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Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

Inside

PERIODICALS:
TIME-SENSITIVE MATERIALS

AMA Wants New Medicare Option That Allows Private Contracting

Physicians could decide on a patient-by-patient basis to contract privately for a fee different from the Medicare payment schedule, and the patient would retain the right to receive reimbursement from the government for the allowable fee.

BY MARK MORAN

Days before a scheduled 21 percent across-the-board cut in Medicare physician payment was to go into effect last month, AMA delegates called for legislation that would create a new payment option—one that would allow physicians and patients to contract privately with each other for a fee different from the Medicare fee, while still allowing patients to use Medicare benefits for partial reimbursement.

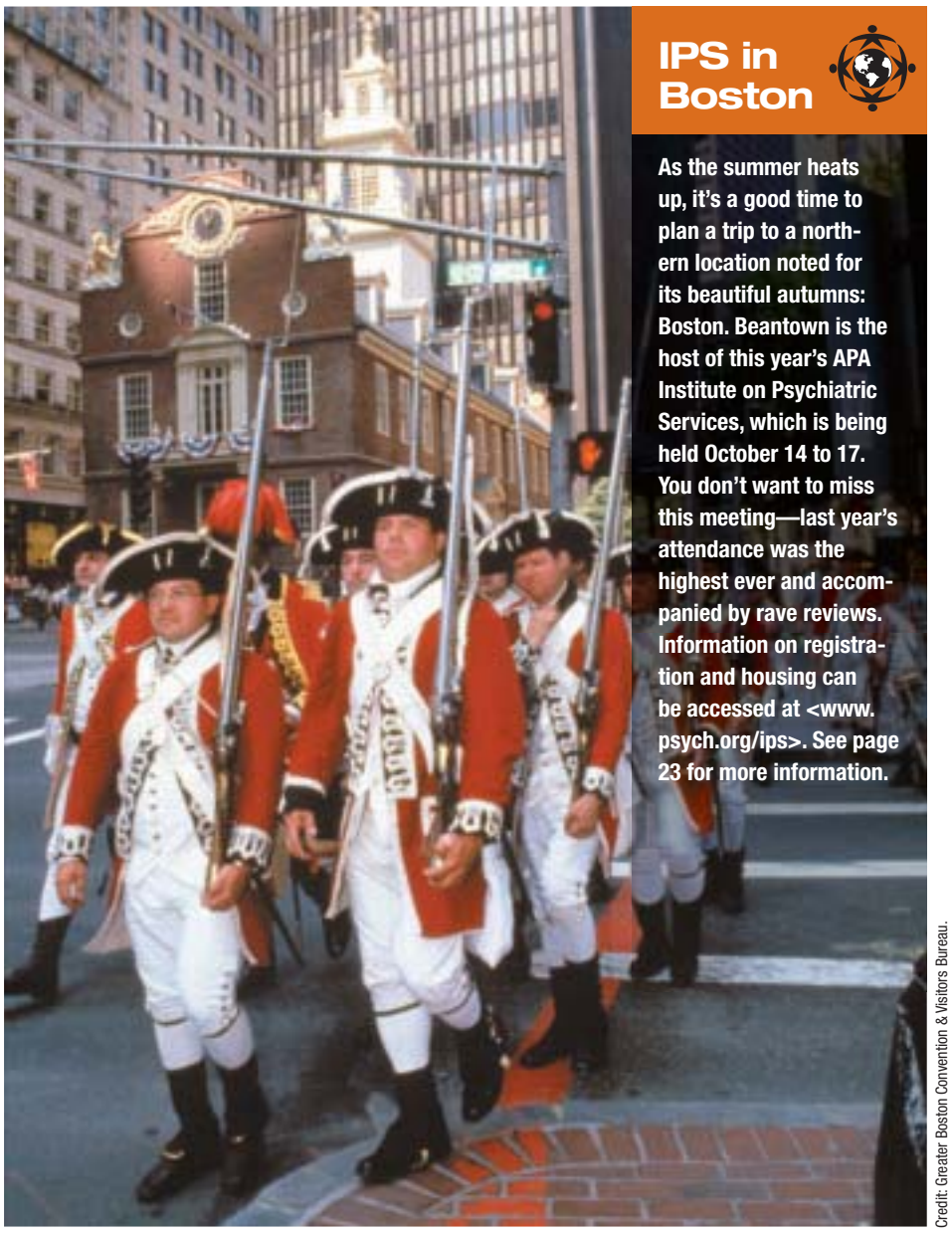
Under current regulations, the only way physicians can negotiate a separate fee is by formally "opting out" of Medicare, which removes the physician from Medicare for two years and necessitates each patient's signing a statement acknowledging that he or she cannot be reimbursed by Medicare.

The resolution calling for the AMA to advocate for the new payment option was approved by more than 70 percent of the 500-plus member House of Delegates during its annual policymaking meeting in June in Chicago.

"Seniors deserve a Medicare benefit that allows them access to and choice of physicians." said AMA Trustee David Barbe, M.D., in a statement. "Low Medicare payments, continued payment uncertainty, and a steep 21 percent payment cut have put access and choice in jeopardy. A new patient-centered category of Medicare payment will allow seniors to use their Medicare benefit fully for the health care they need."

John McIntyre, M.D., senior delegate of the AMA Section Council on Psychiatry, said that though the chances of such a policy being approved by Congress are slim, the resolution was

please see ***Payment*** *on page 24*



Credit: Greater Boston Convention & Visitors Bureau.

IPS in Boston

As the summer heats up, it's a good time to plan a trip to a northern location noted for its beautiful autumns: Boston. Beantown is the host of this year's APA Institute on Psychiatric Services, which is being held October 14 to 17. You don't want to miss this meeting—last year's attendance was the highest ever and accompanied by rave reviews. Information on registration and housing can be accessed at <www.psych.org/ips>. See page 23 for more information.

Judge Throws Out Lawsuit Challenging New Parity Law

Plaintiffs in the lawsuit cited complaints about the government's regulations, but in dismissing the case, the court focused on a procedural complaint that the government bypassed due process when it issued an interim final rule.

BY MARK MORAN

A lawsuit filed in March by three managed care organizations over regulations issued by the federal government interpreting the new mental health parity law was dismissed last month.

U.S. District Court Judge Colleen Kollar Kotelly on June 21 dismissed the case filed by a group calling itself the Coalition for Parity Inc. The group consisted of three managed behavioral health care organizations (MBHOs)—Magellan Health Services Inc., Beacon Health Strategies Inc., and Value Options *(Psychiatric News*, May 7).

The suit sought to delay implementation of the government's interim final rule that provides regulations interpreting the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The rule was issued in February *(Psychiatric News*, March 5).

In response to a "request for information" issued in 2009 by the Department of Health and Human Services, APA argued for a stringent interpretation of the parity law—one that views parity as "not just

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Diagnosis of Hoarding Disorder Proposed for *DSM-5*

This article is part of a series of commentaries from members of the task force and work groups involved in developing the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5).*

BY DAVID MATAIX-COLS, PH.D.

Like most human behaviors, saving and collecting possessions can range from being totally normal and adaptive to excessive or pathological. Hoarding and compulsive hoarding are some of the more commonly used terms to refer to an excessive and problematic form of collectionism. Hoarding is highly prevalent and, when severe, is associated with substantial functional disability and represents a great burden for the sufferers, their families, and society.

Hoarding can occur in the context of a variety of neurological and psychiatric conditions, such as dementia or schizophrenia, but available research findings indicate that hoarding also exists as a syndrome distinct from other disorders. It is generally considered difficult to treat.

In *DSM-IV-TR*, hoarding is listed as one of the diagnostic criteria for obsessive-compulsive personality disorder (OCPD). According to *DSM-IV-TR*, when hoarding is extreme, clinicians should consider a diagnosis of obsessive-compulsive disorder (OCD) and may diagnose both OCPD and OCD if the criteria for both are met. It is clear that, in some cases, hoarding can be a symptom of OCD. For example, hoarding secondary to aggressive or contamination obsessions (for example, fear of contaminating/harming others if "contaminated" possessions are discarded), superstitious thoughts (for example, unreasonable belief that throwing something away will result in a catastrophe of some kind), or feelings of incompleteness or "not just right" (for example, the need to keep things to preserve all life experiences or the loss of one's identity, or to keep objects in a pristine state).

However, recent research has shown that in most cases hoarding appears to be independent from other neurological and psychiatric disorders, including OCD. These individuals do not experience intrusive thoughts, images, or impulses (that is, obsessions) or repetitive behaviors (that is, compulsions) as defined in the current classification systems and required for a diagnosis of OCD. This means that a large proportion of sufferers may remain undiagnosed and thus not receive adequate treatment. A relevant case that has recently come to our attention provides an example: A severe hoarder who, because of her hoarding behavior, lost custody of her child and may face eviction from her home and even imprisonment (on neglect charges) and whose psychiatric report concluded that she did not have any mental disorder.

The *DSM-5* Obsessive-Compulsive Spectrum Sub-Work Group of the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group is proposing the creation of a new diagnosis in *DSM-5* named "hoarding disorder." This proposed diagnosis would apply to hoarding that occurs in the absence of, or independently from, other organic or mental disorders.

please see ***Hoarding*** *on page 24*

David Mataix-Cols, Ph.D., is advisor to the *DSM-5* Obsessive-Compulsive Spectrum Sub-Work Group of the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group. He is head of the Psychobiology of Anxiety and Obsessive-Compulsive Disorders Group at the Institute of Psychiatry, King's College, London.

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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- **Mental Health Parity Watch**
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  Web Site: www.Mentalhealthparitywatch.org

What Is the APA Budget, and Why Are Your Dues Important?

CAROL A. BERNSTEIN, M.D.

Summer has begun—school is out, and youngsters are heading off to camp while parents are lowering the thermostat and planning family vacations. As the pace of life slows for many, that's not the case for APA; we have a very full and busy summer scheduled. Our calendar of summer events includes the yearlong preparation for our annual meeting (May 14 to 18, 2011, in Honolulu), as well as the final preparations for an outstanding Institute on Psychiatric Services in Boston October 14 to 17 (see page 23). One of the most important summer activities of APA's calendar—the yearly budget preparation—revs up in June and peaks in early fall.

As many of you know, I spent four years as APA treasurer. Until that time, I didn't have a good understanding of the APA budget process and how our annual budget related to our district branches (DBs) and Areas. So I thought it might be helpful to give you a brief overview, especially given today's challenging economic environment and the changes in APA policy regarding the pharmaceutical industry.

The Finance and Budget Committee has responsibility for developing a budget for the next calendar year to be presented to the Board of Trustees for final action. The committee, chaired by Frank Brown, M.D., includes officers of the Board and Assembly and psychiatrists with expertise in financial issues. During the committee's meeting in June, members reviewed the overall financial status of the Association, including revenue and expenses in 2009 and projections for 2010, and began the process of developing budget options for 2011. Since that meeting, APA staff have prepared departmental and program budgets for internal review, and these will form a basis for the committee's October meeting.

APA's annual revenue in 2009 was approximately $54 million—a drop of $10 million from 2008. This revenue comes from three major sources: membership dues, publications, and CME—primarily our annual meetings. Publications and meetings generate considerable expenses (the two together account for almost three-quarters of our budgeted expense), leaving a net income from revenue-producing activities of about $11 million, mainly from dues.

So where does this $11 million go? Twenty-seven percent is allocated to governance (Board, Assembly, components, and support for our district branches and state associations); 37 percent goes to our advocacy work, which includes the departments of Government Relations, Communications and Public Affairs, and Healthcare Systems and Financing; and approximately 32 percent goes to support education and research (but not *DSM)*, including Minority and National Affairs. We spend about 4 percent of our discretionary budget (about $500,000) on public education work by the American Psychiatric Foundation. Overall, our expense budget runs about $3 million to $4 million less than our revenues, and we have put about that amount into our reserves and used some of the surplus to fund *DSM-5* expenses.

There are several other important facts. First, from 2008 to 2009, APA experienced a drop of about $3.5 million in advertising revenue in our publications. In addition, during that time, we experienced a drop of $2.6 million in CME support from the pharmaceutical industry. These revenue losses are projected to continue.

APA has worked hard to hold national dues rates steady with minimal increases, but your total dues bill also includes local charges set by Area Councils and DBs.

Why is this information important? For as long as I have belonged to APA, I have noted that there are many resources at our national headquarters that never seem to reach our membership. For the most part, our DBs have few staff and rely heavily on the dedicated volunteer efforts of local psychiatrists. The DB executives do a terrific job with limited resources. We need to find a way to leverage local initiatives more effectively and take better advantage of centralized expertise.

As we move away from our financial dependence on big pharma, efforts to provide resources for state advocacy efforts, local educational programs, mentorship for young psychiatrists, media outreach, and so on will be challenged. I welcome your thoughts, particularly with regard to how we can help our national organization reach more of you where you live and work. Also, what are your thoughts regarding finding new revenues to offset the losses from advertising and the pharmaceutical industry? Should we raise dues? Should we try to centralize our functions? Let me know. I invite you to contact me at cbernstein@psych.org.

As part of our commitment to transparency, more specific financial information can be found in the Members Corners of the APA Web site at <www.psych.org>. ■

Members Thanked

APA members have donated a total of $7,247 to the New Orleans Mission. The donations came in response to a program sponsored by APA prior to its 2010 annual meeting, which was held in New Orleans in May, to benefit the misson.

The mission assists homeless individuals by providing meals, clothing, shelter, and literacy and job-skills training.

Ron Gonzales, executive director of the mission, noted that demands for the mission's services have skyrocketed in recent years. "Your money will provide a warm meal, hot shower, and clean bed for about 1,000 guests," he said.

AMA Addresses Sequelae Of Child Psychiatry Shortage

Physicians from several specialties express concerns about a serious situation that is causing clinical and sometimes legal problems for doctors trying to fill the gap left by a shortage of child and adolescent psychiatrists.

BY MARK MORAN

The shortage of child psychiatrists in the United States has reached crisis levels

And in the gap left by that shortage, pediatricians, family physicians, and other doctors prescribing antipsychotic medication to children need guidance regarding safety and appropriate use of such medications.

That's what physicians from several specialties said last month at the AMA House of Delegate's annual policymaking meeting in Chicago in support of two resolutions brought to the house by the Section Council on Psychiatry.

One of those resolutions requests a report from the AMA's Council on Science and Public Health (CSAPH) on the safety and appropriate use of antipsychotics in children. The second, addressing the shortage of child and adolescent psychiatrists, calls on federal agencies to amend current policy to allow National Health Service Corps scholars to complete their training in child and adolescent psychiatry prior to initial practice assignments.

Both resolutions were approved with strong support from other specialties and with no opposition.

Credit: Mark Moran

Child psychiatry fellow and APA Member-in-Training Trustee Kayla Pope, M.D., reports that in the inner-city clinic where she works in the District of Columbia, the average wait for an initial psychiatric evaluation is two or three months.

Legal, Disciplinary Challenges Involved

The resolutions on antipsychotic medication and on the shortage of child psychiatrists elicited urgent testimony from physicians about an ongoing crisis that is causing clinical and sometimes legal problems for doctors trying to fill the gap left by a shortage of child psychiatrists.

"Antipsychotics are being used with greater frequency, and we have a rising epidemic of mental illness among children," pediatrician Melissa Garretson, M.D., of Fort Worth, Texas, testified during reference committee hearings on antipsychotic use in children.

"There is a dearth of child and adolescent psychiatrists, so general pediatricians, family physicians, and internal medicine-pediatric doctors are having to take care of these kids with extreme mental health issues," she said.

"So it's critical that we have information from the AMA about what the indications are for use of these antipsychotics, what their side effects are, and how we can help parents and families minimize the side effects so the kids can get the appropriate care."

Child psychiatrist Louis Kraus, M.D., a delegate from the American Academy of Child and Adolescent Psychiatry and vice chair of the section council who also does forensic work, testified that there are "tens of millions of dollars of lawsuits against physicians" who prescribe antipsychotics for children and that documentation from the AMA would go a long way toward supporting physicians in legal proceedings.

He added that there are many other physicians who are afraid of using the drugs for fear of losing their licenses.

Similarly, child psychiatrist Maria Lymberis, M.D., an alternate delegate from California, testified that she reviews disciplinary cases that come before the Board of Medicine in California and said that "there are many pediatricians who are facing disciplinary action for prescribing antipsychotic medication without a psychiatric consult."

"So some guidelines from the AMA would be very welcome," she said.

Shortage at Crisis Levels

Likewise, the call for amending policies to allow for completion of child and adolescent psychiatry training within the National Health Service Corps was widely supported by physicians from multiple specialties, many of whom testified that the shortage of child psychiatrists was at alarming levels in many parts of the country.

"Even where I practice in Boston, which has the highest number of phy-

Please see ***Shortage*** *on page 25*

Voting Booth Shouldn't Be Off Limits Due to Mental Illness, AMA Says

Individualized assessments of functional capacity to vote are feasible, AMA delegates state, and should be the basis for determining eligibility to vote. States should not be able to prohibit voting based solely on a diagnostic category.

BY MARK MORAN

The AMA will advocate for the repeal of state laws that prohibit people with mental illness from voting on the basis of membership in a diagnostic class.

The resolution, put forward by the Section Council on Psychiatry with support from six state delegations, was approved without debate or opposition at last month's meeting of the AMA House of Delegates. (The Section Council on Psychiatry consists of APA, the American Academy of Child and Adolescent Psychiatry, and the American Academy of Psychiatry and the Law.)

Forensic psychiatrist Barry Wall, M.D., author of the resolution and an alternate delegate from the American Academy of Psychiatry and the Law, told *Psychiatric News* that 38 states have laws that limit or prohibit people with mental illness from voting. He said that states should be able to regulate the ability to vote based on individual assessments of a person's functional capacity to vote, but should not be able to do so simply on the basis of a diagnosis. "The idea is that if someone is going to be prohibited from voting, it shouldn't be on a categorical basis," he said.

He is director of forensic services at Eleanor Slater Hospital and a clinical associate professor of psychiatry at Brown University Medical School.

The AMA resolution states that "physicians have a duty to promote human well-being without discrimination, including advocating for the broad protection of civil liberties among patients" and that "legal criteria for which persons may be deemed incompetent to vote often focus on membership in a class based on illness (such as all persons under guardianship) rather than an assessment of a person's functional ability to vote."

The resolution also states that "the move to individualized, functional determinations of the capacity to vote parallels similar advances in assessing capacity to consent to research or treatment or to complete an advance directive."

In 2007, the American Bar Association (ABA) approved its own policy urging "federal, state, local, and territorial governments to ensure that no governmental entity exclude any otherwise qualified person from voting on the basis of medical diagnosis, disability status, or type of residence."

The ABA policy also noted, "State constitutions and statutes that permit exclusion of a person from voting on the basis of mental incapacity, including guardianship and election laws, should explicitly state that the right to vote is retained, except by court order where the following criteria must be met: the exclusion is based on a determination by a court of competent jurisdiction; appropriate due process protections have been afforded; the court finds that the person cannot communicate, with or without accommodations, a specific desire to participate in the voting process; and the findings are established by clear and convincing evidence."

"The. . . resolution puts the AMA behind efforts to reduce the disenfranchisement of people with mental illnesses. . . ."

In 2001, a federal court decision in Maine, *Doe v. Rowe*, established a functional standard for capacity to vote. The decision stated that "persons are considered incompetent to vote only if they lack the capacity to understand the nature and effect of voting such that they cannot make an individual choice."

Using what has since become known as the "*Doe* Standard," past APA President Paul Appelbaum, M.D., developed an instrument known as the Competency Assessment Tool for Voting (CAT-V). In a report published in the May 2009 *Psychiatric Services*, Appelbaum wrote that the instrument was an "easy and efficient method of determining voting capacity according to the *Doe* Standard" in 52 community-dwelling people with mental illness.

Performance on the test was high, with 92 percent scoring a 5 or 6 out of 6 possible points, and performance did not correlate with cognition, verbal IQ, or symptom severity.

Appelbaum, whose work was cited in the AMA resolution, called the resolution a "strong endorsement of the right of persons with mental illnesses to vote, unless specifically found incompetent to do so."

"To this day, some states retain archaic restrictions on voting by people with mental illnesses, including those under guardianship, patients who have been hospitalized, and other groups—without regard to their actual abilities to vote," Appelbaum told *Psychiatric News*. "Our research suggested that even most people with serious mental illnesses can meet reasonable standards for capacity to vote, and other work has shown that hospitalized patients display the same voting patterns as are found in the communities from which they came.

"The AMA resolution puts the AMA behind efforts to reduce the disenfranchisement of people with mental illnesses, and hence is a very positive step." ■

AMA Debate Shows Divisions Over Industry CME Funding

An AMA report appears to come closer to balancing a complex set of nuances, but founders on language that many delegates think is dictating how organizations—as opposed to individual physicians—should interact with industry.

BY MARK MORAN

How will medicine work with the pharmaceutical and medical-device industries to support continuing medical education?

It's the question that won't go away and one that the AMA continues to wrestle with. But for the fourth time in two years, a report by the AMA's Council on Ethical and Judicial Affairs (CEJA) titled "Financial Relationships With Industry in Continuing Medical Education" was rejected by the House of Delegates.

This time around, CEJA's report garnered praise from a number of quarters for its careful weighing of the benefits and risks associated with industry financial support of continuing medical education (CME), and the reference committee—where hearings are held on all items of AMA business before coming to the full of House of Delegates—recommended that the report be accepted.

But the House of Delegates sent the report back to CEJA yet again, with many physicians saying that language throughout the report exceeded the jurisdiction of the AMA in governing the behavior of individual physicians and encroached on the territory of organizations and specialty societies, many of which—like APA—interact with industry to provide CME to their members.

Most of those arguing against the report pointed out that the organizational interaction with industry was governed by strict rules for accreditation from the Accreditation Council for Continuing Medical Education and the Council of Medical Specialty Societies.

"The report goes well beyond the purview of the council, and we strongly believe that organizational issues should be dealt with by the organizations themselves," said William Golden, M.D., chair of the delegation from the American College of Physicians. "It is very problematic for the AMA's Council on Ethical and Judicial Affairs to make pronouncements about the behavior of other organizations."

Ted Epperly, M.D., chair of the delegation from the American Academy of Family Physicians, said that CEJA had "confused the relationship between individual physicians and organizations" and had "stepped into the space of professional organizations."

And past APA President Carolyn Robinowitz, M.D., chair of the Section Council on Psychiatry, concurred. "We feel that this report attempts to define what organizations should be doing and goes far beyond the scope of the AMA, which deals with individual physicians."

(Robinowitz is also a member of the APA Board of Trustees and interim editor in chief of *Psychiatric News*.)

'Perfection Is Out of the Question'

CEJA's struggle to master the issue of industry funding for CME reflects the enormous sea change that all of medicine has undergone with increasing public and regulatory oversight of relationships that had for years drawn little attention.

In April, APA's Board of Trustees adopted a new code of conduct aimed at creating greater transparency for APA's organizational relationships with industry (*Psychiatric News*, June 18). The code formalizes some practices that were already in place and establishes a new Board-level Conflict of Interest Committee to oversee APA's relationships with industry.

"The entire field of medicine is moving toward greater transparency in its relationships to industry, and APA has been at the forefront of that trend," APA Medical Director James H. Scully Jr., M.D., said in a statement. "While we think there is a place for industry support of our organization's goals, we believe any relationship should be transparent and that marketing should be clearly separate from medical education."

But the issue of how organized medicine will move forward in a new era in which industry funding will be scrutinized much more closely remains a contentious one, as was evident at times in the debate at AMA's House of Delegates.

"The entire field of medicine is moving toward greater transparency in its relationships to industry, and APA has been at the forefront of that trend."

One representative from the Association of Clinical Researchers and Educators said that the CEJA report was a "bad report" that differed little from previous iterations and that there was little or no clear evidence that industry support of CME contributed to educational bias or to bias in physician behavior.

But it was also clear that the CEJA report went a long way toward satisfying the concerns of many physicians in the House of Delegates and toward balancing the nuances of what John McIntyre, M.D., APA senior delegate and member of the the Section Council on Psychiatry, called "an enormously complex issue."

Issue Likely to Return

McIntyre predicted that CEJA would come back again, possibly at next year's meeting in June, with another report and that it stood very good chance of being adopted.

And there were some at this year's meeting who argued that the AMA could not afford to wait for a report that pleases everyone.

In presenting the CEJA report to the House of Delegates, council member and neurosurgeon Patrick McCormick, M.D., of Toledo, Ohio, said the report "grants that knowledge is gained and shared in collaboration with many shareholders, but that we in medicine must manage these collaborations to ensure that we are in control of medical education.

"This is essential for public trust," he observed.

Laura Meyers, M.D., an orthopedic surgeon from St. Louis, speaking for the Section Council on Orthopedic Surgery, said, "Realistically, perfection is out of the question. The complexity of this issue precludes it. This is a good report."

The CEJA report is posted at <www.ama-assn.org/assets/meeting/2010a/a10-ehandbook-addendum-c-and-b.pdf>. ■

Mental Health Issues Again Prominent on AMA Agenda

Two AMA reports were the fruit of resolutions brought to the House of Delegates at last year's meeting by the Section Council on Psychiatry.

BY MARK MORAN

The AMA House of Delegates approved two reports by the AMA's Council on Science and Public Health (CSAPH) on physician suicide and on lead levels and their effects on children.

Without debate or opposition the House approved an extensive report by CSAPH titled "Suicide in Physicians and Physicians-in-Training," which concluded that "routine occurrence of burnout and mental disorders in physicians and physicians-in-training warrants continued examination and development of more transparent and efficient solutions."

The report was the result of a resolution brought to the House of Delegates last year by the Section Council on Psychiatry.

The council performed a PubMed search of literature from 1970 to March 2010 using the terms "student/medical," "internship and residency," and "physicians" in combination with "mortality," "suicide/epidemiology," "burnout/professional," and "stress/psychological."

The council concluded that the periods of medical school and residency are stressful; that many medical students, residents, and practicing physicians experience substantial distress, which contributes to a decline in mental health and well-being; and that physicians often face barriers to the prompt diagnosis and treatment of mental disorders.

In response, the council advised the formation of an expert panel to address the subject and develop specific recommendations.

Credit: Mark Moran

APA Treasurer David Fassler, M.D., testifies at the AMA House of Delegates last month in support of a report on health effects of lead in children. The report was the result of a resolution brought to the house by the Section Council on Psychiatry.

"Unfortunately, this is a huge problem among the medical student population," said Ryan Ribeira, a representative from the Medical Student Section, at reference committee hearings on the report. "It's a personal issue for me as one of my own classmates decided to take his life a year ago, and the year before that a student in the class above me also committed suicide. Across the country I hear the same stories over and over again. . . . This is a very serious problem, and it is entirely appropriate that the AMA form an expert panel to address this issue."

A second council report, also resulting from a resolution submitted by the Section Council on Psychiatry last year, updates a 1994 report on lead levels in children.

The new report noted that data since 1994 have shown impaired cognition, lowered IQ, and behavioral problems for children exposed to lead at blood concentrations below the Centers for Disease Control and Prevention's current "level of concern" of 10 µg/dL. One analysis of National Health and Nutrition Examination Survey (NHANES) data from 1988 to 2004 showed performance on cognitive tests was diminished in children with blood lead concentrations as low as 2.5 µg/dL.

Also, a 2006 analysis of NHANES data specifically evaluated lower blood concentrations as a risk factor for attention-deficit/hyperactivity disorder (ADHD), finding a "significant dose-response relationship" between blood lead concentrations and ADHD.

Please see ***MH Issues*** *on page 12*

Consent Process Said Crucial At Each ECT-Treatment Step

A task force that is updating APA's guidelines on electroconvulsive therapy reports on the most recent thinking about regulation, dosage, and informed-consent procedures regarding this treatment.

BY AARON LEVIN

"Acute electroconvulsive therapy is the most effective treatment for an acute melancholic episode, but it is also the most controversial," said Mustafa Husain, M.D., at APA's annual meeting in New Orleans in May.

Husain and other speakers at the meeting were members of APA's Task Force to Revise the Practice of Electroconvulsive Therapy, now reviewing key clinical and procedural aspects of electroconvulsive therapy (ECT).

The controversial element still surrounding ECT means that clinicians must pay particularly close attention to the consent process at every step.

"Obtain informed consent prior to an acute course of ECT and also before beginning maintenance therapy," advised Husain, a professor of psychiatry and internal medicine at the University of Texas Southwestern Medical Center in Dallas.

Consent should be obtained by not only the treating psychiatrist, but also by the patient's attending physician and any other clinicians involved, such as anesthesiologists, Husain emphasized.

The consent form should describe the rationale for ECT treatment and note alternative treatment possibilities, he said. The success rate for ECT is about 80 percent, but that means it does not work for 20 percent of patients, and there is a high relapse rate, "so there are no guarantees," and this should be conveyed to patients and their families.

Having a psychiatric disorder does not, of course, automatically mean that a patient is incompetent to provide consent to ECT treatment, he noted, as long it is clear that he or she understands the risks and benefits of the procedure.

However, many states have laws stating that anyone who has been involuntarily hospitalized cannot give informed consent for ECT treatment, he cautioned.

The risks and side effects that patients should understand may follow ECT treatment include headaches, cardiopulmonary dysfunction, memory problems, or confusion. These should be explained in the informed-consent process.

"There are profound long-term memory problems in a subgroup of patients, but

please see ***ECT*** *on page 25*

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., M.D.
Medical Director & CEO
American Psychiatric Association

Credit: David Hathcox

Titrating dosage and proper electrode placement are critical for successful ECT, says Sarah Lisanby, M.D., of the Department of Neuroscience at Columbia University and chair of APA's Task Force to Revise the Practice of Electroconvulsive Therapy.

Credit: David Hathcox

Mustafa Husain, M.D., advises psychiatrists to obtain informed consent prior to an acute course of ECT and before beginning maintenance therapy. He is a professor of psychiatry and internal medicine at the University of Texas Southwestern Medical Center in Dallas.

Israeli Military Helps Medics Cope With Combat Stress

Following combat operations in which injuries occur, Israeli army medical teams discuss their professional performance and their emotional reactions to the experience.

BY AARON LEVIN

Combat medical teams experience both the general risks of combat and the added burden of dealing with badly wounded comrades and are thus at special risk for posttraumatic stress disorder (PTSD) and other combat-related stress problems, said Haim Knobler, M.D., a lecturer in psychiatry at the Hadassah Medical School at the Hebrew University in Jerusalem. Knobler, who is a former head of the Israel Defense Forces (IDF), spoke at APA's 2010 annual meeting in New Orleans in May.

The IDF has developed guidelines intended to enhance coping ability and reduce the chances of negative stress reactions in these field medical units, said Knobler.

Outcome data on the program are not available for several reasons, he told *Psychiatric News*. Since all medical personnel operate under the same guidelines, there is no control group, rendering a true clinical trial impossible. Also, closer attention paid to early combat stress reactions might result in identifying more acute cases in the short run, compared to previous stratagems. Early identification and treatment should then reduce numbers of chronic cases observed years later.

Primary prevention of stress reactions begins even before entry into the army, said Knobler.

Exhaustive preinduction physical, cognitive, behavioral, and personality testing at age 16 or 17 helps determine assignment of recruits to military specialties. Tests cover social functioning, individual autonomy, and organizational abilities. (The original version of the psychological tests was designed in the mid-1950s by Daniel Kahnemann, who won a Nobel Prize for economics in 2002.)

The recruits also provide psychiatric histories and some family medical history. When the tester suspects any psychological disorder, the subject is referred for evaluation. "This testing is strongly predictive of success and failure in front-line services," said Knobler.

Secondary Prevention Also Addressed

While this screening process may help select the best candidates for high-stress jobs such as combat medics, it cannot entirely prevent stress or PTSD. Hence, the IDF also has guidelines for secondary prevention, employed immediately following an episode of combat.

The guidelines mandate comprehensive professional field medical training for unit members, including studying combat-induced PTSD and its treatment. Unit drills include simulated but stressful traumatic events.

A second element of the preventive strategy involves a structured post-action meeting with the medical team. The unit gathering is not designed as a psychological intervention and is specifically not "critical incident stress debriefing," because it is not focused on trauma, said Knobler. The context is a routine post-combat debriefing, held by all military units to determine what happened during an operation and what can be learned from it. The unit maintains its command structure and cohesion.

"But it is more than that," said Knobler. "It also serves as part of a preventive strategy."

Meeting Held When Fight Ends

The session is held after any event in which unit members treat combat injuries. The meeting lasts 30 to 60 minutes and is held minutes to hours after the fighting ends, close to the unit's

please see ***Medics*** *on page 25*

Credit: David Hathcox

Structured after-action discussions among members of combat medical teams may lessen acute and long-term stress reactions, says Haim Knobler, M.D., former head of the Israel Defense Forces' mental health department.

Mid-East Psychiatrists Explore Mind of Suicide Bombers

Psychiatrists from Egypt and Saudi Arabia say that much remains to be learned about the psychology of those who become suicide bombers.

BY AARON LEVIN

Credit: David Hathcox

Psychiatrists Yasser Elsayed, M.D., Mostafa Ismail, M.D., and Mohsen Khalil, M.D., argue that suicide bombers may be extraordinarily committed to a political or religious cause but are not psychopathological.

Suicidal bombing differs from ordinary suicide because the primary goal of the person carrying the explosives is not just to die, but rather to accomplish a mission in the process, Yasser Elsayed, M.D., told a packed room at the APA annual meeting in New Orleans in May.

"They are human bombs, not suicide bombers," said Elsayed, a professor of psychiatry at the Institute of Psychiatry at Ain Shams University in Cairo. The bombers resort to suicide through an absence of other choices, believing that their behavior is a form of martyrdom in service of a higher cause.

Elsayed was one of three speakers on a panel discussing the psychology of suicide bombing.

One might assume that people recruited to be bombers would exhibit some psychopathology, but that is not the case, at least in a clinical sense, said Mohsen Khalil, M.D., of the Al-Amal Complex for Mental Health in the Ministry of Health of Saudi Arabia.

"Studies have shown that there are no distinctive psychological traits shared by suicide bombers," he said. "Many are smart, successful, sociable, young, male, single."

They are convinced to act by some perceived injustice in their community, but they are not psychopathological, he said. Their frustration leaves them vulnerable to brainwashing at the hands of recruiters looking for human bomb-delivery vehicles, he said.

Suicide bombing is not an impulsive, individual act; it is less about individual dynamics than group dynamics. Individuals are needed to perpetrate such bombings, but 95 percent of bombings are planned and carried out by organizations, supported by their surrounding communities.

The bombers may be seen as "altruistic" in the sense that it means sacrificing one's ego to a greater cause, said Khalil. The cause is generally political or religious, characterized by perceived injustice and frustration with conventional means for change, he said.

Suicide bombers feel honor and pride but not guilt, he noted. They may hate their victims or have no feelings toward them, but their intention is to produce a political effect rather than merely kill people. In that sense, "the victim is never the target, and the target is never the victim."

The speakers referred to analyses by American political scientist Robert Pape concluding that contemporary suicide bombers are characterized by four D's: deprivation (of political rights or through foreign occupation); deception (in how they are recruited and prepared by others); devotion (to a national or religious cause); and death (the conversion of death into a "meaningful" life).

"Any society has a minority of disaffected groups who have a sense of injustice and persecution," said Mostafa Ismail, M.D., a professor at the Institute of Psychiatry at Ain Shams.

While Americans may associate suicide bombing with Islamic fundamentalism, the tactic was largely initiated by the Tamil Tiger rebels in Sri Lanka, who accounted for 76 of the 315 suicide bomb attacks between 1980 and 2003, according to Pape's research.

Furthermore, Islam formally opposes killing civilians, even in war, and prohibits suicide for any reason, said Elsayed. Even attempted suicide is a crime under Islamic law. And while all Western societies may oppose suicide bombing, they too glorify the sacrifice in war of one to save many, he stated.

Ismail noted that he and his two colleagues were mental health professionals, not politicians. "We are all against terrorizing, killing, or threatening innocent civilians," he said. "These are unusual and unnatural acts."

Psychiatrists and mental health professionals have a limited role in diverting potential suicide bombers from the path they have chosen. Such interventions occur rarely, usually after bomb plots are interrupted by police or if bombers are captured after their bombs fail to explode. "We must bring them back to their senses," said Elsayed.

Officials in Saudi Arabia say that a rehabilitation program there for captured "militants" or "terrorists" (but not specifically for suicide bombers), appears to be working, he said. The program includes religious re-education by clerics, art therapy, sports, and financial help to start a new life.

However, researchers do not have full access to data that would permit analysis of the program's success, and there are no clinical studies on actual terrorists, said Elsayed.

Indeed, observed one member of the audience in the discussion that followed, "Suicide bombers never present for treatment."

Governments might do more to investigate the psychology of suicide bombers by organizing teams of psychiatrists, social workers, clergy, and politicians to study the problems. Elsayed said, "A lot could be done with 1 percent of the military budget." ■

Consumers Give Good Reviews To Talk Therapy's Effectiveness

Respondents to a *Consumer Reports* poll who have been treated for depression and/or anxiety say that combined treatment—psychotherapy and medication—is the most effective.

BY RICH DALY

The use of so-called talk therapy provided by psychiatrists and mental health professionals in treating both depression and anxiety received a boost in a recent poll of patients, who responded that it was as effective for them as prescribed antidepressants. The best results were reported for combined therapy.

The 2009 survey of 1,544 *Consumer Reports* readers who indicated that they had sought treatment for depression, anxiety, or both from January 2006 to April 2009 found that patient satisfaction levels were similar regardless of whether their treatment consisted of medication alone or talk therapy alone.

The survey responses, published in the July *Consumer Reports*, indicated that the highest satisfaction, however, was associated with combination therapy that included at least seven visits to a psychiatrist or mental health professional as well as medication.

The findings echoed those from a similar survey that Consumers Union, the nonprofit organization that publishes *Consumer Reports*, conducted six years earlier. Those findings also agree with previous academic studies on the clinical efficacy of combining psychotherapies and medication treatments, as well as the superior results provided by longer-term psychotherapies, especially among patients with mild or moderate depression.

"Most of us believe, and most studies show, that psychotherapy works, that antidepressants work, and that psychotherapy and well-selected medications tend to produce better outcomes than either modality alone," Robert Roca, M.D., M.P.H., vice chair of APA's Council on Adult Psychiatry, told *Psychiatric News*.

The biggest impact of talk therapies appeared when patients had at least seven therapy sessions.

"That was where there was a jump in the outcome score," said Jamie Hirsh, associate health editor for *Consumer Reports*, in an interview with *Psychiatric News*. "With [talk] therapy there seems to be this trend where the longer people go [to therapy sessions], the better they do."

No similar improvement in patient benefit was reported based on the number of medication-management visits, although nearly 80 percent of the respondents said they were treated with antidepressants.

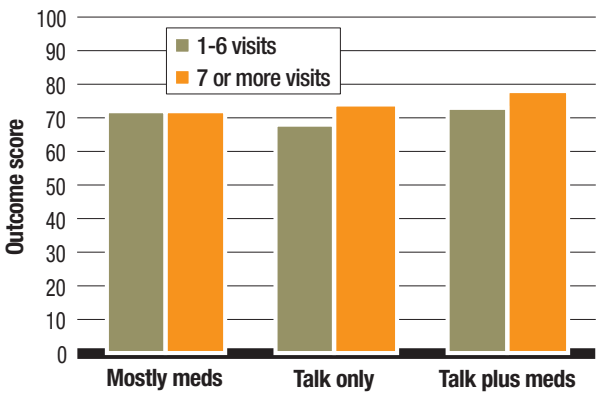
However, survey respondents rated psychiatrists as being more beneficial than mental health professionals (which the survey authors defined as psychologists, social workers, and licensed professional counselors). The authors based this determination on a score that rated "helpfulness," self-assessed improvement, and overall satisfaction.

A majority of respondents (59 percent) treated by psychiatrists received both medication and some form of talk ther-

please see ***Consumers*** *on page 25*

At Least Seven Visits Get the Best Results

A recently released 2009 survey of 1,544 *Consumer Reports* readers found the major determinant of the outcome of any type of depression or anxiety treatment was the number of visits to a psychiatrist or mental health professional.



Source: *Consumer Reports* 2009 Annual Questionnaire

APA's 2010 ANNUAL MEETING: BIG IDEAS IN THE BIG EASY

Photos by David Hathcox

New Orleans rolled out the red carpet as its bestowed its legendary hospitality on the 11,000 APA members and others who attended the 2010 annual meeting. During the day, attendees enjoyed a cutting-edge scientific program led by nationally recognized experts in psychiatry, featuring special tracks whose sponsors included the National Institute on Drug Abuse and the developers of *DSM-5*. And as evening came on and the heat dissipated, they wandered into the French Quarter to partake of some of this country's finest regional cuisine and relax as the music pouring out from nightclubs enticed them to come in and listen. Next year, APA moves on to a very different setting—Honolulu. (Information about that meeting is posted at http://psych.hawaiiconvention.com/us.)

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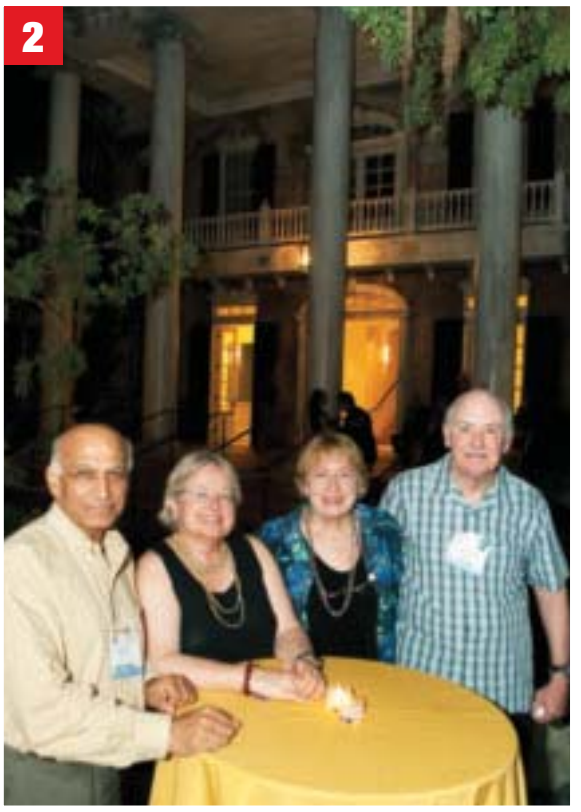
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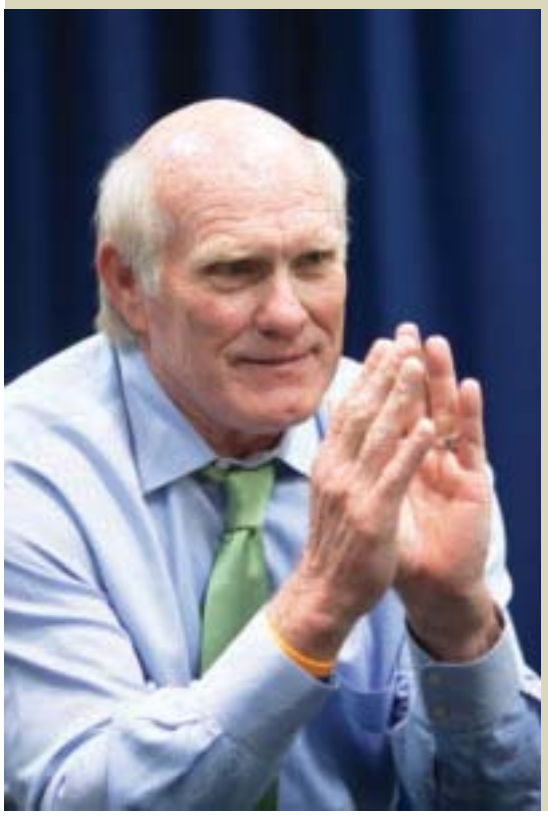
Quarterback Handed Off to Psychiatrist

Terry Bradshaw's extensive experience with mental health clinicians helps him know where to place psychiatrists.

They just aren't as emotional as the preachers and family counselors he went to when his third marriage was collapsing, said the former Pittsburgh Steelers quarterback and current football analyst for Fox Sports.

"I respected their expertise, but I didn't want to hug them," he told listeners in the Conversations event sponsored by the American Psychiatric Foundation at APA's 2010 annual meeting in New Orleans.



Credit: David Hathcox

He was interviewed by Pittsburgh psychiatrist and Steelers fan Alan Axelson, M.D.

Bradshaw took a winding path to a psychiatrist's office. When he was young, he was a "hyper kid who wouldn't shut up or be still," a natural athlete but a poor student who struggled to learn the plays he orchestrated so masterfully on the football field.

Only much later did he learn that he had attention-deficit/hyperactivity disorder (ADHD) and, still later, depression. "I just had some issues. I dealt with it. It's how we deal with it that's important."

He now continues taking medications for ADHD and talk therapy.

"I tell people there's hope, there's answers," he said. "I know there are people who care about me."

When the conversation ended and Bradshaw stood to leave, Axelson walked over and gave him a big hug, to appreciative applause from the audience.


5

1 A flag carrying the logo of APA's 2010 annual meeting was seen in numerous places as New Orleans welcomed APA members to the city. Here, it's flying outside the convention center. **2** Nasir Khan, M.D., Kay Khan, Lee Mondale, and Jason Mondale, M.D., enjoy an evening of Southern hospitality at the Grand Oaks Mansion, where the American Psychiatric Foundation held its annual benefit. Funds raised at the event are used to support the foundation's mental health initiatives, including public education. **3** Attendees at the annual MindGames competition root for their favorite team. This year's winner was the team from Brown University. **4** Robert Trivus, M.D., snaps a photo of his wife, Heather Newman-Trivus, M.S.W., at the APA Art Association exhibit. She is posing with his photograph of the sculpture "The Rape of the Sabine Women." **5** Babatunde Fagbamiye, M.D., and Jelil Onanuga, M.D., check out one of the displays in the Exhibit Hall.

Obama Sees Malpractice Reform Arising From State Actions

The Obama administration begins distributing grants aimed at lowering the risk of malpractice lawsuits through the development of legislative models to define a legal standard of care for physicians and health care workers.

BY RICH DALY

A series of new federal grants aims to encourage the development of legal structures and patient-care policy changes with the goal of reducing the number of medical malpractice lawsuits.

The Agency for Healthcare Research and Quality awarded $25 million in funding in June for state programs to improve patient safety and thus reduce the number of malpractice lawsuits patients file. The grants are part of a patient safety and medical liability initiative that President Obama first outlined in September 2009 as part of his effort to garner physician support of the massive health care overhaul legislation then moving through Congress.

The legislation had drawn criticism from some physicians for omitting any federal changes of the nation's malpractice-related laws.

The new grants will fund demonstration projects aimed at reducing preventable injuries, ensuring that patients are compensated more quickly by physicians and hospitals in cases of legitimate claims, improving communication between physicians and patients, and reducing liability insurance premiums. Included in the funding is a series of one-year grants that, among other provisions, will fund the development of evidence-based guidelines to curb lawsuits, craft state legislative proposals to define a legal standard of care for health care providers, and develop measures to reduce patient suicides.

The initiative drew praise from the AMA. (APA does not have a position on this particular initiative but generally supports efforts to reform malpractice law.)

"As our nation works to reduce the growth in health care costs, it's clear that medical liability reform must be part of the solution," said then AMA president J. James Rohack, M.D., in a June 11 statement.

Although the AMA had urged Congress to include comprehensive tort reform within the health care overhaul, the AMA opted to continue providing critical support to the legislation when such measures did not make it into the final version of the bill.

The health reform law enacted in March included only limited "demonstration projects" aimed at curbing such lawsuits.

> **"As our nation works to reduce the growth in health care costs, it's clear that medical liability reform must be part of the solution."**

The need for broader federal action to curb malpractice lawsuits was based on research, such as a December 2009 report by the nonpartisan Congressional Budget Office (CBO), which described the impact of clinicians ordering more tests or procedures than are necessary primarily to protect themselves from lawsuits. According to CBO researchers, medical-liability reform proposals at the federal level could save at least $54 billion over 10 years, in part by reducing the need for physicians to practice defensive medicine (*Psychiatric News*, February 5).

In responding to the new grant program, Rohack also praised the more extensive medical liability changes enacted in states such as California and Texas. In Texas, for example, legislators placed a $250,000 cap per claimant on noneconomic damage awards, limited time for filing a malpractice case, toughened the standard of proof, and allowed damage payments to be paid out periodically.

Instead of moving toward comprehensive liability reform, the new grants target state efforts to streamline lengthy legal processes. Programs included under the grants are those to develop a judge-directed legal-negotiation program, "safe harbors" for following state-endorsed evidence-based care guidelines, and early disclosure of medical errors by hospitals and clinics with offers of prompt compensation. The goal of such efforts is to expedite the legal process and lower the overall legal costs of malpractice litigation.

Information about the federal grant program is posted at <www.ahrq.gov/news/press/pr2010/hhsliabawpr.htm>. ■

HIT Leaders Tout Multiple Benefits, Improved Privacy Protections

Developers of health information technology systems urge federal regulators to complete work on national standards, despite continuing concerns from physician advocates over patient privacy, cost, and requirements unrelated to the physician's medical practice.

BY RICH DALY

Companies that make health information technology products are pressing federal regulators to expedite creation of national regulations on electronic medical record systems—despite continuing concerns by physician groups—maintaining that the promised benefits outweigh the misgivings of critics.

Credit: Rich Daly

Neal Neuberger, executive director of the Institute for e-Health Policy, calls for expedited regulations to implement a federal electronic medical record incentive program. Goals are to improve patient health and catch up to the information-sharing capabilities of other industrialized nations.

Leaders of the many companies that build and implement health information technology (HIT) systems were in Washington, D.C., in June to lobby Congress and urge regulators to speed up development of rules to implement a federal program aimed at spurring nationwide adoption of digital medical information systems. Physician concerns have helped slow the process of issuing regulations to implement provisions of the American Recovery and Reinvestment Act of 2009 (ARRA, PL 111-5), which included $17 billion in grants to encourage clinicians to use electronic medical records (EMRs)—a central component of HIT systems.

APA and other physician groups have criticized the federal program, in part because of concerns that federal regulators have underestimated the high cost to physician practices of EMR adoption and continuing HIT system maintenance. Physician advocates warn that the true cost to physicians of HIT systems that would comply with all of the proposed regulations could dwarf federal assistance provided through the ARRA.

But the HIT industry, which manufactures and installs costly EMR systems, said such concerns do not warrant further delays in the completion of the regulations and launch of the multibillion-dollar incentive program.

"We need to implement these tools as quickly as possible," said Barry Chaiken, M.D., chair of the Healthcare Information Management Systems Society, at a June 15 press conference in Washington, D.C. "We believe these goals are not—repeat, not—too aggressive."

The technology companies emphasized that nationwide adoption of HIT systems would provide a range of benefits to patients and physicians through improved record keeping, reduction in medical errors, and expedited access by medical personnel to critical information that could save lives.

"We want to fundamentally change the way we deliver care," said David Muntz, a member of the board of trustees of the College of Healthcare Information Management Executives.

The health-technology leaders continue to reach out to physicians, who not only will spend billions of federal and their own dollars on new record systems as part of the federal goal for every American to have an EMR by 2014, but also can provide critical information to their colleagues on which HIT system they prefer. To that end, the HIT manufacturers are also urging federal officials to maintain antitrust exemptions for physicians that would allow them to communicate with each other regarding adoption and implementation of HIT systems.

"Physicians no longer talk about walking away from the technology; now they embrace it," Muntz said.

The HIT providers also stressed the improvements that they have made to the privacy protections included in their electronic data systems. For example, EMRs now allow patients to view "audit trails" of their records to see who has viewed the information. Physician and patient-privacy advocates have repeatedly warned that existing law and technology standards provide insufficient security and patient control of their health data. This is particularly troubling to mental health advocates, due to the societal stigma often directed at people with mental illness.

Generally, the HIT leaders don't expect additional federal funding beyond the $19 billion in federal incentives for hospitals and physicians that will be provided under the ARRA; however, more federal money could be directed at encouraging adoption of EMRs in specific areas of medicine. For example, Rep. Patrick Kennedy (D-R.I.), co-chair of the 21st Century Health Care Caucus in Congress, introduced the Health Information Technology Extension for Behavioral Health Services Act (HR 5040) in April to provide incentives and grants to mental health care providers and psychiatric hospitals that establish interoperable HIT systems.

More information on the Health Information Technology Extension for Behavioral Health Services Act can be accessed at <http://thomas.loc.gov> by searching on the bill number, HR 5040. ■

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government news

Prevention Council to Target Mental Illness, Substance Use

Heightened focus on preventing psychiatric disorders is a major goal of a new White House initiative, which is only the first of several prevention efforts expected to arise from the health care reform law.

BY RICH DALY

Prevention of psychiatric illness was a key feature of President Obama's June 10 executive order creating a National Prevention, Health Promotion, and Public Health Council. Such an advisory group was authorized by the new health care reform law, known as the Patient Protection and Affordable Care Act.

The council will be composed of senior government officials from numerous departments and agencies and will be tasked with coordinating federal "health promotion" efforts and developing a national strategy to reduce "the incidence of preventable illness and disability."

The council will receive input from an advisory council of up to 25 "licensed health professionals" who are experts in illness prevention.

The initiative has drawn interest from some mental health advocates because its objectives include the development of prevention strategies that focus, in part, on "mental health, behavioral health, [and] substance-use disorder[s]."

It's a focus long called for by many in the mental health field who view prevention and early intervention as a practical way to avoid or minimize the need for treatment of advanced psychiatric illness.

For example, "if care providers consistently screen and intervene with early-stage substance abuse, the health care system can avert enormous human and economic costs," said A. Thomas McLellan, Ph.D., deputy director of the Office of National Drug Control Policy, in testimony before a House of Representatives subcommittee on June 23.

The need for increased mental illness prevention and early-detection efforts has also been acknowledged as critical by suicide-prevention advocates, who have stressed that the vast majority of suicide victims have untreated mental illness.

"We need to get better in recognizing the underlying psychological problems in vulnerable age groups," Robert Gebbia, executive director of the American Foundation for Suicide Prevention, told *Psychiatric News*.

The federal initiative comes as efforts to prevent psychiatric illness have gained ground in recent years (*Psychiatric News*, January 1). Thomas Insel, M.D., director of the National Institute of Mental Health, highlighted the potential of "preemptive" schizophrenia treatment that targets individuals with risk factors such as family history combined with unusual thoughts and changes in social functioning. His comments came in a February 2009 editorial in the *Archives of General Psychiatry*.

Other new prevention initiatives include grants totaling $250 million authorized by the health care overhaul law to support prevention efforts specifically within the nation's public-health system, according to an announcement by Kathleen Sebelius, secretary of Health and Human Services (HHS), in June. The grants include $126 million to help integrate primary care services into publicly funded, community-based mental health facilities.

Professionals in the public mental health arena have long urged such integration, because many people with serious mental illness have co-occurring nonmental medical disorders, while people with serious nonmental health conditions are at risk of developing psychiatric conditions.

"Investing in proven preventive services will help patients get the care they need early, avoiding costly and unnecessary care later," said Sebelius in a written statement. "This prevention-focused approach is better for doctors, patients, and our national balance sheet."

The HHS grants also will provide $23 million to expand training in prevention-related care for those in the public-health workforce.

Such federal funding for prevention, detection, and early intervention of psychiatric illnesses among public-health workers is key, said McLellan, as is the new law's first-time requirement that private insurers also reimburse physicians for providing such activities.

Information on the National Prevention, Health Promotion, and Public Health Council is posted at <www.whitehouse.gov/the-press-office/executive-order-establishing-national-prevention-health-promotion-and-public-health>. ■

Adopting a Few Simple Remedies Could Treat Soaring Costs

A range of health care system changes, including some that will be implemented on a pilot basis in the new health care overhaul, may provide $3.6 trillion in savings over the next 10 years if implemented nationally.

BY RICH DALY

Widespread adoption of preventive care measures and health information technology could provide $3.6 trillion in savings over the next 10 years if legislators and regulators can overcome significant implementation cost and inertia challenges, according to a new analysis. The savings identified by an economic research and consulting firm could keep overall health care costs flat over that period.

An analysis of the nation's leading public- and private-sector efforts to save money in the health care system identified several "proven strategies" that could cut costs and improve patient care if implemented widely. The white paper issued June 14 by Thomson Reuters concluded that existing measures aimed at cutting waste, increasing patients' involvement in their own care, better coordinating care among clinicians, and improving patient safety could provide hundreds of billions of dollars in annual savings.

Systematically incorporating "best practices" into the organizational structure of the health care industry, the analysis reports, could cut "waste" by 5 percent each year. The researchers generally considered as waste any spending that didn't go toward improving patient health, such as fraud. Over 10 years, such waste reduction, combined with prevention and technology efforts, could add up to $3.6 trillion and keep total health care expenditures at their current rate of about 17 percent of U.S. gross domestic product.

The researchers noted that they "investigated initiatives that have successfully reduced health care costs without sacrificing quality—what they described as 'real-world examples of what's possible'—and then estimated the savings if they were widely replicated."

"The result, detailed in this paper, is one path for reaching this goal over the next decade," said Ray Fabius, M.D., chief medical officer at Thomson Reuters and coauthor of the paper, in a written statement.

The researchers concluded that expanded clinician access to patients' medical records through electronic record systems will help reduce the duplication of tests and inappropriate treatments that are estimated to cost up to $50 billion annually. Such information availability is a major goal of the 2009 American Recovery and Reinvestment Act (ARRA, PL 111-5), which included $17 billion in grants to encourage clinicians to use electronic medical records—a central component of health technology systems (see page 10).

Another cost savings strategy cited in the report is the expansion of disease-prevention efforts. The federal health care reform law includes several pilot programs to encourage patients to manage their own health through attention to personal behavior, disease prevention, early detection of illness, and appropriate care for chronic diseases.

The authors also concluded that up to $100 billion in annual savings could come through preventing medical errors. They called for adoption of a simple checklist approach stemming from data on evidence-based best practices, which some health care systems have already implemented to improve patient outcomes and reduce costs.

The increasing federal efforts to battle fraud throughout the health care system, including efforts targeting the estimated $60 billion in annual Medicare fraud, also should be bolstered, according to the researchers. Increased fraud-fighting efforts could provide some of the greatest savings in overall health care spending, since fraud accounted for up to 10 percent of the $2.3 trillion in total health care spending in 2007, according to a report published by the George Washington University School of Public Health and Health Services.

The Thomson Reuters researchers advocated widespread use of computerized systems that track data anomalies to identify fraud and breaches in payment integrity. Such systems are already in use in several state Medicaid programs.

The analysis can be accessed at <http://info.thomsonhealthcare.com/?elqPURLPage=685>. ■

professional news

MH Issues

continued from page 5

The CSAPH recommended that several policies be updated to reflect the findings of its report and proposed that the following new policy be adopted: "That our AMA urge the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with exposure to blood lead concentrations below the current 'level of concern' in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure."

"This report offers reasonable recommendations based on data available and furthers our overall goal of enhancing awareness [of hazards associated with lead] even at levels currently considered in the acceptable range," said APA Treasurer David Fassler, M.D., a delegate from the American Academy of Child and Adolescent Psychiatry.

Both council reports can be accessed at <www.ama-assn.org/assets/meeting/2010a/a10-annotated-d.pdf>. ■

Experts Learning Much About Cannabis-Use Disorders

Several behavioral strategies have shown effectiveness in helping patients quit cannabis use, and some medications appear to merit further clinical research.

BY JUN YAN

Marijuana is the most widely used illegal substance in the United States, with 15 million or more current users, and approximately 10 percent of these users develop cannabis-use disorders, epidemiological data have shown. The extent of this problem for clinicians was evident at a symposium on cannabis-use disorder, as the session attracted a full house of attendees at APA's annual meeting in New Orleans in May.

It is often difficult to conduct and interpret epidemiological studies of the adverse consequences and risks of marijuana use, David Gorelick, M.D., Ph.D., chief of the Pharmacotherapy Section in the Intramural Research Program at the National Institute for Drug Abuse (NIDA), told the attendees.

The observed outcomes of chronic use are influenced by many factors, including genetic variations, differences in the potency of and cumulative exposure to marjuana use, concurrent use of other substances such as tobacco and alcohol, comorbid psychiatric conditions, and psychosocial risk factors.

Growing evidence supports a link between marijuana use and psychosis, said Gorelick, citing population research from the United Kingdom. The link appears to be particularly strong with early exposure to marijuana in adolescence. Epidemiological research by Stanley Zammit, Ph.D., M.B., of Cardiff University estimated that the effect size of this link translates to this: stopping approximately 3,000 cases of cannnabis-use disorder might prevent one case of schizophrenia.

Research so far has shown no association between in-utero exposure to marijuana and the development of psychotic disorders later in life, according to Gorelick. However, two longitudinal studies using brain imaging found subtle differences in brain activities during executive-function tests between young adults with and without in-utero exposure to marijuana, even though their performance did not differ.

Meanwhile, patients with schizophrenia have reported a high rate of cannabis use—up to 50 percent in some studies, Gorelick noted. Marijuana smoking in these patients is associated with significantly worse psychotic symptoms, poorer treatment compliance, and exacerbated metabolic side effects from antipsychotic medications. "It's clearly bad for them," he said. "The question is why they use marijuana—and there is no clear answer."

According to recent research, physical effects of long-term cannabis use are somewhat different from those of tobacco smoking, Gorelick pointed out. Respiratory symptoms such as cough, phlegm, and wheezing have been reported. The association with chronic obstructive pulmonary disease, lung cancer, and myocardial infarction appears to be smaller for marijuana smoking than for tobacco smoking.

Marijuana Use Poses Driving Hazard

Aviv Weinstein, Ph.D., of the Department of Nuclear Medicine at Hadassah Hospital Ein Kerem in Jerusalem, Israel, reported findings from a recent study to measure the acute effects of cannabis on cognitive-motor functions.

Weinstein and colleagues enrolled 14 volunteers who regularly smoked marijuana and tobacco and gave them a driving test in a virtual-reality maze after smoking a cigarette containing 17 mg of tetrahydrocannabinol (THC), the psychoactive ingredient in marijuana, a cigarette containing 13 mg of THC, and a tobacco cigarette with no THC. The virtual maze was designed to test their motor-cognitive functions.

The volunteers had a higher collision rate in the virtual-maze test, indicating reduced cognitive-motor skills, immediately after a dose of 17 mg THC, compared with 13 mg THC and with tobacco. On PET scans performed after the maze test, the researchers saw that brain areas associated with motor coordination and visuospatial attention showed increased metabolism, while areas related to visual integration of motion in the occipital lobes were decreased.

Weinstein also reported that after administering 17 mg THC, the subjects made more errors on a cognitive test than they did after taking 13 mg THC or placebo, suggesting reduced attention and working memory, and showed an increased tendency for risk-taking behaviors in a simulated gambling task.

Behavioral Treatments Prove Effective

A number of studies have demonstrated the effectiveness of behavioral therapies to treat cannabis-use disorder, according to Alan Budney, Ph.D., a professor of psychiatry and a research scientist at the Center for Addiction Research at the University of Arkansas for Medical Sciences.

Summarizing recent studies on motivational enhancement therapy (MET), cognitive-behavioral therapy (CBT), abstinence-based therapy, and contingency management strategies, Budney noted that a combination of MET and CBT has been shown to reduce cannabis use and promote abstinence in many patients.

MET techniques help strengthen the patient's motivation to change and quit, Budney explained. The key to the motivational interviewing style is to convey a nonjudgmental, accepting attitude toward the patient and not overstate the risk of marijuana use. "Combined with teaching coping skills [with CBT], this approach works well in the real-world setting," he said.

Contingency management, which involves offering rewards to patients who maintain abstinence, has been extensively studied and shown to be effective in treating various addiction disorders. The reward may be vouchers to exchange for goods, assistance for work or housing, or nonmonetary incentives, Budney said. For adolescents in treatment, parents can be taught to implement contingency strategies effectively. For example, an adolescent may be rewarded with a gift or privilege for staying free of marijuana use.

Budney is a proponent of frequent urine testing to monitor treatment efficacy.

Perhaps most important, behavioral treatment for cannabis-use disorders should be tailored to each patient's situation, needs, motivation, and concerns.

Pharmacological Treatments Promising

Margaret Haney, Ph.D., a professor of clinical neurobiology at the College of Physicians and Surgeons of Columbia University, and colleagues have developed a human laboratory model to study marijuana withdrawal, relapse, and intoxication symptoms and to test medications that may be effective in treating the addiction. The model is "an intermediary between preclinical animal experiments and randomized, controlled clinical trials," said Haney at the annual meeting session.

In this model, volunteers who were heavy marijuana smokers with no major psychiatric disorders and not seeking treatment were assessed and tested under confined, controlled, experimental conditions of simulated withdrawal and relapse.

During withdrawal conditions, the subjects were given placebo rather than marijuana, while medications were tested for their effectiveness to reduce withdrawal symptoms such as cravings, anxiety, irritability, restlessness, decreased food intake, and disrupted sleep. Researchers found that bupropion worsened the symptoms, divalproex worsened mood and cognitive performance, and nefazadone relieved such symptoms such as anxiety and muscle pain to an extent. "The medication show-

please see ***Cannabis*** *on page 21*

Lithium May Come to the Rescue When Brain Is Inflamed

Lithium treatment subdues an inflammatory compound and increases an anti-inflammatory compound in the brains of animals. Such actions may help explain why it stabilizes moods in bipolar patients.

BY JOAN AREHART-TREICHEL

Although it has been 40 years since lithium carbonate was approved by the Food and Drug Administration to treat bipolar disorder, exactly how it works has not been clear. A common belief, however, is that it reduces brain inflammation during the manic phase. Indeed, postmortem frontal cortex samples from individuals with bipolar disorder have shown signs of inflammation.

And now another study bolstering the hypothesis that lithium counters bipolar disorder by countering inflammation has been published in the May *Journal of Lipid Research*.

The study found that when lithium reaches the brain, it both reduces levels of the inflammatory compound arachidonic acid and increases levels of the anti-inflammatory compound 17-OH-DHA, which is formed from an omega-3 fatty acid—docosahexaenoic acid.

Mireille Basselin, Ph.D., a scientist at the National Institute on Aging, and colleagues fed 17 rats lithium chloride for six weeks to produce brain concentrations of lithium that were therapeutically similar to those obtained in patients taking lithium carbonate. They fed 17 other rats a lithium-free diet during the six-week period.

During a six-day period, bacterial lipolysaccharide was infused via cannulas into the brains of both groups of rats to produce an inflammatory response. The rats were then sacrificed, and findings from the brains of the two groups were compared.

The group that had not received lithium had a substantial amount of the inflammatory compound arachidonic acid in their brains, whereas the group that had received lithium did not. In contrast, the group that had received lithium had a substantial amount of the anti-inflammatory compound 17-OH-DHA in their brains, which was not the case for the lithium-free rats.

So it looks as if lithium can reduce levels of the inflammatory compound arachidonic acid and increase levels of the anti-inflammatory compound 17-OH-DHA in the brain. Such actions may explain how lithium helps people with bipolar disorder, the researchers believe.

Moreover, aspirin, like lithium, is known to increase levels of 17-OH-DHA, Basselin told *Psychiatric News*. So these findings may also explain why researchers recently reported that bipolar subjects who took aspirin plus lithium did even better than those taking lithium alone.

Lithium has also been reported to show some therapeutic benefit in other brain illnesses besides bipolar disorder, Basselin and her colleagues noted, including Alzheimer's disease, amyotrophic lateral sclerosis, and HIV-related dementia. These illnesses, like bipolar disorder, are known to involve brain inflammation. Thus lithium's therapeutic effectiveness against these illnesses may be due to its anti-inflammatory actions, Basselin and her team speculated.

The study was funded by the National Institutes of Health.

An abstract of "Lithium Modifies Brain Arachidonic and Docosahexaenoic Metabolism in Rat Lipopolysaccharide Model of Neuroinflammation" is posted at <www.jlr.org/cgi/content/abstract/51/5/1049>. ■

Opioid-Addiction Treatment: Maintenance or Abstinence Better?

Opioid agonist maintenance therapy with methadone or buprenorphine is consistently more effective than the detox-and-abstinence approach studied in many clinical trials.

BY JUN YAN

Research has shown that opioid-addicted patients have a very high rate of relapse if they are not given long-term opioid maintenance therapy, but how long that therapy should last and when it can be safely discontinued remain unanswered questions.

Clinicians have little more than anecdotes to go on, the speakers agreed at a workshop at APA's 2010 annual meeting in New Orleans in May. Before research is conducted, addiction psychiatrists should be mindful of the proven effectiveness of long-term maintenance therapies with methadone and buprenorphine and the risk of premature treatment discontinuation, they recommended.

The workshop, titled "Maintenance Treatment for Opiate Dependence: Terminable or Interminable?," was part of a track sponsored by the National Institute on Drug Abuse (NIDA).

Detoxification followed by abstinence "carries the risk of a very high relapse rate and treatment failure," Steven Batki, M.D., a professor of psychiatry and behavioral sciences at Upstate Medical University in Syracuse, told attendees. He cited studies and reviews consistently showing that about two-thirds of opioid-dependent patients would relapse without maintenance therapy. For example, in a study published in the March 8, 2000, *Journal of the American Medical Association*, Karen Sees, D.O., and coauthors found that methadone maintenance therapy was more effective than abstinence-based psychosocial treatment for reducing heroin use and retaining patients in treatment.

The "right" duration of methadone or buprenorphine treatment is clinically driven by the objectives of treatment, such as increasing life expectancy, reducing morbidity, improving health and quality of life, decreasing heroin and other substance use, decreasing crime, and minimizing costs to family and society, Batki noted.

"At present, [opioid receptor] agonist and partial-agonist maintenance treatment of open-ended and uncertain duration appears to be closest to a 'cure'," Batki said.

Because of its short time on the market, there is less long-term evidence on buprenorphine, according to Herbert Kleber, M.D., a professor of psychiatry and director of the Division on Substance Abuse at the New York State Psychiatric Institute. No clinical trial data are currently available. His recommendation is to taper patients off buprenorphine very slowly and carefully; his experience has shown that many patients have difficulty reducing their dosages below 1 mg or 2 mg.

Clinicians should test patients' urine samples throughout the treatment course, Kleber emphasized, because buprenorphine does not appear on a regular urine toxicology screen. Without the test, the clinician would not be able to detect diversion if it occurs.

Both Kleber and Batki noted that research has been unable to offer much useful guidance on predicting prognosis and identifying risk factors for relapse.

Patient Retention a Challenge

The key to the effectiveness of maintenance therapy is treatment retention, which has been shown to significantly reduce mortality and other negative outcomes; however, "in methadone clinics, patients are often discharged from the clinic against their will," said Robert Schwartz, M.D., the medical director and a senior research scientist at the Friends Research Institute in Baltimore.

The patient's autonomy and the methadone clinic's perspective are sometimes in conflict and become a source of tension, according to Schwartz. The methadone clinic staff may be discouraged by a patient's lack of progress or incomplete abstinence despite some degree of improvement. "They may hope to replace that patient with a 'good' patient," he said.

On the question of how long the patient will stay in a methadone maintenance program, Schwartz said that about half of patients entering these programs drop out in the first year.

He and his colleagues conducted a study at six methadone clinics in the Baltimore area and found that nearly 80 percent of patients left the programs for program-related reasons. For example, clinics dropped patients who had treatment interrupted because of brief incarceration, drug use, missed medications, failure to adhere to clinic rules, failure to pay nominal fees, or interpersonal conflicts with staff or counselors. Staff frustration often leads to discharge against a patient's wishes, particularly since physicians are typically not closely involved in the program operation on a daily basis.

Since approximately 60 percent of methadone clinics in the United States are run by for-profit entities, there have been concerns about the quality of treatment provided and a lack of sufficient physician oversight at many clinics, Kleber noted.

To increase patient retention and improve outcomes at methadone clinics, Schwartz suggested several approaches: include the patient's need for autonomy and perspective in the treatment plan rather than have the clinic dictate it; review program rules and make them simple, sensible, and patient friendly; change counselors or transfer patient to another program if conflicts arise; and be more cautious in making the decision to discharge a patient.

Furthermore, clinicians should address psychiatric comorbidities while treating addiction, Schwartz recommended. "We also need to make decisions based on the patient's functioning rather than exclusively on urine test results."

Contingency Management Works

The effectiveness of contingency management, which uses a system of incentives and disincentives designed to make abstinence attractive and drug use unattractive, was supported by research on various substance use disorders, Kenzie Preston, Ph.D., a senior investigator and chief of the Clinical Pharmacology and Therapeutics Research Branch within the Intramural Research Program at NIDA, said at the workshop.

There are a variety of flexible contingency-management strategies that can be used effectively along with other treatments, she explained. For example, if a patient meets all the scheduled specimen collections and produces consecutive negative drug-screen results, he or she is given a voucher with monetary value to exchange for various prizes or merchandises. The value of the vouchers can remain the same or increase over time with more clean results. Other forms of reinforcement are assistance with child care, access to housing, vocational training, and greater flexibility with treatment (for example, take-home doses of methadone).

Targeted behaviors are not limited to abstinence from opioid use, she added, but may also include abstinence from other substance use, adherence to naltrexone treatment, and therapy retention.

"As for the question of whether [contingency management] is terminable or interminable, at this point there is no yes or no answer, and [we need to] look at it long term," she said. ■

Certain Antidepressants Linked With Higher Miscarriage Risk

A study with a large number of subjects suggests that antidepressant use during pregnancy increases the risk of miscarriage. But the dilemma is that untreated depression can also adversely affect pregnancy.

BY JOAN AREHART-TREICHEL

Antidepressant use during pregnancy is linked with a heightened risk of miscarriage, a new study suggests.

The study was headed by Anick Berard, Ph.D., associate professor and research chair on medications, pregnancy, and lactation in the Faculty of Pharmacy at the University of Montreal. Results were published in the May 31 *Canadian Medical Association Journal*.

The study cohort consisted of more than 5,000 women in the Quebec Pregnancy Registry who had had a clinically verified miscarriage. Each was matched with 10 controls who were at the same gestational stage as when the miscarriage occurred, so there were more than 50,000 controls.

> **"[As] with all treatment decisions, we must weigh the risk-benefit ratio and discuss this with the patient."**

The researchers compared antidepressant use by the women who had miscarried with that of the control subjects.

Six percent of the women who had miscarried had at least one prescription for an antidepressant filled during pregnancy, compared with 3 percent of the controls. But after potentially confounding variables such as a history of depression or anxiety, sociodemographic characteristics, antidepressant exposure in the year before pregnancy, or use of other medications during pregnancy were considered, miscarriage risk in antidepressant users was determined to be 68 percent greater than in nonusers.

The researchers also examined the increased risk of miscarriage in antidepressant users according to the class of antidepressant used. Again, possibly confounding variables were considered. The risk increased by 27 percent for tricyclics, 61 percent for SSRIs, 210 percent for SNRIs, and 351 percent for the combined use of two or more classes of antidepressants.

When the researchers grouped women according to the specific antidepressant they received and compared them with nonusers, paroxetine use alone and venlafaxine use alone were independently associated with an increased risk of miscarriage. The increased risk for the former was 75 percent and for the latter 211 percent.

Finally, the researchers found a significant dose-response relationship between paroxetine and miscarriage risk and between venlafaxine and miscarriage risk: the higher the averagely daily dose of paroxetine or venlafaxine used, the greater the miscarriage risk.

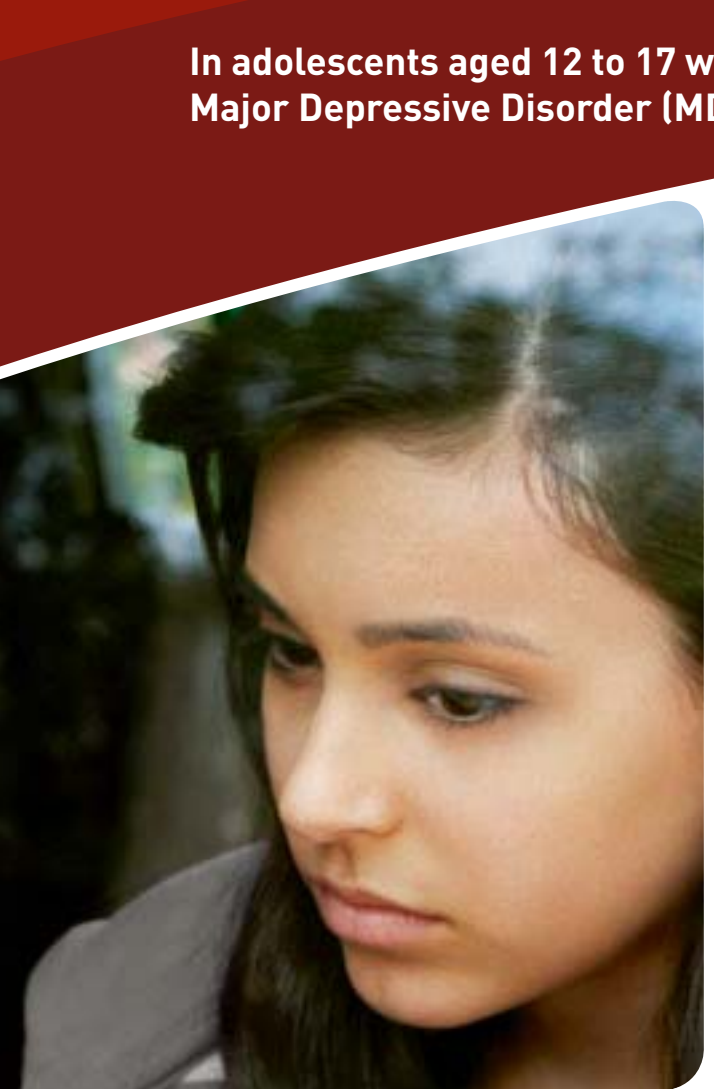
"Overall, it does seem that there is a small, but statistically significant increase in miscarriage with antidepressant use," Gail Robinson, M.D., a professor of psychiatry and director of the Women's Mental Health Program at the University of Toronto, told *Psychiatric News*. "[But] there is no information [in the report] as far as I could see about subjects' previous reproductive history, which may increase the risk. It is likewise not clear whether subjects receiving antidepressants actually took them; getting a prescription is not the same. And, most importantly, what is the risk of miscarriage in women with untreated depression? We know that there are a variety of negative outcomes associated with untreated depression in pregnancy, including pre-eclampsia, premature birth, and low birth weight, let alone suicide or attempts to self-abort. So depression itself confers a risk on pregnancy."

please see ***Miscarriage*** *on page 21*

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.

There is no generic available for LEXAPRO

- 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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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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Autism Drug Choice Usually Matter of Trial and Error

Medication can help relieve some behavioral symptoms in autism patients, but research evidence is scant, and physicians often have to try various treatment strategies to find one that works.

BY JUN YAN

With just two drugs having been approved for the treatment of only a small portion of symptoms associated with autistic spectrum disorders (ASDs), many clinicians struggle to find effective methods to manage disruptive and vexing symptoms such as aggression, agitation, sleep and mood disturbances, and repetitive behaviors.

At APA's 2010 annual meeting in New Orleans in May, Chris McDougle, M.D., gave a lively presentation to a full house of attendees on pharmacotherapeutic options for treating both pediatric and adult patients with ASDs.

McDougle is the Albert Eugene Sterne Professor of Clinical Psychiatry, chair of the Department of Psychiatry, and director of the Section of Child and Adolescent Psychiatry at Indiana University School of Medicine.

Only risperidone and aripiprazole are approved by the Food and Drug Administration for irritability associated with ASD in children aged 6 or older. No other medications have been approved for treating any aspects of ASD.

Among the many symptoms seen in autism patients, some can be controlled and managed by pharmacological interventions. These symptoms include motor hyperactivity and inattention; interfering ritualistic behavior; aggression, self-injury, and property destruction; and mood and sleep disturbances. "This is not to minimize the importance of nondrug treatments by any means," said McDougle.

For motor hyperactivity and inattention, McDougle suggested first using alpha$_2$ agonists, namely guanfacine and clonidine, for their favorable efficacy and safety profiles. These drugs may cause sedation and hypotension, however, and patients should be closely monitored. Atomoxetine is another potentially useful option.

Stimulants, in contrast, which are commonly used to treat attention-deficit/hyperactivity disorder, can worsen these symptoms and tics in many autism patients. Thus, stimulants should be started with caution. "The goal [of using these drugs] is primarily to reduce hyperactivity," said McDougle. "These drugs by themselves are not very effective in treating aggression or self-injury."

Risperidone and aripiprazole have the most evidence to support their use for treating ASD-associated irritability in children and adolescents with autism, McDougle noted. In this case, irritability refers to aggression, self-injury, severe tantrums, or severe mood swings associated with ASD. Other first- and second-generation antipsychotics may also relieve irritability with varying efficacy and safety profiles, with notable concerns about weight gain, metabolic disturbances, extrapyramidal symptoms, and cardiac side effects in children and adolescents.

Alpha$_2$ agonists such as guanfacine and clonidine may have some benefits on irritability as well, but few or no data support the use of mood stabilizers, anticonvulsants, or naltrexone.

Treating Ritualistic Behaviors

Ritualistic, repetitive behaviors, including hand-flapping, rocking, and lining things up, are hallmark symptoms in ASDs and often vary by patient. "Many times patients do it in order to feel better and. . . reduce anxiety and irritability," said McDougle.

Although such behaviors may bother the patient's parents, he suggested that clinicians should determine whether they serve as a form of relief for the patient rather than automatically trying to suppress or eliminate the behaviors, unless they interfere with other key aspects of the patient's functioning.

Repetitive behavior in most autism patients is different from obsessive-compulsive disorder symptoms, he emphasized, noting that studies have produced conflicting data on the effectiveness of selective serotonin reuptake inhibitors (SSRIs) in reducing repetitive behavior. Citalopram, for example, was found to be no different from placebo in a large, controlled study of children and adolescent patients. McDougle and colleagues have found fluvoxamine to be helpful in adult but not pediatric patients. Nevertheless, individual patients may respond clinically to an SSRI, he pointed out.

In addition, risperidone and aripiprazole are more effective than placebo in reducing stereotypical behavior in large, controlled clinical studies, according to McDougle. "Beyond that, the field doesn't have great ideas," he said.

Little Research Done on Mood Disorders

Mood disorders are not uncommon in patients with ASDs or developmental disabilities, but they are often undiagnosed because of communication difficulties between the patient and the clinician, and so far they haven't been studied by researchers, according to McDougle. When SSRIs or antiepileptic drugs are initiated in younger patients, he cautioned, clinicians should be mindful to monitor for suicidal ideation, even if the patient may not be able to articulate it.

In addition, sleep disturbance is common in autism patients, and McDougle recommended melatonin, clonidine, or trazodone as first-line treatment options. Clinicians prescribing trazodone should be alert to the risk for priapism, he advised.

Inappropriate sexual behavior in postpubertal autism patients can be troubling and very difficult to manage. McDougle pointed out that autism is not a children's disease, even though it is often perceived so. Many adult patients have "mature sexual function with immature sexual judgment," he said. Hormonal therapies and high-dose SSRIs are tried for some patients but rarely work well. "Generally I haven't had success with pharmacological approaches" to sexual-behavior problems in autism patients, he acknowledged.

He also said that behavioral interventions can be helpful for some patients, but challenges remain in using them effectively.

Unfortunately, the core symptom of ASDs, social impairment, remains pharmacalogically untreatable at this time, he noted. Researchers are, however, pursuing a number of promising pharmaceutical and behavioral approaches that may offer hope for patients and families in the near future. ■

Early PTSD Treatment Could Avert Vets' Multiple Physical Illnesses

A strong link between PTSD and circulatory, musculoskeletal, digestive, and other diseases shows up soon after veterans return from fighting in Iraq or Afghanistan.

BY AARON LEVIN

Veterans of the Iraq and Afghanistan wars diagnosed with posttraumatic stress disorder (PTSD) have higher-than-usual rates of several physical ailments, according to a study of 4,416 such veterans.

The diagnosis in primary care settings of physical disorders in these combat veterans came only three to seven months after they received a PTSD diagnosis.

"What is particularly striking about these findings is that diseases traditionally considered to develop across the lifespan (e.g., circulatory system and hypertensive conditions) appeared shortly after the end of military service," wrote Judith Andersen, Ph.D., and colleagues from the Center for Integrated Healthcare at the Department of Veterans Affairs Medical Center in Syracuse, N.Y.

Veterans of recent conflicts may thus be subject to increases in "lifespan morbidity, mortality, and health care utilization in the coming years," they pointed out.

"I'm not surprised by the findings," commented Joseph Boscarino, Ph.D., M.P.H. "But I am surprised at how quickly these problems showed up. I thought it would take another five or 10 years."

Boscarino is senior investigator at the Geisinger Center for Health Research in Danville, Pa, and an adjunct professor of psychiatry at Temple University. He has researched the effects of PTSD on physical illness among Vietnam War veterans, but was not involved in the present study.

Andersen and colleagues examined the VA medical records of service members who had served in "zones of imminent danger" from September 11, 2001, to December 31, 2007. They were screened for mental and physical conditions when they entered the VA system and annually thereafter.

The average age of the participants was 29; 85 percent were white. Roughly half (53 percent) had served in the active-duty components of their service, while 47 percent were National Guard or reserve veterans.

At entry, 277 (6 percent) of the 4,416 participants were diagnosed with PTSD. Over the six-year study, 1,031 (24.6 percent) of the veteran participants received a PTSD diagnosis. Patients were followed for an average of about 17 months.

The researchers adjusted initial results for covariates such as age, gender, marital status, depression, substance use disorders, and unit type.

They found that a PTSD diagnosis was associated significantly with a 56 percent increased risk of hypertensive disease, a 36 percent increased risk of circulatory disease, a 24 percent increased risk of digestive disease, an 81 percent increased risk of nervous system disease, and a 70 percent increased

*See **Vets** on facing page*

Physical Illness Tied to PTSD

A study of the medical records of 4,416 veterans of the wars in Iraq and Afghanistan showed significant differences in rates of physical illnesses in those with and without PTSD.

Disease category	With PTSD (%) (n=1258)	Without PTSD (%) (n=3158)	Odds ratio	Time between PTSD + disease diagnoses (mos.)
Endocrine/nutritional/metabolic	21.1	20.1	0.98	6.7
Nervous/sensory	43.8	27.3	1.98**	2.8
Circulatory	15.9	12.2	1.29*	4.9
Hypertensive	9.2	6.6	1.38*	4.5
Respiratory	25.3	20.4	1.18	4.9
Digestive	35.5	21.3	1.34**	2.9
Musculoskeletal	57.9	43.0	1.84**	2.6
Signs/ill-defined	49.9	33.9	1.78**	6.8

*p<.05; **p<.001

Source: Judith Andersen, Ph.D., et al., *Psychosomatic Medicine,* June 2010

Humble Organism Points Way To Future of MH Research

A flash of blue light functions as a switch in a mouse's brain and illuminates a path for new directions in neuroscience research.

BY AARON LEVIN

The next great arena for neuroscientific research has its origins in light-sensitive proteins derived from algae found in ponds—hardly the first place to look for new ways to understand and maybe someday treat depression or epilepsy.

The new science of optogenetics, barely a decade old, not only expands the researcher's tool kit but offers some important insights into the nature of science itself, one of its leading practitioners said in a lecture at APA's annual meeting in New Orleans in May.

"You couldn't predict the impact of algae on Parkinson's disease," said Karl Deisseroth, M.D., Ph.D., an associate professor of bioengineering and psychiatry at Stanford University.

Credit: David Hathcox

Karl Deisseroth, M.D., Ph.D., explains that blue light running through optical fibers turns a protein in a neuron into an on-off switch that can influence behavior. He is an associate professor of bioengineering and psychiatry at Stanford University.

Bench and bedside are not far apart for Deisseroth, perhaps one of the few bioengineers who also works as a clinical psychiatrist, seeing patients one day a week.

His research is largely based on channelrhodopsin-2, a protein found in the multicellular chlorophyte alga Volvox carteri that regulates the conductance of ions into cells, including neurons. When activated by blue light, channelrhodopsin-2 allows sodium ions to enter the neuron, increasing its positive charge and thus its activity. When the light is turned off, the channel closes, and neuronal activity decreases.

Another protein, called halorhodopsin and discovered in a different microorganism living in a salt lake in Egypt, responds to yellow light. Halorhodopsin transfers chloride ions into the neuron, increasing its negative charge and reducing its activity.

Several other proteins are also in the optogeneticist's library or under development and are likely to broaden the constellation of optical controls, said Deisseroth.

Scientists can insert the proteins into cells or use transgenic mice bred to express them in their brains.

Firing different-colored light down an optical fiber thin enough to plug into a single neuron triggers or suppresses the neuron's action.

Timing of the light impulse can be controlled to the millisecond, and the experimental rodents can roam freely throughout their cages while they are being studied.

Flexible, lightweight, implanted fiber optics have several advantages over the metal electrodes used in research and in treatment interventions like deep brain stimulation, said Deisseroth.

Electrical inputs can stimulate surrounding cells, not just the ones targeted for investigation. Those adjacent cells may fire along with the target, making it difficult to tell just what the target cell is doing when stimulated.

Also, the neuron's output is electrical and can be masked by the electrode's input. Because the fiber-optic procedure uses light as an input, it does not obscure the neuron's electrical output.

Deisseroth demonstrated the effects of the optogenetic system in a short video. A mouse with an optical fiber embedded in its brain wandered randomly about its cage. When the blue light was turned on, it began to walk in a counterclockwise circle. When the light was switched off, it resumed its undirected ramble.

The information provided by the process is not limited to a single cell, said Deisseroth. Researchers can follow the neuron's signal throughout the neural circuits to which it belongs.

"Using fMRI, we can see the global maps and local signals causally driven by defined cells," he said. "We can not only evoke spikes, but also put neurons into an excitable state and let the native signals work."

The field is changing so fast that the technology has outstripped researchers' understanding of what it can do, Deisseroth noted. "But we are still going forward at top speed."

He concluded with two observations that went beyond the promise of optogenetics in comprehending the brain and its workings. "There's a lesson here about preserving ecological niches," he said, referring to extreme locations where the microbes that stimulated his research were found. "And it shows the value of pure, undirected basic science."

Information about Deisseroth's work is posted at <www.stanford.edu/group/dlab/about_pi.html>. ■

Vets

continued from facing page

risk of "ill-defined signs and symptoms," compared with veterans who did not have PTSD.

No increased risk of respiratory or endocrine, nutritional, or metabolic illnesses was observed, they noted.

PTSD is a "unique contributor to disease" even after controlling for depression, substance abuse, and other factors known to affect physical-illness onset, the authors said.

The study was not designed to determine causality. Several theories have been suggested to explain a causal relationship between PTSD and development of physical disease, but there is widespread agreement that many factors are involved.

These include substance abuse, preexisting vulnerabilities, and changes in the stress axes and in hormones affecting the immune system.

"It's hard to sort out what causes some people to get PTSD and others not, even when exposed to the same traumatic events," said Boscarino. "We always thought there would be multiple pathways."

One big question for clinicians is whether early treatment of PTSD and these physical illnesses would contain the damage they cause, he said. Interventions instituted shortly after trauma might ultimately improve the quality of life and save money in future treatment costs, he noted.

Andersen and colleagues argued for early intervention after deployment to lessen the impact of PTSD on general health, and Boscarino agreed that this is a strategy worth pursuing.

"Even some types of psychoeducational program in the war zones would keep memories from getting fixed through the amygdala," Boscarino said. Such brief therapies apparently helped many 9/11 victims, but few clinical trials have been carried out to test the efficacy of these early therapies.

However, no one wants to wait years or decades while memories engrave themselves in the brain before intervening to help affected veterans, as happened with so many who served in Vietnam, he said.

An abstract of "Association Between Posttraumatic Stress Disorder and Primary Care Provider–Diagnosed Disease Among Iraq and Afghanistan Veterans" is posted at <www.psychosomaticmedicine.org/cgi/content/abstract/PSY.0b013e3181d969a1v1>. ■

Cannabis

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ing the most promise in attenuating withdrawal symptoms was dronabinol, an oral THC," Haney pointed out.

To study predictors of relapse after abstinence and possible treatment, the subjects were given placebo for three days and then given the option of purchasing "real" marijuana for a high cost. The amount of money subjects are willing to pay to smoke marijuana is a measure of the severity of their relapse.

The alpha$_2$ adrenergic receptor agonist lofexidine significantly reduced the amount of marijuana smoked during the simulated relapse condition, and the effect appeared to be more robust with the combination of lofexidine and dronabinol.

Taken alone, dronabinol did not appear to have a significant effect on relapse in the experimental condition. Baclofen, a gamma-aminobutyric acid type B (GABA-B) receptor agonist, did not affect marijuana relapse but significantly reduced tobacco smoking. Mirtazapine improved sleep disturbance during withdrawal but did not differ from placebo in relapse outcome, and it significantly increased tobacco smoking.

"We did not see any significant correlation between the magnitude of withdrawal symptoms and the likelihood of relapse," Haney said, although certain withdrawal symptoms (especially disrupted sleep) increased the severity of relapse. She noted that, curiously, the degree of cravings and irritability during abstinence did not significantly predict relapse. ■

Miscarriage

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"The bottom line," Robinson emphasized, "is that there may be a slightly increased risk of miscarriage, but, as with all treatment decisions, we must weigh the risk-benefit ratio and discuss this with the patient."

Nada Stotland, M.D., a professor of psychiatry, obstetrics, and gynecology at Rush Medical College and a former APA president, also commented on the study for *Psychiatric News*. "Half of the pregnancies in this country are unplanned. In addition, many are not diagnosed for the first weeks or months. That places clinicians—and patients—in a difficult position with regard to the treatment of a very common and significant disease: depression," she said. "It would be nice if these findings led to more appropriate [health insurance] coverage of psychotherapy by psychiatrists. They are the health professionals with the medical background to understand such findings and to work with patients who may end up needing antidepressant medications in the physiologically complex context of pregnancy."

Previous studies have also addressed the possible impact of antidepressants on miscarriage, but findings have been inconsistent. Furthermore, most of these studies had small samples of subjects and therefore lacked statistical power, were biased by confounding factors, or did not examine miscarriage as a primary outcome.

The study was funded by the Quebec Health Research Fund and the Quebec Reserve for Research on the Use of Medications.

"Use of Antidepressants During Pregnancy and the Risk of Spontaneous Abortion" is posted at <www.cmaj.ca/cgi/rapidpdf/cmaj.091208v1>. ■

med check

COMPILED BY JUN YAN

This is the second of a two-part special edition of Med Check featuring new research posters presented at APA's 2010 annual meeting in New Orleans in May.

New research poster presentations are usually preliminary in nature and often involve results that have not been peer reviewed for publication. In addition, reports may involve the use of medications for indications that the Food and Drug Administration has not approved, and they are predominantly funded by product manufacturers.

Schizophrenia

• The size of placebo response in clinical trials of antipsychotic drugs varies by the duration, year of publication, sample size, and other factors, a meta-analysis of 63 randomized, controlled trials revealed. Ofer Agid, M.D., of the University of Toronto and colleagues identified these trials, whose results were published between 1970 and 2009. The extent of placebo response as measured by the Brief Psychiatric Rating Scale (BPRS) or Positive and Negative Syndrome Scale (PANSS) was analyzed. The authors found that more recent studies, studies with shorter duration, studies conducted in community hospitals, and studies involving patients with higher baseline BPRS or PANSS scores reported larger placebo response than older, longer, academically conducted studies and studies enrolling less severely ill patients.

Since the size of placebo response directly affects the detection of drug response as well as the effect size of the drug, the authors suggested that researchers should consider factors that may systematically influence placebo response when they design placebo-controlled studies. This meta-analysis was funded by Pfizer.

• An open-label pharmacokinetic study, conducted by Mona Darwish, Ph.D., of Cephalon Inc. and colleagues, showed that concomitant administration of ***armodafinil*** and ***quetiapine*** appears to result in significant interaction. In this pharmacokinetic study, 25 adult patients diagnosed with schizophrenia took quetiapine alone for several days, and their blood samples were analyzed for the drug's plasma concentrations. They were then given armodafinil and quetiapine on the same day, and blood samples were again analyzed for quetiapine concentrations. The maximum plasma concentration of quetiapine was reduced by 45 percent, and the total drug exposure, measured by area under the time-concentration curve within 24 hours, was reduced by 42 percent when both drugs were taken on the same day.

Cephalon is the maker of armodafinil. In June the company announced that armodafinil had failed a phase 2 clinical trial in which it was tested for effectiveness to treat negative symptoms in schizophrenia. The company will no longer pursue this indication.

Autism

• The effectiveness and tolerability of ***paliperidone*** for the treatment of irritability in adolescents and young adults with autistic disorder are being tested in an ongoing open-label study. Kimberly Stigler, M.D., and colleagues at the Christian Sarkine Autism Treatment Center at Indiana University School of Medicine reported preliminary findings to date. The study included patients aged 12 to 21 with autistic disorder and substantial irritability, defined as having a Clinical Global Impression-Severity (CGI-S) score of at least 4 and an Aberrant Behavior Checklist-Irritability (ABC-I) score of at least 18 at baseline. The patients were given paliperidone 3 mg to 9 mg a day for eight weeks.

Of the first 24 enrolled patients who took at least one dose of paliperidone, 20 (83 percent) achieved clinical response, defined as having a score on the CGI-Improvement scale of 1 or 2 and at least 25 percent improvement from baseline in ABC-I score. The patients' mean body weight increased by 5.1 pounds from baseline, the authors also reported.

The study was funded by Janssen Pharmaceuticals, which makes paliperidone.

• The use of ***aripiprazole*** in treating irritability in pediatric patients aged 6 to 17 with autistic disorder was studied in an open-label, 52-week clinical trial led by Meeta Patel, Pharm.D., of Bristol-Myers Squibb (BMS). This long-term study enrolled 330 patients, of whom 244 had participated in two previous double-blind, placebo-controlled, eight-week trials on the short-term efficacy of aripiprazole in autism-related irritability; 86 had not participated in prior trials.

Of the 330 patients, 199 completed 52 weeks of treatment. The mean ABC-I score increased by 0.7 points in patients who had received aripiprazole previously, decreased by 6.1 in patients who had received placebo previously, and decreased by 6.5 in patients who had not participated in previous trials. No statistical analysis was reported.

Aripiprazole is approved to treat autism-associated irritability based on the above two short-term studies, but its long-term use for this indication has not been approved. The study was funded by BMS and Otsuka Pharmaceutical, which co-own aripiprazole.

Addiction

• A large, randomized, double-blind, placebo-controlled study found that once-monthly ***extended-release naltrexone injection*** was well tolerated and effective in reducing opioid use and craving and increasing treatment retention among patients with opioid dependence. The patients in the study, which was conducted at 13 sites in Russia, were predominantly male and using heroin and had a history of opioid dependence for nearly 10 years. Patients were given either placebo (n=124) or extended-release naltrexone 380 mg (n=126) injections every four weeks for 24 weeks, accompanied by biweekly sessions of manual-based individual drug counseling.

Approximately 90 percent of patients on naltrexone had opioid-free urine samples from week 5 to week 24, compared with approximately 35 percent of patients on placebo, and the difference was statistically significant. The placebo group reported no change in opioid craving on a visual analog scale throughout the 24 weeks of study, while the naltrexone group reported significant and persistent reduction in craving. The retention rate in treatment was 53.2 percent in the naltrexone group and 37.9 percent in the placebo group, which was also a statistically significant difference.

The study authors, led by Evgeny Krupitsky, M.D., of the St. Petersburg Regional Center of Addiction, cautioned that effective treatment of opioid dependence requires not only opioid antagonism but also overall health promotion and recovery.

This study was funded by Alkermes Inc., which manufactures extended-release naltrexone injection.

• Chronic cocaine abuse may be associated with hypoglycemia, a retrospective observational study found. Faiz Cheema, M.D., and colleagues reviewed the medical records of 170 patients diagnosed with cocaine dependence who were admitted to the Bergen Regional Medical Center in New Jersey between January 2007 and January 2009. Twenty-two patients (12.9 percent) had hypoglycemia, defined as having a fasting blood glucose level of below 70 mg/dL; five (2.9 percent) had hyperglycemia with fasting blood glucose higher than 125; and the rest were euglycemic. The authors pointed out that clinicians should be mindful of hypoglycemia as well as hyperglycemia when treating chronic cocaine users.

Suicide

• Family structure in early childhood may influence suicide and suicide attempts later in life, according to a large epidemiological study from Finland. In a longitudinal cohort of 10,742 persons born in 1966 in northern Finland, 121 suicide attempts and 69 suicides were identified in 271 people (2.4 percent) from birth through the end of 2005. Because the demographic and family data were extensively recorded for this cohort, the authors, led by Antti Alaraisanen, M.D., of the University of Oulu, were able to analyze and identify family-related factors at the time of the mother's pregnancy and delivery for the offspring's risks of suicide and suicide attempts.

Having a psychiatric disorder was a significant risk factor for both male and female subjects in the offspring. The presence of a psychiatric disorder in either or both parents was associated with higher risk of suicide attempts in female offspring, and the mother's having a psychiatric disorder was associated with increased risk of suicide in male offspring.

After statistically controlling for psychiatric disorders in the parents and offspring to exclude the confounding influence of genetic risk factors, being born to a single-parent family was significantly associated with suicide attempts among male offspring, and mother's grand multiparity, or having five or more previous pregnancies, was significantly associated with suicides among male offspring.

"Suicide seems to be a long process that begins even before birth," the authors concluded. ■

letters to the editor

With EMR, Don't Reinvent Wheel

I am writing in response to the article "Several Concerns Keep Psychiatrists Wary of Electronic Records" in the April 16 issue.

Most electronic record systems are not workable for my solo-practice office. Since 1987 I have used standard, off-the-shelf programs that make up a system that can do everything and works.

All told, the total cost was about $5,000 to $7,000. Match that commercially with a "user unfriendly one size fits all," "click on boxes," "can't send to anyone else" outrageously expensive program that is not interoperable with other systems.

The way to create an interoperable electronic medical record system is to get the Department of Defense DARPA (Defense Advanced Research Projects Agency, which invented networking) to work with the Department of Defense and VA as they merge their records. They should develop a number of "flavors" of medical records from office to hospital that will communicate universally. Then they should sell the software at cost as an open software program. Why have a number of software companies that can go broke make over developed programs that try to do too much and do not fit most doctors' needs and that will be expensive because they are "medical"? Except for one, the programs I used are regularly improved through upgrades. I have designed the format that fits my needs.

RAYMOND C. YERKES, M.D.
Newburyport, Mass.

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

Sessions Focus on Restoring 'Lost Art of Leadership'

APA's 2010 Institute on Psychiatric Services has been planned around the theme "Leadership in Discovery and Service: 21st Century Psychiatry." APA members won't want to miss this opportunity to interact with experts in an informal, collegial environment.

BY ANITA EVERETT, M.D

Credit: Greater Boston Convention & Visitors Bureau.

Faneuil Hall Marketplace has attracted shoppers for 250 years.

What a thrill it has been to work with the planning committee to put together the program for APA's 62nd Institute on Psychiatric Services (IPS), to be held October 14 to 17 at the Boston Marriott Copley Place Hotel. This year's theme is "Leadership in Discovery and Service: 21st Century Psychiatry."

Leadership has become a lost art for many in our profession. As services have disseminated into local community-based sites over the last 50 years and as allied professionals in social work and counseling have grown in terms of numbers and skills, psychiatry is becoming increasingly narrow in the range of services we provide.

Being a leader in psychiatry requires being a master clinician as well as being knowledgeable about the context in which we practice. This year's program is designed to convey knowledge and skills to support the leaders and future leaders in our field. Our goal is to make each attendee feel rejuvenated, recharged, and ready to reengage in the practice of psychiatry. Specifically, we aimed to provide sessions that promote insight into individual best-practice skills and increased understanding of the opportunities associated with the context and future of our profession.

There are a number of sessions that will focus on clinical excellence and clinical leadership. These include Ken Minkoff, M.D., and Chris Cline, L.C.S.W., on the ABCs of recovery in co-occurring treatment; Jeffrey Lieberman, M.D., on schizophrenia treatments; and Lisa Dixon, M.D., on a "survival guide" for mental health services researchers. We have drawn from local Boston talent to create a Boston all-stars immersion course on pharmacotherapy that will feature Donald Goff, M.D., Gary Sachs, M.D., and Janet Wozniak, M.D. Robert Goisman, M.D., will lead a master class on cognitive-behavioral therapy. The popular course that includes buprenorphine certification will also be offered.

A number of sessions are aimed at leaders in administration and services design. Barry Herman, M.D., will lead the popular course on administrative psychiatry, and Wes Sowers, M.D., has organized a symposium on leadership in public health services.

Other sessions have been planned on the implications of health care reform for psychiatry to equip attendees to take an active role in leading its implementation. A prominent leader in President Obama's administration, Richard Frank, will talk about the president's priorities in health care reform.

There will be numerous sessions on cultural psychiatry provided by APA's ONMA on Tour lecturers, and by Russell Lim, M.D., Rajvee Vora, M.D., and Lewis Mehl-Madrona, M.D. (OMNA stands for the Office of Minority and National Affairs.)

The keynote speaker at the opening session will be Kay Redfield Jamison, Ph.D., the Dalio Family Professor in Mood Disorders and co-director of the Mood Disorders Center at Johns Hopkins University. Jamison, author of the best-sellers *An Unquiet Mind* and *Manic Depressive Illness: Bipolar Disorders and Recurrent Depression*, is one of this country's most respected researchers on manic-depressive illness.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) will sponsor leading researchers to discuss the latest and greatest evidence-based services tool kits. The SAMHSA tool kits have been the leading influence on the state and community mental health implementation of evidence-based services. Attendees at these sessions will learn the newest information from some of the most prominent services researchers in the United States.

But it won't be all work and no play while you are in Boston. The city is at its most beautiful in the fall as the leaves burst into a spectrum of reds and golds. A good way to enjoy the foliage is to take a walk along the city's Freedom Trail or through the indoor courtyard of the Isabella Stewart Gardner Museum. And the is a special treat this time of year, as the crowds thin out and the weather is still pleasant.

Last year's institute was the most successful ever—it drew the largest attendance and won rave reviews. So plan now to attend this year's institute. More information on the meeting and its host city will appear in future issues of *Psychiatric News*. Meanwhile, go to <www.psych.org/ips> to register and reserve a hotel room. I look forward to seeing you in Boston. ■

Anita Everett, M.D., is chair of the IPS Scientific Program Committee and section director of Community and General Psychiatry at Johns Hopkins Bayview Medical Center.

BOSTON, OCTOBER 14-17, 2010

Credit: Greater Boston Convention & Visitors Bureau.

Register Now and Save on Fees

You can now register and make your hotel reservations for APA's 2010 Institute on Psychiatric Services. Registration and hotel information can be found on APA's Web site at <www.psych.org/ips>. The preliminary program is posted at <www.psych.org/Departments/EDU/Meetings/2010-IPS-Preliminary-Program.aspx>. Advance registration closes September 24. Medical students can attend free; psychiatry residents can attend at a reduced rate.

62nd Institute on Psychiatric Services
APA's Leading Educational Conference on Public and Community Psychiatry

Payment

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nevertheless a statement reflecting mounting exasperation among doctors with Congress's repeated failure to fix the payment formula. (The Section Council on Psychiatry consists of APA, the American Academy of Child and Adolescent Psychiatry, and the American Academy of Psychiatry and the Law.)

McIntyre told *Psychiatric News*, "Virtually any member of Congress you speak with says that the sustainable growth rate [SGR] component of the formula doesn't make sense and needs to be fixed, but they don't fix it because fiscal conservatives in Congress say it would be too costly. But there is a growing sense that the entire Medicare payment formula just is not workable and that we should return to physicians and patients privately contracting."

For seven consecutive years, the SGR component of the formula has required that increases in Medicare volume be compensated for by decreases in physician payment, without taking into account increases in practice cost. Each year, the required cuts have grown progressively steeper, only to be averted by last-minute Congressional action.

This year, Congress enacted a series of short-term postponements of a 21 percent pay cut, but the deadline finally came when the cut became active on June 17. That same afternoon, the Senate voted yet again to delay the cut for another six months and approved a 2.2 percent increase through November. On June 24 the House voted to adopt that Senate proposal.

"The [AMA] resolution says that doctors and patients should be able to freely contract without penalty to either party and in a manner that does not forfeit benefits otherwise available to the patient," McIntyre explained. "The assumption is that the physician could decide on a patient-by-patient basis to contract privately and that, most importantly, the patient could still get receive the Medicare allowable rate as a partial reimbursement."

He said senior groups such as AARP would likely oppose such a policy, and many in Congress would see the move as undermining the Medicare program.

But McIntyre said the concept is not without logic. He noted, for instance, that in his own practice he sees some patients who are relatively well-to-do and would be pleased to see him compensated fairly for services, and who could with relative ease shoulder the cost of a usual-and-customary fee.

Moreover, many such patients are aware that their services under Medicare are being indirectly subsidized by non-Medicare patients who are not well off but who are paying higher fees imposed by physicians trying to compensate for the low rates they receive for treating Medicare patients.

Finally, the steadily mounting cuts necessitated by the current payment formula are now at levels widely acknowledged as making it difficult for many doctors to continue treating Medicare patients.

"This is no way to run a major health coverage program—already the instability caused by repeated short-term delays is taking its toll," said AMA President Cecil Wilson, M.D. "About 1 in 5 physicians say they have already been forced to limit the number of Medicare patients in their practice. Nearly one-third of primary care physicians have already been forced to take that action. The top two reasons physicians gave for these actions were the ongoing threat of future cuts and the fact that Medicare payment rates were already too low." ■

Lawsuit

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about equality of coverage, but equality of access to care and equality in how providers are treated relative to other providers," APA Director of the Office of Healthcare Systems and Financing Irvin "Sam" Muszynski, said *(Psychiatric News*, June 19, 2009).

Regarding the dismissal of the parity lawsuit, Muszynski said in an interview, "Obviously we are happy with the result and hope it removes a cloud so that the Department [of Health and Human Services] can proceed posthaste with a final rule."

He added that though for most plans the regulations will not take effect until January 1, 2011, there is a "good faith compliance standard" by which plans will be expected to begin making changes to meet the law's requirements.

The government's final interim rule was largely in line with APA's interpretation, and that interpretation was at the heart of the dispute: can MBHOs impose certain kinds of management strategies not imposed on medical-surgical services and still comply with the parity law?

But in dismissing the suit, Kollar Kotelly focused almost entirely on a more arcane procedural complaint brought by the MBHOs—namely, the claim that the government bypassed due process by issuing an interim final rule implementing the law, instead of following the more typical process of issuing a "proposed rule for comment."

The judge cited a "good cause" exception to that process in the Administrative Procedure Act (APA), which governs the issuance of regulatory guidance by the government. She also cited the fact that Congress had authorized issuance of an interim final rule in view of the complex nature of the new parity law.

"[B]ased on the totality of the circumstances surrounding [the government's] promulgation of interim final rules to implement the [parity law], the court finds that [the government] properly invoked the 'good cause' exception to the notice and comment requirements of [the Administrative Procedure Act]," Kotelly ruled. "The court reaches this conclusion based on the congressional authorization for the issuance of interim final rules [and] the need for prompt regulatory guidance. . . ."

> **"Obviously we are happy with the result and hope it removes a cloud so that the Department [of Health and Human Services] can proceed posthaste with a final rule."**

In response to the dismissal, a lawyer for the coalition contacted by *Psychiatric News* issued the following statement:

"Members of the Coalition for Parity fought for and strongly supported the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The Coalition took issue with the rule-making process because the [interim final rules] were announced without prior notice or a period for public comment, as required by the [Administrative Procedures Act], and could have negative, unintended consequences for patients and providers alike.

"While the Coalition for Parity is disappointed in the ruling, it intends to work closely with the government to ensure the original intent of the Act, to increase patient access, is fully realized."

Jennifer Tassler, J.D., deputy director for regulatory affairs in the APA Department of Government Relations, told *Psychiatric News* that "now that the suit has been dismissed, there is no question that the government's interim final rule stands and is in effect for plans whose policies begin the calendar year July 1."

However, Tassler noted that for most plans the regulations will take effect January 1, 2011, when most insurers begin their new plan year. She also said that APA would begin outreach to the business community to help monitor compliance with the law and urged psychiatrists to contact APA if they experience problems with compliance on the part of patients' health plans.

The MBHOs' complaint about the interim final rule involved two substantive issues—one that requires a single deductible for both mental health and other medical conditions and one that prohibits "nonquantitative" treatment limitations.

The latter include medical management standards, formulary design, standards for provider admission to networks, fail-first policies and step-therapy protocols, and conditioning benefits on completion of a course of treatment.

Such practices are prohibited under the government's interpretation of the paritiy law if they are not applied comparably to other medical-surgical services.

In their suit, the MBHOs insisted that the nonquantitative treatment limitations are essential to managing behavioral health care costs and maintaining equality of coverage. They claimed as well that the unified deductible for both mental health and general medical care would result in cost increases and serve as a barrier to care for lower-income individuals (*Psychiatric News*, May 7). ■

Resignation

Monte Meldman, M.D., of Deerfield, Ill., resigned from the American Psychiatric Association and from the Illinois Psychiatric Society during the course of an ethics investigation. APA's "Procedures for Handling Complaints of Unethical Conduct" requires that resignations that occur during the course of an ethics investigation be reported in *Psychiatric News*. ■

Hoarding

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To meet the currently proposed diagnostic criteria, the person needs to experience persistent difficulties with discarding or parting with possessions, accumulate large amounts of clutter that impede the normal use of their living areas, and experience marked distress and interference in activities of daily living. Furthermore, in the customary hierarchical diagnostic approach of *DSM*, the clinician needs to rule out any possible organic (for example, brain injury) or other psychiatric disorders (for example, OCD, dementia, psychosis, autism) that could better explain the hoarding behavior. The provisional diagnostic criteria for hoarding disorder are listed at <www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=398>. They were developed based on criteria that had already been widely adopted by the field.

We hope that the addition of this diagnosis in *DSM-5* will increase public awareness, improve identification of cases, and stimulate both research and the development of specific treatments for this problem.

So far, the Obsessive-Compulsive Spectrum Sub-Work Group has received largely positive responses from both professionals and the public regarding the inclusion of hoarding disorder in the nomenclature. Their suggestions have already led to improvements in the wording of the criteria.

It's important to emphasize two things. First, the proposed diagnostic criteria for hoarding disorder are not final. They may change based on additional data that become available, secondary data analyses of existing datasets, the results from a survey of clinicians, data from the *DSM-5* field trials, and further input from the field.

Second, it is not yet known whether hoarding disorder will be included as an official disorder in *DSM-5* or be added to the Appendix of Criteria Sets Provided for Further Study. It appears that most experts support its inclusion as an official disorder in *DSM-5*, but the work group awaits further guidance from the *DSM-5* Task Force regarding this issue.

The Obsessive-Compulsive Spectrum Sub-Work Group is now conducting a survey among OCD/hoarding experts and other clinicians to test the reliability, validity, and acceptability of the new criteria using clinical vignettes describing a variety of clinical presentations that involve pathological hoarding. Participation is open to interested mental health professionals by following this link: <www.surveygizmo.com/s/294620/hoarding-survey-apa>.

Several people inquired on <www.dsm5.org> about animal hoarding and squalor, which are not directly mentioned in the proposed criteria for hoarding disorder. In response to these comments, the sub-work group has commissioned a literature review on these topics, which will inform whether mentioning these issues in the text accompanying the criteria (as opposed to mentioning them in the criteria set) will be sufficient. The Obsessive-Compulsive Spectrum Sub-Work Group will continue to examine issues such as these that have been put forward by professionals and the wider public. ■

ECT

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that must be compared with the suffering and memory problems that accompany chronic depression," said Husain.

It is also important that patients understand that consent to treatment is voluntary and that they can withdraw it at any time. "If consent is withdrawn," Husain said, "stop treatment but inform the patient of the consequences."

"Obtain informed consent prior to an acute course of ECT and also before beginning maintenance therapy."

Patients with comorbid medical conditions are often good candidates for ECT, given its rapid action and relative safety, Husain said. There are no absolute contraindications to providing ECT, but some conditions carry added risk. These include unstable angina, recent heart attack or ischemic stroke, cardiac arrhythmias, and poorly compensated congestive heart failure.

Clinical Issues to Consider With ECT

ECT outcomes are affected not only by the strength of the electrical charge applied but also by electrode placement, said Sarah Lisanby, M.D., a professor of psychiatry at Columbia University and chair of the APA ECT task force.

"Electrode placement affects distribution of the electric current, seizure topography, and treatment effects on regional brain activity," she said.

Individual patients vary in the dose needed to trigger seizures, so it is necessary to titrate dosage in the initial session and adjust, if needed, for subsequent treatments. Placement is as important as dose is in this process.

"Without titration, right unilateral placement may be insufficiently dosed, leading to inferior clinical outcomes," she pointed out. "Or bilateral placement may be given at an overly high dose, which may cause greater side effects."

For instance, bilateral placement appears to produce a faster response but may result in greater memory loss, compared with right unilateral placement, she said.

Thus it is critical to individualize dosage for each patient and discuss electrode placement in advance as part of the informed-consent process, she said.

APA Addressed Issue Several Times

APA issued its first report on ECT in 1978, concentrating on a review of efficacy and safety, but discussing little about practice, said Richard Weiner, M.D., Ph.D. a professor of psychiatry at Duke University School of Medicine. Weiner edited the most recent APA guidelines on ECT, issued in 2001.

A 1985 consensus conference at the National Institute of Mental Health focused on standardizing and optimizing practice and offered recommendations on who should perform ECT, what training was needed, and how best to use it. The conference led APA to issue revised guidelines in 1990. APA updated those standards in 2001; the new guidelines are due out in 2011.

ECT's place in the regulatory spectrum has been under review for an unusually long time, said Weiner. Legislation governing medical devices passed in 1976 permitted ECT use without requiring further research data. However, a 1990 law opened the door for the Food and Drug Administration (FDA) to reconsider whether ECT devices would be classified as Class II or Class III medical devices.

Class II devices (which include noninvasive equipment such as x-ray machines, wheelchairs, or infusion pumps) are subject to heightenened controls such as special labeling requirements, mandatory performance standards, and postmarket surveillance. Class III devices, those deemed life sustaining or that present "a potential unreasonable risk of illness or injury" (such as heart valves or implantable pacemakers), require premarket scientific review to ensure safety and effectiveness.

If ECT is placed in Class II, the FDA will not require specific additional safety or efficacy data but will determine its indications and adopt "special conditions" attached to its use, said Weiner. If it is placed in Class III, a higher burden of proof of efficacy will fall on manufacturers, mostly small companies who have implied that they can't afford new clinical trials of their devices. APA has recommended classification into Class II.

The review process for ECT machines is still underway, and the issue is unlikely to be resolved soon, said Weiner. "Stay tuned." ■

Shortage

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sicians per capita in the United States, the shortage of child psychiatrists is a crisis," said pediatric emergency physician Samantha Rossman, M.D., during hearings on the resolution. "I see kids everyday who are on waiting lists to see a psychiatrist, and they show up in my emergency department after they have had [an emergency] or been discharged from school. No one will prescribe their medication, and I don't have the training to manage complex psychiatric illnesses in children. This is really at crisis levels, and there are so many children suffering as a result."

Child psychiatry fellow Kayla Pope, M.D., said that at the inner-city clinic where she works in Washington, D.C., the average wait for an initial psychiatric evaluation is two or three months. "Two or three months is a really long time for a child who is fighting with a teacher, being aggressive toward his classmates, and spending more time in suspension than in school."

There was some movement within the reference committee to expand the scope of the resolution to encompass training within the NHSC for all shortage specialties, but the dire nature of the shortage of child psychiatrists was underscored by a number of physicians who argued persuasively that the focus on child psychiatry should be maintained.

"This resolution is specific to child and adolescent psychiatry, where the shortages are profound," said addiction psychiatrist Mike Miller, M.D., of Wisconsin. "In my field, we know there are not enough addiction medicine docs around. Pediatric addiction medicine physicians? There are so few, we have to rely on [other specialists]. The kids are just not getting access. Almost every area of the country is underserved, and it is acute and tragic in rural areas."

And Brian Johnson, M.D., an emergency physician in Los Angeles said, "These are some of the most heartbreaking cases—we get kids who are having an acute psychotic break, and there is nowhere to send them. There are no facilities and not enough practitioners, so this really does need to be focused on child and adolescent psychiatry."

Both reports and all other actions taken by the House of Delegates are posted at <www.ama-assn.org/ama/pub/meeting/reports-resolutions-listing.shtml>. ■

Medics

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location but in a tent or room to isolate the team members. If the fighting occurred at night, the unit gathers the morning after.

The session is divided into four parts. The first clarifies the goals of the debriefing and rules for the discussion. The unit's commanding officer, usually a physician, leads the discussion, but a mental health professional is present.

Next, the discussion section of the meeting clarifies the circumstances of the event. The unit leader asks team members what injuries they saw and how they were treated. The leader also asks if this was the first time the medic has seen the injury described. Medics are asked about their feelings but not to elaborate on their emotional reactions.

"The personal experience of each man is different," said Knobler. "So collecting their stories gets them closer to a comprehensive view of the operation."

Participation Not Optional

Every participant must take part. A soldier can't just agree with what a previous speaker has said and leave it at that.

"Everyone must express his own views," he said. "We do not tolerate silence."

No accusatory or critical language is permitted. If a person admits a mistake, he is not criticized, but the discussion leader tries to elicit the proper treatment procedures to be used in the future.

All participants have their say, and then the unit's commanding officer summarizes his view of the action.

The third stage is the "gathering of strength," said Knobler. The leader offers some positive reinforcement to each soldier and opens the floor to questions. Officers or mental health personnel at this session observe team members who might be at risk for stress reactions or exhibiting "call for help behavior" and invite them to participate in further individual interventions.

The final part of the meeting sums up the lessons learned and concentrates on preparing for the next period of activity.

This postcombat discussion is just one part of a more comprehensive program that educates medical corps personnel about acute stress reactions and PTSD; screens soldiers for symptoms; and offers early treatment by a psychiatrist, psychologist, or social worker when needed.

Similar postevent, structured group discussions might well be adaptable for other military or emergency service workers who face stressful tasks in their professional lives, said Knobler. ■

Consumers

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apy, while 41 percent were treated only with medication.

"I found it interesting and encouraging that most patients who saw psychiatrists received psychotherapy as well as medications," noted Roca about the survey results.

Among those who received antidepressant medications for their illness, a minority of respondents—47 percent—said they were prescribed by a psychiatrist; the rest said they were prescribed by a primary care physician.

The survey, based on self-selecting respondents, is not intended as a nationally representative sample. The average age of the survey respondents was 58, with 30 percent reporting depression only, 18 percent having anxiety only, and 52 percent suffering from both disorders. The diagnoses respondents reported were not verified.

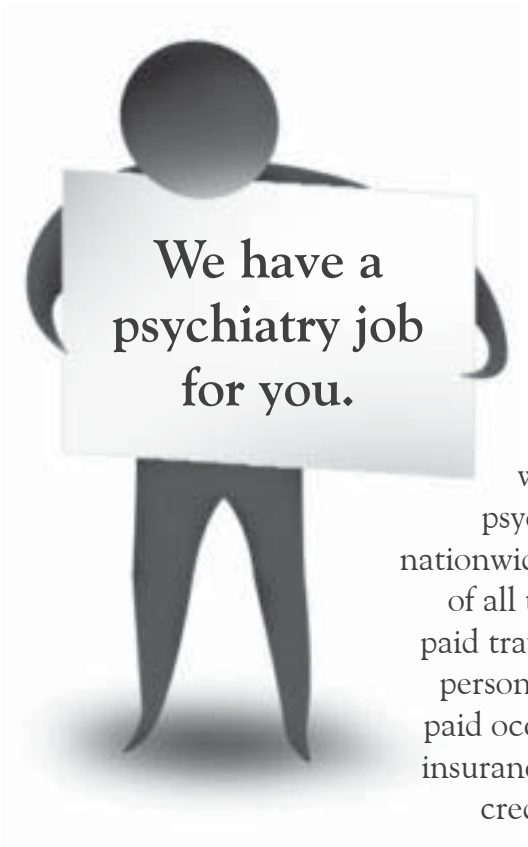
The experience of respondents with side effects from antidepressants varied considerably. In general, the selective serotonin reuptake inhibitors (SSRIs) had lower rates of side effects than did the newer serotonin-norepinephrine reuptake inhibitors (SNRIs). However, the patients who took SSRIs were about as likely as patients who took SNRIs to find them helpful, 53 percent versus 49 percent.

"Most of us believe that SSRIs are better tolerated than other agents but recognize that they produce side effects that discourage some patients from taking them," Roca noted.

The side-effect rates reported for antidepressant use in this survey were generally higher than those reported in drug-company clinical studies, according to *Consumer Reports*.

The editors who prepared the *Consumer Reports* analysis acknowledged the nonscientific nature of their survey, but pointed out that "results provide a window onto mental health treatment as it's practiced in the real world, as opposed to the carefully controlled environment of clinical trials or psychiatric drugs."

More information on the survey is posted at <www.consumerreports.org/health/conditions-and-treatments/depression-anxiety/depression-and-anxiety/index.htm>. ■



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UHealth | MILLER

Director of ECT Service at the University of Miami Hospital and Assistant/Associate/Professor of Psychiatry & Behavioral Sciences

The Department of Psychiatry and Behavioral Sciences of the University of Miami (UM) Miller School of Medicine is in an exciting phase of growth and expansion under the leadership of a new chairman, Charles B. Nemeroff, M.D., Ph.D.

We are recruiting for a new full time faculty member to serve as the Director of the ECT Service at the prestigious University of Miami Hospital. The University of Miami Hospital, located in the heart of Miami, is an accredited 560-bed, full service hospital that provides acute care and private rooms for all patients. The psychiatry service is comprised of 104 beds. UMH is committed to education and success; remaining true to its mission, patients and community.

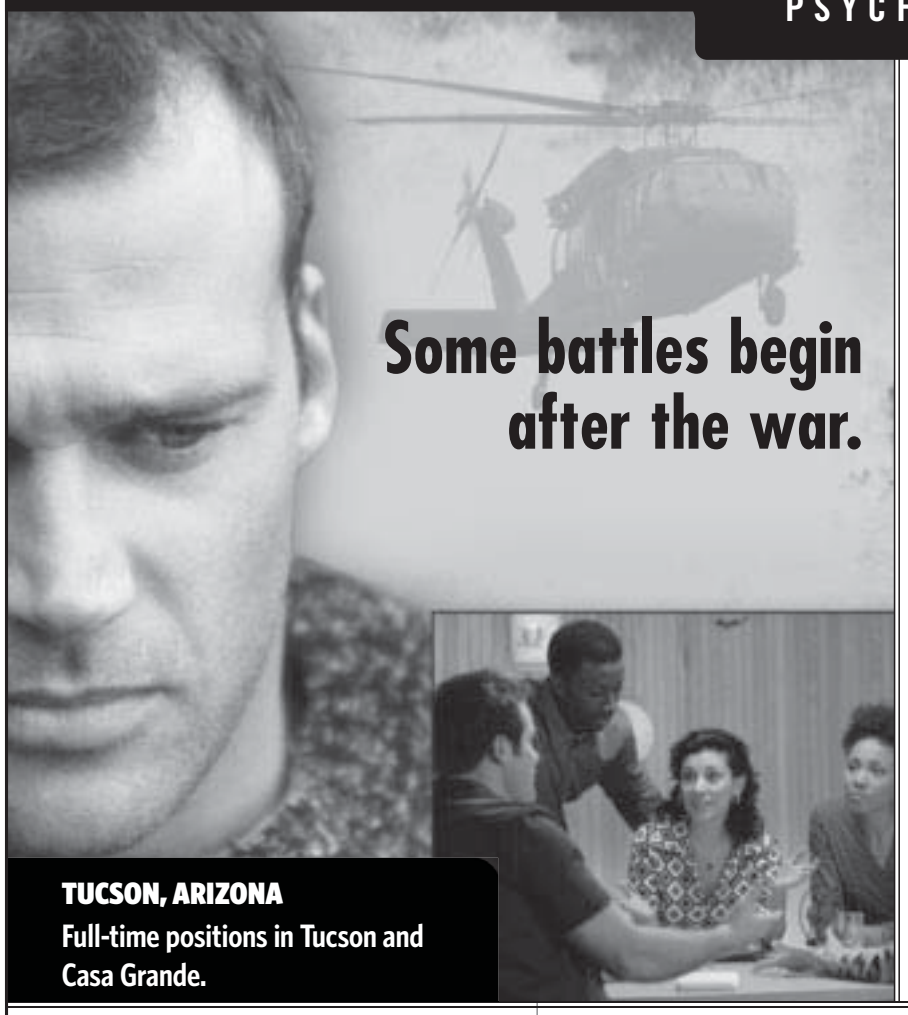
This individual will be responsible for leading and directing the UMH ECT Service and be involved in the evaluation and treatment of patients who present to the Unit as well as other UM affiliated hospitals and clinics. Additional duties include serving as an inpatient attending on UMH units as needed. This position includes the teaching of medical students, supervision of psychiatry residents, and opportunities for participation in research and other academic activities. We seek an experienced ECT practitioner, able to handle the demands of this challenging opportunity.

The successful and dynamic candidate will be adept in handling a variety of psychiatric services and must demonstrate excellent interpersonal and communication skills, which are essential to partnership with other departments and our community. A successful track record in research and mentoring is highly desirable. M.D. or M.D. / PhD is required as well as board certification in psychiatry and a current unrestricted Florida medical license.

The University of Miami offers competitive compensation and excellent benefit packages. Salary will be based upon education and experience, and hiring is dependent on meeting the requirements for Florida medical licensure, board certifications and credentialing with the University of Miami and affiliated hospitals.

Interested candidates should send letter and CV addressed to Charles B. Nemeroff, M.D., Ph.D., Leonard M. Miller Professor and Chairman, Department of Psychiatry & Behavioral Sciences, University of Miami Miller School of Medicine, 1120 NW 14th Street, Suite 1455, Miami, Florida 33136 or email mgerdes@med.miami.edu.

PSYCHIATRISTS



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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. Inpatient & partial programs. Salary, benefits & bonus. **Student loan assistance.** Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

CALIFORNIA

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PRIVATE PRACTICE OPPORTUNITY-CENTRAL CALIFORNIA

Adventist Health Hospitals seek full time general psychiatrist for private practice. Offer includes practice establishment assistance, two year income guarantee, sign on bonus, five weeks paid time off, stipend for CME, and relocation reimbursement. Only California licensed BC/BE need apply.
- **Email CV to Physician Services: larkinme@ah.org or Tel: (559) 585-5275.**

California Department of Mental Health
Care and Treatment with Respect and Dignity
Patton State Hospital, Patton, CA

CALIFORNIA
BC/BE STAFF PSYCHIATRIST

Patton State Hospital is recruiting board certified/eligible psychiatrists. Patton is a Joint Commission accredited, 1500 bed, adult forensic psychiatric hospital, with an extremely interesting and challenging patient population. The hospital is nestled below Arrowhead and the San Bernardino Mountains, 65 miles east of Los Angeles; an hour's drive to beaches, Palm Springs, or mountain lakes and skiing. Salary with Board Certification starts at **$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.

BE/BC Psychiatrists for CA locations $160-185/hr up to $44k/month. 8-12hr/day. 5days/wk. beeper $42/hr.

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Butte County Behavioral Health Department invites applicationsfor 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 theabove address.

For additional information, please feel free to call (530) 538-6950 or (530) 538-7651. The filing date for this position is April 19, 2010 through **07/30/2010 (filing period extended).** All applications must be received by 11:59 pm on the closing date, July 30, 2010. Butte County is an Equal Opportunity Employer.

COLORADO

Horizon Health seeks Psychiatrist for a 24-bed Adult and Adolescent inpatient program in **Greeley, CO**. One hour from Denver, Boulder, and Estes Park! Great quality of life with outstanding salary and benefits. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE.

CONNECTICUT

N. STONINGTON-Fulltime, parttime positions, or 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

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.

Renaissance Behavioral Health Systems (RBHS), a comprehensive mental health center, Joint Commission accredited, is seeking a Psychiatrist for its Adult Florida Assertive Community Treatment (FACT) Program in Jacksonville, FL. Enjoy cultural events and recreational activities year round and beautiful Northeast Florida beaches. Florida has no state income tax and Jacksonville offers a low cost-of-living. Must be Board Certified or Board Eligible and possess Florida medical license. Full-time position with competitive salary and excellent benefits package. Part-time opportunities also available.

For more information, contact: Robert Sommers, Ph.D., President/CEO, RBHS, P.O. Box 19249, Jacksonville, FL 32245-9249. Phone: 904-743-1883, ext. 7103. Fax: 904-743-5109. Email: rbhspres@bellsouth.net.

PSYCHIATRIST

Henderson Mental Health Center, located in Fort Lauderdale, Florida, is currently seeking a Florida licensed Psychiatrist responsible for providing services to University students. Duties include conducting psychiatric evaluations, providing ongoing medication management, consultation with counseling center and faculty staff, and participation in training of counseling staff. Experience and expertise in working with the college age population, and skills in working cooperatively as a member of a multidisciplinary staff required. Board certification preferred. Please contact our Medical Director, Dr. Sahasranaman at 954/731-5100 ext. 3058 or e-mail: bsahas@hendersonmhc.org. or madorno@hendersonmhc.org. EOE D/F/W/P.

PSYCHIATRIST

Henderson Mental Health Center, located in Fort Lauderdale, Florida, is currently seeking a Florida licensed Psychiatrist to provide psychiatric services at our facility.

Please contact our Medical Director, Dr. Sahasranaman at 954/731-5100 ext. 3058 or e-mail: bsahas@hendersonmhc.org. or madorno@hendersonmhc.org. EOE D/F/W/P.

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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 Clinical Coordinator, Linda at 866-936-5250.

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.

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Medical College of Georgia
Augusta, GA
Growing Department Seeks New Faculty in Adult, Child and Adolescent, Neuroscience and Public Psychiatry Programs

The Medical College of Georgia (MCG) Department of Psychiatry and Health Behavior is recruiting MD and PhD faculty in adult, consultation/liaison, forensic, child and adolescent and public psychiatry. Both clinician-educator and research intensive positions are available, including a dedicated research neuroscientist position in psychotic disorders. The department, which is growing and financially stable, has strong training programs in general, child and adolescent, and forensic psychiatry, an internship program in health psychology, and competitively funded clinical and preclinical research. Our new public psychiatry partnership with the Georgia Department of Behavioral Health and Developmental Disabilities to manage and provide clinical care to the regional state hospital (located only five miles from the medical school campus), expands our faculty recruitment, educational and clinical research opportunities. MCG's strong research infrastructure includes core laboratories, statistical consultation and core genetics facilities. Extensive research training program for junior faculty includes a master's program in clinical translational, internal grant programs with generous career development awards.

Augusta, home of Masters Golf Tournament, is a charming Southern city with low cost of living (particularly housing), and is close to Georgia/Carolina mountains and Georgia/Florida coast. The position has excellent salary and benefits. Academic appointment depends on qualifications. MCG is an equal employment, equal access and equal educational opportunity and affirmative action institution. It is the policy of the University to recruit, hire, train, promote and educate persons without regard to age, disability, gender, national origin, race, religion, sexual orientation or veteran status.

See http://www.mcg.edu/som/psychiatry/ for more information. Contact: Donald Manning, MD, Director of Public Psychiatry, dmanning@mcg.edu or (706) 721-6719.

Atlanta Psych Consultants, an established multidisciplinary private practice strategically located in Atlanta, has an immediate need for an Adult or Child Psychiatrist to affiliate with 2 psychiatrists and 5 psychologists. Full service practice is located in class 'A' medical building near 3 major hospitals. Collegial atmosphere with great potential for a clinical practice through medication management for current patients, referral sharing and joint marketing.

Please email CV to consula@bellsouth.net or call Kim Oppenheimer, Ph.D. at 404-847-9560.

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

ILLINOIS

Faculty Child and adolescent Psychiatrist

Chicago- The Feinberg School of Medicine Northwestern University (NU), and the Children's Memorial Hospital (CMH) are seeking a child and adolescent psychiatrist to join a multidisciplinary child psychiatry department in a nationally ranked freestanding children's hospital. Position is primarily outpatient clinical care and teaching. Research pilot funding available. ABPN certification or eligibility in child and adolescent psychiatry required. Full-time continuing appointment faculty position requiring clinical training with diverse and acute populations, experience and excellence in teaching, and an interest in an academic environment. Instructor or assistant professor - rank and salary commensurate with qualifications and experience. NU and the Children's Memorial Medical Group are Affirmative Action/Equal Opportunity Employers. Women and minorities are encouraged to apply. Fluency in Spanish would be a plus. Hiring is contingent upon eligibility to work in the United States and licensure in Illinois. Start date after licensure in Illinois and CMH medical staff membership completed. Applications will be evaluated as received; to assure full consideration, must be received by **October 1, 2010**, but position open until filled.

Send CV with a letter describing clinical and academic interests to: Mina Dulcan, MD, Head, Department of Psychiatry, Box #10, Children's Memorial Hospital, 2300 Children's Plaza, Chicago, IL 60614, or e-mail: m-dulcan@northwestern.edu.

KANSAS

Civilian General/Adult Psychiatrist Opportunity at Fort Riley, KS
Work as a civilian Psychiatrist at Irwin Army Community Hospital and help serve those who serve our country! Trustaff hires healthcare professionals to work as civilians at military and VA hospitals nationwide. We are seeking Psychiatrists for immediate long term full-time opportunities at Irwin Army Community Hospital, located at Fort Riley near Kansas State University in greater Manhattan, KS. Working as a part of the hospital's Behavioral Health Team, you will have the rewarding opportunity to care for active duty military and their dependents. **As a company we are offering:**

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- Relocation Assistance, Continuing Education Assistance
- Malpractice 100% Covered
- Any state license is acceptable to work at this facility

Contact: Christine Fuka, 877-880-0346 x 1105, Fax: 866-546-3115, Email: cfuka@trustaff.com, www.trustaffgovernmenthealthcare.com.

KENTUCKY

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

MAINE

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.

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.

MARYLAND

Potomac Psychiatry seeks part-time outpatient psychiatrist. Expertise treating eating disorders, substance abuse, desired.

Send C.V. to:
terry.vinston@potomacpsychiatry.com.

Inpatient, Special Unit for Deaf Patients. Springfield Hospital Center is seeking a BC/BE **general psychiatrist** for the state of Maryland's special inpatient psychiatric unit for deaf patients. ASL interpreters are available 24/7. Salary is negotiable, within MHA guidelines. For other descriptive information, please see our accompanying ad for a general psychiatrist. Please send CV to **Jonathan Book, M.D., Clinical Director, SHC, 6655 Sykesville Road, Sykesville, MD 21784. For questions, call (410)970-7006 or e-mail JBook@dhmh.state.md.us.** EOE

Faculty Opportunity
Division of Child and Adolescent Psychiatry
University of Maryland, Baltimore

The University of Maryland School of Medicine, Division of Child and Adolescent Psychiatry is seeking a full-time child and adolescent psychiatrist, psychologist, and social worker. The positions carry faculty appointments at the University and offer exciting opportunities for clinical care, teaching and research. Academic rank and salary are commensurate with experience.

Send a letter of introduction and CV to: David B. Pruitt, M.D, Professor of Psychiatry and Pediatrics, Director, Division of Child and Adolescent Psychiatry, 701 W. Pratt Street, #429, Baltimore, Maryland 21201.

The University of Maryland is an AA, EOE, and ADA Employer. Minorities and women are encouraged to apply.

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.

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.

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.

WORCESTER, Child Psychiatry - ½ time position at UMass Medical School/UMass Memorial Medical Center providing a mix of Inpatient Child Psychiatry Consultation-Liaison and Outpatient Child Psychiatry. The Outpatient component involves oversight of a multidisciplinary team that is located at Community HealthLink, part of the UMass Memorial Health Care system. CHL is a multi-service, non-profit organization committed to promoting, maintaining and restoring the dignity, well-being and mental health of individuals and families in Central Massachusetts. The child psychiatrist works with a dedicated multidisciplinary team and provides evaluation and treatment services to persons with a range of psychiatric and substance abuse disorders. 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. Join a vibrant and growing Division of Child and Adolescent Psychiatry. Must be BE/BC in Child Psychiatry with experience in Child Psych C/L.

If you want to know more about job opportunities or the department in general, please email. Please send CV and letter of interest to: 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.

Child and Adolescent Psychiatrist /Faculty Position

WORCESTER, MA.-The University of Massachusetts Medical School (UMMS), Department of Psychiatry, is seeking a half -time child psychiatrist to join the faculty and serve as a Child Psychiatrist at the UMass Continuing Care Adolescent Inpatient Units at Worcester State Hospital. Experience in inpatient care of adolescents is highly desired. Community orientation and community-based experience is also highly desired. Candidates must be BC/BE in Child and Adolescent Psychiatry. Experience in teaching and training residents and medical students highly desired. Teaching and research opportunities available and encouraged. Competitive salary and excellent benefits. Join a vital and growing academic division of Child Psychiatry.

Please send CV and letter of interest to: 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.

MICHIGAN

Directorship Position - An Easy Income of $220k to $240k (Or More) - No long workdays necessary to make a great income. Clinical and part-time admin. responsibilities on adult psychiatric services in the Saginaw, MI area. C/A work is also available. Salary w/benefits or contract arrangement available. Close to 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.

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.

MINNESOTA

Clinical Psychiatrist

Sophisticated, innovative healthcare system offers new and exciting career opportunities. Generous salary and benefit package. 651-431-3724 or trace.kinley@state.mn.us.

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 Child Psychiatrist Positions. Inpatient & Partial programs. Adult & Geriatric. Salary, benefits & incentive plan. Contact: Joy Lankswert Inhouse 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

Outpatient Community Mental Health Clinic in Old Bridge, NJ is seeking FT or PT Psychiatrists to join a diverse practice and work with experienced Psychiatrists and LCSW's. Excellent income is guaranteed. Benefits available. Fax CV to 732-679-4549 or email to stressmg@optonline.net.

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.

Westampton Township - East of Philadelphia. Geriatric or General Psychiatrist - predominant caseload geriatric w/ some adult. Competitive compensation and benefits. Minimal call - no w/end on site. Joy Lankswert, Inhouse recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

NEW MEXICO

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

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

NEW YORK CITY & AREA

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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PSYCHIATRIST-Outpatient

The highly regarded **Pederson-Krag Center** offers the following positions in our Huntington Mental Health Clinic.

- Child Psychiatrist-to provide assessments, pharmacotherapy, and supervision (20hrs).
- Adult Psychiatrist-to provide assessments and pharmacotherapy (26hrs).

Flexible schedule. Excellent benefits.
Mail CV to: Roger Kallhovd, M.D., Pederson-Krag Center, 55 Horizon Drive, Huntington, N.Y. 11743 or fax 631-920-8165. EOE/AA.
www.pederson-krag.org.

Columbia University
College of Physicians and Surgeons
Department of Psychiatry

F/T Position available for Instructor or Assistant Professor level to act as an Attending Psychiatrist as part of the Psychiatric Emergency Room in collaboration with the Medical Emergency Room at the New York Presbyterian Hospital of Columbia University Medical Center. Responsibilities include direct patient care, supervision and teaching of housestaff (residents and fellows) and medical students and active participation in Department activities. This position requires NYS license, DEA and graduation from a psychiatric residency program. Applicants should have strong clinical and teaching qualifications. Applicants must have training and/or experience in Psychiatry and subspecialty. Bilingual English/Spanish preferred but not essential. Board certification and post residency clinical experience is expected for Assistant Professor Level. Columbia University is an Equal Opportunity and Affirmative Action Employer.

Please apply:
https://academicjobs.columbia.edu/applicants/Central?quickFind=53388.

NEW YORK STATE

Horizon Health seeks **Medical Director** and **Associate Medical Director** for 20-Bed Inpatient Acute Psychiatric Service in Scenic Southern Tier Finger Lakes area of New York State . The Inpatient unit treats over 1000 clients per year and is part of 283 Bed Acute Care Hospital and Comprehensive Health Care Organization. Enjoy a variety of coverage responsibilities including consults, outpatient contract coverage rotation, and call with other members of a highly collaborative team of psychiatrists. Competitive salary and benefits package included. Successful candidate must be Board eligible or Boarded in Psychiatry. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

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 County Mental Health Clinic in Canton, NY seeks full time (35 hrs/week) BC/BE psychiatrist to join interdisciplinary treatment team in providing outpatient mental health services to both children and adults. Competitive salary and excellent fringe package and malpractice coverage.

Canton is situated between the Adirondack foothills and the St. Lawrence River Valley with four universities nearby. St. Lawrence County is an EO/AAE, federally designated as MHPSA.

Submit letter of interest and CV to Dan Dodge, LCSW-R, St. Lawrence County Mental Health Clinic, 80 State Highway 310, Suite 1, Canton, NY 13617. Email: ddodge@co.st-lawrence.ny.us. If you have questions, please call 315-386-2167.

Rockland Psychiatric Center, a 470 bed state hospital that takes referrals from Manhattan and the 4 counties to the north, has an opening for an inpatient psychiatrist. RPC has a staff of 70 psychiatrists in our network between the hospital and clinics, so there are opportunities for advancement or movement to other locations once in the system.

RPC is located 30 minutes north of Manhattan, in the beautiful Hudson Valley. The hospital is affiliated with NYU, offers CME, regular hours, on-call is voluntary and for extra pay.

Send CV to Mary Barber, MD
Clinical Director
rpmeb01@omh.state.ny.us.

Central New York Psychiatric Center, a State-operated, JCAHO Accredited Facility, is seeking full time Psychiatrists at its main Inpatient Facility in Marcy, NY, and at its Forensic Outpatient Units throughout New York State, including: Albion, Clinton (Dannemora), Collins Downstate (Fishkill), Elmira, 5 Points (Romulus), Groveland, Mid-State (Marcy), Sullivan (Fallsburg) and Wende (Alden).

Comprehensive NY State Benefits package available. Outstanding NY State Pension Plan. Opportunity for Loan Forgiveness Program. Opportunities exist for additional compensation.

Assistant Psychiatrist: $107,318-$119,449 (general salary increases of 4% in 2010 is scheduled).
Qualifications: Possession of a NY State Limited Permit AND completion of a training program in psychiatry approved by the American Board of Psychiatry and Neurology for entrance into their certifying examination AND eligibility for full and unconditional participation in Medicaid and Medicare programs.

Psychiatrist 1: $168,421.
Qualifications: Possession of a License to practice medicine in NY State OR possession of a Limited Permit and licensure in another state or by written examination in Canada; AND completion of a training program in psychiatry approved by the American Board of Psychiatry and Neurology for entrance into their certifying examination; AND eligibility for full and unconditional participation in Medicaid and Medicare programs.

Psychiatrist 2: $174,798 (general salary increase 4% in 2010 isscheduled).
Qualifications: Possession of a license to practice medicine in NY State OR possession of a Limited Permit and licensure in another state or by written examination in Canada; AND certified in psychiatry by the American Board of Psychiatry and Neurology; AND eligibility for full and unconditional participation in Medicaid and Medicare programs.

Direct Contact Information:
Dr. Jonathan Kaplan, Clinical Director
Central New York Psychiatric Center
Box 300 Marcy, NY 13403
Phone: (845) 483-3443
Fax: (845) 483-3455.
E-mail: CN00025@OMH.STATE.NY.US.

Medical Director Needed in Syracuse!

Small, family-like private practice. 1/2 Mental Health, 1/2 Substance Abuse. DX & Meds. Must be NYS Licensed/Board Certified. Personal staff supervision. Perfect for someone starting out, or retiree. Email us at shaddin@mac.com!

NORTH CAROLINA

LUCRATIVE POSITION, GREAT LOCATION- Adult inpatient and outpatient work right near 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.

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

Psychiatrist (BE) or (BC)
Announcement #2010-07
DMHSAS/Oklahoma Forensic Center (OFC)-Vinita, OK
Salary Range: $184,000-$215,500

Minimum Qualifications: Must be licensed to practice medicine by the State of Oklahoma and be Board Eligible or Board Certified.
Benefits include: Insurance, Retirement, Vacation, Holiday & Sick Leave. Must be able to pass drug screen and OSBI background check. Reasonable accommodations to individuals with disabilities may be provided upon request. To apply contact Human Resources at 918-713-5549. OFC is an EOE.

OREGON

BC/BE Psychiatrists
Oregon State Hospital (OSH)
Salem, Oregon

Oregon Department of Human Services (DHS), OSH is looking for Oregon BC/BE Psychiatrists. OSH offers FT, PT and flexible opportunities in our general adult, geriatric, and forensic programs. A generous and comprehensive benefit and PERS retirement package is included, as well as a new hospital in 2011 which will incorporate state-of-the-art architecture, treatment space and technology. Salary is very competitive and includes psychiatric differential, certification pay and opportunities for additional on-call work.

Dr. Mark Diamond, CMO, invites you to call and/or send your CV to us today! Phone: (503) 945-2887; email: lila.m.lokey@state.or.us; fax: (503) 945-9910; mail: Human Resources, 2600 Center Street NE, Salem, OR 97301-2682. Please visit our website at www.oregon.gov/DHS/mentalhealth/osh. The State of Oregon is an Equal Opportunity Employer.

CHILD PSYCHIATRIST
Corvallis, Oregon

Full-time position with **Trillium Family Services**, the leading provider of mental and behavioral health treatment for Oregon's most vulnerable children. Treatment facilities are located in Corvallis and Portland. The Children's Farm Home campus is in the heart of the Mid-Willamette valley, beautifully situated on 300 acres of farm land adjacent to the Willamette River. Must be board-certified or board-eligible with adolescent psychiatric experience. Competitive salary and comprehensive benefits package.

For more information, please visit our website at www.trilliumfamily.org. To apply, please call Cari Riegel at 503-205-4335, or email criegel@trilliumfamily.org. Trillium Family Services is an equal opportunity agency in the provision of client services and employment opportunities.

PENNSYLVANIA

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.

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.

PSYCHIATRIST

Full-time or part-time BE/BC adult or child psychiatrist for private outpatient clinic located 45 minutes north of downtown Pittsburgh in designated Health Physician Shortage Area (HPSA). Duties include psychiatric evaluations and medication management. 37 ½ -hour work week M-F 8:30A.M. to 4:30P.M. with no on-call. $170,000-$190,000 with excellent compensation package including health care, retirement, paid time off, malpractice insurance, and CME. Will participate in moving expenses. EOE.

Submit Vita by e-mail to hr@fccac.org or mail to Executive Director, Family Counseling Center of Armstrong County, 300 South Jefferson Street, Kittanning PA 16201 **www.fccac.org.**

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.

Horizon Health, in partnership with **St. Vincent Health Center (Voted 5th Best Place to work in Pennsylvania!)**, a 436-bed tertiary care hospital in **Erie, PA**, has an exciting opportunity for an Adult Psychiatrist for a 32-bed Adult and Geriatric Inpatient Psychiatric Program. Opportunities for input and growth, tertiary care, teaching opportunities in FP residency program and LECOM medical school. Excellent compensation package with full benefits. Located on the shores of Lake Erie with 7 miles of beaches, Erie is the fourth largest city in Pennsylvania with a metropolitan population of 280,000.

For more information, contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

PITTSBURGH SOUTH HILLS-Office space available. Remarkable practice opportunity for BE/BC psychiatrist. Affiliate with a 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.

PHILADELPHIA and suburbs- Adult Psychiatrists-Inpatient services. Child Psychiatrist for Partial O/P Program.
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. Some outpatient also an option. Fulltime positions. Salary & benefits. Contact Joy Lankswert @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

SOUTH CAROLINA

Income Potential $280k to $350+
Medical Director -New Geropsych Unit
Very lucrative position (salaried with benefits or practice opportunity for those who prefer independence) in northeast SC-a small town with a BIG 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 (Adult with some adolescent if interested). 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

TEXAS

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.

McALLEN: Private Practice Opportunity. Inpatient & Outpatient. General Psychiatrist.
WEST TEXAS San Angelo: Child or General Psychiatrist. Salaried Employment or Private Practice. **Student Loan assistance in San Angelo. DALLAS:** Independent contractor for part-time inpatient coverage. Contact: Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

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.

VIRGINIA

Staff Psychiatrist # 2010

Full-time BE/BC psychiatrist, 100% Outpatient, Monday - Friday. Located in the beautiful Shenandoah Valley within commuting distance of Charlottesville, VA. Submit CV or resume to Human Resources 85 Sanger's Lane, Staunton, VA. 24401, or e-mail to sgray@vcsb.org or Fax to 540-213-7501. For additional information call 540-213-7340 or 540-213-7559.

WASHINGTON

The Everett Clinic, a large multi-specialty clinic located north of Seattle Washington is seeking a full-time Psychiatrist to join our team at Mill Creek, our newest multi -disciplinary facility.

Practice includes outpatient consultations and short term medication management, with minimal call responsibilities. Staff includes a Child Psychiatrist and is supported by medical assistant, clinical and reception staff. Referrals come from our primary care physicians and our behavioral health department which is staffed predominately by PhD level therapists. Strong interest in liaison work with primary and specialty care is welcomed.

TEC is a highly respected, physician owned and managed, multi-specialty group with multiple satellites throughout Snohomish County. The clinic has a strong focus on physician well-being and staff satisfaction and has an excellent benefits package. TEC serves predominately an insured population.

If you are interested in more information, please send DV and cover letter to:
Libby Atkinson
latkinson@everettclinic.com.

WEST VIRGINIA

HIGHLY DESIRABLE MID-ATLANTIC REGION!

DIRECTOR OF PSYCHIATRY

A Director of Psychiatry is needed to practice General Psychiatry and guide a 30-bed inpatient Psychiatric Unit located in a 207-bed community hospital. Enjoy leadership responsibilities and practice medicine. Call will be 1:4 and is shared with two other Psychiatrists and a Physician Assistant. A new 18-bed geriatric Psychiatric Unit will open in December 2010. This exquisite community surrounded by beautiful lakes and rolling hills is less than 30 minutes from Morgantown and Clarksburg, 2 1/2 hours from Pittsburgh and 3 1/2 hours from Washington, D.C. Each year thousands of outdoor enthusiasts converge on West Virginia's rivers, streams and woodlands to fish, hunt, canoe, boat, whitewater raft and jet ski. Historic museums, traveling exhibits, concerts, stage plays and numerous other cultural activities offer fun for the whole family. Don't miss out on this rare opportunity! Contact George at (800) 243-4353 or givekich@strelcheck.com **TODAY!**

WISCONSIN

Psychiatrists - Appleton, Wisconsin. Affinity Medical Group an integrated health care organization in East Central Wisconsin is recruiting a **BC/BE Child/Adolescent and BC/BE Adult Psychiatrists** for our Appleton location. These opportunities will encompass the full scope of services that support the needs that a psychiatric patient may present. Benefit from an industry leading compensation and exceptional benefits package. The Appleton area offers a unique quality of family oriented living, all season recreation, a nationally acclaimed educational system, a diverse growing economy, and a host of cultural opportunities.
For information, contact Cookie Fielkow, Affinity Physician Recruitment; Phone: 800-722-9989; E-mail: cfielkow@affinityhealth.org; Fax: 920-727-4350. Visit our website at: www.affinityhealth.org. EOE. Not a J-1 opportunity. A partnership of Ministry Health Care and Wheaton Franciscan Healthcare.

Upcoming Issues of Psychiatric News

Issue:	Deadline:
August 6	July 23
August 20	August 6
September 3	August 20
September 17	September 3
October1	September 17
October 15	October 1
November 5	October 22
November 19	November 5

PSYCHIATRIST
20 hours/week
Regular Part Time

Waukesha County Health and Human Services is presently recruiting for an individual to join our medical staff as the staff psychiatrist (part time). The psychiatrist will join a team of two full-time psychiatrists in providing direct patient care and medical leadership to members of the multidisciplinary treatment staff of our 28 bed adult acute care psychiatric hospital. This position reports directly to the Chief Psychiatrist, and may also participate in activities of the medical staff and in the systematic planning and development of behavioral health services of the department as assigned.

Educational requirements are possession of a degree from a recognized medical school; completion of an approved internship; completion of three years of approved residency training in psychiatry and possession of or eligibility to obtain a license to practice medicine in the State of Wisconsin. Board certification in psychiatry or eligibility required.

Salary range: $86,223 - $99,956. Our benefit package includes vacation, holidays, sick time, health, dental and life insurance, CME time, deferred compensation program, professional liability insurance, retirement program and the opportunity for private practice on site.

Waukesha County (pop. 380,000) is located in southeastern Wisconsin, thirty minutes from downtown Milwaukee, two hours from downtown Chicago, and one hour from Madison. The City of Waukesha was named one of the 2006 Money Magazine Best Places to live.

Interested individuals should contact Dr. Michele Cusatis at 262-548-7950 or at mcusatis@waukeshacounty.gov for more information about the position.

For information about the benefits package, contact Renee Gage, Senior Human Resources Analyst, in our Human Resources Department at 262-548-7053 or at rgage@waukeshacounty.gov.

For more information, please see our web site. Please attach a resume to application at www.waukeshacounty.gov/employment:

Waukesha County: (262) 548-7044
Hearing Impaired Number
(262) 548-7903
www.waukeshacounty.gov/employment
Equal Opportunity Employer

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

ADDICTION PSYCHIATRY FELLOWSHIP

The Addiction Psychiatry Fellowship Program at the **Medical University of South Carolina (MUSC)** is a PGY-5 one year clinical fellowship, which is accredited by the ACGME. Our program focuses on the evaluation and treatment of substance-related disorders. Our fellows receive clinical experience in variety of treatment settings including, outpatient, inpatient, methadone clinic, pain clinic, intensive outpatient program, community substance abuse treatment programs. Research opportunities are available in a number of basic and clinical areas. Salary is $52,154 per year, including generous benefits. No on-call. Qualified candidates must have completed a psychiatry residency program in an ACGME approved program.

For more information, contact: Tara M. Wright, M.D., Program Director c/o Christine Horne Medical University of South Carolina/ Clinical Neuroscience Division, 125 Doughty St, Suite 190, Charleston, SC 29425. (843) 792-5807.

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.

Practice for Sale

Available for purchase, Mental Health Center, DPH licensed as free standing clinic, privately owned, in successful operation for many years, experienced multidisciplinary staff, numerous contractual arrangements, participant under aegis of many carriers, sophisticated protocols for high level service delivery, fully operational with potential for facilitated transfer. Lease in well located building with option for purchase is available. Owner wishes to retire.

Contact Administrator at: P.O. Box 8288, New Bedford, MA 02742 Cell:(508) 951-6801.

Office Space Available

N. Bethesda, MD. Available Full or Part Time immediately. Fully furnished spacious, sunny, luxury office and waiting room in mental health suite. This office, located in a prestigious office building with concierge, has large windows and offers a beautiful view. Easy access to White Flint Mall + Metro. Call (301) 881-0433 OR email jbgoodman1@aol.com.

Furniture

ANALYTIC COUCH COMPANY!

Handmade iconic couches. See our online catalogue at www.analyticcouch.com Contact Randy for fabric samples 206-794-4779. Some custom options available.

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.**

Training

Indiana University (IU): 2 post-doctoral NIH-funded traineeships, Common Themes in Reproductive Diversity, offer integrative training in areas of sexual reproduction and development with a focus on the behavior of animals including humans. View full description and apply at: http://www.indiana.edu/~reprodiv/index.htm. Trainees must be citizens, non-citizen nationals, or permanent US residents. EO/AAE.