Volume 45
Number 12
June 18, 2010

Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

inside

PERIODICALS:
TIME-SENSITIVE MATERIALS

Schatzberg Cites Reasons To Be Proud of APA

APA's outgoing president leaves office after working to ensure that APA is an educationally, scientifically, and financially stronger organization.

BY CATHERINE F. BROWN

These days, it's all about outcomes, results, accountability, and metrics.

At last year's APA annual meeting, Alan Schatzberg, M.D., outlined four aims that he planned to address during his presidential year: reestablishing pride in the profession of psychiatry, continuing to improve APA's annual meetings, finding optimal ways to interact with industry, and improving APA's financial status.

Credit: David Hathcox

The Opening Session gets off to a hand-clapping start as a Dixieland band plays "When the Saints Go Marching In."

How well did he do? The applause and standing ovation at the end of his presidential address at the Opening Session of this year's annual meeting in New Orleans indicated that the APA members in attendance were pleased with the results. And after he recapped his leadership efforts, he urged his colleagues to continue along with him to address a number of major issues important to APA and the profession of psychiatry.

Credit: David Hathcox

Outgoing APA President Alan Schatzberg, M.D., gives an accounting of his presidential year to attendees at the Opening Session of APA's 2010 annual meeting in New Orleans last month. There were about 11,000 registrants for the meeting.

"Psychiatrists should take pride in their often heroic efforts to take care of those with mental illness," he said to an audience of about 1,000 on a muggy afternoon in the Big Easy. "Not only are we dedicated physicians, but we lobby hard on behalf of the disadvantaged."

That dedication and advocacy paid off most recently in legislation that is expected to improve the care of this country's mentally ill individuals. "Witness the great 10-year-plus struggle to enact parity for mental illnesses, to eliminate the discriminatory Medicare copay for psychiatric treatment, and to cover under Medicare the prescription costs for many drugs, including benzodiazepines," Schatzberg

please see ***Schatzberg*** *on page 23*

FDA Wants M.D.s to Enlist In War Against Illegal Ads

Physicians and health care professionals are urged to report misleading or inaccurate advertisements of prescription drugs they see at conferences or in their offices.

BY JUN YAN

The Food and Drug Administration (FDA) has launched a campaign to recruit physicians and health care professionals to report potentially illegal advertisements and promotions by drug companies.

This outreach effort, termed the "Bad Ad" program, is being implemented by the FDA's Division of Drug Marketing, Advertising, and Communications (DDMAC).

A Web site at <www.fda.gov/badad> has been set up to educate health care professionals about the types of drug advertisements and promotions that violate the law. Among the examples are overstating efficacy, omitting or downplaying safety risks, and promoting off-label indications.

please see ***FDA*** *on page 23*

New Insurance Carrier Endorsed

APA has announced that it has selected American Professional Agency Inc. (APA Inc.) as the new provider of malpractice insurance for APA members. The company formerly endorsed by APA, PRMS, was no longer willing to keep its program exclusive to APA members. APA Inc.'s commitment to an exclusive program ensures that premium rates are based on APA members' experiences and not impacted by nonmember psychiatrists' claims. Also, the program provides a major coverage upgrade. For example, coverage for fire damage, legal liability, personal and advertising injury, and HIPAA fines and penalties is included at no additional charge. Details about the new program will appear in a future issue. In the meantime, questions may be sent to insurance@psych.org.

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Newspaper of the American Psychiatric Association **PSYCHIATRIC news**

Psychiatric News, ISSN 0033-2704, is published bi-weekly on the first and third Monday of each month by the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Periodicals postage paid at Arlington, Va., and additional mailing offices. Postmaster: send address changes to Psychiatric News, APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Online version: ISSN 1559-1255.

Subscriptions
U.S.: individual, $105. International: APA member, $142; nonmember, $158. Single issues: U.S., $21; Canada and international, $35. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or e-mail institutions@psych.org.

Editorial Offices
Telephone: (703) 907-7868; E-mail: PNews@psych.org; Web site: pn.psychiatryonline.org

Advertising Sales
Pharmaceutical Print Advertising: Frank Cox, Kathleen Harrison, Valentin Torres, Pharmaceutical Media, Inc., 30 East 33rd Street, New York, N.Y. 10016; (212) 685-5010; Fax: (212) 685-6126; vtorres@pminy.com

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Govt. Can Commit Sex Offenders To Mental Hospitals, Court Rules

The ruling raises problematic issues including the equation of sexual offenses with mental illness, the questionable efficacy of treatment for sexual offenders, and the use of civil commitment for reasons of public safety.

BY MARK MORAN

The Supreme Court ruled in May that Congress has the authority to extend civil commitment beyond the term of a prison sentence for sexual offenders who fall under federal jurisdiction.

In practical terms, the Court's decision in *United States v. Comstock* will affect a small number of people—as few as 100—who have committed sexual offenses that fall under federal jurisdiction; such crimes might include transportation of child pornography across state lines. But some 22 states have similar laws that have allowed state authorities to mandate psychiatric hospitalization for thousands of sexual offenders after they complete their prison sentences.

The Court's decision is symbolically significant in its support of several concepts that are highly problematic for psychiatry—conflation of sexual offenses with mental illness, civil commitment by authorities other than mental health professionals, and the use of psychiatric hospitalization for reasons that likely have more to do with public safety than with treatment.

The case involved five individuals convicted of sexual offenses that fell within federal jurisdiction and the imposition of civil commitment at the expiration of their prison sentences. Arguments in the Court's decision focused on the extent to which the Constitution grants Congress power to enact laws covering issues not specifically mentioned in the Constitution; of special importance was interpretation of the "necessary and proper" clause that grants to the federal government the power to enact necessary legislation to carry out its enumerated functions.

The majority opinion, written by Justice Stephen Breyer, held that civil commitment of federal sex offenders was within the federal government's scope—in part because the federal government already had a history of civil commitment of people with mental illness.

"Congress has long been involved in the delivery of mental health care to federal prisoners and has long provided for their civil commitment," Breyer wrote. He noted the establishment of St. Elizabeths Hospital in the 19th century and the use of the hospital for civil commitment by the government of people living in the District of Columbia or serving in the military. Before the century was over, Breyer wrote, that power was extended to cover broader categories of prisoners under federal jurisdiction.

"Thus, over the span of three decades, Congress created a national, federal civil-commitment program under which any person who was either charged with or convicted of any federal offense in any federal court could be confined in a federal mental institution," Breyer wrote.

The statute in question granting the government the power to extend civil commitment to sexual offenders is, Breyer reasoned, "a modest addition to a longstanding federal statutory framework, which has been in place since 1855."

In this way, said APA past President Paul Appelbaum, M.D., a forensic psychiatrist, "the Court has thoroughly bought into the notion that people who are sexually dangerous are mentally ill."

please see ***Sex Offenders*** *on page 23*

APA Voting Moving to Online Only

Is Your Correct E-Mail Address on File?

APA's national elections are transitioning to an all-electronic process with a fast, easy, and secure means to vote online. Online voter participation has steadily increased, reaching a rate of 50 percent in APA's last election, and shows promise of continued growth. Beginning with the 2011 election, all eligible voting members with a valid e-mail address on file will receive only an electronic ballot.

To ensure that you get your ballot, please update your contact information in Members Corner on APA's Web site at <https://myaccount.psych.org/MembershipProfileUpdate/tabid/163/Default.aspx>. E-mails sent directly from APA will include a link to personalized electronic ballots, voting instructions, and candidate information.

Voting members without a valid e-mail address on file will still be sent a paper ballot for the 2011 election. APA members with questions or comments may e-mail them to election@psych.org.

APA RESOURCES

- ***Psychiatric News* Web Site:** pn.psychiatryonline.org
- **APA and the APA Answer Center:** (888) 35-PSYCH in the U.S. and Canada; in other countries: (703) 907-3700. The Answer Center is open Monday through Friday, 8:30 a.m. to 6 p.m. Eastern time. All APA departments and staff may be reached through the Answer Center. Fax: (703) 907-1085 E-Mail: apa@psych.org
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What Do Members Want?

CAROL A. BERNSTEIN, M.D.

It is truly a privilege to be your president. I look forward to an exciting year ahead and hope to work with all of you to lead our Association in a direction that will be productive, effective, and efficient at meeting the needs of our patients and our membership.

In my nearly 30 years of involvement in APA, I have had the opportunity to view our work from many different perspectives. Beginning as a resident, my participation was driven by a desire to improve access to care for patients in New York City. I subsequently worked with my local district branch, my state organization, the Assembly, and ultimately the Board of Trustees. I also chaired several committees related to my career in psychiatric education. I looked up to teachers and supervisors who were active in the organization and viewed the mission of APA as central to my identity as a psychiatrist.

Through these years, a constant theme for elected leadership and staff at both the national and local levels has revolved around these questions: What do our members really want? What issues are of most importance? What are our key priorities? Given the diversity of membership, these questions have been difficult to answer since we represent many constituencies—individual private practice, academia, the public sector, the subspecialties of psychiatry, and many more.

We have made a number of attempts to "reorganize" and to clarify our goals. Our younger members are less inclined to join organizations, more inclined to link with their subspecialty groups, and place a high value on work-life balance that limits its energy and resources available to work outside of standard jobs. I have held a series of "town halls" throughout the past year to better understand younger members' issues and concerns. With the assistance of the newly established Committee on Members in Training (CoMIT), I will be reviewing all of the comments from these town halls and prioritizing those to implement. However, it is quite clear that one of the key concerns of our young colleagues is the need for mentorship. I hope to establish cross-cutting mentorship programs that will connect national leaders with local leaders across affinity groups to facilitate cross-generational collaboration.

Advances in technology hold the promise of new ways to engage our membership without requiring extensive travel. However, we still grapple with how to be most relevant and effective.

In the next year, I plan to work with our current leaders, including Drs. Alan Schatzberg and John Oldham, as well as Dr. Jay Scully, national staff, and representatives from our district branches and the Assembly to figure out how to meet these challenges. APA is fundamentally an educational organization with a mission to educate our members, our legislators, and the general public. We must continue to address stigma; help ensure that patients have sufficient, nondiscriminatory access to effective psychiatric care; provide our members with the latest scientific information to enhance their practices; and continue to work with our legislators both locally and nationally to assure the implementation of parity.

Our current governance structure is unwieldy and inefficient. We must think of creative ways to bring issues of local importance to the attention of our Board of Trustees and to bring some of the resources available at the national level back to our state associations and district branches. At the recent Assembly meeting in New Orleans (see page 10), I challenged each district branch to identify the three issues of most concern to its local members. I have also asked that the Areas and the Assembly Executive Committee distill these issues to a total of 10 by the end of the summer so that the Board of Trustees can use this information to strategize for 2010-2011.

In September, I will work with the Board to identify strategic goals for my presidential year and develop programs and services that derive from them. These goals in turn will be disseminated to the Assembly, councils, and other components immediately afterward to facilitate discussions across the Association regarding priorities and projects. Such communication within APA has been suboptimal, which has limited our ability to be as effective and efficient as we would like. As we continue to refine our organizational structure and be more accountable to the membership and our patients, I would like to work with you to assure the success of this approach.

We can succeed at this task and have a profound impact if we each do our own small part to ensure that those suffering from psychiatric disorders have access to the best possible psychiatric care, benefit from the most recent research and treatment strategies, and are able to live productive and useful lives as citizens. This isn't just about my leadership—it is about our leadership for our profession, for our patients, and for the general public.

I welcome your suggestions and comments in this process. Please e-mail them to me at cbernstein@psych.org. ■

Your Choice!

APA members can now go online to choose the information they want to receive from APA by e-mail. Visit <www.psych.org/optinoptout/Default.aspx>, log in as an APA member, confirm or update your contact information, and then, under "E-mail options," choose the e-mail newsletters, offers, and updates you would like to receive.

White House Shifts Focus In Drug-Abuse Fight

The goal of limited new federal funding is to better coordinate existing programs and to move effective treatment and prevention techniques more quickly from the research lab to the community.

BY RICH DALY

A new national drug-control strategy announced in May places a heightened emphasis on the distribution of information to local communities on successful strategies for preventing and treating drug abuse.

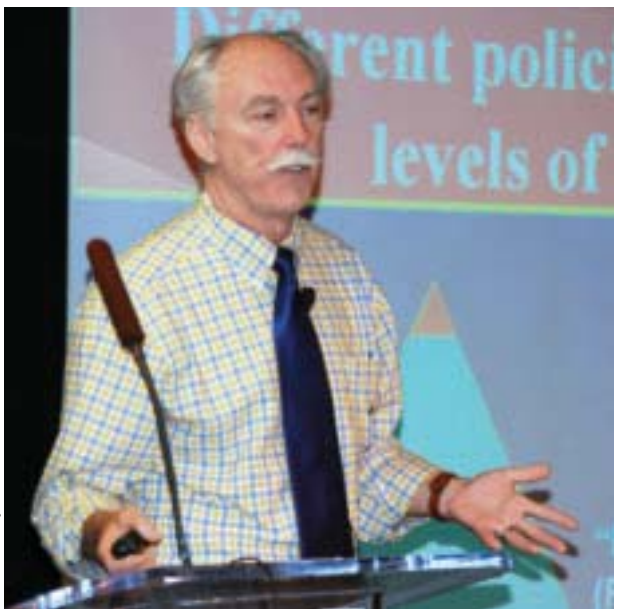
"We don't need more [prevention and treatment] programs," said Thomas McLellan, Ph.D., deputy director of the White House Office of National Drug Control Policy, during a May drug-prevention event in Washington D.C., sponsored by the Mentor Foundation, a substance abuse prevention organization.

Instead of funding new programs, federal resources will be targeted to better and wider dissemination of the many effective evidence-based practices that have yet to be widely implemented.

McLellan emphasized that the new federal strategy does not include a significant shift in federal spending, which will continue to tilt heavily toward law enforcement rather than treatment and prevention.

The focus of some media and drug-legalization advocates on the uneven spending levels between law enforcement and prevention/treatment "is a construct that is designed to pit the prevention-treatment-recovery community against law enforcement," said McLellan in an interview with *Psychiatric News*. "We don't buy [that division] one bit."

Strong enforcement efforts are costly but crucial, he noted, because of the growing drug-trade-fueled violence in Mexico that some experts see starting to spill over the U.S. border, where drug-related violence is already a law-enforcement challenge.



Credit: Rich Daly

Thomas McLellan, Ph.D., deputy director of the White House Office of National Drug Control Policy, describes the administration's new approach to substance abuse prevention and treatment, which will emphasize education throughout the teen years and helping local communities access the most effective approaches available.

McLellan said that the administration's new strategy would add $151 million to the $5.6 billion already in its Fiscal 2011 budget request for treatment and prevention of drug abuse. In the context of federal budget requests, the new funding is "not much money," he noted, but it is only the smallest part of a five-year effort to increase the focus on prevention and treatment.

The new funding would help implement the Obama administration's first national drug control strategy, which will encourage local communities to adopt the most effective, evidence-based substance abuse prevention and treatment approaches available.

McLellan explained that the administration did not want to develop new programs, noting that there are enough government programs already. "We wanted to do something where we might reasonably leave infrastructure that might endure."

The new strategy aims to collect and distribute information and implementation strategies on effective prevention and treatment programs to local communities and then let those communities tailor them to local conditions.

'Spillover' Benefits Sought

Among the lesser-used approaches that McLellan said have shown efficacy in research studies is combining prevention programs for seemingly disparate problems like substance abuse, depression, and teen pregnancy into coordinated and continuing educational efforts throughout adolescence. The combination approach stems from research that has found that the prevention programs can provide "spillover" benefits in preventing other unhealthy conditions.

The focus on continuous prevention education throughout the teen years also differs from the practice of many local education systems, which provide substance use prevention seminars to middle-school students and then leave the issue unaddressed through high school. Again, McLellan cited the evidence-based lifelong efficacy of continuing drug and alcohol education throughout the "high-risk" teenage years.

"Kids that don't [develop] an addiction problem—cigarettes, alcohol, other problems—by the time they are approximately [ages] 21 to 24 practically do not get them," McLellan stated.

The emphasis on combined and ongoing prevention programs is, however, likely to provide the most benefit to suburban children from stable families, said Moddy Kiluvia, M.D., a former member of the APA Corresponding Committee on Treatment Services for Patients With Addictive Disorders, in an interview with *Psychiatric News*. Children from "the inner city" and those thrown into the foster-care system would need a much broader range of supports to avoid the cycle of addiction and incarceration.

"Most of the patients I see in Rikers [Island prison in New York] are self-medicating because of [past] trauma," said Kiluvia, who is a part-time staff psychiatrist at Rikers.

Physician Role Emphasized

For adults, the new plan includes an emphasis on physician involvement. Many of the 68 million American adults whose drug and alcohol intake is at the level of "harmful use" but not yet "abuse" are regularly seen by physicians but are "mostly undiagnosed" as far as their substance use is concerned, McLellan said. Two or three routine questions are enough to identify most such patients, and then five to 10 minutes of counseling by clinicians trained to respond to someone with a substance use problem can help curtail such harmful behaviors before they develop into addiction.

That type of physician involvement is "the kind of thing that's eminently practical to do, and it will save a lot of money," McLellan said, in terms of later hospitalizations or other far more expensive interventions.

Wilson Compton, M.D., director of the Division of Epidemiology, Services, and Prevention Research at the National Institute on Drug Abuse, agreed that clinicians have a greater role to play in reducing substance abuse. Specifically, physicians need to increase their awareness of opioid abuse and addiction linked to management of "medium" pain management, which has become a leading cause of accidental death. Those deaths have come despite the majority of opioid abusers having seen a physician in the month before they died, according to a study published in the December 8, 2009, *Canadian Medical Association Journal*.

"We see physicians playing a key role in this epidemic, and we'll be working closely with them to address it," said Compton, in comments during the Mentor Foundation event.

More information on the 2010 National Drug Control Strategy is posted at <www.ondcp.gov/news/press10/051110.html>. ■

Five-Year Plan

The Obama administration's new national drug-control strategy—released May 11—aims to reduce illicit drug use and its negative consequences through a five-year plan that balances prevention, treatment, law enforcement, and international cooperation to fight the illegal drug trade.

These are the three specific "drug challenges" that administration officials said they will focus on this year:

- Cutting prescription drug abuse,
- Reducing driving while under the influence of drugs, and
- Preventing drug abuse.

They have also announced related numerical goals for the next five years, which include the following:

- Decreasing drug abuse among young adults by 10 percent,
- Reducing the number of drug-related deaths by 15 percent, and
- Cutting the incidence of driving under the influence of drugs by 10 percent.

'Alarming' Suicide Trend May Free Stalled Prevention Legislation

The latest federal mortality data showing that suicide continues to lead all other causes of violent death adds urgency to efforts by suicide-prevention proponents to expand government initiatives to curtail its occurrence.

BY RICH DALY

Advocates for more and better-funded suicide-prevention programs hope that the latest federal finding that suicide continues to account for the majority of violent deaths in the nation will spur legislative action on initiatives to reduce that tragic toll.

Suicide accounted for 57 percent of violent deaths in 2007—the latest year for which data are available—according to federal sampling data from 16 states released by the Centers for Disease Control and Prevention (CDC) in May. The dominant role of suicide—defined by the authors as any intentional self-inflicted death—in violent deaths mirrors findings in previous years by the CDC's National Violent Death Reporting System.

Those findings, which demonstrate a rising trend in suicides since 2000, concerned suicide-prevention proponents, who plan to highlight the continued prevalence of suicide in their efforts to gain traction for suicide-prevention initiatives slowly wending their way through Congress.

"It's an alarming trend," Robert Gebbia, executive director of the American Foundation for Suicide Prevention (AFSP), told *Psychiatric News*. "It's going in the wrong direction."

Another trend the report found was that for the second straight year people aged 45 to 54 had the highest suicide rate

please see ***Suicide*** *on facing page*

Insel: Revolution Coming in How Mental Illness Is Conceptualized

Rare 'private' mutations may be associated with multiple disorders, and in any individual the mutation may take different development pathways that eventually affect multiple brain circuits and result in distinct disorders.

BY MARK MORAN

Mental illnesses may share common genetic mutations, differentiated into varying clinical presentations and symptoms—now categorized as distinct diagnoses—by all manner of environmental influences affecting multiple brain circuits and ultimately human behavior.

That's the picture that is emerging from cutting-edge research in the last two years, a picture that is certain to transform the way clinicians and researchers regard mental illness in the future, said National Institute of Mental Health Director Thomas Insel, M.D.

In a media briefing last month introducing the May 19 mental health theme issue of the *Journal of the American Medical Association (JAMA)*, Insel called for a "revolution" in the way mental illness is conceptualized.

In that *JAMA* issue, Insel wrote a commentary titled "Rethinking Mental Illness," in which he said that "[g]enetics and neuroscience finally have the tools to transform the diagnosis and treatment of mental illness. But first, it is time to rethink mental disorders, recognizing that these are disorders of brain circuits likely caused by developmental processes shaped by a complex interplay of genetics and experience."

The *JAMA* theme issue includes six research papers and four commentaries, including one by Darrel Regier, M.D., M.P.H., head of APA's Division of Research, and David Kupfer, M.D., chair of the *DSM-5* Task Force. The commentary by Regier and Kupfer focused on "Why All of Medicine Should Care About *DSM-5*" (see box). The *JAMA* issue also includes an article on Vincent van Gogh's treatment for mental illness; on the cover of the journal is van Gogh's painting "Courtyard of the Hospital at Arles," depicting the hospital where he was treated in 1889, the year before his death.

Speaking to reporters at the briefing, Insel said that current diagnostic categories based on how people present to the clinician—self-reported symptoms and clinical judgment of appearance and behavior—must at some time give way to the new findings based on genetics and neuroscience.

"We have been locked into a diagnostic structure based on how people present," Insel said. "We did that 100 years ago in cardiology and infectious disease. There is a value in that, but most of medicine has gone way beyond that."

Where the rest of medicine has gone, and where research and treatment of mental illness must go, is in the direction of genetic and biological markers of disease. Insel said that what is emerging today is a picture of mental illness as the result of a pathophysiological chain from genes to cells to distributive systems within the brain, based on a patient's unique genetic variation.

"In the case of people with schizophrenia or autism or bipolar disorder or ADHD, we are beginning to find lots of rare but highly [potent] lesions in the genome," he said. "Unlike what we see for common medical illnesses, in the case of mental illness we are looking at many, many different genetic contributors, so rare they are called 'private mutations.'

"Even more surprising is the fact that these very rare mutations appear not to be associated with any single illness," Insel said. "Rather, the same genetic lesion may be associated with different disorders."

For any individual, the private mutation may take a different developmental pathway that affects multiple complex brain circuits, resulting in the anomalous thoughts, feelings, and behaviors that have been categorized in today's diagnostic system.

Incorporating these cutting-edge research findings into clinical practice will ultimately result in a new paradigm for treatment. In the case of psychosis, for instance, Insel said they will pave the way for much earlier intervention.

"Psychosis is a very late stage in the developmental process, in the same way that a myocardial infarction is a late-stage symptom of cardiovascular disease," he said. "The real 'bang for the buck' in cardiovascular medicine is getting much earlier identification of people with high cholesterol and intervening at that stage to prevent a heart attack.

"That is what we would like to do with schizophrenia, but today all the effort goes into very-late-stage treatment of psychosis during the phase of chronic illness. Ultimately we need to begin identifying patients not only when they start to lose function but even prior to that, when they are still presymptomatic and have only the risk factors for psychosis." ■

JAMA Explores *DSM-5*

Stating that all medical specialties have a stake in the emerging *DSM-5,* Darrel Regier, M.D., M.P.H., and David Kupfer, M.D., outlined principal issues in the development of the manual in a special theme issue of the *Journal of the American Medical Association* on mental illness.

They noted that when development of the new manual began in 1999, an overriding concern was how to address issues that emerged from research on mental illness in the previous 25 years. "Such concerns included the potential for adding dimensional assessments to disorders, exploring the option of separating diagnoses from their associated disabilities, examining the expressions of all disorders across the entire life span, and the need to address differences in mental disorder expression as conditioned by gender and cultural characteristics," they said.

Progress since that time has yielded "a clear set of priorities for *DSM-5*." These include evaluating the consequences of continuing to use the hierarchical "pure" diagnostic categories now in place and reified since *DSM-III,* the high rates of co-occurring diagnoses identified by these criteria in individuals with at least one mental disorder, the frequent use of the "not otherwise specified" designations for patients who do not fit any of the criteria, and the heterogeneous mix of conditions within current diagnostic boundaries.

Kupfer and Regier also highlighted the following questions that will be emphasized in forthcoming stages of the diagnostic manual's revision:

- How can the clinical assessments of mental disorders be improved?
- How can *DSM-5* better address the interface between psychiatry and general medicine?
- Can clinicians move away from reliance on signs and symptoms to classify disorders?
- What can be done to make *DSM-5* more flexible so it can easily incorporate advances in neuroscience and behavioral science?

Another issue that they indicated will be part of the *DSM-5* discussion is how the manual should align with the international community classification. "The timelines of publishing *DSM-5* and the U.S. introduction of the *ICD, Tenth Revision, Clinical Modification* in 2013 coincide well and will offer an invaluable opportunity to ensure integration of *DSM-5* with the rest of the U.S. medical classification changes," Regier and Kupfer said. "Likewise, a cross-national alignment of diagnoses will be facilitated when *ICD-11* is adopted by the [World Health Organization] in 2014. Accordingly, *DSM-5* will be of value for all of medicine."

"Why All of Medicine Should Care About* DSM-5" *is posted at <http://jama.ama-assn.org/cgi/content/full/303/19/1974>.

Suicide

continued from facing page

of any age group (17.6 per 100,000)—even higher than people aged 75 to 84, who in previous studies have had the highest rates.

Gebbia noted that the rising middle-age suicide rate presented a new challenge, because this age group saw their physicians less frequently than older people did and were less likely to have mental illnesses linked to suicide diagnosed and treated.

Enhanced Act Action Stalled

The rising rate of suicide nationwide has led prevention advocates such as the AFSP to urge congressional funding of the Enhanced Act in Fiscal 2011. The measure, which authorizes the establishment of up to 30 national "centers of excellence" that are to develop standards to translate depression research into clinical practices, was included in the federal health care reform law. However, the law left it up to Congress to appropriate the funding for the new centers, which lawmakers have not yet done.

"This federal funding will provide much-needed resources and coordination to the mental health community, allowing them to develop universally accepted evidence-based, multidisciplinary approaches and real-time clinical and care management guidelines," Gebbia wrote in a May 20 letter to the leaders of the House and Senate panels with jurisdiction over medical-research funding.

Gebbia noted that depression, bipolar disorder, and substance use disorders are among the leading causes of suicide, so funding centers to study treatments for them could make a major dent in the nation's suicide rate.

Bill Targets Bullying

Another federal initiative that could impact suicide rates came in May with the introduction of a bullying-prevention bill (HR 5184). Sponsored by Rep. Danny Davis (D-Ill.), the legislation is designed to address a widespread problem that can result in psychological damage or even suicide, according to supporters of the bill.

"When we empower schools to teach both children and adults to prevent and address bullying, we not only make schools safer, we make learning happen, and we even save lives," said Rep. Linda Sanchez (D-Calif.).

"This federal funding will provide much-needed resources and coordination to the mental health community. . . ."

The bill would amend the Safe and Drug-Free Schools and Communities Act to require schools to add bullying and harassment-prevention programs if they wanted to prevent cuts in their federal education funding.

Gebbia said such legislative efforts to force school administrators to focus on bullying as a real threat to the lives and mental health of children were needed because educators often overlook the impact of schoolyard intimidation.

"Bullying is directly related to those who are vulnerable to suicide," Gebbia said. "If you put such [at risk] kids in an environment where they are bullied or harassed, it greatly increases their risk for suicide."

The Enhanced Act can be accessed at <http://thomas.loc.gov> under the bill number, HR 5170. ■

Alzheimer's Prevention Strategies Continue to Elude Researchers

Alzheimer's disease may start as early as age 20 or 30, or maybe even before, believes a psychiatrist and member of an independent NIH panel on Alzheimer's prevention.

BY JOAN AREHART-TREICHEL

Ann (not her real name) possessed a number of assets that have been linked with a reduced risk of Alzheimer's disease. She was married, well educated, intellectually and socially engaged, trim, and very active physically. Nonetheless, she was diagnosed with Alzheimer's at age 68.

Ann's outcome should perhaps come as no surprise in view of an announcement made by an independent National Institutes of Health (NIH) panel: Although a number of factors have been linked with a reduced risk of Alzheimer's disease, none has been firmly demonstrated to prevent it.

As a result, people need to understand that if they eat this or that food or engage in this or that activity to escape Alzheimer's, there is no guarantee that they will do so, the panel concluded.

Or as Martha Daviglus, M.D., Ph.D., a professor of preventive medicine at Northwestern University and panel chair, noted in a press statement: "We wish we could tell people that taking a pill or doing a puzzle every day would prevent this terrible disease, but current evidence does not support this."

Credit: Michael Westhoff/istockphoto

Martha Daviglus, M.D., Ph.D.: "We wish we could tell people that taking a pill or doing a puzzle every day would prevent this terrible disease, but current evidence does not support this."

And as Wade Berrettini, M.D., Ph.D., a professor of psychiatry at the University of Pennsylvania and a panel member, told *Psychiatric News:* "There are no medications, vitamins, natural products, or brain exercises that are proven to prevent or improve Alzheimer's disease."

The panel consisted of 15 members representing the fields of genetic medicine, geriatrics, health economics, health services research, human nutrition, internal medicine, neurology, neurological surgery, nursing, pharmacology, preventive medicine, and psychiatry. Family caregivers of Alzheimer's patients were also included. Twenty-one Alzheimer's experts presented data to the panel during a three-day conference on the NIH campus in Bethesda, Md., in late April. The following are among the conclusions the panel announced at the end of the conference:

- A number of factors—say, eating a diet low in saturated fats and high in fruits and vegetables, use of statin medications, light to moderate use of alcohol, more years of education, higher levels of cognitive engagement, and participation in physical activities—have been associated with a reduced risk of Alzheimer's in various studies. Other factors, such as current smoking, never having been married, low social support, depression, diabetes, and elevated blood cholesterol at midlife, have been linked with an increased risk of Alzheimer's in still other studies. But the scientific quality of all of this evidence generally is low. The primary limitation with most of the studies is that they do not distinguish between association and causality.
- Cognitive decline ranges from the most severe forms of dementia, an example of which is Alzheimer's disease, to mild cognitive impairment and age-related cognitive decline. Cognitive decline is multicausal, and mild cognitive impairment may or may not lead to dementias such as Alzheimer's disease.
- Evidence does not support a clear role for most of the nutritional factors that have been examined as possible shields against cognitive decline. The most consistent has been for the omega-3 fatty acids, often measured as fish consumption.
- High blood pressure has been consistently linked with a heightened risk of

please see ***Alzheimer's*** *on page 24*

American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
Internet www.psych.org

May 2010

Dear APA Member:

After decades, your Association has decided not to renew the endorsed malpractice insurance program with Professional Risk Management Services ("PRMS").

After an extensive search, we are pleased to announce that we have selected American Professional Agency, Inc. ("APA, Inc.") as our new provider of malpractice insurance based on their industry reputation as a leading national provider of mental health professional liability insurance.

The reasoning behind our decision is important. First, PRMS no longer was willing to keep our program exclusive to our members. APA, Inc. has committed to an exclusive program, which will ensure that the premium rates are based on our members' experiences and not impacted by non-member psychiatrists' claims.

Second, PRMS is owned by the insurer backing the policies, while APA, Inc. is a broker with access to a variety of insurance companies. This will avoid any potential conflict of interest and enhance the program's availability to all of our members.

Most importantly, our new program administrator and insurer are providing a major upgrade to the coverage you need in today's complex environment. For example, the new program includes Fire Damage, Legal Liability, Personal and Advertising Injury Coverage and HIPAA fines and penalties coverage at no additional charge. Also, there are no surcharges for filing a claim or board complaint.

I encourage you to contact APA, Inc. to learn more about this important member benefit. Their toll free number is 800-421-6694.

Sincerely,

James H. Scully, Jr. MD

James H. Scully, Jr., M.D.
Medical Director & CEO
American Psychiatric Association

Truth in Advertising May Apply to Health Workers

Physician groups want federal legislation passed requiring honest advertising by allied health professionals, whose self-marketing practices sometimes blur the differences between them and physicians.

BY RICH DALY

Enactment of the sweeping new law that aims to open access to health care for millions of uninsured people may also increase the opportunity for a large expansion in misleading marketing practices by some allied health care workers. That's why physicians' advocates are urging passage of a federal measure to require truth in advertising by professionals who provide health care.

Rep. John Sullivan (R-Okla.) introduced the Healthcare Truth and Transparency Act (HR 5295) on May 13 to require all health care professionals to fully and accurately inform patients of their qualifications and training. The measure would direct the Federal Trade Commission to take action when it finds misrepresentations in advertisements of a health care professional's licensing, education, training, degree, or clinical expertise.

The issue of professional misrepresentation in ads has long concerned physician groups and has taken on a new urgency with the enactment of a national health care law that will dramatically expand health coverage.

"Patients today are confused about the health care system in general, especially when it comes to differentiating among the qualifications of the many types of health care providers, including physicians," said Sullivan in a written statement. "The need for this problem to be addressed is only growing as the new health care law will add more than 32 million Americans to our health care system."

The urgent need for clarity in advertising is a point echoed by physicians' advocates, who note that patients place a priority on knowing the qualifications of clinicians prior to treatment. The vast majority of Americans (90 percent) appear to be concerned about the qualifications of the professionals who provide their health care, according to a 2006 nationwide survey by the Coalition for Health Care Accountability, Responsibility, and Transparency (CHART), a physicians' advocacy group that includes APA.

The CHART survey also found that 86 percent of Americans support federal legislation to make it easier for them to understand the qualifications of the health care professionals who treat them and their families.

Accurate disclosure of professional qualifications is especially critical for patients with psychiatric illness.

"Patients living with mental illness can easily be confused about the level of qualifications of health professionals and are especially vulnerable to fraudulent advertising," said then APA President Alan Schatzberg, M.D., in a written statement. "This bill will help Americans better understand the types of care that are provided by different professionals and allows them to have more manageable expectations in terms of the care they are going to receive."

The legislation is backed by a coalition of physician groups, including APA and the AMA. In a May 11 letter to the bill's sponsors, APA and 11 other medical organizations cited increasing patient confusion regarding the qualifications of the many types of health care providers—including physicians, technicians, nurses, physician assistants, and other allied health professionals.

"All of these providers play an important and distinct role in the health care delivery system," the medical groups said. "However, ambiguous provider nomenclature and related advertisements and marketing are exacerbating patient uncertainty."

The legislation faces opposition from nurse advocates, including the American Nurses Association (ANA), which views it as part of a continuing effort to limit the scope of practice of nonphysician health care workers. A statement by the ANA says that advanced-practice registered nurses "are prepared through advanced education and clinical training to provide a wide range of health care services to individuals of all ages."

Supporters of the bill counter that it would hold physicians and allied health workers to the same truth-in-advertising standards so patients can be better informed about who is treating them.

The legislation mirrors similar bills that were introduced but did not advance in previous years. However, its supporters hope to leverage the needs of the coming wave of newly insured patients seeking clinical care to drive it forward.

The Healthcare Truth and Transparency Act can be accessed at <http://thomas.loc.gov> by searching on the bill number, HR 5295. ■

Gen-Xers Poised to Change Psychiatric Practice—and APA

Incoming APA President Carol Bernstein, M.D., says that APA will need to reach out to young psychiatrists for their help in creating the APA of tomorrow.

BY MARK MORAN

Carol Bernstein, M.D., has a pretty good idea of what tomorrow's psychiatrist—and tomorrow's APA—will look like.

The new APA president, who took office at the close of the APA annual meeting last month in New Orleans, has spent much of her career educating psychiatry residents. In an annual meeting address, she told psychiatrists that the "Gen-Xers"—those born from 1964 to 1982—and the "millenials" (those born after 1982), would be changing the face of psychiatry.

And APA will have to change too.

"The generation Xers and the millennials are our field's future leaders, educators, researchers, and clinicians," Bernstein said. "The communication and technological changes they have witnessed and are part of will radically alter the way in which they live their lives. They are the most racially and ethnically diverse in our nation's history. . . . [T]hey are digital natives and have been using computers since pre-kindergarten. They are accustomed to giving feedback and getting to speed. They are optimistic and oriented toward collective action."

Most important, Bernstein said, they have a dramatically different idea of what their working lives should be like.

Credit: David Hathcox

During her presidency, Carol Bernstein, M.D., hopes to "build communications and build bridges" to APA's younger members.

"Generation X is moving into its peak family-raising years, and previous census data show an increase in stay-at-home Gen-X moms," she noted. "They are all looking for a less 'frazzled' lifestyle. Most of them have no intention of having one job throughout their lives. Their view of authority is based on competence, not on how many years someone has worked. And most of all, they believe that we have gotten it all wrong about work-life balance."

Bernstein said she would make it a goal of her presidency to help APA "build communities and build bridges" across the generations. "We must redefine important concepts such as work-life balance—and view this not as either/or—but as a dynamic interplay that redefines who we are and what we do."

And she noted that in pursuit of this goal, she has been hosting "town-hall meetings" with residents around the country. "These gatherings have been enormously helpful to me in beginning to understand some of the vital issues that are of concern to our young colleagues," she said. "We must look to them to help us figure out how to redefine and reconfigure our Association so that it can be the most effective and efficient as possible in confronting the issues that we and our patients face."

In other ways, too, the field is poised for change. "American psychiatry is at a pivotal point as we enter the second decade of the 21st century," Bernstein emphasized. "With the passage of a health care reform bill and parity legislation, we are positioned to help assure that our patients are fully integrated into the house of medicine. The culture of discrimination against the mentally ill is starting to change," she said, but added that while such bias is receding, hard work and vigilance will be needed to make sure that this trend continues.

"The law is not perfect," she stated. "Many fear that since parity is only required if mental health and substance abuse services are offered in an insurance plan, insurance companies will no longer offer those categories of coverage. There is also concern that if reporting requirements are too onerous, psychiatrists and mental health professionals will not participate in these plans. Still others are concerned about the lawsuits that have been filed by managed care companies opposing implementation of parity.

"Nevertheless, I cannot begin to describe the unprecedented consequence of the parity law, coming as it does with the initiation of real health care reform for the first time in this country's history. Because of the parity law, insurance programs must manage mental illness and substance abuse disorders the same way that other medical disorders are managed."

She predicted that with the growing momentum behind concepts such as the "medical home" and "accountable care organizations," medical specialties would be increasingly integrated into primary care. And she said psychiatry could lead the way.

"For decades, we have utilized the team model in the treatment of our patients," Bernstein said. "We have understood the significance of 'disability, not just diagnosis,' the need to address social issues such as housing, vocational rehabilitation, and an approach called 'recovery,' which focuses on helping individuals with chronic illnesses to be valued members of our society. We are the glue for all of medicine. Without an appreciation of human behavior and the many factors that contribute to how people approach both health and illness, efforts to try to combat obesity, hypertension, diabetes, smoking, cancer—to say nothing of depression, anxiety, psychosis, and suicide—will all go for naught." ■

Entertainer Thanks Psychiatrists For Working 'Miracles'

Carrie Fisher, who has been an advocate for mental health treatment, extolled the benefits of psychotherapy and ECT and lamented the "bad rap" given to the latter.

BY MARK MORAN

It was probably the first time an APA Convocation speaker offered herself up to any willing psychiatrist as a "bipolar bride"—but then anyone who was expecting Carrie Fisher to give a conventional talk was at the wrong meeting.

At APA's 2010 annual meeting in New Orleans, the star of stage and screen, novelist, screenplay writer, and memoirist delivered a short but vibrant description of her long experience with depression and bipolar disorder and with psychiatric treatment.

Along the way she treated members at the William C. Menninger Convocation Lecture to a seemingly light-hearted tour of a rambunctious Hollywood life that included at least one bedmate whom she discovered to be dead when she woke up ("My psychiatrist asked me if he was dead when we got in bed, which I thought was insightful. I said, 'Not that I'd noticed.' ")

Fisher, who is perhaps most famous for her role as Princess Leia in "Star Wars," has fashioned a comical take on a life that might be generously described as colorful (or more honestly described as chaotic and painful). And her sense of humor about celebrityhood lends her a perspective that other Hollywood types could probably use. (Informed that Desmond Tutu would be the Convocation speaker at the 2011 annual meeting in Honolulu, Fisher garnered laughs when she suggested she could see the connection—Carrie Fisher, Desmond Tutu. "Wasn't he good in 'Star Wars?' ")

But her remarks also revealed that the humor is a mask for much emotional suffering, and she did not hide her earnest appreciation of what psychiatric treatment has done for her. She commented especially on the "bad rap" given to electroconvulsive treatment, which Fisher said she had been receiving.

"Those treatments really did work miracles for me," she said. "I wish I had done it years ago because I might have been able to shortcut some of these long drives up and down the mood mountain. But like most people, I believed the [misinformation] I heard about ECT, so that I had to be really desperate in order to agree to this so-called barbaric treatment."

Credit: David Hathcox

Outgoing APA President Alan Schatzberg, M.D., poses with Carrie Fisher before the start of the Convocation. Fisher, who has bipolar disorder, went on to tell attendees how she coped with her problems through humor.

And she also celebrated the importance of psychotherapy. "I believe in insight," she commented. "I believe in the borrowed perspective that my psychiatrist and confessor sitting across from me could give. I believe in you. And that belief panned out—you listened to me. . . .Without help from psychiatrists, I would be in a back room somewhere watching reality TV."

The lecture was preceded by the induction of 359 new fellows and 52 life fellows into the Association. Also inducted were 88 new distinguished fellows (those who have been APA members or fellows for eight years and who have made a significant contribution to the profession) and 172 distinguished life fellows (those whose age and years of active membership equal 95). Life fellows and life members who have held APA membership for 50 years were also recognized. All were greeted with applause as they solemnly processed at the start of the session into the large hall in the New Orleans convention center. ■

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NAMENDA® (memantine HCl) is indicated for the treatment of moderate to severe Alzheimer's disease.

NAMENDA is contraindicated in patients with known hypersensitivity to memantine HCl or any excipients used in the formulation. The most common adverse events reported with NAMENDA vs placebo (≥5% and higher than placebo) were dizziness, confusion, headache, and constipation. In patients with severe renal impairment, the dosage should be reduced.

References: 1. Reisberg B, Doody R, Stöffler A, Schmitt F, Ferris S, Möbius HJ, for the Memantine Study Group. Memantine in moderate-to-severe Alzheimer's disease. *N Engl J Med.* 2003;348:1333-1341. **2.** Tariot PN, Farlow MR, Grossberg GT, Graham SM, McDonald S, Gergel I, for the Memantine Study Group. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004;291:317-324. **3.** Cummings JL, Schneider E, Tariot PN, Graham SM, for the Memantine MEM-MD-02 Study Group. Behavioral effects of memantine in Alzheimer disease patients receiving donepezil treatment. *Neurology.* 2006;67:57-63. **4.** Data on file. Forest Laboratories, Inc. **5.** NAMENDA® (memantine HCl) Prescribing Information. Forest Pharmaceuticals, Inc., St Louis, Mo. **6.** Wimo A, Winblad B, Stöffler A, Wirth Y, Möbius HJ. Resource utilisation and cost analysis of memantine in patients with moderate to severe Alzheimer's disease. *Pharmacoeconomics.* 2003;21:327-340. **7.** Winblad B, Poritis N. Memantine in severe dementia: results of the ³M-BEST Study (Benefit and efficacy in severely demented patients during treatment with memantine). *Int J Geriatr Psychiatry.* 1999;14:135-146.

Forest Pharmaceuticals, Inc.

For more details, please visit **www.namenda.com**.

Please see brief summary of Prescribing Information on the adjacent page.

62-1014307R R2 03/09

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Brief Summary of Prescribing Information.

For complete details, please see full Prescribing Information for Namenda.

INDICATIONS AND USAGE
Namenda (memantine hydrochloride) is indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

CONTRAINDICATIONS
Namenda (memantine hydrochloride) is contraindicated in patients with known hypersensitivity to memantine hydrochloride or to any excipients used in the formulation.

PRECAUTIONS
Information for Patients and Caregivers: Caregivers should be instructed in the recommended administration (twice per day for doses above 5 mg) and dose escalation (minimum interval of one week between dose increases).

Neurological Conditions
Seizures: Namenda has not been systematically evaluated in patients with a seizure disorder. In clinical trials of Namenda, seizures occurred in 0.2% of patients treated with Namenda and 0.5% of patients treated with placebo.

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

Special Populations
Hepatic Impairment
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.

Renal Impairment
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	1	2
Pain	1	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, paranoic 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 of 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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New Guidelines Govern APA's Relations With Industry

The newly adopted APA "code of conduct" will govern the Association's interface with all outside entities and establish a Conflict of Interest Committee to enforce them.

BY JUN YAN

APA's Board of Trustees has approved a set of principles and standards to govern the Association's relationships with all outside organizations, including pharmaceutical and medical-device companies, that seeks to minimize the potential for conflicts of interest.

These principles and standards, referred to as a code of conduct, were proposed by the Work Group on Future Relationships with Industry, which was appointed in 2009 by APA president Alan Schatzberg, M.D., and approved unanimously by the Board of Trustees on April 26.

The code of conduct specifies critical criteria by which all potential organizational relationships must abide: The relationship must aid APA's mission, foster APA's goals, and obey all laws and regulatory rules. In addition, APA will maintain full control of its name as well as any products it develops.

Sidney Weissman, M.D., a professor of clinical psychiatry at Northwestern University School of Medicine in Chicago and a former member of the Board of Trustees, chaired the work group.

Whether APA should have or maintain relationships with industry was a fundamental question the work group members discussed extensively, according to Weissman. Their answer was yes.

Weissman acknowledged that this stance may be unpalatable for some psychiatrists who feel that APA should sever all ties with pharmaceutical or device companies. "However, we do not believe [such an approach] is feasible," he noted. Weissman said the work group concluded that relationships with the industry that researches, develops, and markets the treatments psychiatrists prescribe every day are "inevitable."

At the work group's recommendation, incoming APA President Carol Bernstein, M.D., will appoint a Conflict of Interest Committee of the Board to implement the code of conduct in the form of specific policies and procedures and review APA relationships with outside organizations to ensure that they comply with the new guidelines.

Further, the code of conduct incorporates special guidelines for selecting APA practice guideline committees. It states that a practice guideline committee "be directly funded solely by APA or one of its subsidiaries," and the chair of a practice guideline committee will not have any financial or professional relationships that could be perceived as affecting decision-making capacity. Individuals with financial or other ties to industry can serve on practice guideline committees with the approval of the committee chair or the Conflict of Interest Committee.

This code of conduct has formalized "the way APA is doing business every day," Paul Burke, executive director of the American Psychiatric Foundation and the committee's staff liaison, told *Psychiatric News*. Although these guidelines do not change APA's operational philosophy, making them official will ensure that all future relationships will continue to follow these principles.

In July 2009, the Board of Trustees approved a policy for disclosure of interests and affiliations for APA members and participants in APA activities, including elected officials of the Association. The policy stresses "maximum transparency" and requires individuals to disclose all forms of involvement related to psychiatry, financial as well as uncompensated, regardless of whether the involvement is perceived as a conflict of interest or not.

"The entire field of medicine is moving toward greater transparency in its relationships to industry, and APA has been at the forefront of the trend," APA Medical Director James H. Scully Jr., M.D., said in a written statement.

In addition to Weissman, members of the work group were Jack Barchas, M.D., Mary Helen Davis, M.D., Richard Harding, M.D., John Hayes, M.D., Bruce Hershfield, M.D., and Dilip Jeste, M.D.

"The work group members included psychiatrists in private practice, academia, and industry," Weissman pointed out in an interview with *Psychiatric News*. "This diverse group represents people engaged in all areas of American psychiatry."

The Web address for APA's code of conduct for relationships with outside organizations will be announced in a future issue. ■

Nominations Invited

APA's Council on Adult Psychiatry invites nominations for the 2011 Jack Weinberg Memorial Award for excellence in the field of geriatric psychiatry.

The award, established in 1983 in memory of Jack Weinberg, M.D., recognizes a psychiatrist who has demonstrated special leadership or has done outstanding work in clinical practice, training, or research in geriatric psychiatry.

Candidates must be psychiatrists who are nominated by an APA member. Nominations must include a letter describing the accomplishments of the nominee, two additional letters of endorsement by APA members, and a current curriculum vitae including bibliography.

The selected individual will receive a plaque at the APA Convocation and an honorarium in the amount of $500.

The deadline for nominations is August 13. Nomination materials should be mailed to American Psychiatric Association, QIPS, Attn: Urysha Moseley, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209.

More information is available from Moseley at umoseley@psych.org. ■

'Healthy Minds' TV Show Earns Emmy Nominations

A television show whose goal is to replace the silence that often accompanies mental illness with knowledge and hope gets a rare and unexpected honor.

BY KEN HAUSMAN

Being nominated for Emmy Awards is probably the furthest thing from the minds of psychiatrists and others who develop media projects to educate the public about mental illnesses and their treatment. But earlier this year, those involved in creating the PBS series "Healthy Minds" learned that their show had indeed received such recognition.

The 16-part series garnered New York Area Emmy Award nominations for two of its episodes—one titled "Autism" and one titled "PTSD: Helping Our Troops."

The program is hosted by psychiatrist Jeffrey Borenstein, M.D., medical director of Holliswood Hospital in Queens, N.Y., and chair of the APA Council on Communications.

The awards are given out by the New York Chapter of the National Academy of Television Arts and Sciences. "Healthy Minds" was nominated for special programming in the medical/science category.

The American Psychiatric Foundation (APF) provides financial support for national distribution of the series, which is produced by New York PBS station WLIW. And at the meeting of the APA Assembly last month in New Orleans, APF President Richard Harding, M.D., announced that the Substance Abuse and Mental Health Services Administration will also be providing financial support for the program.

The mission of the "Healthy Minds" series is to destigmatize mental illness and the people who suffer from it and to show those individuals and their families that the mental health system offers an array of effective interventions for these often-misunderstood disorders.

Each of the 30-minute programs is devoted to a specific mental health condition or psychiatric disorder and is built around interviews with researchers and clinical experts who discuss diagnosis and treatment of that disorder. The episodes also feature an interview with a person who is recovering from the particular disorder and may also include family members who discuss their experiences. The goal of these interviews is to humanize what to many in the public is a mysterious and sometimes frightening illness.

Attending the New York Area Emmy Awards ceremony on April 18 are (froom left) psychiatrist Jeffrey Borenstein, M.D., host of the TV show "Healthy Minds"; show producer Theresa Statz-Smith; and Paul Burke, director of the American Psychiatric Foundation.

Among the topics that the show has featured are living with schizophrenia, eating disorders, suicide prevention in teenagers, and chemical dependency. Well-known personalities have also been interviewed about mental illnesses for which they have been treated, including Patty Duke and Jane Pauley on bipolar disorder and Mike Wallace on depression.

"My hope for the show," Borenstein said, "is to encourage people who may have a mental disorder to seek help and not to suffer in silence."

The series' executive producer, Theresa Statz-Smith, commented that the public's response and the Emmy nominations demonstrate "that 'Healthy Minds' is serving a need in people's lives, which is what we set out to do."

When the envelope containing the Emmy winner was opened in an April 18 ceremony in New York, "Healthy Minds" was, however, not the name that was announced. The winner was "Race for the Cure," a special about breast cancer produced by WCBS TV. ■

Assembly Tackles Patient Care, Professional Issues

Whether psychiatrists have been in practice for decades or are new to the field, their relationships with the drug industry are being scrutinized, and the APA Assembly weighs in with policy recommendations.

BY KEN HAUSMAN

An array of issues that could have a significant impact on patient care and the way that psychiatrists practice dominated last month's meeting of the APA Assembly in New Orleans, as representatives debated issues such as psychiatrists' relationship with industry and their ability to deliver care that is not compromised by third-party influence.

The Assembly passed, for example, an action paper calling on all training programs to discuss with residents and fellows issues concerning their relationship with industry and noted that these discussions "should include the nature of responsible physician-industry relationships in general and their potential advantages and disadvantages in patient care and research." Also to be encouraged in these discussions is the importance of disclosing potential conflicts of interest.

Representatives also passed a proposed APA position paper on industry relationships that stated that APA "affirms that in all relationships between psychiatrists and industry, psychiatrists must endeavor to identify conflicts of interest and manage those conflicts to assure the highest standard of care for patients." As with Assembly action papers addressing policy issues, this proposal must be approved by the Board of Trustees to become official APA policy.

Concerned about the lax federal monitoring of direct-to-consumer (DTC) pharmaceutical ads, the Assembly passed a resolution saying that APA "supports efforts to adequately regulate [DTC] advertising [and] encourages cooperation by pharmaceutical manufacturers for public education and prevention rather than the direct marketing of medications to consumers."

Also regarding prescription drugs, the Assembly called for a ban on what it said is the profit-maximizing policy of some pharmacy benefit management companies to provide "incentives that require the provision of dangerous quantities of medications." The representatives' concern stemmed from the delivering of "large quantities of medications by mail, with multiple refills, sufficient to supply medication for one year. . . ." They want APA to support legislation or regulations that would prohibit these companies from rejecting prescription refills written for less than a 90-day supply "or such other minimum amount that may be clinically inappropriate" and from applying "punitive copayments" to small amounts of prescribed medications.

Another proposal that won Assembly backing urged APA to endorse legislation or regulations "that will authorize physicians to cancel or rescind renewals of their previously written prescriptions and that will mandate that pharmacies, including pharmacy benefit plans, implement procedures to permit physicians to cancel or rescind renewals . . . and prevent such renewals from being filled or mailed to the patient when directed by the physician. . . ."

Credit: David Hathcox

Jacquelyn Brechtel Clarkson, vice chair of the New Orleans City Council, tells Assembly members that "the most important thing [the city] lost after Katrina was access to mental health care." She said that as the city rebuilds, mental health care will not be an afterthought.

Credit: David Hathcox

Caroll Stewart, widow of psychiatrist Dudley Stewart, M.D., displays the gift the Assembly presented as it honored her husband with the Ronald A. Shellow Award. The award recognizes an Assembly member who makes significant contributions to that body. While the award was for 2009, Stewart wanted to receive it this year in his hometown of New Orleans, but he died before he could accept it. Flanking Stewart are Daniel Winstead, M.D., president of the Louisiana district branch; Assembly Speaker Gary Weinstein, M.D.; and Harold Ginzburg, M.D., the district branch's Assembly representative. Deborah Cross, M.D., won the 2010 Shellow award.

In other actions, the Assembly voted to

- have APA oppose "discriminatory restrictions imposed by health plans" when psychiatrists bill for inpatient or outpatient services they code as evaluation and management. The representatives were concerned about reports that insurers were denying payment for such coded services when provided by psychiatrists, while they pay them for other types of physicians. This practice may, however, come to an end as a result of the federal parity law.
- establish a corresponding Assembly committee to make recommendations on how APA, through information technology, can more rapidly disseminate new clinical guidance than can now be done through the Association's publication of updates topractice guidelines.
- allow the Nevada Psychiatric Association to explore the possibility of scheduling an annual meeting in Las Vegas, a city in which APA has not held an annual meeting, and then consult with APA staff in developing a proposal for the Board of Trustees, which approves annual meeting sites. The next unbooked annual meeting dates are 2021 and 2022.
- ask the Board of Trustees to express APA's "outrage for the 26 psychiatric patients who died from cold exposure and neglect last January in the Havana Psychiatric Hospital [and] for the unfortunate death of political prisoner Orlando Zapata Tamayo from a hunger strike protesting the physical and psychological abuses to which he and all other political prisoners are subjected in Cuban prisons."

The Assembly also heard a request from Carol Bernstein, M.D., who became APA president at the close of last month's annual meeting, to have each district branch and state association identify three issues that it believes are the most crucial for its members and in which APA has a role to play. Once these have been submitted, she plans to ask the Assembly Executive Committee to distill the list to 10 issues, which will then be discussed at the September Board meeting.

In addition, Ardis Dee Hoven, M.D., chair-elect of the AMA Board of Trustees, addressed the Assembly and thanked APA for its hard work and productive collaboration on the recently passed health care reform law and other critical issues being debated on Capitol Hill. Health reform "would have been a lousier piece of legislation," she said, without the work of medical specialty organizations, the AMA, and state medical societies. While medicine in general did not get everything it wanted in a health care reform law, such as malpractice-liability reform and a fix for the Medicare reimbursement formula, a key lesson reinforced in the long legislative process is "don't let the perfect be the enemy of the good," she stressed. ■

Election Results Announced

During their three-day meeting in New Orleans last month, members of the APA Assembly cast their votes to determine who will lead them during the next year. The representatives elected current Assembly recorder Ann Marie Sullivan, M.D., as the new speaker-elect and Scott Benson, M.D., to succeed Sullivan in the recorder position.

At the close of the Assembly meeting on May 23, Bruce Hershfield, M.D., took charge of the ceremonial gavel as he moved from speaker-elect to speaker.

Sullivan, who is from New York City, outpolled Kushro Unwalla, M.D., of Highland, Calif., who was the Assembly's international medical graduate representative. Benson, who is from Pensacola, Fla., bested Jo-Ellyn Ryall, M.D., of St. Louis, who was the Area 4 representative. Benson was the deputy representative for Area 5.

Ann Marie Sullivan, M.D.

Scott Benson, M.D.

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Recidivism Drops in Those Supervised by MH Courts

Research on the outcomes of mental health courts is steadily accumulating, and the results show promise, but some critical questions remain unanswered.

BY AARON LEVIN

Criminal defendants who complete programs supervised by mental health courts are less likely to be rearrested in the following two years, according to a new study by North Carolina researchers appearing in the May *Psychiatric Services*.

About 72 percent of those who completed the program were not rearrested in that time, compared with just 19 percent of those who were expelled from the program and 37 percent of those who chose to leave, said Virginia Hiday, Ph.D., a distinguished professor of sociology and anthropology, and doctoral student Bradley Ray, M.A., both at North Carolina State University.

Also, more time passed before defendants who successfully finished the court process were rearrested, they wrote. For instance, at five months after the end of court supervision, only 8 percent of completers had been rearrested, compared with 46 percent of noncompleters.

The study adds to a small, but growing, body of research on mental health court outcomes. Future research into the psychological and demographic characteristics of those who enter such programs would help differentiate who does and does not complete them, said the authors.

Mental health courts serve as a voluntary alternative to either trial or sentencing for eligible defendants diagnosed with mental disorders. When successful, they keep such defendants out of jail.

"We need to find alternatives to putting people with mental illness in prison," said Renée Binder, M.D., a professor and interim chair of the department of psychiatry and director of the Psychiatry and the Law Program at the University of California, San Francisco, in an interview. Binder has also published studies of mental health court outcomes, but was not involved in the North Carolina research.

In mental health courts, the judge supervises a nonadversarial, collaborative process in which a variety of professionals work with the defendant both to satisfy criminal justice requirements and to meet the individual's mental health needs. The team includes prosecutors, defense attorneys, social workers, mental and physical health clinicians, and employment, education, and housing specialists.

Hiday and Ray compared court administrative data and state arrest records for 99 defendants who left the local mental health court in 2005.

About 72 percent of the defendants were male and 65 percent were white. The 99 individuals entered the court with a total of 172 misdemeanor and 18 felony arrests.

The most common misdemeanor was assault (26 percent), and the most common felony violation was theft (83 percent).

Defendants who were eventually expelled from the program and those who opted out had much higher numbers of prior arrests than did completers.

That does not mean that they were more severely ill, said Hiday in an interview.

"Research has shown time and again that it is not any clinical factor such as severity of the mental illness that accounts for offending; rather, it is the same criminological factors that affect offending among others who are not mentally ill," she said.

Of the 99 defendants, 60 completed the program in an average of just over a year. Of the 39 who did not complete the program, eight voluntarily left, and 31 were expelled for failing to show up for scheduled treatment or court appearances or for engaging in prohibited behavior, such as use of illegal drugs. Simply being rearrested did not mean that a defendant would be removed from the program, which explicitly acknowledged the possibility of relapse.

Contact with the mental health court was associated with fewer arrests regardless of whether the defendant completed the program. Overall, defendants had an average of 4.19 arrests in the two years prior to entering the program and 1.79 arrests in the two years afterward.

Defendants who completed the program were arrested on average only once in the following two years, and 72 percent of them were not rearrested. The percentages were reversed for the noncompleters: 81 percent of those who were expelled from the program and 63 percent of those who opted out were rearrested.

One of the limitations of this and similar studies on mental health courts is a lack of data about the symptoms and severity of mental illness among program participants at entry and following completion, as the authors noted.

Having that information would probably help identify which defendants have done well in mental health courts and which might do so in the future, said Binder.

"We really don't know what part of the process works," she said. "Is it the contact with the judge, who has the authority to put the defendant in jail or keep him or her on the streets? Is it the constant contact with the court or some professional acting on its behalf? Is it the mobilization of many resources to help? Or is the person simply responding to a lot of positive attention?"

Hiday and Ray agreed. The North Carolina study was conducted in a single court, keeping that variable unchanged, they said.

However, defendant variables, such as substance abuse; having a supportive family, employment, more education, housing, and so on; lack of insight leading to unwillingness to acknowledge that they needed psychosocial help; motivation to change; and the quality and appropriateness of treatment were more highly correlated with completion and require further research, said Hiday.

She and Ray are continuing research into mental health courts, looking at the role of judges and how the defendants' psychological and social histories influence the courts' effects.

An abstract of "Arrests Two Years After Exiting a Well-Established Mental Health Court" is posted at <http://ps.psychiatryonline.org/cgi/content/abstract/61/5/463>. ■

Sticking With MH Courts Cuts Recidivism

Defendants who completed a mental health court program in North Carolina were rearrested fewer times in the next two years than those who had dropped out or were expelled.

Exit status	N	Proportion rearrested (%)	Arrests before program (mean)	Arrests after program (mean)	Difference (mean)
Completed program	60	28	3.18	1.02	–2.17
Ejected from program	31	81	5.65	2.55	–3.10
Opted out of program	8	63	6.13	4.63	–1.50
All defendants	99	48	4.19	1.79	–2.40

Source: Virginia Hiday, Ph.D., Bradley Ray, M.A., *Psychiatric Services*, May 2010

Georgia MH System Adopts Cure For Decades of Troubled Care

Georgia is expected to expand resources for community-based care for mental illness—including greater use of peer support—following court-ordered negotiations with the Justice Department and patient advocates.

BY RICH DALY

Georgia is likely to increase its focus on and public resources devoted to community-based mental health care as part of an agreement with the Department of Justice (DoJ) and patient-advocacy organizations, with implementation expected in the coming months.

> **"The opportunity presented by this new department brings with it both a higher profile and higher expectations."**

The ongoing negotiations were ordered by a federal judge as part of a federal examination of the state's public mental health system, which followed a series of publically reported deaths in its state psychiatric hospitals. U.S. District Judge Charles Pannell and DoJ attorneys initially focused on obtaining state commitments to improve Georgia's psychiatric hospitals but expanded their examination to the community-based mental health system at the urging of patient advocates in Georgia (*Psychiatric News*, December 4, 2009).

According to state mental health officials, the negotiations are expected to expand the state's growing financial commitment to community-based care, including increased funding through Medicaid and use of Crisis Intervention Teams (CITs). The nearly 400 CIT programs nationwide—which train and coordinate law enforcement and mental health professionals to improve interactions with people suffering from a mental-illness-related crisis—have increased the safety of people with psychiatric conditions. For example, one study found CIT-trained police were much less likely to resort to force in situations in which they were confronted with someone who appeared to be mentally ill (*Psychiatric News*, November 20, 2009).

Georgia has already undertaken numerous initiatives in the last year to improve its public delivery of and attention to mental health care, including the establishment in July 2009 of a separate government department—the Department of Behavioral Health and Developmental Disabilities—solely focused on mental health and directed by a psychiatrist, Frank Schelp, M.D., M.P.H.

"The opportunity presented by this new department brings with it both a higher profile and higher expectations," said Schelp in a written statement at the department's launch. "And while we know that the challenges we face in Georgia won't disappear overnight, I'm confident that, with new thinking and new initiatives, our efforts will result in better care and stronger support."

Schelp's outreach efforts to patient groups have included statewide "listening sessions" over the last year and his attendance at the 2009 annual meeting of the Georgia Mental Health Consumer Network, which was a first for the state's chief of mental health care. Additionally, he has increased resources to expand the use of "peer support," or training people recovering from mental illness to provide ongo-

please see ***Georgia*** *on facing page*

Court Says Juvenile Felons Entitled to Second Chance

The ruling to ban sentences of life without parole for those who commit crimes unrelated to murder when they were juveniles comes as psychiatrists cite a growing body of knowledge about adolescents' brain development.

BY RICH DALY

Psychiatrists and other mental health advocates praised a Supreme Court decision barring certain lifetime prison sentences for people who commit crimes as minors that are unrelated to murder.

The Court's May 17 decision in *Graham v. Florid*a held that the Eighth Amendment's ban on cruel and unusual punishment categorically bars life sentences when they come without the possibility of parole for crimes committed before age 18.

The 6-3 decision—with Chief Justice Roberts limiting his support to only this case, instead of all such cases—was hailed by mental health advocates as recognition of research evidence that juveniles are incapable of fully understanding the consequences of their actions and controlling impulsive behavior to the extent adults can.

The Court agreed with the reasoning that due to minors' lack of understanding, they should not have to sacrifice their freedom for the rest of their lives because of crimes they committed that can be influenced by their incomplete brain development.

"Juveniles differ from adults in their decision-making capacities, which can be seen in our nation's laws regarding voting, driving, access to alcoholic beverages, consent to treatment, contracting, and in the juvenile court itself," said Louis Kraus, M.D., a member of the APA Council on Children, Adolescents, and Their Families, in a press statement.

The majority decision also echoed some aspects of the amicus brief APA and other organizations filed in the case and in its companion case, *Sullivan v. Florida*.

"Juveniles—including older adolescents—are less able to restrain their impulses and exercise self-control; less capable than adults of considering alternative courses of action and maturely weighing risks and rewards; and less oriented to the future and thus less capable of appreciating the consequences of their often-impulsive actions," according to an amicus brief filed by APA and other mental health organizations. "For all those reasons, even once their general cognitive abilities approximate those of adults, juveniles are less capable than adults of mature judgment, and more likely to engage in risky, even criminal, behavior as a result of that immaturity."

The Court decision was based on the life sentence given to Terrance Graham for a parole violation. The crime for which he had originally been convicted when he was 16 was the robbery of a restaurant during which an accomplice severely beat the manager. Graham was sentenced to a one-year jail term and three years of probation. At 17, Graham and two accomplices carried out a home-invasion robbery, for which they were tried and convicted. It was for violating his parole by committing the second crime that a judge sentenced him to life in prison without the possibility of parole.

The decision also was significant, Howard Zonana, M.D., a member of APA's Council on Psychiatry and Law, told *Psychiatric News*, because it marked the first time that the Court barred a given punishment for an entire class of offenders outside the confines of the death penalty. In 1988, the Court barred the death penalty for people who committed crimes before the age of 16, under the Constitution's prohibitions against cruel and unusual punishment. That ban was extended in 2005 to juveniles under age 18.

The application of the finding was significant to the justices too, with Justice Clarence Thomas—who wrote the dissent—criticizing the categorical ban on life sentences for juveniles instead of using case-by-case reversals when a sentence was disproportionate to the crime.

But the ban on juvenile life sentences when there is no chance for parole makes sense, said Zonana, because otherwise adolescents who can mature out of such behavior will lose the opportunity to prove that as adults they are able to reform their lives.

Child psychiatrist and APA Treasurer David Fassler, M.D., agreed that the elimination of such irrevocable life sentences will accommodate the individual ability of juvenile convicts to mature and improve beyond their mental capacity when they committed their crimes.

"As Justice [Anthony] Kennedy notes, these biological and developmental differences do not excuse violent or criminal behavior," Fassler told *Psychiatric News*. "However, they can and should be taken into account when determining consequences or weighing the potential for future rehabilitation."

The decision could affect laws in 37 states, the District of Columbia, and federal law, which allow life-without-parole sentences for juveniles convicted of nonhomicide offenses. Of the 129 juveniles now imprisoned with life-without-parole sentences, 77 are in Florida.

Despite most states allowing juveniles to receive these sentences, Kennedy's majority opinion also stated that the rare use of this sentencing option clearly showed that "a national consensus has developed against it."

The majority opinion explicitly noted that it does not require states to "guarantee eventual freedom to a juvenile offender convicted of a nonhomicide crime. What the State must do, however, is give defendants like Graham some meaningful opportunity to obtain release based on demonstrated maturity and rehabilitation."

How states pursue that "meaningful opportunity" for future review of such inmates will draw court scrutiny because it was left so vague, said Peter Ash, M.D., a member of the APA Committee on Judicial Action, in an interview with *Psychiatric News*.

Also left unresolved by the decision is the use of extremely long fixed sentences, which may have the same effect as life sentences. In fact, Justice Samuel Alito's separate dissent said the Court's decision would not affect such sentences.

Additionally, Zonana noted, it remains unclear whether the ruling will affect all juveniles currently serving life sentences or just those whose cases are under appeal, in addition to future cases. Furthermore, the case highlights the contentious issue of juvenile sentences in general, and advocates are expected to try to extend its logic to the more than 2,000 inmates serving life sentences where parole is not an option for participating in killings as juveniles.

The* Graham v. Florida *decision is posted at <www.supremecourt.gov/opinions/09pdf/08-7412.pdf>. ■

Illegal Drug Promotion Costs Company Half-Billion Dollars

The settlement of a federal lawsuit resolves yet another of the massive lawsuits drug companies have faced in recent years over off-label promotions of psychiatric drugs.

BY JUN YAN

AstraZeneca has agreed to pay $520 million to settle a federal civil lawsuit in which the company was accused of illegally promoting its antipsychotic drug quetiapine, marketed under the brand name Seroquel, for unapproved indications.

The April 27 announcement marked the latest case in a string of federal lawsuits filed by the Department of Justice (DoJ) against major drug companies involving off-label drug marketing.

Last fall, Pfizer paid a record $2.3 billion to settle cases involving illegal promotions of four drugs, including ziprasidone (Geodon) and pregabalin (Lyrica) (*Psychiatric News*, October 2, 2009). Previous cases involving off-label promotions included ones against Eli Lilly for marketing olanzapine (Zyprexa), Bristol-Myers Squibb for marketing aripiprazole (Abilify), and Cephalon for marketing modafinil (Provigil).

Federal prosecutors alleged that from 2001 through 2006 AstraZeneca promoted quetiapine for treating unapproved conditions, including aggression, agitation, dementia, attention-deficit/hyperactivity disorder, depression, posttraumatic stress disorder, and insomnia.

Last December, the FDA approved quetiapine as an adjunctive treatment for depression but rejected the company's application for its use in depression as a monotherapy.

The lawsuit alleged that the company targeted off-label promotion to primary care physicians, pediatricians, and geriatricians "who do not typically treat schizophrenia or bipolar disorders," according to the DoJ statement. The company was also accused of influencing continuing medical education programs it sponsored to promote the off-label use of quetiapine.

Quetiapine is one of AstraZeneca's leading products and accounted for more than $4.8 billion in worldwide sales in 2009. However, AstraZeneca recently announced that as part of a corporate restructuring, it plans to eliminate its research and development programs involving medications to treat psychiatric disorders.

In the settlement of the federal suit, AstraZeneca denied any wrongdoing. The company continues to face more than 10,000 civil suits filed by individuals alleging personal injuries, primarily development of diabetes, due to taking quetiapine. ■

Georgia

continued from facing page

ing guidance, but not treatment, to other people with such illnesses.

The organizational change in the state's public mental health programs—previously housed in the state's Department of Human Services—came with a boost in its Fiscal 2010 and 2011 budgets, even as every other department has seen cuts, according to state officials.

Policy changes over the last year have included an end to the institutionalization of children and adolescents, who will instead receive treatment in community-based settings.

The changes so far have been hailed by consumer advocates and psychiatrists. Lasa Joiner, executive director of the Georgia Psychiatric Physicians Association, described the new initiatives as "as much clinically focused as budget driven."

"Allowing them to deal with mental health as a full department—I think that helps," she said.

In terms of the ongoing negotiations, a final agreement could come in June or several months later, according to state officials. Then the federal judge will need to sign off on it.

More information on the initiatives of the Georgia Department of Behavioral Health and Developmental Disabilities is posted at <http://dbhdd.georgia.gov/portal/site/DBHDD/>. ■

Imaging Studies May Someday Help Predict Behavior

A Duke neuroscientist uses functional magnetic resonance imaging to discover how human behavior derives from the chemistry and genetics of the brain.

BY AARON LEVIN

Deep in the heart of neuroscience, a worldwide network of researchers is exploring how genetics, imaging, and biochemistry can predict what the mind will do seconds or years in the future.

A few dozen of that band met in a small, but potentially influential conference in Washington, D.C., early in May. The conference was organized by Ilina Singh, Ph.D., a lecturer in bioethics and society at the London School of Economics, and Walter Sinnott-Armstrong, Ph.D., a professor of philosophy at Duke University. It was sponsored by the Wellcome Center for Neuroethics, the Law and Neuroscience Project, the Kenan Institute for Ethics at Duke, and BIOS, an international center for research and policy on social aspects of the life sciences and biomedicine at the London School of Economics.

The complexities of this research and how far it has to go were illustrated by the work of Ahmad Hariri, Ph.D., who has explored the biological pathways and mechanisms of human behavior.

Hariri bases his research on observations of stable traits in humans and then uses a variety of methods to connect brain chemistry, circuitry, and genetics to behavior.

"We probe the underlying brain circuit functions and compare them to well-verified personality measures using functional magnetic resonance imaging [fMRI]," said Hariri, a professor of psychology and neuroscience at the Institute for Genome Sciences and Policy at Duke University.

Variability in brain chemistry drives changes in brain circuitry, and genomic differences drive changes in brain chemistry, he said.

"Changes in trait anxiety are due to underlying brain circuitry. We're limited in using drug challenges to illuminate the dopaminergic and serotonergic signaling systems in humans, but we can do unlimited genetic studies."

Much of his recent work has concentrated on the amygdala, the tiny part of the brain that is common to all animals with backbones.

That brain region "alerts us to something critical in the environment, usually referred to as 'fear' and 'threat,' but in reality alerts us to a number of stimuli that may or may not be important."

Trouble—in the form of maladaptive behavior—happens when that system goes awry. Hariri suggested that the problem is not with amygdala dysfunction but rather with abnormal integration of the amygdala response with the prefrontal cortex.

"Concentrating on a single area of the brain may be less productive than looking at the distributive circuitry across the entire brain to better capture the complexity of information processing," he said.

Understanding that complexity demands more than one approach

For example, Hariri placed healthy human volunteers in an fMRI machine and gave them either placebo or tetrahydrocannibinol (THC), the main psychoactive ingredient in marijuana. He then showed them pictures of fearful faces.

The amygdalas of the volunteers given placebo were more activated when shown the faces than were those of subjects given THC. Subjects given THC showed less anxiety and reduced processing of information in the area of the amygdala that contributes to anxiety.

Hariri next explored that same pathway using molecular genetics to model differences in how individuals process an enzyme that limits the activity of THC. A change in just one single-nucleotide polymorphism alters the amino-acid sequence used to create the protein associated with changes in function and in behavior. The A-allele (found in about 25 percent of individuals) reduces expression of the enzyme, resulting in more endogenous cannabinoids and a diminished response to threat by the amygdala.

The A-allele also results in an enhanced reward-related response, compared with the more common C-allele.

A diminished threat response coupled with a higher response to reward is "a deadly combination," said Hariri. The A-allele is associated with increased impulsivity, illicit drug use, and obesity.

Can such studies predict behavior or psychopathology in individuals? Certainly not yet, said Hariri. The brain, to no one's surprise, is far too complex, and the research is still in a relatively early stage.

For example, his study of four dopaminergic alleles in the ventral striatum accounted for only 13 percent of the variation in response to reward prediction—and there may be dozens of such alleles, he said. Also, brain scans aren't cheap to acquire and require big machines.

Studies so far have been in Caucasian populations, and Hariri cautions against extrapolating conclusions to other races or genetic groups.

"The pieces fit together, but we have yet to test these hypotheses," he said. The subtle effects of genes on chemistry and vice versa exert equally subtle effects on behavior.

"We need long-term prospective studies with large numbers of subjects testing chemistry, circuitry, and genetics to see if these patterns predict the emergence of psychopathology," he said.

However, even at this stage, his research has produced some intriguing results, even if they cannot yet be generalized.

Hariri tells of testing a volunteer for genetic markers that reveal response to threat and reward. The middle-aged man scored high on two markers for increased threat response, lower on two other threat markers, and high on three markers for reward response.

"He had the right balance of reward-related drive and a normal sensitivity to threat and danger," Hariri explained.

The subject was well adapted for the career he had chosen—a writer on the ups and downs of investing. Presumably, said Hariri, a Wall Street trader would have a much lower response to threat.

More information on Hariri's work is posted at <www.haririlab.com/LONG/>. ■

Opening a Window on Decision Making

Predicting what someone will do next has been the purview of fortune-tellers, linebackers, and sometimes forensic psychiatrists, but give a neuroscientist an MRI machine and he can tell you exactly what a research subject will do seven seconds in the future.

The science is still at an early stage, but the implications for use range from the emergency room to the courtroom, said John-Dylan Haynes, Ph.D., M.Sc., a professor at the Bernstein Center for Computational Neuroscience in Berlin, Germany, at the BioPrediction Conference in Washington, D.C., in May.

Recently, Haynes has been seeking to observe the point at which a subject has made a decision but before he or she is aware of it.

His studies present simple tests that involve a free choice with no emotional content for his subjects. Will they add or subtract two numbers? Will they push the button on the right or the left?

Next, he asks the subjects to remember the letter on the screen when they make their decision. The letters change every half second, serving as timing markers.

By looking backward at the MRI scans from the time the letter appeared on the screen, Haynes and his colleagues can see changes in brain activity that predict the decision up to seven seconds before the subject acts.

Even a first step into an unbiased snapshot of the mind's intentions intrigues people from divergent fields.

Market researchers are already interested in the technology. Police and military interrogators would probably love to have a foolproof lie detector. Ultimately, understanding how the brain makes decisions may lead to technologies permitting direct control of computers by physically disabled people.

Those practical applications are still a while off, despite the claims of some commercial interests to the contrary, said Haynes. While results so far have been interesting, the system has a host of limitations.

Decision making is encoded in fine-grain detail in the brain, said Haynes. "It is hard to generalize from person to person."

In addition, the visual and temporal resolution are not yet fine enough, other thoughts impose themselves as the desired question is answered, and intersubject differences like age and personality undoubtedly play a role.

And besides, people are not automatons, said Haynes. "What we see is more like a bias than a full-blown decision."

Maybe they can still change their minds in that seven seconds, but maybe a better machine will spot that, too, before long.

Information on Haynes' work is posted at <www.bccn-berlin.de/People/haynes>.

Dieting May Cause More Problems Than It Solves

Dieting does not seem to be the answer to obesity—not just because people tend to gain back the weight they lose, but because dieting is so stressful.

BY JOAN AREHART-TREICHEL

The battle of the bulge in America is big: Almost half of all Americans are trying to lose weight at any given time, studies have found.

Yet dieting often does not lead to weight loss over the long term, and it can have deleterious psychological effects—anxiety, decreased self-esteem, depression, irritability, and nervousness. In addition, it can cause both psychological and physiological stress, according to a study reported April 5 in *Psychosomatic Medicine*.

Ayako Janet Tomiyama, Ph.D., a Robert Wood Johnson Foundation Health and Society Scholar at the University of California, San Francisco, and colleagues launched a study to test the hypothesis that dieting can cause stress. They recruited 121 women who were planning to diet to lose weight, then randomly assigned them to one of four groups for a three-week period.

The first group tracked their calories and restricted their caloric intake to 1,200 kcal/day. The second group was given prepackaged daily meals equaling 1,200 kcal/day but did not track their calories. The third group tracked their calories but ate normally. The fourth group did not track their calories and ate normally.

Subjects in all four groups filled out a psychological stress questionnaire before and after the three-week test period and gave saliva samples before and after the test period to be evaluated for levels of the stress hormone cortisol.

please see ***Dieting*** *on page 24*

COMPILED BY JUN YAN

Genetics

• People with a polymorphism in one of the genes coding for alcohol dehydrogenase (ADH) enzymes, known as ADH1B*3, have been shown in previous research to have a lower risk of developing alcohol use disorders than individuals without this mutation. Now researchers from the University of Missouri, Washington University in St. Louis, and the University of California, San Diego have conducted an experiment to explain the protective effect of ADH1B*3.

The authors enrolled 91 African-American young adults and gave them an alcohol-challenge test. About one-third of the study subjects carried at least one ADH1B*3 allele, and the rest carried two ADH1B*1 alleles. The ADH1B*3 carriers reported a greater degree of sleepiness and a sharper increase in pulse rate immediately after drinking a moderate dose of alcohol than other subjects did.

ADH enzymes in the liver are the main pathway for metabolizing ethanol to acetaldehyde. The protein generated from the ADH1B*3 gene, found primarily in people of African descent, appears to turn ethanol rapidly into acetaldehyde, resulting in a "burst" of acetaldehyde in the body. The researchers suggested that this high level of acetaldehyde may explain the polymorphism carriers' uncomfortable physiological response to drinking and, in turn, leads to a lower risk of alcohol dependence.

McCarthy DM, Pedersen SL, Lobos EA, et al.: ADH1B*3 and Response to Alcohol in African Americans. Alcohol Clin Exp Res. Published online May 4, 2010

• A single nucleotide polymorphism (SNP) at the rs10473984 position in the CRHBP gene, one of the genes in the corticotrophin-releasing system, was significantly associated with remission and symptom reduction in patients with major depression treated with citalopram.

The study was a new analysis of data from the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study sponsored by the National Institute of Mental Health. The authors analyzed known SNPs in 10 genes involved in the regulation of the corticotropin-releasing hormone (CRH) and arginine vasopressin neuronal systems, both of which are a part of the hypothalamic-pituitary-adrenocortical (HPA) system and play an important role in stress response. The CRHBP gene codes for the CRH binding protein, which binds CRH in circulation and prevents CRH binding to receptors.

Patients who carry the T allele in the CRHBP gene had poorer response to citalopram treatment. This association was statistically significant in African-American and Hispanic patients and more pronounced in patients with anxious features. In addition, patients who carry the T allele had higher plasma corticotropin levels of free CRH.

Binder EB, Owens MJ, Liu W, et al.: Association of Polymorphisms in Genes Regulating the Corticotropin-Releasing Factor System With Antidepressant Treatment Response. Arch Gen Psychiatry. 2010; 67(4):369-379

• A polymorphism in the OPRM1 gene, which encodes the mu-opioid receptor in the brain, accounts for different levels of dopamine released in response to alcohol consumption in the ventral striatum, according to a new study. This finding may explain why some people derive a great sense of pleasure from drinking while others do not, which predisposes the former group to a higher risk of alcohol dependence.

Dopamine release in the ventral striatum is a key part of drug- and alcohol-induced reward response. Using positron emission tomography, researchers observed that the brains of men who carry one copy of the 118G allele (n=12) had a higher amount of striatal dopamine release after the men were given a standard dose of an intravenous infusion of alcohol compared with men carrying two copies of the 118A allele (n=16). Homozygous 118G carriers are rare, but 15 percent of the Caucasian population are heterozygous carriers (that is, they carry an A allele and a G allele).

To confirm that the genetic variation is the cause of the brain response, the researchers used a mouse model in which the human OPRM1 gene was inserted. As expected, mice that carried the human OPRM1 gene with two copies of the G allele released four times as much dopamine in the brain as mice that carried two copies of the A allele after receiving a dose of alcohol.

Ramchandani VA, Umhau J, Pavon FJ, et al.: A Genetic Determinant of the Striatal Dopamine Response to Alcohol in Men. Molecular Psychiatry. Published online May 18, 2010

Case Reports

• A case of eosinophilic hepatitis associated with the use of lisdexamfetamine dimesylate in an adolescent patient was reported in *Pediatrics* last month. A 14-year-old boy had been taking lisdexamfetamine dimesylate (marketed as Vyvanse) 30 mg per day for treatment of attention-deficit/hyperactivity disorder (ADHD) for five months before presenting to his primary care physician with abdominal pain, nausea, vomiting, and generalized jaundice. Biochemical tests indicated a diagnosis of hepatitis. Viral causes were ruled out with serological tests. He had not been taking any other drugs. The patient was hospitalized because of worsening signs of hepatitis. A liver biopsy was performed and led to the diagnosis of drug-induced eosinophilic hepatitis.

After discontinuation of the medication and treatment with steroids, the patient's aminotransferase levels normalized in two months. A second liver biopsy, four months after the initial one, showed no abnormalities. The authors concluded that the ADHD drug was the probable cause of the hepatitis.

Hood B, Nowicki MJ: Eosinophilic Hepatitis in an Adolescent During Lisdexamfetamine Dimesylate Treatment for ADHD. Pediatrics. Published online May 10, 2010

• A retrospective case study of children who were referred to a pediatric ophthalmological service in Glasgow, Scotland,

please see ***Journal Digest*** *on page 24*

Vertigo Drug Shows Promise As Depression Treatment

An intravenous infusion of scopolamine induced significant depression improvement in three to five days. The effect persisted for at least two weeks after three doses.

BY JUN YAN

The hunt for a fast-acting antidepressant moved a step forward with a report of the efficacy of scopolamine, a drug commonly used to treat vertigo, in a clinical trial.

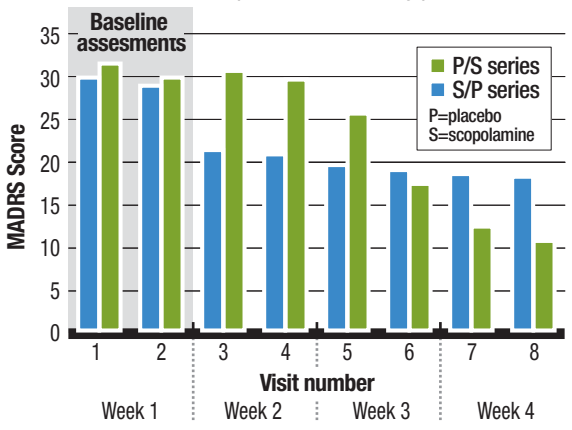
A muscarinic cholinergic receptor antagonist, scopolamine is commonly available in a type of transdermal patch indicated for treating motion sickness. The patch delivers up to one milligram of scopolamine over three days.

To test the drug's effect on depression, Wayne Drevets, M.D., a senior investigator, and Maura Furey, Ph.D., a staff scientist at the Mood and Anxiety Disorders Program of the National Institute of Mental Health, used a dosage of 4 micrograms of scopolamine per kilogram of body weight, given through intravenous infusion.

Twenty-two volunteers with a *DSM-IV* diagnosis of major depressive disorder were randomized to two regimens: three doses of placebo followed by three doses of scopolamine infusions, or three doses of scopolamine followed by three doses of placebo. Every two infusions were separated by an interval of three to five days.

Scopolamine Treats Depression Symptoms

Patients with major depressive disorder showed significantly greater improvement, measured by the Montgomery-Asberg Depression Rating Scale (MADRS), after scopolamine infusions, compared with after placebo infusions ($p<0.001$). All patients received one placebo infusion as the first dose. After that, patients in the P/S series (n=11) received three doses of placebo followed by three doses of scopolamine. Patients in the S/P series (n=11) received three doses of scopolamine followed by placebo.



Source: Wayne Drevets, M.D., and Maura Furey, Ph.D., *Biological Psychiatry*, March 1, 2010

The effect of scopolamine treatment on the patients' depressive symptoms, measured by change in the Montgomery-Asberg Depression Rating Scale (MADRS) score, was significantly larger than the effect of placebo infusion (see chart). Significant reduction in MADRS scores was observed as early as the assessment three to five days after the initial dose of scopolamine.

Among patients who received scopolamine before placebo, the clinical improvement persisted during the placebo phase.

At the end of the study, 14 (64 percent) of the study patients achieved full response, defined as at least 50 percent reduction of MARDS score from baseline. Eleven (50 percent) reached remission, defined as having a MADRS score of 10 or below.

The study participants had moderate to severe depression at baseline, with mean MADRS scores of about 30. Eight participants had comorbid anxiety disorder, and 13 had been in the current depressive episode for more than two years. In addition, six participants had failed to respond to previous treatment.

Furey and Drevets had published a study on the rapid antidepressant effect of scopolamine infusion in the October 2006 *Archives of General Psychiatry*. In that study, scopolamine significantly reduced depressive symptoms in patients with major depressive disorder and with bipolar disorder. The current study, which replicates previous findings in a group of unipolar depressive patients, was published in the March 1 *Biological Psychiatry*.

The adverse effects of scopolamine observed in the study were not serious and were expected of anticholinergic drugs. They included drowsiness, blurred vision, dry mouth, light-headedness, and hypotension.

Although the actual mechanism of scopolamine's antidepressant effect is still unknown, the researchers proposed two possible explanations. First, the drug indirectly reduces N-methyl-D-aspartate receptor (NMDAR) in the brain, and NMDAR antagonism is one of the consequences observed with other antidepressant drugs and with electroconvulsive therapy. A second possible explanation is that scopolamine enhances the activity of the parasympathetic nervous system and, in turn, reverses the relatively heightened sympathetic system seen in depression.

An abstract of "Replication of Scopolamine's Antidepressant Efficacy in Major Depressive Disorder: A Randomized, Placebo-Controlled Clinical Trial" is posted at <www.journals.elsevierhealth.com/periodicals/bps/article/S0006-3223(09)01414-0/abstract>. ■

Children's Psychosis Symptoms Should Set Off Alarms

Psychotic symptoms during childhood may be a marker for an impaired developmental process and should be actively assessed.

BY MARK MORAN

Children with symptoms of psychosis as early as age 12 are likely to have a constellation of other risk factors common to individuals who later develop schizophrenia.

That was the finding of a birth cohort study of 2,232 12-year-olds in Great Britain followed since age 5. The report appeared in the April *Archives of General Psychiatry*.

The study found that children's psychotic symptoms are familial and heritable and occur in the context of a range of other social, familial, and behavioral risk factors associated with later development of schizophrenia. These include living in a city and disadvantaged social conditions, lower birth weight, greater perinatal complications, social isolation, self-harm, negative maternal expressed emotion, and a chaotic household environment.

> **"The study strongly validates the need to study psychosis as a 'dimensional' phenomenon rather than only as part of a disease or syndrome."**

The study appears to confirm that children's self-report of psychotic symptoms—including delusions and hallucinations—is reliable, and that those symptoms may be part of a disease process consistent with the neurodevelopmental theory of schizophrenia.

"I think there is a natural inclination to dismiss such symptoms as part of a child's natural flight of fancy," said study author Avshalom Caspi, Ph.D. "We don't want to be unduly alarmist, but I think one of the things we have learned from this work is that there is a minority of children for whom these kinds of experiences and beliefs signal what is perhaps the early part of a disease process consistent with schizophrenia."

Participants in the study were members of the Environmental Risk Longitudinal Twin Study, which tracks the development of a nationally representative birth cohort of 2,232 British children. The sample was drawn from a larger birth registry of twins born in England and Wales in 1994 and 1995.

At age 12, children were assessed for psychosis symptoms. When a child endorsed any symptoms, the interviewer prompted the child to describe his or her experience further to discriminate between experiences that were plausibly real (such as, "I was followed by a man after school") and those that were probably psychotic ("I was followed by an angel who guards my spirit"). Interviewers then coded the descriptions as "not a symptom," "probably symptom" and "definite symptom," and the codes were then reviewed and confirmed by a psychiatrist with expertise in schizophrenia, a child and adolescent psychiatrist, and a psychologist with expertise in interviewing children.

Psychosis symptoms were reported by 416 children—291 had "probable" symptoms and 125 had at least one "definite symptom." Those children were significantly more likely than children not reporting symptoms to have a mother with a psychosis spectrum disorder, to have a family member ever admitted to a psychiatric unit, and to have a family member who had attempted suicide, according to the report.

The following social and behavioral risk factors, common to individuals who later develop schizophrenia, were also found to be statistically significantly more common among the children who had psychosis symptoms at age 12: urban living and socioeconomic disadvantage; low birth weight and low IQ; high maternal expressed emotion score; household chaos and physical maltreatment; antisocial behavior, symptoms of ADHD, social isolation, and internalizing problems at age 5; and antisocial behavior, depressive and anxiety symptoms, tobacco use, and self-harm at age 12.

Caspi told *Psychiatric News* that the findings build on a November 2000 study reported in the *Archives of General Psychiatry* in which he and colleagues found that self-reported psychosis symptoms at age 11 predicted a very high risk of schizophreniform disorder at age 26.

For clinicians, that report, combined with the new findings, strongly indicate that psychosis symptoms in childhood are likely to be a marker for an impaired developmental process and should be actively assessed. They generally occur in the context of other psychiatric problems that should be a focus of attention, he said.

For researchers, Caspi said that they may want to recruit children reporting psychotic symptoms into neuroimaging and other studies examining the pathophysiology of schizophrenia.

Nitin Gogtay, M.D., a staff psychiatrist with the Child Psychiatry Branch at the National Institute of Mental Health, reviewed the study and said that the presence of psychosis symptoms in children even younger than 12 is well known.

"However, this study is one of the first to systematically document [the presence of childhood psychotic symptoms] in a large sample and also the first to establish the heritability of such symptoms," he told *Psychiatric News*. "The study also strongly validates the need to study psychosis as a 'dimensional' phenomenon rather than only as part of a disease or syndrome."

"Etiologic and Clinical Features of Childhood Psychotic Symptoms: Results From a Birth Cohort Study" is posted at <http://archpsyc.ama-assn.org/cgi/content/full/67/4/328>. "Children's Self-Reported Psychotic Symptoms and Adult Schizophreniform Disorder: A 15-Year Longitudinal Study" is posted at <http://archpsyc.ama-assn.org/cgi/content/full/57/11/1053>. ■

Group Intervention Reduces Relapse In Bipolar Illness Patients

When combined with medication management, psychosocial interventions can help people with bipolar disorder reduce relapses. Such findings also bolster the mental illness recovery movement.

BY JOAN AREHART-TREICHEL

Cognitive-behavioral therapy (CBT), group psychoeducation, and possibly family therapy may help keep bipolar patients who have been stabilized by medication from relapsing, research suggests.

Now it looks as if teaching various psychosocial interventions in a group setting might be able to do the job as well, according to a study published in the May *British Journal of Psychiatry*. The lead investigator was David Castle, M.D., a psychiatrist at the University of Melbourne in Australia.

The study population included 72 subjects with bipolar disorder who had been recruited from various settings in or near Victoria, Australia. Some subjects were receiving private care, others public care. All were on psychotropic medications and stabilized at the time of study entry.

Subjects were randomized to either a control group or an experimental group for the 12-week study period.

During this time, the control group received treatment as usual—that is, psychotropic medications—and weekly telephone calls to maintain engagement in the trial and to control for this aspect of contact time in the experimental group.

The experimental group received psychotropic medications plus a structured group psychosocial intervention consisting of an eclectic mix of psychosocial education, CBT, dialectical behavior therapy (that is, learning certain stress-tolerance skills), social rhythms, and motivational interviewing aimed at helping participants deal with their health vulnerabilities and cope with stress.

Moreover, during the 12-week period, the experimental group received weekly telephone calls to remind them about the next group session and to offer support for any homework assignment that arose during the group intervention. After the study period ended, this group received three monthly "booster" sessions to reinforce skills that they had learned.

During the nine months following the 12-week study period, subjects were evaluated for relapses using *DSM-IV-TR* criteria.

The data indicated that the experimental group experienced significantly fewer relapses than the control group did, whether depressive, manic, hypomanic, mixed, or other. For instance, regarding depression relapses, 15 were experienced by control-group subjects, but only four by experimental-group subjects. In addition, six of the control subjects experienced mania relapses, while none of the experimental group did.

Thus, it looks as if the group intervention reduced the risk of relapse in subjects with bipolar disorder, the researchers concluded.

They noted, however, that the results need to be confirmed in another trial, and preferably one in which subjects and those conducting the assessments would be blinded as to who was receiving the experimental intervention, which was not the case in this study.

The study was funded by the Medical Benefits Fund Foundation and Victorian Center of Excellence in Depression and Related Disorders.

An abstract of "Group-Based Psychosocial Intervention for Bipolar Disorder: Randomized Controlled Trial" is posted at <http://bjp.rcpsych.org/cgi/content/abstract/196/5/383>. ■

Koplewicz Honored

Harold Koplewicz, M.D., is the winner of the Quest for the Test Award for advancing the understanding of early-onset bipolar disorder. The Quest for the Test funds investigations focused on finding an empirical test for bipolar disorder.

Koplewicz will use the $20,000 accompanying prize to support the groundbreaking resting-state fMRI research of F. Xavier Castellanos, M.D., which could lead to a diagnostic tool for early-onset bipolar disorder. "Dr. Castellanos' unique brain imaging work has the potential to truly transform the field of child and adolescent psychiatry" said Koplewicz. "Just as pediatricians can take a blood test to determine if a child has a virus, these brain growth charts have promised to diagnose brain disorders like early-onset bipolar disorder."

Koplewicz is the director of the Nathan S. Kline Institute for Psychiatric Research and founding president of the Child Mind Institute, a new organization dedicated to transforming mental health care for the world's children.

The Quest for the Test is a key initiative of the Ryan Licht Sang Bipolar Foundation, which was established in 2004 in memory of Ryan Licht Sang, a young man who suffered from early-onset bipolar disorder and died at age 24. ■

Treat your patients with the demonstrated efficacy of LEXAPRO[1-5]

In adolescents aged 12 to 17 with Major Depressive Disorder (MDD)[1]

In adults with MDD and Generalized Anxiety Disorder (GAD)[1]

Lexapro® escitalopram oxalate

WARNING: 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 less than 12 years of age.

Please see additional Important Safety Information on following pages.

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- Significantly improved MDD symptoms in adolescents[2]

Lexapro (escitalopram oxalate) is indicated for the acute and maintenance treatment of major depressive disorder (MDD) in adults and adolescents aged 12-17 years. Lexapro is also indicated for the acute treatment of generalized anxiety disorder (GAD) in adults.

*LEXAPRO is indicated as an integral part of a total treatment program for MDD. Drug treatment may not be indicated for all adolescents with this syndrome.

IMPORTANT SAFETY INFORMATION (continued)

Contraindications

- Lexapro is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs). There have been reports of serious, sometimes fatal, reactions with some cases resembling neuroleptic malignant syndrome (NMS) and serotonin syndrome. Features may include 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. Serotonin syndrome was reported for two patients who were concomitantly receiving linezolid, an antibiotic which has MAOI activity. Lexapro should not be used in combination with an MAOI or within 14 days of discontinuing an MAOI. MAOIs should not be initiated within 14 days of discontinuing Lexapro.
- Lexapro is contraindicated in patients taking pimozide or with hypersensitivity to escitalopram or citalopram.

Warnings and Precautions

- All patients treated with antidepressants should be monitored appropriately and observed closely for clinical worsening, suicidality and unusual changes in behavior, especially within the first few months of treatment or when changing the dose. Consideration should be given to changing the therapeutic regimen, including discontinuing medication, in patients whose depression is persistently worse, 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. Families and caregivers of patients treated with antidepressants should be alerted about the need to monitor patients daily for the emergence of agitation, irritability, unusual changes in behavior, or the emergence of suicidality, and report such symptoms immediately. 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.

- Significantly higher rates of response and remission vs placebo in MDD and GAD in adults[4,5]

- A major depressive episode may be the initial presentation of bipolar disorder. In patients at risk for bipolar disorder, treating such an episode with an antidepressant alone may increase the likelihood of precipitating a mixed/manic episode. Prior to initiating treatment with an antidepressant, patients should be adequately screened to determine if they are at risk for bipolar disorder. Lexapro should be used cautiously in patients with a history of mania or seizure disorder. Lexapro is not approved for use in treating bipolar depression.
- The concomitant use of Lexapro with other SSRIs, SNRIs, triptans, tryptophan, antipsychotics or other dopamine antagonists is not recommended due to potential development of life-threatening serotonin syndrome or neuroleptic malignant syndrome (NMS)-like reactions. Reactions have been reported with SNRIs and SSRIs alone, including Lexapro, but particularly with drugs that impair metabolism of serotonin (including MAOIs). Management of these events should include immediate discontinuation of Lexapro and the concomitant agent and continued monitoring.
- Patients should be monitored for adverse reactions when discontinuing treatment with Lexapro. During marketing of Lexapro and other SSRIs and SNRIs, there have been spontaneous reports of adverse events occurring upon discontinuation, including dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias), anxiety, confusion, headache, lethargy, emotional lability, insomnia and hypomania. A gradual dose reduction rather than abrupt cessation is recommended whenever possible.
- SSRIs and SNRIs have been associated with clinically significant hyponatremia. Elderly patients and 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.

Please see Boxed Warning on first page and additional Important Safety Information on next page.

Lexapro®
escitalopram oxalate

Visit the LEXAPRO website at www.lexapro.com

LEXAPRO: Proven efficacy in MDD in adolescents aged 12 to 17, and in MDD and GAD in adults[1-5]

Warnings and Precautions (continued)

- SSRIs (including Lexapro) and SNRIs may increase the risk of bleeding. Patients should be cautioned that concomitant use of aspirin, NSAIDs, warfarin or other anticoagulants may add to the risk.
- Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro does not affect their ability to engage in such activities.
- Lexapro should be used with caution in patients with severe renal impairment or with diseases or conditions that alter metabolism or hemodynamic responses. 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.
- For pregnant or nursing mothers, Lexapro should be used only if the potential benefit justifies the potential risk to the fetus or child.

Adverse Reactions

- In clinical trials of MDD, the most common adverse reactions in adults treated with Lexapro (approximately 5% or greater and at least twice the incidence of placebo) were nausea (15% vs 7%), insomnia (9% vs 4%), ejaculation disorder (9% vs <1%), fatigue (5% vs 2%), somnolence (6% vs 2%), and increased sweating (5% vs 2%). In pediatric patients, the overall profile of adverse reactions was similar to that seen in adults; however, the following additional adverse reactions were reported at an incidence of at least 2% for Lexapro and greater than placebo: back pain, urinary tract infection, vomiting, and nasal congestion.
- In clinical trials of GAD, the most common adverse reactions in adults treated with Lexapro (approximately 5% or greater and at least twice the incidence of placebo) were nausea (18% vs 8%), ejaculation disorder (14% vs 2%), insomnia (12% vs 6%), fatigue (8% vs 2%), decreased libido (7% vs 2%) and anorgasmia (6% vs <1%).

Please see accompanying brief summary of Prescribing Information for LEXAPRO, including Boxed Warning.

References: 1. LEXAPRO [package insert]. St. Louis, Mo: Forest Pharmaceuticals, Inc.; 2009. **2.** Emslie GJ, Ventura D, Korotzer A, Tourkodimitris S. Escitalopram in the treatment of adolescent depression: a randomized placebo-controlled multisite trial. *J Am Acad Child Adolesc Psychiatry*. 2009;48:721-729. **3.** 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. **4.** 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. **5.** Wade A, Lemming OM, Hedegaard KB. Escitalopram 10 mg/day is effective and well tolerated in a placebo-controlled study in depression in primary care. *Int Clin Psychopharmacol*. 2002;17:95-102.

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 Printed in U.S.A. 41-1016226hR2 3/10

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Lexapro® escitalopram oxalate

LEXAPRO® (escitalopram oxalate) TABLETS/ORAL SOLUTION **Rx Only**

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

WARNINGS: 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 less than 12 years of age. *[See Warnings and Precautions: Clinical Worsening and Suicide Risk, Patient Counseling Information: Information for Patients, and Used in Specific Populations: Pediatric Use].*

INDICATIONS AND USAGE: Major Depressive Disorder-Lexapro (escitalopram) is indicated for the acute and maintenance treatment of major depressive disorder in adults and in adolescents 12 to 17 years of age [*see Clinical Studies*]. 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. **Generalized Anxiety Disorder**-Lexapro is indicated for the acute treatment of Generalized Anxiety Disorder (GAD) in adults [*see Clinical Studies*]. 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.

CONTRAINDICATIONS: Monoamine oxidase inhibitors (MAOIs)-Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated [*see Warnings and Precautions*]. **Pimozide**-Concomitant use in patients taking pimozide is contraindicated [*see Drug Interactions*]. **Hypersensitivity to escitalopram or citalopram**-Lexapro is contraindicated in patients with a hypersensitivity to escitalopram or citalopram or any of the inactive ingredients in Lexapro.

WARNINGS AND PRECAUTIONS: 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	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 Dosage and Administration*]. 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 health care providers. Such monitoring should include daily observation by families and caregivers [*see also Patient Counseling Information*]. 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. **Serotonin Syndrome or Neuroleptic Malignant Syndrome (NMS)-like Reactions**-The development of a potentially life-threatening serotonin syndrome or Neuroleptic Malignant Syndrome (NMS)-like reactions have been reported with SNRIs and SSRIs alone, including Lexapro treatment, but particularly with concomitant use of serotonergic drugs (including triptans) with drugs which impair metabolism of serotonin (including MAOIs), or with antipsychotics or other dopamine antagonists. 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). Serotonin syndrome, in its most severe form can resemble neuroleptic malignant syndrome, which includes hyperthermia, muscle rigidity, autonomic instability with possible rapid fluctuation of vital signs, and mental status changes. Patients should be monitored for the emergence of serotonin syndrome or NMS-like signs and symptoms. The concomitant use of Lexapro with MAOIs intended to treat depression is contraindicated. 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. The concomitant use of Lexapro with serotonin precursors (such as tryptophan) is not recommended. Treatment with Lexapro and any concomitant serotonergic or antidopaminergic agents, including antipsychotics, should be discontinued immediately if the above events occur and supportive symptomatic treatment should be initiated. **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*]. **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. **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. **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. **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 SSRIs and SNRIs 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. **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*]. **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.

ADVERSE REACTIONS: Clinical Trials Experience-Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice. **Clinical Trial Data Sources; Pediatrics (6 -17 years)**-Adverse events were collected in 576 pediatric patients (286 Lexapro, 290 placebo) with major depressive disorder in double-blind placebo-controlled studies. Safety and effectiveness of Lexapro in pediatric patients less than 12 years of age has not been established. **Adults**-Adverse events 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 reactions 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; Pediatrics (6 -17 years)**-Adverse events were associated with discontinuation of 3.5% of 286 patients receiving Lexapro and 1% of 290 patients receiving placebo. The most common adverse event (incidence at least 1% for Lexapro and greater than placebo) associated with discontinuation was insomnia (1% Lexapro, 0% placebo). **Adults**-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; Adults**-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 Reactions in Placebo-Controlled Clinical Trials; Major Depressive Disorder; Pediatrics (6 -17 years)**-The overall profile of adverse reactions in pediatric patients was generally similar to that seen in adult studies, as shown in Table 2. However, the following adverse reactions (excluding those which appear in Table 2 and those for which the coded terms were uninformative or misleading) were reported at an incidence of at least 2% for Lexapro and greater than placebo: back pain, urinary tract infection, vomiting, and nasal congestion. **Adults**-The most commonly observed adverse reactions 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. 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.

TABLE 2
Treatment-Emergent Adverse Reactions Observed with a Frequency of ≥ 2% and Greater Than Placebo for Major Depressive Disorder

Adverse Reaction	Lexapro (N=715)	Placebo (N=592)
Autonomic Nervous System Disorders		
Dry Mouth	6%	5%
Sweating Increased	5%	2%
Central & Peripheral Nervous System Disorders		
Dizziness	5%	3%
Gastrointestinal Disorders		
Nausea	15%	7%
Diarrhea	8%	5%
Constipation	3%	1%
Indigestion	3%	1%
Abdominal Pain	2%	1%
General		
Influenza-like Symptoms	5%	4%
Fatigue	5%	2%
Psychiatric Disorders		
Insomnia	9%	4%
Somnolence	6%	2%
Appetite Decreased	3%	1%
Libido Decreased	3%	1%
Respiratory System Disorders		
Rhinitis	5%	4%
Sinusitis	3%	2%
Urogenital		
Ejaculation Disorder[1,2]	9%	<1%
Impotence[2]	3%	<1%
Anorgasmia[3]	2%	<1%

[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; Adults-The most commonly observed adverse reactions 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. 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.

TABLE 3
Treatment-Emergent Adverse Reactions Observed with a Frequency of ≥ 2% and Greater Than Placebo for Generalized Anxiety Disorder

Adverse Reactions	Lexapro (N=429)	Placebo (N=427)
Autonomic Nervous System Disorders		
Dry Mouth	9%	5%
Sweating Increased	4%	1%
Central & Peripheral Nervous System Disorders		
Headache	24%	17%
Paresthesia	2%	1%
Gastrointestinal Disorders		
Nausea	18%	8%
Diarrhea	8%	6%
Constipation	5%	4%
Indigestion	3%	2%
Vomiting	3%	1%
Abdominal Pain	2%	1%
Flatulence	2%	1%
Toothache	2%	0%
General		
Fatigue	8%	2%
Influenza-like Symptoms	5%	4%
Musculoskeletal System Disorder		
Neck/Shoulder Pain	3%	1%
Psychiatric Disorders		
Somnolence	13%	7%
Insomnia	12%	6%
Libido Decreased	7%	2%
Dreaming Abnormal	3%	2%
Appetite Decreased	3%	1%
Lethargy	3%	1%
Respiratory System Disorders		
Yawning	2%	1%
Urogenital		
Ejaculation Disorder[1,2]	14%	2%
Anorgasmia[3]	6%	<1%
Menstrual Disorder	2%	1%

[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 Reactions-The potential dose dependency of common adverse reactions (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 reactions 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 Reactions in Patients with Major Depressive Disorder

Adverse Reaction	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%

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
Incidence of Sexual Side Effects in Placebo-Controlled Clinical Trials

Adverse Event	Lexapro	Placebo
	In Males Only	
	(N=407)	(N=383)
Ejaculation Disorder (primarily ejaculatory delay)	12%	1%
Libido Decreased	6%	2%
Impotence	2%	<1%
	In Females Only	
	(N=737)	(N=636)
Libido Decreased	3%	1%
Anorgasmia	3%	<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 Reactions Observed During the Premarketing Evaluation of Lexapro**-Following is a list of 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. The listing does not include those events already listed in Tables 2 & 3, those events for which a drug cause was remote and at a rate less than 1% or lower than placebo, those events which were so general as to be uninformative, and those events reported only once which did not have a substantial probability of being acutely life threatening. Events are categorized by body system. Events of major clinical importance are described in the Warnings and Precautions section. Cardiovascular - hypertension, palpitation. Central and Peripheral Nervous System Disorders - light-headed feeling, migraine. Gastrointestinal Disorders - abdominal cramp, heartburn, gastroenteritis. General - allergy, chest pain, fever, hot flushes, pain in limb. Metabolic and Nutritional Disorders - increased weight. Musculoskeletal System Disorders - arthralgia, myalgia jaw stiffness. Psychiatric Disorders - appetite increased, concentration impaired, irritability. Reproductive Disorders/Female - menstrual cramps, menstrual disorder. Respiratory System Disorders - bronchitis, coughing, nasal congestion, sinus congestion, sinus headache. Skin and Appendages Disorders - rash. Special Senses - vision blurred, tinnitus. Urinary System Disorders - urinary frequency, urinary tract infection. **Post-Marketing Experience; Adverse Reactions Reported Subsequent to the Marketing of Escitalopram**-The following additional adverse reactions have been identified from spontaneous reports of escitalopram received worldwide. These adverse reactions have been chosen for inclusion because of a combination of seriousness, frequency of reporting, or potential causal connection to escitalopram and have not been listed elsewhere in labeling. However, because these adverse reactions were reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These events include: Blood and Lymphatic System Disorders: anemia, agranulocytis, aplastic anemia, hemolytic anemia, idiopathic thrombocytopenia purpura, leukopenia, thrombocytopenia. Cardiac Disorders: atrial fibrillation, bradycardia, cardiac failure, myocardial infarction, tachycardia, torsade de pointes, ventricular arrhythmia, ventricular tachycardia. Ear and Labyrinth Disorders: vertigo Endocrine Disorders: diabetes mellitus, hyperprolactinemia, SIADH. Eye Disorders: diplopia, glaucoma, mydriasis, visual disturbance. Gastrointestinal Disorders: dysphagia, gastrointestinal hemorrhage, gastroesophageal reflux, pancreatitis, rectal hemorrhage. General Disorders and Administration Site Conditions: abnormal gait, asthenia, edema, fall, feeling abnormal, malaise. Hepatobiliary Disorders: fulminant hepatitis, hepatic failure, hepatic necrosis, hepatitis. Immune System Disorders: allergic reaction, anaphylaxis. Investigations: bilirubin increased, decreased weight, electrocardiogram QT prolongation, hepatic enzymes increased, hypercholesterolemia, INR increased, prothrombin decreased. Metabolism and Nutrition Disorders: hyperglycemia, hypoglycemia, hypokalemia, hyponatremia. Musculoskeletal and Connective Tissue Disorders: muscle cramp, muscle stiffness, muscle weakness, rhabdomyolysis. Nervous System Disorders: akathisia, amnesia, ataxia, choreoathetosis, cerebrovascular accident, dysarthria, dyskinesia, dystonia, extrapyramidal disorders, grand mal seizures (or convulsions), hypoaesthesia, myoclonus, nystagmus, Parkinsonism, restless legs, seizures, syncope, tardive dyskinesia, tremor. Pregnancy, Puerperium and Perinatal Conditions: spontaneous abortion. Psychiatric Disorders: acute psychosis, aggression, agitation, anger, anxiety, apathy, completed suicide, confusion, depersonalization, depression aggravated, delirium, delusion, disorientation, feeling unreal, hallucinations (visual and auditory), mood swings, nervousness, nightmare, panic reaction, paranoia, restlessness, self-harm or thoughts of self-harm, suicide attempt, suicidal ideation, suicidal tendency. Renal and Urinary Disorders: acute renal failure, dysuria, urinary retention. Reproductive System and Breast Disorders: menorrhagia, priapism. Respiratory, Thoracic and Mediastinal Disorders: dyspnea, epistaxis, pulmonary embolism, pulmonary hypertension of the newborn. Skin and Subcutaneous Tissue Disorders: alopecia, angioedema, dermatitis, ecchymosis, erythema multiforme, photosensitivity reaction, Stevens Johnson Syndrome, toxic epidermal necrolysis, urticaria. Vascular Disorders: deep vein thrombosis, flushing, hypertensive crisis, hypotension, orthostatic hypotension, phlebitis, thrombosis.

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 and Precautions*]. The concomitant use of Lexapro with other SSRIs, SNRIs or tryptophan is not recommended. **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 and Precautions*]. **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 and Precautions*]. **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.

USE IN SPECIFIC POPULATIONS: 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 also 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 and Precautions*]. 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**-Escitalopram is excreted in human breast milk. Limited data from women taking 10-20 mg escitalopram showed that exclusively breast-fed infants receive approximately 3.9% of the maternal weight-adjusted dose of escitalopram and 1.7% of the maternal weight-adjusted dose of desmethylcitalopram. There were two reports of infants experiencing excessive somnolence, decreased feeding, and weight loss in association with breastfeeding from a racemic citalopram-treated mother; in one case, the infant was reported to recover completely upon discontinuation of racemic citalopram by its mother and, in the second case, no follow-up information was available. Caution should be exercised and breastfeeding infants should be observed for adverse reactions when Lexapro is administered to a nursing woman. **Pediatric Use**-Safety and effectiveness of Lexapro has not been established in pediatric patients (less than 12 years of age) with Major Depressive Disorder. Safety and effectiveness of Lexapro has been established in adolescents (12 to 17 years of age) for the treatment of major depressive disorder [*see Clinical Studies*]. Although maintenance efficacy in adolescent patients with Major Depressive Disorder has not been systematically evaluated, maintenance efficacy can be extrapolated from adult data along with comparisons of escitalopram pharmacokinetic parameters in adults and adolescent patients. Safety and effectiveness of Lexapro has not been established in pediatric patients less than 18 years of age with Generalized Anxiety Disorder. **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 *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.

DRUG ABUSE AND DEPENDENCE: Abuse and Dependence; Physical and Psychological Dependence-Animal studies suggest that the abuse liability of racemic citalopram is low. Lexapro has not been systematically studied in humans for its potential for abuse, tolerance, or physical dependence. The premarketing clinical experience with Lexapro did not reveal any drug-seeking behavior. However, these observations were not systematic and it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, physicians should carefully evaluate Lexapro patients for history of drug abuse and follow such patients closely, observing them for signs of misuse or abuse (e.g., development of tolerance, incrementations of dose, drug-seeking behavior).

OVERDOSAGE: Human Experience-In clinical trials of escitalopram, there were reports of escitalopram overdose, including overdoses of up to 600 mg, with no associated fatalities. During the postmarketing evaluation of escitalopram, Lexapro overdoses involving overdoses of over 1000 mg have been reported. As with other SSRIs, a fatal outcome in a patient who has taken an overdose of escitalopram has been rarely reported. Symptoms most often accompanying escitalopram overdose, alone or in combination with other drugs and/or alcohol, included convulsions, coma, dizziness, hypotension, insomnia, nausea, vomiting, sinus tachycardia, somnolence, and ECG changes (including QT prolongation and very rare cases of torsade de pointes). Acute renal failure has been very rarely reported accompanying overdose. **Management of Overdose**-Establish and maintain an airway to ensure adequate ventilation and oxygenation. Gastric evacuation by lavage and use of activated charcoal should be considered. Careful observation and cardiac and vital sign monitoring are recommended, along with general symptomatic and supportive care. Due to the large volume of distribution of escitalopram, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. There are no specific antidotes for Lexapro. In managing overdosage, consider the possibility of multiple-drug involvement. The physician should consider contacting a poison control center for additional information on the treatment of any overdose.

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Baby Boomers Challenge Theory About Seniors' Mental Health

While older people are generally less depressed and anxious than younger ones, a geriatric psychiatrist predicts that aging baby boomers may have higher rates of mental illness than the generation that has already reached their senior years.

BY JOAN AREHART-TREICHEL

Could it be that mental health, like a good wine, improves with age? Evidence has been building that this might be the case (*Psychiatric News*, November 2, 2007).

Now still more evidence bolstering this possibility was published in the May *Archives of General Psychiatry*. The study has found that the prevalence rates of mood and anxiety disorders decline with age.

The study's lead investigator was Amy Byers, Ph.D., an assistant professor of psychiatry at the University of California, San Francisco.

Byers and her colleagues used data from the National Comorbidity Survey Replication (NCS-R) for their study. The NCS-R surveyed, from 2001 to 2003, 9,282 participants aged 18 or older who were representative of the American population. The NCS-R has already provided a wealth of information about mental health and illness in Americans.

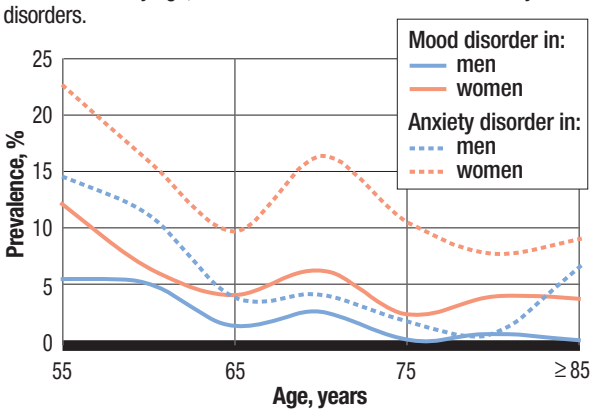
The researchers focused on data for the 2,575 NCS-R participants who were aged 55 or older. They wanted to determine the 12-month prevalence rates of mood and anxiety disorders for "young-old" subjects (aged 55 to 64), "mid-old" subjects (aged 65 to 74), "old-old" subjects (aged 75-84), and "oldest-old" subjects (aged 85 or older).

They found that the likelihood of having a mood, anxiety, or combined mood-anxiety disorder significantly declined with age. For example, whereas 8 percent of subjects aged 55 to 64 had experienced a major depressive disorder during the preceding year, only 2 percent of subjects aged 85 or older had. The trend applied to both men and women and to people of various races and ethnicities.

But at the same time, the researchers found that mood and anxiety disorders were far from uncommon in subjects aged 55 or older, especially women. Moreover, anxiety seemed to be more of a problem for subjects in this age range than depression was. For example, 9 percent of subjects aged 65 to 74 had experienced an anxiety disorder during the previous year, while only 4 percent of subjects in this age range had experienced a mood disorder during the previous year.

Down but Not Gone

While the prevalence of mood and anxiety disorders in Americans tends to decline as they age, this is less so for women and for anxiety disorders.



Source: Amy Byers, Ph.D., et al., *Archives of General Psychiatry*, May 2010

"This study was a well-conducted analysis of a unique database and conducted by some of the top experts in geriatric psychiatry," Dilip Jeste, M.D., a geriatric psychiatrist and chair of aging studies at the University of California, San Diego, told *Psychiatric News*. "Their finding that while the prevalence rates of mood and anxiety disorders decline with age but still remain high in older people is of considerable public-health significance because of the implications for prevention and treatment."

Furthermore, the rates of these and other major psychiatric disorders will increase further among older adults in the decades to come, Jeste said, since other data have suggested that aging baby boomers are likely to have higher rates of mental illness than the current population of older adults. Thus the need for geriatric psychiatrists will increase dramatically during the next few years, he predicted.

The study was funded by the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, the Robert Wood Johnson Foundation, and the John W. Alden Trust.

An abstract of "High Occurrence of Mood and Anxiety Disorders Among Older Adults" is posted at <http://archpsyc.ama-assn.org/cgi/content/abstract/67/5/489>. ■

Research Shows Importance of Studying Different Ethnic Groups

It's important to include Latinos in Alzheimer's treatment trials now that those who carry a particular gene variant have been found to be as susceptible to Alzheimer's as Caucasians who carry it.

BY JOAN AREHART-TREICHEL

After age, the APOE e4 gene variant is the best-established risk factor for late-onset Alzheimer's disease. However, the precise role that the variant plays in Alzheimer's risk for various ethnic groups is still being clarified.

During the past quarter century, a number of scientists have found that people with Alzheimer's have progressive reductions in glucose metabolism in the posterior cingulate, the precuneus, and some parietal, temporal, and prefrontal regions of the brain.

During the past 15 years, scientists have found that cognitively healthy individuals of Caucasian ancestry who carry the APOE e4 variant also experience reduced glucose metabolism in these brain regions.

And now Jessica Langbaum, Ph.D., a staff scientist at Banner Alzheimer's Institute in Phoenix, and colleagues have learned that cognitively healthy individuals of Latino ancestry who have the gene variant also show reduced glucose metabolism in the brain. They reported their findings in the April *Archives of Neurology*.

The study included 11 cognitively healthy APOE e4 carriers as well as 16 cognitively healthy controls from Arizona's Latino community (mostly Mexican Americans). The two groups were matched on gender, educational level, and family history of dementia. The average age of both groups was 55.

PET scans were used to evaluate the rate of glucose metabolism in various regions of the brain of each subject.

(The use of a small number of subjects, in this case 27, is not uncommon in neuroimaging studies, Langbaum told *Psychiatric News*. One reason why, she said, is cost. Another is that "we are often able to detect associations and changes with much smaller sample sizes using neuroimaging measures, compared to traditional cognitive or clinical outcome measures.")

Compared with controls, carriers of the gene variant had a significantly lower rate of glucose metabolism bilaterally in brain regions previously found to be preferentially affected by Alzheimer's, including the posterior cingulate, precuneus, and parietal cortex.

"Our results support the role of APOE e4 in the risk of Alzheimer's disease for Latinos, particularly Mexican-American Latinos, and suggest that the role of many Alzheimer's disease risk factors may be similar for both non-Latino and Latino groups," Langbaum told *Psychiatric News*.

"Our results [also] support the inclusion of Latino APOE e4 carriers in our proposed presymptomatic Alzheimer's disease treatment trials," she added. "At the present, we are preparing for a clinical trial to evaluate the most promising presymptomatic treatments in cognitively healthy late-middle-aged adults who carry two copies of the e4 allele. This study will complement those trials being proposed in other groups at increased risk, such as carriers of genes for early-onset Alzheimer's."

It is not yet known whether individuals of Asian or African descent who carry the e4 allele also experience reduced glucose metabolism in brain areas often affected by Alzheimer's, Langbaum said.

The study was funded by the National Institutes of Health, the Evelyn G. McKnight Brain Institute, the state of Arizona, the Banner Alzheimer's Foundation, and the Mayo Clinic Foundation.

An abstract of "Hypometabolism in Alzheimer-Affected Brain Regions in Cognitively Healthy Latino Individuals Carrying the Apolipoprotein e4 Allele" is posted at <http://archneur.ama-assn.org/cgi/content/abstract/67/4/462>. ■

APA Needs Your Help

APA needs its members who have billing experience with general evaluation and management codes (99XXX series codes) to participate in a survey designed to evaluate the time, complexity, and intensity of work required to perform a procedure, relative to other procedures used for comparison. APA members interested in participating in the survey should call the Office of Healthcare Systems and Financing at (888) 357-7924, ext. 8593, or e-mail Becky Yowell at byowell@psych.org.

Psychiatry Meeting to Be Held in Asheville, N.C.

The Southern Psychiatric Association and the Tennessee Psychiatric Association are holding their annual meeting from September 29 to October 3 at the Grove Park Inn in Asheville, N.C. The theme of the meeting is "Psychiatry on the Verge of *DSM-5*."

The Southern Psychiatric Association held its first meeting 75 years ago and will be marking that occasion at this meeting. The program will provide a review and update on new and emerging techniques, guidelines, clinical information, and managed care issues regarding the biological, psychodynamic, and administrative aspects of psychiatry.

The Grove Park Inn offers a variety of amenities, including golf, tennis, a spa, four restaurants, and a "dueling" piano bar. Reservations may be made by calling (800) 438-5800 and providing the group ID number #68Q7MO. The deadline for hotel reservations and meeting registration is August 22.

Further information about the program and a registration form are posted at <www.sopsych.org>. Additional information is available from Susan Proctor at sproctor@sheppardpratt.org or (410) 938-3403. ■

Schatzberg

continued from page 1

said. Topping off these achievements was the passage of health care reform.

Regarding his aim to restore pride in the profession, Schatzberg noted that APA members have much to be proud of: APA's annual meetings, which showcase the great progress that has been made in the neurosciences; the American Psychiatric Foundation (APF), which supports numerous educational and community initiatives and even an Emmy-nominated TV show, "Healthy Minds" (see page 9); the American Psychiatric Institute for Research and Education (APIRE), which has made contributions in many areas of psychiatry; the development of *DSM-5;* and the outstanding journals, books, and newspaper produced under American Psychiatric Publishing Inc. (APPI).

Among these, *DSM-5* had the highest public profile this past year. A Web site containing the proposed diagnostic criteria for *DSM-5* was launched in February and invited feedback from psychiatrists, other physicians, mental health professionals, and the public. "The Web site generated 41 million hits and over 8,700 substantive comments—truly remarkable and a great example of transparency," Schatzberg observed.

Nonetheless, there have been attacks on *DSM-5* that reflect many misperceptions that psychiatry needs to combat. The first involves overdiagnosis and inappropriate diagnosis. Schatzberg countered, "Psychiatric disorders are unfortunately common, independent of the number of psychiatrists. In fact, we have a major shortage of psychiatrists in this country. Psychiatrists do not need to look for business."

Second, stigmatization is still very real. For example, critics have attacked the proposed diagnosis of mild neurocognitive impairment. "Are the same critics attacking the neurologists for their [diagnosis of] proposed mild cognitive impairment? No. This hypocrisy really reflects stigmatization."

Schatzberg noted that some of the criticisms have come from English and history professors, which suggests to him a different kind of problem. The general public, for example, read pop psychology articles or watch pop psychologists on TV and think they know a lot about emotions and feelings. Adding to this false sense of understanding is the common language used in psychiatric nosology.

"Other medical specialties have disorders based on Latin and Greek terms that are complemented by lay terminology or descriptors—take, for example, myocardial infarction and heart attack. When you look at psychiatry, you see disorders that are distinctly unmedical in sound in many ways—binge-eating disorder, major depression, panic disorder, etc., with no real parallel and more technical medical terminology. . . . We need to be more medical to be taken more seriously."

Education, Industry Relations Addressed

Regarding his aim to improve APA's annual meetings, he observed that APA's fall 2009 Institute on Psychiatric Services had the highest attendance ever and enjoyed rave reviews, and for this year's annual meeting, experts were engaged to serve as consultants to the Scientific Program Committee and help evaluate submissions. The result was a "dynamite program with the best people to teach all of us. . . . We should be proud of the meeting and that we can provide a high-level meeting without industry support."

Still, even though industry support of educational programs at APA's annual meeting is almost gone, "we do need to have ways of interacting with industry if we are to stay current," said Schatzberg. Thus, during his presidential year, he appointed a task force to help define guidelines for interacting with industry. The task force promulgated a "code of conduct" for dealing with outside organizations and companies. The APA Board of Trustees approved the code in May (see page 9), which is hoped to serve as the basis for developing new strategies of APA's interactions with industry.

APA's Financial Status Firm

Schatzberg became president of APA in the midst of a quickly devolving financial situation due largely to a precipitous drop in advertising and other industry revenue. The Board, working with staff, took steps to reduce expenses dramatically. These moves, in addition to such developments as a stronger than expected stock market, allowed APA to close the year with a surplus of $1.2 million.

"A great turnaround," said Schatzberg, "but times are still iffy." While APA is now meeting revenue projections, "it will take great effort to ensure continued financial health."

One cost-saving initiative now under way is reducing APA's current structure of four organizations (APA, APF, APPI, and APIRE) to two. This reorganization "will better ally the funds flow with the member-oriented missions of APA and allow for focused activities in the foundation. We will all gain in the end. We expect to finalize the reorganization shortly and will outline the details to all of you over the next few weeks."

Recent discussions with the leaders of the affiliate organizations have revealed "a number of intriguing possibilities" for APA's future, said Schatzberg. For example, APA should be members' one-stop shop for education, maintenance of skills, and preparation for recertification through its annual meetings and publications. The Practice Research Network could be expanded to answer many questions—say, regarding the genetics of many disorders and outcomes and effectiveness.

"Psychiatrists should take pride in their often heroic efforts to take care of those with mental illness. Not only are we dedicated physicians, but we lobby hard on behalf of the disadvantaged."

"Why not ennoble our work by providing ourselves—and the rest of the world—the answers to how best to diagnose and treat our patients? Think of the contributions each of us could make," he challenged his colleagues. "Then we will only be prouder of our work as psychiatrists and as members of the oldest medical specialty society in the country—the American Psychiatric Association." ■

FDA

continued from page 1

Drug companies are prohibited from discussing or promoting unapproved indications of their products, but it is not illegal for them to distribute articles published in peer-reviewed medical journals that investigate or review unapproved uses of a medication.

The FDA is encouraging physicians and other professionals to report suspected violations they encounter at medical conferences, in professional and lay media, in materials they receive, at company-sponsored presentations, and during sales-representatives' visits. Complaints can be submitted, with supporting materials or other evidence, to the agency by e-mail at badad@fda.gov, telephone at (877) RX-DDMAC, or mail. The reports can be submitted anonymously, but the agency recommends that those filing a complaint provide their name and contact information for follow-up and collection of additional materials.

"This is a reasonable effort on the part of the FDA," said David Fassler, M.D., APA treasurer and a child and adolescent psychiatrist in Vermont. He is also a clinical professor of psychiatry at the University of Vermont. "At a minimum, it may help educate physicians about the regulations governing ads and promotions."

He suggested, however, that the initiative indicates the FDA's lack of resources when it comes to reviewing drug-marketing activities. "Improving compliance will ultimately require a substantial increase in the resources available for monitoring and enforcement," he said.

The DDMAC, housed in the FDA's Center for Drug Evaluation and Research, is in charge of monitoring and regulating the advertisements and promotional activities for prescription drugs. Medical devices and over-the-counter drugs are not regulated by this division.

Although spontaneous reports from health care professionals have occasionally led to investigation and regulatory actions, the DDMAC has traditionally focused its reviews on advertising materials voluntarily submitted by drug companies, complaints filed by competitor drug companies, and surveillance of medical conferences. In a public letter posted on the Bad Ad program Web site, FDA Commissioner Margaret Hamburg, M.D., wrote that the "FDA's ability to monitor other promotional activities, which may occur in any number of settings, is limited."

In 2009, the DDMAC issued 38 enforcement letters to pharmaceutical companies, up from 22 letters in 2008.

According to Hamburg's letter, the DDMAC will have exhibits at major medical conferences to educate physicians and others about drug-marketing regulations and to promote the Bad Ad program. She urged practitioners to assist the FDA in identifying and stopping misleading drug promotion. ■

Sex Offenders

continued from page 2

That equivalence "really reflects a battle lost by the psychiatric profession trying to differentiate traditional mental disorders from the disturbances associated with sexual offending that are usually much more volitional," he said.

The lone dissenting opinion, written by Justice Clarence Thomas, held that no such civil commitment authority was enumerated in the Constitution. "To be sure, protecting society from violent sexual offenders is certainly an important end," Thomas wrote. "But the Constitution does not vest in Congress the authority to protect society from every bad act that might befall it. . . . The fact that the Federal government has the authority to imprison a person for the purpose of punishing him for a federal crime—sexual-related or otherwise—does not provide the government with the additional power to exercise indefinite civil control over that person."

Appelbaum said the government's use of civil commitment of sexual offenders raises a host of questions, not the least of which involves the questionable efficacy of "therapy" for sexual offenders. "For psychosis, for instance, we know what to do as clinicians and have some reasonable prospect that conditions will be improved," he said. "For sexually dangerous offenders, the data are much weaker, and such treatments as exist haven't become part of the psychiatric mainstream."

More fundamentally, the ruling gives the Supreme Court's approval to a practice that very likely has little to do with treating people—mentally ill or not—and more to do with keeping people perceived to be a public menace off the streets.

"The traditional commitment process is predicated on the idea that the patient will benefit from the intervention," Appelbaum said. "With regard to the sexual offender, the primary goal of civil commitment is to protect the public, not to benefit the person.

"What makes that clear is that in both the federal case under question and in the state laws that allow civil commitment of sexual offenders, the government is creating the commitment process to begin when the individual's prison sentence expires," he said. "If the government were really interested in treating, they would start the treatment from day one in the prison."

In January 2006, Rhode Island psychiatrist Brandon Krupp, M.D., resigned his position as chief of psychiatry at Eleanor Slater Hospital in Cranston after Gov. Donald Carcieri sought continued hospitalization of a convicted sexual predator who had completed a 17-year prison sentence.

"I am as concerned as anyone about sexual offenders being in the community unsupervised, because I have treated their victims," Krupp told *Psychiatric News* at the time. "But it makes no sense to misuse the medical system for political ends" *(Psychiatric News*, January 20, 2006).

The Supreme Court's decision is posted at <www.supremecourt.gov/opinions/09pdf/08-1224.pdf>. ■

Dieting

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Finally, differences in psychological stress scores and differences in cortisol levels for the four groups were compared, and the researchers also assessed whether possibly confounding variables such as physical-activity level, pain, or stressful life events unrelated to dieting had any effect on their findings.

The two groups that had counted calories experienced more psychological stress at the end of the test period than they had at the start, although the difference was not quite statistically significant. The two groups that had not counted calories did not show a similar increase in psychological stress.

The two groups that had restricted their caloric intake during the test period experienced more cortisol production at the end of the test period than before, and the difference was statistically significant. The two groups that had not restricted their caloric intake during the test period did not show more cortisol production.

At first glance, there seems to be a disconnect between these findings. Why didn't calorie tracking, as well as caloric restriction, produce both psychological and physiological stress responses? The researchers expected that to happen. An explanation for why it didn't happen, they suggested, may be because psychological and physiological stress responses do not always coincide. Another possible explanation, they wrote, is that the psychological stress experienced by their subjects might have translated into physiological stress if they had followed their subjects for a longer period than they had.

Thus it looks as if counting calories produces psychological stress, and restricting caloric intake produces physiological stress. So when dieting includes both activities, it may be, as the researchers concluded, "deleterious to psychological well-being and biological functioning."

The researchers also suspect that the psychological and physiological stress created by dieting may be one reason why dieters often lose weight over the short term but then gain it back, since chronic psychological and physiological stress are known to cause weight gain. The challenge now, they said, is to test the hypothesis that "dieting is ineffective because it is a stressor."

Whether or not this is the reason that dieting is often ineffective, the results still have important implications, the researchers believe. "Clinicians may need to rethink recommending dieting to their patients to improve health. In addition to promoting weight gain, chronic stress has been linked with a host of negative health outcomes, such as atherosclerosis, coronary heart disease, hypertension, diabetes, cancer, and impaired immune functioning."

The study was funded by the National Institutes of Health, National Science Foundation, and American Psychological Association.

An abstract of "Low Calorie Dieting Increases Cortisol" is posted at <www.psychosomaticmedicine.org/cgi/content/abstract/72/4/357>. ■

Nominations Invited For Child Psychiatry Awards

APA invites applications for the Blanche F. Ittleson Research Award, Agnes Purcell McGavin Award for Prevention, and Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry. These awards are given to psychiatrists who have made significant contributions to child and adolescent psychiatry. They will be presented at APA's 2011 annual meeting in Honolulu.

The Blanche F. Ittleson Research Award recognizes research that promises to foster important advances in promoting the mental health of children and adolescents. A psychiatrist or a group of psychiatric investigators either must have published this research within five years or have it officially accepted for publication in the near future.

The Agnes Purcell McGavin Award for Prevention recognizes a psychiatrist who has been successful in research or policy that is recognized as contributing to primary prevention of mental illness among children and adolescents.

The Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry recognizes a psychiatrist whose career demonstrates success in research, teaching, publications, clinical care, or policy. The deadline for nominations is August 31.

Detailed information about the materials required for nomination and the address for submission is posted at <www.psych.org/share/OMNA/APAShireChildAdolescentPsychiatryFellowship.aspx> or available from Alison Bondurant at abondurant@psych.org or (703) 907-8639. ■

Call for Nominations

APA members are invited to identify individuals who are deserving of recognition for their professional contributions and achievements for the following 2011 APA awards:

- **John Fryer Award** honors an individual whose work has contributed to the improvement of the mental health of sexual minorities.
- **Solomon Carter Fuller Award** honors a black U.S. citizen who has pioneered in an area that has significantly benefited the quality of life for black people.
- **Oskar Pfister Award** honors an outstanding contributor in the field of psychiatry and religion.
- **Kun-Po Soo Award** recognizes an individual who has made significant contributions toward understanding the impact and import of Asian cultural heritage in areas relevant to psychiatry.
- **Alexandra Symonds Award** recognizes a woman psychiatrist who has made significant contributions to promoting women's health and the advancement of women.

The deadline for nominations is August 1.

Detailed information about the materials required for nomination and the address for submission can be accessed at <www.psych.org/share/OMNA/MURawards.aspx> or from Alison Bondurant at abondurant@psych.org or (703) 907-8639. ■

journal digest

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suggested that infants born to women who were on methadone replacement therapy during pregnancy may be at risk for visual problems. Twenty children aged 3 months to 7 years who had in utero exposure to methadone, underwent electrophysiological examinations at the specialty service because of suspected visual impairment. Nineteen of these children were found to have reduced visual acuity; 14 had nystagmus; 10 had delayed visual maturation; seven had strabismus; and six had refractive errors. Twelve of these children showed abnormal visual electrophysiology. A majority of these children were exposed to other illicit drugs in utero in addition to methadone, including benzodiazepines and heroin, the authors commented. Thus, the contribution of methadone on their visual problems needs further attention and research.

Hamilton R, McGlone L, MacKinnon JR, et al.: Opthalmic, Clinical, and Visual Electrophysiological Findings in Children Born to Mothers Prescribed Substitute Methadone in Pregnancy. Br J Ophthalmol. Published online April 21, 2010

Longitudinal Observation

- Watching more television at about age 2 was associated with several unhealthy trends at age 10, a prospective, longitudinal study shows. More than 2,000 children born in 1997 or 1998 in Quebec, Canada, were followed periodically by researchers at the Institut de la Statistique du Quebec to document their physical and psychosocial health status. A total of 1,314 of the children had parent-reported data on weekly hours of television viewing during early childhood.

After adjusting for potential confounding factors, the authors found that higher amounts of television exposure at 29 months was associated at age 10 with significantly lower classroom engagement and math achievement, increased likelihood of being bullied by classmates, less time spent on weekend physical activities, more intake of soft drinks and snacks, and a higher body mass index. These behavioral observations were reported by parents and teachers. Reading achievement was not significantly associated with television exposure at 29 months. The authors noted that the associations between early television exposure and developmental outcomes were "modest, yet nontrivial."

Pagani LS, Fitzpatrick C, Barnett TA, et al.: Prospective Associations Between Early Childhood Television Exposure and Academic, Psychosocial, and Physical Well-Being by Middle Childhood. Arch Pediatr Adolesc Med. 2010;164(5):425-431. ■

professional news

Alzheimer's

continued from page 6

cognitive decline. Diabetes has also been linked with such decline, but less consistently, and the association appears to be more modest. Regarding other possible risk factors—sleep apnea, traumatic brain injury, and obesity—there is a lack of good-quality studies, or findings have been inconclusive.

- Depression has been linked with Alzheimer's disease. There also seems to be a fairly robust association between loss of a spouse and cognitive decline.
- Preliminary evidence suggests a beneficial effect of physical and leisure activities on the preservation of cognitive function.
- There is evidence for an association between current smoking and increased risk of Alzheimer's.

The panel members did make recommendations regarding measures that can be taken to improve science in the Alzheimer's prevention arena.

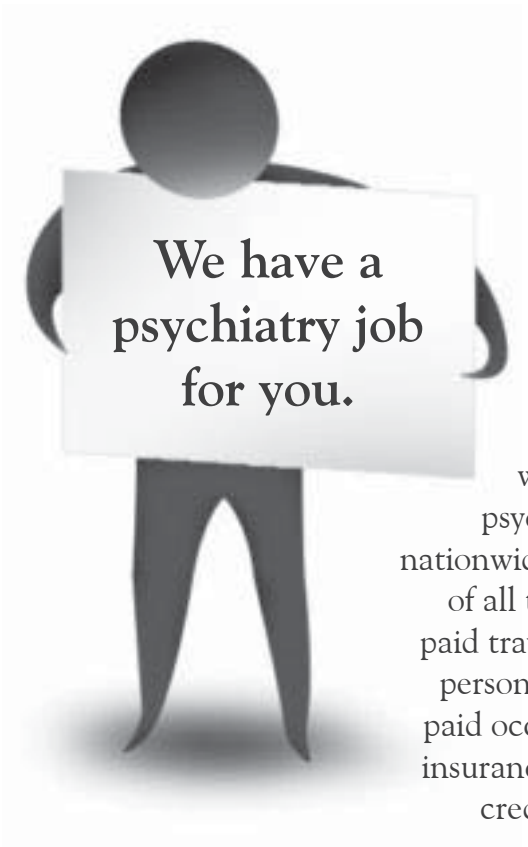
For example, rigorous diagnostic criteria for Alzheimer's should be uniformly used across studies. There is an urgent need for identification of Alzheimer's biomarkers and for further development of brain-imaging techniques to diagnose Alzheimer's. Following the model for other chronic diseases, large-scale, long-term, population-based studies using precise, well-validated exposure and outcome measures are needed to generate strong evidence about factors that may help protect people from Alzheimer's or cognitive decline. Individuals in such studies need to be followed from middle to older age.

Or ideally, even younger than middle age, Carl Bell, M.D., a professor of psychiatry at the University of Illinois at Chicago and one of the panel members, told *Psychiatric News*. "It is my opinion—not necessarily that of other panel members—that Alzheimer's starts around age 20 or 30, or even before," he said.

In fact, there is some evidence to bolster his stance. A study has found that children and teens who possessed the APOE-e4 gene variant, a well-established risk factor for Alzheimer's, already showed signs of a deteriorating entorhinal cortex—the first brain area to be affected by Alzheimer's (*Psychiatric News*, June 1, 2007).

"So hopefully scientists will find a biomarker for Alzheimer's, maybe for the APOE-e4 gene variant, and we can start studying the disorder earlier than when people are 55 and older," Bell asserted.

The panel's consensus statement, "Preventing Alzheimer's Disease and Cognitive Decline," is posted at <http://consensus.nih.gov/2010/alzstatement.htm>. ■



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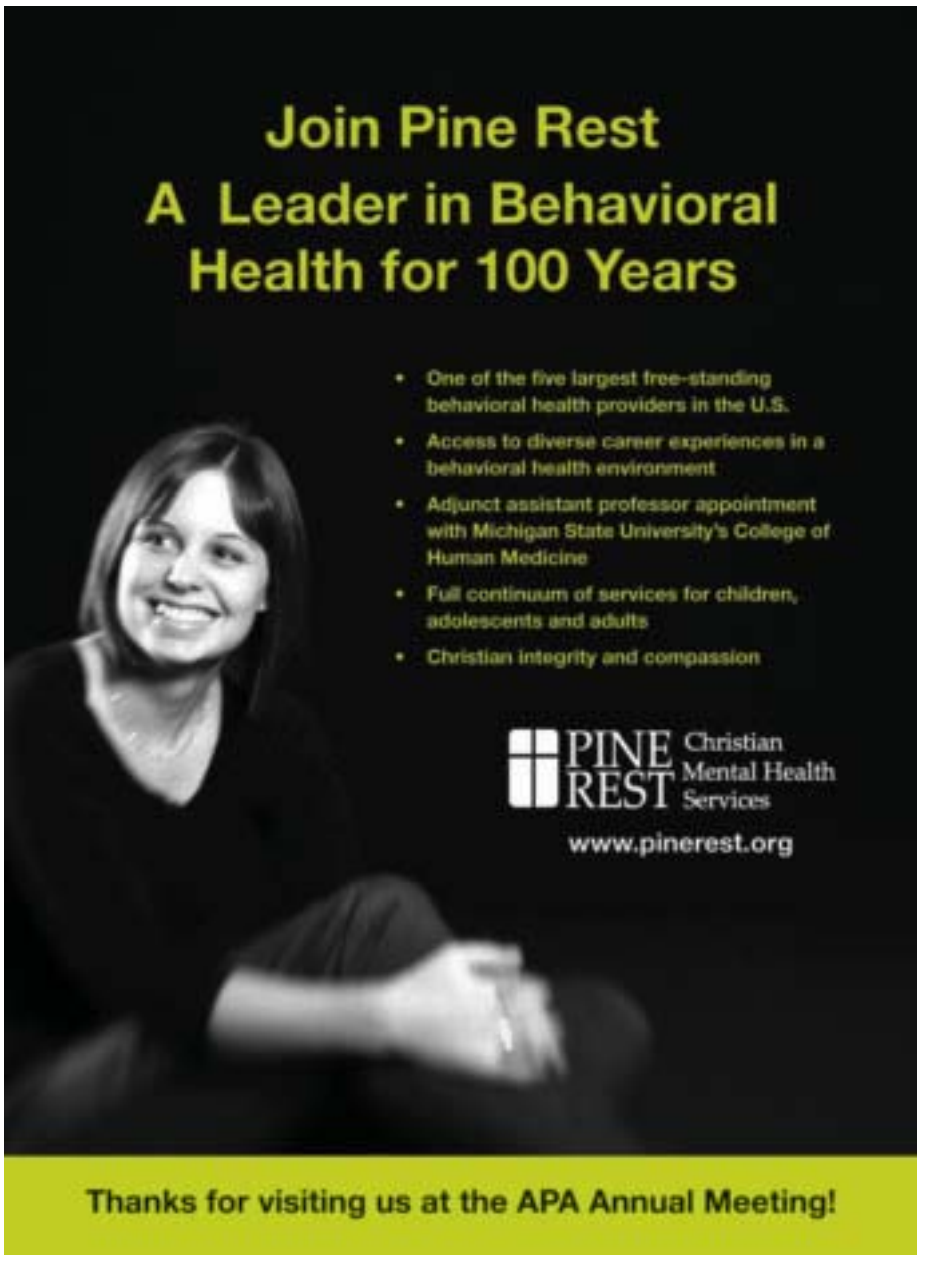

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Dr. William C. Torrey, MD is the search chair for this position and Vice Chair for Clinical Services for the Department of Psychiatry. The letters of reference should be addressed to Dr. William Torrey.

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Search No. 2010-560

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This is an exciting time to be at the University of Connecticut and in this Department of Psychiatry. The Department has undergone considerable transformation over the past nine years, retaining its considerable strength in Addictions while building expertise in Psychopharmacology, Trauma, Psychiatric Genetics, and Public Sector Psychiatry.

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Search No. 2009-461

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Isaac Ray Award

The American Psychiatric Association and the American Academy of Psychiatry and the Law invites nominations for the Isaac Ray Award for 2011. This Award honors Dr. Isaac Ray, one of the original founders and the fourth President of the American Psychiatric Association, and is presented to a person who has made outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence. The Award, which will be presented at the Convocation of Fellows at the Annual Meeting of the American Psychiatric Association in Honolulu, HI, in May 2011, includes an honorarium of $l,500. The recipient obligates him or herself to deliver a lecture or series of lectures on these subjects and to present the manuscript for publication.

Nominations are requested as follows:

1. Primary nominating letter (sent with the consent of the candidate), which includes a curriculum vitae and specific details regarding the candidate's qualifications for the Award.
2. Supplemental letter from a second nominator in support of the candidate. Additional letters related to any particular candidate will not be accepted or reviewed by the Award Committee. Nominators should not submit letters on behalf of more than one candidate.

The deadline for receipt of nominations is **July 1, 2010**. Nominations will be kept in the pool of applicants for two years.

Nominations, as outlined above, should be submitted to:

Renee L. Binder, M.D., Chairperson
c/o Yoshie Davison, Staff Liaison
Isaac Ray Award Committee
American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209
E-mail: advocacy@psych.org

HUMAN RIGHTS AWARD

Purpose

The Human Rights Award was established to recognize an individual and an organization whose efforts exemplify the capacity of human beings to act courageously and effectively to prevent human rights violations, to protect others from human rights violations and their psychiatric consequences, and to help victims recover from human rights abuses.

Nomination Procedures

APA members are asked to submit nominations by July 1, 2010 to:

Council on Psychiatry and Law
American Psychiatric Association
c/o Yoshie Davison, Staff Liaison
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209
E-mail: advocacy@psych.org

The nomination letter should succinctly describe the contributions that are the basis for the nomination and be accompanied by a curriculum vitae of the nominee. The Council on Psychiatry and Law will serve as the award review panel in determining the recipients of this award. The recipients will receive a plaque which will be awarded during the Convocation at the APA's Annual Meeting in May 2011.

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Issue	Deadline (Friday, 2 p.m. E.T.)
July 16	July 2
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STG International, a government contractor with more than 1,000 healthcare professionals in 41 states, is a national leader in the provision of medical staff and support services. We work in a variety of inpatient and outpatient settings including behavioral, mental, occupational and correctional health.

We have immediate full-time civilian opportunities for Psychiatrists MD/DO at the following Department of Immigration Health Services detention facilities:

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- Lumpkin, GA
- El Centro, CA
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- El Paso, TX
- Pearsall, TX
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Eligible Psychiatrists must be Board Certified or Board Eligible, with the appropriate state specific license. Interested candidates please apply online at our website **www.stginternational.com/careers** or send a current CV to **acooper@stginternational.com** or **smcneil@stginternational.com.**

STG is an EOE.

Top Docs has immediate positions available for Adult and Child Psychiatrists throughout the US. Long and short term positions available including locum tenens and permanent positions. Please call **Top Docs** *TODAY* @ 866-867-3621. www.topdocs.net.

ARIZONA

Unit Director

Aurora Behavioral Health System, a 90 bed JC Accredited, Psychiatric Hospital located in Glendale, Arizona is seeking a BE/BC Psychiatrist to join our team. This position offers clinical opportunities to join our medical staff comprised of private physicians. Our facility offers high quality mental health and chemical dependency programs for adults and adolescents. We are located in the Phoenix area and are only minutes away from professional sports venues, winter snow skiing, and renowned dining and shopping opportunities. Clinical hospital experience in Psychiatry is preferred.

For consideration, please send your C.V. and letter of interest to Sally Fangman at: **Aurora Behavioral Health Systems, 6015 W. Peoria Avenue, Glendale, AZ 85302, or call 623-344-4403.**

ARKANSAS

FAYETTEVILLE- General or Child Psychiatrists. Staff position. Inpatient & partial programs. Fulltime or part-time with highly competitive salary, benefits & bonus. **Student loan assistance.** Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

CALIFORNIA

Full Time contract psychiatrists needed at Napa & Coalinga State Hospitals, CA. No weekends or calls. Pays $180/hr+ malpractice. Call 661-274-9674. Fax CV to 800-758-7013. E-mail hahacorp@gmail.com. Work with recruiters.

Psychiatrist

Butte County Behavioral Health Department invites applications for the position of Psychiatrist. This position, under general direction, provides clinical assessments and treatment services to alleviate suffering in clients with behavioral health disorders. The monthly equivalent salary range for this position is $11,803-$15,817, and includes a comprehensive benefits package featuring retirement, health insurance, leave time, life insurance, and more.

Please submit a Butte County regular help application to: Butte County Human Resources, 3-A County Center Drive, Oroville, CA 95965, Recruitment# 104125045.

The application can be obtained and submitted to the Human Resources Department website at www.buttecounty.net/personnel. Applications may also be mailed to the above address. For additional information, please feel free to call (530) 538-6950 or (530) 538-7651. **The filing period is 04/20/2010-06/25/2010. Applications must be received by 11:59 p.m. on the closing date. Butte County is an Equal Opportunity Employer.**

Medical Director

Butte County Behavioral Health Department invites applications for the position of Medical Director. This position, under administrative direction, plans, organizes, and manages the medical services component of the Butte County Department of Behavioral Health. The salary range for this position is $211,584 -$259,000 annually, and includes a comprehensive benefits package featuring retirement, health insurance, leave time, life insurance, and more.

Please submit a Butte County regular help application to: Butte County Human Resources, 3-A County Center Drive, Oroville, CA 95965, Recruitment# 104116044.

The application can be obtained and submitted to the Human Resources Department website at www.buttecounty.net/personnel. Applications may also be mailed to the above address. For additional information, please feel free to call (530) 538-6950 or (530) 538-7651. **The filing date for this position is April 20, 2010 through June 25, 2010. All applications must be received by 11:59 pm on the closing date, June 25, 2010. Butte County is an Equal Opportunity Employer.**

Mental Health

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 **$18,622 and goes to $21,311 monthly.** Salary for Board Eligible starts at **$18,146 and goes to $20,711 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 George Christison, M.D., (A) Medical Director, 3102 East Highland Avenue, Patton, California 92369, (909) 425-7326 or Fax (909) 425-6635.

San Diego County needs Psychiatrists. Salary extremely competitive for San Diego - up to 170K plus 10% Boards and extra 5% second Boards. CV to Marshall Lewis, MD, Clinical Dir, County Behavioral Health Div, Marshall.Lewis@sdcounty.ca.gov. Must apply at www.sdcounty.ca.gov/hr.

Immediate need for **BE/BC Psychiatrists** for multiple CA locations. **$160-$185 an hour.** $320k-$370k yr for 40 hr week. Wknds available. 8-12 hr days. On call $42 an hr.

Bay Area Doctors, Inc.
Tel:(707)694-6890/(707)226-2426/
(707)694-3805.
Fax:(415)814-5764/email CV to
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Inpatient Forensic opportunity offering a flexible, 40-hour work schedule with no call. Exceptional compensation of at least $300,000. Live in one of northern California's finest communities. A vibrant and modern town with safe neighborhoods, clean air and perfect weather, this is a wonderful place to live.

Contact Rosa Herring, **Alpha Medical Group** at 800.504.3411 or rherring@alphamg.org. Additional opportunities at **www.alphamg.org**.

COLORADO

The Colorado Coalition for the Homeless (CCH) seeks a **part-time PSYCHIATRIST** to provide psychiatric leadership and clinical services on a high intensity treatment team affiliated with Denver's non-profit community mental health center.. This collaborative team has the resources of a CMHC with the flexibility and creativity of a homeless service organization. Its downtown location is across the street from the Stout Street Clinic, CCH's Federally-Qualified Health Center, giving access to consultation & collegial support from medical and psychiatric staff.

Working with homeless or near-homeless patients can be incredibly rewarding. We offer full benefits (starting on day of hire) including 403(b) deferred compensation plan. We are a National Health Service Corps loan repayment site. No calls. Please forward your CV to Elizabeth Cookson MD, Director of Psychiatry, via fax: 303.293.6511, or e-mail: ecookson@coloradocoalition.org.

Outstanding Psychiatric Practice Opportunity! Nationally acclaimed, JCAHO **eating disorder center** seeks qualified **Psychiatrist** with **ED interest/experience**. Ideal Location! Contact Steve Weiner, Pres., F-O-R-T-U-N-E at fpccareers@aol.com or (573) 424-6624.

CONNECTICUT

N. STONINGTON-Fulltime or part-time employment or contract weekend coverage. Inpatient rehab and partial programs. Salaried employment or independent contractor compensation. Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

DELAWARE

DOVER: General or Child Psychiatrist. Inpatient/partial programs for adolescents & adults. Highly competitive salary, benefits & incentive plans. Contact Joy Lankswert In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

FLORIDA

LifeStream, an accredited community health center in Central Florida is seeking **Psychiatrists, ARNP and Physician's Assistants** to provide comprehensive psychiatric care to children and/or adults. The position delivers psychiatric healthcare services to individuals in the inpatient and/or outpatient facilities and determines the most appropriate level of care required. This position is responsible for the psychiatric evaluation, treatment, emergency intervention and psychopharmacological treatment of clients of LifeStream Behavioral Center. Must have a clear understanding of the characteristics and problems of individuals with severe and persistent mental illnesses. **Apply online at www.lsbc.net.**

PSYCHIATRIST; FULL TIME, FL LICENSE REQUIRED; Aventura, FL; private practice located equidistant between Miami and Ft. Lauderdale; children/adolescent/adult/geriatric pts; email CV to aventuraoffices@bellsouth.net or FAX to Dusty: 305-935-1717.

Addiction Psychiatrist- Board Certified with added qualifications in addiction and/or ASAM/ABAM Certification. **Assistant Medical Director Position** for PRN of Florida, the Florida Impaired HealthCare Practitioners Program. Salary commensurate with experience. Excellent benefits package. PRN is affiliated with the Florida Medical Assocation. Send CV and letter of interest to PRN, P.O. Box 1020, Fernandina Beach, FL 32035.

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.

Great Practice Opportunity near Cocoa Beach - Fantastic opportunity to get into private practice in the area (inpatient, outpatient). Or should you already have a practice in the area, increase your revenue/capture new market. Offering generous annual stipend. Inpatient unit is adult and geriatric. Please **call Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

GEORGIA

BE/BC PSYCHIATRIST

COLUMBUS: Joint Commission accredited state hospital with modern facilities, congenial staff, and up-to-date programs desires BE/BC PSYCHIATRIST to join medical staff of board certified psychiatrists. No primary care duties, back-up call by phone. Adult and forensic programs. Excellent salary and benefits. Physicians seeking H-1 Visa may apply. Send CV or contact Abiodun Famakinwa, M.D., Clinical Director, West Central Georgia Regional Hospital, 3000 Schatulga Road, Columbus, GA 31907. 706.568.5209. FAX 706.568.2257; email aofamakinwa@dhr.state.ga.us.

ATLANTA: Medical Director & Staff Positions - Inpatient, residential, or partial day programs. Child/Adol, Adult, Addiction, and Geriatric services depending on location. Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

Georgia Regional Hospital in Atlanta, a 300-bed Joint Commission accredited State Psychiatric Facility, is currently seeking Board Certified or Board Eligible Psychiatrists to work in our inpatient Mental Health units and inpatient Forensic units **(Forensic experience preferred)**. In addition to a competitive and negotiable salary, we offer a generous benefits package. Selected applicants may be eligible for up to $100,000 in educational loan reimbursements.

Please email your resume in Microsoft Word format to:
DHR_GRHAtlanta_HR@dhr.state.ga.us with Psychiatrist in the subject line.

Tired of managed care and spending less time with patients and more on paperwork? Dwight D. Eisenhower Medical Hospital (Joint Commission accredited) at Fort Gordon in Georgia is seeking Board Eligible and Board Certified Psychiatrists with an active and valid medical license for Department of Defense positions. Medical license in Georgia is not necessary for this federal position. Outpatient positions for the evaluation and treatment of active duty service members with Posttraumatic Stress Disorder and other psychiatric disorders are available. Positions available as a medical director for an inpatient substance abuse unit and in an outpatient mild Traumatic Brain Injury program are also available. Positions come with full benefits including competitive salary, health benefits, vacation, 401K, malpractice coverage, and funds for CME. Call taken from home is currently 1 in 8 with psychology "first call" support at all times. Fort Gordon is located in Augusta, Georgia which has been designated the most affordable city for housing in the US. It is home to the Masters, and is the second largest city in Georgia, providing the amenities of a much larger city in a smaller setting.
Note: There are positions for clinical psychologists working with the inpatient substance abuse unit and outpatient services. There are also positions available for licensed clinical social workers and licensed professional counselors with experience in the treatment of alcohol and other substance use disorders. ***To apply, contact Trish Beam at (706)787-6377.***

ILLINOIS

Adolescent/Adult Psychiatrist

Large outpatient practice looking to add additional Psychiatrist to work in our Crystal Lake office. Flexiblehours and ability to work with great team of therapists and physicians in highly respected practice. **Email CV to Paula Comm, Practice Administrator at pmc@prapsych.com.**

INDIANA

Child & Adolescent Psychiatrist
CUMMINS BEHAVIORAL HEALTH SYSTEMS, INC
Joint Commission Accredited

Cummins Behavioral Health Systems, Inc. is an outpatient behavioral health provider serving central and west central Indiana that currently has an opening for a Child Psychiatrist to work throughout our regional network. Qualified psychiatrists, who possess current Indiana Medical license, are Board Certified/Eligible in Child & Adolescent Psychiatry, have successfully completed 2 years Child Psychiatry fellowship or those who have experience working with children and adolescents are encouraged to apply. An attractive compensation and benefit package includes: health, dental & vision insurance, 401(k), paid time off program, paid holidays, group term life and LTD insurance.

Human Resources Department
Cummins Behavioral Health Systems, Inc
6655 East U.S. 36
Avon, IN 46123
Fax: (317) 272-1713
E-Mail: tiles@cumminsbhs.org
EOE.

GENERAL PSYCHIATRIST: FULL TIME OUTPATIENT OPPORTUNITY

Private owned practice, No week-end responsibilities, located west of Indianapolis. J1 eligibility. E-mail C.V to aquizrn@yahoo.com.

KENTUCKY

LOUISVILLE /RADCLIFF: Staff Psychiatrist - General & Specialty Inpatient & Day Programs including work with military personnel. Fulltime or part-time positions, Mon-Fri schedule. Contact: Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

MAINE

Adult inpatient psychiatrist. Mid Coast Hospital is an independent, non-profit community hospital located in beautiful coastal Maine one of Maine's most desirable regions. We are searching for an inpatient psychiatrist for our 12-bed unit. Our team uses a multi-disciplinary approach to treat both voluntary and involuntary patients. This is a full-time position for a BC/BE psychiatrist. Must have or be willing to obtain certification for ECT and a waiver for suboxone management. Share on-call responsibilities with eight other physicians. 40-hour week. Generous benefits, excellent work environment. Please send letter of introduction with CV to: mmackellar@midcoasthealth.com.

BE/BC Adult and Child Psychiatrists
Acadia Hospital, the nation's first Psychiatric Magnet Hospital, is a 74 bed community-based, full service psychiatric hospital located in Bangor, Maine. We are currently recruiting for BE/BC adult and child psychiatrists to cover our inpatient and outpatient units. We offer acute psychiatric care for adults and children, as well as substance abuse programs, and have recently opened a 10 bed psychiatric observation unit. Acadia Hospital is a teaching site for Tufts and University of New England medical schools. Positions are tailored to specialty interest. Acadia Hospital offers a competitive salary, full benefits, moving expenses and a loan repayment program. The area offers an international airport, symphony, and the University of Maine flagship campus. Four season outdoor activities include boating, hiking, biking, skiing and golfing. The area includes excellent school systems, affordable housing and a safe living environment. Bangor is located less than one hour from Acadia National Park and two hours New England's largest ski resorts. Acadia accepts and supports candidates working toward/on a J-1 Visa Process. Contact: Nancy Barrows at nbarrows@emh.org or apply on line at www.acadiahospital.org - careers.

MARYLAND

Psychiatrist for Group Practice

Human Services, Inc. out of Baltimore City, MD focuses primarily on persons with co-occurring mental health and substance abuse diagnoses. Medication management, some counseling, staff training, and related activities would be primary duties and responsibilities. Psychiatrist must have, or be eligible for, their own Medical Assistance billing number. Fax/email CV to 443-388-9535/hchaim@aol.com or call 410-519-1208.

MASSACHUSETTS

Attending Psychiatrist-UMass Department of Psychiatry seeks a half to full-time attending psychiatrist for its adult mental health unit at the university medical center. A strong focus on teaching residents and medical students. Moderate case load, multidisciplinary treatment team, and superb treatment program. The position involves academic appointment to the medical school and opportunities for involvement in the academic activities of the department based on interests.

Our Department of Psychiatry has a large clinical faculty with clinical, teaching and academic opportunities at a wide variety of inpatient and outpatient programs. We have faculty development programs, commitment to our care, training and research missions, and a great living and learning environment in Central Massachusetts.

If you want to know more about job opportunities or the department in general, please email psychiatryrecruitment@umassmemorial.org or fax to 508-856-5990. Or, please call Cara Sanford at 508-856-3079.

We are an AA/EOE employer. No recruiting agencies please. Thank you.

BOSTON - Central & Suburb locations - Westwood, Brookline, Pembroke, Attleboro, Lowell. Medical Director & Staff Positions—General and Child.. Inpatient & Partial. Salary, benefits & incentive plans. **NO CALL**. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

Starr Psychiatric Center seeks a 20-40 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/or Adult Psychiatrist to join, busy, large, established private psychiatric group practice. Work consists of outpatient psychiatric treatment, both psychotherapy and psychopharmacology, and some hospital consultations. A lot of flexibility in terms of job and schedule. Please send C.V. to Paul Menitoff, M.D. Greater Lowell Psychiatric Associates, LLC 9 Acton Road Suite 25 Chelmsford, MA 01824.

CAMBRIDGE: Adult Psychiatry

Weekend Moonlighting Psychiatrist Positions available at Cambridge Health Alliance: Lucrative and flexible opportunities available for attending psychiatrists to provide weekend/holiday coverage of inpatient units at our Whidden Memorial Hospital campus.

Cambridge Health Alliance is an Equal Employment Opportunity employer, and women and minority candidates are strongly encouraged to apply.

CV & letter to: Susan Lewis, Department of Psychiatry, 1493 Cambridge Street, Cambridge, MA; Fax: 617-665-1204. **Email preferred:** SLewis@challiance.org.

MICHIGAN

Opportunity for attending psychiatrist in the U.P. of Michigan. Mostly outpatient work with some inpatient responsibility on 20-bed, adult psychiatric unit. Excellent salary and benefits. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

An Easy Income of $220k to $240k (Or More) - No long workdays necessary to make a great income. Medical Director and Staff position available in Saginaw. Adult and C/A psychiatric services. Very close to Bay City on Lake Huron. Only an hour and a half to Detroit and Ann Arbor. Please call **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

MINNESOTA

Duluth Clinic
An affiliate of SMDC Health System

Psychiatry Opportunities in Beautiful Duluth, MN

SMDC Health System, a member of Essentia Health, serves a regional population of 460,000 in Northeastern Minnesota, Northwestern Wisconsin and Michigan's Upper Peninsula. The integrated health system includes five hospitals, as well as the Duluth Clinic, a nationally recognized 450+ physician multispecialty group providing care at 17 locations. Located along Lake Superior's rugged hillside, Duluth's spectacular scenery, abundant recreational opportunities and vibrant arts community earned it inclusions on best small cities lists from Outside and Money magazines. Two hours from Minneapolis/St. Paul metro area. EOE/AA

CHILD/ADOLESCENT AND ADULT PSYCHIATRISTS

Join a group of 4 adult and 1 child/adolescent psychiatrists as part of a Behavioral Health Care Team to also include doctoral level psychologists, advanced practice nurses, nurse clinicians and psychotherapists.

- Full range of psychiatric problems and diagnoses
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- 24/7 referral center for triage and assessment services
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Sandra Kramer, Physician Recruiter
800-342-1388; 218-786-1035;
Fax: 218-722-9952
skramer@smdc.org

Duluth Clinic.
An Affiliate of SMDC Health System
The soul and science of healing.

MISSISSIPPI

North Central Mississippi, just one hour south of **Memphis, TN.** Attending Psychiatrist position available for 15-bed Adult and 22-bed Geriatric inpatient units, in addition to a 23-bed Chemical Dependency Program. Excellent salary and benefits. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

MISSOURI

Medical Director - Base Salary $220k to $230k - Can easily make well over base with Very Generous Bonus Plan - Close to Springfield - Extremely lucrative opportunity. Can be inpatient and nursing homes or inpatient and outpatient work. Unit is a 10-bed geropsychiatric program; outpatient adult &/or geriatric. Strong hospital support for behavioral health with plans for expansion. Please **call Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

KANSAS CITY: Medical Director & Staff Physicians. Inpatient & Partial programs. Adult & Geriatric. Salary, benefits & incentive plan. Contact: Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

MONTANA

Horizon Health invites you to consider an exciting practice opportunity for two NEW distinct **Adult** and **Geriatric** Inpatient Psychiatric Units, comprised of 26 total beds in Helena, MT. Nestled beneath the foothills of the Montana Rockies, **Helena**, the Capital of Montana, is alive with history and culture. This charming and beautiful Victorian city of 70,000 people provides a diverse attraction with many street festivals, theater, museums, symphonies, fairs and rodeos. There is truly something for everyone here! Excellent practice opportunity with great income ($200K+) and unparalleled quality of life! For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

NEW JERSEY

CHILD & ADOLESCENT PSYCHIATRIST
WESTFIELD, CEDAR KNOLLS, RIDGEWOOD & PRINCETON

Excellent opportunity for Child/Adolescent Psychiatrist to join our Center in one of our four locations. We are a successful private fee for service comprehensive child, adolescent and adult therapy Center with locations in Westfield, Princeton, Cedar Knolls and Ridgewood, New Jersey. Candidate will be part of a multi-disciplinary team and will provide psychiatric evaluation, medication management and, if desired, psychotherapy. He/She will also clinically oversee treatment at the Center. Salary and benefit package is generous and includes medical/dental insurance, retirement plan, professional liability coverage and substantial continuing education and vacation. Supportive collegial atmosphere. Candidate must be board certified or board eligible in child/adolescent psychiatry. E-mail cv to abbazn@aol.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

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

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PSYCHIATRISTS
Best in Brooklyn!

Lutheran HealthCare, located in the Southwest section of Brooklyn, offers a continuum of community-orientedbehavioral health services within its Department of Psychiatry.

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Please email: tirvin@lmcmc.com, fax 718-630-8594, or send your CV to: Tracey Irvin, Dept. ofPsychiatry, Lutheran Medical Center, Suite 2-45, 150 55th St., Brooklyn, NY11220. EOE/AA M/F/D/V. **www.LutheranHealthCare.**

Psychiatrists
F.E.G.S is one of the largest and most diversified health and human services organizations in the country. Our Behavioral Health Division offers extensive services to adults, children and families through a variety of clinic, day treatment, rehab and residential services. We seek board eligible Psychiatrists for the following opportunities:

Adult Psychiatrists
Manhattan Article 31 Clinic-FT/PT
Suffolk Assertive Community Treatment Team (ACT) 25 hrs; with benefits
Child & Adolescent Psychiatrist
Rego Park Article 31 Clinic, Queens
7 hours; afternoons/eves

NYS license/registration, board eligibility and DEA required. Competitive rates; collegial work environment; malpractice covered by the Agency. Apply on-line at **www.fegs.org/careers** or contact Sue Boyle at 212-366-8428. EOE.

NEW YORK STATE

Western New York-Chautauqua Region: Jamestown Psychiatric PC is seeking a Psychiatrist to join our rapidly growing Adult and Child Psychiatric team. Competitive salary and flexible growth opportunities are offered. We will offer a starting bonus to eligible candidates. Loan repayment, J1 or H1 assistance available. Please contact Mrs. Linda Jones, office manager @ lj@psychwebmd.com or Phone 716-483-2603. Fax CV and qualifications to 716-483-2828.

St. Lawrence Psychiatric Center, a fully accredited NYS Office of Mental Health facility, is seeking a Licensed Psychiatrist to provide full-time Adult Inpatient Services. Full and part-time opportunities also exist in our Gouverneur, Ogdensburg and Massena locations. In addition to salary ($161,750 to $174,798) and guaranteed additional compensation for voluntary participation in an on-call program, benefits package includes medical/dental/vision insurance, paid vacation, holiday and sick time, an excellent retirement plan, and educational and professional leaves. SLPC is an EO/AAE, federally designated as MHPSA.

Located on the scenic St. Lawrence Seaway in northern New York, St. Lawrence Psychiatric Center is located within reasonable driving distance of many cultural, educational and economic opportunities, including metropolitan Ottawa and Montreal, Canada, and Syracuse, NY. Close proximity to the Adirondack Mountains and Canada offers easy access to a wide variety of unspoiled natural areas and provides abundant recreational opportunities throughout the year.

Submit letter of interest to: Rosella Turnbull, St. Lawrence Psychiatric Center, One Chimney Point Drive, Ogdensburg, NY 13669 or at slmrrmt@omh.state.ny.us. If you have questions, please call (315) 541-2189.

The Albany Medical Center Faculty Practice Group is currently recruiting for two psychiatric faculty positions to join the Department of Psychiatry: one **child psychiatrist** and one **general psychiatrist**. Responsibilities include patient care, didactic and clinical instruction for residents and medical students. Participation in clinical research is encouraged. Albany is located within easy driving distance of Boston and New York City. It offers excellent schools and diverse recreational and cultural opportunities.

Send CV to: Jana Mastandrea, Physician Recruitment Coordinator, Albany Medical Center, MC 47, 47 New Scotland Ave, Albany, NY 12208; email mastanj@mail.amc.edu, (518) 262-1333, Fax (518) 262-6996.

Exceptional lifestyle opportunity! 100% inpatient with minimal call of 1:11. Provide inpatient clinical services to the Adolescent population in a JCAHO accredited hospital. Superior compensation and benefits. This upscale community rich in character, history, charm offers both cultural and recreational amenities. Come enjoy a rewarding work environment and outstanding quality of life!

Contact Jim Hock, **Alpha Medical Group** at 800.504.3411 or jhock@alphamg.org. Additional opportunities at **www.alphamg.org.**

NORTH CAROLINA

Carolina Partners in Mental HealthCare, PLLC is seeking BE/BC psychiatrists for our practices in Cary and Chapel Hill, NC. Child/adolescent and/or adult psychiatrists welcome in Chapel Hill, Cary position requires willingness to treat children, but C/A not required. 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, Burlington 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.

VERY LUCRATIVE POSITION RIGHT NEAR RALEIGH - Adult inpatient and outpatient work in Rocky Mount - only 45 minutes from Raleigh. Offering very attractive package: salary with benefits and bonus plan or practice opportunity. Contact **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; terry.good@horizonhealth.com.

View your ad online for free!
All line classified ads are posted on the *Psychiatric News* web-site:
pn.psychiatryonline.org

Adult Staff Psychiatrist
Emergency Room Psychiatrist
Charlotte, NC

Carolinas HealthCare System has unique opportunities for Adult Staff Psychiatrists at its Behavioral Health Center. The center is part of a 874- bed regional teaching facility nestled in the heart of Charlotte. Join an outstanding team of psychiatrists in a very collegial working environment.
Adult Staff Position - Inpatient and outpatient.
Emergency Room Psychiatry Position - Work in the facility's in-house emergency department. Rotating shifts.
Excellent benefits package which includes:
- **Two weeks CME**
- **Paid vacation**
- **Short and long-term disability**
- **401K, 457B and pension plan**

Opportunity for extra income by seeing private patients or by taking shifts in the ER
Interested applicants should email their CV to Elaine Haskell at: elaine.haskell@carolinashealthcare.org **or call 800-847-5084 for more information.**

EOE/AA

OKLAHOMA

OKLAHOMA CITY: General Psychiatrist. Fulltime position for inpatient & partial programs. Competitive salary, benefits & bonus plan. Contact Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

PENNSYLVANIA

DIRECTOR,
Child Psychiatry Division

The Department of Psychiatry at The Penn State Hershey Medical Center and College of Medicine is currently recruiting a board-certified child psychiatrist to provide leadership to growing division of child psychiatry. This position will also hold the University Chair in Child Psychiatry, an endowed position, at Penn State University. The Director's responsibilities will include the development of an expanding clinical program and quality improvement initiatives. Teaching of residents, child fellows and medical students will be essential facets of the position, as well as scholarly pursuits in a specific area of expertise.

With our clinical partner, Pennsylvania Psychiatric Institute, the Department staffs a 16 bed child and adolescent inpatient unit, a child and adolescent partial hospitalization program and outpatient services at two locations. Our faculty have research interests in eating disorders, PTSD, anxiety, mood disorders, and substantial research funding in the areas of sleep, imaging and autism. Our current child/adolescent psychiatry faculty numbers 12, and we have 6 fellows in training.

The successful candidate should have strong clinical skills and an established record of scholarly achievement. An established program of research and a history of extramural grant funding are highly desirable. The successful candidate will also have evidence of effective leadership and a demonstrated ability to promote an environment that fosters productive collaboration with colleagues in psychiatry and other disciplines.

Candidates with interest and skills in this area should send a curriculum vitae and cover letter to:
Alan J. Gelenberg, MD
Professor and Interim Chair
Penn State Hershey Medical Center
Department of Psychiatry, H073
P.O. Box 850, Hershey, PA 17033
Phone: 717.531.8516
Fax: 717.531.6491
agelenberg@hmc.psu.edu

Penn State Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce.

PITTSBURGH SOUTH HILLS-Office space available. Remarkable practice opportunity for BE/BC psychiatrist. Affiliate with our premier community hospital. Outpatient and inpatient work. Call 412-429-1646/fax 412-531-1617/email burstpsych@aol.com.

EASY DRIVE TO PHILADELPHIA, BALTIMORE, AND WASHINGTON, DC -Seeking a Psychiatrist for inpatient work in an impressive med/surg hospital in eastern PA. Can be primarily adult or gero or a mix of both. Offering salary/benefits, relo pkg, and bonus plan. Please call **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

Meadowbrook, PA - Philadelphia Suburb Associate Medical Director on geropsychiatric unit in the Holy Redeemer Hospital. Great location-close to Philly. Please call for details: **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

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.

There are also practice options in a traditional psychotherapy model. Psychiatric Hospitalist positions are available for weekday and weekend rounding and Crisis. 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.

Great Opportunities!! Outpatient, Telepsychiatry, Inpatient Gero-psychiatric unit, Child/Adolescent and Adult Psychiatrists: Positions available in the scenic Laurel Highlands of Southwestern Pennsylvania (60 minutes SE of Pittsburgh/3 hours NW of D.C.). Join team of 14 psychiatrists in a progressive community-based behavioral health program. Full time and part time positions. Treatment provided in concert with a team of PA's, CRNP's, certified psychiatric nurses and professional counselors. Crisis intervention team provides 24/7 on-call coverage. Competitive salary and excellent benefit package. J-1/H-1 positions available. Please forward CV to: Mike Quinn, CEO, Chestnut Ridge Counseling Service, Inc., 100 New Salem Rd, Uniontown, PA 15401 Fax:724-439-2779. Email: mquinn@crcsi.org. To learn more about Chestnut Ridge Counseling please visit our website at www.crcsi.org.

PHILADELPHIA and suburbs- Child Psychiatrists for Inpatient, RTC and/or Partial Programs. General/Addiction Psychiatrist for Adult Dual Unit. **CLARION-just east of Pittsburgh.** Child OR General Psychiatrist for inpatient & partial programs. **SHIPPENSBURG:** General Psychiatrist with interest in Dual Diagnoses. STATE COLLEGE: Child OR General Psychiatrist for inpatient & partial programs. Fulltime positions. Salary & benefits. **Student loan assistance at Clarion**. Contact Joy Lankswert @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

Unparalleled Loan Repayment. **Assistant Director of Adult Psychiatric Services** sought by one of the largest healthcare providers in Pennsylvania. Oversee inpatient and outpatient services, teach Medical Students and Residents. Outstanding compensation package of not less than $250,000 in addition to a comprehensive benefit package. Community offers diverse housing options and an abundance of outdoor activities including golf and skiing.

Jim Hock, **Alpha Medical Group** at 800.504.3411 or jhock@alphamg.org. Additional opportunities at **www.alphamg.org.**

Stroudsburg, PA. Full Time outpatient Adult/Child Psychiatrist.ISL Psychiatric Services is looking to recruit additional psychiatrists to join our excellent group of 20 psychiatrists and other mental health workers. Starting salary of 170K and an excellent benefit package. Fax CV to (570) 424 6271, or call (570) 424 6187.

SOUTH CAROLINA

Myrtle Beach, South Carolina. Please visit www.doctornewlin.com. Direct-pay private practice. Seeking one or more **Child & Adolescent and/or Gen Adult Psychiatrist(s)**. Complete autonomy, PT or FT. Please email CV & cover letter to myrtlebeachmd@msn.com.

Income Potential $280k to $350+
Medical Director - Geropsych Unit
Very lucrative position (salaried with benefits or practice opportunity for those who prefer independence) in northeast SC-a place with a great quality of life and lots of opportunity. An easy drive to Florence, SC and Fayetteville, NC; 2 hours from Columbia, Myrtle Beach, Charlotte and Raleigh. Please **call Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

AIKEN: Staff Psychiatrist - Predominant caseload in Partial Day - some inpatient & C/L - adults and adolescents. Salaried Position with benefits and bonus - good call. Contact: Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

TENNESSEE

Board-certified/eligible psychiatrists needed for a large Psychiatry Service at Mountain Home VAMC in Johnson City, Tennessee. Inpatient/outpatient psychiatrist on a 24 bed teaching unit staffed by two psychiatrists, 1 NP, 1 PA, and residents rotating from ETSU College of Medicine. Must be board certified in psychiatry or board eligible if within 2 years of residency completion. 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 (full time positions only) 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: Tana Johnson, (423) 926-1171, ext. 7184, or Tana.Johnson@va.gov and George.Brown@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 Email: mtnhomehrmservice@va.gov
Equal Opportunity Employer

The Department of Psychiatry at the University of Tennessee Health Science Center (UTHSC) in Memphis, TN is undergoing a faculty growth plan.We are seeking a BC/BE Child and Adolescent psychiatrist and BC/BE Adult/ Geriatric psychiatrist to join our innovative clinical program and services including the evolving technology of telepsychiatry.

We have opportunities for inpatient, consultation-liaison and intensive outpatient practice settings. Participating in teaching activities at medical students, resident, and fellowship levels is encouraged and rewarded.

Memphis offers an exceptional medical climate including LeBonheur Children's Hospital, St. Jude Research Hospital, Methodist University Hospital, and St. Francis Hospital. Also affiliated with UTHSC are the Memphis Mental Health Institute (MMHI) the VA Medical Center and The Regional Medical Center (MED). Memphis also offers an interesting array of award-winning restaurants, sports events and a culture encompassing both the charm of the old South and Midwestern values. We offer above average income potential and a generous fringe benefit package.

For more information, please contact Dr. James Greene at 901-448-4572 {email: jgreen41@uthsc.edu} The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADEA institution in the provision of its education and employment programs and services.

TEXAS

WEST TEXAS San Angelo: Child or General Psychiatrist. Salaried Employment or Private Practice. **Student loan assistance in San Angelo.**
DALLAS: Independent contractor practice position for coverage of inpatient services. Also weeknight and weekend call coverage options. Contact: Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

Interested in loving where you live and work? Then consider Lufkin.

Lufkin State Supported Living Center is looking for a psychiatrist. We are located in beautiful deep east Texas near two national forests, boasting of great lakes, parks and one of the best golf courses in Texas. According to the Chamber of Commerce - Lufkin is the #1 Micropolitan community in Texas and has many dining and shopping opportunities. The Center is a developmental facility for people with mental retardation and physical disabilities as well as persons with dual diagnosis which includes mental illness. A typical work schedule is Monday - Friday 8 a.m. to 5 p.m. The work environment is casual and the medical problems are challenging. We have a strong support system and offer excellent benefits (competitive salary, retirement, health/dental insurance, paid vacation and sick days, life insurance, longevity pay, up to 15 paid holidays per year, and more). Employee housing is available on the grounds with all bills paid and a modest rent.

For more information, call 936-853-8350, or e-mail: gale.wasson@dads.state.tx.us

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McALLEN: Private Practice Opportunity. Inpatient & Outpatient. General Psychiatrist. Contact: Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

Texas A&M College of Medicine and Scott & White Healthcare
Growing Department Seeks Faculty in Adult and inChild & Adolescent Psychiatry

The Texas A&M and Scott & White Department of Psychiatry in Temple is recruiting faculty in adult and in child & adolescent psychiatry. The Department is growing and has healthy training programs in general and child & adolescent.

Texas A&M is ranked as a top university worldwide, with strong clinical and basic research and excellent biomedical research infrastructure. The Department has competitive federal funding with active imaging and stem cell research and the resources to support academic work. A&M offers an extensive research training program for junior faculty, and Scott & White, one of the nation's largest and most respected health care systems, offers a strong career development program in medical management. Joint appointment with the Central Texas VA is available where advantageous to career development.

Scott & White is a fully integrated health system and is the largest multi-specialty practice in Texas, and the sixth largest group practice in the nation. Scott & White employs more than 1,100 providers, physicians and research scientists who care for patients covering 25,000 square miles across Central Texas. Scott & White owns, is partnered with, or manages 9 hospitals across Central Texas. Scott & White primary facility is a 636-bed Level I Trauma acute care facility in Temple, along with an additional 50-bed Long Term Acute Care Hospital in Texas, another 150-bed acute care hospital in Temple, a 76-bed acute care facility in Round Rock (greater Austin area), and a network of 50 primary and specialty clinics throughout the region.

Salaries are competitive, with excellent benefits and an incentive plan. Temple has a warm climate and strong schools and is close to Austin. There are many area locations for boating, fishing, skiing, golf, and hiking.

Academic appointment depends on qualifications. Women and minorities are encouraged to apply. **Contact Karmen Smotek, RN, BSN, Physician Recruiter, klsmotek@swmail.sw.org.**

Salaried Opportunities for Adult Psychiatrists - San Antonio, TX

Vericare (www.vericare.com) is the leader in providing mental health services to residents of long term care. We have immediate, salaried positions for Adult or Geriatric Psychiatrists in San Antonio. We offer flexible scheduling, 100% paid malpractice, administrative support, no on call/weekend requirement and a complete benefits package. Board Certified preferred. **Call Sanel Lekic at 800-257-8715 x1166 or email your resume/inquiry to slekic@vericare.com.**

AMARILLO - Hospitalist - Salaried Employment & benefits offered. Adult general psych and dual programs. Contact: Courtney Williams, In-house recruiter @ 866-227-5415 or email courtney.williams@uhsinc.com.

Psychiatrist

The Department of Psychiatry and Behavioral Sciences of the University of Texas Medical School at Houston has extraordinary opportunities for psychiatrists seeking to develop a career in inpatient psychiatry. Under new leadership, the Department is expanding clinical and research areas and is seeking general psychiatrists, child and adolescent psychiatrists and geriatric psychiatrists to join a growing academic department dedicated to excellence in training, education, and research. The University of Texas Harris County Psychiatric Hospital is a state of the art 250 -bed facility serving patients in all age groups and affiliated with department of Psychiatry at University of Texas Medical School at Houston. The Medical School is part of the University of Texas Health Science Center at Houston, located in the Texas Medical Center - the largest medical center in the world. Houston is 4th largest metropolitan city offering the charm of southwestern hospitality and a low cost of living.

Individuals applying for these positions must be Board Certified in general psychiatry, child & adolescent psychiatry and geriatric psychiatry or have completed an accredited training in these specialty and subspecialty areas in the United States. Additionally, they must be licensed or be eligible for licensing in the State of Texas. Experience or interest in research and/or education is preferred. Recent graduates from accredited residency program are also encouraged to apply. Depending upon the applicant's qualifications and credentials, faculty appointment at the level of Assistant Professor, Associate Professor or Professor will be offered. Salary levels are very competitive and also carry excellent fringe benefit packages. For more information about these unique academically-driven positions or to apply for them, please write to Jair C. Soares, M.D., Professor and Chair, and include a copy of your curriculum vitae and a letter of interest to 1941 East Road, Houston, Texas 77054, e-mail: Jair.C.Soares@uth.tmc.edu phone 713-486-2507; fax 713-486-2553. The University of Texas Health Science Center at Houston is an EO/AA employer. M/F/D/V.

UTAH

PSYCHIATRIST

Ski Park City and Snowbird, attend Sundance film festival, and work in nearby Provo! On-Call is optional. **Utah State Hospital** seeks psychiatrists for adult inpatient unit. JCAHO/MEDICAID/CMS accredited. Electronic chart and pharmacy. New buildings on a 300-acre campus at the base of the mountains. Collegial environment. Salary negotiable, with full benefits.

Send CV to: Richard Spencer, MD, Clinical Director, PO Box 270, Provo, UT 84603, (801) 344-4201, rspencer@utah.gov. EOE.

VERMONT

We are looking for a **Medical Director and Inpatient Clinical Psychiatrist** to join our Psychiatric Services Department here at Rutland Regional Medical Center. This is a hospital employed position in a 19 bed inpatient unit. Includes 80% general, 20% Geriatric, pediatric consults only and no forensics. Oversee physicians and staff in Outpatient facility which opened October 2008. Call 1 in 5 with strong Crisis Team doing intake in the Emergency Dept. Benefits include Malpractice, Health, Dental, and Disability insurances, Pension Plan, 403B with match, CME account, and relocation. Educational loan repayment money available. It's a chance to do what you love...in a setting you'll adore!

Rebecca Banco, CMSR
Physician Recruiter
Rutland Regional Medical Center
160 Allen Street
Rutland, Vermont 05701
bbanco@rrmc.org
802-747-3844

VIRGINIA

PSYCHIATRY HOSPITALIST POSITION
RICHMOND, VIRGINIA

We are seeking a BE/C Adult Psychiatrist to join the Behavioral Health Division of a major health care system located in Richmond, Virginia. This is primarily an inpatient practice with a C-L component. The inpatient unit consists of 40 beds and runs a census of 85%-90% with an average length of stay of 6.5 days. First call is provided by licensed mental health professionals. Physician telephonic call will be no more than 1:3.

Compensation will be competitive and include a salary and full benefits including 401K plan. Interview, relocation assistance and other incentives will be provided.

Richmond is an attractive city with a vibrant economy, top-rated schools, a broad selection of housing, and numerous cultural events and recreational activities available; www.virginia.com. There are several colleges and universities in the area including a medical university. Washington, D.C, Chesapeake Bay, and Blue Ridge Mountains are within two hours drive.

For details contact Stephen Schoen, Executive Director, MDR Associates, at (800) 327-1585 or by email at stephen@mdrsearch.com.

Assistant Commissioner for Behavioral Health Services

The Virginia Department of Behavioral Health & Developmental Services (DBHDS) is seeking an accomplished executive who will serve as the Assistant Commissioner for Behavioral Health Services (#46). Leads, directs, manages & supports the Commonwealth's behavioral health system that includes 9 statewide behavioral health facilities & the offices of Mental Health, Substance Abuse, Forensic Services, Child & Family, Clinical Pharmacy, & Criminal Justice. For more details & to apply visit: https://jobs.agencies.virginia.gov.

WEST VIRGINIA

Shenandoah Valley-Recruiting 3rd psychiatrist for behavioral health department in multi- disciplinary community health center **90 minutes from Washington/Baltimore**. Experience/ training in addictionology and/or child/adolescent psychiatry a plus. Salaried position w/incentive compensation, standard benefits. Approved site for Federal Loan Repayment.

Contact Tina Burns 304 596 2610, ext 1066; tburns@svms.net FAX 304 263 0984. Visit our website **www.svms.net!**

WISCONSIN

Luther Midelfort
Mayo Health System

Eau Claire, Wisconsin: Luther Midelfort - Mayo Health System, is seeking a **BC/BE Adult Psychiatrist** with interest in inpatient and outpatient work. We require a physician who is collaborative in his/her approach and engages the non-physician team and patient in a collegial manner. Call of 1:6. Outpatient unit is attached to a newly renovated inpatient unit.

Luther Midelfort - Mayo Health System is a vertically integrated, physician directed hospital and multi-specialty clinic of 240 physicians owned by Mayo Clinic. Our physicians practice evidence-based, protocol-driven medicine.

Eau Claire is a university community with a metro area of 95,000, located 90 minutes east of Minneapolis. Business Week ranked Eau Claire as the best place to raise your kids in the State of Wisconsin for 2009. Eau Claire was also ranked one of the safest small cities in US (12/09). Outstanding schools, a family oriented community, a state with a favorable malpractice climate, and a strong compensation and benefits package may be expected.

For more information, contact Cyndi Edwards 800-573-2580, fax 715-838-6192, or e-mail edwards.cyndi@mayo.edu . You may also visit our website at **www.luthermidelfort.org.** EOE.

WYOMING

CASPER & CHEYENNE: Psychiatrist for inpatient & outpatient services. Highly competitive salary, benefits, & bonus plan. Student loan assistance negotiable. Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

International

AUSTRALIA & NEW ZEALAND
PSYCHIATRY JOBS
Gen. Adult - Child & Adoles. - Forensics
Locum Tenens or Permanent Jobs
Salaries of up to $350,000 per annum
www.IMRpsychiatry.com

Fellowships

Boston University Medical Center Fellowship Program in Psychosomatic Medicine

Boston University Medical Center is seeking applicants for its ACGME-accredited Fellowship Program in Psychosomatic Medicine for July 1, 2011. All participating fellowship programs are Equal Opportunity Employers.

Fellowship Program in Psychosomatic Medicine: This is a 12-month program, which provides extensive training in Psychosomatic Medicine at both Boston Medical Center and the VA Boston Healthcare System. Fellows will have the opportunity to work with a diverse patient population in both acute medical/surgical inpatient and outpatient settings. In addition to providing consultation and teaching to the medical staff, fellows are involved in a variety of educational experiences and have the opportunity to pursue research interests. This one-year program meets all requirements for Board Examination eligibility for Added Qualifications in Psychosomatic Medicine. Interested applicants should send CVs to: Dr. Isidore Berenbaum, M.D., Boston Medical Center, Suite B-410, 88 East Newton St., Boston, MA 02118 Tel: 617-638-8670 Fax: 617-638-8724 Email: bbq@bu.edu.

Addiction Psychiatry Fellowship - Position Open. Univ. of Cincinnati top teaching, clinical sites. VA Nat'l Center of Excellence. NIDA, CTN, NIAAA trials. ACGME accredited. Robust benefits/pay. Dir: Shannon Miller, MD. www.psychiatry.uc.edu, kathleen.peak@va.gov.

EAST TENNESSEE STATE UNIVERSITY
JAMES H. QUILLEN COLLEGE OF MEDICINE
Department of Psychiatry and Behavioral Sciences

THE SOTERION NEUROPSYCHIATRIC and MOLECULAR IMAGING RESEARCH (POST DOCTORAL) FELLOWSHIP

The Research Fellow will carry out a number of multimodal imaging studies, with an emphasis on EEG and PET. Studies include antibody removal of Alzheimer's disease plaques, and investigational PET scans of these plaques. Research includes other dementias, neuropathic pain and EEG biofeedback. Opportunities for additional clinical research and training are available. The Fellowship will be for two years, with the salary based on that of a PGY-V. Position contingent upon outside funding. The position will be classifed as an Administrative Post Doctoral Fellow.

Apply to the position at https://jobs.etsu.edu/applicants/Central?quickFind=51015. Applicants should have two letters of reference sent directly to Norman C. Moore, MD, Professor of Psychiatry, East Tennessee State University, Box 70567, Johnson City, TN 37614. Inquiries can be made by telephone to 423-439-2235 or by email to lovedayc@etsu.edu. AA/EOE.

Software

Psychiatric Diagnosis, History and Treatment software for Android, Blackberry, Iphone and Windows. Quick, accurate diagnosis and numerical score based psychopharmacology. Improve outcomes and efficiency. **www.SoftPsych.com.**

Volunteer for DSM-5 Field Trials

American Psychiatric Institute for Research and Education
Practice Research Network is recruiting

Practicing Psychiatrists

As the 2013 date for publication of the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) draws near, the research and clinical experts working on DSM-5 will be finalizing the diagnostic criteria and testing potential revisions and assessment tools in field trials across a number of clinical settings.

The DSM-5 Field Trials involving practicing psychiatrists will focus primarily on 1) the feasibility and clinical utility of the proposed modifications to the diagnostic criteria for a broad range of disorders in the full range of clinical settings, and 2) the feasibility and clinical utility of cross-cutting and diagnostic-specific dimensional measures that are incorporated into the diagnostic scheme for DSM-5.

Practicing psychiatrists interested in volunteering for potential participation in DSM-5 field trials should send an email to aparesearch@psych.org with the following information:

- Full name
- Institution or organizational affiliation
- Mailing address
- Job title
- Preferred e-mail
- Area of expertise (e.g., child psychiatry, geriatric psychiatry, etc.)

This information will help determine your eligibility to participate in the DSM-5 field trials.

For information about revisions to the DSM please visit www.DSM5.org

The American Psychiatric Institute for Research and Education is a 501 (c) (3) subsidiary of the American Psychiatric Association.

Practice Management for Early Career Psychiatrists: A Reference Guide

Created by the American Psychiatric Association's Office of Healthcare Systems and Financing, this handbook provides APA members with an overview of many of the things they need to be aware of as a psychiatrist. Although specifically designed to meet the needs of **Residents** and **Early Career Psychiatrists** (ECPs), the information it contains may also be of value to those who have been in practice for years. Contents include:

I. STARTING OUT

1. Conducting an Effective Job or Practice Search
2. Negotiating an Employment Contract
3. Licensing and Board Certification
4. Practice Options

II. ESTABLISHING YOUR PRACTICE

5. Incorporation Options
6. Buying or Leasing Office Space and Equipment
7. Medical Professional Liability Insurance
8. Hiring and Managing Administrative Staff
9. Selecting Computer Applications and Software
10. Marketing Your Practice Effectively
11. Putting Your Practice on a Budget

III. MAINTAINING YOUR PRACTICE

12. Managing Relationships with Other Clinicians
13. Managing Appointment Scheduling
14. Insurance Terminology
15. Verifying Benefit Coverage Accurately and Efficiently
16. Coordinating Benefits for Patients with More than One Source of Insurance Coverage
17. Implementing Electronic Billing Capabilities
18. Increasing the Success Rate of Collections Efforts
19. Avoiding Common Procedure Coding Problems

IV. PATIENT CARE ISSUES

20. Confidentiality
21. Duty to Warn
22. Informed Consent
23. Civil Commitment
24. Medical Records
25. Conducting a Patient Satisfaction Survey

V. MANAGED CARE ISSUES

26. Defining Managed Care
27. Getting on Managed Care Panels
28. Reviewing and Negotiating Contracts
29. Appealing Reimbursement Denials
30. Getting Paid
31. Maintaining Confidentiality in the Era of Managed Care
32. Handling Medical Record Reviews
33. Avoiding Deselection
34. Managed Care Resources

VI. PROFESSIONAL ISSUES

35. Principles of Medical Ethics
36. Opinions of the Ethics Committee
37. Managing Relationships with Patients
38. Reducing Malpractice Risk
39. Practice Guidelines

VII. LEGAL ISSUES

40. Medicare and Medicaid

40a. How to Appeal Decisions by Medicare Carriers

40b. Compliance Programs

41. Fraud and Abuse

41a. HIPAA

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43. An Overview of Antitrust Laws Affecting Physicians
44. The National Practitioner Data Bank

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in the "Members Corner"

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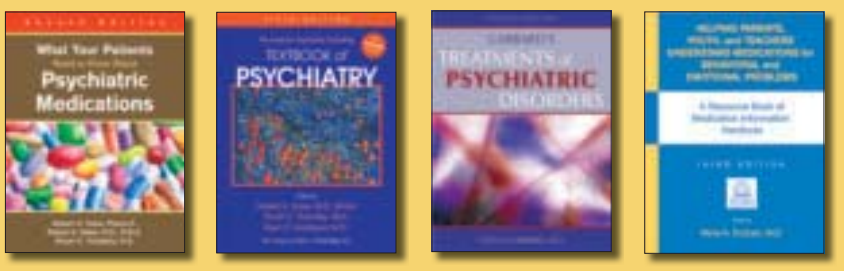

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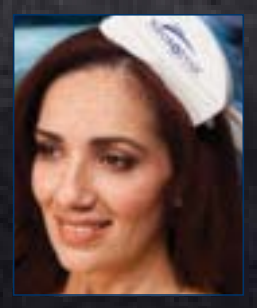

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