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PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

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David Hathcox

Edward Kennedy Jr., the son of the late senator from Massachusetts, describes his involvement in the disability-rights movement. When he lost his leg to cancer at age 12, there was little recognition of the need for psychosocial support. Much has improved since then, but with the continued help of psychiatrists, he said, more can be accomplished. See story below.

APA Urges VA To Boost Hiring And Salaries Of Psychiatrists

Veterans are entitled to more timely access to mental health services, says APA in comments released on the same day as a new report on the VA's failings regarding provision of mental health care.

BY JONATHAN WOLFE

While the Department of Veterans Affairs (VA) is to be commended for its ongoing efforts to improve access to mental health care, there are several actions the agency can take to ensure that returning veterans and their families receive appropriate and effective treatment in a timely manner.

APA emphasized this point in comments submitted April 23 to the Senate Committee on Veterans' Affairs in advance of an April 25 hearing on mental health care delivery led by committee Chair Patty Murray (D-Wash.) and ranking Republican member Scott Brown (R-Mass.)

In its letter, APA praised the VA's April 19 announcement of its intent to hire an additional 1,600 psychiatrists, psychologists, social workers, and nurses to meet the growing number of veterans with mental health care needs.

However, APA also urged the agency to bolster its efforts to recruit and retain psychiatric physicians, some of whom may be deterred from applying out of concern that their VA workload would primarily consist of

see ***VA*** *on page 26*

Kennedy Carries on Family's Commitment to MH Issues

Kennedy hailed APA for its advocacy on behalf of "the most vulnerable, misunderstood, and stigmatized populations"; for quality patient care; and for dignity and respect for patients .

BY MARK MORAN

Everyone can be an advocate.

That was the message Edward "Ted" Kennedy Jr. brought to APA's 2012 annual meeting as he presented the William C. Menninger Memorial Lecture at the Convocation of Distinguished Fellows. Speaking 20 years after his father—the renowned late senator from Massachusetts—spoke at APA's Convocation, Kennedy urged psychiatrists to be active advocates for their patients and their practices in state and federal legislative bodies.

"[Legislators] are starved for real-life testimony," Kennedy said. "I think physicians are sometimes reluctant to be involved in politics, but I think you cannot afford not to be."

In his lecture he recounted the history of the disability-rights movement and his involvement with the movement, dating from the time when as a child he lost his leg to cancer—a trauma that he called a "transformational event."

"When I was diagnosed with cancer," he said, "I received incredible medical treatment, but there was virtually no recognition of the need for psychosocial supports. It was a scary, traumatic, and sad event."

He is the president and cofounder of Marwood Group and Co., a health-care-focused financial services firm with offices in New York City, Washington, D.C., London, and Kuwait specializing in proprietary health care research, asset management, and private equity advisory services. Previously, he served as an asso-

see ***Kennedy*** *on page 26*

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Comprehensive coverage of APA's 2012 annual meeting will begin in the next issue of *Psychiatric News*.

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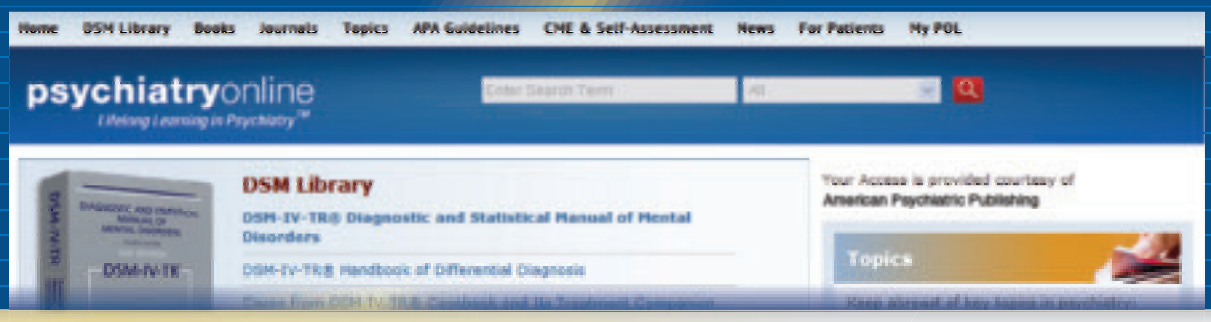

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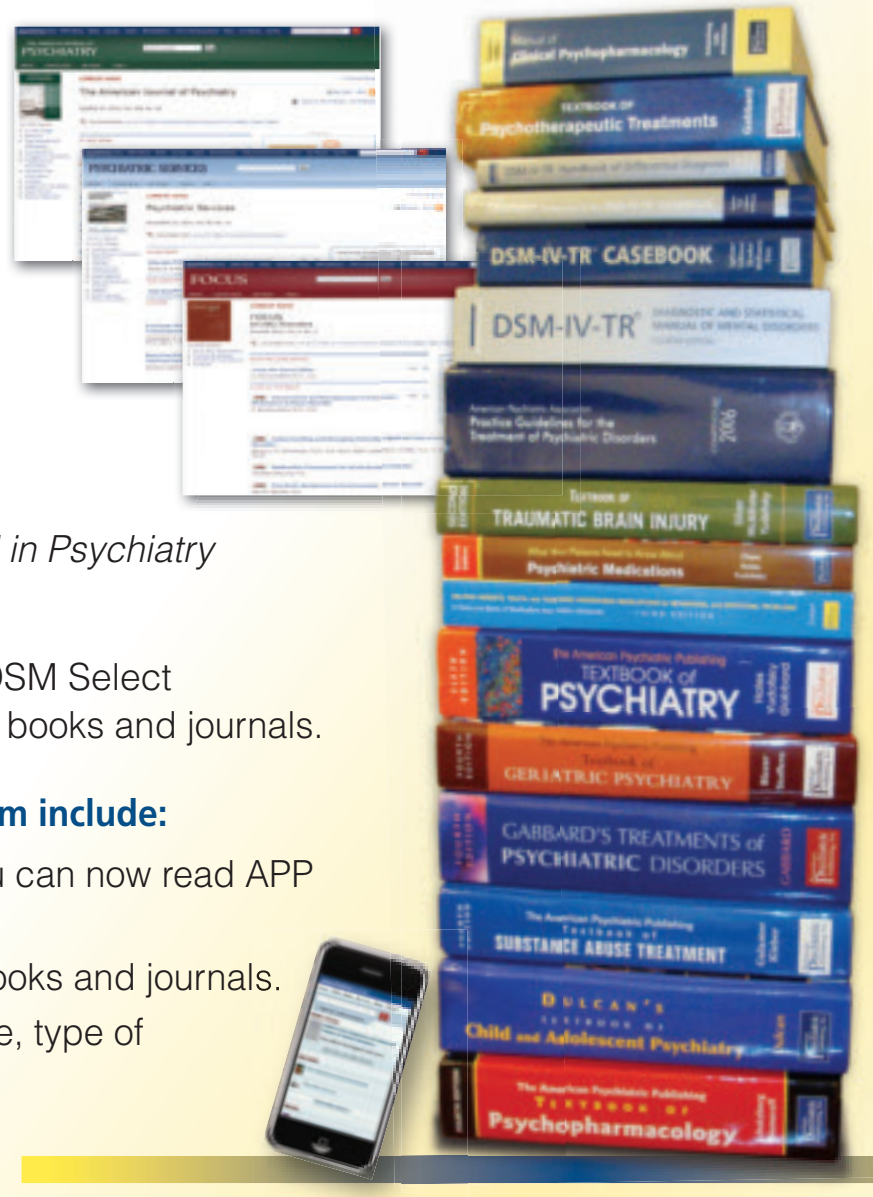

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Scan to learn more about LATUDA

INDICATIONS AND USAGE

LATUDA is an atypical antipsychotic agent indicated for the treatment of patients with schizophrenia. Efficacy was established in four 6-week controlled studies of adult patients with schizophrenia. The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

IMPORTANT SAFETY INFORMATION FOR LATUDA

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. LATUDA is not approved for the treatment of patients with dementia-related psychosis.

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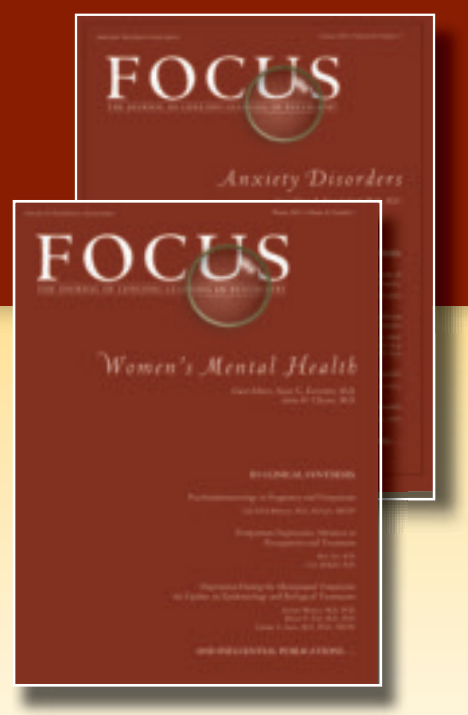

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INDICATIONS AND USAGE

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IMPORTANT SAFETY INFORMATION

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5% compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. LATUDA is not approved for the treatment of patients with dementia-related psychosis.

CONTRAINDICATIONS

LATUDA is contraindicated in any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone. LATUDA is contraindicated with strong CYP3A4 inhibitors (e.g., ketoconazole) and strong CYP3A4 inducers (e.g., rifampin).

WARNINGS AND PRECAUTIONS

Cerebrovascular Adverse Reactions, Including Stroke: LATUDA is not approved for the treatment of patients with dementia-related psychosis.

Neuroleptic Malignant Syndrome (NMS): NMS, a potentially fatal symptom complex, has been reported with administration of antipsychotic drugs, including LATUDA. NMS can cause hyperpyrexia, muscle rigidity, altered mental status and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available.

Tardive Dyskinesia (TD): The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. Given these considerations, LATUDA should be prescribed in a manner that is most likely to minimize the occurrence of TD. If signs and symptoms appear in a patient on LATUDA, drug discontinuation should be considered.

Metabolic Changes

- **Hyperglycemia and Diabetes Mellitus:** Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.
- **Dyslipidemia:** Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics.
- **Weight Gain:** Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Hyperprolactinemia: As with other drugs that antagonize dopamine D2 receptors, LATUDA elevates prolactin levels. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported in patients receiving prolactin-elevating compounds.

Leukopenia, Neutropenia, and Agranulocytosis: Leukopenia/neutropenia has been reported during treatment with antipsychotic agents. Agranulocytosis (including fatal cases) has been reported with other agents in the class. Patients with a preexisting low white blood cell count (WBC) or a history of drug induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy, and LATUDA should be discontinued at the first sign of a decline in WBC in the absence of other causative factors.

Orthostatic Hypotension and Syncope: LATUDA may cause orthostatic hypotension. LATUDA should be used with caution in patients with known cardiovascular disease (e.g., heart failure, history of myocardial infarction, ischemia, or conduction abnormalities), cerebrovascular disease, or conditions that predispose the patient to hypotension (e.g., dehydration, hypovolemia, and treatment with antihypertensive medications). Monitoring of orthostatic vital signs should be considered in all patients who are vulnerable to hypotension.

Seizures: LATUDA should be used cautiously in patients with a history of seizures or with conditions that lower seizure threshold (e.g., Alzheimer's dementia).

Potential for Cognitive and Motor Impairment: In short-term, placebo-controlled trials, somnolence was reported in 22.3% (224/1004) of patients treated with LATUDA compared to 9.9% (45/455) of placebo patients, respectively. The frequency of somnolence increases with dose. Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with LATUDA does not affect them adversely.

Body Temperature Regulation: Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing LATUDA for patients who will be experiencing conditions that may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration.

Suicide: The possibility of suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. Prescriptions for LATUDA should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

Dysphagia: Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. LATUDA is not indicated for the treatment of dementia-related psychosis, and should not be used in patients at risk for aspiration pneumonia.

DRUG INTERACTIONS

Drug Interactions: Given the primary CNS effects of LATUDA, caution should be used when it is taken in combination with other centrally acting drugs and alcohol.

ADVERSE REACTIONS

Commonly Observed Adverse Reactions (≥5% and at least twice that for placebo): The most commonly observed adverse reactions in patients treated with LATUDA in short-term clinical studies were somnolence, akathisia, nausea, parkinsonism, and agitation.

Before prescribing LATUDA, please see brief summary of prescribing information on adjacent pages, including **Boxed Warning**.

Reference: 1. LATUDA prescribing information. Sunovion Pharmaceuticals Inc. December 2011.

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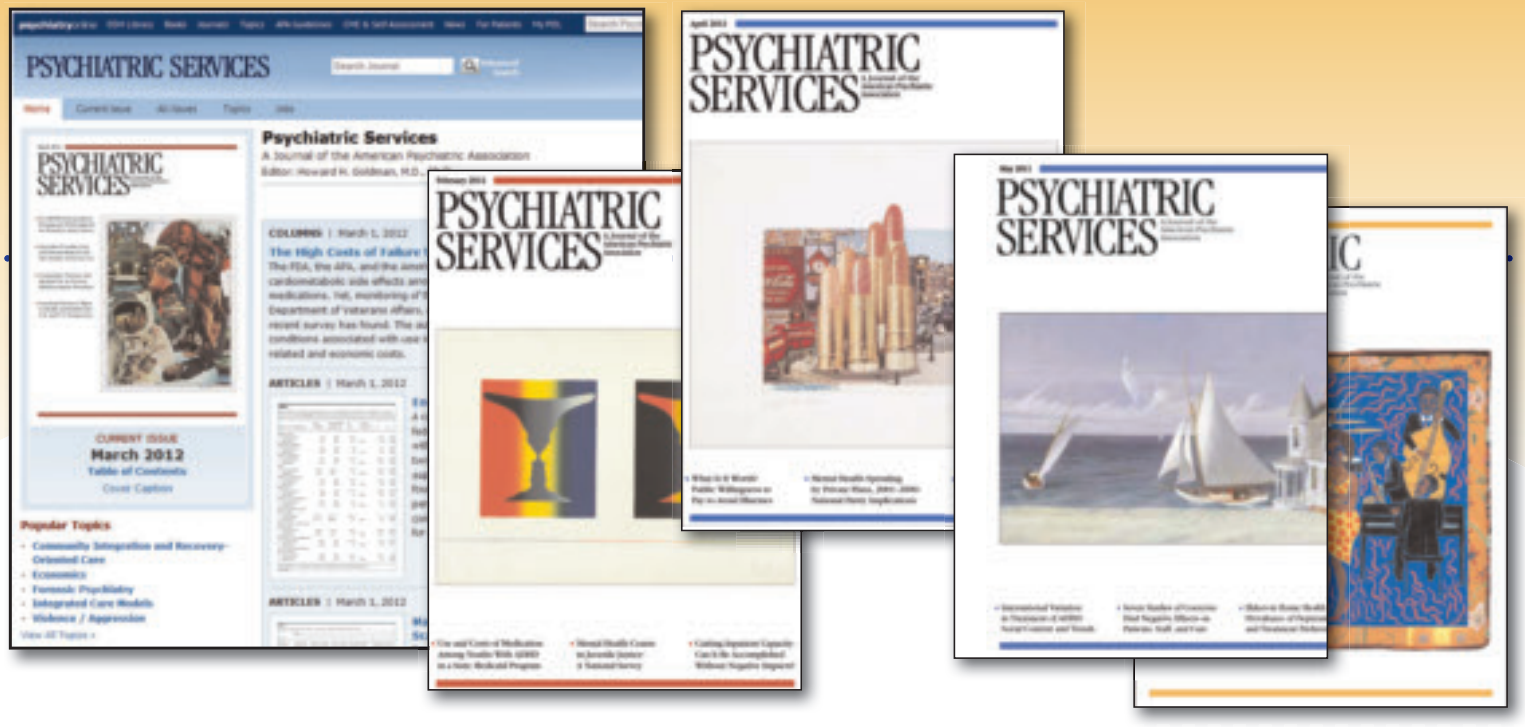

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WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS
Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature.

Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear.

LATUDA is not approved for the treatment of patients with dementia-related psychosis. *[see Warnings and Precautions (5.1)]*

1. INDICATIONS AND USAGE

LATUDA is indicated for the treatment of patients with schizophrenia.

The efficacy of LATUDA in schizophrenia was established in four 6-week controlled studies of adult patients with schizophrenia *[see Clinical Studies]*.

The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient *[see Dosage and Administration]*.

4. CONTRAINDICATIONS

LATUDA is contraindicated in any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone [*see Adverse Reactions (6.6)*].

LATUDA is contraindicated with strong CYP3A4 inhibitors (e.g., ketoconazole) and strong CYP3A4 inducers (e.g., rifampin) [*see Drug Interactions (7.1)*].

5. WARNINGS AND PRECAUTIONS

5.1 Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. LATUDA is not approved for the treatment of dementia-related psychosis [*see Boxed Warning*].

5.2 Cerebrovascular Adverse Reactions, Including Stroke

In placebo-controlled trials with risperidone, aripiprazole, and olanzapine in elderly subjects with dementia, there was a higher incidence of cerebrovascular adverse reactions (cerebrovascular accidents and transient ischemic attacks), including fatalities, compared to placebo-treated subjects. LATUDA is not approved for the treatment of patients with dementia-related psychosis *[see also Boxed Warning and Warnings and Precautions (5.1)]*.

5.3 Neuroleptic Malignant Syndrome

A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with administration of antipsychotic drugs, including LATUDA.

Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatinine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure.

The diagnostic evaluation of patients with this syndrome is complicated. It is important to exclude cases where the clinical presentation includes both serious medical illness (e.g. pneumonia, systemic infection) and untreated or inadequately treated extrapyramidal signs and symptoms (EPS). Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever, and primary central nervous system pathology.

The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for NMS.

If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. If reintroduced, the patient should be carefully monitored, since recurrences of NMS have been reported.

5.4 Tardive Dyskinesia

Tardive Dyskinesia is a syndrome consisting of potentially irreversible, involuntary, dyskinetic movements that can develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

The risk of developing tardive dyskinesia and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses.

There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown.

Given these considerations, LATUDA should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who suffer from a chronic illness that (1) is known to respond to antipsychotic drugs, and (2) for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically.

If signs and symptoms of tardive dyskinesia appear in a patient on LATUDA, drug discontinuation should be considered. However, some patients may require treatment with LATUDA despite the presence of the syndrome.

5.5 Metabolic Changes

Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and body weight gain. While all of the drugs in the class have been shown to produce some metabolic changes, each drug has its own specific risk profile.

Hyperglycemia and Diabetes Mellitus

Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Because LATUDA was not marketed at the time these studies were performed, it is not known if LATUDA is associated with this increased risk.

Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

Pooled data from short-term, placebo-controlled studies are presented in Table 1.

Table 1: Change in Fasting Glucose

	Placebo	LATUDA 20 mg/day	LATUDA 40 mg/day	LATUDA 80 mg/day	LATUDA 120 mg/day
Mean Change from Baseline (mg/dL)					
	n=438	**n=71**	**n=352**	**n=270**	**n=283**
Serum Glucose	-0.7	-0.6	2.5	-0.9	2.5
Proportion of Patients with Shifts to ≥ 126 mg/dL					
Serum Glucose (≥ 126 mg/dL)	8.6% (34/397)	11.7% (7/60)	14.3% (47/328)	10.0% (24/241)	10.0% (26/260)

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in glucose of +1.6 mg/dL at week 24 (n=186), +0.3 mg/dL at week 36 (n=236) and +1.2 mg/dL at week 52 (n=244).

Dyslipidemia

Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics. Pooled data from short-term, placebo-controlled studies are presented in Table 2.

Table 2: Change in Fasting Lipids

	Placebo	LATUDA 20 mg/day	LATUDA 40 mg/day	LATUDA 80 mg/day	LATUDA 120 mg/day
Mean Change from Baseline (mg/dL)					
	n=418	**n=71**	**n=341**	**n=263**	**n=268**
Total cholesterol	-8.5	-12.3	-9.4	-9.8	-3.8
Triglycerides	-15.7	-29.1	-6.2	-14.2	-3.1
Proportion of Patients with Shifts					
Total Cholesterol (≥ 240 mg/dL)	6.6% (23/350)	13.8% (8/58)	7.3% (21/287)	6.9% (15/216)	3.8% (9/238)
Triglycerides (≥ 200 mg/dL)	12.5% (39/312)	14.3% (7/49)	14.0% (37/264)	8.7% (17/196)	10.5% (22/209)

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in total cholesterol and triglycerides of -4.2 (n=186) and -13.6 (n=187) mg/dL at week 24, -1.9 (n=238) and -3.5 (n=238) mg/dL at week 36 and -3.6 (n=243) and -6.5 (n=243) mg/dL at week 52, respectively.

Weight Gain

Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Pooled data from short-term, placebo-controlled studies are presented in Table 3. The mean weight gain was 0.75 kg for LATUDA-treated patients compared to 0.26 kg for placebo-treated patients. In study 3 [*see Clinical Studies (14.1)*] change in weight from baseline for olanzapine was 4.15 kg. The proportion of patients with a ≥ 7% increase in body weight (at Endpoint) was 5.6% for LATUDA-treated patients versus 4.0% for placebo-treated patients.

Table 3: Mean Change in Weight (kg) from Baseline

	Placebo (n=450)	LATUDA 20 mg/day (n=71)	LATUDA 40 mg/day (n=358)	LATUDA 80 mg/day (n=279)	LATUDA 120 mg/day (n=291)
All Patients	0.26	-0.15	0.67	1.14	0.68

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in weight of -0.38 kg at week 24 (n=531), -0.47 kg at week 36 (n=303) and -0.71 kg at week 52 (n=244).

5.6 Hyperprolactinemia

As with other drugs that antagonize dopamine D_2 receptors, LATUDA elevates prolactin levels.

Hyperprolactinemia may suppress hypothalamic GnRH, resulting in reduced pituitary gonadotrophin secretion. This, in turn, may inhibit reproductive function by impairing gonadal steroidogenesis in both female and male patients. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported with prolactin-elevating compounds. Long-standing hyperprolactinemia when associated with hypogonadism may lead to decreased bone density in both female and male patients *[see Adverse Reactions (6)]*.

In short-term placebo-controlled studies, the median change from baseline to endpoint in prolactin levels for LATUDA-treated patients was 1.1 ng/mL and was -0.6 ng/mL in the placebo-treated patients. The increase in prolactin was greater in female patients; the median change from baseline to endpoint for females was 1.5 ng/mL and was 1.1 ng/mL in males. The increase in prolactin concentrations was dose-dependent (Table 4).

Table 4: Median Change in Prolactin (ng/mL) from Baseline

	Placebo	LATUDA 20 mg/day	LATUDA 40 mg/day	LATUDA 80 mg/day	LATUDA 120 mg/day
All Patients	-0.6 (n=430)	-1.1 (n=70)	0.3 (n=351)	1.1 (n=259)	3.3 (n=284)
Females	-1.5 (n=102)	-0.7 (n=19)	-0.9 (n=99)	2.0 (n=78)	6.7 (n=70)
Males	-0.5 (n=328)	-1.2 (n=51)	0.5 (n=252)	0.9 (n=181)	3.1 (n=214)

The proportion of patients with prolactin elevations ≥ 5x ULN was 3.6% for LATUDA-treated patients versus 0.7% for placebo-treated patients. The proportion of female patients with prolactin elevations ≥ 5x ULN was 8.3% for LATUDA-treated patients versus 1% for placebo-treated female patients. The proportion of male patients with prolactin elevations > 5x ULN was 1.9% versus 0.6% for placebo-treated male patients.

In the uncontrolled longer-term studies (primarily open-label extension studies), LATUDA was associated with a median change in prolactin of -1.9 ng/mL at week 24 (n=188), -5.4 ng/mL at week 36 (n=189) and -3.3 ng/mL at week 52 (n=243).

Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent in vitro, a factor of potential importance if the prescription of these drugs is considered in a patient with previously detected breast cancer. As is common with compounds which increase prolactin release, an increase in mammary gland neoplasia was observed in a LATUDA carcinogenicity study conducted in rats and mice *[see Nonclinical Toxicology]*. Neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans, but the available evidence is too limited to be conclusive.

5.7 Leukopenia, Neutropenia and Agranulocytosis

Leukopenia/neutropenia has been reported during treatment with antipsychotic agents. Agranulocytosis (including fatal cases) has been reported with other agents in the class.

Possible risk factors for leukopenia/neutropenia include pre-existing low white blood cell count (WBC) and history of drug induced leukopenia/neutropenia. Patients with a pre-existing low WBC or a history of drug induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and LATUDA should be discontinued at the first sign of decline in WBC, in the absence of other causative factors.

Patients with neutropenia should be carefully monitored for fever or other symptoms or signs of infection and treated promptly if such symptoms or signs occur. Patients with severe neutropenia (absolute neutrophil count < 1000/mm^3) should discontinue LATUDA and have their WBC followed until recovery.

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5.8 Orthostatic Hypotension and Syncope
LATUDA may cause orthostatic hypotension, perhaps due to its α1-adrenergic receptor antagonism. The incidence of orthostatic hypotension and syncope events from short-term, placebo-controlled studies was (LATUDA incidence, placebo incidence): orthostatic hypotension [0.4% (4/1004), 0.2% (1/455)] and syncope [< 0.1% (1/1004), 0%]. Assessment of orthostatic hypotension defined by vital sign changes (≥ 20 mm Hg decrease in systolic blood pressure and ≥ 10 bpm increase in pulse from sitting to standing or supine to standing positions). In short-term clinical trials orthostatic hypotension occurred with a frequency of 0.8% with LATUDA 40 mg, 1.4% with LATUDA 80 mg and 1.7% with LATUDA 120 mg compared to 0.9% with placebo.

LATUDA should be used with caution in patients with known cardiovascular disease (e.g., heart failure, history of myocardial infarction, ischemia, or conduction abnormalities), cerebrovascular disease, or conditions that predispose the patient to hypotension (e.g., dehydration, hypovolemia, and treatment with antihypertensive medications). Monitoring of orthostatic vital signs should be considered in patients who are vulnerable to hypotension.

5.9 Seizures
As with other antipsychotic drugs, LATUDA should be used cautiously in patients with a history of seizures or with conditions that lower the seizure threshold, e.g., Alzheimer's dementia. Conditions that lower the seizure threshold may be more prevalent in patients 65 years or older.

In short-term placebo-controlled trials, seizures/convulsions occurred in < 0.1% (1/1004) of patients treated with LATUDA compared to 0.2% (1/455) placebo-treated patients.

5.10 Potential for Cognitive and Motor Impairment
LATUDA, like other antipsychotics, has the potential to impair judgment, thinking or motor skills.

In short-term, placebo-controlled trials, somnolence was reported in 22.3% (224/1004) of patients treated with LATUDA compared to 9.9% (45/455) of placebo patients, respectively. The frequency of somnolence increases with dose; somnolence was reported in 26.5% (77/291) of patients receiving LATUDA 120 mg/day. In these short-term trials, somnolence included: hypersomnia, hypersomnolence, sedation and somnolence.

Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with LATUDA does not affect them adversely.

5.11 Body Temperature Regulation
Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing LATUDA for patients who will be experiencing conditions that may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration *[see Patient Counseling Information (17.9)]*.

5.12 Suicide
The possibility of a suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. Prescriptions for LATUDA should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

In short-term, placebo-controlled studies in patients with schizophrenia, the incidence of treatment-emergent suicidal ideation was 0.6% (6/1004) for LATUDA treated patients compared to 0.4% (2/455) on placebo. No suicide attempts or completed suicides were reported in these studies.

5.13 Dysphagia
Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. LATUDA is not indicated for the treatment of dementia-related psychosis, and should not be used in patients at risk for aspiration pneumonia.

5.14 Use in Patients with Concomitant Illness
Clinical experience with LATUDA in patients with certain concomitant systemic illnesses is limited *[see Use in Specific Populations (8.7, 8.8)]*. LATUDA has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from premarketing clinical studies *[see Warnings and Precautions (5.1, 5.8)]*.

6 ADVERSE REACTIONS

6.1 Overall Adverse Reaction Profile
The following adverse reactions are discussed in more detail in other sections of the labeling:
- Use in Elderly Patients with Dementia-Related Psychosis *[see Boxed Warning and Warnings and Precautions (5.1)]*
- Cerebrovascular Adverse Reactions, Including Stroke *[see Warnings and Precautions (5.2)]*
- Neuroleptic Malignant Syndrome *[see Warnings and Precautions (5.3)]*
- Tardive Dyskinesia *[see Warnings and Precautions (5.4)]*
- Hyperglycemia and Diabetes Mellitus *[see Warnings and Precautions (5.5)]*
- Hyperprolactinemia *[see Warnings and Precautions (5.6)]*
- Leukopenia, Neutropenia, and Agranulocytosis *[see Warnings and Precautions (5.7)]*
- Orthostatic Hypotension and Syncope *[see Warnings and Precautions (5.8)]*
- Seizures *[see Warnings and Precautions (5.9)]*
- Potential for Cognitive and Motor Impairment *[see Warnings and Precautions (5.10)]*
- Body Temperature Regulation *[see Warnings and Precautions (5.11)]*
- Suicide *[see Warnings and Precautions (5.12)]*
- Dysphagia *[see Warnings and Precautions (5.13)]*
- Use in Patients with Concomitant Illness *[see Warnings and Precautions (5.14)]*

The information below is derived from a clinical study database for LATUDA consisting of over 2096 patients with schizophrenia exposed to one or more doses with a total experience of 624 patient-years. Of these patients, 1004 participated in short-term placebo-controlled schizophrenia studies with doses of 20 mg, 40 mg, 80 mg or 120 mg once daily. A total of 533 LATUDA-treated patients had at least 24 weeks and 238 LATUDA-treated patients had at least 52 weeks of exposure.

Adverse events during exposure to study treatment were obtained by general inquiry and voluntarily reported adverse experiences, as well as results from physical examinations, vital signs, ECGs, weights and laboratory investigations. Adverse experiences were recorded by clinical investigators using their own terminology. In order to provide a meaningful estimate of the proportion of individuals experiencing adverse events, events were grouped in standardized categories using MedDRA terminology.

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. Treatment-emergent adverse events were defined as adverse experiences, which started or worsened on or after the date of the first dose through seven days after study medication discontinuation. There was no attempt to use investigator causality assessments; i.e., all events meeting the defined criteria, regardless of investigator causality are included. It is important to emphasize that, although the reactions occurred during treatment with LATUDA, they were not necessarily caused by it. The label should be read in its entirety to gain an understanding of the safety profile of LATUDA.

The figures in the tables and tabulations cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical studies. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatment, uses and investigators. The cited figures, however, do provide the prescriber with some basis for estimating the relative contribution of drug and nondrug factors to the adverse reaction incidence in the population studied.

6.2 Clinical Studies Experience
The following findings are based on the short-term placebo-controlled premarketing studies for schizophrenia in which LATUDA was administered at daily doses ranging from 20 to 120 mg (n = 1004).

Commonly Observed Adverse Reactions: The most common adverse reactions (incidence ≥ 5% and at least twice the rate of placebo) in patients treated with LATUDA were somnolence, akathisia, nausea, parkinsonism and agitation.

Adverse Reactions Associated with Discontinuation of Treatment: A total of 9.4% (94/1004) LATUDA-treated patients and 5.9% (27/455) of placebo-treated patients discontinued due to adverse reactions. There were no adverse reactions associated with discontinuation in subjects treated with LATUDA that were at least 2% and at least twice the placebo rate.

Adverse Reactions Occurring at an Incidence of 2% or More in LATUDA-Treated Patients: Adverse reactions associated with the use of LATUDA (incidence of 2% or greater, rounded to the nearest percent and LATUDA incidence greater than placebo) that occurred during acute therapy (up to 6-weeks in patients with schizophrenia) are shown in Table 5.

Table 5: Adverse Reaction in 2% or More of LATUDA-Treated Patients and That Occurred at Greater Incidence than in the Placebo-Treated Patients in Short-term Schizophrenia Studies

	Percentage of Patients Reporting Reaction	
Body System or Organ Class Dictionary-derived Term	**Placebo (N=455)**	**All LATUDA (N=1004)**
Gastrointestinal Disorders		
Nausea	6	12
Vomiting	6	8
Dyspepsia	6	8
Salivary hypersecretion	<1	2
General Disorders and Administration Site Conditions		
Fatigue	3	4
Musculoskeletal and Connective Tissue Disorders		
Back Pain	3	4
Nervous System Disorders		
Somnolence*	10	22
Akathisia	3	15
Parkinsonism**	5	11
Dystonia***	1	5
Dizziness	3	5
Psychiatric Disorders		
Insomnia	7	8
Agitation	3	6
Anxiety	3	6
Restlessness	2	3

Note: Figures rounded to the nearest integer
*Somnolence includes adverse event terms: hypersomnia, hypersomnolence, sedation, and somnolence
**Parkinsonism includes adverse event terms: bradykinesia, cogwheel rigidity, drooling, extrapyramidal disorder, hypokinesia, muscle rigidity, parkinsonism, psychomotor retardation, and tremor
***Dystonia includes adverse event terms: dystonia, oculogyric crisis, oromandibular dystonia, tongue spasm, torticollis, and trismus

6.3 Dose-Related Adverse Reactions
Based on the pooled data from the placebo-controlled, short-term, fixed-dose studies, among the adverse reactions that occurred with a greater than 5% incidence in the patients treated with LATUDA, the apparent dose-related adverse reactions were akathisia and somnolence (Table 6).

Table 6: Dose-Related Adverse Events

	Percentage of Subjects Reporting Reaction				
Adverse Event Term	**Placebo (N=455) (%)**	**LATUDA 20 mg/day (N=71) (%)**	**LATUDA 40 mg/day (N=360) (%)**	**LATUDA 80 mg/day (N=282) (%)**	**LATUDA 120 mg/day (N=291) (%)**
Akathisia	3	6	11	15	22
Somnolence*	10	15	19	23	26

Note: Figures rounded to the nearest integer
*Somnolence includes adverse event terms: hypersomnia, hypersomnolence, sedation, and somnolence

6.4 Extrapyramidal Symptoms
In the short-term, placebo-controlled schizophrenia studies, for LATUDA-treated patients, the incidence of reported EPS-related events, excluding akathisia and restlessness, was 14.7% versus 5.1% for placebo-treated patients; and the incidence of akathisia for LATUDA-treated patients was 15.0% versus 3.3% for placebo-treated patients. Akathisia appeared to be dose-related and the greatest frequency of parkinsonism and dystonia occurred with the highest dose of LATUDA, 120 mg/day (Table 7).

Table 7: Percentage of EPS Compared to Placebo

Adverse Event Term	**Placebo (N=455) (%)**	**LATUDA 20 mg/day (N=71) (%)**	**LATUDA 40 mg/day (N=360) (%)**	**LATUDA 80 mg/day (N=282) (%)**	**LATUDA 120 mg/day (N=291) (%)**
All EPS events	9	10	24	26	39
All EPS events, excluding Akathisia/ Restlessness	5	6	13	11	22
Akathisia	3	6	11	15	22
Dystonia*	1	0	4	5	7
Parkinsonism**	5	6	10	7	17
Restlessness	2	1	4	1	3

Note: Figures rounded to the nearest integer
*Dystonia includes adverse event terms: dystonia, oculogyric crisis, oromandibular dystonia, tongue spasm, torticollis, and trismus
**Parkinsonism includes adverse event terms: bradykinesia, cogwheel rigidity, drooling, extrapyramidal disorder, hypokinesia, muscle rigidity, parkinsonism, psychomotor retardation, and tremor

In the short-term, placebo-controlled schizophrenia studies, data was objectively collected on the Simpson Angus Rating Scale for extrapyramidal symptoms (EPS), the Barnes Akathisia Scale (for akathisia) and the Abnormal Involuntary Movement Scale (for dyskinesias). The mean change from baseline for LATUDA-treated patients was comparable to placebo-treated patients, with the exception of the Barnes Akathisia Scale global score (LATUDA, 0.2; placebo, 0.0). The percentage of patients who shifted from normal to abnormal was greater in LATUDA-treated patients versus placebo for the BAS (LATUDA, 16.0%; placebo, 7.6%) and the SAS (LATUDA, 5.3%; placebo, 2.5%).

Dystonia
Class Effect: Symptoms of dystonia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during the first few days of treatment. Dystonic symptoms include: spasm of the neck muscles, sometimes progressing to tightness of the throat, swallowing difficulty, difficulty breathing, and/or protrusion of the tongue. While these symptoms can occur at low doses, they occur more frequently and with greater severity with high potency and at higher doses of first generation antipsychotic drugs. An elevated risk of acute dystonia is observed in males and younger age groups.

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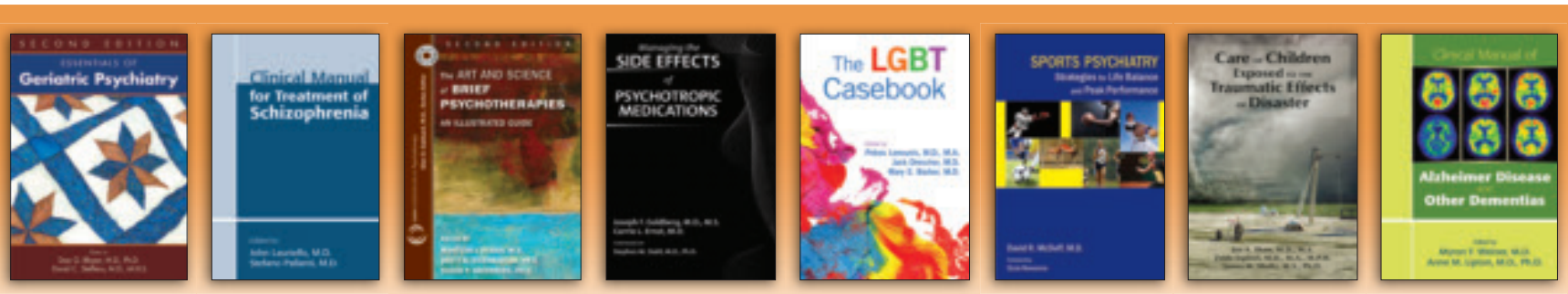

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In the short-term, placebo-controlled clinical trials, dystonia occurred in 4.7% of LATUDA-treated subjects (0.0% LATUDA 20 mg, 4.2% LATUDA 40 mg, 4.6% LATUDA 80 mg and 6.5% LATUDA 120 mg) compared to 0.7% of subjects receiving placebo. Seven subjects (0.7%, 7/1004) discontinued clinical trials due to dystonic events – 4 were receiving LATUDA 80 mg/day and 3 were receiving LATUDA 120 mg/day.

6.5 Laboratory Test Abnormalities and ECG Changes in Clinical Studies

Laboratory Test Abnormalities

In a between-group comparison of the pooled data from short-term, placebo-controlled studies, there were no clinically important changes in total cholesterol measurements; triglycerides or glucose from Baseline to Endpoint [*see Warnings and Precautions (5.5)*]. There were also no clinically important differences between LATUDA and placebo in mean change from baseline to endpoint in routine hematology, urinalysis, or serum chemistry. LATUDA was associated with a dose-related increase in prolactin concentration [*see Warnings and Precautions (5.6)*]

Creatinine: In short-term, placebo-controlled trials, the mean change from Baseline in creatinine was 0.06 mg/dL for LATUDA-treated patients compared to 0.03 mg/dL for placebo-treated patients. A creatinine shift from normal to high occurred in 3.1% (30/977) of LATUDA-treated patients and 1.4% (6/439) on placebo. The threshold for high creatinine value varied from ≥ 1.1 to ≥ 1.3 mg/dL based on the centralized laboratory definition for each study [*see Dosage in Special Population; Use in Specific Populations*].

Transaminases: The mean changes in AST and ALT for LATUDA- and placebo-treated patients were similar. The proportion of patients with transaminases (AST and ALT) elevations ≥ 3 times ULN was similar for all LATUDA-treated patients (0.8% and 0.8%, respectively) to placebo-treated patients (0.9% and 1.1%, respectively).

ECG Changes

Electrocardiogram (ECG) measurements were taken at various time points during the LATUDA clinical trial program. No post-baseline QT prolongations exceeding 500 msec were reported in patients treated with LATUDA. Within a subset of patients defined as having an increased cardiac risk, no potentially important changes in ECG parameters were observed. No cases of torsade de pointes or other severe cardiac arrhythmias were observed in the pre-marketing clinical program.

The effects of LATUDA on the QT/QTc interval were evaluated in a dedicated QT study involving 87 clinically stable patients with schizophrenia or schizoaffective disorder, who were treated with LATUDA doses of 120 mg daily, 600 mg daily, or ziprasidone 160 mg daily. Holter monitor-derived electrocardiographic assessments were obtained over an eight hour period at baseline and steady state. No patients treated with LATUDA experienced QTc increases > 60 msec from baseline, nor did any patient experience a QTc of > 500 msec.

6.6 Other Adverse Reactions Observed During the Premarketing Evaluation of LATUDA

Following is a list of MedDRA terms that reflect adverse reactions reported by patients treated with LATUDA at multiple doses of ≥ 20 mg once daily during any phase of a study within the database of 2096 patients. The reactions listed are those that could be of clinical importance, as well as reactions that are plausibly drug-related on pharmacologic or other grounds. Reactions listed in Table 5 are not included. Although the reactions reported occurred during treatment with LATUDA, they were not necessarily caused by it.

Reactions are further categorized by MedDRA system organ class and listed in order of decreasing frequency according to the following definitions: those occurring in at least 1/100 patients (frequent) (only those not already listed in the tabulated results from placebo-controlled studies appear in this listing); those occurring in 1/100 to 1/1000 patients (infrequent); and those occurring in fewer than 1/1000 patients (rare).

Blood and Lymphatic System Disorders: ***Infrequent:*** *anemia;* ***Rare:*** *leukopenia, neutropenia*
Cardiac Disorders: ***Frequent:*** *tachycardia;* ***Infrequent:*** *AV block 1st degree, angina pectoris, bradycardia*
Ear and Labyrinth Disorders: ***Infrequent:*** *vertigo*
Eye disorders: ***Frequent:*** *blurred vision*
Gastrointestinal Disorders: ***Frequent:*** *abdominal pain, diarrhea;* ***Infrequent:*** *gastritis, dysphagia*
General Disorders and Administrative Site Conditions: ***Rare:*** *Sudden death*
Investigations: ***Frequent:*** *CPK increased*
Metabolic and Nutritional System Disorders: ***Frequent:*** *decreased appetite*
Musculoskeletal and Connective Tissue Disorders: ***Rare:*** *rhabdomyolysis*
Nervous System Disorders: ***Infrequent:*** *tardive dyskinesia, cerebrovascular accident, dysarthria, syncope;* ***Rare:*** *neuroleptic malignant syndrome, seizure*
Psychiatric Disorders: ***Infrequent:*** *abnormal dreams, panic attack, sleep disorder;* ***Rare:*** *suicidal behavior*
Renal and Urinary Disorders: ***Infrequent:*** *dysuria;* ***Rare:*** *renal failure*
Reproductive System and Breast Disorders: ***Infrequent:*** *amenorrhea, dysmenorrhea;* ***Rare:*** *breast enlargement, breast pain, galactorrhea, erectile dysfunction*
Skin and Subcutaneous Tissue Disorders: ***Frequent:*** *rash, pruritus;* ***Rare:*** *angioedema*
Vascular Disorders: ***Infrequent:*** *hypertension, orthostatic hypotension*

7 DRUG INTERACTIONS

Given the primary CNS effects of LATUDA, caution should be used when it is taken in combination with other centrally acting drugs and alcohol.

7.1 Potential for Other Drugs to Affect LATUDA

LATUDA is not a substrate of CYP1A1, CYP1A2, CYP2A6, CYP4A11, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6 or CYP2E1 enzymes. This suggests that an interaction of LATUDA with drugs that are inhibitors or inducers of these enzymes is unlikely.

LATUDA is predominantly metabolized by CYP3A4; interaction of LATUDA with strong and moderate inhibitors or inducers of this enzyme has been observed (Table 8). LATUDA should not be used in combination with strong inhibitors or inducers of this enzyme *[see Contraindications (4)]*.

Table 8: Summary of Effect of Coadministered Drugs on Exposure to LATUDA in Healthy Subjects or Patients with Schizophrenia

Coadministered drug	Dose schedule		Effect on LATUDA pharmacokinetics		Recommendation
	Coadministered drug	LATUDA	C_{max}	AUC	
Ketoconazole (strong CYP3A4 inhibitor)	400 mg/day for 5 days	10 mg single dose	6.9-times LATUDA alone	9-times LATUDA alone	Should not be coadministered with LATUDA
Diltiazem (moderate CYP3A4 inhibitor)	240 mg/day for 5 days	20 mg single dose	2.1-times LATUDA alone	2.2-times LATUDA alone	LATUDA dose should not exceed 40 mg/day if coadministered
Rifampin (strong CYP3A4 inducer)	600 mg/day for 8 days	40 mg single dose	1/7th of LATUDA alone	1/5th of LATUDA alone	Should not be coadministered with LATUDA
Lithium	600 mg BID for 8 days	120 mg/day for 8 days	0.9-times LATUDA alone	1.1- times LATUDA alone	No LATUDA dose adjustment required.

7.2 Potential for LATUDA to Affect Other Drugs

Digoxin (P-gp substrate): Coadministration of LATUDA (120 mg/day) at steady state with a single dose of digoxin (0.25 mg) increased C_{max} and $AUC_{(0-24)}$ for digoxin by approximately 9% and 13%, respectively relative to digoxin alone. Digoxin dose adjustment is not required when coadministered with LATUDA.

Midazolam (CYP3A4 substrate): Coadministration of LATUDA (120 mg/day) at steady state with a single dose of 5 mg midazolam increased midazolam C_{max} and $AUC_{(0-24)}$ by approximately 21% and 44%, respectively relative to midazolam alone. Midazolam dose adjustment is not required when coadministered with LATUDA.

Oral Contraceptive (estrogen/progesterone): Coadministration of LATUDA (40 mg/day) at steady state with an oral contraceptive (OC) containing ethinyl estradiol and norelgestimate resulted in equivalent $AUC_{(0-24)}$ and C_{max} of ethinyl estradiol and norelgestromin relative to OC administration alone. Also, sex hormone binding globulin levels were not meaningfully affected by coadministration of LATUDA and OC. Dose adjustment of OC dose is not required when coadministered with LATUDA.

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Teratogenic Effects

Pregnancy Category B

Lurasidone was not teratogenic in rats and rabbits. There are no adequate and well-controlled studies of LATUDA in pregnant women.

No teratogenic effects were seen in studies in which pregnant rats and rabbits were given lurasidone during the period of organogenesis at doses up to 25 and 50 mg/kg/day, respectively. These doses are 3 and 12 times, in rats and rabbits respectively, the maximum recommended human dose (MRHD) of 80 mg/day based on body surface area.

No adverse developmental effects were seen in a study in which pregnant rats were given lurasidone during the period of organogenesis and continuing through weaning at doses up to 10 mg/kg/day; this dose is approximately equal to the MRHD based on body surface area.

Non-teratogenic Effects

Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress and feeding disorder in these neonates. These complications have varied in severity; while in some cases symptoms have been self-limited, in other cases neonates have required intensive care unit support and prolonged hospitalization.

LATUDA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

8.3 Labor and Delivery

The effect of LATUDA on labor and delivery in humans is unknown.

8.4 Nursing Mothers

LATUDA was excreted in milk of rats during lactation. It is not known whether LATUDA or its metabolites are excreted in human milk. Breast feeding in women receiving LATUDA should be considered only if the potential benefit justifies the potential risk to the child.

8.5 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.6 Geriatric Use

Clinical studies of LATUDA in the treatment of schizophrenia did not include sufficient numbers of patients aged 65 and older to determine whether or not they respond differently from younger patients. In elderly patients with psychosis (65 to 85), lurasidone concentrations (20 mg/day) were similar to those in young subjects *[see Clinical Pharmacology]*. No dose adjustment is necessary in elderly patients.

Elderly patients with dementia-related psychosis treated with LATUDA are at an increased risk of death compared to placebo. LATUDA is not approved for the treatment of patients with dementia-related psychosis *[see Boxed Warning]*.

8.7 Renal Impairment

It is recommended that LATUDA dose should not exceed 40 mg/day in patients with moderate and severe renal impairment (Cl_{cr} ≥ 10 mL/min to < 50 mL/min).

After administration of a single dose of 40 mg LATUDA to patients with mild, moderate and severe renal impairment, mean C_{max} increased by 40%, 92% and 54%, respectively and mean $AUC_{(0-\infty)}$ increased by 53%, 91% and 2- times, respectively compared to healthy matched subjects.

8.8 Hepatic Impairment

It is recommended that LATUDA dose should not exceed 40 mg/day in patients with moderate and severe hepatic impairment (Child-Pugh Class B and C). In a single-dose study of LATUDA 20 mg, lurasidone mean $AUC_{(0-last)}$ was 1.5-times higher in subjects with mild hepatic impairment (Child-Pugh Class A), 1.7-times higher in subjects with moderate hepatic impairment (Child-Pugh Class B) and 3-times higher in subjects with severe hepatic impairment (Child-Pugh Class C) compared to the values for healthy matched subjects. Mean C_{max} was 1.3, 1.2 and 1.3-times higher for mild, moderate and severe hepatically impaired patients respectively, compared to the values for healthy matched subjects.

8.9 Gender

Population pharmacokinetic evaluation indicated that the mean AUC of LATUDA was 18% higher in women than in men, and correspondingly, the apparent oral clearance of LATUDA was lower in women. Mean C_{max} of LATUDA was similar between women and men. No dosage adjustment of LATUDA is recommended based on gender.

8.10 Race

Although no specific pharmacokinetic study was conducted to investigate the effects of race on the disposition of LATUDA, population pharmacokinetic evaluation revealed no evidence of clinically significant race-related differences in the pharmacokinetics of LATUDA. No dosage adjustment of LATUDA is recommended based on race.

8.11 Smoking Status

Based on in vitro studies utilizing human liver enzymes, LATUDA is not a substrate for CYP1A2; smoking is therefore not expected to have an effect on the pharmacokinetics of LATUDA.

10. OVERDOSAGE

10.1 Human Experience

In premarketing clinical studies involving more than 2096 patients and/or healthy subjects, accidental or intentional overdosage of LATUDA was identified in one patient who ingested an estimated 560 mg of LATUDA. This patient recovered without sequelae. This patient resumed LATUDA treatment for an additional two months.

10.2 Management of Overdosage

Consult a Certified Poison Control Center for up-to-date guidance and advice. There is no specific antidote to LATUDA, therefore, appropriate supportive measures should be instituted and close medical supervision and monitoring should continue until the patient recovers.

Cardiovascular monitoring should commence immediately, including continuous electrocardiographic monitoring for possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide, and quinidine carry a theoretical hazard of additive QT-prolonging effects when administered in patients with an acute overdose of LATUDA. Similarly the alpha-blocking properties of bretylium might be additive to those of LATUDA, resulting in problematic hypotension.

Hypotension and circulatory collapse should be treated with appropriate measures. Epinephrine and dopamine should not be used, or other sympathomimetics with beta-agonist activity, since beta stimulation may worsen hypotension in the setting of LATUDA-induced alpha blockade. In case of severe extrapyramidal symptoms, anticholinergic medication should be administered.

Gastric lavage (after intubation if patient is unconscious) and administration of activated charcoal together with a laxative should be considered.

The possibility of obtundation, seizures, or dystonic reaction of the head and neck following overdose may create a risk of aspiration with induced emesis.

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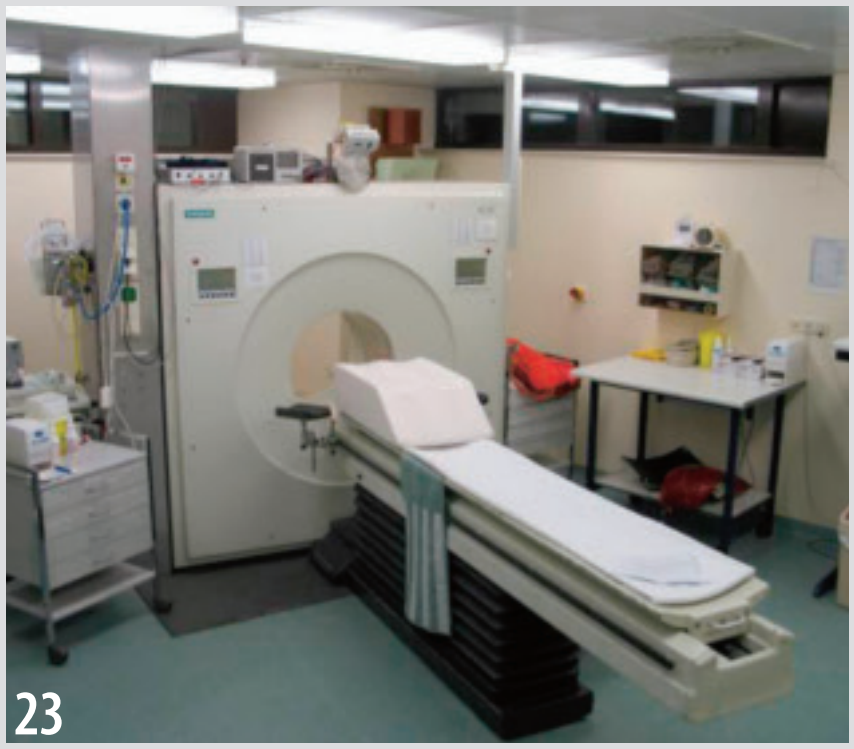
CONTENTS



PROFESSIONAL NEWS

IN THE COMMUNITY

INTERNATIONAL NEWS

CLINICAL & RESEARCH NEWS

Plan Now For APA's Fall Meeting

Stuart Monk/Shutterstock

The excitement of this year's annual meeting has been replaced by anticipation of APA's next major meeting—the Institute on Psychiatric Services. It is often referred to as APA's "little gem" because of its smaller size and more intimate settings that facilitate one-on-one interaction with faculty. This year's institute is being held October 4 to 7 in New York City. The theme is "Pursuing Wellness Through Recovery and Integration."

Advance registration begins June 4 at *http://www.psychiatry.org/learn/institute-on-psychiatric-services*. See page 39.

Departments

FROM THE PRESIDENT

My Journey From India to APA

BY DILIP V. JESTE, M.D.

I am honored to serve as the president of APA for the coming year. It is a great privilege and a great opportunity. In my first column for *Psychiatric News* as APA president, I would like to introduce myself to the readers.

I am a psychiatrist specializing in geriatric psychiatry, based in San Diego, Calif. (Notwithstanding some competition, San Diegans call this America's Finest City!) My journey toward becoming a psychiatrist began in India. I was born in a village in the state of Maharashtra. As a teenager, I happened to read Sigmund Freud's books for lay people, such as those on interpretation of dreams and everyday errors of life. Freud's insights into common daily experiences seemed both captivating and intriguing—like detective stories. Instead of solving murder mysteries, they sought to uncover secrets of mind using behavioral clues. Fascination with Freud's work shaped my desire to try to understand the human mind and brain. In a nonphysician family, I enrolled in medical school with the explicit goal of becoming a psychiatrist, a choice that was considered by some to be rather strange, to put it mildly.

I earned my medical degree from B. J. Medical College in Pune and completed psychiatry training at Seth G.S. Medical College in Mumbai, India. Two of my mentors there had received psychiatric training in the United States. We all read the *American Handbook of Psychiatry* and looked forward to getting each new issue of the *American Journal of Psychiatry* as if it were a new edition of the Bible. To pursue a career in academic psychiatry, I emigrated to the United States with my wife, Sonali, who had just completed her medical education. We had relatively few resources other than an accented (pun intended) desire to learn and grow. I did my psychiatry residency at New Jersey Medical School and Cornell University, neurology residency at George Washington University, and research fellowship at the National Institute of Mental Health. Afterward I joined the faculty of the University of California, San Diego (UCSD).

APA has long been an important part of my professional life. I became an APA member while I was a resident. Since then I have rarely missed an APA annual meeting. I have been involved in numerous APA activities over the years and became a member of its Board of Trustees four years ago.

At UCSD, my interest in geriatric psychiatry was driven, in part, by a realization of the public-health significance of geriatric care in view of the aging of the population. Starting with one fellow, we developed a geriatric psychiatry program at UCSD and VA San Diego Healthcare System. Today it is the Geriatric Psychiatry Division, with clinical, research, and training components. It includes the Senior Behavioral Health Program, led by my colleague Dan Sewell, and provides comprehensive clinical care to older people with neuropsychiatric disorders. I also direct the Sam and Rose Stein Institute for Research on Aging—a multidisciplinary institute at UCSD dedicated to the development and application of the latest advances in biomedical and behavioral science to issues of successful, healthy aging.

I take pride in having mentored (and learned from) a large number of young trainees, many of them women and members of minority groups, who have gone into various aspects of American psychiatry—clinical, academic, and administrative. Over the past three decades, my research areas have ranged from neuroscience to community psychiatry, and from schizophrenia to successful aging. My recent interest has focused on understanding and enhancing successful psychosocial aging and aging-related wisdom in people with or without mental illness. A sizable proportion of older adults in the community function at a high level, making major contributions to society. Even in a serious mental illness like schizophrenia, psychosocial functioning tends to improve with aging—*if* there is optimal psychosocial management.

Our group has developed evidence-based therapies such as cognitive-behavioral therapy combined with social-skills training, functional adaptation skills training, and cognitive training to aid work rehabilitation in middle-aged and older adults with schizophrenia. These NIH-funded randomized, controlled trials, with results published in peer-reviewed journals, have demonstrated the efficacy of psychosocial interventions for schizophrenia in later life. We partner with the San Diego County public mental health system, which serves about 40,000 seriously mentally ill adults, to attempt implementation of such treatments in the community setting. The goal of future investigations will be to understand the nuances of these processes and to translate discoveries into better prevention and treatment strategies, hoping to make successful psychosocial aging a norm in our society.

I am grateful to all APA members for their trust and faith in my ability to lead APA. I look forward to working with you, continuing our dialogue through this column. We must be united to help APA succeed in its mission to serve our patients. Thank you. PN

Important Change Regarding Membership Dues Cycle

The new deadline for paying APA membership dues is June 30. If you have not paid your dues by that date, your membership will automatically expire (unless you are enrolled in the APA Scheduled Payment Plan. To enroll, visit *www.psychiatry.org/File%20Library/Join%20and%20Govern/2011-APA-Scheduled-Payment-Plan-Color-Web.pdf*). Don't let your membership inadvertently expire! Renew online at *https://myaccount.psychiatry.org/APACustomizations/Payorders/tabid/155/Default.aspx* or over the phone at (888) 357-7924, or enroll in the APA Scheduled Payment Plan to pay your membership dues automatically by credit card in monthly, quarterly, biannual, or annual installments. There is no charge for participation in this plan. PN

Fulfill Part 4 of MOC With Free PIP Module

APA's Division of Education is offering free access to APA members to a new performance-in-practice (PIP) module on substance abuse screening. (Nonmembers must pay $399.) The module has been approved by ABPN to meet the practice assessment component (Part 4) for maintenance of certification (MOC) and offers 20 AMA PRA Category 1 Credits. Beginning in 2013, for psychiatrists applying for 2014 MOC examinations, Part 4 will require physicians to compare patient charts for five patients with published best practices, practice guidelines, or peer-based standards of care and develop a plan to improve effectiveness and efficiency of care delivery in their clinical practice. The performance-in-practice module can be accessed at *www.apaeducation.org/ihtml/application/student/interface.apa/index.htm?page=catalog*.

Successful ACT Programs Share Key Elements

Monitoring program fidelity, training staff, and consulting with outside reviewers are critical to maintaining the quality of assertive community treatment (ACT) programs.

BY AARON LEVIN

Practical steps to measure and ensure the quality of assertive community treatment (ACT) programs are supported by scarce evidence, but a multipronged approach may help maintain ACT team quality and program fidelity until firmer ground is reached.

"[N]o single strategy is sufficient for ensuring adequate ACT implementation and services of consistently good quality," said Maria Monroe-DeVita, Ph.D., director of the Washington Institute for Mental Health Research and Training and an acting assistant professor of psychiatry at the University of Washington School of Medicine, and colleagues in *Psychiatric Services in Advance,* published online April 15.

ACT programs have reported largely positive outcomes since their development 35 years ago, Monroe-DeVita and colleagues noted. These include fewer psychiatric hospitalizations, better retention in treatment, better housing stability, and more. However, programs show a mixed record in meeting basic standards over time, and that might be worrisome, said the authors. "[I]nadequate model implementation suggests less-effective services."

In practice, numerous problems cause difficulties in maintaining fidelity to program ideals, said Robert Kiesling, M.D., medical director of Pathways to Housing in Washington, D.C., which operates four ACT teams. He was not involved with Monroe-DeVita's research.

"It takes time to get up and running," said Kiesling in an interview with *Psychiatric News.* "We have challenging patients with long histories of mental illness and chronic general medical ailments, and staff burnout is a fact of life."

Monroe-DeVita and colleagues reviewed 57 articles published from 2000 to 2011, dividing them into four strategies that the programs use to maintain quality:

- **Policy and administration:** "ACT programs need clearly defined practice standards," they said, noting that several states have already mandated such standards. Licensing or certifying ACT programs is another way to hold programs to their original ideals. Adequate funding is critical, especially in a program's early years, when start-up and recruitment costs are greater than reimbursements. "Funding strategies that support outreach efforts to consumers who may be difficult to locate or engage in services . . . are particularly crucial for ACT teams," they said.

- **Training and consultation:** Practice-based training and supervision are also important, said Monroe-DeVita and colleagues. "Even mature ACT teams . . . will often require ongoing, periodic consultation and training, especially given the high rate of turnover among staff at community mental health programs."

ACT programs do need an outside look, said Kiesling. "Funders have a vested interest in how the organization is functioning."

- **Team operations:** Finding the right mixture of clinical skills, street smarts, pragmatism, and persistence is necessary but never easy, said the authors. "Experience in traditional office-based mental health programs is not necessarily a good predictor of success as an ACT team member, because ACT involves extensive outreach."

When Pathways to Housing hires new staff, for example, it conducts an extensive interview process, but the candidate also spends time with the team as members work in the commu-

see ***ACT*** *on page 28*

PROFESSIONAL NEWS

Huge Health System Makes Integrated Care a Reality

Psychiatrists in Houston working with primary care clinicians in area clinics are beginning to train the trainers to bring better mental health care to patients.

BY AARON LEVIN

Five years ago, psychiatry in Houston's Harris County Hospital District was concentrated in three large hospitals. Today psychiatric and other mental health services are available in 16 general medical clinics and two schools around the county. That transformation says a lot about the real work of making integrated care a reality.

The People's Health Center, the largest in the system, is a one-story building faced with stone blocks in the city's southwest quadrant. It cares for about 100,000 patients a year, said Asim Shah, M.D., in his office just down the hall from other clinicians.

"Patients can see their therapist or psychiatrist the way they see their family doctor," said Shah, the hospital district's associate chief of psychiatry and an associate professor of psychiatry at Baylor College of Medicine. "There's less stigma."

There is a psychiatrist on duty three eight-hour days a week at the clinic, and a resident covers another day. Two full-time social workers provide therapy. Other clinics in the system employ psychiatrists for one to four days a week.

Under the old system, a patient might have to wait months for an appointment at a hospital outpatient clinic. Now, Shah tells his patients he can see them the same day—provided they are willing to sit in the waiting room until he can work them in.

Incidentally, now that the Menninger Clinic is affiliated with Baylor, Shah likes to say that his patients at the Peoples Health Center are getting the same quality care as Menninger's patients, although perhaps with a different length of stay.

Shah and his colleagues play another role as well, providing triage assistance and real-time curbside consults with the other physicians in the clinic.

"They all have my cell-phone number," he said. "They can call or text me anytime. It minimizes the direct load on psychiatry and gives them increased confidence in their ability to handle psychiatric conditions with their patients."

Co-location wasn't enough, though. Preparing primary care doctors to do more mental health work was another part of the district's plan, said Britta Ostermeyer, M.D., chief of psychiatry at Ben Taub General Hospital/Harris County Hospital District and an associate professor of psychiatry and of family and community medicine at Baylor.

"We try to educate family-care doctors, nurse practitioners, and social workers about common psychiatric illnesses, like depression, anxiety, and bipolar disorder," said Ostermeyer in an interview.

So beginning in 2004, they organized (with colleagues in family medicine at Baylor and the University of Texas branch in Houston) an educational program that was given live and also recorded on DVD for distribution around the district.

The goal was to give the primary care doctors enough information so that they could routinely manage patients once they had been diagnosed and stabilized by the psychiatrist, said David Buck, M.D., M.P.H., a professor of family and community medicine at Baylor and founder of Health Care for the Homeless in Houston. The primary care clinicians would adjust medications, write refill prescriptions, and keep watch on side effects. In theory, this would take some of the pressure off the psychiatrists and let them concentrate on more serious cases and new patients.

"Dr. Ostermeyer and her team did a good job," Buck told *Psychiatric News*. But their success in improving the primary care physicians' ability to recognize psychiatric disorders led the latter to fall back on the specialist model of referring patients to psychiatry and not taking them back into their own patient caseload.

> "Patients can see their therapist or psychiatrist the way they see their family doctor."

Paradoxically, that happened because there were psychiatrists at the front of the room doing the teaching, reinforcing their role as highly knowledgeable specialists, agreed Ostermeyer.

So two years ago, they collaborated on a new program to train primary care doctors for an expert panel who would be educated by the psychiatrists and then present the mental health material to their primary care colleagues. Another round of education should also help new clinicians who joined the system after the original campaign ended.

"Psychiatrists are experts, but we don't want them to be the only experts," said Buck. The goal should be less referral to psychiatrists and more consultation with them and encouragement for primary care physicians to assume a larger role.

Finally there's something the psychiatrists can learn too.

"Psychiatry in integrated-care settings can be a challenge to traditionally trained psychiatrists," said Ostermeyer. A psychiatrist who works successfully in a primary care system has to learn how primary care physicians work—going in and out of patient rooms, seeing more than one patient at a time, holding briefer sessions, she noted. "Both need to step out of their traditional roles. The job of the primary care doctor is to practice primary care psychiatry with the help of the psychiatrist." PN

Comorbidity Data Highlight Need For More Comprehensive Screening

New research underscoring the connection of physical and mental health signals a need for more integrative care and improved screening efforts, say mental health experts.

BY JONATHAN WOLFE

Individuals who experienced mental illness within the preceding year were more likely than those who did not to also suffer from chronic physical health conditions.

This finding comes from an analysis of data collected through the National Survey on Drug Use and Health (NSDUH) and published April 5 in the *NSDUH Report,* which is issued by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Among the information provided by adult participants in SAMHSA's annual survey is past-year experience of any mental illness (AMI), serious mental illness (SMI), and/or a major depressive episode (MDE). For the purposes of the survey, AMI is defined as "having a diagnosable mental, behavioral, or emotional disorder . . . of sufficient duration to meet diagnostic criteria specified within *[DSM-IV].*"

SMI is defined as having AMI with "serious functional impairment that substantially interferes with one or more major life activities."

SAMHSA defines an individual as having had an MDE if he or she had at least five of nine symptoms listed in *DSM-IV* in the same two-week period in his or her lifetime, in which at least one of the symptoms was a depressed mood or loss of interest or pleasure in daily activities.

Based on combined 2008 and 2009 NSDUH data, SAMHSA estimated that 44.5 million Americans aged 18 or older, or 19.7 percent of the adult population, had AMI in the preceding year. Of these, approximately 10.4 million adults (4.6 percent of the population) had a past-year SMI, and approximately 14.5 million adults (6.5 percent) had an MDE within the prior 12 months.

In assessing the presence of co-occurring physical health conditions in those affected by mental illness, SAMHSA reported that adults experiencing AMI or an MDE in the prior year were more likely than those without these illnesses to have high blood pressure, asthma, diabetes, heart disease, or stroke.

And individuals with past-year SMI were more likely than those without SMI to have high blood pressure, asthma, or stroke.

The survey data also showed greater health care utilization for individuals with mental illness than for those without. The survey results indicated, for example, that 38.8 percent of adults with AMI used emergency-room services in the prior year, compared with 27.1 percent of adults without mental illness. Additionally, 15.1 percent of adults with past-year AMI required hospitalization, compared with 10.1 percent of the general population.

Similarly, those with past-year SMI and/or an MDE were significantly more likely than those without these illnesses to visit the emergency room or to be hospitalized.

SAMHSA concluded in its report that these findings strongly suggest a greater need to screen for and treat "physical" conditions in those with mental illness and to screen for and treat mental disorders in patients with other kinds of medical illness. As a result, the agency also urged implementation of programs that better integrate mental health care and primary care services. PN

SAMHSA's report on physical health conditions among adults with mental illnesses is posted at *www.samhsa.gov/data/2k12/NSDUH103/SR103AdultsAMI2012.pdf.*

More Research Needed on SSRIs For Treating Autism Disorders

The clinical logic for using SSRIs in autism rests on their efficacy in other obsessive-compulsive symptoms, but research evidence of their effectiveness in treating repetitive behaviors is lacking.

BY MARK MORAN

Meta-analysis of the published literature suggests a small but significant effect of SSRIs in the treatment of repetitive behaviors in autism spectrum disorders (ASDs), but this effect appears to be attributable to selective publication of trial results, according to a report published online April 23 in *Pediatrics*.

The report concludes that without timely, transparent, and complete disclosure of trial results, it is difficult to determine the efficacy of available medications. And child psychiatrists and autism experts who reviewed the report told *Psychiatric News* that SSRIs are not as beneficial for repetitive behaviors in autism as they were once thought to be and should be used with caution.

The study was conducted by Melisa Carrasco, Ph.D., Fred Volkmar, M.D., and Michael Bloch, M.D., M.S., of the University of Michigan and of the Child Study Center and Department of Psychiatry at Yale University.

"This research made it clear that the effects of SSRI treatment in ASD are considerably overrated because of publication bias," they wrote. "In addition, our search strategy uncovered as many completed SSRI trials in ASD with unpublished results as have been published, further supporting the influence of potential publication bias on effect estimates."

For the study, the researchers searched PubMed and Clinicaltrials.gov for randomized, double-blind, placebo-controlled trials evaluating the efficacy of SSRIs for repetitive behaviors in ASD; the primary outcome was mean improvement in ratings scales of repetitive behavior. They identified five published and five unpublished but completed trials eligible for meta-analysis.

They used standard statistical methods for computing effect sizes from available data, then applied special statistical methods to adjust effect sizes for unpublished results or missing data.

The meta-analysis of five published and one unpublished trial with available data demonstrated a small but significant effect of SSRIs for the treatment of repetitive behaviors in ASDs. But when analysis was adjusted for the effect of publication bias, there was no longer a significant benefit of SSRIs for the treatment of repetitive behaviors in ASDs. Secondary analyses demonstrated no significant effect of type of medication, patient age, method of analysis, trial design, or trial duration on SSRI efficacy.

"This paper provides a helpful reminder of the ongoing problems posed by publication bias," said child psychiatrist David Fassler, M.D., a clinical professor of psychiatry at the University of Vermont and APA treasurer. "Utilizing a meta-analysis, the authors demonstrate that the published literature overstates the efficacy of SSRIs in the treatment of repetitive behaviors in children, adolescents, and adults with autism spectrum disorders. Physicians, patients, and family members need and deserve as much information as possible, including accurate and complete research data, to make fully informed decisions about treatment options. Selective publication of trial results can influence clinical practice, potentially placing patients at increased risk and/or postponing access to more appropriate and effective intervention."

Louis Kraus, M.D., an expert in autism, told *Psychiatric News* that there is a dearth of research evidence for effective treatments of the repetitive behaviors commonly seen in autism.

Kraus said treatments for children are often extrapolated from research on adults, which may not be appropriate. And in the case of autism, the clinical logic behind using SSRIs rests on their efficacy for obsessive-compulsive disorder.

"But the reality is that the data regarding effectiveness for stereotypic behaviors in autism is limited," he said in an interview. "There is a concern that SSRIs are not as helpful as we once thought."

He cited a June 2009 article in the *Archives of General Psychiatry* that found no significant benefit for citalopram over placebo for repetitive behaviors. The article is titled "Lack of Efficacy of Citalopram in Children With Autism Spectrum Disorders and High Levels of Repetitive Behavior."

Kraus added that children with autism are unusually sensitive to medication, and even a theoretical benefit from SSRIs is likely to be accompanied by an increase in agitation. "SSRIs may offer some benefit to some children, but in a general way clinicians should not use SSRIs for stereotypic behaviors without the understanding when getting informed consent from parents that the research is not definitive in this area," Kraus said.

Funding for the study was provided by the National Institute of Mental Health and the National Institutes of Health. PN

"Pharmacologic Treatment of Repetitive Behaviors in Autism Spectrum Disorders: Evidence of Publication Bias" is posted at *http://pediatrics.aappublications.org/content/early/2012/04/17/peds.2011-3285.full.pdf+html*. "Lack of Efficacy of Citalopram in Children With Autism Spectrum Disorders and High Levels of Repetitive Behavior" is posted at *http://archpsyc.jamanetwork.com/article.aspx?articleid=210271*.

Key Points

- There is a small but significant effect of SSRIs in the treatment of repetitive behaviors in autism spectrum disorders, but this effect appears to be attributable to selective publication of trial results.
- Clinical logic behind use of SSRIs rests on their efficacy for treating obsessive-compulsive symptoms, but research evidence for their use in repetitive behaviors in autism is limited; one study has shown no benefit over placebo for citalopram.
- Use of SSRIs in children with autism, even when beneficial, may be accompanied by an increase in agitation.

Bottom line: Selective publication of trial results can influence clinical practice, potentially placing patients at increased risk and/or postponing access to more appropriate and effective intervention. SSRIs may be beneficial for some autistic patients with repetitive behaviors, but more research is needed.

Psychiatric Research Funds Scarcer, Still Available for Some Disorders

Since funding from the National Institutes of Health is tight, a new private-funding institute in Washington, D.C., might prove of value to psychiatric researchers looking for funding sources.

BY JOAN AREHART-TREICHEL

For psychiatric researchers looking for grant money, especially in the domain of anxiety disorders, a session held at the annual meeting of the Anxiety Disorders Association of America in Arlington, Va., in April was likely a welcome tonic.

Key figures from government agencies, as well as from a private funding organization, reported which areas of research are of particular interest to them and which they might be more likely to fund.

For example, Philip Wang, M.D., deputy director of the National Institute of Mental Health (NIMH), reported that many pharmaceutical companies are abandoning efforts to find new and efficacious treatments for mental disorders because of clinical-trial failures and a sense that not enough is known about the underlying mechanisms of the disorders *(Psychiatric News,* April 6). So one of NIMH's goals, he said, is to identify mechanisms underlying not only specific disorders, but a range of them. This approach, he hoped, will "help us get better treatment targets" than by simply focusing on individual disorders.

Joan Arehart-Treichel

Josephine Briggs, M.D.: "There are some hints of benefit regarding mind-body practices."

The National Center for Complementary and Alternative Medicine, which is only 10 years old and small compared with many of the other National Institutes of Health (NIH) agencies, has nonetheless made some

see ***Research Funds*** *on page 28*

Dementia Risk Rises When Depression, Diabetes Comorbid

Biological factors associated with depression—dysregulation of the pituitary axis and cortisol levels in the brain—may also lead to increased risk for dementia in people with depression and diabetes.

BY MARK MORAN

Individuals with diabetes who also have depression have a greater risk of developing dementia than do diabetes patients without concurrent depression.

That was the finding of a study that surveyed a racially and ethnically stratified random sample of patients with type 2 diabetes in a large managed-care setting in California.

Patients with comorbid depression and diabetes had a 100 percent increased risk of dementia during a period three to five years after onset of the study.

"Up to 20 percent of people with diabetes have clinically significant depression," lead author Wayne Katon, M.D., told *Psychiatric News*. "This study shows that comorbid depression has an added increased risk of macro- and microcomplications and an increased risk for dementia. It speaks to the importance of providing integrated quality mental health and general health care." Katon is a professor of psychiatry at the University of Washington.

In the study, cases of depression were identified among a sample of 19,239 diabetes registry members aged 30 to 75 enrolled in Kaiser Permanente Northern California using the Patient Health Questionnaire-8, *International Classification of Diseases, Ninth Revision (ICD-9)* diagnoses of depression, and/or antidepressant prescriptions in the 12 months prior to baseline.

Because depression is sometimes a prodromal symptom of early dementia itself (as opposed to an antecedent condition), dementia diagnoses were based only on *ICD-9-CM* diagnoses identified in years 3 to 5 postbaseline.

The risk of dementia for patients with depression and diabetes compared with patients with diabetes alone was estimated using statistical models that adjusted for sociodemographic, clinical, and health-risk factors.

A total of 3,766 (19.6 percent) of the patients with diabetes met criteria for clinically significant depression. Katon and colleagues found that 80 of the 3,766 patients (2.1 percent) with comorbid depression and diabetes had dementia in years 3 to 5; in contrast, 158 of 15,473 participants (1.0 percent) without depression developed dementia during the follow-up period.

"Although the bidirectional associations between depression and diabetes—and between both disorders and dementia—are well known, the study adds important new knowledge about the added impact of depression and diabetes on incident dementia that has important implications for public health, clinical-care delivery, and potentially our understanding of the pathogenesis of dementia," said geriatric psychiatrist Yeates Conwell, M.D., who reviewed the report.

"This carefully conducted study shows that the combination of the two increases the risk of developing dementia two-fold over those who have diabetes alone," he told *Psychiatric News*. "The public-health significance lies in the fact that older adults are the most rapidly growing segment of the population, and the increasing prevalence of diabetes in the population is reaching crisis proportions. In coming decades the impact of these demographic and clinical shifts may combine to cause further increases in the number and proportion of older adults with dementia, and consequently place even greater burden on health care systems and their financing."

"The clinical implications are impor-

see ***Diabetes*** *on page 28*

Key Points

- People with diabetes and concomitant depression are at a two-fold greater risk for dementia that individuals who have diabetes without depression.
- Dementia risk is greater with earlier onset of depression in diabetes patients: younger individuals with depression were at greater risk for dementia than were older patients.
- Treatment with insulin may have a protective effect against dementia, but the findings need to be replicated.

The bottom line: With increasing rates of diabetes and an aging population, the need for early and aggressive treatment of depression in people with diabetes is critical.

Often-Used CPT Codes Are Changing

The CPT revisions that are planned to go into effect January 1, 2013, will make it possible to more accurately capture the complexity of psychiatrists' work.

BY MARK MORAN

Big changes are in the works for how psychiatrists code for their services, including deleting many familiar codes, revising some current codes, and creating new codes to more accurately reflect the way psychiatry is practiced today.

After a review of codes in the psychiatry section of *Current Procedural Terminology* (CPT)—the handbook of codes used by all physicians to receive reimbursement for services—the AMA CPT Editorial Panel has approved a number of important changes, including the elimination of code 90862 for pharmacologic management (see table). Staff of APA's Office of Healthcare Systems and Financing pointed out that general Evaluation and Management (E&M) codes can be used by psychiatrists to describe the work of this service now. Members are urged to familiarize themselves with the E&M codes by visiting APA's online course on E/M coding at *www.apaeducation.org.*

Ronald Burd, M.D., chair of APA's Committee on RBRVS, Codes, and Reimbursement and a participant in the review process, said that in all likelihood a new coding structure will be instituted that will include—like the E&M codes available to all physicians (99xxx series codes)—levels of complexity that will make it possible to more accurately capture clinical work with psychiatric patients.

APA is undertaking outreach to commercial and public payers to ensure that they are aware of the coming changes and will be prepared to reimburse appropriately under the new codes.

The new coding framework is the product of an AMA-convened work group that included representatives from the AMA CPT panel, APA, American Academy of Child and Adolescent Psychiatry, American Nurses Association, American Psychiatric Nurses Association, American Psychological Association, and National Association of Social Workers. APA provided leadership in the shaping and development of the codes that will describe the work of psychiatrists, advanced-practice nurses, psychologists, and social workers.

February 2012 CPT Editorial Panel Meeting: Summary of Actions

These actions reflect discussions at the most recent meeting of the CPT Editorial Panel. Future panel actions may impact these items. Codes are not assigned, nor exact wording finalized, until just prior to publication. Release of this more specific CPT code set information is timed with the release of the entire set of coding changes in the CPT publication. Category I codes will be available in late September or early October. All codes will become effective on January 1, 2013.

Tab #	Title of Request	Description of Request	Description of CPT Editorial Panel Action
93	Psychological and Psychiatric Services (PPS) Workgroup	Workgroup proposal to establish codes	Rejected: establishment of a code for comorbid treatment complexity Accepted: 1) establishment of code for pharmacologic management with concurrent deletion of code 90862; 2) revision of psychiatry guidelines; 3) addition of code 908XE for interactive complexity; 4) deletion of codes 90804-90809, 90810-90815, 90816-90822, 90823-90829, 90857; 5) addition of codes 908P10, 908P10X, 908P20, 908P20X, 908P30, 908P30X, 908CP2, 908CP2 for psychotherapy; and 6) revision of codes 90875, 90876

Source: American Medical Association, 2012

The AMA has released only general information about the code changes, and those who participated in the code review process are bound by a confidentiality agreement not to reveal any more information about the new coding until the 2013 CPT book is published by the AMA, which is anticipated in September or October.

Although the changes have been accepted by the CPT Editorial Panel and recommended values for the new codes have been made to the Centers for Medicare and Medicaid Services (CMS) by the AMA's Resource-Based Relative Value Update Committee (RUC), CMS has the ultimate say in accepting or modifying the RUC's recommendations before valuation of the new codes is final in November. PN

Look to APA's Web site and *Psychiatric News* for coverage of these changes as they become public.

APA Concerned About Psychiatrists' Eligibility for EHR Bonuses

APA lauds federal efforts to incentivize the use of new health information technology but wants to ensure that psychiatrists are not overburdened by restrictive programmatic measures.

BY JONATHAN WOLFE

In late February, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule governing the second stage of the Electronic Health Record (EHR) Incentive Program, which offers Medicare payment bonuses to physicians and hospitals that adopt certified EHR systems and demonstrate "meaningful use" of the new technology.

As in the first stage of the program, which began in 2011, CMS is proposing that meaningful use be defined as fulfilling (or qualifying for an exclusion to) a specific set of "core" and "menu" measures. Eligible physicians and hospitals would also be required to report on 12 clinical quality measures (CQMs) to qualify for incentive payments under the program.

APA submitted comments on the agency's proposal on May 7, commending CMS for its efforts to make the EHR Incentive Program more relevant to specialists through a number of additions and adjustments, but voiced concern that many of the 17 core measures proposed by CMS still cannot be satisfied by most psychiatrists, including several that could compromise the psychiatrist-patient relationship.

One such measure would require physicians to provide more than 50 percent of patients with electronic access to their health information while at the same time ensuring that this information is viewed, downloaded, or transmitted to a third party by more than 10 percent of patients.

"As a general principle, a physician's performance of core measures should not be dependent upon actions being taken by the physician's patients," wrote APA Medical Director James H. Scully Jr., M.D. "This principle rings particularly true for psychiatrists whose successful treatment of a patient is largely dependent upon having the trust of their patients."

On similar grounds, APA recommended that CMS remove a core measure that would require 10 percent of a physician's patients to send a secure message via the electronic messaging function of a certified EHR system.

APA also took issue with CMS's modification of a Stage 1 meaningful-use core measure that required physicians to provide clinical summaries for more than 50 percent of all office visits within three business days. As proposed for Stage 2 of the program, physicians would have only 24 hours to provide a clinical summary—an amount of time APA deems insufficient "to make an informed decision as to what information should or should not be shared with the patient."

In assessing the five menu measures proposed by CMS, at least three of which would also have to be met to qualify for incentive payments, APA commended the agency for devising a sufficient number of exclusions that are broad enough to be satisfied by psychiatrists.

APA also praised CMS for adding to its list of reportable CQMs several measures that are specifically relevant to the treatment of mental illness.

Additionally, APA voiced strong support for CMS's proposal to delay the implementation of the onset of Stage 2 meaningful-use criteria from 2013 to 2014.

However, APA expressed equally strong opposition to the proposed backdating of payment adjustments for physicians participating in Stage 2 of the EHR Incentive Program, maintaining that such a move would "subject numerous physicians to financial penalties and slow down EHR adoption and implementation."

*see **EHR** on page 28*

IN THE COMMUNITY

Advocate Attributes Recovery to Strength of Therapeutic Alliance

A leading mental health advocate emphasizes the importance of a trusting relationship between psychiatrist and patient, which will serve as a strong foundation for recovery.

BY EVE BENDER

For Keris Myrick, M.S., M.B.A., several pivotal moments leading up to her recovery from serious mental illness will remain forever crystallized in her memory: her psychiatrist sitting with her on the floor during one hospitalization, a therapist agreeing to a game of "Chutes and Ladders" during a session, and the realization that she needed to be in charge of her life.

Today, she credits her recovery to a strong therapeutic alliance with her psychiatrist, the steadfast support of family and friends, and a busy schedule as the chief executive of Project Return Peer Support Network, a nonprofit organization in the Los Angeles area. She also jets across the country routinely to fulfill duties associated with roles as the first vice president of the National Alliance on Mental Illness and as a consultant to projects of APA's Office of Minority and National Affairs (OMNA).

"My mind needs to be busy," Myrick told *Psychiatric News*. "If I'm not analyzing some kind of problem, or if I'm not challenged, there is too much room for other things to get in."

Myrick is nothing if not busy as she oversees nearly 100 advisors—also people in recovery from mental illness—who provide peer-support services to "consumers" in Los Angeles County. The peers assist with symptom management, provide a "warm line" for those in distress, and help them navigate the mental health system. "Although managing a high-level job seems to be the key to mental health for me," Myrick said, "I have to be careful that my stress levels don't get too high."

Myrick is also a member of the selection committee of the APA/SAMHSA Minority Fellowship and offers assistance with the psychiatry component of the Recovery to Practice project, a SAMHSA-funded collaborative effort between APA and the American Association of Community Psychiatrists.

As the daughter of an Army colonel, Myrick grew up in places as far flung as Seoul, South Korea; Ft. Leavenworth, Kan.; and Bremerhaven, West Germany, and was never in one place for more than a few years. As an African American living in Europe and Asia, she didn't fit in with her peers. When her family returned to the United States to live in a predominantly African-American community in New Jersey, Myrick explained, she also felt like an outcast. "I thought it would be a good experience because it would be one place I wouldn't stick out, but being an African American, there are expectations about how you will talk and look, and I didn't meet any of those expectations," she noted. "My peers made fun of me because I was different from them, and it was very difficult."

David Hathcox

At APA's annual meeting last month in Philadelphia, mental health advocate Keris Myrick, M.S., M.B.A., spoke to APA minority fellows about fostering recovery and resilience in their patients.

Myrick said her alienation from her peers became more pronounced as she began experiencing early signs of what would years later be diagnosed as schizoaffective disorder and obsessive-compulsive disorder.

She recalled a trip to the grocery store in her early 20s that should have been effortless and routine. For Myrick, however, it was a nightmare of epic proportions as she strolled down the cereal aisle looking for a box of Cheerios. "When I grabbed the box, voices began telling me that it was poison and that it would kill me." With each successive box she chose, the same thing happened—it didn't matter what brand of cereal she chose. When a cleanup was announced in her aisle, she looked behind her and noticed piles of boxes cluttering the floor. "This was a really sad moment for me because I realized that I couldn't do something completely mundane that everyone else can do." Myrick didn't tell anyone about the incident at the time and was later diagnosed with an eating disorder, because the voices often forbade her to eat anything and she became dangerously thin.

Although her family was always supportive of her, they didn't know the truth about the symptoms behind her weight loss. "I never told anyone that I was hearing voices," due to the stigma associated with psychosis, she remarked.

It was only when she forged a trusting relationship with her psychologist and then with her psychiatrist that the truth emerged, Myrick said.

While seeing a therapist who also worked with children, Myrick noticed a game of "Chutes and Ladders" in his office. Therapy felt contrived up to that point, she said, but there was something about the game that enabled her to let down her barriers during the sessions.

During one of several hospitalizations, Myrick met a psychiatrist who also gained her trust over time. Timothy Pylko, M.D., "made the effort to get to know me as a person instead of just asking me about my symptoms," she said. When in a catatonic state during one hospitalization, Pylko sat next to Myrick on the closet floor, where she laid. "All I could think about was that his nice suit must be getting so dirty," she said. Over time, she noted, the two worked as partners to solve the riddles of her illness, including researching treatments together.

Her work at Project Return Peer Support Network, which she joined in 2008, is part of that treatment, as is her work with OMNA, in which she helps train primary care physicians to understand the mental health needs of African-American patients as part of the In Living Color project.

OMNA Director Annelle Primm, M.D., M.P.H, appreciates Myrick's perspective. "Keris is a premier voice among leaders and advocates working to advance the delivery of recovery-oriented services for people with mental illness and substance use disorders," Primm told *Psychiatric News*. "Her knowledge, experience, and eloquence in articulating how psychiatrists and other mental health practitioners can provide more recovery-oriented, culturally competent care have made her an invaluable collaborator." PN

More information about Project Return Peer Support Network is posted at *www.prpsn.org*.

DB Gives Check to Group Promoting Safe Schools

Aaron Levin

APA's New York County District Branch last year began the One for All campaign, asking each member to donate a sum equivalent to one patient hour for a designated charity.

The district branch then donates the funds collected to an organization making an important contribution to the mental health of the New York community.

The first recipient was the Gay, Lesbian, and Straight Education Network (GLSEN). Based in New York City, GLSEN works nationally to promote safe schools for students regardless of their sexual orientation or gender identity/expression.

"I have become attuned to news coverage about bullying and have been struck by just how much the issue, and even GLSEN, has been capturing the public's attention," said district branch President Craig Katz, M.D., handing over a check for $5,400 in April to Robert McGarry, director of training and curriculum development for GLSEN.

Psychiatrists are trained to help people in the darkest, most suicidal moments of their lives, said Katz. "One for All reflects how we can step out of our usual ways of helping to be there for people well before they become suicidal or develop mental illness."

The One for All campaign will continue on an annual basis, said Katz.

More information about the Gay, Lesbian, and Straight Education Network is posted at *www2.glsen.org*.

Increase in Addicted Newborns Sends Treatment Costs Soaring

The number of babies born to opiate-addicted mothers nearly tripled over nine years, leading to a substantial increase in Medicaid expenditures.

BY JONATHAN WOLFE

In 2009, nearly 14,000 babies were born in the United States with drug-withdrawal symptoms, resulting in total hospital charges of approximately $720 million.

This is one of the key findings of a study in the May 9 *Journal of the American Medical Association* designed to quantify the national incidence of neonatal abstinence syndrome (NAS) and the costs associated with delivery of newborns affected by the condition.

For the study, Stephen Patrick, M.D., M.P.H., of the University of Michigan Health System (UMHS) led a team of researchers from UMHS's Department of Pediatrics and Communicable Diseases and the University of Pittsburgh's Department of Obstetrics and Gynecology in reviewing national hospital-discharge data from 2000, 2003, 2006, and 2009.

Statistics about infants born with NAS were obtained through the Healthcare Cost and Utilization Project's (HCUP) nationally representative Kids' Inpatient Database. The researchers also pooled data from HCUP's National Inpatient Sample on mothers identified as prebirth users of opiates.

The researchers found that the number of newborns delivered with NAS increased from a rate of 1.2 per 1,000 hospital births in 2000 to 3.4 per 1,000 hospital births in 2009. The number of opiate-using mothers grew at an even greater rate—from 1.2 per 1,000 hospital births in 2000 to 5.6 per 1,000 hospital births in 2009.

Compared with all other hospital births, newborns with NAS were also found more likely to suffer from a variety of adverse health conditions. In 2009, babies delivered with NAS experienced greater rates of respiratory diagnoses (31 percent vs. 9 percent), low birth weight (19 percent vs. 7 percent), feeding difficulty (18 percent vs. 3 percent), and seizure disorders (2 percent vs. 0.1 percent).

These complications contributed to increased health care expenditures, the researchers found, with mean hospital charges for newborns with NAS increasing from $39,400 per discharge in 2000 to $53,400 in 2009. These figures are more than five times the cost of all other hospital births, which rose from a mean of $6,600 in 2000 to $9,500 in 2009.

Similarly, the average length of hospital stay for newborns with NAS (16.4 days in 2009) dwarfed that for all other hospital births (3.3 days in 2009).

The researchers also noted that Medicaid paid for 77 percent of the charges associated with the delivery of newborns with NAS in 2009, up from 69 percent in 2000.

The study was supported by a grant from UMHS's Robert Wood Johnson Foundation Clinical Scholars Program, with which two of the study authors are affiliated. PN

An abstract of "Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000-2009" is posted at *http://jama.jamanetwork.com/article.aspx?articleid=1151530#Abstract.*

INTERNATIONAL NEWS

Sergey Ivanov

Two Nations Assess Results Of Stigma-Fighting Efforts

A major British antistigma campaign achieves modest progress in reducing mental-health-related discrimination, while Australian researchers report gains in public understanding of mental illnesses and their treatment.

BY JONATHAN WOLFE

How has the public perception of mental illness changed over time? And how does that perception affect the lives of individuals living with these disorders?

These questions are at the center of two new studies—one evaluating first-year results of a high-profile British antistigma program and the other assessing how the ability to recognize mental illness and understand approaches to treatment has evolved over nearly two decades in Australia.

Stigma Appears to Ebb in Britain

The British study, published in the May *Psychiatric Services,* considers discrimination from the viewpoint of those directly experiencing it.

Claire Henderson, M.D., Ph.D., of the Department of Health Service and Population Research at King's College London led a team comprising departmental colleagues and researchers affiliated with the London-based nongovernmental organization Rethink Mental Illness in assessing the amount and types of discrimination reported by adults with mental illness before and after introduction of England's Time to Change (TTC) program.

Launched in January 2009 with $33 million in funding from the Big Lottery Fund and Comic Relief, TTC is focused on achieving a 5 percent reduction in mental-health-related discrimination through such initiatives as an antistigma educational campaign, community activities designed to bring together people with and without mental illness, and a Web-based resource on mental illness in the workplace. Both Rethink Mental Illness and the British mental health charity Mind provide programmatic support for TTC.

For the study, the researchers compared the results of telephone interviews conducted with 537 participants in 2008 and 1,047 individuals in 2009, all of whom were aged 18 to 65, noninstitutionalized, and registered as users of mental health services with Britain's National Health Service. Interviewers used the nationally standardized 22-item Discrimination and Stigma Scale to assess the level of discrimination experienced by participants across a range of life areas.

The survey findings showed that 87 percent of respondents said they experienced more than one instance of discrimination in 2009. While a staggering percentage, this was down from 91 percent of participants in 2008. This drop reflected a significant reduction in discrimination from several sources, including family (from 53 percent in 2008 to 46 percent in 2009) and friends (from 53 percent to 39 percent).

Respondents also reported significant decreases in mental illness discrimination associated with dating (from 31 percent in 2008 to 18 percent in 2009) and finding a job (from 24 percent to 16 percent).

However, the proportion of respondents reporting discrimination from mental health professionals dropped only 2 percent. This finding, according to the researchers, may indicate a need for antistigma efforts targeted at specific audiences rather than merely the public at large.

Public Recognition on Rise Down Under

The Australian study, published in May's *British Journal of Psychiatry,* also found modest gains in the public's understanding of mental illness.

Nicola Reavley, Ph.D., and Anthony Jorm, Ph.D., D.Sc., of the University of Melbourne's Orygen Youth Health Research Centre compared results of a 2011 national survey of 6,019 adults with findings from surveys conducted in 1995 (2,164 adults) and 2003/2004 (3,998 adults).

While the most recent survey was conducted by phone, as opposed to the two earlier in-person surveys, the questions included in all three were similar. Randomly selected respondents were asked to identify the disorder described in vignettes about individuals with depression or schizophrenia, as well as the best course of action for addressing the disorder and the likelihood of recovery or remission.

Survey participants were also questioned about the perceived benefit of various treatment options, including seeing a physician or mental health professional, taking prescription medications or over-the-counter remedies, consulting with clergy, reaching out to friends or family, and exercising.

The researchers observed a marked improvement in the recognition of depression, rising from just 39 percent of participants in 1995 to 67.3 percent in 2003/2004 and 73.9 percent in 2011.

This growth in public understanding could be partly attributable to Australia's "beyondblue" national depression initiative, the researchers suggested.

And while the percentage of respondents identifying psychiatrists, medication, or counseling as the best treatment option for depression dropped significantly from 1995 to 2011, the 16-year time span saw significant growth in beliefs about the helpfulness of these same interventions. In particular, more than twice as many respondents rated antidepressants as being helpful in 2011 than in 1995 (59 percent vs. 28.7 percent).

The public's recognition of schizophrenia was more variable throughout the three study periods, rising from 26.8 percent in 1995 to 42.5 percent in 2003/2004 before dropping slightly to 37.9 percent in 2011. However, the percentage of respondents citing the helpfulness of antipsychotics more than doubled between 1995 and 2011, rising from 23.2 percent to 48.3 percent.

For both disorders, the researchers also noted a significant decrease in the percentage of respondents stating that they believe a full recovery from the disorders is likely, with a corresponding increase in support of a likely full or partial recovery with relapses. PN

"England's Time to Change Antistigma Campaign: One-Year Outcomes of Service User–Rated Experiences of Discrimination" is posted at *http://ps.psychiatryonline.org/article.aspx?articleid=1109160.* An abstract of "Public Recognition of Mental Disorders and Beliefs About Treatment: Changes in Australia Over 16 Years" is posted at *http://bjp.rcpsych.org/content/200/5/419.short.*

Nominations Invited for Child Psychiatry Awards

APA invites applications for the Blanche F. Ittleson Research Award, Agnes Purcell McGavin Award for Prevention, and Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry. These awards are given to psychiatrists who have made significant contributions to child and adolescent psychiatry. They will be presented at APA's 2013 annual meeting in San Francisco. The deadline for nominations is July 1. Nomination and submission information can be accessed at *www.psychiatry.org/File%20Library/Practice/Diversity%20OMNA/Diversity%20Fellowships%20and%20Awards/Awards/Ittleson-Award-Flyer.pdf.* PN

psychoactive substances. Tolerance is a state of adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug effects over time. Tolerance may occur to both desired and undesired effects of drugs and may develop at different rates for different effects. Addiction is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. Drug addiction is a treatable disease, using a multidisciplinary approach, but relapse is common. Studies of abuse potential in former drug abusers found that the effects of single doses of 40 mg of oral zolpidem tartrate were similar, but not identical, to diazepam 20 mg, while 10 mg of oral zolpidem tartrate was difficult to distinguish from placebo. Because persons with a history of addiction to or abuse of drugs or alcohol are at increased risk for misuse, abuse and addiction of zolpidem, they should be monitored carefully when receiving Intermezzo. **9.3 Dependence:** Physical dependence is a state of adaptation that is manifested by a specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Sedative-hypnotics have produced withdrawal signs and symptoms following abrupt discontinuation. These reported symptoms range from mild dysphoria and insomnia to a withdrawal syndrome that may include abdominal and muscle cramps, vomiting, sweating, tremors, and convulsions. The following adverse events which are considered to meet the DSM-III-R criteria for uncomplicated sedative-hypnotic withdrawal were reported during U.S. clinical trials with other oral zolpidem formulations following placebo substitution occurring within 48 hours following the last zolpidem treatment: fatigue, nausea, flushing, lightheadedness, uncontrolled crying, emesis, stomach cramps, panic attack, nervousness, and abdominal discomfort. These reported adverse events occurred at an incidence of 1% or less. However, available data cannot provide a reliable estimate of the incidence, if any, of dependence during treatment at recommended doses. Post-marketing reports of abuse, dependence, and withdrawal resulting from use of oral zolpidem tartrate have been received. **10 OVERDOSAGE: 10.1 Signs and Symptoms:** In post-marketing experience of overdose with oral zolpidem tartrate alone, or in combination with CNS-depressant agents, impairment of consciousness ranging from somnolence to coma, cardiovascular and/or respiratory compromise, and fatal outcomes have been reported. **10.2 Recommended Treatment:** General symptomatic and supportive measures should be used along with immediate gastric lavage where appropriate. Intravenous fluids should be administered as needed. Zolpidem's sedative-hypnotic effect was shown to be reduced by flumazenil and therefore flumazenil may be useful; however, flumazenil administration may contribute to the appearance of neurological symptoms (convulsions). As in all cases of drug overdose, respiration, pulse, blood pressure, and other appropriate signs should be monitored and general supportive measures employed. Hypotension and CNS depression should be treated by appropriate medical intervention. Sedating drugs should be withheld following zolpidem overdosage, even if excitation occurs. The value of dialysis in the treatment of overdosage has not been determined, although hemodialysis studies in patients with renal failure receiving therapeutic doses have demonstrated that zolpidem is not dialyzable. As with management of all overdosage, the possibility of multiple drug ingestion should be considered. The healthcare provider may wish to consider contacting a poison control center for up-to-date information on the management of hypnotic drug overdosage. **14.2 Special Safety Studies**: *Driving Study:* A randomized, double-blind, placebo-controlled, active-control, single-center, four-period, crossover study in 40 healthy subjects was conducted to evaluate the effects of middle-of-the-night administration of Intermezzo on next-morning driving performance. The four randomized treatments included Intermezzo 3.5 mg four hours before driving, Intermezzo 3.5 mg three hours before driving, placebo, and a positive control (an unapproved sedative-hypnotic) given nine hours before driving. The primary outcome measure was the change in the standard deviation of lateral position (SDLP), a measure of driving impairment. The results were analyzed using a symmetry analysis, which determined the proportion of subjects whose change from their own SDLP in the placebo condition was statistically significantly above a threshold thought to reflect clinically meaningful driving impairment. When driving began 3 hours after taking Intermezzo, testing had to be terminated for one subject (a 23-year old woman) due to somnolence. Overall, the symmetry analysis showed a statistically significant impairing effect at 3 hours. When driving began 4 hours after taking Intermezzo, statistically significant impairment was not found, but numerically Intermezzo was worse than placebo. Zolpidem blood levels were not measured in the driving study, and the study was not designed to correlate specific blood level with degree of impairment. However, the estimated blood level of zolpidem in patients whose SDLP worsened according to the symmetry analysis is considered to present a risk for driving impairment. In some women, the 3.5 mg dose of Intermezzo results in zolpidem blood levels that remain at or sometimes considerably above this level 4 or more hours after dosing. Therefore, the recommended dose for women is 1.75 mg. A small negative effect on SDLP may remain in some patients 4 hours after the 1.75 mg dose in women, and after the 3.5 mg dose in men, such that a potential negative effect on driving cannot be completely excluded. *Rebound effects:* In studies performed with other zolpidem formulations (5 mg to 10 mg oral zolpidem tartrate) given at bedtime, there was no objective (polysomnographic) evidence of rebound insomnia at recommended doses seen in studies evaluating sleep on the nights following discontinuation. There was subjective evidence of impaired sleep in the elderly on the first post-treatment night at doses above the recommended elderly dose of 5 mg oral zolpidem tartrate. *Memory impairment in controlled studies:* Controlled studies in adults utilizing objective measures of memory yielded no consistent evidence of next-day memory impairment following the administration at bedtime of 5 mg to 10 mg oral zolpidem tartrate. However, in one study involving zolpidem tartrate doses of 10 mg and 20 mg, there was a significant decrease in next-morning recall of information presented to subjects during peak drug effect (90 minutes post-dose), i.e., these subjects experienced anterograde amnesia. There was also subjective evidence from adverse event data for anterograde amnesia occurring in association with the administration of oral zolpidem tartrate, predominantly at doses above 10 mg.

Healthcare professionals can telephone Purdue Pharma's Medical Services Department (1-888-726-7535) for information on this product.

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RESIDENTS' FORUM

Residents' Voice Getting Stronger

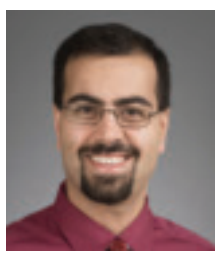
BY ALIK WIDGE, M.D.

For my first column as your member-in-training (MIT) trustee, I'm writing to introduce myself and describe some goals for the coming year.

I'm in my final year of residency at the University of Washington, and next year I will continue on to a research fellowship in psychiatric brain stimulation. I have long been working to increase the voice of psychiatry residents within APA and organized medicine in general and to help make medical societies a force for high-quality, evidence-based care. I hope to keep doing these activities this year as your MIT trustee.

In my campaign for the MIT position last year, I promised to focus on developing more opportunities for involvement of residents in APA and better communication to you from your leaders.

APA is full of opportunities for MITs, but this often leads to our being isolated in different "silos," in which resident-advocates can't communicate easily with their peers in an effort to work together on common issues. Over the past year, my predecessor as MIT trustee, Sarah Johnson, laid the foundation for the establishment of the Caucus of Members-in-Training (CoMIT), a group that will bring together leaders from the APA Assembly, the APA fellowship programs, and the Board of Trustees to address common issues. CoMIT has had quarterly conference calls this past year, and our first serious in-person meeting was held at the APA annual meeting last month in Philadelphia. With some generous donations from the Jefferson residency program, we were even able to provide dinner for attendees, which I hope we can continue next year in San Francisco.



One of my top priorities this year is to develop CoMIT into an active and coordinated force for MITs within APA, so that all your leaders are working in unison to help this organization better serve you. Even more importantly, the caucus will be a place for any trainee who is interested in leadership in the Association (or even just understanding how APA governance works) but hasn't secured any formal office to make a contribution to the organization. By identifying and mentoring those of you who want to be more involved in APA, I hope to help prepare a top-notch crop of leaders for the years ahead.

The other thing you can expect from me this year, as promised, is communication. Both your MIT trustee-elect, Erik Vanderlip, and I believe that APA needs to start communicating through many different channels to effectively reach tomorrow's psychiatrists. There is this column, for example, and if APA has your e-mail address, you've probably received a message from me. This year, we hope to go beyond that. There's an APA MIT group on LinkedIn where I'll be posting updates, and we may shortly be on Facebook, where there's already a general APA page. My personal Twitter feed is @AlikWidge, where I post updates on APA business, but also on my research and work with the Accreditation Council for Graduate Medical Education. In addition, *Psychiatric News Update*, the electronic newsletter e-mailed to members each Wednesday, contains valuable information for MITs about APA programs and opportunities.

Finally, we as psychiatrists know that no amount of electrons can match the value of face-to-face conversation. As I travel this year for conferences and interviews, I hope to hold "roundtable" meetings to gather your feedback about how we can better serve you. At the July Board meeting, I'll be asking for funding for those meetings and will report back to you in late summer.

In future columns, I will have some updates on new developments in residency accreditation and board certification and thoughts on major strategic decisions facing APA. In the meantime, if you're interested in joining the caucus list or otherwise have a question for me, please drop me a line at *alik.widge@gmail.com*. Input from members is essential to help me do my job! PN

Alik Widge, M.D., is a PGY-4 resident at the University of Washington.

CLINICAL & RESEARCH NEWS

Schizophrenia With Catatonia Raises Suicide Risk

Individuals who have both schizophrenia and catatonia may be at an even higher risk of suicide than individuals who have schizophrenia alone.

BY JOAN AREHART-TREICHEL

If you say the word "catatonia," many members of the public think of the 1990 movie "Awakenings" with Robert De Niro and Robin Williams in which patients' stupor and rigidity were due to an encephalitis infection.

In general, however, psychiatrists think of catatonia as a subtype of schizophrenia.

To learn more about catatonia, Dolores Malaspina, M.D., a professor of psychiatry at New York University, and colleagues have conducted what appears to be the first prospective study to determine how catatonic schizophrenia resembles, or differs from, other types of schizophrenia.

They used data from an Israeli population study in which about 90,000 subjects had been followed from birth until ages 29 to 41. Of those subjects, 568 developed schizophrenia, and 43 of them (8 percent) developed catatonic schizophrenia. Malaspina and her team then compared subjects with catatonic schizophrenia with those with other types of schizophrenia and found several notable differences, they reported in the March *Schizophrenia Bulletin.*

> "[C]atatonic schizophrenia might be biologically distinct from other types of schizophrenia."

Women and men were at comparable risk for catatonia, in contrast to other types of schizophrenia in which men were at higher risk. Advancing paternal age had no influence on risk for developing catatonia, in contrast to other types of schizophrenia where a link to paternal age has been identified. At the same time, those with catatonia were somewhat more likely to have mothers who were generally older when they gave birth to a child who later developed catatonia, which was not the case for subjects with other types of schizophrenia.

And most strikingly, individuals with catatonia were significantly more likely to attempt suicide than individuals with other forms of schizophrenia. "This is notable," the researchers said, "because those with schizophrenia are already considered at high risk for suicide." And as Malaspina stressed to *Psychiatric News,* "the high risk for suicidal ideation should be particularly noted by clinicians."

"Our results lend support to the hypothesis that catatonic schizophrenia might be biologically distinct from other types of schizophrenia," Malaspina and colleagues concluded. But exactly what biological mechanisms might contribute to such a subtype remain to be elucidated. Yet in two other studies, subjects with catatonic schizophrenia were found to have lower blood levels of brain-derived neurotrophic factor and higher blood levels of C-reactive protein than subjects with schizophrenia without catatonia.

Also to be determined, Malaspina told *Psychiatric News*, is whether the biological mechanisms that cause catatonia in individuals with schizophrenia are the same as those that cause catatonia in people without schizophrenia, since "catatonia as a condition can exist in many other disorders and perhaps even present alone."

The study was funded by the National Institutes of Health and the Brain and Behavior Research Foundation (formerly NARSAD). PN

An abstract of "Catatonic Schizophrenia: A Cohort Prospective Study" is posted at *http://schizophreniabulletin.oxfordjournals.org/content/38/2/331.abstract.*

FROM THE EXPERTS

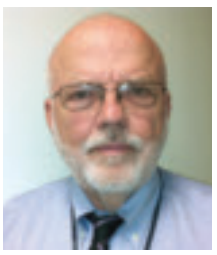
Disaster, Children, and Chance Happenings

BY JON A. SHAW, M.D.

Disaster is a severe psychosocial or ecological disruption of a community that exceeds the adaptive capacity of the community. In most situations, it is chance happening.

Most survivors of disaster, particularly children, have trouble with the idea of chance happening. There is a general reluctance to accept randomness in human affairs. How does the child growing up in the world begin to understand the chance happenings of everyday life? How do children respond to the accidental events that impact their lives? What are the emotions that make it so difficult for individuals, both children and adults, to accept the impersonal forces that often shape our surroundings? Both Freud and Piaget recognized that a belief in chance happenings is a late cognitive acquisition.

A survey of 2,030 children, 2 to 17 years of age, in the United States indicates that the lifetime exposure to disaster is 13.9 percent and that 4.1 percent of the children had experienced a disaster in the prior year. Children are particularly limited in their cognitive capacities to process the meaning of sudden, unexpected chance happenings such as disaster and other traumatic events that uproot their personal and family lives. In 2010, the National Commission on Children and Disasters



recognized the unique vulnerability of children to disaster, noting their cognitive and emotional immaturity and their elevated risk for emotional and behavioral problems, including posttraumatic stress disorder, depression, anxiety, bereavement, academic failure, delinquency, and substance abuse.

Young children do not recognize the existence of chance happenings. Children with their egocentric theory of causality tend to believe that everything that happens in the universe is related to something they did or did not do. For the child 2 to 7 years of age, physical reality is perceived as animated and alive. There is a lack of differentiation between one's inner subjective world and the physical universe. Egocentric assimilation leads the child to assume certain principles of causality, that is, the principles of animism, finalism, and artificialism.

- **Animism** is the tendency to conceive of things as living beings like ourselves. A child believed the "eye of the hurricane" was a monster coming for him.

- **Finalism** assumes that events happen in the world with intentionality to achieve a purpose. A young girl believed that the Chowchilla bus kidnapping was a punishment because she had called her mother "the meanest mother in the world" as she left for school that morning.

- **Artificialism** is the belief that everything has been built or determined by man. One child believed a flood that devastated communities was a direct consequence of his repeatedly flushing the toilet at home, a behavior for which he had been reprimanded.

Therapy with young children requires sensitivity to their cognitive level and proclivity for an egocentric theory of causality. Frequently the child's processing of the meaning of disaster is mirrored and shaped by the parents' interpretations within the limitations of their own cognitive capacities. The helper/therapist is a first-line responder or a mental health professional who uses psychological first aid, skills for psychological recovery, or other more sustained interventions to consider the child's and often the adults' striving to interpret and place meaning on the disaster experience. Each survivor will have to determine vis-à-vis his or her individual belief system that disaster "happens for a reason," is a product of a higher purpose, a product of one's intrapsychic machinations, or a chance happening. Whatever the causal explanation, it will have derivative effects on the therapeutic process and recovery.

It is essential for the therapist, however, not only to be sensitive to the child's readiness for egocentric theories of causality but also to be sensitive to the family's interpretation of the meaning of the disaster and to be able to facilitate a more adaptive interpretation, thus mitigating guilt and the idiosyncratic sense of responsibility so often present in the survivors of disaster. PN

Jon A. Shaw, M.D., is professor and director of the Division of Child and Adolescent Psychiatry and Behavioral Sciences at the University of Miami Miller School of Medicine. He is coauthor of *Care of Children Exposed to the Traumatic Effects of Disaster*, published by American Psychiatric Publishing. APA members can purchase the book at a discount at *www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62426.*

CLINICAL & RESEARCH NEWS

Many Mysteries Unsolved In Binge-Eating Disorder

Although cognitive-behavioral therapy and interpersonal therapy, as well as the anticonvulsant topiramate, can help patients who binge eat, a magic bullet for the disorder remains elusive.

BY JOAN AREHART-TREICHEL

It is likely that binge-eating disorder (BED) will be included as a psychiatric diagnosis in *DSM-5,* Timothy Walsh, M.D., said at an April workshop on the topic at the Uniformed Services University of the Health Sciences in Bethesda, Md.

Walsh is a professor of pediatric psychopharmacology at Columbia University/New York State Psychiatric Institute and chair of the Feeding and Eating Disorders Work Group for *DSM-5.*

Timothy Walsh, M.D.

"One reason that I believe BED is going to make it into *DSM-5* is because sufficient research has been conducted on it," Walsh explained. As he told *Psychiatric News* earlier this year, "In the 20 years since publication of *DSM-IV,* there have been more than 1,000 papers published on BED" (*Psychiatric News,* January 6).

Nonetheless, many questions about the disorder press for answers, Walsh and other workshop speakers concurred.

For example, one gene, called FTO, which is expressed in the hypothalamus, has been linked with BED, Marian Tanofsky-Kraff, Ph.D., an associate professor of medical and clinical psychology at the Uniformed Services University, reported. But are other genes involved as well? Researchers don't know.

While maltreatment, teasing, and bullying have been identified as BED risk factors, other childhood risk factors for BED also need to be identified, Cynthia Bulik, Ph.D., director of the eating disorders program at the University of North Carolina, stressed.

Chevese Turner, founder and chief executive officer of the Binge Eating Disorder Association, related that when she was a little girl, her mother had anorexia nervosa and talked a lot about dieting. Both factors encouraged Turner to start binge eating, she believes, and she started doing so as early as at age 5. Yet BED is usually uncommon before adolescence, Tanofsky-Kraff said. Why is this? Researchers don't have the answer.

A major criterion for BED is loss of control over eating. Yet how does the mechanism of loss of control in BED compare with that of the loss of control in alcoholism or drug abuse? Stephen Wonderlich, Ph.D., associate chair of clinical neuroscience at the University of North Dakota, asked. "And there is not yet enough research to determine whether binging in BED is the same or different from binging in bulimia nervosa," Walsh noted. "We also need to determine the relationship of loss of control to amount consumed," he added. "Our knowledge of how these pieces fit together isn't as good as it could be."

Although there is a strong cross-sectional relationship between BED and obesity, there have been few longitudinal studies to see whether BED causes excessive weight gain and obesity, Alison Field, Sc.D., an associate professor of pediatrics at Harvard Medical School, said.

Even if binge eating can lead to obesity, why don't all binge eaters become obese? Mary Boggiano, Ph.D., an associate professor of psychology at the University of Alabama, asked that question after she and her colleagues conducted a binge-eating study in rats that found that not all binging rats became obese.

The experts are also wondering how grazing and night eating fit into the BED picture. "I don't think there is much data about grazing," Walsh commented. "There has been some research about night eating, but the definition does not seem to be stable. This doesn't mean that they don't exist, but there is insufficient data to recognize them formally in *DSM-5* as disorders."

see ***Binge Eating*** *on page 28*

CLINICAL & RESEARCH NEWS

Intelligence, Bipolar Disorder: What's Behind the Link?

In a highly powered study containing about 1 million subjects and spanning 23 years, hospitalization for bipolar disorder shows strong links to intelligence level.

BY JOAN AREHART-TREICHEL

A prospective study of more than a million Swedish men—in which their intelligence was measured during their military conscription with verbal, logical, spatial, and technical subtests—has found a highly significant link between high intelligence and hospitalization for bipolar disorder during the subsequent 23 years.

However, when the researchers restricted their analyses to men with bipolar disorder and no other psychiatric diagnoses other than a mood disorder, they found a significant link between hospitalization for bipolar disorder and both high and low intelligence levels.

The researchers do not yet have solid explanations for these apparently conflicting results.

However, regarding the link between bipolar disorder and high intelligence, lead researcher Catharine Gale, Ph.D., a reader in epidemiology at the University of Southampton in England, suggested in an interview with *Psychiatric News* that it is "consistent with anecdotal and biographical reports linking high intelligence or great creativity with bipolar disorder. . . ."

And as for the relationship between bipolar disorder and low intelligence level, Gale said, "We know from previous research we have done in this cohort of men that lower intelligence is associated with an increased risk of a wide range of mental disorders and of having more comorbid mental disorders. So it is entirely consistent with this that lower intelligence was associated in this study with an increased risk of bipolar disorder. . . ."

Nonetheless, another study finding baffled Gale and her colleagues, she admitted. "When we examined the relationship between performance on the IQ subtests and . . . bipolar disorder . . . , we found that both high and low verbal ability, and, to a lesser extent, high and low technical ability were associated with increased risk. But there was no increased risk among men with high or low spatial or logical ability. This surprised us because, in general, people who perform well on one subtest tend to perform well on the others."

These results probably do not have clinical implications for psychiatrists, Gale added, since "IQ is not a good predictor of whether someone will need to be hospitalized with bipolar disorder. On the other hand, our findings are likely to be of interest to those who are researching the etiology of bipolar disorder."

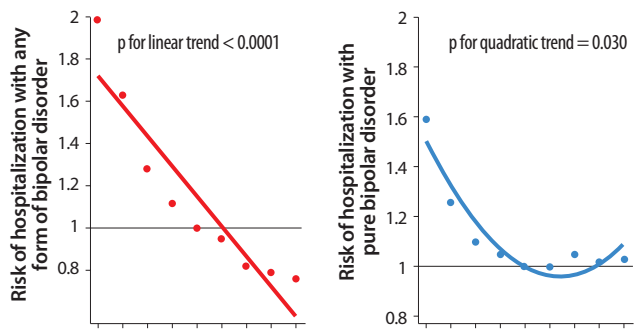
The study cohort consisted of 1,049,607 subjects, 3,174 of whom were hospitalized for bipolar disorder; of the hospitalized subjects, 1,079 (34 percent) were hospitalized for symptoms of bipolar disorder without any comorbid psychiatric illness.

The study results were published April 3 online in *Molecular Psychiatry.* The study was funded by the U.K. Biotechnology and Biological Sciences Research Council, the Swedish Council for Working Life and Social Research, and several other governmental organizations. PN

An abstract of "Is Bipolar Disorder More Common in Highly Intelligent People? A Cohort Study of a Million Men" is posted at *www.nature.com/mp/journal/vaop/ncurrent/abs/mp201226a.html.*

Link Between Bipolar Disorder and IQ Is Not Simple

The graph on the left shows that the risk of hospitalization with any form of bipolar disorder regardless of whether it was accompanied by other psychiatric illnesses fell as intelligence increased. In contrast, the graph on the right shows that pure bipolar disorder—that is, with no other psychiatric diagnoses other than a mood disorder—was linked with both high and low intelligence.



Source: Catharine Gale, Ph.D., et al., *Molecular Psychiatry,* April 3, 2012

Despite Frustration, Search Continues For Gene Causing Depression

Scientists who failed to identify genes specifically underlying major depressive disorder are wondering whether major depressive disorder, bipolar disorder, and schizophrenia share common genes.

BY JOAN AREHART-TREICHEL

Genomewide association studies have proven remarkably successful at identifying genes contributing to a number of diseases, notably breast cancer, lung cancer, diabetes, Parkinson's disease, multiple sclerosis, lupus, and age-related macular degeneration.

But the largest genomewide association study conducted to date to identify genes contributing to major depressive disorder has not been fruitful.

The study was headed by Patrick Sullivan, M.D., a professor of psychiatry and genetics at the University of North Carolina. The results appeared online April 3 in *Molecular Psychiatry.*

In the discovery phase of the study, Sullivan and colleagues compared snips of genetic material taken from some 9,000 individuals who had had a major depressive disorder with genetic material from 9,000 individuals who had not had a major depressive disorder.

During a replication phase of the study, they compared snips of genetic material taken from some 7,000 individuals who had experienced major depression with genetic material taken from about 51,000 who never had the disorder.

The researchers were unable to find any snip of genetic material that was present significantly more often in individuals who had had major depression than in individuals who had not had the disorder in the combined discovery and replication analysis.

The researchers did acknowledge that an analysis of snips taken only from women with major depressive disorder and an analysis of snips taken only from people with recurrent major depressive disorder pointed toward a gene that might be involved in major depressive disorder—a gene on chromosome 3—yet neither finding was "strongly compelling," Sullivan and his coworkers noted.

"What implications do these null results have for research into the genetics of major depressive disorder?" Sullivan and his colleagues asked in their paper. "Why might the results have turned out this way?"

One possibility, they conjectured, is that even though theirs was one of the largest genomewide association studies conducted on a psychiatric disorder—second in size only to one concerning schizophrenia—the sample size may still have been too small to detect genes involved in major depressive disorder.

Another possibility, they suggested, is that gene-environment interactions are crucial in major depressive disorder. If that is so, then perhaps the genetic contributions to the disorder might be uncovered only if genetic and environmental risk factors are explored simultaneously.

Meanwhile, Sullivan and his team are forging ahead in their search for genes that underlie major depressive disorder. "More samples are becoming available," he told *Psychiatric News.* "We are also looking across disorders to ask questions such as, 'Do major depressive disorder, bipolar disorder, and schizophrenia share genetic etiological factors?' " Also, "analysis of [gene] copy number variation has provided important leads for autism and schizophrenia and might prove informative for major depressive disorder," Sullivan and his group noted.

Eight other genomewide association studies have looked for major depressive disorder genes. Only one of them, conducted by German and American scientists, led to a possible candidate—a neuron amino-acid transporter gene called SLC6A15. The gene is expressed in the hippocampus, a brain region implicated in the pathophysiology of major depressive disorder.

Sullivan's study was funded by the U.S. National Institute of Mental Health, the European Union, the German Federal Ministry of Education and Research, and other organizations. PN

An abstract of "A Mega-analysis of Genome-wide Association Studies for Major Depressive Disorder" is posted at *www.nature.com/mp/journal/vaop/ncurrent/abs/mp201221a.html.*

JOURNAL DIGEST

BY LESLIE SINCLAIR

Cortex Volume Abnormalities Predate Cannabis Use

Researchers at the Orygen Youth Health Research Centre at the University of Melbourne and the Turning Point Alcohol and Drug Centre in Fitzroy, Australia, believe that some of the regional brain-volume alterations seen in long-term, heavy cannabis users might predate cannabis use and represent markers of vulnerability, rather than being due to the drug's neurotoxic effects.

They enrolled 121 primary school students as part of a larger study examining adolescent emotional development. The students underwent structural magnetic resonance imaging at age 12 and were assessed for cannabis use four years later. At that time, 28 had begun using cannabis, and 93 had not. Smaller orbitofrontal cortex volumes—but not the volumes of other brain regions, including the amygdala, hippocampus, and anterior cingulate cortex—predicted cannabis use by age 16.

The researchers believe their results "provide evidence that some structural abnormalities observed in cannabis users might exist before exposure and suggest that alterations in regions that underlie inhibitory and decision-making processes might influence risk for early cannabis use." Their work also supports recent findings that structural changes in the amygdala and hippocampus are a consequence of chronic cannabis exposure rather than a premorbid vulnerability.

Cheetham A, Allen N, Whittle S, et al. "Orbitofrontal Volumes in Early Adolescence Predict Initiation of Cannabis Use: A 4-Year Longitudinal and Prospective Study," 2012. Biol Psychiatry 71(8):684-692. *www.ncbi.nlm.nih.gov/pubmed/22129756*

Statin Drugs May Affect Depression

New data suggest that hydroxymethylglutaryl-CoA reductase inhibitors, otherwise known as statins, are beneficial for more than their cardiovascular effects. Among the most commonly prescribed medications, statins might also exert antidepressive effects.

To evaluate the association between statin use and depressive symptoms, researchers at the Veterans Affairs Medical Center in San Francisco assessed statin use in 965 outpatients from 12 clinics in the San Francisco Bay Area. All had stable coronary heart disease and had their depressive symptoms measured annually for six years.

Statin use was associated with 34 percent decreased odds of exhibiting depressive symptoms during six-year follow-up after adjusting for potential confounding variables in patients with coronary heart disease. Among patients free of depression at baseline, statin use was associated with 38 percent decreased odds of developing depression. But "our observational data cannot infer causality, which would need to be proven by a randomized controlled trial," wrote the researchers. They noted that it would not be possible to randomize patients with established coronary heart disease to placebo, given that statins are recommended for secondary prevention.

Otte C, Zhao S, and Whooley M. "Statin Use and Risk of Depression in Patients With Coronary Heart Disease: Longitudinal Data From the Heart and Soul Study," 2012. J Clin Psychiatry. Feb 21 [Epub ahead of print]. *www.ncbi.nlm.nih.gov/pubmed/22394433*

CBT Without Medication Leads To Remission in Adult ADHD

Cognitive-behavioral therapy (CBT) is an effective treatment for attention-deficit/hyperactivity disorder (ADHD) in adults, but medication doesn't significantly enhance the outcome of CBT. Researchers based at the University of British Columbia have published the results of a secondary analysis comparing 23 participants randomized to CBT plus dextroamphetamine with 25 participants randomized to CBT plus placebo.

Both groups showed robust improvement in symptoms and functioning, but the use of medication did not significantly improve the outcome over and above use of CBT and placebo.

CBT was administered individually for nine sessions. Patients had to attend a minimum of eight of the nine sessions and take 80 percent of the medication to remain in the protocol. Patients received a comprehensive evaluation at baseline and 15 and 20 weeks later to determine if there was a lag effect differentiating psychological and medication treatment. All patients showed significant improvement, going into remission and maintaining those gains over the 20 weeks.

Their results, said the researchers, suggest that CBT can be effective in adults with ADHD, even in patients who are not able to use stimulants.

Weiss M, Murray C, Wasdell M, et al. "A Randomized, Controlled Trial of CBT Therapy for Adults With ADHD With and Without Medication," 2012. BMC Psychiatry. Apr 5 [Epub ahead of print]. *www.biomedcentral.com/1471-244X/12/30/abstract*

Implanted Naltrexone Treats Polydrug Addiction

Available treatments for opioid dependence present multiple problems. Substituting another opioid (methadone or buprenorphine) for the opioid of abuse can lead to dependence on the replacement. The opioid receptor antagonist naltrexone has been used for treatment of both alcohol and opioid dependence, but oral naltrexone has proved ineffective because of poor treatment adherence. And there is no effective pharmacological treatment now available for polydrug dependence.

A group of Finnish researchers suggests that a sustained-release form of naltrexone—known as Prodetoxon and administered as a surgical implant—may overcome these obstacles. They assessed the effectiveness of the implant in the treatment of coexisting heroin and amphetamine dependence in 100 heroin- and amphetamine-dependent outpatients in a 10-week randomized, double-blind, placebo-controlled trial. Outcome measures were retention in the study, proportion of drug-free urine samples, and

*see **Journal Digest** on page 28*

Alexander Raths/Shutterstock

Statin drugs may have antidepressive effects in addition to cardiovascular benefits.

CLINICAL & RESEARCH NEWS

Antibody Shows Promise As Alzheimer's Treatment

CSF biomarker levels can be diagnostic for early Alzheimer's. Immunotherapy with bapineuzumab alters those levels and may have effects on the degenerative processes associated with Alzheimer's.

BY LESLIE SINCLAIR

It's too soon to say if the monoclonal antibody bapineuzumab can cure or even prevent Alzheimer's disease, but new information about its ability to affect Alzheimer's biomarkers makes it a promising candidate.

As reported in the online April 2 *Archives of Neurology*, research teams based at the University of Gothenburg in Mölndal, Sweden, and at Brown University in Providence, R.I., have completed two 12-month trials—one in the United States and one in England and Finland—to evaluate the effects of bapineuzumab on 46 patients with mild to moderate Alzheimer's disease.

Their intention was to determine whether immunotherapy with bapineuzumab would result in decreases in cerebrospinal fluid (CSF) biomarkers, which might in turn indicate downstream effects on the degenerative processes associated with Alzheimer's.

"We evaluated whether bapineuzumab impacted the CSF levels of the downstream biomarkers total tau (T-tau) and phosphorylated tau (P-tau), and the primary biomarker beta-amyloid in these trials," wrote lead author Kaj Blennow, M.D., Ph.D., who is associated with the Clinical Neurochemistry Laboratory of the Sahlgrenska Academy at the University of Gothenburg, and colleagues.

Blennow's work has focused on the development of laboratory measures for clinical diagnosis and therapy monitoring in Alzheimer's disease, with significant implications for both drug development and patient care. The European College of Neuropsychopharmacology (ECNP) awarded Blennow the 2010 ECNP Neuropsychopharmacology Award in recognition of his original and influential contributions to Alzheimer's disease research.

Blennow's previous work includes a 2009 *JAMA* publication that reported the results of a multicenter study that verified that CSF levels of beta-amyloid, T-tau, and P-tau can identify incipient Alzheimer's with good accuracy.

In this latest report, Blennow and colleagues make the case for the use of these same biomarkers for assessing the efficacy of disease-modifying therapies, particularly those aimed at the treatment of Alzheimer's. Historically, the identification of a beneficial clinical effect of Alzheimer's treatments required very large and extended clinical trials.

Their results? In a pooled analysis of CSF data from the two trials of passive immunotherapy with bapineuzumab in patients with mild to moderate Alzheimer's, a decrease in both P-tau and T-tau at the end of the study compared with baseline within the bapineuzumab group was observed. For CSF P-tau, a statistically significant treatment difference was observed between the bapineuzumab and placebo groups.

"These findings may indicate downstream effects of bapineuzumab treatment on the degenerative process," explained Blennow and colleagues, who acknowledged that the important question is whether such changes in CSF biomarkers correlate with clinical benefit. They intend to address that question in the ongoing bapineuzumab phase 3 trials.

The study was funded by Elan (acquired by Janssen Alzheimer Immunotherapy in 2009) and Wyeth Pharmaceuticals (acquired by Pfizer in 2009). Employees of both sponsor companies were involved in the study design, collection, analysis, and interpretation of data, as well as in the development and submission of the scientific report. PN

An abstract of "Effect of Immunotherapy with Bapineuzumab on Cerebrospinal Fluid Biomarker Levels in Patients With Mild to Moderate Alzheimer Disease" is posted at *http://archneur.jamanetwork.com/article.aspx?articleid=1151841#Abstract.*

FDA Approves Radioactive Drug To Help Assess Cognitive Decline

A new type of nuclear-medicine test will allow physicians to "see" the beta-amyloid plaques in the brains of patients who have declining cognitive function.

BY LESLIE SINCLAIR

Physicians will soon have a new tool to help them evaluate patients with cognitive decline who might have Alzheimer's disease. The Food and Drug Administration (FDA) announced April 10 the approval of Amyvid (florbetapir F 18 injection), a radioactive drug that binds to brain beta-amyloid. Amyvid will be available from Avid Radiopharmaceuticals, a subsidiary of Eli Lilly and Company.

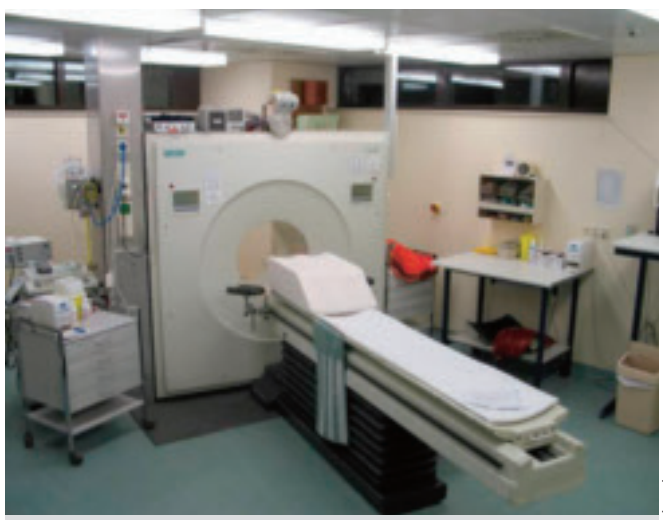
Following intravenous injection, Amyvid can be detected by positron emission tomography (PET) to produce images of the amyloid neuritic plaques in the brains of individuals who are being evaluated for Alzheimer's disease and other causes of cognitive decline.

A negative Amyvid scan indicates few to no neuritic plaques and reduces the likelihood that any cognitive impairment is due to Alzheimer's. A positive scan indicates moderate to frequent plaques, an amount that can be found in patients with Alzheimer's, patients with other types of cognitive impairment, and older people with normal cognition.

In a press release announcing the FDA's approval of Amyvid, Eli Lilly was careful to note that Amyvid is not being touted as a diagnostic test for Alzheimer's: "Amyvid is an adjunct to other diagnostic evaluations. A positive Amyvid scan does not establish a diagnosis of Alzheimer's disease or other cognitive disorder. Additionally, the safety and effectiveness of Amyvid have not been established for predicting development of dementia or other neurologic conditions or monitoring responses to therapies."

Despite those limitations, Amyvid is likely to be a valuable addition to physicians' armament for evaluating signs of Alzheimer's, a disease that can be definitively diagnosed only by postmortem pathological exam.

"Many Americans undergo evaluations to try to determine the cause for a decline in cognitive functioning," said Janet Woodcock, M.D., director of the FDA's Center for Drug Evaluation and Research, in a press release announcing Amyvid's approval. "Until now, the brain content of beta-amyloid neuritic plaques could only be determined with a brain biopsy or examination of the brain at autopsy. This imaging agent is one tool to help physicians in the assessment of their patients by serving as an adjunct to other diagnostic evaluations."



Jens Langner

Positron emission tomography units like this one will be used to detect the distribution of Amyvid in the brains of patients with cognitive decline.

Amyvid's journey to FDA approval has not been without controversy. When Avid Radiopharmaceuticals researchers published the results of their study of florbetapir F 18 in the January 19 *JAMA*, concluding that their work provided evidence that a molecular imaging procedure can identify beta-amyloid pathology in the brains of individuals during life, critics argued that the researchers withheld critical data from the journal that showed substantial variation in the interpretation of the PET scans from one reader to the next.

In a statement at the time of the drug's approval, Eli Lilly said it had "worked collaboratively with the FDA and nuclear-medicine experts to identify the appropriate ways to support accurate and consistent interpretation of Amyvid scans by physicians. These efforts resulted in the development and validation by Lilly of both an online and in-person reader-training program for physicians using Amyvid."

Lilly cautioned that Amyvid images should be interpreted only by readers who have successfully completed Amyvid reader training and that errors may occur in the estimation of plaque

*see **Radioactive** on page 24*

CLINICAL & RESEARCH NEWS

More Being Learned About Memory, Neuron by Neuron

Infusing a single neuron with a transcription factor can make a memory, and a bit of diphtheria toxin can take it away.

BY AARON LEVIN

The late experimental psychologist Karl Lashley, Ph.D., spent three decades sectioning the brains of rats and mice, hoping to find the "engram," the physical evidence of memory, only to conclude that memory was distributed throughout the cortex.

Yet more recent work finds that single, specific neurons in the human hippocampus are indeed part of a memory trace, said Sheena Josselyn, Ph.D., a senior scientist in neurosciences and mental health at the Hospital for Sick Children in Toronto and an associate professor of physiology at the University of Toronto.

Josselyn spoke at the 7th Annual Conference on the Amygdala, Stress, and Posttraumatic Stress Disorder (PTSD), held at the Uniformed Services University of the Health Sciences in Bethesda, Md., in April.

She noted a 2008 report by Hagar Gelbard-Sagiv, Ph.D., now a postdoctoral fellow in biology at the California Institute of Technology, on "the activity of single neurons in the human hippocampus and surrounding areas when subjects first view cinematic episodes consisting of audiovisual sequences and again later when they freely recall these episodes."

Among the test sequences was the often-shown clip of Tom Cruise jumping up and down on Oprah Winfrey's couch.

"That single neuron fired only when viewing the Tom Cruise video or when remembering it, but not at other times," said Josselyn.

Josselyn uses classic auditory fear conditioning in mice to study memory neuron by neuron in the lateral nucleus of the amygdala. The transcription factor CREB preferentially activates neurons there in the encoding of fear memories. Neurons with high levels of CREB are preferentially incorporated into the fear memory trace, while decreased CREB levels are actively excluded from memory function, she said.

Infusing CREB with a modified viral vector into CREB-knockout mice rescued the memory deficit by recruiting neurons to the memory trace.

Next she used diphtheria toxin to kill only the cells previously infected with the viral CREB.

"The diphtheria toxin blocks the enhancement of memory," said Josselyn. "The effects are robust, specific to cells with high levels of CREB, and persisted for up to 10 days. The effects were not due to disruption of reconsolidation or to overall disruption of lateral amygdala function."

The animal can still form new memories with retraining and deleting neurons with the CREB vector before training does not impair memory, she said. Neurons in the lateral amygdala with increased CREB competitively advantage memory, and killing them is sufficient to induce memory loss.

Thus, those neurons constitute a critical component of the neuronal network required for the subsequent expression of that memory, she explained.

However, killing neurons to eliminate memories was an extreme step, so Josselyn sought to block the action of the affected cells in some less drastic way.

One solution was using tetanus toxin to prevent activity-dependent release of neurotransmitters at the cell terminal.

"That simply cuts off communication with a cell infected by CREB," she said. "The cell can receive input and fire, but it cannot communicate with the next cell in line. The fear memory is never expressed."

Ultimately, work like that from Josselyn's lab may improve understanding of the mechanisms of memory and lead to new ways of treating anxiety and learning-based disorders in humans. PN

The Web site for Josselyn's lab is *www.sickkids.ca/AboutSickKids/Directory/People/J/Sheena-Josselyn.html*.

Genes May Hold Key to Roots Of Anxiety Disorders

The 7th Annual Amygdala Conference offers insights into cross-genre studies that explore the structure, function, and genetics of human behavior.

BY AARON LEVIN

Single genes may explain just a fraction of the risk of developing anxiety disorders, but genetics is useful when allied with other approaches, said Jordan Smoller, M.D., Sc.D., at the 7th Annual Conference on Amygdala, Stress, and Posttraumatic Stress Disorder, held at the Uniformed Services University of the Health Sciences in Bethesda, Md., in April.

Family studies are the first step in testing for heritability, said Smoller, an associate professor of psychiatry at Harvard Medical School and an associate professor of epidemiology at the Harvard School of Public Health. A look at first-degree relatives of affected individuals with panic, phobic, generalized anxiety, or obsessive-compulsive disorder finds a population-attributable risk of between 20 percent and 40 percent, compared with a rate of 80 percent for bipolar disorder or schizophrenia.

Smoller's work focuses on genes with a clear association between genotype and anxiety. The phenotype can be observed in temperament and brain structure.

Variations in temperament—the normal variation in behavioral affectivity—and in the structure and function of the amygdala and prefrontal cortex are associated with risk for anxiety disorders, he said. Smoller has studied a cohort of children who were first observed at 14 months. At that time, about 15 percent exhibited behavioral inhibition—an avoidant response to novel environments.

"They were quiet, inhibited, and shy," said Smoller. "These characteristics were visible well before they had experienced a lot of environmental effects."

The same children (n=158) underwent neuroimaging in late adolescence. The researchers then found a pattern of increased amygdala activation and decreased cortical thickness in these adolescents. Genotyping revealed a correlation with the RGS2 gene, previously found to be associated with anxiety in mice. Certain single-nucleotide polymorphisms in this gene were associated with shy, inhibited temperament in the children.

Smoller's group has also studied a group of 1,050 young adults aged 18 to 35, none of whom had a psychiatric diagnosis. Structural imaging showed that left amygdala volume correlated with a composite negative affectivity score. The correlation was strongest in those with the highest score and was inversely correlated with rostral anterior cingulate cortex thickness.

Doing genetic studies in anxiety disorders is not easy, Smoller noted. It is difficult to find uncommon genes, and it appears that most complex disorders are likely caused by many rare genes, each with small effects. In addition, research is hampered by uncertain phenotype definition boundaries that have shifted over time and become more complex, as any reader of *DSM* knows, he said. Candidate-gene studies have inherent limitations because they involve making an educated guess ahead of time about which gene to look for. Most studies have been small, underpowered, and not longitudinal, he pointed out.

Smoller's next step will be joining with the worldwide Psychiatric Genomewide Association Study Consortium to combine genomewide association studies with genotyping and with imaging to look for both rare and common gene variants and phenotypic associations. PN

Radioactive

continued from page 23

density during image interpretation.

The FDA reiterated those cautions to the general public, saying, "This is a new type of nuclear medicine test, and images should be interpreted only by health care professionals who successfully complete a special training program developed by the manufacturer."

The availability of Amyvid may be limited initially. Because Amyvid loses over half of its radioactivity every two hours, it must be distributed directly from a radiopharmacy to the imaging centers where it will be administered within several hours. According to Avid Radiopharmaceuticals, a limited number of radiopharmacies will be distributing Amyvid beginning this month, with the goal of making the product available in more areas as soon as possible. PN

An abstract of "Use of Florbetapir-PET for Imaging Beta-Amyloid Pathology" is posted at *http://jama.jamanetwork.com/article.aspx?articleid=645188*.

CLINICAL & RESEARCH NEWS

Studies Find Conflicting Data For Olanzapine in Anorexia

The atypical antipsychotic olanzapine increases survival in mouse models of anorexia nervosa, in contrast to fluoxetine, which does not. Finding out why may lead to new treatments.

BY LESLIE SINCLAIR

New information from University of Chicago researchers indicates the need for more clinical investigation into the effects of the atypical antipsychotic olanzapine on the core features of anorexia nervosa.

Stephanie Dulawa, Ph.D., an assistant professor in the Department of Psychiatry and Behavioral Neuroscience at the University of Chicago, and her colleagues published in the online March 7 *Neuropsychopharmacology* the results of a study in which they found that olanzapine, but not the antidepressant fluoxetine, reduces activity-based anorexia in mice.

They first assessed mouse strains for susceptibility to activity-based anorexia and then evaluated the effects of different food-access durations.

They found that experimentally naïve female mice of the Balb/cJ strain exhibited significantly shorter survival time (days until 25 percent bodyweight loss) compared with another strain. "Our findings indicate that Balb/cJ mice exhibit high susceptibility to developing activity-based anorexia and exhibit a neurochemical profile that supports use of this strain as an anorexia nervosa-like mouse," they said. They also found that six hours of food access reduced survival in mice housed with wheels without reducing survival in mice housed without wheels.

Administering fluoxetine or olanzapine to these mice under these feeding conditions resulted in greater survivability of mice given olanzapine, who showed a reduced occurrence of activity-based anorexia.

New Data Back Earlier Findings

Their conclusions support the findings of Hany Bissada, M.D., an associate professor of psychiatry at the University of Ottawa and director of the Regional Centre for the Treatment of Eating Disorders at Ottawa Hospital. Bissada and his colleagues performed a randomized, double-blind, placebo-controlled trial of olanzapine in the treatment of low body weight and obsessive thinking in women with anorexia nervosa *(American Journal of Psychiatry,* October 2008), concluding that olanzapine may be safely used in achieving more rapid weight gain and improvement in obsessive symptoms in women with anorexia nervosa.

Stephanie Dulawa, Ph.D.

Other recent studies have not as strongly supported the use of olanzapine as an anorexia nervosa treatment. Mark Norris, M.D., an assistant professor of pediatrics at the Children's Hospital of Eastern Ontario, and his colleagues recently performed a retrospective matched-groups comparison study of olanzapine for adjunctive treatment of adolescents with anorexia nervosa *(Journal of Child and Adolescent Psychopharmacology,* 2011), but wrote that they were "unable to draw any firm conclusions regarding the potential efficacy of olanzapine." Their analysis did, however, suggest that olanzapine is often prescribed for those with greater illness severity.

Norris and colleagues expressed concern about the side effects associated with olanzapine, citing studies that found its use was associated with an increased risk of dyslipidemia and diabetes mellitus compared with other atypical antipsychotics.

Little Efficacy Seen in Adolescent Study

Vivian Kafantaris, M.D., a child and adolescent psychiatrist at the Zucker Hillside Hospital in Glen Oaks, N.Y., and colleagues also recently performed a placebo-controlled pilot study of adjunctive olanzapine for adolescents with anorexia nervosa *(Journal of Child and Adolescent Psychopharmacology,* June 2011), but concluded that their findings, while admittedly preliminary, did not support a role for adjunctive olanzapine for underweight adolescent girls with anorexia nervosa–restricting type who are receiving standard care in an eating disorder treatment program.

"Several factors could have contributed to the negative findings of this study, which had a small sample size (n=15 total)," Dulawa explained to *Psychiatric News.* "This study used a fixed dose for all subjects, which increased over time to 10 mg/kg of olanzapine, while other studies have reported significant weight gain using lower doses (2.5 mg/kg). Furthermore, this study lasted 10 weeks, while therapeutic effects of olanzapine in anorexia nervosa have been reported to improve up to nine months into treatment. Therefore, dosing and chronicity of olanzapine might not have been optimized in this study."

Despite their variable findings, all of these researchers agreed on one thing: Olanzapine deserves a closer look and might eventually be the first pharmacologic treatment for anorexia nervosa, or at least a prototype of the first one. But more information is needed to elucidate the drug's therapeutic mechanism in anorexia patients.

Dulawa and her colleagues have already moved in that direction. "We are currently attempting to identify which aspect of olanzapine's complex pharmacology reduces activity-based anorexia, an animal model for anorexia nervosa. This information could lead to the development of more selective compounds with fewer side effects for treating anorexia nervosa," she told *Psychiatric News.*

The work was supported by grants from the National Institutes of Health. Coauthor Daniel Le Grange is supported by a grant from the National Institute of Mental Health and honoraria from the Training Institute for Child and Adolescent Eating Disorders. PN

An abstract of "Olanzapine, but Not Fluoxetine, Treatment Increases Survival in Activity-Based Anorexia in Mice" is posted at *www.nature.com/npp/journal/vaop/ncurrent/full/npp20127a.html.*

Brain Biomarkers Suggest Pathway To Addiction Vulnerability

A predisposition to addiction to stimulant drugs may be mediated by brain abnormalities linked to impaired self-control.

BY LESLIE SINCLAIR

It's a classic case of which comes first, the chicken or the egg: Does stimulant use cause the brain changes known to be present in those with drug addiction, or do those brain abnormalities lead to drug addiction?

Brain abnormalities *can* be associated with the duration of stimulant abuse, suggesting that stimulant abuse is their cause, but researchers at the University of Cambridge in England have published new data suggesting that the brains of stimulant drug addicts may have been different to start with.

Karen Ersche, Ph.D., a senior research associate in the Department of Psychiatry at the University of Cambridge, and colleagues, compared brain structure and the ability to regulate behavior in 50 biological sibling pairs; within each pair, one sibling satisfied the *DSM-IV* criteria for dependence on stimulant drugs and the other had no history of chronic drug or alcohol abuse.

Using fractional inosotropy, the researchers assessed the density of white-matter fiber tracts, those axonal fibers that transmit neural signals between brain regions. They also assessed the participants' degree of self-

see ***Biomarkers*** *on page 26*

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The abnormality that may indicate susceptibility to stimulant drug addiction is shared between members of the same family.

VA

continued from page 1

writing prescriptions and reviewing disability paperwork rather than providing treatment.

"[D]espite the high number of veterans treated with medications, there has been virtually no training for VA mental health staff on evidence-based pharmacotherapy. . . [or] on using a combined approach that involves both psychotherapy and pharmacotherapy," wrote APA Medical Director James H. Scully Jr., M.D.

According to Scully, the VA spends between $10 million and $20 million each year on evidence-based psychotherapy (EBP) training, but only 5 percent to 10 percent of the clinicians receiving that training are psychiatrists.

"The emphasis on EBP and EBP training, while valuable, is a monodimensional approach that ignores the complex mental health care needs of veterans," Scully said.

APA also called on the VA to incentivize the participation of psychiatric physicians by offering starting salaries commensurate with those of psychiatrists in both the public and private sectors; ensuring that agency-affiliated human-resource departments prioritize the hiring of psychiatrists and quickly process new hires; and increasing the development of residency-training and loan-forgiveness programs.

Other APA recommendations centered on providing mental health services to veterans wherever they may live. This could be achieved, said Scully, through the employment of psychiatrists working in rural areas, an expansion of telepsychiatry options, and the increased engagement and training of existing community psychiatrists and primary care physicians.

Concern about veterans' access to mental health care was also the impetus for an April 25 report written by the VA's Office of Inspector General (OIG) at the request of the House and Senate committees on Veterans' Affairs and VA Secretary Eric Shinseki.

The OIG's 63-page report revealed that only 49 percent of veterans seeking mental health care for the first time were seen within 14 days, as opposed to the 95 percent reported earlier by the Veterans Health Administration (VHA). The remaining first-time patients waited an average of 50 days for a comprehensive mental health evaluation.

The OIG also noted that despite the VHA's reported 39 percent increase in mental health clinicians from 2005 to 2010, 71 percent of clinicians responding to a 2011 VA survey said "their medical center did not have adequate numbers of mental health staff."

Among the report's recommendations are that the VHA develop a more accurate method for measuring how long veterans wait for appointments and that it conduct a comprehensive staffing analysis. PN

APA's letter to the Senate Committee on Veterans' Affairs is posted at *www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/APA%20on%20the%20Issues/Government%20Affairs/04-23-2012-Senate-VA-Psych-Shortage.pdf*. The OIG's "Review of Veterans' Access to Mental Health Care is posted at *www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf*.

Kennedy

continued from page 1

ciate and later as counsel to the law firm of Wiggin and Dana in New Haven, Conn. His health-law practice focused primarily on state and federal regulatory and reimbursement issues affecting hospitals, home-care agencies, long-term-care providers, physicians, and mental health professionals. His wife, Katherine, is a psychiatrist and member of APA.

Kennedy noted his family's long-standing interest in and support of issues related to mental health. His father served 47 years as a senator from Massachusetts and was a staunch supporter of parity coverage for the treatment of mental illness and of funding for research on mental illness. His brother, Patrick Kennedy, was a member of the U.S. House of Representatives from Rhode Island from 1995 to 2011 and was instrumental in the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, signed into law on October 3, 2008.

And at the Convocation, Kennedy shared some of his insights into the "insider baseball" of Washington politics, predicting that if the Supreme Court—whose ruling on the constitutionality of the "individual mandate" in the health care reform law is anticipated this summer—should rule against the law it would rebound to President Obama's benefit in the fall elections.

"It will force the Republicans to come up with an alternative," Kennedy said, adding that so far the Republicans don't have an alternative.

At the Convocation, Kennedy hailed the advocacy efforts of APA. "You should all be proud on the huge impact APA has had efforts to serve the most vulnerable, misunderstood, and stigmatized populations, for the way you have advocated for quality patient care, and for dignity and respect for each and every person. . . . You don't see patients for their disabilities but for their humanity. I congratulate you for what you have done." PN

Biomarkers

continued from page 25

control by measuring their performance in a classic test of inhibitory control called the "stop signal reaction time."

The surprising result was that the fiber-tract density and self-control deficits—compared with a control group—were as pronounced in stimulant-dependent individuals as in their nondependent siblings.

Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA), and Ruben Baler, Ph.D., a neurobiologist and NIDA's health science administrator, discussed the significance of the work in an editorial that accompanied the research report: "This finding is important for it suggests not only that dysfunctions in the frontostriatal circuits that handicap self-control—and are a hallmark of addiction—are influenced by genetics, but also that the increased vulnerability for substance use disorders engendered by these dysfunctions can be overcome."

Ersche and her colleagues also compared the gray matter volume maps of healthy volunteers with those of the drug-dependent individuals and of their nondrug-abusing siblings and found that the brains of the sib-pairs showed distinct abnormalities compared with the healthy-control volunteers.

Specifically, key structures previously implicated in addiction, such as the medial temporal lobe and the basal ganglia, were significantly enlarged in the sib-pairs. They were also able to identify a significant reduction of gray matter volume in the posterior postcentral gyrus and adjacent areas, such as the superior temporal gyrus and the posterior insula, in both drug-dependent individuals and their siblings. And the which-came-first nature of the changes was clearly apparent: "[G]ray matter regions associated with the duration of stimulant drug exposure differed clearly in location from the regions identified as markers of familial risk for stimulant drug dependence," they found.

The researchers believe that their findings may indicate markers of neural vulnerability for pathological habit formation, which could further facilitate the effects of drugs of abuse by interfering with limbic-striatal functions, and they noted the possibility that "resilience factors that counteract the familial vulnerability to drug dependence" might explain the existence of the nonaddicted siblings.

Volkow and Baler took that thought one step further, saying the work of Ersche and colleagues has clinical implications, providing a potential biomarker that can be targeted for interventions to strengthen it. "[A] deeper, endophenotype-based understanding of personality traits that can promote resilience and their degree of malleability may help prevent adverse trajectories such as those leading to substance use disorder or other conditions with underlying deficits in self-control."

This work was funded by the U.K. Medical Research Council. PN

"Abnormal Brain Structure Implicated in Stimulant Drug Addiction" is posted at *www.sciencemag.org/content/335/6068/601.abstract*.

MUR Members Share Concerns Through Caucuses

Psychiatrists who identify with any of APA's recognized minority and underrepresented (MUR) groups are urged to join that group's caucus. The MUR group caucuses provide a networking opportunity and foster communication among members who share a special interest. Caucuses meet during APA's annual meeting. There are caucuses for the following groups: American Indian/Alaska Native/Native Hawaiians; Asian Americans; blacks; Hispanics; lesbians, gays, and bisexuals; international medical graduates; and women.

Participation in a caucus is a pathway to the following: exploring concerns about professional growth and advancement; identifying, supporting, and electing top-notch MURs for leadership posts; networking with members with shared backgrounds; advocating for minority patient populations; talking about key issues facing APA; initiating mentoring relationships; bringing concerns to APA leadership; and assuming leadership roles in APA.

To join a caucus, go to APA's Web site at*/www.psychiatry.org/join-participate*, click on "Online Member Profile," and then log in; proceed to Section 3, question 3F—APA Caucus Membership. More information is available from Alison Bondurant in APA's Office of Minority and National Affairs at abondurant@psych.org.

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2012 PHILADELPHIA

ACT

continued from page 9

nity, said Kiesling. Once on board, new hires spend two to three weeks taking didactic courses (like the D.C. Department of Mental Health's day-long training) and shadowing staff on their rounds.

- **Program evaluation:** "ACT teams rarely collect outcome data," they noted. But they emphasized that staff should gather and evaluate regular measurements of frequency, duration, and type of services provided, along with consumer outcomes like employment, housing, symptom reduction, and psychiatric hospitalization.

Doing research at his program would require a full-time staff person, something Pathways to Housing can't afford now, said Kiesling. Keeping up with the documentation required by insurers or Medicaid is time-consuming enough, he noted.

These approaches should be seen as "working hypotheses" for the moment, said the authors. "Additional rigorous research on implementing and sustaining the quality of ACT and other evidence-based practices is needed." PN

"Program Fidelity and Beyond: Multiple Strategies and Criteria for Ensuring Quality of Assertive Community Treatment" is posted at *http://ps.psychiatryonline.org/Article.aspx?ArticleID=1103903*.

Research Funds

continued from page 11

the center's director, Josephine Briggs, M.D., reported. For example, while studies exploring the possible effectiveness of dietary supplements such as glucosamines and fish oil have produced mixed or contradictory results, there are "some hints of benefit" with mind-body practices such as mindfulness meditation, which has been found to reduce the need for opioids in people with back pain. Consequently, her center is interested in funding studies in the mind-body domain, she indicated.

NIH is moving toward the creation of a National Institute of Substance Use and Addiction Disorders, David Shurtleff, Ph.D., acting deputy director of the National Institute on Drug Abuse (NIDA), reported. But meanwhile NIDA is alive and well, he said, and interested in funding research on a number of anxiety topics—for example, why anxiety appear to be a major cause of drug-abuse relapse.

The good news for anxiety researchers is that "there are 18 NIH institutes that fund anxiety research," reported Ellen Stover, Ph.D., director of the Division of Mental Disorders, Behavioral Research, and AIDS at NIMH, and last year some $64 million was earmarked for anxiety research across the 18 institutes.

The good news for anxiety researchers—and for psychiatric researchers in general—comes with a dose of bad news, however, namely, that only about 8 percent of grant applications to NIH get funded, said Briggs. "It is clear to all of us that these are tough times," she acknowledged.

Yet if anxiety and other psychiatric researchers can't get funding from NIH, there is a nongovernmental funding institute that might fund their studies. It is the Patient-Centered Outcomes Research Institute in Washington, D.C. "We are new, and we have $120 million to commit to research in 2012," Joseph Selby, M.D., executive director of the institute, reported. Moreover, "we are interested in [funding] compelling research across the spectrum," including psychiatric disorders. A requirement, however, is that the research has to be patient-focused.

Still another potential funding source for psychiatric researchers, especially those researching anxiety disorders, is the Agency for Healthcare Research and Quality (AHRQ), the agency's director Carolyn Clancy, M.D., pointed out. The focus of AHRQ, which is a division of the Department of Health and Human Services, is on improving health care, she explained, and it often funds research that looks at how health care is organized and its impact on patient outcomes. She and colleagues are also interested in funding research that involves integrating primary care doctors with those providing behavioral health services. And while they have funded a lot of research concerning depression, they haven't funded much concerning anxiety. So they would like to hear more from anxiety researchers, she said. PN

Diabetes

continued from page 12

tant as well," Conwell said, "adding further impetus to the need for early diagnosis and aggressive treatment of depression in people with diabetes."

Conwell is vice chair of psychiatry and director of the geriatric psychiatry program at the University of Rochester Medical Center. His research has focused on the incorporation of community-based services into a more comprehensive collaborative-care model for older adults.

Katon told *Psychiatric News* that the study also looked at other variables that may affect the association between comorbid depression and diabetes and later development of dementia. Among the key findings is that depression seemed to have a greater impact on younger patients with diabetes in terms of later development of dementia. "It suggests that we may be seeing the development of dementia earlier in patients with comorbid depression," he said.

Also noteworthy is the finding that treatment with insulin appears to have a protective effect against development of dementia. "Data have emerged recently that the brain may have insulin receptors in areas implicated in memory," Katon said. "And some new studies have indicated that intranasal insulin gets immediately to the brain and may help prevent cognitive decline. But our findings of a protective effect need to be replicated."

Finally, the study also looked at whether lifestyle characteristics that sometimes accompany diabetes influenced the risk for dementia. "We found that actually when we adjusted for those factors they had very little effect," Katon said.

That finding suggests that biological factors associated with depression may be at work in dementia risk in these patients. "We know that dysregulation of the pituitary axis and cortisol levels—which can be caused by depression—have effects on the brain that can also contribute to dementia," Katon noted. "There is also evidence that depression is associated with inflammatory factors that increase the risk for dementia and that depression is also associated with decreased insulin sensitivity." PN

EHR

continued from page 13

APA also questioned the amount of time that CMS predicts will be required by physicians and hospitals to fulfill the proposed Stage 2 meaningful-use measures, calling the agency's minimum burden estimate of 10 hours, 15 minutes "too low."

Similarly, APA predicted that physicians and hospitals will be required to "expend an enormous amount of financial resources" to fulfill the proposed Stage 2 meaningful-use measures.

"Much of the legislative intent of health reform has been to facilitate physicians' ability to deliver more efficient, cost-effective, and coordinated care to Medicare beneficiaries," Scully wrote. "With a growing shortage of psychiatrists currently available to all Americans, we cannot afford to further restrict Medicare beneficiaries' access to psychiatrists." PN

CMS's proposed rule on Stage 2 of the EHR Incentive Program is posted at *www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4443.pdf*. APA's comments on the proposed rule are posted at *www.psychiatry.org/advocacy--newsroom/advocacy/c22b66ed-554b-432d-bb5c-bde30df55a3d*.

Binge Eating

continued from page 20

As for treatment for BED, better options are needed, workshop speakers pointed out. Specifically, ample research has demonstrated that cognitive-behavioral therapy and interpersonal therapy can counter binge eating and lead to long-term weight loss, reported Denise Wilfley, Ph.D., a professor of psychiatry at Washington University. Yet the amount of weight lost with these two therapies is modest, she said. And while there is one drug on the market that has shown good efficacy against BED—the anticonvulsant topiramate—it can have undesirable cognitive side effects, noted James Hudson, M.D., Sc.D., a professor of psychiatry at Harvard Medical School.

Walsh asked Hudson what he thought about using topiramate and the appetite suppressant phentermine together to treat BED. Hudson replied: if the combination is approved by the Food and Drug Administration as a treatment for it, undoubtedly it will be widely used. PN

Journal Digest

continued from page 22

improvement score on the Clinical Global Impressions Scale.

Their results indicated that patients implanted with naltrexone had higher retention in the study, decreased their heroin and amphetamine use, and had improved clinical conditions. The implant was also generally well tolerated. The researchers, whose prior work led to Food and Drug Administration approval of the injectable depot formulation of naltrexone known as Vivitrol, said their current findings are "the first evidence of an effective pharmacological treatment for this type of polydrug dependence." PN

Tiihonen J, Krupitsky E, Verbitskaya E, et al. "Naltrexone Implant for the Treatment of Polydrug Dependence: A Randomized, Controlled Trial," 2012. Am J Psychiatry. February 17 [Epub ahead of print]. *http://psychiatryonline.org/article.aspx?articleid=1111312&journalid=13*

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UNIT CHIEF - ADULT INPATIENT UNIT

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We are currently seeking a full-time BC/BE Psychiatrist to join our team. In this key role, you will provide clinical leadership of a multidisciplinary treatment team on an adult general psychiatry inpatient unit. Teaching opportunities are available.

To qualify, you must have an M.D. degree with NYS License and DEA registration, along with prior inpatient psychiatric experience. Completion of an approved Psychiatric Residency training is also required. Fluency in Spanish, Mandarin, Cantonese, or Korean preferred, but not required.

We offer an excellent compensation and benefit package, and an academic appointment to the Mount Sinai School of Medicine is available at a level commensurate with credentials and experience.

Please send CV, along with a brief description of career interests and goals to: **Howard Gould, M.D., Deputy Director of Psychiatry, Elmhurst Hospital Center, 79-01 Broadway, Rm. D10-34, Elmhurst, NY 11373; Phone: 718-334-3556; Fax: 718-334-2642; or E-mail: gouldh@nychhc.org**.

The Mount Sinai Medical Center 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.

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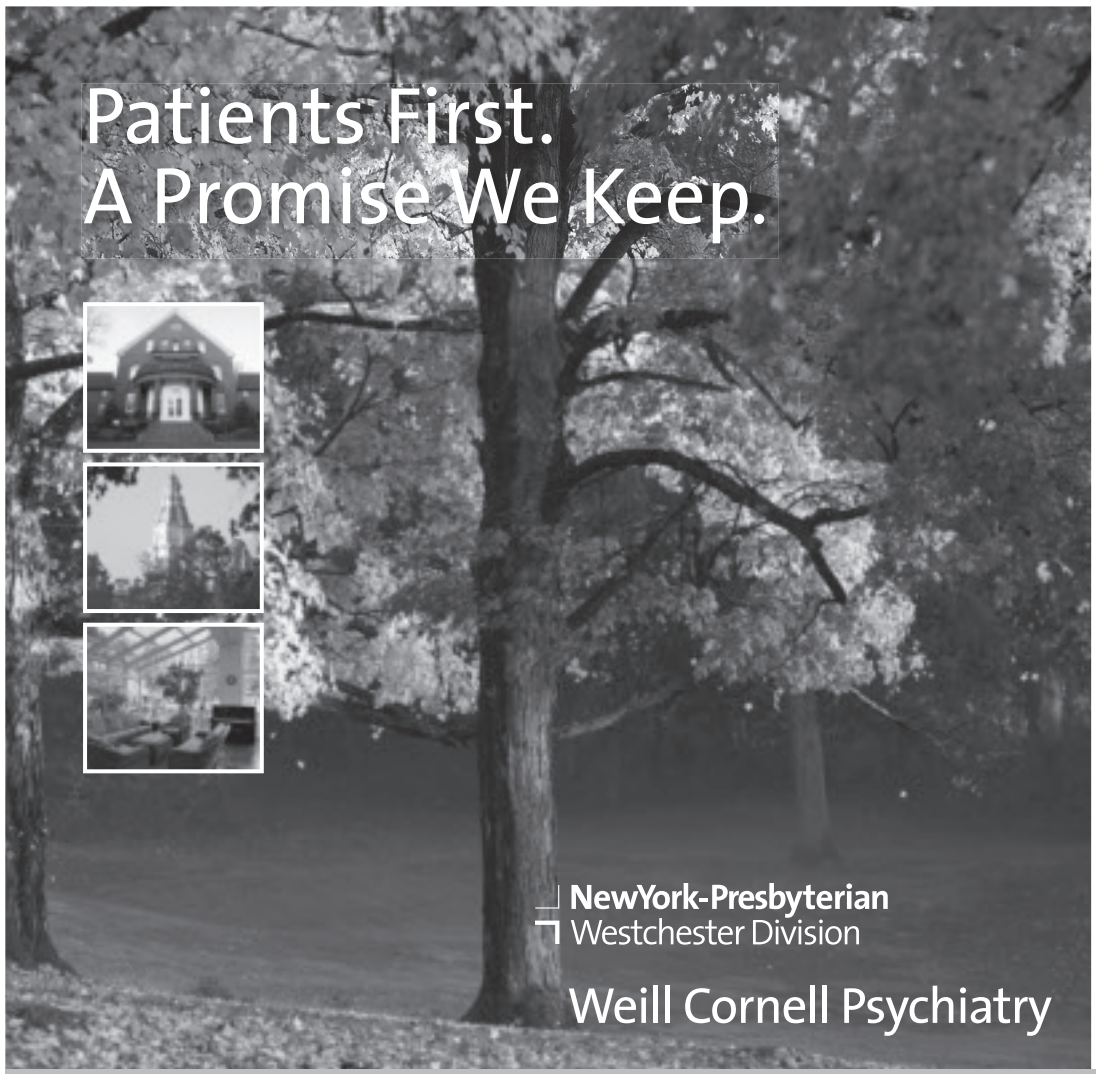
University of Connecticut Health Center

Looking for a meaningful career change?

Principal Psychiatrist. The University of Connecticut Health Center (UCHC), Correctional Managed Health Care (CMHC) is seeking a full-time BC/BE psychiatrist to work at the Janet S. York Correctional Institution in Niantic, Connecticut, the state's only correctional facility for women. York CI is a nationally recognized leader in developing mental health treatment models for incarcerated women. The ideal candidate would have a strong commitment to women's healthcare and enjoy working as part of a treatment team. Responsibilities may include inpatient and outpatient services. Strong psychopharmacologic background and leadership skills a big plus. Experience in the treatment of serious mental illness and co-occurring disorders highly desired. The position offers a generous salary and benefits package in a beautiful coastal New England setting in the southeastern part of Connecticut.

Detailed information about the requirements and benefits of this position are available at our website **https://jobs.uchc.edu**. Please apply online for the posted vacancy of Principal Psychiatrist in the category of Correctional Managed Health Care.

The University of Connecticut Health Center is an Affirmative Action Employer. The University of Connecticut has a strong commitment to the principle of diversity and in that spirit, seeks a broad spectrum of candidates including women, minorities, and people with disabilities. Individuals requiring special accommodations in the application process should notify the Office of Diversity Management & Equal Opportunity at (860) 679-3563 or TDD (860) 679-2242. Any information on positions should be addressed to: University of Connecticut Health Center, Department of Human Resources, P.O. Box 4035, Farmington, CT 06034-4035 or (860) 679-2426 or **jobs@adp.uchc.edu**.



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We are consistently recognized as one of the nation's best psychiatric hospitals – ranked first in New York and 4th in the country by *U.S. News & World Report*. And also recognized by Castle Connolly for having the most top psychiatrists. We extend our appreciation to every physician, nurse, employee and volunteer who make these achievements possible.

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DIRECTOR OF PSYCHIATRIC RESIDENCY TRAINING
San Mateo County

San Mateo County's Behavioral Health & Recovery Services (BHRS) is seeking an experienced Psychiatrist to serve as Director or Psychiatric Residency Training for our clinical system of care. San Mateo County has one of the most progressive integrated behavioral health programs in the country and the Psychiatric Residency Training Program is an integral part of that system. The next session of this award winning program starts July 1, 2012 and currently has 16 Residents (4 PGY-1, 4 PGY-II, 4 PGY-III and 4 PGY-IV).

In this part-time role (30 hrs/wk), you will be responsible for all activities related to the San Mateo Psychiatric Residency Program including designing the instruction and curriculum for the program, meeting the American College of Graduate Medical Education (ACGME) accreditation guidelines, coordinating CME activities, arranging for the supervision of all 16 interns/residents, organizing selection of 4 new incoming resident interns each year through the National Match, providing direct teaching, case consultation and supervision, as well as collaborating with San Mateo Medical Center and other health care entities where the interns and residents rotate for clinical training and services.

The ideal candidate will be a Board Certified Adult Psychiatrist and have at least 1 year of experience supervising psychiatrists and/or psychiatry residents, a keen interest in policy and planning around behavioral health issues and knowledge of addictions.

This part-time position offers a competitive salary and excellent benefits including County-funded malpractice insurance, reimbursement of professional dues and expenses ($2,000/yr) and an additional 5% each up to two qualifying Board Certifications.

To view the complete job description and instructions on how to apply, visit the San Mateo County website at: www.smcgov.org/hr/jobs. Applications are only accepted online. EOE

CLASSIFIEDS

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Adult Psychiatrists

County of San Diego's Health & Human Services Agency needs psychiatrists for key components in the Behavioral Health Division's continuum of care. Our Psychiatrists work with a dynamic team of medical and nursing professionals to provide outpatient treatment, telepsychiatry, inpatient and emergency services and crisis intervention.

For more information or to apply online, go to www.sdcounty.ca.gov/hr. Interested candidates can contact Gloria Brown at 858-505-6525 or email CV & cover letter to Gloria.Brown@sdcounty.ca.gov, and you may also email Marshall Lewis, MD, Beh. Health Clinical Director, @ marshall.lewis@sdcounty.ca.gov. Please state clinical area of interest.

Unique telepsychiatry opportunity for psychiatrists licensed in California and/or adjacent states.

Access Psychiatry Solutions integrates behavioral health services in primary care settings and delivers specialty care by videoconferencing technology. No investment or financial risk, many quality-of-practice and quality-of-life benefits. We are seeking BC/BE child/adolescent AND general adult psychiatrists with experience in and commitment to primary care integration and/or rural health care. Please sent brief letter of interest and CV to info@accesspsych.com. All inquiries will be handled confidentially.

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LAWRENCE + MEMORIAL HOSPITAL 100

Psychiatric Opportunity in Southeastern Connecticut - Lawrence & Memorial Hospital is seeking a Medical Director of the Inpatient Psychiatric Unit. Who we are: Situated along the beautiful, historic New England coastline, Lawrence & Memorial Hospital is one of the premier healthcare institutions in Connecticut. A 280-bed, not-for-profit, award winning facility, L&M serves over a quarter of a million people in southeastern Connecticut and western Rhode Island. The Department of Psychiatry provides a continuum for behavioral health care including inpatient, adult intensive outpatient, adult, adolescent and child outpatient, crisis services and consult/liaison services. With beautiful, safe communities, great schools and close proximity to Boston, Providence, Hartford and New York City, Southeastern Connecticut is a very desirable place to live. What we offer: Employed by hospital affiliated multispecialty group; competitive salary and generous benefit; CME allowance; relocation assistanc; 401(k) Plan Interested Candidates, please contact: Sally Williams-Gaenzle, Lawrence & Memorial Hospital, 365 Montauk Avenue, New London, CT 06320, swilliams@lmhosp.org or fax (860)442-3578.

PSYCHIATRISTS

Join our team and help put health and hope back into people's lives. Qualified H1B VISA Candidates encouraged to apply.

The Department of Mental Health & Addiction Services has rewarding opportunities for BE/BC Psychiatriststo work with multidisciplinary staff to provide a variety of behavioral health care services for adults ranging in age from young adults through older adults. For directions and to learn more about DMHAS, visit: http://www.ct.gov/dmhas

Employment Opportunities are available: Connecticut Valley Hospital - A 615 bed public inpatient, behavioral health facility, Middletown, CT (between New York and Boston) near by cultural and sports activities typical of a New England setting. The Hospital is composed of three divisions: General Psychiatry (Adult, Geriatrics and Young Adult), Addiction Services and Forensics Divisions. The salary is competitive, a comprehensive benefits package is included and there is opportunity to increase compensation through optional on-call duties.

For information relative to opportunities at Connecticut Valley Hospital please call or email: Dr. Thomas Pisano at 860-262-7030, Thomas.Pisano@po.state.ct.us Or Dr. Sabita Rathi 860-262-5493, Sabita.Rathi@po.state.ct.us.

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GEORGIA

Psychiatrist- Metro Atlanta (Contract)

Cobb-Douglas Community Services Boards, a behavioral healthcare organization in metro Atlanta, seeks part-time and contract, BC/BE Psychiatrist for Community Outpatient Behavioral Health Clinics. Please email CV to Bryan Stephens at bgstephens@cobbcsb.com. With questions call Bryan at (404) 969-5247.

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PT psychiatrist needed in well established psychiatric practice in Gaithersburg, MD, 10-20 hours per week to treat adolescents and/or adults. Schedule is flexible, Board Certified Only, experience in meds management a must. Please mail CV to GMPS at 9055 Shady Grove Ct, Gaithersburg, MD 20877 or email to glassermedical@verizon.net.

MASSACHUSETTS

The Department of Psychiatry at Mount Auburn Hospital, affiliated with Harvard Medical School, is recruiting for a full-time position as attending psychiatrist on our geriatric psychiatry inpatient unit. The 15 bed unit, fully accredited by DMH, provides acute treatment to geriatric patients with a variety of psychiatric disorders. The full medical resources of our general hospital are utilized in the care of our patients. Responsibilities include attending patients on the unit, consultation to the medical/surgical services of the hospital, and participation in the teaching activities of the Department. A clinical appointment in psychiatry 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: 617 499-5054; email: jdafflit@mah.harvard.edu.

Berkshire Health Systems

CHILD / ADOLESCENT PSYCHIATRIST OPPORTUNITY IN THE BEAUTIFUL BERKSHIRES

The Brien Center for Mental Health and Substance Abuse Services in collaboration with Berkshire Health Systems is seeking a BC/BE Child/Adolescent Psychiatrist to join an innovative, integrated Community Outpatient Clinic. This position offers Academic Appointment through affiliations with UMASS Medical School as well as the opportunity to supervise psychiatry residents. The Brien Center is Berkshire County's largest community provider of Mental Health and Substance Abuse Services.

Competitive salary and benefits package, including relocation costs offered. The Berkshires is a 4-season resort community with endless cultural and recreational opportunities. Excellent public and private schools make this an ideal family location, just 2 ½ hours from both Boston and New York City.

Qualified candidates are invited to send their CV to:
Antoinette Lentine
Physician Recruitment Specialist
725 North St.
Pittsfield, MA. 01201
alentine@bhs1.org
413-395-7866

CLASSIFIEDS

HALLMARK HEALTH SYSTEM - INPATIENT PSYCHIATRIST

F/T psychiatry position for 22-bed, general adult inpatient unit at Melrose-Wakefield Hospital, 8 miles north of Boston, part of Hallmark Health's comprehensive behavioral health service. On-call coverage optional. The adult unit is Competitive comp & ben pkg and flex schedule. Tufts faculty appointment available. Current MA license preferred. Please forward CV to Gina Mariona, gmariona@hallmarkhealth.org or call 781-338-7517.

BOSTON MEDICAL CENTER

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Boston University School of Medicine/ Boston Medical Center Department of Psychiatry Associate Medical Director, Emergency Psychiatry

The Boston University School of Medicine/ Boston Medical Center Department of Psychiatry is recruiting for an Associate Medical Director, Emergency Psychiatry, for an administrative/clinical/training role in our emergency psychiatry service.

Boston Medical Center, a teaching hospital for the Boston University School of Medicine, is a busy community hospital in Boston which serves a diverse, multicultural patient population.

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Academic appointment commensurate with experience. Competitive salary and excellent benefit package. All interested applicants should send CV and cover letter to Joan Taglieri, c/o BU Psychiatry, 85 East Newton Street, Suite 802, Boston, MA 02118 or email to Joan.Taglieri@bmc.org.

Boston University School of Medicine/ Boston Medical Center is an equal opportunity/affirmative action employer.

Psychiatrist, Concord, Mass. Unique opportunity for board certified/eligible psychiatrist or psychiatric RNCS to join strong psychiatric service at Emerson Hospital. Provide moonlighter coverage between 4 pm Friday and 5 pm Sunday. In-hospital time varies based on number of admissions and consultation requests. Overnight call is home-call only, except for rare emergency visits to the hospital for seclusion/ restraint. Continuous back up support provided by full-time psychiatrists who round on existing patients. Compensation is $108K/year without benefits. Position may be split between two qualified applicants who each agree to work two weekends per month. Please contact Robert Stern MD, chair, department of Psychiatry, 978-287-3512 or rstern@emersonhosp.org.

Berkshire Health Systems

Massachusetts. Consult-Liaison Psychiatrist Needed. Top notch colleagues.

Berkshire Medical Center's Department of Psychiatry and Behavioral Science provides you the opportunity to become part of a stable, highly integrated clinical collaboration among Psychiatry, Primary Care, and Medical Specialty Services. Our Health System has an excellent opportunity for a consultation-liaison Psychiatrist to work in a highly integrated clinical collaborative at the interface of Primary Care and Behavioral Health. A clinical background in geriatric psychiatry is preferred. Our psychiatry residency program allows you to contribute to the education of the next generation of mental health specialists. Berkshire Medical Center is nationally recognized by HealthGrades and many other independent organizations for outstanding care.

Please contact Antoinette Lentine in the Physician Recruitment Department at 413-395-7866 or e-mail at alentine@bhs1.org.

CENTRAL MASSACHUSETTS - Child and Adolescent Psychiatrist Positions

The University of Massachusetts Medical School (UMMS), Department of Psychiatry, is seeking child psychiatrists for the UMass Residential Treatment Programs located at Worcester State Hospital, serving adolescents ages 13-19 years. Length of stay of several months or more supports a milieu treatment program/team approach. Positions may be full or part-time (20 hours/ week). Candidates must be BC/BE in Child and Adolescent Psychiatry. Experience in teaching and training residents and medical students is desirable. Faculty appointment, teaching, and research opportunities available. Competitive salary and excellent benefits. Join a vital and growing academic division of Child Psychiatry.

Send letter of interest and C.V. to: Negar Beheshti, M.D., Assistant Director, Child & Adolescent Psychiatry, UMass Medical School, 55 Lake Avenue North, Worcester, MA 01655 or e-mail negar.beheshti@umassmemorial.org AA/EOE.

Intensive MH/Outpatient Psychiatrist

The ENRM VA Hospital in Bedford, MA is looking for a full-time outpatient Psychiatrist to join our Psychiatry staff. The Psychiatrist will treat patients in an intensive outpatient program as part of a multidisciplinary team, and in follow-up settings including clinics.

The ENRM VA Hospital has a full spectrum of Mental Health treatment programs as well as a large Primary Care population. Our philosophy emphasizes patient empowerment and optimization of function. Our strong academic affiliation is with Boston University School of Medicine, where a teaching appointment is encouraged. Our Psychiatry staff has low turnover and provides a welcoming collegial climate for learning and professional development. The setting is a beautiful suburban campus. Salary and benefits are competitive, and the VA is an Equal Opportunity Employer.

US citizenship and verification of licensures is required. Applications received by COB July 1, 2012 will have first consideration.

WORCESTER, The University of Massachusetts Medical School, Division of Public Sector Psychiatry is seeking a psychiatrist with a career interest in Public Sector Psychiatry for a position at Worcester Recovery Center and Hospital (WRCH). WRCH, a state-of-art inpatient and rehabilitation facility to open spring 2012, is a short walk from the Medical School so research and teaching opportunities are easy to accommodate and actively encouraged. Faculty appointment at appropriate rank, competitive salary and excellent benefits. Send letter of interest and C.V. to Jeffrey Geller, MD, MPH, Director, Public Sector Psychiatry, UMMS, 55 Lake Avenue North, Worcester, MA 01655, email Jeffrey.Geller@umassmed.edu, or fax 508-856-3270. UMMS is an affirmative action, equal opportunity employer.

CAMBRIDGE: Adult Psychiatry Weekend Moonlighting Psychiatrist

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

Cambridge Health Alliance is an Equal Employment Opportunity employer, and women and minority candidates are strongly encouraged to apply. CV & letter to Susan Lewis, Department of Psychiatry, 1493 Cambridge Street, Cambridge, MA; Fax: 617-665-1204. Email preferred: SLewis@challiance.org.

MICHIGAN

PSYCHIATRIST

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Pathways Community Mental Health in the Upper Peninsula (Michigan) is recruiting for an adult psychiatrist to provide services in our Escanaba (Delta County) Office. This position involves being the leader of a team of nurses, case managers and therapists. Applicant must possess a Medical degree and have completed residency in Psychiatry with a license to practice Medicine in the State of Michigan.

Competitive salary and benefit package includes 21 paid days off, 11 paid holidays, 5 paid CME days, malpractice coverage and paid expenses. There are no on-call obligations with this position. Equal opportunity employer.

Call Joseph Cools, M.D., Pathways Medical Director, at 906.225.7202 for further information or to set up a phone interview. Send CV to Dr. Cools at jcools@up-pathways.org.

Sparrow Hospital, located in Lansing, Michigan is seeking dynamic BC/BE Adult Psychiatrists. Two positions are available-adult inpatient and addictions medicine. Sparrow offers a competitive salary with production bonuses and an excellent benefit package. To learn more about these exciting opportunities, please contact Barb Hilborn at 1-800-968-3225 or e-mail barbara.hilborn@sparrow.org.

MINNESOTA

Opportunities for BC/BE Adult Psychiatrists with Sanford Health Fargo

Detroit Lakes: Great opportunity to live in the heart of Minnesota's lake country and have a rewarding outpatient practice in an integrated primary care setting. The Behavioral Health Department is staffed with four psychologists and one part-time psychiatrist. Opportunity exists to collaborate with the Fargo Behavioral Health Department. Detroit Lakes is a community of 8,600 located on the shores of Detroit Lake. Forty-five minutes away, the metropolitan community of Fargo-Moorhead will meet your more urban needs.

Thief River Falls: Excellent opportunity to be part of an established mental health program of 100 diverse & talented team members. Practice is primarily out-patient with no call. 10-bed inpatient unit, out-patient unit, residential treatment facility for mentally ill adults, mental health treatment cen-

CLASSIFIEDS

ter for children; 4-county outreach program for adults, adult work therapy program and community based services for children and families. The growing and economically diverse community of 9,000 is a regional health center to a mostly rural population of 75,000. Just an hour away is Grand Forks, North Dakota, a thriving community of 65,000.

When you join Sanford Health you are joining a leader in the health care industry in the Upper Midwest. Sanford Health, an integrated health system headquartered in Fargo, ND and Sioux Falls, SD, is the largest, rural, not-for profit health care system in the nation serving 112 communities in six states. It includes 34 hospitals, 116 clinic locations and more than 900 physicians in 70 specialty areas of medicine.

Both opportunities can accept J1 or H1B visa applicants. **Contact:** Jean Keller at (701) 280-4853 or jean.keller@sanfordhealth.org.

Consult Liaison Psychiatrist
Park Nicollet, Minneapolis, MN

Park Nicollet is in need of full or part time consultation-liaison psychiatrists. We provide psychiatric consultation to Methodist Hospital, the hospital owned by our group. We do not have inpatient psychiatric services, and consultation is to the medical floors and occasionally emergency department. We have a highly competitive and comprehensive compensation and benefits package including pension, paid malpractice, and yearly CME funds of $4000. Call is by pager only, and receives additional compensation.

Our integrated health care system, including Park Nicollet Clinic and Methodist Hospital, is recognized locally and nationally for great care and leadership. Share your expertise in an environment that supports new treatments and innovations while embracing a strong work-life balance. The Twin Cities offer a wonderful quality of life, with two immediately accessible major metropolitan areas as well as lakes, forests, bike paths, a rich tradition of arts and theater, and diverse restaurants. For immediate consideration, send or email CV to Jenny Bredeson-Clinician Recruitment, Park Nicollet Health Services, 3800 Park Nicollet Blvd, Minneapolis, MN 55416; jennifer.bredeson@parknicollet.com.

For more information contact Ms. Bredeson at (952) 993-2804 or apply online at www.parknicollet.com/clinicianrecruit. We are proud to be an EEO/AA employer M/F/D/V.

NEW JERSEY

Child and Adolescent Psychiatrist - Premier for profit outpatient mental health practice with offices in South Jersey and Philadelphia. Immediate opening for a board eligible Child and Adolescent Psychiatrist. Excellent referral base and reputation. Private practice model within comprehensive multi-disciplinary group of highly qualified clinicians which includes three other established Child and Adolescent Psychiatrists. Fax CV to 856-985-8148 or call 856-983-3866 ext. 3018.

CHILD & ADOLESCENT PSYCHIATRIST FREEHOLD OR CEDAR KNOLLS, NJ

Part-Time, 3PM-8PM, Monday-Thursday. Child/Adolescent Psychiatrist for either of our Cedar Knolls or Freehold, New Jersey locations, to join our private fee-for-service comprehensive child, adolescent and adult therapy Center. Candidate will be part of a multi-disciplinary team and will provide psychiatric evaluation, medication management and, if desired, psychotherapy, in a supportive collegial atmosphere. He/She will also clinically oversee treatment at the Center. Salary and benefit package are generous. Candidate must be board certified or board eligible in child/adolescent psychiatry. E-mail cv to abbazn@aol.com.

Stress Care of New Jersey, LLC a Community Mental Health Center in Matawan, NJ is seeking FT or PT Psychiatrists. Benefits available. Fax CV to (732) 679-4549 or email to Stressmg@optonline.net. To learn more about Stress Care, please visit our website, www.stresscareclinic.com.

NEW MEXICO

LAS CRUCES: Staff Psychiatrist - Psychiatric Hospitalist. Highly competitive salary, benefits & bonus opportunity. Reasonable call. Great support teams and program services. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

NEW YORK CITY & AREA

We are in the process of recruiting full time psychiatrists for a new Admissions Ward.

Manhattan Psychiatric Center serves as an integral resource for the psychiatric facilities in Manhattan, with innovative cognitive behavioral and psychoeducational modalities in addition to a neurocognitive remediation program. Qualifications are Board eligibility/certification, experience with rapid assessment, triage and psychopharmacological interventions for this population, together with skill in the multidisciplinary team approach.

Manhattan Psychiatric Center is an affiliate of NYU with opportunities for the teaching of residents and medical students. Weekly Grand Rounds and case conferences are an essential component of the training and education available at the facility.

Please FAX resume to Samuel J. Langer, MD; Chief of Psychiatry; 646-672-6386

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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ADULT PSYCHIATRIST HOSPITAL POSITIONS

F/T or P/T inpt positions avail. Treat inpts as a member of treatment team, as well as doconsultations, and emergency room coverage. Flexible weekday hours. Smithtown, NY, LI suburb of NYC. Infrequent weekend and evening coverage with compensatory time off. Competitive salary with benefits. Please fax resume to 631-265-6890 or email to nspc222@optonline.net.

Rockland Psychiatric Center, Orangeburg, NY Psychiatrists

Rockland Psychiatric Center, the largest NY State psychiatric hospital, is affiliated with New York University and located 18 miles north of Manhattan in the scenic lower Hudson Valley. We are looking for Psychiatrists for our outpatient and inpatient units, serving seriously mentally ill adults. RPC offers regular hours, optional on-call for extra pay, excellent benefits, including NYS retirement system. Weekly Grand Rounds, large medical staff, collegial atmosphere. With 400 inpatient beds and an extensive regional outpatient network, there are many opportunities for movement and advancement once on staff.

Send CV to Mary Barber, MD, Clinical Director, mary.barber@omh.ny.gov.

Columbia University College of Physicians and Surgeons Department of Psychiatry

F/T positions available in Consultation-Liaison Psychiatry. Instructor Level or above. Must be Board eligible in Psychiatry and have post-residency clinical fellowship in Psychosomatic Medicine. Assistant Professor requires Board certification in psychiatry, post-residency fellowship, board certification in Psychosomatic Medicine, and 2-3 years post residency clinical experience. Candidates with board certification in both Internal Medicine and Psychiatry will be considered. These are Faculty positions with full-time inpatient and outpatient activity working with the Internal Medicine Service. Applicants should have demonstrated ability to teach in the medical setting. Must have NYS license and DEA certificate. Equal Opportunity, Affirmative Action Employer.

Please apply:
academicjobs.columbia.edu/applicants/Central?quickFind=56320

Gouverneur Healthcare Services: Full Time Outpatient Psychiatrist (Spanish fluency preferred)

Gouverneur's Diagnostic & Treatment Center is operated by the New York City Health and Hospitals Corporation, located on the Lower Eastside in Manhattan. We are recruiting a board eligible or board certified psychiatrist to work in our outpatient mental health clinic. The psychiatrist will be responsible for medication management, consultations and some intake evaluations of adults. The psychiatrist will work as part of an interdisciplinary treatment team that includes psychologists, social workers and other psychiatrists. Approximately half of the patients on the caseload will be monolingual Spanish speakers. Please e-mail resume with a brief cover letter to David Nardacci, M.D. at nardaccd@nychhc.org or fax to 212-238-7399.

NEW YORK STATE

Mid-Hudson Valley

Ulster County Mental Health, an outpatient clinic with a wide range of services, has full time psychiatry positions open in the Kingston and Highland clinics. We are looking for recovery oriented board certified or board-eligible community psychiatrists to treat adult patients. Kingston is located in the beautiful Hudson Valley, two hours north of NYC. Competitive salary, good benefits, NYS retirement system, onsite psychopharmacology supervision and collegial atmosphere. No on-call or weekends. Ulster County is an equal opportunity employer. All civil service laws, rules and regulations apply. Send CV to JuLita Adamczak, MD, Medical Director, FAX #845-340-4094 or email: jada@co.ulster.ny.us. Telephone #845-340-4173. Ulster County Mental Health, 239 Golden Hill Lane, Kingston, NY 12401.

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.

MDs & NPs needed for Psychiatry Consultation services in Long Term Care Facilities (NH, SNF). Locations: Upstate NY & NYC Metro Area- **Priority Staten Island.** PT/FT Above average salaries/benefits, flexible hours. Please email CV to manager@medcarepc.com or via Fax: 718-239-0032 Tel:718-239-0030.

CLASSIFIEDS

St. Lawrence Psychiatric Center
Psychiatrists NYS Licensed or Limited Permit
(Limited Permit option - see below)**

Salary based on experience:
Earn up to an additional $74,000/year through a voluntary on-call program. Fringe Benefits equal to 50.96% of your salary. Monday - Friday, 8:00A - 4:30P

St. Lawrence Psychiatric Center is seeking Licensed Psychiatrists for Adult, Children/Youth, and Sex Offender Treatment Inpatient Services and for Adult and Children/Youth Outpatient Services.

- Student loan repayment may be available (Up to $60,000 for a 2-year FT commitment; up to $170,000 with a 5-year FT commitment, and possible total debt alleviation with 6 or more years of service)
- Excellent NYS Benefits to include medical/dental/vision insurance, paid vacation, holiday and sick time, an excellent retirement plan, and educational and professional leaves.
- Our location offers quality housing prices, mild traffic, a regional airport, Clarkson University, St. Lawrence University, and 2 SUNY colleges; 1 hr drive to Ottawa; 2 hr drive to Montreal, Lake Placid, and Syracuse
- **Limited Permit Option:** If you have finished your residency, but not the USLME, you may be appointed on limited permit, initially for 2 years, renewable for further 2 years

Applications are available by calling (315) 541-2179 or send resume to:
Personnel Office
St. Lawrence Psychiatric Center,
1 Chimney Point Drive, Ogdensburg, NY 13669-2291
or to Angela Grant at Angela.Grant@omh.ny.gov. SLPC is a fully accredited Joint Commission program/AA/EEOE/Self-indemnified Affiliated with SUNY Upstate Medical University

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Chautauqua County Department of Mental Hygiene
Adult and Child Psychiatrist

Chautauqua County Department of Mental Hygiene Services offers an exciting opportunity for a full-time Adult and a full-time Child Psychiatrist.

Chautauqua County Department of Mental Hygiene Services is an outpatient community based provider of mental health and addiction services. Chautauqua County is located in western NY, which is a recreational area with easy access to larger cities. We offer a competitive salary, an excellent benefit package, and J1 and H1 assistance.

CV/resume may be faxed to:
Attn: Sue Hawley @ (716) 753-4230 or submitted to Sue Hawley, hawleys@co.chauatuqua.ny.usor mail to: Chautauqua County Department of Mental Hygiene, Attn: Sue Hawley, 7 North Erie Street, Mayville, NY 14757.

NORTH CAROLINA

Psychiatrists - Addiction medicine, Locums tenens and/or permanent staff. Stat needs in beautiful Asheville, North Carolina. Full benefits and paid housing. Call Leo Blatz, R.N., M.S.N. @ 866-633-3700 or e-mail LBlatz@worldwidetravelstaffing.com All inquiries in strict confidence.

NORTH DAKOTA

Opportunity for BC/BE Psychiatrist with Sanford Health Fargo

Medical Director, In-Patient and Partial Hospitalization Programs. Join a team of inpatient hospitalists covering a 24-bed inpatient unit and a partial hospitalization unit with a 16-bed capacity. Sanford Behavioral Health Sciences department is staffed by more than 30 psychiatrists, clinical nurse specialists, doctorate-level psychologists and masters-level psychologists offering a continuum of care, from inpatient hospitalization, partial hospitalization programs to outpatient individual and group therapy including eating disorders at the highly regarded Eating Disorders Institute. Responsibilities include teaching psychiatry residents & medical students through the University of North Dakota School of Medicine. Fargo, ND is a metropolitan community of 190,000 located on the southeastern border of North Dakota just a few miles from the lake country of Minnesota. The community offers two universities, one private college, excellent schools, a wonderful blend of cultural and recreational activity, low crime, affordable and upscale living. To learn more about Sanford Health and our community visit **www.sanfordhealth.org** and **www.fmchamber.com**.

When you join Sanford Health you are joining a leader in the health care industry in the Upper Midwest. Sanford Health, an integrated health system headquartered in Fargo, ND and Sioux Falls, SD, is the largest, rural, not-for profit health care system in the nation serving 112 communities in six states. It includes 34 hospitals, 116 clinic locations and more than 900 physicians in 70 specialty areas of medicine.

Contact: Jean Keller at (701) 280-4853 or jean.keller@sanfordhealth.org.

OHIO

Wright State University Department of Psychiatry, Boonshoft School of Medicine, seeks an Assistant or Associate Professor to serve as Director of the Division of Community Psychiatry. The successful applicant will develop, coordinate, and evaluate teaching and training in community psychiatry within the graduate and undergraduate medical education programs. He or she will also hold the position of Chief Clinical Officer of the Montgomery County Alcohol, Drug Abuse and Mental Health Services Board (ADAMHS). Opportunity for private practice through the auspices of Wright State Physicians.

For additional position information and to apply go to: https://jobs.wright.edu. An AA/EO employer.

OKLAHOMA

Unique telepsychiatry opportunity for psychiatrists licensed in Oklahoma and/or adjacent states.

Access Psychiatry Solutions integrates behavioral health services in primary care settings and delivers specialty care by videoconferencing technology. No investment or financial risk, many quality-of-practice and quality-of-life benefits. We are seeking BC/BE child/adolescent AND general adult psychiatrists with experience in and commitment to primary care integration and/or rural health care. Please sent brief letter of interest and CV to info@accesspsych.com. All inquiries will be handled confidentially.

PENNSYLVANIA

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, Geriatric and Addictions psychiatrists**. We also seek psychiatric leadership to run our Pain Management and ECT services.

Psychiatric Hospitalist positions are also available. Excellent salaries and exceptional benefits package. Send CV to Kevin Caputo, MD, Chairman Department of Psychiatry, Crozer-Keystone Health System, One Medical Center Blvd., Upland, PA 19013 or call 610-874-5257.

The Department of Psychiatry at the University of Pennsylvania School of Medicine seeks candidates for several Assistant Professor positions in the non-tenure academic-clinician track. The successful applicant will have experience in the field of Psychiatry with a focus on Outpatient Adult Psychiatry. Responsibilities include establishment of diagnoses, and provision of direct ongoing care and services to psychiatric outpatients. Applicant will be responsible for teaching and supervising residents, medical students and other trainees. Applicants must have an M.D. degree and have demonstrated excellent qualifications in Clinical Care and Education. Board Certification/Board Eligibility in Psychiatry and PA medical license required.

Successful applicant will have completed a residency training program in Psychiatry at an ACGME accredited institution.

The University of Pennsylvania is an equal opportunity, affirmative action employer. Women and minority candidates are strongly encouraged to apply.

Apply for this position online at: http://www.med.upenn.edu/apps/faculty_ad/index.php/g332/d2372.

View the classifieds online at pn.psychiatryonline.org

PHILADELPHIA: Child Psychiatrist - Inpatient Staff and Medical Director Position.

CLARION - General or Child Psychiatrist - Inpatient/Partial Services. J1 eligible. Contact Will DeCuyper, In-house recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.

STATE COLLEGE: General or Child Psychiatrist - Inpatient or All Outpatient. Salary, benefits, bonus. Paid call. Contact: Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com.

THREE POSITIONS IN PSYCHIATRY
LEHIGH VALLEY HEALTH NETWORK

The Psychiatry Department at Lehigh Valley Health Network (LVHN) is expanding, and we are seeking three board certified/eligible psychiatrists for salaried positions with our well-established group of over 20 psychiatrists and mental health professionals. Our **ER/Inpatient Psychiatrist** will split time between doing psychiatric emergency evaluations and crisis stabilization and crisis follow-up care and back coverage on the inpatient unit. We have ERs in each of our three hospital campuses in the neighboring cities of Allentown and Bethlehem and utilize telemedicine to reduce travel time. Our **C/L Psychiatrist** will join a vibrant C/L service with six collegial psychiatrists and will split time doing consults in the hospital and seeing patients in the outpatient setting. Our C/L service does 330-370 consults/month. A strong interest in and comfort with medically ill patients is required, C/L fellowship is a plus.

Our **Child and Adolescent Psychiatrist** will join three well-trained psychiatrists who manage our inpatient adolescent unit, see patients in the office and also do consults. We have a children's ER, new pediatric residency and supportive network that fosters individual interests. At LVHN we have a great continuum of care in behavioral health from emergency evaluation to intensive care, partial hospital and outpatient follow-up, homecare and skilled nursing facility consultation. Our inpatient behavioral health unit is located at our Muhlenberg campus and has 65 beds, 13 of which are for adolescents. LVHN comprises 3 hospital campuses with 988 beds, and is a tertiary care facility with a Level I trauma center, regional burn center, Level III NICU and Level II PICU. We have a busy cancer center, large heart and vascular center, and transplant program. This fiscally sound, high performing health network has been ranked by **U.S. News and World Report** as one of the top hospitals for the past 16 years and is academically affiliated with the University of South Florida, where our physicians are eligible for academic appointments. We are located in eastern Pennsylvania's Lehigh Valley, an attractive suburban area with good schools, diverse cultural and recreational offerings, and a reasonable cost of living. We are only 1 hour north of Philadelphia and 1.5 hours west of New York City.

Interested physicians, please email a CV to Michael Kaufmann, MD, Chair of Psychiatry, c/o tammy.jamison@LVHN.org, or call (610) 969-0207 for more information.

CLASSIFIEDS

RHODE ISLAND

Rhode Island Hospital and The Miriam Hospital Affiliated Hospitals of the Warren Alpert Medical School of Brown University Positions in Psychiatry

Outpatient Psychiatrist(s): We are seeking candidates with a strong clinical focus with general, disorder specialty, or medical/psychiatry interests.

These positions are eligible to be considered for Faculty teaching appointments at Brown University. Scholarly and academic capabilities can be accommodated depending on the qualifications of the candidate. There are also opportunities for research participation.

Applicants must be Board Certified in Psychiatry or Board eligible (within three years of training completion). Salary and benefits are competitive and commensurate with level of training and experience. To learn more, visit www.lifespan.org. Please send CV's along with a letter of interest to Richard J. Goldberg, M.D., Psychiatrist-in-Chief, APC-9, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903 and/or email: rjgoldberg@lifespan.org.

SOUTH CAROLINA

AIKEN (Augusta GA area) Join an established private practice of 3 physicians and other therapists. Offering salaried employment with benefits and little call. **Predominantly Outpatient**. Contact: Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

TENNESSEE

Multiple board-certified/eligible psychiatrists needed for full time positions in a large Psychiatry Service at Mountain Home VA Medical Center in Johnson City, Tennessee. Primary responsibility will be managing outpatients with a variety of psychiatric disorders. One position will include some administrative responsibilities. Join staff of over 30 prescribers, including 20 psychiatrists at ETSU-affiliated residency training program with medical students, adult and med-psych residencies. Clinical appointment potential and some teaching expected. Research, telemedicine, and buprenorphine experience are all a plus. On-call is backup to residents and shared amongst staff psychiatrists. Recruitment incentive a possibility. Excellent Federal benefits package. NO STATE INCOME TAX, LOW COST OF LIVING, BEAUTIFUL MOUNTAINOUS REGION, LOTS OF PARKS, GOLF COURSES, LAKES, NATIONAL FOREST.

Inquiries: Joe Anderson, (423) 926-1171, ext 2476, or by email Joseph.Anderson@va.gov and George.Brown@va.gov. Applications and/or CVs to James H. Quillen VA Medical Center, P.O. 4000 (05), Mountain Home, TN 37684 or Fax (423) 979-3443 or Email mtnhomehrmservice@va.gov.

MEMPHIS and surrounding area - Child Psychiatrist for Inpatient services. Independent contractor or salaried employment option. Great support teams and program services. Will DeCuyper, In-house recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.

Professor and Chair of the Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine of East Tennessee State University

The Department of Psychiatry & Behavioral Sciences, James H. Quillen College of Medicine of East Tennessee State University is inviting applications and nominations for the position of Professor and Chair of the Department of Psychiatry & Behavioral Sciences. We seek a candidate who is board certified in psychiatry and has a proven record of clinical, academic, and administrative leadership. Major clinical activities are located at three community-based psychiatric care centers including Woodridge Hospital, a psychiatric facility and subsidiary of Mountain States Health Alliance, and Frontier Health one of the region?s largest providers of behavioral health, mental health and substance abuse services. As a Teague-Cranston school, the Quillen College of Medicine has a unique working relationship with the Veterans Affairs hospital, benefiting greatly from the synergistic relationship forged through research, service, and education. The chair should be a leader and visionary who will plan, manage and foster the enhancement of ongoing academic programs which include research, the teaching of medical students and an accredited residency in general adult psychiatry.

Salary is competitive with funding available through the Medical School, and the faculty private practice plan. The Quillen College of Medicine is a community-based medical school located in the beautiful mountains of northeast Tennessee. Quillen College of Medicine serves southern Appalachia and the healthcare needs of over one million people and is nestled in the Tri-Cities area on the bucolic grounds of the James H. Quillen VA Medical Center. The Tri-Cities area is rated the #1 place in North America in climate, health care and for having a low crime rate. No state income tax, low cost of living, beautiful mountainous region, lots of parks, golf courses, lakes and national forest.

Candidates should forward a letter of interest, curriculum vitae, and three references to the search committee chair, John P. Franko, M.D., via the university?s online application system (https://jobs.etsu.edu/). Review of applications will begin in March, 2012 and continue until the position is filled. Applications from women and minority candidates are encouraged.

East Tennessee State University is an equal opportunity /affirmative action employer.

VIRGINIA

NORFOLK, PORTSMOUTH and DANVILLE - Child Psychiatry - Residential Treatment setting. Fulltime or Part-time employed positions offering salary, benefits and more. Little call. Contact Will DeCuyper, In-house recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.

PSYCHIATRIST

Northern Virginia Mental Health Institute is a state psychiatric inpatient facility seeking a Psychiatrist to provide psychiatric evaluations and treatment of adults with mental disorders. Northern Virginia is an internationally diverse, family-friendly region that is situated only minutes away from Washington DC and all its cultural/historical attractions. It also boasts one of the finest public school systems in the country. Leadership of an interdisciplinary treatment team and liaison with fellow hospital disciplines is intrinsic to this role. Leadership of hospital committees to help further best hospital practices is also encouraged. Opportunities for faculty appointment at local area medical schools will be available to allow for supervision of psychiatric residents and medical students. Responsibilities include on-site commitment/detention evaluations as well as off-site forensic assessments for pre-trial, temporary custody and other commissioner requests as assigned. Training is provided for forensic work. Caseload will reflect a varied mix of acuity and complexity of psychiatric disorders in a culturally diverse, urban/suburban population. This is an excellent opportunity for a clinician to expand his/her clinical, administrative and leadership skills in a collegial, non-managed care environment that promotes quality, compassionate treatment and recovery-based practice.

Good interpersonal and clinical psychiatric skills; ability to work with other mental health specialties in a team model; knowledge of evidence-based practices desirable. Unrestricted medical licensure by the Virginia Board of Medicine is required. Board Certification preferred but board eligible accepted. Medical degree and completion of ACGME-approved residency training in Psychiatry is required. Post-residency practice and medical training experience desirable but not mandatory. A fingerprint-based criminal history check and pre-employment drug screening will be required for the selected candidate.

Call us to discuss our competitive salary. We also offer a state benefits package which includes health insurance, life insurance, malpractice insurance, a generous leave package and a retirement program along with other outstanding benefits. We can be reached at 703-645-3162 for more details. Please visit the Career Opportunities page on our website at www.nvmhi.dbhds.virginia.gov for more information. EOE.

Faculty Psychiatrist: F34250

Virginia Commonwealth University, Department of Psychiatry is recruiting BE/BC faculty psychiatrist at the Assistant Professor level, for mixed inpatient-outpatient position. Inpatient responsibilities include daily clinical and teaching rounds on acute inpatient and crisis teams, outpatient work including supervision of teaching psychiatry clinics, and faculty practice. Experience in similar setting preferred. Pursuit of scholarly work encouraged and supported. Demonstrated experience working in and fostering a diverse faculty, staff, and student environment or commitment to do so as a faculty member at VCU.

VCU is a large urban university with robust health science campus and 750 beds university hospital. Department of Psychiatry employs over 70 full time faculty and is nationally ranked in federally funded research. Richmond, the State Capital, has moderate climate and a rich mix of historical and contemporary facilities. Excellent suburban housing, public/private schools. See comparative cost of living via Internet at www.coli.org/. Send CV to Joel Silverman, MD, Chairman, c/o Tammy Newcomb, Human Resources, Department of Psychiatry, VCU/MCV, Box 980710, Richmond, VA 23298. Virginia Commonwealth University is an Equal Opportunity/Affirmative Action employer. Women, minorities, and persons with disabilities encouraged to apply.

WISCONSIN

Psychiatrists - Oshkosh, Wisconsin. Affinity Medical Group an integrated health care organization in East Central Wisconsin is recruiting BC/BE Adult Psychiatrists for our Oshkosh location. These opportunities will encompass the full scope of services that support the needs that a psychiatric patient may present. Benefit from an industry leading compensation and exceptional benefits package. The Oshkosh area offers a unique quality of family oriented living, all season recreation, a nationally acclaimed educational system, a diverse growing economy, and a host of cultural opportunities.

For information, contact Cookie Fielkow, Affinity Physician Recruitment; Phone: 800-722-9989; E-mail: cfielkow@affinityhealth.org; Fax: 920-727-4350. Visit our website at: www.affinityhealth.org. EOE. Not a J-1 opportunity.

Mayo Clinic Health System in Eau Claire, Wisconsin seeks two **BC/BE Adult Psychiatrists** for primarily outpatient positions. Call of 1:7. Outpatient unit attached to 20 bed inpatient unit. Inpatient unit is covered by daytime Psychiatric Hospitalists Monday through Friday. Mayo Clinic Health System is a family of clinics and hospitals serving over 70 communities in Iowa, Wisconsin and Minnesota. Eau Claire, metro area of 99,000, is home to the 11,400 students at the University of Wisconsin-Eau Claire. Located 90 minutes east of Minneapolis, Eau Claire is a family friendly community with the cost of living below the national average, a low crime rate and strong public schools. Contact Cyndi Edwards: 800-573-2580, fax 715-838-6192, or edwards.cyndi@mayo.edu . EOE

CLASSIFIEDS

Milwaukee or Kenosha - Outpatient mental health and AODA clinic seeks part-time psychiatrists to provide clinical services at our Milwaukee and/or Kenosha locations. Regular, scheduled hours. Number of hours per week flexible. Fax CV to 877-709-2725 or e-mail hr@irnw.net.

International

AUSTRALIA & NEW ZEALAND PSYCHIATRY JOBS

Gen. Adult - Child & Adoles. - Forensics
Locum Tenens or Permanent Jobs
Salaries of up to $350,000 per annum
www.IMRpsychiatry.com. 1-800-961-0342 (free call).

Fellowships

The Department of Psychiatry at UCSD (http://psychiatry.ucsd.edu/) is committed to academic excellence and diversity within the faculty, staff, and student body and is seeking faculty candidates with expertise in community and public psychiatry. The faculty appointed will provide leadership for a new Fellowship program in Community Psychiatry being initiated by the UCSD Department of Psychiatry in partnership with the Behavioral Health Division of the Health and Human Services Agency of San Diego County. This Fellowship program will be starting in July, 2012 and will ultimately have two Fellows in an Adult Fellowship, one Fellow in each of the two years of the Child Psychiatry Fellowship, and a Community Psychiatry Track within the residency. The primary focus of this Fellowship will be training psychiatrists for leadership roles in public psychiatry. Strong preference will be given to candidates with documented track record of peer-reviewed publications and research grants in services research or related fields and demonstrated commitment to excellence by providing leadership in teaching, research or service towards building an equitable and diverse scholarly environment.

Candidates with experience in one or more of the following areas are encouraged to apply: Health Services Research, integration of mental health and primary care, or cross cultural psychiatry. In addition, the Fellowship Director will have a role in training general psychiatry residents and medical students. The Fellowship Director position will be a full-time position, with minimal additional clinical duties. Candidates must have or be eligible for a California Medical licensure and be board-eligible or preferably board-certified. The candidate's academic rank and series will be determined by their individual academic qualifications and achievements.Salary is commensurate with qualifications and based on University of California pay scales.

Review of applications will begin April 30, 2012 and continue until the position is filled.

Candidates should submit a curriculum vitae and other supporting documents and a personal statement summarizing past or potential contributions to diversity (see http://facultyequity.ucsd.edu/Faculty-Applicant-C2D-Info.asp for further information) via our on-line submission website at https://apol-recruit.ucsd.edu Please select the following job opening: School of Medicine, Psychiatry [Asst./Assoc./Full Clinical/Adjunct/In Residence Professor] (10-392)

UCSD is an Affirmative Action/Equal Opportunity Employer with a strong institutional commitment to excellence through diversity.

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

Entering its 35th year, this ACGME-accredited fellowship on Psychosomatic Medicine is currently accepting applications for **three PGY-5 positions to start July 1, 2012**.

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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

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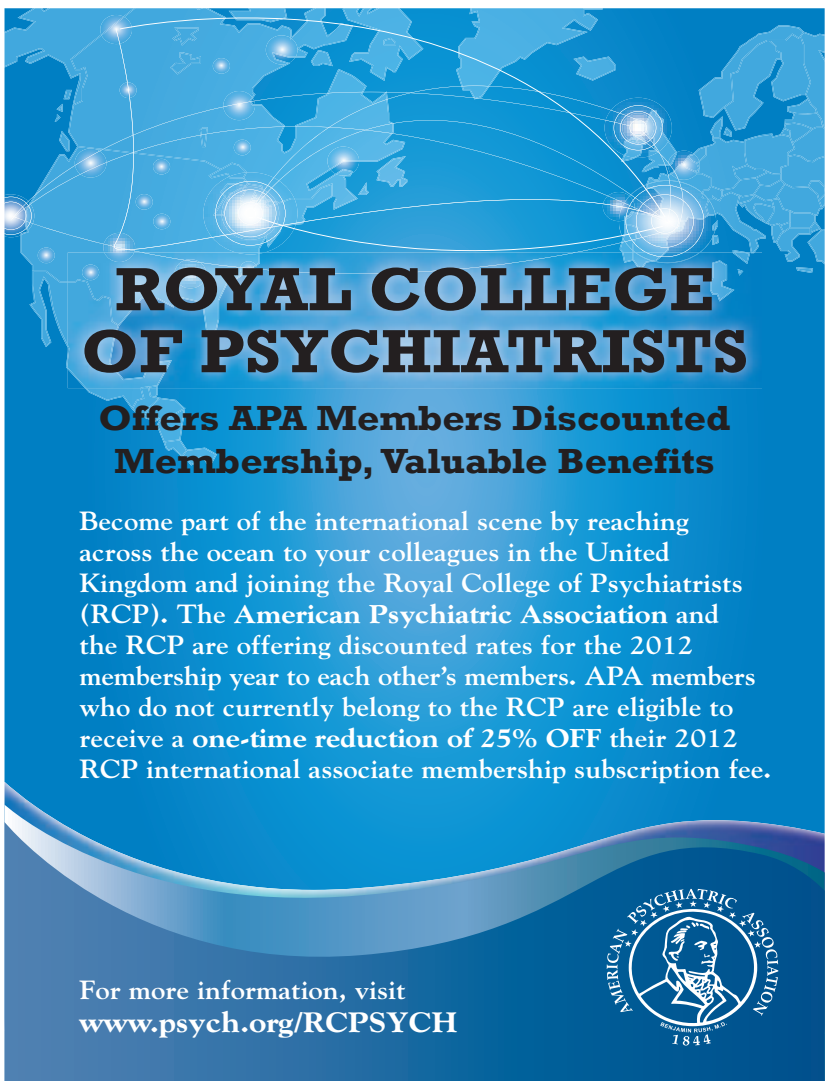
Nominations are requested as follows: (1) a primary nominating letter (sent with the consent of the candidate), which includes a curriculum vitae and specific details regarding the candidate's qualifications for the Award, and (2) a supplemental letter from a second nominator in support of the candidate. Additional letters related to any particular candidate will not be accepted or reviewed by the Award Committee. Nominators should not submit letters on behalf of more than one candidate. The deadline for receipt of nominations is July 1, 2012. Nominations will be kept in the pool of applicants for two years.

Nominations, as outlined above, should be submitted to:

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



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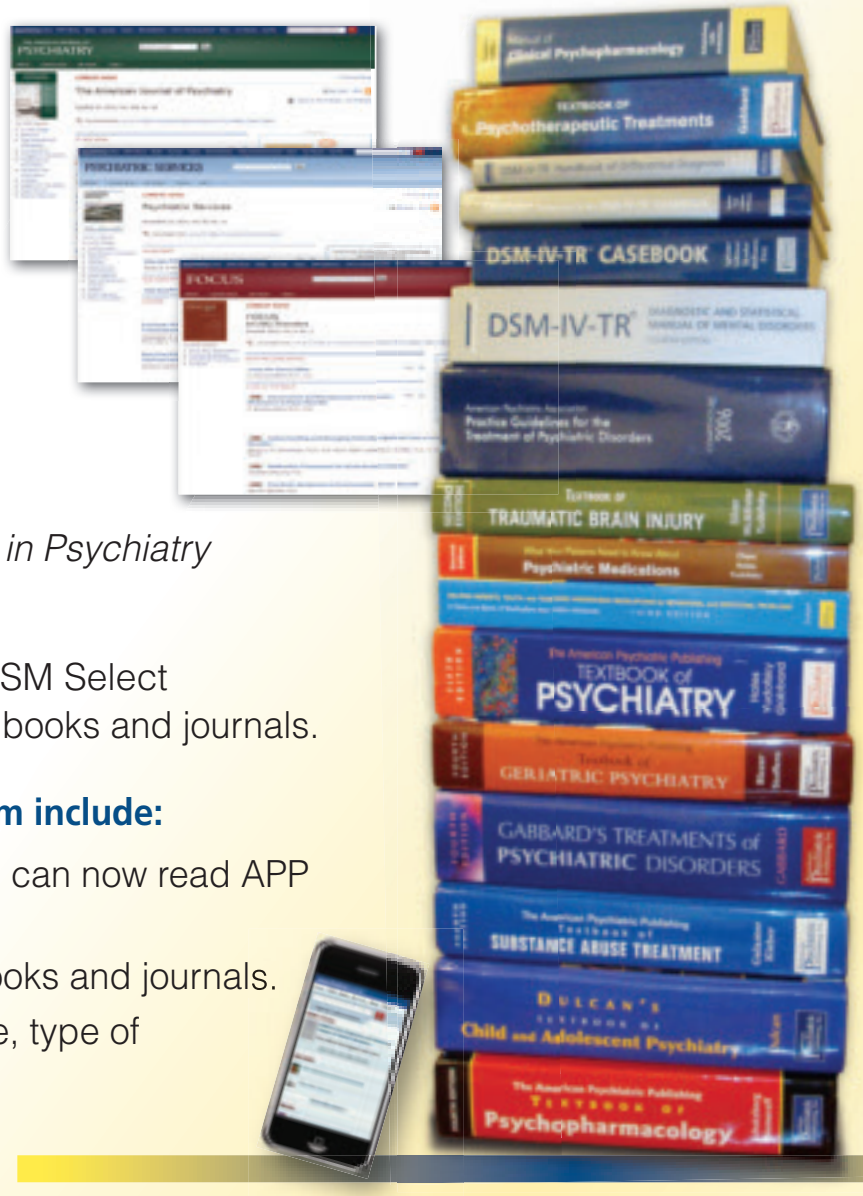

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