Volume 45
Number 22
November 19, 2010

Newspaper of the
American
Psychiatric
Association

PSYCHIATRIC NEWS

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Inside

PERIODICALS:
TIME-SENSITIVE MATERIALS

Reform Law Ends Most Bias Against Mental Health Care

Parity for and integration of mental health treatment with general medical care are operating principles of the new health care reform law, with a few crucial provisions for treating individuals with severe and persistent mental illness.

BY MARK MORAN

The Patient Protection and Affordable Care Act doesn't say much about mental health—and that's a good sign, said Richard Frank, Ph.D., deputy assistant secretary and director of the Office of Disability, Aging, and Long-Term Care Policy at the Department of Health and Human Services.

Frank, a health care economist and mental health policy expert who is no stranger to APA audiences, spoke last month at APA's Institute on Psychiatric Services in Boston.

He outlined the three central pillars of the new health care reform law—public insurance expansion, private insurance market reform, and payment and delivery system reform—noting that all three are intended to occur under an umbrella of parity and integration of mental health treatment with general medical care.

"Parity permeates the Affordable Care Act," Frank said. "The exceptionalism that has characterized mental health policy for the last 50 years is not a part of this law. I see the fact that there isn't very much singling out of mental health as a mark of success. Mental health is a part of the mainstream in this law."

At the same time, he noted that in a few crucial areas—especially the extension of traditional Medicaid benefits to the seriously and persistently mentally ill and the inclusion of community mental health centers in the definition of a "health home"—the law does contain special provisions that designate serious and persistent mental illness as requiring special attention.

Of overriding importance to the mental health community is the expansion of Medicaid eligibility to 133 percent of the federal poverty level, with income limits of $14,404 for individuals and $29,326 for a family of four. Additionally, the law provides 100 percent federal funding to all states for newly

please see ***Reform Law*** *on page 15*

APA President Carol Bernstein, M.D., opens APA's 2010 Institute on Psychiatric Services last month in Boston with the traditional bell-ringing ceremony. Coverage of the institute begins in this issue.

Credit: Ellen Dallager

Credit: Ellen Dallager

Health economist Richard Frank, Ph.D., says parity "permeates" the new health care reform law.

Substantial Rates of Mental Illness Found in U.S. Adolescents

Many psychiatric disorders begin well before adulthood. Anxiety disorders seem to occur earliest, followed by behavior disorders, mood disorders, and then substance use disorders.

BY JOAN AREHART-TREICHEL

Almost half of American adolescents experience at least one mental disorder, over a fourth experience a severely impairing one, and at least a fifth experience a severely impairing one other than a substance use disorder, a new study has found.

This appears to be the first nationally representative study of the subject.

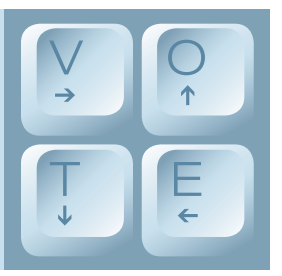
The research team was headed by Kathleen Merikangas, Ph.D., a senior investigator and chief of the Genetic Epidemiology Research Branch of the National Institute of Mental Health. Results appeared in the October *Journal of the American Academy of Child and Adolescent Psychiatry*.

The design consisted of face-to-face interviews of a nationally representative sample of more than 10,000 adolescents aged 13 to 18, with an average age of 15. The interview instrument used was a modified version of the World Health Organization Composite International Diagnostic Interview Version 3.0. During the interviews, the youth were asked whether they had ever experienced symptoms of various *DSM-IV* anxiety, mood, behavior, sub-

please see ***Adolescents*** *on page 25*

Vote in APA's 2011 Election: It Matters!

The next issue of *Psychiatric News* will contain a special section on APA's 2011 election. It will provide you with the information you need to help you choose APA's next leaders. An e-mail link to vote online will be sent on December 5 to all APA voting members whose e-mail addresses are on file. The deadline for online voting and receipt of paper ballots is February 7, 2011.



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Number 22
November 19, 2010

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Newspaper of the American Psychiatric Association
PSYCHIATRIC NEWS

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

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

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

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End Ban on Condolences After Soldier Dies by Suicide, APA Says

President Obama is urged to end a policy that bars him from sending a letter of condolence to family members of troops who die by suicide. The policy reflects a lack of appreciation of service members who suffered from mental illness.

BY RICH DALY

APA has joined the push for a change in the White House policy that prohibits the president from sending official letters of condolence to the families of members of the military who die by suicide during or after their combat tours.

In October, APA issued a public statement urging President Obama to reverse the policy barring such letters. The Association is one of a number of mental health groups, including the American Foundation for Suicide Prevention and Mental Health America, that are pushing for the policy change.

"The contributions of these men and women to their country are not less for having suffered a mental illness," said APA President Carol Bernstein, M.D., in a written statement. "A reversal of this policy to allow condolence letters to family members will not only help to honor the contributions and lives of the service men and women, but will also send a message that discriminating against those with mental illness is not acceptable."

Members of the military who die by suicide receive full military honors, but only the families of service members killed in combat (or as a result of combat injuries) or in noncombat incidents in a war zone receive condolence letters.

The condolence-letter policy is unwritten but longstanding, according to mental health advocates. Since November 2009, the Obama administration has been reviewing whether to maintain the policy, according to the Suicide Prevention Action Network USA.

The House of Representatives voted in May to add an amendment to the Defense Authorization bill (HR 5136) that urged the policy be overturned.

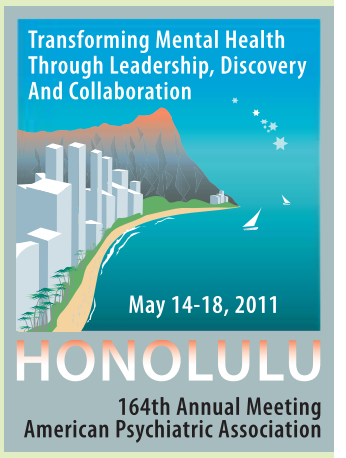
The call for presidential recognition of the service that these military members provided comes as the military continues to search for ways to reduce the growing suicide rate among military personnel. The numbers have continued to climb since the military began tracking them in 2003, with 162 active-duty members of the Army dying by

please see ***Condolence*** *on page 25*

Important Annual Meeting Announcements

Early-Bird Registration Ends January 3!

- **Register Early and Save on Fees!**
  APA members can now register, enroll in courses, and make hotel reservations for APA's 2011 annual meeting in Hawaii at advanced registration fees. Registration and hotel information, including hotel rates and descriptions, can be accessed on APA's Web site at <http://www.psych.org/annualmeeting>. This year's Convocation lecturer is human-rights activist and Nobel Peace Prize recipient Archbishop Desmond Tutu.



- **Look for Annual Meeting Information Online**
  Visit <www.psych.org/annualmeeting> to view the entire Annual Meeting Advance Registration Packet. This contains information on airline reservations, registration, housing, courses, local information about Hawaii, and other topics. The site will be updated as specific details on the scientific program are finalized.

- **New This Year!**
  Pre- and post-meeting tours will be offered to the outer Hawaiian islands. While in Honolulu, be sure to take advantage of the many tours and fun activities available for the whole family. Don't be left out—sign up now! Information on tour packages is posted on APA's Web site.

More information is available by calling the APA Meetings and Conventions Department at (703) 907-7822 or by e-mailing apa@psych.org.

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What Is Maintenance of Certification And How Does It Impact You?

BY CAROL A. BERNSTEIN, M.D.

Many of you have expressed both concern and confusion about the new plans for Maintenance of Certification (MOC). It is not as complicated or demanding as many of us think. In fact, many of you are already meeting some of the requirements involved, particularly if you participate in a self-assessment or institutional performance quality improvement program.

MOC is an initiative mandated by the American Board of Medical Specialties (ABMS) to ensure that physician specialists offer quality patient care through an ongoing process of self-improvement and performance improvement.

MOC is not an initiative specific to APA but was put in place in 2006, when ABMS's 24 member boards adopted a standard for recertification for all specialties. The ABMS determines the basic MOC requirements for the American Board of Psychiatry and Neurology (ABPN) and other member boards. Additionally, many state-licensing boards are developing similar requirements for Maintenance of Licensure.

These are among the principles of the ABPN MOC program: it must follow ABMS guidelines, address the competencies set forth by the ABMS and the Accreditation Council for Graduate Medical Education, fulfill federal-government requirements, and fulfill the requirements of Maintenance of Licensure.

In compliance with the ABMS's mandate, the ABPN has developed an MOC program for all diplomates with time-limited certificates. To maintain certification, diplomates must show evidence that they have met or exceeded requirements in each of four components over the 10-year cycle. Here are the four components:

• Diplomates must possess an unrestricted medical license in at least one state, commonwealth, territory, or possession of the United States or a province of Canada. This has always been a requirement for ABPN certification.

• Diplomates must participate in self-assessment activities that award CME credit, and an average of at least 8 CME credits a year must come from self-assessment activities. Such activities have already been developed by professional organizations and approved by the ABPN as meeting this requirement; information is linked to the ABPN Web site at <www.abpn.com>.

Some examples include the Psychiatrist in Practice Examination (PIPE), the *Focus* Annual Self-Assessment Examination, educational modules by the American Academy of Child and Adolescent Psychiatry, and the Geriatric Psychiatry Self-Assessment Program. The phase-in of this requirement has already begun. Other CME activities are already required by some states for Maintenance of Licensure.

• The cognitive-expertise portion mandates that diplomates pass a recertification examination prior to the expiration date of their certificates. A passing score on the cognitive examinations extends the renewal date of time-limited certificates to December 31 after the 10th year of the examination.

• The Performance in Practice (PIP) aspect of MOC has probably generated the most controversy. The phase-in of this requirement is scheduled to begin in 2013. The PIP component is a quality-improvement program to evaluate whether a physician has shown practice improvement over the 10-year MOC cycle.

Diplomates must complete three PIP units, each consisting of a clinical module and a feedback module. The clinical module must assess at least five cases in a specific category (for example, diagnosis, type of treatment, treatment setting) from the diplomate's clinical practice over the previous three years. All data from clinical modules are kept by the diplomate and not sent to the ABPN.

The feedback modules must be based on feedback from at least five patients and five peers over the previous three years. Diplomates will select their own peers and patients, and all data are, again, kept by the diplomates and not sent to the ABPN. Diplomates must attest to the ABPN that peer and patient feedback modules have been completed. The ABPN will randomly audit a sample of diplomates who will be required to explain further and document what they have done for MOC. However, even in these cases, no specific patient data will be sent to the ABPN.

To help APA members fulfill MOC requirements, APA is developing programs for self-assessment and PIP. APA's PIP modules are guided practice-improvement programs created for the general psychiatrist. In 2011, APA will introduce its clinical chart review modules. Sample modules for major depression and PTSD are available now, each offering 5 hours of CME credit.

APA already offers *FOCUS: The Journal of Lifelong Learning* and the FOCUS Self-Assessment Program. The FOCUS Self-Assessment is a yearly 100-question, multiple-choice examination on topics consistent with those listed by the ABPN in its content outline for recertification. The self-assessment exam must be completed before the MOC cognitive exam, but the CME requirement for self-assessment will not be enforced until 2013. In 2011 APA will launch the APA Annual Meeting Self-Assessment

please see ***From the President*** *on page 17*

Be Prepared to Set Limits Before Boundary Is Reached

Better education of psychiatric trainees and careful, proactive thinking by psychiatric clinicians can lessen the chances of boundary violations and their consequences.

BY AARON LEVIN

Sadly, somewhere, sometime, Dr. Sick, Dr. Predator, and Dr. Hysteric are in.

Such are some of the shorthand names that Thomas Gutheil, M.D., a forensic psychiatrist and professor of psychiatry at Harvard Medical School, gives to psychiatrists who violate the boundaries between patient and therapist.

Not all boundary violations in psychiatry have to do with sex, although that topic still dominates ethical issues in psychiatry, said Gutheil at APA's 2010 Institute on Psychiatric Services in Boston in October. And not all boundary violations are initiated by physicians; patients cross lines as well. Some accusations are false, but an added burden falls on psychotherapists to avoid any real or perceived boundary violation because of their codes of professional ethics and the need to maintain a high level of trust between therapist and patient for a successful therapeutic alliance.

Violations of the line between personal and professional behavior come in two degrees, said Gutheil. Boundary *crossings* occur when the therapist simply steps out of the therapeutic role. Offering a tissue to a sniffling patient may not be therapy, but it is good manners, he said. Boundary *violations*, however, are actions that exploit and harm the patient and often impair therapy.

The list of ethical complaints patients have leveled at psychiatrists in recent years includes accepting gifts from patients, taking the patient to lunch, asking the patient for advice (often financial), offering gifts for referrals, revealing too much personal information, accepting a party invitation, and joining the patient's book group.

With regard to psychiatrists' revealing too much about themselves, he said, "Every self-disclosure burdens the patient and reverses the parties' roles."

In general, boundary violations occur when behavior occurs outside the time, place, or activity appropriate to therapy, he said, drawing on years of court testimony and consultation to cite the potholes on the road to professional ruin.

"Start by asking yourself, 'Is this what a therapist does?' " he said.

Credit: Ellen Dallager

Thomas Gutheil, M.D., a forensic psychiatrist and professor of psychiatry at Harvard Medical School, says that many ethical problems involving boundary violations with patients can be avoided if psychiatrists ask themselves "Is this what a therapist does?"

It also means not engaging in a unique therapy (that is, a therapy that other psychiatrists do not do), so that the therapy becomes more important to the therapist than to the patient.

Extra-long sessions or those at odd hours, like 2 a.m. to 6 a.m., are also unwise. Places other than office settings are poor choices to hold therapy sessions—restaurants and automobiles are examples, said Gutheil. Intense conversation in such locations gives the appearance of being on a date.

If a blizzard or other extraordinary circumstance leads to offering the patient a ride, for example, Gutheil urged retaining a professional demeanor, documenting the encounter the next day, and discussing it with the patient at the next office visit: "What was it like for you to ride in a car with me?"

Money can sometimes be an issue as well. "Forgetting" to charge for therapy raises the question of whether the therapist is getting paid in a less impersonal currency.

"Always document the circumstances and rationale for not charging a patient if you decide to treat without payment," said Gutheil.

Psychiatrists should not hug patients, he said, blaming the 1960s therapy guru Leo Buscaglia for starting that unwelcome trend. The only exception might be for

please see ***Boundary*** *on page 24*

Oil Spill Found to Be Toxic To Workers' Mental Health

A psychiatrist experienced in postdisaster mental health issues has been steadily moving federal health policy to include mental health issues as part of worker safety after the BP oil spill.

BY AARON LEVIN

Workers hired to clean up water and beaches after the BP oil spill last spring and summer faced numerous hazards on the water and on Gulf beaches. However, for the first time, the official catalogue of dangers included psychological toxins, said a leading disaster psychiatrist at the APA Institute on Psychiatric Services in Boston in October.

"Psychological and behavioral problems are no longer the stepchildren among occupational hazards, but are viewed as a normal part of what we look at," said psychiatrist Dori Reissman, M.D., M.P.H., a senior medical advisor to the director of the National Institute for Occupational Safety and Health (NIOSH), a division of the Centers for Disease Control and Prevention.

Credit: Ellen Dallager

"The effects of an event like this is measured in decades, not days, reflecting the impact of the ecosystem damage on local cultural patterns," says medical anthropologist Lawrence Palinkas, Ph.D., an expert on the 1988 Exxon Valdez oil spill. Speaking at the same session was Dori Reissman, M.D., M.P.H. (left), who discussed the psychiatric hazards for those working on the BP oil spill cleanup.

NIOSH safety officers at cleanup work sites were trained to recognize psychological and behavioral dangers, not just those caused by chemicals and other familiar safety hazards. Those behavioral problems arose from several sources, said Reissman, speaking on a panel about the mental health aftereffects of the spill.

Many fell under the heading of fatigue, caused or compounded by intense daily heat, long hours, and heavy protective clothing. Some tasks were so physically stressful in mid-summer that safety officers permitted workers on those jobs only a 15-minute working stretch out of every hour. To compensate for the downtime and still get the work done in a timely manner, these workers had to put in 14 to 17 hours a day, a schedule that took its toll on their bodies and minds.

Heat, fatigue, and working at unfamiliar jobs may have impaired judgment, leading to accidents, said Reissman. A variety of preexisting factors, such as being overweight or taking certain medications (such as tranquilizers, antidepressants, mood stabilizers, anxiolytics, or stimulants), may have increased or decreased sweating and contributed to problems too.

Unfamiliarity with assigned tasks could also have led to accidents. Around the Gulf, boat owners and crew members were usually local people experienced at fishing but without training in industrial cleanup work.

The potential for accidents or work disruption went beyond the individual. If one person had to stop work, the activities of several others might come to a halt as well. People thus might have felt pressured to stay on the job longer than was safe.

In response, NIOSH safety officers encouraged a buddy system based on military practices in which workers keep an eye on their colleagues.

"You're better at looking after someone else than yourself," she said.

Crew chiefs received "fatigue management guidance," a psychiatric intervention under a different name, said Reissman. This boiled down to getting workers to drink water and to rest—usually when neither they nor the boss wanted them to. But it also means encouraging appropriate time off and getting proper sleep.

Reissman would like to follow these workers not only while they clean up the spill but over the long term. A similar project is under way with World Trade Center workers, but that started after cleanup efforts began. The oil spill workers were evaluated before they began work, providing a better baseline for evaluating changes caused by their experiences on the job.

NIOSH teams have begun to collect data on at least 52,000 individuals. Already some interesting patterns are visible, even though formal studies are not yet complete.

For instance, exposure to oil and dispersant chemicals was highest closer to the

please see ***Oil Spill*** *on page 15*

PTSD Treatment Guidelines Take Diverse Paths to Similar Ends

Ten experts sort out how organizations using different standards for different types of practitioners create guidelines for treating PTSD.

BY AARON LEVIN

A good guide can lead us through an impenetrable thicket, but which guide should we choose from those standing ready at the head of the trail?

Equally, treatment guidelines are intended to help clinicians select the appropriate treatment for their patients, but multiple guidelines for the same condition can create confusion instead of clarity.

So 10 co-authors, all veterans of guideline development for posttraumatic stress disorder (PTSD), have offered a guidebook to the forest by explaining a little something about each of the trees.

"[I]t is wise to first consider interventions for which good evidence does exist . . . such that the research evidence is carefully interpreted and translated to ensure its appropriate application to routine clinical care," wrote the authors in the *Journal of Traumatic Stress*, published online September 13. They were led by David Forbes, Ph.D., an associate professor at the University of Melbourne and clinical director of the Australian Centre for Posttraumatic Mental Health.

Forbes and his team discussed seven clinical practice guidelines available for PTSD. They included guides from APA, the International Society for Traumatic Stress Studies (ISTSS), the American Academy of Child and Adolescent Psychiatry (AACAP), the U.K. National Institute for Health and Clinical Excellence, Australia's National Health and Medical Research Council, and a combined Veterans Affairs/Department of Defense standard. A seventh document, an assessment of evidence from the U.S. Institute of Medicine (IOM), is not strictly a guideline, but was included because of its widespread influence.

"Our goal was to help clinicians of all disciplines understand why we need guidelines, what they comprise, and how they can be helpful to them in their clinical practices, in research, and in creating public policy across the world," said co-author Terence Keane, Ph.D., director of the Behavioral Science Division at the National Center for PTSD in White River Junction, Vt., and a professor of psychiatry at Boston University School of Medicine, in an interview. "It was also to assist people in understanding why there might be discrepancies or inconsistencies among the extant guidelines."

"The guidelines differ, but there is an overarching theme," said David Spiegel, M.D., a professor of psychiatry and behavioral science at Stanford University School of Medicine and a member of the PTSD subgroup of the anxiety disorders work group for *DSM-5*. He was not involved in the survey of the guidelines.

Most of the guidelines conclude that there is some benefit in using medications—usually SSRI antidepressants—and in providing a structured environment to work through the effects of trauma, but the specifics differ.

The IOM's report, however, said that there was not enough evidence to support the use of SSRIs. None recommend the use of psychological debriefing.

"Theoretically, there ought to be an absolute gold standard, but it all depends on what you define as gold," said Spiegel in an interview.

"Where differences exist, they are often a matter of degree," wrote Forbes and co-authors. "In general, they relate to the strength of recommendation rather than fundamental differences in what is, or is not, recommended."

Thus, each guideline begins by reflecting the constituency that commissioned it or drew it up. APA's guideline reflects the view of psychiatrists; AACAP's that of child and adolescent psychiatrists in particular; the IOM's that of the VA system, which requested the study; and so on.

Another way to evaluate a guideline is by how it assigns a level of rigor to the evidence under consideration. A third avenue is the strength of the recommendation in favor of a particular treatment.

So, for instance, SSRIs were acceptable first-line interventions in APA's and the VA/Department of Defense guidelines, but they failed to meet the IOM's stricter evidentiary standards because of what the IOM saw as deficiencies in study design.

The ISTSS guidelines, intended for a wider tent of practitioners, is less clear in its priority of recommendations, according to Forbes.

The authors concluded that many recommendations lack sufficient empirical evidence, but that is no reason for clinicians to throw up their hands. Guideline

please see ***PTSD*** *on page 16*

Nurture Your Resilience And You'll Avoid Burnout

The key to dealing with professional stress and avoiding burnout is not to work less, but to do the work you love, a psychiatrist with a passionate interest in the subject advises young psychiatrists.

BY JOAN AREHART-TREICHEL

Jodi Lofchy, M.D., an associate professor of psychiatry at the University of Toronto, was scheduled to give a talk on resilience at 9 a.m. on Sunday, September 26, at the Canadian Psychiatric Association's annual meeting in Toronto.

The day and hour she had been assigned were most unfavorable, she thought, as she drove toward the downtown convention center where the meeting was being held. Who would want to get up to hear a talk at 9 a.m. on a Sunday? To make matters worse, she encountered a marathon taking place in downtown Toronto that morning, which meant that many streets were blocked off to traffic. She parked her car as close to the convention center as possible, then walked many blocks in high heels while lugging her computer.

By the time she got to the convention center, she was tired and frazzled, but in a position to practice what she was going to be talking about, which was developing resilience in psychiatry. And what better way to practice resilience than to show a sense of humor? she thought. "I got mixed up in a marathon coming here this morning," she commented. "But at least I got some exercise!"

She also got an audience: she was relieved to see at least 30 psychiatrists in the room—mostly residents and early-career psychiatrists, and some seasoned ones as well.

Certain Physicians Especially Vulnerable

Although medicine is inherently stressful as a profession, research has shown that certain types of physicians are especially vulnerable to such stress, Lofchy reported—those who have poor self-esteem, an avoidant coping style, have a type A personality, score high on the personality trait of neuroticism, and cannot say "no."

Credit: Joan Arehart-Treichel

Jody Lofchy, M.D., tells psychiatrists that setting priorities and firm limits will help them avoid burnout.

Residency can be an especially stressful period for psychiatrists, just as it is for other types of physicians, Lofchy pointed out. Residents arrive directly from medical school, so are still in a student role, but are expected to be "real" physicians and supervisors as well. "So you have a number of roles and identities. You doubt yourself and are anxious. You may also keep negative emotions about certain patients or experiences inside yourselves, and that can be stressful. High-risk patients can also create stress, especially when you are alone in the night with them. Then there is all that fatigue. . . ."

Although the stress usually eases by the final years of residency, it certainly does not end when residency ends, she continued. "I was once at a conference in another country, and when I returned, I found that my office had been moved and my secretary was somewhere else. It was incredibly stressful."

On another occasion, she assumed new duties, yet did not receive the necessary clerical help. "Such a situation was more stressful for me than working as an emergency room psychiatrist or working with high-risk patients."

When psychiatrists or other physicians are faced with too much stress, it can lead to burnout, Lofchy said. "Burnout is an erosion of the soul—emotional exhaustion, depersonalization, a form of mild depression." She surveyed psychiatrists at various stages of their careers to learn more about burnout. The survey responses revealed that it can be characterized by stupor, irritability, dreading to go to work, a loss of a sense of humor, and taking longer to perform tasks than would usually be the case.

"Burnout in turn can lead to impaired job performance, poor mental and physical health, and substance abuse problems," she said.

Lofchy told her audience that one way to deal with stress and avoid burnout is to develop resilience. "The concept of resilience, not just in psychiatric patients, but in psychiatrists, is getting a lot more attention than it used to," she opined.

How to Become More Resilient

Here's the advice she shared with her audience:

- "If you can do only one thing to successfully deal with stress and prevent burnout, it is not to work less, but to do work that you love. If you work a lot and love it and feel valued, it will not lead to burnout, but if you do not love it and do not feel valued, it may. Early on in your career try on different hats, but always fine-tune the process so that you learn what you love and what you don't, what fits."
- "Do what you love not just professionally, but nonprofessionally as well. And don't be driven by money. You are going to be a psychiatrist for a long time, and you'll earn a good income eventually."
- "If you are good at what you do, people will recognize it and give you more work, but that may not be good for you. Set priorities and learn to say no."
- "If you are a resident, seek out faculty whom you like and whom you want to hang out with. Pick their brains about how they've handled stress in their careers. These should not be faculty members who evaluate you, though."
- Time management is essential. Some residency programs are starting to address this issue. But a reduction in work hours, as is happening in American residency programs, is not the answer to stress manage-

please see ***Resilience*** *on page 26*

"Burnout is an erosion of the soul—emotional exhaustion, depersonalization, a form of mild depression."

Where Psychiatrists Are Few, Volunteers Make Key Contributions

There are global opportunities for adventuresome psychiatrists—in developed countries such as New Zealand or in developing ones such as Dominica or Ethiopia.

BY JOAN AREHART-TREICHEL

Did you ever think about pursuing psychiatry in a far-off place for a few weeks or months?

Two psychiatrists who have acted on that thought reported their experiences at the Canadian Psychiatric Association meeting in Toronto in September at a session titled "International Initiatives and Opportunities for Canadian Psychiatrists and Psychiatric Residents."

The psychiatrists were Raymond Tempier, M.D., a professor of psychiatry at the University of Saskatchewan, and Emiko Moniwa, M.D., a Vancouver psychiatrist.

One winter, Tempier worked in the Caribbean, on the island of Dominica, where there is only one psychiatrist for some 75,000 residents. This psychiatrist earns a living from a private practice, but then works pro bono for the poor and homeless on the island. Tempier joined him on his rounds.

"He would give shots of antipsychotics to the poor and homeless with schizophrenia and tell them, 'This is your vaccination,' " Tempier reported. "Working on this island for a while would be a wonderful experience for a psychiatry resident, I think [both to help people in desperate need of psychiatric care and as a learning experience]. The situation is similar on the Caribbean island of Montserrat."

Moniwa worked in Ethiopia for five weeks during her fourth year of residency as part of a University of Toronto program for psychiatry residents.

"One of the reasons I did it," she explained, "is because I love to travel. But there were also concerns—a new culture, a need to be flexible, being away from home with few supports. I had to use older medications, learn a new model of care, and deal with language barriers. And the conditions were modest and basic. A number of people with severe mental illness were kept in chains. Some had reportedly gone off to the desert and had died."

Credit: Joan Arehart-Treichel

Emiko Moniwa, M.D.: "If you work abroad, you may take a salary hit, but it can be good for the soul. It can remind you of why you went into medicine."

But since there were only eight psychiatrists in all of Ethiopia when the program started, Moniwa felt that her presence, even for such a short time, made a difference in the lives of mentally ill people and that she learned a lot from the experience.

"The first lesson I learned was a lesson in humility," she said. "I learned that even with few resources, you can provide good care. I learned about the effectiveness of some of the older medications that I otherwise would not have used. I learned about the importance of kindness. I watched and learned as an Ethiopian psychiatrist calmed a disruptive patient with a kind hand instead of restraints."

Moniwa also worked in New Zealand for six months after she completed her psychiatry residency. It was similar to working in Vancouver, she reported, except that she got to work closely with the indigenous population. The pay was not as high as in Canada, but her flights, accommodations, and insurance were paid for.

"[The country also has] a huge need for psychiatrists, so you can work there for as long as you want," she noted.

Working in another highly underserved area—the Yukon—either short or long term, is another possibility, Moniwa said. "Psychiatrists working there receive generous remuneration."

Tempier and Moniwa named several Web sites for psychiatrists interested in working abroad.

- A Web site regarding work in New Zealand is <www.aucklandhealthjobs.com>.
- Psychiatrists can volunteer for the International Medical Corps and work two to eight weeks in a foreign country in response to an emergency. A stipend, housing, and insurance are provided. The Web site is <www.internationalmedicalcorps.com>.
- Doctors Without Borders wants psychiatrists who have experience in trauma, HIV and AIDS, tuberculosis, or sexual violence. The Web site is <www.msf.ca>. ■

Judge Works for MH Reform Of County Criminal Justice System

The special guest at the "Conversations" event at APA's Institute on Psychiatric Services is on a personal crusade to ensure that mentally ill people in a Florida county aren't criminalized and denied the treatment they need.

BY MARK MORAN

The story of individuals with mental illness in jails and prisons is one that judges and judicial activists in almost every city and county in the United States can tell.

But not every city has an advocate like Miami–Dade County Court Judge Steven Leifman.

Leifman, who was the guest at the American Psychiatric Foundation's "Conversations at IPS" event during APA's Institute on Psychiatric Services last month in Boston, has made reform of the system that criminalizes mental illness a personal crusade.

He is associate administrative judge for the Criminal Division of Miami–Dade County Court, and since 2007 he has served as special advisor on criminal justice and mental health to the Florida Supreme Court. He is also a member of the American Psychiatric Foundation Board of Directors.

Leifman described the beginnings of his involvement in the issue when he promised a couple that he would help obtain treatment for their son who was mentally ill and was charged with a crime. He found, however, that because the son was not deemed a danger to himself or others, he could not involuntarily hospitalize him, and thus would not be able to keep his promise to the parents.

The experience led him on a fact-finding journey in which he learned that Dade County has "the largest percentage of people with serious mental illness of any urban area in the country"—9.1 percent. At the same time, the state was providing treatment to only 1 percent.

This situation is not different from that in many other areas in the country: jails and prisons have become de-facto psychiatric facilities.

"Dade County Jail has become the largest psychiatric facility in Florida," said Leifman. "On any given day we have 1,200 people in the Miami-Dade County Jail on psychotropic medications. Three of the nine floors [of the county jail] are mental health floors, and because we have not done a very good job of training our law-enforcement officers to deal with this issue, since 1999 we have had 20 people with mental illness die during encounters with the police."

He cited an internal study of the highest utilizers of psychiatric services in the criminal justice system covering the five years prior to their most recent arrest. It found that 97 individuals—75 of whom had been diagnosed with schizophrenia—had spent almost 27,000 days in jail, 3,000 days in state psychiatric hospitals, and 7,000 days in other inpatient psychiatric facilities and have had more than 2,500 emergency department visits.

"It has cost taxpayers $12.5 million, and we have absolutely nothing to show for it, while giving these individuals no hope or opportunity for recovery."

And yet, he said, county officials have responded by looking to build more jails. "There is really something horrifically wrong with that."

The situation is slowly beginning to draw positive action, however. Leifman said that in the last 10 years the issue of the criminalization of individuals with mental illness has garnered the attention of policymakers, and important reforms have begun in his own jurisdiction.

Nationally, he cited the 2002 "Mental Health/Criminal Justice Consensus Project Report" by the Council of State

please see ***MH Reform*** *on page 26*

Credit: Ellen Dallager

Judge Steven Leifman (third from left) was the featured speaker at this year's "Conversations" event sponsored by the American Psychiatric Foundation (APF) at APA's Institute on Psychiatric Services. From left are Fred Osher, M.D., who hosted the event; Linda Bueno, director of industry relations for the APF; Leifman; and Paul Burke, APF executive director.

Patients Abandon Antidepressants, Deterred by High Costs

Clinicians may need to discuss affordability issues with their patients who have depression in the wake of new data suggesting that a growing number of people can't afford their prescriptions.

BY RICH DALY

An increasing number of insured patients with diagnosed depression are leaving their prescriptions unretrieved at the pharmacy counter, according to a recent analysis.

A review of private-insurance claims data released to *Psychiatric News* showed that so-called abandonment increased from a little more than 3 percent of all antidepressant prescriptions (brand name and generic) tracked in 2008 to more than 4 percent of such prescriptions in the first half of this year. The data were collected by Wolters Kluwer Pharma Solutions, a health care data company.

The rising rate of antidepressant abandonment came even as the total number of prescriptions written for antidepressants increased from 2008 to 2009 among private-insurance beneficiaries by 2.9 percent, to a total of about 240,000 new antidepressant prescriptions. Data were unavailable for the first half of 2010.

Among all categories of brand-name drugs only, the rate of abandonment for new prescriptions increased from 6.5 percent at the beginning of 2008 to nearly 10 percent in the second quarter of 2010.

Data on abandonment rates were derived from an analysis of 80 million claims that pharmacies submit each month for payment, or about 40 percent of the total market. Wolters Kluwer collects the data from more than 24,000 independent and chain pharmacies to help pharmaceutical manufacturers assess the reasons for lost sales.

Patients' failure to pick up their prescribed antidepressants is being driven, in part, by rising costs for the medications, according to Wolters Kluwer officials and a mental health researcher.

The data on abandoned antidepressant rates were similar to those for unfilled prescriptions reported by Medicare beneficiaries in a 2008 study. Jae Kennedy, Ph.D., an associate professor in the Department of Health Policy and Administration at Washington State University, and colleagues found that more than 5 percent of prescriptions that beneficiaries reported not filling were for antidepressants.

"Our research shows that an increasing number of patients in the United States are unable to fill their prescriptions due to medication cost, including critical prescriptions for chronic-disease management like antidepressants," Kennedy told *Psychiatric News*.

Jesse Wright, M.D., Ph.D., a professor of psychiatry and behavioral sciences at the University of Louisville, said in an interview that because of the large number of low-cost antidepressant generics now available, cost should be less of a factor in whether patients decide to fill their prescriptions. He advised clinicians to raise the issue of affordability with their patients and prescribe a generic substitute when suitable.

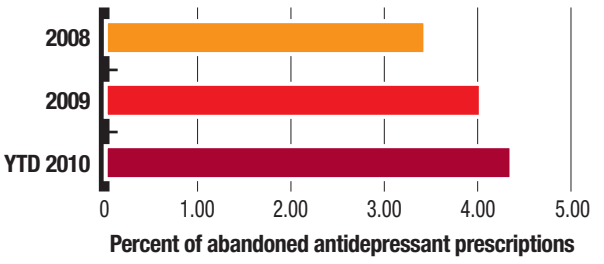
"I wouldn't have been surprised if the [Wolters] data had found higher [abandonment] rates," he said.

Kennedy gave similar advice to Wright's, noting that clinicians should routinely ask patients about their prescription insurance coverage. If patients cannot afford the medication, psychiatrists can suggest alternatives for obtaining it, such as programs offered by pharmaceutical manufacturers that provide medications for free or at low cost.

The 2008 Kennedy study, "Unfilled Prescriptions of Medicare Beneficiaries: Prevalence, Reasons, and Types of Medicines Prescribed," is posted at <http://www.amcp.org/data/jmcp/JMCPMaga_553-560.pdf>. ■

More Antidepressants Go Uncollected

The rate of patients who have left their depression medications uncollected from their local pharmacies has steadily increased over the last two and a half years. Experts believe that a major reason is cost, which indicates a need for psychiatrists to address affordability with their patients.



Source: Wolters Kluwer Pharma Solutions, October 2010

Societal Toll Substantial for Often Ignored Personality Trait

People who score high on the personality trait of neuroticism cost society an extraordinary amount of money, which raises the issue of how to help such people become less neurotic.

BY JOAN AREHART-TREICHEL

The personality trait of neuroticism, which is essentially the tendency to respond negatively to threat, frustration, or loss, has received a formidably negative press in the scientific literature.

For example, people with neuroticism have been found to be vulnerable to anxiety disorders, depression, eating disorders, and personality disorders. Neuroticism also has been implicated in physical illnesses such as asthma, irritable bowel syndrome, and cardiovascular disease.

Now Dutch scientists have found that neuroticism costs society a stunning amount economically, not just in health care service use, but in lost wages. They reported their study's results in the October *Archives of General Psychiatry*.

Their study was based on the Netherlands Mental Health Survey and Incidence Study, which included a relatively large, representative community sample in the Netherlands—5,504 people. The neuroticism scale of a widely used personality questionnaire in the Netherlands, the Amsterdam Biographic Inventory, was used to assess each individual for the personality trait of neuroticism.

The scale contains questions such as "Do you often feel lonely?" "Are you sometimes worried without knowing why?" "Do you suffer from nightmares?" "Are you often dissatisfied and grumbling?" "Do you take disappointments so seriously that you cannot get them out of your mind?" and "Do you have the feeling that you are eventually alone in the world?"

The researchers divided subjects based on how they had scored on the neuroticism scale; the higher the score, the greater the degree of neuroticism. Out of the 5,504 individuals, 1,376 scored within the upper 25 percent of the scale, 550 scored within the upper 10 percent, and 275 scored within the upper 5 percent.

The researchers determined the 2007 costs incurred by the people surveyed for general health care service use and lost wages due to illness. Health care service use included visits to psychiatrists, general practitioners, psychologists, social workers, and physiotherapists, as well as days of hospitalization and prescription drugs used. The average cost for all subjects was $3,641. But subjects who scored high on the neuroticism scale cost considerably more than the average. The excess cost above the $3,641 average for the 25 percent group was $5,572, the excess cost for the 10 percent group was $8,243, and the excess costs for the 5 percent group was $12,362.

Finally, the researchers determined what these excess costs would mean if they were applied to the population in general, that is, to 1 million inhabitants in the same proportions. The 25 percent highest neuroticism scorers would cost an excess of $1.4 billion.

This amount is "enormous," they commented. "Although the costs in this study are calculated for the Netherlands, it does seem probable that neuroticism also plays a highly important role in the costs of health care systems in other Western countries."

Pim Cuijpers, Ph.D., the lead investigator and a professor of clinical psychology at VU University Amsterdam, told *Psychiatric News*, "We had not expected that the costs of neuroticism would be so high."

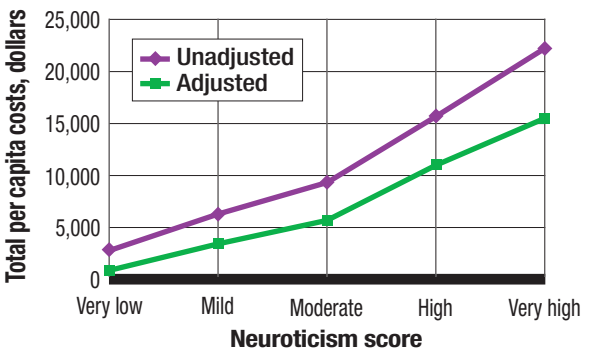
The question now is whether those high costs can be reduced, the researchers wrote. For instance, is there some way to help people become less neurotic even though neuroticism is moderately heritable and a relatively stable personality trait? "Randomized trials should be conducted . . . to evaluate the malleability of neuroticism," they proposed. There are indications that personality can change to a certain extent during the life course and some indications that the SSRI antidepressants can reduce neuroticism in depressed persons (*Psychiatric News*, January 15).

The study was funded by the Netherlands Ministry of Health, Welfare, and Sport.

An abstract of "Economic Costs of Neuroticism" is posted at <http://archpsyc.ama-assn.org/cgi/content/abstract/67/10/1086>. ■

Neuroticism Is Expensive

There is a dose-response relationship between neuroticism and per capita excess economic costs. In a study of 5,504 subjects, the average annual cost of health care and lost wages was $3,641. The excess cost for someone with a very low level of neuroticism was less than $3,000 per year, whereas the cost for someone with a very high level was over $22,000 per year. Even when mental disorders were considered, the relationship held firm.



Source: Pim Cuijpers, Ph.D., et al., *Archives of General Psychiatry*, October 2010

Medicare Fee Update

As this issue of *Psychiatric News* was going to press, the Centers for Medicare and Medicaid Services released its interim final rule on the Medicare physician fee schedule for 2011. The staff of APA's Office of Healthcare Systems and Financing will post important information for APA members at <www.psych.org/MainMenu/PsychiatricPractice/MedicareMedicaid/MedicareFeeSchedule.aspx>. *Psychiatric News* will carry a full report on the interim final rule in the next issue.

Federal Lawsuit Ends With Major MH Care Investment

A statewide system of community-based treatments and support services for people with serious psychiatric illness in Georgia is expected to emerge from a final settlement of a lawsuit brought against the public mental health system by the Department of Justice.

BY RICH DALY

Public mental health services in Georgia are expected to improve dramatically as a result of a wide-ranging settlement of a lawsuit against the state that has dragged on for years.

The lawsuit was initially intended to redress the harmful conditions of the state's psychiatric hospitals, but the settlement goes further: it requires the state to commit to a series of reforms in its public mental health system, including a large expansion of its community-based treatments and supports.

The settlement reached by officials in Georgia and the Department of Justice (DoJ) was approved by a federal judge on October 29.

The agreement also applies to people with developmental disabilities. The state must stop admitting people with a primary diagnosis of a developmental disability into state hospitals by July 2011 and instead place them directly into community-based service programs.

Psychiatrists and other mental health advocates said that the agreement's most important benefit is that much of the estimated $130 million it requires the state to spend over five years on mental health services will fund an expansion in community treatment, including 24-hour community "crisis service centers," psychiatric beds in private hospitals, psychiatric crisis-intervention teams, and other local services.

Georgians who have poorly treated serious mental illness will benefit most directly from the settlement, according to William McDonald, M.D., president of the Georgia Psychiatric Physicians Association (GPPA) and a formal advisor to the governor in the case.

The lack of community treatment and support for this population had placed a large burden on public psychiatry because these patients frequently decompensated and overburdened the underfunded psychiatric hospital system, McDonald said.

Patrice Harris, M.D., chair of the Legislative Committee of the GPPA, described the settlement plan as "a win" for patients in the public system but raised concerns about future financial support from the state to fully implement the agreement.

The governor has called for the legislature to come up with $15 million in the amended annual budget for 2011 and $62 million in the 2012 budget. But the recession could make future increases difficult.

"All involved will have to remain vigilant as we move forward through the implementation phase of this historic agreement," Harris said.

McDonald is confident that the state will continue to authorize the funding that the settlement requires. He told *Psychiatric News* that the state already has provided additional mental health funding in recent budget cycles, despite cutting almost every other area of the state government.

Patient advocates from groups such as the National Alliance on Mental Illness plan to maintain pressure on legislators to continue authorizing the necessary funding as well as highlight the potential long-term savings the state may realize by reducing the need for costly inpatient psychiatric care as more patients are stabilized with community care.

"There may be painful costs in the first few years, but it [community care] can be very cost-effective over the long term," said Robert Bernstein, Ph.D., executive director of the Judge David L. Bazelon Center for Mental Health Law in Washington, D.C., at an October press briefing to discuss the settlement. The Bazelon Center represented a coalition of mental health advocates that advised the judge in the case, *United States v. Georgia*.

The case stemmed from a 2007 DoJ investigation of published allegations that a large number of patients had died under questionable circumstances in state psychiatric hospitals in the preceding years. The DoJ filed suit after its investigation found systemic problems in the state's public mental health system. The DoJ lawsuit originally focused on the hospital facilities, but the judge increased its scope to allege violations of the Americans With Disabilities Act and the Supreme Court's landmark decision in *Olmstead v. L.C.*, which requires states to provide care in the least-restrictive environment possible.

The plan to expand Georgia's community-based system dovetails with community psychiatry's efforts to move people with severe and chronic mental illness toward recovery through rehabilitation. The approaches of the hospitals will change from simply stabilizing patients to better preparing them for life outside of the hospital by teaching the importance of medication adherence and using the range of clinical and life-skill supports that the agreement requires in their community.

The settlement is posted at <www.bazelon.org/LinkClick.aspx?fileticket=sfK-8EPFvDc%3d&tabid=40>. ■

Iraqis' Visit Turns Into Mutual Learning Experience

Teams of mental health professionals from Iraq observe the U.S. system and adapt what they see for use back home.

BY AARON LEVIN

Credit: Aaron Levin

Visiting Iraqi psychiatrists and their American hosts found much to learn from each other's experiences. From left: Jamar Omar Tawfiq, M.B.Ch., from Sulaymaniyah; Allen Dyer, M.D., of International Medical Corps; and Rebwar Ghareeb Hama, M.D., also from Sulaymaniyah.

Psychiatrists and other professionals from Iraq spent five weeks this fall observing American practices in school-based mental health, forensics, trauma care, substance abuse, services for women and children, and chronic psychiatric disability services.

They learned a lot while in the United States but also taught something to their American hosts.

The 24 Iraqis in the program were supported by the Iraqi and Iraqi Kurdistan ministries of health and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

The Iraqi visitors were divided into six teams, each specializing in a different area (see box).

"Everywhere we went, we learned something new," said Rebwar Ghareeb Hama, M.D., a psychiatrist from Sulaymaniyah in Iraqi Kurdistan, in an interview. "Especially the greater use of psychotherapy."

In Iraq, mental health care has been carried out historically on a narrow medical model, by doctors and nurses, with heavy reliance on drugs, he said.

"A community psychiatry model is hard to apply in Iraq for several reasons," added Jamar Omar Tawfiq, M.B.Ch., also a psychiatrist from Sulaymaniyah. Just six psychiatrists serve that city of 2 million people.

Tawfiq and Hama were both part of the group studying trauma services in primary care.

"There is a lack of psychiatrists, psychologists, clinical social workers, and nurses," Tawfiq told *Psychiatric News*. "There is also a great deal of stigma and misunderstanding in the general population about mental illness."

There are 350 clinics in Iraqi Kurdistan. On their return to Sulaymaniyah, the psychiatrists and their colleagues will choose 12 geographically dispersed health centers and teach the primary care staff—usually just one physician, a physician assistant, and a nurse—more about mental illness and its treatment.

"We will train them in trauma care, teach them to talk to the patient, ask if they experienced trauma, then develop rapport and educate the patient," said Tawfiq. "If a case is severe, the patient will be referred to the hospital's psychiatric department."

In addition to a shortage of psychiatrists, Iraq also lacks sufficient nonphysician mental health personnel.

"Our biggest problem is training enough nurses, clinical psychologists, and clinical social workers to create the multidisciplinary teams we need," added Hama.

Looking for Models to Take Home

The Iraqis visiting the Johns Hopkins Bayview campus in east Baltimore studied school-based mental health systems. Nearly 50 percent of Iraqis are under age 18, but there are few mental health professionals in community settings to identify children with special needs or learning disabilities, said Anita Everett, M.D., director of community and general psychiatry at Bayview and the Iraqis' host there.

The visitors sat in on Baltimore public-school classrooms, observed children's mental health services in schools, and talked to principals and other school officials. Their hosts discussed questions such as how to differentiate behavioral problems from learning disabilities, attention-deficit/hyperactivity disorder, or post-traumatic stress disorder.

Eventually, the Iraqis will pass on such knowledge to teachers to help them identify students who need to be referred for services. They were particularly intrigued by an after-school program's therapeutic intervention to combat substance abuse, in which students are bused from their schools to Bayview.

Learning Worked Both Ways

The primary intent of the program was for Iraqis to learn about the most applicable aspects of U.S. mental health services and how to make use of them back in their devastated country.

But something else happened as well. The Americans learned a lot from the Iraqis.

"Our staff benefit from exchanges with our guests," said Everett. "Those discussions help us understand our systems better. We're not learning techniques, but we are gaining perspective on our services that we get blinded to."

For one thing, the Iraqis illuminated the fact that much of American psychiatry is focused on the individual.

"In the U.S., we design programs to make patients more independent," noted Everett. "Many of our patients are disengaged from their families by the time they get to the clinic."

But in Iraq, even with all its stresses, family bonds remain stronger and can serve as a source of support for patients. For example, one group from Mosul that took part in a similar program in 2008 set up a program in which a family member becomes a paid member of the patient's care team.

"We can look at how the Iraqis try to provide mental health services in a resource-poor setting and learn something about how to work in underserved areas of this country," said the International Medical Corps's Allen Dyer, M.D., the host for the trauma group in Virginia.

please see ***Iraqis*** *on page 26*

Iraqi Forensic Experts Face Daunting Challenges

Two of the six mental health teams from Iraq concentrated on concerns that suffered from Iraq's long isolation from the rest of the world (see article above). They hope to adapt what they learn for use at home, said participating Iraqi psychiatrists.

One group sought to learn more about modernizing Iraq's forensic psychiatry system. Forensic facilities there consist of just one 250-bed unit in a 1,200-bed psychiatric hospital in Baghdad.

Iraq has a mental health code, but it is not consistently adhered to, and the line between civil and compulsory commitment is not clear, said Naamah Humaidi, M.D., of Baghdad's Al Rashaad Hospital and the Iraqi Ministry of Health.

The Iraqis wanted to observe the U.S. practice to better separate the two and to improve communications with the Ministry of Justice, said Humaidi in an interview in Washington, D.C.

Credit: Aaron Levin

Naamah Humaidi, M.D.

At mental health courts in Baltimore and in Montgomery County, Md., they observed how judges, lawyers, and mental health personnel worked together to get mentally ill defendants back on track. At present, Iraqi law does not permit conditional release or probation, but those strategies may someday become options, said Humaidi.

Team members also attended a three-day training program run by the state of Maryland for new forensic evaluators.

"They got a real understanding of the array of services for persons in the criminal-justice system or at risk of being in it," said Erik Roskes, M.D., director of forensic services at Springfield Hospital Center in Sykesville, Md., where the Iraqi forensic group was based. "They saw how the system worked from the point of police intervention through parole or probation."

They also observed forensic mental health fellowship programs and discussed human-rights aspects of mental health care, like confidentiality, patient privacy, informed consent, and patient rights.

"We want to be a national resource when we return home," said Humaidi.

Another team studied U.S. practices in substance abuse treatment at INOVA Fairfax Hospital in Fairfax, Va.

Substances of abuse are different in Iraq from those in the United States, said Nasif Al-Hemiary, M.D., of the Iraqi Ministry of Health and a professor of psychiatry in the College of Medicine at the University of Baghdad.

The problem there is less with heroin, cocaine, or marijuana than with alcohol, tobacco, and certain prescription drugs, he said. Of abused prescription drugs, the most common are not opioids or benzodiazepines, but artane, an anticholinergic used to counter the effects of antipsychotic medications.

At INOVA, Hemiary's group studied ways of doing patient intake assessments and managing the admission process, said Maria Hadjiyane, M.A., L.P.C., the hospital's counseling manager. On the psychiatric unit, they observed the interaction between nurses and patients, a different relationship from the one they are used to in Iraq.

"We are already working to integrate substance abuse services into primary care in Iraq, but that requires more training for mental health professionals beyond lectures," said Hemiary.

They will be backed up by frequent Internet consultations with their mentors at INOVA Fairfax Hospital and UCLA, said Hadjiyane.

Former Soviet Dissidents Believed APA Pressure Forced Change

APA letters to incarcerated Soviet dissidents served notice to Soviet officialdom that the world was watching, and documents in Soviet archives reveal that authorities paid attention. This is the second article in a three-part series on psychiatry and the Cold War.

BY MARK MORAN

In March 1971, a French human-rights organization released to the Western press 150 pages of documents said to be the photocopied forensic reports on six citizens of the Soviet Union being held involuntarily in psychiatric hospitals.

Accompanying the documents was a letter addressed to Western psychiatrists. As reported by Peter Reddaway and Sidney Bloch, M.D., in their 1978 book, *Psychiatric Terror*, the letter read, in part: "In recent years in our country a number of court orders have been made involving the placing in psychiatric hospitals . . . of people who in the opinion of their friends and relatives are mentally healthy."

The letter noted that the six individuals were "well known for their initiatives in defense of civil rights in the Soviet Union" and contained a specific request to psychiatrists: Did the forensic reports describe evidence of mental illness sufficient to warrant incarceration?

The letter was signed by Vladimir Bukovsky, a biophysicist and human-rights activist who had himself been incarcerated; the documents were compiled by a small group of underground activists in Moscow. It was a dramatic breakthrough and one of the first glimpses the Western world had of a fledgling human-rights movement that had begun to emerge in the Soviet Union, including a group who formed the Working Commission to Investigate the Use of Psychiatry for Political Purposes.

Reddaway, at the time a political science professor at the London School of Economics, recalled that the dissidents in Moscow in the early 1960s had adopted the tactic of taking Soviet law at face value to protect their right to protest.

"They would point out that they were only exercising the rights afforded under the Soviet constitution," he told *Psychiatric News*. "It sounds simple, but in many cases it worked because the authorities were not sure how to handle the dissident movement.

"One of the responses the authorities developed was to argue that because there could be no flaws in a socialist society, the only explanation for the dissidents' behavior was a distorted view of reality," Reddaway said. "On a small scale at first, but increasingly throughout the 1960s and 1970s, they began to put the early Soviet dissidents into psychiatric hospitals. Sometimes they did this through administrative means without a trial, placing individuals in mental hospitals, and in other instances [the dissidents] had a trial in which they were examined by a psychiatrist who would do what the authorities demanded."

Photo courtesy of Peter Reddaway

Peter Reddaway, co-author of *Psychiatric Terror,* is photographed on a bridge overlooking Seville, Spain, in May. Reddaway was a consultant to the APA Committee on International Abuse of Psychiatry.

The World Is Watching

The "Bukovsky papers" were among the first substantiated evidence of the practice of using psychiatric incarceration to detain political dissidents—a practice that, as recorded by Reddaway, was used sporadically as early as the Stalin period, but in time became a systematic response to political dissent. And it was a practice that would eventually arouse Western psychiatric opinion and lead to a confrontation between APA—and other Western psychiatric organizations—and the Soviet All-Union Society of Psychiatrists and Neuropathologists.

The confrontation resulted in a statement by the World Psychiatric Association in 1977 denouncing political abuse of the profession and later in the withdrawal of the All-Union Society from the world body under threat of expulsion (see box). In 1989 the face-off culminated in a remarkable visit by American psychiatrists led by the U.S. State Department in which the American delegation interviewed individuals believed to be incarcerated in psychiatric hospitals due to political activity.

But movement by Western psychiatry was hesitant at first, and Reddaway and others acquainted with the period described a fitful process—a slow accretion of evidence, the surreptitious establishment of a network of contacts within and outside of the Soviet Union, widening publicity for the dissidents' cause and about the nature of psychiatric abuse, and only later the mobilization of professional and organizational protest.

This epic story is told in a new book, *Cold War in Psychiatry: Human Factors, Secret Actors,* published this year by Dutch human-rights activist Robert van Voren, and in two volumes by Reddaway and British psychiatrist Sidney Bloch, M.D. (The first, *Psychiatric Terror*, earned Reddaway and Bloch APA's Manfred S. Guttmacher Award in 1978. Their second book, *Soviet Psychiatric Abuse: The Shadow Over World Psychiatry*, was published in 1985.)

APA Gets Involved

At APA, a crucial development was the arrival of Melvin Sabshin, M.D., as medical director in 1974. Sabshin brought with him an international perspective and a commitment to the development in the United States of a more rigorously scientific psychiatric nosology—as opposed to ideological or theoretical approaches—that made effective confrontation with the Soviets possible (*Psychiatric News*, November 5).

During Sabshin's tenure, APA's Board of Trustees, with the strong recommendation of the Council on International Affairs, established the Committee on International Abuse of Psychiatry. Sabshin hired world traveler Ellen Mercer, who served as staff liaison to the committee and later as director of APA's Office of International Affairs when it was formed in 1982.

Reddaway was appointed a consultant to the committee and van Voren served informally as an advisor to Mercer (van Voren had befriended Bukovsky after the latter was released from the Soviet Union in an exchange for Chilean communist leader Luis Corvalan in December 1976). With the help of Reddaway and van Voren's contacts in the Soviet dissident community, the committee began to make contact with incarcerated individuals, their family members, and official Soviet psychiatry.

The strategy was straightforward and modeled on the practice of Amnesty International: the committee wrote letters.

"Cases would come to us through various channels but mostly from the Moscow Working Commission," Mercer recalled in an interview with *Psychiatric*

please see ***Soviet*** *on page 26*

Soviets Left WPA Under Expulsion Threat

When Vladimir Bukovsky in 1971 leaked to the Western press photocopies of forensic reports on prominent Soviet dissidents who had been incarcerated in psychiatric hospitals, it came with a pointed request to Western psychiatrists that they place the subject of the Soviet dissidents "on the agenda for discussion by the next international congress of psychiatrists."

The congress to which Bukovsky referred was the upcoming meeting of the World Psychiatric Association (WPA) in Mexico City that year. But to Bukovsky's disappointment, and that of others in the dissident and human-rights community, the WPA failed to take up the subject of psychiatric abuse in the Soviet Union.

The follow-up meeting in 1977, in Honolulu, would be different.

The subject of the allegations of Soviet abuse dominated the conference. Ellen Mercer, then the staff liaison to APA's Committee on International Abuse of Psychiatry, recalls that there was a special forum on the issue led by Paul Chodoff, M.D., then a member of the APA committee. Melvin Sabshin, M.D., APA medical director at the time, said other members of the American delegation—including then APA President Jack Weinberg, M.D., as well as Judd Marmor, M.D., Alfred Freedman, M.D., Walter Reich, M.D., and Shervert Frazier, M.D.—directly confronted the Soviets about the charges.

"They denied it, and said it was Cold War politics," Sabshin told *Psychiatric News* in an interview from his home in London. "They said they had their own classification system and denied the allegations."

The politics of confronting the Soviets at the WPA Congress were complex, with some Western delegations hesitant to alienate the Soviets for fear the All-Union Society of Psychiatrists and Neuropathologists would leave the WPA and thereby diminish the international standing of the body. And Mercer recalled that delegates from some Eastern bloc countries under the domination of the Soviets—especially Poland—made themselves conspicuously absent whenever the issue was brought up.

She also recalled that the issue of how to approach the All-Union Society was contentious even within the APA membership. "Some said that we were 'alienating our Soviet colleagues,' while others were very much in favor of [active confrontation], especially in the Assembly," Mercer told *Psychiatric News*. "So, there was always an active debate."

At the Honolulu meeting, a statement denouncing the abuse of psychiatry and affirming the rights of psychiatric patients—which came to be known as the "Declaration of Hawaii"—was approved by the world body, without specifically mentioning the Soviets. A version of the declaration, updated in 1983 at the WPA meeting in Vienna, Austria, is posted on the WPA Web site (see end of article).

As reported by Robert van Voren in his new book, *Cold War in Psychiatry: Human Factors, Secret Actors,* a resolution by the British delegation censuring the Soviets passed narrowly by a vote of 90 to 88 (with delegates from Poland and Romania absenting themselves from the vote). An American resolution to establish a review committee that would field complaints about abuses wherever they occurred passed more easily by a vote of 121 to 66.

Sabshin and Mercer said that the Soviets consistently stonewalled the review committee whenever it sought information about allegations of abuse. But events at the Honolulu meeting had drawn a line in the sand, and prior to the next meeting of the WPA in 1983, the Soviet All-Union Society of Psychiatrists and Neuropathologists withdrew under threat of expulsion.

"It would have been a close vote," Sabshin told *Psychiatric News.* "But I believe the Soviets would have been expelled."

The updated version of the Declaration of Hawaii is posted at <www.wpanet.org/v1/content/ethics-hawaii.shtml>.

In Memoriam

APA honors the following members whose deaths were reported to APA from November 1, 2009, to September 30, 2010. All deceased APA members are also remembered at APA's annual business meeting, held each year during APA's annual meeting in May.

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APA, Other Medical Groups Could Face Unpleasant Choice

The repeal of the Medicare physician payment formula could become a bargaining chip by Republicans seeking repeal of all or part of the new health care reform law.

BY MARK MORAN

Repeal of the sustainable growth rate component of the Medicare payment formula is APA's legislative priority in the wake of health system reform, said APA Director of Government Relations Nicholas Meyers.

Speaking to psychiatrists at last month's Institute on Psychiatric Services in Boston, Meyers said that a 21.3 percent across-the-board reduction in Medicare physician payments is scheduled to go into effect at the end of this month. And he said APA is working with the AMA and with other specialty societies to secure a 13-month postponement of the massive pay cut, from December 1, 2010, to December 31, 2011.

In the meantime, a permanent fix to the payment formula becomes an ever more dire necessity; every month the cut is postponed costs the government $1.3 billion. So the price tag for another 13-month postponement is on the order of $16 billion, Meyers said.

(The sustainable growth rate [SGR] is the component of the Medicare physician payment formula that requires that increases in Medicare volume be compensated for by decreases in physician payment. For seven consecutive years, the Centers for Medicare and Medicaid Services has announced increasingly steep cuts in physician payment, and each year the cuts have been postponed by Congress after fierce lobbying from physician groups.)

But with a likely change of the political landscape—Meyers was speaking three weeks prior to the November 2 elections in which he predicted the Republican takeover of the House of Representatives—it is not impossible that repeal of the SGR could be held hostage to demands from Republicans for repeal of all or parts of the Patient Protection and Affordability Act approved by Congress and signed by President Obama.

It is not a prospect that APA, the AMA, and other physician groups that supported the health reform law relish. "A concern we have is that if the issue [of the SGR] isn't taken care of, it could get tied into a presumed Republican House or Senate takeover, and the health care community is going to be given a very difficult decision," Meyers warned. "Potentially, Republican lawmakers will say, 'We'll be glad to get rid of the SGR. What parts of the health reform law are you willing to let go of?'

"APA and the AMA supported [the health reform law]," he continued, "and that is a debate we don't want to get into. It puts health care practitioners between their own economic interests—which can't be discounted—and the interests of patients."

On the plus side of a GOP takeover of Congress, Meyers noted that Republicans are much less likely to support regulatory policies that physicians perceive as intrusive and will be more likely to promote medical malpractice reform.

But the problem of the Medicare payment formula looms as something close to a national emergency. Meyers noted that APA's Office of Healthcare Systems and Financing has estimated that for psychiatrists, the 21.3 percent across-the-board cut in payments would mean a reduction on the order of $20 per service per CPT code.

Meyers said the impending reimbursement cut will disproportionately affect providers of "cognitive services"—including psychiatrists—because such services are defined by time and hence can't be compensated for by increasing the volume of services.

"On one hand," Meyers said, "you have health care reform that expands access to treatment, and on the other hand, you have reductions in physician payment on the order of $20 per service that aren't going to help anyone get access, because I suspect our members will be reluctant to maintain or expand the proportion of Medicare patients they treat." ■

Reform Law

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eligible Medicaid recipients for three years, and additional federal matching funds to states that already cover childless adults in their Medicaid programs.

"Medicaid has always been the single largest payer for mental health in this country, and it's going to be more important in the years ahead," Frank said.

Frank noted that based on 2003-2004 data, the percentage of people without a mental disorder of any kind, including substance abuse, among the uninsured was about 11 percent. But the percentage of uninsured with severe mental illness is about 20 percent, and the percentage of the uninsured with any other mental illness is 18 percent. (And among the uninsured, a remarkable 52 percent have some form of substance abuse disorder.)

"Right away, if you are expanding coverage, you are almost sure to disproportionately benefit people with mental illness," he said. "And the benefit for those with addictions is even more striking. While the law is important for people with mental illness, it's even more important in the world of addiction, and it creates new opportunities to rethink the way we finance and deliver care to people with addictions."

Importantly, he noted, the package of benefits for the expanded Medicaid population will not be the same as the traditional benefit, but will look more like the "benchmark benefit" linked to private-insurance models that was established in the State Children's Health Insurance Program (SCHIP) legislation.

(SCHIP, reauthorized in 2009, establishes a "benchmark" benefit that can be the coverage offered under the BlueCross/BlueShield plan for federal employees, a coverage plan that is offered to state employees, or a coverage plan that is offered by a health maintenance organization with the largest commercial enrollment in a state.)

But Frank noted also that there is within the health reform law a provision allowing for exemptions from the benchmark benefit for those with serious mental illness so that they could have access to the more generous traditional Medicaid benefit. "So for example, if you have schizophrenia or bipolar disorder but have not qualified for SSI or SSDI, you can still meet criteria for the traditional [Medicaid] benefit," Frank said.

The second important element of the Affordable Care Act is reform of the insurance market, establishing insurance market exchanges in 2014 that will operate much as large corporations such as IBM or General Electric do—or as state governments do—allowing individuals and small employers to shop for standardized health packages. The law includes an employer mandate, also beginning in 2014, requiring companies with 50 or more employees to offer coverage to employees.

These provisions all require parity coverage of mental illness, Frank said.

The third component of the reform law is delivery-system and payment reform. And as part of that, a crucial element—and one where Frank said mental health has been singled out for exceptional treatment—is the state-based option for providing "health homes" for enrollees with chronic conditions. In part because of APA lobbying, that provision also includes persistent and serious mental illnesses in the definition of chronic illness.

Frank emphasized that the definition of a "health home" can include community mental health and home health agency services if they meet the criteria for integrating primary care and provide wraparound services. Wraparound services can include case management, home-based care, crisis intervention, individual and family therapy, treatment for substance abuse, transportation, and health education.

"This provision for Medicaid health homes integrates mental illness and addiction treatment into the mainstream thinking about chronic disease, while at the same time recognizing the special circumstances of people with severe and persistent mental illness."

Frank called the "health home" as envisioned in the law a "broader conception of chronic disease [than commonly envisioned]" and one that "relaxes the idea that a health home is uniquely located in a primary care practice." Some $50 million is earmarked for co-locating primary care services within behavioral health centers to ensure that people with severe and persistent mental illness receive medical care, and a similar amount is designated for fostering mental health care in community health centers.

Overall, the way that treatment for mental illness, including substance abuse, is regarded within the reform law is "a great mark of advance and something that we should celebrate, not fear," Frank told psychiatrists at the meeting.

"I think this is really a historic moment in terms of how we care for the sickest people with mental illness and addictive disorders," he said, "It is a huge opportunity to improve the way we pay for care for people who are extremely vulnerable, but also to rethink how we use our resources.

"Mental illness and substance abuse treatment are entering the mainstream," Frank said. "We don't mention mental health all the time [in the law] because we don't have to. We have parity, and we have an administration and a field that are committed to doing integration where it is sensible, and recognizing the places where it has its limits." ■

Oil Spill

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site of the spill, but psychological problems were more intense on shore, said Reissman.

Physical stressors were not the only ones burdening the workers.

How jobs were organized by off-site higher-ups, the amount of control an individual worker had over a given task, or a supervisor's management style might have induced anxiety, poor sleep patterns, or anger.

Some job sites included workers hired by different contractors, leading to conflicting work directives, especially in regard to safety. BP frequently changed field supervisors, who then changed work rules without giving any justification, she said. Workers understood that asking why could leave them without jobs.

Makeshift living arrangements in the field were often crowded and noisy, making it hard to relax after work, said Reissman. There was little time off and nowhere to go when time was available. Limited cell phone and Internet service made it hard to stay in touch with families.

At one site, workers dined at a company-run commissary. They were evacuated when a hurricane threatened the area, but when they returned, the commissary was gone and workers had to scramble for other ways to find meals.

Having identified a population at risk, NIOSH is now tracking who is hurt, how, and in what way. That information can be fed back to the incident commander and integrated into the ongoing response. Reissman's team at NIOSH will then decide which subpopulations should be followed more closely. Some will be tracked with periodic health surveys, while others will get more intensive medical monitoring and surveillance for both behavioral and physical problems, said Reissman.

"It looks simple, but it's hard to do." ■

IMGs Reduce Bias by Being 'More Equal Than Others'

A psychiatry chair laments the low board certification rate among IMGs and says it is the responsibility of training programs—not the trainees—to set very high standards and ensure that everyone achieves them.

BY MARK MORAN

Everyone is created equal—but some people need to be "more equal than others."

Which is why international medical graduates (IMGs) may need to work harder and be more resourceful in seeking out opportunities in training if they are going to be successful within American psychiatry, said Mantosh Dewan, M.D., distinguished professor and chair of the Department of Psychiatry at Upstate Medical Center in Syracuse, N.Y., and winner of the 2010 George Tarjan Award.

In a lecture last month at APA's Institute on Psychiatric Services in Boston titled "Imagine: The Untapped Potential of IMGs," Dewan said discrimination is undeniably a part of the IMG experience in America, but it should not be blamed for every setback faced by residents and early-career psychiatrists who received medical training in other countries.

"I have no doubt that for IMGs discrimination is real—not a lot, not always, not everywhere," said Dewan, "But there is an element of that."

He recounted his own experience coming from Bombay, India, to train in the United States at Syracuse, which he described as very positive. But when applying for a job in the South following training, Dewan said he felt the sting of bias. "What I pledged to myself was that I would have to be 'more equal than others,' " he said.

"Very often when IMGs get together, they blame every setback on discrimination," he told attendees. "And that is simply not true. There is no doubt that some people are better qualified than you. So if you don't get something, it is a fallacy to complain that it is always because you are an IMG."

Photo courtesy of Mantosh Dewan, M.D.

Mantosh Dewan, M.D.: "What I would love is to be able to replace the phrase 'there is a good IMG psychiatrist' with 'there is a good psychiatrist.' "

Dewan added, "If you must be discriminated against, America is by far the best place for it" with abundant opportunities that do not exist in other systems. IMGs have thrived in American medicine in ways they could not in other countries, and there is no question that they can provide care of a quality on a par with that provided by American-trained colleagues.

Dewan referenced a study in the August *Health Affairs* that analyzed mortality rates for 244,153 hospitalizations in Pennsylvania among patients with congestive heart failure or acute myocardial infarction. The study, "Evaluating the Quality of Care Provided by Graduates of International Medical Schools," found that patients of doctors who graduated from international medical schools and were not U.S. citizens at the time they entered medical school had significantly lower mortality rates than patients cared for by doctors who graduated from U.S. medical schools or who were U.S. citizens and received their degrees abroad.

So rather than complain about discrimination, Dewan said, IMGs in residency programs will serve themselves far better by seeking out ways to make themselves "more equal than others"—through pursuing research opportunities and publishing, obtaining additional credentials through electives, taking on administrative jobs others are unwilling to do, and following other strategies that will make them attractive to employers.

Dewan's most strident criticisms were directed to the gap that exists in certification by the American Board of Psychiatry and Neurology (ABPN) among IMGs, a gap that he said is the responsibility of teaching programs—not the trainees—to rectify. (IMGs have consistently had only a 50 percent to 60 percent pass rate, and overall, psychiatry has had a lower rate of board certification than most other specialties.)

The result of the gap has been that in state and rural psychiatric hospitals, where salaries are significantly lower, the vast majority of psychiatrists are IMGs who are not board certified. "Many of them are dispirited because they don't see an option," Dewan said. "There is a palpable sense of demoralization because they have fewer job opportunities and lower salary. It is something we should not be tolerating.

"The differential in pay is something like $30,000 a year," he said. "Think about this young person who takes a state hospital job and is going to be working for 30 years losing $30,000 a year. I think it's unconscionable.

"It is our responsibility, the training program's responsibility, to teach so that we can get a 100 percent pass rate. We have failed in that."

But Dewan was also critical of the decision by the ABPN to phase out the Part II oral examination. Those aspects of clinical care that had been tested by the oral exam—the ability to relate to a patient, conduct an interview, and make a case presentation—will instead be assessed by training programs for documentation of specific competencies prior to a resident's being credentialed to take the new ABPN board exam.

Dewan asked his audience—composed of IMGs and educators—to predict the probable success rate under the new credentialing system, and there was general agreement that 100 percent of trainees would likely receive approval.

"Instead of addressing why 50 percent of these residents who were credentialed by their training programs as [meeting the training requirements to enter the certifying system] failed the [Part II] exam and improving our training efforts so that they can all pass, we are going to a system where we make no change, eliminate the exam, and get training programs to 'pass' or credential 100 percent of residents," Dewan later told *Psychiatric News*. "What we should be doing instead is setting very high standards and encouraging all psychiatrists to achieve them—not simply changing the standard."

Strategies for Being 'More Equal'

Dewan related strategies that in his capacity as director of residency training and later as chair of the department he used to help increase the number of IMGs in training at Syracuse and to help them be "more equal than others." Among them:

- **Research and publishing**. Dewan said he believes all clinicians should learn to incorporate research into their practice and emphasized that research "on a shoestring" can be done without acquiring large grants. So he has encouraged all residents to publish case reports and series reports. "Since we know 99 percent of residents are not publishing, if you publish one case report it puts you in the top 1 percent, so it's automatically something that will get people to take a look at you."

- **Extra credentials.** At Syracuse the training program has incorporated the university's top-ranked master's of public administration (MPA) program into the curriculum as an elective. "With psychiatry training and an MPA, it makes it very hard for someone to turn you down."

- **Language proficiency**. Dewan emphasized that facility with the language is crucial in psychiatry and said he has employed speech pathologists to help IMGs improve language skills.

- **Mock boards.** The training program has conducted mock boards including assessors from outside the training program to help residents prepare for board certification examinations.

"Everything we have been doing is good for American graduates as well as IMGs," Dewan said. "We should set universal high standards and help everyone—U.S. medical graduates, IMGs, and U.S.-born IMGs—achieve them."

He added, "What I would love is to be able to replace the phrase 'there is a good IMG psychiatrist' with "there is a good psychiatrist.' "

"Evaluating the Quality of Care Provided by Graduates of International Medical Schools" is posted at <www.ama-assn.org/ama1/pub/upload/mm/18/health-affairs-imgs-usmg.pdf>. ■

Bernstein Elected To ACGME Board

APA President Carol Bernstein, M.D., has been elected to the Board of Directors of the Accreditation Council for Graduate Medical Education (ACGME), the national accrediting body for residency education in the United States.

Bernstein is vice chair for education and associate dean for graduate medical education at the New York University School of Medicine.

The ACGME is a private, nonprofit organization that was established in 1981 from a consensus in the academic medical community for an independent accrediting organization. ACGME's parent members are the AMA, American Board of Medical Specialties, Council of Medical Specialty Societies, American Hospital Association, and Association of American Medical Colleges.

"I am honored and privileged to have been appointed to the ACGME Board of Directors," Bernstein told *Psychiatric News*. "I look forward to using my perspectives from my leadership experiences at APA and in graduate medical education at NYU and Columbia to further advance the GME agenda on a national level."

"It is good to have someone from psychiatry with as much experience as Carol on the board of the ACGME," said James H. Scully Jr., M.D., APA medical director and president of the Council of Medical Specialty Societies. "In the world of medical education, ACGME is the place to be. It is the body that determines all manner of rules governing medical training, and we are lucky to have someone as widely respected as Carol to represent us there."

Bernstein's election expands psychiatry's involvement in the ACGME leadership. Among other psychiatrists on its Board of Directors are Christopher Colenda, M.D., chancellor for health sciences at West Virginia University, and Kayla Pope, M.D., J.D., APA's member-in-training trustee, who is the ACGME resident director. ■

PTSD

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producers should present their work in a form that helps practitioners "easily differentiate which recommendations are evidence based and which are based on clinical consensus, as well as which are informed by the service system and which are independent of service systems."

Developing better guidelines will depend on more and more rigorous research, with regular updating based on reviews of new evidence.

In the meantime, researchers and clinicians will have to read these *Baedekers* according to their own clinical traditions and their patients' individual needs.

"Guidelines are just that, guidelines," said Spiegel. "We try to draw from the best we know, but our assumptions influence our results."

An abstract of "A Guide to Guidelines for the Treatment of PTSD and Related Conditions" is posted at <http://onlinelibrary.wiley.com/doi/10.1002/jts.20565/abstract>. ■

Don't Confuse Depression And Grief, Author Advises

Kay Redfield Jamison, Ph.D., who has endured mental illness and her husband's death, realizes that depression is destructive and alienating, but that grief acts to preserve the self and draw people together.

BY AARON LEVIN

"It has been said that grief is a kind of madness," Kay Redfield Jamison, Ph.D., told listeners at APA's Institute on Psychiatric Services in Boston in October. "I disagree."

She spoke in hope of adding to the discussion over proposed elimination of the grief exclusion from the *DSM-5*'s criteria for major depressive disorder. That possible change has been characterized by some as medicalizing normal human experience.

"There is a kind of sanity to grief," continued Jamison, a professor of psychiatry at the Johns Hopkins School of Medicine and honorary professor of English at the University of St. Andrews in Scotland. "It provides a path—albeit a broken one—by which those who grieve can find their way. Grief is not a disease; it is a necessity."

Jamison has a deep personal acquaintance with both mental illness and grief. She chronicled her experience with bipolar illness in several well-known books, including *An Unquiet Mind*. The death of her husband, National Institute of Mental Health neuropsychiatry researcher Richard Wyatt, M.D., of cancer in 2002, gave her a powerful understanding of grief as well. She wrote about that experience in *Nothing Was the Same*.

Credit: Ellen Dallager

Kay Redfield Jamison, Ph.D.: "Madness prepared me for grief. It gave me an unsentimental gauge by which to test my sanity within my grief and a respect for the true terror that is at the core of madness."

In the years since, she came to appreciate the differences between the two. She found many contrasts between her experience with mental illness and her experience after her husband's death.

At first, she feared that her depression would return, but it did not. The loss of Wyatt was devastating but not deadly.

"In grief, death occasions the pain," she said. "In depression, death is the solution to the pain."

She noticed other differences. If depression was unending, grief came in waves, returning and receding as memories of her husband came and went, she said.

She was distraught and restless, but it was not the agitation of mania. Her thoughts churned, but thinking helped her cope, she said. In depression nothing good came from endless ruminations. She felt better physically than she had during depressive episodes, and she did not think of suicide.

However, some things that were once comforting became burdensome. Listening to Beethoven and Schumann was too intense, too painful, so she gave away her classical music collection. She compensated with words. Tennyson's "In Memoriam" saw her through the most difficult stretches.

"I never had an appreciation for what solace words could bring. In depression, words were meaningless and brought me no comfort."

Depression was indiscriminately destructive, but grief acted to preserve the self.

Unlike in depression, her mood varied, rising in response to connections with family and friends.

If depression is alienating, she explained, then grief draws together the people who knew the deceased, bonded by the same emotions. Rituals, religious and otherwise, that surround grief are defenses against alienation. Grief begins to alienate and resemble depression only when it becomes too prolonged and too severe.

"There is wisdom in the pain attached to grief, but not in the irredeemable suffering of depression," she said. "In grief, I understood for the first time how sick I had been. It is not suffering without end."

As for whether extended or extreme grief should be considered a treatable condition, Jamison noted that people have different reactions to illness and death. Some are frozen in time and can't move on. They should not suffer needlessly; they should be evaluated for depression and receive any needed care.

"I hope the *DSM-5* team looking at the issue of grief and depression will go where the data go but also bring in people from religion, ethics, art, or literature," she said in an interview after her talk. ■

Bereavement Intervention Successful In Preventing MH Sequelae

A psychiatric illness prevention program demonstrates long-term mental health benefits for families in which a parent has died, a group that is often vulnerable to such illnesses.

BY RICH DALY

The Family Bereavement Program (FBP), which aims to prevent psychiatric illness in children who had a parent die and in their surviving parent, has demonstrated improved mental health outcomes for at least six years after treatment was initiated, compared with other prevention approaches.

A psychiatric illness prevention program tailored for bereaved family members was found to provide long-term mental health benefits. The research design consisted of a randomized, controlled trial and compared two approaches—single-family counseling sessions and reading bereavement literature—among families in which a parent had died within four to 30 months before enrollment.

The study, conducted by Arizona State University researchers and published in the October *Archives of Pediatric Adolescent Medicine*, randomly assigned the children and parents to the FBP preventive treatment or a control group that used bereavement support literature rather than an active intervention. The study included 218 bereaved youth (aged 8 to 16) and 113 parents whose spouses had died, none of whom was currently receiving mental health or bereavement treatment services.

"Caregiver" was defined as a parent or other adult acting in a parental role. The FBP approach included 12 two-hour sessions for each family alone, led by master's-level clinicians, that focused on strengthening the quality of the caregiver-youth relationship and teaching developmentally appropriate skills (which were not specified) to strengthen the children's relationship with their caregiver. Additionally, the sessions sought to decrease the adults' mental health problems.

The literature control included bereavement books for youth and caregivers and a syllabus to guide their reading. Forty-two percent of caregivers reported reading at least half the literature, which could have included half of each book or half of the total literature provided, while 71 percent of children and 38 percent of young adults also reported reading at least half the literature.

At the end of the six-year program, interviews were conducted with 209 youths and 143 caregivers. Youth in the FBP program had significantly lower "internalizing" and "externalizing problems" as assessed by the Child Behavior Checklist, the Youth Self-Report, the Young Adult Behavior Checklist, and the Young Adult Self-Report, as reported by caregivers, the youth, and teachers. Parents in the FBP had lower depression scores (on the Beck Depression Inventory) than did those in the control group.

"Because externalizing problems in adolescence and young adulthood are associated with a wide array of social adaptation and mental health problems later in development, the current findings have significant public-health implications," wrote Irwin Sandler, Ph.D., regent's professor in the Department of Psychology at Arizona State University and the study's lead author, and his colleagues.

Specifically, youth with low baseline untreated mental health problems in the FBP group were less likely to have mental disorders diagnosed throughout the six years during which they were followed, compared with other youth with low baseline untreated mental health problems in the control group.

Additionally, the program bolstered self-esteem, as measured by the Self-Perception Profile for Children at both the children's entry into the program and six years later. The authors noted that this finding is meaningful, given that poor self-esteem is a risk factor for depressive disorders in early adulthood.

The authors cautioned that the findings should not be generalized to the types of families who were excluded from the trial, including those already receiving mental health services. Also excluded were ethnic minority families and families that had experienced parental suicide.

"Six-Year Follow-Up of a Preventive Intervention for Parentally Bereaved Youths" is posted at <http://archpedi.ama-assn.org/cgi/content/abstract/164/10/907>. ■

from the president

continued from page 3

in Psychiatry, a 100-question examination that will provide additional opportunities to obtain CME credit at the annual meeting.

Information about ABPN's requirements for MOC is posted at <www.abpn.com>. APA has posted information about lifelong learning at <www.psych.org/MainMenu/EducationCareerDevelopment/LifelongLearning.aspx> and resources for MOC at <www.psych.org/moc>.

APA will continue to work closely with our members to ensure that MOC requirements are appropriate and not unnecessarily burdensome. Nevertheless, we must recognize the patient-advocacy movement's support for patient feedback on the quality of our work and not advocate for some type of special status different from the rest of medicine. As physicians, we must continue to remain current with advances and new knowledge in our field and work collaboratively with our patients to ensure the highest quality outcomes in our treatments. ■

Learn How to Enjoy Every Moment in Paris

Resetting the biological clock prior to a flight across multiple time zones can eliminate or reduce symptoms of jet lag, chronobiologists report.

BY LYNNE LAMBERG

Timed use of bright light and melatonin, along with shifting sleep earlier or later before departure, can foster a traveler's daytime performance and sleep on arrival in a new time zone, according to Charmane Eastman, Ph.D., a professor of behavioral sciences and director of the Biological Rhythms Research Laboratory at Rush University Medical Center in Chicago.

Diplomats, lawmakers, military commanders, and their support staffs are among those for whom escaping the discomfort and fogginess of jet lag holds high priority, Eastman said in a talk for the Congressional Biomedical Research Caucus in Washington, D.C., in September.

Physicians, business travelers, athletes, musicians, and others whose work takes them around the globe also can benefit from using jet-lag countermeasures, Eastman told *Psychiatric News*.

Jet lag results from a temporary misalignment between the body's internal clock and the demands of the destination time zone. Disturbed nighttime sleep and diminished daytime alertness rank highest among travelers' complaints. Dysphoric mood and digestive upsets also occur frequently.

Symptoms ordinarily persist about a half day to one day for every time zone crossed, but can last longer or dissipate faster, Eastman said, depending on the time of outdoor light exposure.

Most people find it harder to travel east, which asks them to fall asleep earlier, relative to home time, than to travel west, which calls for staying up later.

Bright light, obtained outdoors or from a light box (see photo), and exogenous melatonin advance or delay the body clock depending on their time of administration, Eastman said. Light exposure before the body's temperature minimum—about 4 a.m. in people who usually wake between 6 a.m. and 7 a.m.—pushes the internal clock later. Light exposure after the temperature minimum shifts the clock earlier.

When the temperature minimum occurs in waking hours, as commonly occurs after eastward travel, cognitive performance and manual dexterity often deteriorate, Eastman noted. Jet-lag countermeasures aim to keep the temperature minimum in sleep or to realign it quickly with sleep.

While the hormone melatonin is secreted only in the dark, taking exogenous melatonin in the afternoon shifts the biological clock earlier. Taking it in the morning shifts the clock later.

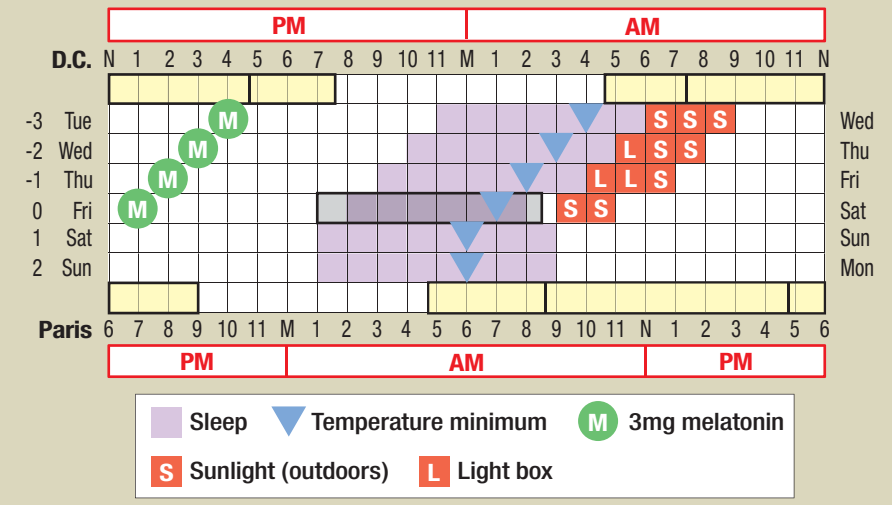
Although melatonin is neither a sedative nor a hypnotic, it may increase sleepiness. New users of melatonin should take test doses at home, Eastman said, and avoid driving afterward.

In her talk, Eastman focused on a trip familiar to her audience—one from Washington, D.C., to Baghdad, with a stopover in Germany, a shift of eight time zones east in winter, and seven in summer, when Daylight Saving Time is in effect. Shorter trips eastward employ the same principles to hasten adaptation. The chart above shows how to prepare for a trip from Washington, D.C., to Paris.

Eastman occasionally designs jet-lag prevention schedules for travelers in return for daily feedback on their progress. She can be contacted at ceastman@rush.edu.

More information can be found in Eastman's review, "How to Travel the World Without Jet Lag," in the June 1, 2009*, Sleep Medicine Clinics, *posted at <www.ncbi.nlm.nih.gov/pmc/articles/PMC2829880/>. ■

Sample Schedule for Paris



The lines of numbers at the top and bottom of the chart indicate time of day in Washington, D.C., and in Paris. The purple boxes represent hours of sleep. The gray box shows flight time. Three days before departure, a traveler should take 3 mg of melatonin at 4 p.m., seven hours before an 11 p.m. bedtime. On arising at 6 a.m., he or she should go outside to get sunlight exposure or use a light box. Light exposure need not be continuous: time-out for a shower is fine. That afternoon, the traveler again should take 3 mg of melatonin seven hours before bedtime, an hour earlier than the night before, and get bright light on awakening the next morning. This routine should continue through the day of travel. Spending time outdoors on arrival in Paris will further aid adaptation.

Jet Lag May Exacerbate Mood Disorders

For leisure travelers, jet lag usually amounts to only a minor inconvenience. In people with mood disorders, however, circadian misalignment may trigger more acute sleep and mood disturbances, Robert Sack, M.D., a professor of psychiatry at Oregon Health and Science University, told *Psychiatric News*. People with mood disorders need to be aware of this possibility when traveling across multiple time zones.

Psychiatrists may want to encourage such patients to use light exposure and melatonin prior to departure to hasten their adaptation to the new local time, Sack said.

A hypnotic medication or melatonin may help improve sleep on the plane and when taken at bedtime the first few nights in the new time zone. A Northwestern University study found ramelteon, a melatonin receptor agonist, taken at bedtime, was more effective than a placebo in speeding sleep onset for the first four nights after arrival in 110 healthy adults who had flown five hours eastward.

Individuals who have not taken such medications previously should take a test dose at home before a trip, Sack said. Hypnotics' potential adverse effects include amnesia and confusion.

Caffeine can help counter daytime sleepiness. The potential usefulness of other alerting agents is being studied.

Researchers at the Atlanta Sleep Medicine Clinic found the wake-promoting medication armodafinil improved daytime alertness, assessed by both objective and subjective measures, in 427 people traveling from the eastern United States to France. The Food and Drug Administration has approved armodafinil for use in treating sleepiness in narcolepsy, shift-work sleep disorder, and obstructive sleep apnea. In March, however, the FDA declined to approve armodafinil's use for jet lag.

More information is in Sack's review, "Jet Lag," in the February 4 New England Journal of Medicine *posted at <www.nejm.org/doi/pdf/10.1056/NEJMcp0909838>.*

All Antipsychotics Not Created Equal When It Comes to Diabetes Risk

Whether antipsychotics play a role in diabetes seems to depend partially on the drug used. The risk among the second-generation drugs seems to be highest for ziprasidone and sertindole and lowest for amisulpride, quetiapine, and aripiprazole.

BY JOAN AREHART-TREICHEL

Antipsychotic medications increase patients' risk of developing diabetes, some studies have suggested. A new study now provides more evidence of such a concern. But it also suggests that the risk varies considerably depending on the antipsychotic used, the duration of use, and whether more than one antipsychotic is used.

This new study appears to be the largest and longest exploring the subject. It was headed by Lars Vedel Kessing, M.D., a professor of psychiatry at the University Hospital of Copenhagen in Denmark. Results were published in the October *British Journal of Psychiatry*.

In Denmark, all 5 million or so residents have a unique personal identification number that is recorded in linked registers whenever they receive medical services or purchase medications. Kessing and his coworkers used data in these registers to select their study sample—some 346,000 individuals who had purchased antipsychotics between 1996 and 2005 as well as some 1,427,000 individuals (about a third of the total Danish population) who had not. More than 50,000 people were diagnosed with diabetes in that period.

In reviewing the data, the researchers found a link between having been diagnosed with diabetes and taking an antipsychotic medication during the 10-year study period, even when some possibly confounding factors—age, gender, calendar period, and the use of lithium or anticonvulsants—were considered.

Compared with unexposed individuals, those receiving a first-generation antipsychotic medication such as zuclopenthixol, perphenazine, or haloperidol had a diabetes rate of 1.53, and those receiving a second-generation antipsychotic medication had a diabetes rate of 1.32. However, the rates of diabetes varied substantially among the second-generation antipsychotic medications.

please see ***Diabetes*** *on page 25*

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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Rev. 05/09

BY JOAN AREHART-TREICHEL

Do Disasters Foster Drinking Problems?

What is the relationship, if any, between disasters and alcohol abuse? Carol North, M.D., chair of crisis psychiatry and a professor of psychiatry at the University of Texas Southwestern Medical Center in Dallas, and colleagues set about answering this question.

They merged data from 10 disaster-related studies that included about 700 individuals. The disasters studied included a tornado, an earthquake, a firestorm, a plane crash into a hotel, mass-murder episodes, and the Oklahoma City terrorist bombing.

After their data analysis, North and her coworkers concluded that these disasters did not lead most subjects to initiate or increase their drinking. Only 0.3 percent of the sample developed a new alcohol use disorder in the wake of a disaster. However, 83 percent of those in recovery from an alcohol use disorder did consume alcohol in the wake of a disaster.

So while disasters do not generally drive people to drink, they do seem to be capable of triggering relapses in people who already had an alcohol problem, the researchers concluded in their paper, which was published online October 4 in the *Archives of General Psychiatry*.

The study was funded by the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration.

An abstract of "Post-Disaster Course of Alcohol Use Disorders in Systematically Studied Survivors of 10 Disasters" is posted at <http://archpsyc.ama-assn.org/cgi/content/abstract/archgenpsychiatry.2010.131v1>.

Identifying Children Who May Be Gamblers

A study conducted on 163 children in Montreal, Canada, has found that impulsive behaviors in kindergarteners, such as inattentiveness, distractibility, or restlessness, presage buying lottery tickets, playing video poker, wagering on sports, or other gambling behaviors in the sixth grade.

The impulsive behaviors were evaluated with kindergarten-teacher ratings on the Social Behavior Questionnaire (age-determined norms). The link held even when possibly confounding factors such as gender, maternal education, family dysfunction, or parental gambling were considered.

Subjects in the prospective longitudinal study were part of the 1999 kindergarten cohort of the Montreal Longitudinal Preschool Study that was followed up in the sixth grade.

The researchers hope that others will attempt to confirm their findings with more rigorous population-based prospective analyses.

The study was headed by Linda Pagani, Ph.D., a professor in the University of Montreal's School of Psycho-Education, and was published in the August *Canadian Journal of Psychiatry*. The study was funded by Canada's Social Science and Humanities Research Council.

"Does Early Emotional Distress Predict Later Child Involvement in Gambling?" is posted at <http://publications.cpa-apc.org/browse/documents/2> under the August issue.

Seizure Drugs Can Influence Nicotine Metabolism

Two antiepileptic drugs—carbamazepine and oxcarbazepine—may speed up nicotine metabolism in individuals who smoke, a study reported September 14 in *Cancer Epidemiology, Biomarkers, and Prevention* suggests.

The study included 149 individuals with schizophrenia or bipolar disorder who were smokers. Eight were taking carbamazepine, six were taking oxcarbazepine, and 40 were taking valproic acid. The rest were not taking an antiepileptic drug.

Nicotine metabolism was found to be significantly higher in subjects taking carbamazepine or oxcarbazepine than in those taking valproic acid or no antiepileptic drug.

Whether carbamazepine and oxycarbazepine's ability to speed up nicotine metabolism influences how much a person smokes is unknown. But fast nicotine metabolizers are known to be more prone to smoking more and to developing nicotine dependence than slow metabolizers are.

A drawback of the study is that some of the subjects were using antipsychotics as well as antiepileptics. However, study results indicated that the antipsychotics had no influence on the subjects' nicotine metabolism.

The study was headed by Jill Williams, M.D., an associate professor of psychiatry at the UMDNJ-Robert Wood Johnson Medical School in New Jersey. It was funded by the National Institutes of Health.

An abstract of "Carbamazepine but Not Valproate Induces CYP2A6 Activity in Smokers With Mental Illness" is posted at <http://cebp.aacrjournals.org/content/19/10/2582.abstract?sid=d899062c-3be5-4fd2-a481-cc01a24aab81>.

Another Gene Variant Found to Influence Drug Response

During the past 15 years or so, the field of psychiatric pharmacogenetics has advanced considerably.

Variants in genes that code for drug-metabolizing enzymes in the liver are being found to influence those enzymes' handling of psychotropic medications in the body (*Psychiatric News*, May 20, 2005).

Variants of genes that code for certain brain receptors and transporters can also alter psychotropic medications' clinical outcome once they enter the brain. For instance, a variant of a gene that codes for a potassium channel in neurons has been found to influence antidepressant response (*Psychiatric News*, May 2, 2008). So have variants in the serotonin transporter gene (*Psychiatric News*, January 16, 2009).

And now a variant of a gene that codes for a membrane protein in serotonin and noradrenaline receptors has been found to influence the impact of the antidepressant nortriptyline, Robert Keers, a doctoral student in pharmacogenetics at the Institute of Psychiatry, King's College, London, and colleagues reported online September 8 in the *Journal of Psychopharmacology*.

Specifically, depressed patients who had two copies of a particular variant of the GNB3 gene experienced significantly greater appetite and sleep improvements from nortriptyline than did depressed patients who had only one copy or no copies of the variant.

Interestingly, the GNB3 variant that influenced nortriptyline action in depressed patients did not influence the action of another antidepressant, escitalopram, in them, the researchers found. This finding did not surprise him, Keers said, since nortriptyline works better than escitalopram on the somatic symptoms of depression such as sleep and appetite problems, and the GNB3 gene is crucial to the pineal gland, which is involved in the regulation of sleep and appetite by the release of melatonin.

Citing the potential clinical implications of their findings, Keers said, "Drug response is . . . influenced by multiple genetic and environmental factors. This means that the effects of one genetic variant, such as the one reported in this paper, are small. . . . Pharmacogenetics is, however, moving toward incorporating these and other polymorphisms to make more clinically useful predictive models. . . ."

The study was funded by the European Commission Framework.

An abstract of "Variation in GNB3 Predicts Response and Adverse Reactions to Antidepressants" is posted at <http://jop.sagepub.com/content/early/2010/09/07/0269881110376683.abstract>. ■

professional news

Boundary

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HIV-positive patients for whom a modest, nonsexual, physical contact, like a handshake or pat on the shoulder, can lower the patient's sense of shame or stigma.

Reports of sexual misconduct by psychiatrists with patients have decreased because of increased ethical sensitivity to such behavior and publicity surrounding cases that get into the media. Psychiatrists are more aware today that such behavior is always wrong and that they can lose their licenses over it.

Nevertheless, some members of state regulatory boards still overreact to accusations of boundary violations, harboring suspicions of sex between doctor and patient foremost in their minds, said Gutheil. For instance, merely using a patient's first name has been construed as sexual misconduct by some boards, while others see any last appointment of the day as a likely sexual encounter, he said.

Sexual misconduct may have declined, but it has not disappeared. There are no excuses, because the therapist can never blame a seductive patient, said Gutheil.

"If both parties are competent adults, both are responsible for their actions, but only the therapist is liable for a violation because only the therapist has a professional code of conduct to be violated," he said. Therapists are required to place the needs and interests of patients ahead of their own.

Those who don't have earned places in Gutheil's lexicon of shame.

On the male side, "Dr. Loman" (named after the protagonist in "Death of a Salesman") is going through a midlife crisis and deals with it by falling madly in love with a patient. "Dr. Sick" is characterized by an Axis I problem, hypomania, grandiosity, and often stimulant abuse. "Dr. Predator" is psychopathic, exploiting multiple patients in multiple ways—physically, socially, financially, sexually. "Dr. Weird" is schizoid and paraphilic.

Nor are female clinicians exempt, said Gutheil. "Dr. Hysteric" has unresolved Oedipal conflicts and gets involved with male patients. "Dr. Mother" is a lesbian who gets involved with female patients, in a relationship that is first nurturing and later sexual.

Problems can also arise from the patient's side, too. Patients may falsely accuse therapists out of revenge or retaliation. In one case, a patient threatened to file a charge of molestation against a psychiatrist if he didn't change the diagnosis in the chart.

When cases of eroticized transference arise, the therapist should seek supervision. Reporting the problem removes it from the realm of the guilty secret, and the therapist also may get specific suggestions for defusing the problem. If false claims do arise, it may help to show that the clinician sought help beforehand.

The best defense is prevention, and that should begin in training, said Gutheil. He bemoaned the decline in psychodynamic training that followed the rise of biological psychiatry and psychopharmacology.

"I don't care what your ideology is, you need to teach transference and countertransference to your trainees," he said. "It's part of their equipment for the real world."

Trainees should also learn about legal and clinical pitfalls and to be alert to "exceptions" from their standard practices.

"Be clear in your own mind when it's time to set limits, and prepare responses in advance for when those limits are reached," he emphasized. ■

Nominations Invited

Psychiatry residency training directors are invited to nominate one resident for the American Psychiatric Leadership Fellowship. The two-year program is designed to develop future leaders in psychiatry. During this time, fellows will participate in a component of the APA governance structure, attend APA annual meetings, and receive leadership training.

Psychiatry residents who are in PGY-2 at the time of nomination (or PGY-3 of a five-year program), are APA members or have applied for membership, and have passed all national or state board exams needed for full state licensure are eligible.

The deadline for nominations is January 15, 2011. More information and nomination requirements are posted at <www.psych.org/share/OMNA/psychiatric-leadership-fellowship.aspx>. ■

Diabetes

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For example, the rate was between 1.17 and 1.57 for those taking olanzapine, risperidone, or clozapine, and 2.00 or more for those taking ziprasidone or sertindole. In contrast, there was no significantly increased rate of diabetes in those taking amisulpride, quetiapine, and aripiprazole.

Finally, for individuals on either first-generation or second-generation antipsychotic medications, the rate of diabetes increased with duration of treatment and the number of antipsychotics the patients took.

For instance, the rate of diabetes was 0.98 in subjects who had purchased one or two second-generation antipsychotic prescriptions, 1.30 in subjects who had purchased 20 to 24 of them, and 1.81 in subjects who had purchased 40 or more. Along similar lines, the rate of diabetes was 1.48 in subjects using one antipsychotic medication, 2.38 in subjects using four, and 3.41 in subjects using five or more.

The study had no outside funding.

In a related study also published in the October *British Journal of Psychiatry*, British researchers reported that individuals who have both schizophrenia and diabetes or both bipolar disorder and diabetes have a significantly increased risk of death compared with individuals with diabetes alone.

The cohort included some 44,000 people with diabetes. Out of these subjects, 257 also had schizophrenia, 159 also had bipolar disorder, and 14 had been diagnosed with both schizophrenia and bipolar disorder. Their survival rates between 2000 and 2005 were the focus of the study.

There are several possible explanations for the results, the researchers believe.

One is that in people with schizophrenia and diabetes or in people with bipolar disorder and diabetes, diabetes may be more poorly controlled than in people with diabetes alone. However, a study by other researchers does not support this explanation, they pointed out. It found that diabetes care in the United Kingdom is as good for people with schizophrenia or bipolar disorder as for those without it.

Another explanation is that people who have schizophrenia or bipolar disorder and diabetes have more comorbid physical illnesses than people with diabetes alone.

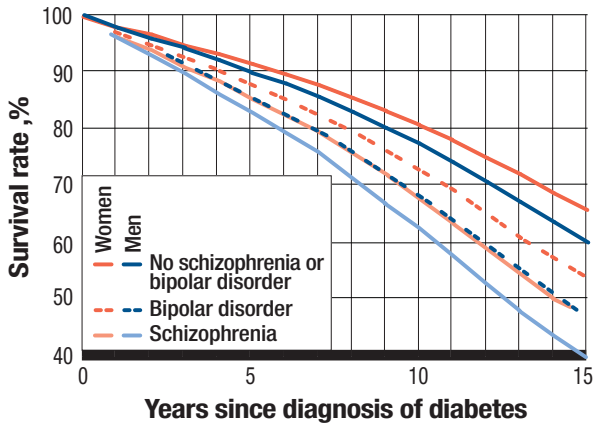
The researchers did not address the possibility that people with schizophrenia and diabetes or with bipolar disorder and diabetes are at increased risk of death because they do not take good care of themselves in ways other than diabetic control or because of suicide.

This study was headed by Yana Vinogradova, M.Sc., of the University of Nottingham and funded by that university and the U.K. Disability Rights Commission.

An abstract of "Treatment With Antipsychotics and the Risk of Diabetes in Clinical Practice" is posted at <http://bjp.rcpsych.org/cgi/content/abstract/197/4/266>. An abstract of "Effects of Severe Mental Illness on Survival of People With Diabetes" is posted at <http://bjp.rcpsych.org/cgi/content/abstract/197/4/272>. ■

Outlook Unfavorable When Diabetes Is Coupled With Serious Mental Illness

The estimated survival rates in both women and men with diabetes at age 60 were highest for those who had neither schizophrenia nor bipolar disorder, next highest for those who had bipolar disorder, and lowest for those who had schizophrenia.



Source: Yana Vinogradova, et al., *British Journal of Psychiatry*, October 2010

Adolescents

continued from page 1

stance use, or eating disorders. Parents of the subjects also filled out questionnaires to provide additional information about their offspring's mental and physical health as well as sociodemographic characteristics.

In addition to the results noted above, the data showed that anxiety disorders were the mental illnesses most commonly experienced by subjects at some point in their lives. Anxiety disorders had affected 32 percent of subjects, behavior disorders had affected 19 percent, mood disorders had affected 14 percent, substance use disorders had affected 11 percent, and eating disorders had affected 3 percent.

The average age of onset for disorder classes was earliest for anxiety at 6 years, followed by age 11 for behavior disorders, age 13 for mood disorders, and age 15 for substance use disorders.

Subjects whose parents were not college graduates were at increased risk for all disorder classes. In addition, the lifetime prevalence rates for anxiety disorders, behavior disorders, and substance use disorders were higher for respondents whose parents were divorced or separated than for those whose parents were married or cohabiting.

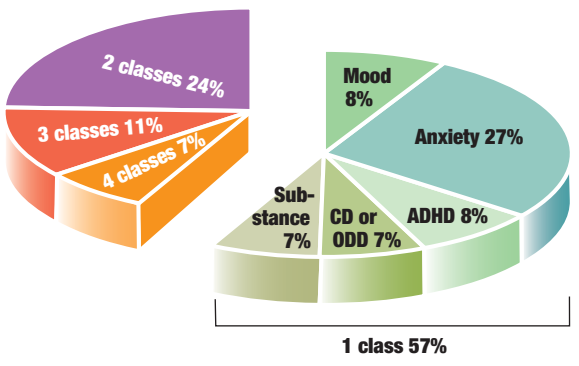
However, family income level and urbanicity were not associated with any of the classes of mental disorders.

"The results of this study are consistent with previous results," David Fassler, M.D., a child and adolescent psychiatrist and clinical professor of psychiatry at the University of Vermont, told *Psychiatric News*. "The findings confirm that more than one adolescent in five will experience significant signs and symptoms of mental illness. The study also underscores our growing awareness that many, if not most, psychiatric disorders begin well before adulthood. The good news is that we can help almost all of these young people. The real tragedy is that the majority don't receive the effective and appropriate treatment they need and deserve."

An abstract of "Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results From the National Comorbidity Study–Adolescent Supplement" is posted at <www.jaacap.com> under the October issue. ■

Is America Overflowing With Anxious Youth?

A new nationally representative study underscores psychiatrists' growing awareness that many of America's youth have, or have experienced, mental illness. The pie chart below gives a breakdown of *DSM-IV* disorders among a subsample of the 10,123 youth in the study. The subsample consisted of the 6,483 subjects for whom there were both parent and child reports available.



Source: Kathleen Merikangas, Ph.D., et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, October 2010

Condolence

continued from page 2

suicide in 2009 and 80 dying by suicide in the first six months of 2010, according to Army reports (*Psychiatric News*, September 3). The elevated suicide rate continues despite the Department of Defense strengthening its suicide-prevention programs and trying to remove the stigma many in the military attach to seeking mental health care.

The APA statement is posted at <www.psych.org/condolenceletterpolicy>. ■

World Congress to Be Held in Buenos Aires

The World Congress of Psychiatry, organized by the World Psychiatric Association every three years, is the main international scientific event in the field of psychiatry. The next World Congress, whose theme is "Our Heritage and Our Future," aims to provide a comprehensive overview of those achievements that have stood the test of time and of the most promising current trends in psychiatric research and practice, with the contribution of the most prominent experts of the various topics.

The next World Congress—the 15th—will be held September 18 to 22, 2011, at the Sheraton Buenos Aires Hotel and Convention Center.

An outstanding scientific program is being put together, according to Mario Maj, M.D., the president of the World Congress. The list of the keynote lectures and core symposia is posted on the Web site of the Congress, <www.wpa-argentina2011.com.ar>.

To help attendees get the most out of their trip to Buenos Aires, a schedule of tours is also being offered. Descriptions can be found at <www.wpa-argentina2011.com.ar/local_tours.htm>.

Submissions are still being accepted. The deadline for submissions of WPA section and zonal symposia, oral communications, and posters is November 30. Submission guidelines can be found on the World Congress Web site. Attendees can earn up to 32 Category 1 credits.

Registration and other information about the World Congress is posted at <www.wpa-argentina2011.com.ar/>. ■

Applicants Sought for VA Fellowship

The U.S. Department of Veterans Affairs is seeking applicants for its academic year 2011-2012 Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery-Oriented Services for veterans with serious mental illness.

The purpose of the fellowship is to develop future mental health leaders with vision, knowledge, and commitment to transforming mental health care systems in the 21st century by emphasizing functional capability, rehabilitation, and recovery.

Fellows will work with veterans with serious mental illness, including schizophrenia, schizoaffective disorder, other psychoses, bipolar disorder, and major depression, and receive training in delivering a range of evidence-based practices. Veterans may also have comorbid diagnoses, such as PTSD, substance use disorders, depression, and anxiety.

Psychiatry fellows must be U.S. citizens and graduates of professionally accredited academic and training programs. Fellows are eligible for health and life insurance benefits and can earn leave.

The fellowship is offered at six VA sites. Applications will be accepted and reviewed at each site until all positions are filled. Application requirements and specifications may differ across sites.

Here are the Web sites for each location: Bedford, Mass.: <www.psychologytraining.va.gov/bedford/>; Durham, N.C.: <www.psychologytraining.va.gov/durham/>; Little Rock, Ark.: <www.littlerock.va.gov/careers/psychology/fellowship/Psychology_Fellowship_Prgram.asp>; San Diego: <www.psychologytraining.va.gov/sandiego/>; Waco, Texas: <www.centraltexas.va.gov/services/MHBM/Teaching.asp#Fellowship>; West Haven, Conn.: <www.psychologytraining.va.gov/westhaven>. ■

Soviet

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News. "We would send letters to the prisoners, their families, and to the institutions where they were incarcerated. We didn't always have their family members' contact information, but we would write to them if we did.

"The content of the letters was less important than the fact that they were on APA letterhead and had the name of the individual in the letter," she said. "We would always say something like, 'It has come to our attention that _____ has been incarcerated in _____ hospital allegedly for nonmedical reasons. We would appreciate your sharing with us the reason the person is there and whatever other information is available.' "

Incarcerated individuals were not always strictly political dissidents protesting human-rights abuses, but included members of disparate national groups seeking independence, as well as members of religious sects, including the Russian Orthodox Church and Protestant denominations, and Jews seeking to emigrate to Israel or the West.

Some of the cases also involved psychiatrists who refused to cooperate with KGB authorities in detaining individuals. Among these were two—Semyon Gluzman, M.D., and Anatoly Koryagin, M.D.—on whose behalf APA was vocal. Gluzman had early on protested the incarceration of Pytor Grigorenko, a Soviet World II hero, and earned for his courage seven years in a forced-labor camp and three years in exile. Gluzman was later made a distinguished life fellow of APA, and in 1982 he returned to Kiev and later became a leader of Ukrainian psychiatry.

Koryagin was a consultant to the Moscow Working Commission to Investigate the Use of Psychiatry for Political Purposes and wrote an article in the April 11, 1981, *The Lancet* titled "Unwilling Prisoners." A footnote to that article stated that earlier that same year, Koryagin had been arrested and charged with "anti-Soviet agitation." After serving time in prison, he was exiled to Switzerland and later returned to the Soviet Union.

APA's letters rarely, if ever, received a response, but the communication served notice to Soviet officialdom that the world was watching.

And it had an effect. Mercer recalled that in a meeting with dissidents at the American Embassy in Moscow in 1989, prior to the visit of American psychiatrists led by the State Department, many stated that the publicity had saved their lives.

"We know from people who were released that they received much better treatment because of the letters than those who did not come to the attention of people and organizations in the West," Mercer said. "And, usually, they had no idea how and why they were noticed and others were not."

Reddaway agreed. "The dissidents themselves firmly believed the more foreign pressure the better, and if someone was released, they all felt the pressure had played an important part," he said. "I have studied official documents in the Soviet archives, including minutes from meetings of the Politburo, and it is obvious that Soviet authorities at high levels paid close attention to foreign responses to these cases."

In the third article of this series,* Psychiatric News *will look back on the 1989 visit of American psychiatrists to the Soviet Union. ■

MH Reform

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Governments as a critical turning point. And on the local level he drew attention to a 2007 report by the Florida Supreme Court titled "Constructing a Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Treatment System: Strategies for Planning, Leadership, Financing, and Service Development."

"We have begun to lay the groundwork to make some significant changes," he said.

In Leifman's jurisdiction, a jail-diversion system was established in 2000 in which arrested individuals suspected of having a mental illness are assessed by a staff psychiatrist within 24 hours, and if they meet criteria for hospitalization, they are diverted to treatment.

Leifman said the program has resulted in dramatic reductions in re-arrests: the rate of recidivism for misdemeanors has dropped from 72 percent to approximately 20 percent, he said.

An especially important development, he said, has been a training program for police and the establishment of Crisis Intervention Teams (CITs), composed of uniformed police officers. The CITs respond to calls for law-enforcement assistance that may involve persons with mental illness, evaluate the situation, help to "de-escalate" any potential for violence, and transport individuals to appropriate mental health facilities for evaluation, treatment, and referrals.

"This has been one of the most remarkable cultural changes I have ever seen, because the police have embraced this issue in a way we could not have imagined," he said. "Prior to the CIT program, in Miami the police were shooting and killing someone on the average of once a month, primarily people with mental illness. Since the program, we have had only or two shootings in the last four years, and our police injuries have dropped to zero."

In the arena of public opinion, Leifman said a dramatic turning point was the 15-part television news series by local CBS reporter Michelle Gillen titled "The Forgotten Floor," which aired in 2008. The series, one part of which Leifman showed at the Boston meeting, depicted in disturbing detail the conditions of mentally ill inmates in the county jail.

Public response to the series was profound, resulting in multiple lawsuits that have moved many inmates into treatment settings. "[Gillen] did what we didn't think was possible," he said. "She made our population sympathetic to the community."

Leifman said reversing the criminalization of mentally ill individuals is a multifaceted effort, and he called on psychiatrists to be a part of the solution. "The reality is that none of us created this problem," he said. "And it is going to take everyone—psychiatrists, politicians, the judiciary, law-enforcement officials—to come together to resolve it. This is a community problem and requires a community solution."

"Conversations" is an annual event at APA's Institute on Psychiatric Services and the annual meeting sponsored by the American Psychiatric Foundation, with past speakers including Terry Bradshaw, Brooke Shields, George Stephanopoulos, and Carrie Fisher. This year's event was hosted by Fred Osher, M.D., director of the Center for Behavioral Health, Justice, and Public Policy at the University of Maryland School of Medicine.

"Constructing a Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Treatment System: Strategies for Planning, Leadership, Financing, and Service Development" is posted at <www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf>. Clips of "The Forgotten Floor" can be accessed at <www.michelegillen.com/investigations/forgottenfloor.htm>. The Web site for the Council of State Government's "Mental Health/Criminal Justice Consensus Project" is <http://consensusproject.org/the_report>. ■

Erratum

The article "FDA Faulted for Lax Standards on Medical-Device Approval" in the August 20 issue quoted remarks made by Mark George, M.D., on transcranial magnetic stimulation. The article should have noted that Mark George, M.D., was the lead author on a study cited in the article "Daily Left Prefrontal Transcranial Magnetic Stimulation Therapy for Major Depressive Disorder," which appeared in the May *Archives of General Psychiatry*. George's disclosure of financial interests appear at the end of that article, which can be accessed at <http://archpsyc.ama-assn.org/cgi/content/full/67/5/507>. ■

Resilience

continued from page 6

ment. If there are fewer hours, but with the same expectations, it can lead to stress.

- A sense of humor with colleagues can be a useful way of coping with stress and preventing burnout.
- "Aerobic exercise can be incredibly helpful. I once took six months off from psychiatry and cycled across China to deal with burnout. I also climbed to the top of Mount Kilimanjaro this year."
- "Variety in your practice is healthy—for example, a little teaching along with a clinical practice. Psychiatry offers an amazing number of opportunities."
- "Keep in mind that what you do is not forever. Keep your options open to new opportunities."

"Nurturing resilience is not only the way to deal with stress and burnout, but is the key to professional success and satisfaction," Lofchy emphasized. ■

Iraqis

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The experience has even sparked some new thoughts on diagnosis and treatment that might be applicable here.

"Perhaps PTSD is not the right description for the trauma faced by people in Iraq," said Winnie Mitchell, M.P.A., international officer at SAMHSA. "We're thinking of calling it OTSD—'ongoing traumatic stress disorder'—because the violence continues on and on, and is not a single event. We face the same thing in the U.S. with domestic violence, street violence, and the aftermath of combat. Our providers also need to pay attention to that ongoing experience of trauma."

The Iraqi groups were based at the National Center for Trauma-Informed Care in Alexandria, Va.; Children's National Medical Center in Washington, D.C.; the Maryland Department of Health and Mental Hygiene's forensic services division at Jessup and Sykesville, Md.; INOVA Fairfax Comprehensive Addictions Treatment Services in Falls Church, Va.; the Johns Hopkins School of Medicine in Baltimore; and the UCLA Integrated Substance Abuse Programs in Los Angeles.

They also visited sites in Boston and Greenfield, Mass., Milford, Conn., Yonkers, N.Y., Philadelphia, and Sacramento, Calif.

"We hope that this exchange will go on to permit the continuing education of psychiatrists and other mental health professionals," said Hama. ■

Active in AMA? Let Us Know!

The AMA House of Delegates is composed primarily of physicians representing specialty organizations and physicians representing state medical societies. The AMA Section Council on Psychiatry continues to work well with the other medical specialty organizations involved in the AMA. It also wants to strengthen its relationship with the state medical societies, which comprise slightly more than half of the House of Delegates. To that end, APA would like to connect with psychiatrists who hold (or have held) leadership positions in their state or county medical society.

If you are a leader in your local or state medical society, or if you know of a psychiatrist colleague who has such involvement, please contact Becky Yowell at BYowell@psych.org or the section council chair, Carolyn Robinowitz, M.D., at carolynrobinowitz@usa.net.

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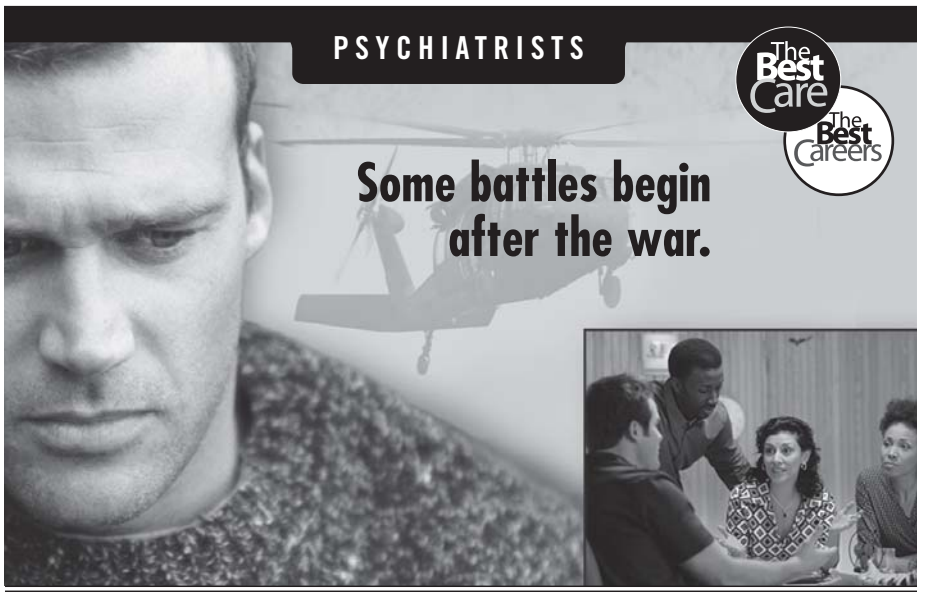

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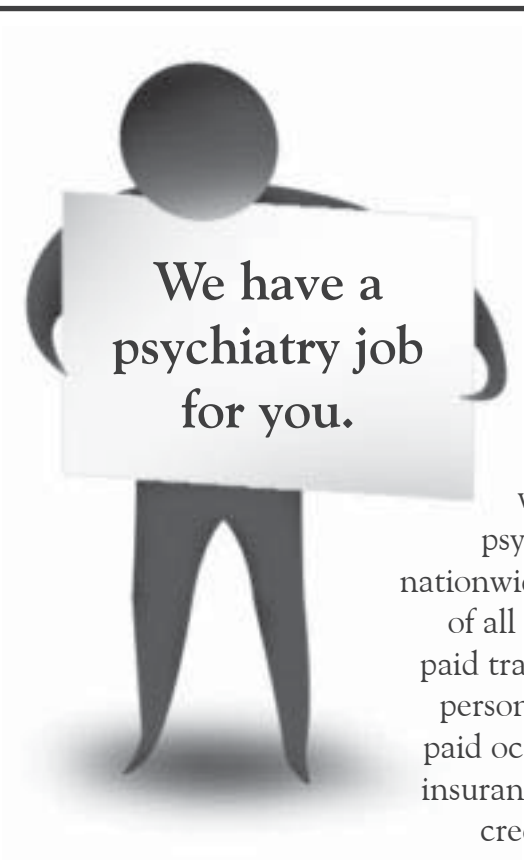

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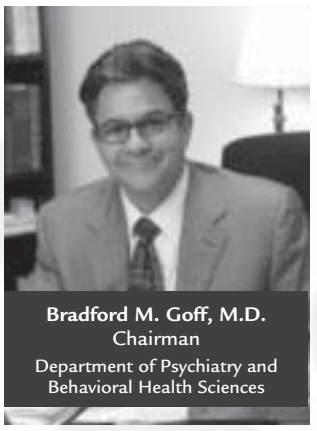

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CALIFORNIA
BC/BE STAFF PSYCHIATRIST

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.

Medical Director
for San Diego County Psychiatric Hospital

The San Diego County Psychiatric Hospital is a free-standing adult facility located in the heart of the County and is a key component in the County Behavioral Health Division's continuum of care. The Medical Director can play a leading role in the development of the overall County safety net health system, and is a key medical leader in the dynamic, innovative Health & Human Services Agency. Teaching opportunities available. Requires proven leadership and supervisory skills. Interest in primary care integration helpful. Salary competitive.

CV and letter of interest can be submitted online at www.sdcounty.ca.gov/hr. For questions about the application process, please contact Gloria Brown, Human Resources Analyst at (619) 531-5117 or **Gloria.Brown@sdcounty.ca.gov**. Questions about the position may be directed to Marshall Lewis, MD, Behavioral Health Clinical Director, HHSA at **Marshall.Lewis@sdcounty.ca.gov**

J1 and H1 Opportunities in California

Adult and child psychiatrists in out-patient and hospital practices near the Bay Area of California. Locations meet criteria for designated shortage area. Please view our web site at CommunityPsychiatry.com or call (800) 244-5807 for more information. Fax: (916) 285-0338 or Email stephanimartinez@communitypsychiatry.com your CV with CA in the subject line.

COLORADO

Psychiatry opportunities in Colorado: DENVER, COLORADO SPRINGS, BOULDER

Join our successful team of clinicians. Full/Part time - flexible schedules. Inpatient/Outpatient, blend of both. Compass Health Systems was founded in July 1990. Physician owned and operated. Contact sfaulkner@compass.md or (786) 347-0355.

Horizon Health seeks **Medical Director** and **Attending Psychiatrist** in **Greeley, CO** for a 22-bed Adult and Adolescent inpatient program and an outpatient psychotherapy and medication management clinic that sees all ages. Inpt srvcs operated on modified hospitalist model with core of three doctors covering inpt and outpt srvcs following either 6 adults or 4 adolescents based upon a 50% assign't to inpt and a 50% assign't in outpt. Call only every third week Monday through Thursday. Physicians hand off call responsibilities to our dedicated weekend doctors at 5:01 pm on Friday and enjoy weekends off with their families free of call responsibilities!

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.

IMMEDIATE OPENING for full-time psychiatrist in new High Security Forensic Institute at the Colorado Mental Health Institute @ Pueblo. Employed by the University of Colorado School of Medicine with full benefits, 4 1/2 weeks paid vacation, excellent CME program on campus, a strong, stable medical staff with little turnover, option for flexible schedule, including 4 ten-hour days, and a new salary schedule with optional paid call. We have no J1-Visa opportunities at this time.

For further information, phone or e-mail
A.O. Singleton, III, M.D.
Chief of Medical Staff
(719) 546-4637; al.singleton@state.co.us.

CONNECTICUT

VA Connecticut Healthcare System and Yale University School of Medicine, Department of Psychiatry is recruiting a **Staff Psychiatrist** in the field of posttraumatic stress disorder (PTSD). The candidate will be responsible for the development of a research program in the field of PTSD and as such will have protected research time. For clinical work, this person will function as a staff psychiatrist, providing psychiatric care to veterans within the psychiatry service and will work with a team of psychiatrists, psychologists and other members of a multidisciplinary team at the VA Connecticut Healthcare System and the National Center for Posttraumatic Stress Disorder. Applicants must have successfully completed psychiatric residency training in an accredited, U.S. program, be board certified (or eligible), licensed to practice in CT and legally employable. Preference will be given to applicants who have independent grant funding, show academic productivity and be in a position to grow a research program.

VACHS and Yale University are Equal Opportunity/Affirmative Action Employers. Women and members of underrepresented minority groups are encouraged to apply. All applicants tentatively selected for VA employment in a testing designated position are subject to urinalysis to screen for illegal drug use prior to appointment. Applicants who refuse to be tested will be denied employment with VA. This announcement is a solicitation for applications from current, former federal and the general public, U.S. CITIZENSHIP: All applicants for federal employment must be a U.S. Citizen. Actions to fill this position will not be based on discrimination which is prohibited by law. Academic rank will be dependant upon review of academic achievements and must meet qualifications to fulfill the Yale University School of Medicine criteria for faculty appointments.

Please mail, e-mail or fax CV/application (VA 10-2850), OF306 most recent SF-50 if, latest proficiency and training and award records no later than **December 15, 2010**, if applicable, to:

Department of Veterans Affairs
VA Connecticut Healthcare System
Human Resources Management Service/05
950 Campbell Avenue, West Haven, CT 06516
Attention: Emily I. Wayne-Lane
Or email emily.wayne-lane@va.gov
Fax (203) 937 4740 or 203-937-4718.

Yale Department of Psychiatry, Yale-New Haven Psychiatric Hospital (YNHPH) is recruiting an inpatient attending with adolescent fellowship experience and interest in affective disorders of adolescents and young adults. The successful candidate must have extensive experience in imaging, inpatient experience and have solid evidence of teaching effectiveness and extra-mural grant support potential. Must be knowledgeable and effective in grantsmanship and research methodology and design. Must be board eligible or certified by ABPN, license eligible in CT and able to obtain credentials at YNHPH and the Yale School of Medicine. Academic appointment will be at the rank of Assistant Professor.

Please send a CV and 3 references by (fill in date) to **William Sledge, MD, Medical Director** Yale New Haven Psychiatric Hospital, 184 Liberty Street., New Haven, CT, 06506. Direct inquiries to William.sledge@yale.edu. Yale values diversity in its faculty, students, and staff, and especially encourages applications from women and underrepresented minority scholars.

FLORIDA

DAYTONA - MELBOURNE - ORLANDO - OCALA-
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.

Attractive Practice Opportunity Near Cocoa Beach - Beautiful Area - Seeking Board Certified (or recent grad) Psychiatrist to join busy inpatient/outpatient practice in the area. Hospital-based adult/geropsych unit. Relocation package available. Please **call Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

Vero Beach - Half-Time Position - Seeking Board Certified (or recent grad) Adult Psychiatrist already in the area for 20 hour per/week position Offering salary and partial benefits. Come be part of this friendly, top notch mental health team in an impressive general hospital.. Please call **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

GEORGIA

Psychiatrist - Metro-Atlanta (contract)

Cobb-Douglas Community Services Board, a behavioral healthcare organization in metro Atlanta, seeks a part-time, BC/BE Psychiatrist for Community Outpatient Behavioral Health clinic. Please email CV to cholt@cobbcsb.com.

PRIVATE PRACTICE OPPORTUNITY

Be the only psychiatrist accepting new patients in Hall County. GA. 50 miles north of Atlanta. Earning potential well over $200,000. Email CV to mkingphd@gmail.com.

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.

HAWAII

This is your opportunity to live and work in Hawaii!

The Adult Mental Health Division of the State of Hawaii Department of Health is recruiting psychiatrists. We have openings for outpatient psychiatrists to work at Community Mental Health Centers in Hilo, Kona, Maui, and in Honolulu County, and for inpatient psychiatry at the Hawaii State Hospital in Kaneohe, on Oahu.

Employment with the State of Hawaii offers competitive salaries and benefits. Benefits include 21 days of vacation per year, 21 days of sick leave per year, 13 paid state holidays, liability insurance, medical/vision/dental insurance, and a generous pension plan with vesting after 5 years of service.

For more information about the outpatient positions, contact Mr. Wayne Law at 808-832-5770. For the Hawaii State Hospital, contact Dr. Jim Westphal at 808-236-8236.

ILLINOIS

Methodist Medical Center in Peoria, Illinois seeks two general adult Psychiatrists for its busy behavioral health service. Methodist, a 353-bed teaching facility affiliated with the University of Illinois College of Medicine, is the predominant behavioral health caregiver in the community and offers a full continuum of care in a modern state-of-the-art facility. The current physicians provide a mixture of inpatient/outpatient care and share a reasonable call coverage situation. An outstanding compensation and benefit package is offered.

Peoria is a great mid-size city centrally located 2 1/2 hours from Chicago and St. Louis. The community offers affordable housing, excellent schools, and a safe quality lifestyle notorious in the Midwest. **Please respond to:** Sheri Johns, Physician Recruiter, Methodist Medical Center of Illinois, 800-621-8543, email: sjohns@mmci.org. **Please visit our website: www.mymethodist.net.**

Chicago Area
Psychiatrist Addiction & Pain Program

Advocate Christ Medical Center, Department of Psychiatry seeks a qualified and experienced Liaison Psychiatrist for our addiction and pain program. Candidates must be experienced in addiction psychiatry and psychosomatic medicine, hold a current Illinois license and be board certified or board eligible.

Advocate Christ Medical Center (ACMC) is a 695-bed, not-for-profit teaching, research and referral medical center located in the southwest suburbs of Chicago. ACMC is part of Advocate Health Care, Chicago's largest provider of care and one of the nation's leading integrated health systems. The selected candidate for this highly visible position will lead the addictions detox and medical psych unit which is joined with an active pain program and cooperate with a multidisciplinary consultation liaison service for hospital based medical and surgical services. There further exists the opportunity to teach and supervise medical students and residents. This exciting part time salaried position includes health and retirement benefits. The incumbent may also enjoy an opportunity to perform out patient work seeing substance abuse patients and general psychiatry as part of a progressive multi specialty psychiatric group practice located in Orland Park, Illinois. To apply directly, please submit a CV and cover letter to: donna.kutka@advocatehealth.com or for more information contact Donna C. Kutka, RN, MS, Director, Physician Recruitment, at 708.684.5009.

FORENSIC CLINICAL SERVICES
CIRCUIT COURT OF COOK COUNTY

Full-time position available for BC/BE Psychiatrist with the Cook County Circuit Court in Chicago, Illinois. Perform evaluations of adult offenders in a large, urban, court setting. Forensic training required. **Contact: Peter Lourgos, M.D., Assistant Director, Forensic Clinical Services; 773.674.6078 or Fax your CV to 773.674.5113.**

MENTAL HEALTH SOLUTIONS, P.C., a multidisciplinary group private practice seeks full- or part-time board certified PSYCHIATRIST, licensed in Illinois, for work in outpatient office(s) in **Barrington, IL and/or Mundelein, IL**. Flexible hours. Competitive compensation.Office space, referrals, supplies, and support staff provided.

For more information call (847)566-0164 Ext. 619. Fax Resume to (847)566-0375 or email bfellowes@ilmentalhealthsolutions.com.

Immediately seeking **Child/Adolescent Psychiatrist** for Summit Clinical Services, a well-established multidisciplinary mental health practice, composed of M.Ds, Licensed Psychologists, Licensed Clinical Social Workers, and Licensed Clinical Professional Counselors, in Chicago's western suburbs. The position offers an excellent opportunity to quickly build a practice among experienced professionals known for providing quality mental health services in a caring and respectful manner. Willingness to also be on staff at nearby hospital is desirable. Must be comfortable working with a conservative Christian patient population. Flexible hours, set by individual clinician, and generous compensation based on the number of hours worked. Benefits include health insurance and Flexible Spending Account; disability insurance, 401K; and opportunity for partnership and profit sharing.

For more information about our practice, see our Website at **www.summitclinical.com**. Contact Dan Wyma, M.D., at Summit Clinical Services, (630) 260-0606.

KANSAS

Bert Nash Community
Mental Health Center, Inc

The Bert Nash Community Mental Health Center, in **Lawrence KS**, has an immediate opening for a full time adult psychiatrist for outpatient work. Lawrence is home of the University of Kansas and Haskell Indian Nations University. Commuting distance from Kansas City and Topeka. Visit our website www.bertnash.org and click on Employment for more information, or contact Karan Baucom, Human Resource Manager at kbaucom@bertnash.org Ph. 785-830-1734.

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 a second 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. 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.

MAINE

We are currently recruiting for outpatient psychiatrists to work with children and/or adults. BC/BE preferred. We have full-time and part-time opportunities. Positions involve direct patient care at one or more of our community mental health centers located in Kittery, Springvale, Biddeford, and Westbrook. Our physicians work with a multi-disciplinary team providing outpatient services to a variety of programs.

Counseling Services, Inc. is a comprehensive and integrated community mental health center serving adults and children with serious mental health and substance abuse issues. Our programs are comprised of Community Support Teams, including Psychiatric Services, Assertive Community Treatment (ACT), Community Integration (CI), Outpatient Therapy, Crisis Response Services, and Complementary Therapies.

We offer a comprehensive salary and benefits package. If you are interested in exploring opportunities with us, please contact the Human Resources Department at 207-294-7096. A resume and cover letter may be sent to: Counseling Services, Inc., P.O. Box 1010, Saco, Maine 04072 or human.resources@csimaine.com. We invite you to visit us online at **www.counseling-services.org**. We are an equal opportunity employer.

MARYLAND

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

The VA Maryland Health Care System (VAMHCS,), Mental Health Clinical Center (MHCC) is actively recruiting for a **full time psychiatrist to work at the Perry Point Medical Center** as clinical manager of inpatient mental health. This position is 50% administrative and 50% clinical; providing clinical care on the two inpatient units. Perry Point is a small town on the Chesapeake Bay about 35 miles north of Baltimore City. The MHCC is the largest clinical center within the VAMHCS and is organized into four Sub-Product lines: Inpatient Mental Health; Residential Treatment; Community (outpatient) Mental Health; and Special Programs (Addictions and Trauma). Mental health activities are conducted at all divisions and sites. Mental Health Professionals assigned across the various Sub-Product Lines consist of nurse practitioners, addiction therapists, vocational rehabilitation specialist, physician assistants, etc. The hospital has inpatient, outpatient, and residential programs for substance abuse, PTSD, and the chronically mentally ill. It also has a program in schizophrenia affiliated with the University of Maryland. The VAMHCS offers competitive salary rates, health, and life insurance, retirement planning including Thrift Savings Plan, generous paid leave and educational opportunities plus the satisfaction of serving those who served. **Please mail your CV and Letter of Interest to Human Resources Management Service, Attn: Kenneth Reil, Jr., HR Specialist, P.O. Box 1045, Perry Point, MD 21902 or send by e-mail to Kenneth.ReilJr@va.gov.** The VAMHCS is an Equal Opportunity Employer.

MASSACHUSETTS

CAMBRIDGE: Consultation Liaison Psychiatry Position

PSYCHIATRIST: Cambridge Health Alliance is seeking a half- to full-time psychiatrist to join our Consultation-Liaison Psychiatry Service serving a multi-ethnic and diverse patient population. The position will include some inpatient work but will be focused on outpatient work and program development within Women's Health, Medical Specialty, and Primary Care Clinics. The Department of Psychiatry at Cambridge Health Alliance is an appointing department at Harvard Medical School. Our public health commitment coupled with a strong academic tradition and existing collaboration with medicine, make this an ideal opportunity for candidates interested in integrated medical and psychiatric care with underserved populations. We have strong training programs in Primary Care, Adult and Child Psychiatry, and Psychosomatic Medicine and innovative educational programs for medical students. These programs provide many opportunities for teaching and research. Academic appointment is anticipated, as determined by the criteria of Harvard Medical School.

Qualifications: BC, strong clinical skills, commitment to public sector populations, team oriented, problem solver, interested in working closely with primary care and medical specialists. Fellowship training in Psychosomatic Medicine, as well as bilingual and/or bicultural abilities, is desirable. Interest and experience with substance use disorders preferred. We offer competitive compensation and excellent benefits package.

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.

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

WORCESTER, DIRECTOR OF CLINICAL AND PROFESSIONAL SERVICES

The University of Massachusetts Medical School, Division of Public Sector Psychiatry is seeking an experienced, board certified psychiatrist to serve as CLINICAL LEADER at the closely affiliated Worcester State Hospital (WSH). Worcester State Hospital is a JACHO accredited Department of Mental Health hospital, providing inpatient services to patients who require intermediate and long term care for severe and persistent mental illness and/or acute forensic evaluations. WSH is a short walk from the medical school and the Brudnick Neuropsychiatric Research Institute is contiguous with the hospital. The Director of Clinical and Professional Services serves as a member of the hospital leadership, provides supervision to other psychiatrists, and performs clinical consultations and other patient services as needed. Candidates should have a career interest in Public Sector Psychiatry. Research interest and experience would be an added qualification. Faculty appointment and teaching at the medical school and at WSH (rotation site for 3rd year medical students and PGY 2 residents) is part of the job.

Send letter of interest and C.V. to:
Jeffrey Geller, MD
MPH, Director, Public Sector Psychiatry,
UMMS
55 Lake Avenue North
Worcester, MA 01655
or to jeffrey.geller@umassmed.edu. AA/EOE.

Associate Director of Psychiatry Residency Training University of Massachusetts Medical School

Board certified Psychiatrist educator wanted to serve as Associate Director of Adult Psychiatry Residency Training at UMass Memorial Healthcare/University of Massachusetts Medical School. The Associate Director provides teaching and supervision to psychiatry residents, participates in residency administration, and has major responsibility for the residency curriculum. Candidates should have expertise in psychotherapy and/or psychopharmacology education, excellent administrative experience, a desire to contribute to innovative program development, and an identified clinical or research interest in adult psychiatry. The Associate Director will be expected to devote half time to residency training and the other half to research or clinical work based on qualifications and interests. The position offers a competitive salary, excellent benefits, and a faculty appointment with the University of Massachusetts Medical School. UMMHC is an AA/EOE. **Send letter of interest and curriculum vitae to:** Sheldon Benjamin, M.D., Vice Chair for Education and Residency Training Director, **University of Massachusetts Medical School** Department of Psychiatry, Rm. S7-823, 55 Lake Avenue North, Worcester, MA 01655, Phone: 508-856-4087 Fax: 508-856-5000, Email: sheldon.benjamin@umassmed.edu.

St. Elizabeth's Medical Center
A CARITAS FAMILY HOSPITAL

Psychiatry St. Elizabeth's Medical Center-BOSTON

St. Elizabeth's Medical Center (SEMC) is seeking a BC/BE Psychiatrist for a position in Boston. In addition to the 32 adult beds, there is a new 16-bed inpatient geriatric psychiatry unit, an outpatient clinic, partial hospital program and a fully accredited Psychiatric Residency Program. Our specially trained team of health care professionals includes: Board-certified psychiatrists, internal medicine hospitalists, clinical social workers, geriatric and psychiatric nursing staff, nutritionists, occupational therapists, and physical therapists. Responsibilities will include clinical care, and teaching residents, medical students and physician assistants.

SEMC is a community-based 317-bed tertiary care hospital and part of Caritas Christi Health Care, the second largest health network in Eastern Massachusetts. Academic appointment available to qualified applicants. Competitive salary and excellent fringe benefits are offered.

Interested applicants should send a current CV, and contact information for three references to: Christine Kady, Physician Recruiter, at Christine.Kady@caritaschristi.org or call 617-562-7717.

The Department of Psychiatry at Mount Auburn Hospital, affiliated with Harvard Medical School, is recruiting for a full-time and a half-time position in our Outpatient Psychiatry Service. Responsibilities include evaluation and treatment of adult patients with a variety of psychiatric disorders, including dual diagnosis patients, and coordination of care with other psychiatric clinicians and with primary care and specialty physicians. Position includes participating in the teaching activities of the Department. Academic appointment to the clinical faculty at Harvard Medical School is anticipated.

Please send letter of interest and cv to: Joseph D'Afflitti, M.D., Chair, Department of Psychiatry, Mount Auburn Hospital, 330 Mount Auburn Street, Cambridge, MA 02138; tel: 617 499-5008; email: jdafflit@mah.harvard.edu.

Exceptional Professional Opportunity for psychiatrist to provide high quality care as part of a well respected multidisciplinary private group practice loacted 2 hours north of NYC in Columbia County/Hudson Valley, NY and **neighboring Berkshire County, MA**. Inpt/outpt. Flexible hours.

Excellent salary packages $200,000 + (with opportunity for additional income). **Call Dennis Marcus, M.D.** at (413)528-1845, fax CV to (413)528-3667 or email to scppcmd@yahoo.com.

Starr Psychiatric Center seeks a 20-40 hr psychiatrist for dynamic established psychiatric practice On Boston's South Shore. Medical model, multi-disciplinary staff. Stimulating environment, good pay. Clinic has a reputation for successful care, where others have failed. Email davidzstarr@juno.com or call 508.580.2211.

MICHIGAN

J1 and H1 Opportunities in Michigan

Adult and child psychiatrists in out-patient and hospital practices, near Ann Arbor, Michigan. Locations meet criteria for designated shortage area. Please view our web site at Community-Psychiatry.com or call (800) 244-5807 for more information. Fax: (916) 285-0338 or Email stephanimartinez@communitypsychiatry.com your CV with MI in the subject line.

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. Staff Psychiatry position also available. Please call **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

MISSISSIPPI

Region IV Mental Health Services, a community mental health center, designated as an HSA, located in north Mississippi, is seeking to employ two psychiatrists to work in its outpatient facilities. Monday/Friday 8:00 a.m. - 5:00 p.m./ no weekends, holidays, or on call. Great compensation package.

Call Charlie Spearman, Sr.
662-665-1000. www.timberhills.com

MISSOURI

Very Lucrative Opportunity Right Near Springfield- -Lucrative opportunity for psychiatrist to do outpatient work and consults. Also share call for 10-bed geropsychiatric unit. Offering very compensation package w/benefits and relocation package. Springfield is a city of 161,000 people; about an hour from Branson. Please call Terry B. Good at 1-804-684-5661, Fax #: 804-684-5663; Email: terry.good@horizonhealth.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

Westampton - East of Philadelphia. 2 positions. General/Addiction AND Geriatric Psychiatrists. Fulltime positions - no on site call! Contact Joy Lankswert, In-house 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

Rockland Psychiatric Center, a state psychiatric hospital affiliated with NYU and located 30 minutes north of NYC in the scenic lower Hudson Valley, has openings for inpatient psychiatrists. We offer regular hours, optional on-call for extra pay, excellent benefits including state retirement system. Weekly grand rounds, large medical staff, collegial atmosphere. With 430 inpatient beds and 11 clinics in 5 surrounding counties, there are many opportunities for movement and advancement once on staff.

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

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

Stony Brook University's Department of Psychiatry and Behavioral Science has a F/T or P/T position immediately available for a board certified/eligible psychiatrist in University-affiliated inpatient service located at Eastern Long Island Hospital, 23-bed adult unit in scenic Greenport, NY. Position includes faculty appointment and academic opportunities. N.Y. State license necessary. To apply, submit cover letter and CV to Mark J. Sedler, M.D., MPH, Department of Psychiatry and Behavioral Science, Health Sciences Center, T-10, Room 020, Stony Brook University, Stony Brook, NY 11794-8101; or fax (631) 444-1560. For a full position description or application procedures, visit www.stonybrook.edu/jobs (Ref. #F-6508-10-09).

Stony Brook University/SUNY is an equal opportunity/affirmative action employer.

Long Island College Hospital

On Call Psychiatrists: Psychiatrists, Fellows and Senior Residents to cover days, nights, weekends and Holidays in the Psychiatric Emergency Department at the Long Island College Hospital. Please fax resume to: THE LONG ISLAND COLLEGE HOSPITAL, DEPARTMENT OF PSYCHIATRY, 339 Hicks Street, FAX: (718) 780-1827. Attn: Deborah Dwoskin, 718-780-1159.

PSYCHIATRISTS
Moonlighting/FT positions
BEST IN BROOKLYN!

- Night/weekends/Holidays
- IP/ED/CL/ Detox/Assisted Living
- Physician friendly staff!
- No insurance calls!
- Competitive hourly rates/salaries
- Additional pay per encounter possible

Please FAX 718.630.8594 or send CV to: Tracey Irvin, Dept. of Psychiatry, Lutheran Medical Center, Suite 2-41A, 150 55th St., Brooklyn, NY 11220. EOE/AA M/F/D/V. **www.LutheranHealthCare.com.**

PSYCHIATRIC EMERGENCY ROOM COVERAGE

Brookdale University Hospital and Medical Center-seeks BC/BE Psychiatrists for full time, part-time, and per diem positions. Salaries and hourly rates recently increased with differential.

Please fax CV to Seeth Vivek, M.D., at 718-206-7169 or e-mail to SVivek@JHMC.org.

General Adult and Addiction Psychiatrists

The Department of Psychiatry at The Mount Sinai Medical Center (MSMC) in Manhattan has openings for General Adult and Addiction Psychiatrists. The FT/PT positions include outpatient work at the World Trade Center Mental Health Program with opportunities for teaching and clinical research. An academic appointment will be offered at Mount Sinai School of Medicine (MSSM) commensurate with experience. Applicants who have completed their residency training prior to July 2005 must be certified in General Adult Psychiatry by The American Board of Psychiatry and Neurology. Qualified candidates must possess an MD or DO degree, be comfortable with using an electronic medical record, and preferably have experience in treating mood and anxiety disorders. Spanish and/or Polish speaking physicians are strongly encouraged to apply. The MSMC is a premier 1,171 bed tertiary-care facility internationally acclaimed for excellence in clinical care, education and scientific research in nearly every aspect of medicine. The MSMC/MSSM is an equal opportunity/affirmative action employer. We recognize the power and importance of a diverse employee population and strongly encourage applicants with various experiences and backgrounds.

Interested applicants should contact Fatih Ozbay, MD, Associate Medical Director of the WTC Mental Health Program by sending their CVs via email to natacha.lamour@mssm.edu.

NEW YORK STATE

NURSE PRACTITIONER

For Adult Mental Health Clinic, exp. in providing ancillary psychiatric services. NYS NP License, Masters Info at: www.htcorp.net EOE, resumes to: apply@htcorp.net.

PSYCHIATRIST

For Adult Mental Health Clinic, Unrestricted license to practice and dispense controlled substances in NYS; Info at: www.htcorp.net EOE, resumes to: apply@htcorp.net.

EMPLOYMENT OPPORTUNITY
PSYCHIATRIST

Hudson Valley Mental Health, Inc., (HVMH) a provider of outpatient adult mental health services in Dutchess County, New York is seeking full time Psychiatrists and Nurse Practitioners for our Article 31 outpatient clinics. The position requires NYS license and BC/BE in Psychiatry or a Nurse Practitioner license. New graduates will be considered. The position is full time, Monday through Friday. No weekends and no on call.

The Hudson Valley Mental Health clinics are located in Dutchess County.

Send CV and cover letter to Medical Director, Hudson Valley Mental Health, Inc. 230 North Road, Poughkeepsie, NY 12601. Fax: 845-790-2199; email richardmil@dcdmh.org or call 845-486-2781 for additional information.

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.

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.

Exceptional Professional Opportunity for psychiatrist to provide high quality care as part of a well respected multidisciplinary private group practice loacted 2 hours north of NYC in Columbia County/Hudson Valley, NY and **neighboring Berkshire County, MA**. Inpt/outpt. Flexible hours.

Excellent salary packages $200,000 + (with opportunity for additional income). **Call Dennis Marcus, M.D.** at (518)697-8010, fax CV to (413)528-3667 or email to scppcmd@yahoo.com.

NORTH CAROLINA

Associate Medical Director
for Med-Psych Inpatient Service
Department of Psychiatric Medicine
Brody School of Medicine at
East Carolina University

The Department of Psychiatric Medicine at the Brody School of Medicine at East Carolina University is now accepting applications for a full-time faculty position (Assistant or Associate Professor) to serve as Associate Medical Director for Med-Psych inpatient service. The position emphasizes a clinical leadership role and an active interest in educational and scholarly activities. This 52 bed service houses acute beds, combined MI-DD beds, and combined Med-Psych beds in an 800+ bed tertiary care hospital serving Eastern and coastal NC. The hospital provides acute, intermediate, rehabilitation, and outpatient health services to more than 1.2 million people in 29 counties. Position offers an excellent blend of clinical care, teaching, and scholarly activities in this growing multi-disciplinary and collegial department. Greenville is the hub of Eastern NC and the home of East Carolina University, the 3rd largest public university in the state. Located near many recreational areas, including the Atlantic Ocean coastal resorts, Greenville is a university town, rich in cultural activities with charm and an easy pace of life. Minimum Qualifications: MD or equivalent degree; completion of an approved combined medicine or family medicine-psychiatry residency training program or satisfactory completion of training in both internal or family medicine and psychiatry; BC or board qualified in both psychiatry and internal or family medicine; and eligibility for licensure in the state of NC. Salary and academic rank commensurate with experience and academic background. Fixed-term or tenure-track available. Screening will begin **11/26/10**, and continue until position is filled. Please submit a candidate profile online at **www.jobs.ecu.edu** with the following required documents: CV, letter of interest, and list of three references with contact information. View this job posting (vacancy #966043) at https://ecu.peopleadmin.com/applicants/Central?quickFind=64045. EEO/AA employer.

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

All line classified ads are posted on the *Psychiatric News* web-site: pn.psychiatryonline.org

Carolina Partners in Mental HealthCare, PLLC is seeking **BE/BC psychiatrists** for our practices in Wake Forest and Raleigh, NC. PAs and NPs also welcome to apply. Private outpatient practices, full partnership from day one - no investment required. FT, PT flexible. Carolina Partners has ten offices in Raleigh, Durham, Cary, Chapel Hill, Burlington and Wake Forest, North Carolina. Good opportunity to control your life and clinical practice, while making a good income!

Contact Executive Director or send CV to: Carolina Partners in Mental HealthCare, 1502 W. Hwy 54, Suite 103, Durham, NC 27707. Phone 919-967-9567; Fax 919-882-9531; Email carolinapartners@bellsouth.net. Find us online at www.carolinapartners.com.

PSYCHIATRISTS
Greensboro and High Point, NC

The Guilford Center has current openings for an Adult and Child Psychiatrist. Our Psychiatrist's provide high quality clinical services to consumers of all diagnostic categories. Flexible scheduling and no required on call or weekend coverage. Must have NC medical license, DEA and prefer board certification. We offer an excellent benefit package with salary negotiable depending on experience.

Interested individuals must apply through **e-recruit at www.co.guilford.nc.us.** For additional information contact DCox@GuilfordCenter.com. (EOE).

OHIO

Psychiatrist. The Ohio State University, Columbus, OH.
Counseling and Consultation Service at **The Ohio State University** is seeking a board eligible/ board certified psychiatrist for a 1.0 FTE Senior Staff position. The psychiatrist will provide outpatient services to the student population, collaborate with a multidisciplinary staff, supervise trainees and consult with other campus units. State of Ohio benefits with no call or weekend duties. Ohio licensure and board eligibility/certification required at time of hire. To assure consideration, please apply by **01/02/2011** by visiting our web site at www.jobsatosu.com and search by **requisition #354089**. Candidates should submit a cover letter and curriculum vitae when they apply. To build a diverse workforce, Ohio State encourages applications from individuals with disabilities, veterans and women. EEO/AA employer.

Geriatric Psychiatrist

The Department of Psychiatry at The MetroHealth System, a major teaching hospital of Case Western Reserve University, is expanding under the leadership of the new Chair, Ewald Horwath, M.D. We are currently seeking a board-certified (or board eligible) geriatric psychiatrist, who will provide clinical care, teaching of residents and students and have the opportunity for academic and career development at the largest medical research institution in Ohio and a top1% ranked hospital. Benefits include a competitive salary, incentive potential, health insurance, paid time off, liability insurance, an academic appointment and CME opportunities.

In employment, as in education, MetroHealth System and Case Western Reserve University are committed to Equal Opportunity and World Class Diversity. Please send CV and a letter outlining clinical and academic interests to ehorwath@metrohealth.org.

Addiction Psychiatrist

The Department of Psychiatry at The MetroHealth System, a major teaching hospital of Case Western Reserve University, is expanding under the leadership of the new Chair, Ewald Horwath, M.D. We are currently seeking a board-certified (or board eligible) addiction psychiatrist, who will provide clinical care, teaching of residents and students and have the opportunity for academic and career development at the largest medical research institution in Ohio and a top1% ranked hospital. Benefits include a competitive salary, incentive potential, health insurance, paid time off, liability insurance, an academic appointment and CME opportunities.

In employment, as in education, MetroHealth System and Case Western Reserve University

are committed to Equal Opportunity and World Class Diversity. Please send CV and a letter outlining clinical and academic interests to ehorwath@metrohealth.org.

Child and Adolescent Psychiatrist

The Department of Psychiatry at The MetroHealth System, a major teaching hospital of Case Western Reserve University, is expanding under the leadership of the new Chair, Ewald Horwath, M.D. We are currently seeking a board-certified (or board eligible) child and adolescent psychiatrist, who will provide clinical care, teaching of residents and students and have the opportunity for academic and career development at the largest medical research institution in Ohio and a top1% ranked hospital. Benefits include a competitive salary, incentive potential, health insurance, paid time off, liability insurance, an academic appointment and CME opportunities.

In employment, as in education, MetroHealth System and Case Western Reserve University are committed to Equal Opportunity and World Class Diversity. Please send CV and a letter outlining clinical and academic interests to ehorwath@metrohealth.org.

Consultation-Liaison Psychiatrist

The Case Western Reserve University Department of Psychiatry at MetroHealth is expanding under the leadership of the new Chair, Ewald Horwath, M.D. We are currently seeking a board-certified (or board eligible) consultation-liaison psychiatrist, who will provide clinical care, teaching of residents and students and have the opportunity for academic and career development at the largest medical research institution in Ohio and a hospital ranked in the top 1% for outcomes and efficiency. Benefits include a competitive salary, incentive potential, health insurance, paid time off, liability insurance, an academic appointment and CME opportunities.

In employment, as in education, MetroHealth System and Case Western Reserve University are committed to Equal Opportunity and World Class Diversity. Please send CV and a letter outlining clinical and academic interests to ehorwath@metrohealth.org.

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.

PENNSYLVANIA

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.

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.

PHILADELPHIA: Admission Services Physician (Mon-Fri)
PHILADELPHIA suburb Doylestown: Child Psychiatrist - Inpatient /RTC;
CLARION - just east of Pittsburgh. Child Psychiatrist for inpatient & partial programs.
SHIPPENSBURG: General Psychiatrist w/ interest in Dual Diagnoses.
STATE COLLEGE: Child OR General Psychiatrist - Inpatient OR All Outpatient. Some positions J1 eligible. Salary & benefits. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

One Hour to PHILADELPHIA - Two Hours from WASHINGTON, DC --Pretty Area - so close to several amazing metro areas. Inpatient adult unit and geropsych unit in a med/surg hospital in eastern PA near Harrisburg. Can be primarily adult or gero or a mix of both. Can be a very lucrative position; lots ofopportunity for growth. Please call Terry B. Good at 1-804-684-5661, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

Meadowbrook, PA - Philadelphia Suburb - Associate Medical Director on geropsychiatric unit in the Holy Redeemer Hospital. Great opportunity in Montgomery County near Bucks County line. Call for details: **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

TENNESSEE

EAST TENNESSEE STATE UNIVERSITY
JAMES H. QUILLEN COLLEGE OF MEDICINE
DEPARTMENT OF PSYCHIATRY & BEHAVIORAL SCIENCES

GENERAL PSYCHIATRIST AND CHILD PSYCHIATRIST

Full-time positions available for General Psychiatrist and Child Psychiatrist. General Psychiatrist position may include inpatient and/or outpatient. Responsibilities include training of psychiatric residents and medical students and research activities. Salary is competitive with funding available through the Medical School, faculty private practice and extramural contracts. ETSU is located in the Tri-Cities area, rated #1 place in North America in cost-of-living, crime rate, climate and health care.

Applicants should submit a CV and two letters of reference to: Merry N. Miller, M.D., Chair, Department of Psychiatry and Behavioral Sciences, ETSU, Box 70567, Johnson City TN 37614. Telephone inquiries should be made at (423)439-2235 or e-mail at lovedayc@etsu.edu. AA/EOE.

SCHOOL OF MEDICINE
VANDERBILT UNIVERSITY

INPATIENT PSYCHIATRIST
Vanderbilt University School of Medicine, Department of Psychiatry

The Department of Psychiatry is recruiting psychiatrists to lead teaching services at Vanderbilt Psychiatric Hospital, an 88-bed teaching hospital on the campus of Vanderbilt University Medical Center. The hospital offers specialized inpatient programs for children & adolescents and for adults with mood disorders, psychotic disorders, addictions, and cognitive disorders. Successful BE/BC candidates will receive a faculty appointment on the clinician-educator track, with rank and salary commensurate to experience.

Applicants should email or send letter of interest with an updated CV to Harsh K. Trivedi, MD, Executive Medical Director and Chief of Staff, Vanderbilt Psychiatric Hospital, 1601 23rd Avenue South, Nashville, TN 37212. Interested and eligible candidates may obtain further information by contacting Dr. Trivedi at 615-327-7024 or harsh.k.trivedi@vanderbilt.edu.

TEXAS

Interested in Life on the Texas Gulf Coast?

Corpus Christi State Supported Living Center is hiring a FT board certified or board eligible psychiatrist. Corpus Christi - on the beautiful Texas Gulf Coast has great fishing and beaches and offers easy access to Padre Island National Seashore. Corpus Christi, home to Texas A&M University-CC, Hooks baseball, & Ice Rays hockey, averages 288 days of sunshine a year with an average daily temperature of 71 degrees and an average July temperature of 84. Corpus Christi has an international airport and is a short drive to San Antonio, Houston, Austin and Mexico. The Corpus Christi State Supported Living Center is a developmental facility for people with mental retardation who may also have physical disabilities as well as mental illness. Typical work schedule is 8 a.m. to 5 p.m. M-F. Work environment is casual and medical problems are challenging. Strong support system with excellent benefits. 200K+, state funded pension plan, paid health insurance, paid vacation and sick days, longevity pay, up to 15 paid holidays per year, and more.

For more information, contact: Sandra G. Rodrigues, MD, Medical Director @ Sandra.Rodrigues@dads.state.tx.us or Gloria Grande, Administrative Assistant @ Gloria.Grande@dads.state.tx.us.

AUSTIN: Psychiatrist for geriatric practice. Office, long term care, research, TMS. Full or part time. Excellent salary with benefits or contract. **Send CV and 3 references to:** jw@senioradults.net. www.senioradults.net. Or call Zandra 512-476-3556.

PSYCHIATRISTS: Mental Health Mental Retardation Authority of Harris County (MHMRA) in Houston, Texas is one of the largest mental health centers in the United States.

Harris County Jail
Second shift 2:00 PM to 10:00 PM
Perform psychiatric evaluations
& medication management
Some on call at 24/7 facility

Texas licensure is required for all positions.

MHMRA offers competitive salary plus a generous benefit package. Houston offers excellent quality of life, lower than average cost of living, no state income tax and exciting cultural, entertainment, sporting and tourists venues. **Contact Charlotte Simmons at (713) 970-7397**, or submit your C.V. to **charlotte.simmons@mhmraharris.org** or fax: 713-970-3386 or go on-line at www.mhmraharris.org to complete application.

VIRGINIA

Staff Psychiatrist # 2010

Valley Community Services Board located in the beautiful Shenandoah Valley is seeking a Full-time BE/BC psychiatrist. This position is 100 % Outpatient, Monday - Friday. VCSB offers health/dental/life insurance, paid sick and annual leave and participation in the Virginia Retirement System. Candidate will receive 5 days allowable for CME training plus $2,500.00 per year for educational requirements. Salary range is $155K- $175K depending on experience.

To apply for this position, submit a CV or resume along with a VCSB Employment Application, which is available on our website, **www.vcsb.org**. Applications should be submitted to Human Resources 85 Sanger's Lane, Staunton, VA. 24401, or e-mailed to sgray@vcsb.org or Fax to 540-213-7501. For additional information feel free to call 540-213-7340 or 540-213-7559.

VIRGINIA COMMONWEALTH UNIVERSITY: Department of Psychiatry, School of Medicine, in collaboration with the Hunter Holmes McGuire Veterans Administration Medical Center, and VCU Institute for Drug and Alcohol Studies, is recruiting an academic physician Chair for the Division of Addiction Psychiatry. Chair is responsible for developing research, teaching and clinical programs. Funded Addictions Fellowship. Strong programs in psychiatric genetics, epidemiology, pharmacology, toxicology, and women's health. State funded health practitioner impairment program, Behavioral Public Health, laboratory and community based research are active areas for collaboration. Wonderful work environment. Department of Psychiatry has over 75 full-time faculty, 39 residents, multiple fellowships and research centers including an addiction genetics research center. The Veterans Administration Medical Center has robust residential and outpatient addictions programming, and an outstanding program in Psychiatry and Primary Care. VCU is Virginia's largest university with robust health science campus and 750-bed university hospital. Richmond, the State Capital, has moderate climate, a rich history, cultural activities, excellent choices for urban, suburban, or country living, outstanding public/private schools.

Send applications to Joel J. Silverman, M.D., Chairman, c/o Takeya McLaurin, Department of Psychiatry, MCV/VCU Box 980710, Richmond, VA 23298. Please contact Dr. Joel Silverman at (804) 828-9156 or email jsilverman@mcvh-vcu.edu.

Virginia Commonwealth University is an Equal Opportunity/Affirmative Action employer. Men, women, persons with disabilities, and minorities are encouraged to apply.

VIRGINIA COMMONWEALTH UNIVERSITY: Department of Psychiatry, School of Medicine, in collaboration with the Hunter Holmes McGuire Veterans Administration Medical Center, and VCU Institute for Drug and Alcohol Studies, is recruiting an academic physician Chair for the Division of Addiction Psychiatry. Chair is responsible for developing research, teaching and clinical programs. Funded Addictions Fellowship. Strong programs in psychiatric genetics, epidemiology, pharmacology, toxicology, and women's health. State funded health practitioner impairment program, Behavioral Public Health, laboratory and community based research are active areas for collaboration. Wonderful work environment. Department of Psychiatry has over 75 full-time faculty, 39 residents, multiple fellowships and research centers including an addiction genetics research center. The Veterans Administration Medical Center has robust residential and outpatient addictions programming, and an outstanding program in Psychiatry and Primary Care. VCU is Virginia's largest university with robust health science campus and 750-bed university hospital. Richmond, the State Capital, has moderate climate, a rich history, cultural activities, excellent choices for urban, suburban, or country living, outstanding public/private schools.

Send applications to Joel J. Silverman, M.D., Chairman, c/o Takeya McLaurin, Department of Psychiatry, **MCV/VCU** Box 980710, Richmond, VA 23298. Please contact Dr. Joel Silverman at (804) 828-9156 or email jsilverman@mcvh-vcu.edu.

Virginia Commonwealth University is an Equal Opportunity/Affirmative Action employer. Men, women, persons with disabilities, and minorities are encouraged to apply.

Medical Director in Historic Williamsburg, Virginia Come live where America began and History lives, even today!

Eastern State Hospital, a 300 bed Joint Commission Accredited Hospital, is seeking a Board Certified/Board Eligible psychiatrist licensed by the Virginia Board of Medicine to serve as the Chief Medical Director. This leadership position offers diverse clinical and administrative opportunities with oversight of all clinical departments; medical, psychology, nursing, social work, rehabilitation and pharmacy services. This is an excellent opportunity to work with a team to provide innovative client-centered services.

Our new award winning geriatric and adult mental health center's offer high quality behavioral health and recovery programs to the individuals we serve. Located in Williamsburg, we are only minutes away from the Historic Triangle of Virginia—Williamsburg, Yorktown, and Jamestown; the College of William and Mary; world renowned golf courses and retirement communities; and excellent dining and shopping opportunities. The area enjoys mild climate and provides for a variety of cultural, historic, sports, and recreational venues.

Candidate should demonstrate knowledge and experience in administrative and clinical activities in the field of behavioral health; knowledge of Joint Commission Standards and CMS Regulations; and, the ability to facilitate a broader clinical interface with other facility and community service entities.

We offer a competitive salary and state benefit package, including life, health, disability and malpractice insurance; an excellent deferred compensation and retirement program; and a generous leave package. Educational affiliations include the College of William and Mary and Eastern Virginia Medical School.

Send CV's to:
Renee Foster, Employee Relations Manager
Human Resources Department
Eastern State Hospital
4601 Ironbound Road
Williamsburg, Virginia 23188-2652
Tour: www.esh.dbhds.virginia.gov

To apply on line: https://job.agencies.virginia.gov. (757) 253-5411. Fax: (757) 253-4996 Eastern State Hospital is an Equal Opportunity/Affirmative Action employer. Women, persons with disabilities, and minorities are encouraged to apply.

VIRGINIA COMMONWEALTH UNIVERSITY, School of Medicine, is recruiting a BE/BC psychiatry educator to serve as Ambulatory Care Division Chair in large, financially stable department. Duties include development of new programs, resident and student education, direction of general and specialty clinics, clinical care and a significant role in overall departmental leadership. Experience in academic ambulatory care, psychiatric education and administration desired. Ambulatory Care Clinics are located at the VCU Medical Campus, and have an estimated 16,000 patient visits/year. Department of Psychiatry has over 75 full-time faculty, 39 residents, multiple fellowships and research centers including an addiction genetics research center. Richmond, the State Capital, has moderate climate and rich mix of history, a diverse multicultural community, excellent housing and public/private schools.

Send applications to Joel J. Silverman, M.D., Chairman, c/o Takeya McLaurin, Department of Psychiatry, MCV/VCU Box 980710, Richmond, VA 23298. Please contact Dr. Joel Silverman at jsilverman@mcvh-vcu.edu.

Virginia Commonwealth University is an Equal Opportunity/Affirmative Action employer. Men, women, persons with disabilities, and minorities are encouraged to apply.

PSYCHIATRIST - INPATIENT TREATMENT Southwestern Virginia Mental Health Institute

We invite you to consider our psychiatrist opening for inpatient treatment. Our hospital has 156 inpatient beds and is located in Marion, Virginia, in the heart of the ***Blue Ridge Mountains.***

The position offers a new challenge and reward every day and includes:
- Competitive salary (Call and negotiate with us!).
- Sign-on bonus up to $10,000.
- Relocation allowance up to $8,000.
- Generous state benefits including low cost health, dental and vision insurance; employer paid long and short term disability, long-term care, life insurance, and malpractice insurance; employee contribution to defined benefit retirement; 457-b Deferred Compensation Plan available; and medical and family tax-deferred reimbursement accounts. Assuming a salary of $185,000 the total compensation including benefits would amount to $258,466. The amount would be approximately $265,000 if health benefits included family coverage.
- No on-call required; compensated on-call available.
- Medical school affiliation.
- Monday through Friday 8-5 work day affords a work/life balance.

Come and see all that Southwestern Virginia has to offer:
- A paradise for outdoor enthusiasts who enjoy kayaking, canoeing, hunting, fishing, hiking, biking, horseback riding, or camping.
- Five state parks in the Blue Ridge Highlands Region.
- Historic Barter Theater located in Abingdon, Virginia.
- Historic Lincoln Theater located in Marion, Virginia.
- Numerous arts, crafts, antique, and music festivals.
- Several local wineries featuring outdoor summer concerts and wine-tasting/tours.
- Local farmers' markets.
- Close to several metropolitan areas and airports.

I look forward to your call at (276) 783-1204 to discuss the job opportunity we have available, and share with you some of the wonderful things the region of Southwestern Virginia has to offer.

Ruby L. Wells, Human Resource Analyst
Southwestern Virginia Mental Health Institute
340 Bagley Circle
Marion, VA 24354
Phone: 276-783-1204
Fax: 276-783-0844
E-mail: Ruby.wells@dbhds.virginia.gov
Website: www.swvmhi.dbhds.virginia.gov
Job Application Site: https://jobs.agencies.virginia.gov
EOE

Full-time Psychiatrist (POS #323)

Colonial Behavioral Health, a community based outpatient mental health center, in Williamsburg Virginia is seeking a board certified or eligible psychiatrist to join the medical staff. CBH has well established multidisciplinary mental health services, serving a diverse population including patients with severe mental illness, dual diagnosis, intellectual disabilities, co-occurring medical illness and substance use disorders. The clinical responsibilities of this position will emphasize current psychopharmacologic therapies, and will include diagnostic evaluations and evidence-based treatment modalities to promote recovery to a diverse clinical population of children, adolescents, adults and geriatric patients. The individual must possess a medical degree, have completion of approved residency in psychiatry and be licensed to practice in Virginia. Salary commensurate with experience. Excellent fringe benefit package. CBH AGENCY APPLICATION REQUIRED. **Contact:** Nancy Shackleford, Director of Human Resources, Colonial Behavioral Health, 921 Capitol Landing Road, Williamsburg, VA 23185. (757) 253-4061. www.ColonialBehavioralHealth.org. Closing Date: Open until filled. EOE.

WASHINGTON

Interfaith Community Health Center is seeking a **Psychiatrist or Psychiatric Nurse Practitioner** to support PCPs & other BH professionals with their patients' BH issues & perform assessments, treatment, & medication management. ICHC is a federally qualified community health center providing medical, dental, and behavioral health services. Providing access to high quality health care for all is our mission. Please view our website and application process at **www.interfaithchc.org** or call HR at 360-788-2623.

The University of Washington and Harborview Medical Center (HMC) in Seattle, WA is accepting applications for a hospital-based psychiatrist at the rank of Acting Instructor or Acting Assistant Professor. This position is 1.0 FTE and will work doing a combination of inpatient psychiatry and hospital psychiatry consultation work with a large team consisting of another psychiatrist, psychologist, nurse and social worker. Two half-days a week will be spent in an ambulatory outpatient setting seeing patients. There is an MD requirement for this position. The position will also be responsible for teaching residents and medical students. Application deadline is Sept 15, 2010. Start date Jan 2, 2011 (sooner is possible).

Please send application and CV to: Peter Roy-Byrne MD, Chief Psychiatry, Harborview Medical Center 325 9th Ave. Box 359911, Seattle, WA 98104 or email roybyrne@uw.edu. The UW is building a culturally diverse faculty and strongly encourages applications from females and minority candidates. The UW is and EOE/AA employer.

Summit Research Network (Seattle) LLC is seeking a licensed, board certified Psychiatrist to work with adult and pediatric/adolescent populations in clinical research trials. Must be comfortable working in a team environment as a Sub Investigator and Principal Investigator in primarily psychiatric pharmaceutical research at our site in **Seattle, WA.**

This position is part time with the potential to increase to full time. Summit offers competitive salary based on experience/credentials with an excellent benefit package.

Please send inquiries and CV to: James R. Hockley, MBA, Summit Research Network Management, Inc., 2701 NW Vaughn St., Ste.350; Portland, OR or via email: jhockley@summitnetwork.com.

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madigan Healthcare System

Madigan Healthcare System, Tacoma, WA

The Department of Psychiatry at Madigan Army Medical Center (MAMC) is a leader in the field of military psychiatry and the application of empirically based treatments for Service Members and their families. The Department includes a 14 bed inpatient unit, an adult outpatient clinic, an Intensive Outpatient Program, a Consultation and Liaison position, and a Forensic Psychiatry section. MAMC is located on Joint Base Lewis-McChord in the southern Puget Sound Region of Western Washington State. While the installation is less than an hour from Seattle and SeaTac International Airport, the alpine playgrounds of Mt. Rainier and the Cascade Mountains are within an easy drive as are Pacific Ocean beaches.

Recruiting continues for: multiple board eligible Child and Adolescent and/or Adult Psychiatrists (GS-15). These positions will provide a range of behavioral interventions to the Soldier and family member population of Joint Base Lewis-McChord. Focus is on evidence based treatments, prevention and brief interventions for deployment and combat-related stressors and symptom presentations. Programs provide a combination of focused evaluations, brief treatment, and organizational consulting. Qualifications include current state medical licensure, current BLS, and Board Eligibility/Certification in the respective specialty. Qualified applicants may also be eligible for a recruitment/retention allowance.

Applications will be reviewed until positions are filled.

Apply on-line @ http://careers-civilianmedical-jobs.icims.com/jobs/job or send CV to Medical Provider Recruiter @ henry.laguatan@us.army.mil or call 253-968-4994.

WEST VIRGINIA

Medical Director Western State Hospital

The University of Washington (UW) and **Western State Hospital (WSH)** in Tacoma, WA are accepting applications for Medical Director at WSH at the rank of Associate Professor (without tenure) or Professor (without tenure). Requirements include an MD, completion of an accredited psychiatry residency program, ABPN board certification, expertise in the treatment of individuals with chronic and serious mental health disorders, and significant leadership experience at a major institution. This is a full-time position to provide medical oversight and direction to WSH treatment programs, assume the medical responsibility for all patients, and participate in strategic planning and program development. This position is a member of the hospital Executive Leadership Team and reports directly to the WSH Chief Executive Officer. The UW faculty engage in teaching, research, and service.

Please send CV and cover letter to **Jess C. Jamieson, Ph.D., Chief Executive Officer, Western State Hospital**, 9601 Steilacoom Blvd. SW, Lakewood, WA 98498-7213 or e-mail Jess.Jamieson@dshs.wa.gov. For questions concerning the faculty appointment, please contact **Richard C. Veith, MD, Professor and Chair, UW Psychiatry and Behavioral Sciences** at (253) 543-3752 or e-mail rcv@uw.edu.

The UW is building a culturally diverse faculty and strongly encourages applications from females and minority candidates. **The UW** is an EOE/AA employer.

BC/BE Psychiatrist

West Virginia University School of Medicine Department of Behavioral Medicine and Psychiatry is recruiting an entry level BC/BE psychiatrist to assume a full time faculty position for general inpatient services, including teaching and other scholarly activities at William R. Sharpe, Jr. Psychiatric Hospital in Weston, WV. Applicants must be board certified/eligible in Psychiatry by June 30, 2011. This non tenure, clinical emphasis track position will offer diverse experiences in clinical and administrative psychiatry.

Position will remain open until filled. Salaries are competitive and benefits are excellent.

Please forward letter of interest, curriculum vitae, and three letters of recommendation to **Carl R. Sullivan, M.D., Vice Chair**, Department of Behavioral Medicine and Psychiatry, c/o Laura Blake, blakel@wvuh.com, Fax 304-293-0230. WVU is an AA/EO employer.

Shenandoah Valley- Recruiting 3rd psychiatrist for Behavioral Health department in multidisciplinary community health center **90 minutes from Washington/Baltimore**. Experience/training in addictionology and/or child/adolescent psychiatry a plus. Salaried position w/ incentive compensation, standard benefits. Approved site for Federal Loan Repayment. Contact Tina Burns 304 596 2610, ext 1066; tburns@svms.net FAX 304 263 0984. Visit our website www.svms.net.

WISCONSIN

Luther Midelfort
Mayo Health System

Eau Claire, Wisconsin: Luther Midelfort - Mayo Health System, is seeking a **BC/BE Adult Psychiatrist** with interest in inpatient and outpatient work. The ideal physician will be collaborative and engaging in their approach to patients and non-physician team members. Call of 1:7. Outpatient unit is attached to a newly renovated 20 bed inpatient unit.

Luther Midelfort - Mayo Health System is a vertically integrated, physician directed hospital and multi-specialty clinic of 250 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** .

Fellowships

PGY 5 Fellowship in University Student Mental Health at The University of Chicago

This post-residency training program focuses on teaching the knowledge and skills necessary to provide mental health care to a university student community. The program will train future student mental health psychiatrists, and includes mentorship by the faculty based at the Student Counseling and Resource Service at The University of Chicago, an active student mental health service staffed by six psychiatrists and over 20 non-physician psychotherapists serving a population of approximately 14,000 extraordinary students. Clinical skills for this fellowship include training in psychosocial treatments for students including short-term psychotherapy, crisis intervention, and group psychotherapies that are particularly important in this population, such as cognitive behavioral procrastination groups and eating disorder groups. It will also include intensive training in the unique aspects of psychopharmacology in this setting, such as addressing target symptoms without impairing cognition. Other aspects of training would be treatment of Attention Deficit Hyperactivity Disorder, substance abuse, mood and anxiety disorders, and first break psychotic disorders. The fellowship will also include administrative aspects of student mental health. This includes an understanding of the university's processing of applications for mental health disability accommodation, consultation for students going on and off medical leave for psychiatric reasons, providing liaison to the Department of Psychiatry for services provided to students, and doing training sessions for groups around campus who are likely to deal with troubled students. The fellow will receive supervision and training on becoming a good consultant for behavioral health issues on campus. These consultations include inquiries by faculty, University staff, and peers about how to deal with troubled students. The fellow will have experience and education on how to be an effective mental health expert as a member of the team of student life and student services professionals.

Please send a personal statement, curriculum vitae, and three letters of recommendation by **February 4, 2011** to: Thomas A. M. Kramer M.D., Director, Student Counseling and Resource Service, The University Of Chicago, 5737 South University, Chicago, IL 60637.

For information about the Student Counseling and Resource Service at
The University of Chicago:
http://counseling.uchicago.edu.

PGY5 Fellowship Position at Silver Hill Hospital/Yale University Department of Psychiatry

In collaboration with the Yale University Department of Psychiatry, Silver Hill Hospital, a private psychiatric hospital with 129 beds in New Canaan, CT, is offering a one year PGY5 fellowship position. The Hospital provides long-term residential treatment programs as well as inpatient treatment. The position offers experience working in the following core areas: General Psychiatry; Substance Use Rehabilitation; Treatment of Severe Personality Disorders; and Treatment of Adolescents. Additional educational and research elective opportunities are available through the Yale Department of Psychiatry.

Interested applicants should contact Ann Cohen DePalma at 203.785.2095.

FELLOWSHIP PUBLIC PSYCHIATRY at YALE

Yale University School of Medicine is accepting applications for a one-year Fellowship in Public Psychiatry for **July 2011**, based at the Connecticut Mental Health Center [CMHC], for individuals interested in public mental health and administration. CMHC is a major site for training, research and clinical service within the Yale and State systems. As a state-funded, academic, urban mental health center it provides a unique setting for psychiatrists to obtain advanced training as they pursue careers as leaders in the field. Fellows spend 50% time in seminars, supervision, and administrative/policy meetings of CMHC and the CT Dept. of Mental Health and Addiction Services; and up to 50% effort providing direct clinical service and/or consultation within public mental health settings in the New Haven area. Child & Adolescent trained psychiatrists may apply for a combined advanced fellowship position with CMHC and the Yale Child Study Center. All candidates must be eligible for board certification and CT licensure. Minority applicants are encouraged to apply.

For further information contact Jeanne Steiner, D.O. Medical Director, CMHC - Yale Univ., 34 Park St New Haven, CT 06519 or Jeanne.Steiner@yale.edu.

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

Entering its 34th year, this ACGME-accredited fellowship on Psychosomatic Medicine is currently accepting applications for three PGY-5 positions to start July 1, 2011. Under the guidance of **Dr. Thomas Wise** and **Dr. Catherine Crone**, the fellowship offers consultation-liaison training in a wide variety of medical specialties in both inpatient and outpatient settings. This includes: oncology, ob/gyn, HIV, trauma, organ transplantation, pulmonary medicine, and cardiology. Didactic seminars address clinical, biological, and psychodynamic approaches to understanding the medically ill. Opportunities in teaching, research, and outpatient psychotherapy are readily available. Training is tailored to fellow's area of interest and career goals. The fellowship is based at Inova Fairfax Hospital, an 833-bed tertiary care teaching facility located in the suburbs of Washington, D.C.

Interested individuals should contact:

Catherine Crone, M.D.
PM Fellowship Program Director
George Washington University
Medical Center
c/o Inova Fairfax Hospital
3300 Gallows Road Falls Church, VA 22042
Phone: 703-776-3380
E-mail: cathy.crone@inova.org

PUBLIC PSYCHIATRY FELLOWSHIP COLUMBIA UNIVERSITY

Now celebrating its 30th year, the Public Psychiatry Fellowship of Columbia University Medical Center and NYS Psychiatric Institute serves as the model for almost all other public/community psychiatry fellowships throughout the country. The program prepares psychiatrists for clinical and management roles in the public sector, combining a rich academic curriculum with three days/week on-site field placement selected by Fellows according to their interests. The curriculum includes evidenced-based and recovery-oriented services in public psychiatry, strategic organizational management, internal program evaluation and public policy. Ten full-time one-year positions are offered, with stipends of $85,000 and higher, depending on field placement agency. Applicants are encouraged to apply before **December 15, 2010**. Tuition support is available for one Fellow to enroll in the MPH program at the Mailman School of Public Health.

Please direct inquiries to **Jules Ranz, M.D.**, Director, Public Psychiatry Fellowship, Box 111, NYS Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032; (212) 543-5655, e-mail: jmr1@columbia.edu. Website: ppf.hs.columbia.edu. Columbia University is an AA/EOE.

STANFORD UNIVERSITY

RESEARCH TRAINING FELLOWSHIPS IN CLINICAL PSYCHOLOGY. Stanford University Department of Psychiatry and Behavioral Sciences anticipates openings for post-doctoral fellows to begin 7/2011 and 9/2011 of the 2011-12 academic year. NIMH-funded training fellowships are designed for those who plan to pursue careers in clinical research with a specialization in adult disorders including mood, anxiety, eating disorders, insomnia, or related areas. These are one- to three-year positions contingent upon funding. Fellows will participate in research projects with faculty mentors and are also expected to develop their own investigations. Candidates should have a clearly identified area of interest and demonstrated capability in scholarly research. Stipends for NIMH training fellowships are $47,500 plus benefits. These positions are open to PhDs and MDs. Candidates are encouraged to contact faculty in their area of interest before applying (http://psychiatry.stanford.edu).

Requirements: All PhD applicants must have: 1) attended an APA-accredited graduate program; 2) completed an APA-accredited internship; 3) completed all requirements for their PhD prior to beginning their appointment. MD applicants must have completed an approved residency program. Applicants must be US citizens.

To apply: Send the following as email attachments to Beth Sherman (bsherman@stanford.edu): 1) a cover letter specifying research aims; 2) your CV; 2) three letters of recommendation sent by email directly from your recommenders to Beth Sherman (bsherman@stanford.edu). (Questions: bsherman@stanford.edu.) Minority candidates are strongly encouraged to apply. **Application deadline is 1/5/2010.**

Practice Wanted

Psychotherapist Seeks Psychiatrist To Share Office (Space) With In Concord (MA) Area.

If interested, please call **Steven Bernstein, LMHC, Professional Coach** at (978) 274-2915 or e-mail at ucanshine@comcast.net.

Practice for Sale

PRACTICE FOR SALE:

Available for purchase, an established private Psychiatry practice. Leased office is well located across from Texas Health Resources Hospital in Bedford close to DFW Airport. Lots of potential for growth, doctor is retiring. Please call 817-545-8895.

Key Benefits

- *Broad definition of Insured includes the business entity and any present or former partner, executive officer, director, stockholder or employee*
- *Payment under the policy of Defense Expenses is in addition to the Limit of Liability (except as respects information privacy coverage)*
- *Reimbursement of up to $1,000 per day for loss of earnings resulting from the insured professional being away from the practice at the insurer's request to assist in defense of claims*
- *Coverage for costs incurred to defend a hearing or disciplinary action before a state or other licensing board or government body*
- *Punitive and exemplary damages where insurable by law*
- *Medical Payments coverage for injuries sustained by persons on your premises, regardless of fault*
- *Notice provision allows for reporting of incidents that have not yet resulted in actual claims*
- *Insured's consent is required for any settlement recommended by the insurer; policy provides for arbitration by your peers to resolve any "consent to settle issues"*
- *Extended reporting period coverage is available whereby claims may be reported if first made after the insured's death, permanent disability or retirement*
- *Premium for the extended reporting period coverage may be waived under certain circumstances*

Limits

- *Up to $2 million per claim/$6 million policy aggregate for Professional Liability and Business Liability*

Premium Credits Available

- *Completion of approved risk management seminars*
- *Favorable claim history*
- *Child and Adolescent Psychiatry*
- *Newly established practice*
- *Part-time practice or temporary suspension of practice*
- *Insureds new to program*
- *Members in training*

Please contact The American Professional Agency, Inc. for information regarding this program. Applications, information and rates can be obtained by calling 800-421-6694 or visiting www.americanprofessional.com

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and subsidiaries including

Darwin National Assurance Company

Program Administrator

American Professional Agency, Inc.