Baltimore. Experience/training in addictionology, child/adolescent psychiatry preferred. Salaried position w/incentive compensation, benefits. Community Health Center HPSA status offers potential Federal Loan Repayment. Contact Tina Burns 304 596 2610, ext 1066; tburns@svms.net FAX 304 263 0984.

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Clinical/Research Fellowship
This is an excellent opportunity for a 2009 fellowship with the Schizophrenia Treatment & Research Program (STAR) which is a division of the Mt Sinai School of Medicine's Department of Psychiatry, ranked in the top 10 research departments in the US and its affiliate institution, the James J. Peters VA Medical Center. The program provides comprehensive psychiatric care for schizophrenia, schizoaffective disorder, and other primary psychotic disorders. The program focuses on patients who require active treatment and support for integration in the community, providing services addressing a broad spectrum of psychiatric, medical, and psychosocial needs. A particular program goal is to conduct research to improve treatment and outcomes of schizophrenia. The program is co-directed by Eran Chemerinski, M.D. and Larry Siever, M.D.

Fellowship Goals:
-To develop clinical skills in the multi-disciplinary care of schizophrenia patients
-To introduce concepts in community integration for schizophrenia patients
-To promote research in the etiology, pathophysiology and treatment of schizophrenia.

Competitive Salary, candidates for this position must be US Citizens. We are an Equal Opportunity Employer. For further information contact: Eran Chemerinski, M.D. 718-584-9000 ext 5169 or e-mail: eran.chemerinski@mssm.edu Visit our website at: http://www.mssm.edu/psychiatry/fellowships/clinical_research.html

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Washington, DC
George Washington University School of Medicine

Entering its 32nd year, this ACGME-accredited fellowship in Psychosomatic Medicine is currently accepting applications for three PGY-V positions to start July 1, 2009. Under the guidance of **Thomas N. Wise, MD** and **Catherine C. Crone, MD**, the fellowship offers consultation-liaison training in a wide variety of medical specialties in both inpatient and outpatient settings. This includes: oncology, Ob-Gyn, HIV, trauma, internal medicine, organ transplantation, pulmonary rehabilitation and cardiology. Seminars include clinical, biological and psychodynamic approaches to understanding the medically ill. Opportunities in teaching, research, and outpatient psychotherapy are readily available and strongly encouraged. Training is tailored according to the fellow's area of interest and career goals. The fellowship is based at Inova Fairfax Hospital, an 850-bed tertiary care teaching facility located in the suburbs of Washington, D.C.

Interested individuals should contact
Catherine C. Crone MD,
Fellowship Director
George Washington University
Medical Center
c/o Inova Fairfax Hospital,
3300 Gallows Rd., Falls Church, VA 22042
(703) 776-3380 Fax: (703)776-3029
cathy.crone@inova.org

Fellowship in Addiction Psychiatry
University of Massachusetts Medical School

NEWLY ACCREDITED Fellowship in Addiction Psychiatry in a department with a major focus on addictions, including psychopharmacology, multiculturalism, basic neuroscience, psychosomatic medicine (working with primary care medicine's addiction faculty), and state-of-the-art psychosocial interventions. Major public and private sector affiliations including 120-bed private sector addiction hospital, a first-of-its-kind 16-bed public sector adolescent detoxification & rehabilitation unit, a new general hospital buprenorphine clinic with an intensive outpatient program for co-occurring disorders, organizational-wide tobacco cessation program, and a continuum of care for opioid dependent patients from detoxification through substitution therapy to community rehabilitation. We are in the midst of a major expansion of clinical and research services in the addictions, and the establishment of an academic Center of Excellence in Addiction Psychiatry. There are many clinical and translational research opportunities for trainees. This is an exciting time to join the UMass Addiction Psychiatry Program. Interested persons should contact: Gerardo Gonzalez, MD, Director of Addiction Psychiatry Fellowship Program, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655. Call Diana Langford (508) 334-0577 or email gerardo.gonzalez@umassmed.edu AA/EOE

INFANT PSYCHIATRY FELLOWSHIP. The Section of Child and Adolescent Psychiatry at Tulane University School of Medicine is seeking a full-time Fellow in Infant Psychiatry. This one or two year fellowship includes clinical and research experiences with the multidisciplinary Infant Mental Health group at Tulane. MD/DO required. Completion of a fellowship in Child and Adolescent Psychiatry preferred. Faculty appointment at the Instructor level with very competitive salary is possible. Applications will be accepted until a suitable qualified candidate is found. Applicants should send letter of interest, updated CV and list of references to Charles Zeanah MD, Vice Chair and Director of Child and Adolescent Psychiatry, 1440 Canal Street TB52, New Orleans, LA 70112. Interested eligible applicants may obtain further information regarding this position by contacting Dr. Zeanah at 504-988-5402 or czeanah@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

"Forensic Psychiatry Fellowship opening at University of Massachusetts Medical School".

The University of Massachusetts Medical School (UMMS), Law and Psychiatry Program, has an unexpected opening in its ACGME-accredited Fellowship in Forensic Psychiatry starting 7/1/09. This one-year, full-time position involves participation in intensive academic and clinical training in issues related to forensic psychiatry and the legal regulation of mental health. Fellows conduct a wide variety of court-ordered inpatient forensic evaluations and rotate at major court clinic sites. Private civil and criminal forensic evaluations are conducted through the Forensic Evaluation Service. The program emphasizes intensive supervision of all work and a weekly schedule of structured didactic seminars, as well as opportunities for research with a multidisciplinary team of forensic professionals who are among the national leaders in the field. Nationally recognized research programs in forensic psychiatry, psychiatric neuroscience, psychopharmacology, addiction psychiatry, child psychiatry, mental health policy, and other areas, a major commitment to public sector psychiatry, and over 250 faculty make UMass an exciting place to train. Interested individuals should contact: Paul Noroian, M.D., Director, Forensic Psychiatry Fellowship, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655. Call (508)856-3079 or email: Paul.Noroian@umassmed.edu . AA/EOE

Postdoctoral Fellowship
Intramural Research Program
Section on Nutritional Neurosciences, NIAAA
Bethesda, Maryland, USA

The National Institute of Alcohol Abuse and Alcoholism (NIAAA), Section on Nutritional Neurosciences, seeks an applicant for a fellowship in nutritional neurosciences. The fellowship is designed to train psychiatrists in nutritional neurosciences, omega-3 fatty acid biochemistry, addiction psychiatry, biostatics and clinical research design.

The position is available for June 2009.

Applicants should have and M.D. or D.O. and a minimum of three years residency training.

NIAAA is a major research component of the National Institutes of Health and the Department of Health and Human Services, which have nationwide responsibility for improving the health and well being of all Americans. **Interested applicants should send a curriculum vitae and bibliography, together with three letters of reference to: CAPT Joseph R. Hibbeln, M.D., Acting Chief, Section on Nutritional Neurosciences, 5625 Fishers Lane, Rm 3N-07, Bethesda MD, USA or e-mail to jhibbeln@mail.nih.gov.**

This position is subject to a background investigation.

NIH and DHHS Are
Equal Opportunity Employers.

Augusta, Georgia
Research Fellowship in Psychotic Disorders

The Medical College of Georgia, Department of Psychiatry and Health Behavior, has 1-2 year PGY-5 Schizophrenia Research Fellowship position, starting July, 2009. The fellow will be a psychiatrist who has completed residency and is eligible for Georgia license. Fellow will participate in psychopharmacological, genetic and epidemiological studies of schizophrenia with competitively funded mentors, attend national/international meetings and learn neurobiology research methods, statistics, and scientific writing. Augusta is an inexpensive and superb place to live.
See http://mcg.edu/som/psychiatry/fellowship.htm for more information. MCG is an equal employment, equal access and equal educational opportunity and affirmative action institution. It is the policy of the University to recruit, hire, train, promote and educate persons without regard to age, disability, gender, national origin, race, religion, sexual orientation or veteran status. Contact: Brian Kirkpatrick, M.D., bkirkpatrick@mail.mcg.edu.

PSYCHOSOMATIC MEDICINE FELLOWSHIP

One year exciting, well-established, fellowship program, one of the first accredited by the ACGME, in a 750-bed university hospital, accepting applications for July 1, 2009. Advanced training offered to psychiatrists who have completed residency. Please write or call: James L. Levenson, M.D., Chairman, C-L Division, VCU Health System, Department of Psychiatry, Box 980268, Richmond, VA. 23298-0268, jlevenson@mcvh-vcu.edu (804) 828-0762; Yaacov R. Pushkin, M.D. ypushkin@mcvh-vcu.edu, or Sherif Meguid, M.D. aabdel-meguid@mcvh-vcu.edu

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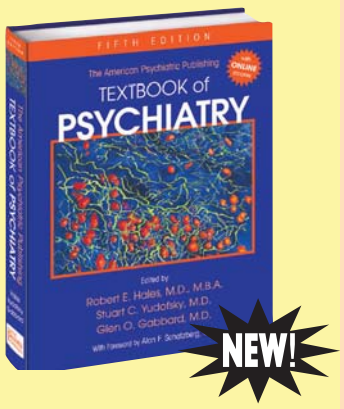

The American Psychiatric Publishing Textbook of Psychiatry

Edited by Robert E. Hales, M.D., M.B.A., Stuart C. Yudofsky, M.D., and Glen O. Gabbard, M.D.

With Foreword by Alan F. Schatzberg, M.D.

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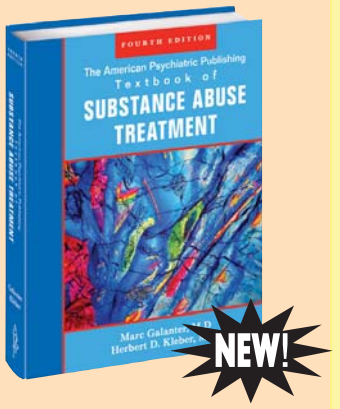

The American Psychiatric Publishing Textbook of Substance Abuse Treatment, Fourth Edition

Edited by Marc Galanter, M.D., and Herbert D. Kleber, M.D.

This book has been fully updated to present the most current scientific and clinical information on a wide range of substance use disorders, from tobacco and alcohol to methamphetamine and "club drug" abuse. It is a comprehensive guide to treatment written at a level appropriate to both experienced and new clinicians, reflecting the expertise of leading addiction specialists in psychiatry and allied fields. With most chapters extensively revised by new authors, it incorporates the latest biomedical research findings as well as recent advances in treatment modalities and the growth of pharmacotherapies.

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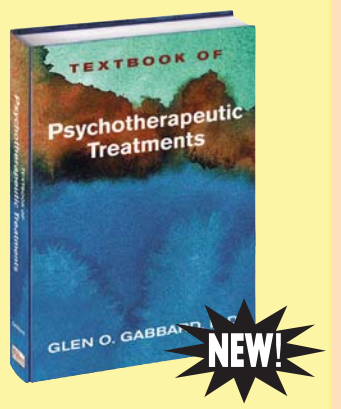

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Edited by Glen O. Gabbard, M.D.

Glen O. Gabbard, author or editor of more than 22 books and over 280 scientific papers and book chapters, is a leader in the fields of psychiatry and psychoanalysis. He has assembled 50 of the world's most renowned experts in every psychotherapeutic school of thought to create this definitive volume, sure to become the standard text for all student and practicing psychotherapists.

Treatment outcome depends on carefully matching the therapeutic modality to the patient or client, and this book will both facilitate and enhance that meticulous process. Up-to-date and scientifically rigorous, this book is the "go-to" reference for the conscientious psychotherapist.

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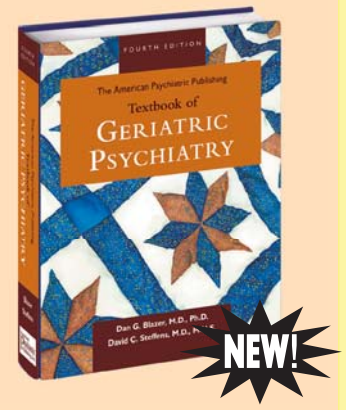

The American Psychiatric Publishing Textbook of Geriatric Psychiatry, Fourth Edition

Dan G. Blazer, M.D., Ph.D., David C. Steffens, M.D., M.H.S.

Widely recognized as the standard in its field, *The American Psychiatric Textbook of Geriatric Psychiatry* has been revised and updated while continuing the tradition of providing both scholar and clinician with the practical skills and knowledge required for understanding mental disorders in later life. It offers an authoritative review of a wide range of topics written by leaders in geriatric psychiatry, gerontology, geriatric medicine, and geriatric nursing, offering a solid grounding in both basic science and clinical applications.

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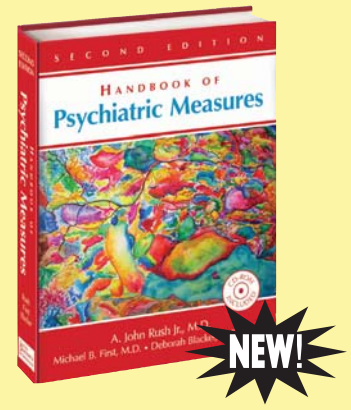

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This book offers a concise summary of key evaluations that clinicians can use to enhance the quality of patient care. It contains more than 275 rating methods, from the Abnormal Involuntary Movement Scale to the Zung Self-Rating Depression Scale.

Forty measures have been added to the discussion and to the CD-ROM. In addition to reassessing measures for inclusion—adding measures that empirically provide better patient evaluation and subtracting measures that have been superseded. Costs, translations, and contact information for each measure have also been updated.

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